



ACCREDITATION CANADA



Driving Quality Health Services

Accreditation Report

Prepared for:
Glacier View Lodge

Courtenay, BC

On-site Survey Dates:
June 22, 2011 - June 24, 2011

July 8, 2011



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Accreditation Report

About this Report

The results of this accreditation survey are documented in the attached report, which was prepared by Accreditation Canada at the request of Glacier View Lodge.

This report is based on information obtained from the organization. Accreditation Canada relies on the accuracy of this information to conduct the survey and to prepare the report. The contents of this report is subject to review by Accreditation Canada. Any alteration of this report would compromise the integrity of the accreditation process and is strictly prohibited.

Confidentiality

This Report is confidential and is provided by Accreditation Canada to Glacier View Lodge only. Accreditation Canada does not release the Report to any other parties.

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

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About the Accreditation Report

The accreditation report describes the findings of the organization's accreditation survey. It is Accreditation Canada's intention that the comments and identified areas for improvement in this report will support the organization to continue to improve quality of care and services it provides to its clients and community.

Legend

A number of symbols are used throughout the report. Please refer to the legend below for a description of these symbols.

-  Items marked with a GREEN flag reflect areas that have not been flagged for improvements. Evidence of action taken is not required for these areas.
-  Items marked with a YELLOW flag indicate areas where some improvement is required. The team is required to submit evidence of action taken for each item with a yellow flag.
-  Items marked with a RED flag indicate areas where substantial improvement is required. The team is required to submit evidence of action taken for each item with a red flag.
-  Leading Practices are noteworthy practices carried out by the organization and tied to the standards. Whereas strengths are recognized for what they contribute to the organization, leading practices are notable for what they could contribute to the field.
-  Items marked with an arrow indicate a high risk criterion.

Surveyor's Commentary

The following global comments regarding the survey visit are provided:

Glacier View Lodge Society is to be commended for its 2011 accreditation survey planning. The survey documentation was well organized and prepared. Staff were involved in the Worklife Pulse, the Client Safety tool, and Board members were involved in the Governance Survey tool. In addition, it is evident that improvement activities occurred as a result of these three survey tools and the quality roadmap produced by the organization related to this survey. During the survey itself, staff, board members, community partners, residents and family members were actively engaged in the survey visit, and all of these client groups were able to speak to the quality of care and services provided by this organization. Also of note is that this organization has addressed all of its recommendations from its June 2008 Accreditation Canada survey.

Glacier View Lodge Society has a strong foundation and roots within the local community. As such, it has many long service staff and a large volunteer base. The organization has a formal link to St. Joseph's General Hospital that is over 16 years old, sharing some of its senior positions (e.g. President and CEO, and Vice President of Residential Services) and services (e.g. Finance, Payroll, Maintenance, IT, and Support Services). Credentialing of physicians is through the hospital and Glacier View Lodge has harmonized its policies and practices with St. Joseph's General Hospital. Although this relationship is close, the boards of both organizations are autonomous entities and the organizations do operate as such. To ensure its independence, a Glacier View Lodge Board member does sit on the Board of St. Joseph's General Hospital.

It is apparent that this organization has a strong focus on person-centred care. This approach was articulated in meetings, discussions and observations of residents, staff, volunteers, community partners, and family members.

The organization has a strong commitment to education and ongoing staff development. A potential does exist for the home to streamline and organize its mandatory and voluntary educational opportunities offered through the year (i.e. annual calendar listing educational events each month). As well, it could be beneficial for the home to complete a learning needs assessment to help identify staff needs, identify trends, and assist with planning.

The organization has recognized it is challenged by its existing physical plant and environment, given increasing client acuity and needs (e.g. wider hallways, doorways, and aging infrastructure). However, the site has made significant investments to its physical plant over the past three years, including a new call bell system, ceiling lifts, new generator, a computerized preventative maintenance program, new boiler, and the acquisition of hi-lo beds. As well, the organization has contracted the services of an architect to provide some plans and options to address its physical plant challenges. The site itself is well-maintained and clean, and it is clear that staff and the organization as a whole take pride in its presentation. The interior and exterior of the property is well-kept and a source of pride for the home are the outdoor spaces developed and maintained for the residents.

The organization has a commitment to quality and safety evidenced in its practices and approaches to care and service delivery. The board does receive reports about the organization's performance and monitors accordingly. The site should continue to build on the organization's performance measurement system, and the introduction of Point Click Care later in 2011 and its indicator and quality improvement features will support this activity. The site does report internal indicators but is constrained with analysis of such data externally given regulatory body inability to provide such information. As well, the organization should consider a broader posting and further communicating trends of such data internally to showcase improvements and also support the identification of further resources. This suggestion will also be aided by applications within Point Click Care.

