ACCREDITATION
AGRÉMENT
CANADA

Accreditation Report

Qmentum Global™ Program

Northern Health Authority

Report Issued: 26/11/2024

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About Accreditation Canada

Accreditation Canada (AC) is a global, not-for-profit organization with a vision of safer care and a healthier world. Together with our affiliate, Health Standards Organization (HSO), our people-centred programs and services have been setting the bar for quality across the health ecosystem for more than 60 years, and we continue to grow in our reach and impact. HSO develops standards, assessment programs and quality improvement solutions that have been adopted in over 12,000 locations across five continents. It is the only Standards Development Organization dedicated to health and social services. AC empowers and enables organizations to meet national and global standards with innovative programs that are customized to local needs. Our assessment programs and services support the delivery of safe, high-quality care across the health ecosystem.

About the Accreditation Report

The Organization identified in this Accreditation Report is participating in Accreditation Canada's Qmentum Global™ accreditation program.

As part of this ongoing process of quality improvement, the organization participated in continuous quality improvement activities and assessments, including an on-site survey from 09/06/2024 to 14/06/2024.

Information from the cycle assessments, as well as other data obtained from the Organization, was used to produce this Report. Accreditation Canada is reliant on the correctness and accuracy of the information provided by the Organization to plan and conduct the on-site assessment and produce this Report. It is the Organization's responsibility to promptly disclose any and all incidents to Accreditation Canada that could impact its accreditation decision for the Organization.

Confidentiality

Executive Summary

About the Organization

Northern Health is a regional Health Authority located in Northern British Columbia. It is the largest rural health region in the province. It serves a population of approximately 300,000 people across two-thirds of British Columbia's land mass. Seventeen percent of the population is Indigenous. There are 55 First Nations Communities, 9 Tribal Councils, 17 distinct linguistic groups, and 11 Metis Nation of BC Charter Communities.

Services provided by Northern Health include acute, primary and community care, mental health and substance use specialized services, long term care, and population and public health. The region has 18 hospitals, 25 long-term care homes, 9 diagnostics and treatment facilities, and community health services in 27 communities.

Northern Health has a strong focus on partnerships and has set as its mission “in partnership with communities, organizations, and Indigenous peoples, we provide exceptional health services for Northerners.”

This survey is the second sequence for Northern Health and concentrates on acute care services. Eleven sites were visited including: University Hospital of Northern BC (UHNBC), Prince George Surgery Centre, G.R. Baker Memorial Hospital in Quesnel, Prince Rupert Regional Hospital in Prince Rupert, Mills Memorial Hospital in Terrace, Kitimat General Hospital and Health Centre in Kitimat, Mackenzie and District Hospital and Health Centre in Mackenzie, Dawson Creek and District Hospital in Dawson Creek, Bulkley Valley District Hospital in Smithers, Lakes District Hospital and Health Centre in Burns Lake, and Fort Nelson General Hospital in Fort Nelson.

A key goal identified by the organization for this survey is the opportunity to evaluate the existence of a consistent approach to required organizational practices, in particular, compliance with identified actions for suicide risk assessment, information transfer at care transitions, and medication reconciliation.

Surveyor Overview of Team Observations

Northern Health is governed by a ten-member Board with representation from throughout the geographic region. The Board set a strategic plan last year with five key priorities including: healthy people, healthy communities; coordinated accessible services; quality and a commitment to being a learning organization; supporting their staff and physicians; and continuing to advance technology and infrastructure to support safe, high-quality care.

Northern Health is divided into four health service delivery areas (HSDA); the Northeast, the Northwest, the Northern Interior Rural, and Prince George. Each HSDA is led by a senior operating officer who is responsible for the operations of the HSDA. Health service administrators in each HSDA are responsible and accountable for the day-to-day operations. The HSDAs develop annual operational plans, in keeping with the overall strategic plan, which is specific to the services and context within the region. Care has been taken to identify specific needs for each site, in particular for very rural sites, as these vary across the region.

Northern Health has identified 11 service networks including: child and youth, chronic disease, critical care, elder, mental health, emergency trauma and transfer, mental health and substance use, perinatal, primary and community care, rehabilitation, and surgical. These service networks are in varying degrees of development and Northern Health is encouraged to support continued efforts to expand their role and influence supporting care in the specific clinical area. There is a medical co-leadership model for each network, and all have developed annual priorities in keeping with the overall strategic directions of Northern Health. The priority for 2024 is the enhancement of cultural safety by incorporating Indigenous perspectives throughout network activities. In addition, Northern Health has a number of other regional programs that are in support of safe, quality care, such as Pharmacy, BioMed and Infection Prevention Control.

A key clinical focus for Northern Health is reducing the wait times for surgical procedures and much work has been done to prioritize and expand services to meet this objective. Another key area of work is the implementation of an electronic health record in acute inpatient and emergency department settings. There is work underway to move towards documentation with the acute care information system, the organization is encouraged to move forward with this as quickly as possible to increase efficiency and reduce the risk of paper and hybrid documentation. Work has been done to strengthen primary care across the region, which has been beneficial in some areas while there is a need for continued efforts to provide primary care to very rural and remote areas.

Northern Health is commended for its continued efforts to ensure patient safety and quality care in spite of the very rural and remote nature of the area and the ever-growing number of natural disasters, including a very recent forest fire in Fort Nelson causing the community and hospital to be evacuated. There is a constant effort to prepare and respond to disasters and climate change as it is understood that it is not if but when the next will occur.

As with many healthcare organizations across the country, Northern Health has, and continues to experience a health human resources shortage. The staffing challenges are exacerbated by the geography of the region and, at this time, 20 per cent of baseline positions across Northern Health are unfilled. This has led to service disruptions in acute programs and emergency departments, as well as a high use of agency staff. A number of recruitment strategies have been implemented and in particular, a strong focus on growing and supporting their own staff and team members. Northern Health is commended for the work that has been done to provide experiences for students of various disciplines and to bring in house the critical care nursing course which has been well received and will better prepare nurses to work in the emergency department and critical care areas. Retention of staff and physicians is also a key focus of Northern Health and the stay interviews that have been implemented are but one of the methods that is in place.

In addition to staff shortages, the toxic drug crisis has created additional stress on teams. The incidence of death due to drug misuse and overdose is higher in the north than elsewhere in the province.

Another significant issue across Northern Health is the large percentage of alternate level of care (ALC) patients in acute care beds with a rate that is much higher than in the rest of the province. Northern Health has developed a multi-pronged strategy to address the high number of ALC patients, including the introduction of sub-acute beds to try to avoid the transfer to ALC, the introduction of transition beds to support longer term rehabilitation, and additional long term care beds are planned. Northern Health is encouraged to move forward with these initiatives as quickly as possible to reduce the overcrowding and hallway admissions within acute care.

Northern Health has a very strong focus on partnerships including those with other geographic Health Authorities, the First Nations Health Authority, the Provincial Health Services Authority, academic partnerships, philanthropy partnerships, and the Office of Health and Resource Development, which is a central contact point for industry in the area. All of these partnerships have been engaged and kept informed of the various capital redevelopment projects that Northern Health is very pleased to have underway.

Patients and families spoken with throughout the survey were very grateful for the access to care close to home. Provincial satisfaction surveys are conducted every two years, and the last results indicate a good degree of overall patient satisfaction. A number of other programs across Northern Health are conducting patient experience surveys relative to their services. It is suggested that Northern Health look at the potential of a standardize tool that can be used by various services to address more timely feedback from patients and families. Provincial patient experience surveys are conducted regularly by the BC Patient Centred Measurement (PCM) Steering Committee. The BC PCM group is currently piloted a standardized \"core\" tool that can be used by various services to address continuous feedback from clients and families.

Key Opportunities and Areas of Excellence

Areas of Excellence

The commitment of the team to patients, families, and their communities was felt strongly across Northern Health. The organization has identified and put in place new and emerging leaders who are enthusiastic and energized to implement change and support safe, high-quality care. Northern Health, like many health care organizations, has a major health human resources challenge and the organization is recognized for the innovative recruitment efforts that have been introduced, as well as the various staffing models that have been implemented.

Mental health and substance use concerns are on the rise in many communities and Northern Health has responded to this need by implementing enhancements to the mental health and substance use program. The implementation of relational security has created a new sense of support and protection across the organization particularly in times of potential violence.

The population served by Northern Health is very appreciative of all the efforts that have been taken to support treatment and care close to home, whether that is cancer treatment, obstetrical care, or support from the critical care outreach team. Northern Health has established strong community connections across the many rural and remote communities served.

Key Opportunities

Unplanned and often sudden service interruptions, such as closures of the Emergency Department or the inability to provide obstetrical care, are occurring in sites across Northern Health due to health human resource challenges. There is an opportunity to optimize all available resources by adjusting allocation to certain areas, potentially mitigating service disruptions. This includes providing support for rural and remote sites by understanding their specific needs, building capacity in quality improvement through support and resources to continue to advance the implementation of a standardized quality improvement program across all areas of Northern Health, and continuing to address aging infrastructure to enhance safety and efficiency.

It is essential to advance progress on electronic health records to reduce risks associated with hybrid and/or paper documentation, and it is crucial to build upon the current engagement of patients and families in their care, ensuring their voices are included in service planning, design, and decision-making processes.

People-Centred Care

Northern Health has established a culture of building and fostering relationships and partnerships. This is most evident in the work that has been done to recognize and engage the Indigenous communities served. Indigenous advisory groups were noted at a number of sites as was the outcome of their involvement such as murals and Indigenous art throughout hallways and in quiet rooms, smudging areas, and signage translated into the most commonly used Indigenous language in the area. The partnership with the First Nations Indigenous Authority and the Indigenous care coordinator or liaison role has elevated the involvement of the community in a major way and helps to create a safe and welcoming environment. It is suggested that the Indigenous coordinator role be included in many more communities across Northern Health.

Consistent provision of person-centred care (PCC) is also at the core of the organization's quality framework and the engagement of patients and families in their care was witnessed across the region. There is a true sense of caring about the people they serve.

However, there is further opportunity to engage patients and families in organization planning and decision making, both at the leadership level and at the program and service level. The organization has planned for some time to incorporate a leadership position to reinvigorate the person-centred care work and to establish an Engagement Advisory Council. These plans have not materialized due to competing priorities and Northern Health is encouraged to move forward with these key enablers to support greater client and family engagement. The organization is also encouraged to take the opportunity of the development projects currently underway or planned, to involve patients and families in actual co-design of the physical spaces.

Certainly, at the site level there is a need and interest to further engage patients and their families in the planning and review of service delivery. Northern Health is encouraged to provide support and resources to sites to build the necessary structures and processes through which the voice of patients and families will be heard and impact the care in their communities.

Quality Improvement Overview

There is a strong focus across Northern Health on the provision of safe, quality care to the population served. Staff and physicians continually work to provide high-quality, safe care for clients and families in the day-to-day operations. In many communities, care providers know the patients and their families they are caring for and there is a true sense of commitment to their communities.

Northern Health has developed a quality framework and has available the Indigenous Health, Planning, and Quality team to assist in identifying, implementing, and evaluating quality initiatives across the region. Corporately several foundational steps of quality improvement approach have been identified, including the use of the PDSA cycle and the integration of Lean process improvement principles.

Although this infrastructure is in place, there was little evidence at the individual sites of quality improvement programs or the infrastructure to support these types of programs. There are several examples of the use of continuous improvement boards to engage staff in identifying and working through ideas to improve quality, safety, and patient experience. As well, surveyors were made aware of several change projects completed in specific areas in which staff and physicians were engaged.

However, there was little evidence of formal QI projects with indicators, goals, timelines, measurement tools and no evidence of patient and family engagement in QI. Few public-facing quality boards were witnessed and those which were evident had only one or two indicators posted such as hand hygiene and surgical site infections. There were pockets of effective use of patient white boards and the use of MORE OB in obstetrics as platforms to support education, good practice, and quality improvement.

There is a need to continue to spread the Daily Management approach and tools at all sites across Northern Health. It is also suggested that a more fulsome team be engaged in the quality improvement program to include the support services in this work. It was felt that there is a true willingness and interest to move quality improvement further, however there is a need for support to make this happen.

Program Overview

The Qmentum Global™ program was derived from an intensive cross-country co-design process, involving over 700 healthcare and social services providers, patients and family members, policy makers, surveyors, clinical, subject matters experts, Health Standards Organization and Accreditation Canada. The program is an embodiment of People Powered Health™ that guides and supports the organization's continuous quality improvement journey to deliver safe, high-quality, and reliable care.

Key features of this program include new and revised evidence based, and outcomes focused assessment standards, which form the foundation of the organization's quality improvement journey; new assessment methods, and a new digital platform OnboardQi to support the organization's assessment activities.

