ACCREDITATION
AGRÉMENT
CANADA
Qmentum

STANDARDS

Critical Care

For Surveys Starting After:
January 01, 2016

Date Generated: August 17, 2015
Ver. 10

Critical Care

Accreditation Canada is an independent, not-for-profit organization that accredits health care and social services organizations in Canada and around the world. Its comprehensive accreditation programs foster ongoing quality improvement through evidence-based standards and a rigorous external peer review. Accredited by the International Society for Quality in Health Care (ISQua), Accreditation Canada has been helping organizations improve health care quality and patient safety for more than 55 years.

CRITICAL CARE

Accreditation Canada's sector- and service-based standards help organizations assess quality at the point of service delivery and embed a culture of quality, safety, and client- and family-centred care into all aspects of service delivery. The standards are based on five key elements of service excellence: clinical leadership, people, process, information, and performance.

Accreditation is one of the most effective ways for organizations to regularly and consistently examine and improve the quality of their services. The standards provide a tool for organizations to embed accreditation and quality improvement activities into their daily operations with the primary focus being on including the client and family as true partners in service delivery.

Client- and family-centred care is an approach that guides all aspects of planning, delivering and evaluating services. The focus is always on creating and nurturing mutually beneficial partnerships among the organization’s team members and the clients and families they serve. Providing client- and family-centred care means working collaboratively with clients and their families to provide care that is respectful, compassionate, culturally safe, and competent, while being responsive to their needs, values, cultural backgrounds and beliefs, and preferences (adapted from the Institute for Patient- and Family-Centered Care (IPFCC) 2008 and Saskatchewan Ministry of Health 2011).

Accreditation Canada has adopted the four values that are fundamental to this approach, as outlined by the IPFCC, and integrated into the service excellence standards. The values are:

1. Dignity and respect: Listening to and honouring client and family perspectives and choices. Client and family knowledge, values, beliefs, and cultural backgrounds are incorporated into the planning and delivery of care.

2. Information sharing: Communicating and sharing complete and unbiased information with clients and families in ways that are affirming and useful. Clients and families receive timely, complete, and accurate information in order to effectively participate in care and decision-making.

3. Partnership and participation: Encouraging and supporting clients and families to participate in care and decision making to the extent that they wish.

4. Collaboration: Collaborating with clients and families in policy and program development, implementation and evaluation, facility design, professional education, and delivery of care.

Critical care is specialized interdisciplinary care provided to clients with life threatening or potentially life threatening conditions, typically involving one or more organ system failures. This type of care is provided on a 24-hour basis in a variety of settings including on a hospital ward, or in a post-anaesthetic recovery unit (PACU), intensive care unit (ICU), coronary care unit or other high dependency unit. Critical care also includes care provided by outreach teams, known as rapid response or medical emergency teams. These teams typically conduct interventions on the ward in an attempt to halt deterioration of the client's condition and possibly prevent the need for admission to the intensive care unit.

This set of standards contains the following sections:

- **Investing in quality services**
- **Building a prepared and competent team**
- **Providing safe and effective services**
- **Maintaining accessible and efficient information systems**
- **Monitoring quality and achieving positive outcomes**

All Accreditation Canada standards are developed through a rigorous process that includes a comprehensive literature review, consultation with a standards working group or advisory committee comprised of experts in the field, and evaluation by client organizations and other stakeholders.

If you would like to provide feedback on the standards, please complete the feedback form in this document.

Glossary - List of standard terms for all services

Care delivery model: A conceptual model that broadly outlines the way services are delivered. It is based on a thorough assessment of client needs, involving a collaborative approach and stakeholder input, which considers the best use of resources and services that are culturally appropriate. The benefits of using a care delivery model include improving access to services, providing safe, quality care, promoting a client-centred continuum of care, providing access to a balanced range of services, supporting a highly skilled and dedicated workforce, and reducing inequities in health status.

Care plan: May also be known as the service plan, plan of care, or treatment plan. It is developed in collaboration with the client and family and provides details on the client history as well as the plan for services including treatments, interventions, client goals, and anticipated outcomes. The care plan provides a complete picture of the client and their care and includes the clinical care path and information that is important to providing client-centred care (e.g., client wishes, ability/desire to partner in their care, the client's family or support network). The care plan is accessible to the team and used when providing care.

Client: The recipient of care. May also be called a patient, consumer, individual, or resident. Depending on the context, client may also include the client's family and/or support network when desired by the client. Where the organization does not provide services directly to individuals, the client refers to the community or population that is served by the organization.

Client representative or client advisor: Client representatives work with the organization and often individual care teams. They may be involved in planning and service design, recruitment and orientation, working with clients directly, and gathering feedback from clients and team members. Integrating the client perspective into the system enables the organization to adopt a client- and family- centred approach.

Co-design: A process that involves the team and the client and family working in collaboration to plan and design services or improve the experience with services. Co-design recognizes that the experience of and input from the client and family is as important as the expertise of the team in understanding and improving a system or process.

Electronic Health Record (EHR): An aggregate, computerized record of a client's health information that is created and gathered cumulatively from all of the client's health care providers. Information from multiple Electronic Medical Records is consolidated into the EHR.

Electronic Medical Record (EMR): A computerized record of a client's health information that is created and managed by care providers in a single organization.

Family: Person or persons who are related in any way (biologically, legally, or emotionally), including immediate relatives and other individuals in the client's support network. Family includes a client's extended family, partners, friends, advocates, guardians, and other individuals. The client defines the makeup of their family, and has the right to include or not include family members in their care, and redefine the makeup of their family over time.

Indicator: A single, standardized measure, expressed in quantitative terms, that captures a key dimension of individual or population health, or health service performance. An indicator may measure available resources, an aspect of a process, or a health or service outcome. Indicators need to have a definition, inclusion and exclusion criteria, and a time period. Indicators are typically expressed as a proportion, which has a numerator and denominator (e.g., percentage of injuries from falls, compliance with standard procedures, team satisfaction). Counts, which do not have a denominator, may also be used (e.g., number of complaints, number of clients harmed as a result of a preventable error, number of policies revised). Tracking indicator data over time identifies successful practices or areas requiring improvement; indicator data is used to inform the development of quality improvement activities. Types of indicators include structure measures, process measures, outcome measures, and balancing measures.

Interoperable: The ability of two or more systems to exchange information and use the information that has been exchanged.

In partnership with the client and family: The team collaborates directly with each individual client and their family to deliver care services. Clients and families are as involved as they wish to be in care delivery.

Medical devices and equipment: An article, instrument, apparatus or machine used for preventing, diagnosing, treating, or alleviating illness or disease; supporting or sustaining life; or disinfecting other medical devices. Examples include blood pressure cuffs, glucose meters, breathalyzers, thermometers, defibrillators, scales, foot care instruments, client lifts, wheelchairs, syringes, and single-use items such as blood glucose test strips.

Medical equipment: A subset of medical devices, considered to be any medical device that requires calibration, maintenance, repair, and user training.

Partner: An organization or person who works with another team or organization to address a specific issue by sharing information and/or resources. Partnership can occur at the organization level, team level, or through individual projects or programs.

Patient safety incident: An event or circumstance that could have resulted, or did result, in unnecessary harm to a client. Types of patient safety incidents are:

- *Harmful incident:* A patient safety incident that resulted in harm to the client. Replaces adverse event and sentinel event.
- *No harm incident*: A patient safety incident that reached a client but no discernible harm resulted.
- *Near miss:* A patient safety incident that did not reach the client.

Policy: An organization’s position on an issue, plan, or course of action.

Population: Also known as community. A specific group of people, often living in a defined geographical area who may share common characteristics such as culture, values, and norms. A population may have some awareness of their identity as a group, and share common needs and a commitment to meeting them.

Procedure: A written series of steps for completing a task, often connected to a policy.

Process: A series of steps for completing a task, which are not necessarily documented.

Scope of practice: The procedures, actions, and processes that are permitted for a specific health care provider. In some professions and regions, scope of practice is defined by laws and/or regulations. In these cases, licensing bodies use the scope of practice to determine the education, experience, and competencies that are required for health care providers to receive a license to practice.

Self-efficacy: A person's estimate or judgment of his or her ability to cope with a given situation, or to succeed in completing tasks by attaining specific or general goals. An example of achieving a specific goal includes quitting smoking, whereas achieving a general goal includes continuing to remain at a prescribed weight level.

Team: The group of the care professionals who work together to meet the complex and varied needs of clients, families and the community. Teams are collaborative**,** with different types of health care professionals working together in service provision. The specific composition of a team depends on the type of service provided.

Team leader: Person(s) responsible for the operational management of a team. Duties include identifying needs, staffing, and reporting to senior management. Team leaders may be formally appointed or take a role naturally within the team.

Timely/regularly: Carried out in consistent time intervals. The organization defines appropriate time intervals for various activities based on best available knowledge and adheres to those schedules.

Transition in care: A set of actions designed to ensure the safe and effective coordination and continuity of care as clients experience a change in health status, care needs, health-care providers or location (within, between, or across settings (as defined by the Registered Nurses' Association of Ontario).

With input from clients and families: Input from clients and families is sought collectively through advisory committees or groups, formal surveys or focus groups, or informal day-to-day feedback. Input can be obtained in a number of ways and at various times and is utilized across the organization.

Service-Specific Glossary

Collaborative Team: The collaborative team for critical care services may include intensivists, critical care specialists, physicians, nurses, pharmacists, respiratory therapists, physiotherapists, occupational therapists, dieticians, social workers, spiritual care providers, infection prevention and control specialists, clerical staff, and cleaning staff.

Credentials: For example, in addition to the professional designation, the Royal College of Physicians and Surgeons offers a sub-specialty certification in Critical Care Medicine, and a number of medical schools offer fellowships in critical care medicine. The Canadian Nurses Association offers certification in Critical Care Nursing for both adult and paediatric care, and a number of colleges offer specialized graduate level certificates in critical care nursing.

Respiratory therapists are prepared with a degree or diploma in respiratory therapy from an accredited program and have successfully completed the National Respiratory Therapy Certification Examination. They are also certified in Basic Cardiac Life Support and have experience with ventilator management.

Evidence-informed guidelines: Examples of evidence-informed guidelines in critical care include those related to withdrawal of life sustaining treatment, ventilator management and weaning, sedation, analgesia management, VTE prophylaxis, gastrointestinal stress ulcer prophylaxis, early enteral nutrition, a haemoglobin/hematocrit-based red blood cell transfusion strategy, low tidal volume ventilation for clients with acute lung injury or Acute Respiratory Distress Syndrome (ARDS), use of specialty mattresses, low dose steroids to treat septic shock and adrenal insufficiency, barrier precautions for central venous catheter insertion, use of ultrasound during central catheter insertion, and continuous aspiration of subglottic secretions.

NDD: Neurological determination of death

OPO: Organ procurement organization

Legend

Dimensions

Population Focus: Work with my community to anticipate and meet our needs

Accessibility: Give me timely and equitable services

Safety: Keep me safe

Worklife: Take care of those who take care of me

Client-centred Services: Partner with me and my family in our care

Continuity of Services: Coordinate my care across the continuum

Appropriateness: Do the right thing to achieve the best results

Efficiency: Make the best use of resources

Criterion Types

! **High Priority** High priority criteria are criteria related to safety, ethics, risk management, and quality improvement. They are identified in the standards.

ROP **Required Organizational Practices** Required Organizational Practices (ROPs) are essential practices that an organization must have in place to enhance client safety and minimize risk.

Tests for Compliance

Minor Minor tests for compliance support safety culture and quality improvement, yet require more time to be implemented.

Major Major tests for compliance have an immediate impact on safety.

✷ **Performance Measures** Performance measures are evidence-based instruments and indicators that are used to measure and evaluate the degree to which an organization has achieved its goals, objectives, and program activities.

INVESTING IN QUALITY SERVICES

1.0 Services are designed collaboratively to meet the needs of clients and the community.

Client-centred Services

!

1.1 Services are co-designed with clients and families, partners, and the community.

Guidelines

Collaboration with clients, partners, and the community in service design is achieved through client advocacy groups, community advisory committees, and client experience surveys. Gaps in services are identified and addressed where possible.

Population Focus

1.2 Information is collected from clients and families, partners, and the community to inform service design.

Guidelines

New information may be solicited from clients and families, partners, and the community, or existing information may be used when it is still relevant. If it is not within the team's mandate to collect information, the team knows how to access and use information that is available. Information can come from internal and external sources such as the Canadian Institute of Health Information (CIHI), census data, end-of-service planning reports, wait list data, and community needs assessments.

The information includes the expressed needs of clients served by the organization as well as trends that could have an impact on the community and its health service needs.

Health service needs are influenced by health status, capacities, risks, and determinants of health (i.e., income, social support networks, education and literacy, employment/working conditions, access to health services, gender, and culture).

Appropriateness

1.3 Service-specific goals and objectives are developed, with input from clients and families.

Guidelines

Clients and families, the team, and community partners are involved in developing team goals and objectives. Goals and objectives are aligned with the organization’s strategic directions and are the foundation for delivering services. Objectives are clear, have measurable outcomes and success factors, and are realistic and time-specific.

Goals and objectives are meaningful to the team. They are reviewed annually or as needed and their achievement is evaluated.

Goals and objectives align with federal and provincial/territorial objectives as required.

Efficiency

1.4 Services are reviewed and monitored for appropriateness, with input from clients and families.

Guidelines

Monitoring and evaluating its services allows the team to examine what services are being offered to and used by clients, and identify areas for improvement. The type of information gathered about services is determined with input from clients and families.

Monitoring the use of services can make internal processes more efficient by identifying service gaps, either within the organization or in the community. Services are assessed to determine whether they are being offered and used as intended, are of appropriate quality, and whether there are opportunities to improve the service design and range of services.