Glacier View Lodge Society is a well-established service within the area. As such, the organization has numerous links to its internal and external clients. The organization has a Communication Plan that outlines a variety of methods that the site uses to communicate to the wider community. Some of these methods include internal items (e.g. newsletters, staff meetings, annual reports), information for families and residents (e.g. pre-admission and admission process), and external avenues (eg. regulatory environment meetings, public presentations and affiliations with the hospital). The organization has a positive reputation within the local area, and has numerous links to its wider community. Community partners spoke positively of the care and services provided at the site and their relationships with the organization and its staff. Representatives from Glacier View Lodge attend meetings with funding and regulatory bodies, and liaise with other professionals in the local area. Its website provides visitors with a broad overview of the Society, its history and its current services, and as such provides visitors with a solid overview of the organization. The organization's large volunteer base is supplemented by the numerous community groups who provide services to the residents of the home.

Organization's Commentary

The organization has no comment at this time.

Overview by Quality Dimension

The following table provides an overview of the organization’s results by quality dimension. The first column lists the quality dimensions used. The second, third and fourth columns indicate the number of criteria rated as met, unmet or not applicable. The final column lists the total number of criteria for each quality dimension.

Quality Dimension	Met	Unmet	N/A	Total
Population Focus (Working with communities to anticipate and meet needs)	26	0	0	26
Accessibility (Providing timely and equitable services)	14	0	0	14
Safety (Keeping people safe)	100	1	21	122
Worklife (Supporting wellness in the work environment)	30	0	1	31
Client-centred Services (Putting clients and families first)	39	0	2	41
Continuity of Services (Experiencing coordinated and seamless services)	8	0	0	8
Effectiveness (Doing the right thing to achieve the best possible results)	152	2	14	168
Efficiency (Making the best use of resources)	16	1	0	17
Total	385	4	38	427

Overview by Standard Section

The following table provides an overview of the organization by standard section. The first column lists the standard section used. The second, third and fourth columns indicate the number of criteria rated as met, unmet or not applicable. The final column lists the total number of criteria for that standard section.

Standard Section	Met	Unmet	N/A	Total
Sustainable Governance	91	0	0	91
Customized Effective Organization	66	0	0	66
Infection Prevention and Control	72	0	31	103
Customized Managing Medications	41	2	3	46
Long Term Care Services	115	2	4	121
Total	385	4	38	427

Overview by Required Organizational Practices (ROPs)

All Required Organizational Practices (ROPs) have been met by the organization. There is no follow-up required.

Detailed Accreditation Results

System-Wide Processes and Infrastructure

This part of the report speaks to the processes and infrastructure needed to support service delivery. In the regional context, this part of the report also highlights the consistency of the implementation and coordination of these processes across the entire system. Some specific areas that are evaluated include: integrated quality management, planning and service design, resource allocation, and communication across the organization.

Findings

Following the survey, once the organization has the opportunity to address the unresolved criteria and provide evidence of action taken, the results will be updated to show that they have been addressed.

Planning and Service Design

Developing and implementing the infrastructure, programs and service to meet the needs of the community and populations served.

Surveyor Comments

Glacier View Lodge is governed by the Society's Board of Directors, and acts within the regulations and jurisdiction of the Vancouver Island Health Authority (VIHA), providing care and services to individuals with complex care needs. Its mission, vision and values are well communicated in the home, and its vision is incorporated into its Bill of Rights.

Given its physical space and the surrounding 47.5 acres it owns, the Society is well positioned for growth should the regulatory body require and request added beds in the area, and has arranged an external contractor to support a plan for further development of the site, as well as an architect to identify design suggestions related to the needs of its clientele and the existing physical plant.

The organization is guided by its 2011-2013 strategic plan, centred around five board goals and associated organizational goals and activities. The board is apprised of the progress toward these goals through its meetings to ensure ongoing monitoring. The organization has recognized that its clientele has changed and has adjusted its services and purchases to address this changing acuity among its clients (e.g. additional rehabilitation services, staff education, hi-lo beds, ceiling lifts, and increased staffing hours).

The board receives information from the organization on a formal basis through its meeting structure, and also informally through its involvement in such site events as staff barbecues where service awards are presented.

The board's committee structures provide a means to ensure oversight and appropriate governance to the organization, and meetings of such committees and larger board meetings are minuted and available for review.

The organization's values are reflected prominently within the organization through its Bill of Rights and through its communication forums. Glacier View Lodge's ethics framework ties to its values.

Operating and capital budgets are developed within the organization's departmental structures and once approved, are monitored for applicable variances and identification of corrective measures.

No Unmet Criteria for this Priority Process.

Resource Management

Monitoring, administration, and integration of activities involved with the appropriate allocation and use of resources.

Surveyor Comments

The organization allocates financial, material and human resources based on resident and organizational needs and requirements. The organization has recognized that its clientele has changed and has adjusted its services and purchases to address this changing acuity among its clients (e.g. additional rehabilitation services, staff education, hi-lo beds, ceiling lifts, and increased staffing hours). As well, it has engaged an external contractor and an architect to review services and, its physical space issues respectively.

Financial policies and procedures adhere to regulatory and legislative requirements. The organization has a means to ensure ongoing monitoring of its financial status, and is able to participate in provincial purchasing activities through its connection to St. Joseph's General Hospital and VIHA. The organization also participated in energy audits to ensure that such resources were appropriately managed and that improvement opportunities are identified.

No Unmet Criteria for this Priority Process.

