Accreditation Report

Nova Scotia Health Authority

Halifax, NS

On-site survey dates: October 16, 2022 - October 21, 2022

Report issued: December 13, 2022

About the Accreditation Report

Nova Scotia Health Authority (referred to in this report as "the organization") is participating in Accreditation Canada's Qmentum accreditation program. As part of this ongoing process of quality improvement, an on-site survey was conducted in October 2022. Information from the on-site survey as well as other data obtained from the organization were used to produce this Accreditation Report.

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

Confidentiality

This report is confidential and will be treated in confidence by Accreditation Canada in accordance with the terms and conditions as agreed between your organization and Accreditation Canada for the Assessment Program.

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

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

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A Message from Accreditation Canada

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

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

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

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

We look forward to our continued partnership.

Sincerely,

Leslee Thompson
Chief Executive Officer

Table of Contents

Executive Summary 1

Accreditation Decision 1

About the On-site Survey 2

Overview by Quality Dimensions 6

Overview by Standards 7

Overview by Required Organizational Practices 10

Summary of Surveyor Team Observations 22

Detailed Required Organizational Practices Results 29

Detailed On-site Survey Results 30

Priority Process Results for System-wide Standards 31

Priority Process: Governance 31

Priority Process: Planning and Service Design 33

Priority Process: Resource Management 35

Priority Process: Human Capital 36

Priority Process: Integrated Quality Management 39

Priority Process: Principle-based Care and Decision Making 41

Priority Process: Communication 43

Priority Process: Physical Environment 45

Priority Process: Emergency Preparedness 47

Priority Process: People-Centred Care 49

Priority Process: Patient Flow 52

Priority Process: Medical Devices and Equipment 53

Service Excellence Standards Results 57

Standards Set: Acquired Brain Injury Services - Direct Service Provision 59

Standards Set: Ambulatory Care Services - Direct Service Provision 62

Standards Set: Biomedical Laboratory Services - Direct Service Provision 65

Standards Set: Cancer Care - Direct Service Provision 68

Standards Set: Case Management - Direct Service Provision 73

Standards Set: Community-Based Mental Health Services and Supports - Direct Service Provision 76

Standards Set: Critical Care Services - Direct Service Provision 80

Standards Set: Diagnostic Imaging Services - Direct Service Provision 83
Standards Set: Emergency Department - Direct Service Provision 85
Standards Set: Hospice, Palliative, End-of-Life Services - Direct Service Provision 88
Standards Set: Infection Prevention and Control Standards - Direct Service Provision 91
Standards Set: Inpatient Services - Direct Service Provision 93
Standards Set: Long-Term Care Services - Direct Service Provision 95
Standards Set: Medication Management (For Surveys in 2021) - Direct Service Provision 99
Standards Set: Mental Health Services - Direct Service Provision 102
Standards Set: Obstetrics Services - Direct Service Provision 107
Standards Set: Organ and Tissue Transplant Standards - Direct Service Provision 109
Standards Set: Perioperative Services and Invasive Procedures - Direct Service Provision 111
Standards Set: Point-of-Care Testing - Direct Service Provision 116
Standards Set: Primary Care Services - Direct Service Provision 117
Standards Set: Provincial Correctional Health Services Standards - Direct Service Provision 120
Standards Set: Public Health Services - Direct Service Provision 124
Standards Set: Rehabilitation Services - Direct Service Provision 127
Standards Set: Spinal Cord Injury Acute Services - Direct Service Provision 130
Standards Set: Spinal Cord Injury Rehabilitation Services - Direct Service Provision 133
Standards Set: Transfusion Services - Direct Service Provision 135
Instrument Results 137
Governance Functioning Tool (2016) 137
Canadian Patient Safety Culture Survey Tool 140
Worklife Pulse 142
Client Experience Tool 144
Appendix A - Qmentum 145
Appendix B - Priority Processes 146

Executive Summary

Nova Scotia Health Authority (referred to in this report as “the organization”) is participating in Accreditation Canada's Qmentum accreditation program. Accreditation Canada is an independent, not-for-profit organization that sets standards for quality and safety in health care and accredits health organizations in Canada and around the world.

As part of the Qmentum accreditation program, the organization has undergone a rigorous evaluation process. Following a comprehensive self-assessment, external peer surveyors conducted an on-site survey during which they assessed this organization's leadership, governance, clinical programs and services against Accreditation Canada requirements for quality and safety. These requirements include national standards of excellence; required safety practices to reduce potential harm; and questionnaires to assess the work environment, patient safety culture, governance functioning and client experience. Results from all of these components are included in this report and were considered in the accreditation decision.

This report shows the results to date and is provided to guide the organization as it continues to incorporate the principles of accreditation and quality improvement into its programs, policies, and practices.

The organization is commended on its commitment to using accreditation to improve the quality and safety of the services it offers to its clients and its community.

Accreditation Decision

Nova Scotia Health Authority's accreditation decision is:

Accredited with Commendation (Report)

The organization has surpassed the fundamental requirements of the accreditation program.

About the On-site Survey

- **On-site survey dates: October 16, 2022 to October 21, 2022**

- **Locations**

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

1. Central Nova Scotia Correctional Facility
2. CZ - Cobequid Community Health Centre
3. CZ - Community Mental Health and Addictions Facility
4. CZ - Dartmouth General Hospital
5. CZ - East Coast Forensic Hospital
6. CZ - East Preston Community Health and Wellness Centre
7. CZ - Eastern Shore Memorial Hospital
8. CZ - Hants Community Hospital
9. CZ - Hants Community Hospital - Haliburton (LTC)
10. CZ - Joseph Howe Centre
11. CZ - Mumford Professional Centre
12. CZ - Musquodoboit Valley Memorial Hospital
13. CZ - Nova Scotia Hospital
14. CZ - Nova Scotia Rehabilitation Centre
15. CZ - Public Health Burnside
16. CZ - QEII - HI Site - Camp Hill Veterans Memorial Building
17. CZ - QEII Abbie J. Lane Memorial Building
18. CZ - QEII Health Science Centre Dickson Building
19. CZ - QEII Health Sciences Centre Centennial, Victoria, Bethune Buildings
20. CZ - QEII Health Sciences Centre Halifax Infirmary
21. CZ - QEII Health Sciences Centre MacKenzie Building
22. CZ - Twin Oaks Memorial Hospital
23. CZ - Windsor Collaborative Practice
24. EZ - Buchanan Memorial Community Health Centre
25. EZ - Cape Breton Regional
26. EZ - Glace Bay Hospital
27. EZ - Harbourview Hospital

25. EZ - Hospice Cape Breton
26. EZ - Inverness Consolidated Memorial Hospital
27. EZ - Northside General Hospital
28. EZ - Prime Brook site
29. EZ - St. Martha's Regional Hospital
30. Nova Scotia Health Authority Provincial Office
31. NZ - Aberdeen Hospital
32. NZ - All Saints Springhill Hospital
33. NZ - Bayview Memorial Health Centre
34. NZ - Colchester East Hants Health Centre
35. NZ - Colchester East Hants Opioid Treatment and Recovery
36. NZ - Community Mental Health and Addictions Amherst Clinic
37. NZ - Cumberland Health Continuing Care
38. NZ - Cumberland Regional Health Care Centre
39. NZ - Lillian Fraser Memorial Hospital
40. NZ - Northeast Nova Scotia Correctional Facility
41. NZ - Pictou County Community Health Centre - Building #3
42. NZ - Public Health Services, Albion Street, Amherst
43. NZ - South Cumberland Community Care Centre, Parrsboro
44. NZ - Sutherland Harris Memorial Hospital
45. WZ - Chipman Building
46. WZ - Dawson Center
47. WZ - Digby General Hospital
48. WZ - Fishermen's Memorial Hosptial
49. WZ - Gateway
50. WZ - New Germany and Area Medical Centre
51. WZ - Queens General Hospital
52. WZ - Roseway Hospital
53. WZ - Soldiers Memorial Hospital
54. WZ - South Shore Regional Hospital
55. WZ - Valley Hospice
56. WZ - Valley Regional Hospital
57. WZ - Yarmouth Regional Hospital

- **Standards**

The following sets of standards were used to assess the organization's programs and services during the on-site survey.

System-Wide Standards

1. Governance
2. Infection Prevention and Control Standards
3. Leadership

Service Excellence Standards

4. Acquired Brain Injury Services - Service Excellence Standards
5. Ambulatory Care Services - Service Excellence Standards
6. Biomedical Laboratory Services - Service Excellence Standards
7. Cancer Care - Service Excellence Standards
8. Case Management - Service Excellence Standards
9. Community-Based Mental Health Services and Supports - Service Excellence Standards
10. Critical Care Services - Service Excellence Standards
11. Diagnostic Imaging Services - Service Excellence Standards
12. Emergency Department - Service Excellence Standards
13. Hospice, Palliative, End-of-Life Services - Service Excellence Standards
14. Inpatient Services - Service Excellence Standards
15. Long-Term Care Services - Service Excellence Standards
16. Medication Management (For Surveys in 2021) - Service Excellence Standards
17. Mental Health Services - Service Excellence Standards
18. Obstetrics Services - Service Excellence Standards
19. Organ and Tissue Transplant Standards - Service Excellence Standards
20. Perioperative Services and Invasive Procedures - Service Excellence Standards
21. Point-of-Care Testing - Service Excellence Standards
22. Primary Care Services - Service Excellence Standards
23. Provincial Correctional Health Services Standards - Service Excellence Standards
24. Public Health Services - Service Excellence Standards
25. Rehabilitation Services - Service Excellence Standards
26. Reprocessing of Reusable Medical Devices - Service Excellence Standards
27. Spinal Cord Injury Acute Services - Service Excellence Standards
28. Spinal Cord Injury Rehabilitation Services - Service Excellence Standards
29. Transfusion Services - Service Excellence Standards

- **Instruments**

The organization administered:

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

Overview by Quality Dimensions

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

Quality Dimension	Met	Unmet	N/A	Total
Population Focus (Work with my community to anticipate and meet our needs)	103	8	0	111
Accessibility (Give me timely and equitable services)	182	10	0	192
Safety (Keep me safe)	946	52	10	1008
Worklife (Take care of those who take care of me)	208	23	3	234
Client-centred Services (Partner with me and my family in our care)	828	18	3	849
Continuity (Coordinate my care across the continuum)	173	6	1	180
Appropriateness (Do the right thing to achieve the best results)	1608	66	11	1685
Efficiency (Make the best use of resources)	89	3	0	92
Total	**4137**	**186**	**28**	**4351**

Overview by Standards

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

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

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

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

Standards Set	High Priority Criteria *			Other Criteria			Total Criteria (High Priority + Other)		
	Met	Unmet	N/A	Met	Unmet	N/A	Met	Unmet	N/A
	# (%)	# (%)	#	# (%)	# (%)	#	# (%)	# (%)	#
Governance	43 (95.6%)	2 (4.4%)	5	31 (96.9%)	1 (3.1%)	4	74 (96.1%)	3 (3.9%)	9
Leadership	49 (98.0%)	1 (2.0%)	0	94 (97.9%)	2 (2.1%)	0	143 (97.9%)	3 (2.1%)	0
Infection Prevention and Control Standards	39 (97.5%)	1 (2.5%)	0	27 (87.1%)	4 (12.9%)	0	66 (93.0%)	5 (7.0%)	0
Medication Management (For Surveys in 2021)	83 (86.5%)	13 (13.5%)	4	46 (95.8%)	2 (4.2%)	2	129 (89.6%)	15 (10.4%)	6
Acquired Brain Injury Services	44 (95.7%)	2 (4.3%)	0	88 (100.0%)	0 (0.0%)	0	132 (98.5%)	2 (1.5%)	0
Ambulatory Care Services	44 (97.8%)	1 (2.2%)	2	76 (97.4%)	2 (2.6%)	0	120 (97.6%)	3 (2.4%)	2
Biomedical Laboratory Services	59 (81.9%)	13 (18.1%)	0	97 (92.4%)	8 (7.6%)	0	156 (88.1%)	21 (11.9%)	0
Cancer Care	99 (98.0%)	2 (2.0%)	0	121 (94.5%)	7 (5.5%)	0	220 (96.1%)	9 (3.9%)	0

Standards Set	High Priority Criteria *			Other Criteria			Total Criteria (High Priority + Other)		
	Met	Unmet	N/A	Met	Unmet	N/A	Met	Unmet	N/A
	# (%)	# (%)	#	# (%)	# (%)	#	# (%)	# (%)	#
Case Management	46 (100.0%)	0 (0.0%)	0	77 (100.0%)	0 (0.0%)	3	123 (100.0%)	0 (0.0%)	3
Community-Based Mental Health Services and Supports	43 (95.6%)	2 (4.4%)	0	94 (100.0%)	0 (0.0%)	0	137 (98.6%)	2 (1.4%)	0
Critical Care Services	53 (88.3%)	7 (11.7%)	0	104 (99.0%)	1 (1.0%)	0	157 (95.2%)	8 (4.8%)	0
Diagnostic Imaging Services	64 (94.1%)	4 (5.9%)	0	64 (92.8%)	5 (7.2%)	0	128 (93.4%)	9 (6.6%)	0
Emergency Department	65 (90.3%)	7 (9.7%)	0	101 (94.4%)	6 (5.6%)	0	166 (92.7%)	13 (7.3%)	0
Hospice, Palliative, End-of-Life Services	45 (100.0%)	0 (0.0%)	0	108 (100.0%)	0 (0.0%)	0	153 (100.0%)	0 (0.0%)	0
Inpatient Services	60 (100.0%)	0 (0.0%)	0	82 (96.5%)	3 (3.5%)	0	142 (97.9%)	3 (2.1%)	0
Long-Term Care Services	54 (96.4%)	2 (3.6%)	0	97 (98.0%)	2 (2.0%)	0	151 (97.4%)	4 (2.6%)	0
Mental Health Services	47 (94.0%)	3 (6.0%)	0	84 (91.3%)	8 (8.7%)	0	131 (92.3%)	11 (7.7%)	0
Obstetrics Services	72 (98.6%)	1 (1.4%)	0	86 (97.7%)	2 (2.3%)	0	158 (98.1%)	3 (1.9%)	0
Organ and Tissue Transplant Standards	87 (100.0%)	0 (0.0%)	0	118 (100.0%)	0 (0.0%)	0	205 (100.0%)	0 (0.0%)	0
Perioperative Services and Invasive Procedures	100 (87.0%)	15 (13.0%)	0	104 (95.4%)	5 (4.6%)	0	204 (91.1%)	20 (8.9%)	0
Point-of-Care Testing	37 (97.4%)	1 (2.6%)	0	44 (95.7%)	2 (4.3%)	2	81 (96.4%)	3 (3.6%)	2
Primary Care Services	59 (100.0%)	0 (0.0%)	0	91 (100.0%)	0 (0.0%)	0	150 (100.0%)	0 (0.0%)	0
Provincial Correctional Health Services Standards	70 (89.7%)	8 (10.3%)	0	66 (95.7%)	3 (4.3%)	1	136 (92.5%)	11 (7.5%)	1

Standards Set	High Priority Criteria *			Other Criteria			Total Criteria (High Priority + Other)		
	Met	Unmet	N/A	Met	Unmet	N/A	Met	Unmet	N/A
	# (%)	# (%)	#	# (%)	# (%)	#	# (%)	# (%)	#
Public Health Services	43 (91.5%)	4 (8.5%)	0	68 (98.6%)	1 (1.4%)	0	111 (95.7%)	5 (4.3%)	0
Rehabilitation Services	41 (91.1%)	4 (8.9%)	0	79 (98.8%)	1 (1.3%)	0	120 (96.0%)	5 (4.0%)	0
Reprocessing of Reusable Medical Devices	76 (86.4%)	12 (13.6%)	0	37 (92.5%)	3 (7.5%)	0	113 (88.3%)	15 (11.7%)	0
Spinal Cord Injury Acute Services	49 (98.0%)	1 (2.0%)	0	90 (96.8%)	3 (3.2%)	0	139 (97.2%)	4 (2.8%)	0
Spinal Cord Injury Rehabilitation Services	45 (95.7%)	2 (4.3%)	0	86 (98.9%)	1 (1.1%)	0	131 (97.8%)	3 (2.2%)	0
Transfusion Services	75 (100.0%)	0 (0.0%)	1	63 (92.6%)	5 (7.4%)	1	138 (96.5%)	5 (3.5%)	2
Total	**1691 (94.0%)**	108 (6.0%)	12	2323 (96.8%)	77 (3.2%)	13	4014 (95.6%)	185 (4.4%)	25

* Does not includes ROP (Required Organizational Practices)

Overview by Required Organizational Practices

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

This table shows the ratings of the applicable ROPs.

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

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Communication			
Client Identification (Diagnostic Imaging Services)	Met	1 of 1	0 of 0
Client Identification (Emergency Department)	Met	1 of 1	0 of 0
Client Identification (Hospice, Palliative, End-of-Life Services)	Met	1 of 1	0 of 0
Client Identification (Inpatient Services)	Met	1 of 1	0 of 0
Client Identification (Long-Term Care Services)	Met	1 of 1	0 of 0
Client Identification (Mental Health Services)	Met	1 of 1	0 of 0
Client Identification (Obstetrics Services)	Met	1 of 1	0 of 0
Client Identification (Organ and Tissue Transplant Standards)	Met	1 of 1	0 of 0
Client Identification (Perioperative Services and Invasive Procedures)	Met	1 of 1	0 of 0
Client Identification (Point-of-Care Testing)	Met	1 of 1	0 of 0
Client Identification (Provincial Correctional Health Services Standards)	Met	1 of 1	0 of 0
Client Identification (Rehabilitation Services)	Met	1 of 1	0 of 0

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Communication			
Client Identification (Spinal Cord Injury Acute Services)	Met	1 of 1	0 of 0
Client Identification (Spinal Cord Injury Rehabilitation Services)	Met	1 of 1	0 of 0
Client Identification (Transfusion Services)	Met	1 of 1	0 of 0
Information transfer at care transitions (Acquired Brain Injury Services)	Met	4 of 4	1 of 1
Information transfer at care transitions (Ambulatory Care Services)	Met	4 of 4	1 of 1
Information transfer at care transitions (Cancer Care)	Met	4 of 4	1 of 1
Information transfer at care transitions (Case Management)	Met	4 of 4	1 of 1
Information transfer at care transitions (Community-Based Mental Health Services and Supports)	Met	4 of 4	1 of 1
Information transfer at care transitions (Critical Care Services)	Met	4 of 4	1 of 1
Information transfer at care transitions (Emergency Department)	Met	4 of 4	1 of 1
Information transfer at care transitions (Hospice, Palliative, End-of-Life Services)	Met	4 of 4	1 of 1
Information transfer at care transitions (Inpatient Services)	Met	4 of 4	1 of 1

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Communication			
Information transfer at care transitions (Long-Term Care Services)	Met	4 of 4	1 of 1
Information transfer at care transitions (Mental Health Services)	Met	4 of 4	1 of 1
Information transfer at care transitions (Obstetrics Services)	Met	4 of 4	1 of 1
Information transfer at care transitions (Organ and Tissue Transplant Standards)	Met	4 of 4	1 of 1
Information transfer at care transitions (Perioperative Services and Invasive Procedures)	Met	4 of 4	1 of 1
Information transfer at care transitions (Provincial Correctional Health Services Standards)	Met	4 of 4	1 of 1
Information transfer at care transitions (Rehabilitation Services)	Met	4 of 4	1 of 1
Information transfer at care transitions (Spinal Cord Injury Acute Services)	Met	4 of 4	1 of 1
Information transfer at care transitions (Spinal Cord Injury Rehabilitation Services)	Met	4 of 4	1 of 1
Medication reconciliation as a strategic priority (Leadership)	Met	3 of 3	2 of 2
Medication reconciliation at care transitions (Acquired Brain Injury Services)	Met	4 of 4	0 of 0

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Communication			
Medication reconciliation at care transitions (Ambulatory Care Services)	Met	5 of 5	0 of 0
Medication reconciliation at care transitions (Cancer Care)	Met	9 of 9	0 of 0
Medication reconciliation at care transitions (Community-Based Mental Health Services and Supports)	Met	3 of 3	1 of 1
Medication reconciliation at care transitions (Critical Care Services)	Met	4 of 4	0 of 0
Medication reconciliation at care transitions (Emergency Department)	Met	1 of 1	0 of 0
Medication reconciliation at care transitions (Hospice, Palliative, End-of-Life Services)	Met	4 of 4	0 of 0
Medication reconciliation at care transitions (Inpatient Services)	Met	4 of 4	0 of 0
Medication reconciliation at care transitions (Long-Term Care Services)	Met	4 of 4	0 of 0
Medication reconciliation at care transitions (Mental Health Services)	Met	4 of 4	0 of 0

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Communication			
Medication reconciliation at care transitions (Obstetrics Services)	Met	4 of 4	0 of 0
Medication reconciliation at care transitions (Perioperative Services and Invasive Procedures)	Met	4 of 4	0 of 0
Medication reconciliation at care transitions (Provincial Correctional Health Services Standards)	Met	4 of 4	0 of 0
Medication reconciliation at care transitions (Rehabilitation Services)	Met	4 of 4	0 of 0
Medication reconciliation at care transitions (Spinal Cord Injury Acute Services)	Met	4 of 4	0 of 0
Medication reconciliation at care transitions (Spinal Cord Injury Rehabilitation Services)	Met	4 of 4	0 of 0
Safe Surgery Checklist (Obstetrics Services)	Met	3 of 3	2 of 2
Safe Surgery Checklist (Organ and Tissue Transplant Standards)	Met	3 of 3	2 of 2
Safe Surgery Checklist (Perioperative Services and Invasive Procedures)	Met	3 of 3	2 of 2

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Communication			
The “Do Not Use” list of abbreviations (Medication Management (For Surveys in 2021))	Met	4 of 4	3 of 3
Patient Safety Goal Area: Medication Use			
Antimicrobial Stewardship (Medication Management (For Surveys in 2021))	Met	4 of 4	1 of 1
Concentrated Electrolytes (Medication Management (For Surveys in 2021))	Met	3 of 3	0 of 0
Heparin Safety (Medication Management (For Surveys in 2021))	Met	4 of 4	0 of 0
High-Alert Medications (Medication Management (For Surveys in 2021))	Met	5 of 5	3 of 3
Infusion Pumps Training (Ambulatory Care Services)	Met	4 of 4	2 of 2
Infusion Pumps Training (Cancer Care)	Met	4 of 4	2 of 2
Infusion Pumps Training (Critical Care Services)	Met	4 of 4	2 of 2
Infusion Pumps Training (Emergency Department)	Met	4 of 4	2 of 2
Infusion Pumps Training (Hospice, Palliative, End-of-Life Services)	Met	4 of 4	2 of 2
Infusion Pumps Training (Inpatient Services)	Met	4 of 4	2 of 2

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Medication Use			
Infusion Pumps Training (Long-Term Care Services)	Met	4 of 4	2 of 2
Infusion Pumps Training (Obstetrics Services)	Met	4 of 4	2 of 2
Infusion Pumps Training (Organ and Tissue Transplant Standards)	Met	4 of 4	2 of 2
Infusion Pumps Training (Perioperative Services and Invasive Procedures)	Met	4 of 4	2 of 2
Infusion Pumps Training (Rehabilitation Services)	Met	4 of 4	2 of 2
Infusion Pumps Training (Spinal Cord Injury Acute Services)	Met	4 of 4	2 of 2
Infusion Pumps Training (Spinal Cord Injury Rehabilitation Services)	Met	4 of 4	2 of 2
Narcotics Safety (Medication Management (For Surveys in 2021))	Met	3 of 3	0 of 0
Patient Safety Goal Area: Worklife/Workforce			
Client Flow (Leadership)	Met	7 of 7	1 of 1
Patient safety plan (Leadership)	Met	2 of 2	2 of 2
Patient safety: education and training (Leadership)	Met	1 of 1	0 of 0

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Worklife/Workforce			
Preventive Maintenance Program (Leadership)	Met	3 of 3	1 of 1
Workplace Violence Prevention (Leadership)	Met	5 of 5	3 of 3
Patient Safety Goal Area: Infection Control			
Hand-Hygiene Compliance (Infection Prevention and Control Standards)	Met	1 of 1	2 of 2
Hand-Hygiene Education and Training (Infection Prevention and Control Standards)	Met	1 of 1	0 of 0
Infection Rates (Infection Prevention and Control Standards)	Met	1 of 1	2 of 2
Patient Safety Goal Area: Risk Assessment			
Falls Prevention Strategy (Acquired Brain Injury Services)	Met	2 of 2	1 of 1
Falls Prevention Strategy (Cancer Care)	Met	2 of 2	1 of 1
Falls Prevention Strategy (Critical Care Services)	Met	2 of 2	1 of 1
Falls Prevention Strategy (Hospice, Palliative, End-of-Life Services)	Met	2 of 2	1 of 1
Falls Prevention Strategy (Inpatient Services)	Met	2 of 2	1 of 1
Falls Prevention Strategy (Long-Term Care Services)	Met	5 of 5	1 of 1

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Risk Assessment			
Falls Prevention Strategy (Mental Health Services)	Met	2 of 2	1 of 1
Falls Prevention Strategy (Obstetrics Services)	Met	2 of 2	1 of 1
Falls Prevention Strategy (Organ and Tissue Transplant Standards)	Met	2 of 2	1 of 1
Falls Prevention Strategy (Perioperative Services and Invasive Procedures)	Met	2 of 2	1 of 1
Falls Prevention Strategy (Rehabilitation Services)	Met	2 of 2	1 of 1
Falls Prevention Strategy (Spinal Cord Injury Acute Services)	Met	2 of 2	1 of 1
Falls Prevention Strategy (Spinal Cord Injury Rehabilitation Services)	Met	2 of 2	1 of 1
Pressure Ulcer Prevention (Cancer Care)	Met	3 of 3	2 of 2
Pressure Ulcer Prevention (Critical Care Services)	Met	3 of 3	2 of 2
Pressure Ulcer Prevention (Hospice, Palliative, End-of-Life Services)	Met	3 of 3	2 of 2
Pressure Ulcer Prevention (Inpatient Services)	Met	3 of 3	2 of 2
Pressure Ulcer Prevention (Long-Term Care Services)	Met	3 of 3	2 of 2

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Risk Assessment			
Pressure Ulcer Prevention (Perioperative Services and Invasive Procedures)	Met	3 of 3	2 of 2
Pressure Ulcer Prevention (Rehabilitation Services)	Met	3 of 3	2 of 2
Pressure Ulcer Prevention (Spinal Cord Injury Acute Services)	Met	3 of 3	2 of 2
Pressure Ulcer Prevention (Spinal Cord Injury Rehabilitation Services)	Met	3 of 3	2 of 2
Suicide Prevention (Community-Based Mental Health Services and Supports)	Met	5 of 5	0 of 0
Suicide Prevention (Emergency Department)	Unmet	4 of 5	0 of 0
Suicide Prevention (Long-Term Care Services)	Met	5 of 5	0 of 0
Suicide Prevention (Mental Health Services)	Met	5 of 5	0 of 0
Suicide Prevention (Provincial Correctional Health Services Standards)	Met	5 of 5	0 of 0
Venous Thromboembolism Prophylaxis (Cancer Care)	Met	3 of 3	2 of 2
Venous Thromboembolism Prophylaxis (Critical Care Services)	Met	3 of 3	2 of 2
Venous Thromboembolism Prophylaxis (Inpatient Services)	Met	3 of 3	2 of 2

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Risk Assessment			
Venous Thromboembolism Prophylaxis (Organ and Tissue Transplant Standards)	Met	3 of 3	2 of 2
Venous Thromboembolism Prophylaxis (Perioperative Services and Invasive Procedures)	Met	3 of 3	2 of 2
Venous Thromboembolism Prophylaxis (Spinal Cord Injury Acute Services)	Met	3 of 3	2 of 2
Venous Thromboembolism Prophylaxis (Spinal Cord Injury Rehabilitation Services)	Met	3 of 3	2 of 2

Summary of Surveyor Team Observations

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

Nova Scotia Health (NSH) is responsible for the provision of health services to the people of Nova Scotia as well as some specialized services to Atlantic Canada through the operation of hospitals, health centres, and community-based services. Under the Health Authorities Act and along with the IWK Services, NSH has the legislated responsibility to manage and provide health care to Nova Scotians and to engage with the communities that they serve. NSH works in partnership with community groups, schools, governments, foundations, auxiliaries, and community health boards.

