



ACCREDITATION CANADA



Driving Quality Health Services

Accreditation Report

Prepared for:
Vancouver Island Health Authority

Victoria, BC

On-site Survey Dates:
April 3, 2011 - April 8, 2011

May 16, 2011



ACCREDITATION CANADA
AGRÉMENT CANADA

Accredited by ISQua

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 Vancouver Island Health Authority.

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 Vancouver Island Health Authority only. Accreditation Canada does not release the Report to any other parties.

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

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About the 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.

Accreditation Summary

Vancouver Island Health Authority

This section of the report provides a summary of the survey visit and the status of the accreditation decision.

On-site survey dates April 3 to 8, 2011

Report Issue Date: May 16, 2011

Accreditation Decision	Accreditation with Condition (Report)
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Locations

The following locations were visited during this survey visit:

- 1 Aberdeen Hospital
- 2 Bowen Centre Licensing and HS
- 3 Cairnsmore Place
- 4 Campbell River and District General Hospital
- 5 Cowichan District Hospital
- 6 Cumberland Lodge
- 7 Eagle Park (Qualicum Beach)
- 8 Eagle Ridge Manor (Port Hardy)
- 9 HCC Comox Valley
- 10 HCC Gordon Head Oak Bay Health Unit
- 11 HCC Parksville
- 12 Ladysmith Community Health Centre
- 13 MHAS Barons Rd
- 14 MHAS Leaders and Managers
- 15 MHAS Nanaimo Barrons Road
- 16 MHAS SI ACT
- 17 MHAS-Duncan Adult Community Services
- 18 MHAS-SI PES,
- 19 NRGH
- 20 Port Hardy Health Centre
- 21 Port McNeill Health Centre
- 22 Public Health Health Protection
- 23 Public Health Licensing

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24	Public Health Tobacco, MHO and Clinical Prevention and Health Promotion
25	Renal Services
26	Royal Jubilee Hospital
27	Rural and Aboriginal Svcs. Mt. Waddington
28	Saanich Peninsula Hospital (Acute Care)
29	Saanich Peninsula Hospital (Extended Care)
30	Saltspring and the Southern Gulf Islands Community Health Team
31	Seniors Health Geriatric Outpatient (Victoria)
32	Seniors Health Geriatric Outpatient (Nannaimo)
33	Telehealth Support
34	Tofino General Hospital
35	Victoria General Hospital
36	Victoria Hospice Society
37	West Coast General Hospital

Service areas

The following service areas were visited during this survey visit:

1	Ambulatory Care
2	Community Health Services
3	Emergency Department
4	Home Care
5	Hospice/Palliative Care
6	Intensive Care Unit/Critical Care
7	Long Term Care
8	Maternal/Perinatal
9	Medicine
10	Mental Health
11	Operating Room
12	Public Health
13	Rehabilitation
14	Sterilization and Reprocessing of Medical Equipment
15	Surgical Care
16	Telehealth

Surveyor's Commentary

The following global comments regarding the survey visit are provided:

Vancouver Island Health Authority (VIHA) is a large, complex organization serving a diverse and growing population. It has demonstrated significant progress in its development as a high performing health system for the region. In large part, this is due to the dedication and commitment of its greatest asset, the staff and physicians, who make VIHA a strong and progressive health region.

The VIHA board is highly dedicated and committed to effective governance. There is an excellent relationship between the board and the senior leadership team.

VIHA has established an integrated planning cycle, which aligns the strategic plan, infrastructure plans, health service plans, budget and annual objectives and strategies. The region has adopted a "waterfall" model to align goals and objectives, quality improvement plans, and performance measures across the organization. The identification of system wide initiatives (SWIs) is helping the organization to focus its efforts and achieve desired results. This approach is contributing to greater alignment and integration across the island. The region is also using technology effectively to connect staff that are widely spread across the system.

VIHA has made considerable effort to engage and work collaboratively with the communities it serves. Good work has commenced for developing community specific needs assessments and inter agency plans to improve health of the population. Relationships with Aboriginal communities continue to be an area of particular focus, given the large and growing Aboriginal population. Community members identified an aging population, mental health and addictions as particular needs of their communities. Community members expressed a strong desire to partner with VIHA to address these and other community needs.

The organization has worked hard to achieve a stable financial position and has invested strategically in priorities for the region, including capital projects. Notably, the new Patient Care Centre is a world class facility, designed to promote elder friendly/patient centred care as well as quality of work life for staff, while respecting the environment. The investment in a region wide electronic health record is also notable.

VIHA continues to develop an interdisciplinary team based approach to care and services. This is supported by a co leadership model that is effectively engaging physician leaders in region wide and program specific planning, operations and quality improvement.

The organization's commitment to quality improvement is commendable. Staff are incorporating accreditation standards into their practice and quality improvement initiatives. The combined quality council is emerging as an effective forum for leadership and monitoring of regional quality improvement. Infection control is a region wide priority. VIHA has made staff safety and injury prevention a high priority, with particular focus on violence prevention.

The organization has identified numerous opportunities for improvement. Health human resources (HR) continues to be a challenge, to ensure sufficient numbers and mix of skilled health professionals for the region, especially in specific disciplines that are in short supply across the country and beyond.

Despite considerable improvements in some facilities, funding shortages continue to limit the organization's ability to fully address deficiencies of some aging facilities that no longer meet the needs of clients and in some cases, pose considerable safety risks.

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The organization is undertaking a renewal of its mission, vision and values. There is an opportunity for development of a fewer number of values, which are memorable and clearly defined in terms of behavioural expectations.

The organization has recently joined the provincial patient safety learning system (PSLS), which will assist in region wide reporting and analysis of critical patient safety data and monitoring of action on recommendations from critical incidents and near misses.

Although progress has been made in the development of system level performance measurement, some programs are in the early stages of identifying key performance measures, especially outcome measures, and formal program evaluation. VIHA is reviewing its current approach to system performance indicators for the region. As part of this review, the organization is encouraged to raise the bar in setting stretch targets that reflect a high performing organization.

The organization has recently adopted a new learning and performance support system for the region. Staff expressed a desire for more support for professional development and ongoing learning. There appears to be considerable inconsistency in staff access to learning opportunities.

VIHA has embarked on care delivery model redesign to promote team communications, elder friendly care, improved patient assessment, care planning, and functional mobilization. Work is also underway to transform the care continuum to identify at risk individuals, support independent living and provide timely availability of care alternatives. Although progress is being made, considerable work remains in order to ensure evidence based practice and a culture of continuous improvement. This improvement work needs to address unmet required organizational practices, including but not limited to those involving medication safety.

Work is underway to revitalize the approach to ethics services across the region. This should include a focus on organizational ethics and enhanced support for staff, patients and families dealing with challenging ethics issues.

The organization has developed a plan to enhance internal and external communications. This continues to be a challenge, particularly for establishing timely, two way communications with staff across the region.

To support the VIHA's commitment to improving the health of its communities, it is suggested that VIHA carry out a review of its capacity and organizational structure for the delivery of population and public health (PH) services. The recently completed "BC Core Program" provides a solid base to assess capacity. It is suggested that this review be done in collaboration with the Provincial Health Officer.

Organization's Commentary

The following comments were provided to Accreditation Canada post survey.

This report reflects the Vancouver Island Health Authority's (VIHA) first QMENTUM accreditation survey. We are pleased with the outcome of this process and welcome the opportunity to move from a sequential system of evaluation to this comprehensive approach. QMENTUM involved most VIHA program areas, with a particular focus on front line care, and staff reported they felt the tracer methodology allowed them to highlight their quality activities. Preparations leading up to the survey will support on-going and future quality initiatives.

The process has captured our successes and the challenges we face very well. We are proud of the accreditation survey's finding that we comply with 92% of the standards and we will continue to address high priority standards. Ensuring compliance with Required Organizational Practices is a VIHA priority. As an organization that employs Accreditation surveyors, we know the challenges of capturing detailed factual accuracy during an intense one-week survey. After reviewing the report, we offer the following clarifications:

-Effective Organization Standards 1.2 and 2.1: Community needs assessments; on an annual basis population needs assessment profiles are updated and shared on all local health areas in VIHA and form the foundation of planning. As the surveyor was provided with copies of these reports, we are unclear why these standards were unmet. 2.1 The organization uses population and community health needs data as the foundation of all planning.

