ACCREDITATION
AGRÉMENT
CANADA
Qmentum

Accreditation Report

Horizon Health Network

Fredericton, NB

On-site survey dates: April 16, 2023 - April 21, 2023

Report issued: August 14, 2023

About the Accreditation Report

Horizon Health Network (referred to in this report as “the organization”) is participating in Accreditation Canada's Qmentum accreditation program. As part of this ongoing process of quality improvement, an on-site survey was conducted in April 2023. Information from the on-site survey as well as other data obtained from the organization were used to produce this Accreditation Report.

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

Confidentiality

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

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

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

A Message from Accreditation Canada

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

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

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

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

We look forward to our continued partnership.

Sincerely,

Leslee Thompson
Chief Executive Officer

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Executive Summary

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

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

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

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

Accreditation Decision

Horizon Health Network's accreditation decision is:

Accredited (Report)

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

About the On-site Survey

- **On-site survey dates: April 16, 2023 to April 21, 2023**

- **Locations**

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

1. Charlotte County Addiction and Mental Health Services
2. Charlotte County Hospital
3. Dr. Everett Chalmers Regional Hospital
4. Fredericton Addiction and Mental Health Services
5. Fredericton Junction Health Centre
6. Fundy Health Centre
7. Miramichi Addiction and Mental Health Services
8. Miramichi Health Centre
9. Miramichi Regional Hospital
10. Moncton Addiction and Mental Health Services
11. Moncton Primary Health Care
12. Oromocto Community Health Centre
13. Oromocto Public Hospital
14. Petitcodiac Health Centre
15. Public Health Fredericton
16. Public Health Saint John
17. Queens North Community Health Centre
18. Ridgewood Addiction Services
19. Ridgewood Veteran's Health Wing
20. Rogersville Health Centre
21. Sackville Memorial Hospital
22. Saint John Community Mental Health Services
23. Saint John Regional Hospital
24. St. Joseph's Community Health Centre

25. St. Joseph's Hospital
26. Stan Cassidy Centre for Rehabilitation
27. Sussex Health Centre
28. The Moncton Hospital
29. Upper River Valley Hospital
30. Woodbridge Centre

- **Standards**

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

System-Wide Standards

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

Population-specific Standards

4. Population Health and Wellness

Service Excellence Standards

5. Ambulatory Care Services - Service Excellence Standards
6. Cancer Care - Service Excellence Standards
7. Community Health Services - Service Excellence Standards
8. Community-Based Mental Health Services and Supports - Service Excellence Standards
9. Critical Care Services - Service Excellence Standards
10. Diagnostic Imaging Services - Service Excellence Standards
11. Emergency Department - Service Excellence Standards
12. Hospice, Palliative, End-of-Life Services - Service Excellence Standards
13. Inpatient Services - Service Excellence Standards
14. Long-Term Care Services - Service Excellence Standards
15. Medication Management (For Surveys in 2021) - Service Excellence Standards
16. Mental Health Services - Service Excellence Standards
17. Obstetrics Services - Service Excellence Standards
18. Perioperative Services and Invasive Procedures - Service Excellence Standards
19. Point-of-Care Testing - Service Excellence Standards
20. Public Health Services - Service Excellence Standards
21. Rehabilitation Services - Service Excellence Standards

22. Reprocessing of Reusable Medical Devices - Service Excellence Standards
23. Spinal Cord Injury Acute Services - Service Excellence Standards
24. Substance Abuse and Problem Gambling - Service Excellence Standards
25. Telehealth - Service Excellence Standards
26. Transfusion Services - Service Excellence Standards

- **Instruments**

  The organization administered:

  1. Worklife Pulse
  2. Canadian Patient Safety Culture Survey Tool
  3. Physician Worklife Pulse Tool
  4. Client Experience Tool

Overview by Quality Dimensions

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

Quality Dimension	Met	Unmet	N/A	Total
 Population Focus (Work with my community to anticipate and meet our needs)	109	9	0	118
 Accessibility (Give me timely and equitable services)	156	7	0	163
 Safety (Keep me safe)	837	45	9	891
 Worklife (Take care of those who take care of me)	196	11	5	212
 Client-centred Services (Partner with me and my family in our care)	677	28	2	707
 Continuity (Coordinate my care across the continuum)	141	1	0	142
 Appropriateness (Do the right thing to achieve the best results)	1284	77	14	1375
 Efficiency (Make the best use of resources)	74	4	2	80
Total	**3474**	**182**	**32**	**3688**

Overview by Standards

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

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

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

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

Standards Set	High Priority Criteria *			Other Criteria			Total Criteria (High Priority + Other)		
	Met	Unmet	N/A	Met	Unmet	N/A	Met	Unmet	N/A
	# (%)	# (%)	#	# (%)	# (%)	#	# (%)	# (%)	#
Governance	44 (97.8%)	1 (2.2%)	5	27 (90.0%)	3 (10.0%)	6	71 (94.7%)	4 (5.3%)	11
Leadership	45 (90.0%)	5 (10.0%)	0	91 (94.8%)	5 (5.2%)	0	136 (93.2%)	10 (6.8%)	0
Infection Prevention and Control Standards	38 (95.0%)	2 (5.0%)	0	27 (87.1%)	4 (12.9%)	0	65 (91.5%)	6 (8.5%)	0
Population Health and Wellness	4 (100.0%)	0 (0.0%)	0	30 (85.7%)	5 (14.3%)	0	34 (87.2%)	5 (12.8%)	0
Medication Management (For Surveys in 2021)	91 (91.0%)	9 (9.0%)	0	48 (96.0%)	2 (4.0%)	0	139 (92.7%)	11 (7.3%)	0
Ambulatory Care Services	39 (86.7%)	6 (13.3%)	2	70 (89.7%)	8 (10.3%)	0	109 (88.6%)	14 (11.4%)	2
Cancer Care	100 (99.0%)	1 (1.0%)	0	124 (96.9%)	4 (3.1%)	0	224 (97.8%)	5 (2.2%)	0
Community Health Services	41 (93.2%)	3 (6.8%)	0	77 (96.3%)	3 (3.8%)	0	118 (95.2%)	6 (4.8%)	0

Standards Set	High Priority Criteria *			Other Criteria			Total Criteria (High Priority + Other)		
	Met	Unmet	N/A	Met	Unmet	N/A	Met	Unmet	N/A
	# (%)	# (%)	#	# (%)	# (%)	#	# (%)	# (%)	#
Community-Based Mental Health Services and Supports	45 (100.0%)	0 (0.0%)	0	93 (98.9%)	1 (1.1%)	0	138 (99.3%)	1 (0.7%)	0
Critical Care Services	52 (86.7%)	8 (13.3%)	0	105 (100.0%)	0 (0.0%)	0	157 (95.2%)	8 (4.8%)	0
Diagnostic Imaging Services	67 (100.0%)	0 (0.0%)	1	67 (98.5%)	1 (1.5%)	1	134 (99.3%)	1 (0.7%)	2
Emergency Department	61 (84.7%)	11 (15.3%)	0	102 (95.3%)	5 (4.7%)	0	163 (91.1%)	16 (8.9%)	0
Hospice, Palliative, End-of-Life Services	45 (100.0%)	0 (0.0%)	0	101 (100.0%)	0 (0.0%)	7	146 (100.0%)	0 (0.0%)	7
Inpatient Services	47 (78.3%)	13 (21.7%)	0	69 (81.2%)	16 (18.8%)	0	116 (80.0%)	29 (20.0%)	0
Long-Term Care Services	56 (100.0%)	0 (0.0%)	0	99 (100.0%)	0 (0.0%)	0	155 (100.0%)	0 (0.0%)	0
Mental Health Services	47 (94.0%)	3 (6.0%)	0	85 (92.4%)	7 (7.6%)	0	132 (93.0%)	10 (7.0%)	0
Obstetrics Services	71 (100.0%)	0 (0.0%)	2	88 (100.0%)	0 (0.0%)	0	159 (100.0%)	0 (0.0%)	2
Perioperative Services and Invasive Procedures	103 (89.6%)	12 (10.4%)	0	102 (93.6%)	7 (6.4%)	0	205 (91.5%)	19 (8.5%)	0
Point-of-Care Testing **	37 (97.4%)	1 (2.6%)	0	45 (93.8%)	3 (6.3%)	0	82 (95.3%)	4 (4.7%)	0
Public Health Services	46 (97.9%)	1 (2.1%)	0	68 (98.6%)	1 (1.4%)	0	114 (98.3%)	2 (1.7%)	0
Rehabilitation Services	43 (95.6%)	2 (4.4%)	0	79 (98.8%)	1 (1.3%)	0	122 (97.6%)	3 (2.4%)	0
Reprocessing of Reusable Medical Devices	80 (93.0%)	6 (7.0%)	2	38 (95.0%)	2 (5.0%)	0	118 (93.7%)	8 (6.3%)	2
Spinal Cord Injury Acute Services	50 (100.0%)	0 (0.0%)	0	93 (100.0%)	0 (0.0%)	0	143 (100.0%)	0 (0.0%)	0

Standards Set	High Priority Criteria *			Other Criteria			Total Criteria (High Priority + Other)		
	Met	Unmet	N/A	Met	Unmet	N/A	Met	Unmet	N/A
	# (%)	# (%)	#	# (%)	# (%)	#	# (%)	# (%)	#
Substance Abuse and Problem Gambling	43 (93.5%)	3 (6.5%)	0	73 (89.0%)	9 (11.0%)	0	116 (90.6%)	12 (9.4%)	0
Telehealth	48 (98.0%)	1 (2.0%)	3	86 (98.9%)	1 (1.1%)	2	134 (98.5%)	2 (1.5%)	5
Transfusion Services **	76 (100.0%)	0 (0.0%)	0	68 (98.6%)	1 (1.4%)	0	144 (99.3%)	1 (0.7%)	0
Total	**1419 (94.2%)**	88 (5.8%)	15	1955 (95.6%)	89 (4.4%)	16	3374 (95.0%)	177 (5.0%)	31

* Does not includes ROP (Required Organizational Practices)
** Some criteria within the standard sets were pre-rated based on your organization's accreditation through the Quality Management Program – Laboratory Services (QMP-LS) program managed by Accreditation Canada Diagnostics

Overview by Required Organizational Practices

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

This table shows the ratings of the applicable ROPs.

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

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Communication			
Client Identification (Hospice, Palliative, End-of-Life Services)	Met	1 of 1	0 of 0
Client Identification (Inpatient Services)	Met	1 of 1	0 of 0
Client Identification (Long-Term Care Services)	Met	1 of 1	0 of 0
Client Identification (Mental Health Services)	Met	1 of 1	0 of 0
Client Identification (Obstetrics Services)	Met	1 of 1	0 of 0
Client Identification (Perioperative Services and Invasive Procedures)	Met	1 of 1	0 of 0
Client Identification (Point-of-Care Testing)	Met	1 of 1	0 of 0
Client Identification (Rehabilitation Services)	Met	1 of 1	0 of 0
Client Identification (Spinal Cord Injury Acute Services)	Met	1 of 1	0 of 0
Client Identification (Substance Abuse and Problem Gambling)	Met	1 of 1	0 of 0
Client Identification (Transfusion Services)	Met	1 of 1	0 of 0
Information transfer at care transitions (Ambulatory Care Services)	Met	4 of 4	1 of 1
Information transfer at care transitions (Cancer Care)	Met	4 of 4	1 of 1

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Communication			
Information transfer at care transitions (Community-Based Mental Health Services and Supports)	Met	4 of 4	1 of 1
Information transfer at care transitions (Critical Care Services)	Met	4 of 4	1 of 1
Information transfer at care transitions (Emergency Department)	Met	4 of 4	1 of 1
Information transfer at care transitions (Hospice, Palliative, End-of-Life Services)	Met	4 of 4	1 of 1
Information transfer at care transitions (Inpatient Services)	Met	4 of 4	1 of 1
Information transfer at care transitions (Long-Term Care Services)	Met	4 of 4	1 of 1
Information transfer at care transitions (Mental Health Services)	Met	4 of 4	1 of 1
Information transfer at care transitions (Obstetrics Services)	Met	4 of 4	1 of 1
Information transfer at care transitions (Perioperative Services and Invasive Procedures)	Met	4 of 4	1 of 1
Information transfer at care transitions (Rehabilitation Services)	Met	4 of 4	1 of 1
Information transfer at care transitions (Spinal Cord Injury Acute Services)	Met	4 of 4	1 of 1
Information transfer at care transitions (Substance Abuse and Problem Gambling)	Met	4 of 4	1 of 1

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Communication			
Medication reconciliation as a strategic priority (Leadership)	Met	3 of 3	2 of 2
Medication reconciliation at care transitions (Ambulatory Care Services)	Unmet	3 of 5	0 of 0
Medication reconciliation at care transitions (Cancer Care)	Met	9 of 9	0 of 0
Medication reconciliation at care transitions (Community-Based Mental Health Services and Supports)	Met	3 of 3	1 of 1
Medication reconciliation at care transitions (Critical Care Services)	Met	4 of 4	0 of 0
Medication reconciliation at care transitions (Emergency Department)	Met	1 of 1	0 of 0
Medication reconciliation at care transitions (Hospice, Palliative, End-of-Life Services)	Met	4 of 4	0 of 0
Medication reconciliation at care transitions (Inpatient Services)	Unmet	2 of 4	0 of 0
Medication reconciliation at care transitions (Long-Term Care Services)	Met	4 of 4	0 of 0

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Communication			
Medication reconciliation at care transitions (Mental Health Services)	Met	4 of 4	0 of 0
Medication reconciliation at care transitions (Obstetrics Services)	Met	4 of 4	0 of 0
Medication reconciliation at care transitions (Perioperative Services and Invasive Procedures)	Met	4 of 4	0 of 0
Medication reconciliation at care transitions (Rehabilitation Services)	Met	4 of 4	0 of 0
Medication reconciliation at care transitions (Spinal Cord Injury Acute Services)	Met	4 of 4	0 of 0
Medication reconciliation at care transitions (Substance Abuse and Problem Gambling)	Met	3 of 3	1 of 1
Safe Surgery Checklist (Obstetrics Services)	Met	3 of 3	2 of 2
Safe Surgery Checklist (Perioperative Services and Invasive Procedures)	Met	3 of 3	2 of 2
The “Do Not Use” list of abbreviations (Medication Management (For Surveys in 2021))	Met	4 of 4	3 of 3

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Medication Use			
Antimicrobial Stewardship (Medication Management (For Surveys in 2021))	Met	4 of 4	1 of 1
Concentrated Electrolytes (Medication Management (For Surveys in 2021))	Met	3 of 3	0 of 0
Heparin Safety (Medication Management (For Surveys in 2021))	Met	4 of 4	0 of 0
High-Alert Medications (Medication Management (For Surveys in 2021))	Met	5 of 5	3 of 3
Infusion Pumps Training (Ambulatory Care Services)	Met	4 of 4	2 of 2
Infusion Pumps Training (Cancer Care)	Met	4 of 4	2 of 2
Infusion Pumps Training (Critical Care Services)	Met	4 of 4	2 of 2
Infusion Pumps Training (Emergency Department)	Met	4 of 4	2 of 2
Infusion Pumps Training (Hospice, Palliative, End-of-Life Services)	Met	4 of 4	2 of 2
Infusion Pumps Training (Inpatient Services)	Unmet	3 of 4	2 of 2
Infusion Pumps Training (Mental Health Services)	Met	4 of 4	2 of 2
Infusion Pumps Training (Obstetrics Services)	Met	4 of 4	2 of 2

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Medication Use			
Infusion Pumps Training (Perioperative Services and Invasive Procedures)	Met	4 of 4	2 of 2
Infusion Pumps Training (Rehabilitation Services)	Met	4 of 4	2 of 2
Infusion Pumps Training (Spinal Cord Injury Acute Services)	Met	4 of 4	2 of 2
Narcotics Safety (Medication Management (For Surveys in 2021))	Met	3 of 3	0 of 0
Patient Safety Goal Area: Worklife/Workforce			
Client Flow (Leadership)	Met	7 of 7	1 of 1
Patient safety plan (Leadership)	Met	2 of 2	2 of 2
Patient safety: education and training (Leadership)	Met	1 of 1	0 of 0
Preventive Maintenance Program (Leadership)	Met	3 of 3	1 of 1
Workplace Violence Prevention (Leadership)	Met	5 of 5	3 of 3
Patient Safety Goal Area: Infection Control			
Hand-Hygiene Compliance (Infection Prevention and Control Standards)	Met	1 of 1	2 of 2

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Infection Control			
Hand-Hygiene Education and Training (Infection Prevention and Control Standards)	Met	1 of 1	0 of 0
Infection Rates (Infection Prevention and Control Standards)	Met	1 of 1	2 of 2
Patient Safety Goal Area: Risk Assessment			
Falls Prevention Strategy (Cancer Care)	Met	2 of 2	1 of 1
Falls Prevention Strategy (Critical Care Services)	Met	2 of 2	1 of 1
Falls Prevention Strategy (Hospice, Palliative, End-of-Life Services)	Met	2 of 2	1 of 1
Falls Prevention Strategy (Inpatient Services)	Unmet	2 of 2	0 of 1
Falls Prevention Strategy (Long-Term Care Services)	Met	5 of 5	1 of 1
Falls Prevention Strategy (Mental Health Services)	Met	2 of 2	1 of 1
Falls Prevention Strategy (Obstetrics Services)	Met	2 of 2	1 of 1
Falls Prevention Strategy (Perioperative Services and Invasive Procedures)	Met	2 of 2	1 of 1
Falls Prevention Strategy (Rehabilitation Services)	Met	2 of 2	1 of 1

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Risk Assessment			
Falls Prevention Strategy (Spinal Cord Injury Acute Services)	Met	2 of 2	1 of 1
Pressure Ulcer Prevention (Cancer Care)	Met	3 of 3	2 of 2
Pressure Ulcer Prevention (Critical Care Services)	Met	3 of 3	2 of 2
Pressure Ulcer Prevention (Hospice, Palliative, End-of-Life Services)	Met	3 of 3	2 of 2
Pressure Ulcer Prevention (Inpatient Services)	Met	3 of 3	2 of 2
Pressure Ulcer Prevention (Long-Term Care Services)	Met	3 of 3	2 of 2
Pressure Ulcer Prevention (Perioperative Services and Invasive Procedures)	Met	3 of 3	2 of 2
Pressure Ulcer Prevention (Rehabilitation Services)	Met	3 of 3	2 of 2
Pressure Ulcer Prevention (Spinal Cord Injury Acute Services)	Met	3 of 3	2 of 2
Suicide Prevention (Community-Based Mental Health Services and Supports)	Met	5 of 5	0 of 0
Suicide Prevention (Emergency Department)	Met	5 of 5	0 of 0
Suicide Prevention (Long-Term Care Services)	Met	5 of 5	0 of 0

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Risk Assessment			
Suicide Prevention (Mental Health Services)	Unmet	1 of 5	0 of 0
Suicide Prevention (Substance Abuse and Problem Gambling)	Met	5 of 5	0 of 0
Venous Thromboembolism Prophylaxis (Cancer Care)	Met	3 of 3	2 of 2
Venous Thromboembolism Prophylaxis (Critical Care Services)	Met	3 of 3	2 of 2
Venous Thromboembolism Prophylaxis (Inpatient Services)	Met	3 of 3	2 of 2
Venous Thromboembolism Prophylaxis (Perioperative Services and Invasive Procedures)	Met	3 of 3	2 of 2
Venous Thromboembolism Prophylaxis (Spinal Cord Injury Acute Services)	Met	3 of 3	2 of 2

Summary of Surveyor Team Observations

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

Horizon Health Network (Horizon) is to be commended for preparing for and participating in the accreditation program. The Trustee, Executive Leadership Team, team members and community partners should all be commended for their commitment to the quality improvement and accreditation journey. Everyone welcomed the accreditation process and was proud of the programs and services offered and the organization's improvements over the past couple of years. As the organization has progressed through the COVID-19 pandemic, the leadership and front-line staff had to address the health system's demands and pressures, including an aging demographic, a shortage of key resources and increasing demands from the public. The need to transform the healthcare system has been at the forefront of the organization's vision, mission, and values. The goal of putting patients' and clients' needs first while supporting and empowering staff and physicians has guided the organization through this challenging period.