This information is used to improve efficiency by minimizing duplication, evaluating cost-effectiveness of technologies and interventions, and increasing consistency across the organization.

Choosing Wisely Canada (http://www.choosingwiselycanada.org) provides information on services for various areas of service that may be unnecessary or inappropriate.

Continuity of Services

1.5 Partnerships are formed and maintained with other services, programs, providers, and organizations to meet the needs of clients and the community.

Guidelines

Meeting the full range of needs of clients and a community is beyond the capabilities of one team or organization. Partnerships may be created to help clients navigate services across the continuum of care, or to fill service gaps.

Partnerships may be formed with primary care, acute care, community organizations, mental health services, education, housing, or social services. The organization may also partner or establish linkages with federal, provincial, or territorial organizations as well as non-governmental organizations.

Linkages and partnerships vary depending on the range of services provided by the organization and clients’ needs.

Continuity of Services

1.6

The major sources of referral are known and services are coordinated with those units and organizations.

Guidelines

There is a process to work collaboratively with partners to enhance the efficiency and effectiveness of services.

Accessibility

1.7

Information on services is available to clients and families, partner organizations, and the community.

Guidelines

The information addresses, at minimum, the scope of the organization's services; costs to the client, if any; how to access services; contact points; the effectiveness and outcomes of services; other services available to address the client's needs; and any partner organizations.

Clients and families, partner organizations, and the community are engaged to determine what information is required or desired, and to evaluate whether the information provided meets their needs.

Accessibility

1.8

Barriers that may limit clients, families, service providers, and referring organizations from accessing services are identified and removed where possible, with input from clients and families.

Guidelines

There is a process to identify, report, and try to remove barriers to access.

Barriers to access may include the proximity and distribution of services, the physical environment, the cultural acceptability of services, wait times, the types of services available, language barriers, financial barriers, availability of transportation, and access to 24-hour emergency services.

Where barriers are beyond the control of the organization or team, they work with partners and/or the community to minimize them.

2.0 Sufficient resources are available to provide safe, high-quality, and client-centred services.

Appropriateness

2.1 Resource requirements and gaps are identified and communicated to the organization’s leaders.

Guidelines

The resources needed to provide safe, effective, and high quality care are determined by team members and the organization. Resources may be human, financial, structural, informational, or technological.

Identifying resource requirements is a collaborative process between the team and the organization’s leaders. It includes criteria to determine where resources are required, potential risks to the team and clients, gaps in services, service bottlenecks, or barriers to service delivery or access.

The team and the organization’s leaders work together to determine how to effectively use available resources or where additional resources are required.

Appropriateness

2.2 Technology and information systems requirements and gaps are identified and communicated to the organization’s leaders.

Guidelines

Technology includes electronic medical/health records (EMR/EHR), decision tools, client tracking systems, wait list management systems, client self-assessment tools, or access to service-specific registries and/or databases. Depending on the organization, the need for systems could be complex (e.g., advanced software to increase interoperability) or support basic operation (e.g., newer computer systems).

As much as possible, innovative information technology is used to support the work of the service area.

Appropriateness

2.3 The required level of staffing is determined and maintained to provide consistent quality of service at all hours of the day and on all days of the week.

Guidelines

The effectiveness of staffing is evaluated and changes are made as appropriate.

Reduced staffing such as on evenings and weekends may contribute to negative client outcomes.

Appropriateness

2.4 An appropriate mix of skill level and experience within the team is determined, with input from clients and families.

Guidelines

Ensuring an appropriate and optimal mix of skill level and experience supports safe, effective, client-centred service delivery and creates learning opportunities for team members.

Optimal evidence-based ratios of skills and experience are determined. Team members have a broad range of knowledge, skills, and experience working with various client groups.

Client-centred Services

2.5

Space is co-designed with input from clients and families to ensure safety and permit confidential and private interactions with clients and families.

Guidelines

To the extent possible, the physical space is designed to be safe and to respect privacy and confidentiality. Clients and families are involved in planning and designing the layout and use of space to meet their needs. Client dignity; respect, privacy, and confidentiality; accessibility; infection prevention and control; and other needs specific to the clients and community served are considered in space use and design.

When services are provided outside the organization (e.g., in a client’s home or a community partner organization), the team works with the client or partner to maintain safety and privacy.

Appropriateness

2.6

The effectiveness of resources, space, and staffing is evaluated with input from clients and families, the team, and stakeholders.

Guidelines

Evaluating resources, space, and staffing helps determine the extent to which effective services are being provided and identifies opportunities for improvements. Input from clients and families, the team, and stakeholders is gathered through surveys, focus groups, advisory committees, and informal feedback.

Appropriateness

2.7

Team members and clients have access to information about community services, including palliative and end-of-life care.

Guidelines

Written and verbal information is provided as needed, and may include information about rehabilitation, community mental health, and primary care, depending on the population served and the resources available. The level of understanding, literacy, language, disability, and culture of the client population are considered when developing and providing information.

Information on palliative and end-of-life care includes information for clients and families as well as resources for the team.

Accessibility

2.8 A universally-accessible environment is created with input from clients and families.

Guidelines

The service environment is kept clean and clutter-free to support physical accessibility for those who use mobility aids such as wheelchairs, crutches, or walkers. The environment is also accessible for those with language, communication, or other requirements, such as those who have auditory, visual, cognitive, or other impairments.

Where team members work outside the organization (e.g., delivering care in the community, home care) they work with partners, clients, and families to support accessibility.

BUILDING A PREPARED AND COMPETENT TEAM

3.0 **Team members are qualified and have relevant competencies.**

Appropriateness !

3.1 Required credentials, training, and education are defined for all team members with input from clients and families.

Guidelines

Credentials are defined for all team members, including unregulated staff.

Required credentials, training, and education varies by role. They may be defined by a professional regulating body, may be formal or informal, and may include lived experience or work experience.

Appropriateness !

3.2 Credentials, qualifications, and competencies are verified, documented, and up-to-date.

Guidelines

Requirements vary for different roles in the organization, including for regulated or unregulated team members.

Designations, credentials, competency assessments, and training are monitored and maintained to ensure safe and effective delivery of services. Professional requirements are kept up-to-date in accordance with provincial and organizational policies.

Services are delivered within accepted scopes of practice. Team members have the appropriate training and capacities to provide client-centred care and use equipment, devices, and supplies safely.

Appropriateness

3.3 A comprehensive orientation is provided to new team members and client and family representatives.

Guidelines

The orientation program covers, at minimum, the organization’s mission, vision, and values; the team’s mandate, goals, and objectives; the philosophy of client-centred care and how to apply its principles to practice; roles, responsibilities, and performance expectations; policies and procedures, including confidentiality; worklife balance initiatives; and the organization’s approach to integrated quality management (e.g., quality improvement, risk management, utilization management, efficient use of resources).

Orientation processes and activities are documented.

Client-centred Services

3.4 Education and training are provided to team members on how to work respectfully and effectively with clients and families with diverse cultural backgrounds, religious beliefs, and care needs.

Guidelines

Cultural education and training build the skills, knowledge, and attitudes that are required to safely and appropriately deliver interventions and services to culturally diverse populations. The training may cover topics such as disability, level of understanding, or mental health.

Cultural education and experience are part of the recruitment (including position advertisements) and selection processes.

Client-centred Services

3.5 Education and training are provided on the organization’s care delivery model.

Guidelines

The education and training program covers the philosophy of client- and family-centred care adopted by the organization, the expected behaviours associated with a client-centred approach, how to apply the principles to problem solve or address issues in the organization, clients’ rights, the ways in which clients are involved in planning and delivering services in the organization, and the quality improvement initiatives that are being undertaken.

Appropriateness

3.6 Education and training are provided on the organization’s ethical decision-making framework.

Guidelines

Training and support to handle ethical issues is provided to team members. Ethics-related issues include conflicts of interest, conflicting perspectives between clients and family and/or team members, a client’s decision to withdraw care or to live at risk, and varying beliefs or practices.

Safety !

3.7 Education and training are provided on the safe use of equipment, devices, and supplies used in service delivery.

Guidelines

Information about the safe use of equipment is provided to all team members. They are trained on how to use existing and new equipment, devices, and supplies. Retraining may be requested or required if a team member does not feel prepared to use the equipment, device, or supplies, or has not used the equipment or device for a long time.

Training includes handling, storage, operation, and cleaning; preventive maintenance; and what to do in case of breakdown.

Safety ROP

3.8 REQUIRED ORGANIZATIONAL PRACTICE: A documented and coordinated approach for infusion pump safety that includes training, evaluation of competence, and a process to report problems with infusion pump use is implemented.

Guidelines

Infusion pumps, used to deliver fluids into a client's body in a controlled manner, are used extensively in health care, including in the home environment, and are associated with significant safety issues and harm to clients.

This ROP focuses on parenteral delivery (i.e., routes other than the digestive tract or topical application) of fluids, medications, blood and blood products, and nutrients. It includes stationary and mobile intravenous infusion pumps, patient-controlled analgesia, epidural pumps, insulin pumps, and large-volume pumps. It excludes gastric feeding pumps.

Team members need training and education to maintain their competence in using infusion pumps safely, given the variety of pump types and manufacturers, the movement of team members between services, and the use of temporary staff. Safety is best achieved when organizations have a comprehensive approach that combines training and evaluation with the appropriate selection, procurement, and standardization of infusion pumps across an organization (see Accreditation Canada standards for medication management).

When evaluations reveal problems with infusion pump design, organizations can work with manufacturers to make improvements. Organizations are encouraged to report problems externally (e.g., to Health Canada or Global Patient Safety Alerts) so that other organizations can implement safety improvements.

Test(s) for Compliance

Major	3.8.1	Instructions and user guides for each type of infusion pump are easily accessible at all times.

Major	3.8.2	Initial and re-training on the safe use of infusion pumps is provided to team members: • Who are new to the organization or temporary staff new to the service area • Who are returning after an extended leave • When a new type of infusion pump is introduced or when existing infusion pumps are upgraded • When evaluation of competence indicates that re-training is needed When infusion pumps are used very infrequently, just-in-time training is provided.
Major	3.8.3	When clients are provided with client-operated infusion pumps (e.g., patient-controlled analgesia, insulin pumps), training is provided, and documented, to clients and families on how to use them safely.
Major	3.8.4	The competence of team members to use infusion pumps safely is evaluated and documented at least every two years. When infusion pumps are used very infrequently, a just-in-time evaluation of competence is performed.
Minor	3.8.5	The effectiveness of the approach is evaluated. Evaluation mechanisms may include: • Investigating patient safety incidents related to infusion pump use • Reviewing data from smart pumps • Monitoring evaluations of competence • Seeking feedback from clients, families, and team members.
Minor	3.8.6	When evaluations of infusion pump safety indicate improvements are needed, training is improved or adjustments are made to infusion pumps.
Appropriateness	3.9	Education and training are provided on information systems and other technology used in service delivery.

Guidelines

Education and training may cover topics such as knowledge of computer applications, word processing, software, time management tools, communication tools, research applications, cell phone use, and protecting the privacy of client information.

Continuity of Services

! 3.10 Education and training are provided on how to identify palliative and end-of-life care needs.

Guidelines

Training includes information on the organization’s process to provide or facilitate access to palliative care and end-of-life services, communicating with families about end-of-life issues, and how and when to initiate discussions about palliative and end-of-life care.

Federal, provincial, and territorial legislation and regulations regarding consent and substitute decision making are followed.

Worklife

! 3.11 Team member performance is regularly evaluated and documented in an objective, interactive, and constructive way.

Guidelines

An established process to evaluate each team member’s performance is followed. Client and/or peer input is part of the evaluation process.

The evaluation may consider the team member’s ability to carry out responsibilities, apply the principles of client-centred care, and contribute to the values of the organization. It may also consider the individual’s strengths; opportunities for growth; contributions toward patient safety, worklife, and respecting client wishes; or specific competencies described in the position profile. The evaluation may identify issues that require follow up such as unprofessional or disruptive behaviour or challenges adopting client-centred care practices.

A performance evaluation is usually done before the probationary period is completed and annually thereafter, or as defined by the organization. An evaluation may also be completed after retraining or when new technology, equipment, or skills are introduced.

Client-centred Services

3.12 Client and family representatives are regularly engaged to provide input and feedback on their roles and responsibilities, role design, processes, and role satisfaction, where applicable.

Guidelines

Regular communication between team members/leaders and client and family representatives ensures that the relationship is mutually beneficial. Discussions include opportunities for increased collaboration and role satisfaction.

Though an open and transparent dialogue is encouraged, team leaders recognize that client and family representatives are to remain independent from the organization, to ensure their opinions and recommendations remain unbiased.

Worklife

!

3.13 Team members are supported by team leaders to follow up on issues and opportunities for growth identified through performance evaluations.

Guidelines

Issues may be identified by the team member or the team leaders and are used to develop an action plan or professional development plan.

Worklife

3.14 Ongoing professional development, education, and training opportunities are available to each team member.

Guidelines

Team leaders encourage team members to participate in opportunities for professional or skills development on a regular basis. Additional training or education may be given based on the team member's performance evaluation or as identified through professional development plans.

4.0 Services are provided within a collaborative team environment.

Appropriateness !

4.1 A collaborative approach is used to deliver services.

Guidelines

An interdisciplinary collaborative team needs to evolve and adapt to the changing needs of the client. Depending on the needs and desires of the client and family, the team may consist of specialized roles (e.g., care providers) and support roles (e.g., care planners, translators, security staff, or representatives from community partner organizations). Students, volunteers, and client representatives or advisors may also be included as part of the team.

A team leader (or leaders) is defined and the role of each team member is made clear to the client and family.

The collaborative team is established based on defined criteria such as accepted standards of practice; legal requirements; knowledge, experience, and other qualifications; volume or complexity of caseload; changes in workload; and client safety and needs.