Human Capital

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

Surveyor Comments

Board policies and procedures exist to guide board activities. New board members also receive an orientation to their role and the organization in order to ensure a general understanding of its operations and fulfil their duties as board members. The board also has a 2011-12 Education Plan and did complete a board assessment in May 2011. To ensure it addresses actions identified from its self-assessment, the board formally reviews these items at each of its monthly meetings.

CEO oversight is provided through the board and its activities.

Personnel records were reviewed and they contained all necessary information. Criminal records checks are completed as per regulatory and professional body requirements and regulations.

Performance appraisals are completed for employees to ensure feedback on work performance.

A commitment to Occupational Health and Safety is evident at Glacier View Lodge. The Joint Occupational Health and Safety Team reviews incident reports, fire drills, safety inspections and infection control issues. In addition, its minutes record items carried over from previous meetings until addressed. Information related to health and safety in the workplace was evident within the organization even on bulletin boards in the staff room.

Workplace violence is an area that the organization is addressing through ongoing monitoring and reporting of incidents of aggression and behavioural issues within the workplace. An electronic reporting system captures data entered at Glacier View Lodge, and such incidents are reviewed and reported through the organization's internal structures. As well, the organization's policy related to employee safety, its employee code of conduct, and its education to staff regarding managing aggressive behaviours are additional resources that guide the site's management of workplace violence.

Staff education and professional development opportunities exist for staff including orientation for new staff, mandatory training (e.g. WHMIS, Infection Prevention and Control) and continuing educational opportunities. A suggestion for the organization is to consider an annual calendar listing educational events that would occur on a given month to support communication in the home and the administration of staff development.

A complaints management process is in place including a means for all stakeholders to provide a formal concern or compliment through QI cards near the front entrance. Completed forms are then provided through to the departmental managers to address issues and communicate accordingly.

The organization is committed to ensuring its staff contribute to client safety. Staff education related to client safety includes fire safety, emergency planning, infection prevention and control practices, safe lifting, and managing difficult behaviours. In addition, client safety items are referenced in performance review guidelines, orientation, hire checklists, and volunteer placement descriptions. As well, staffing patterns are adjusted based on client acuity and safety concerns including the adjustment of care hours to assist a falls management strategy, and increased staffing levels related to increasing client acuity.

Glacier View Lodge has number of activities and events to support staff retention and appreciation including service awards, barbecues, and ongoing requests for feedback. Events are also held for volunteers.

No Unmet Criteria for this Priority Process.

Integrated Quality Management

Continuous, proactive and systematic process to understand, manage and communicate quality from a system-wide perspective to achieve goals and objectives.

Surveyor Comments

The organization has a commitment to quality and safety evidenced in its practices and approaches to care and service delivery. The board does receive reports about the organization's performance and monitors accordingly. The site should continue to build on the organization's performance measurement system, the introduction of Point Click Care later in 2011 and its indicator and quality improvement features will support this activity. The site does report internal indicators but is constrained with analysis of such data externally given regulatory body inability to provide such information. As well, the organization should consider a broader posting and further communicating trends of such data internally to showcase improvements and also support the identification of further resources. This suggestion will also be aided by applications within Point Click Care.

A process does exist to review, monitor and select contracted services within the organization.

Client safety is an organizational-wide goal with specific actions undertaken to ensure that success is documented in the Culture of Safety Plan - December 2010 Progress Report. Monthly reports from departments and committees are provided to the board that outline client safety issues thereby ensuring board awareness and oversight.

The management and reporting of adverse events, sentinel events, and near misses are governed by policies and procedures within the organization. The site's adverse event reporting policy outlines disclosure protocols, and such disclosure is documented on the client record as required. The organization's sentinel review process outlines steps and definitions followed within the site in these circumstances (e.g. communication and reporting processes).

Medication reconciliation at admission, discharge, transfer or end of service is governed through organizational policies and procedures, and has been in place for over four years. Such reconciliation involves the resident and family as applicable.

The organization completed a prospective review related to the identification of special diet requirements. The Failure Modes and Effects Analysis (FMEA) tool have been used for a prospective review, and the organization recently tested its disaster plan related to earthquake planning and evacuation. This exercise included a debriefing and review of issues from the plan's testing.

Responsibilities for quality improvement are all staff's responsibility. Responsibility for the quality improvement plan, and the monitoring of that plan are through the Leadership team of the organization. In addition to this use of internal monitoring of quality, the organization has also used external contractors to review its services including a January 2011 review of the quality of Housekeeping Services, which concluded that the site met and surpassed standards of cleanliness. Regulatory audits also occur, including a Food Safety audit in May 2011, which concluded that no urgent issues required attention. Leading practices were observed, compliance to appropriate hand hygiene was being done, proper hair restraints were being worn, and proper covering of food was being done.

The organization has numerous means to communicate to its various clients their role in client safety including staff education, family and resident written materials, and verbal communications with such groups (e.g. meetings). Staff education related to client safety includes fire safety, emergency planning, infection prevention and control practices, safe lifting, and managing difficult behaviours.

No Unmet Criteria for this Priority Process.