There is a strong commitment to the vision (Exceptional Care. Every Person. Every Day.), mission (Healthy People Being Healthy), and values of the Horizon. Team members, physicians and leaders all live the values which include: We show empathy, compassion, and respect; We strive for excellence; We are all leaders, yet work as a team; and We act with integrity and are accountable.

Horizon's Board of Directors was replaced by a Trustee appointed by the Department of Health in July 2022 and act in accordance with the Regional Health Authority Act. They hold all responsibilities, duties and powers of the Board of Directors and is tasked with making governance decisions on behalf of the organization. The Trustee has an excellent working relationship with the CEO and is working to ensure the organization continues to advance its priorities and improve upon key system areas. It was clear through discussions with the Trustee that she is dedicated and committed to seeing rapid improvements to the health system. The organization is encouraged to continue this good work and work with the Department of Health, Trustee, and other health system partners to implement "normalized" governance practices.

The organization has embarked on a rapid health system transformation focused on four key priorities:

1) Improving ACCESS to health care, specifically surgical services, emergency care, and addiction and mental health services;
2) RETENTION and recruitment of physicians, nurses and staff;
3) Improving patient FLOW at our healthcare facilities; and
4) Community engagement and patient EXPERIENCE.

The organization should be commended for the greater than 70 projects that have been initiated in eight hospitals across 31 community sites and 17 departments. The organization has invested millions of dollars in the improvement changes. This has enabled citizens of New Brunswick to access emergency care more quickly. Specifically, Horizon added patient monitors who are proactively checking vital signs, providing comfort support, and monitoring the well-being of people in the wait rooms of five hospitals. The

organization also added social workers to emergency departments in four regional hospitals to prevent patients without acute needs from being admitted. Patient Flow Centres have also been established in emergency departments across the three largest hospitals in the region to enable faster access to care. Horizon is encouraged to continue these initiatives to enhance access to care so that patients can be seen, tested, and treated more quickly.

Horizon has undertaken aggressive health human resources recruitment and retention strategies. Several health human resource strategies have led to recruiting of over 1,100 staff, including hundreds of nursing, allied health, and support service workers. Several staff recognition initiatives have also been undertaken, including the Bravo! Program that has recognized over 8,800 staff in 6 months. Programs to enable staff to function at their full scope have also supported staffing challenges across the organization. Horizon is encouraged to continue this great work to stabilize the workforce and the challenges related to health human resources.

Several activities have been implemented across Horizon to support patient engagement and the patient experience. Some of these initiatives include:

1) New online tools have been deployed to allow patients' loved ones to see their surgery status in real time.
2) Implementation of SeamlessMD technology to enable app-based patient care plans.
3) Improving the environment for those presenting with addiction and mental health concerns at the emergency department

Horizon is encouraged to continue enhancing its patient engagement activities to better understand what activities will drive an enhanced patient experience. Enhanced patient and community partner engagement assists the organization in identifying opportunities for improvement and drives enhanced trust, collaboration, and partnership across regions.

The organization has implemented many facility and infrastructure investments, improving the physical environment. There continue to be numerous sites that require physical infrastructure investment to address environmental deficiencies. The organization is encouraged to consider developing a regional facility master plan and prioritize investments in the highest priority areas. Investments are required in clinical and business information systems. Horizon operates with a hybrid clinical and business record which drives inefficiencies and poses a risk to patient care and business continuity. The region is encouraged to investigate investments in an integrated clinical information system and consolidated corporate systems.

Community partners expressed appreciation to organizational leaders for their recent (within the last two years) efforts to communicate and collaborate with them on improving the health system. Municipal leaders acknowledged a marked improvement in communication and collaboration. There continue to be opportunities for the organization to better partner with community groups. Specifically, significant inefficiencies exist in the ability of patients to transition from primary care, acute care and the home, community, and long-term care sectors. Horizon is encouraged to continue to work with the ministries of health and social services as well as the home, community care, and long-term care providers to better transition patients from acute care to alternate levels of care.

There is client and family involvement throughout all programs and services at the regional level of Horizon. Leaders and team members are deeply committed to engaging with clients, families and partners in the planning and service design. Opportunities exist for the organization to continue to enhance the breadth and depth of client and family engagement to positively impact decisions being made at all levels of the organization while creating deep, authentic relationships in the process.

There is a strong culture of safety, quality, and risk management. Quality improvement activities are well-defined at the regional level. Clients, families, and partners are involved in co-designing quality improvement initiatives at the regional and program levels but not at the local level. Unit and site-specific quality improvement activities could be enhanced across the organization. The qualitative and quantitative data that the organization collects could be better disseminated to the front line to support localized quality improvement activities. Horizon is encouraged to continue to promote quality improvement activities at the unit and site level with input from clients and families.

The CEO and Executive Leadership Team are visible and engaged with team members, physicians, community partners, clients, and families. They actively engage with team members to identify and reduce barriers to access to programs and services.

The survey team has had an amazing experience supporting the organization through its accreditation journey. It has been an honour and privilege for the team to interact with and engage with leaders, physicians, team members, and patients and their families throughout the survey. They are recognized for being flexible and resilient over the past several years of COVID-19 to meet the needs of clients, families, and the broader community. Safety, innovation, and creativity were at the forefront of the pandemic response, and Horizon is to be commended for its efforts during these challenging times. Leaders and team members are encouraged to continue their work to transform the health system to provide Exception Care to Every Person, Every Day.

Detailed Required Organizational Practices

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

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

Unmet Required Organizational Practice	Standards Set
Patient Safety Goal Area: Communication	
Medication reconciliation at care transitions Medication reconciliation is conducted in partnership with clients and families to communicate accurate and complete information about medications across care transitions.	· Ambulatory Care Services 8.5 · Inpatient Services 9.7
Patient Safety Goal Area: Medication Use	
Infusion Pumps Training 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.	· Inpatient Services 3.8
Patient Safety Goal Area: Risk Assessment	
Falls Prevention Strategy To prevent falls and reduce the risk of injuries from falling, universal precautions are implemented, education and information are provided, and activities are evaluated.	· Inpatient Services 9.8
Suicide Prevention Clients are assessed and monitored for risk of suicide.	· Mental Health Services 8.8

Detailed On-site Survey Results

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

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

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

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

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

See Appendix B for a list of priority processes.

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

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

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

Priority Process Results for System-wide Standards

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

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

Priority Process: Governance

Meeting the demands for excellence in governance practice.

Unmet Criteria		High Priority Criteria
Standards Set: Governance		
5.5	The governing body has a formal process to understand, identify, declare, and resolve conflicts of interest.	
7.8	The governing body has a succession plan for the CEO.	
13.10	The governing body identifies and addresses opportunities for improvement in how it functions.	!

Surveyor comments on the priority process(es)

Horizon Health Network (Horizon) is governed by a Trustee who was appointed by the Government of New Brunswick in July of 2022 following the death of a patient in the waiting room of the Dr. Everett Chalmers Regional Hospital Emergency Room. The Trustee operates as the Board of Horizon with all the statutory functions of the Board of Directors. This Trustee is expected to remain in office until June of 2023 at which time it is anticipated that a new Board structure will be established.

The Trustee has a very good understanding of the role and responsibilities of the Board governing the organization. Reports with recommendations and decision requests are brought forward to the Trustee addressing the areas of Quality and Patient Safety, Finance and Audit, Human Resources and any issues that may pose a risk to the organization. Minutes of the meetings are captured and document decision records. The organization has a significant focus on quality improvement activities that address opportunities for improvement. The Trustee actively challenges the interim CEO and Executive Leadership Team to identify and implement opportunities for efficiency and quality improvement.

There is an excellent working relationship between the Trustee and the interim CEO. Feedback is regularly provided to the CEO and Executive Leadership Team. The organization is encouraged to establish a robust process for succession planning for the CEO once the organizational and governance structure has been finalized.

The Trustee oversees the privileging and credentialling process for the organization and is actively involved in any medical performance issues, disputes or appeals that are brought forward to the Board for review.

There are several policies governing the operations of the governing body. The organization is encouraged to ensure that these policies are maintained and kept up to date. Horizon is also encouraged to review the organizational conflict of interest policy and ensure that there is a process to address any or perceived conflicts of interest (related to organizational staff and the governing body).

Once a new Board has been appointed, Horizon Health is encouraged to ensure that the governing body has processes in place to evaluate the effectiveness of the Board (and Board chair), size and committee structure, contributions of individual board members, etc.

There is excellent engagement of the Trustee, interim CEO, and Executive Leadership Team with the community, community partners, and patients and families. Several examples of personalized discussions and interactions between the Trustee and CEO and patients and families who had experiences at Horizon were provided. The organization has a several mechanisms to bring forward issues related to patient experience. The Board is encouraged to review and continue implementing mechanisms to engage patients and families into the overall governance of Horizon Health.

Priority Process: Planning and Service Design

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

Unmet Criteria	High Priority Criteria
Standards Set: Leadership	
4.12 Policies and procedures for all of the organization's primary functions, operations, and systems are documented, authorized, implemented, and up to date.	

Surveyor comments on the priority process(es)

Horizon Health Network (Horizon) has a strong Planning and Performance structure that is responsible for business analytics, health analytics, and performance optimization. This team supported the development of the organization's strategic plan which drives the regional health and business plan, balanced scorecard, and priority projects. The team has utilized project management, lean six sigma and change management methodologies to support over 75 regional quality improvement activities. While many of these quality improvement initiatives have led to immediate, measurable change, the organization should closely monitor the capacity of Horizon leadership to continue with the pace of change and assess the organization's level of change fatigue.

All service planning is informed by Horizon's mission, vision, and values and is driven by the organization's strategic plan. The strategic plan has 3 strategic priorities and 13 strategic objectives. Each of these are aligned to four priority action areas that include access to services, recruitment and retention, patient flow, and patient experience. The organization has also ensured that each of these priority areas align to the Provincial Health Plan. Patients and families were represented and engaged in the co-design and development of the strategic plan and key priority areas. The community health needs assessment also assisted the organization to define a community's strength and needs at the local levels.

Community stakeholders also commented on how collaborative Horizon Health has been over the past couple of years. Engagement and communication have improved and all expressed optimism in addressing the challenges facing the health system. Several examples were provided of collaboration between Horizon and municipal leadership that assisted in addressing gaps in health and well- being at the local community level. There continues to be an opportunity for Horizon and community health partners to integrate services better. Several examples were highlighted where patients could not transition out of acute care facilities because of challenges in integrating home and community, and long-term care services. Horizon Health is encouraged to continue working with the Extra Mural Program, health and social services ministries, and other partners to better integrate program planning and service design between the Acute and Primary care sector and the Home, Community, and Long-Term Care Sectors.

Horizon Health is to be commended on the utilization of data to drive system planning and decision making. Both qualitative and quantitative data evidence was used in developing the health system plan. There may be an opportunity for the organization to extend the use of this information at the local level. Several inpatient and care settings were unaware of the data available to them or how to use this data to better deliver services or drive efficiencies. Quality improvement activities at the local level could also be enhanced by leveraging some of the regional tools and resources at the local level.

The organization has numerous policies and procedures available on the Skyline Intranet site. However, several policies are outdated and have not been maintained or refreshed. Several policies had not been reviewed for over a decade and referenced associated policies that no longer exist. The organization is encouraged to review the policy site and ensure that policies and procedures are kept up to date. Also, it will be important to ensure that there is good organizational awareness as to when policies are being newly implemented, revised, or decommissioned.

Priority Process: Resource Management

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

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

The team members and leaders are commended for their commitment to ensuring the financial health of Horizon Health Network (Horizon). The leaders and team members value working as a team. A leader described this approach as, “The way we operate is a team approach across all functions. There is 100% engagement.” Additionally, a leader noted, “I am proud of the staff. We are a small but mighty team.”

Robust accountability processes are implemented throughout the organization. There is a defined resource management cycle which includes budget, capital equipment, infrastructure and information technology planning. There is congruence and synergy between the budgeting, capital equipment, infrastructure and information technology teams. The planning cycles are communicated to team members and leaders. There is a strong collaborative working relationship with the Department of Health supporting the budget, capital equipment, infrastructure and information technology. Policies, procedures and guidelines are developed and implemented to support resource management. The leaders are encouraged to continue to ensure that policies and procedures are reviewed and updated regularly.

A Budget Pressures Priority Template helps guide the budget planning process. Accountability and ethical conversations, and decision making help to guide the planning process. Financial reports outlining variances are developed and analyzed. Education and training are provided to leaders on financial management. This extends to providing a mentor to support team members and leaders. The Trustee approves the capital, operating and infrastructure budgets. There is a legislative requirement for a balanced budget which Horizon has achieved. The audited financial statements are approved by the Trustee. The organization has achieved unqualified audits.

A five-year capital equipment plan is developed. The leaders and team members are proud of their work in ensuring contingency funds to support urgent equipment needs. Additionally, they acknowledged the strong support of the seventeen foundations in supporting the capital equipment needs of Horizon. Meetings are held monthly with the foundations.

Ensuring quality infrastructure and capital improvement to support programs and services is a priority for the team. Priorities are identified using a decision making matrix with the broad involvement of team members and leaders. Patient and staff safety, quality, infection prevention and control, and accreditation recommendations are some considerations for making decisions. The team is proud of their work in addressing infrastructure needs; however, this is an ongoing process. Aging infrastructure and increased demand for services is challenging. The team members and leaders are commended for their work in environmental stewardship.

The information technology team are acknowledged for the development of a Cyber Security Plan. Understanding and managing the risks of cyber security is critical to the operation of Horizon. An Information Technology Strategic Plan is developed and implemented. The team members and leaders are committed to innovation and partnership. Hybrid client records exist in many clinical areas and sites. The leaders are encouraged to explore the implementation of a single integrated health record. Additionally, the leaders are encouraged to explore integrated corporate systems.

Priority Process: Human Capital

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

Unmet Criteria		High Priority Criteria
Standards Set: Leadership		
10.10	Reporting relationships and leaders' span of control is regularly evaluated.	

Surveyor comments on the priority process(es)

Horizon Health Network (Horizon) has a robust human resources (HR) team focused on eight key workstreams: Employee Health, Wellness and Safety; HR Operations; Employee Engagement; Labour and Employee Relations; Workforce Development; HR Analytics and Optimization; Talent Acquisition; and Workforce Optimization. This team has established a very integrated human resources strategic plan that aligns well with the overall Horizon strategic plan.

As part of this plan, each functional area was directed to develop a strategy map that included high level objectives that HR would be undertaking to drive the overall organizational goals. SMART (specific, measurable, attainable, relevant, and timely) objectives were developed to ensure that success could be measured. Initiatives for each objective were identified, along with the responsible leader, timelines and key performance indicators contributing to the overall SMART goal. The result has ensured that the human resources department has a clear vision and accountability for the overall HR Strategy. Human Resources Leaders are actively collaborating across functional areas of responsibility and the team has illustrated measurable results.

Some of the successes of this team include:

1) Activities related to COVID-19 response include implementing new technologies to track and evaluate staff health, wellness and safety. This included the ability for staff to submit proof of vaccine online; evaluate staffing shortages and equipping leaders to make operational decisions; and determining priority areas that require mask fit testing, to name a few.
2) Extensive activities related to talent acquisition include domestic, national and international recruitment events. This has resulted in over 1600 new hires since October 2022 including over 300 registered nurses, nearly 200 licensed practical nurses, and nearly 900 (CUPE) support workers.
3) Building healthier workplaces by preventing workplace violence and implementing initiatives to provide a safe, secure and violence free work environment.
4) Numerous staff retention activities focusing on 4 key areas of focus: Listen & Act: “What You Say Matters at Horizon”; Recognize & Appreciate: “Horizon Acknowledges Your Value”; Health, Safety & Belonging: “Horizon Cares About Your Wellbeing”; and Learning & Development: “Horizon Believes in Your Potential”.

Throughout the week, surveyors interacted with leaders across the organization. Several leaders are new to their roles within the organization. Change in leadership can be challenging for staff as well as the new leaders. The organization is encouraged to continue to great work of supporting these new leaders as they continue to grow and develop their careers. Part of this process is ensuring that regular performance reviews are being conducted. There was variability across the organization as to how recently individuals had performance conversations. The organization is encouraged to support leaders in enabling them to conduct performance reviews in a consistent and timely manner. It was also note that some managers have large spans of control. Horizon Heath is encouraged to complete the span of control review that has been initiated to ensure that leaders have manageable scopes of responsibility.

Horizon Health has undertaken some good work in supporting a culture of diversity, equity and inclusion. There may be opportunity for the organization to further address stigmatization from both a staff and patient perspective. HORIZON is encouraged to continue these good efforts and provide further education and support in this area.

Priority Process: Integrated Quality Management

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

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

There is a strong commitment to quality improvement. The leaders, team members and physicians are actively engaged in ensuring an environment within Horizon Health Network (Horizon) that has safe and quality programs and services for clients and families. The team was described as “dedicated, professional, committed, leadership, real, and having integrity.” A leader noted, “The team is dedicated to having quality and safe care for clients. They do good work.” The team members are recognized for their work in safety and quality through BRAVO Awards, Quality Quest Award, and the Patient Safety Hero Award. Quality improvement, risk management, and safety are priorities for the team. Clients and families are engaged in quality and safety processes. There are Patient Experience Advisors that are embedded in the quality, safety and risk management processes and have a key role in co-design. A Patient Experience Advisor stated, “It is a privilege to be involved. It’s fun. I have learned so much. I am proud to be able to make a positive contribution.” The leaders are encouraged to continue to embed Patient Experience Advisors and Patient Representatives in quality, safety and risk management processes at all levels of the organization, including the program and site level.

A quality plan guides the team members, leaders and physicians in quality improvement. This plan is congruent with the vision, mission, values and Strategic Plan (2021-2026) of Horizon. The Vice President of Quality and Safety represents the Executive Leadership Team in the Horizon Quality and Safety Committee. There are a number of committees and working groups that report to the Horizon Quality and Safety Committee including; infection prevention and control, and medication safety, to name just a few. The Quality of Care and Safety of Patients Committee has a key role fostering a culture of safety and quality, including participating in quality process reviews. PEA’s are active members of the Quality of Care and Safety of Patients Committeelients and families participate in review processes. A leader described the process as, “Bringing humanity in what we do. It is understanding the perspectives of families who have suffered.” A balanced scorecard is developed and monitored. Performance measures are developed and monitored. The CEO and Trustee monitor quarterly quality reports. There is variation across of the integration of quality improvement at the site and unit levels. The leaders are encouraged to continue supporting teams in embedding quality improvement at the site and department levels.

The Horizon Patient Safety Action Plan (2022-2026) has identified key priorities for safety. For example, patient flow, reducing wait times and improving patient/client safety and quality of care are some of the key priorities. There has been communication with communities on key priorities for Horizon. This includes distributing a report to communities, “Update on Horizon’s Critical Action Priorities.” A prospective analysis on oxytocin safety was completed. There were fifteen recommendations provided and implemented.

The Integrated Risk Management Framework supports a proactive approach to managing risk. A regional coordinator was hired in 2021. Robust risk management processes are implemented. Incidents are tracked with trends monitored and reviewed. Follow up is completed on safety incidents, with action plans developed as required. Quarterly risk management reports are provided to the Executive Leadership Team and Trustee. A Risk Assessment Quick Reference Guide is implemented. An Incident Management Reporting System is available for team members and leaders. Team members and leaders are using an Excel file and manual processes to track risk management processes. They are encouraged to implement an automated risk management solution to support the risk management processes.

Priority Process: Principle-based Care and Decision Making

Identifying and making decisions about ethical dilemmas and problems.