Appropriateness

4.2

If outreach services in the form of a rapid response or a medical emergency team are offered, the role of this team is defined and communicated to other teams in the organization.

Guidelines

The outreach team may be responsible for assessing and stabilizing clients, educating and supporting staff, and following up with clients discharged from the ICU.

Appropriateness

4.3

There is a process to communicate with admitting and referring team members and family physicians about their respective roles in the client's care when the client is admitted to an intensive care unit (ICU).

Guidelines

Family physicians and admitting or referring providers are generally not directly involved in care provided in closed ICUs but may have a role in open ICUs.

Appropriateness

4.4

An intensivist or critical care specialist is available daily to consult with admitting physicians in open ICUs.

Guidelines

In open ICUs, the admitting physician is ultimately responsible for the care of the client. Access to physicians with a specialization in critical care may lead to improved client outcomes.

Appropriateness

4.5

The team works in collaboration with clients and families.

Guidelines

Clients and families are engaged in shared decision making and understand how care is provided. The client defines the makeup of their family, and has the right to include or not include family members of their choice in their care, and the right to redefine the makeup of their family over time. Family includes an individual's extended family, their partners, friends, advocates, guardians, and other representatives.

Worklife

4.6 Position profiles with defined roles, responsibilities, and scope of employment or practice exist for all positions.

Guidelines

Position profiles include a position summary, qualifications and minimum requirements, the nature and scope of the work, and reporting relationships. They are developed for all team members including those who are not directly employed by the organization (e.g., contracted team members, partners, client and family representatives).

Role clarity is essential in promoting client and team safety as well as a positive work environment. Understanding roles and responsibilities and being able to work to one’s full scope of practice helps create meaning and purpose for team members.

Safety !

4.7 Standardized communication tools are used to share information about a client’s care within and between teams.

Guidelines

Standardized communication increases consistency, minimizes duplication, and improves teamwork while promoting patient safety. Tools may include protocols, technologies, or standardized processes such as SBAR (Situation Background Assessment Recommendation).

Team members are trained on organizational policies and practices regarding standardized communication tools.

Appropriateness

4.8 The effectiveness of team collaboration and functioning is evaluated and opportunities for improvement are identified.

Guidelines

The process to evaluate team functioning and collaboration may include a review of its services, processes, and outcomes. This could be done by administering a team functioning questionnaire to team members, clients and families, and partners to stimulate discussion about areas for improvement.

The team evaluates its functioning when there has been a significant change to the structure of the team.

5.0 Well-being and worklife balance is promoted within the team.

Worklife

5.1 The workload of each team member is assigned and reviewed in a way that ensures client and team safety and well-being.

Guidelines

Appropriate criteria are used for determining workload depending on the environment and the unique demands of different services areas, including hours of work, caseload, role complexity, complexity of client care, physical or emotional demands, repetitive nature of tasks, and level of responsibility. The preferences and availability of each team members are also considered.

In some cases teams may designate a maximum workload for team members. The process of assigning and reviewing workload includes monitoring and tracking hours and clients and when additional measures are needed (e.g., staffing transfers or team re-design).

An environment where team members are comfortable discussing demands and stress levels in the workplace is promoted by the organization and leaders. Measures are taken to alleviate these pressures as much as possible. These can include scheduling strategies, workload sharing, and scheduled time for documentation.

Worklife

5.2 Work and job design, roles and responsibilities, and assignments are determined with input from team members, and from clients and families where appropriate.

Guidelines

Job design refers to how a group of tasks, or an entire job, is organized. Job design addresses all factors that affect the work, including job rotation, work breaks, and working hours. Client and family input and feedback is considered in job design.

Worklife

5.3 Team members are recognized for their contributions.

Guidelines

Recognition activities may be individual, such as awards for years of service or special achievements, or they may involve team recognition or activities.

Recognition can be formal or informal and may be verbal, written, or focus on promoting an atmosphere where team members feel appreciated for their contributions.

Worklife

5.4 There is a policy that guides team members to bring forward complaints, concerns, and grievances.

Safety

!

5.5 Education and training on occupational health and safety regulations and organizational policies on workplace safety are provided to team members.

Safety !

5.6 Education and training are provided on how to identify, reduce, and manage risks to client and team safety.

Guidelines

Training may include physical hazards; challenges with equipment; handling spills, waste, or infectious materials; working with clients who may pose a risk to themselves or others; and challenges with handling, storing, or dispensing medications.

Common risks to the team may include lack of training on safety issues, performing improper lifts, improper use of equipment, or working alone.

Safety !

5.7 Education and training are provided to team members on how to prevent and manage workplace violence, including abuse, aggression, threats, and assaults.

Guidelines

Acts of violence include abuse, aggression, threats, and assaults. They may be committed by clients, their families, teams, or anyone else in the workplace.

Where possible, team members use de-escalation techniques as a preventive measure. De-escalation techniques are minimally intrusive and the least restrictive way to manage violence. Some training programs on how to safely work with clients who are at risk of or who exhibit aggressive or responsive behaviors include:
- CPI Training (Crisis Prevention and Intervention)
- GPA (Gentle Persuasive Approach)
- U-First!

Training and education include the use of a standardized risk assessment tool such as the Hamilton Anatomy of Risk Management (HARM) tool. Training may address:
- Identifying triggers
- Assessing and communicating a client’s potential for violence and recognizing signs of agitation and aggression
- Reducing harassment
- Responding to and managing violence (e.g., non-violent crisis intervention, emergency code response guidelines, conflict resolution and mediation, and self-defense)
- The trauma-informed approach
- Communication techniques

Training may also specify the team’s alternate procedure for when de-escalation techniques are unsuccessful.

Safety ! 5.8 The organization’s policy on reporting workplace violence is followed by team members.

Guidelines

Perceived, potential, or actual incidents of physical or verbal violence are reported to the appropriate authorities in accordance with applicable legislation, and may be reported in the client medical record depending on the nature of the incident.

PROVIDING SAFE AND EFFECTIVE SERVICES

6.0 Access to services for current and potential clients, families, teams, and referring organizations is provided in a timely and coordinated manner.

Appropriateness

6.1 Standardized criteria are used to determine whether potential clients require critical care services.

Guidelines

The criteria include the client's risk of imminent death or significant physical deterioration and the likelihood the client will benefit from critical care services. Applying these criteria helps determine if the team's services fit the potential client's needs and preferences regarding life sustaining treatment, identify the client's immediate and urgent needs, and determine priorities of service. The process is adjusted for clients and families with diverse needs, e.g. language, culture, level of education, lifestyles, competency.

The views of all service providers, including physicians, nurses, and respiratory therapists are considered.

For organizations with many sites, the process is standardized across all critical care teams.

Appropriateness

6.2 When offering outreach services, such as a rapid response or medical emergency team, other organizational teams are provided with the standardized criteria to determine whether critical care services are required.

Guidelines

Having access to the standardized criteria may help other teams determine when to request critical care services for clients who are outside the designated critical care service area.

Accessibility

6.3 When the team is unable to meet the needs of a potential client, access to other services is facilitated.

Guidelines

In the case where the organization is unable to meet the client's needs, the rationale is explained and access to other services is facilitated. The information is documented for use in service planning.

Accessibility

6.4 Clients and families are made aware of the team member who is responsible for coordinating their service, and how to reach that person.

Guidelines

The assigned team member may be the collaborative team member with the most consistent contact with the client, or the primary provider responsible for care.

7.0 Clients and families are partners in service delivery.

Client-centred Services

7.1 There is an open, transparent, and respectful relationship with each client.

Guidelines

The team supports a respectful and transparent relationship with clients by introducing themselves and explaining their role; asking permission before performing tasks; explaining what they are doing; using a respectful tone; expressing concern or reassurance; providing an opportunity for questions, input, and feedback; respecting cultural and religious beliefs or lifestyle; and respecting confidentiality and privacy.

Client-centred Services

7.2 Clients and families are encouraged to be actively engaged in their care.

Guidelines

The environment encourages clients and families to be active participants in their care, ask questions, and provide input at all stages of the care process.

Client-centred Services

7.3 The capacity of each client to be involved in their care is determined in partnership with the client and family.

Guidelines

Each client will have differing levels of ability to be involved in their own care. At each stage, the appropriate team member works with the client, family, or substitute decision maker to determine how much and what type of information the client or family requires to be meaningfully involved in their care. This information is documented in the client record.

Client-centred Services

7.4 The client’s wishes regarding family involvement in their care are respected and followed.

Guidelines

The team finds ways to include members of the client’s support network in the client’s care.

Applicable legislation when a substitute decision maker or family is involved in decision-making is respected. There is a process to resolve conflicts regarding level of desired involvement between the client and family.

Client-centred Services

7.5 Complete and accurate information is shared with the client and family in a timely way, in accordance with the client’s desire to be involved.

Guidelines

Sharing detailed and complete information is critical for informed choice and shared decision making between clients, families, and the team. Information is delivered according to individual needs and interests, as well as levels of understanding.

Clients and families are made aware of the risks and benefits of care; the client's roles and responsibilities in service delivery; the benefits, limitations, and possible outcomes of proposed services or interventions; how to prepare for tests and treatments; the availability of counselling and support groups; and how to reach team members in an emergency or crisis.

Varying levels of information may be required at different points in the client's care and are accommodated wherever possible. Similarly, different messages will require different delivery methods (e.g., serious topics require a more structured approach).

Client-centred Services

7.6 The team verifies that the client and family understand information provided about their care.

Guidelines

The level of understanding, literacy, language, disability, and culture are considered when providing information to clients and families.

Processes to verify clients' understanding include encouraging and allotting time for questions, having the client repeat back information, ensuring a linguistic or cultural match wherever possible, using visuals or videos where possible, and creating an ongoing exchange where confirming understanding is a recurring event.

The Always Use Teach-back! Website (www.teachbacktraining.org/) provides useful tools to learn how to confirm client understanding of information.

Client-centred Services

7.7 Translation and interpretation services are available for clients and families as needed.

Guidelines

Written materials are available in the languages commonly spoken in the community, as required. Interpretation services are available when required by clients or families, wherever possible.

Client-centred Services

7.8 The client's capacity to provide informed consent is determined.

Guidelines

The process of evaluating a client’s capacity to consent is carried out on an ongoing basis. With respect to decision making for consent purposes, “capacity” means the ability to understand the information relevant to the decision, appreciate foreseeable consequences of a decision or failure to make a decision, and weigh the risks and benefits of that decision.

Federal, provincial, and territorial legislation are followed when working with children and youth. When dealing with the elderly, minors, or those deemed incapable of consenting, clients are involved to the greatest extent possible in making decisions about their services, and the team values their questions and input.

Client-centred Services

! 7.9 The client’s informed consent is obtained and documented before providing services.

Guidelines

Informed consent consists of reviewing service information with the client, family, or substitute decision maker; informing the client about available options and providing time for reflection and questions before asking for consent; respecting the client’s rights, culture, and values including the right to refuse consent at any time; and recording the client’s decision in the client record. The consent process is ongoing.

Implied consent occurs when providing services where written consent is not needed, such as when clients arrive for an appointment or class, have blood pressure taken, present their arm to have blood drawn, arrive for service through Emergency Medical Services (EMS), or present with life-threatening or emergent condition(s) and require immediate resuscitation.

Appropriateness ! 7.10 When clients are incapable of giving informed consent, consent is obtained from a substitute decision maker.

Guidelines

A substitute decision maker is consulted when clients are unable to make their own decisions, and an advance directive is used, where available, to ensure decisions are in line with the client’s wishes. In these cases, the substitute decision maker is provided with information about the roles and responsibilities involved in being a substitute decision maker, and given the opportunity to discuss questions, concerns, and options. Selecting the appropriate substitute decision maker is done in consideration of the applicable legislation and may be an advocate, family member, legal guardian, or caregiver.

If consent is given by a substitute decision maker, his or her name, relationship with the client, and the decision made is documented in the client record.

When working with children and youth, informed consent is received and documented from the child, youth, family or legal guardian before providing services. The consent process includes involving them as much as possible in the decisions about their service, intervention, or treatment, and valuing their questions and input.

Appropriateness

7.11

Clients and families are provided with opportunities to be engaged in research activities that may be appropriate to their care.

Guidelines

There is an ethical review process to determine when to involve a client in a research activity. Research activities may include clinical trials, assessments of new protocols, or changes to existing protocols. Clients and families are included in participatory research project design and implementation where appropriate, (e.g., gathering qualitative data for quality improvement initiatives).

Appropriateness

!

7.12

Ethics-related issues are proactively identified, managed, and addressed.

Guidelines

Ethics-related issues are ones in which values may be in conflict, making it hard to reach a decision. The issues may be very serious, life-and-death matters, or related to day-to-day activities. Examples include conflicts of interest; respecting a client’s choice to live at risk; triaging community members during an emergency; requests to withdraw or end services, including life-sustaining supports or treatments; and end-of-life care.

The organization’s ethics framework is used to manage and address ethic-related issues. They may be addressed by an ethics committee or consultation team that may include health service professionals, clergy, or ethicists. In addition to clinical consultation, the ethics committee may be involved in policy review and ethics education.

Ethics-related issues involving particular clients are documented in the client record.

Client-centred Services

!

7.13 Clients and families are provided with information about their rights and responsibilities.

Guidelines

Client and family rights include the right to have privacy and confidentiality protected; be aware of how client information is used; have access to their record and information about them; be treated with respect and care; maintain cultural practices; pursue spiritual beliefs; live at risk; and be free from abuse, exploitation, and discrimination.

Client and family rights regarding service delivery include the right to refuse service or refuse to have certain people involved in their service; participate in all aspects of their service and make personal choices; have a support person or advocate involved in their service; appeal a care plan decision or file a complaint; take part in or refuse to take part in research or clinical trials; receive safe, competent service; and raise concerns about the quality of service.