Principle Based Care and Decision Making

Identifying and decision making regarding ethical dilemmas and problems.

Surveyor Comments

The organization has an ethics framework which deals with clinical and quality of life issues. It does not include business ethics.

The care staff are able to discuss the organization's values and how they relate to resident care. Ethical dilemmas are brought forward at unit meetings and advanced through the system until resolution. Recent example of sexual intimacy between residents and the issue of consent was successfully resolved.

There is Board and Management support for direct care staff when personal values conflict with the values of the resident and family.

There is a policy for Clinical Research developed by the Board. All such proposals are forwarded to the Board for approval.

No Unmet Criteria for this Priority Process.

Communication

Communication among various layers of the organization, and with external stakeholders.

Surveyor Comments

Records of board activities exist and were reviewed for this survey, including its meeting minutes, self-assessments, and the organizations annual report. The board is aware of organizational occurrences through its meeting structures and also through its participation at site events (e.g. staff appreciation barbecues). Board members are involved with the local and wider community and are able to advocate on the Society's behalf.

The organization has a Communication Plan that outlines a variety of methods that the site uses to communicate itself to the wider community. Some of these methods include internal items (e.g. newsletters, staff meetings, annual reports), information for families and residents (e.g. pre-admission and admission process), and external avenues (e.g. regulatory environment meetings, public presentations, and affiliations with hospital).

The organization has numerous links to its wider community. Representatives from Glacier View Lodge attend meetings with funding and regulatory bodies, and liaise with other professionals in the local area. Its website provides visitors with a broad overview of the Society, its history and its current services.

No Unmet Criteria for this Priority Process.

Physical Environment

Providing appropriate and safe structures and facilities to successfully carry out the mission, vision, and goals.

Surveyor Comments

This is an older building with space concerns for the increased level of resident care. A recent assessment of the building has been completed by an external consultant. The Board and Management are awaiting the recommendations at the present time.

One of the issues identified is the narrow doorways to the resident rooms.

There is a lack of storage area for supplies and equipment.

There is a full time maintenance staff with oversight provided by St. Joseph's General Hospital. Many improvements have occurred over the past 3 years including the purchase of a new generator, boiler and the installation of air conditioning in 3 dining areas. A new nurse call system has been installed.

The property has several secure outdoor spaces well furnished and maintained. The Board and Management appear committed to the improvements necessary to provide safe care for the residents.

No Unmet Criteria for this Priority Process.

Emergency Preparedness

Dealing with emergencies and other aspects of public safety.

Surveyor Comments

Fire training is provided annually. The fire alarm and sprinkler system is tested annually. A recent upgrade of the sprinkler system has prevented repeated false alarms.

In January 2011 the organization conducted an earthquake shakeout exercise and an evacuation of one wing. The plan is to test one part of the emergency plan annually.

There is a well developed pandemic plan with outlined roles and responsibilities. There have been no outbreaks in the past 3 years.

No Unmet Criteria for this Priority Process.

Medical Devices and Equipment

Machinery and technologies designed to aid in the diagnosis and treatment of healthcare problems.

Surveyor Comments

Medical devices and equipment needs are identified by staff and management. Recommendations are made to the board for final approval.

A Preventative Maintenance Program is in place for all medical devices and equipment. This system is being changed from a manual to a computerized system under the direction of the maintenance division of St. Joseph's General Hospital. There are service contracts for repair of lifts, beds and tubs.

All resident rooms have overhead lifts and electric beds.

No Unmet Criteria for this Priority Process.

Direct Service Provision

This part of the report provides information on the delivery of high quality, safe services. Some specific areas that are evaluated include: the episode of care, medication management, infection control, and medical devices and equipment.

Findings

Following the survey, once the organization has the opportunity to address the unresolved criteria and provide evidence of action taken, the results will be updated to show that they have been addressed.

Customized Managing Medications

Medication Management

Interdisciplinary provision of medication to clients.

Surveyor Comments

Medications are administered by RN's and LPN's from a blister pack system. The medication rooms are well organized and secure. Narcotics are stored under double locks.

No heparin is kept on-site. Coumadin is labelled as a high alert medication. No concentrated electrolytes are used. There are no cytotoxic medications on site.

Resident medications are discussed at care conferences and, a quarterly review of medications is done by the pharmacist. The pharmacist sits on the Medical Advisory Committee.

Medication incidents are discussed at this meeting and the findings are used to implement improvements. Adverse drug reactions are reported following the facility incident reporting process. The organization does not do medication utilization reviews at this time. There is a focus on reducing medications at the regular reviews. The feasibility of utilization reviews will be discussed at future meetings.

The table below indicates the specific criteria that require attention, based on the accreditation review.

Criteria	Location	Priority for Action
The organization monitors medication use with an ongoing medication utilization review.	9.4	
Based on the data collected and analyzed, the organization identifies and addresses areas for improvement.	9.5	

Infection Prevention and Control

Infection Prevention and Control

Measures practiced by healthcare personnel in healthcare facilities to decrease transmission and acquisition of infectious agents.