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

The team members and leaders are acknowledged for developing a robust and comprehensive ethics program for Horizon Health Network (Horizon). They are passionate about fostering a principle-based care and decision making environment which supports team members, leaders, physicians, clients and families. The ethics program was described by team members using such words as " educational, transparent, excellent, fabulous, superlative, comprehensive, super-competent, and fun." The ethics program is grounded in Horizon's vision, mission and values. A comprehensive Ethics Framework and Ethics Decision Making Framework are developed. A Balanced Score Card is developed and monitored. An annual report is provided to Horizon Quality and Safety Committee. This information is shared and discussed with Executive Leadership Team and the Trustee.

The leaders and team members of the Ethics Department are acknowledged for their work during COVID-19. Ethics was an integral component of the management of the pandemic through such activities as participation in the emergency operations center, consultation, policy and procedure development, and support. Through the support of ethics, Horizon was one of the first health organizations in Canada to have Designated Support Persons for clients. Other initiatives that received ethical consultation and support include; vaccine mandates for staff, employee COVID-19 testing, and how to safely manage outbreaks. Furthermore, they were integrally involved in how to bring health care workers safely back to work when they were recovering from COVID-19.

Clinical ethics consultations are provided to team members, leaders, clients, families and patient representatives. The ethics decision making framework is used to guide the process. A team member described the benefit of this process to their clinical area. They stated, " The whole team was supportive. It was helpful and validating. Ethically, I feel it was a good process, thorough and supportive." The team are very responsive to the request for clinical ethical consultation, with 100% responded to within 3 days.

There is a strong commitment to providing ethical education and training opportunities to team members, leaders, Trustee, clients and families, and patient representatives. One such forum is Bioethics Grand Rounds, during which the ethical framework is discussed, and senior leaders participate in presenting the Grand Rounds. Another educational opportunity is the Ethics Education Sessions.

The Research Ethics Board supports quality ethical research within Horizon. A major accomplishment is the Human Research Protection Program was accredited through Human Research Accreditation Canada in March 2021 and was renewed in 2021 and 2022. There is a defined process to submit research studies for ethical approval. There is annual tracking of the number of research studies reviewed by the Research Ethics Board and the turn around to provide ethical review. The Research Ethics Board committee

members are proud of their work in promoting research within Horizon. The board has held Research Ethic Board meetings virtually during the pandemic. Some committee members valued the face-to-face discussion and look forward to the return to in-person meetings. There was also a suggestion to have residents and medical learners engaged in the research process.

Priority Process: Communication

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

Unmet Criteria	High Priority Criteria
Standards Set: Leadership	
11.3 Policies and procedures to support the collection, entry, use, reporting, and retention of information are implemented and reviewed and updated regularly.	!

Surveyor comments on the priority process(es)

Horizon Health Network (Horizon) has a very robust Communications team comprised of 28 dedicated professionals focusing on the areas of Corporate Communications, Marketing Communications, and Community Engagement. These resources are available to support the four zones in Horizon, provincial programs, and corporate services.

The Communication team has been focusing on building and enhancing engagement with both internal and external audiences. Excellent efforts have been put forward to develop and implement various approaches to communicating important and accurate information with key external and internal stakeholders. This has been done through paid, social, and internal organizational methods in a way to stand out and garner public attention. The team actively responds to media and external inquiries related to healthcare services within the region. Media training has been provided to members of the Executive Leadership Team and other Subject Matter Experts to support this communication.

Various communication, marketing and community engagement strategies are implemented to promote the Horizon brand, minimize misinformation, and engage and create champions (both internally and externally) among stakeholders. Various measurement tools are utilized (like social media impressions, website clicks, etc.) to evaluate the effectiveness of the communication methodology used. The ultimate goal of these activities is to build trust and enhance engagement among communities, stakeholders, and partners. The team is encouraged to continue this excellent work, and monitor, and adjust the communications strategies to achieve the organization's goals.

Privacy and access to personal health information is well understood and managed at Horizon Health. There are policies and procedures to support the collection, entry, use, reporting, and retention of information. However, the policies are quite dated and require a review to ensure they are still relevant and applicable to the organization's current information systems. Processes exist in response to privacy breaches, cyber security attacks, etc. Systems exist to enable patients or clients to access their personal health information through Health Records.

Several (clinical and corporate) areas are operating in both a paper and electronic documentation system.

The use of multiple record keeping systems presents a risk to the organization, impacting efficiency, clinical operations, and the continuity of care. The organization is encouraged to continue the good work of consolidating systems and digitizing the clinical and corporate records to enhance organizational effectiveness and drive efficiencies.

Priority Process: Physical Environment

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

Unmet Criteria		High Priority Criteria
Standards Set: Perioperative Services and Invasive Procedures		
3.1	The physical layout of the operating and/or procedure room(s) and equipment are designed to consider client flow, traffic patterns, the types of procedures performed, ergonomics, and equipment movement logistics.	
3.2	The area where invasive procedures are performed has three levels of increasingly restricted access: unrestricted areas, semi-restricted areas, and restricted areas.	!
3.9	The operating/procedure room has a restricted-access area for the sterile storage of supplies.	!

Surveyor comments on the priority process(es)

During this survey there was an opportunity to tour and visit with teams in five sites within Horizon Health Network (Horizon), Dr. Everett Chalmers Regional Hospital, Miramichi Regional Hospital, Sackville Memorial Hospital, Saint John Regional Hospital and The Moncton Hospital to review the standards related to the physical environment. Overall, the physical environments within Horizon are well maintained. Investments have been made to support major systems. There is knowledgeable and engaged leadership and staff are happy working with the physical environment team.

Four of the regional hospitals have achieved Energy Star Awards for there work to reduce the environmental impact. Several projects are ongoing, and more to commence soon throughout Horizon Health to expand capacity. These projects are necessary as the current facilities and infrastructure cannot accommodate the demands of the increasing patient population, especially pressures related to patient flow which results in routine overcapacity in all sites.

Significant investments have been made to upgrade new generators to reduce the impact of utility failures on client and team health and safety.

There is a process in place for preventative maintenance and repairs. Frontline staff are aware of the process to input requisitions electrically through the intranet.

During the site visit of Sackville Memorial Hospital the surveyor noted the worked being completed by volunteers to maintain the green space in the atrium.

The organization should consider Master Planning from an overall provincial and site level perspective to meet the changing population demands and care complexities in the regions, in consultation with frontline staff, patients, and families.

Across the sites their were noted deficiencies related to the flow of soiled to clean in areas where reprocessing of probes for endoscopy is occurring, also a review of restricted areas in perioperative

Priority Process: Emergency Preparedness

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

Unmet Criteria		High Priority Criteria
Standards Set: Infection Prevention and Control Standards		
13.7	Policies and procedures are regularly reviewed and improvements are made as needed following each outbreak.	
Standards Set: Leadership		
14.2	An all-hazard disaster and emergency response plan is developed and implemented.	!
14.3	The all-hazard disaster and emergency response plan is aligned with those of partner organizations and local, regional, and provincial governments.	!
14.5	The organization's all-hazard disaster and emergency response plans are regularly tested with drills and exercises to evaluate the state of response preparedness.	!
14.6	The results from post-drill analysis and debriefings are used to review and revise the all-hazard disaster and emergency response plans and procedures as necessary.	
14.8	An emergency communication plan is developed and implemented.	
14.9	A business continuity plan is developed and implemented in order to continue critical operations during and following a disaster or emergency.	
14.10	The business continuity plan addresses back-up systems for essential utilities and systems during and following emergency situations.	!
Standards Set: Public Health Services		
13.3	There are clear activation criteria for initiating an emergency response.	!
13.7	The public health emergency response is tested as part of broader all-hazard disaster and emergency response plan drills.	
Surveyor comments on the priority process(es)		

Horizon Health Network (Horizon) has a small Emergency Preparedness Team of 4 dedicated professionals with a variety of backgrounds and expertise. They serve the region through four administrative areas

consisting of Area 1 (Moncton), 2 (Saint John), 3 (Fredericton/Upper River Valley), and 7 (Miramichi). The team was reorganized in 2021 to develop clearer lines of accountability and to lead Horizon in the design and implementation of activities to enable consistent management of risks. The goal is to prevent risks from occurring, mitigate the impact of the emergency and enhance the organization's preparedness to respond and recover from emergencies. The emergency management team described plans to create areas and specific working groups, including clinical, infection prevention and control, facilities, etc., team members to better plan for emergency response. Horizon is encouraged to activate these working groups as soon as possible to enable the excellent strategies developed by the emergency management team. Given the current state of the emergency preparedness structure at Horizon, the organization is encouraged to assess the resources allocated to this team to ensure sufficient supports are available to achieve an optimal emergency response.

Horizon is encouraged to continue supporting and educating staff, service providers, volunteers, clients, and families in the basic concepts of emergency preparedness. The team has started developing an All Hazards and Emergency Response Plan, including an incident command structure. However, this plan has not been finalized and is in the early stages of implementation. The organization does not have formalized criteria for when the emergency operations centre(s) are activated across the sites, areas, or regions. Horizon may benefit from establishing more rigorous emergency operations centre activation and de-activation criteria, thereby avoiding variability between sites, areas, and the region. The organization is also encouraged to continue to develop and implement strategies to enhance its emergency response plans at the local and regional levels.

The Emergency Procedures online education is an excellent resource for the organization’s staff, physicians and volunteers. The introduction to the Emergency Codes across Horizon is a very robust tool. The annual Code Red training and recertification are well managed in Horizon Health. Staff could articulate the processes and procedures to respond to a Code Red. In many organizations, the requirement to take Code Training education is part of the annual mandatory refresher education. Horizon may wish to consider making addional code education part of the annual (re-)training as numerous staff could not articulate what various codes meant. While there was a good understanding of certain codes (white, blue, red), there was limited understanding of the other code response and what to do in the event of a specific code emergency. Staff did, however, know that there were resources available to them on the unit to support the specific code. However, when an emergency happens, time is of the essence and the organization and staff could benefit from enhanced education, more drills to test the unit/site response, and formalized debriefings to identify lessons learned.

The emergency management team and organization does not have an automated mass notification system. The current system relies on email and individuals to contact people on the fan-out list. Processes are currently very manual and vary across the respective areas in the region. Horizon is encouraged to review current processes and consider investigating / possibly investing in technology to enable a more rapid mass notification process for emergency response.

As cited in the previous accreditation report, Horizon has not developed a business or operational continuity plan for the sites, areas, or health authority. There continues to be a need to establish these

plans to ensure that the organization can respond adequately to emergencies and ensure that business and clinical operations are maintained. Horizon is strongly encouraged to ensure that this important work is given priority and addressed immediately.

While Horizon has participated in emergency response exercises led by municipal and provincial partners, there may be an opportunity to enhance coordination and collaboration through more robust partnerships. Many municipal partners expressed a desire to work more closely with Horizon Emergency Management to integrate and embed the health sector into their overall planning. Horizon is encouraged to enhance these external partnerships as it will further support and enable the organization's ability to prepare for and respond to emergencies.

Priority Process: People-Centred Care

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

Unmet Criteria		High Priority Criteria
Standards Set: Ambulatory Care Services		
1.1	Services are co-designed with clients and families, partners, and the community.	!
2.4	Space is co-designed with clients and families to ensure safety and permit confidential and private interactions with clients and families.	
3.11	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.	
Standards Set: Cancer Care		
2.4	Space is co-designed with clients and families to ensure safety and permit confidential and private interactions with clients and families.	
8.12	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.	
26.9	Patient safety incidents are analyzed to help prevent recurrence and make improvements, with input from clients and families.	!
Standards Set: Community Health Services		
1.1	Services are co-designed with clients and families, partners, and the community.	!
3.10	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.	
Standards Set: Community-Based Mental Health Services and Supports		
4.10	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.	

Standards Set: Emergency Department		
1.1	Services are co-designed with clients and families, partners, and the community.	!
3.5	Barriers within the emergency department that impede clients, families, providers, and referring organizations from accessing services are identified and addressed, with input from clients and families.	
Standards Set: Governance		
2.3	The governing body includes clients as members, where possible.	
Standards Set: Inpatient Services		
2.5	Space is co-designed with clients and families to ensure safety and permit confidential and private interactions with clients and families.	
Standards Set: Perioperative Services and Invasive Procedures		
1.1	Services are co-designed with clients and families, partners, and the community.	!
1.7	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.	
6.3	A comprehensive orientation is provided to new team members and client and family representatives.	
6.12	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.	
25.3	Measurable objectives with specific timeframes for completion are identified for quality improvement initiatives, with input from clients and families.	!

Surveyor comments on the priority process(es)

Congratulations on making patient and family-centered care a strategic priority at Horizon Health Network (Horizon). The organization is also commended on making the re-set of building a culture of patient engagement a priority for this Accreditation survey.

The culture of caring and engagement is at the bedside, in the community and in organizational decision making. The value and importance of patient and family centred care is evident in conversations with patients, families, staff and physician leaders, frontline staff, and Patient Experience Advisors.

Patient Experience Advisors (PEAs) are involved in multiple quality improvement projects and in many areas of the organization. There is a Regional Patient Family Advisory Council with dedicated PEAs who report feeling valued, supported, and welcome to share their lived experience and perspectives.

There is evidence that PEAs have influenced change and have had an impact on decision making. A few projects to note include are the Cancer Survivorship Program, the Family Presence Policy, and design work with the expansion of the Dr. Everett Chalmers Regional Hospital. Horizon is following engagement best practices with the yearly evaluation of PEA experience. The COVID-19 pandemic had a negative impact on engagement opportunities and Horizon is encouraged to work closely with all PEAs to re-establish engagement activities and refresh the patient and family-centered care strategic plan. There are various resources and processes available to support PEAs and the staff who work with them. During conversations with staff, not everyone knew what is available. The organization is encouraged to continue promoting their great resources. There are also opportunities to deepen the involvement of PEAs in projects at a more localized level. As the culture of patient and family-centered care evolves at Horizon, the organization may need to build increased capacity, including staffing resources, to support further community and PEA engagement in decision making and priority setting.

With multiple engagement options available at Horizon, it may be beneficial to review the engagement structures to enhance synergies and deepen opportunities for collaboration. There are currently 44 PEAs diligently supporting patient and family-centered care. The organization is encouraged to continue working on their recruitment efforts to increase the number of PEAs who reflect the community's diversity. Providing honorariums to PEA’s is a topic of much discussion across the country. Horizon is encouraged to explore barriers to PEA participation and identify practical and meaningful solutions. Although virtual meetings have their benefits, PEAs also expressed the desire for some in-person meetings to resume.

In terms of patient, family, and community engagement with the Board of Directors, it is recommended the new Board have regular meetings in the community to hear directly from the people they serve. Working with community partners is an important aspect of providing patient and family-centered care. In particular, Horizon is acknowledged for their collaboration with the First Nations communities in New Brunswick. The establishment of the First Nations Patient Navigator role is an excellent example of supporting equity deserving populations. There are 14 community developers working across Horizon. They play an active role in working with communities and community partners.

Patients and families receiving care spoke very highly of the staff, their caring and compassion. The team, including physicians, worked to ensure patients and families were actively involved and always made aware of their progress and any changes. Patients have described their team as being extremely positive and hopeful with "No" not in their vocabulary. Patients feel supported in helping reach their goals. They also commented they are treated with dignity. Patients and families see how hard staff work in often challenging situations. While the majority of patients that surveyors spoke with had good experiences, it is important to remember that some patients and families have had difficult experiences. It is suggested that more work be done on integrating a trauma informed approach to care. Not all patients and families received information on rights and responsibilities or how to contact the Patient Representative service. There was evidence of the Designated Support Person approach being very appreciated by the support person, their family, and staff. There were inconsistencies with the use of white boards in patient rooms and with patient and family involvement in discharge planning. It is recommended the organization continue to put emphasis on patient and family-centered care at the bedside.

An online engagement website is also used to seek feedback from patients, families, and communities. Not everyone is available to participate on committees with longer time commitments, so online engagement is an excellent option. There are many opportunities to further this approach in alignment with engagement best practices.

Horizon has a solid foundation of patient and family centered care practices. There are many excellent examples of how this is coming to life at Horizon. From the Community Health Action Committee in Sackville, the work on improving oxytocin information on obstetrics units, to posting both positive and constructive comment cards for everyone to see. There is much to be proud of in the warmth and dedication of everyone involved.

Priority Process: Patient Flow

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

Unmet Criteria		High Priority Criteria
Standards Set: Emergency Department		
3.1	Client flow throughout the organization is addressed and managed in collaboration with organizational leaders, and with input from clients and families.	!
3.2	A proactive approach is taken to prevent and manage overcrowding in the emergency department, in collaboration with organizational leaders, and with input from clients and families.	!
3.3	Timely access for clients is coordinated with other services and teams within the organization.	!
3.7	Procedures for transport of high-risk clients are established with EMS providers.	
3.10	There are established protocols to identify and manage overcrowding and surges in the emergency department.	!
3.11	Protocols to move clients elsewhere within the organization during times of overcrowding are followed by the team.	!
Surveyor comments on the priority process(es)		

Horizon Health Network (Horizon) has been experiencing access and flow issues for an extended period of time. Recent enhancements include new patient flow teams, reviewing and standardizing discharge planning, expanding discharge times and collaborating with other program leaders and led by site bed coordinator. There is a strong and passionate team leading patient flow and the organization is encouraged to leverage this strength to ensure that every leader is accountable for their role in patient flow and has the knowledge, skills and confidence to made proactive and timely decisions that result in safe patient outcomes.

Additional opportunities for improvement include an Integrated Operations Command Centre to support flow across the province with an appropriate information technology platform to support flow decisions. Long term care beds and operational direction are not part of Horizon and although they work well in partnership it is challenging to know the post acute capacity or to make policy change to ensure efficient and effective use of such beds.

The use of hospitalists in the outlying hospitals would enable patients to stay in their communities; currently patients paneled with physicians without admitting privileges are transferred to a regional

hospital despite not requiring a higher level of care. Frequently the interfacility transfer of patients creates additional burden on the nursing staff required to accompany the patient, the receiving facility that requires beds for more complex patients and the EMS system that would be better served being available in communities for 911 calls.

Priority Process: Medical Devices and Equipment

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

Unmet Criteria		High Priority Criteria
Standards Set: Perioperative Services and Invasive Procedures		
4.11	Immediate-use (or "flash") sterilization is used in the operating/procedure room only in an emergency, and never for complete sets or implantable devices.	!
Standards Set: Reprocessing of Reusable Medical Devices		
3.2	The MDR department is designed to prevent cross-contamination of medical devices, isolate incompatible activities, and clearly separate work areas.	!
3.3	Access to the MDR department is controlled by restricting access to authorized team members only and being identified with clear signage.	!
5.11	Team member performance is regularly evaluated and documented in an objective, interactive, and constructive way.	!
5.12	Team members are supported by team leaders to follow up on issues and opportunities for growth identified through performance evaluations.	!
8.1	The reprocessing area is equipped with hand hygiene facilities at entrances to and exits from the reprocessing areas, including personnel support areas.	!
8.2	The reprocessing area's designated hand-washing sinks are equipped with faucets supplied with foot-, wrist-, or knee-operated handles, electric eye controls, automated soap dispenser and single-use towels.	
11.3	All flexible endoscopic reprocessing areas are equipped with separate clean and contaminated/dirty work areas as well as storage, dedicated plumbing and drains, and proper air ventilation.	
12.4	The integrity of each sterile package is maintained during storage.	!

Surveyor comments on the priority process(es)

The Medical Device Reprocessing (MDR) program at Horizon Health Network (Horizon) provides services at eleven of the twelve sites. The MDR teams note increased collaboration and communication, utilizing technology to build rapport and sustain meaningful conversations. Efforts to facilitate closer working relationships and sharing of information and resources are apparent.

The organization was successful in decreasing outsourced reprocessing significantly since their last accreditation. There is a plan to move the remaining three outsourced activities to MDR in the next year.

The organization recognizes that aging infrastructure impacts the MDR at several sites and correcting these deficiencies is ongoing. Several sites have new infrastructure in the planning and construction phases. Separation of endoscopic reprocessing from the operating room reprocessing is also in progress at several sites. Pending these infrastructure changes, the MDRs need to be reviewed to ensure access is controlled and practices to separate clean and dirty processes are maximized.