-Patient Flow: A comprehensive Over Capacity Protocol has been developed, implemented and evaluated at all sites. This protocol is in place throughout VIHA and details of the protocol were provided to the surveyor.

-Population Health: A robust process is in place to review training initiative requests and ensure alignment with VIHA goals and objectives. Significant funds have been spent on improvements to acute care competencies in PICU, NICU and LDR.

-Reprocessing and Sterilization 5.7, 5.8: VIHA's policy, which is on the Intranet, addresses the dress code for PPE does not require foot covers.

-Infection Prevention and Reprocessing and Sterilization 5.3: VIHA staff receives extensive hand hygiene training. A comprehensive hand hygiene action plan and training program has been rolled out throughout VIHA, details of which were provided to the surveyor.

-Critical care: A review of the need for a rapid response team was completed by Critical Care Leadership and it was deemed that a rapid response team was not required.

-Critical care 7.5: The statement regarding non-compliance with VTE appears contradictory with later statements in the report 'Safer health care now! Bundles are implemented for VTE ."

-Home Care Standard 4.9: Upon hire, new staff complete the 'Knowledge and Skills' checklist identifying their learning needs. A spreadsheet tracks education for team members in Home & Community Care.

-Medicine Services: Vascular access and the need to reinstate Wednesday service in Diagnostic Imaging to accommodate renal patients was noted by the surveyor. This reflects a need for services in Nanaimo to support Central/North patients.

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-15.3 The Seniors Mental Health program is part of the overall Mental Health standards. VIHA's falls prevention strategy has been implemented within Seniors Mental Health. The surveyor received a report that included falls data.

-Effective Organization 14.4: VIHA's process includes a review of all sentinel events. The Combined Quality Council (CQC) defines the process for managing complex reviews.

Managing Medications Corrections and Updates:

-10.6: Patient allergy information is recorded on a standardized allergy record in Power Chart. This electronic record is viewable by all health care providers. VIHA recognizes the need to have all allergy information documented in one location, thus ensuring it will not be missed or changed through transcription.

-1.6: With the exception of West Coast General Hospital, all VIHA pharmacy sites have a pharmacist on call or have other arrangements to access a pharmacist. West Coast General accesses one of the other site pharmacists on call.

-2.6: Physicians and nurses are educated about new medications (additions to formulary) via the P&T newsletter, pharmacy memos and the pharmacy web site. Where the new drug is part of a clinical order set, the change is made and notification is sent. For every new IV drug a monograph is developed, sent to P&T, and disseminated to all clinical staff. For non-formulary parenteral medication, Pharmacy provides an information sheet which is sent to the patient care area along with the medication. Clinical Pharmacist on patient care units also provide "in-services" on new medications or new uses for old medications.

-Heparin products 3.5: The test for compliance 3.5.4 was met as a review of the listed products has been completed where deemed necessary, products are stocked. Heparin 10,000 units/mL x 1 mL vial is the gold standard for DVT/PE Prophylaxis. This product is on a significant number of clinical order sets (Med/Surg, CCU/CCVU, ER, ICU, Neuro & many others). There are no other strengths of heparin that could be used for this purpose due to the small volume required for SC administration.

VIHA's new Quality structure, the Combined Quality System which includes the Combined Quality Council (CQC), is ideally suited to engage programs and portfolios and focus on Accreditation Canada's identified opportunities. We will be incorporating the QMENTUM methodology into our quality system. This process will be instrumental in addressing opportunities for improvement as well as maintaining our gains.

Many initiatives and opportunities identified in the report are well underway. We will continue this work, and are confident of the completion and evaluation of many of these items in the October 2011 Report.

Once the final accreditation decision is awarded in October, we look forward to providing the updated Accreditation Canada standards to our program areas so they can begin reviewing and completing self assessments early in 2012. This ensures programs and their site-specific units and teams have two planning cycles to work with. This focus will frame much of VIHA's future quality work, supported by improvement at the portfolio and program level, using VIHA's Quality Council model to inform and guide the process. For items that are common to multiple teams, the CQC will assist in maintaining a focus on broad VIHA compliance with Required Organizational Practices and standards.

Programs and Quality Councils will have an opportunity to correct inconsistencies and submit information over the next five months, as we work towards submitting evidence that we're compliant with standards and ROP's in October 2011. At that time we anticipate a revised Report and receiving a final Accreditation Award, ideally Accreditation without report or condition.

Leading Practices

Recognizing innovation and creativity in Canadian health care delivery

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

Leading Practices

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

Vancouver Island Health Authority is commended for the following:



Medication Reconciliation at Admission to Home Care

Building on a previously developed Medication Risk Assessment process, VIHA Home Care and Community Care took the lead in developing a process and tools for Medication Reconciliation at Admission for Home Care.

The process includes a medication risk assessment (safety tool), medication reconciliation form, order sheet, written verification (fax sheets) of communication regarding discrepancies to both the physician and the pharmacist and a medication calendar for the client. The community pharmacies are also involved. If the physician does not respond to the faxed "discrepancy sheet", there is a tracking system in place so that a reminder letter is sent. The medication reconciliation process is not considered to be complete until all discrepancies are identified and resolved. Multiple sources of information are always used to build a Best Possible Medication History.

There is also a "Medication Guide for the Home Patient" developed by pharmacy services, for those clients for whom this brochure would be appropriate.

A visual teaching tool was developed for staff, breaking the medication reconciliation process down into easily understood steps, with clear rationale. The medication reconciliation process is also supported by substantial health teaching for the client, including the importance of medication compliance.

This is a comprehensive process that incorporates multiple safety checks for the client and each clinician on the care team. It is this inclusiveness and completeness that makes the process quite unique and innovative. Medication reconciliation was not introduced as a stand-alone process, but rather was incorporated into an overall medication safety program. (Home Care)



Renal Prospective Medication Reconciliation

The VIHA Renal Program has developed, tested and spread a medication reconciliation method utilizing a web-based database. All dialysis patients on Vancouver Island now have their medications reconciled at least twice yearly - more often if they have transitions in care. The impact has been significant. In addition to having accurate medication profiles, nephrologists can now print hospital admission, discharge and ongoing outpatient medication prescriptions from the database. This saves time in writing orders and those orders are machine printed and clearly indicate any change in therapy. It is now routine practice for all eleven nephrologists on Vancouver Island to admit to and discharge from hospital dialysis patients using these prescription reports. This system has been implemented across British Columbia for dialysis patients. (Medicine Services)



Leading Practice - Best Practice Post Heart Cath Lab Procedure: The Chair Model

The Chair Model for patients using the radial access procedure for heart catheterization has been utilized successfully at the Royal Jubilee Hospital (RJH) since 2009. It enables the least invasive method for patients undergoing cardiac catheterization, enabling same day discharge. The same day patient discharge rate is currently between 80-85 %. This benefits the patient and increases efficiency for the organization in the use of resources. It has modified the traditional view of an illness and subsequent hospitalization by providing a same day process which focuses on the patient coming in for a “procedure not and operation.” The program is based on the philosophy of promoting a sense of well being while hospitalized for a cardiac procedure (Critical Care)



Collaborative Care Relationship Between Seven Oaks Tertiary Care Facility and Seven Oaks ACT Team

The Assertive Community Teams (ACT) is linked with Seven Oaks for the provision of respite and short term admission of two to three days with relapse, thereby preventing acute care access and improved quality of care for clients. This model is unique with the excellent team dedication and coordination of care across the facility and ACT. This has provided hope and opportunity to many patients (who were previously thought to require lifelong “asylum” level care) the chance to live far more independently in the community, often in their own apartments, supported intensively by an outpatient team sponsored by the same facility. As a direct corollary of the Seven Oaks Facility and the local ACT teams being under the same clinical director, the vision, administrative leadership and co-management governance of both the tertiary facility and the ACT teams have been developed in an efficient manner that has allowed for patient-centred focus, and as seamless an orientation possible for all discharge planning and any necessary returning of patients to the facility. This has allowed staff to take full advantage of giving clients opportunities to work towards living outside of the hospital, where the “risk taking” and empiric trials of independent living has been backed up by a hospital that caters to their long-term needs regardless of their abilities and capacities. This has helped both very severely ill and refractory patients, as well as the staff, become much more comfortable in addressing the clinical implications of moving from a hospital based to a community based service orientation. Detailed community service plans, that are electronically repositied and available to all staff of Seven Oaks, provides for transparent and accountable service collaboration, enabling the majority of patients to be supported in independent living arrangements in their own “free market” apartments, or in public mental health housing apartments provided by the health authority and a variety of other agencies in the community. An evaluation framework has been developed and the effectiveness has been demonstrated with utilization performance measures - for example: reduction in emergency visits, inpatient admissions and costs in acute care. (Mental Health Services)