The organization will action the new Qmentum Global™ program through the four-year accreditation cycle the organization is familiar with. As a driver for continuous quality improvement, the action planning feature has been introduced to support the identification and actioning of areas for improvement, from Steps 2. to 6., of the cycle.

To promote alignment with our standards, assessments results have been organized by core and specific service standards within this report. Additional report contents include, the comprehensive executive summary, the organization's accreditation decision, locations assessed during the on-site assessment, required organizational practices results and conclusively a Quality Improvement Overview.

Accreditation Decision

Northern Health Authority's accreditation decision remains:

Accredited

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

Locations Assessed in Accreditation Cycle

This organization has 102 locations.

The following table provides a summary of locations[1] assessed during the organization's on-site assessment.

Table 1: Locations Assessed During On-Site Assessment

Site	On-Site
Acropolis Manor	☐
Alward Place	☐
Aspen 1	☐
Aspen 2	☐
Atlin Health Centre and Primary Care Clinic	☐
Birchwood Place Adult Mental Health	☐
Brunswick Building-Pr. Geo. (IT, HIMS, etc.)	☑
Bulkley Lodge	☐
Bulkley Valley District Hospital	☑
Burns Lake Primary Care Clinic	☐

Site	On-Site
Centre for Healthy Living	☐
Chetwynd General Hospital and Health Centre	☐
Chetwynd Primary Care Clinic	☐
Davis House	☐
Dawson Creek and District Hospital	☑
Dawson Creek Health Unit	☐
Delta King Place	☐
Dunrovin Park Lodge	☐
Duplex Cottage	☐
Fort Nelson General Hospital	☑
Fort Nelson Health Unit	☐
Fort St James Health Centre	☐
Fort St. James Medical Clinic	☐
Fort St. John Health Unit	☐
Fort St. John Hospital	☐
Fort St. John Medical Clinic	☐
Fort St. John Mental Health and Addictions	☐
Fort St. John Prenatal Clinic	☐
Fraser Lake Community Health Centre	☐

Site	On-Site
G.R. Baker Memorial Hospital	☑
Gateway Lodge and Assisted Living	☐
Granisle Health Centre and Medical Clinic	☐
Haida Gwaii Hospital and Health Centre - Xaayda Gwaay Ngaaysdll Naay	☐
Hazelton Community Health	☐
Highland Community Centre	☐
HIV/AIDS Prevention Program (Needle Exchange)	☐
Houston Health Centre and Primary Care Clinic	☐
Hudson's Hope Health Centre & PCC	☐
ICM/ACT/Car 60 Teams - Prof. Bldg - Prince George	☐
Iris House - Prince George	☐
Jubilee Lodge	☐
Kitimat General Hospital & Health Centre	☑
Lakes District Hospital and Health Centre	☑
Laurier Manor	☐
Legion Wing - Seniors Housing, Prince George	☐
Mackenzie and District Hospital and Health Centre	☑
Mackenzie Family Health Clinic	☐
McBride and District Hospital and Health Centre	☐

Site	On-Site
McBride Medical Clinic	☐
McConnell Estates	☐
Mills Memorial Hospital	☑
Mountainview Lodge Care Facility	☐
Native Friendship Centre Prince George	☐
Nechako Centre - Prince George	☐
Northeast Corporate Office	☐
Northern Haida Gwaii Hospital and Health Clinic - Masset	☐
Northern Health Authority Corporate Office	☐
Northern Health Interior - Community Acute Stabilization Team	☐
Northern Interior Corporate Office	☐
Northern Interior Health Unit - Prince George	☐
Northwest Corporate Office	☐
Park Avenue Medical	☐
Parkside Care Facility	☐
Parkwood Mall	☐
Peace Villa Residential Care	☐
Port Clements Medical Clinic	☐
Prince George Family Resource Centre	☐

Site	On-Site
Prince Rupert Community Health Centre	☐
Prince Rupert Regional Hospital	☑
Quesnel (Eileen Ramsey) Health Centre	☐
Quesnel Community Health Services	☐
Quesnel Mental Health/QUESST Unit	☐
Quesnel Primary Care Clinic	☐
Quesnel Urgent and Primary Care Clinic	☐
Rainbow Care Facility - Pr. George	☐
Regional Cancer Care	☐
Rotary Manor	☐
SCAN Clinic	☐
Seven Sisters Centre - Terrace	☐
Sleeping Beauty Medical Clinic	☐
Smithers Community Health Centre	☐
Southside Health and Wellness Centre	☐
Spruceland Seniors Housing	☐
St. John Hospital	☐
Stewart Health Centre and Primary Care Clinic	☐
Stikine Health Centre and Primary Care Clinic	☐

Site	On-Site
Stuart Lake Hospital	☐
Stuart Nechako Manor	☐
Summit Residences	☐
Surgery Centre	☑
Terrace (Skeena) Health Unit	☐
Terraceview Lodge	☐
The Pines Care Home	☐
Tumbler Ridge Health Centre	☐
University Hospital of Northern British Columbia	☑
Urgent Primary and Community Care	☐
Urquhart House - Prince George	☐
Valemount Health Centre	☐
Vanderhoof Health Centre	☐
Victoria Medical	☐
Westside (Grace Young Wellness Centre)	☐
Wrinch Memorial Hospital	☐

[1]Location sampling was applied to multi-site single-service and multi-location multi-service organizations.

Required Organizational Practices

ROPs contain multiple criteria, which are called Tests for Compliance (TFC). ADC guidelines require 75% and above of ROP's TFC to be met.

Table 2: Summary of the Organization's ROPs

ROP Name	Standard(s)	# TFC Rating Met	% TFC Met
Medication Reconciliation at Care Transitions Acute Care Services (Inpatient)	Cancer Care	4 / 4	100.0%
	Critical Care Services	4 / 4	100.0%
	Inpatient Services	4 / 4	100.0%
	Mental Health Services	4 / 4	100.0%
	Obstetrics Services	4 / 4	100.0%
	Perioperative Services and Invasive Procedures	4 / 4	100.0%
Medication Reconciliation at Care Transitions - Ambulatory Care Services	Cancer Care	5 / 5	100.0%

Table 2: Summary of the Organization's ROPs

ROP Name	Standard(s)	# TFC Rating Met	% TFC Met
Falls Prevention and Injury Reduction - Inpatient Services	Cancer Care	3 / 3	100.0%
	Critical Care Services	3 / 3	100.0%
	Inpatient Services	3 / 3	100.0%
	Mental Health Services	3 / 3	100.0%
	Obstetrics Services	3 / 3	100.0%
	Perioperative Services and Invasive Procedures	3 / 3	100.0%
Client Identification	Cancer Care	1 / 1	100.0%
	Critical Care Services	1 / 1	100.0%
	Emergency Department	1 / 1	100.0%
	Inpatient Services	1 / 1	100.0%
	Mental Health Services	1 / 1	100.0%
	Obstetrics Services	1 / 1	100.0%
	Perioperative Services and Invasive Procedures	1 / 1	100.0%

Table 2: Summary of the Organization's ROPs

ROP Name	Standard(s)	# TFC Rating Met	% TFC Met
Information Transfer at Care Transitions	Cancer Care	5 / 5	100.0%
	Critical Care Services	5 / 5	100.0%
	Emergency Department	4 / 5	80.0%
	Inpatient Services	5 / 5	100.0%
	Mental Health Services	5 / 5	100.0%
	Obstetrics Services	5 / 5	100.0%
	Perioperative Services and Invasive Procedures	5 / 5	100.0%
Pressure Ulcer Prevention	Critical Care Services	5 / 5	100.0%
	Inpatient Services	5 / 5	100.0%
	Perioperative Services and Invasive Procedures	5 / 5	100.0%
Venous Thromboembolism (VTE) Prophylaxis	Critical Care Services	5 / 5	100.0%
	Inpatient Services	5 / 5	100.0%
	Perioperative Services and Invasive Procedures	5 / 5	100.0%
Medication Reconciliation at Care Transitions - Emergency Department	Emergency Department	1 / 1	100.0%

Table 2: Summary of the Organization's ROPs

ROP Name	Standard(s)	# TFC Rating Met	% TFC Met
Suicide Prevention	Emergency Department	5 / 5	100.0%
	Mental Health Services	5 / 5	100.0%
Hand-hygiene Education and Training	Infection Prevention and Control	1 / 1	100.0%
Hand-hygiene Compliance	Infection Prevention and Control	0 / 3	0.0%
Reprocessing	Infection Prevention and Control	2 / 2	100.0%
Infection Rates	Infection Prevention and Control	3 / 3	100.0%
Antimicrobial Stewardship	Medication Management	5 / 5	100.0%
High-alert Medications	Medication Management	8 / 8	100.0%
Heparin Safety	Medication Management	4 / 4	100.0%
Narcotics Safety	Medication Management	3 / 3	100.0%
Concentrated Electrolytes	Medication Management	3 / 3	100.0%
The 'Do Not Use' List of Abbreviations	Medication Management	7 / 7	100.0%
Safe Surgery Checklist	Obstetrics Services	5 / 5	100.0%
	Perioperative Services and Invasive Procedures	5 / 5	100.0%

Table 2: Summary of the Organization's ROPs

ROP Name	Standard(s)	# TFC Rating Met	% TFC Met
Infusion Pump Safety	Service Excellence for Cancer Care	6 / 6	100.0%
	Service Excellence for Critical Care Services	6 / 6	100.0%
	Service Excellence for Emergency Department	6 / 6	100.0%
	Service Excellence for Inpatient Services	6 / 6	100.0%
	Service Excellence for Mental Health Services	6 / 6	100.0%
	Service Excellence for Obstetrics	6 / 6	100.0%
	Service Excellence for Perioperative Services and Invasive Procedures	6 / 6	100.0%

Assessment Results by Standard

Core Standards

The Qmentum Global™ program has a set of core assessment standards that are foundational to the program and are required for the organization undergoing accreditation. The core assessment standards are critical given the foundational functions they cover in achieving safe and quality care and services. The core standards are always part of the assessment, except in specific circumstances where they are not applicable.

Infection Prevention and Control

Standard Rating: 88.6% Met Criteria

11.4% of criteria were unmet. For further details please review the following table.

Assessment Results

The Northern Health Infection Prevention and Control (IPC) program is led by an infectious disease physician, a director, and a manager. Northern Health Infection Prevention Council is the overall regional body which provides consultative infection prevention control and medical device reprocessing expertise to acute care, long term care, and community-based programs and monitors overall performance related to key indicators. An annual Infection Prevention and Control Report is developed and shared with the Board, internally, and externally with the community.

To support infection prevention and control measures more locally, Infection Prevention and Control (IPAC) committees have been established in each of the health service delivery areas (HSDAs) across Northern Health. These IPAC committees are interdisciplinary, and report to the NH Infection Prevention Council, NH Medical Advisory Committee and the Senior Executive Team.

Northern Health is commended for recently increasing the IPAC resources in the region. There are 14 infection control practitioners (ICP) across the Health Authority with the larger hospital sites supported by an on-site ICP while the smaller, more remote sites have a practitioner assigned who provides periodic on-site visits but is available virtually on an as-needed basis. However, it was noted that there are smaller sites that do not have ready access virtually and may go many months without an on-site visit. Northern Health is encouraged to ensure that all sites have on-site support on a regular basis.

The ICPs focus on building relationships with the staff by being visible in the patient care areas and being in contact with staff. The teams across the sites conduct frequent unit safety walkabouts, participate in occupational health rounds and provide just in time education to staff. It is suggested that if safety huddles are held in the clinical areas, the ICP attend and provide quick timely IPAC updates.

The IPAC committees work collaboratively with a number of departments and teams across the areas including environmental services, food preparations, maintenance - in particular for any renovations, and the Joint Occupation and Health Safety committee. There is also engagement of IPAC staff in acquisition of equipment and medical devices. It is suggested that the relationship between IPAC and, in particular, laundry and food services departments be strengthened at the UHNBC site with IPAC providing regular review of processes occurring within these departments. As well it may be of benefit at UHNBC to have an in-house infection control committee to bring together these various departments on a regular basis to discuss ongoing methods to improve infection prevention and control.

The Infection Prevention and Control teams also work closely with BC Public Health and local Public Health departments for communicable disease surveillance and reporting.

Sites across Northern Health carry out surveillance on several quality and patient safety indicators including hospital acquired infections (HAI), hand hygiene, and surgical site infection rates. Hand hygiene audits are conducted regularly at most sites and the results are posted for staff, patients and families to see. Most of the sites are achieving a rate of over 85 per cent compliance with hand hygiene. There are several sites where hand hygiene audits are not occurring, primarily due to workload and resources. It is suggested that this be reviewed, and efforts be made to support hand hygiene audits at all sites.

