Qmentum Program

STANDARDS

Common Content – Client - and Family-Centred Services

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Email address or telephone number where an Accreditation Canada Product Development Specialist may contact you about your feedback: _____

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

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

You may also submit your feedback online at: https://www3.accreditation.ca/FeedbackServer5/fs-StandardsFeedback.aspx

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

Accreditation is one of the most effective ways for health services organizations to regularly and consistently examine and improve the quality of their services. Qmentum standards make it easy for health service organizations to embed accreditation and quality improvement activities into their daily operations with the primary focus being on the client and family as true partners in health service delivery. Where clients and families are required to be integrated into processes, the standards refer to “the team,” and where responsibilities lie with staff and service providers, the standards refer to “staff and service providers”.

Qmentum fosters an increased awareness of accreditation as a powerful tool for accountability, and enables health care organizations to use accreditation effectively and easily as a roadmap for quality. Throughout the service-based standards, client- and family-centred care is viewed as an approach to care that guides all aspects of planning, delivering and evaluating services, with the foundation being mutually-beneficial partnerships between clients, families and service providers. The principles of client- and family-centred care include: providing respectful, compassionate, culturally safe and competent care that is responsive to the needs, values, cultural backgrounds and beliefs, and preferences of clients and their family members by working collaboratively with them (adapted from the Institute for Patient- and Family-Centered Care (IPFCC) 2008 and Saskatchewan Ministry of Health 2011).

Accreditation Canada has adopted the four values that are fundamental to this approach outlined by the IPFCC. They are:

1. Dignity and Respect - Health care practitioners listen to and honor client and family perspectives and choices. Client and family knowledge, values, beliefs and cultural backgrounds are incorporated into the planning and delivery of care.

2. Information Sharing - Health care practitioners communicate and share complete and unbiased information with clients and families in ways that are affirming and useful. Clients and families receive timely, complete, and accurate information in order to effectively participate in care and decision making.

3. Partnership and Participation - Clients and families are encouraged and supported in participating in care and decision-making at the level they choose.

4. Collaboration - Clients, families, health care practitioners, and hospital leaders collaborate in policy and program development, implementation and evaluation; in health care facility design; and in professional education, as well as in the delivery of care.

Common Content – Client - and Family-Centred Services

INVESTING IN SERVICES

1.0 The team designs its services to meet the needs of its clients and the community it serves.

Client-centred Services

1.1 The team partners with clients and the community it serves to plan and co-design its services.

Guidelines

The team takes a structured approach to co-design services with clients and families. This could be done through client advocacy groups, community advisory committees, and client experience surveys. In partnership, the team clients, referring organizations, and the community collaborate to ensure that the services are designed to meet the needs of clients and the community, gaps in services are identified, and common requests from clients are addressed where possible.

Population Focus

1.2 The team uses information about the needs of the clients and the community it serves to plan its services.

Guidelines

The team may collect information about clients and the community it serves or gather information that is available. Information collected includes the expressed needs of clients served by the organization, and trends that could have an impact on the community and its health service needs. Health service needs are influenced by health status, capacities, risks, and determinants of health. Examples of the determinants of health include: income, social support networks, education and literacy, employment/working conditions, access to health services, gender, and culture.

If it is not within a team's mandate to collect information, the team knows how to access and use information that is available. Information can come from internal and external sources such as the Canadian Institute of Health Information (CIHI), census data, end-of-service planning reports, wait list data, and community needs assessments.

Client-centred Services

1.3 The team collects and uses feedback about client experience to evaluate its services and make changes as needed.

Guidelines

The team collects information and data about clients' experience with their services on an ongoing basis. Clients have input on the information that is important to collect. This may be done through the Accreditation Canada Client Experience tool or other methods such as surveys, questionnaires, or focus groups. The team uses this information to evaluate and plan their services to ensure clients' needs are being met and that clients are satisfied with services.

Effectiveness

1.4 The team works together to develop goals and objectives that are specific to the services they provide.

Guidelines

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

The team reviews its goals and objectives annually or as needed. Goals and objectives align with organizational, federal, provincial or territorial objectives. The team has a process for evaluating the achievement of goals and objectives.

Efficiency

1.5 The team monitors the provision and use of services for efficiency and appropriateness.

Guidelines

Monitoring and evaluating the services provided allows the team to examine what services are being offered to and accessed by clients,, and to identify areas for improvement. This process increases the efficiency of internal processes by identifying potential gaps in services either provided by the organization or available to the client and/or community. The team assesses whether services are being offered and used as intended, are of appropriate quality, or whether there are opportunities to improve the appropriateness of service design and range of service provided.

The team may use this information to increase their internal efficiency by minimizing duplication, evaluating cost effectiveness of technologies and interventions, and increasing consistency across the organization.

The American Board of Internal Medicine (ABIM) Foundation has developed the Choosing Wisely campaign that has lists of procedures or services for various specialties that may be unnecessary or inappropriate. Information is available on the website: www.choosingwisely.org.

Continuity of Services

1.6 Staff and service providers work with other services, programs, providers, and organizations to meet the needs of the client.

Guidelines

Meeting the full range of needs of the clients and community served is beyond the capabilities of any one team or organization. The team identifies partnerships and works collaboratively to enhance the efficiency and effectiveness of its services, provide access across the continuum of care, and make it easier for clients to navigate services.

Partners may include various levels of care including primary care, acute care, community partners, mental health supports, education, housing, or social services. Linkages and partnerships vary depending on the range of services provided by the organization and clients' needs. The organization may also partner or establish linkages with federal, provincial, or territorial organizations.

Accessibility

1.7 The team provides clients, families, providers, and other organizations with information about the organization and its services.

Guidelines

Information includes the scope of the organization's services and costs for the client, if any; the effectiveness and outcomes of its services; any other services available to address the client's needs; and any partner organizations.

Accessibility

1.8 The team identifies and where possible removes barriers that may limit clients, families, service providers, and referring organizations from accessing services.

Guidelines

The team has a method for identifying, reporting, and working to remove barriers to access. Information may be gathered through team observation and client feedback. Barriers to access may include the proximity and distribution of services, the physical environment, the cultural acceptability of services, wait times, types of service available, language barriers, availability of transportation, and 24 hour emergency services. Where barriers exist outside of the organization's or team's control, the team works with partners and/or the community to minimize barriers.

2.0 The team has sufficient resources to deliver safe, high quality, and client-centred services.


Effectiveness

2.1 Staff and service providers identify resource requirement gaps and advocate to the organization's leaders for resources needed to address identified gaps.

Guidelines

The team determines the necessary resources to provide safe, effective, and quality care for clients while ensuring staff safety. Identifying resource requirements is a collaborative process between the team and team leaders, and includes criteria to determine where resources are required, such as potential risks to staff and clients, gaps in services, service bottlenecks, or barriers to service delivery or access. Resources may be human, financial, structural, informational, or technological. Staff, service providers, and team leaders work together to determine methods to effectively use available resources or where additional resources are required.