NSH is guided by its vision of Healthy People, Healthy Communities – for generations and its mission to achieve excellence through health, healing, and learning through working together. NSH's strategic directions focus on 1) delivering a high-quality and sustainable health system, 2) strengthening and supporting a healthy and high-performing workforce, and 3) working with their communities to improve the health and wellness of Nova Scotians.

In September 2021, the Government of Nova Scotia announced a new health system leadership team with a clear mandate to take immediate action to improve health care in the province. A new interim CEO was appointed, and the board was replaced by an Official Administrator. A Health Leadership Team was put in place to engage and take action to improve the healthcare system.

The Action for Health – A Strategic Plan 2022-2026 is the government's roadmap to change the healthcare system and to fix core issues of recruitment and retention, access to care, and outdated infrastructure.

With the many changes this past year, NSH is commended for its commitment to the accreditation process and for the time and participation of patients, families, community partners, staff, and physicians during the survey visit.

Person-centred care (PCC) has evolved significantly. There are substantial resources to support leaders and teams in engaging authentically with patients and families to take care of them safely, elevate quality, and improve the patient experience. From hiring leaders committed to core PCC principles to supporting staff in their journey to embed PCC in their practice, Nova Scotia Health has set realizable goals and ambitious timelines to spread best practices from centres of excellence to areas of care across the province. The organization is still early in its journey.

Patients and families are aware of their role and responsibility in patient safety. They are also aware of how to raise a concern or complaint. There are some areas throughout the organization that are not aware of NSH's policy on clients' rights and responsibilities. It is recommended that NSH ensure there is organizational awareness including how staff can access the information so that patients and families are informed.

Nova Scotia Health is undertaking an integrated and systems approach to support the people's needs of the organization. A collaborative approach is used to support the various work streams. Coalitions are being built across portfolios, decisions are being made together and teams are debriefing on specific initiatives. As one participant indicated, “it is not just about adding people but looking at how we do the work differently”. NSH is committed to building a healthy workplace and ensuring the engagement of staff and physicians. The organization is committed and invested in supporting a culture of equity, inclusion, and diversity. There is still more work to be done to address stigmatization from both a client and staff perspective.

The approach to ethical decision-making is a strength of Nova Scotia Health. There is a robust Ethics Network in place that draws upon expertise both within and outside the organization. There is also an ethics organization structure at the provincial, zone, and local levels. The organization is to be commended for its commitment to include members of the public in the structure and to draw upon public expertise to review organizational products such as policies and procedures. NSH's Ethics Framework also includes a Patient and Family Ethics tool which is somewhat unique among healthcare organizations.

NSH is commended on the development and implementation of the Improvement and Culture Strategy for 2021 to 2026. There are many examples of how quality is embedded at the unit level. There is still an opportunity to make data more visible to the front-line providers.

The use of multiple record-keeping platforms and approaches can increase risk, impact the continuity of care, and create inefficiencies. NSH recognizes the critical need of having a modernized health information system, One Patient, One Record (OPOR) and is encouraged to move as quickly as possible with implementation.

NSH operates across numerous sites throughout the province in both rural and urban communities. The physical condition of each site varies significantly by age and condition. There are some facilities where the physical infrastructure requires immediate remediation to address physical environment risks. For example, the QEII site (Victoria General) is particularly challenged with heating, ventilation, and air conditioning creating serious challenges for staff and patients receiving care. Legionella in the water systems also makes it very difficult for patients to bathe safely. Capital planning, facility operations, and maintenance teams are working diligently to address issues.

The organization may benefit from reviewing the teams that are responsible for the oversight of the physical environment, medical devices management and maintenance, and medical device reprocessing within the organization. The structure is very decentralized and there may be opportunities to leverage economies of scale related to teams doing this work and contract oversight.

NSH and the emergency preparedness team are to be commended for the extraordinary efforts to mitigate over 1400 emergency events over the past five years. Most recently, NSH's response to hurricane Fiona illustrates the organization's ability to respond to unexpected and emergent events.

The Diagnostic Imaging service was restructured in 2021 from a provincial model to a zone model. Decision-making is now within the zone and occurs locally. Leaders spoke positively of the connections and partnerships made through the provincial structure that serves them well today such as through their Provincial Modality Committees.

The Renal Program has a comprehensive approach to organizing and delivering service at a provincial and local level. Modes of treatment are segregated into conservative care, dialysis, and transplant; the program is commended for ensuring clients understand the potential of movement between these options of care as their needs and disease evolve. Program leadership has acknowledged the need for improved vascular access from surgery and interventional radiology. This current gap in service may lead to less optimal outcomes as clients may have to choose sub-optimal modes of treatment. The program has delineated the scope and service levels between the acute care, regional, and satellite sites across the province. Clients have commented that they truly believe that there is a provincial kidney care program for the management of their care.

The long-term care team is resident centred. Residents and families are encouraged to provide input and feedback on all aspects of their care and well-being. There is good team communication and availability of resources to support care. Quality is monitored through a variety of metrics and communicated to staff, residents, and families through quality boards on each residence and unit. There are opportunities to further enhance care through the adoption of an electronic medical record. A review of medication processes and supports would be beneficial.

Tissue and organ transplant is a very strong program providing service to all four maritime provinces. Services are designed, implemented, and reviewed using international standards and input from clinical experts. Patient-centred care is well embedded into the team and the input of patient advisors is appreciated. Collecting and collating patient care information across four provinces is challenging and time-consuming. It would be very helpful to have an electronic patient record for Nova Scotia and even better if there was an integrated electronic patient record across the Maritimes.

The perioperative program has a dynamic leadership team with resources and expertise to develop standardized order sets and quality improvement projects that are monitored and measured. The development of regional centers in the zones for orthopedic surgery, gynecology, urology, and orthopedics provides centres of excellence and optimizes resource utilization. Engaging surgeons in changing their practice can be challenging and, in some hospitals, there was poor compliance with the use of standardized order sets and resistance to change or engagement in process improvement initiatives.

Provincial corrections are in desperate need of resources. Equitable access to resources needs to be addressed in the central zone where health human resources, medical resources, dental resources, and technology are lacking. There is a large portion of clients with dental abscesses and very few dental resources. Wait times are significant to see medical, mental health, and dental providers. Creating opportunities for retaining staff, especially in the central zone, is strongly encouraged. Teams are taking recommendations that have resulted from a major review of their model of care and are making strides in

quality improvement. They have recently created a patient and family pamphlet on being engaged in their care. Medication administration needs to be reviewed, with emphasis on the central zone. There are medication practices that require some focused attention and improvement.

There are strong proactive provincial partnerships noted in Community-Based Mental Health from schools to seniors' communities, to Indigenous communities, to RCMP/Police. Initiatives to support and reduce access barriers have been noted, such as utilizing telehealth and other virtual visit modalities, especially targeted at rural and remote clients who otherwise may not be able to attend or participate fully in their care. The provincial intake service and registration system for outpatient care also help support access. Continued advocacy, reduction of the stigma of mental health, efforts around cultural safety, and further expansion of rural treatment options are recommended.

The Inpatient Services are steadily moving forward to improve care and coordination. Efforts are being made at all levels to improve the flow and care transition boards. Although the flow to inpatient units can be challenging, many standards are met to ensure safe care through the transitions.

Hospice, palliative, and end-of-life care are supported by a robust provincial network that has evolved over many years to create strategies and excellence across end-of-life services in the province. The provincial network ensures that patient needs are met across the spectrum of end-of-life care. Services have demonstrated their commitment to patient and family-centred care and as a preferred setting for the career development of team members. In realizing the provincial vision for end-of-life care, the network has been assessing demand and capacity to ensure that there is a mix of services available to Nova Scotians so that their care needs can be met locally and supported at the zone and provincial levels.

Critical Care is a multidisciplinary team utilizing evidence-based practices and provides care for the sickest patients and their families. They provide leadership and excellence in education and research. There have been voiced concerns regarding the change of governance from a provincial program to zone governance and they are missing the ability to leverage resources and share best practices as done previously.

There was evidence that emergency departments surveyed are under increasing system flow challenges coupled with staffing pressures, which could affect patient care and staff retention. Teams have demonstrated resiliency in their commitment to patients and providing high-quality care. An organizational commitment to improving system flow is evident across locations. The organization is encouraged to engage patients and their families in the process to tackle the flow challenges. The tertiary ED in Nova Scotia is well-resourced with a robust foundation for innovative quality improvements. Its role must be leveraged as a provincial resource to support and strengthen other emergency departments. There is evidence based on chart reviews and direct observation that suicide screening in the emergency department is not occurring across several emergency departments despite its inclusion in the Patient Care Record for emergency department patients. Information put out by the organization has stated that the screen is intended for people presenting with mental health concerns. However, to truly identify those at risk, universal screening of all presenting patients should occur.

Obstetrics Services has many strengths including excellent collaboration with tertiary sites (IWK); a culture

of commitment and inclusivity and outstanding people-centred care. There is flexibility and commitment around bed pressures and patient flow needs including off-service patients. There are quality improvement efforts such as MoreOB and fostering evidence-based practice. Opportunities for improvement include sharing and standardizing successful approaches across NSH, continuing to invest in, and support Midwifery needs, standardizing informed consent for maternal care and newborns, expanding MoreOB to all sites, creating an action plan with EHS to address current delays and continuing work toward one EMR.

There is a Provincial Advisory Group that has a current strategy focused on wellness, chronic disease, and cardiac care. The group has participated in a consultation with a wide range of providers and the community to develop its strategy. This work should continue to be a priority as access to primary care is critical to address the access issues related to the HHR challenges and over capacity issues in Emergency Departments.

The Infection Prevention and Control (IPAC) team are well organized at the provincial, zone and unit level. At the provincial level, the team develops policies that are implemented at the local level. Each zone has grown their IPAC teams, and they even expand within long-term care facilities adding their knowledge and support in those areas. They have been able to build a very good and strong healthcare associated surveillance program.

The current Point of Care Testing (POCT) structure works well, and it was observed that there is a very good alignment between the organizational policies and the deployment of POCT at the operational level. Because of the broader utilization of POCT, NS Health has been innovative in developing the concept of hybrid labs in some community hospitals to alleviate laboratory-staffing issues.

Public Health (PH) is working hard to align its priorities with the Nova Scotia Action for Health Strategic Plan. The impacts of the current pandemic have resulted in an overwhelming desire to implement a PH Recovery and Renewal Plan. This speaks to leadership commitment to their people and health protection for all Nova Scotians.

The Acquired Brain Injury (ABI) Program at Nova Scotia Rehabilitation and Arthritis Centre has a dedicated team of professionals who are very committed to patient and family centred care. Several research projects and quality improvement initiatives are underway to advance care for those with a sustained ABI. They exemplify a strong desire to strive for excellence in all ABI programs.

The Cancer Care Nova Scotia leadership members discussed the momentum that has been achieved over the past two years where they have created a more efficient reporting structure. The leadership is proud of the focus on a new structure that advances research, innovation and discovery that was supported by the CEO and the province that will enable the team to advance leading practices and lead the way in research and innovation. Innovations such as immunotherapy and oral chemotherapy treatments are to be commended as they are examples of the changing approaches to treatments and improving patient outcomes.

The Nova Scotia Mental Health & Additions Program (MHA) serves a population of over 1M individuals

ranging from Children, Youth and Adults. The adult program has specialty services that range from ambulatory, day, and inpatient and specialty programs. By population percentage 45% live in Central followed by 21% in Western, Eastern 17% and 16% in Northern. The MHA program has undergone a significant transformative change that resulted from the Nova Scotia Auditor General Report. Stage one of this work commenced several years ago resulting in an outside needs assessment of the many challenges in MHA across the province. The resulting assessments and planning that have been released as part of the 2025 plan for change have resulted in significant changes to re-design access to care and treatment with MHA. High level successes are noted with the single point of access for services that are data driven and focus on increasing quality services for the MHA population with program innovations and revitalization of services. In several communities, there is no easy access and virtual care has increased exponentially to provide access to care and treatments. There is clear evidence that aspects of this transformational work are gaining traction and many clinicians are describing patient-centred approaches that are with a provincial lens versus a zone lens.

The organization is working on a 'One Patient, One Record' solution for their electronic health record. This project will support the standardization of the medication management system and improve medication safety. Disparate pharmacy information systems, Meditech and BDM, have impacted the standardization of the medication management system. Disparate dispensing cabinet technology – Omnicell and Pyxis also impact patient care. Despite these two challenges the interdisciplinary teams have managed to coordinate and standardize some policies and procedures. Standardizing to one dispensing cabinet technology provincially is planned and will assist in supporting more standardization pending the implementation of the one electronic health record. The next priorities should focus on having pharmacy validation of orders before the first dose for inpatient units and the full implementation of a pharmacy generated Medication Administration Record in all levels of care.

The success of the antibiotic stewardship program should be celebrated. The newly formed team building on previous work has successfully implemented a program that was able to demonstrate positive outcomes quickly and objectively on antibiotic use.

The Correctional Services medication management system is antiquatedly creating a high risk of medication error. They are not using unit doses and are still using a medication card system. They could benefit from the implementation of automated dispensing cabinets supported by the pharmacy information system.

The quality of the Transfusion service has been recognized through awards and recognized as a centre of expertise in identification of complex antibody identification. The standardization of Standard Operation Procedures across the Nova Scotia Health is commended. Opportunities for improvement include the lack of space and shortage of human resources.

Strengths of Laboratory Medicine including its tracking system and automation, specifically in microbiology and core lab allowing a better turn-around-time. Provincial Toxicology Laboratory has acquired new equipment that can respond to the provincial needs in toxicology and develop a new testing capacity to reduce sending tests out of the province.

The staff who support the Case Management function is an excellent team of compassionate caring, innovative staff providing consideration at every checkpoint with the family and clients. They provide access to resources of care ranging from a meal, house care, home care and long-term care. They provide access to special funding for home equipment such as mobility devices and lifts. They are working to change the culture to one of home first. They are encouraged to continue to work on streamlining communication during transition planning and to be able to meet the Department of Seniors and Housing's target of moving a client to a long-term care bed within 6 days. The team is encouraged to work with the Department of Seniors to address the needs of individuals such as young adults who have had traumatic incidents that result in behaviour concerns.

Numerous access and flow initiatives have been put in place including C-3 real time data reporting, virtual care for unattached patients and the implementation of Safer-F patient flow bundle. Additional initiatives include working closely with community paramedic programs to leverage opportunities for earlier discharge along with updating key policies related to access and flow. The implementation of SAFER-F patient flow bundle in medical units in all zones has allowed inpatient units to prevent unnecessary waiting for patients and improve patient flow. The emphasis on person-centred care and involving clients and families is commendable. Nova Scotia health is encouraged to continue the journey to implement this flow bundle following the implementation plan that has been developed. As a next step key policies that are been updated need to be implemented across all zones within Nova Scotia Health.

Community partners provided some thoughtful insight into NSH. They acknowledged that NSH is a tremendous partner that is open to new ideas and willing to address issues promptly. They indicated that NSH wants to collaborate and move things forward to improve the health care for Nova Scotians. The Community Partners encouraged NSH to not be afraid to reach out to their partners to help with getting the work done; to not lose the partnerships that were developed as a result of the pandemic; to ensure that the appropriate communication strategies are used. For example, not everyone has a computer; improving the availability of translated materials for First Nations and looking for strategies to support the sharing of information when care providers are outside of NSH.

Staff and physicians are compassionate and committed to the mission, vision, and values of NSH. They are highly engaged and truly want to improve health care for Nova Scotians.

Change can be expected in the ongoing and dynamic occurrence of health care. The cohesiveness of governance and leadership coupled with meaningful patient, family, staff, physician and community engagement and effective communication will assist Nova Scotia Health in realizing its vision of Healthy people, and healthy communities – for generations.

Detailed Required Organizational Practices

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

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

Unmet Required Organizational Practice	Standards Set
Patient Safety Goal Area: Risk Assessment	
Suicide Prevention Clients are assessed and monitored for risk of suicide.	· Emergency Department 10.7

Detailed On-site Survey Results

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

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

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

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

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

See Appendix B for a list of priority processes.

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

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

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

Priority Process Results for System-wide Standards

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

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

Priority Process: Governance

Meeting the demands for excellence in governance practice.

Unmet Criteria		High Priority Criteria
Standards Set: Governance		
7.8	The governing body has a succession plan for the CEO.	
13.4	The governing body follows a process to regularly evaluate its performance and effectiveness.	!
13.6	The governing body regularly evaluates the performance of the board chair based on established criteria.	!

Surveyor comments on the priority process(es)

Nova Scotia Health (NSH) is governed by an official administrator (OA) who under the statutory requirements functions as the board. The OA was appointed by the Minister of Health, Government of Nova Scotia, in September 2021. The board has a very clear understanding of their roles and responsibilities in governing the organization. The board celebrates and recognizes the organization's achievements and performance. The board is very active in challenging the organization to be the best that it can be and to remain true to NSH's mission, vision, and values. The board is very diligent in examining the metrics they are provided by the leadership as well as opportunities for efficiencies and quality improvement.

There is an excellent working relationship between the board, the Chief Executive Officer (CEO), and the executive leadership team. The CEO receives a regular performance appraisal. The board is encouraged to develop a succession planning process for the CEO to ensure that there is stable leadership, particularly in an emergent situation.

Briefings brought forward to the board by the leadership team are comprehensive and provide the needed information for the board to make recommendations and decisions. A risk analysis which takes into consideration ethics, patient safety, quality, reputation management, human resource needs and

fiscal requirements occurs. The board works to govern, question, and support the ideas and recommendations that are brought forward by the CEO and the executive leadership team. The focus is to look at the opportunities rather than just on the risks.

Quality and Safety are NSH priorities and the board is committed to ensuring quality and safe patient care. The management of quality is guided by the Quality, Safety and Performance (QSP) Framework which serves as a foundational element in support of NSH's renewed strategic plan. NSH's provincial approach to quality has been identified as a key enabler in achieving NSH's goals. The board receives regular reports on key process and outcome indicators.

There is a well-established policy review process that ensures that NSH policies are reviewed regularly.

The organization has a well-established process for reviewing and granting health care privileges. There are also sound processes in place to address performance issues or disputes and appeals related to healthcare professionals with privileges.

The board receives informal feedback on their performance through various avenues. The board is encouraged to develop a formal process to obtain feedback on the performance of the board.

Patient and family stories are shared at board meetings. The board is encouraged to continue to bring the voice of patients and families to their meetings.

Priority Process: Planning and Service Design

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

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

NSH has undergone a very rigorous and robust process to develop the Integrated Health Services Planning Framework. This work has been a collaboration with Izaak Walton Killam Hospital for Children (IWK), the Department of Health and Wellness, the Departments of Senior and Long-Term Care, and NSH to meet the Minister's mandate that zone health service plans are developed. NSH undertook an extensive engagement and consultative process. The framework sets the standards, planning, guidance, and expectations on how health care will be designed and provided in Nova Scotia. This framework is anchored in the Government of Nova Scotia's Action for Health which articulates a different kind of healthcare experience and health culture which is proactive and focuses on people and patients.

All planning and service planning is informed by the mission, vision, and values of NSH. Health Service Planning committees have been established in each of NSH’s zones. Patients and families are represented and engaged; they assist in the co-design process during the service planning process. Zone project management offices and transformation roles have been established to support this work. Tools such as the use of Smartsheet assist in keeping a line of sight on the progress of initiatives. Several examples were provided on how the framework is guiding health service planning and implementation. A key assumption is that there will always be a provincial view and understanding of the delivery of health services with local planning, design, and implementation.

A culture of discovery and innovation is being embedded throughout NSH. The Network of Scholars Strategy, which includes access to the expertise from various disciplines, has been established to support evaluation, the integration of best evidence, and the rapid implementation of priority initiatives. This group of scientists and clinical champions are assisting in priority setting and transforming how NSH can implement and scale initiatives in a short period of time.

NSH is commended on using data and evidence, both qualitative and quantitative, to drive the planning, decision making, and evaluation. Health service plans will continually need to be updated as new data and information become available. Where appropriate, ensure collaboration with other program initiatives. NSH is supported by their commitment to applying an equity lens to its planning processes and is encouraged to continue to work to understand and meet the needs of the diverse populations it serves.

Although there are policies and processes in place to address the rights and responsibilities of clients, there was evidence that some clinical areas were not aware of what was available. NSH is encouraged to ensure that there is organizational awareness of the client's rights and responsibilities and how to access this information so that it can be shared with patients and families.

With the rapid changes that are occurring, and the number of initiatives being planned and implemented, it will be important to continually monitor change fatigue.

Priority Process: Resource Management

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

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

Nova Scotia Health (NSH) has several systems and controls in place to support resource management processes. There are well-established budgeting and decision-making processes for the development of operating and capital needs. NSH undertakes a principle-based approach when determining operating and capital budget requirements while, at the same time, ensuring financial accountability. The annual operating cycle includes identifying the needs of the business including service pressures and quality gaps and priorities of the government.

Financial analyst support is available at the zone level. The finance team supports the local leaders in their financial responsibilities by developing reporting tools, dashboards, and offering education. There is an expectation that programs and services monitor and manage their budgets.

An evidence-based prioritization and risk assessment system is used to determine capital budget needs. A percentage of the capital equipment budget is allocated to each of the zones. Emergency funds are also available to respond to unexpected and urgent equipment needs.

Patient family advisors, front-line leaders, and physicians participate in the budget planning and prioritization process. They review and validate the capital equipment list and identify any missing items. The team is also working on a 5-to-10-year medical equipment strategy.

The team uses the "We are Listening" email address to receive feedback and suggestions. An excellent example was when a patient asked NSH whether they had considered ostomy-friendly stations in the public washrooms. The facility team responded to this request and there are now ostomy-friendly stations in the main public washrooms across NSH.

The team is looking forward to the implementation of One Patient, One Record (OPOR) as this will support the resource allocation and case costing process. The team is congratulated on their implementation of the Healthy Management of Supplies process which includes the warehouse management system, the transport management system, and the point-of-use system. This will assist the organization when responding to recalls.

Although there are rigorous processes in place to review and determine the allocation of operating and capital budgets across the NSH, staff don't always understand how these decisions are made. The team is encouraged to look for ways to openly share with staff the process that is undertaken to determine resource allocations.

Priority Process: Human Capital

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

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

Surveyor comments on the priority process(es)

Nova Scotia Health (NSH) is undertaking an integrated and systems approach to support the people needs of the organization. A collaborative approach is used to support the various work streams. Coalitions are being built across portfolios, decisions are being made together, and teams are debriefing on specific initiatives. As one participant indicated "it is not just about adding people but looking at how we do the work differently". The areas involved in this integrated approach are People Services, Research, Innovation & Discovery, and Medical Affairs.

The team uses an integrated needs-based planning framework which includes:

- Planning – based on population health needs.
- Recognizing the capacity/competencies of the different healthcare providers
- Demonstrating the gaps in the type of health care provider that is required to provide services needed to meet the health care needs.

The work led by this integrated team is focusing on the areas:

- Integrated Workforce Planning,
- Equity, Diversity, Inclusion, Reconciliation, Accessibility
- Recruitment
- Retention/Engagement
- Occupational Health and Safety/ Wellbeing
- Organizational Development and Learning
- Team Member Feedback and Reporting

The integrated team is committed to supporting the people functions of NSH. Some notable successes that this team has realized include the following:

- The training and implementation of the critical care paramedic role.
- Nursing enhancement strategies such as RN prescribing in specific settings.
- Looking at physician extender roles.
- Implementing new models of care.

The creation of the Learning Institute for Health Care Providers to support the rapid transfer of knowledge which is performance-based. There have been approximately 600 learners that have come knowledge which is performance-based. There have been approximately 600 learners that have come through NSH Learning Institute.

- The appointment of a diversity consultant and an immigration consultant.
- The establishment of Provincial and Zone Equity, Diversity & Inclusion committees, orientation, and support programs for international medical graduates to prepare them for some of the challenges they may face.
- Designated nurse incentives such as supporting individuals to become nurse practitioners to work in specific practice areas such as the Primary Care NICHE program to support internationally educated and trained professionals.
- Partnerships with the International Colleges of Nursing in the Philippines and India. Two recruiters are focused on medical students and learners. A student engagement consultant to engage students early.
- "Stay Interviews" for areas that have been identified as having a high turnover of staff and where further exploration on why staff may be leaving and what will keep staff staying. In one area quick wins were increasing housekeeping and providing new chairs. The establishment of Zone Medical Affairs Leads.

The team utilizes various workforce analytics dashboards where they manage and act on data. They have a line of sight on the demographics and locations of the current workforce and use this information to inform their people strategies.

Exit interviews are conducted for those employees who leave the organization or who transfer within the organization. Currently, a thematic analysis of the exit interview data is occurring. The team is commended on their "stay interviews" pilot and the impact that the quick wins had on those units. The team is encouraged to further expand this approach to other areas in the organization.

The team is committed to building a healthy workplace and ensuring the engagement of staff and physicians. Crisis debrief support as well as Employee Family and Assistance Programs are available. The organization has invested in supporting current and future staff and physician leaders. Some of the strategies to support this work include succession planning, talent identification, mentoring toolkits, physician leadership and executive coaching services, medical education support roles at the regional hospitals, availability of the Dalhousie University Strategic Health Leaders Certificate Program, and education support for new managers.

It was noted that many individuals are new to management or have assumed new manager roles. As a change like this can be daunting for some, the organization is encouraged to ensure that these individuals have the support they need for their success.

It was noted that some managers are responsible for many staff and have large spans of control. Although the organization indicated that they have completed an evaluation and rapid review, they are encouraged to follow through with any actions required to ensure spans of control are appropriate. It was noted that a review of the span of control for educators has been completed and appropriate actions have been taken.

Staff receive education and are aware of how to respond to workplace violence. However, it was noted that the last workplace violence policy was approved in 2017. The organization has drafted an updated policy which has yet to be approved. The organization is encouraged to complete the final steps to have this workplace policy approved and implemented.

The organization is invested in supporting a culture of equity, inclusion, and diversity. There is still more work to be done to address stigmatization from both a client and staff perspective. The organization is encouraged to continuously offer appropriate education and awareness in this area. The organization may wish to consider whether cultural sensitivity and awareness training should be a requirement for all employees and physicians.