Client and family responsibilities include treating others with respect, providing accurate information, reporting safety risks, and observing rules and regulations.

The information is provided at intake or admission and is adapted to meet diverse needs such as language, culture, level of education, lifestyles, and physical or mental disability. When the information cannot be provided to the client and family on intake, it is provided at the earliest opportunity.

Client-centred Services

!

7.14 Clients and families are provided with information about how to file a complaint or report violations of their rights.

Client-centred Services

!

7.15 A process to investigate and respond to claims that clients' rights have been violated is developed and implemented with input from clients and families.

Guidelines

An environment where clients, families, and team members feel comfortable raising concerns or issues is promoted. The organization may provide access to a neutral, objective person from whom clients and families can seek advice or consultation. Where electronic health records are used, there is a process to receive and respond to client complaints and questions regarding the privacy of the electronic record.

Claims brought forward by team members or other teams are also addressed.

8.0 **Care plans are developed in partnership with the client and family based on a comprehensive assessment.**

Appropriateness !

8.1 Each client’s physical and psychosocial health is assessed and documented using a holistic approach, in partnership with the client and family.

Guidelines

Elements of physical health include:
- Medical history
- Allergies
- Medication profile
- Health status
- Nutritional status
- Palliative care needs
- Dietary needs

Elements of psychosocial health include:
- Functional and emotional status family and caregiver involvement
- Communication and self-care abilities and strengths
- Mental health status, including personality and behavioural characteristics
- Cognitive status
- Socio-economic status
- Cultural and spiritual beliefs and needs.

Client-centred Services

8.2 The assessment process is designed with input from clients and families.

Guidelines

The assessment process is as streamlined and straightforward as possible, so that clients are not required to repeat information to multiple providers or team members. Where applicable, an interdisciplinary or collaborative assessment may be completed with the client, family, and appropriate team members.

Client-centred Services

8.3 Goals and expected results of the client's care and services are identified in partnership with the client and family.

Guidelines

The client's physical and psychosocial needs, choices, and preferences as identified in the client assessment are used to develop service goals. Service goals and expected results suit the client's individual circumstances, are achievable, measurable, and complement those developed by other team members and organizations with which the client is involved.

Appropriateness

8.4 During the assessment, there is a process to determine whether the client has an advance directive and this is recorded in the client record in partnership with the client and family.

Guidelines

The advance directive includes the client's preference with respect to resuscitation. Advance directives are recorded in the client record and this information is shared with team members within and outside the organization, as appropriate.

A substitute decision maker may be consulted when clients are unable to make their own decisions. In these cases, the substitute decision maker is provided information on the roles and responsibilities involved in being a substitute decision maker, and discusses questions, concerns, and options. A substitute decision maker may be specified in legislation or may be an advocate, family member, legal guardian, or caregiver.

Client-centred Services

8.5 Standardized assessment tools are used during the assessment process.

Guidelines

Tools are standardized and adopted across the team, and where applicable, across the organization. Assessment tools are designed to assist the team to systematically collect and interpret all of the information gathered during the assessment process. Benefits of using standardized tools for the client and the care provider include being more efficient, collecting more accurate information, consistency of assessment, and reliability of results and improved opportunity for communication between the client and the care provider.

The standardized assessment tools used will vary depending on the needs of the client and the type and range of services provided. Examples of standardized assessment tools are the Glasgow Coma Scale, the Clinical Frailty Scale, the Beck Depression Inventory, or the InterRAI tool. The standardized assessment tools used are evidence-informed and meaningful for the services provided.

Safety

ROP

8.6 REQUIRED ORGANIZATIONAL PRACTICE: A Best Possible Medication History (BPMH) is generated in partnership with clients, families, or caregivers (as appropriate) and used to reconcile client medications at care transitions.

Guidelines

Research suggests that more than 50 percent of clients have at least one discrepancy between the medications they take at home with those ordered upon admission to the hospital. Many of these have the potential to cause adverse drug events.

Medication reconciliation is a structured process to communicate accurate and complete information about client medications at care transitions. Conducting medication reconciliation reduces the possibility that medications will be omitted, duplicated, or ordered incorrectly at transitions of care. Medication reconciliation can be a cost-effective way to reduce medication errors and the re-work that can be associated with managing client medications. Safer Healthcare Now! offers a “Getting Started Toolkit” for medication reconciliation in the acute care setting.

Medication reconciliation begins with generating a Best Possible Medication History (BPMH) for each client. The BPMH is a complete list of the client’s current medications, including prescription, non-prescription, traditional, holistic, herbal, vitamins, and supplements. For each medication, the name, dose, frequency, and route of administration is listed. Creating the BPMH involves interviewing the client, family, or caregivers (as appropriate), and consulting at least one other source of information such as the client’s previous health record, the community pharmacist, or a provincial database. Once it has been generated, the BPMH follows the client through their health care journey and is an important reference tool for reconciling medications at each transition of care.

When a client has been receiving care in a service environment for an extended period of time and is being transferred to another health care organization or service, the current medication list may be used as a BPMH. The ‘extended period of time’ must be specified in organizational policy. The Safer Healthcare Now! Medication Reconciliation Community of Practice provides a number of BPMH tools and forms.

Medication reconciliation at admission can be achieved using one of two models. In the proactive model, the BPMH is used to generate admission medication orders. In the retroactive model, the BPMH is generated after admission medication orders have been written and a timely comparison of the BPMH and admission medication orders is made. Regardless of the model used, it is important to identify, resolve, and document medication discrepancies.

This process needs to be repeated at any transition of care when medication discrepancies can be introduced. For example, when medications are changed or re-ordered as part of a transfer involving a change in the service environment (e.g. from critical care to a medicine unit, or from one facility to another within an organization). Medication reconciliation is not required for bed relocation. Similar to admission, the goal of medication reconciliation at internal transfer is to compare the medications the client was receiving on the transferring/sending unit with those that were being taken at home to determine if any medications need to be continued, restarted, discontinued, or modified.

At all times a current medication list (often called a medication administration record or MAR) is retained in the client record. When discrepancies are resolved, the current medications list is reconciled and updated in the client record.

End of service is a critical transition of care that puts clients at risk of potential adverse drug events. End of service includes discharge home, and external transfer to another service environment or community-based service provider. Examples include a move from acute care to long-term care or hospice, from rehabilitation to home care, or from acute care to home/self-care. The goal of medication reconciliation at end of service is to reconcile the medications the client was taking prior to admission with those initiated in hospital and with those that should be taken at end of service.

The result of medication reconciliation at end of service is a complete list of medications the client should be taking, including information about medications that need to be stopped. A systematic process needs to be followed to ensure this information is documented and shared with the client, family, and subsequent care providers (e.g., primary care provider, community pharmacy, long-term care provider, home care provider, as appropriate). Ideally, information about client medications is part of a Best Possible Medication Discharge Plan (BPMDP) that also includes a medication information transfer letter to the next care provider, a structured discharge prescription to the next care provider or community pharmacist, and clear information for the client about the medications the client should be taking (in plain language that the client can understand).

Test(s) for Compliance

Major	8.6.1	Upon or prior to admission, a Best Possible Medication History (BPMH) is generated and documented, in partnership with clients, families, caregivers, and others, as appropriate.
Major	8.6.2	The BPMH is used to generate admission medication orders OR the BPMH is compared with current medication orders and any medication discrepancies are identified, resolved, and documented.
Major	8.6.3	A current medication list is retained in the client record.
Major	8.6.4	The prescriber uses the Best Possible Medication History (BPMH) and the current medication orders to generate transfer or discharge medication orders.
Major	8.6.5	The client, community-based health care provider, and community pharmacy (as appropriate) are provided with a complete list of medications the client should be taking following discharge.

Safety

ROP

8.7 REQUIRED ORGANIZATIONAL PRACTICE: To minimize injury from falls, a documented and coordinated approach for falls prevention is implemented and evaluated.

Guidelines

In Canada, Safer Healthcare Now! has identified falls prevention as a safety priority. Reducing injuries from falls can increase quality of life for clients and reduce costs.

Falls prevention programs may include team training, risk assessments, balance and strength training, vision care, medication reviews, physical environment reviews, behavioural assessments, and bed exit alarms.

Measures to evaluate the falls prevention approach may include tracking the percentage of clients receiving a risk assessment, falls rates, causes of injury, and balancing measures such as restraint use. Post-fall debriefings may also help identify safety gaps and to prevent the recurrence of falls.

Test(s) for Compliance

Major	8.7.1	A documented and coordinated approach to falls prevention is implemented.
Major	8.7.2	The approach identifies the populations at risk for falls.
Major	8.7.3	The approach addresses the specific needs of the populations at risk for falls.
Minor	8.7.4	The effectiveness of the approach is evaluated regularly.
Minor	8.7.5	Results from the evaluation are used to make improvements to the approach when needed.

Safety ROP 8.8 REQUIRED ORGANIZATIONAL PRACTICE: Each client’s risk for developing a pressure ulcer is assessed and interventions to prevent pressure ulcers are implemented.

Guidelines

Pressure ulcers have a significant impact on client quality of life, resulting in pain, slower recovery, and increased risk of infection. Pressure ulcers are also associated with increased length of stay, cost, and mortality. Effective pressure ulcer prevention strategies can reduce the incidence of pressure ulcers and are an indication of higher quality care and services.

Pressure ulcer prevention strategies require an inter-disciplinary approach and support from all levels of an organization. It is useful to develop a plan to support comprehensive education on pressure ulcer prevention, and to designate individuals to facilitate the implementation of a standardized approach to risk assessments, the uptake of best practice guidelines, and the coordination of health care teams.

Effective pressure ulcer prevention starts with a validated risk assessment scale, such as:
- The Braden Scale for Predicting Pressure Sore Risk
- The Norton Pressure Sore Risk Assessment Scale
- interRAI Pressure Ulcer Risk Scale (long-term care)
- The Waterlow Score
- The Gosnell Scale
- The Knoll Scale
- SCIPUS (Spinal Cord Injury Pressure Ulcer Scale)

A number of best practice guidelines are also available to inform the development of pressure ulcer prevention and treatment strategies, including risk assessments, reassessments, interventions, education, and evaluation. In Canada, comprehensive guidelines have been developed by the Registered Nurses Association of Ontario. International guidelines have been developed in collaboration between the European Pressure Ulcer Advisory Panel and the American National Pressure Ulcer Advisory Panel.

Test(s) for Compliance

Major	8.8.1	An initial pressure ulcer risk assessment is conducted for clients upon admission, using a validated, standardized risk assessment tool.

		Major	8.8.2	The risk of developing pressure ulcers is assessed for each client at regular intervals and when there is a significant change in the client's status.
		Major	8.8.3	Documented protocols and procedures based on best practice guidelines are implemented to prevent the development of pressure ulcers. These may include interventions to prevent skin breakdown; minimize pressure, shear, and friction; reposition; manage moisture; optimize nutrition and hydration; and enhance mobility and activity.
		Minor	8.8.4	Team members, clients, families, and caregivers are provided with education about the risk factors and protocols and procedures to prevent pressure ulcers.
		Minor	8.8.5	The effectiveness of pressure ulcer prevention is evaluated, and results are used to make improvements when needed.
Safety	ROP	8.9		REQUIRED ORGANIZATIONAL PRACTICE: Medical and surgical clients at risk of venous thromboembolism (deep vein thrombosis and pulmonary embolism) are identified and provided with appropriate thromboprophylaxis. NOTE: This ROP is not a requirement for pediatric hospitals. The ROP applies to clients 18 years of age or older.

Guidelines

Venous thromboembolism (VTE) is the collective term for deep vein thrombosis (DVT) and pulmonary embolism (PE).

VTE is a serious and common complication for those in hospital or undergoing surgery. The incidence of VTE can be reduced or prevented by identifying clients at risk and providing appropriate, evidence-informed thromboprophylaxis. The American College of Chest Physicians Evidence-Based Clinical Practice Guidelines are a helpful resource for the prevention of VTE.

The widespread human and financial impact of thromboembolism is well documented. VTE is associated with increased client mortality; it is the most common preventable cause of hospital death. Appropriate evidence-informed thromboprophylaxis reduces cost and median length of stay.

Test(s) for Compliance

Major	8.9.1	There is a written venous thromboembolism (VTE) prophylaxis policy or guideline.
Major	8.9.2	Clients at risk for VTE are identified and provided with appropriate, evidence-informed VTE prophylaxis.
Minor	8.9.3	Measures for appropriate VTE prophylaxis are established, the implementation of appropriate VTE prophylaxis is audited, and this information is used to make improvements to services.
Major	8.9.4	Major orthopedic surgery clients (i.e., those having hip and knee replacements or hip fracture surgery) who require post-discharge prophylaxis are identified and there is a process to provide them with appropriate post-discharge prophylaxis.

Minor 8.9.5 Information is provided to clients and team members about the risks of VTE and how to prevent it.

Appropriateness

8.10 Each client’s preferences and options for services are discussed as part of the assessment, in partnership with the client and family.

Guidelines

The client’s expressed needs, preferences and the options for care and service are discussed with the client and family. The team and client engage in shared-decision making that considers client preferences, expected outcomes, and risks and benefits of the options.

For example, various strategies to manage pain—such as analgesics including opioids and adjuvants, as well as physical, behavioural, and psychological interventions—may be discussed and the client is able to select the preferred option.

Other preferences that are discussed include options for self-care, privacy, visitors, treatments and testing, and personal care, such as sleeping, bathing, and eating.

Client-centred Services

8.11 An assessment of the client’s palliative and end-of-life care needs is completed, where appropriate, in partnership with the client and family.

Guidelines

The need for a palliative care assessment may be expressed by the client or family or identified by the team. The types of services that may be required are identified. Early identification of palliative care needs allows clients and families to be involved in care planning and can improve the quality of care and family satisfaction throughout the process.