Effectiveness

2.2 Staff and service providers identify needs for technology and information systems.

Guidelines

Examples of technology include electronic medical/health records (EMR/EHR), decision tools, client tracking systems, wait list management systems, client self-assessment tools, and access to service specific registries and/or databases. Innovative information technology is used to support the work of the service area.


Effectiveness

2.3 The team identifies the appropriate mix of skill level and experience within the team and advocate to the organization's leaders for required resources.

Guidelines

Team members determine the optimal evidence-based ratios of skills and experience. Team members have a broad range of knowledge, skills, and experience working with various client groups.

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

Client-centred Services

2.4 The team co-designs available space to facilitate confidential, private interactions with clients and families.

Guidelines

The team engages clients and families to plan and design the layout and use of available space to meet the needs of clients safely and comfortably. The team considers client dignity and respect, privacy and confidentiality, accessibility, and infection prevention and control, and other criteria, when determining how to use the space.

Effectiveness

2.5 The team evaluates the effectiveness of resources, space, and staffing.

Guidelines

The team engages clients and families in the evaluation and design of space and use of resources.

Effectiveness

2.6 The team has access to information about community services that are available to clients, including palliative and end-of-life care.

Guidelines

Information is available in a variety of formats including written and verbal. The team considers level of understanding, literacy, language, disability, and culture when providing information to clients.
Information on palliative and end-of-life care includes information for clients and families as well as resources for the team.

Accessibility

2.7 The team creates an environment that is universally accessible to clients.

Guidelines

The team works to keep the environment clean and clear to support physical accessibility, e.g., for those who make use of mobility aids such as wheelchairs, crutches, or walkers. The environment is also accessible for those with special language, communication, or other requirements, such as those who have auditory, visual, or cognitive impairments.

ENGAGING A PREPARED AND PROACTIVE TEAM

3.0 Staff and service providers are qualified and have relevant competencies.

Effectiveness

3.1 The team leaders define the necessary credentials, training, or education for staff and service providers.

Guidelines

The team leaders define credentials for all staff and service providers, including unregulated staff.

Necessary credentials, training, or education may be formal or informal and may include lived experience, or experience gained through employment history.

Effectiveness

3.2 The team leaders verify and document that staff and service providers' credentials, qualifications, and competencies are up-to-date.

Guidelines

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

Team leaders ensure staff and service providers deliver services within their scope of practice and have the appropriate training and capacities to provide client-centred care and use of equipment, devices, and supplies. Requirements will vary for different roles in the organization as well as for staff who are regulated or unregulated.

Client-centred Services

3.3 The team receives appropriate cultural education and training, to work effectively with the clients and communities they serve.

Guidelines

Cultural education and training build the skills, knowledge, and attitudes required to safely and appropriately deliver interventions and services that are culturally sensitive, and respectful.

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

Effectiveness

3.4 The team provides a comprehensive orientation for new team members, including clients and families.

Guidelines

The orientation program covers the organization's mission, vision, and values; the team's mandate, goals, and objectives; the philosophy of client-centred care and how to apply principles to practice; roles, responsibilities, and expectations regarding performance; policies and procedures, including confidentiality; initiatives that support worklife balance; and the organization's approach to integrated quality management, e.g., quality improvement, risk management, and utilization management/efficient use of resources. Training and orientation is documented.

Client-centred Services

3.5 The team receives ongoing training on the organization's care delivery model.

Guidelines

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

Effectiveness

3.6 Staff and service providers receive education and training to use the organization's ethical decision-making framework.

Guidelines

The team receives training and support for handling issues such as identifying conflicts of interest or conflicting perspectives between clients and family and/or service providers and among service providers.

Safety

3.7 Staff and service providers receive education and training on the safe use of equipment, devices, and supplies used in service delivery and the training is documented.

Guidelines

Team members are given service-specific information about the team's approach to safe use of equipment. All team members are trained on how to use existing and new equipment, devices, and supplies. Retraining may be requested or required if the team member does not feel adequately prepared to use the equipment, device, or supply, or has not used the equipment or device in some time.

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

Effectiveness

3.8 Staff and service providers receive education and training on information systems and other technology used in service delivery.

Guidelines

The education and training may cover topics such as knowledge of computer applications, word processing, software, time management tools, communication tools, research applications, or cell phone technology. Topics also include how to protect the privacy of client information.

Client-centred Services

3.9 Staff and service providers receive education and training to identify palliative and end-of-life care needs.

Guidelines

The team receives training on the organization's process to provide or facilitate access to palliative care and end-of-life services. The team also receives training on communicating with families about end-of-life issues, including how and when to initiate discussions about palliative and end-of-life care.

The team respects provincial and territorial legislation and regulations regarding consent and substitute decision making.

Worklife

3.10 Team leaders regularly evaluate and document each staff member and service provider's performance in an objective, interactive, and constructive way.

Guidelines

Team leaders use the organization's established process to evaluate each team member's performance.

When evaluating performance, team leaders review the individual's ability to carry out responsibilities, apply the principles of client-centred care, and consider the individual's strengths, areas for improvement, and contributions regarding respecting clients' wishes, client safety, worklife, and other areas described in the position profile. They may also seek client or peer input.

A performance evaluation is usually done before the probationary program is completed and annually thereafter, or as defined by the organization. The evaluation may identify issues such as unprofessional or disruptive behaviour, challenges adopting client-centred care in practice, that requires follow up. An evaluation may also be completed following periods of retraining, e.g., when new technology, equipment, or skills are introduced.

Client-centred Services

3.11 Team leaders regularly engage client and family representatives to exchange feedback on roles and responsibilities, role design, input on processes, and role satisfaction.

Guidelines

Regular communication between team leaders and client and family advisors ensures that the relationship is beneficial for both the organization and the client or family advisor. Discussions include opportunities for increased collaboration and role satisfaction. Though an open and transparent dialog is encouraged, team leaders recognize that client and family representatives are to remain independent from the organization, to ensure their opinions and recommendations remain unbiased.

Worklife

3.12 Team leaders work with staff and service providers to follow-up on issues and opportunities for growth identified in the performance review.

Guidelines

Issues may be identified by the team member or the team leaders. This information is used to inform an action plan or staff development plan.

Worklife

3.13 Team leaders facilitate ongoing development, education, and training, for each team member.

Guidelines

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

4.0 The team functions effectively and collaboratively.

Effectiveness

4.1 The team uses a collaborative approach to deliver services.

Guidelines

An interdisciplinary, collaborative team will evolve and change with the changing needs of the client. Depending on the needs and desires of the client and family, the team may consist of specialized staff and support staff such as care planners, translators, security staff, or representatives from community partner organizations. The team may also include students and volunteers.