Policies are in place for the completion of performance reviews. It was noted that performance appraisals have not been completed in several areas through NSH. The organization is encouraged to get back on track and follow through on the completion of performance appraisals as indicated in NSH policy.

Priority Process: Integrated Quality Management

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

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

Nova Scotia Health (NSH) is commended on the development and implementation of the Improvement and Culture Strategy for 2021 to 2026 which is anchored in six key elements to support and move NSH to be a high performing learning organization:

- Capacity and capability: Building quality improvement capacity and capability and the coordination of resources.
- Meaningful engagement: Co-designing with staff, physicians, leaders, and patient family advisors to support meaningful engagement in quality improvement.
- Data utilization and prioritization: Patient Safety and system performance data is used to identify trends, inform priorities, and select opportunities for quality improvement.
- Implementation and improvement coaching: Improvement coaching is used to support sustained behaviour change and the integration of a consistent quality improvement approach.
- Sustain, spread, and scale: Establish user friendly structures and processes to test, spread, and scale changes that improve care and outcomes aided by the utilization of change management strategies that support adoption and sustained improvement.
- Communication and evaluation: QI initiatives are evaluated, and results are shared to enhance program planning and delivery, and measure return on investment.

Performance indicators are identified with ongoing monitoring. Quality improvement is evident in most units across the organization. In many areas, there was the use of quality boards visible to staff and the public and safety huddles. There was evidence that there is still room for improvement in continuing to support a culture of quality improvement and safety at the unit level such as sharing indicator data with the frontline staff.

NSH is congratulated on their commitment to patient safety. The organization has put in place the appropriate infrastructure and resources to support patient safety across the organization. In addition to patient safety training and education, the organization has policies and procedures in place to support a culture of quality and safety. A patient safety incident management system (SIMSSS) is implemented to report and monitor incidents. All incidents that are reported are analyzed and followed up on. Processes are in place to review critical incidents and adverse events as well as disclosure of events to patients and families. Patients and families who have been involved in an incident are invited to provide input into the quality review.

Significant effort has been made to engage patients and families as well as patient and family advisors (PFA) in the work related to quality and safety. There are PFAs represented on the Provincial Quality

Council as well as the Zone Quality Councils. Each council meeting is opened with a patient story followed by reflection questions. PFAs receive education and training on how to be a member of a quality team. Staff are provided with education on how to engage with PFAs.

New managers receive training on quality improvement collaboratives. This education has been co-designed and delivered by PFAs. The PFAs also provide coaching or support.

Patients and families are aware of their role and responsibility in patient safety. They are also aware of how to raise a concern or complaint. There were some areas throughout the organization that were not aware of NSH's policy on clients' rights and responsibilities. It is recommended that NSH ensures there is organizational awareness including how staff can access the information so that patients and families are informed.

The organization conducted two patient safety-related prospective reviews. One focused on the deteriorated patient while the second one was related to medication administration. Appropriate improvements were made because of these two reviews.

The organization also shared two initiatives; Virtual Care Nova Scotia and C3 - Care Coordination Centre to demonstrate how the organization's quality process is being used to plan, implement, evaluate, and spread quality initiatives throughout NSH. The team is commended on demonstrating the involvement of PFAs in these two initiatives.

A medication reconciliation process has been developed and is in place. Monitoring of compliance occurs and improvements are made. The Enterprise Risk Management Framework has quality and safety integrated into the framework.

The staff interviewed confirmed that there is a just and trusting culture within NSH. They are aware of and feel comfortable reporting incidents. Staff are also aware of the steps that need to be taken when an adverse event occurs. Disclosure training and supports are available.

NSH is commended on the medical and operations dyad role and the creation of the Physician Lead for Quality. NSH is congratulated on the level of physician engagement throughout the organization.

NSH is commended for the work they are doing to support a culture of quality improvement and patient safety. As indicated by one of the participants "nothing happens without quality, safety, and patient and family engagement". It will be important that the team sustains the successes to date and a foundation that is anchored in quality and safety.

Priority Process: Principle-based Care and Decision Making

Identifying and making decisions about ethical dilemmas and problems.

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

The approach to ethical decision-making is a strength of Nova Scotia Health (NSH). There is a robust ethics network in place that draws upon expertise both within and outside the organization. There is also an ethics organization structure at the provincial, zone, and local levels. The organization is to be commended for its commitment to include members of the public in the structure and to draw upon public expertise to review organizational products such as policies and procedures. NSH's ethics framework also includes a patient and family ethics tool which is somewhat unique among healthcare organizations.

NSH has a long history of having a strong approach to ethics through the organizational structure of its predecessor organizations. As NSH has come together, this strength has supported the development of provincial standards and resources to support ethical decision-making. This is done through both internal capacities as well as drawing upon the expertise of external agencies such as universities.

NSH has strengthened its approach to the approval of research protocols and has an all-encompassing process for the review of research projects that follows international standards for the conduct of research and takes an innovative approach to a research review. The research enterprise is to be congratulated for its application of an indigenous and diversity lens to the approval process for research.

The overall approach to ethical decision-making within NSH is through the lens of provincial and zonal standards coupled with a local approach to supporting staff and teams in addressing ethical issues.

Given NSH's commitment to people-centred care, it may wish to consider how patient and family advisors can play a role in the ethical structure of the organization and influence the future evolution of the ethics framework and organizational structure to support ethical decision-making.

There are excellent staff educational resources in place to support ethical decision-making. NSH may wish to probe the awareness of ethics tools and resources at the local level as it was not evident that staff could readily talk about ethical decision-making and the approach they would take in resolving an ethical dilemma. This may simply be related to comfort levels concerning using the term "ethics".

There are good intake processes for requests for ethics support and the intake process generates data that is used to understand the demand for ethics support and the type of situations that are being referred for ethics consultation. The intake and referral process focuses on capacity building at the local level. The ethics team supports the mantra “When in doubt, ask!”

The organization's pandemic plan did have an ethics component concerning decision-making in the case of limited resources to provide care. In addition, an ethicist and two patient representatives have been involved in the COVID-19 Network.

Through the referral process, there is a sense that requests for consultation are becoming more complex and challenging. This may be due to the nature of the requests being made as well as success in building local knowledge, expertise, and capacity where ethical decision-making can occur at the local level without the need for a consultation request.

Overall, NSH is to be commended on its structure, resources, and approach to ethical decision-making. As the organization matures, it will be exciting to see the future evolution of NSH's approach to ethics and the continued development of the organization's leadership in health ethics.

Priority Process: Communication

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

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

Surveyor comments on the priority process(es)

NSH is fortunate to have access to communication and information management professionals within the organization. NSH has recently refreshed its organizational public engagement and communication plan.

Communication resources are available to support zones, provincial programs, corporate service portfolios, medical affairs, and patient relations. The communications team is heavily involved with facilitating engagement sessions in the community. An example of this is the "State of the Union" event which occurred in three communities.

The communication team also supports the sharing of NSH stories both internally and externally. They use a variety of strategies to share the work of NSH. They also respond to stories and inquiries from external stakeholders such as the government, media, and community groups. They provide media training to prepare and support those speaking on behalf of NSH.

The team utilizes a variety of approaches to evaluate the effectiveness of their communication strategies. They provide support and guidance to NSH teams during the planning and implementation of new initiatives and special projects. These include the opening of the province's first Urgent Care Centre and the implementation of virtual care. The team also provides communication support related to the change management process such as assisting leaders in developing key messages and FAQs.

The team is encouraged to continue to monitor and adjust their communication strategies to ensure that the desired objective can be achieved. Continue to look for opportunities internally and externally to tell NSH’s story and to share the excellent and innovative work that is happening at NSH.

The importance of privacy and access to personal health information is well understood. Policies for the retention and destruction of files exist and are followed. There is a process in place to respond to privacy breaches. Auditing of access to information occurs. There are also processes in place for clients to access their healthcare information.

There are clinical areas that work in paper and electronic systems. The use of multiple record keeping platforms and approaches can increase risk, impact the continuity of care, and create inefficiencies. NSH recognizes the critical need of having a modernized health information system such as One Patient, One Record (OPOR) and is encouraged to move as quickly as possible with implementation. It was also identified that the systems and processes in place to support the function of timekeeping and scheduling is time consuming and inefficient. The finance and human resource teams have indicated that automating timekeeping and staff scheduling would streamline and improve the efficiency of this function and assist in obtaining key data elements. NSH is encouraged to explore options to facilitate this process.

Priority Process: Physical Environment

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

Unmet Criteria		High Priority Criteria
Standards Set: Perioperative Services and Invasive Procedures		
3.2	The area where invasive procedures are performed has three levels of increasingly restricted access: unrestricted areas, semi-restricted areas, and restricted areas.	!
3.3	Heating, ventilation, temperature, and humidity in the area where surgical and invasive procedures are performed are monitored and maintained according to applicable standards, legislation, and regulations.	
3.7	Rooms where surgical and invasive procedures are performed have at least 20 complete air exchanges per hour.	!
3.9	The operating/procedure room has a restricted-access area for the sterile storage of supplies.	!

Surveyor comments on the priority process(es)

Nova Scotia Health (NSH) operates across numerous sites throughout the province in both rural and urban communities. The physical condition of the various sites also varies significantly by age and condition. There are some facilities where the physical infrastructure is challenging to the clinical teams who are delivering patient care. For example, the QEII site (Victoria General) is particularly challenged with heating, ventilation, and air conditioning which creates challenges for staff and patients receiving care. Legionella in the water systems also makes it difficult for patients to bathe safely.

To address these challenges, significant redevelopment work is underway across NSH. NSH works closely with Nova Scotia Lands and Public Works with any redevelopment projects greater than $3M. Patients, families, staff, and community partners have been invited to participate in the planning process for these new facility redevelopments. Staff comment that they have been actively engaged in the process of facility design and are excited about the opportunity to move into new facilities that will enable better care, efficiency, and workflow. The Voluntary Facilities Accreditation (VFA) Facility Condition Assessment is being utilized to allow NSH to prioritize the areas requiring the most urgent investment. The coordination between areas such as infection prevention and control, facilities capital planning, facilities operations, maintenance, emergency preparedness, and environmental services have been exceptional, especially as they deal with various infrastructure related emergency responses. As the organization has made some investments to address the physical environment, several new facilities present a wonderful care environment for patients, clients, and residents. NSH is encouraged to rapidly address the critical infrastructure issues that remain and continue its efforts to redevelop and rejuvenate sites across NSH.

Numerous contractors provide support in maintaining the physical environment across NSH. In some sites, the physical environment is managed by a contracted providers (e.g., those under lease agreements, contracted environmental services, and maintenance contracts.). While contracts exist with specific deliverables for the maintenance, environmental services, and quality of the physical environment, there appears to be an opportunity to ensure that the contractual deliverables are being monitored and achieved. The organization is encouraged to investigate how these contracts are being managed, continue to harmonize the various contracts, and ensure that proper oversight of the contractual deliverables is being monitored and addressed.

Several environmental initiatives have been undertaken by the organization to mitigate NSH's environmental impact. Numerous examples were provided by the team of initiatives focusing on mitigating the environmental footprint of NSH. The team indicated $188M worth of projects have been identified to support further environmental stewardship that is being currently assessed. NSH is encouraged to continue this important work across all sites.

Priority Process: Emergency Preparedness

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

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

The emergency preparedness team across Nova Scotia Health (NSH) is a diverse group of professionals with varying backgrounds and expertise. The team of twelve individuals is divided geographically into the Central, Western, Eastern and Northern zones. While separated geographically, the team operates as a single cohesive unit sharing information and providing coverage for one another. Additional resources were also provided to address COVID-19 related emergency responses. Given the magnitude of emergency response events and the number of sites and geographic coverage, NSH is encouraged to review the resources allocated to this team to ensure that sufficient support is available to the organization to continue to respond to emergency events.

NSH and this team are to be commended for their success in responding to numerous emergency events including the most recent hurricane and the aftermath of this event. With over 1400 emergency events that the team has responded to over the past five years, the organization is well positioned to respond to and recover from a variety of emergency situations. They have utilized these challenging occurrences to continue to refine and enhance the organization's emergency response plans and strategies to react to future events.

There is good coordination and collaboration with local, regional, and provincial partners. Since 2019, NSH has completed 208 exercises with a variety of partners across the province. Some of these partners have included IWK, Nova Scotia Power, the department of health, municipal governments, and many more. The emergency preparedness team has a database where the exercises and lessons learned from the exercises are logged. These exercises are an excellent way for NSH to continue to test the organization's emergency response plans and to coordinate with other partners across the system. NSH is encouraged to continue holding these exercises and encouraging staff and team members to participate in them. The organization is also encouraged to continue to strengthen existing external partnerships as they will support NSH's ability to prepare for and respond to broader emergent events.

NSH is encouraged to continue to support educating staff, service providers, and clients/families related to emergency preparedness. While the team has established a very robust emergency response plan and incident command structure, the organization does not have any formal criteria as to when the emergency operations centres (EOC) are activated across the sites, zones, and the province. NSH may benefit from establishing more formal EOC activation and shut-down criteria. This will avoid any variability that may exist across sites and zones. The organization is encouraged to continue with strategies to enhance emergency response plans, augment education, and continue to promote drills and debriefings as appropriate.

The emergency management team has identified the need for an automated mass notification system which would enable the organization to communicate with appropriate stakeholders more rapidly. Processes are currently very manual and vary across the organization. NSH is encouraged to investigate and invest in technology that can enable a more rapid mass alert notification process to deploy the emergency response.

The emergency preparedness team has continued to maintain a very robust SharePoint site that documents all the activities of this team including the tracking of drills and exercises, lessons learned, and key indicators and highlights areas for future improvement.

While NSH has continued to develop business and operational continuity plans across sites, zones and provincially in some areas, there continues to be a need to complete this work. Lessons learned through events such as hurricane Fiona and other emergency responses enable the organization to identify opportunities for business and operational continuity. NSH is encouraged to continue with this work until completed.

Priority Process: People-Centred Care

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

Unmet Criteria		High Priority Criteria
Standards Set: Cancer Care		
2.4	Space is co-designed with clients and families to ensure safety and permit confidential and private interactions with clients and families.	
Standards Set: Inpatient Services		
3.3	A comprehensive orientation is provided to new team members and client and family representatives.	
Standards Set: Perioperative Services and Invasive Procedures		
1.1	Services are co-designed with clients and families, partners, and the community.	!
Standards Set: Rehabilitation Services		
15.3	Measurable objectives with specific timeframes for completion are identified for quality improvement initiatives, with input from clients and families.	!

Surveyor comments on the priority process(es)

Nova Scotia Health (NSH) has invested considerable human resources and infrastructure to advance person-centred care (PCC) as a cultural norm and a core principle informing all streams of care delivery and planning. From direct bedside care to program redesign, quality improvement, and policy creation, NSH is committed to ensuring the voices of their diverse community members, patients, and families are not just heard but respected, acknowledged, and integrated into their work.

Invariably, patients receiving care spoke highly of the compassion, commitment, endless energy, and boundless enthusiasm of their entire care team. They made note often they were aware of the immense pressures faced by care providers in these challenging times. They spoke often of their appreciation of the commitment NSH has made to keeping communities safe through and beyond COVID-19. The organization is to be commended for establishing and maintaining the trust of those they serve.

Frontline staff articulated a clear understanding of PCC. Many had received training or orientation to it as a philosophy of care, but others admitted they only learned of it from coworkers, informally. There is an opportunity to establish clear expectations for hiring, orientating, and offering ongoing learning around evolving PCC best practices. That said, it is clearly part of ongoing professional practice education.

Conversations with staff, patients, and families showed a common belief that all care plans were co-created, explained in detail, and updated as conditions changed. All patients interviewed knew why they were receiving care, what they could expect as next steps, and what role they could play in advancing a return to better health. Consistent use of whiteboards in patient rooms is noteworthy and clearly reassures patients.

Considerable efforts have been made to support care for those beyond the hospital walls; where people live, and where they prefer to access resources. The expansion of clinics into remote communities, advancing virtual care options as pilot projects, and offering 24-hour consults for programs such as palliative care are innovative ways to drive an increase in equity of access.

Some remote communities still feel, however, that the "best" care requires travel to larger urban centres. Continuing the spread of urgent treatment centres, integrating nurse practitioners, and leveraging partnerships with emergency health services are encouraging steps NSH has taken to deliver care where and when it is needed in a person-centred centred way.

Patient flow, wait times, and the lack of sufficient primary care physicians in Nova Scotia are concerning. Patients and staff live it daily. Focused "bed meetings" and the creative use of "provincial beds" across regions have mitigated but not eliminated the issue. Engaging with communities consistently to ensure their voices are heard is a good practice that NSH has implemented widely. Town halls, focus groups, and abundant patient/community surveys ensure planners have good data to inform change.

There is a robust patient engagement program that relies very heavily on a large, active pool of trained patient and family advisors (PFAs). Almost three hundred such volunteers have been recruited using a variety of methods such as social media, public outreach, connections made with those receiving care, and referrals. It brings forward those interested in improving care at a program or system level.

Still, more advisors are needed. Best practice, as NSH well knows, is that all programs, areas of care, planning tables, councils, and committees include patients and families where possible. While there are signs of excellence in many provincial programs and leadership groups there are abundant gaps. Many program managers expressed frustration that they do not have easy access to PFAs. Some have tried to recruit locally where possible but would benefit from more support from the Patient Engagement team.

Significantly, the busy Quality Improvement teams across the four zones are well-versed in including patients and families in their work. They have provided additional training to PFAs attached to QI work, enabling them to be full and equal partners in this important work.
Similarly, researchers are committed to not just including patients and families as research partners but making engagement and PCC a subject of research. NSH is an acknowledged leader in building engagement frameworks and spreading best practices. They have received accolades and awards for their innovative work.

PFAs expressed their strong commitment to bettering care for others and for supporting their healthcare providers to do more with less. They voiced some frustration with the ways they were often abruptly disconnected from their ongoing engagement activities with the onset of COVID-19. There is work to be done to re-establish trust with these important volunteers. Consider, as well, exploring not just cost mitigation but potential remuneration for these tireless volunteers. It might help eliminate barriers for those not currently engaging.

A large point of pride for the PFAs is a recent celebration/networking event for their peers that brought together people similarly committed to engaging with healthcare systems. It was a PFA-led and executed initiative and they are to be acknowledged as true leaders in defining their work and pushing boundaries beyond their traditional roles. Encourage and allow them to innovate moving forward.

There are simply too many examples to list of terrific work ongoing to grow PCC as a need-to-have, not simply an appendage to "real care." NSH is encouraged to continue spreading best practices, celebrate successes internally and in the broader community, and empower all providers to advance PCC in their work.

Priority Process: Patient Flow

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

Unmet Criteria		High Priority Criteria
Standards Set: Emergency Department		
3.4	There is access to the emergency department 24 hours a day, seven days a week.	!
3.9	Discharge planning is completed with other health care services and includes information about referrals.	
Standards Set: Perioperative Services and Invasive Procedures		
9.8	There is a process to identify and respond to clients whose condition deteriorates to an urgent situation or crisis while on the waiting list.	

Surveyor comments on the priority process(es)

Nova Scotia Health (NSH) operates across multiple sites in both urban and rural communities. Tremendous emphasis has been placed on projects and changes related to patient flow. Patient flow is a priority for all levels of the sites from senior leadership to the bedside and there is both teamwork and commitment to patient flow at the unit and site level. All units visited during the survey understood the pressure on beds as patients were transferred to their areas to help the Emergency Department and bed meetings were held at least once daily to ensure timely transfer and transition.

Numerous access and flow initiatives are in place in various locations of NSH. Some examples include C-3 real time data reporting, virtual care for unattached patients, and virtual care in some emergency departments. Additional initiatives include working closely with community paramedic programs to leverage opportunities for earlier discharge along with updating key policies related to access and flow.

The implementation of the SAFER-f patient flow bundle on medical units in all zones is a good example. This has allowed inpatient units to prevent unnecessary waiting for patients and improve patient flow. The emphasis on person centered care and involving clients and families in this initiative is commendable. NSH is encouraged to continue the journey to implement this flow bundle and others following the implementation timelines that have been developed.

For the many other initiatives that are in early phases, the evaluation component will help to determine future care across the province to improve access and flow system wide. Other shorter-term changes include the implementation of key policies that are being revised across all zones with Nova Scotia Health. Some examples are overcrowding and site overcapacity policies, Emergency Department closure policies, and repatriation policies on the verge of implementation. The team is encouraged to review emergency department closures to ensure there is access 24 hours a day, seven days a week along with the continued work to transition alternate level of care clients to other locations.

Priority Process: Medical Devices and Equipment

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

Unmet Criteria		High Priority Criteria
Standards Set: Diagnostic Imaging Services		
8.1	The individual responsible for the overall coordination of reprocessing and sterilization activities within the organization reviews and approves the team's set up and policies and procedures for cleaning and reprocessing.	
8.7	All diagnostic imaging reprocessing areas are equipped with separate clean and decontamination work areas as well as separate clean storage, dedicated plumbing and drains, and proper air ventilation and humidity levels.	!
8.9	The team follows the organization's policies and procedures and manufacturer's instructions for cleaning and reprocessing diagnostic devices and equipment.	!
8.10	The team stores clean diagnostic devices and equipment according to manufacturer's instructions and separate from soiled equipment and waste.	
8.12	The individual responsible for the overall coordination of reprocessing and sterilization activities within the organization oversees the team's compliance with the organization's policies and procedures on cleaning and reprocessing.	
Standards Set: Perioperative Services and Invasive Procedures		
4.8	Contaminated items are appropriately contained and transported to the reprocessing unit or area.	!
4.9	Contaminated items are transported separately from clean or sterilized items, and away from client service and high-traffic areas.	!
4.10	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.	!
4.11	Immediate-use (or “flash”) sterilization is used in the operating/procedure room only in an emergency, and never for complete sets or implantable devices.	!

Standards Set: Reprocessing of Reusable Medical Devices		
2.4	A designated individual is accountable for quality oversight and for coordinating all reprocessing services across the organization, including those performed outside the MDR department.	!
3.1	The layout of the MDR department is designed based on service volumes, range of reprocessing services, and one way flow of medical devices.	
3.3	Access to the MDR department is controlled by restricting access to authorized team members only and being identified with clear signage.	!
3.6	The MDR department has floors, walls, ceilings, fixtures, pipes, and work surfaces that are easy to clean, non-absorbent, and will not shed particles or fibres.	!
3.7	The MDR department is clean and well-maintained.	!
5.11	Team member performance is regularly evaluated and documented in an objective, interactive, and constructive way.	!
5.12	Team members are supported by team leaders to follow up on issues and opportunities for growth identified through performance evaluations.	!
7.4	Immediate-use steam sterilization (IUSS) is limited to emergencies only, and never for complete sets or implantable devices in line with the organization's policy and the provincial/territorial regulations.	!
8.1	The reprocessing area is equipped with hand hygiene facilities at entrances to and exits from the reprocessing areas, including personnel support areas.	!
8.2	The reprocessing area's designated hand-washing sinks are equipped with faucets supplied with foot-, wrist-, or knee-operated handles, electric eye controls, automated soap dispenser and single-use towels.	
9.2	Point of use cleaning of a device or equipment is performed as part of the decontamination process and occurs immediately after use and prior to decontamination in an MDRD and following manufacturers' instructions.	!
11.3	All flexible endoscopic reprocessing areas are equipped with separate clean and contaminated/dirty work areas as well as storage, dedicated plumbing and drains, and proper air ventilation.	
12.1	The MDR department has an appropriate storage area for sterilized medical devices and equipment.	!

12.2	Access to the sterile storage area is limited to authorized team members.	!
14.3	All sterilized items in storage, or transported to patient service areas or other organizations, can be tracked.	!

Surveyor comments on the priority process(es)

Nova Scotia Health (NSH) has a very good process for the prioritization, selection, and purchase of medical devices and equipment. The process is managed through a roll-up of local, zonal, and provincial prioritization and engages a wide variety of stakeholders from across the organization. A prioritization tool is utilized to support the appropriate allocation and distribution of resources. Foundations have also been great supporters of the organization's capital needs.

The facilities management and clinical engineering teams are to be commended for their commitment and dedication to maintaining medical devices and equipment throughout the organization. The tracking of the preventative and demand maintenance of medical devices and equipment is managed through multiple technologies. Computerized maintenance management systems (there are at least three) are utilized within the facility's operations to track demand and preventative maintenance. The clinical engineering team also has a system that enables their technicians to track workload measurement and preventative/demand maintenance activities. There may be an opportunity for NSH to begin to standardize the various medical device and equipment maintenance management systems across the various operating units. The organization is encouraged to determine whether a standardized and consolidated system (across all zones) could provide the organization with a wide summary of the status and maintenance of equipment would be beneficial.

Numerous teams are involved in the support and maintenance of medical devices and equipment. In some sites, services are contracted to third parties, managed internally by the clinical engineering teams, managed internally by the facilities management teams, or managed by the diagnostic imaging services teams. There may be an opportunity for NSH to leverage the economies of scale and the wide expertise that exists within the organization. The organization is encouraged to investigate the opportunity to consolidate the teams responsible for the maintenance and management of medical devices and equipment under a unified structure.

The oversight of medical device reprocessing within NSH has been decentralized since the last accreditation. There is no longer a single team responsible for overseeing medical device reprocessing within the organization. Reprocessing in departments such as the medical device reprocessing, medical imaging, and endoscopy are managed by various groups. This can lead to a high degree of variability in the level of education, reprocessing standards, and quality oversight. NSH is encouraged to move to a structure where there is single oversight of medical device reprocessing within the organization.

There is a high degree of variability in the functionality and age of facilities and medical device reprocessing equipment across NSH. Numerous manual processes exist in the medical device reprocessing departments that could be automated by the deployment of an electronic instrument management

system. The lack of a cohesive system across the organization means that staff must manually conduct annual reviews of reprocessing and sterilization activities. The teams have done a very good job of undertaking focused quality improvement initiatives and tracking key performance indicators manually. The inability to automatically capture electronic workload statistics and service volumes/trends challenges the leadership of the medical device reprocessing department from being able to identify areas for broader system improvements.

The physical plant in some sites poses an opportunity for improvement. At numerous older sites, the medical device reprocessing departments have multiple issues that need to be addressed to enhance the quality of the service. In some sites, there is no physical separation between the clean and dirty reprocessing workspace. Some sites have challenges with the regulation of air quality, temperature, and humidity. As resources become available, NSH is encouraged to address these facility challenges in a prioritized fashion. The organization is also encouraged to investigate challenges that have been reported related to the environmental cleaning of the medical device reprocessing areas. Numerous staff indicated challenges in receiving support in keeping the environment of the department clean.

There is no reprocessing of single use devices. NSH has undertaken great efforts to reduce the use of flash sterilization. There are, however, some sites where flash sterilization continues to be used excessively and with complete surgical sets. Nova Scotia Health is encouraged to continue with its efforts to reduce flash sterilization and only use it in emergency situations.

Staffing challenges continue to pose difficulties for the medical device reprocessing department. The organization has been very active in recruiting and training new staff and is encouraged to continue with this good work. Health human resource planning aligned with clinical activity forecasting is encouraged.

