


# St. Joseph's Hospital Accreditation : 2010 Quality & Safety Plan

*December 2010*



## Accreditation Quality & Safety Plan


1. Address Required Organizational Practices (ROPs)
2. Address High Risk Priorities
3. Create Goals & Objectives for each department
4. Integrate quality processes into a Quality Framework
5. Improve the amount and extent of bi-directional communication
6. Provide greater education as to Accreditation requirements and processes
7. Apply for a focus visit in Spring 2011



## Address Required Organizational Practices (ROPs)


Effective Organization:

- **6.1: The Organization adopts client safety as a written, strategic priority or goal.**  
**Action:** Client safety, previously identified as a Board goal of "Safety" is now identified as the Board's second strategic goal "Quality Services provided Safely"
- **6.4: The Organization establishes a reporting system for sentinel events, adverse events, and near misses, including appropriate follow-up.**  
**Action:** A comprehensive system exists and education refresher sessions are ongoing to provide information on reporting, disclosure and appropriate follow-up. The software has been modified to now send notification to the file owner (i.e. the event reporter) when an event has been followed up to ensure the originator of the incident report is aware of the follow-up. Each department has been handed a "Quick Guide to Adverse Events," which is to be placed at identified computer terminals. The applicable policies will also be reviewed and updated to reflect any areas where underreporting is suspected.



## Address Required Organizational Practices (ROPs)

- **6.9: Leaders provide the governing body with quarterly reports on client safety, including recommendations arising from adverse event investigation.**  
**Action:** Incident trend reports will replace the existing snapshot reports and will be provided to the Quality Assurance Committee of the Board. The Dashboard of key indicators will subsequently be made available to the Board of Directors.
- **10.5: Leaders implement an effective preventive maintenance program for medical devices, equipment and technology.**  
**Action:** An online maintenance program has been developed. It will be evaluated for its efficacy.
- **12.6: Organization clearly defines the roles, responsibilities, and accountabilities of leaders, staff, service providers, and volunteers for client care & safety.**  
**Action:** The job description update will be completed and ensure that the role of the position in client care and safety is explicitly identified.




## Address Required Organizational Practices (ROPs)

**Infection Control:**

- **6.5: The Organization evaluates compliance with hand hygiene practices.**  
**Action:** The results of hand hygiene audits, performed to monitor and evaluate compliance, will be posted in each department. Infection control staff is also in the process of adopting VIHA's electronic reporting system to improve data collection and collation.
- **12.22: The Organization monitors processes for reprocessing equipment, and makes improvements.**  
**Action:** Work is in progress with SPD to address the staff recertification comment.

**Ambulatory Services:**

- **17.2: The Team implements and evaluates a falls prevention strategy.**  
**Action:** The hospital's Falls Prevention Task Force has adopted The Views' falls prevention policy and interventions. Incident reporting statistics will be utilized to evaluate its effectiveness. This is also to be done in the Cancer Care & Oncology Department, Long Term Care (The Views), Mental Health, Maternal/Child, Surgical Care Services and Medicine Services.
- **17.4: The Team educates its clients/families verbally and in writing, on their role in safety.**  
**Action:** Safety pamphlets are discussed by the nurse with the client/families; the nurse is to now check a box on the chart once this has been completed. Chart audits will assess compliance. This is also to be done in the Critical Care Unit (ICU), Medicine Services, Obstetrics/Perinatal, Surgical Care Services and Mental Health.



## Address Required Organizational Practices (ROPs)

**Critical Care:**

- **12.6: The Team transfers information effectively among service providers at transition points.**  
**Action:** A policy has been implemented that outlines criteria for transferring a patient within the organization (e.g. appropriate documentation and identification). This is also a requirement for the Emergency Department and Surgical Care Services.

**Long Term Care:**


- **16.5: The Team implements verification processes and checking systems for high-risk activities.**  
**Action:** A risk assessment will be conducted to determine which service/process requires a double-checking or verification system. An assessment of High Risk activities will also be carried out in Mental Health.

**Managing Medications:**

- **10.2: The Organization has identified and implemented a list of abbreviations, symbols, and dose designations that are not to be used.**  
**Actions:** A list existed prior to the accreditation. A policy has been implemented. Physicians will now be required to sign the policy, thereby committing to adhere to its list of prohibitions. Education is ongoing.

**Mental Health Services:**


- **9.7: The team uses at least two client identifiers before providing procedures or services.**  
**Actions:** A policy is in progress that aligns with the established standards; Refresher education sessions will be commencing shortly.



## High Risk Priority Areas

**Effective Organization:**

- **6.3: Leaders assign responsibility for implementing/monitoring the client safety plan and leading safety improvement activities.**  
**Action:** The plan has been developed and the Quality, Research & Patient Safety Consultant has been assigned responsibility for its revisions. The Quality Improvement Working Group, which reports to Senior Leadership, is responsible for communicating and leading quality/safety improvement initiatives, as indicated in its terms of reference.
- **7.1: The Organization identifies quality improvement as a strategic goal.**  
**Action:** In its draft form, "Quality Services Provided Safely" is now identified as one of the Board's overall strategic goals. This aligns with each ROP. The previous reference to quality was under the Board's goal of Safety ("Safeguarding all from harm through comprehensive quality and safety programs and the implementation of best practice").