The team has a defined leader or leaders and the role of each member of the collaborative team is made clear to the client and family.

The organization uses defined criteria based on accepted standards of practice, legal requirements, knowledge, experience and other qualifications, volume or complexity of caseload, changes in workload, and client safety and needs to establish the collaborative team.

Effectiveness

4.2 The collaborative team includes the client and their family as members of the team.

Guidelines

The team involves clients and families to ensure they have an opportunity to engage in shared decision making and understand how care is provided. Clients identify which family members they wish to have involved in their care, including non-traditional family members.

Worklife

4.3 Team members have position profiles that define their role, responsibilities, and scope of employment/practice.

Guidelines

Position profiles include a position summary, qualifications and minimum requirements, the nature and scope of the work, and reporting relationships and are developed for all team members including the role of clients and family members.

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

Effectiveness

4.4 Staff and service providers use standardized communication tools to share information regarding a client's care within and between teams, particularly during transitions.

Guidelines

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

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

Safety

4.5 The team evaluates the effectiveness of its communication processes for critical information.

Guidelines

The team determines what information needs to be shared and the points at which communication is essential (e.g. client who are transferring to a different service area, shift changes, or changes to the client's care plan).

Miscommunication or a lack of communication among team members and clients may compromise client safety. Making accurate and timely communication a priority promotes continuity of care and helps prevent harmful incidents, no harm incidents, and near misses. Communications involve the client, family, caregiver, or client advocate.

Communication mechanisms may include huddles, electronic messaging, meetings, teleconferences, or computer technologies such as telehealth or web-conferencing.

Effectiveness

4.6 The team evaluates whether it is collaborating effectively and identifies opportunities for improvement.

Guidelines

The team's process to evaluate its functioning may include a review of its services, processes, and outcomes. This may involve administering a team functioning questionnaire to team members to stimulate discussion about areas for improvement.

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

5.0 The team promotes the well-being and worklife balance of its members.


Worklife

5.1 Team leaders assign and review the workload of each team member in a way that ensures client and staff safety and well-being.

Guidelines

The team uses appropriate criteria for determining workload depending on the environment and the unique demands of different services areas (e.g. hours of work, caseload, complexity of the role, complexity of client care, physical or emotional demands, repetitive nature of tasks, and level of responsibility). The organization also considers staff preference and availability. In some cases teams may designate a maximum workload for team members. The process of assigning and reviewing workload includes monitoring and tracking, of hours and clients, and when additional measures need to be taken, (e.g., staffing transfers or team re-design).

Team leaders promote an environment where team members are comfortable discussing demands and stress levels in the workplace. Team leaders work to alleviate these pressures as much as possible; this can include scheduling strategies, workload sharing, and scheduled time designated to documentation.


Worklife

5.2 The team is encouraged to provide input on work and job design, including their roles, responsibilities, and assignments, where appropriate.

Guidelines

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


Worklife

5.3 The team has a process to recognize team members for their contributions.

Guidelines

Recognition activities may be individual, such as awards based on years of service, or team-based, such as team recognition or activities. Recognition can be formal or informal and may take many forms such as verbal, written, or promoting an atmosphere where team members feel appreciated for their contributions.


Worklife

5.4 The team follows the organization's policy to bring forward complaints, concerns, and grievances.


Safety

5.5 The team is aware of and follows relevant occupational health and safety regulations and organizational policies on workplace safety.


Safety

5.6 The team is trained to identify, reduce, and manage risks to client and team safety.

Guidelines

Training may include topics such as: physical hazards; problems with equipment; spills, waste, or infectious materials; working with clients that may pose a risk to themselves or others; and problems with handling, storing, or dispensing medications.

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

The team works with its leaders and the organization to reduce risks.


Safety

5.7 The team receives education and training on how to prevent and manage workplace violence.

Guidelines

Acts of violence include abuse, aggression, threats, and assaults. Violent and aggressive behaviour includes acts committed by clients (or their families) or staff and service providers, and presents a risk to the safety of oneself or others.

Examples of training programs to safely work with clients who are at risk of, or exhibit aggressive or responsive behaviors include:
• CPI Training (Crisis Prevention and Intervention)
• GPA (Gentle Persuasive Approach)
• U-First!

Where possible, team members use de-escalation techniques as a preventive measure. De-escalation techniques are minimally intrusive and are the least restrictive way to manage violence. Training and education includes the use of a standardized risk assessment tool, such as the Hamilton Anatomy of Risk Management (HARM) tool. Training may address:
• Identifying triggers
• Assessing and communicating a client's potential for violence, and recognizing signs of agitation and aggression
• Harassment reduction
• Responding to and managing violence (e.g., non-violent crisis intervention, emergency code response guidelines, conflict resolution and mediation, and self-defense)
• The trauma-informed approach
• Communication techniques

The education may also specify the team's alternate procedure for when de-escalation techniques are unsuccessful.

Safety

5.8 The team follows the organization's policy on reporting workplace violence.

Guidelines

Reporting occurs for perceived, potential, or actual incidents of physical or verbal violence. The incident may be reported in the client medical record or to the appropriate authorities in accordance with applicable legislation, depending on the nature of the incident.

PROVIDING SAFE AND EFFECTIVE SERVICES

6.0 The team coordinates timely access to services for current and potential clients, families, service providers, and referring organizations.


Accessibility

6.1 Staff and service providers have a process to respond to requests for services in a timely way.

Guidelines

Requests for services may come from clients, families, other service providers, or referring organizations. There may be different processes to respond to requests based on who is requesting the services and what is being requested.

The team monitors its responsiveness by setting and tracking times for responding to requests for services.


Effectiveness

6.2 Staff and service providers have a process to gather or receive appropriate information as part of the intake process and at times when required.

Guidelines

This process may be called admission, intake, pre-admission, screening, start of service, or moving in. The team reviews and validates the information gathered. It is used to determine if the organization's services fit with the client's needs and preferences, to identify the client's immediate needs, and decide on service priorities.

The process is adjusted for clients and families with diverse needs such as language, culture, level of education, lifestyles, and physical or mental disability.


Accessibility

6.3 Staff and service providers follow clear criteria for determining when to initiate services with clients.

Guidelines

The team assesses the needs of potential clients in relation to the capacity of the organization to meet those needs.


Accessibility

6.4 When the team is unable to meet the needs of a potential client, staff and service providers facilitate access to services offered by other organization.

Guidelines

In the case where the organization is unable to meet the client's needs, the team explains the reasons why, actively identifies and facilitates access to other available services offered by another organization, and records the information for use in service planning.


Accessibility

6.5 Staff and service providers ensure clients and families are aware of the team member who is responsible for coordinating their service, and how to reach that person.