In an organization or service area that does not provide palliative and end-of-life care, the assessment identifies the need to connect the client and family to the appropriate services.

Accessibility

8.12 There is access 24 hours a day, seven days a week, to supporting services such as laboratory testing and diagnostic imaging, including point-of-care testing.

Guidelines

Timely access to services such as laboratory testing and diagnostic imaging is essential if the critical care team is to provide high quality and effective care. Point-of-care testing may include laboratory tests, such as blood collection, or diagnostic imaging, such as ultrasound or endoscopy.

Client-centred Services

8.13 The least invasive diagnostic tests are selected to obtain the necessary information and, where possible, multiple tests are performed at the same time.

Guidelines

The comfort of the client is considered when determining the order in which tests will be performed.

Continuity of Services

8.14 The results of the assessment are shared with the client and other team members in a timely and easy-to-understand way.

Guidelines

Sharing assessment results as applicable improves clarity and prevents duplication. In order to provide information that is easy to understand, information is tailored to the client’s literacy level, language, and culture.

Continuity of Services

! 8.15 A comprehensive and individualized care plan is developed and documented in partnership with the client and family.

Guidelines

The care plan is based on the results of the assessment and the client's service goals and expected results. It includes the roles and responsibilities of the team, other organizations, and clients and their families. It includes detailed information about the client's history, assessments, diagnostic results, allergies, and medication, including any medication issues or adverse drug reactions.

The plan addresses where and how frequently services will be delivered; timelines for starting services, reaching the service goals and expected results, and completing services; how achievement of the service goals and expected results will be monitored; and plans for transition or follow-up once service ends, if applicable.

Client-centred Services

8.16 Planning for care transitions, including end of service, are identified in the care plan in partnership with the client and family.

Guidelines

Including information in the care plan about transition planning, whether to home, another team, an alternate level of care, or end of service, enhances coordination among teams or partner organizations and helps prepare clients for the end of service. Client involvement in end-of-service planning ensures the client and family are prepared and know what to expect.

Discussions about the client's transition and post-care needs and preferences are part of developing the care plan. The discussion may include post-care follow up, ability to perform self-care, referrals to community supports, or other anticipated needs or challenges.

9.0 Care plans are implemented in partnership with clients and families.

Appropriateness

9.1 The client's individualized care plan is followed when services are provided.

Continuity of Services !

9.2 Other units or facilities are provided with the expected discharge dates for clients who will be repatriated so those units or facilities can plan for a timely transition.

Appropriateness

9.3 Daily rounds are conducted by the collaborative team.

Guidelines

The team conducting rounds may include intensivists, physicians, nurses, pharmacists, dieticians, physiotherapists, respiratory therapists, social workers, and spiritual care providers. Representatives from other professions may be invited to join the rounds on an as-needed basis.

Safety ROP

9.4 REQUIRED ORGANIZATIONAL PRACTICE: Working in partnership with clients and families, at least two person-specific identifiers are used to confirm that clients receive the service or procedure intended for them.

Guidelines

Using person-specific identifiers to confirm that clients receive the service or procedure intended for them can avoid harmful incidents such as privacy breaches, allergic reactions, discharge of clients to the wrong families, medication errors, and wrong-person procedures.

The person-specific identifiers used depends on the population served and client preferences. Examples of person-specific identifiers include the client’s full name, home address (when confirmed by the client or family), date of birth, personal identification number, or an accurate photograph. In settings where there is long-term or continuing care and the team member is familiar with the client, one person-specific identifier can be facial recognition. The client’s room or bed number, or using a home address without confirming it with the client or family, is not person-specific and should not be used as an identifier.

Client identification is done in partnership with clients and families by explaining the reason for this important safety practice and asking them for the identifiers (e.g., “What is your name?”). When clients and families are not able to provide this information, other sources of identifiers can include wristbands, health records, or government-issued identification. Two identifiers may be taken from the same source.

Test(s) for Compliance

Major 9.4.1 At least two person-specific identifiers are used to confirm that clients receive the service or procedure intended for them, in partnership with clients and families.

Appropriateness

9.5 All services received by the client, including changes and adjustments to the care plan, are documented in the client record.

Guidelines

The client record is accessible to the team involved in care, including the client, and is contained in a single client record.

Appropriateness !

9.6 Treatment protocols are consistently followed to provide the same standard of care in all settings to all clients.

Appropriateness !

9.7 The client’s health status is reassessed in partnership with the client, and updates are documented in the client record, particularly when there is a change in health status.

Guidelines

Delays or failures to report a change in health status, in particular deterioration in a client’s condition, are significant barriers to safe and effective care and services. Changes in the client’s health status are documented accurately, in a timely manner, and communicated to all team members.

Appropriateness

9.8 Standardized clinical measures are used to evaluate the client's pain on a continuous basis in partnership with the client and family.

Guidelines

Standardized clinical measures are used to determine pain intensity, quality, location, alleviating and contributing factors, and impact on usual activities. Examples for adults include the Numerical Rating Scale (NRS) for pain intensity and relief (0-10), the Critical-Care Pain Observation Tool (CPOT), and the Brief Pain Inventory for functional ability. Examples for infants and children include Stevens' Premature Infant Pain Profile and the Faces Pain Scale – Revised (FPS-R). Examples for non-verbal and/or cognitively impaired persons include Feldt's Checklist of Nonverbal Pain Indicators and McGrath's behavioural and physiological indicators.

Pain may also be assessed in combination with other symptoms using a comprehensive assessment tool such as the Edmonton Symptom Assessment Scale (ESAS).

Whenever possible, the client self-reports pain intensity. Other techniques to determine pain intensity are used when the client is unable to self-report, as with infants and preverbal toddlers, unconscious clients, and clients with advanced dementia.

Sleep and sedation are not necessarily indicative of an absence of pain or effective pain relief.

Strategies to manage pain include analgesics, including opioids when needed, and adjuvants along with physical, behavioural, and psychological interventions. Experts are consulted, and research and evidence are used to understand the best ways to manage pain.

Appropriateness	9.9	The client's level of sedation is evaluated and managed on a continuous basis in partnership with the client and family.

Guidelines

To measure the client's level of sedation, one or more sedation scales is selected, such as the Comfort Scale (for paediatric clients), Riker Scale, Sedation-Agitation Scale, or Motor Activity Assessment Scale.

Inadequate sedation may cause the client to experience pain and anxiety and may increase the risk of self-extubation, while over-sedation can interfere with the evaluation of the client's neurological status, may increase the risk of ventilator-associated pneumonia and may contribute to increased duration of mechanical ventilation and length of stay. Adequate sedation is particularly important during paralysis.

Appropriate sedation allows clients to be free from pain and anxiety, but able to be awakened and to respond to commands.

Appropriateness

9.10 A protocol is followed when conducting a daily interruption in sedation.

Guidelines

Daily interruption of sedation, referred to as a ‘sedation vacation,' is used to assist in evaluating the client's neurological readiness for extubation and has been shown to contribute to decreased duration of mechanical ventilation which may in turn decrease the rate of ventilator-associated pneumonia.

The protocol for daily interruption in sedation includes preventive measures to avoid self-extubation.

Appropriateness

9.11 A delirium screening tool is used to assess clients for delirium in partnership with the client and family.

Guidelines

Delirium, a heightened state of agitation, contributes to increased length of stay and may cause clients to self-extubate or remove catheters.

A delirium screening tool is identified and consistently applied.

Safety

!

9.12 The client's need for restraints is assessed on a daily basis in partnership with the client and family, and the least invasive restraint required is used to meet that need.

Guidelines

The rationale for using restraints is explained to the client and family, and consent is sought.

When restraints are used, the following information is documented in the client record: the reason for using restraints; any alternatives used; evidence that the use of restraints was discussed with the client or substitute decision-maker; and the client's response to being restrained.

Appropriateness

9.13 A protocol is followed to achieve glycemic control in clients.

Guidelines

Effective glucose control may contribute to reduced morbidity and mortality.

The protocol includes criteria for application, a range of ideal glucose levels, suggested dosage of insulin and glucose, and timeframes for monitoring glucose level.

Glycemic control is one of the interventions proposed by the Institute for Healthcare Improvement (www.ihi.org).

Safety

!

9.14 The Safer Healthcare Now! Ventilator-Associated Pneumonia (VAP) bundle is implemented for all clients on ventilators, in partnership with the client and family.

Guidelines

This intervention is aimed at preventing ventilator-associated pneumonia. Elements of the intervention include elevation of the head of the bed between 30 and 45 degrees, daily ‘sedation vacations' to assess readiness for extubation, use of oral versus nasal tubes to access the trachea or stomach, and the use of EVAC tubes to drain subglottic secretions. For the intervention to be most effective, each of these elements must be in place.

More information about this intervention is available on the Safer Healthcare Now website (www.saferhealthcarenow.ca) and on the Institute for Healthcare Improvement website (www.ihi.org).

Safety

!

9.15 The Safer Healthcare Now! Central Line (CLI) bundle is implemented for all clients requiring a central line, in partnership with the client and family.

Guidelines

This intervention is aimed at preventing catheter-related bloodstream infections. Elements of the intervention related to insertion of central lines include hand hygiene, maximal barrier precautions, chlorhexidine skin antisepsis, and optimal catheter site selection. Elements of the intervention related to maintenance of central lines include daily review of the necessity for the line, dedicated lumen for parenteral nutrition, accessing lumens asceptically, and checking the entry site for inflammation with every dressing change. For the intervention to be most effective, each of these elements must be in place.

More information about this intervention is available on the Safer Healthcare Now website (www.saferhealthcarenow.ca) and on the Institute for Healthcare Improvement website (www.ihi.org).

Appropriateness

9.16 Client progress toward achieving goals and expected results is monitored in partnership with the client, and the information is used to adjust the care plan as necessary.

Guidelines

Documenting progress toward goals is done using both qualitative and quantitative methods and includes the client and family. It may include the use of standardized assessment tools, discussion with clients and families, and observation.

Client-centred Services

9.17 Access to spiritual space and care is provided to meet clients' needs.

Guidelines

Spiritual care is available to meet the needs of clients, as required. It includes access to a spiritual leader appropriate to the client's beliefs (e.g., a chaplain, imam, rabbi, or non-denominational counsellor). Clients and families have access to a designated space to observe spiritual practice.

The client's spiritual needs and preferences are seen as integral to the care and healing process, and are discussed when making care decisions that may involve an ethical or spiritual component.

Client-centred Services

9.18 Clients and families have access to psychosocial and/or supportive care services, as required.

Guidelines

Emotional support and counselling can help clients and families cope with the health needs and health-related issues. Supports may address coping with a diagnosis, help with decision making, dealing with side effects, or ethics-related issues such as advance directives.

Client-centred Services

9.19 There is a process for initiating palliative and end-of-life care, as required.

Guidelines

Services are initiated by the team, client, or family, and take into consideration the assessment results. Involvement in palliative and end-of-life care will differ depending on the services provided by the team and the clients served. Where palliative and end-of-life care is not provided by the team, clients are connected with the appropriate services.

Client-centred Services

9.20 Support for the family, team members, and other clients is provided throughout and following the death of a client.

Guidelines

Relevant information is shared with clients and families about the dying process, such as the signs and symptoms of imminent death; coping strategies; how to provide support and comfort during the final hours; and grief and bereavement services.

The client's family and friends are encouraged to use community support systems. When these are insufficient, or when family and friends are identified as being at risk for complex grief reactions, access is facilitated to bereavement services for clients, families, team members, and volunteers, including volunteer support or professional services.

Safety

ROP

9.21 REQUIRED ORGANIZATIONAL PRACTICE: Information relevant to the care of the client is communicated effectively during care transitions.

Guidelines

Effective communication is the accurate and timely exchange of information that minimizes misunderstanding.

Information relevant to the care of the client will depend on the nature of the care transition. It usually includes, at minimum, the client's full name and other identifiers, contact information for responsible providers, reason for transition, safety concerns, and client goals. Depending on the setting, information about allergies, medications, diagnoses, test results, procedures, and advance directives may also be relevant.

Using documentation tools and communication strategies (such as SBAR [Situation, Background, Assessment, Recommendation], checklists, discharge teaching materials and follow-up instructions, read-back, and teach-back) support effective communication, as does standardizing relevant information, and tools and strategies across the organization. The degree of standardization will depend on organizational size and complexity. Electronic medical records are helpful but not a substitute for effective communication tools and strategies.

Effective communication reduces the need for clients and families to repeat information. Clients and families need information to prepare for and improve care transitions; this may include written information or instructions, action plans, goals, signs or symptoms of declining health status, and contact information for the team.

Test(s) for Compliance

Major	9.21.1	The information that is required to be shared at care transitions is defined and standardized for care transitions where clients experience a change in team membership or location: admission, handover, transfer, and discharge.
Major	9.21.2	Documentation tools and communication strategies are used to standardize information transfer at care transitions.

Major 9.21.3 During care transitions, clients and families are given information that they need to make decisions and support their own care.

Major 9.21.4 Information shared at care transitions is documented.

Minor 9.21.5 The effectiveness of communication is evaluated and improvements are made based on feedback received. Evaluation mechanisms may include:
- Using an audit tool (direct observation or review of client records) to measure compliance with standardized processes and the quality of information transfer
- Asking clients, families, and service providers if they received the information they needed
- Evaluating safety incidents related to information transfer (e.g., from the patient safety incident management system).

10.0 Clients and families are encouraged to actively participate in service delivery to achieve service goals.

Client-centred Services

10.1 Oral communication is facilitated or alternate means of communication are used when the client is unable to communicate orally due to ventilator use, physical condition, or other reason.

Guidelines

Techniques to facilitate oral communication include temporary tracheostomy cuff deflation or use of a tracheostomy speaking valve. Other means of communication may include gesturing, writing, or a communication board with pictures, words, or letters.