There are processes in place to support the regular cleaning of patient equipment. Anti-microbial cleaning products are used on equipment such as infusion pumps and other patient use equipment. As well a green “I am clean” sticker is used to identify that the equipment has been cleaned.

The majority of sites visited have good access to alcohol rub hand sanitizer and at some sites there are hand washing sinks with motion sensors positioned in a number of places in the corridor of patient care areas (seen in UHNBC). The new builds will see hand washing sinks in each client room. Northern Health is encouraged to ensure that information on proper hand washing techniques is posted consistently across the organization.

The program is commended for work that was done to implement quality assessments in both acute and long-term care centres in 2022/2023 and the actions that have been taken since to address the majority of the critical, high, and moderate issues which were identified. Some risks were related to the environment, storage needs and the design of the facilities. Not all of these have been able to be fully addressed at some sites and the organization is encouraged to continue to work at these. For example, it is encouraged that the lack of storage space at the UHNBC site be addressed to reduce the clutter in hallways and increase cleanliness. As well, the removal of hoppers and the potential for doors to be placed on the clean and dirty utility rooms are encouraged at UHNBC. It is recommended that all sites review the presence of cardboard boxes in areas where food supplies or other supplies are stored and consider replacing the cardboard with plastic bins which can be readily cleaned and reduce the risk of harbouring bacteria. There are plans to continue these quality IPAC assessments on a regular basis and the organization is encouraged to ensure that this work does continue.

There is a very comprehensive outbreak management protocol with distinct criteria and processes that has been revised since the pandemic. Staff are aware of the protocol and where to locate reference material.

There are further opportunities to engage patients and families in the work of infection prevention and control. At this time there was little evidence that patients and families had been engaged in planning or evaluating any elements of the infection prevention and control program. Prior to the pandemic, patients and families were provided with information on how to support their health and safety while in hospital including the importance of hand hygiene. It was unclear whether information is still being provided to patients and families however the organization is encouraged to ensure that this type of information is made available to all patients and visitors.

Table 3: Unmet Criteria for Infection Prevention and Control

Criteria Number	Criteria Text	Criteria Type
2.2.2	Team members, clients and families, and volunteers are engaged when developing the multi-faceted approach for infection prevention and control .	NORMAL
2.4.6	There are policies and procedures for disposing of sharps at the point of use in appropriate puncture-, spill-, and tamper-resistant sharps containers.	HIGH
2.5.5	Reminders are posted about the proper techniques for hand-washing and using alcohol-based hand rubs.	NORMAL
2.5.6	Hand-hygiene Compliance 2.5.6.1 Compliance with accepted hand-hygiene practices is measured using direct observation (audit). For organizations that provide services in clients' homes, a combination of two or more alternative methods may be used, for example: • Team members recording their own compliance with accepted hand-hygiene practices (self-audit). • Measuring product use. • Questions on client satisfaction surveys that ask about team members' hand-hygiene compliance. • Measuring the quality of hand-hygiene techniques (e.g., through the use of ultraviolet gels or lotions). 2.5.6.2 Hand-hygiene compliance results are shared with team members and volunteers. 2.5.6.3 Hand-hygiene compliance results are used to make improvements to hand-hygiene practices.	ROP
2.6.5	Compliance with policies and procedures for cleaning and disinfecting the physical environment is regularly evaluated, with input from clients and families, and improvements are made as needed.	NORMAL

Criteria Number	Criteria Text	Criteria Type
2.7.13	Items that require cleaning, disinfection, and/or sterilization are safely contained and transported to the appropriate area(s).	HIGH

Medication Management

Standard Rating: 93.5% Met Criteria

6.5% of criteria were unmet. For further details please review the following table.

Assessment Results

Leadership for the medication management program across Northern Health includes the regional director, medication safety officer, director of operations, professional practice lead and medical coordinator for the Antibiotic Stewardship Program. The program's central Medication Safety and Quality Committee, which reports to the Northern Health (NH) executive and liaises with the provincial Pharmacy and Therapeutics Committee. The Medication Safety and Quality Committee is the decision-making body for NH for formulary, order sets, exceptions to high concentrated medications in patient care areas, the infusion pump library, and narcotic stewardship. All these functions are dealt with centrally and communicated out to the various sites across the region.

There is a high vacancy rate for pharmacists (40 per cent) and of pharmacy technicians (30 per cent) across Northern Health. The region has supported the access to a pharmacist and medication order verification by employing pharmacists from across the province who work virtually to provide this service. The goal is to have at minimum, a pharmacy technician always on site, with on-site visits from a pharmacist at regular intervals. Unfortunately, it was noted that there are sites such as Fort Nelson which has not had an on-site visit for some months. The organization is encouraged to try to address this issue and ensure on-site visits from a pharmacist occur at all sites regularly.

The pharmacists and pharmacy technicians are supported by an operational lead for each HSDA. Medication management policies and procedures are currently under review through the Medication Safety and Quality Committee and this work has fallen behind such that only about one half of all medication management policies are up to date. The organization is encouraged to work to update all policies and procedures as quickly as possible.

The Antimicrobial Stewardship Program is active and provides an annual report with overall data as well as data broken down by HSDAs. The sites visited reported good communication regarding this program.

Medications are packaged as unit doses with the majority of all packing occurring at UHNBC in Prince George. Northern Health is encouraged to ensure that best practice is observe with unit dose medications remaining in their packaging until given directly to the client. It was noted at some sites that medications are being removed from the packaging and delivered to the client in a small medication cup.

Other medications are also distributed from the larger sites to the small rural areas. There are several hospitals that have met the NAPRA standards and chemotherapy preparation is occurring in well-ventilated and contained spaces. It is recommended that the organization address the current chemotherapy preparation in Dawson Creek and ensure that the mixing of chemotherapy is occurring only in areas which meet NAPRA standards.

Medication storage areas are generally clean and organized, however in a number of the sites the pharmacy department is very small and creative solutions are required to support workflow. This is particularly true at Kitimat and Northern Health is encouraged to address this issue as quickly as possible. At least one pharmacy was found to have a sign outside the main door identifying it as a pharmacy and the organization was encouraged to remove the sign to prevent un-intended visits. Mediation rooms in patient care areas are small and many are not really a room with a door but rather an alcove. Automated drug dispensing units (pyxis machines) are found in almost all areas;

however, there are still some that do not have these machines and Northern Health is encouraged to ensure that ADU are used throughout all facilities where medications are administered. The organization is encouraged to review the current processes for medication delivery at the Surgery Centre in Prince George and to provide a pyxis machine to support best practice for medication delivery.

The pharmacy department at the Prince Rupert Regional Hospital (PRRH) is a well-organized and functioning area which has secure access and where the department is not visible to the public. The staff are well prepared and qualified to fulfill their functions. They are committed to serving the needs of the patient and the site. They experience periods of being short staffed, but they continue to provide service without compromising standards. They are benefiting from NH's standardization of various medication management processes. This was noted when speaking to a staff member from Dawson Creek, who due to staffing issues at the PRRH was supporting the site for two weeks. They indicated that because the roles and the physical set up is standardized it makes it easy to come and support the PRRH Pharmacy Department. The team also provides 24-hour access to pharmacy services.

The pharmacy department conducts morning huddles and a weekly 'tailgate' meeting which is considered the department's staff meeting. This provides an opportunity for staff to participate in a round table discussions. They also participate in ongoing education. A recent example was where they practiced emergency management of a spill.

Medication Rooms are audited every six months and the data from the audit is reviewed and held by the Medication Safety Officer. The site and clinical managers do not see this data. The NH Pharmacy Service is encouraged to share this audit information with the appropriate site leaders so that these clinical areas can partner with Pharmacy to address opportunities for improvement as well as celebrate when there is compliance with the required organizational practices.

Automated dispensing units (ADUs) are available on the inpatient units. Processes are in place to support staff in how to use these units. With the planned renovation on the inpatient unit to accommodate a secure space for Maternity Care, an additional medication room with an ADU is planned. This will hopefully ease some of the space pressure as the current medication room is serving 30 patients. The site is looking forward to having ADU's in the Emergency Department and the High Acute Care Unit once that renovation is completed.

It was noted that some staff are removing the medication from the unit dose packaging and placing in a medication cup prior to administrating the medications to the patient. The site is encouraged to remind staff that medications should remain in the unit dose packaging and brought to the patient for administration.

It was also noted that two, Group 2 medications continue to be prepared in the Cancer Care Unit by the nursing staff. Ideally, these medications should be prepared in a biohazard hood. The organization is encouraged to revisit this practice and to consider transitioning the preparation of these medications to pharmacy.

Table 4: Unmet Criteria for Medication Management

Criteria Number	Criteria Text	Criteria Type
5.1.2	Medication storage areas are clean and organized.	HIGH

Criteria Number	Criteria Text	Criteria Type
5.1.7	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.	HIGH
5.1.9	Multi-dose vials are used only for a single client in client service areas.	HIGH
6.1.1	A structured program has been implemented to reduce the risks associated with polypharmacy, especially with frail or vulnerable clients.	HIGH
7.2.1	Medication preparation areas are clean and organized.	HIGH
7.2.3	There is a separate negative pressure area for preparing hazardous medications, with a 100 percent externally vented biological safety cabinet.	HIGH
7.2.4	Sterile products are prepared in a separate area that meets standards for aseptic compounding.	HIGH
8.1.3	Unit dose oral medications are kept in manufacturer or pharmacy packaging until they are administered.	HIGH

Service Specific Assessment Standards

The Qmentum Global™ program has a set of service specific assessment standards that are tailored to the organization undergoing accreditation. Accreditation Canada works with the organization to identify the service specific assessment standards and criteria that are relevant to the organization's service delivery.

Cancer Care

Standard Rating: 98.5% Met Criteria

1.5% of criteria were unmet. For further details please review the following table.

Assessment Results

The Cancer Care program was reviewed at the Bulkley Valley District Hospital and GR Baker Memorial Hospital. Both are part of the nine Community Oncology Networks (CONs) in the Northern Health Region that deliver systemic therapy through day programs served by General Practitioner Oncologists and directed by medical oncologists. Standardized care is by disease as defined under the umbrella of care delivery as defined in by BC Cancer.

The quality of care received is personalized and addresses the patients' desire to be treated closer to home. Care is coordinated to accommodate patients' wishes and resources while operating within the confines of evidence-informed care as defined by the provincial delivery of care. This hub-and-spoke model is vital to the success of the program across geographically challenging distances.

Both locations met most of the criteria as defined by the accreditation process. There was concern with respect to a thorough approach to universal falls precautions at the Bulkley Valley District Hospital, ,which was addressed with both leadership at the program and hospital level. All other high priority ROPs were met.

Patients felt well cared for and were aware that they had options in terms of their treatment and care. They knew whom to contact in case of emergency and felt comfortable that their questions were being answered. All patients were very positive about the caring culture in the clinic, the professionalism and compassion shown by staff, and the quality of the care they were receiving. They felt well prepared for treatment and felt that they could reach out to staff with questions and concerns.

Nurse staffing FTEs are currently stable. Additional GPOs are being sought with ongoing recruitment challenges at Quesnel where there is only one GPO. There is access to Telehealth videoconferencing for rural and remote patients to connect with clinicians in the CON; BC Cancer Fertility Counselling is one example of virtual care.

The physical environment is aging and the infrastructure needs renovation; there is a lack of storage space; however, there is a dedicated medication room with doors, and access to a spiritual care space.

ROPs were met except for falls prevention at the Bulkley Valley Hospital site, which was discussed with both the program and hospital leadership. Falls prevention was a key focus at Quesnel and patients receive education and support; patients with falls risk are identified in the care plan.

Staff performance appraisals are not conducted regularly as per policy; however, staff do feel supported

by managers.

While there is a core focus around quality of care and safety given the patient population, formal quality improvement (QI) initiatives, and staff and patient engagement in determining projects/initiatives, are not core components of the clinic model. There was no evidence of clinic goals or formalized QI indicators, measures, timelines or patient and family engagement.

The programs are to be commended for their efforts to personalize care based on clients' circumstances while meeting the high standards as defined by BC Cancer.

Table 5: Unmet Criteria for Cancer Care

Criteria Number	Criteria Text	Criteria Type
3.2.12	Clients and families are provided with opportunities to be engaged in research activities that may be appropriate to their care.	NORMAL
4.1.6	Indicator data are compared to available benchmarks.	NORMAL

Critical Care Services

Standard Rating: 98.2% Met Criteria

1.8% of criteria were unmet. For further details please review the following table.