Guidelines

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

7.0 Staff and service providers partner with clients and families in service delivery to achieve goals.


Client-centred Services

7.1 The team determines the desire and capacity of each client to be involved in their care.

Guidelines

Each individual will have differing levels of interest and ability to be involved in their own care. At each stage of the client's care, the provider partners with the client to determine how much and what type of information the client requires to be meaningfully involved at the level they choose.


Client-centred Services

7.2 Staff and service providers develop an open, transparent, and respectful relationship with each client.

Guidelines

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

Client-centred Services

7.3 Staff and service providers respect and follow the client's wishes regarding family involvement in their care.

Guidelines

The client is encouraged to define their family and the people they would like to have involved in their care. This may be defined as the client's support network and may include non-traditional family members. The team finds ways to include members of the client's support network in the client's care.

Client-centred Services

7.4 Staff and service providers share timely, complete, and accurate information with the client about aspects of the client's care, in accordance with their wishes.

Guidelines

Sharing of information is critical for shared decision making between clients, families and providers. Information is packaged and delivered according to individual needs and interests, as well as literacy level. Detailed and complete information helps clients, and families where applicable, to make informed choices about their care. Information provided includes risks and benefits of care, the client's roles and responsibilities in service delivery, the benefits, limitations, and possible outcomes of proposed services or interventions, how to prepare for tests and treatments, the availability of counseling and support groups, and how to reach providers in an emergency or crisis.

The team understands and accommodates varying information requirements at different points along the client's care process. Similarly, different messages will require different delivery methods, e.g. those that are more serious require a more structured forum for delivery and discussing the information.

Client-centred Services

7.5 Staff and service providers verify that the client understands the information provided about their care.

Guidelines

The team considers level of understanding, literacy, language, disability, and culture when providing information to clients.

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

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

Client-centred Services

7.6 Staff and service providers facilitate access to translation and interpretation services for clients and families to ensure participation in their care.

Guidelines

The team or organization may choose to have written materials available in the languages commonly spoken in their community or made available as required. Interpretation services are available when required by the client or family.

Client-centred Services

7.7 Staff and service providers work with the client, including child and youth clients, to determine the client's capacity to provide informed consent.

Guidelines

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

The team follows federal, provincial, and territorial legislation when working with child and youth clients.When dealing with minors or those deemed to be incapable of consenting, the team continues to involve the clients to the greatest extent possible in making decisions about their services, and values their questions and input.

Client-centred Services

7.8 Staff and service providers receive and document the client's informed consent before providing services.

Guidelines

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

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

Effectiveness

7.9 When clients are incapable of giving informed consent, staff and service providers obtain consent using a substitute decision maker.

Guidelines

The team consults with a substitute decision maker when clients are unable to make their own decisions, and uses an advanced directive, where available, to ensure decisions are in line with the client's wishes. In these cases, the team provides the substitute decision maker with information on the roles and responsibilities involved in being a substitute decision maker, and discusses questions, concerns, and options. Selecting the appropriate substitute decision maker is done in consideration of the applicable legislation and may be an advocate, family member, legal guardian, or caregiver.

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

When working with child and youth clients, the team receives and documents informed consent from the child, youth, family or legal guardian before providing services. When dealing with child and youth clients, the team's consent process includes involving them as much as possible in the decisions about their service, intervention, or treatment, and valuing their questions and input.

Client-centred Services

7.10 Staff and service providers engage clients and families in research activities and opportunities that may be available, where applicable.

Guidelines

Research activities may include clinical trials, assessments of new protocols, or changes to existing protocols. Clients and families are included in participatory research project design and implementation, where appropriate, e.g., gathering qualitative data for quality improvement initiatives in the organization.

Effectiveness

7.11 The team follows the organization's procedure to proactively identify, manage and address ethics-related issues once they are identified.

Guidelines

Ethics-related issues are ones in which two or more values may be in conflict, leaving uncertainty as to which decision to make. Issues may be of a very serious nature, or related to day-to-day activities. Examples of ethics-related issues include conflicts of interest; respecting a client's choice to live at risk; triaging community members during an emergency; requests to withdraw specific services, including life-sustaining supports or treatments; and end-of-life care.

Ethics-related issues may be addressed by an ethics committee or consultation team that may include health service professionals, clergy, or ethicists. In addition to clinical consultation, the ethics committee may be involved in policy review and ethics education.

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


Client-centred Services

7.12 The team educates clients and families about their rights and responsibilities.

Guidelines

Client and family rights include the right to have privacy and confidentiality protected, be treated with respect and care, maintain cultural practices, pursue spiritual beliefs, live at risk, and be free from abuse, exploitation, and discrimination.

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

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

Education is provided at intake or admission and is adjusted for clients and families with diverse needs such as language, culture, level of education, lifestyles, and physical or mental disability.
Under circumstances where the client and/or family are not able to participate in education at the point of admission, it is provided at the earliest opportunity.

Education includes how to file a complaint or report a violation of their rights.


Client-centred Services

7.13 The team provides clients and families with information about how to file a complaint or report violations of their rights.


Client-centred Services

7.14 The team follows a process to investigate and respond to any claims that client's rights have been violated.

Guidelines

The team works to promote an environment where clients and families feel comfortable raising concerns or issues. For example, the organization may provide access to a neutral, objective person from whom clients and families can seek advice or consultation. The team also addresses claims brought by team members or other service providers.

Where electronic health records are used, the team has a process to receive and respond to client complaints and questions regarding their electronic record or issues of privacy.

8.0 Staff and service providers, in partnership with the client and family, conduct a comprehensive assessment and develops a care plan.


Effectiveness

8.1 Staff and service providers partner with the client to assess and document the client's physical and psychosocial health using a holistic approach.

Guidelines

Elements of physical health include:
- medical history
- allergies
- medication profile
- health status
- nutritional status
- palliative care needs
- special dietary needs.

Elements of psychosocial health include:
- functional and emotional status,
- family and caregiver involvement
- client's communication and self-care abilities;
- mental health status, including personality and behavioural characteristics
- cognitive status
- socio-economic situation
- spiritual orientation and needs
- cultural beliefs.


Client-centred Services

8.2 The team designs the assessment process to meet the needs of the client.

Guidelines

The assessment process is as streamlined or simple for the client as possible, such that they are not required to repeat information to multiple providers or team members. The team may choose to complete an interdisciplinary, or collaborative assessment together with the client and appropriate service providers.


Client-centred Services

8.3 The team identifies the goals and expected results of their care and services.

Guidelines

The team discusses the client's physical and psychosocial needs, choices, and preferences as identified in the client assessment to develop care goals in partnership.

Service goals and expected results suit the client's individual circumstances, are achievable, measurable, and complement those developed by other service providers and organizations with which the client is involved.