Appropriateness !

10.2 A process which meets legal requirements is followed to address decisions about providing, forgoing, or withdrawing life-sustaining treatment in partnership with the client and family.

Guidelines

The process meets legal requirements under Advanced Medical Directives and is shared with clients and families. It includes guidelines for handling disagreements, both between clients and/or families and team members, and among team members.

Client-centred Services

10.3 One or more interdisciplinary meetings are scheduled with clients and their family members in a private setting.

Guidelines

These meetings facilitate the communication of relevant information to all involved family members at once. Topics of discussion may include course of treatment, the client's prognosis, end-of-life preparations, including cultural or religious considerations, and transition planning.

The facilitator of the meeting should have experience in conflict management to help mediate for those involved in the decision-making process.

Appropriateness

10.4 A protocol is followed that meets legal requirements when approaching clients and families about organ donation.

Guidelines

The protocol for discussing organ donation conforms to existing legislation, and set criteria are used to identify potential donors. The client and/or family member’s decision is recorded in the client record.

Client-centred Services

10.5 A dignified death is facilitated for clients at the end of life.

Guidelines

As much as possible is done to meet the needs of the dying client. This may include affording privacy to the client and family, designating a team member to be present 24 hours a day so the client does not die alone, and attending to the client's appearance and hygiene needs.

Client-centred Services

10.6 The cultural practices and spiritual beliefs of clients and families in regard to death and dying are respected.

Client-centred Services

10.7 Where possible, the presence of the client's family members in the room is accommodated when performing emergency procedures.

Guidelines

A standard protocol is followed to determine who should be in the room during emergency procedures. This may include involving a social worker when family members are present.

The presence of family members at a traumatic event such as resuscitation may be a comfort to the client and may assist the family with the grieving process.

The number of family members present in the room may need to be limited due to lack of space or safety concerns.

11.0 Clients and families are partners in planning and preparing for transition to another service or setting.

Client-centred Services

!

11.1 Clients and families are actively engaged in planning and preparing for transitions in care.

Guidelines

Clients and families are involved in all transition planning. The team, client and family discuss the client’s care plan, goals, and preferences; the care provided; outstanding issues, clinical or otherwise; what to expect during transition; follow-up appointments; exercise and nutrition plans, where applicable; contact information for the team members and details on when they should be contacted.

Continuity of care is improved when clients participate in transition planning and preparation and have comprehensive information about transitions and end of service.

Examples of key transition moments include rounds, shift changes, handoffs, moving in or out of an organization, to another community provider or at end of service.

Talking with the client and family about transitions helps them understand the process and provides an opportunity to ask any questions. It also helps ensure all information is accurate and complete, and that the client’s wishes are respected.

Client-centred Services

11.2 Clients and families are assisted to plan and prepare for death.

Client-centred Services

11.3 The client’s physical and psychosocial readiness for transition, including their capacity to self-manage their health, is assessed.

Guidelines

This assessment happens as early as possible within the care process. Instances where self-management would benefit the client are determined. Capacity to self-manage is influenced by factors such as access to a support network, community care options, cognitive and physical ability, and literacy level.

Client-centred Services

11.4 Clients are empowered to self-manage conditions by receiving education, tools, and resources, where applicable.

Guidelines

Education that promotes empowerment and helps clients self-manage chronic conditions may include action planning; modeling behaviors and problem solving strategies; reinterpreting symptoms; and social persuasion through group support and guidance for individual efforts. Self-management training topics should include exercise; nutrition; symptom management techniques; risk factor management; fatigue and sleep management; use of medications; managing emotions; cognitive and memory changes; training in communication with health professionals and other individuals; and health-related problem solving and decision making.

Tools and resources made available to help clients to self-manage and are tailored to each client's needs. For example, tools and resources can be modified based on level of understanding, literacy, language, disability, and culture.

Continuity of Services

11.5 Appropriate follow-up services for the client, where applicable, are coordinated in collaboration with the client, family, other teams, and organizations.

Guidelines

Responsibility for the client's care continues until service has ended or the client has been transferred to another team, service, or organization.

Follow-up services may include primary care, home and community services, community-based rehabilitation, psychological counselling services, and recommendations for ongoing care. Working together to establish proper placement for the client helps ensure the client receives the most appropriate services in the most appropriate setting, and minimizes temporary solutions or unnecessary transfers.

To ensure clients receive seamless and continuous care, placement and follow up includes a process for when transitions do not go as planned.

Continuity of Services

11.6 The transition plan is documented in the client record.

Client-centred Services

11.7 A client's wish to end or limit services, transfer to another service, or transition home, is respected.

Guidelines

Shared decision making regarding a client's transition takes place in consultation with the family or substitute decision maker, when required, and takes the client's decision-making capacity into consideration. The risks of the transition are discussed with the client and family, as well as other community-based services that are available to them after the transition.

An ethical or values-based decision making framework is used when working with clients who have chosen options against the team's recommendation. In the event the client wishes to continue service against the team's recommendation or beyond the capacity of the organization, an ethical or value-based decision making framework is used to ensure a fair and equitable outcome for the client and the organization.

Client-centred Services

!

11.8 The client's risk of readmission is assessed, where applicable, and appropriate follow-up is coordinated.

Guidelines

Where need for follow up has been identified, the appropriate type and method is determined. This includes the responsibilities of the team such as following up on testing, providing a referral to a partner organization, setting timelines for client contact, or reminding the client of an appointment. It also includes client responsibilities such as following up with other care providers (e.g., primary care or a community health centre), reporting worsening or changing symptoms, and taking medications as prescribed.

A standardized assessment tool (e.g., the LACE Index Scoring Tool). is used to assess risk of readmission after the end of service.

Appropriateness

11.9 The effectiveness of transitions is evaluated and the information is used to improve transition planning, with input from clients and families.

Guidelines

At regular intervals, a sample of clients, families, or referral organizations is contacted to determine the effectiveness of the transition or end of service, monitor client perspectives and concerns after the transition, and monitor follow-up plans. Evaluating transitions is an opportunity to verify that client and family needs were met and concerns or questions addressed.

Client feedback and the overall results of the evaluation are shared with the organization's leaders and the governing body and the information is used to improve transitions.

12.0 Potential organ and tissue donors are identified, referred, and managed in a timely and effective manner.

Appropriateness

12.1 Clinical referral triggers are established to identify potential organ and tissue donors.

Guidelines

Clinical referral triggers that define criteria for imminent death should be established. For organ donation, these clinical triggers should address patients requiring mechanical ventilation; having clinical findings consistent with a score on the Glasgow Coma Scale less than or equal to an agreed-upon threshold; being evaluated for a diagnosis of neurological death; having withdrawal of life-sustaining therapies ordered by a physician; or lacking of brain stem reflexes. For tissue donation, these triggers address patients with cardiac death who are under 85 years of age.

Appropriateness

12.2 Training and education on the definition of imminent death, the use of clinical referral triggers, who to contact when potential organ and tissue donation opportunities arise, how to approach families about donation, and other donation issues is provided to the team.

Guidelines

Education on when and how to make referrals to physicians qualified to determine neurological death or how to link with donation services such as Organ Procurement Organizations is provided to team members, e.g., nurses, physicians, or respiratory therapists.

Appropriateness

12.3 There is a policy on neurological determination of death (NDD).

Guidelines

To allow for organ donation, policies for NDD should cover but are not limited to vital signs such as body temperature, clinical NDD and ancillary testing, qualifications of physicians conducting NDD, and verification of NDD by a second qualified physician.

Appropriateness

12.4 A written protocol is followed for NDD that includes accessing the people qualified to determine neurological death.

Guidelines

Determining neurological death does not require a particular level of specialty certification, only that physicians have the requisite skills and knowledge necessary to determine neurological death. In instances where access to physicians that are qualified to determine death is limited, a protocol should be in place to access centres capable of NDD and organ recovery or critical care lines.

Appropriateness

12.5 The physicians that are accessed to determine neurological death must be independent of the intended recipient's care team.

Guidelines

In every province that has legislation on organ and tissue donation such as The Human Tissue Gift Act, the law prohibits physicians determining neurological death from participating in transplant procedures. This includes association with potential recipients and is intended to prevent influences in physicians' judgments.

Client-centred Services

12.6 Appropriate information about the implications of neurological death is provided to the family.

Guidelines

Materials such as pamphlets or booklets on neurological death may help the family to better understand the nature or gravity of neurological death and what has happened to their family member.

Efficiency

12.7 The Organ Procurement Organization (OPO) is notified in a timely manner when death is imminent or established for potential donors.

Guidelines

Rapid notification of potential donors to the OPO increases the likelihood of organ and tissue donation.

In many jurisdictions, legislation specifies procedures to be followed when death is imminent. In those provinces, team members are required by law to notify their OPO when a patient has died or a physician has made an NDD.

Appropriateness

12.8 The provincial donor registry, where one exists, is checked to determine if the patient is a registered donor.

Client-centred Services

12.9 Before approaching the family, a discussion takes place between the team and the donation coordinator regarding how they will approach the family about donation.

Guidelines

There is a quick meeting between team members, e.g., physicians, attending physician, intensivists, spiritual advisors, nurses, and donation coordinator to discuss how they will approach the family about donation and how to support the family and meet their needs during the process. There should be a process to establish where potential donors are best managed and where the family will be approached.

The family's understanding of the situation, when the best time to discuss donation would be, the best person to approach the family, and how the OPO staff and the donor coordinator will be introduced to the family may be discussed.

There is a policy that describes those circumstances under which the potential donor's family is approached or the donor is managed in the emergency department.

Client-centred Services

12.10 When approaching families about donation, a decoupling approach is used.

Guidelines

A decoupling approach is approaching the family about donation only after they have had the opportunity to grasp the confirmed or imminent death of their loved one.

Client-centred Services

12.11 A written process is followed when approaching families about organ and tissue donation.

Guidelines

Discussions regarding organ and tissue donation and determining if the family is interested in donation should be handled by the person that the team identifies as the most skilled, capable and experienced. This professional could be a nurse, physician, social worker, spiritual advisor, or a representative from an OPO.

Client-centred Services

12.12 When approaching the family, the sensitivity of the situation, as well as the client’s and family's culture, beliefs, and decisions about organ and tissue donation are respected.

Guidelines

This may include using interpreters where necessary so that the family understands the information being provided.

Appropriateness

12.13 All aspects of the donation process, including the family's decision about organ and tissue donation, are recorded in the client record in partnership with the family.

Guidelines

The client record includes that the client was identified as a potential donor, the family was approached for donation, the OPO was contacted, and the decision about organ and tissue donation.

Appropriateness

12.14 There is access to consultants with expertise in proper donor management.

Appropriateness

12.15 There are written protocols for donor management.

Guidelines

Donor management protocols include monitoring hemodynamics, glycemia and nutrition, electrolytes, temperature, endocrine, oxygenation, and ventilation. For more information on these protocols refer to the best practice reports Medical Management to Optimize Donor Organ Potential: A Canadian Forum, Report and Recommendations (October 2004, The Canadian Council for Donation and Transplantation) and Organ Donor Management in Canada: Recommendations of the Forum on Medical Management to Optimize Donor Organ Potential, Shemie et al. (2006) CMAJ; 174 (6).

Client-centred Services

12.16 Potential donors are managed and cared for during testing and screening.

Guidelines

The donor is treated the same as any other ICU patient. Prior to the donation procedure, potential organ and tissue donors undergo screening procedures such as blood and transmittable disease testing. During these procedures, the donor is cared for and medically managed as soon as possible after death is declared to optimize organ potential.

Medical management of donors may include implementing the proper recruitment measures such as monitoring hemodynamics, glycemia and nutrition, electrolytes, temperature, endocrine, oxygenation, and ventilation.

Appropriateness

12.17 Appropriate clinicians are available to properly manage the donor.

Guidelines

There is a bedside nurse and a physician to oversee the donor's care.

Appropriateness

12.18 All aspects of the donor management process are recorded in the potential donor's medical record.

Appropriateness

12.19 Data gathered on all ICU deaths is accessible and there is a process for reviewing that data to identify lost opportunities for donation.

Guidelines

By examining all deaths, team members can assess which deaths might have resulted in organ or tissue donation. Chart audits and reviewing the missed opportunities encourages identification of subsequent potential donors.

MAINTAINING ACCESSIBLE AND EFFICIENT INFORMATION SYSTEMS

13.0 Client records are kept accurate, up-to-date, and secure.

Appropriateness !

13.1 An accurate, up-to-date, and complete record is maintained for each client, in partnership with the client and family.

Guidelines

Client records are accessible and up-to-date. Information is easy to find and identify, and is organized for ease of use. The record includes the dates of service, is signed by the appropriate authority, and is legible.

Only recognized abbreviations are used in the record, and critical client information is prominently displayed.

The client record is updated whenever there is a change in health status, the care plan, the client's medications, or when the client is transitioned to another level of care or service.

Organizational and professional standards are followed when determining what information is needed for the client record to be considered complete. These include significant changes in condition, diagnostic results, alert notations, progress notes, significant events or patient safety incidents, and others.

Clients and families are involved in providing and documenting information, and ensuring the information captured is accurate and complete.

Appropriateness

13.2 A standardized set of health information is collected to ensure client records are consistent and comparable.

Guidelines

Collecting standardized information applies whether the client records are paper-based or electronic.

The nature of the health information collected will vary depending on the type of organization and the services provided. Standards for data collection may be set out in provincial/territorial or national guidelines. Standardized data elements can be found through the Canadian Institute for Health Information, as well as provincial platforms for electronic records (e.g., e-Health Ontario). Where information is not available, the organization works with partner organizations and/or the health region to determine what information to collect for each client.

Appropriateness

!

13.3

Policies and procedures to securely collect, document, access, and use client information are followed.