Annual competency assessments were being consistently undertaken in the medical device reprocessing departments as well as the facilities operations and maintenance departments. Some staff in clinical engineering reported that performance conversations were not occurring with regularity. NSH is encouraged to ensure that annual performance conversations are occurring across all areas consistently.

Service Excellence Standards Results

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

Priority processes specific to service excellence standards are:

Organ and Tissue Transplant

- Providing organ and/or tissue transplant service from initial assessment to follow-up.

Point-of-care Testing Services

- Using non-laboratory tests delivered at the point of care to determine the presence of health problems

Clinical Leadership

- Providing leadership and direction to teams providing services.

Competency

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

Episode of Care

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

Decision Support

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

Impact on Outcomes

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

Medication Management

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

Organ and Tissue Donation

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

Infection Prevention and Control

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

Diagnostic Services: Imaging

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

Diagnostic Services: Laboratory

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

Public Health

- Maintaining and improving the health of the population by supporting and implementing policies and practices to prevent disease, and to assess, protect, and promote health.

Transfusion Services

- Transfusion Services

Standards Set: Acquired Brain Injury Services - Direct Service Provision

Unmet Criteria		High Priority Criteria
Priority Process: Clinical Leadership		
The organization has met all criteria for this priority process.		
Priority Process: Competency		
3.12	Team member performance is regularly evaluated and documented in an objective, interactive, and constructive way.	!
3.14	Team members are supported by team leaders to follow up on issues and opportunities for growth identified through performance evaluations.	!
Priority Process: Episode of Care		
The organization has met all criteria for this priority process.		
Priority Process: Decision Support		
The organization has met all criteria for this priority process.		
Priority Process: Impact on Outcomes		
The organization has met all criteria for this priority process.		

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

The Acquired Brain Injury (ABI) program at Nova Scotia Rehabilitation and Arthritis Center (NSRAC) consists of many services and teams that collaborate to optimize the quality of life for clients with a sustained ABI and their care partners. The program includes a 23-bed inpatient tertiary rehabilitation unit, the district stroke program, physiatry and interprofessional clinics, OT, PT, neuropsychology, and acute epilepsy psychology services. The ABI program also offers a day program, outreach program, and concussion education sessions.

The ABI program has developed strong collaborative partnerships with acute care, emergency, and primary care to support ABI clients and families in their transitions of care. Other key stakeholder relationships include the Brain Injury Association of Halifax, Concussion Nova Scotia and the Heart and Stroke foundation. Together, they are raising awareness of at-risk populations for ABI, making it a collective responsibility.

The leadership team has recently drafted an action plan from the Nova Scotia Department of Health and Wellness Strategic Plan. These actions include providing the care Nova Scotians need and deserve;

cultivating excellence on the frontlines; building accountability at every level; and being resilient and responsive. Work is underway with the implementation of many initiatives supporting these actions with measurable outcomes such as increasing the utilization of current high-tech spaces by 50%.

There is strong evidence of client and family centered care across programs. Clients and families provide feedback through surveys and family conferences. This information is regularly reviewed for opportunities. An example included the implementation of food services improvements in May 2022 which focused on coordinated meal delivery times so patients are present when meals arrive and not attending appointments.

Priority Process: Competency

The ABI program has a full-time clinical nurse educator who supports a robust staff orientation process. This also involves a two-day component geared towards what being a rehabilitation nurse looks like and the mindset. There are well defined training and education requirements for all staff disciplines. The clinical nurse educator tracks the completion of all required competencies and recertifications regularly. This information is provided to the program manager. Staff have access to the learning module system which provides an extensive library of courses.

Staff are provided with educational opportunities throughout the year. The team recently participated in mental health first aid training in April 2022. The course was well received by staff as they are recovering from working excessive overtime hours during the COVID-19 pandemic and feeling burnout. Staff report that performance evaluations have not been completed regularly as management has been hindered by many competing priorities and a large staffing complement of over 100 staff. Management does address staff concerns as they arise and is very supportive of the team.

The team works collaboratively where all disciplines come together to share knowledge and clinical expertise. There are daily rounds where physiatrists are readily available and responsive to client needs.

Priority Process: Episode of Care

There are well established criteria used to determine when to initiate services for clients and families. There is 24/7 access to the inpatient rehabilitation unit. All other programs operate Monday to Friday. Concerns from patients regarding limited access to OT and PT services during statutory holiday weekends were recently addressed by the leadership team. This feedback was very valuable and in April 2022 OT and PT services were established with clinic access on statutory holidays that fall on a weekend. The ABI program is commended for its efforts in being responsive to the needs of the clients and families they serve.

Improving access to community rehabilitation for persons with stroke has been identified as a high priority area requiring development. Stroke patients ready for community rehabilitation could be managed in the comfort of their home if a community rehabilitation program was available. This lack of community-based rehabilitation services is having a profound impact on emergency department

congestion due to off servicing of stroke clients to acute care beds causing surgery cancellations and increasing patient hospital days. An SBAR was submitted in June 2019 by physiatrists and the ABI leadership team seeking support for access to early rehabilitation for persons with stroke and they are currently awaiting a decision. The team is applauded for their ongoing desire to improve access for those clients and families experiencing the effects of stroke.

Universal falls precautions have been implemented across all ABI programs. Staff and family awareness related to fall prevention has been well established with regular evaluations carried out to look for opportunities for improvement. Staff could easily apply medication reconciliation, two patient identifiers, and effective communication at care transitions when providing client-centred care.

Priority Process: Decision Support

The ABI inpatient unit has clear processes in place related to medical records management. They are using a paper-based system for medical records and some laboratory orders. An accurate and up to date medical record is maintained on all clients. The unit clerk was very organized and had good practices in place to ensure the confidentiality of client information. Policies are in place related to restoring, retaining, and destroying client records. Clients can access their records in a timely way.

Staff and leadership did express a desire for an integrated electronic charting system. A senior executive has supported the need for an electronic medical record system and is in the process of sourcing a vendor.

Priority Process: Impact on Outcomes

There is a culture of continuous quality improvement embedded across ABI programs. A dedicated quality lead is on site and provides ongoing support to staff and leadership with quality improvement projects. Quality boards are on display for staff and families to review.

A Safety Incident Management System (SIMSSS) is in place and all staff are provided with training during general orientation. The quality lead provides regular reports from the SIMSSS to the manager who then shares learnings with staff. Daily safety huddles take place where all staff are briefed on any changes in client cognition impacting safety. There is a quarterly newsletter - On the QT- Quality Talk created by the nova scotia rehabilitation and arthritis centre (NSRAC). Various information related to best practices, upcoming QI projects, and staff highlights is included in the newsletter. The NHRAC has put patient safety at the forefront and is encouraged to keep up the outstanding work.

Standards Set: Ambulatory Care Services - Direct Service Provision

Unmet Criteria		High Priority Criteria
Priority Process: Clinical Leadership		
2.6	The effectiveness of resources, space, and staffing is evaluated with input from clients and families, the team, and stakeholders.	
Priority Process: Competency		
4.4	Standardized communication tools are used to share information about a client's care within and between teams.	!
Priority Process: Episode of Care		
The organization has met all criteria for this priority process.		
Priority Process: Decision Support		
11.2	A standardized set of health information is collected to ensure client records are consistent and comparable.	
Priority Process: Impact on Outcomes		
The organization has met all criteria for this priority process.		

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

The Renal Program has a comprehensive approach to organizing and delivering service at a provincial and local level. Programs are segregated into conservative care, dialysis, and transplant. The program is commended for ensuring clients understand the potential of movement between these options of care as their needs and disease evolve.

The program continues to expand ambulatory sites for dialysis and prevention, with evidence-based data on community needs and improved access. The program leadership has acknowledged the need for improved vascular access from surgery and interventional radiology. This current gap in service may lead to less optimal outcomes as clients may have to choose sub-optimal modes of treatment.

The program has delineated the scope and service levels between the acute care, regional, and satellite sites across the province. Clients have commented that they understand how the provincial kidney care program operates, which gives them comfort.

Centralized wait lists are monitored and the teams work to ensure the best location for treatment from a

travel and access perspective. The team is encouraged to continue to revise criteria for access predicated on need and capacity.

This team is a leader in person centered care which it practices through interdisciplinary teams.

The program is encouraged to engage with First Nations patient and family advisors.

Priority Process: Competency

The team is commended for standardized education and training across the province. All 500 staff have uniform learning management tools and materials for consistency of service delivery. The team has developed, in the form of a policy framework, standardized operating procedures (SOPs) to further the consistency and quality management of care.

Effective measures exist to report risk and improve upon identified incidents. The System for Incident Management (SIMSS) is effectively used to report and mitigate risk or near miss failures.

Staff identified a greater number of behavioural patients in the program but always felt safe and supported in their care delivery.

The nephrology leadership also indicated best practices being introduced through their research efforts with Dalhousie at the QEII site.

Priority Process: Episode of Care

The program continues to drive efforts to improve outcomes with a robust quality improvement program. At the provincial level, quarterly quality review sessions ensure oversight of the program's performance with meaningful adjustments to outcomes. This drives many system improvements across NHS. Locally, there are regular weekly and monthly improvement efforts from daily huddles to quality boards and incident reviews through SIMSSS. Staff were very knowledgeable about projects and initiatives such as Standardization of all order sets, anemia management throughout NSRP, and expansion of KPAC from the central zone to NSRP.

Care is also improved through extensive patient and family engagement, with provincial and local patient and family councils. Efforts from these councils include renal nurse orientation and patient handbook.

Patients interviewed have a high level of trust and regard for the care team. Patients can request a change in their schedule if required.

Quality boards are visible in the units and available for patients, families, staff, and the general public to review. As there is a lot of data on the quality boards which may be a challenge for patients and families to understand, the team may wish to look at visual aids to simplify the presentation of key indicator data.

This team truly understands quality and safety and how to be a data driven program.

Priority Process: Decision Support

The current approach for clinical documentation exists in three independent systems.

The core program demographics and diagnostic reporting (LAB, Diagnostic Imaging) are in the Meditec system. The program has a unique IT system, Renal Insight, which connects to the dialyzers and provides complete reporting of each episode of care. Finally, the final form of documentation is the paper chart. Staff and leadership have acknowledged this is not ideal, creating workarounds, duplication of effort, and some patient risk. The team is looking forward to the implementation of One Patient, One Record.

Despite these challenges, the Renal Insight software provides the program with important Quality Assurance and Quality Improvement data which continues to drive benefits to patient care.

Priority Process: Impact on Outcomes

The program has acknowledged a continued increase in the demand for service due to demographics. A 4.5 % annualized rise in disease incidence will put pressure on service delivery. Robust data is used in planning and driving the expansion of satellite sites, such as the recently opened unit in Digby. Clients have expressed great improvement in access to this new site and an improvement in their well being.

The team is commended for their efforts with primary care clinicians to prevent the onset of disease through health education materials while also ensuring primary care understands how to access services when required.

Standards Set: Biomedical Laboratory Services - Direct Service Provision

Unmet Criteria		High Priority Criteria
Priority Process: Episode of Care		
The organization has met all criteria for this priority process.		
Priority Process: Diagnostic Services: Laboratory		
1.1	The team collects information at least every two years about service volumes and wait times for accessing laboratory services.	
1.2	The team collects information at least every two years from laboratory users and clients about their needs for laboratory services.	
5.4	The team is made up of a sufficient number of qualified team members who are able to carry out the required volume of laboratory services, day-to-day operations, and any other responsibilities.	
6.1	The team receives a comprehensive orientation to the organization's laboratory's services.	!
6.7	The team has access to continuing education and professional development opportunities related to laboratory services.	
7.2	The laboratory has sufficient space to carry out laboratory services.	
7.9	The laboratory is equipped to communicate information within and outside the laboratory in an efficient manner.	
8.1	The laboratory's work areas are clean and well-maintained.	!
8.3	The layout of the laboratory makes it easy to clean and disinfect work areas, equipment, floors and walls.	!
10.5	The team monitors its compliance with laws, regulations, and standards of practice, and makes improvements to its instructions or training activities as required.	!
12.4	The team informs laboratory users if a critical result needs to be followed up with access to counselling.	!
14.3	The team identifies, investigates, and corrects problems with equipment in a timely way.	!
20.1	The team follows SOPs to transport samples to and from the laboratory in a safe and confidential manner that is in line with applicable laws and regulations.	!

29.4	The team identifies measurable objectives for its quality improvement initiatives and specifies the timeframe in which they will be reached.	!
29.7	The team sets targets and tracks wait times and average response times for elective, urgent, and emergent requests for laboratory services.	!
29.8	The team designs and tests quality improvement activities to meet its objectives.	!
29.11	The team regularly analyzes and evaluates its indicator data to determine the effectiveness of its quality improvement activities.	!
29.12	As part of the quality management system, the team evaluates its services using formal internal audits, evaluations, and improvement processes.	!
29.15	The team implements effective quality improvement activities broadly.	!
29.16	The team shares information about its quality improvement activities, results, and learnings with clients, families, staff, service providers, organization leaders, and other organizations, as appropriate.	
29.17	The team regularly reviews and evaluates its quality improvement initiatives for feasibility, relevance and usefulness.	

Surveyor comments on the priority process(es)

Priority Process: Episode of Care

The personnel are using universal fall precautions to reduce the risk of falls.

Priority Process: Diagnostic Services: Laboratory

In hospitals, phlebotomy is generally provided by technologists and assistant technologists. In some hospitals such as Dartmouth General Hospital, nurses are responsible for phlebotomy in the emergency room and intensive care. Outpatients can easily book an appointment by phone or online. In addition, outpatients at Dartmouth General Hospital can also make an appointment for a drive-thru phlebotomy service. It would seem that this service is highly appreciated by the population. The waiting time for phlebotomy is relatively long in several hospitals (three weeks). Therefore, there are multiple STAT requests. The organization is encouraged to consider solutions to reduce the wait time for phlebotomy, such as a walk-in service.

Specimens taken from hospitalized patients by nurses do not contain barcodes. This forces the laboratory assistants to print and paste the barcode. A well-identified patient with a barcode during sampling reduces the risk of error and optimizes the process both on the floor and in the laboratory.

The lack of technologists poses a problem in the majority of the laboratory departments in the various

hospitals of the Nova Scotia Health. Several technologist assistants have been hired to make up for part of the shortage. This challenge is a priority for the organization and several steps have been taken to address it: use automation; international recruitment with accommodations to allow foreign graduates to work as technologists; recruitment in other Canadian provinces by offering incentives; and discussions with the college to increase the number of students in laboratory technology.

In several departments of the laboratories, the equipment has not been changed for several years. The combination of increasing test volume over the years and the age of the instruments are causing an increase in failures of these devices. Consequently, the response time is significantly increased, which may delay diagnosis. The organization is aware of this issue and is in the process of bidding to replace multiple devices. This process can be long, especially because of the number of devices (and departments involved). The organization is encouraged to consider short-term alternatives to address this issue.

Quality indicators are a very important tool for quality monitoring. They also make it possible to identify shortcomings to correct them. Employees are aware of the importance of these indicators. Monitoring the volume of tests makes it possible to identify the equipment and human resource needs to respond adequately to requests. However, partly due to the laboratory's current information system and the lack of personnel, this data is not monitored regularly. A more suitable laboratory information system will correct these shortcomings.

Clinical specialists (microbiologists, hemato-pathologists, biochemists) are present in the central zone and their contribution is highly appreciated by technologists and doctors. The other areas do not have these specialists. Doctors and technologists have identified an opportunity for more specialists to be located outside the central zone. The involvement of these specialists outside the central zone will allow for better standardization and collaboration in the different zones.

The toxicology laboratory has acquired three new LC-MS tandem devices. This allows it to cover the toxicology needs of the province. The department is encouraged to develop other methods and thus repatriate tests that are currently referred to in Ontario or the United States.

Standards Set: Cancer Care - Direct Service Provision

Unmet Criteria		High Priority Criteria
Priority Process: Clinical Leadership		
2.5	The effectiveness of resources, space, and staffing is evaluated with input from clients and families, the team, and stakeholders.	
Priority Process: Competency		
8.11	Team member performance is regularly evaluated and documented in an objective, interactive, and constructive way.	!
Priority Process: Episode of Care		
13.6	The team has and follows wait time guidelines for time from referral to consultation, and from ready to treat to first treatment.	
13.10	There is a process to ensure that each client is able to effectively navigate their services.	
14.2	There is a process to communicate with the primary care or referring provider, in partnership with the client and family.	
18.5	Environmental distractions are minimized for team members who are performing critical tasks requiring concentration.	
24.4	Technologies, systems, and software are interoperable.	
Priority Process: Decision Support		
The organization has met all criteria for this priority process.		
Priority Process: Impact on Outcomes		
The organization has met all criteria for this priority process.		
Priority Process: Medication Management		
6.2	Systemic therapy only: Computerized physician order entry (CPOE) or Pre-Printed Orders (PPO) are used when ordering systemic cancer therapy medications.	!
Surveyor comments on the priority process(es)		

Priority Process: Clinical Leadership

The leadership team for Cancer Care Nova Scotia, which was officially launched in 1999, demonstrates depth and commitment to ensuring that all citizens receive access to care no matter where they live. The medical and administrative leads continue to advance the leadership model covering all the zones with the necessary support of healthcare. The leadership members discussed the momentum that has been achieved over the past two years and the de-cluttering of the administrative flow structure where the program medical and administrative leadership reporting structure to the zone executive dyad leads and then to the CEO. This re-alignment of the collaborative relationships and streamlined reporting structures had given the leadership the ability to be nimble and have timely discussions with decisions being made that have real impact.

In 2021, Cancer Care Nova Scotia undertook an operational review of the program with the goal of program improvement to advance care and system effectiveness. The results of the review led to the noted changes as described in the leadership and reporting structure along with ways to enhance communication that have been introduced in 2022. The review solidified the program's focus on five key strategic areas that are now guiding everyone in the program. Additionally, the leadership is proud of the focus on a new structure that advances research, innovation, and discovery that will enable the team to advance leading practices and lead the way in research and innovation with support from the CEO and the province. The focus on data and information is another area that has been identified for opportunities and this work will continue in the future, especially within the new structure. Donations that have been received to support efforts in this space.

Despite the review and positive changes at the higher leadership level in the program and the executive team in the NSH, there is expressed frustration with the inability to advance the program operations within and across services and units. The advancements in cancer care research and science are clear. However, this requires changes and adaptation in the service delivery model and associated spaces to care for cancer patients. The innovations related to immunotherapy and oral chemotherapy treatments are examples of the changing approaches to treatments and improving patient outcomes. These innovations and changes require that clinical operations staff and leaders be able to utilize their knowledge and understanding to make changes, adapt spaces, resources, and processes to align with the evolution of the science that is changing care treatments. Individuals who expressed their frustrations are knowledgeable and committed to their cancer patients. The engagement of seasoned front line workers and leaders will be important to re-design the cancer program for the future. Re-engaging and igniting the senior staff and leadership in clinical operations to plan for short and long term changes will be important for retention and avoiding retirement where possible.

Central Zone Cancer Care is mostly located in the Victoria General Hospital site. Physical environment challenges have brought forth concerns from some staff noting issues such as Legionnaire's disease in the pipe system and HVAC ventilation concerns.

Priority Process: Competency

The Regional Cancer Program is dedicated to education, research, and quality care. As part of the focus on learning, there are good structures in place to ensure that staff are qualified and kept up to date on ways to retain and advance practice. The program has educators in place who work across all units striving to ensure new staff. Those who have worked in the setting for several years are kept up to date with the evolving science as well as corporate practices.

The inpatient units at Victoria Hospital have implemented a new role to support all the hires and mentor staff. The role of Resource Nurse is an additional, new, role that has been added to the clinical team and there is evidence of the positive impact from speaking with staff and seeing how the role is being implemented.

Required Organizational Practices (ROP) are considered important areas to learn and enhance practices in the cancer program. Across all services and units, the focus on ROP education and having these practices lived every day is evident. Congratulations to all the staff on your work to keep patients safe in your care.

Priority Process: Episode of Care

Access to care and capacity challenges are ongoing in the overall system and the cancer program. Enhancing data and analysis is encouraged to fully utilize information to enable patients to obtain access and timely treatment. The team recognizes that once patients are in the program the care is good; however, access is often not easy to navigate. Creating a "One Door" approach for all cancer patients and referring clinicians will be a positive consideration for improving timely access to very specialized care and treatment plans. The "One Door" approach, that can be electronic, will support streamlining access and making clinical pathways and referral processes better for referring primary care team members and patients. Surgical Oncology currently resides outside of the cancer program and there are good relationships between the programs. However, having more dedicated/protected OR resources for cancer patients would decrease unnecessary wait times and focus on this aspect of cancer care. Overall, the team expressed that they work to prioritize cancer patients during COVID-19 to avoid poor outcomes where possible.

In the Cape Breton Regional Hospital, there is a strong interdisciplinary team supporting cancer care. The current space is limited but clean and well maintained. The centre will be moving to a new building in 2024 and the team along with clients, families, and partners such as First Nation communities participate in co-design. The clients at the regional hospital in Cape Breton spoke highly of the care provided at the cancer centre and felt they were treated with care, dignity, and respect. As well, the client indicated that they participated in decisions and their wishes for such things as time of appointments were supported.

Across zones, there are waits times that do not meet set targets. Some patients stated that those who do not have a general practitioner in the community have a longer wait time to gain access to the program. However, no documented evidence of such cases was found. It is encouraged to have discussions with patients regarding wait times for possible quality improvement efforts.
Teams track wait times including:

- wait time from referral to consultation, and
- wait time from the ready to treat until treatment initiation.

There has been an increased demand for services with an increase in referrals. While the team tracks wait times, they have been unable to follow guidelines set regarding acceptable wait times in different services due to the demand for care and high volumes. The team works to call clients as soon as a referral is received. In the hematology clinic, the team has C1-C5 prioritization levels as an example of the wait time targets. However, they are unable to meet or follow the acceptable guidelines for C3-C5 targets due to volumes. This example is similar in radiation oncology as well. The surgical oncology program is separate, and consideration needs to be given to incorporate this into the Cancer Care wait times. The team and leaders are encouraged to continue to monitor and implement innovative solutions to reduce wait times for clients and expand the wait time process for systemic therapy, surgical oncology, and other cancer modalities.

Navigating the system of cancer care is complicated. The program is aiming to have more standardized pathways and implement the role of a patient navigator. During the on-site survey, patients spoke of the lack of support with system navigation and difficulty in obtaining information regarding their wait times, entry into the system, and treatment pathways. This was found to be compounded if patients do not have a GP to support system navigation. This represents opportunities in patient education and support to navigate the cancer care process.

In discussion with team members and leaders across the Regional Cancer Programs in Halifax and Cape Breton, it was discussed how they try and work as diligently as possible to respond to a request for services given the demand for care and increase in the number of referrals. The team has implemented processes and programs to support timely access. One such program is the Timely Access and Patient Support Model study (TAPS) which seeks to reduce delays in starting treatment. A nurse practitioner navigator will see clients within three to five days of receiving a referral. This program ensures that clients receive appropriate workups before seeing an oncologist. Thus, reducing the wait time to start treatment and ensuring that clients receive support early in this cancer care journey.

Priority Process: Decision Support

Areas that the leadership continues to work on ways to enhance patient care and treatment centers around data management and focus on quality. There is a recognition that the data availability needs to be strengthened/prioritized and timely to make quality improvements and changes that impact the overall operations of the program and care at the individual's level. The goal is to have timely data sources that can be pulled into a dashboard for action. The team is proud of the work related to the report card for colorectal cancer and sees this model being expanded to other types of cancer. The program members recognize the resources needed to enhance the program and are aiming to have CPOE for clinical documentation as eMar. Many of the required changes are expensive and will take time. Hence, there is a need to continue to phase in the necessary technology and supports as funding becomes available.

Overall, there are many opportunity areas related to IT support, aging infrastructure, and service design/ delivery. Given the available resources, the team is strong and focused on their 5-year plan and recognizes that it will take time and dedicated resources that need to be planned for. Recently, there have had been business cases developed and presented that were approved at the CEO / Provincial level that have influence, especially for patients in the clinics across the zones.

Quality and Safety are a priority for the cancer program. The team discussed the work they are doing across the zones and are keeping the focus on safety clear. Other efforts are noted with positivity in receiving the Novalis stereotactic body radiation therapy (SBRT) Accreditation and the efforts that are ongoing to achieve accreditation by the foundation for the accreditation of cellular therapy (FACT).

The successful implementation of an electronic documentation and eMar system will enhance quality and safety and contribute to a more efficient program in the longer term. The team is excited about the $20M donation that will be used in the areas of research, innovation, and discovery. Work is underway and encouraged to continue to create one intake referral process and build on the success of the TAPS program and lung clinic to increase timely access to care.

Information and data related to waiting times for each service and treatment modality will be an ongoing area for the future to enhance the Cancer Care Program. This is a recognized area for improvement by individuals and leaders in the program and teams just want to advance the electronic health record and CPOE.

Priority Process: Impact on Outcomes

Cancer Care Nova Scotia continues to work on standardization across the networks throughout the province. The goal is to ensure that evolving evidence and practices are evidence based. New treatments for cancer care continue to evolve and the program adapts and introduces these new treatments to advance care and life expectancy.

The program has spaces and sites that are not keeping up with best practices. Leadership is encouraged to work with their units and services to enable change and innovations within the current spaces and challenges with health human resources. Recognizing there is a longer-term plan that is years out concerning innovative cancer spaces, leadership is encouraged to find ways to re-design current programming and roles to align with treatment practices of their long-term vision.

Priority Process: Medication Management

The medication management system within the cancer program is well managed and controlled. Overall, the level of competency and adherence to standard processes and guidelines is very good.

The overarching, long standing, issue is the lack of electronic documentation and CPOE. This is the standard for cancer care across Canada and with dedicated funding. This will significantly benefit the program.

Standards Set: Case Management - Direct Service Provision

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

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

The case management team of Nova Scotia Health (NSH) is the gateway to continuing care for 30,000 people who will use the service to access supportive living, health assistance, home care, and long term care. There are 500 employees comprised of 5 directors and 270 caseworkers who assess, document, and care plan for each person reaching out to the service. Once the care plan has been agreed upon with the client, the team will reach out to the appropriate service to provide the needed support.

As the complexity of client care has increased, there has been an increased demand for services. The leaders are encouraged to continue to evaluate staffing and to make changes accordingly. There may be a consideration to monitoring the turnaround rate for the LTC beds or implementation of the "overstay" policy.

Each of the teams visited demonstrated energy, consideration, and innovation. The care needs of the clients are front and center to their work. Clients expressed how grateful they are to be able to have a number to call and to have support for their transitions.

Priority Process: Competency

The people hired are screened for appropriate credentials. There is a standardized orientation followed to ensure each person hired is competent to perform in their roles with success. There is a standardized system, "SeaScape", where client care plans are documented. This is accessible for the acute in-patient and emergency units within Nova Scotia.

Staff spoke about the beginnings of work to have a new software system in Nova Scotia Health, creating one true chart for each client. Staff also spoke of the thorough orientation received, the ongoing education, and the support of the leadership. Performance appraisals are current this year.

Priority Process: Episode of Care

Case Management is the gateway from independent living to living with funded healthcare support. Following the line of “home is best”, their efforts are to assist in patient units to decant patients to their own homes, with support, or long-term care. All of the services used are checked for competencies by Accreditation and or the Department of Seniors and Long Term Care for services and licensing. They provide access to home care, physio and rehab therapies, behavioural Health, home oxygen therapy, and housekeeping and/or meal service.