Surveyor Comments

The organization has a dedicated resource related to Infection Prevention and Control who is responsible for the overall program within the site which includes the tracking of infections and infection rates as well as their analysis and communication internally and externally through regulatory bodies. Such external links along with the other relationships that site professionals have with their peers in the community help Glacier View Lodge maintain an awareness of current issues related to infection prevention and control. While responsibility for infection prevention and control within the organization is coordinated through internal resources (e.g. Infection Control Nurse) with links to external members such as the health authority, and educational institutions, the organization also has an internal interdisciplinary Infection Control Committee. This committee has developed actions to address identified opportunities for improvements which will be monitored during the committee's quarterly meetings.

The influenza vaccination policy of Glacier View Lodge reflects the policy of the health authority. Infection prevention and control policies for staff and residents note the organization's adoption of the regulatory body's Infection Prevention and Control Manual. As well, these policies reflect some experiences of another organization and lessons learned from their outbreak. A policy on pneumococcal vaccination is also in place.

Glacier View Lodge has a focus on hand hygiene practices with a revision to its hand hygiene protocol completed in April 2011 and improvements noted on audit scores in 2011 (hand washing and jewellery compliance). Hand hygiene education has occurred for staff and the organization has recently been provided access through the regulatory body for its staff to access a self directed Infection Control module (which includes hand hygiene, as well as isolation precautions, personal protective equipment, and other topics) through the organization's website. The site has adopted the health authority's Hand Hygiene audit tool.

Information to clients and families regarding infection prevention and control is provided, including outbreak protocols, hand hygiene, and staff duty routines (e.g. disinfecting tubs). Cleaning and disinfecting procedures were noted including bath tubs, and policies and procedures regarding soiled linen, and infectious materials were in place. In addition, staff members were able to articulate their role in infection prevention and control, the importance of proper hand hygiene, and the diligence required to minimize infections for the residents.

Outbreak protocols are in place and include procedures for communication and linkages to the regulatory body, as well as communication within the site, and to external stakeholders. MRSA and C-Difficile protocols also exist and education is provided to staff and other clients as required regarding appropriate procedures to follow in the event of an occurrence at the home.

No Unmet Criteria for this Priority Process.

Long Term Care Services

Clinical Leadership

Providing leadership and overall goals and direction to the team of people providing services.

Surveyor Comments

The team has recently started multi-disciplinary unit meetings which includes the care aides, activity staff, housekeeping and occupational therapy.

This has created a willingness to work together to solve issues and bring forward suggestions for improvement. The Director of Residential Services attends the meetings and minutes are distributed to all team members.

The care aides and housekeepers work together to remove clutter in the tub room so cleaning is more effective. Unresolved issues are forwarded to management and feedback is provided at the next meeting.

The organization encourages practicum placements for Care Aides, LPN's and BSN students.

No Unmet Criteria for this Priority Process.

Competency

Developing a highly competent interdisciplinary team with the knowledge, skills and abilities to develop, manage, and deliver effective and efficient programs, services, and care.

Surveyor Comments

There are several initiatives in place to address workplace violence including; a Code of Conduct, Policy on Employee Safety, Policy on Managing Aggressive Behaviour and, a Policy on Personal protection

Education on workplace violence prevention is presented twice annually.

Incidents of workplace injury are reported following the organization's incident reporting process. Staff appreciation events are held annually and long term service awards are given.

No Unmet Criteria for this Priority Process.

Episode of Care

Healthcare services provided for a health problem from the first encounter with a health care provider through the completion of the last encounter related to that problem.

Surveyor Comments

There is a definite focus on client centred care expressed by all members of the care team. Residents and families expressed satisfaction with care and services. There is a good process of assessment and care planning. The present system uses both electronic and paper components of the resident chart. There is a plan to move to change electronic health record software which includes the ability to complete point of care testing. All residents have assessments for pain, skin care, risk of falls and mental status on admission and quarterly thereafter. Resident care conferences are held following admission and annually. Several of the staff have advanced training in palliative care and are able to assist staff residents and families in end of life care. The facility does not admit residents who require a crash cart due to cardiopulmonary conditions. The team has dedicated staff with advanced training for wound and skin care. This allows better monitoring of wounds and consistent treatment protocols. The team has success in implementing the falls prevention program. By changing staff shifts to cover the time most falls were happening they have reported a significant reduction in falls. The team ensures residents are appropriately seated in the dining rooms so they receive the assistance they require and independent residents enjoy their meals.

The table below indicates the specific criteria that require attention, based on the accreditation review.

Criteria	Location	Priority for Action
The organization appropriately conducts resuscitation and potentially life sustaining treatments.	12.5	↑

Decision Support

Information, research and evidence, data, and technologies that support and facilitate management and clinical decision-making.

Surveyor Comments

The team has identified and received approval for new assessment and care planning software. There is a qualified staff member to ensure training is provided to all team members on the information system. The Vancouver Island Health Authority provides the team with current best practice information. The Director of Residential Services is a member of the best practice committee.

No Unmet Criteria for this Priority Process.

Impact on Outcomes

The identification and monitoring of process and outcome measures to evaluate and improve the quality of services to clients and the impact on client outcomes.