Client-centred Services

8.4 Staff and service providers use standardized assessment tools as part of the assessment process.

Guidelines

Tools are standardized and adopted across the team, and where applicable, across the organization. Assessment tools are designed to assist staff and service providers to systematically collect and interpret all of the information gathered during the assessment process. There are several benefits to using standardized tools for the client and the care provider including improved efficiency, accuracy of information, consistency of assessment, and reliability of results and improved opportunity for communication between the client and the care provider.

Standardized assessment tools vary depending on the needs of the client, and type and range of services offered. Examples of standardized assessment tools are the Glasgow Coma Scale, the Clinical Frailty Scale, the Beck Depression Inventory or the InterRAI tool. The team uses standardized assessment tools that are evidence-informed and meaningful for the services they provide.

Effectiveness

8.5 As part of the assessment, staff and service providers engage clients to learn about a client's preferences and discuss options for services.

Guidelines

The team discusses the client's expressed needs, preferences and the different options available for their care and services. The team and client engage in shared-decision making that considers client preferences, expected outcomes, and risks and benefits of available options. For example the client and provider may discuss the various strategies to manage pain, including analgesics, including opioids and adjuvants when needed, along with physical, behavioural, and psychological interventions. The client is provided with the options and can select their preferred option for pain management.

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

Client-centred Services

8.6 The team completes an assessment of the client's palliative and end-of-life care needs, when appropriate.

Guidelines

The client or family express the need for or the team identifies the need for a palliative care assessment, and service providers work with clients to identify the types of services that may be required. Early identification of palliative care needs allows clients and families to be involved in care planning and can improve the quality of care and family satisfaction throughout the process.

In an organization or service area that does not provide palliative and end-of-life care, the assessment helps the team work with the client and family to determine appropriate services to access.

Continuity of Services

8.7 Staff and service providers have access to diagnostic and laboratory testing, results, and expert consultation to complete a comprehensive assessment.

Continuity of Services

8.8 Staff and service providers share the results of the assessment with the client, and other service providers in a timely and easy-to-understand way.

Guidelines

Sharing the assessment with the client, and family where applicable, as well as with other service providers and organizations, improves clarity and prevents duplication. In order to provide information that is easy to understand, information is tailored to the client's literacy level, language of preference, is culturally relevant, and considers any special needs of the client.

Continuity of Services

8.9 Staff and service providers work in partnership with the client to develop and document a comprehensive and individualized care plan.

Guidelines

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

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


Client-centred Services

8.10 The team begins planning for care transitions, including end of service, as part of the care plan.

Guidelines

Planning for transitions to the home, another service provider, an alternate level of care, or end of service in the care plan enhances coordination among teams or partner organizations and helps prepare clients for the end of service. Client involvement in end of service planning is essential as it ensures the client and family know what to expect and are prepared for transitions in care.

The team discusses and documents the client's transition, and post-care needs and preferences while developing the care plan. This may include information such as post-care follow ups, ability to perform self-care, referrals to community supports, and other anticipated needs or challenges.

9.0 The team delivers safe and effective services.


Effectiveness

9.1 Staff and service providers follow the client's individualized care plan when delivering services.


Effectiveness

9.2 Staff and service proivders document all services received by the client, including changes and adjustments to the care plan, in the client record.

Guidelines

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


Effectiveness

9.3 The team regularly reassesses the client's heath status and updates the client record, particularly when there is a change in health status.

Guidelines

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

Effectiveness

9.4 The team monitors whether clients achieve their goals and expected results, and uses this information to adjust the care plan as necessary.

Guidelines

The team documents progress using both qualitative and quantitative methods. This may include use of standardized assessment tools, discussion with clients and families, and observation.

Client-centred Services

9.5 Staff and service providers facilitate access to spiritual space and care to meet client's needs.

Guidelines

The team considers a client's spiritual needs as integral to the care and healing process. Spiritual care is available to meet the needs of clients and includes access to a spiritual leader appropriate to the client's wish or orientation, e.g. a chaplain, imam, rabbi, or non-denominational counselor. Clients and families have access to a designated space to observe spiritual practice. The team discusses a client's spiritual needs when making care decisions that may involve an ethical or spiritual consideration.

Client-centred Services

9.6 Staff and service providers facilitate access to psychosocial and/or supportive care services for clients and families.

Guidelines

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

Client-centred Services

9.7 The team follows a process to initiate palliative and end-of-life care, as necessary, using a whole-person approach.

Guidelines

Services are initiated as a result of an expressed need by the client or family, and consider the results of the assessment. The team's involvement in palliative and end-of-life care will differ depending on the services provided by the team and the clients served. Where palliative and end-of-life care is not provided by the team, the team follows the organization's process to transition the client to the appropriate services.


Client-centred Services

9.8 The team supports family, staff and team members, and other clients throughout and following the death of a client.

Guidelines

The team provides relevant information about the dying process, such as the signs and symptoms of imminent death; coping strategies; how to provide support and comfort during the final hours; and grief and bereavement services to clients and families.

The team encourages the client's family and friends to use existing support systems in the community. When these are insufficient, or when family and friends are identified as being at risk for complex grief reactions, the team facilitates access to bereavement services for clients, families, team members, and volunteers, including volunteer support or professional services, following the death of a client.

10.0 The team partners with clients and families to plan and prepare for transition to another service, or setting.


Client-centred Services

10.1 Staff and service providers have a process to actively engage clients and families to plan and prepare for transitions in care.

Guidelines

Clients and families are involved in all transition planning. The team, client and family discuss the client's care plan, goals, and preferences; a summary of the care provided; an updated list of outstanding issues, clinical or otherwise; what to expect during transition; follow-up appointment information; exercise and nutrition plans, where applicable; contact information for the team members and details on when they should be contacted.
Continuity of care is enhanced when clients participate in the transition planning and preparation process and have comprehensive information about transitions and end of service.

Examples of key transition moments include rounds, shift changes, handoffs, moving in or out of an organization, to another community provider or at end of service.
Conducting transition conversations with the client and family present allows clients and families to participate in the discussion and confirm whether the information being conveyed is accurate and complete. It also helps ensure clients' wishes are respected when discussions happen in the presence of the client.


Client-centred Services

10.2 Staff and service providers work with clients to assess the client's physical and psychosocial readiness for transition, including their capacity to self-manage their health, when required.

Guidelines

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

Client-centred Services

10.3 The team promotes self-efficacy among clients by providing education to improve ability to self-manage conditions, where applicable.

Guidelines

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

Continuity of Services

10.4 Staff and service providers collaborate with the client, family, and other teams, services, and organizations to connect the client to appropriate follow-up services, where applicable.

Guidelines

Staff and service providers' responsibility regarding the client's care continues until service has officially ended or the client has been transferred to another team, service, or organization. Follow-up services may include primary care, home and community services, community-based rehabilitation, or psychological counseling services.