The cases are logged into the SeaScape software, and Tableau tracks the waitlists of those waiting for assessments. Cases are prioritized based on logarithms. Caseloads for each case manager are monitored.

There are close ties with the Department of Seniors Health and Wellness, to advocate for funding model change and suggested improvements to processes. There is an opportunity to review the model to better support the adult population who may not be a senior, to support the population of those with disabilities and or injuries with life changing implications.

Priority Process: Decision Support

There are standardized information systems to record client information. Each client is assessed individually with a standardized assessment form. All documentation is discussed with the family and the client. The services available for each client are based on the provincial Ministry of Seniors Health and Wellness. This department sets the financial obligations of the province and the family/client for services received.

This is one place for opportunity and consideration. As all people do not fit into the perfect criteria of services, flexibility could be considered in the provision of community services. All people accessing the Case Management service are not the frail elderly but also comprise the younger people with disabilities and or injuries. In other words, "assistance for those who fall into the cracks."

Priority Process: Impact on Outcomes

Quality Improvement is supported by one of four quality leads assigned to mental health across the province. The quality structure is robust with zone committees reporting up provincially.

There is an opportunity to more broadly share provincial indicators and outcomes and to cascade learnings and improvements to the clinic level and take meaningful measures from the clinic services rolled up to leadership. There is a sense that quality improvement (QI) is retrospective as opposed to being proactive. It may be helpful to refresh the QI framework and toolkits/training at the operations level, given the turnover of staff.

Service changes have been piloted and evaluated and if successful have been spread. For example, see the central intake process. The CMHA team is encouraged to continue the important work in progress related to the model of care, withdrawal management, child and youth capacity building, and one person record/experience.

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

Unmet Criteria		High Priority Criteria
Priority Process: Clinical Leadership		
The organization has met all criteria for this priority process.		
Priority Process: Competency		
4.9	Team member performance is regularly evaluated and documented in an objective, interactive, and constructive way.	!
Priority Process: Episode of Care		
8.12	Ethics-related issues are proactively identified, managed, and addressed.	!
Priority Process: Decision Support		
The organization has met all criteria for this priority process.		
Priority Process: Impact on Outcomes		
The organization has met all criteria for this priority process.		

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

Community Based Mental Health is providing services in Nova Scotia across the lifespan from childhood to adulthood.

Strong partnerships were noted province-wide, with seniors teams (who do home visits), community organizations/services, Indigenous communities, adult protection, probation, schools, child welfare, local pharmacies, primary care physicians, nurse practitioners, emergency department physicians, and police. Collaboration with local police and RCMP has led to a better understanding of the patient journey and services available for mental health and addictions.

Some communities have new facilities, designed with input from patients and families. Models for the treatment of various populations are used. It is felt that patient support has led to improved access to mental health & addiction services.

Efforts to reduce barriers to access are being addressed. These include funds for public or private transportation to ensure low-income clients can attend appointments. Telehealth and other virtual visit modalities have been increased, especially targeted at rural and remote clients who otherwise may not be

able to attend or participate, fully, in their care. As well, the provincial intake service and registration system for outpatient care are anticipated to streamline access.

Nova Scotia Health has established provincial and zone roles, using dyads to strengthen clinical and operational accountability. Through a stepped model of care, five tiers of service from health promotion to highly specialized care have been defined. The Direction 2025 strategy spans years 2017 to 2025, with a continuous planning and design approach that embeds communication and engagement.

Community Mental Health and Addictions partners with primary health care and other providers enabling people experiencing mild to moderate symptoms to manage their conditions. The service provides specialized, evidence informed, treatment and care to address the needs of people (children, youth, adults) experiencing mild to moderate mental disorders, including addictions. The active work within schools is commendable; helping support young people earlier to avoid more complex interventions or worsening mental health. Some communities have been successful in transferring care of opiate use disorder clients back to their primary care provider once stabilized. There is active work with partners to deliver crisis support and services to people in need of emergency care.

There are challenges with access and delays in some areas of the province due to vacant positions and a lack of health human resources.

Continued advocacy reducing the stigma of mental health, continued efforts around cultural safety, and further expansion of rural treatment options are suggested.

Priority Process: Competency

"In house" training for staff is provided through the Provincial Centre for Training, Education, and Learning (PCTEL). This has helped support the standardization of education, provincially, while providing a level of customization to the skills required for specified jobs. Staff describe educational opportunities as excellent and some community of practice groups have formed amongst psychiatrists. In some settings, staff are only somewhat familiar with the Nova Scotia Health ethics resources. Staff were unable to identify an ethical issue and could not elaborate on the steps to follow in ethical decision making. There is an opportunity to heighten awareness of the ethics framework and support.

There is strong teamwork amongst disciplines, supporting one another. Links with educational institutions are strong, which exposes learners to this sector, and supports the participation in research projects which benefit both the clients and the program overall.

Performance reviews have waned in some areas during COVID-19 and are an important opportunity for interaction and professional growth. Another consideration is to review the model of care for those areas where there is a waitlist for psychiatrists, who are only able to consult for those in urgent need. Perhaps a nurse practitioner would be able to support patients with regular follow up.

Priority Process: Episode of Care

The community mental health services saw over 49,000 outpatient clients and almost 400,000 outpatient appointments last year. Year over year increases is notable with many new clients seeking care. In response, clinics are offering evening hours and recently established provincial peer support for an urgent care model with a toll-free phone line.

To address waitlists, data is being used to assess clinician productivity, and adjust workload accordingly. The provincial tiered/triage is in place to determine care needs according to the five levels. Specified numbers of appointments, urgent clients seen within seven days, and clearly defined goals, along with efforts to fill cancelled appointments with people waiting have been established. Some acute inpatient settings cannot admit; This leads to clients being sent to the nearest accepting facility which may not be the closest.

There are e-Mental Health tools, such as Therapy Assistance Online (TAO), along with the Provincial Crisis Line to help address the need. Adults with autism (many not formally diagnosed) or ADHD has been identified as a gap in service.

Client input and feedback are regularly sought; from care pathway development to harm reduction tools. Opioid treatment centres demonstrated a positive environment where people are treated as persons and provided with choices for treatment of their addiction. Clients speak very highly of the care and involvement in their care, and the outreach support line for supportive conversations. One opportunity is to have a standardized process for the treatment of opioid addiction. Clinics appear to have variations in culture/approach and levels of leniency when clients do choose to use again. Another opportunity is for there to be a standardized point of care testing unit for urine tests for substances. The current one is not sensitive to some of the substances used in the community.

The suicide assessment tool has been revised from a "trauma informed" perspective.

Priority Process: Decision Support

Client records are kept confidential and secure. When staff travel off-site, locking envelope/bags are used to ensure privacy. There are limitations with the current information system, which is cumbersome and there is hope in the future One Patient, One Record /experience electronic health record.

Electronic communications are being advanced through the use of texts and reminders. Through COVID-19, virtual platforms and responsive approaches were used to provide ongoing care.

Some settings are challenged by not having stable Wi-Fi access, which is becoming increasingly required.

Priority Process: Impact on Outcomes

Quality improvement is supported by one of four quality leads assigned to MH across the province. The quality structure is robust with zone committees reporting up provincially.

There is an opportunity to more broadly share provincial indicators and outcomes and cascade learnings and improvements to the clinic level. There is also an opportunity to take meaningful measures from the clinic services rolled up to leadership. There is a sense that quality improvement (QI) is retrospective, "we did these things last year", as opposed to being proactive and “real time”. It may be helpful to refresh the QI framework and toolkits/training at the operations level given the turn-over of staff.

Standards Set: Critical Care Services - Direct Service Provision

Unmet Criteria		High Priority Criteria
Priority Process: Clinical Leadership		
The organization has met all criteria for this priority process.		
Priority Process: Competency		
3.12	Team member performance is regularly evaluated and documented in an objective, interactive, and constructive way.	!
3.14	Team members are supported by team leaders to follow up on issues and opportunities for growth identified through performance evaluations.	!
Priority Process: Episode of Care		
7.15	Clients and families are provided with information about their rights and responsibilities.	!
7.16	Clients and families are provided with information about how to file a complaint or report violations of their rights.	!
9.3	Daily rounds are conducted by the team in partnership with the client and family.	!
9.11	The client's need for restraints is regularly assessed and the least invasive restraint is selected if required.	!
11.4	Appropriate follow-up services for the client, where applicable, are coordinated in collaboration with the client, family, other teams, and organizations.	
Priority Process: Decision Support		
The organization has met all criteria for this priority process.		
Priority Process: Impact on Outcomes		
15.3	There is a standardized process, developed with input from clients and families, to decide among conflicting evidence-informed guidelines.	!
Priority Process: Organ and Tissue Donation		
The organization has met all criteria for this priority process.		

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

There are formal outreach teams that provide care in the ward during codes. There are sites, however, which do not have a formal rapid response team which would promote better patient outcomes with a clinical early warning system. The required level of staffing is determined and maintained to provide consistent quality of service. There are funded beds which remain closed to do lack of staff. Surge capacity management noted to decant to predetermined units to provide safe care. The Coronary Unit at QEII is the major referral centre for cardiac catheterization, having well established protocols as well as referral processes.

Priority Process: Competency

There is no evidence that team member performance is regularly evaluated and documented in an objective, interactive, and constructive way. There is no evidence of the team members were supported by team leaders to follow up on issues and opportunities for growth identified through performance evaluations. This, in part, could be due to changes in leadership at the unit level. There is a high level of cohesive interdisciplinary teamwork and quality initiatives to enhance patient care. Staff are very committed to their learning modules for their education and simulation training.

Priority Process: Episode of Care

In discussions with families and clients, they were not aware of their rights and responsibilities. Clients and families interviewed were not provided with information about how to file a complaint or report violations of their rights. There is a program, "The 3 Wishes Project", which helps to make meaningful memories at the end of life. This program dignifies, honours, and celebrates their lives bringing peace to the final days of a patient's life and helps to ease the grieving process. There is no evidence of follow-up services for the client coordinated in collaboration with the client, family, other team members, and organizations. A post intensive care unit clinic established would promote a collaborative, standardized, patient and family follow-up. There are some inconsistencies in inpatient rounding. Not all facilities are conducting bedside daily rounds including the client and family at a multidisciplinary level. Some site initiatives are implementing an A-F bundle that will pay particular attention to pain management, sedation, delirium, early mobility, and family involvement. The intent is to include the PFS representatives on this project. Overall, most sites are following the least restraint policy. There are some outliers. There have been voiced concerns regarding the change of governance from a provincial program to a zone governance. They are missing the ability to leverage resources, as previously done, and to share best practices.

Priority Process: Decision Support

Staff are looking forward to embracing the integrated electronic patient chart: "One patient, one chart".

Priority Process: Impact on Outcomes

There is a very robust and engaged quality program to improve and drive change. There are quality KPIs which are regularly monitored and reviewed with the stakeholders, including a strong and engaged patient family advisory person, for their review and input. There is no evidence of a standardized process developed with input from clients and families to decide among conflicting evidence-informed guidelines. There is no evidence of guidelines and protocols being regularly reviewed with input from clients and families. There is no evidence of a policy on ethical research practices that outlines when to seek approval which is developed with input from clients and families.

Priority Process: Organ and Tissue Donation

Staff are familiar with and engaged in the give a legacy of life (GIVE) program. Organ and tissue donations from the critical care areas have risen over the past year.

Standards Set: Diagnostic Imaging Services - Direct Service Provision

Unmet Criteria		High Priority Criteria
Priority Process: Diagnostic Services: Imaging		
3.10	The team evaluates and documents each team member's performance in an objective, interactive, and constructive way.	
4.2	The team has a separate service area that includes space for clients to wait and space for conducting diagnostic imaging procedures.	
4.4	The client service area includes a space for screening clients which respects confidentiality issues prior to their diagnostic imaging examination.	!
17.13	The team implements effective quality improvement activities broadly.	!

Surveyor comments on the priority process(es)

Priority Process: Diagnostic Services: Imaging

In 2021 the management structure for diagnostic imaging (DI) was changed from a provincial focus to a zone focus. As well, the service has been linked to a diagnostic therapeutic network which includes pharmacy, laboratory medicine, and diagnostic imaging. Provincial modality committees, which focused on standardization and sharing of resources, have remained in place. Budgets were transferred back to the zones. The network members have developed a DI business case for the next five years that address DI for all of Nova Scotia. Staff spoke positively of the shift back to the zones from a decision-making perspective, as well as acknowledging the relationships that had been developed during the previous structure that will continue to serve them well. Given that this is the second restructuring in the past five years, it will be important to evaluate this model.

Successes since the last survey include standardization of reprocessing of the intracavity probe. All sites visited were noted to comply with the standards. Diagnostic reference levels are reviewed and changes are made as required. Falls have undergone a PDSA and, based on learnings, changes have been made to the approach to assessing patients. Signage has been improved. There is a dashboard to monitor wait lists. An app has been developed to change faxed requisitions into an electronic format and collate them based on modality and urgency. Approval has been given to hire all the new graduates from Dalhousie into full-time positions for the next five years. Patients are now able to book general radiology appointments online. The two dictation systems have been replaced with one system, Power Scribe. Services have been taken into First Nations communities. Interventional radiology has new monitoring guidelines and program changes made have led to an increase in procedures. These improvements acknowledge the focus on quality within the service and leaders are encouraged to share these learnings across all DI sites.

Staff at the sites visited spoke positively about their work environment and the support they receive from their leaders, particularly in professional development. Performance reviews were not completed at all sites.

Waitlists are now being managed by each zone. It will be important for the organization to ensure that issues are addressed provincially and not left up to each zone to manage if numbers continue to increase. Many sites are looking at how to increase CT, MRI, and ultrasound capacity. Focused attention has been on no shows which appear to be lessening. However, until there is one information system for the service, it will continue to be a challenge as the current systems cause duplication and inefficiency. As service disruptions impact zones, it will be important that open lines of communication and collaborative relationships be in the patient's best interest.

Some sites have equipment that is coming to the end of life and service agreements are no longer in place. While there is a focus on capital acquisition provincially, it is likely impossible to replace all that is required. Foundations across the province have been very generous to the service in assisting with the purchase of equipment. The zones will have to work collaboratively to make the best decisions.

Peer review by radiologists is occurring in two of the four zones. The organization is encouraged to ensure that this quality component of diagnostic services is in place across all zones.

Patients are completing satisfaction surveys and the information needs to be reviewed and used where appropriate.

Standards Set: Emergency Department - Direct Service Provision

Unmet Criteria		High Priority Criteria
Priority Process: Clinical Leadership		
2.1	Resource requirements and gaps are identified and communicated to the organization's leaders.	
2.6	Seclusion rooms and/or private and secure areas are available for clients.	!
Priority Process: Competency		
	The organization has met all criteria for this priority process.	
Priority Process: Episode of Care		
9.14	Clients and families are provided with information about their rights and responsibilities.	!
9.15	Clients and families are provided with information about how to file a complaint or report violations of their rights.	!
10.2	The assessment process is designed with input from clients and families.	
10.7	Clients are assessed and monitored for risk of suicide. 10.7.1 Clients at risk of suicide are identified.	ROP MAJOR
10.11	Priority access to diagnostic services and laboratory testing and results is available 24 hours a day, 7 days a week.	!
13.9	The effectiveness of transitions is evaluated and the information is used to improve transition planning, with input from clients and families.	
Priority Process: Decision Support		
	The organization has met all criteria for this priority process.	
Priority Process: Impact on Outcomes		
18.4	Indicator(s) that monitor progress for each quality improvement objective are identified, with input from clients and families.	
18.10	Indicator data is regularly analyzed to determine the effectiveness of the quality improvement activities.	!
18.11	Quality improvement activities that were shown to be effective in the testing phase are implemented broadly throughout the organization.	!

18.12	Information about quality improvement activities, results, and learnings is shared with clients, families, teams, organization leaders, and other organizations, as appropriate.	

Priority Process: Organ and Tissue Donation

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

It was demonstrated at multiple locations that the organization has moved to a true multidisciplinary model of care with physicians, registered nurses, licensed practical nurses, care aides, unit assists, and unit clerks are working to full scope to ensure skill task alignment.

There is an opportunity to better align staffing resources amongst hospitals within nearby geography to level load and ensure that sites, where volumes are increasing due to closures at other locations, are supported by additional staffing from the closed location.

Seclusion rooms are not available in all locations. Further, the overcrowding situation in the EDs has prevented private rooms from being available to those needing them.

Priority Process: Competency

As a provincial organization, there is an opportunity for Nova Scotia Health to support lesser-resourced locations through mentorship and support from better-resourced locations. The tertiary site's commitment to education and training opportunities should be modelled throughout the province. The organization should leverage the resources and expertise of the tertiary ED to support and strengthen the regional EDs.

Priority Process: Episode of Care

The emergency departments (ED) across Nova Scotia Health are struggling with unprecedented system flow challenges coupled with severe staffing pressures. This results in chaotic and stressful work environments for healthcare workers and unfortunate care environments for patients. Teams have demonstrated resiliency in their commitment to patients and providing high-quality care.

Nova Scotia Health has demonstrated a commitment to engaging patients and their families in the design and delivery of health care in the province. While that overall message is clear, there could be greater fulfillment of the vision at the local level by engaging patients more fully in the development of local design and processes.

Provincial processes include the involvement of patient and family partners in their design. The nursing assessment form developed in January 2020 had five patient and family partners at different stages of its creation. However, patient advisors are inconsistently engaged at the local level when processes are designed.

Based on chart reviews and direct observation, there is evidence that suicide screening in the emergency department is not occurring universally at multiple sites despite its inclusion in the patient care record for emergency department patients. Information put out by the organization has stated that the screen is intended for people presenting with mental health concerns. However, universal screening of all presenting patients should occur to identify those at risk.

Transitions of care represent a vulnerability for patients within the system. To ensure that patients flow through the system optimally, care transitions should be evaluated thoroughly.

Priority Process: Decision Support

There is much anticipation from front line health care workers to managers regarding the One Patient, One Record initiative and moving to an electronic medical record within Nova Scotia. This initiative holds great promise.

Priority Process: Impact on Outcomes

Emergency department leadership is encouraged to adopt creative solutions to communicate indicators that monitor quality improvement. Indicator data may be used, but it is not well-known beyond leadership. Quality improvement data needs to be made more visible and available. With increased visibility of actions quality improvements work towards, staff will become more engaged.

The clinical quality improvement committee at the QEII emergency department meets monthly. It is chaired by the medical director of quality improvement and comprises representatives from all disciplines working in the department. It is attended by management. A patient partner is currently being recruited.

The committee considers and spearheads quality improvement initiatives using safety incidents, medical errors, concerns, and trends as inputs. These improvement projects could be spread to regional hospitals across the province.

Priority Process: Organ and Tissue Donation

Organ donation protocols are well-established in the province. There is slightly better awareness of the protocols in the tertiary ED because they are used more often, given volumes. However, there is a growing awareness in regional centres.

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

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

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

Hospice, Palliative, and End-of-Life services at Nova Scotia Health (NSH) benefit from a coordinated provincial approach to service planning and service delivery. A model of care has been developed to ensure that residents of Nova Scotia have access to the appropriate level of service to meet their care needs.

Team composition is designed to meet care needs and volunteers are an important part of the care team. The COVID-19 pandemic has resulted in a pause in the engagement of volunteers but efforts are underway to re-introduce volunteers into the care setting.

The palliative care network uses population data to plan for services at the provincial, zone, and local levels. There are also partnerships with other organizations to ensure that services meet patient needs. There are good information resources available so that members of the public are aware of end-of-life services that are available and how to access services.

As NSH moves forward with a focus on end-of-life care, the planning work of the provincial network as well as the voice of the public and patients and families will continue to shape the service model going forward and strengthen the model of end-of-life care for the province.

Priority Process: Competency

Education is a strength of end-of-life care in Nova Scotia Health (NSH). Team members are supported with ongoing education to work to their full scope of practice and there are rigorous education programs on such topics as infusion pumps and core care processes.

Patients and families are supported through education resources related to their responsibilities for care as well as important systems such as infusion pumps where patients play a role in their care. Training and education also touch volunteers who participate in specific education programs related to end-of-life care and are supported during their orientation to their volunteer role.

Education and training are well done across hospice, palliative, and end-of-life services in NSH. It is a particular area of pride for the network and one where there is great collaboration within the network as well as outside the organization and within NSH to other services.

Priority Process: Episode of Care

The care needs of people requiring hospice, palliative, and end-of-life services are well met across the province of Nova Scotia. This is due to strong provincial, zonal, and local leadership and care delivery. The provincial network has developed some standardization of care processes across the province and is working to identify areas for ongoing standardization to ensure that patients receive a consistent experience regardless of where they access services.

There is good support for ethical decision making through education and resources. In some cases, staff may not identify an issue as being one requiring ethical decision-making support but they do know how to escalate any concerns and access appropriate services to support decision making.

The service model that is in place allows for access to end-of-life expertise twenty-four hours a day. There are processes in place for patients to access services regardless of whether it is their first time accessing end-of-life care services or someone requiring subsequent admission to support their care needs.

Care is very individualized to meet the specific needs of patients and their families. The wishes of patients are considered when planning their care.

Specific high-risk assessments are completed routinely including medication reconciliation and assessments for risks of falls, pressure ulcers, and suicide prevention. Given the complexity of medication management in end-of-life care, the organization has demonstrated that there are good processes and procedures in place for medication administration and medication management.

For sites visited during this survey, there were consistent observations about the excellent collaboration and teamwork between staff and patients, creative partnerships with other service providers both within NSH and outside the organization, and commitment to quality improvement and the ongoing support of staff and volunteers through education and training.

Opportunities for improvement that were identified include improvements in information management and information systems, strengthening the use of indicators to guide planning and service, enhanced collaboration with other providers to standardize care processes, and supporting new leaders and team members as many are new to their roles, re-engaging volunteers into the service, and a unit-level focus on quality improvement.

Overall, excellent care processes are in place to support end-of-life care. These have been designed to support quality of life while at the same time minimizing risk.

Priority Process: Decision Support

As with other services within Nova Scotia Health (NSH), information management for Hospice, Palliative, and End-of-Life services is fragmented and largely paper based. This is one of the biggest opportunities for improvement for this service. NSH has an opportunity to develop an information management strategic roadmap that reduces the dependence upon paper-based record keeping and integrates systems to better support information flow.

There are good policies in place to guide the collection, use, and disclosure of personal information and patient privacy and confidentiality are respected. Team members, including volunteers, are aware of their responsibilities related to protecting privacy and confidentiality. In addition, there are organizational policies in place to allow patients to access their personal information.

Overall, information management is an area for improvement in hospice, palliative, and end-of-life care. As NSH moves forward strategically, hopefully, there will be improvements made to reduce fragmentation and reduce the amount of paper-based documentation.

Priority Process: Impact on Outcomes

There has been a long legacy of person-centred care in hospice, palliative, and end-of-life care in Nova Scotia Health (NSH) and its predecessor organizations. The palliative care network has demonstrated its commitment to hearing the voice of patients as part of its planning process and this will only be strengthened going into the future.

The network has developed a balanced scorecard to measure its performance based on key indicator data. In addition, there is a strong base for using evidence-informed guidelines as part of the care delivery process. In many cases, Nova Scotia is developing evidence-informed knowledge and best practice that will be adopted by other jurisdictions.

The national and international network for providing end-of-life care is very well connected and NSH’s palliative network is developing service models and care processes based on best practices from settings around the world.

As the network continues to evolve, it is encouraged to continue to leverage data and knowledge to support decision-making and planning and to further solidify Nova Scotia's leadership position as a leader in providing end-of-life care.

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

Unmet Criteria		High Priority Criteria
Priority Process: Infection Prevention and Control		
7.7	Safety engineered devices for sharps are used.	!
8.5	Reminders are posted about the proper techniques for hand-washing and using alcohol-based hand rubs.	
9.5	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.	
9.6	When cleaning services are contracted to external providers, a contract is established and maintained with each provider that requires consistent levels of quality and adherence to accepted standards of practice.	
9.7	When cleaning services are contracted to external providers, the quality of the services provided is regularly monitored.	

Surveyor comments on the priority process(es)

Priority Process: Infection Prevention and Control

Infection prevention and control is under the umbrella of a provincial program and is part of quality. At the provincial level, some policies will guide the actions of the different zone. Each zone has different partnerships such as Public Health, IPAC Canada, etc.

The IPC teams are multidisciplinary and they are involved with different aspects of Nova Scotia Health in each zone. They are, for example, involved in the immunization program. They reviewed evidence-based practices, monitor, and promote different best practices such as hand hygiene and do surveillance of any outbreaks as well as many other projects about the prevention of infections.

They monitored all sorts of KPIs on hand hygiene and different types of nosocomial infections that may occur in care units. Results are publicly divulged to staff and patients and appropriate partners if need be.

The IPC team provides robust and creative education to various teams. The IPC has been deeply involved during all phases of the current pandemic. This has enabled them to grow their team a bit and improve the communications between different departments within and outside their network. One great thing about the COVID-19 pandemic is that it allows the IPC teams to expand their surveillance program into long-term care and they now have one full-time dedicated physician for long-term care.

One challenge of importance is the gap in communication between the IT components. Therefore, the passing of information is relying solely on the discussion between the two care units. This puts the organizations at risk. The provincial initiative called OPOR (One Patient, One Record) will be of tremendous help in resolving those risky situations. The province should continue the work to make this OPOR project come to reality.

Strengths:

- Strong leadership and well resources team in place
- Comprehensive healthcare-associated surveillance program across the province
- Clinical IPC support for long-term care facilities
  Opportunities:
- IT infrastructure needs to be harmonized to facilitate better communication (especially during transition care)
- Aging facility with shared room

Standards Set: Inpatient Services - Direct Service Provision

Unmet Criteria		High Priority Criteria
Priority Process: Clinical Leadership		
The organization has met all criteria for this priority process.		
Priority Process: Competency		
The organization has met all criteria for this priority process.		
Priority Process: Episode of Care		
7.1	There is a process to respond to requests for services in a timely way.	
9.14	Diagnostic and laboratory testing and expert consultation are available in a timely way to support a comprehensive assessment.	
Priority Process: Decision Support		
The organization has met all criteria for this priority process.		
Priority Process: Impact on Outcomes		
The organization has met all criteria for this priority process.		

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

The Leadership team plays an important role at each site. There is a collaborative approach to care whereby the smaller and more rural sites work with Cape Breton Regional for pediatric care and complex adult care. The Leadership team is recognized for their team-oriented approach. The managers round with the front-line staff and build relationships with newly recruited healthcare professionals. Leadership listens to new ideas and they create quality initiatives that help the broader team deliver quality care. Patients are provided admission packages. There is the challenge of having enough time for the team to review this package with each patient.

Priority Process: Competency

There are well defined training and education requirements for all staff disciplines. Staff have access to the learning module system which provides an extensive list of courses. Courses are well received by the team. Performance reviews are completed each year and staff will benefit from these reviews when they are completed consistently at each site. Clinical pathways and assessments are embedded in Meditech.