Guidelines

Policies outlining authorized access to client information are available to the team, including how, when, and what information they may access. Only team members who are actively involved in a client's care have access to the client record.

The team is aware of and knows how to comply with applicable legislation to protect the privacy and confidentiality of client information. Applicable legislation may be provincial, territorial, or federal.

Client-centred Services

13.4

Clients are able to access information in their records, including electronic medical/health records, in a routine, client-centred, and timely way.

Guidelines

Client access to their records is facilitated in a proactive way, according to the organization’s policy and applicable legislation. The processes to access records are client-centred and support clients to access their information. Clients have opportunities to discuss the information, ask questions, provide feedback.

Client-centred Services

13.5 Information is documented in the client’s record in partnership with the client and family.

Guidelines

Clients are the owners of their health information. They are included in the process of documenting information in their record and can provide input on the information being documented. Clients are given the right to read and comment on information that is recorded. The charting or documentation process may be conducted in partnership with the client as part of their care, or access to their records may be provided electronically.

Appropriateness

!

13.6 Policies and procedures for securely storing, retaining, and destroying client records are followed.

Guidelines

Relevant legislation, including the federal Privacy Act and the federal Personal Information Protection and Electronic Documents Act, are followed, where applicable. Each province and territory refers to their respective privacy laws, and laws governing health information protection, where relevant.

Continuity of Services

13.7 The flow of client information is coordinated among team members and other organizations, in partnership with the client and in accordance with legislation.

Guidelines

While respecting the client’s right to privacy and with the client’s consent, information is shared as required to facilitate a client-centred approach to service delivery. Effective information sharing helps the team better meet the needs of clients and reduces duplication in obtaining client information. The team obtains client consent to share information.

Clients are involved in sharing information (e.g., maintaining and sharing a current list of medications, or providing a discharge summary to appropriate providers).

Appropriateness !

13.8 There is a process to monitor and evaluate record-keeping practices, designed with input from clients and families, and the information is used to make improvements.

Guidelines

Record-keeping may be paper-based and/or electronic. The monitoring and evaluation process meets any applicable legislation or requirements. The process examines privacy breaches, as well as accuracy and effectiveness of practices.

Evaluation may be done for a sample of records on an irregular or regular basis. Where record-keeping is electronic, evaluation can be triggered based on certain events, such as unusual activity, attempt to retrieve certain data, or unmasking of data.

All electronic activities are linked to a unique user identifier, date and time stamped, and an activity log is maintained to ensure practices can be appropriately monitored.

14.0 Health information is managed to support the effective delivery of services.

Appropriateness

14.1 Training and education about legislation to protect client privacy and appropriately use client information are provided.

Guidelines

Training is provided to all team members and may be formal or informal. Further training or education is provided when there are changes to legislation or after an extended period of time.

Appropriateness

14.2 Policies on the use of electronic communications and technologies are developed and followed, with input from clients and families.

Guidelines

Policies regarding the use of electronic mail, texting, web applications and social media are determined using the perspectives of clients and families. This may include inter-team communication, communication with clients, or communication with partners and potential clients.

When determining what electronic communications and technologies to use, considerations are made for how to manage issues of privacy, professionalism, security of information, client communication preferences, and legislation. Technologies may be used to assist in service provision or care, (e.g., demonstrating procedures on a tablet).

Appropriateness

14.3 Policies and procedures for disclosing health information for secondary use are developed and followed.

Guidelines

Secondary use refers to using health information for a purpose other than direct service provision, such as clinical program management, health system management, public health surveillance, and research.

Policies and procedures cover the appropriate circumstances in which to disclose the data and how to ensure client privacy is maintained (e.g., by de-identifying or aggregating data prior to disclosure). Where identifiable or re-identifiable data is requested, the team follows an ethics approval process and assesses risk prior to disclosure.

MONITORING QUALITY AND ACHIEVING POSITIVE OUTCOMES

15.0 Current research, evidence-informed guidelines, and best practice information is used to improve the quality of services.

Appropriateness !

15.1 There is a standardized procedure to select evidence-informed guidelines that are appropriate for the services offered.

Guidelines

Guidelines may be selected by a committee, council, or individual who makes recommendations to the team on which guidelines to use and how they can be integrated into service delivery.

Guidelines from other organizations or associations can be adopted by the team. The process for selecting guidelines is standardized and formalized. It may include using content experts; a consensus panel; Grades of Recommendation Assessment, Development and Evaluation (GRADE); or the Appraisal of Guidelines Research and Evaluation (AGREE) II instrument, which allows organizations to evaluate the methodological development of clinical practice guidelines from six perspectives: scope and purpose, stakeholder involvement, rigour of development, clarity and presentation, applicability, and editorial independence.

Client-centred Services

15.2 The procedure to select evidence-informed guidelines is reviewed, with input from clients and families, teams, and partners.

Guidelines

A collaborative approach is used to select guidelines that are appropriately linked to improved client experience and outcomes.

Appropriateness !

15.3 There is a standardized process, developed with input from clients and families, to decide among conflicting evidence-informed guidelines.

Guidelines

Comprehensive documents that synthesize the evidence from several guidelines may be used. For example, the Cochrane Collaboration conducts systematic reviews of the available evidence that can help teams and organizations with their review process. Clients and families are consulted to determine whether the method of deciding among guidelines follows a client-centred approach.

Appropriateness ! 15.4 Protocols and procedures for reducing unnecessary variation in service delivery are developed, with input from clients and families.

Guidelines

Selected guidelines and evidence are used to develop procedures and protocols to improve service delivery and provide standardized care to clients. Guidelines may enhance patient safety, improve inter-team collaboration, increase efficiency, and minimize variation in service delivery. Client perspectives are considered when evaluating improvements due to guidelines. Research knowledge is adapted and applied to each unique care setting.

Appropriateness ! 15.5 Guidelines and protocols are regularly reviewed, with input from clients and families, to ensure they reflect current research and best practice information.

Guidelines

The review process includes accessing the most up-to-date research and information and determining its relevance (e.g., through literature reviews, content experts, or national organizations or associations). Research information may include intervention research, program evaluations, or clinical trials.

The review process informs the procedure to select evidence-informed guidelines.

Appropriateness !

15.6 There is a policy on ethical research practices that outlines when to seek approval, developed with input from clients and families.

Guidelines

The need for ethics approval is evaluated and, if necessary, sought, prior to undertaking research or activities (including quality improvement activities), where information is collected.

16.0 Client and team safety is promoted within the service environment.

Safety !

16.1 A proactive, predictive approach is used to identify risks to client and team safety, with input from clients and families.

Guidelines

A proactive, predictive approach is designed to address potential issues by mitigating a risk or hazard before it occurs. While it may not be possible to identify all risks in a service setting, a comprehensive process is used to identify the most probable risks.

Through this approach, the team works to address processes that create errors, delays, or inefficiencies and may be viewed as beyond the team's control. These may be small, continuously occurring interruptions to work flow that create significant loss of resources as time goes on (e.g., having to look up commonly used information, having to search for commonly used items).

Information is gathered to determine the causes of potential problems and strategize possible solutions. These activities include conducting audits, talking to clients, talking to team members, monitoring areas for risk, identifying interruptions, participating in safety briefings, and addressing areas where there is a high margin of error.

Regular opportunities to share information about potential problems and actual incidents can reduce risk and the likelihood of an incident occurring or recurring.

Safety ! 16.2 Strategies are developed and implemented to address identified safety risks, with input from clients and families.

Guidelines

The team works together to increase participation in risk mitigation strategies. Client and family perspectives are incorporated in the process of developing and implementing risk mitigation strategies. The strategies are tested on a small scale and results are monitored. Strategies will vary depending on the types of risks identified and may include action planning and working with other team members to address identified risks.

Safety ! 16.3 Verification processes are used to mitigate high-risk activities, with input from clients and families.

Guidelines

To identify high-risk activities, the team may review its services and use this information to develop and implement checking systems to reduce the risk of harm to clients and team members.

Across the care continuum, verification systems vary depending on services. Examples may include but are not limited to:

- Repeat back or read back processes for diagnostics or verbal orders
- Checking systems for water temperature, especially for bathing
- Standardized tracking sheets for clients with complex medication management needs
- Automated alert systems for communication of critical test results
- Computer-generated reminders for follow-up testing in high-risk clients
- Two person verification process for blood transfusions
- Independent double checks for dispensing and administering high-risk medications
- Medication bar coding systems for drug dispensing, labeling, and administration
- Decision support software for order entry or drug interaction checking
- Safety monitoring systems for teams in community-based organizations or for clients in high-risk environments
- Standardized protocols to monitor vital signs (e.g., fetal heart rate during medical induction/augmentation of labour, or in high-risk deliveries)
- Systems to monitor vaccine fridge temperatures
- Standardized protocols for the use of restraints
- Standardized screening processes for allergies to contrast media.

Safety ! 16.4 Safety improvement strategies are evaluated with input from clients and families.

Guidelines

Adjustments are made as needed to ensure positive change is sustained.

Safety ! 16.5 Patient safety incidents are reported according to the organization’s policy and documented in the client and the organization record as applicable.

Guidelines

Reporting and recording is done is a timely way. Patient safety incidents include harmful incidents, no harm incidents, and near misses, as per the World Health Organization International Classification for Patient Safety.

Client-centred Services

! 16.6 Patient safety incidents are disclosed to the affected clients and families according to the organization’s policy, and support is facilitated if necessary.

Guidelines

The Canadian Patient Safety Institute (CPSI) publishes a guide to disclosing patient safety incidents, for health care providers, interdisciplinary teams, organizations, and regulators who are developing and implementing disclosure policies, practices, and training methods.

Support following a patient safety incident is an important part of the process. Support is provided to clients and families as well as team members affected by a patient safety incident.

Safety

! 16.7 Patient safety incidents are analyzed to help prevent recurrence and make improvements, with input from clients and families.

Guidelines

Analyzing all harmful incidents, no harm incidents, and near misses includes determining the contributing factors, taking action to prevent the same situation from recurring, and monitoring the effectiveness of those actions. Organizations use this information when developing strategies to proactively anticipate and address risks to client and team safety.

The Canadian Patient Safety Institute offers a framework for incident management. It provides an in-depth description of the process of analyzing and managing patient safety incidents. An online Incident Analysis Learning Program series is available to assist organizations to apply the principles of incident analysis at www.patientsafetyinstitute.ca/.

17.0 Indicator data is collected and used to guide quality improvement activities.

Client-centred Services

17.1 Information and feedback is collected about the quality of services to guide quality improvement initiatives, with input from clients and families, team members, and partners.

Guidelines

Information and feedback is collected in a consistent manner from key stakeholders about the quality of services. Feedback can take the form of client and family satisfaction or experience data, complaints, indicators, outcomes, scorecards, incident analysis information, and financial reports. It may be gathered by a variety of methods, including surveys, focus groups, interviews, meetings, or records of complaints.

Appropriateness

17.2 The information and feedback gathered is used to identify opportunities for quality improvement initiatives and set priorities, with input from clients and families.

Guidelines

Feedback and other forms of information, observation, and experience are used to identify and prioritize areas for quality improvement initiatives. This is done using a standardized process based on criteria such as expressed needs of clients and families, client-reported outcomes, risk, volume, or cost.

Appropriateness

!

17.3 Measurable objectives with specific timeframes for completion are identified for quality improvement initiatives, with input from clients and families.

Guidelines

Quality improvement objectives define what the team is trying to achieve and by when. Appropriate quality improvement objectives are typically short term, have targets that exceed current performance, and are usually aligned with longer-term strategic priorities or patient safety areas. The timeframe will vary based on the nature of the objective.

The SMART acronym is a useful tool for setting meaningful objectives. The objectives should be Specific, Measurable, Achievable, Realistic, and Time-bound. The United States Centers for Disease Control and Prevention offers a guide to writing SMART objectives.

Appropriateness

17.4 Indicator(s) that monitor progress for each quality improvement objective are identified, with input from clients and families.

Guidelines

Indicators are used to monitor whether the activities resulted in change and if the change is an improvement. Primarily, indicators are selected based on their relevance and whether they can accurately monitor progress. When there are multiple potential indicators, criteria such as scientific validity and feasibility are used to select them.

If there are difficulties selecting indicators, it may mean the quality improvement objective needs clarification.

Appropriateness

!

17.5 Quality improvement activities are designed and tested to meet objectives.

Guidelines

Quality improvement activities are the actions that are undertaken to initiate improvements, and are part of the larger quality improvement plan. Activities are first designed and tested on a small scale to determine their effect prior to implementing them more broadly.

The Getting Started Kit for Improvement Frameworks is a resource created by the Canadian Patient Safety Institute and is based on the Model for Improvement. The Institute for Healthcare Improvement offers a framework to guide quality improvement activities using Plan, Do, Study, Act cycles.

Appropriateness

17.6 New or existing indicator data are used to establish a baseline for each indicator.

Guidelines

Establishing a baseline reference point makes it possible to monitor progress towards meeting quality improvement objectives by comparing pre- and post-activity data and noting changes. Establishing a baseline may require one or many data points and occurs over a defined period of time. Once the baseline is established, the team may need to reevaluate its quality improvement objectives to ensure they remain feasible and relevant.

Appropriateness

17.7 There is a process to regularly collect indicator data and track progress.

Guidelines

How indicator data will be collected and how often is determined. Regularly collecting data allows the team to track its progress and understand the normal variation of values.

Appropriateness

! 17.8 Indicator data is regularly analyzed to determine the effectiveness of the quality improvement activities.

Guidelines

The team compares the intended and actual effects of its quality improvement activities, and, if the objective has not been achieved, adjusts its actions accordingly to meet the objective.

Analyzing data helps identify trends and may reveal areas that could be considered for future quality improvement initiatives. Indicator data can be displayed in a run chart or control chart, both of which are valid means of data analysis.