Assessment Results

The Northern Health is divided into Health Service Delivery Areas: the Northern Interior Rural, the Northwest, and the Northeast including Prince George. The six critical care unit locations are divided across the Health Service Delivery Areas.. The Northern Interior, including Prince George, has the largest population and is host to G.R. Baker Memorial Hospital in Quesnel with a new unit and five critical beds as of April 2023. The UHNBC in Prince George has 18 critical care beds, 11 intensive care beds, and seven high acuity level beds. The Northwest offers critical care service at Prince Rupert Regional Hospital with two beds, and Mills Memorial Hospital in Terrace has four intensive care level beds. The Northeast at this time has one open critical care unit in Fort St. John with four beds, as the critical care unit in Dawson Creek is under recruitment for an internal specialist to support their unit. There are currently no specialized cardiac treatment facilities in Northern Health Region. The cardiac program is in the process of being built.

Standing orders are used and point of care assessments are completed and documented in the patient record. The teams have twenty-four-hour access to diagnostic and laboratory services. The team has access to respiratory, occupational, and physical therapy and social work, and to the Indigenous Liaisons who supports cultural care.

Staff feel very supported and are provided with ongoing educational opportunities including participating in simulation sessions. They feel engaged and proud of the care they provide. The patients interviewed also acknowledged the excellent care that they were receiving and expressed their gratefulness for having access to this level of care within the Norther Health Region, and all of the surrounding communities.

Quality boards are visible within critical care areas of some units, and quality huddles are conducted weekly. Consideration of these practices is encouraged throughout the critical care services to encourage quality improvement and foster great staff ideas. Some sites are to be commended for their fastidiousness about conducting audits of the ROPs. These are wonderful initiatives, and it is suggested that other sites follow their lead, and that the results are public facing to allow the public to see the inside work being done to ensure quality of care.

It was noted that hand hygiene audits were not being completed in all units and the critical care units are encouraged to find innovative ways to ensure this happens. For example, one site has trained the unit clerks to perform this audit.

Since the last survey visit in 2018 there has been much work done to improve the falls and pressure ulcer prevention initiatives and the relationship with the British Columbia Provincial Organ Donation Team. these initiatives are important and the teams are to be congratulated for the work and education put into making them come to fruition. Work has also been done for the organization to track missed organ donation opportunities.

Table 6: Unmet Criteria for Critical Care Services

Criteria Number	Criteria Text	Criteria Type
1.1.4	Critical care units are designed with input from clients and families to be self-contained and dedicated to the 24-hour care of clients with life threatening or potentially life threatening conditions.	NORMAL
2.4.19	Access to spiritual space and care is provided to meet clients' needs.	NORMAL

Emergency Department

Standard Rating: 89.6% Met Criteria

10.4% of criteria were unmet. For further details please review the following table.

Assessment Results

The emergency departments throughout the Northern Health Region include a mix of new and old facilities serving increasingly diverse populations. In spite of the aging infrastructure, the region has made investments to address deficiencies that pose risks to safety and quality. There are systems such as video surveillance, plexiglass barriers, and other renovations that have been undertaken to improve provider and staff experience. There is a focus on Occupational Health and Safety, Infection Prevention and Control, and flow. Improvements to Code White response and relational security are examples of initiatives being undertaken in response to the prevalence of workplace violence incidents reported in the Patient Safety Learning System (PSLS). It is noted that there are significant recruitment and retention challenges across the system, but that progress has been made on stabilizing staffing and monitoring and taking deliberate steps to avoid service disruptions. Teams are multidisciplinary and mechanisms and protocols have been put in place to address the needs of high-risk populations such as geriatrics and addiction and mental health with quick responses that have proven to be effective in reducing wait times.

Challenges were observed in most emergency sites around patient flow and monitoring of patients in waiting areas. In some cases, these issues appeared to be the result of wayfinding and the way departments are designed, while in other cases the identified issues were related to the order in which patients are registered, triaged, and cared for. Where these issues have been identified there is discussion about potential quality improvement initiatives to value stream map the experience of the patient and come up with strategies to address bottlenecks and other risks to smooth and safe patient flow.

There are policies and protocols in place to support care plans for people who have expressed the desire to participate in organ donation, however there is variation amongst emergency staff in terms of whether this is applicable to their site and how they would proceed if it came up. There is an assumption that geography and access to timely evacuation to tertiary care stands in the way of the participation of rural sites. There is an opportunity to proactively raise the awareness of all staff and patients about the policies and procedures that are in place in the region and the province and what the site's role would be in this program, if applicable.

There is evidence that quality and safety is at the forefront of everything that Northern Health staff are doing but a tendency to refer responsibility for continuous quality improvement to the quality department. At the same time there is evidence of several quality improvement mechanisms such as white boards, quality boards, huddles, and participation in best practice programs throughout the organization. It is suggested that the approach to continuous quality improvement be standardized and designed to support local teams to identify and facilitate opportunities when they arise. For example, local goals and objectives/KPIs should be aligned to the Regional and the Provincial priorities and portrayed on quality boards in a way that showcases local progress or need for corrective action, so that improvement discussions are aligned and also sensitive to local conditions, such as rural and urban sites.

There is variation in work that is done to keep performance reviews up to date and work that is done to ensure reporting and investigation of incidents in a PDSA cycle. It is important to ensure that staff are getting feedback on performance and having opportunities to participate in career laddering to improve retention. It is critical to address risk for workplace violence and the risk for adverse events to patients and staff to have a just culture and be an employer of choice. The survey demonstrated that there are pockets of excellence across the region that can be highlighted as examples of good practices that can be adopted in remaining sites that might be struggling or lagging.

Table 7: Unmet Criteria for Emergency Department

Criteria Number	Criteria Text	Criteria Type
2.1.2	A proactive approach is taken to prevent and manage overcrowding in the emergency department, in collaboration with organizational leaders, and with input from clients and families.	HIGH
2.1.11	Protocols to move clients elsewhere within the organization during times of overcrowding are followed by the team.	HIGH
2.1.12	Protocols are followed to manage clients when access to inpatient beds is not available.	NORMAL
2.1.13	Protocols to manage overcrowding and surges are followed before requesting aid from alternative health care sites or diverting ambulances.	NORMAL
2.1.10	There are established protocols to identify and manage overcrowding and surges in the emergency department.	HIGH
2.3.7	There is ongoing communication with clients who are waiting for services.	NORMAL
2.3.8	Clients waiting in the emergency department are monitored for possible deterioration of condition and are reassessed as appropriate.	NORMAL
2.6.5	Training and education on organ and tissue donation and the role of the organization and the emergency department is provided to the team.	NORMAL
2.6.6	Training and education on how to support and provide information to families of potential organ and tissue donors is provided to the team, with input from clients and families.	NORMAL

Criteria Number	Criteria Text	Criteria Type
2.6.7	When death is imminent or established for potential donors, the Organ Procurement Organization (OPO) or tissue centre is notified in a timely manner.	NORMAL
2.7.17	Information Transfer at Care Transitions 2.7.17.5 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
3.1.3	Data on wait times for services, the length of stay in the emergency department, and the number of clients who leave without being seen is tracked and benchmarked.	NORMAL

Inpatient Services

Standard Rating: 98.9% Met Criteria

1.1% of criteria were unmet. For further details please review the following table.

Assessment Results

Acute care inpatient services across NH typically reflect acute medical and ALC patients. Most inpatient services have general practitioner (GP) providers with internist and specialist consults on request. High inpatient monthly admissions, occupancy, inpatient days across services and ALC inpatient days outline daily system pressures. It is commendable that inpatient acute services strive to meet the needs of an increasingly vulnerable population who are living with chronic and complex disease, mental health and addictions, and the frail elderly. Patient referrals primarily originate from the emergency department, but can originate from primary care, community, palliative care, post-surgery, and patients being repatriated from other services.

Multiple and intersecting system pressures can impact timely access, service coordination, and safety-focused quality of care. High ALC occupancy rates, lack of capacity in the community, such as long-term care, and significant health human resource (HHR) challenges all play a role. Many inpatient services struggle with a shortage of permanent nursing staff with consequent high use of agency and travel nurses and challenges for GPs to provide care with physician vacancies and high patient volumes.

It is encouraging to learn that some agency and travel nurses receive a full orientation to NH inpatient unit services and regularly return to the same inpatient unit. Recruitment of general practitioners (GP) and other providers is ongoing. As patients may be attached to their primary GP, it can be a challenge for a GPs to discharge a peer GP's patients, thus impacting patient flow and contributing to longer stays for shorter term medical patients. Notably, internationally trained physicians are being hired as they follow an accelerated licensure pathway that includes engagement in a practice-ready assessment program.

With a focus on patient safety, staff wellbeing, quality of care, and to support a team-based culture, leadership are to be commended for investing in service enhancements including 24/7 clinical leadership models and support roles. These leadership and service enhancements are to be commended and have had a positive impact on morale and decreased churn. Support roles at some sites include Indigenous care coordinators, Indigenous health care aides, regional NH pharmacists, relational security, and community nurses who are often connected to the care of admitted patients.

Patient intake and assessment processes use standardized patient-centred tools and processes, such as SBAR. In partnership with designated agencies and system partners, decision-making and consent pathways have been created for involuntary admissions and referrals of adults who are vulnerable or incapable.

ROPs have been significantly improved from the 2018 Accreditation visit with improvement in medication reconciliation and information transfer at care transitions. One example is the use of a standardized transfer of care tool that is signed by the ED nurse, inpatient nurse, patient and family member. At some sites where medication reconciliation originates in the ED, there is an effective linkage to a regional pharmacist. There are further opportunities to perform audits on consistency of medication reconciliation, as there were pockets found where physicians are not completing medication reconciliation but continue to hand write admission medication orders with no evidence of an electronic medical record. It is also strongly recommended that pre-printed orders are used as the standard of care.

Palliative and end of life dialogues are coordinated via community-based palliative care nurses who follow patients to provide continuity of palliative care goals. At some sites, there is significant interaction and engagement with Indigenous communities with strategies to incorporate Indigenous customs and values into all aspects of treatment, including palliative care and to cultivate respect for spirituality. The organization is encouraged to continue and to expand this type of meaningful engagement. Medical Assistance in Dying is made accessible to patients, facilitated by a dedicated physician and nursing team.

Table 8: Unmet Criteria for Inpatient Services

Criteria Number	Criteria Text	Criteria Type
2.1.3	Education and training are provided on established clinical care pathways.	NORMAL

Mental Health Services

Standard Rating: 98.9% Met Criteria

1.1% of criteria were unmet. For further details please review the following table.

Substance Abuse and Problem Gambling

Standard Rating: 100.0% Met Criteria

0.0% of criteria were unmet. For further details please review the following table.

Assessment Results

There is a well-developed and comprehensive regional strategic plan for Mental Health services that will guide mental health services across Northern Health. The mental health strategic plan had considerable community and Indigenous partner input and is aligned the overall provincial plan. While the key elements of the strategic plan are now being implemented, communication and understanding at the site level is still evolving. The regional team is currently looking at ways in which to facilitate this understanding at all sites. There is support through the regional strategic leads to support the sites in furthering their understanding and application of the strategic directives at the various sites. The regional team in partnership with the site leadership is encouraged to engage patients and families who have experienced the mental health system in providing input into how the strategic actions can best be implemented at the site level.

Considerable work has been accomplished in the roll out of the regional suicide care strategic priority. The Regional Quality Improvement Advisor supporting Safer Suicide Care has recently presented work at a national quality conference. Suicide assessment and monitoring is well understood by the staff at all sites. At all the sites visited, the leadership was found to be passionate and committed to their mandate. The staff were knowledgeable and were also observed to have respectful interactions among each other as well as with their patients. Staff and physicians are respectful of their patient's diverse needs and do what they can to ensure that those individual needs are met. For many this is also a personal commitment as they have had experiences with family or friends who have had to access the services and support offered by mental health and substance abuse programming.

The implementation of the mental health and substance abuse liaison's role has been a welcome addition to the care team as they help in facilitating patient flow in the emergency department as well as facilitating the timely transfer and/or access of patients to programs and the inpatient mental health unit. The addition of the in-house relational security teams at each site is viewed as a welcome enhancement to overall team functioning and overall staff and patient security.

In speaking with staff and physicians at each of the sites several opportunities were identified. These included the need for defined medical leadership at the site level to work with the site managers and team leaders in developing site specific programming consistent with the regional priorities. In addition, regular interdisciplinary meetings to enhance team delivery and to plan for and implement program enhancements such as electroconvulsive therapy was mentioned. Regular site meetings would also support the exploration of opportunities to streamline processes, further clarify and define admission criteria, and facilitate the exploration of the most efficient and effective use of resources such as detox facilities.

With the imminent move of the Mills Memorial Hospital mental health program to the newly built hospital this fall, there is an excellent opportunity to bring representatives from the emergency department and the mental health program together to explore the potential for streamlining existing processes to facilitate the

movement of patients awaiting admission and to enhance learning and understanding between the two staffs. While there is currently collaboration between the emergency department and the mental health program, fragmentation still exists from time to time. This is an opportunity to review and revise historical and inefficient processes.