Improving Mental Health Care by Primary Care Physicians in British Columbia

Improving Mental Health Care by Primary Care Physicians in British Columbia: This is an innovative training program to assist family physicians to better care for their patients with mental health conditions. The training module includes a wide range of tools that can be used by physicians in their own offices. The training requires no study, offered assessment and cognitive behavioral interpersonal skills treatment approaches-not only pills -for patients. The training also engaged patients in self-management and in a shared responsibility for their treatment, and fit within the time constraints of a busy family physician office, as well as fit each component with their fee codes making this also well-paid practice. Cognitive Behavioral (CBT) Therapy and interpersonal skills are linked to evidence-based treatment for depression and anxiety, the highest prevalence disorders, which are the main lens for this training. (Mental Health Services)

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)	153	15	0	168
Accessibility (Providing timely and equitable services)	137	13	0	150
Safety (Keeping people safe)	506	59	3	568
Worklife (Supporting wellness in the work environment)	192	10	0	202
Client-centred Services (Putting clients and families first)	255	9	1	265
Continuity of Services (Experiencing coordinated and seamless services)	77	2	0	79
Effectiveness (Doing the right thing to achieve the best possible results)	757	61	2	820
Efficiency (Making the best use of resources)	78	5	0	83
Total	2155	174	6	2335

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	84	7	0	91
Effective Organization	89	17	0	106
Infection Prevention and Control	98	5	0	103
Populations with Chronic Conditions	67	2	0	69
Child and Youth Populations	48	3	0	51
Mental Health Populations	68	1	0	69
Public Health Services	104	11	0	115
Ambulatory Care Services	114	6	0	120
Community Health Services	65	3	0	68
Critical Care	110	18	1	129
Emergency Department	116	5	0	121
Home Care Services	93	2	0	95
Hospice, Palliative, and End-of-Life Services	121	11	2	134
Long Term Care Services	110	11	0	121
Managing Medications	111	22	2	135
Medicine Services	97	8	0	105
Mental Health Services	95	15	1	111
Obstetrics/Perinatal Care Services	111	8	0	119
Operating Rooms	102	0	0	102
Rehabilitation Services	95	8	0	103
Reprocessing and Sterilization of Reusable Medical Devices	90	9	0	99
Surgical Care Services	100	2	0	102
Telehealth Services	67	0	0	67
Total	2155	174	6	2335

Overview by Required Organizational Practices (ROPs)

Based on the accreditation review, the table highlights each ROP that requires attention and its location in the standards.

Criteria	Required Organizational Practices
Effective Organization 6.9	The organization's leaders provide the governing body with quarterly reports on client safety, and include recommendations arising out of adverse incident investigation and follow-up, and improvements made.
Effective Organization 12.6	The organization clearly defines the roles, responsibilities, and accountabilities of leaders, staff, service providers, and volunteers for client care and safety.
Infection Prevention and Control 1.2	The organization tracks infection rates, analyzes the information to identify clusters, outbreaks, and trends, and shares this information throughout the organization.
Infection Prevention and Control 6.1	The organization delivers education and training for staff, service providers, and volunteers on hand hygiene.
Critical Care 7.5	The team identifies medical and surgical clients at risk of venous thromboembolism (DVT and PE) and provides appropriate thromboprophylaxis.
Critical Care 7.6	The team reconciles the client's medications upon admission to the organization, with the involvement of the client, family or caregiver.
Critical Care 12.5	The team reconciles medications with the client at referral or transfer, and communicates information about the client's medications to the next provider of service at referral or transfer to another setting, service, service provider, or level of care within or outside the organization.
Critical Care 16.6	The team implements verification processes and other checking systems for high-risk activities.
Emergency Department 8.3	The team reconciles medications for clients with a decision to admit, with the involvement of the client, family or caregiver.
Emergency Department 11.5	The team reconciles medications with the client at referral or transfer and communicates information about the client's medications to the next provider of service at referral or transfer to another setting, service, service provider, or level of care within or outside the organization.
Hospice, Palliative, and End-of-Life Services 7.9	The team reconciles the client's medications upon admission to the organization, with the involvement of the client, family or caregiver.
Hospice, Palliative, and End-of-Life Services 12.2	The team reconciles medications with the client at referral or transfer, and communicates information about the client's medications to the next provider of service at referral or transfer to another setting, service, service provider, or level of care within or outside the organization.
Hospice, Palliative, and End-of-Life Services 16.2	The team implements and evaluates a fall prevention strategy to minimize the impact of client falls.
Long Term Care Services 7.4	The team reconciles the client's medications upon admission to the organization, with the involvement of the client, family or caregiver.

Criteria	Required Organizational Practices
Long Term Care Services 12.3	The team reconciles medications with the client at referral or transfer, and communicates information about the client's medication to the next provider of service at referral or transfer to another setting, service, service provider, or level of care within or outside the organization.
Long Term Care Services 16.2	The team implements and evaluates a fall prevention strategy to minimize the impact of client falls.
Managing Medications 3.5	The organization evaluates and limits the availability of heparin products and has removed high-dose formats.
Managing Medications 7.2	The organization removes concentrated electrolytes (including, but not limited to, potassium chloride, potassium phosphate, sodium chloride >0.9%) from client service areas.
Managing Medications 10.2	The organization has identified and implemented a list of abbreviations, symbols, and dose designations that are not to be used in the organization.
Medicine Services 7.4	The team identifies medical and surgical clients at risk of venous thromboembolism (DVT and PE) and provides appropriate thromboprophylaxis.
Medicine Services 7.5	The team reconciles the client's medications upon admission to the organization, with the involvement of the client, family or caregiver.
Medicine Services 11.3	The team reconciles medications with the client at referral or transfer, and communicates information about the client's medications to the next provider of service at referral or transfer to another setting, service, service provider, or level of care within or outside the organization.
Mental Health Services 7.3	The organization assesses and monitors clients for risk of suicide.
Mental Health Services 7.6	The team reconciles the client's medications upon admission to the organization, with the involvement of the client, family or caregiver.
Mental Health Services 11.3	The team reconciles medications with the client at referral or transfer, and communicates information about the client's medications to the next provider of service at referral or transfer to another setting, service, service provider, or level of care within or outside the organization.
Mental Health Services 15.3	The team implements and evaluates a falls prevention strategy to minimize the impact of client falls.
Obstetrics/Perinatal Care Services 7.12	The team reconciles the client's medications upon admission to the organization, with the involvement of the client, family or caregiver.
Obstetrics/Perinatal Care Services 11.3	The team reconciles medications with the client at referral or transfer, and communicates information about the client's medications to the next provider of service at referral or transfer to another setting, service, service provider, or level of care within or outside the organization.
Rehabilitation Services 7.4	The team reconciles the client's medications upon admission to the organization, with the involvement of the client, family or caregiver.
Rehabilitation Services 11.3	The team reconciles medications with the client at referral or transfer, and communicates information about the client's medications to the next provider of service at referral or transfer to another setting, service, service provider, or level of care within or outside the organization.

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Criteria	Required Organizational Practices
Rehabilitation Services 15.2	The team implements and evaluates a falls prevention strategy to minimize the impact of client falls.
Surgical Care Services 11.4	The team reconciles medications with the client at referral or transfer, and communicates information about the client's medications to the next provider of service at referral or transfer to another setting, service, service provider, or level of care within or outside the organization.

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

High functioning strategic Board that truly has focus on governance process. The strategic planning process is comprehensive and robust and cascades throughout the organization for the most part; however, there are opportunities for increased communication at the “coal face” so that everyone is aware of their contribution to achieving the strategic priorities.

Board evaluation occurs through governance committee which is comprehensive and applauded. Peer evaluation occurs at end of term for each board member. Annual review of all directors is in place and there is in camera at each meeting to evaluate performance.

CEO evaluation process is robust and based on mutually agreed objectives, which are comprehensive and linked to Ministry expectations. Respectful relationship with the CEO was observed.