While new endoscopic and medical device reprocessing areas are planned for many sites, the current infrastructure is aged, does not consistently support appropriate flow, and sometimes fails to provide a clear separation of dirty and clean equipment. The teams are encouraged to follow procedures to mitigate these gaps and monitor audit data to identify potential problems.

With the perioperative and reprocessing separation of endoscopy from the operating rooms and main medical device reprocessing at some sites, there will be a requirement to modify clinical practices. To protect scope integrity and to support optimal flow through the reprocessing area, minimizing transportation of equipment and providing endoscopy only in the designated suites is supported.

The goal of digitizing all inventory across Horizon into an online database to facilitate ease of tracking, monitoring and life cycle will greatly benefit the MDR program and departments across the organization. This will support teams in identifying underutilized or excess equipment and facilitate the transfer of items to a more appropriate site.

As with all areas in healthcare, recruiting trained technicians is an ongoing challenge and the organization is encouraged to continue their efforts in attracting and developing these skilled assets.

The Horizon is supporting several perioperative initiatives that directly impact MDR. The expansion of services needs to ensure MDR capability, capacity, and enough staff to support the additional programs. Clean storage capacity for surgical equipment (e.g. orthopedic trays) must also be considered.

With the expansion of surgical programs and the ongoing move for all scopes and probes to be reprocessed by MDR, there is an opportunity to review the services offered. Reprocessing of devices for community providers is one area for re-evaluation within the priorities of Horizon. Shifting community providers to disposable kits rather than reusable medical devices may help MDR volumes and staffing pressures as the team supports new and/or increased volumes of perioperative cases.

Policies and procedures require review to ensure that they are up to date and continue to reflect best practices. This is also an opportunity to ensure that standardization is supported across the network.

Performance appraisals have not been consistently completed across sites and managers are encouraged to schedule these conversations throughout the year to ensure these valuable conversations are facilitated.

The MDR conducts audits and is involved with Quality Improvement initiatives. Sharing of this information is not consistent across sites and there is an opportunity to improve communication with frontline staff on these activities. This is increasingly important as the workload at some sites is changing and will support staff in recognizing volumes reprocessed and continued success in maintaining quality as demonstrated by audit data.

The preventative maintenance program is managed through contracted providers of the major equipment. Preventative maintenance completion is tracked. The team notes that service providers are responsive to their needs. There is an opportunity to more proactively manage the preventative maintenance program to ensure that maintenance continues to be offered in a timely manner. Centralized tracking of maintenance cycles may be considered to identify potential gaps in maintenance or to identify equipment that is relatively more problematic to manage causality or plan for replacement.

Priority Process Results for Population-specific Standards

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

Priority processes specific to population-specific standards are:

Population Health and Wellness

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

Standards Set: Population Health and Wellness - Horizontal Integration of Care

Unmet Criteria		High Priority Criteria
Priority Process: Population Health and Wellness		
6.1	The organization maintains a clinical information system and longitudinal client records.	
6.3	The organization uses the clinical information system to establish service priorities by classifying clients according to condition and other factors such as co-morbid conditions.	
6.5	The organization uses the information system to generate regular reports about performance and adherence to guidelines, and to improve services and processes.	
6.6	The organization monitors and validates the quality of data in the clinical information system.	
6.7	The organization regularly reviews and improves its clinical information system.	
Surveyor comments on the priority process(es)		
Priority Process: Population Health and Wellness		

Population Health and Wellness for Senior Population at Horizon Health Network (Horizon) is addressed by multiple teams, networks, community partners and other operational departments. Notably the Health and Aging Clinical network, the Collaborative Care Seniors Health and other partnerships such as Horizon's other clinical services, professional services, in patient and outpatient services, community mental health, primary health care, as well as others, all work together to identify strategic priorities and initiatives to advance healthy senior population.

The Health and Aging Clinical Network as well as the Collaborative Care Seniors Health have strategic priorities such as developing a Senior Friendly network orientation packages, reducing neuroleptics on ALC units.

Regionally, a robust community health needs assessment process provides information to the teams about gaps for equity seeking populations. Amongst their accomplishments are improved services for hearing impaired clients; virtual services for chronic disease management; implementation of the evidence based GLA:D program for osteoarthritis of the hip or knee; a pilot of embedding social workers in the ED. They have also embedded patient experience advisors at the strategic level and on many working groups.

The organization is encouraged to review mitigating strategies regarding implementing an integrated clinical information system. An integrated clinical information system would allow to capture information such as number of admitted patients in their various services that have a diagnosis of dementia. Given the ability to extract trends from patient data, the team could implement corresponding measures and interventions.

Service Excellence Standards Results

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

Priority processes specific to service excellence standards are:

Point-of-care Testing Services

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

Clinical Leadership

- Providing leadership and direction to teams providing services.

Competency

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

Episode of Care

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

Decision Support

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

Impact on Outcomes

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

Medication Management

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

Organ and Tissue Donation

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

Infection Prevention and Control

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

Diagnostic Services: Imaging

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

Public Health

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

Transfusion Services

- Transfusion Services

Standards Set: Ambulatory Care Services - Direct Service Provision

Unmet Criteria		High Priority Criteria
Priority Process: Clinical Leadership		
1.2	Information is collected from clients and families, partners, and the community to inform service design.	
1.4	Services are reviewed and monitored for appropriateness, with input from clients and families.	
2.3	An appropriate mix of skill level and experience within the team is determined, with input from clients and families.	
2.5	Resources and infrastructure needed to clean and reprocess reusable devices are accessible in the service area, as required.	
2.6	The effectiveness of resources, space, and staffing is evaluated with input from clients and families, the team, and stakeholders.	
Priority Process: Competency		
3.1	Required training and education are defined for all team members with input from clients and families.	!
3.10	Team member performance is regularly evaluated and documented in an objective, interactive, and constructive way.	!
3.12	Team members are supported by team leaders to follow up on issues and opportunities for growth identified through performance evaluations.	!
Priority Process: Episode of Care		
7.13	Clients and families are provided with information about their rights and responsibilities.	!
7.14	Clients and families are provided with information about how to file a complaint or report violations of their rights.	!
8.5	Medication reconciliation is conducted in partnership with clients and families to communicate accurate and complete information at ambulatory care visits when medication management is a major component of care.	ROP
8.5.2	During or prior to the initial ambulatory care visit, a Best Possible Medication History (BPMH) is generated and documented in partnership with the client, family, caregivers, and others, as appropriate.	**MAJOR**

8.5.3	During or prior to subsequent ambulatory care visits, the BPMH is compared with the current medication list and any medication discrepancies are identified and documented. This is done as per the frequency required by the organization.	**MAJOR**

Priority Process: Decision Support

The organization has met all criteria for this priority process.

Priority Process: Impact on Outcomes

15.1	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.	

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

Locations included during the on-site tracers were the Ambulatory Care Network (at Saint John-Clinic 1, Moncton and Miramichi's), Heart Centre Health&Wellness Clinic and Nephrology services at Saint John Regional Hospital. We also conducted an on-site tracer to the Nephrology service at Upper River Valley Hospital.

The leadership has developed and encouraged a culture of quality, safety, and client-focused care that has cascaded through the organization.

At Saint John Regional Hospital (SJRH), Clinic 1 serves more than 40,000 patients from across Atlantic Canada annually — a number that is expected to reach 46,000 in the next five years. Currently, Clinic 1' services are temporarily offered on the fifth floor while the permanent location is being transformed into 14,700 square feet that is expected to improving accessibility, privacy and patient comfort.

Program strategic directions/objectives were developed before COVID-19 in consultation with staff, clients, and family. Teams are invited to involve staff, clients and family feedback in their upcoming strategic plan.

While some teams use client complaints, walkabouts (informal conversations) and recommendations to design and improve quality of services, the organization is encouraged to resume periodic formal client experience surveys to systematically capture client feedback.

Priority Process: Competency

Staff in the ambulatory care clinics have appropriate education, background, and credentials to provide the care patient needs. Position profiles with defined roles, responsibilities, and scope of practice exist for

all positions. Physician leadership is present. The team is commended for their efforts to improve services, reduce number of fails to present at scheduled appointments, and make efforts to continuously implement patient centred care.

The staff interviewed (at all locations) were proud of their their job and when asked what they were most proud of they all said, 'my team, its a family and I love them'. Management is present and advocates for the team and patients consistently.

New employees are orientated and trained accordingly to their job expectations. However, documentation is not consistently done. The team will benefit from developing a controlled orientation/training checklists to capture activities and staff feedback. Overall, compliance to performance appraisals (PA) is above 80%, however, some clinics are behind the target. Management has created a plan to complete any outstanding PA within the next couple of months.

Education and opportunities for continuing education are supported by the organization and staff take these opportunities to advance their knowledge. Compliance to annual mandatory courses are tracked and enforced.

Priority Process: Episode of Care

The Ambulatory Care Network is committed to ensuring excellence in the care provided to patients.

There are approximately 70 different clinic types across Horizon Health Network (Horizon). Clinics are divided into two groupings based upon the health provider, specifically nurse led clinics and physician led clinics. Nurse led clinics typically provide a specialized service requiring a clinical treatment for the patient’s condition. Examples of these clinics would be Ambulatory Treatment Clinics (ATC) where various IV infusions as well as complex wound dressings may occur.

The NB Heart Centre offers three different programs: Cardiac Rehab, Pulmonary Rehab and Heart Function Clinic. These programs provide education and exercise sessions as well as promotes positive behaviors and lifestyle changes to clients, so they can better manage their clinical conditions. The program is led by a nurse administrators who work in conjunction with a multidisciplinary team that includes physicians, nurses, dieticians and physiotherapists.

Horizon Nephrology spans the care of nephrology patients from Advanced Kidney Care or pre-dialysis to treatment modalities of Hemodialysis, peritoneal dialysis, transplant workup and post-op care through to medical management and collaboration for palliative services.

The Nephrology program is supported by two managers, four physicians and 10 multidisciplinary professionals, including over 95 nurses. There are 32 dialysis stations. Additional nephrology dialysis stations are offered at other satellite locations, including at Upper River Valley and Sussex Health Centre.

Several other clinics are also offered at Miramichi and Moncton locations. There is a strong collaborative multidisciplinary culture in each clinic and care is focused on the needs of the patient and families.

Patient ID verification and identification of patients at risk of falls were properly conducted. Challenges to comply the organization's policy for Best Possible Medication History (BPMH) were noted at Miramichi. It is recommended that the team dedicate continued efforts to ensure that BPMH collection occurs upon initial and subsequent visits are done. Additional education, training, and ongoing audits may be considered.

Care is available at each clinic. During the on-site visit, a good flow of patients was observed and wait times improvements were reported. Consent is obtained and documented.

Patients spoke of their satisfaction with the service and the level of expertise of the teams. Wait times and lack of awareness about how to provide feedback to the organization were identified at Miramichi. Incidents are electronically reported and investigated, however, the action plans and follow ups are not always documented. There is also an opportunity to improve the reporting of incidents and near misses. Incidents are disclosed to the affected clients and families according to the organization's policy, and support is facilitated if necessary.

Priority Process: Decision Support

Each clinic has excellent documentation regarding care provision. Client records are kept up to date. Policies and procedures to securely collect, document, access, and use client information are followed.

Staff is trained and educated about legislation to protect privacy and sensitive information.

In Nephrology, the team is currently working on ADT (admissions, discharges, transfers) interface and to follow up laboratory interface which will capture long term and labs from Area 2 and Area 3, with their ultimate goal to improve time management, communication, and patient safety.

Priority Process: Impact on Outcomes

For most part, quality boards are used at clinics and team huddles and meetings are conducted on a weekly basis. There is an opportunity to use TV screens and boards to share information, campaigns and quality improvement initiatives/progress/results to clients and families.

Patient and families are not always involved in quality and safety improvement activities, however, there is evidence that the Ambulatory Treatment Clinic and NB Heart Centre at SJRH are planning to implement this approach and ensure it is consistently applied. In Nephrology, management reported some challenges recruiting patient advisors.

Overall, the teams is encouraged to identify meaningful ways to engage clients in broad service planning and quality improvement initiatives at all locations.

Standards Set: Cancer Care - Direct Service Provision

Unmet Criteria	High Priority Criteria
Priority Process: Clinical Leadership	
The organization has met all criteria for this priority process.	
Priority Process: Competency	
The organization has met all criteria for this priority process.	
Priority Process: Episode of Care	
22.5 Survivorship planning is incorporated into the transition plans in partnership with clients and families.	
24.4 Technologies, systems, and software are interoperable.	
Priority Process: Decision Support	
The organization has met all criteria for this priority process.	
Priority Process: Impact on Outcomes	
The organization has met all criteria for this priority process.	
Priority Process: Medication Management	
The organization has met all criteria for this priority process.	

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

The Cancer Care Program was assessed through conducting tracers at five sites. In terms of Clinical Leadership all criteria were fully met. There are extensive partnerships that cut across the continuum of oncology services. Annual program reviews of services and volumes consider changing demographic trends. Gap analysis is conducted and included in annual clinical planning and aligned with strategic and operational goals.

An opportunity exists to continue to actively address the physical space requirements for the oncology pharmacy and the inpatient medication room. As you know the crowding, interruptions and noise levels pose potential risks for the cancer care program, clinical staff and for patients. This is very much supported and encouraged.

Priority Process: Competency

Multidisciplinary oncology competency training and education were validated to be fully met in the 5 sites included in the survey. The multidisciplinary team is a rich mix of competencies and talents, which provides a model of highly effective multidisciplinary teamwork. Continue to work to assess team performance against program goals to boost recruitment and retention efforts.

Priority Process: Episode of Care

All patients interviewed, as well as families. feel confident in the oncology service team and feel valued as the most important oncology team member. The Survivorship Program in the Saint John area has benefitted 500 cancer patients and deserves the planned attention to building in other communities. This is a wonderful opportunity to drawing on the lived experience of survivors to lead the building process.

Priority Process: Decision Support

The Cancer Care Program has fully met all requisites related to decision support. Patients and families expressed appreciation for the attention to adjustments in their plan of care. Continue to advocate for the technology and decision support requirements that will facilitate clinical recording as well as client and family self-rating contributions to their oncology treatment plan adjustments.

Priority Process: Impact on Outcomes

No deficits related to validated compliance with the impact on outcomes standards. Use of clinical trials is incorporated in clinical care delivery and impressively are approximately 30 in numbers. The team is very much encouraged to consider the impact of research on daily human resource requisites. Well Done!

Priority Process: Medication Management

Impressive compliance with systemic therapy standards was validated. The Cancer Care Program is commended for ensuring and supporting the provision of systemic therapy as close to home for patients and family for whom it is appropriate. They very much appreciate this and the virtual care aspects of care delivery.

Standards Set: Community Health Services - Direct Service Provision

Unmet Criteria		High Priority Criteria
Priority Process: Clinical Leadership		
2.5	The effectiveness of resources, space, and staffing is evaluated with input from clients and families, the team, and stakeholders.	
Priority Process: Competency		
	The organization has met all criteria for this priority process.	
Priority Process: Episode of Care		
	The organization has met all criteria for this priority process.	
Priority Process: Decision Support		
12.6	Policies and procedures for securely storing, retaining, and destroying client records are followed.	!
12.8	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.	!
Priority Process: Impact on Outcomes		
16.1	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.	
Surveyor comments on the priority process(es)		
Priority Process: Clinical Leadership		

The community Health Centres are hubs of service for residents across New Brunswick. They provide primary care services for patients, and in some locations limited specialized services (i.e. women's health) to bridge the gaps experienced in the system. Services are planned provincially based on 'Areas', engaging communities to understand unique needs and anticipated population growth. The last series of planning documents observed were conducted anywhere from three to five years ago. Shared by leadership was an awareness across the system of the ever-changing community needs and a desire to re-engage in a more standardize process of planning for community services. Leaders shared that the planning process should have occurred in the past three years, however COVID-19 took precedence and there is a gap currently.

The Moncton clinic provides a very unique service to refugees and asylum seekers. This clinic provides care to over 1,500 patients with continued growth as the Federal government continues to accept

patients through MAGNA. Expressed by the team was the need to plan more purposefully for this growth of service and ensuring that services are expanded that will address specifically the mental health and sexual health needs.

Noted across all sites was the challenge of adequate space to allow for a continuous and integrated care model. Many of the facilities are dated with needs of repair or updating of physical space to allow for storage, secure containment of medications and reducing the risk of falls for patients, caregivers, and staff.

What is evident is the dedication of leadership to provide support for their teams, advocate for services for the community and resilience during COVID-19. Many of the community care centres were shifted focus to assist in operationalizing COVID-19 based assessment centres and vaccine centres. Within days leadership was able to operationalize assessment centres (in person and drive through) as well as large vaccination clinics using other community locations. Staff and physicians across the sites provided their services, beyond their individual roles at clinics, responding to the needs of the community as the epidemiology of COVID-19 changed during the waves. A tremendous amount of work was done during the pandemic to provide services and pivot to virtual offer of services.

There is significant opportunity for leadership to re-define community-based care over the next few years (post COVID-19) in partnership with families at the local and provincial levels. Leadership should continue to harness the 'joy' that staff has working within the centres and leverage the community's trust as this was evident across all sites.

Priority Process: Competency

The teams across sites vary with some being solely physician and nurse practitioner focused and others with larger interdisciplinary teams including nurse practitioners, nurses and LPN's. There is a desire to create more standardized teams that offer a broad array of services to meet community needs and provide a 'one stop shop' of services to minimize travelling, integrate care plans and maximize health outcome.

Education for the teams was profession and task based. Where infusion pumps existed, there was clear education to ensure competency and patient safety. Staff indicated that their needs were met, and where there was a gap in education that their leadership provided the opportunity to upskill and/or attend educational opportunities.

Priority Process: Episode of Care

Primary care across New Brunswick is accessed through the Community Health Centres. There is variation in the models of clinics ranging from traditional primary care physician/nurse models to a more interdisciplinary approach including physician, nurse practitioners (NP), registered nurses (RN), liscenced practical nurses (LPN) and social workers. The planning of services has not occurred since 2018, and with the changes in community demographic (age, co-morbidities, complexity) an expedited review would be

warranted. Additionally, As the Federal and Provincial government continues to welcome new Canadians (i.e., refugees/asylum seekers) from other countries this will likely change the footprint of the clinics, as in the services that will need to be provided, with a clearer focus on mental health, immunization/infectious diseases, sexual health and management of chronic health conditions. The clinics have all demonstrated an extremely dedicated group of professionals who absolutely love what they do and want to continue positively impacting the community. Their desire is to continue to grow the programs through additional resources and space that will meet the future needs.

Since 2018 the community care programming has implemented the NB Health Link/tele-health (811) and community hub navigators to ensure that patients have appropriate access to care while supporting emergency room volumes. This redirection across the Areas allows for the 3rd available appointment within 5 days to be realized by many clinics while smoothing the demand for access across sites. These coordinators assist in redirecting patients across the Areas to access primary health care (when appropriate) and are redirected back to tele-health if there is local concern that the individual requires more care. Since implementation there has been a documented improvement in ED diversion in some local areas and quicker access to care (primary) by patients. The patient navigator has been implemented more recently to provide more health education and navigation to services. This will be an exciting initiative to follow on the impact on patient experience, health outcome and access to services.

Transitions in the Community Health Centres are very strong with providers linked into professional networks, communities of practice (locally and nationally) and having contact with resources in the system to meet their patient's needs. Transitions are planned with services wrapped around the patient where possible and strong advocacy for services. More recently, social work has been introduced in several clinics to assist patients and their families to navigate the healthcare system and access health/social services. The need for more social work and/or psychology was shared by leadership and staff to assist patients with their psycho/social needs and mental health.