As part of the mental health tracers the child and youth program at UHNBC was visited as well as the adult program. The child and youth unit is small and crowded with poor lines of site. Outdated surfaces and furniture are a risk to staff when violent incidents occur, and furniture can be lifted and thrown around.

The team has worked with Spirit of the North Healthcare Foundation to get funds to give the unit a facelift and purchase new furniture that is purpose built for this type of setting. There is a solid algorithm for care planning from admission through to discharge. The program begins in Emergency where there is a (nurse) Child and Youth MH and Addictions specialist. There is a high degree of frustration from physicians and staff that this unit is expected to take very complex cases without the resources and support it needs to provide the quality of service they would like. There are good relationships with community services for discharge planning purposes but they are not able to do much in terms of follow-up care. Those practitioners spoken to seemed distressed about not being able to confidently ensure continuity of care.

Across the Northern Health Mental Health service much work has been done to avoid transferring to Vancouver or other places when care needs are complex. Support has been built in to mitigate the risks associated with taking and keeping complex patients, including forensic psychiatry patients at UHNBC. Throughout the region there are collaborative relations with community partners such as the RCMP, corrections personnel, and other community agencies. At UHNBC correctional services staff are expected to stay and supervise their patients who require secure isolation. Additionally, there has been a high level of collaboration with unions and other stakeholders to reduce the risks associated with workplace violence prevention.

The Mental Health and Substance Use Program offers a broad spectrum of services designed to support individuals and their families facing challenges related to mental health and substance use. These services range from short-term assessment and treatment options to long-term programs specifically designed for individuals with serious and persistent mental health or substance use disorders. The mental health and substance abuse liaison nurse(s) located in each of the emergency departments have a significant role in bridging and facilitating access to the substance abuse and mental health unit programs. The introduction of this important role is excellent and it is hoped that all vacancies will soon be filled. Even with two nurses per site, the liaison nurses are in high demand given the increasing volumes of patients in need of assessment and referral. Currently, access to the substance abuse program is not 24/7 however there are extended hours with the potential goal of offering seven day a week coverage.

Table 9a: Unmet Criteria for Mental Health Services

Criteria Number	Criteria Text	Criteria Type
3.5.9	The effectiveness of transitions is evaluated and the information is used to improve transition planning, with input from clients and families.	NORMAL

Table 9b: Unmet Criteria for Substance Abuse and Problem Gambling

There are no unmet criteria for this section.

Obstetrics Services

Standard Rating: 98.0% Met Criteria

2.0% of criteria were unmet. For further details please review the following table.

Assessment Results

Northern Health has a large spread-out population of around 300,000 people. A long-term strategic plan has been developed to provide high quality, safe, evidence-based peri-natal care to the population as close to home as possible. This plan relies on strong partnerships with the communities, a quality culture in each site, and strong linkages and collaborations across sites and to the referring centers. The perinatal group is to be commended for their goals and aspirations. Northern Health has been successful in developing new models to meet the needs of their people. Hopefully this creativity and energy will carry them through to completion of this plan.

Northern Health currently operates 11 birthing sites. The model of care involves three different medical professionals to assist at births. Family physicians, obstetricians and midwives all share in their work in partnership with the hospitals, birthing units and primary care centers. There is one tier 4 birthing center at UHNBC in Prince George with full specialist and NICU support. Several tier 2 hospitals spread throughout the region currently have very varied specialist back up. Some of these sites are inconsistent in their availability. At the time of the survey St. John Hospital was transporting patients to Prince George for lack of appropriate staff. Of note, there was a recent closure of obstetrical services in a neighboring hospital in another region. The services in Quesnel have seen a major increase as these patients arrive here.

All perinatal care in the region depends on their community links to provide the continuum of perinatal care. In some communities this dependency was particularly strong. Quesnel and Prince Rupert described strong connections. These partnerships supported smooth transitions from community to the hospital and back to community with good support for the new mothers.

All patient care interactions were highly patient, and family focused. There is a culture of caring within Northern Health which is commendable.

The model of care for delivery is dependent on development of collaborative teams. This happens organically sometimes, but it would be worth time and effort to invest in understanding the science and developing skills to work in collaborative teams. This will be particularly important to be able to include the independent practitioners. Difficulties with team work often translates to tensions in the delivery suite which is negatively felt by the new moms and their partners.

Work in Quesnel, Smithers and Prince George through their Indigenous advisors has resulted in stronger partnerships, and enhanced collaboration for programs and support. UHNBC has partnered to create a mural on a corridor as you enter the unit. G.R. Baker in Quesnel has worked with the Indigenous liaison to create opportunities for art in the building as well as smudging to occur in the individual patient rooms. These partnerships can continue to be strengthened and broadened to include others in the community.

Patient-centered care was very evident in the individual interactions with patients and families throughout the week. Opportunities for the community to have more input into the larger decisions like planning and development of buildings or services is not yet seen in Quesnel or Prince George. Building on the successes and gaining support and skills from administration would help to develop these opportunities. The staff is ready for this new step.

Table 10: Unmet Criteria for Obstetrics Services

Criteria Number	Criteria Text	Criteria Type
1.1.4	Defined criteria are used to determine when to initiate services with clients.	NORMAL
1.3.14	There is a protocol for timely reporting of and response to abnormal test results and reports.	HIGH

Perioperative Services and Invasive Procedures

Standard Rating: 97.2% Met Criteria

2.8% of criteria were unmet. For further details please review the following table.

Assessment Results

The Prince Rupert Regional Hospital (PRRH) has a high functioning team who take extreme pride in the care and service they provide to those they serve. They have strong leadership with passionate, knowledgeable, and engaged staff and physicians. A commitment to quality and safety is evident throughout, with daily huddles, visible quality improvement and 100 per cent compliance with all the required organizational practices. The department is well laid out including three operating room (OR) theatres. Preoperative optimization is completed on all patients and all appropriate patients are identified for additional consultation prior to being booked for surgery. The team, including the operating room manager and representatives from MDR, the booking office, and the pre assessment office review the upcoming OR slate to ensure that the appropriate equipment is available as well as identifying any specific patient needs.

The team can be very proud of exceeding the Ministry of Health's elective surgical and endoscopy targets. They have embraced a culture of quality improvement and have empowered staff to lead quality initiatives. Performance appraisals are completed. Ongoing training and education are provided to the staff. There is a strong sense of teamwork. Staff are very proud of the work that they do, and they feel very supported and engaged by leadership.

The OR environment meets the air exchange requirements. Transport of case carts to and from MDR are stainless steel and fully enclosed. The safe surgical check list and surgical pause is consistently completed and regularly audited.

PRRH perioperative program is still using a paper based charting system. As many of NH's perioperative sites are already on an electronic medical record system, PRRH is hoping they will have the same soon.

Patient feedback is very positive. The team is encouraged to formalize processes to engage with patients and families at the site level, and continue to use the provincial patient centered measurement to gather feedback on services.

The ORs at UHNBC Prince George are older but well equipped. Patient flow is relatively good and there are three levels of increasing restrictions. Space within the theatres can be an issue, however the team tends to work around these limitations. Heating, ventilation, temperature, and humidity are closely monitored. Mitigating strategies have been put in place to meet as closely as possible the required air exchanges within the OR theatres. However, given the age of the facility the number of air exchanges within some of the areas are not met.

For patients who have been admitted to hospital prior to surgery, a full assessment is completed including a risk for falls and pressure ulcers, and the VTE protocol is ordered and implemented for those patients who may be at risk.

Documentation within the OR is electronic, and the information is readily transferable from the OR to the recovery room and to day surgery or to the inpatient units. Documentation within the inpatient units is on paper but there is full access to the electronic documentation that occurred in the OR. To further reduce risk and enhance efficiency, the organization is encouraged to continue efforts toward implementing a fully electronic charting system across all areas.

The manager at UHNBC is relatively new in their role and has just begun doing performance reviews. The staff indicate that it has been several years since they have had a review.

The program is commended for the practice of having a daily huddle with the full team (nurses, anesthetists, and surgeons) who will be working together, prior to the start of the day (07:30 hours). This huddle provides an opportunity to highlight any concerns or to discuss the plan for the day. Several quality improvement initiatives are underway in the program including the implementation of several best-practice care bundles including one for Cesarian sections, and one for orthopedic joint replacement surgeries.

The G.R. Baker Memorial Hospital is a level 4 trauma center. They have a pre-surgical program (they were part of a Doctors of BC initiative to optimize surgical outcomes) to identify potential risks and work with the patient to overcome them prior to surgery.

The site has implemented the OR computer system to support the clinical work in the area. They have all converted to using this for charting and find it helpful, however there are significant accommodations made when they transfer care to the other parts of the hospital that remain on paper. They are still not able to use the data from the system. They would benefit from some IT expertise to mine the data and provide them with information in many areas. Monitoring the ROPs would be possible through this system, and they attempt to do this. Monitoring the data on such things as surgical complications, infections, and deaths is possible but not currently done.

Quality initiatives are common and include weekly OR slate review, endoscopy patient satisfaction results, and the creation of the surgical optimization nurse position. These initiatives were also recognized in the other sites visited. The site is encouraged to work differently with their young staff to broaden the team's understanding of the whole QI process including recognizing areas for improvement, reviewing the data, and devising potential solutions. There is interest at the staff level in participating in this.

There is a lack of visible sharing of information on QI topics. There are no QI boards in staff areas, or public areas, and no communication with the community on the good work they are doing. This is a great opportunity toshare your story!

The OR is in an older part of the facility and is not meeting code for some things such as the appropriate air exchanges and the equipment in the MDR area. Dirty items from the OR cross through a busy corridor to reach the MDR.

The Kitimat General Hospital and Health Centre's surgical team has strong leadership that is knowledgeable and enthusiastic. There is a spirit of teamwork, the nurses are highly skilled and rotate between all facets of the perioperative service. There is good physician engagement. Space is clean, flow is good, equipment is standardized and well maintained.

There are two operating rooms. One OR is primarily used for general surgery, orthopedics and C-sections. The other OR is mainly used for endoscopies.

The team implemented the electronic medical record in February 2024 and staff appreciate it. The team has realized success with the optimization project for joint surgeries. As a result of this initiative, the team has reduced wait times, reduced the number of cancellations, and reduced the overall length of stay for patients. The team is currently working on a project called 'Direct Scope' to reduce wait times for patients waiting for endoscopy. If a patient meets certain criteria and is willing to travel to another site they can have their scope done sooner if there is free OR time.

The site is encouraged to address the following opportunities. There is a need to clearly mark the levels of increasing restrictions in the department as the red tape on the floor is rubbed off; doors were left or propped open when the signage clearly indicated that they were to be closed; and, testing of chemical cleaners for appropriate strength is not consistently documented.

Table 11: Unmet Criteria for Perioperative Services and Invasive Procedures

Criteria Number	Criteria Text	Criteria Type
1.1.2	The area where invasive procedures are performed has three levels of increasingly restricted access: unrestricted areas, semi-restricted areas, and restricted areas.	NORMAL
1.1.7	Rooms where surgical and invasive procedures are performed have at least 20 complete air exchanges per hour.	HIGH
1.2.8	Contaminated items are appropriately contained and transported to the reprocessing unit or area.	HIGH
1.2.9	Contaminated items are transported separately from clean or sterilized items, and away from client service and high-traffic areas.	HIGH
1.2.10	When transporting contaminated equipment and devices, applicable regulations are followed; environmental conditions are controlled; and clean and appropriate bins, boxes, bags, and transport vehicles are used.	HIGH

Reprocessing of Reusable Medical Devices

Standard Rating: 88.8% Met Criteria

11.2% of criteria were unmet. For further details please review the following table.

Assessment Results

The Medical Device Reprocessing (MDR) program of the Northern Health (NH) is organized as one corporate program, with a designated individual assigned accountability for overseeing all MDR functions. In addition to the MDR leader, the program is also supported by representatives from Biomedical Engineering and Infection Prevention and Control. It is evident that this is a high functioning program that recognizes their responsibilities and accountabilities. The MDR program has worked to consolidate MDR processes across NH and to establish an MDR centre that supports the entire NH. Due to the centralization of reprocessing functions, NH is not only realizing cost savings but safer practices for patient safety. The MDR program also provides reprocessing functions for Correctional Health Services, Home Care, Primary Care and Midwives.

The MDR program undertakes Ministry of Health yearly audits. The results of these audits inform quality improvement work. In 2023, the regional average audit score was 96 per cent in all categories with all high priority items being 100 per cent. Some of the themes from these audits are need for more education, clutter and/or lack of sterile storage, and the continued presence of laminate and wood in some facilities. The team is currently working on initiatives to address these findings and is encouraged to rectify these deficiencies as soon as possible. For example, weekly five-minute education huddles are held with MDR and operating room staff to review policy and standards. The MDR program is encouraged to evaluate this approach and solicit feedback from staff. The MDR program may wish to consider recording these huddles, so all staff have an opportunity to access this information.