Monitoring strategy plan through performance indicators takes place at every meeting. Strategic plan refreshed annually, informed by environmental scan and status on plan achievement. Budget plan relates back to strategic plan. Alignment of goals, measures, strategies and decisions are evident.

The board and leadership team need to refresh their mission, vision, and values to reflect where the organization is now and focus their values on the principles, behaviours, and expectations that can drive transformation for future generations.

Community engagement is an opportunity for VIHA in that the communities are reaching out to be helped especially in relation to mental health and addictions. An equitable strategy for all parts of the island needs to be explored.

Board member appointment process: There is a targeted recruitment asking for specific skills, the governance committee develops a short list and selects the nominees to put forward to Minister. There is currently no aboriginal representation on Board. As VIHA's Board is appointed by Government the challenge and issues in terms of health status and hard to reach populations which might be facilitated through aboriginal representation are noted.

Quality and Safety: There is a combined quality council. They receive regular reports from various portfolios. They are doing some benchmarking and have a relentless drive for quality.

Ethical Framework: The board has vigorous discussions regarding ethical issues. Structure and process are in place. Different criteria for tough decisions to assist in transparency have been observed. Outside expertise is sought as needed. Two former board members and the CEO have had training as part of formal governance education, including ethics education. Work is underway to revitalize the approach to ethics services across the region. This should include a focus on organizational ethics and enhanced support for staff, patients and families dealing with challenging ethics issues.

Planning process: Operational, infrastructure plans align with strategic plan and are updated every three years. Health service plan is done annually, aligned with the Ministry plan. Annual goals and objectives are monitored semi annually. Targets are assessed semi annually and personal accountabilities are aligned. Metrics around System initiatives could be pulled into a dashboard and cascaded throughout the organization even on KPI(key performance indicators) on all units which would leverage performance.

The leadership team and the board have made significant progress since their last survey and they need to continue to see the focus of quality improvement as not just a scorecard or a mark but to weave it into the fibre of their being and in their values with the vision of quality and safety being woven into the philosophy of the organizational culture. The leadership team is innovative and are really bringing the culture of the organization to a tipping point that said now is the time to have continued investments in collaborative efforts to drive transformation through investing further in the engagement of your internal and external partners.

Leadership group meets periodically, followed by a manager meeting. Regular reports are issued at six and twelve months. The leadership group uses a balanced scorecard for monitoring as well as a qualitative update on progress. It is encouraged that the organization use stretch target to assist them in moving forward with the view of aligning targets with industry. Reporting to board is scheduled on a regular basis. The board is Moving to iPad reports with ability to drill down on data which is encouraged.

Mission, vision, values updates: Values are updated every five years which is due this year. This has been delayed slightly because of the new board members and chair. It will begin with the board session regarding the process and looking at community engagement. It is expected to begin that work in the fall with travelling road show to many communities and meeting with staff. It is anticipate the change in brand and language, which is needed to reflect the evolution of the organization.

Budget: Programme budgeting and marginal analysis (PBMA) process for investment and reinvestment is in place. Methodology works well and staff understand how proposals are reviewed. Leadership believes in involving staff in budget process both for investment and re investment. Capital funding process limits multiple-year capital planning. Capital needs identification has been done. Some of the challenge to meet needs including small rural facilities such as Tofino.

Population Health: Port Alberni needs assessment is in the early days of development. It was done collaboratively with many partners to look at determinants of health. Needs assessments have been done in other communities as well. There is a process to report back to the community on the findings.

The organization has developed a plan to enhance internal and external communications. This continues to be a challenge, particularly for establishing timely, two way communications with staff across the region.

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

Criteria	Location	Priority for Action
Effective Organization		
The organization’s community needs assessment is maintained in a format that is up-to-date and easy to understand.	1.2	↑
The organization’s leaders share information from the community needs assessment with the governing body, staff and service providers, and other organizations.	1.3	
The organization’s leaders use information about the community to plan its scope of services.	2.1	↑
The organization’s mission, vision, and strategic direction are reflected in the scope of services.	2.2	
When developing the operational plans, the organization’s leaders seek input from staff, service providers, volunteers, and other stakeholders, and communicate the plans throughout the organization.	4.3	
The organization’s leaders provide input in defining or updating the organization’s values statement.	5.1	
The organization’s leaders communicate the values statement throughout the organization and educate staff, service providers, and clients and families about it.	5.2	
Public Health Services		
The organization reviews the community health assessment every year and updates it as necessary	1.2	
The organization’s partners reflect the community’s diversity.	4.2	

With its partners, the organization tailors the communication strategy to meet the needs of different target audiences and community groups.	5.2
The organization works with partners to provide equitable access to its services and to reduce potential and actual barriers to access.	6.2

Sustainable Governance

The information received by the governing body is accurate, up-to-date, and in a format that is easy to understand.	4.3
The governing body regularly reviews the available information to assess its appropriateness, and identify information needs and gaps.	4.6

Resource Management

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

Surveyor Comments

Resource management in VIHA is done in an effective manner. Even though shared services application may be coming in the future, the organization is encouraged to look at software applications and options that would advance the development of line by line budgets to advance the information technology (IT) and information management (IM) business model. VIHA's reliance on some 'orphaned' applications and sunset architectures inflates system reliability and business continuity risks.

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

Criteria	Location	Priority for Action
Effective Organization		
The organization's leaders gather input from community partners and stakeholders to make resource allocation decisions.		9.1

Human Capital

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

Surveyor Comments

Responsibility for human resource (HR) services is positioned within the People, Organizational Development, Practice and Chief Nurse portfolio. This structure promotes alignment between HR activities and support for clinical services. The HR team has been restructured to form integrated service teams aligned with specific programs and departments across the region. Managers have been identified as the primary customer of the HR teams. This change in structure was developed in response to an assessment of the needs of the organization, a desire to be more nimble and responsive, to create increased capacity for effective human resource management, and a desire to support organizational needs. This change in structure and strategy is still in progress.

There is evidence of a strong commitment to staff safety. Staff safety and injury prevention is one of the four priority system wide initiatives (SWIs). There is a particular focus on reducing work place violence, including establishment of Code White teams. Safety scorecards have been developed to assess department specific risks related to violence, infection, falls and other staff safety risks. This risk assessment is communicated to staff and informs selection of unit level priorities for work place safety improvement. Orientation of new staff on emergency preparedness includes information about how staff can keep themselves and their families safe in the event of a disaster such as an earthquake.

Occupational health and safety (OHS) is a separate department. It is focused on improving work place safety in response to the Fast Report, which identified the need to develop a culture of safety and reduce work place injuries. The department is commended for its analysis of the ways in which the OHS team supports VIHA's approach to meeting required organizational practices (ROPs). The organization has significantly enhanced its approach to region wide occupational health and safety, including a new committee structure that is co chaired by a union leader and VIHA's chief operating officer (COO). Progress on the region wide staff safety strategy is reported to the board semi annually.

The organization's commitment to staff safety and a healthy work place is exemplified in the design of the new Patient Care Centre. Staff were extensively involved in the planning and small changes continue to be made in response to staff feedback. The design includes many features to promote staff safety, team work and healthy living. The facilities include a cafe, fitness centre and outdoor garden specifically for staff.

VIHA has begun to develop a more evidence based HR forecasting model for the region, which factors in changes in clinical practice as well as other factors.

VIHA generally has low vacancy and turnover rates, with the exception of a small number of hard to recruit job categories. It took an aggressive approach to recruitment of new nursing graduates, although this has been tempered more recently because of low nursing vacancy rates and budget constraints. A recruitment and retention plan to increase the number of Aboriginal employees is under development.

Position descriptions are reviewed periodically but there is no schedule for these reviews and some have not been reviewed for at least five years. All position descriptions should reference responsibility for patient safety.

A learning management system has been developed and it includes e-learning and places emphasis on learning in the work place.

Accreditation Report

VIHA has established a very effective co leadership model that partners physician leaders with administrative leaders. This appears to have contributed to a high level of physician engagement. Physician leaders expressed a high level of satisfaction with this model and indicated that they are valued and meaningfully involved in strategy, decision making, and leadership in the organization.

