ACCREDITATION CANADA

Required Organizational Practices

2021 Handbook

Qmentum

For on-site surveys starting January 2021

For on-site surveys starting January 2021

CONTENTS

ABOUT THE ROP HANDBOOK

For convenience and ease of use, all of the Required Organizational Practices in the Accreditation Canada Qmentum program have been collected into this handbook. Most apply to more than one health sector or service and therefore appear in multiple sets of standards. The applicable standards sets are identified at the beginning of the ROP or in the table at the end of the handbook.

In this handbook, the ROPs are presented as follows:

The ROP

The ROP statement defines the expected practice. For example:

Accountability for quality: *The governing body demonstrates accountability for the quality of care provided by the organization.*

Guidelines

The guidelines provide context and rationale on why the ROP is important to patient safety and risk management. They also show supporting evidence and provide information about meeting the tests for compliance.

While the guidelines provide insight and information, they are not requirements and the tests for compliance can be met without using the guidelines.

Tests for Compliance (major and minor)

The tests for compliance are categorized as major or minor. They outline the specific practices, activities, and expectations that the organization must have in place to comply with the ROP. For the ROP to be assessed as compliant, all of the associated tests for compliance must be rated as 'met.'

Surveyors assess the tests for compliance during the on-site survey.

Major tests for compliance have an immediate impact on safety, while minor tests for compliance support longer-term safety culture and quality improvement activities and may require additional time to be fully developed and/or evaluated. As a rule, required follow-ups for major unmet tests for compliance must be submitted within five months, while those for minor unmet tests for compliance must be submitted within eleven months.

Reference Material

Supporting evidence used to develop the ROP, as well as tools and resources to assist organizations in meeting the tests for compliance. The reference materials do not appear in the standards.

OVERVIEW

In the Accreditation Canada Qmentum accreditation program, Required Organizational Practices (ROPs) are evidence-informed practices addressing high-priority areas that are central to quality and safety. Accreditation Canada defines an ROP as an essential practice that organizations must have in place to enhance patient safety and minimize risk.

Accreditation Canada began developing ROPs in 2004 under the leadership of its Patient Safety Advisory Committee. The first steps in developing a new ROP involve national and international literature reviews to identify key safety areas and best practices, analysis of patient safety-related on-site survey results and compliance, and field-specific research. Feedback is then sought from expert advisory committees and through national consultation with client organizations, surveyors, and other stakeholders such as governments and content experts before it is released to the field.

ROPs are reviewed and updated regularly. At times, as some ROPs become widely implemented, Accreditation Canada transitions them into high-priority criteria within the accreditation program.

ROPs are categorized into six patient safety areas, each with its own goal, as follows:

SAFETY CULTURE: Create a culture of safety within the organization

COMMUNICATION: Promote effective information transfer with clients and team members across the continuum of care

MEDICATION USE: Ensure the safe use of high-risk medications

WORKLIFE/WORKFORCE: Create a worklife and physical environment that supports the safe delivery of care and service

INFECTION CONTROL: Reduce the risk of health care-associated infections and their impact across the continuum of care

RISK ASSESSMENT: Identify and mitigate safety risks inherent in the client population

For more information on ROPs, Accreditation Canada, or the Qmentum accreditation program, visit accreditation.ca.

REQUIRED ORGANIZATIONAL PRACTICES

SAFETY CULTURE	▪ Accountability for quality ▪ Patient safety incident disclosure ▪ Patient safety incident management ▪ Patient safety quarterly reports
COMMUNICATION	▪ Client identification ▪ The 'Do Not Use List' of abbreviations ▪ Information transfer at care transitions ▪ Medication reconciliation as a strategic priority ▪ Medication reconciliation at care transitions ▪ Safe surgery checklist
MEDICATION USE	▪ Antimicrobial stewardship ▪ Concentrated electrolytes ▪ Heparin safety ▪ High-alert medications ▪ Infusion pump safety ▪ Narcotics safety
WORKLIFE/WO0RKFORCE	▪ Client flow ▪ Patient safety: education and training ▪ Patient safety plan ▪ Preventive maintenance program ▪ Workplace violence prevention
INFECTION CONTROL	▪ Hand-hygiene compliance ▪ Hand-hygiene education and training ▪ Infection rates ▪ Reprocessing
RISK ASSESSMENT	▪ Falls prevention and injury reduction ▪ Home safety risk assessment ▪ Pressure ulcer prevention ▪ Skin and wound care ▪ Suicide prevention ▪ Venous thromboembolism prophylaxis

ACCOUNTABILITY FOR QUALITY

For the Governance and Governance for Aboriginal Health Services standard.

The governing body demonstrates accountability for the quality of care provided by the organization.

GUIDELINES

Governing bodies are accountable for the quality of care provided by their organizations. When governing bodies are engaged in overseeing quality, their organizations have better quality performance (better care, better client outcomes, better worklife, and reduced costs).