The MDR program has implemented processes to support the planning, acquisition, and replacement of equipment. A preventative maintenance plan is in place. Standard operating procedures are current and up to date with regard to cleaning, sterilizing, and reprocessing of medical devices. Staff have ready access to this information. All team members must complete the appropriate training and certification before they can work in MDR. Ongoing training is provided to the MDR staff.

The MDR program is supported in its desire to have an Instrument Tracking System. Currently all processes are manual and are recorded on paper. The team has commenced standardizing tray sets for the perinatal program. They are encouraged to continue to move forward with standardization of tray sets for other services.

As staffing continues to be a challenge, the MDR program is encouraged to explore ways to raise the profile and career opportunities in MDR. This could include visiting local high schools as well as profiling the opportunities within the NH family.

In partnership with Infection Prevention and Control, the MDR program is working on a dashboard. Some of the items they are considering to be highlighted on the dashboard include leadership, planning, supports, operations, performance evaluations and quality performance. The program is encouraged to follow through with implementing this dashboard, to make it visible to all MDR sites, and to view the information as an enabler in informing and amplifying quality improvement activities within the overall MDR program. The program is also encouraged to formalize site specific quality improvement work.

As the MDR program prepares for moves into new facilities, and to support the staff with this change, the team is encouraged to do simulations in the new space prior to occupancy.

The MDR service at the Prince Rupert Regional Hospital is in a renovated and ergonomic space that meets all MDR standards. The department is well organized and access into the department is secure. There is strict adherence to dress codes. All staff meet the certification requirements. Stainless steel and enclosed case carts are used to transport equipment to and from the operating room. The team collects a significant amount of data manually. A quality board is visible in the department and daily huddles are held with staff.

As the manager of MDR is also the manager of the operating room, the MDR team is truly integrated into the entire surgical team. Required processes and practices are in place and consistently followed for the reprocessing of endoscopes.

There is a collaborative and supportive relationship from the Infection Prevention Control (IPC) practitioner. Working in partnership with the MDR supervisor, the IPC practitioner provides guidance and advice as well as monitoring IPC practices.

The G.R. Baker Memorial Hospital MDR supports the OR, the rest of the hospital, and the community medical needs. While a designated individual is accountable for overseeing quality and coordinating reprocessing services across the organization, there is concern that the MDR leadership at this site has yet to address deficiencies identified by NH leadership, highlighting a key area for improvement.

This is an aging facility where the sink is dated and does not meet ergonomic standards. There is a new sink available on site and ready for installation. The site is encouraged to install this sink as soon as possible to meet MDR and Accreditation standards.

The flow in the MDR department is poor where the initial cleaning section is a narrow corridor and where cleaning of scopes occurs on one side and everything else occurs on the other side. There is positive air pressure on the dirty side but not the other. There is only a red mark on the floor to indicate the end of the cleaning section and the beginning of the rest. There is a wall between the dirty section and the cleaning section but no door on the dirty section. There is also one cupboard top which is not metal.

Even though the physical plant has deficiencies, the processes in the department are good. The department reports to the perioperative manager and is staffed by three people who work well together.

There is no air pressure to wash out the scopes nor where solid material has been found further down the line. NH needs to rectify cupboard surfaces and access to air pressure.

As there is no evidence of quality improvement activity and collecting and reporting of indicators, the team is encouraged to develop and implement continuous quality improvement. The staff need to be empowered as they shared many good ideas.

As workloads have been expanding without the appropriate human and physical resources, there have been times when the sterilizers have been overfilled.

The MDR at UHNBC has good clean to dirty separation and flow. Instruments from the OR are transported in covered bins to MDR and sterilized equipment travels back up to the OR via a different elevator used only for this purpose. The storage space available in the MDR for equipment that has been reprocessed is limited. All processes within the MDR are followed appropriately. There are some physical issues including the stationary sinks which are due to be replaced shortly as well as several wooden cupboards which need to be replaced. The department is encouraged to look at the possibility of having the sinks be hands free and to ensure that the dedicated hand washing sink can be operated through a hands-free method. As there are still several wooden cabinets and cupboards in the MDR the department is encouraged to have these replaced with metal cabinets.

All staff working in MDR are trained and some also have the CSA certification. The department also has students, and the plan is to have a few of these students hired into permanent positions as they finish their training. Staff rotate through the various areas of MDR, and they indicated that they enjoyed their work. Performance reviews have not been occurring for MDR staff.

Although policies are online, most of the SOPs that staff need to follow are in binders. The department is encouraged to look at putting these online as well,

The cleaning and reprocessing of endoscopes is carried out in a room immediately between two endoscopy suites. The dirty scopes come in from the endo suites through one set of doors and are cleaned on one side and then walked to the other side of the room for sterilization. The separation of the dirty and clean side of the room is marked only by a red line on the floor. Once washed and cleaned the clean scopes leave the room through a different door and are transported to the cabinets where they are hung until the next use. The cabinets are within the endoscopy suites and the department is encouraged to keep the doors to these cabinets always closed.

UHNBC is encouraged to engage leaders from both the OR and MDR in the planning of the new tower to ensure that the current issues are addressed, and the building supports best practice.

At the Kitimat General Hospital and Health Centre there are two reprocessing technicians. Both are very knowledgeable and have worked at the hospital for several years. They are certified in reprocessing and are recredentialed every five years.

The main reprocessing area is proximal to the ORs. Flow into and out of the reprocessing area is good. There are new stainless sinks that are hydraulic, so they adjust to the height of the worker however, they are not hands free. The washer is new within the last two years. There are two steam sterilizers. All the appropriate biological indicators are done to ensure sterility. A record is kept for seven years. The sterile storage area is well organized with like equipment organized into color coded bins.

The team is encouraged to have the open doorway between the dirty reprocessing area and the sterile storage area closed off with a wall. Currently there is a plastic curtain covering the area and the opening is blocked so people cannot use it.

Used instruments are transported from the OR to the reprocessing area wrapped in a sterile drape. This is not best practice so all soiled instruments should be transported in a container with a lid.

There is a need for a pediatric endoscope.

Ultrasound vaginal probes are cleaned in the Diagnostic Imaging (DI) department by trained DI technicians following manufactures guidelines however the team is looking to fundraise to purchase a Trophon which is absolutely the way to go in the future.

Endoscopies are done in one of the ORs with the scopes being transported down a hallway to the reprocessing area. Scopes are transported in a bin with only a towel laid over the top. These should be transported in a container with a lid. The endoscopy reprocessing area is small but functional with good processes in place for checking the scopes and cleaning. Scopes once sterilized are dried then taken down another hall to the endoscopy closet which is in an old housekeeping closet that is also used for storage and old supplies. It is not ideal. The team is encouraged to explore the options and feasibility of having a dedicated endoscopy suite with reprocessing and storage of scopes and other needed equipment in a less fragmented environment.

Table 12: Unmet Criteria for Reprocessing of Reusable Medical Devices

Criteria Number	Criteria Text	Criteria Type
1.2.4	A designated individual is accountable for quality oversight and for coordinating all reprocessing services across the organization, including those performed outside the Medical Device Reprocessing (MDR) department.	HIGH
1.3.4	The Medical Device Reprocessing (MDR) department has an area for decontamination that is physically separate from other reprocessing areas and the rest of the facility.	HIGH
1.3.6	The Medical Device Reprocessing (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.	HIGH
1.4.1	Reprocessing equipment is purchased based on service volumes, input from team members, and considerations for maintenance, cleaning, and infection prevention and control.	NORMAL
2.1.11	Team member performance is regularly evaluated and documented in an objective, interactive, and constructive way.	HIGH
3.2.9	Workplace assessments of the Medical Device Reprocessing (MDR) department are regularly conducted for ergonomics and occupational health and safety.	HIGH
4.3.6	Before beginning high level disinfection, each flexible endoscopic accessory is cleaned, rinsed, and dried according to the manufacturers' instructions for use.	HIGH
5.3.11	Information about quality improvement activities, results, and learnings is shared with stakeholders, teams, organization leaders, and other organizations, as appropriate.	NORMAL

Criteria Number	Criteria Text	Criteria Type
5.3.12	Quality improvement initiatives are regularly evaluated for feasibility, relevance, and usefulness, with input from stakeholders.	NORMAL
5.3.5	Indicator(s) that monitor progress for each quality improvement objective are identified, with input from stakeholders.	NORMAL
5.3.6	Quality improvement activities are designed and tested to meet objectives.	HIGH
5.3.7	New or existing indicator data are used to establish a baseline for each indicator.	NORMAL
5.3.9	Indicator data is regularly analyzed to determine the effectiveness of the quality improvement activities.	HIGH
5.3.10	Quality improvement activities that were shown to be effective in the testing phase are implemented broadly throughout the organization.	HIGH

Service Excellence for Cancer Care

Standard Rating: 85.0% Met Criteria

15.0% of criteria were unmet. For further details please review the following table.

Assessment Results

There was significant evidence that the leadership teams at both facilities were actively involved in designing appropriate services and removing physical and emotional barriers to care and understanding. They were aware of how to access appropriate resources to enhance patient satisfaction and care delivery. There was a focus on care along the entire continuum with access to palliative care, community services, and spiritual care being readily available. Leaders consistently worked with and effectively communicated with BC Cancer leaders to direct care of patients across their Community Oncology Network (CON)s. At the Bulkley Valley site a library focused on oncology related issues, the Lending Library, has been made available to patients and their families by the leadership.

Appropriate credentials are present for all staff, with training as required for all processes and equipment being up to date. Cultural sensitivity is ensured with special emphasis on an approach to Indigenous patients and families that meets their needs across the care continuum. Although informal recognition and feedback regarding performance is provided, formal performance reviews with professional development as a focus are not always carried out.

Care is led by evidence-informed guidelines as set out by BC Cancer. Safety is approached in a proactive way. There was a noted lack of proactive continuous quality improvement informed by defined goals and outcome measures. Quality improvement initiatives should be defined and supported by the region.

Medical records are standardized and up to date. Privacy concerns and access are addressed appropriately.

There was significant evidence of person-centred care with consideration of both patients/families and staff. There were multiple examples of enhancements to patient care such as scheduling multiple appointments to limit travel, accommodating the need for resources such as housing, and providing access to a library centred on topics related to the cancer patient journey. Staff were accommodated to work to their strengths and in a manner consistent with other obligations.

Table 13: Unmet Criteria for Service Excellence for Cancer Care

Criteria Number	Criteria Text	Criteria Type
1.2.3	The team leadership engages with clients and families to determine the required mix of skill levels and experience within the team.	NORMAL

Criteria Number	Criteria Text	Criteria Type
2.1.12	The team leadership supports staff to follow up on issues and opportunities for growth identified through performance evaluations.	HIGH
2.1.10	The team leadership regularly evaluates and documents each staff member's performance in an objective, interactive, and constructive way.	HIGH
4.3.11	The team regularly evaluates quality improvement initiatives for feasibility, relevance, and usefulness.	NORMAL
4.3.3	The team identifies measurable objectives for its quality improvement initiatives including specific timeframes for their completion.	HIGH
4.3.4	The team identifies indicators to monitor progress for each quality improvement objective.	NORMAL
4.3.5	The team leadership works with staff to design and test quality improvement activities to meet objectives.	HIGH
4.3.6	The team leadership works with staff to use new or existing indicator data to establish a baseline for each indicator.	NORMAL
4.3.7	The team leadership works with staff to regularly collect indicator data and track progress towards quality improvement objectives.	NORMAL
4.3.8	The team leadership works with staff to regularly analyze indicator data to evaluate the effectiveness of its quality improvement activities.	HIGH
4.3.9	The team leadership works with staff to implement throughout their services the quality improvement activities that were shown to be effective in the testing phase.	HIGH

Criteria Number	Criteria Text	Criteria Type
4.3.10	The team leadership ensures that information about quality improvement activities, results and learnings are shared with staff, clients and families, organizational leaders, and partners, as appropriate.	NORMAL

Service Excellence for Critical Care Services

Standard Rating: 81.2% Met Criteria

18.8% of criteria were unmet. For further details please review the following table.

Assessment Results

The critical care teams are pleased to see the launch of the NH Critical Care Network. They view the network as enabling planning and standardization of critical care processes across the NH as well as facilitating a community of practice. Partnerships have been made with provincial authorities and networks including the Provincial Critical Health Improvement Network, and the Provincial Patient Health Network that will be supportive in assisting the recruitment of patient advisors. The Health Quality BC is also a great resource of information for the formation of formalized quality initiatives.