Training for infusion pumps is provided by the clinical educator. The staff knows how to escalate concerns and Meditech helps provide calculations for early recognition of deterioration. Aggressive behaviour is managed by using Code Whites and the local police are called when de-escalation tactics fail. There is a

managed by using Code Whites and the local police are called when de-escalation tactics fail. There is a collaborative approach to the use of a shared IPAC resource. Daily bullet rounds with the multidisciplinary team and provincial initiatives are shared across each site.

Priority Process: Episode of Care

There is collaborative work across the organization to develop an early warning system where patients who are deteriorating can be assessed systematically, scored, and then a decision is made by the nurse to contact the physician and alert them to this deterioration. Currently, work is being done in the system to have early identification of a deteriorating condition and to standardize the response to the situation. There is access to mental health crises by using virtual consults with expertise located in Sydney.

Medication Reconciliation is well established along with Falls Prevention. Pharmacy technicians have helped improve BPMH collection. Information is collected using Tableau and readmission rates and key performance indicators are made available to the leadership team. Given the challenges with staffing, creative ideas have resulted in having environmental services serving morning meals at one site. Innovative staffing ideas are beneficial if able to maintain patient safety. Nursing is identified by their uniforms. This visual management idea was spearheaded by patient feedback.

Priority Process: Decision Support

Data is reviewed using Tableau and metrics are shared at the staff level. Each site has navigated its response to the COVID-19 pandemic and the recent environmental emergencies (hurricane Fiona) by adopting better ways to serve its patients. For example, transfers are made more accessible by transferring patients using trained transport personnel versus experiencing delays with the ambulance service. Point-of-care testing is more widely used at the rural level. Policies are in place related to storing, retaining, and destroying client records. An accurate and up-to-date medical record is maintained on all patients. Each site is using a hybrid paper-based and electronic system for medical records. There is a desire to have a more integrated medical record.

Priority Process: Impact on Outcomes

The provincial committees are well attended by leadership. The medical/surgical committee uses evidence-based practices when initiating quality improvements. Patient advisors attend each provincial committee. Patient flow is a challenge at each site. Initiatives have been made to improve flow which has been started in the emergency department as well as the inpatient units. Several projects like SAFER-F have integrated physicians into discussions that help with patient flow and it has also helped coordinate care between the multidisciplinary team.

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

Unmet Criteria		High Priority Criteria
Priority Process: Clinical Leadership		
1.3	Service-specific goals and objectives are developed, with input from residents and families.	
Priority Process: Competency		
	The organization has met all criteria for this priority process.	
Priority Process: Episode of Care		
7.19	The use of anti-psychotic medications is assessed for appropriateness and the information is used to make improvements.	!
11.2	Responsibility for overseeing the delivery of POCT and maintaining quality is assigned to a health care professional.	
Priority Process: Decision Support		
7.12	Ethics-related issues are proactively identified, managed, and addressed.	!
Priority Process: Impact on Outcomes		
	The organization has met all criteria for this priority process.	

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

Long-term care sites visited during this survey include those at Yarmouth Regional Hospital, Bayview Memorial Health Centre, Glace Bay Hospital, Sutherland Harris Memorial Hospital, Harbourview Hospital, South Cumberland Community Care Centre, Hants Community Hospital, and Camp Hill Veterans Memorial Building.

Expanding access to long-term care beds has been identified as an organizational priority. New infrastructure and the transitioning of long-term beds to best meet the current demand of community members has been a focus of the long-term care leadership team. The team is committed to maintaining a strong veteran culture as they move forward.

There are strong partnerships in place to best serve the future and current residents of the long-term care program. The team is commended for the broad scope of their partnerships. Volunteers are slowly being welcomed back post COVID-19 and this will allow homes to reintroduce these important services.

Service specific goals and objectives are in place at most sites. The team is encouraged to adopt a standardized process for developing, communicating, and monitoring goals and objectives at the site level.

As increased complexity and volumes in service needs grow, much work has been done to manage available resources within the program. Staffing level, skill mix, working to the full scope of practice, and changes to existing work roles and responsibilities have been reviewed and adjusted. This has promoted professional growth for staff and has had a positive impact on resident care. The leadership team is encouraged to formally monitor and evaluate these changes with input from residents and families.

Priority Process: Competency

There is a robust education process in place. Initial and ongoing education through online learning is required by job category. Other educational opportunities are also available to staff. Clinical educators are key in providing timely education on each residence/unit. Staff report satisfaction with the opportunities available to them.

Team functioning is currently being evaluated and opportunities for improvement are being identified.

Standardized communication tools are in place by zone. The team is encouraged to continue to work towards province wide standardization.

Although informal staff recognition processes were halted during the COVID-19 pandemic, staff continue to feel they are recognized for their contributions in both formal and informal ways. There are several innovative recognition initiatives in place.

Spiritual care is available through community partners or on-site resources. This is appreciated by residents, family, and staff. Bereavement committees are in place in some sites and there is an opportunity to expand this work across the organization.

Priority Process: Episode of Care

The long-term care team embraces a resident centred approach within its multidisciplinary team. Leaders and staff are dedicated to partnering with residents and families. There are several innovative and creative approaches in place to evidence this work. The team is encouraged to explore best practices within their zones and provincially. Veteran culture is promoted throughout the living space and in the programming for residents. Residents report this is a very important aspect of their well-being.

There is a fulsome assessment using tools that are standardized by zone with work underway to standardize across the organization. Care planning is well done with input from residents and their families. Updates occur regularly.

Antipsychotic medication use data is not readily available to the care team nor discussed as a

multidisciplinary team at all sites. The ability to initiate improvements is not possible without this information.

Pharmacy support varies widely across long-term care sites. In addition, clinical oversight at many sites would be valuable.

Universal falls precautions and purposeful rounding are well established. Sites are monitoring fall rates and degrees of injury. Post fall interventions are implemented as appropriate. Suicide prevention protocols are in place and utilized effectively. The team is commended for implementing this important resident safety initiative.

The team has access to a wide range of clinical resources in-house and specialty services. The allied health team brings a wealth of knowledge with referrals available to physiotherapy, occupational therapy, recreation, music therapy, and more. Although all resources are not available at all sites, this has a positive impact on resident quality of care where available.

Information at the transition of service is well done by the long-term care team. Information received from sending facilities on the return of long-term care residents could be improved.

Team collaboration and communication have been a theme throughout site visits. Team members value the contributions and skills of others and work collaboratively to provide resident centred care. Their dedication and commitment to residents are evident.

Priority Process: Decision Support

Paper-based record keeping does not support care well. At this time, Inter-RAI or other electronic information system has not been adopted. This is recognized as a gap by both the long-term care (LTC) leadership team and the staff. The team is encouraged to continue to advocate for new technology solutions which will better support care and quality monitoring.

There is a provincial ethics process in place and the long-term care program accesses this resource as appropriate. Further education regarding the ethics framework and ethical issues in long-term care would be helpful for some staff.

At the site and zone level, a standardized set of health information is collected for each resident. The team is encouraged to continue their work towards standardizing all processes and tools across the organization. Similarly, with policies and procedures, the team is encouraged to continue to develop province wide policies.

There is a good flow of information across the broad interdisciplinary team and with other partners. The manual nature of health information can present challenges within the larger team.

Priority Process: Impact on Outcomes

Patient safety incidents are reported. Analysis and improvements are made as needed. Residents indicate that staff discuss their safety with them and changes to their physical environment are made when required. Families report that they are promptly notified of any incidents involving their loved ones.

Quality improvement initiatives are occurring at the local level. Quality boards are in place and provide various metrics related to safety and improvement projects. This information is available to families. It is also communicated to staff through huddles, team meetings, and during education sessions. There has been a focus on identifying and addressing risk, with projects such as call bell availability, purposeful rounding, and increasing mobility. The team is encouraged to spread these initiatives across all sites.

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

Unmet Criteria		High Priority Criteria
Priority Process: Medication Management		
2.13	There is a procedure to handle medications brought into the organization by clients and families.	!
13.2	Medication storage areas are clean and organized.	!
13.4	The organization maintains medication storage conditions that protect the stability of medications.	!
13.6	Medication storage areas meet legislated requirements and regulations for controlled substances.	!
13.9	Multi-dose vials are used only for a single client in client service areas.	!
13.11	Medication storage areas are regularly inspected, and improvements are made if needed.	
14.3	Chemotherapy medications are stored in a separate negative pressure room with adequate ventilation and are segregated from other supplies where possible.	!
15.1	A structured program has been implemented to reduce the risks associated with polypharmacy, especially with frail or vulnerable clients.	!
15.8	Steps are taken to reduce distractions, interruptions, and noise when team members are prescribing medications or transcribing and verifying medication orders.	
15.10	Medication orders are accurately transcribed into clinical documents such as medication administration records.	!
16.1	The pharmacist reviews each medication order prior to the first dose being administered	!
17.1	Medication preparation areas are clean and organized.	!
17.2	Appropriate ventilation, temperature, and lighting are maintained in the medication preparation areas.	!
17.4	Sterile products are prepared in a separate area that meets standards for aseptic compounding.	!

18.3	Unit dose oral medications are kept in manufacturer or pharmacy packaging until they are administered.	!

Surveyor comments on the priority process(es)

Priority Process: Medication Management

The medication management system is in evolution within NSH based on the new structure. The medication management leaders represented by pharmacy, nursing, and physicians have been able to navigate the new structure to improve medication safety effectively.

The organization is working on a “One Patient, One Record” solution for their electronic health record. This project will support the standardization of the medication management system and improve medication safety. Disparate pharmacy information systems, Meditech and BDM, have negatively impacted the standardization of the medication management system. Disparate dispensing cabinet technology such as Omnicell and Pyxis also pose a problem. Despite these two challenges, the interdisciplinary teams have managed to coordinate and standardize some policies and procedures.

Standardizing to one dispensing cabinet technology, provincially, is planned and will assist in supporting more standardization pending the implementation of the one record electronic health record. The next priorities should focus on having pharmacy validation of orders before the first dose for inpatient units and the full implementation of a pharmacy generated medication administration record in all locations.

The organization is encouraged to continue the implementation of automated dispensing cabinets on all sites. They can build on their success at some rural sites.

The correctional services medication management system is antiquatedly creating a high risk of medication error. They are not using unit doses and are still using a medication card system. They could benefit from the implementation of automated dispensing cabinets, pharmacy generated medication administration records, and unit dose packaging.

Despite the hospital pharmacy practice is regulated by the Nova Scotia College of Pharmacists, the organization should strive to meet the same standards. The sterile compounding standards enforced in the community in Nova Scotia and the rest of Canada have two major components.

The facilities requirements such as room ventilation and set up, as well as clinician practice (e.g., staff education and certification) were seen as opportunities for growth during the on-site visit. The standards were put in place to reduce the risk of bacterial or viral contamination of the prepared medications.

Pending infrastructure investments, the production of sterile compounding should be re-assigned to the compliant sites. More specifically, consideration to move the production of sterile non-hazardous compounding to Dartmouth hospital for the city of Halifax. In addition, the organization may wish to consider reducing the beyond use date (BUD) of compounded products in non-compliant pharmacies as an interim measure. This mitigation strategy may have an impact on medication wastage and increase pharmacy staff workload.

The clinical pharmacy services are well integrated with the clinical team. Many pharmacists can practice within their full scope of expertise in support of patient care. They are performing at an advanced practice level. The clinical pharmacy patient load seems to be inconsistent between sites. A clinical pharmacist staffing model based on the number of clients to support, and their level of complexity, could be developed.

There is no formal polypharmacy program. The organization could create a structured program with the process and outcome metrics launch a structured program.

The hybrid medication dispensing system for some high-cost products (e.g., HIV medications) and oncology agents increases the risk of medication error. Depending on the medication prescribed, it can be dispensed by the hospital or by a community pharmacy. This results in neither hospitals nor community pharmacies having a complete picture of the care provided. In addition, the hospital dispensed medications do not make it to the provincial drug information system. For example, oncology patients get their IV chemotherapy from the hospital, and other oral antineoplastic agents and adjuvant therapy from community pharmacies. A “one stop shopping model” could be implemented to allow some high-volume cancer care hospital pharmacies, potentially licensed pharmacies, to dispense all these medications based on a business case.

The success of the antimicrobial stewardship program should be celebrated. The newly formed team, building on previous work, has successfully implemented a program that was able to demonstrate positive outcomes quickly and objectively on antibiotic use. They have successfully implemented iv to PO conversion step down therapy, treatment guidelines, and utilization metrics such as Define Daily Dose.

The recent launch of the phone applications has enabled the program to support more practitioners within the hospitals and in the community.

A robust, well established Best Possible Medication History and Medication Reconciliation Pharmacy Practice Assistant and Pharmacist model is in place for inpatient areas and ambulatory clinics.

The organization has succeeded in improving reports from the safety incident management (SIMSS) system to extract medication safety indicators to assist them to target interventions. The organization is encouraged to further develop medication management key performance indicators/metrics as a corporate dashboard to proactively assess the effectiveness of the medication management system.

At some sites, the unit dose oral medications are not kept in manufacturer or pharmacy packaging until they are administered.

Standards Set: Mental Health Services - Direct Service Provision

Unmet Criteria		High Priority Criteria
Priority Process: Clinical Leadership		
1.6	Processes and policies to meet the diverse needs of the clients and families served are established with input from clients and families.	
1.8	Partnerships are formed and maintained with other services, programs, providers, and organizations to meet the needs of clients and the community.	
2.6	A universally-accessible environment is created with input from clients and families.	
3.12	A strategy to reduce stigma of mental illness among the team is developed with input from clients and families.	
Priority Process: Competency		
3.14	Team member performance is regularly evaluated and documented in an objective, interactive, and constructive way.	!
Priority Process: Episode of Care		
2.7	The physical environment is safe, comfortable, and promotes client recovery.	
Priority Process: Decision Support		
The organization has met all criteria for this priority process.		
Priority Process: Impact on Outcomes		
15.5	Quality improvement activities are designed and tested to meet objectives.	!
15.6	New or existing indicator data are used to establish a baseline for each indicator.	
15.7	There is a process to regularly collect indicator data and track progress.	
15.8	Indicator data is regularly analyzed to determine the effectiveness of the quality improvement activities.	!
15.11	Quality improvement initiatives are regularly evaluated for feasibility, relevance, and usefulness, with input from clients and families.	

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

The Nova Scotia Mental Health & Additions Program (MHA) serves a population of over 1 million individuals ranging from children to youth and adults. The adult program has specialty services that range from ambulatory, day, inpatient, and specialty programs. The MHA program has undergone a significant transformative change that resulted from the Nova Scotia Auditor General Report. High level successes are noted with the single point of access for services that are more data driven and focus on was to better serve the MHA population with program innovations and revitalization of services. In several communities, there is no easy access and virtual care has increased exponentially to provide access to care and treatments. There is clear evidence that aspects of this transformational work are gaining traction and many clinicians are describing patient centred approaches with a provincial lens versus a zone lens.

There are children and adolescent MHA services in the North, West, and East Program and partnerships with IWK in Central Region for care. The partnerships with IWK for mental health (MH) for children services in the central zone support the specialty care needed and during crisis scenarios such as the mass shooting incident. Across the Maritimes, there are good partnerships within MHA programming as well as a collaborative relationship for education and learning with local universities.

The Mental Health Inpatient Withdrawal Management program at Nova Scotia Hospital is a voluntary program for individuals who seek treatment and support to recover from addictions. The program initially had longer length of stay (LOS), up to 21 days, however this has been reduced to 7 days for patients to improve access and decrease wait times for admission. Interviews with clients indicated that the program is a lifeline and they truly feel welcomed and trust the team as often they are at the receiving end of caregivers in other settings where they feel stigmatized because of their addictions. The leadership can review the LOS as there are individuals who return to the program. As well, the team is encouraged to set up a cross continuum working group to advance innovations in the care of individuals with MHA as there many challenges with how their clients are treated in the emergency departments and the community.

Priority Process: Competency

The Mental Health and Addictions program (MHA) has many partnerships with academic organizations that include the medical school across other provinces in the Maritimes. As well, in the Atlantic region, some partnerships focus on aspects of programming related to MHA. The forensic program, while provincial in nature, resides in the central region and the elevated use of this program needs to be considered given that 50% of the clients served to reside outside the central region.

There are opportunities to advance the programming, from a design perspective, to advance care closer to home and ensure that the right individuals receive as much care possible close to home with all the necessary safety measures in place.

Completion of performance appraisal is a noted opportunity area across the mental health program in both the inpatient and outpatient settings.

Priority Process: Episode of Care

In the forensic program, which is provincial in nature, there are noted pressures with admissions from the court system. The team in forensics has worked to increase virtual care and assessments before court appearances to ensure that unnecessary admissions are avoided from the court system which has eased some pressures. The forensic program is provincial in scope. However, it lies within the central zone and there is an opportunity to create program innovations with more hub and spoke type of modelling as 50% of the clients that come into the program in the central region are from other regions. The recognition of this program as provincial in nature is an important aspect that needs to be recognized. However, this can be lost given the alignment to the central zone.

The Mental Health Inpatient Withdrawal Management program at Nova Scotia Hospital is a voluntary program for individuals who seek treatment and support to recover from addictions. The team is encouraged to set up a cross continuum work group to advance innovations in the care of individuals with MHA as there many challenges with how their clients are treated in the emergency departments and the community. Having an engagement strategy that looks at the strength and gaps in the addictions program within and across regions will be beneficial in building an integrated approach with processes and education that focuses on the care and treatment of these individuals over time. Changing perceptions about MHA is another area for focus for staff in the health continuum and the general public. Education is needed to remove stigmas and ensure vulnerable individuals with addictions are treated appropriately and receive respectful person-centred care. The addiction program in Dartmouth would benefit from more structured programming for patients to work on issues related to managing relapse, self-awareness, and tools to support the path to recovery. Currently, the patients expressed the lack of programming during the day. As well, there is a need to look at the site support as clients indicated that remotes were missing or broken, lack of access to recreational activities, or social engagement.

Across MHA programs, capacity challenges exist within current structures as volumes increase. The notion of home hospital and further community base programming needs to be discussed and innovation opportunities explored as the models of the future will need to see care for MHA patients in the community and closer to home. The treatment of individuals with MHA in overnight inpatient settings would benefit from a review to ensure that inpatient beds are used in a more acute situation where there are concerns regarding safety and treatment plans need to be stabilized. Challenging the status quo of care and determining who can be safely cared for and treated at home during periods of escalation is an area of interest and opportunity for the MHA. On the inpatient units, capacity is 100% and there is a need to further determine the need for more acute beds as well as the expansion of programs that are being implemented such as the day hospital and advancing the home hospital concept.

The MHA program has done positive work to support the standardization of care across the province. The standardization of care processes, along with care pathways with accountabilities related to clinical job standardization, will support access to care and treatment.

During the on-site visit in Amherst, there were challenges raised related to the capacity for MH patients due to the current number of psychiatrists on staff. Given the capacity of psychiatrists for adults, they are only able to see urgent cases due to the population served and demands. As well, collaboration challenges exist with the Truro site despite protocols being developed where Amherst clients are being blocked from admission to the IP Mental Health unit when the referral comes from the emergency department. The MHA program is encouraged to engage teams from Amherst and Truro to identify barriers and solutions to developing and sustaining partnerships and processes to support patient-centred care.

Priority Process: Decision Support

Mental Health and Addictions (MHA) have established a structure for quality that includes a Mental Health and Addictions Program QIS that reports to the broader Nova Scotia Health QIS Council. These councils meet regularly with the focus on advancing quality and safety in the provinces with input from the four mental health and addictions zone committees. The teams are continuing to advance quality at the zone and provincial levels. The use of data and metrics of performance is evolving and there are noted areas of pressure with an increase of 9% across inpatient and outpatient settings for mental health and addiction services. These increase demands for care have increased with COVID-19 related stresses and opioid replacement clients have increased by 5% along with mental health and addiction services live intake calls increasing by 10%. The pressure is not easing and the program leads are working to advance access to care with more virtual care. The leadership of the program is working to be data driven and patient outcomes focus.

Virtual Care has expanded exponentially in the MHA program. The medical director for forensics has worked with key stakeholders to advance the documentation of virtual care and in the Spring of 2022, the virtual visits had codes activated in MEDITECH and STAR. This new expanded approach to care with virtual has been incorporated into the scheduling system and can ensure that virtual visits are being captured and dictated documentation recorded in the patient's electronic record.

Access to care and monitoring the waitlist is a priority for the MHA program. Targets are set for urgent and non-urgent waits. For the most part, the program has been successful in meeting the urgent tart needs that are within a week. Areas of focus on the non-urgent referrals is an ongoing priority and the program leads are encouraged to look at opportunities for innovation and decentralized approaches with virtual care. The MHA program is commended for its work to advance system flow and capacity since the auditor general report came out several years ago.

Priority Process: Impact on Outcomes

The leadership of the forensic program and the interim dyad structure is providing support and is seen as being successful as they work to innovate and bring care closer to home in the zones where 50% of the clients reside originally. Leadership is encouraged to continue to have clients with forensic history return to their home communities. It was identified that the team has a strong sense of person-centred care with goals and interventions from a dedicated and compassionate team.

Housing is a challenge for individuals with MHA concerns. Currently, the Department of Social Services has oversight for housing and there are expressed barriers and supports for the MHA population. Leadership is encouraged to work in partnership with the Office of Mental Health to advance strategies that enable the MHA program to have oversight and affordable housing for their population through partnerships with non-profit organizations.

Space challenges exist in many areas of the MHA program. In the Cape Breton Regional Hospital, there is limited space in the inpatient unit. On the 22-bed unit, there were some double rooms with shared washrooms. This is challenging from infection prevention and control and therapeutic perspective.

Additionally, there are two eight-bed units and a 16-bed unit providing inpatient mental health care. The leaders are encouraged to review the unit configuration with the input of clients and families to identify opportunities to efficiently and effectively use and allocate the mental health beds and resources. As well, the infrastructure on the acute mental health unit at the QE II Hi site is challenging related to space. Leadership is encouraged to work with the infrastructure team to address issues on the 6 Lane mental health unit. Issues include a space constraints, supporting proper storage and shelving, and removal of non-unit equipment such as ladders in the soiled utility. Leadership is encouraged to collaborate with IPAC at 6 Lane for problem solving around issues such as separating clean items and equipment from the soiled utility.

The COVID-19 pandemic has increased referrals to MHA across the province. Some communities are seeing an upward of 30% volume increase because of the mental health impacts. In Colchester, this increase in volume which is at 30% is further impacted by the 50% vacancy rate of psychiatrists. The community of Colchester is currently using clinical assistants who are trained MDs as a means to meet patient demand. However, leadership is encouraged to work towards a long sustainable solution for the future. Across communities, the use of virtual care has been a way to improve the access to care. The utilization of standardized practice and assessment tools is helping and the interprofessional team is working together to support patients. The New Day hospital in Halifax will be an important program to watch as this can be spread to other communities and reduce the impact on bed utilization and increase access while clients remain home. Beyond COVID-19, the legalization of marijuana has impacted communities where there are notable increases in drug induced psychosis with the legalization of cannabis and more highly potent drugs available through street dealers which is impacting mental health services.

Since the last survey, there has been a mass shooting in the province of Nova Scotia that has traumatized the community and province. Currently, there is a commission underway to identify the issues and provide recommendations for action to improve and prevent a similar incident. Through various discussions in the MHA program, the response by the team in partnership with many stakeholders including the police, communications, and community response services has been very positive. Individuals and teams need to be commended for their support and actions during this time and several staff participate in the work of the commission for the program.

Standards Set: Obstetrics Services - Direct Service Provision

Unmet Criteria		High Priority Criteria
Priority Process: Clinical Leadership		
The organization has met all criteria for this priority process.		
Priority Process: Competency		
9.12	Access to spiritual space and care is provided to meet clients' needs.	
Priority Process: Episode of Care		
7.9	The client's informed consent is obtained and documented before providing services.	!
8.13	Diagnostic and laboratory testing and expert consultation are available in a timely way to support a comprehensive assessment.	
Priority Process: Decision Support		
The organization has met all criteria for this priority process.		
Priority Process: Impact on Outcomes		
The organization has met all criteria for this priority process.		

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

During the week, 5 of the 9 sites that offer women and children care were surveyed for Obstetrics. All sites had highly engaged leaders with an interest in quality service and people centred care. Where there has been leadership or staff turnover, sites are keen to move forward with new staff and expected stability. Despite demands of COVID-19, vacancies and now escalating hospital occupancy levels at some sites, the Obstetrics units function very well and with spirit. When overflow patients are admitted to this area, the teams maintain a high standard of care for all patients and families.

Priority Process: Competency

There is a high standard of education preparation expected of teams and many often add additional education. The multidisciplinary teams freely share their expertise across NSH. IWK also can provide support. Competency can be achieved by the mix of required online education, (such as NSH employee courses and the provincial Perinatal Orientation Education Program), in-person courses provided by educators or team members such as neonatal resuscitation program (NRP) or case study review, and additional interprofessional efforts such as the classifications for caesarean section.

The sites are fortunate to have educators with some about to increase that service. All staff voiced their appreciation of these roles.

Opportunities are to review education across NSH, for identifying a core bundle of required courses, such as the MoreOB Program, as well as standardizing the educational process across the region.

Priority Process: Episode of Care

It was a pleasure for all surveyors to see these active obstetrical areas with their genuine care, commitment, and teamwork.

All units largely do paper-based charting and at times routine key areas of assessment are missed, such as falls risk level, as the units care for off service patients. In an EMR this would be caught and there would be increased efficiencies as well as safety within its use and setup. The next steps are to continue to work toward one EMR.

There are a large number of initiatives designed or adopted by teams to provide the best possible path of care. The obstetrics service is to be commended for the development of programs at the different sites such as the postpartum feeding clinic that provides post-discharge outpatient support for newborns and their families; the pregnancy navigator; the perinatal mental health RN; the prenatal clinics and staff; or the expanding clinical nurse educator service. The strong team is critical and its efforts show. The obstetrician service and leadership, GPs, midwives and RNs, social work, and pharmacy are a sample of the many providers involved.

Priority Process: Decision Support

Decision support tools were numerous with many initiated from NSH, as would be expected. All staff spoken to were aware of essential practices regarding charts and patient information. The next steps are to continue to ensure information shared virtually (for example: email or text) has consent and needed security levels.

Priority Process: Impact on Outcomes

This is a program that fully embraces QI initiatives and person and family centred care. All interviewees saw care as more than they expected with continuous care by one provider throughout events at many times. This team works to meet standards and continuously improve. Incidents or concerns are managed at the appropriate level and families have participated in the resolution and follow-up. Staff have a solid awareness and use of policies, protocols, and guidelines. QI follows a full circle path from identification to evaluation and then additional work as needed. This is shown in the number of initiatives taken on following data review, an event, concern, or chart review. While the site does not initiate research, it does participate in research such as a study by IWK on COVID-19 and pregnancy.

An opportunity for this program is to start to develop metrics for the key initiatives that have been started in NSH and were shared with surveyors. Measurement will allow evaluation and continued strengthening of efforts. The next step would be to share some of this work nationally and/or to consider highlighting Accreditation Canada as leading practice. Well done, obstetrics/women and children.

Standards Set: Organ and Tissue Transplant Standards - Direct Service Provision

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

Surveyor comments on the priority process(es)

Priority Process: Organ and Tissue Transplant

After data collection is complete, a transplant committee reviews the data and determines the suitability of a patient to be placed on the waitlist. The waitlist is reviewed regularly and patients are made aware that getting a transplant occurs when there is a good match and not when the patient is at the top of the list.
When there is exceptional distribution, patients are informed of the reasons the organ is on the exceptional distribution list.