Since 2018, all Community Health Centres have implemented the 'language line' to assist in the delivery of care for providers when interacting with 'New Canadians'. The platform allows for the intake, booking, assessment and follow-up of all services in the language preferred by the patient and family. In density focused areas of 'New Canadians' this ensures they are accessing care timely, feeling safe when interacting with providers and following up with recommendations that may lessen the risk of ED admission. The 'language line' is used frequently and confidently by providers and has seamlessly integrated into the workflow.

Across many of the Community Health Centres medication storage and access was not restricted. While no dispensing of medication or narcotics occurs like a traditional pharmacy, there are medications (samples) that may be easily accessible which may cause harm. Suggested was to immediately create limited access to the areas through lock and key.

Shared across the sites was the pride of staff, physicians, and leadership in their ability throughout COVID-19 to be a resource for the community, support assessment centres and provide vaccination in partnership with Public Health. The Community Health Centres expressed their connection and

integration within the health system to provide care that saved lives through the vaccination clinics while also creating innovative ways to provide ongoing care through virtual platforms. All staff expressed their strong satisfaction and joy of being in their cohesive teams and collectively providing exceptional care. Staff also expressed their hopes of expanding services to meet the needs of their communities even further through more resources and space. This group of care providers are clearly dedicated to their community, their patients, and patients' families. They are passionate about their work, colleagues, and impact in the community. This commitment of care should continue to be celebrated and amplified across Horizon Health as the future of community care is planned.

Priority Process: Decision Support

Across the sites evaluated, patient charts were paper based and stored locally. There was variation in the method of storage with some sites having a more secure method of keeping patient charts. Storage, retention and destruction across some sites was not adequate with boxes not clearly labelled, no structured taxonomy for storage (i.e. how stored, where stored) and placed in spaces where other organizations could have access (e.g. Miramichi storage space in the basement with access from an medical clinic next door through an adjoining door). While there is a retention and destruction policy for files the process in which this implemented across sites was not supportive of the policy.

Clinicians/physicians documentation practices met standard with thorough notes and clear follow-up actions. The services continue to be paper based at all locations. There continues to be a desire to pivot to electronic documentation that would allow for more integrated and collaborative patient record.

Priority Process: Impact on Outcomes

Patient and caregiver feedback is critical to assist in community planning for health centres. Typically client experience conducted through survey methodology is carried out by New Brunswick Health Council (every three years) or through Horizon Health Network (Horizon). New Brunswick Health Council conducted Primary Care client experience surveys for the Community Health Centres from October 2022 – January 2023. The results of the survey will be available in Spring 2023. Shared across all sites was the change in demographic, the growth in various centres (i.e. Moncton), the diversification of the population (i.e equity seeking, vulnerable/marginalized or new Canadians)and the current inability to seek input in language of origin (i.e. Arabic, Kurdish, Armenian). Within the Moncton clinic they current serve a refugee/asylum seeking population that represents over 20 different languages, however information is solely provided in the two official languages of English and French. Recommended for consideration and review are the following:

1. Survey frequency ~ having surveys conducted monthly allows for a better cross-sectional representation of the community, as well as better recall of the experience that may allow for improvements.

2. Survey language ~ while survey translation may be costly, the risk of excluding communities experiences and needs may impact longer term planning or health outcome. As Moncton continues to grow with a diverse population Horizon Health will have to consider how to be more inclusive in gathering information.

3. Written information ~ presently all information provided to patients and families are in the two official languages at the Community Health Centres. Consideration of expanding this to the languages of the community.

The leadership team and clinical staff are acutely aware of the metrics they monitor and endeavour to meet target through creative ways. Metrics are actively monitored centrally and locally. Suggested is for community clinics to have more local metrics to better represent local needs that may provide leadership with a better representation pressure points in accessing services.

All Community Health Centres clearly identified the system Quality Improvement initiatives (i.e. smoking cessation, virtual care and 3rd next available appointment) as well as some local initiatives to address space and flow. There is clearly a desire to champion Quality Improvement in ways that provide better service and access for the community.

Patients and families shared with surveyors their appreciation of the team and the dedication to keep them healthy and well. Patients trusted providers and felt they were advocates of their care. Additionally clients described being treated with care, dignity and respect, feeling comfortable in escalating concerns and/or asking questions. Observed was a very close connection between patient/providers within the clinic.

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

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

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

The team expressed confidence in the ability of their leadership. There is a strong interdisciplinary team. They offer a robust array of community based mental health services. They have strong community partnerships which supports quality community based mental health services. The staff have been empowered to personalize their work stations to create warm and inviting spaces for their therapeutic interactions.

Priority Process: Competency

They place a high priority on education, and they have created an education pathway that exceeds organizational standards in order to meet the needs of their client that they serve. There has been a significant amount of work done in the area of violence intervention and prevention. There are safety protocols in place for staff who are out in the community and making home visits. The staff shared that they feel safe at work.

Priority Process: Episode of Care

There is a strong interdisciplinary team. They offer a robust array of community based mental health

services. They have strong community partnerships which supports quality community based mental health services. The site is spacious, bright with no clutter. Client art work decorates the space. Clients who miss appointments are promptly follow up with to ensure safety and risk mitigation.

Priority Process: Decision Support

There is a combination of paper and electronic health records.

The client records are comprehensive and up to date. The team receives good support from the organization to manage the health records in the community sites.

There would be benefited to move towards one electronic health record that would be compatible throughout the organization.

Priority Process: Impact on Outcomes

Safety incidents related to violence have significantly decreased following review of critical incidents and implementation of safety plans and education.

The Current Key Performance Indicators are being collected and shared throughout the organization; however, the data collection process is not standardized throughout each site. The organization would benefit from standardization of the data collection process.

Standards Set: Critical Care Services - Direct Service Provision

Unmet Criteria		High Priority Criteria
Priority Process: Clinical Leadership		
The organization has met all criteria for this priority process.		
Priority Process: Competency		
The organization has met all criteria for this priority process.		
Priority Process: Episode of Care		
The organization has met all criteria for this priority process.		
Priority Process: Decision Support		
The organization has met all criteria for this priority process.		
Priority Process: Impact on Outcomes		
15.3	There is a standardized process, developed with input from clients and families, to decide among conflicting evidence-informed guidelines.	!
15.4	Protocols and procedures for reducing unnecessary variation in service delivery are developed, with input from clients and families.	!
15.5	Guidelines and protocols are regularly reviewed, with input from clients and families.	!
15.6	There is a policy on ethical research practices that outlines when to seek approval, developed with input from clients and families.	!
16.1	A proactive, predictive approach is used to identify risks to client and team safety, with input from clients and families.	!
16.2	Strategies are developed and implemented to address identified safety risks, with input from clients and families.	!
16.3	Verification processes are used to mitigate high-risk activities, with input from clients and families.	!
16.4	Safety improvement strategies are evaluated with input from clients and families.	!
Priority Process: Organ and Tissue Donation		
The organization has met all criteria for this priority process.		

Surveyor comments on the priority process(es)
Priority Process: Clinical Leadership
There are outreach teams however in some sites this work needs continued effort to fully implement new and revised frameworks. A new NICU is nearing completion as one site and input from families was incorporated to ensure safety and needs are met. Overall leadership is visible including strong informal dyads with physician leadership that strengthen the program.
Priority Process: Competency
Regular performance assessments are completed. Required education is completed and monitored minimally monthly by managers. There is support for staff and in some areas robust orientation and phased approached learning have been introduced to maximize learning.
Priority Process: Episode of Care
Through discussions with families there was clear demonstration of understanding their rights and responsibilities. Families felt their individual and often complex needs were supported. There continues to be some pressures for trained staff however this is seeing some stabilization and continued effort is recommended.
Priority Process: Decision Support
The hybrid documentation that includes both paper and electronic was identified as an opportunity to ensure there are continued efforts for one mode of documentation.
Priority Process: Impact on Outcomes
There are quality KPIs which are posted and monitored on a regular basis. In some areas there was no evidence that input from clients and families was included in quality improvement, guidelines, procedures, and protocols. The overall organization does have patient advisors however it is recommended that this area be enhanced across all sites.
Priority Process: Organ and Tissue Donation
There is an awareness of organ and tissue donation amongst staff. Documentation also reflects organ donation and there have been efforts with staff changes and turn over to enhance education in this area.

Standards Set: Diagnostic Imaging Services - Direct Service Provision

Unmet Criteria	High Priority Criteria
Priority Process: Diagnostic Services: Imaging	
2.2 The team identifies, and removes where possible, physical and systemic barriers that prevent clients or referring medical professionals from accessing diagnostic imaging services.	
Surveyor comments on the priority process(es)	
Priority Process: Diagnostic Services: Imaging	

Surveyors had the opportunity to visit five sites within Horizon Health Network (Horizon) that offer Diagnostic Imaging services. Notable was the team's dedication to Quality Improvement and advancing technologies across all modalities. Overall, there is strong leadership, with a committed team providing safe, quality services. Much progress has been made in addressing wait times for services. Recommend continuing efforts with wait time work on CT, MRI, and ultrasound waits in particular to meet Provincial benchmarks.

While the team has implemented a standardized requisition form for medical imaging across the Health Authority and has regular collaboration meetings to include all sites where quality indicators and incidents are identified and reviewed, there is an identified opportunity to implement a central booking process to ensure that patient access to diagnostic imaging programs is equitable throughout the province.

With the advancement in technologies and equipment Horizon must be mindful of the need to increase its human resource budget to align with the additional equipment if they are to continue to realize increased patient access and decrease wait times.

Simplicity Project has been implemented in The Moncton Hospital in collaboration with the emergency department to improve turn around times for CT. This project resulted in a reduction from 2.1 hours to 1.5 hours, along with the addition of 1.5 FTE for technologists and 1.5 for PCA II.

Staff expressed feeling valued and acknowledged. They "love working here". The department has recently implemented Professional Practice Award of Distinction and CAMRT Atlantic Career in Excellence Award. Investments in education to upskill existing staff have resulted in improvements in the retention of staff throughout the region.

At the Dr Everett Chalmers Regional Hospital because of COVID-19, the access to DI and the Fracture Clinic is cut off and clients/families are re routed through the hospital. The route is much farther now and clients with walkers, wheelchairs, disabilities, and other challenges are finding it difficult to get to DI and the Fracture Clinic. The signage is unclear, and many patients find it difficult to find where they are going

and how to get out. The organization is encouraged to review this and consider options, with input from those clients and families using these services.

Rapid AI technology would enhance patient-centred care & access to timely treatments.

Construction timelines are challenging sites and receive budgets for infrastructure that are not realized due to these constraints.

Standards Set: Emergency Department - Direct Service Provision

Unmet Criteria		High Priority Criteria
Priority Process: Clinical Leadership		
2.6	Seclusion rooms and/or private and secure areas are available for clients.	!
2.9	The effectiveness of resources, space, and staffing is evaluated with input from clients and families, the team, and stakeholders.	
Priority Process: Competency		
4.14	Team member performance is regularly evaluated and documented in an objective, interactive, and constructive way.	!
4.16	Team members are supported by team leaders to follow up on issues and opportunities for growth identified through performance evaluations.	!
Priority Process: Episode of Care		
12.10	Information on pediatric medication dosages is available and accessible to the team.	!
12.11	Medications are administered to pediatric clients using weight-based pediatric dosages and appropriately sized equipment.	!
13.9	The effectiveness of transitions is evaluated and the information is used to improve transition planning, with input from clients and families.	
Priority Process: Decision Support		

The organization has met all criteria for this priority process.

Priority Process: Impact on Outcomes		
18.12	Information about quality improvement activities, results, and learnings is shared with clients, families, teams, organization leaders, and other organizations, as appropriate.	
Priority Process: Organ and Tissue Donation		

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)
Priority Process: Clinical Leadership

Emergency services have been well designed to meet the needs of the communities Horizon Health

Network (Horizon) provides service to. A Patient Experience Advisor (PEA) sits on the Horizon Health Emergency Network committee.

Further expansion of team-based models of care to include more Personal Support Workers within the Emergency Departments is encouraged.

The ED at Miramichi is in the process of constructing a seclusion room in their ED. The have a process in place currently to mitigate high-risk patients for short-term intervention to protect the safety of the client or others in the emergency department. St Joseph's Urgent Care Centre does not have a seclusion room. Any patient presenting that would benefit from this setting is transferred to Saint John Regional Hospital. Sussex Health Centre does not have a seclusion room, and selected patients are placed in a room close to the nursing station with as much equipment removed as possible.

The Emergency Department is inadequate for the volume of activity provided at Dr. Everett Chalmers Regional Hospital. Sight lines are lacking for critical areas, clutter is abundant in all areas of the department and there is a utility room with an open ceiling. Aging infrastructure is evident. A process improvement analysis is underway at the site, and the organization is encouraged to optimize the learnings from this work and prioritize work in the Emergency Department to ensure patient and staff safety.

The emergency department at Upper River Valley Hospital is spacious and well laid out. Storage of non-critical items (holiday decorations) should be removed from patient care areas. Emergency spaces such as the decontamination room should not be used for storage, especially as there are other options available. Clean supplies such as linens should be covered and doors to storage rooms should be kept closed. Medical equipment should be kept clear of pinch points (such as between the patient washroom and medication room).

St Joseph Urgent Care Centre is meeting the needs of their clients, however, curtains separate the care spaces and there is a lack of privacy and space for patients during care. A reconfiguration of the department would improve patient flow and patient experience.

The number of boarded patients within the Moncton Hospital ED is affecting the flow, as a result there is increase in wait times for this hospital above the benchmark. IPC breaches related to crowding, congestion, and overcapacity in this ED were noted while on-site.

Priority Process: Competency

New staff members have a comprehensive orientation, including laboratory supported point of care testing training. All team members work to their full scope of practice and expressed feeling a part of a strong collaborative multidisciplinary team.

A simulation program has been established that involves the entire multidisciplinary team and is being performed in all locations.

Horizon is to be commended for their use of their in-house Bravo! platform to recognize employees for their contributions. Peer to peer recognitions were validated as well as patient to staff recognition as a very good practice to maintain.

Performance appraisals have not been consistently completed at Upper River Valley Hospital emergency department, but the new manager has a plan to get them done and staff indicate that they have had informal opportunities to identify areas of learning and growth. All other sites are up to date and/or in progress.

Priority Process: Episode of Care

Patients presenting for emergency or urgent care at any of the Horizon Health Network's departments receive safe, standardized and high-quality care.

Dr. Everett Chalmers Regional Hospital is encouraged to optimize its Braslow cart with a medication kit to support the teams in the timely care of pediatric resuscitations - currently, the medications are located in the medication room, and the cart is only holding supplies.

Horizon Health is to be commended for the implementation of patient monitors in the waiting rooms at most facilities that conduct wellness checks and perform reassessments during the waiting phase.

Many facilities have translation on wheels technology, with more than 200 languages available to support clients and families. The organization is to be commended on their commitment to removing language barriers.

The BPMH is completed, but there are opportunities for education on prompting (which is already on the form) to ask specifically about OTC, herbal medications, vitamins, etc. Two patients interviewed had BPMH completed with Rx medications, but OTC and vitamins were not included. The Pharmacist embedded in the Moncton ED has positively impacted the medication reconciliation and BPMH compliance.

Data is collected around transitions but this tends to be a numerical value and other elements of the transition process have not been reviewed. Evaluating the root cause(s) around transition gaps and delays has not occurred. This analysis might identify opportunities for quality improvement initiatives to address transition delays and improve processes. Involving patients and families is also recommended.

Priority Process: Decision Support

All Emergency and Urgent Care programs use a hybrid documentation system using various platforms that are not integrated with other programs. The organization would benefit from exploring the feasibility of selecting a single electronic clinical information system that would mitigate patient safety issues and inform patient flow and quality improvement activities. Similarly, allowing the full functionality of existing

EMRs to include electronic clinical ordering would mitigate the patient safety risks associated with manual order entry and transcription.

Priority Process: Impact on Outcomes

The Emergency Network has been successful in scaling and spreading pilot projects trialed in one department and adapting it to other programs. Horizon is encouraged to continue to leverage this approach to optimizing learnings from QI initiatives.

Patient and family satisfaction surveys have not been conducted since prior to the commencement of the pandemic, although, the team does review concerns and commendations. Resuming this feedback would be very valuable to help the teams identify potential quality improvement projects.

Sharing QI information and activities with staff is strongly encouraged to increase awareness of key performance indicators and involve the team in identifying and participating in QI initiatives.

Priority Process: Organ and Tissue Donation

Staff in all emergency and urgent care departments in Horizon are trained to identify criteria that make a patient suitable for organ or tissue donation and are aware of the role that they play in the process.

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

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

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

The hospice program is regional with an oversight committee with regional representation including patient and family advisors. This group ensures standardization of approach and management. There is a combination of institutional care and community care with the ability for patients to opt for either or a mix of both.

At present there is no volunteer program COVID-19 related but this will be reinstituted in the near future.

Priority Process: Competency

The program is adequately staffed with well trained nursing and physician components. There are opportunities for professional development and onsite educational sessions take place regularly.

Patients and families are fully involved with the development of their individual care plan-goals and objectives. Care is provided in a collaborative fashion always respecting the wishes of the patient and based upon the trajectory of their demise.

Priority Process: Episode of Care

There are set criteria for admission to this program and initial assessments are standardized. There is strong evidence of patient and family input into this process and goals and objectives are laid out in the care plan. Patients can be cared for within the unit-within the community or a combination of both.

Patients may be admitted and stabilized enabling them to return to their community-recognizing that readmission may be facilitated prior to their demise.

The facility allows unfettered family and visitors including pets! All wishes of the patients are respected and death occurs in a dignified manner respecting cultural and spiritual nuances.

Priority Process: Decision Support

Documentation is in a hybrid form but access to patient information is easy for all caregivers both within the institution and the community.

All documentation modalities comply with the organizational and provincial legalities.

Priority Process: Impact on Outcomes

The program via its oversight committee utilizes evidence based guidelines to standardize all aspects of hospice and palliative care. These guidelines are chosen from national and international entities and modified as required to adapt to the local nuances. The oversight committee with its patient and family representation chooses , reviews and implements these guidelines.

Patient safety issues are identified and remediated at early stages following the regular assessments provided by the staff. All incidents are reported and investigated by the management team with appropriate actions where necessary.

Indicator development ,data collection and analysis is controlled by the oversight committee and results and proposed changes in practice communicated to the front line staff.

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

Unmet Criteria		High Priority Criteria
Priority Process: Infection Prevention and Control		
2.7	Input is gathered from the IPC, and the OHS teams to maintain optimal environmental conditions within the organization.	
2.8	Environmental services and the IPC team are involved in maintaining processes for laundry services and waste management.	!
2.9	Input is gathered from the IPC team to maintain processes for selecting and handling medical devices/equipment.	!
4.6	Compliance with IPC policies and procedures is monitored and improvements are made to the policies and procedures based on the results.	
5.6	The effectiveness of the multi-faceted approach for promoting IPC is evaluated regularly and improvements are made as needed.	
Surveyor comments on the priority process(es)		
Priority Process: Infection Prevention and Control		

The infection prevention and control team (IPC team) at Horizon Health Network (Horizon) proved itself to be an essential partner for patient safety during the COVID-19 pandemic. In this post COVID-19 period, the organization is encouraged to maintain infection prevention and control practices at the forefront of its activities.

Aging infrastructure complicate Infection Prevention and Control in Horizon facilities. Several buildings lack sufficient hand washing stations, shared bathrooms, and construction materials and building design in older buildings make thorough disinfection very difficult.

Audits are performed to ensure the quality of housekeeping cleaning and disinfection practices. Although environment services and IPC teams are involved in maintaining processes for laundry and waste management, linen carts are not all covered at some sites. In addition, contrary to recommendations from the IPC team, certain sites have been observed to top-up linen carts with newly delivered linen.

During this survey, certain facilities were observed to have inadequate processes for transport and storage particularly around medical devices reprocessing processes. The organization is encouraged to ensure respect of IPC recommendations in order to ensure patient safety, and to ensure that clean and soil material do not cross paths in order to minimize risks of contamination.