In terms of quality improvement initiatives, it is strongly suggested the organization and the network begin to build the support for the individual units to begin to grow their own QI initiatives. These would include the building blocks of an idea, with an objective, a timeline, with indicators to monitor how they are moving forward to the end objective. There is a strong team of interested health professionals in the critical care units wanting to build a critical care quality system to help the patients of Northern Health.

The Critical Care Network has been involved in multiple projects. The Critical Care Service Plan has begun to move forward and will see an increase of critical care beds within Northern Health. The largest obstacle for the expansion project is the availability of staffing to work in these rural communities. Another project that has been completed and has become the base for acuity in British Columbia is the Critical Care Acuity Tool.

The Surge Plan is currently under review. The organization is encouraged to push forward on this strategic opportunity. This will be useful with new critical care beds to ensure the right patient is in the right place for the right care. It was noted that some site leads are beginning to create their own access and flow documents, and this may be a source of confusion in the future as the population continues to age.

Indicators for critical care are listed in Tableau. Most are directives are from the Ministry and are not linked to a specific objective other than to do better. Examples of these are the quarterly collection of sepsis, VAP, pain management, transfer of care documentation, and capacity data. The Critical Care team is working towards having a critical care dashboard with the indicators easily found. This work will improve with the implementation of the Cerner Electronic Medical Record. Of note, the network has recently created a team out of UHNBC to respond to Fort St. John and Dawson Creek for urgent medical support to assist in decreasing the number of transfers to the UHNBC critical care unit. The team includes nursing and respiratory with the intensivist a call away.

There are Quality Improvement projects at the local level with timelines, indicators, and distinct objectives. These include but are not limited to, Sage waterless bathing, and UHNBC Critical Care Recovery Program, where a team member reaches out to a person who recovered in the critical care unit, two to three months post discharge. This is in person or virtually, and they ensure the safety nets such as adequate care, and proper medications are available for client success. A project related to organ donor successes is the return of families who were related to a donor, and those who received an organ, coming back to the hospital to celebrate. This is supported by Organ Donation, BC, and is called Operation Popcorn.

During the survey it was noted there are significant staffing shortages for many of the critical care units that include internal specialists, intensivists, registered nurses, respiratory, physio and occupational therapists. Purposeful work is being done by the human resources team to hire for these positions. Physician recruitment is being spearheaded by the Critical Care Medical Director. Success has been found since the new contract agreement in the last couple years. Other innovative ideas have been creative education for a fellowship with a commitment of time served post completion. There is work being done to begin a program to train internal medical practitioners to become intensivists. Support for physicians in the more rural settings is also being considered, and there is work being done to create a position of a critical care outreach team (CCOT) intensivist who would call the critical care sites daily and round with the responsible physician on their patients. This would allow uniform care for critical care patients.

It is evident that the teams are committed to patient and family centered care, however the engagement of patients and families is not formalized for the operational levels of decision making. Many initiatives in the critical care areas are from complaints of the patients and families. With the critical care service expecting to see an expansion of service beds in its six sites and the implementation of a cardiac service, this is an excellent opportunity to formally engage patient and family advisors. They could provide input to quality huddles, network meetings, unit design and staffing models. NH patient surveys are administered across the organization; however the team is encouraged to consider leadership rounds where they can obtain 'just-in-time' feedback from patients and families.

Table 14: Unmet Criteria for Service Excellence for Critical Care Services

Criteria Number	Criteria Text	Criteria Type
1.1.1	The team co-designs its services with its partners and the community.	HIGH
1.1.2	The team uses information about the service needs of clients and the community to guide its service design.	NORMAL
1.1.3	The team develops its service-specific goals and objectives.	NORMAL
1.1.4	The team monitors and evaluates its services for appropriateness.	NORMAL
1.2.3	The team leadership engages with clients and families to determine the required mix of skill levels and experience within the team.	NORMAL

Criteria Number	Criteria Text	Criteria Type
1.2.4	The team works with the organization to co-design its physical spaces to meet its safety and service needs including confidential and private interactions for clients and families.	NORMAL
1.2.5	The team leadership engages with team members and other stakeholders to evaluate the effectiveness of its resources, including staffing and space.	NORMAL
2.1.1	The team leadership engages with clients and families to define the required training and education for all team members.	HIGH
2.1.11	The team leadership regularly engages with client and family representatives to gather input and feedback on their roles and responsibilities as well as role design, processes, and satisfaction.	NORMAL
4.3.3	The team identifies measurable objectives for its quality improvement initiatives including specific timeframes for their completion.	HIGH
4.3.4	The team identifies indicators to monitor progress for each quality improvement objective.	NORMAL
4.3.6	The team leadership works with staff to use new or existing indicator data to establish a baseline for each indicator.	NORMAL
4.3.7	The team leadership works with staff to regularly collect indicator data and track progress towards quality improvement objectives.	NORMAL
4.3.8	The team leadership works with staff to regularly analyze indicator data to evaluate the effectiveness of its quality improvement activities.	HIGH

Criteria Number	Criteria Text	Criteria Type
4.3.10	The team leadership ensures that information about quality improvement activities, results and learnings are shared with staff, clients and families, organizational leaders, and partners, as appropriate.	NORMAL

Service Excellence for Emergency Department

Standard Rating: 85.0% Met Criteria

15.0% of criteria were unmet. For further details please review the following table.

Assessment Results

The survey team was impressed by the high level of engagement among local leaders with oversight of Emergency Departments (ED) experiencing significant challenges with staff and physician shortages and the resulting service disruptions. Many of the people leading and providing care in these facilities have significant experience in northern and rural areas so are well versed in contingency planning and the importance of networking to ensure that surge planning and patient flow are top of mind, with safety at the forefront. There are mechanisms in place to collaborate with provincial and regional teams to get patients to the most appropriate location for diagnostics and treatment when EDs are out of service.

Some of the rural sites are very small, seldom experiencing crowding or wait times. In these situations, it was evident that there are good relationships amongst the physicians, hospital-based teams, and their community partners. There is a strong connection with primary care.

Quick response initiatives are in place at UHNBC specifically and in other sites where wait times can be problematic. These initiatives provide fast tracked access to vulnerable populations such as Continuing Care and Mental Health and Addictions where an ED is not the ideal place to receive services.

It was noted that there was not significant awareness of the protocols in place for people who wish to participate in organ donation. The default position seemed to be that this program is not applicable to rural and remote locations. Some of the staff who participated in Accreditation tracer activities noted that the policies and procedures are in place and that they would access these as required. The survey team recommends that an awareness initiative be undertaken with staff and physicians so that there will be more of a comfort level amongst staff if a pertinent situation presents itself.

There are very good orientation mechanisms in place to support recruitment and retention of new staff, however it was noted that staff who are new to the north or who are new to the ED may require additional training and support. Staff frequently get re-deployed to the ED from inpatient medical units.

It was noted that there are various degrees of interest and knowledge about quality improvement among staff and local leaders. There is a QI initiative underway in Bulkley Valley District Hospital looking at flow from arrival at the ED to registration and triage. The organization is encouraged to support and take the learnings from this initiative to make decisions about best practices at NH for registration and triage. Several of the facilities expect patients to register on arrival and then the patient may or may not be triaged in a timely way, but in some cases, they may not be monitored while waiting. This appears to be both a design issue and a flow issue. Patients should be monitored while waiting in ED waiting rooms.

The approach to Quality Improvement, both for awareness and facilitation of improvement initiatives should be standardized across the region. The quality boards are very interactive and informative in some sites, and in others they are out of date and not used to facilitate information sharing by displaying key performance indicators and the associated data. Regular huddles could be used to look at performance on KPIs and to collaborate on potential improvements as required.

The staff work with a mix of paper and electronic systems for patient information and decision support. There is a high degree of interest in the implementation of a comprehensive EMR.

The survey team saw a strong commitment to excellence in rural and northern healthcare. From a patient and family centred care perspective, staff are committed to facilitating timely access and providing service close to home.

Table 15: Unmet Criteria for Service Excellence for Emergency Department

Criteria Number	Criteria Text	Criteria Type
1.1.1	The team co-designs its services with its partners and the community.	HIGH
1.2.3	The team leadership engages with clients and families to determine the required mix of skill levels and experience within the team.	NORMAL
1.2.4	The team works with the organization to co-design its physical spaces to meet its safety and service needs including confidential and private interactions for clients and families.	NORMAL
2.1.11	The team leadership regularly engages with client and family representatives to gather input and feedback on their roles and responsibilities as well as role design, processes, and satisfaction.	NORMAL
2.1.10	The team leadership regularly evaluates and documents each staff member’s performance in an objective, interactive, and constructive way.	HIGH
4.3.3	The team identifies measurable objectives for its quality improvement initiatives including specific timeframes for their completion.	HIGH
4.3.4	The team identifies indicators to monitor progress for each quality improvement objective.	NORMAL
4.3.5	The team leadership works with staff to design and test quality improvement activities to meet objectives.	HIGH

Criteria Number	Criteria Text	Criteria Type
4.3.6	The team leadership works with staff to use new or existing indicator data to establish a baseline for each indicator.	NORMAL
4.3.7	The team leadership works with staff to regularly collect indicator data and track progress towards quality improvement objectives.	NORMAL
4.3.8	The team leadership works with staff to regularly analyze indicator data to evaluate the effectiveness of its quality improvement activities.	HIGH
4.3.9	The team leadership works with staff to implement throughout their services the quality improvement activities that were shown to be effective in the testing phase.	HIGH

Service Excellence for Inpatient Services

Standard Rating: 82.5% Met Criteria

17.5% of criteria were unmet. For further details please review the following table.

Assessment Results

A current leadership strategy and opportunity for improvement centres on enhancing flow and opening up capacity by focusing on the large ALC population across inpatient services. Inpatient services are benefiting from the NH Acute Care Stabilization Strategic Initiative which is actively striving to implement priority service enhancements for accessible and stable acute care services.

An acute services leadership committee, linking NH sites, has reconvened meeting post pandemic. This is an essential and positive step as both the broader NH and local site leadership teams will be required to collectively focus on driving down higher-level service enhancements to the local level to ensure uptake, spread of initiatives, and consistent monitoring of system enhancements. This committee can also provide a generative space for engagement and leadership team building. The priority for clinical leaders will be to focus on ensuring safe quality service availability based on community and population need, available health human resources, engaged patients and families, and a focus on quality of care and patient safety. Of note, a number of these goals are being realized with local leadership models, for example, supporting managers with funding for additional staffing FTEs, new directors in place at some sites, a unit leadership model of a team lead, patient care coordinator, clinical practice leader, discharge planner, each with defined roles and responsibilities. The role of educator/ mentor has been created to support nursing education and at-the-elbow practice coaching/ mentoring for nurses in more remote communities. The organization is to be commended for acknowledging system needs with strategic action.

Due to lack of permanent staff, changing leadership and unclear pathways for engagement, forming partnerships with other services, programs or authorities has been a challenge. The organization is encouraged to work closely with other health authorities and system partners to further meet the needs of the community.

Staff in the clinical areas wear VOCERA devices as an effective staff to staff communication tool with safety alert capability. Charting and documentation are still mainly on paper, with some access to electronic tools such as PowerChart to check labs and imaging, and access external patient information such as community care plans. There is a patient portal in development where patients will have access to their information. Working in a hybrid documentation system presents a risk and challenge for collaboration, care navigation, and the timely exchange of patient information across providers and staff. Different physician and clinician providers may use different electronic tools and platforms that don’t speak to each other which could cause further fragmentation of care. The implementation of a new EMR will bring about positive change.

Sites offer a variety of online (on the LearningHub) clinical competency training and education modalities, including ROP education and ACLS certification for staff. Clinical practice leaders and education leads at the unit level focus on documentation audits to assess knowledge uptake and completion of required education. Education and training modules are comprehensive and link new graduate nursing staff to onboarding and orientation, and existing staff to annual or bi-annual nursing competency refreshers. One site created an at-a-glance robust education and training dashboard listing all the mandatory professional, clinical and organization education offerings, and timelines to complete them. Currently, only the manager of the unit or clinical practice leader can track competency completions, such as for IV pump refreshers, ALCS and BLS (all LearningHub modules). It may be an improvement to make this accessible in a dashboard for leadership.

Performance appraisals are not consistently completed across sites. The organization is encouraged to explore change processes to support managers in completing appraisals and to enable coaching conversations with staff to support them on their professional growth journeys. Health human resource (HHR) challenges exist across the system. The organization and teams are commended for the creation / execution of innovative staffing, recruitment and retention models. The GoHealthBC nursing agency is centralized under NH auspices and has expanded to have its own Agency Deployment Office to focus on basic onboarding education and training for nursing staff to enable the local sites to focus on unit and site-specific clinical orientation. As managers strive to recruit permanent nursing staff, it is suggested that sites monitor access patterns and site needs to ensure equitable and timely access to NH agency nursing staff. A positive recruitment strategy and staffing support role is the hiring of student nurses as care aides after their second year as a student. Sites are also encouraged to continue to recruit IEN's (internationally educated nurses) and new graduate nurses where organizations receive funding support for onboarding and skill acquisition to support full scope nursing. The organization is encouraged to support full scope of practice for LPNs, noting that at some sites LPNs are trained in starting IV's.