VIHA has used the Worklife Pulse survey and distributed the results to areas with sufficient numbers of respondents. The overall survey results were not generally distributed to VIHA staff. Results of the survey informed the decision to focus on improved internal communications across the region. Encouragement is offered to continue to use this tool to inform human resource strategies. Plans are underway to repeat the Gallop 12 staff opinion survey, which has previously been used across the province.

The organization could benefit from investment in a robust HR information system to support its commitment to timely reporting of data to support planning, decision making, and management of human resources.

A variety of mechanisms have been established to evaluate and provide feedback on individual staff performance. This continues to be a challenge, especially in areas where managers have large spans of control and 24/7 operations. Some staff that were interviewed indicated they had not received performance reviews in more than two years.

VIHA's board is committed to excellence in governance. There is an excellent relationship with the CEO. The board takes an active role in promoting quality and safety and demonstrates effective oversight of organizational strategy and system performance. In keeping with the organization's commitment to work place diversity, the board should consider placing increased emphasis on cultural diversity in selection of future board members.

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

Criteria	Location	Priority for Action
Effective Organization		
The organization monitors the quality of its worklife culture using the Worklife Pulse Tool.	8.8	
The organization does not have any unaddressed priority for action flags based on their most recent Worklife survey results.	8.8.2	
The organization's leaders develop and regularly update position profiles for each position.	12.5	
The organization clearly defines the roles, responsibilities, and accountabilities of leaders, staff, service providers, and volunteers for client care and safety.	12.6	↑
Attention to client safety is demonstrated by defining roles and responsibilities for client safety in position profiles, performance appraisals, handbooks, orientation material, and by addressing client safety on regular basis in newsletters and client safety committee minutes.	12.6.2	

Sustainable Governance		
The governing body has the right mix of background, experience, and skill sets to govern effectively.	5.2	
The governing body provides an annual, formal statement of its achievements.	7.5	↑

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

VIHA has made a significant commitment to quality, patient safety and client centred care and services. This goal is supported by two objectives related to improving integration of services to support access and flow, and improving planning and delivery of services via a focus on sustainability, quality and safety. In 2010/11, particular focus was placed on infection prevention and control, care continuum transformation, care delivery redesign, and staff safety as the four highest priority system wide initiatives (SWIs). Progress on these goals is tracked and reported to the board semi annually. In addition, the board receives a semi annual performance report consisting of 47 performance indicators.

The performance scorecard is under review. Encouragement is offered to explore leading practices in this area and in particular to re examine the performance targets, many of which appear to be set at lower levels than one would expect to see in a high performing health system. Ongoing work is underway to improve the timeliness of performance measurement data.

The organization has adopted a "waterfall" model to align goals and objectives, quality improvement plans, and performance measures across the region. This approach however, is not yet fully implemented consistently across the region. A good example of this alignment was observed in the medical unit in Campbell River, where staff are involved in developing the unit goals and objectives. Alignment with the four system wide strategic initiatives is demonstrated in the way these are posted in the staff lounge, with strategic initiatives at the top and unit goals and objectives for each initiative listed below. Staff interviewed could easily speak to how these relate to their roles and the work that they do on a daily basis. In other units, there was limited awareness of organizational priorities and enunciation of unit priorities and related performance measures.

The recently established combined quality council has been well received as an effective mechanism to integrate medical quality improvement and regional quality improvement structures and processes.

VIHA has recently adopted the provincial patient safety learning system, which will provide a more efficient and effective mechanism to report critical incidents and near misses and other patient safety data, with a mechanism to track recommendations and action taken to improve patient safety. Previous manual systems were unwieldy and especially ineffective in capturing near misses.

Accreditation Report

The organization conducts on annual basis between two and four prospective analyses, using failure modes effects analysis (FMEAs) to adopt a more proactive approach to patient safety. Efforts are underway to include information from client concerns as part of the evidence to inform performance evaluation and priorities of quality improvement strategies. Proposals for investments, as part of the annual budget process, now include consideration of impact on quality.

A comprehensive enterprise risk management program has been established. Regular reports are provided to the board on VIHA's strategic risk register, including identification of the risk, clinical/business impact, mitigation strategy and status update. This risk assessment informs the strategic plan and annual priorities, including the current focus on staff safety and infection control.

The care delivery redesign initiative has involved a year of structured learning. Particular focus has been placed on patient care planning, resulting in practice changes such as setting care goals with patients, huddles, interdisciplinary rounds and use of white boards in patient rooms. Plans are underway to spread this improvement work to non acute care and rural settings. Considerable work has been done to address the needs of seniors at risk, including care planning when seniors are receiving care in the emergency department.

Other areas of quality improvement include hand hygiene, with regular auditing of compliance and automated feedback to managers. A medication safety quality council has led development of a medication safety quality plan, including plans to enhance medication reconciliation across the region. Considerable work still needs to be done to meet this required organization practice (ROP) across all services. There has been considerable investment in patient lifts. Patient safety is a significant consideration in facility construction, as exemplified by the new Patient Care Centre, which includes many design features to reduce infections, prevent falls, and promote other aspects of quality and patient safety.

Some work has been done on developing more client and family centred care, including development of a video entitled: "Journey of Mrs. G". The VIHA has a patient advisory council. Leaders expressed a desire to enhance this work and they may benefit from guidance and support from the Institute for Patient and Family Centred Care and from other regions that have made considerable progress in this area.

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

Criteria	Location	Priority for Action
Effective Organization		
The organization monitors its client safety culture by using the Patient Safety Culture Instrument.		6.8
The organization does not have any unaddressed priority for action flags based on their most recent Patient Safety Culture survey results.		6.8.2

The organization’s leaders provide the governing body with quarterly reports on client safety, and include recommendations arising out of adverse incident investigation and follow-up, and improvements made.	6.9	↑
Quarterly client safety reports have been provided to the governing body.	6.9.1	
As part of the integrated risk management approach, the organization’s leaders review the frequency and severity of sentinel events, adverse events, and near misses identified by the organization’s reporting system.	14.4	↑

Principle Based Care and Decision Making

Identifying and decision making regarding ethical dilemmas and problems.

Surveyor Comments

VIHA is undertaking a review of its core values. Staff expressed a desire for greater clarity and focus on a more limited number of core values and the related behavioural expectations to support further development of a values' based organizational culture. This represents a significant opportunity to engage staff region wide, in ongoing development of a workplace where people are proud to work and feel valued.

Staff interviewed identified significant ethics issues, including end of life care, futile care, patient autonomy and conflicts between patients' rights and staff safety. They noted that these and other ethical situations result in significant moral distress for staff. The organization has identified that its approach to ethics support requires renewal. A new Leader of patient engagement and clinical ethics is leading this work. The terms of reference of the ethics committee were outdated and have being revised. Membership of the ethics committee has been expanded to include a broader representation including a member of the public and physicians. The committee includes a member of the public. There are also two ethics committees for the child, youth and family program and residential care program.

Improvements are also underway relative to the ethics resource team, which will now link to the ethics committee. There are few requests for consults by the resource team, with between 12 and 14 last year and most consultations involve retrospective reviews. There is an opportunity for VIHA to heighten staff awareness of the resource team to assist staff in dealing with difficult ethics issues. The organization has access to ethicists on an as needed basis.

The tracer to review the ethics consultation process illustrated that the process included: initiation of the request; intake by the on call member of the ethics resource team; planning and conducting a guided discussion with members of the team experiencing the ethical dilemma; and, debriefing for those leading the process with the leader of patient engagement and clinical ethics. This was the first time that subject matter experts were used to support the facilitator in an ethics consultation. This added value to the process and will continue to be used, as appropriate, for future consultations. There was no structured evaluation or opportunity for individual participants to provide feedback on the process. An evaluation process will be developed for use in future ethics consultations. There was no documentation of the ethics consultation because of concerns related to privacy and confidentiality. Appropriate documentation of ethics consultation is under review with the director of information access and privacy. Sample policies and practices being used in other organizations are being collected. A VIHA policy and template for documentation will be developed to meet legislative and privacy requirements. This will enable tracking and trending of ethics cases/consultations for program evaluation and identification of learning and capacity building opportunities.

VIHA ethics program is in transition. Members of the ethics resource team are no longer on call for the intake line, and this is now done by the Leader of patient engagement and clinical ethics. This is a first step in data collection to prepare for further development, review and/or revision of ethics resources and case consultation process.