Surveyor Comments

Residents and families express satisfaction and appreciation with care and services. The team is very good at reporting and follow up of sentinel events. A family satisfaction survey is completed every two years. The organization pays attention to the results and uses the information to guide improvements.

Safety of the residents and staff is woven into the culture of the organization. The team monitors the outcomes of resident care and services and makes changes appropriately. There is good communication between caregivers at all levels. The organization has started submitting MDS data to VIHA for future comparison purposes and is encouraged to continue with this process.

The table below indicates the specific criteria that require attention, based on the accreditation review.

Criteria	Location	Priority for Action
The team compares its results with other similar interventions, programs, or organizations.	17.3	↑

Performance Measure Results

The following section provides an overview of the performance measures collected for the entire organization. These measures consist of both instrument and indicator results, which are valuable components of evaluation and quality improvement.


Instrument Results

The instruments are questionnaires completed by a representative sample of clients, staff, leadership and/or other key stakeholders that provide important insight into critical aspects of the organization’s services. The following tables summarize the organization’s results and highlight each item that requires attention. Results are presented in three main areas: governance functioning, patient safety culture and worklife.

Governance Functioning Tool








The Governance Functioning Tool is intended for members of the governing body to assess their own structures and processes and identify areas for improvement. The results reflect the perceptions and opinions of the governing body regarding the status of its internal structures and processes.

Summary of Results

Governance Structures and Processes	% Agree	% Neutral	% Disagree	Priority for Action
	Organization	Organization	Organization	
1 We actively recruit, recommend and/or select new members based on needs for particular skills, background, and experience.	90	0	10	
2 We have explicit criteria to recruit and select new members.	60	0	40	
3 Our renewal cycle is appropriately managed to ensure continuity on the governing body.	90	0	10	
4 The composition of our governing body allows us to meet stakeholder and community needs.	100	0	0	
5 Clear written policies define term lengths and limits for individual members, as well as compensation.	100	0	0	
6 We regularly review, understand, and ensure compliance with applicable laws, legislation and regulations.	80	0	20	
7 Governance policies and procedures that define our role and responsibilities are well-documented and consistently followed.	90	0	10	

Governance Structures and Processes	% Agree	% Neutral	% Disagree	Priority for Action
	Organization	Organization	Organization	
8 We review our own structure, including size and sub-committee structure.	90	0	10	
9 We have sub-committees that have clearly-defined roles and responsibilities.	100	0	0	
10 Our roles and responsibilities are clearly identified and distinguished from those delegated to the CEO and/or senior management. We do not become overly involved in management issues.	100	0	0	
11 We each receive orientation that helps us to understand the organization and its issues, and supports high-quality decision-making.	100	0	0	
12 Disagreements are viewed as a search for solutions rather than a “win/lose”.	100	0	0	
13 Our meetings are held frequently enough to make sure we are able to make timely decisions.	100	0	0	
14 Individual members understand and carry out their legal duties, roles and responsibilities, including sub-committee work (as applicable).	100	0	0	
15 Members come to meetings prepared to engage in meaningful discussion and thoughtful decision-making.	100	0	0	
16 Our governance processes make sure that everyone participates in decision-making.	100	0	0	
17 Individual members are actively involved in policy-making and strategic planning.	90	0	10	
18 The composition of our governing body contributes to high governance and leadership performance.	90	0	10	
19 Our governing body’s dynamics enable group dialogue and discussion. Individual members ask for and listen to one another’s ideas and input.	100	0	0	
20 Our ongoing education and professional development is encouraged.	100	0	0	
21 Working relationships among individual members and committees are positive.	100	0	0	
22 We have a process to set bylaws and corporate policies.	90	0	10	

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Governance Structures and Processes	% Agree	% Neutral	% Disagree	Priority for Action
	Organization	Organization	Organization	
23 Our bylaws and corporate policies cover confidentiality and conflict of interest.	100	0	0	
24 We formally evaluate our own performance on a regular basis.	70	0	30	
25 We benchmark our performance against other similar organizations and/or national standards.	50	0	50	
26 Contributions of individual members are reviewed regularly.	30	0	70	
27 As a team, we regularly review how we function together and how our governance processes could be improved.	60	0	40	
28 There is a process for improving individual effectiveness when non-performance is an issue.	44	0	56	
29 We regularly identify areas for improvement and engage in our own quality improvement activities.	60	0	40	
30 As a governing body, we annually release a formal statement of our achievements that is shared with the organization's staff as well as external partners and the community.	80	0	20	
31 As individual members, we receive adequate feedback about our contribution to the governing body.	20	0	80	
32 We have a process to elect or appoint our chair.	100	0	0	
33 Our chair has clear roles and responsibilities and runs the governing body effectively.	100	0	0	

Patient Safety Culture Survey

The patient safety culture survey results provide valuable insight into staff perceptions of patient safety, as well as an indication of areas of strength, areas of improvement, and a mechanism to monitor changes within the organization.