Although trends in healthcare-associated infections and significant findings are shared with other organizations, public health agencies, clients and families, and the community, the organization is encouraged to, given the patient's ability to choose between 2 service providers in the province, investigate the possibility of formal data sharing relationships with Réseau de Santé Vitalité to ensure adequate follow up of infection risks.

During this survey, some sharps containers were observed to be simply placed unsecured on the medication cart and the opening of some containers was quite large, making the contents potentially accessible. The organization is encouraged to ensure that all sharps containers be secured and to ensure they are safe for residents who are mobile.

The IPC team tracks healthcare-associated infections using an outdated database tool, and this information is analyzed to identify outbreaks and trends and is shared throughout the organization. However, the organization is encouraged to implement a more suitable and user-friendly information system to gather and extract information quickly and accurately.

The multidisciplinary infection prevention and control committee at Horizon has access to many stakeholders who contribute to patient safety, including the Medical Officer of Health, a microbiologist, as well as infectious diseases specialists.

Partnerships with Public Health NB, Réseau de Santé Vitalité and other partners need to be better defined and consolidated in order to ensure uniform application of IPC guidelines and practices for all New Brunswick citizens.

Standards Set: Inpatient Services - Direct Service Provision

Unmet Criteria			High Priority Criteria
Priority Process: Clinical Leadership			
1.2	Information is collected from clients and families, partners, and the community to inform service design.		
1.5	Service-specific goals and objectives are developed, with input from clients and families.		
2.4	An appropriate mix of skill level and experience within the team is determined, with input from clients and families.		
2.6	The effectiveness of resources, space, and staffing is evaluated with input from clients and families, the team, and stakeholders.		
6.2	Work and job design, roles and responsibilities, and assignments are determined with input from team members, and from clients and families where appropriate.		
Priority Process: Competency			
3.8	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.		ROP
	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.	**MAJOR**
Priority Process: Episode of Care			
9.4	The assessment process is designed with input from clients and families.		
9.7	Medication reconciliation is conducted in partnership with clients and families to communicate accurate and complete information about medications across care transitions.		ROP
	9.7.1	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**
	9.7.2	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**

9.8	To prevent falls and reduce the risk of injuries from falling, universal precautions are implemented, education and information are provided, and activities are evaluated.	ROP
9.8.3	The effectiveness of fall prevention and injury reduction precautions and education/information are evaluated, and results are used to make improvements when needed.	**MINOR**
11.9	The effectiveness of transitions is evaluated and the information is used to improve transition planning, with input from clients and families.	
Priority Process: Decision Support		
12.8	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.	!
Priority Process: Impact on Outcomes		
14.2	The procedure to select evidence-informed guidelines is reviewed, with input from clients and families, teams, and partners.	
14.3	There is a standardized process, developed with input from clients and families, to decide among conflicting evidence-informed guidelines.	!
14.4	Protocols and procedures for reducing unnecessary variation in service delivery are developed, with input from clients and families.	!
14.5	Guidelines and protocols are regularly reviewed, with input from clients and families.	!
15.1	A proactive, predictive approach is used to identify risks to client and team safety, with input from clients and families.	!
15.2	Strategies are developed and implemented to address identified safety risks, with input from clients and families.	!
15.3	Verification processes are used to mitigate high-risk activities, with input from clients and families.	!
15.4	Safety improvement strategies are evaluated with input from clients and families.	!
15.5	Protocols to move clients elsewhere within the organization during times of overcrowding are followed by the team.	!
16.1	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.	

16.2	The information and feedback gathered is used to identify opportunities for quality improvement initiatives and set priorities, with input from clients and families.	
16.4	Indicator(s) that monitor progress for each quality improvement objective are identified, with input from clients and families.	
16.5	Quality improvement activities are designed and tested to meet objectives.	!
16.6	New or existing indicator data are used to establish a baseline for each indicator.	
16.7	There is a process to regularly collect indicator data and track progress.	
16.8	Indicator data is regularly analyzed to determine the effectiveness of the quality improvement activities.	!
16.9	Information and data on bed availability is collected and used for quality improvement initiatives in collaboration with organizational leaders, and with input from clients and families.	!
16.10	Quality improvement activities that were shown to be effective in the testing phase are implemented broadly throughout the organization.	!
16.11	Information about quality improvement activities, results, and learnings is shared with clients, families, teams, organization leaders, and other organizations, as appropriate.	
16.12	Quality improvement initiatives are regularly evaluated for feasibility, relevance, and usefulness, with input from clients and families.	

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

The leadership team is visible and plays a vital role at each site. Collaboration within and across sites is evident. This has benefits clients and families who have described experiences of coordinated care when moving across sites or within facilities. In some areas there were strong linkages with communities to support and inform service design and delivery.

Priority Process: Competency

Training and education requirements for staff is well defined. Staff have access to online learning and in person education in some areas has also expanded. Performance reviews are completed and documented in most areas. Staff also shared the value of informal reviews. Training for infusion pumps is provided by identified staff in each unit. There are clear processes for escalation of care and collaboration within the unit and across sites is evident. Required training also includes workplace violence including abuse, aggression, threats, and assaults.

Continued efforts in ensuring all staff receive both training and retraining with infusion pumps is recommended to be a priority. There was a site where there was no evidence this was completed.

Priority Process: Episode of Care

There is clear demonstration of collaborative work within units and across the organization. Clients and families understand their rights and responsibilities. Though there are some areas where Medication Reconciliation is well established along with Falls Prevention there were other sites where all tests for compliance were not observed. It is recommended that the organization dedicate continued effort in those areas to ensure that BPMH collection occurs upon admission and upon discharge. Further the effectiveness of fall and injury precautions requires evaluation to ensure continuous improvements occurs in this area. Overall ongoing input from clients and families is recommended to support and strengthen patient safety work within this service area. There were several improvement initiatives shared throughout the week. One that staff were excited to share was the pressure injury prevention initiative to impact pressure injuries.

During several site and unit visits observations included continued pressure due to overcrowding in ERs which often leads to pressure for discharges. A coordinated team based approach across the continuum of care is recognized as priority work for the organization and drilling this down to the front line with continued focus is required.

Priority Process: Decision Support

Most sites are using a hybrid paper based and electronic system for medical records. There is a need to have a more integrated medical record. Data is used and KPIs are communicated back to the unit level. In some areas this data is generated from outside the program. Continued effort to produce KPIs in a timely manner that is meaningful and understood at the unit level is recommended. There are policies in place related to storing, retaining, and destroying client records. An accurate and up-to-date medical record is maintained on all patients.

Priority Process: Impact on Outcomes

Patient flow continues to be a challenge in some areas. This is further impacted by health human resources. There has been some stabilization in this area and continued effort is recommended.

Linkages and new partnerships with new nursing programs demonstrate innovation.

At some sites organization wide bed huddles are not coordinated. This is an area to explore to ensure overflow in emergency services are addressed daily.

There is work underway to look at hospitalist model in some sites.

KPIs are established and a working group is active in this work.

Patients have expressed positive experiences in transitioning across different sites and highlighted the benefits of continuity of care. It is recommended that the organization ensure there are processes to gather input from clients and families around key areas such as improvement, development of guidelines and protocols.

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

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

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

The long-term care program at Ridgewood Veterans Wing is one of two Long Term Care facilities under Horizon Health Network (Horizon) as all other long term care/adult residential facilities are managed by the Department of Social Development.

40 beds are designated as Preferred Veterans Affairs and 40 beds have been funded to be utilized as transition beds to support the organization in patient flow for Alternate Level of Care clients being assessed and approved for a facility living option. The physical space in long term care is designed with the resident at the center. There is clear input from client and families and evidence of inclusiveness with cultural diversity. The environment is free from clutter and the atmosphere is home like.

The well resourced team at Ridgewood Veterans Wing are passionate about their facility and are to be commended for their commitment to the delivery of high-quality care to veterans.

Priority Process: Competency

The Ridgewood Veterans Wing is generously staffed with a well trained multidisciplinary team. Opportunities for professional development are encouraged and the many relationships that they have with external groups ensure that inservices on a variety of topics take place regularly. The organization

has recently adopted the Gentle Pursuasion Approach to respond to behaviours associated with dementia and is available for all team members to access.

Residents and families are consistently involved in the development of their individualized care plans and reflect their goals.

Priority Process: Episode of Care

Initial assessments for admission to Ridgewood Veteran's Wing are standardized and comprehensive. There is strong evidence of patient and family input into the admission process and goals, objectives and preferences are outlined in the care plan.

Documentation throughout time at Ridgewood is complete and all transitions are thorough and consistent. Evidence of a high commitment to resident safety was noted in all areas.

Ridgewood Veteran's Wing has threaded the principles of resident and family care across their teams. This is evident in food choices, the physical spaces, and the design. There is evidence of cultural diversity and bilingual services are available. Staff demonstrate a commitment to quality care and are interested in improving safety and quality of experience for their residents and families.

Priority Process: Decision Support

Documentation is in a hybrid form with both electronic and paper charting performed and follow a standardized format. Ethics issues are managed just in time according to established protocols.

Priority Process: Impact on Outcomes

Long-term care guidelines are selected from national and international best practice. The teams are creative in their adaptation of best practice to align with their local context and individual resident needs.

Patient safety issues are identified and remediated immediately upon discovery. All incidents are reported and investigated by the management team with appropriate actions where necessary. All incidents are discussed in team meetings and inform future quality improvement activities.

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

Unmet Criteria		High Priority Criteria
Priority Process: Medication Management		
8.6	The CPOE system is integrated with other information systems used for medication management.	!
13.1	Access to medication storage areas is limited to authorized team members.	!
13.2	Medication storage areas are clean and organized.	!
13.5	Lighting in medication storage areas is sufficient for teams to read medication labels and information sheets.	!
13.6	Medication storage areas meet legislated requirements and regulations for controlled substances.	!
13.7	Separate storage in client service areas and in the pharmacy is used for look-alike medications, sound-alike medications, different concentrations of the same medication, and high-alert medications.	!
13.11	Medication storage areas are regularly inspected, and improvements are made if needed.	
14.3	Chemotherapy medications are stored in a separate negative pressure room with adequate ventilation and are segregated from other supplies where possible.	!
17.1	Medication preparation areas are clean and organized.	!
17.4	Sterile products are prepared in a separate area that meets standards for aseptic compounding.	!
29.1	Resources are provided to support quality improvement activities for medication management.	
Surveyor comments on the priority process(es)		
Priority Process: Medication Management		

The infrastructure of the Provincial Drugs and Therapeutics Committee is enviable. There is solid alignment and integration of the regional medication management/ Quality and Safety committee structure that is validated as working well.

The organization is very much structured, supported and engaged in clinical trials. Many are active in the Cancer Care Program at Saint John Regional Hospital (SJRH). There is a dedicated Pharmacist for Clinical Trials and a dedicated Oncology Clinical Pharmacist. Novel ideas are encouraged to consider ways to integrate additional clinical pharmacists within appropriate clinical programs.
.
Antimicrobial stewardship is impressive. Within the pharmacies, blood culture flags are monitored, medical microbial results, step down from IV to oral protocols, urine cultures, and therapeutic drug monitoring, as a few. There is effective collaboration with IPC nurses, as well as the use of structured electronic notes to prescribing physicians.

ROP requirements related to medication reconciliation were not validated to be met in some areas where tracers were conducted.

Since the last survey, allergy alerts, medication duplicates, order entry flags, and dose checking have been introduced to the existing electronic pharmacy platform at the SJRH site. Drug interaction flags are actively being worked on as the next and last inclusion. Well done!

There are opportunities to reassess pharmacy physical spaces as well as medication rooms in all sites. Many are small, crowded, and noisy, with pneumatic tubes operating, conducive to interruptions. It was observed that multiple automatic locking medication carts were overflowing beyond the area.

Some narcotics were noted to be stored in locked carts, and others in Acudose systems. Standardization for reliability was a common wish expressed by staff and is very much encouraged. Electronic medication systems and barcoding requisites, as well as a selected CPOE system, are things that staff spoke to as their dream.

There is an opportunity for standardization of practices in the surgical suites, perioperative recovery areas, anesthesia carts/trays, outpatient clinics and emergency carts. Strategic expansion of satellite services and growth day surgery access in smaller sites, with surgeons from other areas, will further drive this need and may serve as an opportunity to test a formal Quality Improvement plan tied to a specific action to improve access.

There were multiple observations of unlocked and unattended medication carts while surveyors were conducting tracers; medication room doors propped open and unattended; and, in several areas, emergency crash carts with drugs stored on top of carts accessible to the patients and the public. These are considered risks which warrant immediate attention and corrective action.

Based on observation and discussion with the satellite pharmacy and site staff, standard use of Acudose systems in all areas was preferred. The intended solution will create a “just in time” capacity and ability to monitor pharmaceutical utilization.

A major frustration in terms of "duplication and rework" for scarce nursing and pharmacy resources is the inability to complete medication reconciliation (Med Rec) electronically. At this time the “old Med Rec” is

printed, and the Best Possible Medication History (BPMH) completed by the nurse with the patient, documented manually, and then entered the system and reprinted.

There is also concern that the turn around time for building standardized clinical order sets into the electronic system once developed. This may well be a decision support resource issue.

Although there is a ten year old policy for community health services related to storage and use of sample medications and a Horizon policy, which excludes inpatient areas, the practice should be reviewed as it has been eliminated completely in most regional and provincial structures due to risks.

Standards Set: Mental Health Services - Direct Service Provision

Unmet Criteria			High Priority Criteria
Priority Process: Clinical Leadership			
The organization has met all criteria for this priority process.			
Priority Process: Competency			
The organization has met all criteria for this priority process.			
Priority Process: Episode of Care			
8.8	Clients are assessed and monitored for risk of suicide.		ROP
	8.8.2	The risk of suicide for each client is assessed at regular intervals or as needs change.	**MAJOR**
	8.8.3	The immediate safety needs of clients identified as being at risk of suicide are addressed.	**MAJOR**
	8.8.4	Treatment and monitoring strategies are identified for clients assessed as being at risk of suicide.	**MAJOR**
	8.8.5	Implementation of the treatment and monitoring strategies is documented in the client record.	**MAJOR**
Priority Process: Decision Support			
The organization has met all criteria for this priority process.			
Priority Process: Impact on Outcomes			
15.1	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.		
15.2	The information and feedback gathered is used to identify opportunities for quality improvement initiatives and set priorities, with input from clients and families.		
15.4	Indicator(s) that monitor progress for each quality improvement objective are identified, with input from clients and families.		
15.5	Quality improvement activities are designed and tested to meet objectives.		!
15.6	New or existing indicator data are used to establish a baseline for each indicator.		

15.7	There is a process to regularly collect indicator data and track progress.	
15.8	Indicator data is regularly analyzed to determine the effectiveness of the quality improvement activities.	!
15.9	Quality improvement activities that were shown to be effective in the testing phase are implemented broadly throughout the organization.	!
15.10	Information about quality improvement activities, results, and learnings is shared with clients, families, teams, organization leaders, and other organizations, as appropriate.	
15.11	Quality improvement initiatives are regularly evaluated for feasibility, relevance, and usefulness, with input from clients and families.	

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

There is evidence of highly engaged teams delivering mental health and addiction services across the continuum from community to inpatient service. There has been an emphasis on patient flow, particularly the implementation of brief interventions to reduce waitlists and support individuals who have requested service and are waiting.

There are pockets of excellence in certain areas of the province where leadership is highly engaged in supporting a "no wrong door philosophy". It is recommended that the lessons learned from leading practice in these areas be highlighted and featured in strategic and operational plans around the delivery of addiction and mental health services.

The Miramichi Area demonstrated some well-established modes of service delivery that ensure a responsive and coordinated continuum of care to clients wherever they show up in the system.

In rural and urban areas, it was mentioned that there is some reluctance to acknowledge that lessons learned in rural delivery are applicable to urban areas even if the model is working well and has all of the components in community, Emergency Department, and inpatient services. From a quality improvement perspective, if the preferred outcomes are the same from the client perspective modes of service delivery could be very similar from community to acute care and from rural to urban centres.

Priority Process: Competency

There are clearly defined roles for multidisciplinary teams across the continuum of care. Job descriptions are in place. There is solid evidence that teams collaborate routinely and pay close attention to transitions in care. There is access to online learning and support for additional professional development, particularly for clinical practices that are deemed to be preferred modes of service delivery.

Priority Process: Episode of Care

There are good communication strategies in place from the top down, including the relationships between the two provincial health authorities to collaborate on programs and services that may be accessed by individuals from areas where there are overlaps because of things like geography, language, culture or access to more tertiary services. There is evidence that a "no wrong door" approach has effectively improved access and led to a commitment to put mechanisms in place that strengthen the continuum of care. The investments in providing quick access to one day or brief interventions appear to have been very impactful in terms if reducing waitlist and providing service to people in crisis.

Suicide risk assessment had not been completed on a client who participated in the survey.

Priority Process: Decision Support

Documentation is organized and thorough. There are challenges with the combination of electronic and paper-based records. This results in some inconsistency in the way that information is communicated at points of transition but mechanisms have been put in place to ensure that information is communicated as required. It appears that duplication is more of an issue than the risk of missing information that is pertinent to care planning.

Priority Process: Impact on Outcomes

There is evidence of some effort to identify and monitor key performance indicators and to continuously improve programs but based on the evidence gathered it appears that the approach to quality improvement is somewhat ad hoc with very little engagement of the team, clients, and families. Most of the improvement initiatives that were identified were presented as Government or Health Authority directed. Many of these initiatives were identified as good improvements to the system but there is skepticism about the sustainability of initiatives that are reactive rather than proactive. Great work done around access and patient flow.

Standards Set: Obstetrics Services - Direct Service Provision

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

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

Obstetrics is coordinated under the Women and Children's Health Clinical Network, along with Neonatal ICU, and Pediatric services.

Obstetrics is provided at five sites including Moncton, Fredericton, Upper River Valley, Saint John, and the Miramichi. Four of the five sites were visited.

High risk pregnancy care is provided at the three tertiary sites: Moncton, Fredericton, and Saint John.

The Network highlights five working groups: Maternal Newborn, Baby Friendly Committee (BFI Committee), Pediatric Advanced Care team, Neonatal ICU and Pediatrics.

Horizon Health Network (Horizon) actively seeks input on services from the communities, patients and families, and has completed a survey via Facebook. These results are being compiled and will be shared at the next Network meeting. The team use a number of ways to get community feedback. They used QR Codes on cards, given at discharge on the baby feeding experience and overall satisfaction. They utilize the Bravos, acknowledging the staff, to gain feedback on the services as well.

The Upper River Valley Hospital has a Prenatal Clinic attached to the Labor and Birth Unit where they see

approximately 13-16 patients/day, 5 days per week. This is very good support for the patients and their families, and enables the patients to become familiar with the staff, the unit and what to expect on admission.

The nurse for the Prenatal Unit is also a lactation consultant and is available to support breastfeeding. All nurses on the unit are skilled in breastfeeding information and ensure patients have the information they need to make informed decisions.

The Dr Everett Chalmers Regional Hospital is considering a similar Prenatal Clinic when they move to the new expansion in 2024. Clients, families and staff have been engaged in the expansion project around space, design and flow.

There is an inclusive Breastfeeding Guide available for the patients and the families called Every Drop Counts. There is also an online version available. This was a collaborative initiative between the NB Department of Health, the Baby Friendly Initiative Education working group, and Horizon and Réseau de Santé Vitalité Networks BFI Coordinators.

Priority Process: Competency

There are a number of different populations including the Amish, Mennonites, First Nations, and new immigrants to the area. Cultural education and training is an important component for the staff in this area.

The staff have their infusion pump safety training and evaluation completed as part of their 5K mandatory eLearning requirements. This is monitored for compliance. A number of other courses that are available include falls prevention, hand hygiene, Patient Rights and Responsibilities, ethics, privacy and confidentiality, and workplace violence prevention.

A number of staff referenced MoreOB (Managing Obstetrical Risk Efficiently) Program as a comprehensive performance improvement program, that would enhance the culture of patient safety. Leadership is encouraged to review and consider MoreOb, as a continuous patient safety program for health care providers and managers.