Transplant fellows are accompanied by a staff surgeon when they are sent out to harvest organs until the staff surgeon is comfortable that the fellow is qualified to do the harvesting alone without damaging the organ.

Patients are educated before discharge on how to take their medications, the follow up required, follow up, and given all the psychosocial support they need.

Priority Process: Clinical Leadership

There is a very strong and committed leadership team that is passionate about serving patients who need transplant surgery from New Brunswick, PEI (other than cardiac), and Newfoundland and Labrador. It is well organized and maintains all standards concerning patient care and needs.

There is a mature program to ensure patients from all the Maritime provinces have access to the transplant program.

The management of the transplant program would be greatly assisted if Nova Scotia was able to implement a province wide patient electronic record which facilitates the collecting of patient care information and reduce the efforts currently required to collect information. Even better would be the adoption of an electronic patient record that was integrated with all four provinces.

All aspects of the transplant program are covered by written SOPs which are reviewed regularly.

Priority Process: Competency

All members of the transplant team have appropriate training concerning their role in the investigation, management, and treatment of patients coming for transplant.

Priority Process: Episode of Care

The three ROPs in this area are all met. There is support for staff, patients, and families as they go through the transplant process. Patients have access to support from a social worker from the time they enter the program through the transplant itself and ongoing afterwards.

Priority Process: Decision Support

All patient records are collected, kept up to date, collated, and maintained in a way consistent with the legislation. Collecting data from 4 different provinces can be a challenge. A province wide electronic patient record or a Maritime enterprise patient record would facilitate the collation of patient records and reduce the workload for staff in the transplant program.

Priority Process: Impact on Outcomes

The process to develop evidence-based guidelines is very mature, reviewing international standards and utilizing the expertise of international and Canadian experts. The standards are reviewed regularly.

Patients can access several different research trials and the Nova Scotia group has a considerable number of publications. All research is appropriately reviewed by an established research ethics board.

Patient safety incidents are entered into the SIMSSS electronic program and reviewed to look for opportunities to improve patient care.

All transplant patients are followed on an ongoing basis creating a large database of outcome measures which can be used to identify an area for quality improvement or program development.

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

Unmet Criteria		High Priority Criteria
Priority Process: Clinical Leadership		
The organization has met all criteria for this priority process.		
Priority Process: Competency		
6.11	Team member performance is regularly evaluated and documented in an objective, interactive, and constructive way.	!
6.13	Team members are supported by team leaders to follow up on issues and opportunities for growth identified through performance evaluations.	!
Priority Process: Episode of Care		
9.3	Defined criteria are used to determine when to initiate services with clients.	
10.15	Clients and families are provided with information about their rights and responsibilities.	!
10.16	Clients and families are provided with information about how to file a complaint or report violations of their rights.	!
17.2	A dress code is followed within the surgical suite.	!
17.8	Soiled linen, infectious material, and hazardous waste are handled appropriately.	!
Priority Process: Decision Support		
The organization has met all criteria for this priority process.		
Priority Process: Impact on Outcomes		
The organization has met all criteria for this priority process.		
Priority Process: Medication Management		
5.3	The contents of medication carts for the surgical area are standardized across the organization.	
15.3	Every medication and solution on the sterile field is labeled.	!
16.3	Medications and related supplies stored on anesthesia carts are standardized.	

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

Nova Scotia Health collects and utilizes health care data which drives planning for surgical care throughout the province. Centres of excellence or specialty care in each of the zones have been developed to help standardize and improve outcomes. An example of this is the zone centres for orthopedic surgery. Transfer protocols to ensure access to care in centres of specialization appear to be mature and working well.

Goals and objectives for the province are set through Nova Scotia Health but the evidence was seen in smaller zone hospitals where feedback from patients was used to make process improvements to provide better service for their patients.

The surgical suites are well supplied with the instruments and equipment to provide safe surgical and anesthetic care. Repairs are, for the most, part done and the instruments are returned promptly to the operating suite. Most biomedical engineering is contracted out but done by contracted out staff who work fulltime within the hospitals.

Priority Process: Competency

A high level of interprofessional cooperation and teamwork was often recognized as enhancing patient care and team cohesiveness. Pharmacists, OTs, and PTs are well embedded as full members of the care teams.

Nova Scotia Health (NSH) has an online learning module that employees are to complete on an annual basis. If the learning modules are not completed, the staff are reminded that it is outstanding. NSH is encouraged to audit compliance to ensure all staff complete the learning modules.

There is an opportunity to audit clinical capacity reports as reported to be under-utilized. Staff said the turnover in the surgical unit was large and mostly due to chronic overwork. Staff could leave for jobs elsewhere in the hospital or other hospitals where the workload was lighter.

As a rule, staff said they felt comfortable reporting errors through the SIMSS incident reporting system.

Performance reviews were not consistently done. The COVID-19 outbreak and considerable turnover of managers in some areas have contributed to reviews not being completed. There were areas of periop where performance reviews were done regularly while other staff state they did not get regular performance reviews. Without performance reviews, managers are unable to identify areas for professional development. Nova Scotia Health is encouraged to perform an audit of performance review completion as there is considerable value in doing them. Although performance reviews were not consistently done, staff were aware that they could apply to an education fund to take courses to enhance their knowledge and skill.

At Colchester, there is an ongoing quality improvement project to improve the OR start times. The surveyor was aware that surgery and anesthesia were each interviewing patients outside the operating after the 8:00 start time. While cleaning staff and nursing turned the rooms over quickly, a lack of buy in from the medical staff to get cases started on time is creating a barrier to the success of this quality improvement process.

Priority Process: Episode of Care

There appear to be well understood procedures to transfer care from smaller hospitals to regional hospitals and on to tertiary facilities as per the level of care needed by an individual patient. Nova Scotia is advised to monitor satisfaction with transfer of accountability as nursing staff report they frequently get poor or inaccurate information when patients are transferred in from other zones or Provinces.

The North Zone provides all admitted patients with a pamphlet which outlines the rights and responsibilities of a patient and gives them a number to contact should they have a complaint or concern. This pamphlet could be shared with other hospitals where patients did not appear to be aware of their rights and responsibilities.

As Aberdeen Hospital is the referral centre for orthopedics in the North Zone, staff are very aware of their responsibility to the other hospitals in the zone to accept their patients expeditiously.

Pharmacy support is clearly imbedded in the management of patient care and are a key support for thorough medication reconciliation.

At the Colchester East Hants Health Centre, the criteria for double check when giving medication is scored yes, however when the surveyor asked to observe a nurse giving a medication, the nurse told the surveyor she would do a double check but only because she was being observed. She said she had done a double check in the morning and because she had only one patient, would not usually do it later in the day when giving the patient another medication. The nurse did do a proper double check but the hospital should reinforce that double checks when administering medication need to be done every time a medication is given.

Not all surgeons are compliant with using standardized order sets. Hand written personalized orders increase the risk of errors being made because of transcription errors or variation from standardized treatment.

Nurses at the Cape Breton Regional Health Centre expressed concern that transfer of accountability (TOA) from the operating room to the PACU was only done by anesthesia and did not involve nursing from the operating room. The standard does not require this be done by nursing but a review of the quality of the TOA should be done to determine if improvements need to be made to ensure PACU nurses receive appropriate information coming from the operating room.

At the Glace Bay Hospital and Cape Breton Regional Health Centre, it was noted there were no defined criteria as to when to initiate services. Operating room flow is in the hands of the surgeons and there is no organizational input into wait lists, booking priorities, or scheduling other than the distribution of blocks.

At the Cumberland Regional Health Centre, soiled instruments are covered with a drape and transported through the clean area where clients are waiting in the preop holding area. While the criteria is not met, it is recognized that without renovations to improve the flow of the department, it is not likely to be feasible to change the current processes and the staff and are doing their best to mitigate risk.

There was no evidence that clients and families were provided with information about their rights and responsibilities at the QEII Health Sciences Centre Centennial, Victoria, Bethune Buildings.

There are no posters ,pamphlets or material in the pre op package re Rights and responsibilities seen at Cape Breton Regional or Glace Bay Hospital.

There was no evidence of clients and families provided with information about how to file a complaint or report violations of their rights.

There was no evidence of clients and families provided with information about their rights and responsibilities at the QEII Health Sciences Centre Centennial, Victoria, Bethune Buildings.

There are no posters ,pamphlets or material in the pre op package re Rights and responsibilities seen at Cape Breton Regional or Glace Bay Hospital.

At the South Shore Regional Hospital and Valley Regional Hospitals it was difficult to find information on the unit with respect to patient rights and responsibilities, and patient responses on this were vague. The organization consider signage or written information for patients on the units .

At the QEII Health Sciences Centre Centennial, Victoria, Bethune Building, there was evidence of a nurse in the surgical suite that was not in dress code. She was wearing a sweater over top of her scrubs, which was not approved in the dress code. This may be a one off incident however the facility is advised to review its policy or dress code in the OR.

At the Cumberland Regional Health Care Centre soiled instruments are covered with a drape and transported through the clean area where clients are waiting in the preop holding area and while the criteria is not met, it is recognized that without renovations to improve the flow of the department, it is not likely to be feasible to change the current processes and the staff and doing their best to mitigate risk.

Priority Process: Decision Support

The hospitals are in the middle of computerization with considerable charting online while maintaining many of the components of the old paper chart. Nova Scotia Health is encouraged to move forward with the implementation of an integrated electronic patient chart.

There are two EMRs available to primary care sites in the province of Nova Scotia. A review of health records associated with episodes of care conducted in the primary care sites visited during the onsite survey indicated that records are complete and in compliance with the standards for clinical and administrative decision-making in primary care. Having said that, there are many places where a combination of paper and electronic health records are maintained. There is a desire on the part of the emerging workforce to move to a single interoperable health record for the health system.

Priority Process: Impact on Outcomes

Nova Scotia Health has a well organized and supported team at the provincial level which develops clinical practice guidelines and order sets using input from practitioners with expertise in the specific area. These are then rolled out to the zones. This is an asset to standardizing treatment and providing high quality care.

There are examples within several hospitals where surgeons refuse to use standardized order sets or clinical practice guidelines. Influencing change in a surgeon's practice can be challenging. NSH is encouraged to identify those surgeons not using standardized order sets or clinical practice guidelines and work with them to encourage their adoption.

Person advisors are well embedded in the surgical platform at the provincial level. There is less evidence of personal advisors being part of the team at the hospital level.

Priority Process: Medication Management

The pharmacist and pharmacist tech are a part of the surgical team at Aberdeen. They play a significant role in ensuring medication reconciliation is done for every patient on the surgical service. They also monitor the use of Do Not Use Abbreviations, teach patients about new medications, and monitor medications such as aminoglycosides and anticoagulants.

In Cape Breton, anesthesia carts are not standardized with each anesthetist having their own medication cart. This is a significant patient safety risk and attention to standardization should be implemented.

Anesthesiologists who rotate through different sites said they must use anesthesia carts that are stocked differently at the different sites and indicated concern that this created a risk of error.

Non safety engineered needles were found in anesthesia carts in multiple hospitals. The surveyor was told they were liked by anesthesia because it is faster to draw up the drugs with them and orthopedic surgeons like them for injecting local anesthesia. Sharp needles pose a risk to staff and hospitals across the country have removed these from stock with a few exceptions such as when they are used for epidural, spinal anesthetics, and arterial lines.

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

Unmet Criteria		High Priority Criteria
Priority Process: Point-of-care Testing Services		
9.5	When the health care professional verbally reports POCT results to clinicians, the results and methods used to obtain those results must later be documented in a written format and identified as POCT results.	!
9.6	The health care professional delivering POCT completes a comprehensive and accurate report for every point-of-care test carried out that is distinct from clinician notes in the record.	
9.8	When completing the POCT report and filing it in the client record, the health care professional delivering POCT clearly labels the results as “POCT”.	

Surveyor comments on the priority process(es)

Priority Process: Point-of-care Testing Services

At the provincial level, a POCT coordinator works in collaboration with different technical specialists assigned in each zone. Each zone has a multidisciplinary committee responsible for keeping track of quality indicators and proper utilization of POCT. In addition, the multidisciplinary committee will study any new request for new POCT. The current POCT structure works well, and we can see a very good alignment, on the field, between the organizational policies and the deployment of POCT at the operational level.

The broader utilization of POCT has allowed NS Health to develop the concept of hydride labs in some community hospitals where the central lab was closed during the evening and nights because of staffing issues. Although far from being perfect, this solution enables NSH to maintain a certain level of laboratory services to the local community.

Most the community hospital have a POCT room where all the devices are installed and connected to the middleware Aegis POC. The nursing staff, LPNs for the most part, are trained and they are the ones performing the testing. The laboratory technicians are supporting the nursing team with internal and external quality control (QCs) and troubleshooting.

In Halifax, the nursing team are trained to perform both QC and testing, so the model is a little different. The wards in Halifax are conducting tests using glucose meters, blood gas analyzers, and urine analyzers.

The technical specialists are running audits on the wards and share the results with the unit managers to improve quality and best practices.

There is a strong POCT structure at the provincial level and within each zone. There is a good quality culture to track quality indicators and do audits. Harmonized e-learning modules are provided.
There are opportunities to follow on physicians' and patients' needs and to input continuous effort in the training of the nursing staff.

Standards Set: Primary Care Services - Direct Service Provision

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

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

The Primary Care Advisory Group has engaged in a consultation process including several patient advisors to develop a primary health care strategy with defined priorities around access, attachment, CDM, partnerships, enablers, and support to the workforce. At the core of the strategy, the priorities are self-management, system navigation, and wellness. The team recognizes the need for innovative service delivery models and, as such, embraces the idea of learning from other jurisdictions, trying new models, and spreading "what works" across the system.

There is variation in how primary care sites operate across the province. Where clients have the most need for the service there appears to be a quicker and more consistent availability of treatment from a multidisciplinary team. In some communities, clients describe wait times as same day or with days in these circumstances, whereas clients in the same family may describe a six week wait time to see a physician in a more traditional physician practice. Access to primary care services is hampered even more in the current health human resource shortage.

In the spirit of continuous quality improvement, the provincial advisory group is encouraged to continue its initiatives to try new modes of service delivery and adopt and spread what works well. There is a lot of feedback from the clients who gave input to the survey that, especially in underserved areas, there is a spirit of readiness to adopt new models and to participate in modes of service delivery that improve access to the right service in the right place at the right time.

Priority Process: Competency

Generally the teams that participated in primary care settings across the province were highly engaged and demonstrated collaborative and integrated care. There is significant variation in the skill-sets of individual team members across the province. It appears that this has to do with the challenges associated with recruiting and retaining the expertise that is needed, and it some cases it is because there are deliberate efforts to respond to what the population health data says about the areas of greatest need. The organization is encouraged to continue the work of determining what models "work" in various settings and make every effort to standardize the models and socialize the primary care model in such a way that public becomes more knowledgeable about the most appropriate points of access. There are certain sites, such as the urgent treatment centre in North Sydney where the health professionals and clients shared observations about how the program continues to be tweaked with the intention of diverting people from the Emergency Department in Sydney while providing a venue where people can receive episodic care that provides what people need while keeping the onus on the client to choose the right service in terms of resource intensity.

Priority Process: Episode of Care

There are two EMR applications used for primary care in Nova Scotia: Acuro and MedAccess. The applications are thorough; providing for scheduling, care planning, reporting process, and the production of management reports to support quality improvement efforts supported by data and specified indicators and outcomes.

Hours of opening are a challenge for clients who would choose a primary care setting over a visit to an emergency department. This challenge is particularly problematic in the current health human resource recruitment and retention environment.

There is evidence that client advisors have been engaged in planning for improvements to the primary care system and that patients can provide input to the sites based on their experience when accessing an episode of care. Clients who participated in clinical tracers expressed a high level of satisfaction with the services. Their main concerns had to do with access outside of business hours and availability of appointment times to see a practitioner. There was some suggestion that the scope of practice of nurse practitioners and physician assistants would help to ease the expectations and the burden on physicians, particularly in rural areas. There is variation across the province in terms of how Nurse Practitioner services are deployed and utilized.

Priority Process: Decision Support

There are systems and processes for access to practice guidelines and protocols. Work continues to standardize/harmonize processes at the different sites.

The Corrections Team has been advocating for automated dispensing cabinets and single dose pill packers for several years. They have submitted a business case for technology and information systems for safe medication administration and access to Tableau to input hand hygiene compliance audits.

Priority Process: Impact on Outcomes

The work that is being done by the Provincial Advisory Group demonstrates a responsive and coordinated approach to the development of a provincial approach to primary care that is gravitating toward healthy homes and healthy services that provide services under one roof based on measuring, monitoring, evaluating, and adapting to the identified needs of the population. The intention is to learn from models such as the collaborative emergency centres (CEC) to renew and improve primary care based on lessons learned. Efforts have been undertaken to consult with providers and the public to determine what is wanted and needed. There is recognition that there is a sense of urgency because of the challenges with recruiting and retaining professionals who will work in traditional models of service delivery. Change is needed but "what works" can only be determined through ongoing efforts to renew and evaluate. The advisory committee is supporting the submission of business cases to try and evaluate new approaches and research into what other jurisdictions are doing that might be replicated here.

Standards Set: Provincial Correctional Health Services Standards - Direct Service Provision

Unmet Criteria		High Priority Criteria
Priority Process: Clinical Leadership		
The organization has met all criteria for this priority process.		
Priority Process: Competency		
3.10	Team member performance is regularly evaluated and documented in an objective, interactive, and constructive way.	!
3.11	Team members are supported by team leaders to follow up on issues and opportunities for growth identified through performance evaluations.	!
Priority Process: Episode of Care		
6.4	Timely access to dental care is provided for clients.	!
7.14	Ethics-related issues are proactively identified, managed, and addressed.	!
Priority Process: Decision Support		
The organization has met all criteria for this priority process.		
Priority Process: Impact on Outcomes		
18.3	Measurable objectives with specific timeframes for completion are identified for quality improvement initiatives.	!
18.4	Indicator(s) that monitor progress for each quality improvement objective are identified.	
18.5	Quality improvement activities are designed and tested to meet objectives.	!
18.6	New or existing indicator data are used to establish a baseline for each indicator.	
18.8	Indicator data is regularly analyzed to determine the effectiveness of the quality improvement activities.	!
18.9	Quality improvement activities that were shown to be effective in the testing phase are implemented broadly throughout the organization.	!
18.11	Quality improvement initiatives are regularly evaluated for feasibility, relevance, and usefulness.	

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

Nova Scotia Health (NSH) provides health services in all the adult provincial correctional facilities in Nova Scotia and is coordinated under NSH Mental Health and Addictions Program. The on-site survey visits included the Central Nova Scotia Correctional Facility (CNSCF) located in Dartmouth, the Northeast Nova Scotia Correctional Facility (NNSCF) located in New Glasgow, and Cape Breton Correctional Facility (CBCF) located in Sydney. The Southwest Nova Scotia Correctional Facility (SWCF) has not been in use since March 2020. This is the first time that Correctional Health Services (CHS) have been accredited as part of NSH.

CHS should be commended on the work that they have done in preparation for the on-site survey. With their limited resources, they have done a tremendous amount of work to meet the accreditation standards. They should be proud of the work that has been done to date and they recognize that more needs to be done to retain staff and provide quality care to their clients.

CHS is under the umbrella of the Mental Health and Addictions Program. Specifically for CHS, there is a program leader that has overall responsibility and clinical operations supervisors at each of the three sites. In addition, there is a provincial CHS quality lead.
Depending on the facility, healthcare teams include physicians, psychiatrists, nurses, mental health and substance use specialists, social workers, and dentists. Clients can also see specialists via virtual health services.

To meet the specific needs, of their clients, CHS offers the following services: medical and nursing care; mental health and substance use treatment programs and services; basic emergency response services; public health services such as flu immunizations; urgent dental care; medication administration; wound care; and health-related discharge planning to help clients transition successfully to community-based care. As up to 60 percent of people in custody have either a mental illness, an addiction, or both, there is additional support for people with opioid use disorder. One key support is wide access to opioid agonist treatment.

CHS works with the Department of Justice corrections officers as partners in client care. While the Correctional Health Services team provides care, correctional officers keep both staff and clients safe.

The corrections team has submitted a business case outlining all of their resource requirements for increased mental health nurses, social workers, pharmacist, physician coverage, weekend clerical support, clinical educator, clinical resource leader, and identification gaps in technology such as automated dispensing cabinets and single dose pill packaging.

Priority Process: Competency

Priority Process: Competency

There is a mixture of contracted staff (some independent contractors and some from the VON) and NSH staff that makes up the health care team.

There are ethics related resources in the Learning Management System (LMS). However, the majority of staff were unsure of how to access resources should they have an ethics related concern.

Correctional health services (CHS) has undergone a major review of their model of care. This included an assessment of all their current services while eliciting feedback from all service providers. One of the outcomes of the engagement was to change their name from Offender Health Services to Provincial Correctional Health Services.

The major outcome we have thus far is having gathered all the information required and submitting a comprehensive business plan to the Department of Health and Wellness which includes an increase in all physician time, adding a full-time pharmacist to the team, and adding additional mental health and addictions staff (RNs and another social workers that will be able to better support our smaller sites).

Performance Evaluations are not regularly performed and as such issues and opportunities for growth have not been identified through them.

Priority Process: Episode of Care

A very extensive assessment is completed on clients upon admission to the Corrections Health Facilities. Audits for assessments to be completed within 24 hours are done monthly. Medication reconciliation is done well.

There is some triaging of health care requests that are done for clinic visits, but there are only 2 half days per week when there is a physician on-site to see clients, which results in wait times of 6-8 weeks to be seen by the general practitioner. This is the same amount of physician availability that is awarded to the Northeast Nova Scotia Correctional Facility, which has a third of the number of clients (persons in custody) and less acuity.

The organization would benefit from a review of how dental care is (or is not) provided for clients. Many of the clients were noted to have dental abscesses or caries and there are growing and significant wait times to see a dentist. It was reported that there are dentists that are wanting to work for corrections. However, the funding for dental services is a barrier. There is a new dental suite in the Northeast Correctional Facility that has never been used due to not having a dentist. However, a dentist has been recently recruited and is scheduled to start providing care shortly. At the Central Correctional Facility, there is a dental suite with old equipment (still using film x-rays) and a recently recruited dentist has been in place since August 2022. The funding for this dentist only provides 2 days per month of dental care. This has resulted in significant waitlists for dental services.

Some staff were aware that there was an ethics program but the majority of the staff that were interviewed during the survey did not know how to get assistance for ethics related issues.

Priority Process: Decision Support

There are systems and processes for access to practice guidelines and protocols. Work continues to standardize/harmonize processes at the different sites.

The Corrections Team have been advocating for Automated Dispensing Cabinets and Single Dose Pill Packers for several years. They have submitted a Business Case for technology ad information systems for safe medication administration and access to Tableau to input Hand Hygiene Compliance Audits.

Priority Process: Impact on Outcomes

Monthly chart audits for many items such as admission assessments that are completed within 24 hours; Consent documented; Medication reconciliation; Suicide risk assessments completed; TOA for health care holds and an initial care plan developed within 24 hours of admission; MARS sheet fully signed off.

Clients that were interviewed were highly complimentary of the care provided, speaking about the support received with care planning, education, and emotional care. Their comments affirm the realization of the team’s resolve to support holistic patient care.

The teams are encouraged to continue their work with quality improvement initiatives and particularly on profiling the impact of those initiatives on care and practices. Increased transparency will support greater engagement of staff, patients, and families with this organization's priority.

Standards Set: Public Health Services - Direct Service Provision

Unmet Criteria		High Priority Criteria
Priority Process: Clinical Leadership		
The organization has met all criteria for this priority process.		
Priority Process: Competency		
4.3	Team member performance is regularly evaluated and documented in an objective, interactive, and constructive way.	!
Priority Process: Impact on Outcomes		
The organization has met all criteria for this priority process.		
Priority Process: Public Health		
1.1	A population health assessment is conducted at least every five years.	!
3.11	Ethics-related issues are proactively identified, managed, and addressed.	!
10.8	Equitable, evidence-based screening programs are provided or promoted.	!
14.5	The data system, i.e., hardware and software, is evaluated annually and upgrades to improve the access, quality and use of health data are planned and implemented.	
Surveyor comments on the priority process(es)		
Priority Process: Clinical Leadership		

Population and Public Health is a provincial program that has direct accountability to Nova Scotia Health. They have identified four priority areas of work which include their people: re-introduction of services, learnings, and readiness. Public Health (PH) is also collaborating with the Department of Health and Wellness to revise the emergency response plan and review health protection legislation.

Public Health organizational structure includes zone specific medical officers of health who work with zone administrative leaders and teams. Staff feel supported by leadership and there is a strong sense of team cohesiveness.

There is evidence of strong partnerships with various key stakeholders including community health boards, patient advisory committees, education, correction facilities, shelters, municipalities, Indigenous communities, and African groups. These partnerships assist to inform the development of public policies with population health implications and identify health equity gaps.

PH works closely with clients and families to hear their perspectives and seek out feedback regarding the services offered. This is done through surveys and speaking directly with clients and their families. Clients' and families' perspectives help inform their work, job design, roles, and responsibilities.

Priority Process: Competency

Public Health has a comprehensive orientation that is provided to all staff. This training includes how to work respectively and effectively with clients and families with diverse backgrounds, religious beliefs, and care needs. Staff competencies are continuously reviewed to ensure they are up to date and meet department requirements.

Annual performance appraisals are completed for staff and growth opportunities are discussed. Staff indicated they appreciate one on one time with their managers.

Client and team safety are at the forefront for PH. Workloads are regularly assessed to ensure safe client care practices are maintained.

Priority Process: Impact on Outcomes

Quality improvement projects are well designed and carried out within PH. This includes identifying indicators to monitor progress with input from clients and families, establishing a baseline using existing data, analyzing data for relevance, and implementing effective projects broadly across the organization.

In December 2020, during a heightened time of the COVID-19 pandemic, a provincial PH quality improvement initiative was established whereby a housing and isolation program (HIP) was created to respond to inequities faced by Nova Scotians. The aim was to reduce the barriers to self-isolation, such as lack of housing, and work with partners to coordinate and respond to needs. A total of 1,846 referrals were supported from December 2020 to March 2022. This QI project had a tremendous impact on the ability to reduce the spread of COVID-19 and help those in need. It raised awareness for frontline staff who gained increased knowledge and understanding of those facing food insecurity and a lack of stable housing. A staff member said, “it allowed me to bring this to my healthy public policy work to try to influence system change”. PH is commended for this excellent work.

Priority Process: Public Health

Public Health uses significant population health data to inform health equity gaps that exist between and within populations. Implementation of a provincial targeted Topical Fluoride Program is one example where population health data was used to identify gaps related to oral health. A population health assessment has not been carried out since 2015. Leadership acknowledged the value of conducting this assessment.

Accountability in the development of a population health improvement plan falls within the Nova Scotia Department of Health and Wellness. PH work is guided by the Nova Scotia Public Health Standards. PH is aligning its work to reflect the priorities outlined in the Nova Scotia Action for Health strategic plan.

Current public policies with population health implications are analyzed and policy gaps are identified.