Summary of Results

Number of survey respondents = 54 respondents

A. Patient Safety: Activities to avoid, prevent, or correct adverse outcomes which may result from the delivery of health care	% Disagree	% Neutral	% Agree	Priority for Action
	Organization	Organization	Organization	
1 Patient safety decisions are made at the proper level by the most qualified people	13	19	69	⚠
2 Good communication flow exists up the chain of command regarding patient safety issues	17	13	70	⚠
3 Reporting a patient safety problem will result in negative repercussions for the person reporting it	81	6	13	
4 Senior management has a clear picture of the risk associated with patient care	26	19	56	⚠
5 My unit takes the time to identify and assess risks to patients	14	12	75	⚠
6 My unit does a good job managing risks to ensure patient safety	10	8	83	
7 Senior management provides a climate that promotes patient safety	13	22	65	⚠
8 Asking for help is a sign of incompetence	81	6	13	
9 If I make a mistake that has significant consequences and nobody notices, I do not tell anyone about it	94	2	4	
10 I am sure that if I report an incident to our reporting system, it will not be used against me	7	17	76	
11 I am less effective at work when I am fatigued	7	4	89	
12 Senior management considers patient safety when program changes are discussed	4	27	69	⚠
13 Personal problems can adversely affect my performance	26	19	56	⚠
14 I will suffer negative consequences if I report a patient safety problem	87	2	11	

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A. Patient Safety: Activities to avoid, prevent, or correct adverse outcomes which may result from the delivery of health care	% Disagree	% Neutral	% Agree	Priority for Action
	Organization	Organization	Organization	
15 If I report a patient safety incident, I know that management will act on it	13	13	74	
16 I am rewarded for taking quick action to identify a serious mistake	31	33	35	
17 Loss of experienced personnel has negatively affected my ability to provide high quality patient care	62	20	18	
18 I have enough time to complete patient care tasks safely	40	19	40	
19 I am not sure about the value of completing incident reports	77	17	6	
20 In the last year, I have witnessed a co-worker do something that appeared to me to be unsafe for the patient in order to save time	47	4	49	
21 I am provided with adequate resources (personnel, budget, and equipment) to provide safe patient care	39	18	43	
22 I have made significant errors in my work that I attribute to my own fatigue	83	13	4	
23 I believe that health care error constitutes a real and significant risk to the patients that we treat	34	15	51	
24 I believe health care errors often go unreported	34	23	43	
25 My organization effectively balances the need for patient safety and the need for productivity	15	26	59	
26 I work in an environment where patient safety is a high priority	15	6	80	
27 Staff are given feedback about changes put into place based on incident reports	33	13	54	
28 Individuals involved in patient safety incidents have a quick and easy way to report what happened	21	19	60	
29 My supervisor/manager says a good word when he/she sees a job done according to established patient safety procedures	28	21	51	
30 My supervisor/manager seriously considers staff suggestions for improving patient safety	16	18	67	

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A. Patient Safety: Activities to avoid, prevent, or correct adverse outcomes which may result from the delivery of health care	% Disagree	% Neutral	% Agree	Priority for Action
	Organization	Organization	Organization	
31 Whenever pressure builds up, my supervisor/manager wants us to work faster, even if it means taking shortcuts	76	14	10	
32 My supervisor/manager overlooks patient safety problems that happen over and over	69	18	14	⚠
33 On this unit, when an incident occurs, we think about it carefully	10	20	71	⚠
34 On this unit, when people make mistakes, they ask others about how they could have prevented it	14	29	57	⚠
35 On this unit, after an incident has occurred, we think about how it came about and how to prevent the same mistake in the future	8	19	73	⚠
36 On this unit, when an incident occurs, we analyze it thoroughly	17	33	50	✖
37 On this unit, it is difficult to discuss errors	65	14	22	⚠
38 On this unit, after an incident has occurred, we think long and hard about how to correct it	23	29	48	✖
B. These questions are about your perceptions of overall patient safety	% Good/Excellent	% Acceptable	% Poor/Failing	Priority for Action
	Organization	Organization	Organization	
39 Please give your unit an overall grade on patient safety	65	30	6	⚠
40 Please give the organization an overall grade on patient safety	70	20	9	⚠
C. These questions are about what happens after a Major Event	% Disagree	% Neutral	% Agree	Priority for Action
	Organization	Organization	Organization	
41 Individuals involved in major events contribute to the understanding and analysis of the event and the generation of possible solutions	8	26	66	⚠
42 A formal process for disclosure of major events to patients/families is followed and this process includes support mechanisms for patients, family, and care/service providers	4	33	63	⚠

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C. These questions are about what happens after a Major Event	% Disagree	% Neutral	% Agree	Priority for Action
	Organization	Organization	Organization	
43 Discussion around major events focuses mainly on system-related issues, rather than focusing on the individual(s) most responsible for the event	16	37	47	
44 The patient and family are invited to be directly involved in the entire process of understanding: what happened following a major event and generating solutions for reducing re-occurrence of similar events	6	40	53	
45 Things that are learned from major events are communicated to staff on our unit using more than one method (e.g. communication book, in-services, unit rounds, emails) and / or at several times so all staff hear about it	12	26	62	
46 Changes are made to reduce re-occurrence of major events	4	16	80	

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Worklife Pulse





The concept of ‘quality of worklife’ is central to Accreditation Canada’s accreditation program. The Pulse Survey enables health service organizations to monitor key worklife areas. The survey takes the ‘pulse’ of quality of worklife, providing a quick and high level snapshot of key work environment factors, individual outcomes, and organizational outcomes. Organizations can then use the findings to identify strengths and gaps in their work environments, 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.