The orientation for new nurses is good including 6-8 weeks with an experienced obstetrical nurse. This is greatly appreciated by those new nurses.

There is good acknowledgement of the staff through the years of service awards, Bravo recognition, safety awards, to note a few.

Priority Process: Episode of Care

The following Obstetrical Services were visited: The Moncton Hospital (1200 deliveries annually), Miramichi Regional Hospital (350 deliveries), Dr. Everett Chalmers Regional Hospital (1500-1600

deliveries), and the Upper Valley Regional Hospital (120-180 deliveries). Obstetrical services are also provided at Saint John Regional Hospital.

There is good collaboration with the patients and their families to ensure active involvement in their care and decision making. The patients and families validated this and shared how they were included in all aspects of their care.

The obstetrics and labor and delivery teams are strong and knowledgeable in their respective areas. Leadership is responsive and readily available to the teams.

Moncton is opening its new space in 2023. At the Dr Everett Chalmers Regional Hospital (DECRH), they are planning for a new space in late 2024. At these respective hospitals, there is limited space and storage. The staff do their best to ensure patient, family, newborn, and staff safety by organizing the units to maximize flow and keep equipment and supplies in their places.

Infection prevention and control resources are in the basement at URVH and DECRH. It is suggested that the organization review these positions as to their location. Communication is strengthened when services and resources are closer to the areas they support.

Staffing remains challenging and numerous efforts have been underway to address the problem. They receive student placements, and the LPNs are working to their full scope (DECRH), giving medications and completing head-to-toe assessments for newborns, therefore relieving the workload for the RNs. As well this supports the LPNs to work to full scope. New RNs are offered a 3-month orientation with an experienced nurse to support their learning journey.

A URVH Labor and Birth staffing plan is in place to address an obstetrical surge. URVH works closely with Fredericton in these events.

There are a number of quality improvement projects underway. Patient Safety Key Performance Indicators (KPIs) are regularly tracked, monitored and reported.

There is good communication between the staff across Area 3. The Administrative Directors meet regularly and with Réseau de Santé Vitalité at least annually.

The Performance Development Plans (PDPs) are completed, underway or scheduled. For managers with less than 40 staff, PDPs are completed annually, beyond 40, they are done every two years. The managers pay good attention to this, and the staff appreciate the conversation, setting their goals and addressing their professional development needs.

The staff have a resource nurse or supervisor for support, an educator, and expertise from IPC. There is also a manager who may have more than one unit or service.

There are numerous new initiatives to support mothers and babies, including Eat, Sleep and Console, to

support babies at risk of substance withdrawal. They have a breastfeeding guide, Every drop counts. There are lots of examples where improvements have been made.

Good examples of involvement from clients and families include the design of the new spaces and expansions in Moncton and Fredericton. The new plans will improve patient flow, infection prevention, meet storage needs, and improve space requirements.

Some concerns that patients and families shared included the following, when you come up to the Obstetrical Unit at the DECH in the night, the patient and family shared that the corridors were dark and the signage was not good. They had difficulty finding where they were to go for Labor and Delivery, although they had been there before. That may need to be discussed prior to the move. Some areas have an escort that will bring the patient up to the unit after hours.

Another family shared that they would like to see more sleep chairs so the mothers' support can get rest as well. They used a lounge chair but were not offered a sleep chair or a cot. This is an improvement opportunity that can be reviewed.

Priority Process: Decision Support

At present, clinical documentation is made up of a hybrid chart. The team is encouraged to continue to pursue transition of hybrid clinical documentation to an electronic health record. This will ensure timely access to information.

The organization is encouraged to ensure policies and procedures are reviewed, updated and dated. There are policies in place to ensure client information is secured, private and confidential. Education regarding this is in place for staff and it is reviewed on an annual basis.

There is collaboration with the client and family on information documented on the clients record. The client has access to their record upon their request.

Priority Process: Impact on Outcomes

There are a number of quality initiatives underway. Some of these include developing and implementing a Prenatal Clinic at Dr Everett Chalmers Regioal Hospital following their expansion, ensuring LPN's worked to their full scope of practice to give medications and complete head-to-toe assessments on infants, Eat-Sleep-Console for babies at risk of substance withdrawal, to note a few.

In Fredericton, the labor and delivery nurses complete an OR Course focused on C-Sections. This allows those nurses to assist in the OR in emergencies, therefore, saving valuable time.

In labor and delivery, they will have a full-time nurse working 50% of their time as an educator and the other 50% as a floor nurse in the fall of 2023. This resulted from a pilot project to determine the best combination for an educator role.

Posters on the Patients Rights and Responsibilities were posted in several places.

There has been active involvement from patients and families in planning and designing the new expansions for Moncton and Fredericton.

Quality Improvement projects were identified through patient feedback from various places, including satisfaction surveys from the NB Health Council, dietary surveys, Your Opinion is Important, comment boxes, conversations with staff, monitoring incident reports and near misses.

At URVH, the team is working on a Labor and Birth staffing Plan in the event of an obstetrical surge. URVH works closely with the Dr Everett Chalmers Regional Hospital (DECRH) in these situations.

At the DECRH, the labor and delivery team are developing an OB Code for obstetrical emergencies such as prolapsed cord, bleeds, seizures, to note a few. Presently, they use ACT teams within the hospital for emergencies, ensuring OBS experienced staff are available to assist and support the best possible outcomes.

Mother and baby outcomes are monitored by staff and where indicated, improvements are made.

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

Unmet Criteria		High Priority Criteria
Priority Process: Clinical Leadership		
The organization has met all criteria for this priority process.		
Priority Process: Competency		
6.11	Team member performance is regularly evaluated and documented in an objective, interactive, and constructive way.	!
6.13	Team members are supported by team leaders to follow up on issues and opportunities for growth identified through performance evaluations.	!
Priority Process: Episode of Care		
14.4	Procedure-specific care maps or guidelines are used to guide the client through preparation for and recovery from the procedure.	
17.8	Soiled linen, infectious material, and hazardous waste are handled appropriately.	!
Priority Process: Decision Support		
The organization has met all criteria for this priority process.		
Priority Process: Impact on Outcomes		
23.4	Protocols and procedures for reducing unnecessary variation in service delivery are developed, with input from clients and families.	!
24.1	A proactive, predictive approach is used to identify risks to client and team safety, with input from clients and families.	!
24.2	Strategies are developed and implemented to address identified safety risks, with input from clients and families.	!
Priority Process: Medication Management		
5.2	Medications in the surgical area are stored in a locked area or similarly secured, as per the organization's policies regarding medication storage.	!
5.3	The contents of medication carts for the surgical area are standardized across the organization.	

16.3 Medications and related supplies stored on anesthesia carts are standardized.	

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

The Horizon Health Network (Horizon) provides perioperative services at nine sites across the four Areas. As part of the organization's strategic plan, improved perioperative service access and efficiency are a priority.

Long and expanding wait lists have been identified as a concern, and proactive measures to address this issue are ongoing. The organization is targeting specific surgical programs to improve the percentage of patients who receive surgery within the targeted time frame.

Patients who have waited an extended period are identified and prioritized for review in the clinic. Efforts to streamline surgical intake are underway to support the prioritization of patient care and to distribute and maximize operating room resources.

Multiple sites within the organization were noted to have separate physician and staff lounges within the perioperative areas. This division detracts from team building while gathering on breaks. It is also noted that these legacy physician lounges have male washrooms attached without consideration for female physicians. It is suggested that combined lounges for physicians and staff be considered where possible and with new infrastructure.

Underutilization of operating rooms is an issue at some locations, predominantly due to lack of anesthesia availability. The leadership is encouraged to engage the Departments of Surgery and Anesthesia to determine coverage options to maximize operating room utilization.

With the change and expansion of programs, continued efforts to obtain feedback from patients and families are encouraged to help identify successes and further opportunities for program improvement.

Priority Process: Competency

Recruiting and retention of skilled professionals to support the perioperative program is an ongoing challenge. With the expansion of the perioperative program to provide services including total knee and hip replacements at new sites, the orientation and training requirements of staff are significant.

The teams have been innovative and successful in their efforts to develop and train these specialized skill sets to support the ongoing success of the perioperative program, to achieve the strategic goals of the organization and care for patients and families in the community. The enthusiasm with which the frontline nursing, allied health and administrative staff have stepped up to this challenge is commendable.

Performance appraisals are not consistently completed across all sites. The organization is urged to

support managers in completing appraisals and having these valuable conversations with staff.

Ongoing challenges filling anesthesia positions have resulted in underutilized operating room space at some locations. Consideration of alternative resources to fill or support this gap including GP anesthesia and anesthesia assistants may be considered. Operating room utilization and decreasing surgical waitlists are strategic priorities and expanding anesthesia capability to support the perioperative program should be considered.

Priority Process: Episode of Care

Horizon's strategic priorities are improved perioperative access and decreased wait times for targeted surgeries. The organization has prioritized accessibility of perioperative services due to recognition of extended wait times due partly to operating room closures and restrictions during the pandemic.

Expansion of existing operating room utilization in terms of extended hours and expansion of services at some sites have contributed to successes in decreasing wait lists. Frontline nursing, allied health, technicians and administrative staff have supported these initiatives with overtime and a commitment to extended orientation and training to learn new processes and procedures to support the expanded perioperative programs.

Emphasis on care surrounding perioperative to improve patient experiences and outcomes has also been emphasized, including Enhanced Recovery After Surgery (ERAS), which supports patients before, through and after surgery and Seamless MD, which supports patients and families with the ERAS program. Monitoring the impacts of these initiatives with Average Length of Stay (ALOS) and readmission rate data is ongoing to verify the positive impacts of programs and identify further areas of opportunity and development. Should these pilot projects prove successful, rolling them out throughout the organization and to other surgical programs should be considered.

Recruiting and retaining skilled professionals to support the perioperative program is an ongoing challenge and concern. The team has been innovative and successful in endeavours to develop and train these specialized skill sets to support the ongoing success of the perioperative program and achieve the strategic goals.

Bed availability remains a challenge, and the organization is encouraged to continue efforts working with government and community partners to expand and improve home care services, alternate level of care designations and prioritization of long-term care bed utilization to improve bed availability for acute care and perioperative patients.

Consideration of new or expanded surgical programs should always be reviewed through the network to confirm that the program is supportable. Building programs based on a single specialist's availability is discouraged unless it fits into the network priorities. Additionally, potential surgical programs need to consider other departments and review staffing considerations, space for equipment storage, and reprocessing services.

The organization is encouraged to review where and how bronchoscopy is offered to confirm that the spaces utilized are appropriate and include negative pressure capability.

The Safe Surgical Checklist is completed but there is an opportunity to make it patient-centred. The patient should be included in the initial briefing and provided the opportunity to be introduced to the surgical team and their roles. The patient is central to confirming their surgery and site, prior to the induction of anesthesia. Including this patient-centred piece within the current Safe Surgical checklist may be considered by the organization moving forward.

While the organization does utilize procedure-specific care maps, physician-specific care maps are found throughout the organization. Standardizing the care maps in accordance with evidence-based best practices would streamline the support provided by inpatient and community nursing and allied health providers. it is recommended that specialties within the Department of Surgery standardize their guidelines for patients through surgical preparation and recovery.

Priority Process: Decision Support

The perioperative program at Horizon remains predominantly paper-based with some computerized elements. This hybrid chart requires some effort duplication and increases the risk of missing or inconsistent information. Incorporating the perioperative service into a comprehensive electronic health record remains a goal for the organization.

As the organization continues to progress as a network rather than a site-based program, attention to standardization of process and paperwork requires ongoing vigilance.

It is recognized that there is significant variation in technology utilization within and between sites. It was noted that barcoding at one site was used throughout the hospital but was not used within the operating room. There may be opportunities to utilize technology to improve tracking and standardization.

Priority Process: Impact on Outcomes

The perioperative service has done extensive work in utilizing quality improvement data and Key Performance Indicators to identify priorities for the service. This work translates into real-world successes in reducing surgical wait times and providing patients with the care they need. The organization is encouraged to continue to monitor and build on these successes.

Service delivery is often physician rather than procedure-based and there is significant variation. The development of standardized protocols is recommended. The inclusion of patient and family input and implementation of a Patient Experience Advisor position will be helpful to access this valuable perspective.

Multiple walk-throughs and audits have identified unsecured high-risk medications within the

perioperative department. Narcotic management and accurate counts are inconsistently completed and require pharmacy follow-up. Although previously recognized, strategies have not been implemented to address these recognized deficiencies. The organization needs to tighten up medication processes in the perioperative area to comply with legislation surrounding restricted substances. Implementation of new processes or implementation of automated dispensing units for narcotics is recommended to mitigate further safety and legislative risk.

Priority Process: Medication Management

Medication management within perioperative services would benefit from increased Department of Anesthesia involvement from a network perspective, pharmacy oversight, education and standardization.

Several sites had unsecured medication within the surgical area. Propped-open medication room doors and unlocked drawers were noted at one location. Another location was noted to have high-risk medications including narcotics unsecured on top of anesthesia carts. It is recommended that perioperative services review medication management processes in conjunction with the Department of Anesthesia and the pharmacy team to identify areas of risk and provide education to support safe practices.

Anesthesia carts are not standardized at all sites. Lack of standardization increases the workload for the nursing and pharmacy staff and decreases flexibility in adjusting workflow and space utilization. It is recommended that the Department of Anesthesia be engaged to standardize carts across the organization and develop a plan that allows individuals to access preferred items if not included within the standardized cart. If there is an opportunity to implement automatic dispensing units in the operation rooms, this should be considered to improve safety and decrease risk.

A distinctive Braslow cart was noted in one operating room to store medical supplies, not pediatric emergency equipment. Carts that are visibly associated with pediatric emergencies should not be used to store other supply items.

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

Unmet Criteria		High Priority Criteria
Priority Process: Point-of-care Testing Services		
3.4	As part of their performance evaluation, health care professionals delivering POCT must routinely demonstrate their competence. CSA Reference: Z22870:07, 5.1.5.	
4.4	The organization places the SOPs in areas where health care professionals delivering POCT can easily access them.	
8.3	Before performing the point-of-care test, health care professionals properly label the request form and the samples in front of the client, with the same information (family name, given name, record number and Medicare number) so that they can maintain traceability between the client and the sample.	!
9.6	The health care professional delivering POCT completes a comprehensive and accurate report for every point-of-care test carried out that is distinct from clinician notes in the record.	
Surveyor comments on the priority process(es)		
Priority Process: Point-of-care Testing Services		

The Point of Care Testing (POCT) program at Saint John Regional Hospital (SJRH) is comprehensive. The POCT committee has approved devices for glucose, urine, b-HCG, PT, blood gases and a few other markers with the purpose of improving TAT and support physicians in timely decision for management and treatment of clinical conditions.

It was reported that only at SJRH, close to 15,000 POCT glucose determinations are done. It is evident that teams must commit to implement and follow best quality practices to guarantee reliable results while reduce error occurrence. POCT and nurse management are invited to track and monitor Patient ID errors as well as work with senior leader to get the high-volume devices interfaced to LIS or HIS to avoid/eliminate potential transcription errors.

The POCT Regional Advisory Committee is comprised of multidisciplinary representatives from the laboratory administration and clinical programs including nursing. Meetings are held on a quarterly basis to review the overall performance of the program, discuss non-conformances, POCT requests and opportunities for improvements.

Quality Control and EQA procedures are performed and documented. Training and education is given before users are authorized to perform testing. Periodic training and re-certification is also offered. However, competency assessment challenges were reported with Activated Clotting Time and COVID-19 POCT testing. Obsolete documents were observed in ED.

Standards Set: Public Health Services - Direct Service Provision

Unmet Criteria	High Priority Criteria
Priority Process: Clinical Leadership	
The organization has met all criteria for this priority process.	
Priority Process: Competency	
The organization has met all criteria for this priority process.	
Priority Process: Impact on Outcomes	
The organization has met all criteria for this priority process.	
Priority Process: Public Health	
The organization has met all criteria for this priority process.	

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

Horizon Public Health Services are provided by Horizon Health Network (Horizon) staff in the Saint John, Fredericton and Miramichi areas. All Public Health Services in the Monton area are provided by Réseau de Santé Vitalité by agreement since 2009. Public Health is delivered by public health nurses, dietitians, and support staff who work with medical officers of health as well as staff from the Department of Health.

Priority Process: Competency

Public Health staff are well supported with training be it through Horizon e-learning platform as well as specific public health training opportunities. Performance appraisals are conducted annually or bi-annually. Team members can be recognized through informal and formal performance appraisal or by client through the Horizon Bravo initiative.

Priority Process: Impact on Outcomes

Public Health has a number of Key Performance Indicators related to all of their programs that they measure and report. Of course the pandemic curtailed and postponed their measurement and reporting while all resources were diverted to mass vaccination programs, following adverse events related to COVID-19 vaccination and contact tracing. As normal programming resumes so is the reporting of KPIs.

Priority Process: Public Health

Horizon Public Health is delivered in 3 areas covering the geographic area of Horizon. The six programs

delivered by Public Health are directed by the Province's Department of Health but operationalized by the health authority. These programs are planned and funded by the Office of the Chief Medical Officer of Health. (Immunization; Healthy Families-Healthy babies; Healthy learners; sexual health; communicable disease; nutrition; and baby friendly initiative. All these programs are based on current recommendations, best practices and community data from PH New Brunswick. The Office of the Medical Officer of Health introduced a Public Health Information System (PHIS) that includes an Inventory management module and an immunization management module. This has improved the ability to provide more immunizations in schools as they can do real time entry of immunization as well as reduce paper.

However, the roll out of the Investigation and Outbreak module has been delayed which hinders Public Health's tracking and surveillance of all communicable disease. There is good collaboration between PH Areas and the other Provincial Health Authority, Réseau de Santé Vitalité, as well there are strong community partners relationships.

Standards Set: Rehabilitation Services - Direct Service Provision

Unmet Criteria		High Priority Criteria
Priority Process: Clinical Leadership		
The organization has met all criteria for this priority process.		
Priority Process: Competency		
The organization has met all criteria for this priority process.		
Priority Process: Episode of Care		
7.13	Clients and families are provided with information about their rights and responsibilities.	!
7.14	Clients and families are provided with information about how to file a complaint or report violations of their rights.	!
10.8	The effectiveness of transitions is evaluated and the information is used to improve transition planning, with input from clients and families.	
Priority Process: Decision Support		
The organization has met all criteria for this priority process.		
Priority Process: Impact on Outcomes		
The organization has met all criteria for this priority process.		

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

The multidisciplinary teams are collaborative in their approach to creating client and family specific care plans. There is a “can-do” culture in the rehabilitation environment. They demonstrate their leadership by sharing knowledge and resources both provincially and intra-provincially with PEI, to help to build capacity in the system and to ensure equal access to the most recent and up to date rehabilitation care.

Priority Process: Competency

The leaders of these departments are actively engaged with staff, clients, and families. The staff felt they had the equipment and resources to complete their work safely. There are strong relationships with other departments, as well as, ease of access to the online educational resources with just in time education when required. Congratulations on your high functioning and engaged teams.

Priority Process: Episode of Care

There is a high priority placed on client safety and helping clients and families meet their individual goals. Teams demonstrate a high degree of creativity to helping clients to achieve their highest level of independence possible. There is inconsistency in how clients and families are informed about their rights and responsibilities, and where resources exist, the rehabilitation programs could serve their clients and families better by standardizing the content of their welcome package to include information on their rights, responsibilities and, on how to file complaints or report violations of their rights.

Priority Process: Decision Support

There is good use of standardized tools for risk and functional assessments. There is a mix of paper and electronic health record. The organization should consider implementing one electronic medical record that is consistent and compatible throughout the organization.

Priority Process: Impact on Outcomes

The rehabilitation units place a high emphasis on risk assessment and injury prevention, in particular falls and pressure injury prevention. The organization could benefit by leaning into the expertise of these teams for sharing their enthusiasm and expertise.