There appears to be very little focus on organizational ethics that is, to deal with non clinical ethical issues. The ethics committee is not involved in applying an ethical lens to policies that have potential ethical implications and this reflects an additional opportunity for the VIHA.

Various mechanisms are used to provide staff education on ethics, including on line reference material and ethics workshops.

There are two research ethics boards (REBs), to deal with clinical trials and non clinical research. A gap analysis is underway to compare current REB processes with the newly revised tri council guidelines. Mechanisms are in place to provide expedited reviews for lower risk research and time sensitive research proposals.

Work is underway in developing a code of conduct for VIHA staff and physicians. The organization is considering engaging a third party to respond to complaints of wrongful misconduct in the region.

VIHA has established a patient advisory council. This is a good foundation for further expansion of the region wide engagement of patients and families as partners in care, planning and decision making. The organization can benefit from learning from the success of other organizations and from the Institute of Patient and Family Centred Care to further develop this important work.

No Unmet Criteria for this Priority Process.

Communication

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

Surveyor Comments

All the recommendations from the previous accreditation survey have been addressed. There are varying degrees of communication across the organization. There seems to be a positive culture shift that is starting to gain traction and that said, it is pivotal to ensure that communication occurs with internal and external partners on a regular basis. Community focus groups expressed a need for VIHA to 'get out and about' to hear their stories and to help them increase their community capacity especially in hard to reach populations in the region. The Worklife Pulse survey identified some opportunities that need to be shared and implemented in terms of an action plan in order to be responsive, respectful and transparent to VIHA's audience.

The idea to resource communication leaders to engage in front line communication strategies with the team for SWIs is a stellar example of proactive engagement to effect purposeful and thoughtful transformation. Website users indicated that navigation of the website is not user friendly and would like to see it revised. There is a communication plan, newsletters, meetings, email, teleconference, video conferencing, web based learning tools, leadership walk abouts and presentations that all enhance communication. It is impressive to see outbreak status noted on the public website to inform communities in this region.

Great strides have occurred with the electronic health record in VIHA since the 2008 survey. It has been deployed in acute, mental health, and residential care across the region, which is a huge undertaking and this is acknowledged. Not all users are using the technology and there are still parallel paper systems in place, which need to be monitored to minimize risk.

There is a comprehensive innovative and impressive IM/IT plan that aligns with the strategic plan and demonstrates action plans of where the team has been and where the team is going. There is certainly the vision and the expertise to get there. This is a group of very inspiring individuals making a difference to their clients by aggressively pursuing and implementing 'boarding' options for a comprehensive strategic solution across the continuum of health. The team is encouraged to continue to leverage all possibilities in defining and pursuing a strategic option for VIHA to establish an integrated business system infrastructure to enable decision making and planning via an integrated business intelligence infrastructure. Business models and clinical models need to foster further integration to optimize flow, efficiency and effectiveness. Enhancement of the interactive desktop collaboration tools will enable the VIHA team to virtually connect, despite diverse geography, will foster real time collaboration and communication and reduce travel costs. Access to hardware however, is not available in all programs and this does limit access and communication in these areas.

Innovation is very apparent in the team. The change management framework particularly in integration of clinical systems is both commended and respected and the team should seriously consider writing this up as a best practice for the industry, as it is great work. The appetite for thoughtful ethical change is apparent in the entire team, as it looks for research options to support best practice and is already recognized as a Canadian leader on this front. There is passion for making a difference and it is clear from the team's proven track record that this traction will continue into the future.

This team needs to be involved in planning infrastructure changes at the beginning to optimize outcomes for the 'build' as it has expertise, knowledge and experience that will leverage integration and optimization for and with all teams.

Accreditation Report

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

Criteria	Location	Priority for Action
Effective Organization		
The organization’s leaders identify and interact with the organization’s internal stakeholders.	3.2	
The organization’s leaders develop and implement a communication plan to disseminate information to, and receive information from, stakeholders.	3.3	
The organization’s leaders select and implement information management systems that meet the organization’s current needs, and anticipate future needs.	13.1	
Sustainable Governance		
The governing body, with the CEO, communicates with staff and the rest of the organization.	9.6	
The governing body works with the CEO to identify stakeholders and gather information about their characteristics.	11.1	
In consultation with the CEO, the governing body anticipates, assesses, and responds to stakeholders’ interests and demands.	11.2	

Physical Environment

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

Surveyor Comments

A number of capital projects are underway including: completion of master site plans at Nanaimo Regional General Hospital (NRGH) and Cowichan District Hospital; seeking funding approval from Regional Hospital Districts for \$13 million for capital equipment and minor capital projects; disposal of Oak Bay Lodge as part of a redevelopment of 580 complex care beds and licensed dementia unit; acquisition of new leased space for Courtney Home and community care and mental health and addiction programs; and, relocation of remaining programs and staff to the Royal Jubilee Hospital Patient Care Centre. These projects will make a positive impact on service delivery.

The emergency department (ER) at the Victoria General Hospital is 18 months new, is clean, with plenty of storage space and room to care for patients. There is good space for staff classrooms, washrooms, and locker rooms. The Patient Care Centre (PCC) is a P3 project developed in partnership with an international consortium and the Centre of Healthcare Design. The three objectives that drove design are elder friendly/patient centred care; staff attraction and retention; and, Green design (certified LEED Gold). There are many features to prevent infection and falls, and staff comment on the quiet, lack of clutter and amount of light. Provision is made for patient comfort and family inclusion. The facility has been designed with maximum flexibility and a high degree of standardization. The design is intended to support and promote more "lean" care and service processes and multidisciplinary care. As a 'Pebble Project' facility, the success of the new building will be evaluated using a set of performance indicators related to patient safety, staff and client satisfaction. When this evaluation is completed, VIHA should consider submitting this project as a leading practice.

Protection services is provided via a mix of in house services at larger sites, and contracted services at smaller sites. Staff interviewed at various sites were largely satisfied with protection services and acknowledged they participated in regular fire drills. Security services are overall adequate. The staffing model at various sites is based on monthly reports, which measure response times, number of incidents and factors driving incidents. Both contracted and in house security are licensed by the province by the Attorney General's Office and are certified in basic standards and advanced training.

General support services is provided also via in house and contracted services. Staff indicated they were satisfied with services provided and at one site visited namely, Eagle Park Residential Care Facility, both patients and families commented on the quality of food as being excellent. Food safety, cleanliness audits and patient satisfaction surveys are undertaken by food services and housekeeping. Contracted services are not members of OHS committees.

Purchasing processes are well entrenched in the organization and an equipment standardization committee meets regularly to evaluate products. Procurement and inventory services have been transferred to the provincial Health Shared Services British Columbia (HSSBC) and it liaises regularly with the VP of OSS and attends monthly director meetings. This partnership has created opportunities for standardization and sustainability with purchasing power. The health authority has two materiel management systems namely AMS and Meditech and a plan is in place to convert to one, using the Meditech system.

The average age of buildings on the South Island is 42 years, 27 years in the Central Island and 26 years in the North Island. The Royal Jubilee (RJH) campus has buildings more than 100 years old, making the maintenance of such building systems challenging. In the ER at Tofino, the foundation is supported by posts that have been added to reinforce stability of the floor. The generator is used frequently owing to numerous power outages. The organization is looking at establishing a back up generator system to support the aging machinery in the event of a power failure. This has been added to the capital list and should be considered a priority.

VIHA is searching for opportunities to apply for energy saving grants and energy conservation initiatives. A retrofit of lighting fixtures in 2010 resulted in major kilowatts of energy savings. The Victoria General Hospital does composting.

Little to no storage space was noted at Tofino, Nanaimo Regional General Hospital, Campbell River Hospital and Victoria General Hospital. Staff at RJH would like to see more storage areas but were not as pressed for storage space as other facilities. On patient care units there was evidence of equipment, beds/cribs, portable computer stations, linen bags and garbage bins in the hallway all of which gives the appearance of clutter, as well as posing a fire and infection control hazard. Attempts are made to move items to one side of the hall, as directed by fire marshals but this is not always possible due to isolation carts outside patient rooms. The rehabilitation department at Nanaimo consists of four bed areas, with the exception of one private room. This creates issues with maintaining patient privacy and confidentiality, as well as creating challenges for infection prevention and control (IPAC). The space in the rehabilitation unit does not support the interdisciplinary model of care that the team desires.

A fleet of 200 plus leased/owned transport vehicles is maintained and operated by VIHA, with evaluation plans in place.