The members of the governing body need to be aware of key quality and safety principles if they are to effectively understand, monitor, and oversee the quality performance of the organization. Knowledge gaps among the membership can be addressed through targeted recruitment for specific competencies (e.g., quality assurance, risk management, quality improvement, and safety) from health care or other sectors (e.g., education or industry) or by providing education through workshops, modules, retreats, virtual networks, or conferences.

The governing body can demonstrate a clear commitment to quality when it is a standing agenda item at each meeting. Often the governing body overestimates the quality performance of an organization, so discussions need to be supported with indicator data and feedback from clients and families. A small number of easily understood performance indicators that measure quality at the system level (i.e., 'big-dot' indicators) such as number of clients who died or were harmed by patient safety incidents, quality of worklife, number of complaints, and client experience results will help answer the question "are the services we provide getting better?"

Quality performance indicators need to be directly linked to strategic goals and objectives and balanced across a number of priority areas. Knowledge gained from the review of quality performance indicators can be used to set the agenda, inform strategic planning, and develop an integrated quality improvement plan. It can also be used to set quality performance objectives for senior leadership and to determine whether they have met their quality performance objectives.

TESTS FOR COMPLIANCE

Minor	The governing body is knowledgeable about quality and safety principles, by recruiting members with this knowledge or providing access to education.
Major	Quality is a standing agenda item at all regular meetings of the governing body.
Major	The key system-level indicators that will be used to monitor the quality performance of the organization are identified.
Major	At least quarterly, the quality performance of the organization is monitored and evaluated against agreed-upon goals and objectives.
Minor	Information about the quality performance of the organization is used to make resource allocation decisions and set priorities and expectations.
Major	As part of their performance evaluation, senior leaders who report to the governing body (e.g., the CEO, Executive Director, Chief of Staff) are held accountable for the quality performance of the organization.

REFERENCE MATERIALS

- Baker, G.R., Denis, J., Pomey, M., MacIntosh-Murray, A. (2010). Designing effective Governance for quality and safety in Canadian healthcare. Healthc.Q. 13(1);38-46.
- Bismark, M.M., Studdert, D.M. (2014). Governance of quality of care: a qualitative study of health service boards in Victoria, Australia. BMJ. Qual.Saf.23(6):474-82.
- The Health Foundation. (2013). Quality improvement made simple: what every board should know about healthcare quality improvement. The Health Foundation. London, UK.
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- Martin, L.A., Nelson, E.C., Lloyd, R.C., Nolan, T.W. (2007) Whole System Measures. IHI Innovation Series white paper. Institute for Healthcare Improvement; Cambridge, MA.
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- Roberts, J., Durbin, S. (2007). The Board's Role in Quality and Safety: 7 Key Governance Questions. Providence Health Care. Seattle, WA.

PATIENT SAFETY INCIDENT DISCLOSURE

For the following standards: Independent Medical/Surgical Facilities, Leadership, Leadership for Aboriginal Health Services, Leadership for Small Community-Based Organizations, and Medical Imaging Centres.

A documented and coordinated approach to disclosing patient safety incidents to clients and families, that promotes communication and a supportive response, is implemented.

GUIDELINES

Disclosure of patient safety incidents is an ongoing discussion that includes the following core elements:

- Informing those affected that a patient safety incident has occurred and offering an apology
- Explaining what happened and why, as facts are known
- Discussing the immediate actions taken to care for the client and mitigate further harm
- Reviewing recommended actions to prevent future incidents
- Offering support to all involved

The support provided meets the needs of those involved (clients, families, and the team), and can be practical (e.g., reimbursement for out-of-pocket expenses) or emotional/psychological (e.g., helping with access to support groups or offering counselling).

Disclosing a patient safety incident that affects multiple clients (e.g., failures in sterilization, privacy breaches) includes additional elements, for example:

- Identifying which clients have been exposed to risk
- Deciding which clients should be contacted and how
- Locating and communicating with clients who have been affected
- Informing the community, other organizations, and the media

When asked for their feedback, clients and families are encouraged to speak from their own perspective and in their own words about their experience.

TESTS FOR COMPLIANCE

Major There is a documented and coordinated process to disclose patient safety incidents to clients and families that identifies:

- Which patient safety incidents require disclosure
- Who is responsible for guiding and supporting the disclosure process
- What can be communicated and to whom about the incident
- When and how to disclose
- Where to document the disclosure

Minor The disclosure process is reviewed and updated, if necessary, once per accreditation cycle, with input from clients, families, and team members.

Major Those responsible for guiding and supporting the disclosure process are provided with training on disclosure.

Major Communication occurs throughout the disclosure process with clients, families, and team members involved in the patient safety incident. Communication is documented and based on their individual needs.

Major As part of the disclosure process, practical and emotional/psychological support is offered to clients, families, and team members involved in the patient safety incident.

Minor Feedback is sought from clients, families, and team members about their experience with disclosure and this information is used to make improvements, when needed, to the disclosure process.