Staff and service providers make recommendations for the client for follow-up or ongoing care. Working together to establish proper placement for the client helps to ensure the client receives the most appropriate services in the most appropriate setting, and minimizes temporary solutions or unnecessary transfers.

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

Continuity of Services

10.5 Staff and service providers document the transition plan in the client record.

Continuity of Services

10.6 The team follows a process to provide the client with information and instructions at the time of transition.

Guidelines

Continuity of care is enhanced when clients and their families have comprehensive information about their health, transitions, or the end of service. This assists in reducing the stress of transition to the home or community, and also helps to minimize delays in end-of-service when the client feels confident they are able to maintain their health after service.

Information provided to the client at the time of transition may include written discharge information or instructions, action plans, goals, signs or symptoms of declining health status, and contact information for follow-up with the team.

The SMART Discharge Protocol is a set of tools to assist teams to standardize and improve their discharge process. The tools are available on the Institute for Healthcare Improvement website: http://www.ihi.org/resources/Pages/Tools/SMARTDischargeProtocol.aspx.

Client-centred Services

10.7 The team respects a client's wish to end or limit services, transition home, or transfer to another service against their recommendation.

Guidelines

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

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

Client-centred Services

10.8 Staff and service providers assess the client's risk of readmission, where applicable, and coordinate appropriate follow-up.

Guidelines

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

The team uses a standardized assessment tool such as the LACE Index Scoring Tool to assess risk of readmission after the end of service.

Effectiveness

10.9 The team has a process to evaluate the effectiveness of transitions, and uses this information to improve its transition planning.

Guidelines

At regular intervals, the team contacts a sample of clients, families, or referral organizations to determine the effectiveness of the transition or end of service, monitor client perspectives and concerns after the transition, and monitor follow-up plans. The team uses this as an opportunity to verify that the client and family needs have been met and respond to any concerns or questions.

The team shares client feedback and the overall results of the evaluation with the organization's leaders and the governing body, and uses this information to improve transitions.

MAINTAINING ACCESSIBLE AND EFFICIENT INFORMATION SYSTEMS

11.0 The team keeps client records accurate, up-to-date, and secure.


Effectiveness

11.1 The team maintains an accurate, up-to-date, and complete record for each client.

Guidelines

The team ensures that the client record is accessible and up-to-date. Information is easy to find and identify, and is organized for ease of use.
The record includes the date of services, is signed by the appropriate authority, and is legible. The team only uses recognized abbreviations and any critical client information is prominently displayed in the record.

The team updates the client record whenever there is a change in health status, the care plan, the client's medications, or when transitioning to another level of care, or service. The team follows organizational and professional standards for what information the client record needs to contain to be considered complete, and includes: significant changes in condition, diagnostic results, alert notations, progress notes, significant events or safety incidents, and others.


Effectiveness

11.2 Staff and service providers collect a standardized set of health information.

Guidelines

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


Effectiveness

11.3 Staff and service providers follow the organization's policies and procedures to securely collect, document, access, and use client information.

Guidelines

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

The team is able to demonstrate that they are aware of and meet applicable legislation for protecting the privacy and confidentiality of client information. Applicable legislation may be federal or provincial/territorial.

Client-centred Services

11.4 Staff and service providers enable clients' access to information in their records in a routine and timely way, including electronic medical/health records.

Guidelines

The team facilities clients' access to their information in a proactive way and according to the organization's policy. Clients are informed of their right and the process to access information in their record. The team takes the time to discuss a client's record with them and answer questions regarding the information.

Client-centred Services

11.5 Staff and service providers, in partnership with the client, document information in the client's record.

Guidelines

Clients are the owners of their health information and as such are included in the process of documenting information in their record, and can provide input on the information being documented. Clients have the right to read and comment on all information about them that is recorded by the team. Teams may conduct the charting or documenting process in partnership with the client as part of their care or can provide open access to records online.

Client-centred Services

11.6 Staff and service providers follow the organization's policies and procedures on securely storing, retaining, and destroying client records.

Guidelines

The team complies with the federal Privacy Act, and where applicable, the federal Personal Information Protection and Electronic Documents Act. Each province and territory refers to their respective privacy laws, and laws governing health information protection, where relevant.

Continuity of Services

11.7 The team shares client information and coordinates its flow among service providers, other teams, and other organizations, in accordance with applicable privacy legislation.

Guidelines

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

Effectiveness

11.8 The team has a process to monitor and evaluate its record-keeping practices, and uses the information to make improvements.

Guidelines

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

Evaluation may be done on a random or regular basis. Where record-keeping is electronic, evaluation can be triggered based on certain events, such as unusual activity, attempt to retrieve certain data or unmasking of data. All electronic activities should be linked to a unique user identifier and a log of activity maintained to ensure practices can be appropriately monitored.

12.0 The team effectively manages health information to support the effective delivery of services.

Effectiveness

12.1 Staff and service providers receive training on how to comply with legislation to protect client privacy and appropriately use client information.

Effectiveness

12.2 Staff and service providers follow the organization's policies on the use of electronic communications and technologies.

Guidelines

The team determines policies regarding the use of electronic mail, texting, web applications and social media. This may include inter-team communication, communication with clients, or communication with partners and potential clients.

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

Effectiveness

12.3 Staff and service providers follow policies and procedures for disclosing health information for secondary use.

Guidelines

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

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

MONITORING QUALITY AND ACHIEVING POSITIVE OUTCOMES

13.0 The team uses current research, evidence-informed guidelines, and best practice information to improve the quality of its services.


Effectiveness

13.1 The team has a standardized procedure to select evidence-informed guidelines appropriate for the services it offers.

Guidelines

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

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


Client-centred Services

13.2 The team engages clients and families, staff, other teams in the organization, and partners in their process to review the selection of guidelines and their link to client experience and outcomes.


Effectiveness

13.3 The team develops and follows procedures and protocols for service delivery based on evidence-informed guidelines to reduce unnecessary variation.

Guidelines

The team uses selected guidelines to develop procedures and protocols to improve service delivery and provide standardized care to clients. Guidelines may enhance client safety, improve inter-team collaboration, increase efficiency, and minimize variation in service delivery. The team is actively involved in adapting and applying research knowledge to their unique care setting.


Effectiveness

13.4 The team follows a standardized process to decide among conflicting evidence -informed guidelines.

Guidelines

The team may refer to comprehensive documents that synthesize the evidence from several guidelines. For example, the Cochrane Collaboration conducts systematic reviews of the available evidence which can help service providers and organizations with their review process.


Effectiveness

13.5 The team regularly reviews its guidelines and protocols to make sure they reflect current research and best practice information.