Facilities ensure that all construction contractors follow Canadian Standards Association (CSA) standards and IPAC attends all construction meetings. On site contractors are provided with orientation and training, dust control, risk assessment and follow OHS guidelines.

No Unmet Criteria for this Priority Process.

Emergency Preparedness

Dealing with emergencies and other aspects of public safety.

Surveyor Comments

The region has done an assessment of its greatest disaster risks, which include earthquake, tsunami and exposure to radioactive substances. VIHA has demonstrated its ability to respond to large scale emergencies. In particular, it effectively collaborated with many local, provincial and federal agencies to respond to the arrival of a migrant ship carrying 400 refugees from Sri Lanka. The region used two vacated units to establish required facilities to process and accommodate these individuals, many of whom posed a considerable risk with regard to infectious diseases. The region also coped well with the 2009 H1N1 pandemic and a fire in one of its acute care facilities. Fire drills are conducted regularly.

The new Patient Care Centre includes a state of the art emergency command centre. The facilities also includes generous provisions for negative pressure rooms.

The region has well established emergency response structures and processes, including regional and site command centres. Staff are trained in EOC procedures.

Most site disaster plans were developed in 2005-6 and are very outdated. Updating these plans is underway.

Staff identification and 'prox' cards include the VIHA emergency codes and staff who were interviewed knew to check these if a code is called. Work is underway to develop a user friendly quick response guide for staff.

The emergency department has a disaster response kit and staff are aware of its location.

Staff orientation includes training on emergency preparedness. Staff receive information on how to care for themselves and their families in the event of a disaster such as an earthquake.

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

Criteria	Location	Priority for Action
Public Health Services		
The organization, with its partners, reviews and revises the plan at least every two years, and more often if necessary.	14.9	↑

Patient Flow

Smooth and timely movement of clients and their families through appropriate service and care settings.

Surveyor Comments

The current way of measuring over capacity has been recognized as deficient. Administrators are very aware when the ER is over capacity and they work to address the problem locally and by working with physicians and community agencies, based on numbers and types of patients. There is frustration in that there is no plan that really responds to the ER's need for surge relief without involving administration and with looking at one off solutions on a situation by situation basis. This takes time and requires the cooperation and coordination of several administrators, directors and managers. While there are comprehensive strategies and protocols in place, there is significant variation of application and understanding across the region.

There are varied approaches for access and flow for mental health populations and these need to be explored to enhance services and outreach to these populations upstream.

The construction of the PCC has taken patient flow into the design and commendation is given for that thoughtful reflection. The vision and leadership of this portfolio is very strong and will continue to deliver great results for the population served. The organization is truly on the right path and has the upstream vision that is needed to effect change. The leadership is starting to see results and is integrating strategies across the continuum in a spirit of team work that will continue to optimize the client's experience. The patient flow strategy is aligned with a common purpose.

Information system interfaces at transition points is helpful for the team and bed management. The organization needs to continue to minimize risk by eliminating hall way medicine by continued implementation of its visionary patient flow strategies such as chronic disease management and going out into the population. It needs to continue with lean strategies to optimize the future state. An activation strategy needs to be put into place to assist with the bottlenecks. The team is very aware of this and is working on a plan to address alternate level of care (ALC) to ensure it is providing the right care in the right place by the right provider.

Consistent discharge rounds (rounding) needs to include all members of the team to increase flow.

Accreditation Report

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

Criteria	Location	Priority for Action
Emergency Department		
The team has strategies in place to effectively manage overcrowding and surges in the Emergency Department.	2.3	↑
Mental Health Populations		
Clients served by the organization know where and how to access services.	7.1	

Medical Devices and Equipment

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

Surveyor Comments

There is an excellent preventive maintenance (PM) program in place for all medical devices, equipment and technology across VIHA from within, which is cost effective, and appropriate training provided and documentation noted.

Although all endoscopy areas visited are following Standards, and a full audit has been completed this year with appropriate policies and processes, it is suggested to continue working in this area to ensure that written requirements for education, qualifications and routine competency testing of all staff shall be completed and documented.

There exists a well organized tracking system of PM documents.

There is an excellent recall policy with follow up of communication and documentation.

All but the RJH site have signage, and a plan is in place for this site.

No foot, wrist or knee faucets are noted however, all sinks noted in units have single use towels to use to turn off faucets

Leadership has a strong understanding of the policy of Creutzfeldt-Jakob disease, and it should be shared with the front line workers and team leads.

The operating room (OR) team appropriately contains and transports contaminated items to the reprocessing area in a closed case cart however, concern was raised that contaminated fluid was being transported and staff from reprocessing/sterilization is exposed. Removing gross contaminates, applying enzymatic gel/foam in the OR is recommended.

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

Criteria	Location	Priority for Action
Infection Prevention and Control		
The organization has written requirements for education, qualification, and competency of staff involved in the reprocessing of endoscopy devices.	13.1	↑
Reprocessing and Sterilization of Reusable Medical Devices		
Supervisors and staff members involved in reprocessing have completed a recognized course in reprocessing and sterilization.	2.4	
The organization conducts baseline and annual competency evaluations of staff members involved in reprocessing and sterilization.	2.5	
The organization documents and retains records of education, training, and competency assessments.	2.7	
The organization regulates the air quality, ventilation, temperature, and relative humidity, and lighting in decontamination, reprocessing, and storage areas.	3.5	
Staff members receive training on proper hand hygiene techniques.	5.3	↑
The team follows a detailed dress code while in the clean reprocessing area that addresses clothing, hair, jewelry, artificial fingernails of any form, and covered footwear.	5.7	↑
The team wears the appropriate and properly maintained personal protective equipment (PPE) in the decontamination area.	5.8	↑
The team follows manufacturers' instructions and accepted standards of practice to perform manual cleaning.	8.6	
The team participates in periodic audits.	12.9	

Horizontal Integration of Care

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.

Chronic Disease Management

Integration of services to meet the needs of populations across the continuum of care.

Surveyor Comments

Many innovative programs have been built on some very strong community partnerships that are continually cultivated. As example in the Mount Waddington area many high risk clients are identified through a partnership with the Vancouver Island AIDES organization, who are co-located with VIHA programs. The collaboration with community partners is basically seamless so far as the client services is concerned. The involvement with the Aboriginal Advocacy and Engagement Committee is a strong linkage.

In some areas such as Mt. Waddington the organization is taking full advantage of opportunities with community partners, however not the same level of opportunity development is realized in all areas, as example the Victoria Native Friendship Centre state they are eager to accommodate more VIHA services and their service population is need of additional services, in particular, Mental Health Services. There is also opportunity here for encompassing an interdisciplinary approach.

VIHA has identified enhancement and expansion of mental health services as a strategic priority and resources have been dedicated to northern areas of the island (redeployment from the south) to address areas of inequity.

The leadership team has not completed a mental health strategy for the program, but is encouraged in their efforts to align with the BC provincial plan, through which several leaders and staff in the VIHA Mental Health program have participated. Good planning processes are in effect at the local level with established general VIHA approaches to Population Health that are assisting the Mental Health Program overall e.g. Cowichan Valley based on data-engagement and evidence.

Evidence of incentives exists for Family Medicine and the attachment of mental health to practice. The multi-interdisciplinary primary care centre in Ladysmith that is a great example of patient focused Primary Health care provision.

There is good evidence of the organization/program's efforts to target hard-to-reach populations through Assertive Community Teams (ACT), and other internal and external committees input.

Excellent partnerships with primary care are evident with a focus on the training modules and uptake (Identified as a leading practice in mental health services). An additional example is the partnership VIHA and the Mental Health Program have with "the Greater Coalition to End Homelessness". Strengths identified and confirmed by partners involved in service include: communication; combined efforts to increase awareness and develop an action plan. The grant funding received based on the partnerships developed.

Good development of education and training for staff is in place - e.g. Compassion Fatigue; Non Violent Crisis Intervention; Suicide Risk Assessment incorporating evidence informed practice guidelines. The new Cultural Awareness and Safety Training Program has over 400 people pre-registered. Education for clients is also evident and some clients express their appreciation for the information and education they have received.