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

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

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

The Spinal Cord injury (SCI) program is a provincial initiative with two active sites--Saint John and Moncton for acute care and Stan Cassidy Rehabilitation Centre for long term rehabilitation. The leadership group has made efforts to standardize treatment approaches in the acute stage and for the transition to rehabilitation.

Resources are adequate and clinical staff are sufficient for the management of the approximately 30 patients per year that present with SCI. There is good cooperation between all provincial sites receiving patients and the transfer to an appropriate center is smooth and timely.

The overall program is encouraged to have a permanent patient/family representative on the oversight committee to ensure complete participation in planning and implementation. There would appear to be reasonable involvement at the site level but the addition of a participant at the program level would be helpful, which is anticipated to occur in the near future.

Priority Process: Competency

All staff have had specific training in the management of these complex patients-both in the acute phase

and the transition to long term rehabilitation. Orientation programs are in place and a clinical educator ensures that ongoing education and updates are available. The units provide regular onsite rounds, professional seminars and case reviews to ensure that staff are familiar with advances in care and approach. Performance reviews are up to date and opportunities for professional development are encouraged.

Care is provided in a collaborative fashion with major input from the patient and family. Communication is fluid at all levels and patients and families are full participants in all care decisions and management.

Priority Process: Episode of Care

The SCI program is imbedded in the Neurosurgical / Neuroscience inpatient areas. All documentation and ongoing care is recorded and specific documentation regarding SCI is available to all caregivers.

There is a comprehensive booklet on the Management Protocol for Spinal Cord Injury developed at the Saint John site with evidence based guidelines. This covers all aspects from the acute phase to the transition to rehabilitation. Unfortunately it would appear that this document has not been shared with the Moncton site despite both being parties to the Provincial SCI program--strongly encourage a wider distribution of this document to ensure consistency and standardization within the program.

The SCI program works closely with the Stan Cassidy Rehabilitation Centre and the transition to this entity is smooth and collaborative. The average LOS for the acute phase of management is 2-3 weeks and during that period all psycho-social, physio and occupational efforts are instituted at an early stage prior to the transfer to Stan Cassidy Rehabilitation Centre.

Priority Process: Decision Support

Documentation of patient activity is consistent but still recorded in a hybrid fashion--electronic platform and paper based. The transfer of information also has a hybrid method-particularly from the referral partners and to the Stan Cassidy Rehabilitation Centre.

All documentation methods are subject to the institutional and provincial legalities regarding protection, distribution and privacy.

Priority Process: Impact on Outcomes

The standardized approach to the management of SCI has been based upon evidence based guidelines developed by National and International experts and societies concerned with SCI--these sources have considerable end user input.

The Saint John site of the program submits patient information in a national data base and uses the analysis for bench marking and remediation for possible improvements. The Moncton site has not participated at the national level and is strongly encouraged to do so. At the present time only half of the Provincial SCI program is being monitored and bench marked through a wider resource base and major information and possible clinical improvement data lost.

Patient safety is paramount and many mechanisms to ensure that this vulnerable group is protected are in place. Safety incidents are reviewed and remediation where necessary occurs.

The involvement by a portion of the program in National and International organizations provides a venue for good quality improvement. Due to the low provincial numbers the interaction with other centers allows for accurate comparisons and improvement pathways. The organization is encouraged to incorporate the Moncton site as part of this data base and the Provincial SCI program is encouraged to utilize this opportunity for QI programming.

Standards Set: Substance Abuse and Problem Gambling - Direct Service Provision

Unmet Criteria		High Priority Criteria
Priority Process: Clinical Leadership		
1.3	Service-specific goals and objectives are developed, with input from clients and families.	
1.4	Services are reviewed and monitored for appropriateness, with input from clients and families.	
Priority Process: Competency		
The organization has met all criteria for this priority process.		
Priority Process: Episode of Care		
8.2	The assessment process is designed with input from clients and families.	
Priority Process: Decision Support		
The organization has met all criteria for this priority process.		
Priority Process: Impact on Outcomes		
13.2	The procedure to select evidence-informed guidelines is reviewed, with input from clients and families, teams, and partners.	
15.1	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.	
15.2	The information and feedback gathered is used to identify opportunities for quality improvement initiatives and set priorities, with input from clients and families.	
15.4	Indicator(s) that monitor progress for each quality improvement objective are identified, with input from clients and families.	
15.5	Quality improvement activities are designed and tested to meet objectives.	!
15.8	Indicator data is regularly analyzed to determine the effectiveness of the quality improvement activities.	!

15.9	Quality improvement activities that were shown to be effective in the testing phase are implemented broadly throughout the organization.	!
15.10	Information about quality improvement activities, results, and learnings is shared with clients, families, teams, organization leaders, and other organizations, as appropriate.	
15.11	Quality improvement initiatives are regularly evaluated for feasibility, relevance, and usefulness, with input from clients and families.	

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

There is evidence that leadership is present and engaged at the point of care. There are good mechanisms for sharing of information for day-to-day activity, client care, and program development. There is focus on safety for clients and care providers. Client records are largely paper-based although there is a basic online EMR that is quite outdated. Mechanisms are in place to define the skillsets needed for teams and individual positions and people are recruited based on what is needed to do the jobs.

Priority Process: Competency

Job descriptions including qualifications for each position are in place. There is an online learning management system available for basic mandatory and other training as well as support to access specific professional development to build competencies in program areas that have been selected as components of the service delivery model.

Priority Process: Episode of Care

There is robust programming at the community level with evidence of integration between addiction and mental health services to provide wrap-around service to clients. Access to residential treatment is somewhat of an issue because of the geographic locations for these services but the Intensive Day Treatment Program provides an alternative mode of service delivery to people on a waitlist or not able or ready to travel for residential treatment. Addiction Services are delivered in a similar way to mental health programs in the sense that there is "no wrong door" and there are options for brief intervention as well longer term supports. Harm reduction strategies are appropriately considered and integrated with recovery programs so that care plans are tailored to the circumstances of the client. Care plans are developed collaboratively with, endorsed by, and shared with clients.

Priority Process: Decision Support

Administrative supports are in place for client records, policies, and procedures. The client record system has paper and electronic components to it. There is consensus that a current electronic client record system would be a significant improvement to facilitate evidence based care-planning and decision-making.

Priority Process: Impact on Outcomes

There is evidence of an integrated approach to substance abuse, problem gambling, and mental health services. There has been a focus on flow and access to care.

The initiatives around mobile crisis and brief interventions have facilitated reductions in wait times for more intensive interventions.

Harm reduction approaches to recovery have been implemented. There are some challenges around the geographical locations for residential treatment, particularly for urban centres such as the Moncton area.

The introduction of the Indigenous Liaison position and the work being done to better serve Indigenous communities that are adjacent to Horizon Health programs is commendable. The organization is encouraged to continue its work to support cultural competency and safety around diversity and inclusion.

Standards Set: Telehealth - Direct Service Provision

Unmet Criteria	High Priority Criteria
Priority Process: Clinical Leadership	
2.5 The effectiveness of resources, space, and staffing is evaluated with input from clients and families, the team, and stakeholders.	
Priority Process: Competency	
The organization has met all criteria for this priority process.	
Priority Process: Episode of Care	
The organization has met all criteria for this priority process.	
Priority Process: Decision Support	
13.1 There is a multi-faceted approach to protect the confidentiality of data and information exchanged during the telehealth encounter.	!
Priority Process: Impact on Outcomes	
The organization has met all criteria for this priority process.	

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

The telehealth team has equipped over 100 rooms in the Horizon Health Network (Horizon) for virtual meetings and telehealth consultations. Although telehealth activities existed at Horizon prior to the COVID-19 pandemic, this service has grown over 10-fold since.

A dedicated team is in place to support clinician-users. Teams are very in-tune with patient feedback and will work with the external vendor to fine-tune the platform used for telehealth in response to patient needs. However, despite this feedback, the team is encouraged to evaluate the effectiveness of these services and the degree to which it responds to the patients needs in a more formal manner.

Priority Process: Competency

In the two departments visited during this survey, services delivered via telehealth mirror services delivered in-person. As such, the clinical structure, organization of services, as well as policy and procedures are the for both.

The additional training for staff pertains to the use of the telehealth equipment, and a dedicated team is in place to support the clinician-users.

Priority Process: Episode of Care

Patients are always provided the option of in-person or virtual follow-ups. Episodes of care follow the same principles and protocols as service provided in-person.

As the telehealth platform serves as a communication tool, clinical documentation is done according to each service's practices.

The nature of teleconsultations necessitates the active cooperation of patients and their families, and facilitates the participation of some external care partners as travel time and cost are thereby eliminated.

Priority Process: Decision Support

The telehealth platform provided by the external vendor "2nd Opinion" is used as a communication tool whereby patients can communicate with clinicians via messaging and attach videos and photos. There is no interoperability between this platform and the clinical documentation systems used at Horizon. This platform also integrates Zoom for the audio/video portion of telehealth.

In the pediatric rehabilitation service, access to telehealth is granted by administrative personnel. External partners such as school therapists, private practitioners working with the patients concerned, etc. can request and be granted access to this platform with consent from patients/parents.

The organization is encouraged to implement a formal written consent outlining the limitations of access to be signed by parents. In addition, the organization is encouraged to review the access-granting process including the possibility to implement confidentiality agreement with external partners in order to ensure security of patient information.

Priority Process: Impact on Outcomes

The two teams visited during this survey proactively review and determine which new evidence based guidelines to adopt for care standardization and reliability. Guidelines and protocols are updated frequently in response to new literature.

In addition to the usage data currently used as indicators, the telehealth teams are encouraged to identify indicators which measure the quality as well as the effectiveness of these services, particularly in comparison to conventional in-person service delivery models.

Standards Set: Transfusion Services - Direct Service Provision

Unmet Criteria	High Priority Criteria
Priority Process: Episode of Care	
The organization has met all criteria for this priority process.	
Priority Process: Transfusion Services	
25.11 The team shares information about its quality improvement activities, results, and learnings with clients, families, staff, service providers, organization leaders, and other organizations, as appropriate.	

Surveyor comments on the priority process(es)

Priority Process: Episode of Care

SJRH has adopted fall precautions for all clients to ensure a safe environment that prevents falls and reduces the risk of injuries from falling.

Priority Process: Transfusion Services

The Transfusion Medicine service at Saint John Regional Hospital (SJRH) is staffed by experienced, knowledgeable, and dedicated medical laboratory professionals. The service is provided 24/7.
At SJRH, over 7,000 red blood cells units are annually transfused. Blood issuing and administration follows a very comprehensive process that includes the proper identification and labelling of the blood product, the record of the person picking up the product and the documentation of the patient identifiers prior transfusion. In addition, vital signs prior, during and post transfusion are recorded. O negative blood for women at childbearing age and young kids is issued during emergency cross-matching requests until an ABO is performed and blood specific units are issued

The team is commended for developing a significant number of policies and procedures from blood collection, labelling storing, testing and releasing and transportation. Proper policies and procedures are developed for the proper follow up of lookbacks and tracebacks.

Management monitors several indicators such as TAT, % outdated platelets, O negative utilization and crossmatched/transfused ratios. The team is encouraged to implement other evidence-based practices from Choosing Wisely Canada and apply for the Using Blood Wisely designation. Also, the program is encouraged to share information about the program quality improvement activities, results, and learnings with clients and families.

The Transfusion Medicine committee is chaired by a Transfusion Medicine physician. Management reported that the existing Committee's Terms of Reference is under review. There is an opportunity to revise leadership model and frequency of local and regional meetings.

Instrument Results

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

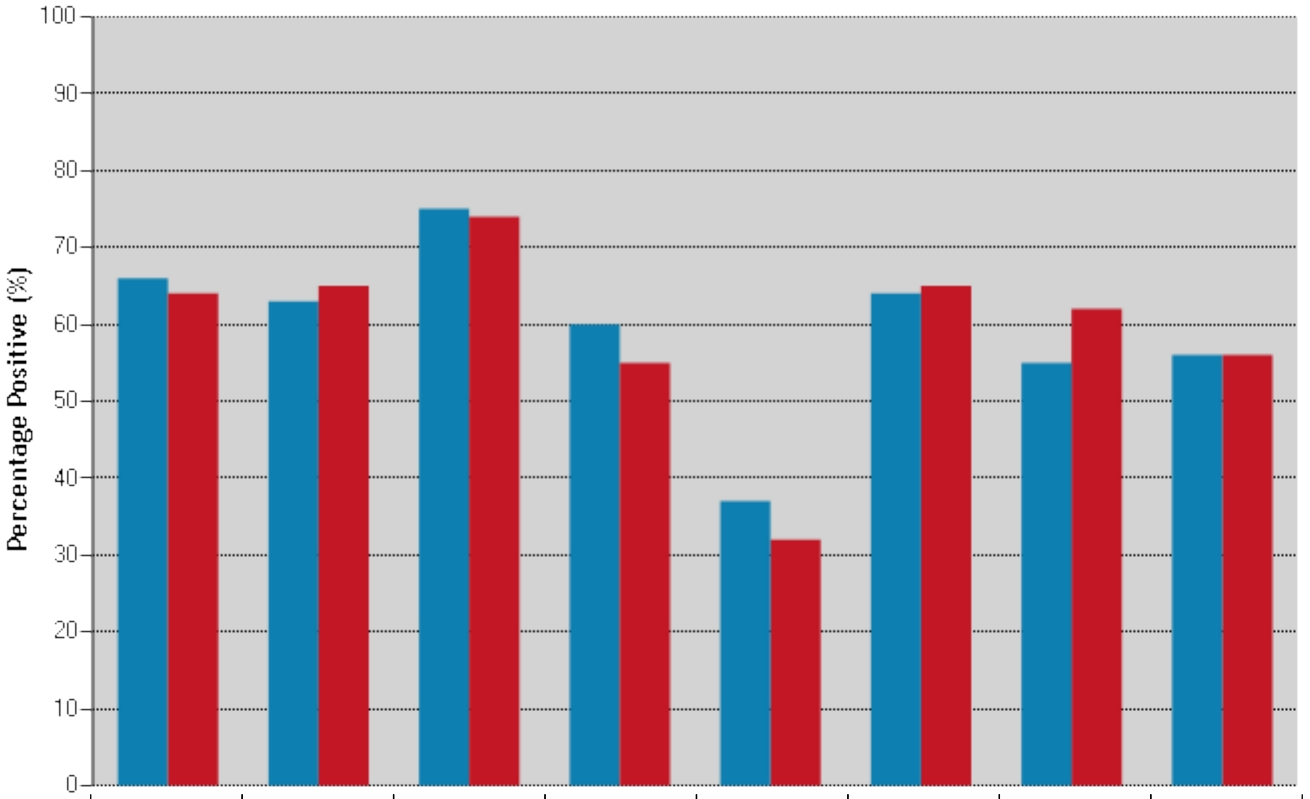
Canadian Patient Safety Culture Survey Tool

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

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

- **Data collection period: January 29, 2019 to March 14, 2019**
- **Minimum responses rate (based on the number of eligible employees): 367**
- **Number of responses: 3241**

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



	Organizational (senior) leadership support for safety	Supervisory leadership for safety	Unit learning culture	Enabling Open Communication I: judgment-free environment	Enabling Open Communication II: job repercussions of error	Incident follow up	Stand-alone items	Overall Perceptions of Client Safety
	66%	63%	75%	60%	37%	64%	55%	56%
	64%	65%	74%	55%	32%	65%	62%	56%

Legend

Horizon Health Network

* Canadian Average

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

Worklife Pulse

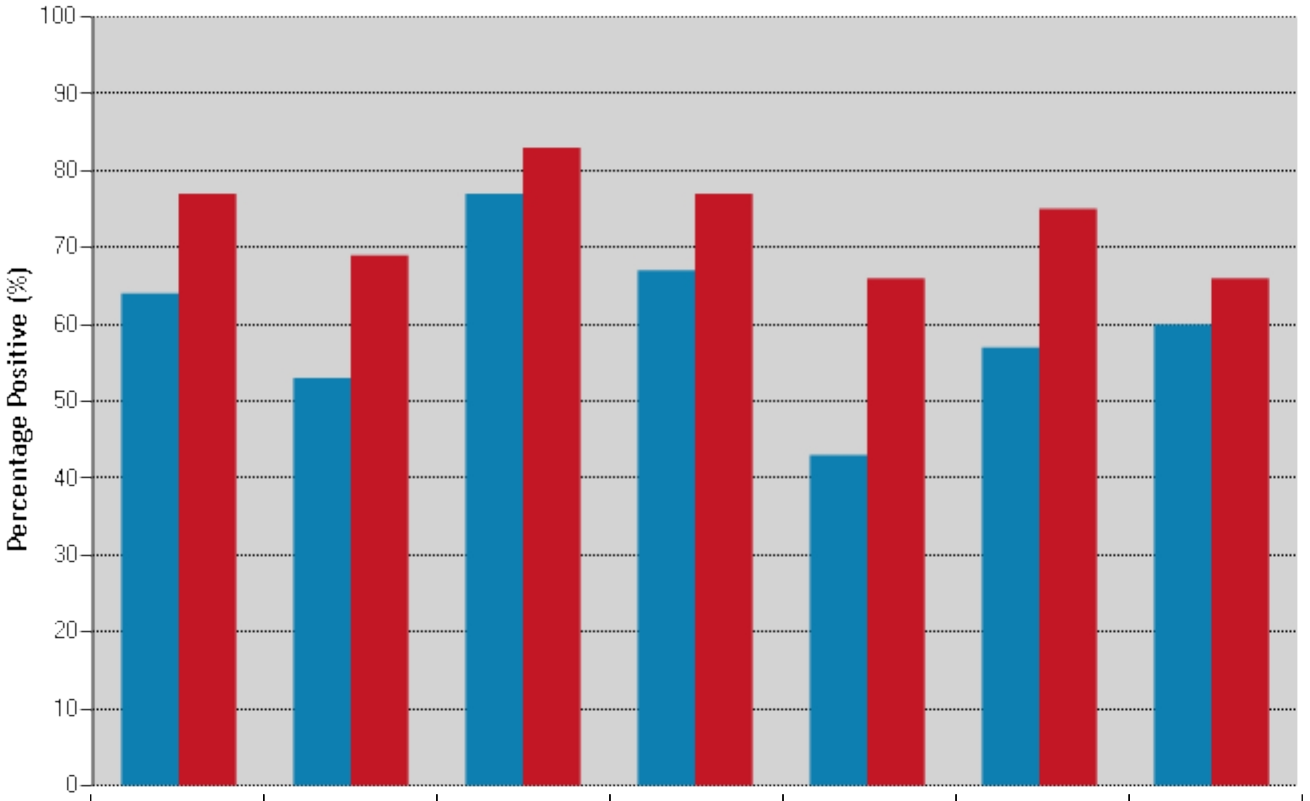
Accreditation Canada helps organizations create high quality workplaces that support workforce wellbeing and performance. This is why Accreditation Canada provides organizations with the Worklife Pulse Tool, an evidence-informed questionnaire that takes a snapshot of the quality of worklife.

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

Accreditation Canada provided the organization with detailed results from its Worklife Pulse Tool prior to the on-site survey through the client organization portal. The organization then had the opportunity to address areas for improvement. During the on-site survey, surveyors reviewed progress made in those areas.

- **Data collection period: December 13, 2021 to June 30, 2022**
- **Minimum responses rate (based on the number of eligible employees): 371**
- **Number of responses: 3806**

Worklife Pulse: Results of Work Environment



	Job	Training and Development	Coworkers	Immediate Supervisor	Senior Management	Safety and Health	Overall Experience
	64%	53%	77%	67%	43%	57%	60%
	77%	69%	83%	77%	66%	75%	66%

Legend

Horizon Health Network

* Canadian Average

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

Client Experience Tool

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

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

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

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

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

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

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

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

Appendix A - Qmentum

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

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

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

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

Action Planning

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

Appendix B - Priority Processes

Priority processes associated with system-wide standards

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

Priority processes associated with population-specific standards

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

Priority processes associated with service excellence standards

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

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