Guidelines

The team's review process includes ways to access the most up-to-date research and information and determine its relevance, e.g., through literature reviews, content experts, or national organizations or associations. Research information may include intervention research, program evaluations, or clinical trials.

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


Effectiveness

13.6 The team follows the organization's policy on ethical research practices and knows when to seek approval.

Guidelines

The team evaluates whether ethics approval is required prior to undertaking any research or activities where information is collected, including quality improvement activities.

14.0 The team promotes safety in the service environment.


Safety

14.1 The team uses a proactive, predictive approach to identify risks to client and team safety.

Guidelines

A proactive, predictive approach is designed to address issues that have the potential to cause incidents and allows the team to mitigate these risks or hazards before they occur. While it may not be possible to identify all conceivable risks to an organization, the team uses a comprehensive process to ensure they identify the most probable risks.

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

The team gathers information to determine the causes of potential problems and meets to strategize possible solutions. These activities include conducting audits, talking to clients, talking to team members, monitoring areas for risk, identifying interruptions, participating in safety briefings, and addressing areas where there is a high margin of error. Regular opportunities to share information about potential problems and actual incidents can reduce risk and the likelihood of an incident occurring or reoccurring.


Safety

14.2 The team collaborates with clients, and families to identify safety risks.

Guidelines

The team engages clients and staff in the processes of identifying and prioritizing risks and utilizes their perspectives when determining how to address those risks. Including clients and families helps to raise awareness of potential risks, ongoing activities in the organization to enhance safety, and to promote safety as an organizational priority.


Safety

14.3 The team develops and implements strategies to address identified safety risks.

Guidelines

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


Safety

14.4 The team implements verification processes to mitigate the risks of activities and services that pose a high risk to clients.

Guidelines

To identify high-risk activities the team may review their services and use this information to develop and implement checking systems to reduce the risk of harm to clients. Across the care continuum, systems will vary depending on services. Examples may include but are not limited to:
• Repeat back or read back processes for diagnostics or verbal orders
• Checking systems for water temperature for client bathing
• Standardized tracking sheets for clients with complex medication management needs
• Automated alert systems for communication of critical test results
• Computer-generated reminders for follow-up testing in high-risk patients
• Two person verification process for blood transfusions
• Independent double checks for the dispensing/administration of high-risk medications
• Medication bar coding systems for drug dispensing, labeling, and administration
• Decision support software for order entry and/or drug interaction checking
• Safety monitoring systems for service providers in community-based organizations, or for clients in high-risk environments
• Standardized protocols for the monitoring of fetal heart rate during medical induction/augmentation of labour, or in high-risk deliveries
• Systems for monitoring of vaccine fridge temperatures
• Standardized protocols for the use of restraints
• Standardized screening processes for allergies to contrast media.


Safety

14.5 The team monitors and evaluates the safety improvement strategies to assess their impact.

Guidelines

The team makes adjustments to activities to ensure positive change is sustained.


Safety

14.6 Staff and service providers follow the organization's policy on reporting safety incidents and documents the information in the client record.

Guidelines

Reporting and recording is done is a timely way. Safety incidents include harmful incidents, no harm incidents, and near misses. (WHO International Classification for Patient Safety resource).
The team documents the safety incident in the client record as well as for the organization's record.


Client-centred Services

14.7 Staff and service providers follow the organization's policy and process to disclose safety incidents to clients and families affected, and coordinate support if necessary.

Guidelines

The Canadian Disclosure Guidelines, published by the Canadian Patient Safety Institute (CPSI), is a resource to encourage and support health care providers, interdisciplinary teams, organizations, and regulators in developing and implementing disclosure policies, practices, and training methods. The guidelines can be accessed on the CPSI website.


Safety

14.8 The team reviews and evaluates safety incidents and uses the information to prevent recurrence and make improvements.

Guidelines

Analyzing all harmful incidents, no harm incidents, and near misses includes determining the contributing factors, and taking action to prevent the same situation from recurring, as well as monitoring the effectiveness of those actions. Organizations use this information when developing strategies to proactively anticipate and address risk to client and staff safety.
The Canadian Incident Analysis Framework by the Canadian Patient Safety Institute is a resource that provides an in-depth description of the process of analyzing and managing safety incidents. An online Incident Analysis Learning Program series is available to assist organizations to apply the principles of incident analysis at www.patientsafetyinstitute.ca/.

15.0 The team collects and uses indicator data to guide its quality improvement activities.


Client-centred Services

15.1 The team collects information and feedback from clients, families, staff, service providers, organization leaders, and other organizations about the quality of its services to guide its quality improvement initiatives.

Guidelines

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

Effectiveness

15.2 The team uses the information and feedback it has gathered to identify opportunities for quality improvement initiatives and set priorities.

Guidelines

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

Effectiveness

15.3 The team identifies measurable objectives for its quality improvement initiatives and specifies the timeframe in which they will be reached.

Guidelines

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

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

Effectiveness

15.4 The team identifies the indicator(s) that will be used to monitor progress for each quality improvement objective.

Guidelines

The team uses indicators to monitor whether the activities resulted in change and if the change is an improvement. Primarily, indicators are selected based on their relevance and ability to accurately monitor progress. When there are multiple potential indicators, the team uses criteria to select indicators, such as scientific validity and feasibility. If the team has difficulty selecting indicators, it may mean the quality improvement objective needs further clarification.

Effectiveness

15.5 The team designs and tests quality improvement activities to meet its objectives.

Guidelines

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

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

Effectiveness

15.6 Staff and service providers collect new or uses existing data to establish a baseline for each indicator.

Guidelines

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

Effectiveness

15.7 Staff and service providers follow a process to regularly collect indicator data to track its progress.

Guidelines

The team determines how the data will be collected and how often it will be collected. Regularly collecting data allows the team to track its progress over time and understand the normal variation of values.

Effectiveness

15.8 Staff and service providers regularly analyze and evaluate their indicator data to determine the effectiveness of its quality improvement activities.

Guidelines

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

Analyzing data identifies trends and may reveal service areas that may need to be considered for quality improvement initiatives. Indicator data collected over time can be displayed in a run chart or control chart, both of which are valid means of data analysis. Safer Healthcare Now! offers Patient Safety Metrics, a web-based tool where organizations can submit data on various interventions, analyze results over time, and generate reports.

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

Effectiveness

15.9 The team implements effective quality improvement activities broadly.

Guidelines

The team broadly implements the quality improvement activities that were shown to be effective in the testing phase. The way in which the team implements activities broadly will vary based on the scope and scale of the team's services and considers the timeframe, e.g., an effective activity is implemented in more than one area of care and for a longer period of time.

Population Focus

15.10 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.

Guidelines

The team tailors the information to the audience and considers the messaging and language level that is appropriate for each audience.