Safer Healthcare Now! offers Patient Safety Metrics, a web-based tool where organizations can submit data on various interventions, analyze results, and generate reports.

If it is not within the team's capacity to analyze the data, it seeks qualified internal or external assistance.

Appropriateness

!

17.9

Quality improvement activities that were shown to be effective in the testing phase are implemented broadly throughout the organization.

Guidelines

The way in which activities are implemented broadly will vary based on the scope and scale of the team's services and the timeframe (e.g., an effective activity is implemented in more than one area of care and for a longer period of time).

Population Focus

17.10

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

Guidelines

Information is tailored to the audience and considers the messaging and language that is appropriate for each audience.

Sharing the results of evaluations and improvements helps familiarize stakeholders with the philosophy and benefits of quality improvement and engage them in the process. It is also a way for organization to spread successful quality improvement activities and demonstrate its commitment to ongoing quality improvement.

Among other benefits, sharing indicator data externally allows for comparisons with organizations offering similar services.

Appropriateness

17.11 Quality improvement initiatives are regularly evaluated for feasibility, relevance, and usefulness, with input from clients and families.

Guidelines

The evaluation of quality improvement initiatives includes activities, objectives, and indicators. Results are used to plan future quality improvement initiatives including how and when to sustain or spread existing initiatives.

Outcomes of the quality improvement initiatives are considered with respect to how they align with the organization's overall quality improvement plan, goals and objectives, mission and values, and strategic plan. The team evaluates whether objectives were met within the timeframes and whether the timeframes are still relevant.

Based on the review of the initiatives, objectives and indicators may be added, amended, or removed as appropriate. The rationale for amending or removing them is documented.

Resources

Association of Public Health Observatories (APHO). (2008). The Good Indicators Guide: Understanding how to use and choose indicators. NHS Institute for Innovation and Improvement.

Audet, A.M. (2006). Adoption of Patient-Centered Care Practices by Physicians: Results From a National Survey. *Arch Intern Med*, 166(7):754-9.

Balik, B. (2011). Leaders' role in patient experience: Hospital leadership must drive efforts to better meet patients' needs. *Healthcare Executive.* 26(4):76-78.

Balik, B. (2012). Patient- and Family-Centredness: Growing a Sustainable Culture. *Healthcare Quarterly 15:* 10-12.

Balik, B., J. Conway, L. Zipperer & J. Watson. (2011). Achieving an Exceptional Patient and Family Experience of Inpatient Hospital Care. IHI Innovation Series White Paper. Cambridge, Massachusetts: Institute for Healthcare Improvement.

Bate, P., & Robert, G. (2006). Experience-based design: from redesigning the system around the patient to co-designing services with the patient. *Qual Saf Health Care,* 15: 307-310.

BC Patient Safety & Quality Council. (2010) Measurement strategies for improving the quality of care: A review of best practice. Vancouver BC.

Bergeson, S.C. (2006). A Systems Approach to Patient-Centered Care. *JAMA,* 296 (23): 2848-51.

Black, N. (2013). Patient reported outcome measures could help transform healthcare. *BMJ,* 346: f167.

British Columbia Ministry of Health (2011). Integrated primary and community care patient and public engagement Framework. www.impactbc.ca

Canadian Foundation for Health care Improvement (2013). On Call Webinars - *Patient Engagement Series.* www.cfhi-fcass.ca

Canadian Institutes of Health Research (2011). News Release. Government of Canada puts patients first with new research strategy. August 22, 2011. www.cihr-irsc.gc.ca

Canadian Malnutrition Task Force (2014). Canadian Malnutrition Task Force Screening Tool. June 2014. www.nutritioncareincanada.ca

Canadian Medical Association (2007). Putting Patients First: Patient-Centred Collaborative Care, A Discussion Paper. July 2007. www.cma.ca

Canadian Medical Association (2010). Health care transformation, *Change that Works. Care that Lasts.* Building a culture of patient-centred care. Charter for Patient-Centred Care. www.cma.ca

Cancer Quality Council of Ontario (2013). Environmental Scan: Patient and Family Experience June 2013.

Centers for Disease Control and Prevention (2003). *Prevention Works: CDC Strategies for a Heart-Healthy and Stroke-Free America.* Atlanta, GA: U.S. Department of Health and Human Services. www.cdc.gov

Chan, & Wood (2010). Preparing Tomorrow's Healthcare Providers for Interprofessional Collaborative Patient-Centred Practice Today. *UBCMJ* 1(2).

Change Foundation (2011). Winning Conditions to improve patient experiences: integrated healthcare in Ontario. www.changefoundation.ca

Chow, S., Teare, G., & Basky, G. (2009). Shared decision making: Helping the system and patients make quality health care decision. Saskatoon: Health Quality Council. www.hqc.sk.ca

Conway, et al. (2006). Partnering with Patients and Families To Design a Patient- and Family-Centered Health Care System, A Roadmap for the Future. www.ipfcc.org

Coulter, A. (2012). Leadership for patient engagement. The King's Fund. London: UK. www.kingsfund.org.uk

Coulter, A. (2012). Patient Engagement-What Works? *J Ambulatory Care Manage,* 35(2): 80-89.

Davis, R., Sevdalis, N., & Vincent, C. (2010). Patient involvement in patient safety: How willing are patients to participate? *BMJ Quality and Safety*, 20: 108-114.

Dentzer, S. (2013). Rx for the 'Blockbuster Drug' of Patient Engagement. *Health Affairs*, 32(2):202.

Epstein, R.M., & Street, R.L. (2011). The values and value of patient-centered care. *Annals of Family Medicine,* 9(2): 100-103.

Epstein, R.M., Fiscella, K., Lesser C.S., & Stange, KC. (2010). Why The Nation Needs A Policy Push On Patient-Centered Health Care. *Health Affairs,* 29(8): 1489-1495.

Frampton, S., Charmel, P. Eds. (2009) Putting Patients First: Best Practices in Patient-Centered Care, Second edition. San Francisco: Planetree, Inc.

Frampton, S., Guastello, S., Brady, C., Hale, M., Horowitz, S., Bennett Smith, S., & Stone, S (2008). *Patient-Centered Care Improvement Guide*. Derby, Connecticut: Planetree. www.ihi.org

Frankel, et al (2011). Crossing the Patient-Centered Divide: Transforming Health Care Quality Through Enhanced Faculty Development, *Academic Medicine,* 86(4), 445-452.

Hall, J., Peat, M., Birks, Y., Golder, S. et al (2010). Effectiveness of interventions designed to promote patient involvement to enhance safety: A systematic review. *BMJ Quality and Safety in Health Care,* 19(5):e10.

Hibbard, J.H., Greene, J., & Overton, V. (2013). Patients with Lower Activation Associated with Higher Costs; Delivery Systems Should Know Their Patients' 'Scores'. *Health Affairs,* 32(2): **216-222.**

Hudon, et al (2011). Measuring Patients' Perceptions of Patient-Centered Care: A Systematic Review of Tools for Family Medicine, *Annals of Family Medicine,* 9:155-164.

Institute for Healthcare Improvement (IHI) (2012). How to Improve. www.ihi.org

Institute for Healthcare Improvement, the National Initiative of Children's Healthcare Quality, the Institute for Patient and Family-Centered Care (2011). *Patient- and Family-Centered Care Organizational Self-Assessment Tool.* www.ihi.org

Institute for Healthcare Improvement (2004). Strategies for Leadership: Patient-and Family-Centred Care: A Hospital Self-Assessment Inventory. www.ihi.org

Johnson, et al (2008). Partnering with Patients and Families to Design a Patient and Family-Centered Health Care System: Recommendations and Promising Practices. The Institute for Patient- and Family-Centered Care. www.ipfcc.org

Kingston General Hospital (2012). Press Release: KGH wins patient-centred care award from NRC Picker. www.kgh.on.ca

Langley, G.L., Nolan, K.M., Nolan, T.W., Norman, C.L., & Provost, L.P. (2009). The Improvement Guide: A Practical Approach to Enhancing Organizational Performance (2nd edition). San Francisco: Jossey-Bass Publishers.

Levinson, W. (2011). Patient-centred communication: a sophisticated procedure. *British Medical Journal of Quality and Safety,* 20(10): 823-825.

Lewis, S. (2009). Patient-Centered Care: An Introduction to What It Is and How to Achieve It: A Discussion Paper for the Saskatchewan Ministry of Health. www.health.gov.sk.ca

Lloyd, R. (2004) Quality healthcare: A guide to developing and using indicators. Sudbury MA. Jones and Bartlett Publishers.

Longtin, Y., Sax, H., Leape, L., Sheridan, S., Donaldson, L., & Pittet, D (2010). Patient Participation: Current Knowledge and Applicability to Patient Safety. *Mayo Clinic Proceedings*, 85: 53-62.

Luxford, et al. (2011). Promoting Patient-centred care: a qualitative study of facilitators and barriers in healthcare organizations with a reputation for improving patient experience, *International Journal for Quality in Heath Care*, 23(5): 510-15.

National Committee for Quality Assurance. The Patient-Centred Medical Home: Health Care that Revolves Around You. An Established Model of Care Coordination. www.ncqa.org

New Brunswick Health Council (2010). Our Health. Our Perspectives. Our Solutions. Results of our First Engagement Initiative with New Brunswick Citizens. www.nbhc.ca

Ontario Medical Association (2010). Patient-Centred Care, Ontario Medical Review, Policy Paper, June 2010. www.oma.org

Picker Institute (2012). Always Events: Health Care Solutions Book. Publications. www.alwaysevents.pickerinstitute.org/?p=1759

Raleigh, V.S., & Foot, C. (2010). Getting the Measure of Quality: Opportunities and Challenges. London: The King's Fund.

Safer Healthcare Now! (2011). Improvement Frameworks Getting Started Kit. Canadian Patient Safety Institute. www.saferhealthcarenow.ca

Safer Healthcare Now! Patient Safety Metrics: Measuring to Reduce Harm. www.saferhealthcarenow.ca

Saint Elizabeth Health Care (2011). Client-Centred Care in the Canadian Home and Community Sector: A Review of Key Concepts. September 2011. www.saintelizabeth.com

Saskatchewan Ministry of Health (2011). Patient- and Family-Centred Care in Saskatchewan: A Framework for Putting Patients and Families First. www.health.gov.sk.ca

Shaller, D., & Darby, C. (2009). High-Performing Patient and Family-Centered Academic Medical Centers: Cross-Site Summary of Six Case Studies. The Picker Institute.

Shaller, D. (2007). Patient-Centered Care: What Does it Take? The Commonwealth Fund. www.commonwealthfund.org

Smith, et al (2011). Behaviorally Defined Patient-Centered Communication-A Narrative Review of the Literature, *Journal of General Internal Med* 26(2): 185-91.

Spragins, & Lorenzetti (2008). Public Expectation and Patient Experience of Integration of Health Care: A Literature Review. The Change Foundation. www.changefoundation.ca

Stange, K.C., Nutting, P.A., et al (2010). Defining and Measuring the Patient-Centered Medical Home. *Journal of General Internal Med,* 25(6): 601-12. www.commonwealthfund.org

The Australian Council on Healthcare Standards (ACHS) (2010). The ACHS EquIP5 Guide: Book 2-Accreditation, Standards, and Guidelines-Support and Corporate Functions. Sydney, Australia: ACHS.

The Australian Commission on Safety and Quality of Health Care (2010). Patient-Centred Care: Improving Quality and Safety by Focusing Care on Patients and Consumers, Discussion paper. www.safetyandquality.gov.au

The Health Council of Canada (2008). How Engaged are Canadians in their Primary Care? Results from the 2010 Commonwealth Fund International Health Policy Survey. Canadian Health Care Matters. Bulletin 5. www.healthcouncilcanada.ca

The Health Council of Canada (2012). Turning what we know into action: A commentary on the National Symposium on Patient Engagement. www.healthcouncilcanada.ca

The Health Foundation (2013). Evidence Scan: Involving patients in improving safety. The Evidence Centre. London: UK. www.health.org.uk

The King's Fund (2013). Patient Centred Leadership: Rediscovering our Purpose. www.kingsfund.org.uk

Wagner, et al (2012). Guiding Transformation: How Medical Practices Can Become Patient-Centred

Medical Homes. The Commonwealth Fund. February 2012. www.commonwealthfund.org

Wasson, & Baker (2009). Balanced Measures for Patient-Centered Care. *J Ambulatory Care Manage*, 32(1), 44-55.

Weingard, S.N. (2013). Patient Engagement and Patient Safety: Perspective on Safety. Agency for Healthcare Research and Quality: WebM&M. www.webmm.ahrq.gov

WIHI. Recognizing Person- and Family-Centered Care: Always Events at IHI Radio Broadcast. September 26, 2013. www.ihi.org

World Health Organization (2007). People-Centred Health Care: A Policy Framework. Geneva. www.who.int

Wynia, & Matiasek (2006). Promising Practices for Patient-Centred Communication with Vulnerable Populations: examples from eight hospitals. The Commonwealth Fund. August 2006. www.commonwealthfund.org

Accreditation Canada would appreciate your feedback on these standards

Your Name: ______________________________

Organization Name: ______________________________

Email address or telephone number: ______________________________

(A Product Development Specialist may contact you about your feedback.)

Feedback: Please indicate the name of the standard, as well as the criterion number in your comments. Please be as specific as possible in your comments.

For example: I would like to provide comments on the Long-Term Care Services standards, criterion 3.12. Clients should be included in this process. I suggest you change the wording to "The team engages staff, service providers, and clients in the process to plan services."

You may also submit your feedback online HERE

[YOUR COMMENTS HERE]

Thank you for your input! Please send this page to:

Program Development, Accreditation Canada, 1150 Cyrville Road, Ottawa, ON K1J 7S9
Fax: 1-800-811-7088, Email: ProgramDevelopment@accreditation.ca