## High Risk Priority Areas


**Infection Control:**

- **8.1: Staff and service providers store, prepare and handle food appropriately.**  
**Action:** Aprons are to be worn at all times in the kitchen and beard guards will be utilized. The department continues to have excellent reports by external auditors who specialize in Food Services. A rating of 95% was achieved in the report completed Nov. 29, 2010

**Critical Care:**

- **9.4, 9.7: Team follows a process that meets legal requirements to address decisions about forgoing, providing or withdrawing life-sustaining treatment; when unable to provide consent, the Team refers to the advanced directive, or substitute decision maker.**  
**Action:** The Ethics Committee has met on this issue; A policy and Ethical Framework is in place however more education of physicians and staff will be provided in January from a lawyer specializing in advanced directives. The ICU has also created a checklist to ensure broad consultation is taken before providing intubation, etcetera. An informed consent form has recently been drafted that addresses the substitute decision maker. It will be in serviced throughout the hospital

Critical Care will also discuss with all stake holders the best method to conduct multidisciplinary safety rounds and medication reconciliation to address the additional 2 high priority criteria. Physician engagement is required and is essential to meet this requirement.




## High Risk Priority Areas

**Mental Health:**

- 15.1: Team is aware of the process to initiate the work refusal policy.

**Action:** Mental Health will lead the development of this policy with reference to provincial workplace standards that currently exist. Education of the policy once in place will be ongoing and hospital wide.

Mental Health will also be conducting multidisciplinary weekly safety briefings and monitoring their compliance with reporting and adverse event and follow-up.

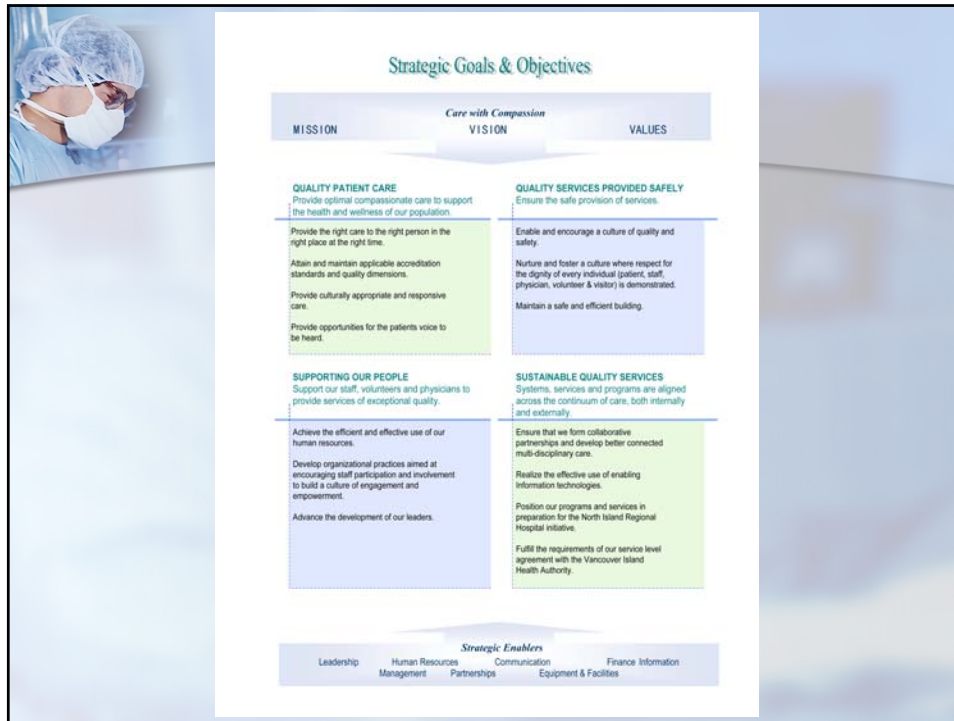


## Development of a Consultation and Communication plan

To ensure the strategic plan is relevant and measurable down to the department level.

Revised Strategic Goals & Objectives have been worked on by the Leadership staff and other key senior staff. These align with the Ministry of Health, the Vancouver Island Health Authority (VIHA) and also meet Accreditation Canada's requirements. They are being presented for the Board consideration to amend its current Goals & Objectives. Following Board approval they will be provided to the Leadership to discuss with their staff and to assemble departmental goals that align with the hospital's Strategic Goals & Objectives.

A report on the progress toward each of the major hospital-wide Goals & Objectives will be provided at each Board meeting; either as part of a formal Committee report or under the President & CEO's report if there is no assigned Committee.



## Establish a Quality Framework

The hospital uses evidence based standards but needs to document this in detail.

Each period the hospital collects a tremendous amount of data by department. It is available at the end of each financial period to the Leadership.

It shows performance measures for the most recent financial period; year to date against prior year and budget and for the last five years all on a simple spread sheet. That information consistently shows the hospital to be a good performer in most areas. A subset of that information is provided to the Vancouver Island Health Authority in accordance with our Service Level Agreement.

While available to departments and presented through Committees to the Board, it also needs to be assembled into a Quality Framework. The Quality Framework will include processes to not only report on measures and indicators but set targets for improvement that can be achieved through quality improvement processes. Use of Accreditation Canada's Quality Framework will ensure the presentation and reporting of information is in compliance with their standard. Additionally the role of the Medical staff Departments and Committees in quality will be encompassed into the Framework.

The objective of this Quality Framework is to ensure that indicators and data sets are consistent, measurable and easily accessible to all levels.



## Develop Multidisciplinary Quality Committees

To monitor goals and objectives, patient outcomes and embed problem solving processes at the team level.

The Senior Leadership team has established a multidisciplinary committee to monitor quality at the departmental level on a hospital wide basis. It will report to the Senior Leadership on a regular basis. Linkage with the responsibilities of the Medical staff Committees under their Bylaws will be addressed.



## Orientation to Accreditation

*As part of the process a reorientation to the new accreditation process will be provided at all levels of the organization.*