Summary of Results

Number of survey respondents = 80 respondents

How would you rate your work environment	% Disagree	% Neutral	% Agree	Priority for Action
	Organization	Organization	Organization	
1 I am satisfied with communications in this organization.	20	25	55	⚠
2 I am satisfied with communications in my work area.	19	25	56	⚠
3 I am satisfied with my supervisor.	4	11	85	
4 I am satisfied with the amount of control I have over my job activities.	9	14	78	
5 I am clear about what is expected of me to do my job.	3	6	91	
6 I am satisfied with my involvement in decision making processes in this organization.	13	25	63	⚠
7 I have enough time to do my job adequately.	30	26	44	✖
8 I feel that I can trust this organization.	4	28	69	⚠
9 This organization supports my learning and development.	8	13	80	
10 My work environment is safe.	4	20	76	
11 My job allows me to balance my work and family/personal life.	4	21	75	

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Individual Outcomes	% Not Stressful	% A bit Stressful	% Quite or Extremely Stressful	Priority for Action
	Organization	Organization	Organization	
12 In the past 12 months, would you say that most days at work were...	36	51	13	
	% Very Good/ Excellent	% Good	% Fair/ Poor	Priority for Action
	Organization	Organization	Organization	
13 In general, would you say your health is...	61	34	5	
14 In general, would you say your mental health is...	66	30	4	
15 In general, would you say your physical health is...	53	40	8	
	% Very Satisfied	% Somewhat Satisfied	% Not Satisfied	Priority for Action
	Organization	Organization	Organization	
16 How satisfied are you with your job?	98	1	1	
	% < 10	% 10 - 15	% > 15	Priority for Action
	Organization	Organization	Organization	
17 In the past 12 months, how many days were you away from work because of your own illness or injury? (counting each full or partial day as 1 day)	84	4	13	
18 During the past 12 months, how many days did you work despite an illness or injury because you felt you had to (counting each full or partial day as 1 day)?	91	8	1	
	% Never/ Rarely	% Sometimes	% Often/ Always	Priority for Action
	Organization	Organization	Organization	
19 How often do you feel you can do your best quality work in your job?	5	13	83	

	% Disagree	% Neutral	% Agree	Priority for Action
	Organization	Organization	Organization	
20 Overall, I am satisfied with this organization.	6	10	84	
21 Working conditions in my area contribute to patient safety.	8	14	79	

Appendix A - Accreditation Decision Guidelines

The key factor that Accreditation Canada uses to determine an accreditation decision is the degree to which client organizations comply with high-priority criteria and Required Organizational Practices (ROPs). *High-priority criteria* are criteria related to safety, ethics, risk, and quality improvement; *ROPs* are practices that must be in place to enhance client safety and minimize risk.

There are three possible accreditation decisions under Qmentum.

Accreditation	Accreditation with Condition (Report, Focused Visit, or both)	Non-accreditation
<i>Issued when the client organization has:</i>	<i>Issued when the client organization has:</i>	<i>Issued when the client organization has:</i>
Met 90 to 100% of high-priority criteria in each applicable set of standards AND	Met 71 to 89% of high-priority criteria in each applicable set of standards OR	Met 70% or less of high-priority criteria in one or more sets of applicable standards AND
Complied with all applicable ROPs AND	Failed to comply with one or more applicable ROPs OR	Failed to comply with one or more applicable ROPs AND
Submitted all required performance measure data	Failed to submit required performance measure data	Met 80% or less of the total criteria in all applicable sets of standards
*CSSS only: obtained 66.6% or more on all CQA indicator questionnaires	*CSSS only: obtained less than 66.6% on any CQA indicator questionnaire	*CSSS only: obtained less than 66.6% on any CQA indicator questionnaire

*CSSS (Centre de santé et de services sociaux) clients in the joint Accreditation Canada/Conseil québécois d'agrément (CQA) program must also administer CQA's Client Satisfaction indicator questionnaire and the Employee Mobilization indicator questionnaire.

NOTES

Accreditation with Condition means the organization must meet conditions specified by Accreditation Canada to maintain its accredited status. The nature of the unmet criteria and ROPs determines the timelines for compliance (six or twelve months) and whether the organization must submit a report, undergo a focused visit, or both. If the conditions are not met within the timelines, Accreditation Canada may grant an extension of six months, based on surveyor input, proof of progress, and a plan to meet the criteria.

Failure to comply within the allotted time may result in accreditation being revoked, at the discretion of Accreditation Canada.

Non-accreditation: A non-accreditation organization may have its status reviewed six months after the on-site survey if it completes a focused visit within five months. The organization maintains its non-accredited status if the focused visit results are unsatisfactory.