Health promotion programs that address the determinants of health are delivered at various levels of the population. There is a good implementation of services to support early childhood development, communicable disease prevention, chronic disease prevention, and immunization programs. Nova Scotia's "Enhanced Immunization Access Project" was an example of their commitment to work with First Nations communities across all zones to better understand and sustain immunization coverage rates. Smoking avoidance and cessation support is provided by PH but could be augmented by arranging direct referrals to cessation programs. Evidence-based screening programs are offered through primary care and are not provided by PH. An opportunity exists for PH to take on a health promotion approach to this work in partnership with cancer care and primary care.

Excellent practices are occurring at the PH biological depo related to safe vaccine storage and handling. They are applauded for their work. A Cold Chain Investigation/Adverse Storage Conditions standard operating procedure is in place. Audits are performed to ensure good compliance with standards.

Compliance with public health laws and regulations is monitored. Surveillance data is regularly monitored to identify and investigate immediate public health threats. Data is analyzed to assess potential implications for population health. This data is shared with senior leadership. There are procedures in place to issue public health advisories.

Challenges exist with a lack of IT integration. Primary care provides childhood immunizations but have no access to Panorama, which is used to obtain immunization rates. This results in manual data entry which impacts access to accurate and real time immunization data.

PH is applauded for its strong provincial COVID-19 response. To meet the needs of communities across the province, a provincial Public Health Mobile Unit program was developed in the fall of 2020. PH teams were established to provide COVID-19 services and testing support during outbreaks. Ten mobile health vans were designed and strategically placed across the province on a quest to support Nova Scotians. They provided 211 clinics and 28, 851 COVID-19 tests over 6 months.

Standards Set: Rehabilitation Services - Direct Service Provision

Unmet Criteria		High Priority Criteria
Priority Process: Clinical Leadership		
The organization has met all criteria for this priority process.		
Priority Process: Competency		
3.11	Team member performance is regularly evaluated and documented in an objective, interactive, and constructive way.	!
3.13	Team members are supported by team leaders to follow up on issues and opportunities for growth identified through performance evaluations.	!
4.4	Standardized communication tools are used to share information about a client's care within and between teams.	!
Priority Process: Episode of Care		
10.8	The effectiveness of transitions is evaluated and the information is used to improve transition planning, with input from clients and families.	
Priority Process: Decision Support		
The organization has met all criteria for this priority process.		
Priority Process: Impact on Outcomes		
The organization has met all criteria for this priority process.		

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

The MSK-Amps rehabilitation team uses patient survey data as well as patient and family advisors (PFA) to guide and provide input on quality improvement initiatives. The team is very judicious in the participation of these PFAs and ensures that mandates proposed to them correspond to their skillset and patient experience. Patients have had the chance to participate in many initiatives such as the renovation of the therapeutic pool, the design of the transitional apartments, and others.

The team has a full complement of professionals, including hospitalist physicians, physiatrists, nursing staff, as well as allied health professionals such as physiotherapists, occupational therapists, nutritionists, social workers, and psychologists.

Patients come from 3 referral sources: Halifax QEII Hospitals, other community hospitals in Nova Scotia, or patients admitted directly from home. The team has a strong partnership with the QE2 partners, and physiatrists from rehab accept consultations at the QEII Hospitals to evaluate and estimate the discharge timing of patients to prepare for admission to rehab.

Priority Process: Competency

The team has access to training on the ethics framework as well as the procedure to request an ethics support consultation.

The team has a very collaborative approach with patients and families but also with other providers to ensure continuity of service to its patients. The team also reviews its functioning and tries to put in place improvement initiatives such as the creation of the interprofessional clinical leadership roles.

The team is encouraged to resume regular formal performance feedback to its staff and use these meetings as opportunities for managers and staff to discuss and exchange on their everyday work.

The team has a variety of strategies to communicate with partners and provides a thorough summary of discharge instructions to patients. It is encouraged to develop a standardized minimum set of data required from referral sources before admission and a standardized set of information to send to collaborators upon the transition of patients to another service provider.

Priority Process: Episode of Care

Following the reception of requests for admission, physiatrists on this team proceed to a consultation either in person or on paper based on a defined set of admission criteria evaluating readiness for rehabilitation. Patients meeting admission criteria are then placed on a waitlist for admission based on clinical needs as well as resource capacity.

The team indicates that since there have been more requests for stroke patient rehabilitation over the past several months, more admissions have had to be dedicated to stroke patients because research evidence shows an optimal window to maximize rehabilitation potential in this population. This has consequently resulted in sometimes long waits for other clients.

Upon admission, patients receive complete interdisciplinary evaluations and the patient's treatment goals, if realistic, are then adopted by the team in the treatment plan. Patients express high satisfaction with the team's approach and indicate that they are encouraged to actively encouraged to participate in their treatment, discharge planning, and preparation.

This service has offered palliative care to patients but expresses questioning the role of a rehabilitation team in providing palliation to patients. The team is encouraged to continue the exchange and conversation and to consult the ethics committee, if necessary, to arrive at a common vision on this question.

The team has a variety of strategies to communicate with partners and provides a thorough summary of discharge instructions to patients. It is encouraged to develop a standardized minimum set of data required from referral sources before admission and a standardized set of information to send to collaborators upon the transition of patients to another service provider.

After discharge, the physiatrists and team professionals offer a follow-up to patients who require it. This "safety net", especially for patients without adequate follow-up or family doctors, ensures minimum safety for patients.

Priority Process: Decision Support

The team maintains a paper patient file. Audits are performed to ensure consistency and conformity to charting guidelines.

The organization is encouraged to pursue the “One Patient, One Record” initiative to ensure communication of patient data across sites

Priority Process: Impact on Outcomes

The team is very motivated and keeps itself up to date on treatment developments based on evidence. With the support of the foundation, the team has been able to acquire up to date equipment to support its treatment interventions.

Patient safety incidents are recorded in the SIMSSS incident management system and follow-ups are done according to policy and procedure. In addition, quarterly trending information on incidents, as well as other quality indicators, are shared with staff to motivate continuous improvement.

Standards Set: Spinal Cord Injury Acute Services - Direct Service Provision

Unmet Criteria		High Priority Criteria
Priority Process: Clinical Leadership		
2.5	Sufficient space is available to accommodate patients with spinal cord injury and provide safe and effective services, including private space for patients and families.	
Priority Process: Competency		
4.5	Standardized communication tools are used to share information about a patient's care within and between teams.	!
4.6	The effectiveness of team collaboration and functioning is evaluated and opportunities for improvement are identified.	
Priority Process: Episode of Care		
10.9	The effectiveness of transitions is evaluated and the information is used to improve transition planning, with input from patients and families.	
Priority Process: Decision Support		
The organization has met all criteria for this priority process.		
Priority Process: Impact on Outcomes		
The organization has met all criteria for this priority process.		

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

The Spinal Cord Injury Acute Services team has a dedicated staff that has been very resilient despite the COVID-19 pandemic and staffing challenges. Patients interviewed expressed satisfaction and feel that services are very patient-centred. Patient goals and objectives are respected and services such as meal services have been improved following feedback from patients.

Space on the 7.3 unit is quite limited and certain "double" rooms afford little private space for patients and families. On the contrary, a 6-bed IMCU adjacent to 7.3 offers 6 single-bed rooms with individual toilets and is well adapted to the needs of the clientèle assigned there.

The team has a strong partnership with the spinal cord injury rehabilitation service and physiatrists from rehab round weekly to evaluate and estimate the discharge timing of patients on this unit. The team is also one of the early adopters of the C3 platform and contributes with partners from other units such as emergency and neurology/medicine to the bed and patient flow.

Clinical protocols are developed and reviews are done annually with the team to ensure pertinence as well as to integrate new evidence-supported practices if necessary.

Priority Process: Competency

The team is trained to use standardized assessment tools such as the ASIA evaluation, and Braden and Morse scales.

The team has access to the ethics committee for support for potential ethical dilemmas but indicates that the PATH (Palliative and Therapeutic Harmonization) team is more frequently solicited and provides excellent support for the level of care and intervention decisions for the spinal cord injured population. In addition, several research studies are ongoing to identify and finetune the approach to the discussion with patients regarding rehabilitation vs palliative and end-of-life needs.

Although a lot of communication exists between team members as well as with external collaborators (ex. Rehab), the 7.3 Unit is encouraged to develop standardized tools to ensure uniform information transfer at moments such as shift changes. In addition, following the deployment of these standardized tools, the team is encouraged to measure the effectiveness and adjust the tools according to the results.

Priority Process: Episode of Care

With the arrival of the C3 command center, the team tries to improve its capacity to respond to requests for services in a timely way. The team has a strong partnership with the spinal cord injury rehabilitation service and physiatrists from rehab round weekly to evaluate and estimate the discharge timing of patients on this unit. The C3 participation requires the team to follow patient progress closely, adjust intervention plans, and ensure access to diagnostic testing.

Upon arrival to the unit, patients are encouraged to actively participate in their care to the limit of their capacity. The team also discusses with patients the expected outcome and resulting physical limitations from their injuries in a respectful but clear and transparent and realistic fashion.

Patients have opportunities to participate in pharmaceutical as well as qualitative psychosocial research studies that may be appropriate to their care.

Although this team applies fall risk assessments and puts in place mitigation strategies for identified risks, it is encouraged to evaluate the effectiveness of the intervention by following trending information.

Psychosocial support is available when needed to support the needs of patients.

Patients interviewed express satisfaction and feel that services are very patient-centred. Patient goals and objectives are respected and services such as meal services have been improved following feedback from patients. They also feel well prepared and solicited to participate in transition planning. Transitions are well planned. However, the team is encouraged to find strategies to measure the effectiveness of these transfers.

Priority Process: Decision Support

Patient records are paper-based and staff often have to re-copy information from one form to another. Chart audits are done to ensure conformity to record-keeping procedures.

The organization is encouraged to pursue its “One Patient, One Record” initiative to ensure uniformity of documentation as well as accessibility, especially in a multi-site organization.

Priority Process: Impact on Outcomes

The team participates in research studies and uses research results to guide their revision of treatment protocols. Protocols are reviewed regularly by the team. However, the team is encouraged to include patients and/or families in the selection of evidence and revision of protocols.

Incident report is done through the electronic incident management system and disclosure is done according to policy.

Standards Set: Spinal Cord Injury Rehabilitation Services - Direct Service Provision

Unmet Criteria		High Priority Criteria
Priority Process: Clinical Leadership		
The organization has met all criteria for this priority process.		
Priority Process: Competency		
3.13	Team members are supported by team leaders to follow up on issues and opportunities for growth identified through performance evaluations.	!
4.5	Standardized communication tools are used to share information about a patient's care within and between teams.	!
4.6	The effectiveness of team collaboration and functioning is evaluated and opportunities for improvement are identified.	
Priority Process: Episode of Care		
The organization has met all criteria for this priority process.		
Priority Process: Decision Support		
The organization has met all criteria for this priority process.		
Priority Process: Impact on Outcomes		
The organization has met all criteria for this priority process.		

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

The SCI rehabilitation team uses patient survey data to guide quality improvement initiatives. The team also has patient family advisors and is very conscious of their participation and ensures that mandates proposed to them correspond to their skillset and patient experience.

The team has a full complement of professionals including hospitalist physicians, physiatrists, nursing staff, as well as allied health professionals such as physiotherapists, occupational therapists, nutritionists, social workers, and psychologists.

The team has a strong partnership with the acute spinal cord injury service, and physiatrists from rehab round weekly on unit 7.3 to evaluate and estimate the discharge timing of patients on this unit.

Priority Process: Competency

The team is committed to offering training and education to its staff. However, during the COVID-19 pandemic over the past 2 years, much training was done internally by staff to each other. Training is also provided for various tools used by the team as well as on the newly acquired infusion pumps and other equipment.

Although the team leaders aim to complete performance evaluations annually, they realize that this may not be feasible and some staff have not had their evaluation meetings for over 12 months.

Priority Process: Episode of Care

The team has the mechanisms to respond to requests for services in a timely way, including the presence of its physiatrist in the acute care unit to evaluate and propose treatments to prepare patients for transfer to rehab. However, according to a physiatrist interviewed, the pressure of bed flow forces the admission of some off-service patients to the rehab unit. This reduces the accessibility of rehabilitation beds for spinal cord injury patients.

An assessor evaluates rehabilitation admission requests according to a written list of criteria and communicates with the referrer to organize the eventual transfer. Upon admission, the team uses a complement of standardized tools such as the ASIA evaluation, the Morse, and the Braden scales. The team also discusses with patients the expected outcome and resulting physical limitations from their injuries in a respectful but clear and transparent and realistic fashion.

Priority Process: Decision Support

Patient records are paper-based and staff often have to re-copy information from one form to another. Chart audits are done to ensure conformity to record-keeping procedures.

The organization is encouraged to pursue its “One Patient, One Record” initiative to ensure uniformity of documentation as well as accessibility, especially in a multi-site organization.

Priority Process: Impact on Outcomes

The team bases its treatment interventions on evidence-informed guidelines. Much effort is invested to include patients in the planning and design of services offered.

Risks to patients are identified through analysis of the incident management system. The team also proactively identifies patient safety risks such as falls, pressure ulcers, depression, and suicide.

Quality improvement initiatives are shared with staff and patients. Indicators and progress are posted in areas accessible to all to consult.

Standards Set: Transfusion Services - Direct Service Provision

Unmet Criteria		High Priority Criteria
Priority Process: Episode of Care		
The organization has met all criteria for this priority process.		
Priority Process: Transfusion Services		
4.2	The team has access to ongoing professional development, training, and educational activities.	
6.1	The team's physical environment and equipment support efficient functioning and safe activities.	
25.1	The team collects information and feedback from clients, families, staff, service providers, organization leaders, and other organizations about the quality of its services to guide its quality improvement initiatives.	
25.2	The team uses the information and feedback it has gathered to identify opportunities for quality improvement initiatives.	
25.11	The team shares information about its quality improvement activities, results, and learnings with clients, families, staff, service providers, organization leaders, and other organizations, as appropriate.	

Surveyor comments on the priority process(es)

Priority Process: Episode of Care

The staff use universal fall precautions to reduce the reduce for patient's risk of falls.

Priority Process: Transfusion Services

Transfusion services are available in most, if not all, hospitals in Nova Scotia Health. The technologists responsible for this program are competent. The training of new technologists is adequate. The program is standardized across Nova Scotia Health. For several years, the network has obtained recognition for the quality of service: Using Blood Wisely. The organization is encouraged to monitor transfusions and make doctors aware of the importance of optimal transfusion by following the algorithm of transfusion.

The lack of staff affects all sectors including the blood transfusion department. This lack is more significant in some areas than in others. The organization is aware of this challenge and several initiatives are underway in collaboration with the Ministry of Health and the community college to increase the number of technologists. There are also initiatives for international recruitment and work on the recognition of diplomas for technologists trained abroad.

In some areas, the space is insufficient for the volume of work in the blood transfusion department. In addition, there are sources of distraction present, and they can increase the risk of errors. The organization is encouraged to assess the workspaces for needs and make corrections when necessary.

Although in most hospitals the quality indicators are monitored regularly, this is not the case in other centers. The main barriers are a laboratory information system that does not easily extract data and a lack of staff to do it manually. A more suitable laboratory information system will overcome this problem. It seems that the organization is in the final stages of a request for proposals for a new laboratory information system and that the implementation should begin soon.

In several transfusion departments, the equipment is adequate. However, in some departments the devices are relatively old. The organization is requesting a proposal for new equipment.

The technologists pay particular attention to patient safety and the response time for blood bank services is monitored regularly. It seems, there are no complaints from users (doctors, nurses, and patients). The department is encouraged to carry out surveys regularly with doctors, nurses, and patients to obtain feedback on the service to continue the improvement process.

Instrument Results

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

Governance Functioning Tool (2016)

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

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

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

- **Data collection period: September 2, 2020 to November 26, 2020**
- **Number of responses: 10**

Governance Functioning Tool Results

	% Strongly Disagree / Disagree	% Neutral	% Agree / Strongly Agree	%Agree * Canadian Average
	Organization	Organization	Organization	
1. We regularly review and ensure compliance with applicable laws, legislation, and regulations.	0	0	100	95
2. Governance policies and procedures that define our role and responsibilities are well documented and consistently followed.	0	0	100	97
3. Subcommittees need better defined roles and responsibilities.	80	0	20	73
4. As a governing body, we do not become directly involved in management issues.	0	0	100	87
5. Disagreements are viewed as a search for solutions rather than a “win/lose”.	0	0	100	96

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

	% Strongly Disagree / Disagree	% Neutral	% Agree / Strongly Agree	%Agree * Canadian Average
	Organization	Organization	Organization	
20. As a governing body, we regularly identify areas for improvement and engage in our own quality improvement activities.	10	0	90	82
21. As individual members, we need better feedback about our contribution to the governing body.	90	0	10	43
22. We receive ongoing education on how to interpret information on quality and patient safety performance.	0	10	90	83
23. As a governing body, we oversee the development of the organization's strategic plan.	0	0	100	93
24. As a governing body, we hear stories about clients who experienced harm during care.	0	0	100	79
25. The performance measures we track as a governing body give us a good understanding of organizational performance.	0	0	100	95
26. We actively recruit, recommend, and/or select new members based on needs for particular skills, background, and experience.	0	0	100	90
27. We lack explicit criteria to recruit and select new members.	100	0	0	78
28. Our renewal cycle is appropriately managed to ensure the continuity of the governing body.	0	0	100	90
29. The composition of our governing body allows us to meet stakeholder and community needs.	0	0	100	92
30. Clear, written policies define term lengths and limits for individual members, as well as compensation.	0	0	100	92
31. We review our own structure, including size and subcommittee structure.	0	0	100	81
32. We have a process to elect or appoint our chair.	14	0	86	90
33. Patient safety	0	10	90	83
34. Quality of care	0	10	90	83

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

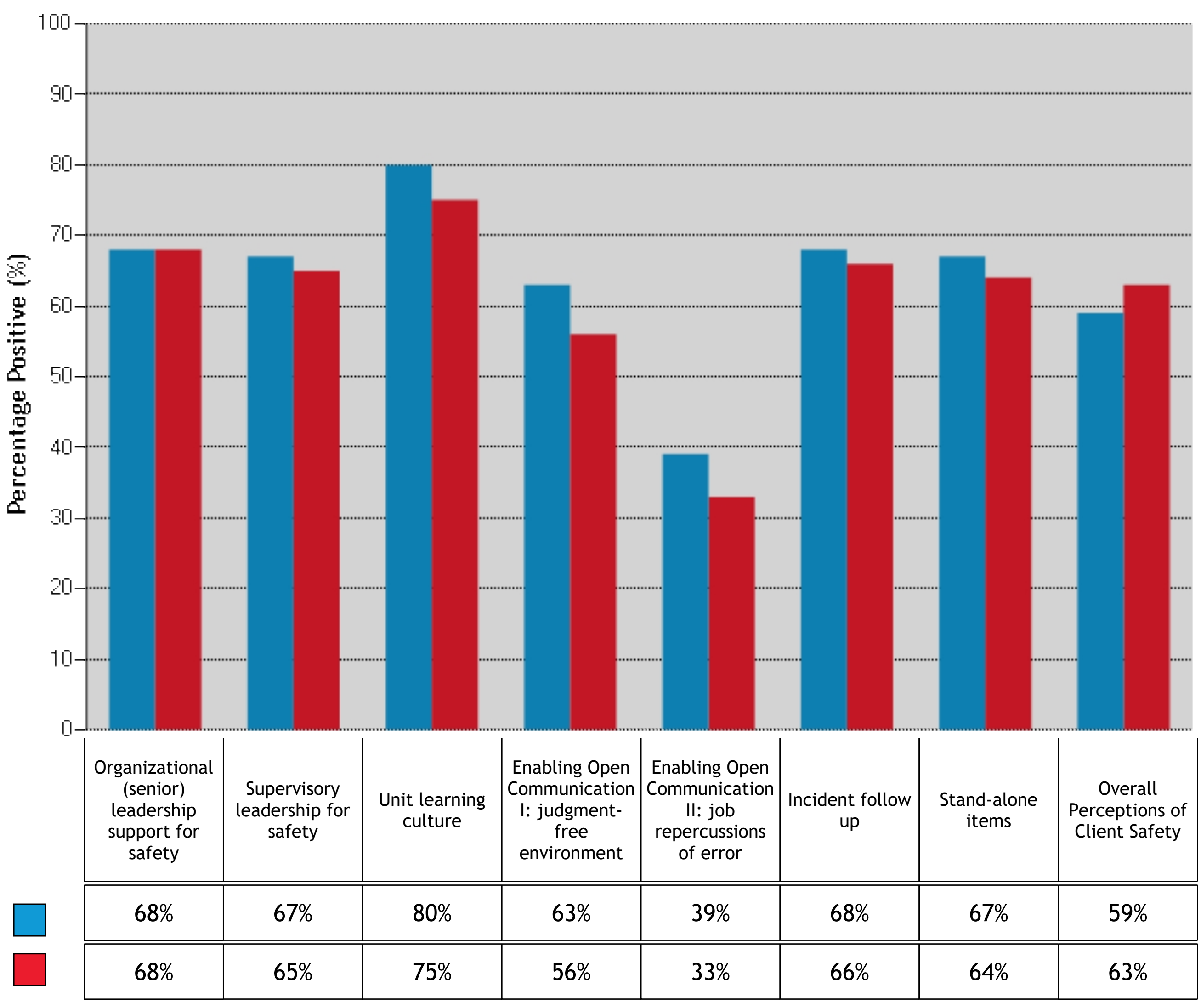
Canadian Patient Safety Culture Survey Tool

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

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

- **Data collection period: December 2, 2019 to February 2, 2020**
- **Minimum responses rate (based on the number of eligible employees): 368**
- **Number of responses: 3264**

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



	Organizational (senior) leadership support for safety	Supervisory leadership for safety	Unit learning culture	Enabling Open Communication I: judgment-free environment	Enabling Open Communication II: job repercussions of error	Incident follow up	Stand-alone items	Overall Perceptions of Client Safety
Nova Scotia Health Authority	68%	67%	80%	63%	39%	68%	67%	59%
* Canadian Average	68%	65%	75%	56%	33%	66%	64%	63%

Legend

- Nova Scotia Health Authority
- * Canadian Average

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

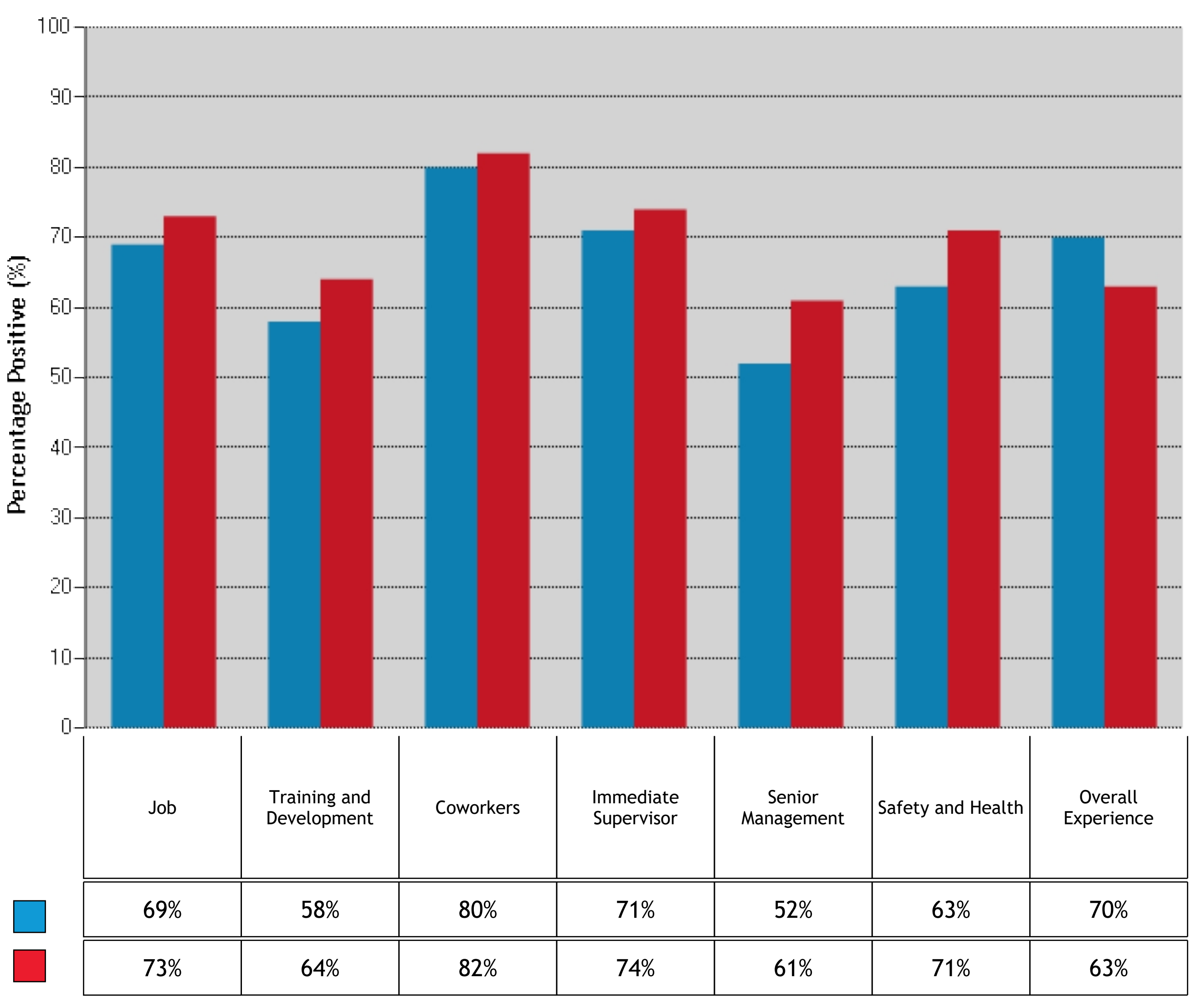
Worklife Pulse

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

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

The organization used an approved substitute tool for measuring the quality of worklife but did not provide Accreditation Canada with results.

Worklife Pulse: Results of Work Environment



	Job	Training and Development	Coworkers	Immediate Supervisor	Senior Management	Safety and Health	Overall Experience
Nova Scotia Health Authority	69%	58%	80%	71%	52%	63%	70%
* Canadian Average	73%	64%	82%	74%	61%	71%	63%

Legend

Nova Scotia Health Authority

* Canadian Average

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

Client Experience Tool

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

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

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

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

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

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

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

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

Appendix A - Qmentum

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

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

An important adjunct to the Accreditation Report is the online Quality Performance Roadmap, available to client organizations through their portal. The organization uses the information in the Roadmap in conjunction with the Accreditation Report to ensure that it develops comprehensive action plans.

Throughout the four-year cycle, Accreditation Canada provides ongoing liaison and support to help the organization address issues, develop action plans, and monitor progress.

Action Planning

Following the on-site survey, the organization uses the information in its Accreditation Report and Quality Performance Roadmap to develop action plans to address areas identified as needing improvement.

Appendix B - Priority Processes

Priority processes associated with system-wide standards

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

Priority processes associated with population-specific standards

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

Priority processes associated with service excellence standards

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

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