Site teams are commended for generating and acting on quality improvement with many ideas and projects that are underway at many sites, including implementation of the SBAR for reporting concerns to physicians, space co-design with patients, families and staff, a nurse-led patient mobilization plan for discharge readiness, and the development of a complex patient discharge tool.

While many teams and staff generate ideas for change and improvement, bringing those ideas forward to create formal quality improvement (QI) projects linked to indicators, metrics, goals, and timelines can be a challenge without knowledge of QI methodology and infrastructure. There are pockets of engagement in more formal QI on units driven by and enabled by the presence of a leader well versed in QI methods.

There is a keen interest and energy for positive change and engagement in quality, and the organization is encouraged to invest in developing system and staff capacity with a formal QI program to enable front line staff and teams, in partnership with patients and families, to shift quality ideas into projects. Teams are encouraged to engage in quality and safety-focused processes including rounding, daily safety huddles, and ensuring care transitions include patients and families.

The provision of safe and compassionate person-centred care was clearly a central focus across the organization and sites. Teams, staff, and leaders showed a commitment to caring, compassion and service. Teams are encouraged to continue to engage/deepen clinical processes including rounding, daily safety huddles, and safe care transitions in partnership with patients and families. The organization is encouraged to create a process and team/role to focus on engaging with patients and families around what person-centred care and partnership with patients and families could look like. A number of ideas have surfaced from patients and families, such as patient involvement in space co-design and to improve use of the white boards. Teams and staff are eager to engage in more formal quality improvement projects, which is an opportunity for person-centred partnership with patients and family engagement.

Table 16: Unmet Criteria for Service Excellence for Inpatient Services

Criteria Number	Criteria Text	Criteria Type
1.1.5	The team leadership forms and maintains partnerships with other services, programs, providers, and organizations to meet the needs of clients and the community.	NORMAL

Criteria Number	Criteria Text	Criteria Type
1.2.3	The team leadership engages with clients and families to determine the required mix of skill levels and experience within the team.	NORMAL
1.2.4	The team works with the organization to co-design its physical spaces to meet its safety and service needs including confidential and private interactions for clients and families.	NORMAL
2.1.1	The team leadership engages with clients and families to define the required training and education for all team members.	HIGH
2.1.11	The team leadership regularly engages with client and family representatives to gather input and feedback on their roles and responsibilities as well as role design, processes, and satisfaction.	NORMAL
2.1.12	The team leadership supports staff to follow up on issues and opportunities for growth identified through performance evaluations.	HIGH
2.1.10	The team leadership regularly evaluates and documents each staff member's performance in an objective, interactive, and constructive way.	HIGH
4.3.11	The team regularly evaluates quality improvement initiatives for feasibility, relevance, and usefulness.	NORMAL
4.3.3	The team identifies measurable objectives for its quality improvement initiatives including specific timeframes for their completion.	HIGH
4.3.4	The team identifies indicators to monitor progress for each quality improvement objective.	NORMAL
4.3.6	The team leadership works with staff to use new or existing indicator data to establish a baseline for each indicator.	NORMAL

Criteria Number	Criteria Text	Criteria Type
4.3.7	The team leadership works with staff to regularly collect indicator data and track progress towards quality improvement objectives.	NORMAL
4.3.8	The team leadership works with staff to regularly analyze indicator data to evaluate the effectiveness of its quality improvement activities.	HIGH
4.3.10	The team leadership ensures that information about quality improvement activities, results and learnings are shared with staff, clients and families, organizational leaders, and partners, as appropriate.	NORMAL

Service Excellence for Mental Health Services

Standard Rating: 95.0% Met Criteria

5.0% of criteria were unmet. For further details please review the following table.

Assessment Results

While staffing concerns are evident across the region, the intensity of the issue can vary from site to site. For example, at the Mill Memorial site there is a very low turnover rate compared to other sites in the Northwest. It is felt that this is partly due to a strong and long-standing workforce that has been in place for several years as well as ongoing leadership support in seeking and maintaining ways to achieve an equitable workload. At all sites the willingness of staff and physicians to step in to fill gaps in scheduling as they are able was noted by the leadership. While this dedication and loyalty is commendable it is not sustainable. The ongoing recruitment and creative retention efforts of the teams is encouraged and supported.

Mandatory and ongoing education and training for the team is found on the education hub. Team leaders have access to a report that identifies who and when training has occurred and follows up with staff as may be required. Staff have access to continuing education and professional development opportunities. Nonviolent crisis intervention training is mandatory for all staff with regular refresher courses offered. Physicians' participation in this training is also encouraged.

While the sites follow the strategic priorities and directives as articulated from the region's strategic plan for mental health. The sites are encouraged to develop their own site-specific goals and objectives that align with the regional plan. The development of site-specific goals and objectives will help address the nuances and resources at each site as well as promote accountability in the achievement of the goals. Again, there is an opportunity to include patients and families in the development of each site's goals and objectives, not only in the implementation and achievement of the strategic goals but also other areas of importance to the patients and families.

Quality improvement initiatives are undertaken by the teams to improve the patient experience and/ or their service. For example, patient satisfaction surveys indicated that patients were not happy with the food offered. In collaboration with the dietician a food app was implemented that allowed patients to choose their own meals. Additionally, quality improvement is underway to map out the processes related to the waitlist and acceptance of patients to the Terrace unit. The intent is to communicate in an open and transparent way the processes involved in the patient transition to the Terrace site. It is hoped that this process mapping will result in an effective communication tool such as an algorithm to clearly depict the processes and help dispel any misinformation among the partners. Ideally the tool will be made available prior to the move into the new hospital slated for November this year. For each of the sites, the teams are encouraged to build capacity and embed a culture of continuous quality improvement by identifying at least one quality initiative per year and formally developing the chosen improvement using the organization's quality framework and the PDSA cycle. This would include the identification of a defined goal, performance indicators and a cycle of plan, do, study and act. For each initiative a team would be established that would be inclusive of staff as well as potentially patients and families. The teams are encouraged to document these activities, communicate their successes and the challenges and at the conclusion celebrate the experience and the achievement.

Table 17: Unmet Criteria for Service Excellence for Mental Health Services

Criteria Number	Criteria Text	Criteria Type
4.3.3	The team identifies measurable objectives for its quality improvement initiatives including specific timeframes for their completion.	HIGH
4.3.4	The team identifies indicators to monitor progress for each quality improvement objective.	NORMAL
4.3.5	The team leadership works with staff to design and test quality improvement activities to meet objectives.	HIGH
4.3.6	The team leadership works with staff to use new or existing indicator data to establish a baseline for each indicator.	NORMAL

Service Excellence for Obstetrics

Standard Rating: 98.8% Met Criteria

1.2% of criteria were unmet. For further details please review the following table.

Assessment Results

Northern Region has put a great deal of resources into training the staff to ensure safe delivery of care. All staff commented on the ease and availability of educational programs. The largest site at UHNBC supported staff from other sites to come in and enhance their skills in an environment with more frequent deliveries. The staff are often young and energetic. One of the difficulties for the region is the relatively short length of service delivery after the investment in training. Retention of these highly skilled individuals needs to be a high priority for the region. Multiple potential solutions were put forward by the staff. These ideas could form the basis for collaborative solutions.

The quality culture is building in the perinatal program. There were many ideas and successful plans in place. New programs or processes developed to support patient care areas and linkages were visible at all sites. They are encouraged to share their successes more widely within the broader staff mix and with their public. There is also a MoreOB program that supports improvement and teamwork.

The strategic plan created for the next period is ambitious. The team is encouraged to stay the course as they attempt to provide their goal of care near to home in a region with a widely distributed population.

Table 18: Unmet Criteria for Service Excellence for Obstetrics

Criteria Number	Criteria Text	Criteria Type
4.3.10	The team leadership ensures that information about quality improvement activities, results and learnings are shared with staff, clients and families, organizational leaders, and partners, as appropriate.	NORMAL

Service Excellence for Perioperative Services and Invasive Procedures

Standard Rating: 91.2% Met Criteria

8.8% of criteria were unmet. For further details please review the following table.

Assessment Results

In 2023/2024 Northern Health (NH) performed 15,681 surgeries and 11,223 endoscopies. This was approximately 5000 surgeries short of the Ministry's target.

NH has recently established a corporate Surgical Services Network which is led by an operations lead, a surgical physician and an anesthetist. These individuals work as a triad. The overall objective for the network is to optimize surgical services to ensure timely access to high-quality surgeries, enabled by the right workforce, infrastructure, and governance, across NH. They have created clear goals and objectives including:

1. Increasing and optimizing surgical capacity by identifying and addressing any constraints to delivery of surgical services.
2. Targeting surgical service improvements by developing strategies and improvements to improve surgical flow and capacity.
3. Establishing a surgical services engagement framework to support ongoing engagement and improvements across NH.

NH is working towards a five-year plan to achieve targets for all surgical and endoscopy cases. The Ministry of Health provides NH with surgical targets and they must report their performance on a regular basis. Five of NH's rural sites have increased their hours of operating room time. They are experiencing health human resource challenges.

The network is working on implementing a multi-year plan to achieve 80 per cent of urgent cases within four weeks and 95 per cent of elective cases within the Ministry of Health's benchmark. The target for Endoscopy is 100 per cent of urgent cases within four weeks and 95 per cent of elective cases within the Ministry of Health benchmarks. They are working on establishing a Surgical Services Network Plan, collaborating with Medical Affairs for recruitment and retention of anesthesia and striving to meet the ORNAC and NAPAC standards for safe staffing.

The Surgical Services Network will be introducing new programs across NH. These include the following:

- National Surgical Quality Improvement Program
- Pre-surgical screening Optimization Program
- Waitlist Management Team
- Patient and Surgical Team Travel Funding Program

There is no evidence to indicate that patients and families have been engaged in co-designing or planning of programs and services. Informal feedback through patient concerns and complements is the only source of feedback the surgical program is currently receiving. As there are no formalized processes in place to engage with patients and families, the Surgical Services Network as well as the site based surgical services are encouraged to establish processes to partner with patients and families on all aspects of surgical services planning and delivery.

With the launch of the Surgical Services Network, the network is viewed as an important vehicle in bringing together all the surgical sites within NH. This is an excellent opportunity for this network to facilitate and enable strategic planning, the development and monitoring of performance indicators, the development of standards and practices, and the home for a community of practice. The network is

encouraged to engage with other key partners such as MDR, infection prevention and control, facilities, biomedical engineering, and materials management when appropriate.

All staff in the perioperative program receive a comprehensive orientation and are required to complete additional courses relevant to the area where they are working. As well there is annual re-training that occurs including infusion pump training for those staff who use the infusion pumps.

Since Surgical Services is a data rich program, the mining of data whether from the use of the paper chart or from the electronic medical record, can be very labor intensive. NH is encouraged to explore how it may be able to support these teams on data access and use. NH Surgical Services is commended for monitoring and reporting the following indicators:

1. Elective surgery and endoscopy case volumes.
2. The collection of patient satisfaction data from endoscopy patients,
3. Monitoring of fiscal accountability.
4. Surgical emergency management.
5. Operating room turnover and first patient entry time.

NH is encouraged to move forward with the implementation of the surgical electronic medical record at all surgical sites. The sites that have the EMR are seeing the power and reaping the benefits.

Table 19: Unmet Criteria for Service Excellence for Perioperative Services and Invasive Procedures

Criteria Number	Criteria Text	Criteria Type
1.1.1	The team co-designs its services with its partners and the community.	HIGH
1.2.3	The team leadership engages with clients and families to determine the required mix of skill levels and experience within the team.	NORMAL
1.2.4	The team works with the organization to co-design its physical spaces to meet its safety and service needs including confidential and private interactions for clients and families.	NORMAL
2.1.11	The team leadership regularly engages with client and family representatives to gather input and feedback on their roles and responsibilities as well as role design, processes, and satisfaction.	NORMAL
2.1.10	The team leadership regularly evaluates and documents each staff member’s performance in an objective, interactive, and constructive way.	HIGH

Criteria Number	Criteria Text	Criteria Type
4.3.8	The team leadership works with staff to regularly analyze indicator data to evaluate the effectiveness of its quality improvement activities.	HIGH
4.3.10	The team leadership ensures that information about quality improvement activities, results and learnings are shared with staff, clients and families, organizational leaders, and partners, as appropriate.	NORMAL