There is a comprehensive planning and action plan development in alignment with the Ministry's Plan; in addition to ongoing community assessment and planning to establish priorities for action. Population data has assisted the program to work at strengthening the collaboration with the aboriginal communities - for example: through cultural awareness training opportunities as provided through the Provincial Health Services Authority (PHSA). Further development for Addiction and Mental Health is encouraged, including further integration.

Use of data collected electronically with a focus on key indicators and a focus on outcome measurement is also encouraged. Partnership development around key initiatives could be better integrated into operations to strengthen the integration of this work with the program priorities.

Staff would like to see the ability to access information in one place - a form of electronic health record such as Mental Health have, but for all services. There is excellent advancement of the Electronic Health Record through use of Cerner's and the Mental Health and Addiction Services Bridges tool (Pathways). Expansion of the Bridges Pathways tool was mentioned to be a promising possibility.

Transition points for the transfer of information have been developed (transition protocols) but are not fully developed. They are not implemented with the Child and Youth Mental Health, Child and Youth Addiction services, or with the Forensic Services. This is particularly important in the urban centres where there is less naturally spontaneous information transfer. The expansion of Aboriginal Health Liaison Nurses has assisted greatly. The integration of Mental Health and Addiction Services needs to move forward. The communities experience a lack of both of these services and can give examples of the impact this has on their client care planning. The Aboriginal Health Services group especially expressed the need for an integrated approach, both between these services and with the other programs. Also of concern is the need for additional Diabetic services and nutrition services. The fact that Diabetic issues too, are often not a separate issue from Mental Health and Addictions was noted.

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

Criteria	Location	Priority for Action
Populations with Chronic Conditions		
The organization sets measurable and specific goals and objectives for its services for populations with chronic conditions.	1.4	
The organization defines how it will achieve its strategic direction, goals, and objectives for populations with chronic conditions.	1.5	

Population Health and Wellness

Promoting and protecting the health of the populations and communities served, through leadership, partnership, innovation, and action.

Surveyor Comments

Note on limitations of this review - it is not possible to provide comment on the full scope of mental health services provided to the child youth and family population because tertiary services provided at Leger House were not visited during this accreditation survey. It is understood that there is an internal report on Ledger House services but the surveyor did not have an opportunity to review the report. It should be noted that concerns related to access to tertiary services were identified as a concern by team members. This assessment covers a number of service groups or teams and multiple sites.

Evidence of innovation to better respond to the needs of the population and individuals clients was seen across the services ranging from care mapping and protocols for paediatric mental health client who present after hours to identifying and responding to population health threats such as tanning bed exposures for youths.

The staff of the Child, Youth and Family team demonstrated a strong commitment to providing quality client care and responding to the needs of the communities that they serve. They spoke with pride about their achievements but staff also expressed frustration over the impact that the reduction in funding and freeze on staffing positions has had on service delivery in health protection and public health service delivery areas.

Staff also expressed frustration over administrative delays of up to 12 weeks in getting approval for continuing education activities for which funding was guaranteed under collective agreements. There appears to be variation in the experience of different components of the team in accessing support for continuing education. Some groups reported support from local foundations for their continuing education requests.

for continuing education activities for which funding was guaranteed under collective agreements. There appears to be variation in the experience of different components of the team in accessing support for continuing education. Some groups reported support from local foundations for their continuing education requests.

The organization has recently implemented a new structure that includes public health, child, youth, and family services. While it is recognized that people are still adjusting to this new organizational structure there are some specific issues that surfaced over the course of the accreditation survey in interviews with staff.

1. Concern about stove piping in Mental Health

Some staff in mental health indicated that they did not feel that the structure allowed for joint planning around mental health issues that overlap between adults, children, youth and family such as addictions services.

2. Leadership and Clinical Accountability of Medical Leaders

In Public Health, the accountability relationship of public health staff to the Chief Medical Health Officer and other Medical Health Officers should be clarified.

In Child, Youth and Family, there is also a need to further strengthen the involvement of the medical consultants/medical administrators in decisions related to mental health service delivery. For example in discussion with the child psychiatrist supporting Children Youth Mental Health, his role and accountability as the Medical Director for Leger House in identifying and implementing the necessary service changes to address capacity issues was not clearly identified.

3. Access to Required Resources

The Population Health Observatory which provides critical support to the key public health function of Health Assessment and Surveillance was recently realigned with the Planning Department. It is suggested that the service agreement under development be finalized in conjunction with the Chief MHO to ensure that support for key public health functions and deliverables is maintained.

4. Clarification of the Enforcement Ladder

Sound public health practice involves the use of a progressive enforcement ladder. Currently staff perceive that there is not support for enforcing regulations other than through education. It is suggested that the enforcement ladder or approach used in public health be reviewed and endorsed by the Executive team and Board so that staff feel supported when they are carrying out their regulatory responsibilities.

5. Public Health Capacity

It is strongly suggested that VIHA carry out an independent review of its capacity and organizational structure for the delivery of population and public health services. The recently completed BC Core Programs provides a solid base to assess capacity against.

There is a well developed structure within the Child Youth and Family program that addresses quality for paediatric and perinatal services. Information on quality rolls up from the quality committees for each clinical grouping through the island-wide paediatric and perinatal councils to the overarching Child and Youth Family Quality Council which reports directly to their CYF portfolio quality council. The organization is encouraged to further strengthen this quality infrastructure with the establishment of the planned Perinatal Council. The team is encouraged to examine how public health and population health information is incorporated into the Quality Council.

Accreditation Report

An interdisciplinary approach which maximizes the scope of practice is evident in all service delivery areas.

The team partners widely with their communities including both government and non governmental groups as well as businesses to advance programs for children and youth and to protect and promote health; Examples include formal interagency partnerships with the Ministry of Children, Youth and Family, School Boards, and First Nations.

Some components of Public Health, Child, Youth and Family Services grouping are participating in an inpatient care model redesign as part of the organization-wide project.

It is recommended that Medical Health Officers and Public Health services participate in the program planning that is planned with the Family Partnerships Groups. It will be important to ensure that this planning includes both a population health perspective and an individual client perspective.

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

Criteria	Location	Priority for Action
Child and Youth Populations		
The organization dedicates resources to services and programs for child and youth populations.	1.2	
The organization is knowledgeable about and advocates for public policies to improve the health of child and youth populations.	4.3	
The organization provides staff and service providers, including primary care providers, with access to specialist expertise to manage services for child and youth populations.	9.1	
Public Health Services		
The organization's health promotion activities are based on priorities identified in the community health assessment and population health improvement plan.	11.3	
The organization's injury prevention activities are based on priorities identified in the community health assessment.	12.2	
The organization is able to rapidly initiate prevention services in response to detecting the early signs of health problems.	12.3	

The organization monitors compliance with health protection laws, regulations, and ordinances of regulated organizations.	13.1	↑
When necessary, the organization takes immediate action to enforce compliance with the law.	13.10	↑
The team identifies areas for improvement and addresses them in a timely way.	17.2	

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.

Ambulatory Care Services

Clinical Leadership

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

Surveyor Comments

Both the site visits in ambulatory care suggest that there is an understanding of the population served by the ambulatory team such as the seniors' programming at the RJH site.

The program tracks demographic factors on the population seen in the clinic. There is good annual demographic profile review, trending and analysis to assist with program planning goals at RJH, and this is beginning at NRGH. In Naniamo, and at RJH, strategic program planning for more than one year is envisioned, and will link to the new strategic plan. Both sites comment on work starting in the area of standardization specifically, forms.

The Naniamo and RJH programs link to community partners in providing care. Given the success of the program, the staff have been challenged to seek new approaches to timely assessments and care planning. They have used pod teaching as appropriate and have linked visits for clients to make accessing care in an easier process, using one stop care. They link to other services in providing care, and gave as an example, speech pathology for swallow testing in Nanaimo. One of the greatest care needs was failure to thrive for the population served. This has been addressed with a re engineering of staff, and there are some casual dollars set aside for enhancing dietician care.

In Naniamo, the program has outgrown the space in that confidential space for seeing patients is at a minimum. Physiotherapy (PT) is confined to classes of four persons due to spacing limitations. This is a young team with a vision for the future. Encouragement to put to paper a program vision aligned with the new VIHA strategic plan, with goals, benchmarks and measurement on a consistent basis is envisioned. This will help to address anticipated growth of the program in the future. Student placements were seen in Nursing. Other students have rotated through the program. Staff are clear on their role and that of their colleagues, and there is a real team approach to care.