Sharing the results of evaluations and improvements helps staff, service providers, and stakeholders become familiar with the philosophy and benefits of quality improvement and engages the organization's leaders in the process. It also helps the organization to spread successful quality improvement activities within and outside the organization and demonstrate its commitment to ongoing quality improvement. Among other benefits, sharing indicator data externally allows for comparison with organizations offering similar services.

Effectiveness

15.11 The team regularly reviews and evaluates its quality improvement initiatives for feasibility, relevance and usefulness.

Guidelines

The team regularly reviews and evaluates its quality improvement initiatives, including its activities, objectives, and indicators. The team uses the information to plan its future quality improvement initiatives including how and when to sustain or spread existing initiatives within the organization. The team considers outcomes of the quality improvement initiatives as they align with the organization's overall quality improvement plan, goals and objectives, mission and values, and strategic plan. The team evaluates whether objectives were met within their timeframes and whether the timeframes remains relevant.

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

Legend:

Dimensions

Population Focus	Working with communities to anticipate and meet needs
Accessibility	Providing timely and equitable services
Safety	Keeping people safe
Worklife	Supporting wellness in the work environment
Client-centred Services	Putting clients and families first
Continuity of Services	Experiencing coordinated and seamless services
Effectiveness	Doing the right thing to achieve the best possible results
Efficiency	Making the best use of resources

Criterion Types

Required Organizational Practices	Required Organizational Practices (ROPs) are essential practices that an organization must have in place to enhance client safety and minimize risk.
Performance Measures	Performance measures are evidence-based instruments and indicators that are used to measure and evaluate the degree to which an organization has achieved its goals, objectives, and program activities.

Priority

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

ROP Tests for Compliance

Minor	Minor tests for compliance support safety culture and quality improvement, yet require more time to be implemented.
Major	Major tests for compliance have an immediate impact on safety.

References:

Glossary (List of standard terms for all services)

Care Plan - The care plan may also be known as the service plan or treatment plan. It is developed in collaboration with the client and family and provides details on the client history as well as the plan for services including treatments and/or interventions, client goals, and anticipated outcomes. The care plan is accessible to the team and used when providing care.

Client - The client may also be known as a patient, consumer, individual, or resident, and is the recipient of care. The client may also include the clients' family and/or support network when desired by the client. Where the organization does not provide services directly to clients, the client may refer to the larger community or population that is served by the organization.

Client Representative - May also be known as a client advisory, client representatives work with the organization and often individual care teams. Examples of areas of involvement include: planning and service design, recruitment and orientation, working with clients directly, and gathering feedback from clients and staff members. Integrating the client perspective into the system enables the organization to adopt a client- and family- centred approach.

Co-design - The process of professionals and client and family members working in collaboration to plan and design services or improve the experience of services. Co-design emphasizes that the experience and input from the client or family is equally as important as the expertise of the health care professionals to understanding and improving a system or process, and that the aspect of experience is important in health care.

Electronic Health Record (EHR) - An aggregate record of computerized health information on an individual that is created and gathered cumulatively across many health care providers. Client information from multiple EMRs is consolidated.

Electronic Medical Record (EMR) - A computerized record of health-related information about an individual that is created and managed by care providers in a single health care organization, e.g. a primary care clinic.

Family - Two or more persons who are related in any way (biologically, legally, or emotionally), including immediate relatives and others individuals involved in the person's support network or circle of support. Family includes an individual's extended family, their partners, friends, advocates, guardians, and other representatives. The client defines the makeup of their family, and has the right to include or not include family members of their choice in their care, and the right to redefine the makeup of their family over time.

Indicator - A single, standardized measure, expressed in quantitative terms, that captures a key dimension of individual or population health, or health service performance. An indicator may measure an aspect of a process or a health or service outcome. Indicators need to have a definition, a numerator, a denominator, inclusion and exclusion criteria, and a time period. Tracking indicators data over time identifies successful practices or areas requiring improvement; indicator data is used to inform the development of quality improvement activities. Types of indicators include: structure, process, outcome and balancing measures.

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

Medical Devices and Equipment - A medical device is an article, instrument, apparatus or machine that is used for:
- The prevention, diagnosis, treatment, or alleviation of illness or disease
- Supporting or sustaining life
- Disinfection of other medical devices

Some examples include blood pressure cuffs, glucose meters, breathalyzers, thermometers, defibrillators, scales, foot care instruments, client lifts, wheelchairs, and syringes. This also includes single use items such as blood glucose test strips.

Medical equipment is a subset of medical devices - any medical device that requires calibration, maintenance, repair, and user training.

The process for selecting and buying devices and equipment takes into account:
• Information from staff, service providers and clients
• The level and type of services provided, including clients' functional abilities
• The knowledge and skills needed for use
• Potential risks or impacts on infection control including sterilization and reprocessing occupational health and safety, and waste creation and disposal
• The latest research and evidence and advances in technology
• Whether the benefits are worth the costs

Partner - An organization or person who works with another team or organization on a project to address a specific issue by sharing information and/or resources. The organization or person involved would benefit from the success of the project.

Policy - A document outlining an organization's plan or course of action.

Populations - A group of clients who are at risk for or who have a specific health condition.

Procedure - A written series of steps for completing a task.

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

Safety Incident - An event or circumstance which could have resulted, or did result, in unnecessary harm to a client. Types of safety incidents include:

· Harmful incident - A safety incident that resulted in harm to the client. Replaces "adverse event" and "sentinel event."
· No harm incident - A safety incident which reached a client but no discernible harm resulted.
· Near miss - A safety incident that did not reach the client. Replaces "close call."

Scope of practice - Defines the procedures, actions, and processes that are permitted for a specific health care provider. In some countries, scope of practice is defined by laws and/or regulations. In such countries, licensing bodies use the scope of practice to determine specific education, experience, and demonstrated competencies required for health care providers to receive license to practice.

Staff and service providers - Staff and service providers make up the collaborative care team where the primary responsibility and accountability rests with the care professionals, rather than the clients or families.

Team - Clients and families are included as part of the collaborative team. The team is comprised of the client and the care professionals that work together to meet the complex and varied needs of clients, families and the communities in which they live. Teams are collaborative, which means that different types of health care professionals work together to provide services. The composition of a collaborative team will depend on the type of service provided. Including clients and families can take many forms including taking client and family perspectives and feedback into consideration when making decisions, planning, or evaluating services. Depending on the activity, client and family representatives maybe be involved in processed (e.g., planning) whereas in many cases the client or family member who is the recipient of care is engaged as part of the team (e.g., in care planning and decisions).

Team Leader - Person(s) responsible for operational management of a team. Duties include identifying needs, staffing, and reporting to senior management. Team leaders may be formally appointed or take a role naturally within the team. This also includes a client or family member acting as in a leadership role (e.g., in an advisory capacity).

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

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