REFERENCE MATERIAL

- Canadian Medical Protective Organization (2015). Disclosing harm from healthcare delivery: Open and honest communication with patients. Second edition. Canadian Medical Protective Organization. Ottawa, ON.
- Conway J, Federico F, Stewart K, & Campbell MJ (2011). Respectful Management of Serious Clinical Adverse Events (Second Edition). IHI Innovation Series white paper.
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- National Reporting and Learning Service (2009). Being open: saying sorry when things go wrong. National Patient Safety Agency. London, UK.
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PATIENT SAFETY INCIDENT MANAGEMENT

For the following standards: Independent Medical/Surgical Facilities, Leadership, Leadership for Aboriginal Health Services, Leadership for Small Community-Based Organizations, and Medical Imaging Centres.

A patient safety incident management system that supports reporting and learning is implemented.

GUIDELINES

In a culture of patient safety, everyone is encouraged to report and learn from patient safety incidents, including harmful, no-harm, and near miss. A reporting system that is simple (few steps), clear (what needs to be reported, how to report, and to whom), confidential, and focused on system improvement is essential. Clients and families may report patient safety incidents differently than team members, but everyone needs to know how to report. Information about how to report can be tailored to the needs of team members or clients and can be part of team member training and included in written and verbal communication to clients and families about their role in safety.

The immediate response to a patient safety incident is to address the urgent care and support needs of those involved. It is also important to secure any items related to the incident (for testing and review by the analysis team), report the incident using the approved process, begin the disclosure process (if required), and take action to reduce any risk of imminent recurrence.

Through incident analysis (also known as 'root cause analysis'), contributing factors and recommended actions can be identified in order to make improvements. Analyzing similar patient safety incidents (such as near misses) together, to look for patterns or trends, can yield helpful information, as can analyzing incidents in isolation. Communicating incident analysis findings broadly (e.g., with clients and families, governance, leadership, clinical teams, and external partners) builds confidence in the incident management system and promotes learning from patient safety incidents.

Global Patient Safety Alerts is an on-line, searchable database where lessons learned from patient safety incidents are shared.

TESTS FOR COMPLIANCE

Major	A patient safety incident management system is developed, reviewed, and updated with input from clients, families, and team members, and includes processes to report, analyze, recommend actions, and monitor improvements.
Major	Information is shared with clients, families, and team members so they understand what, when, and how to report patient safety incidents.
Major	Training is provided, and documented, for team members on the immediate response to patient safety incidents.
Major	There are procedures to review patient safety incidents and established criteria are used to prioritize those that will be analyzed further.
Major	All recommended actions resulting from the analysis of patient safety incidents are reviewed and the rationale to accept, reject, or delay implementation is documented.
Major	Information about recommended actions and improvements made following incident analysis is shared with clients, families, and team members.

Minor The effectiveness of the patient safety incident management system is evaluated and improvements are made based onfeedback received. Evaluation mechanisms may include:

- Gathering feedback from clients, families, and team members about the system
- Monitoring patient safety incident reports by type and severity
- Examining whether improvements are implemented and sustained
- Determining whether team members feel comfortable reporting patient safety incidents (e.g., based on results from theCanadian Patient Safety Culture Survey Tool)

REFERENCE MATERIAL

- Baker, G. R., Norton, P. G., Flintoft, V., Blais, R., Brown, A., Cox, J. et al. (2004). The Canadian Adverse Events Study: the incidence of adverse events among hospital patients in Canada. *CMAJ*, 170, 1678-1686.
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- Conway J, Federico F, Stewart K, & Campbell MJ (2011). Respectful Management of Serious Clinical Adverse Events (Second Edition). IHI Innovation Series white paper.
- Etchegaray, J.M., Ottosen, M.J., Burress, L. Madelene J. (2014). Structuring patient and family involvement in medical error event disclosure and analysis. *Health Affairs*,33,46-52
- Gallagher, T.H., Mazo, K.M. (2015). Taking complaints seriously: using the patient safety lens. *BMJ Qual Saf.*24:352-5. World Health Organization (2009). Conceptual Framework for the International Classification for Patient Safety (Version 1.1). World Health Organization.

PATIENT SAFETY QUARTERLY REPORTS

For the following standards: Independent Medical/Surgical Facilities, Leadership, Leadership for Aboriginal Health Services, Leadership for Small Community-Based Organizations.

The governing body is provided with quarterly reports on patient safety that include recommended actions arising out of patient safety incident analysis, as well as improvements that were made.

GUIDELINES

The governing body is ultimately accountable for the quality and safety of the services delivered by the organization. It plays an important role in enabling an organizational culture that enhances patient safety.

An organization is more likely to make safety and quality improvement a central feature if the governing body is aware of patient safety issues and patient safety incidents, and leads the organization's quality improvement efforts. In addition, the governing body needs to be informed about and have input into follow-up actions or improvement initiatives resulting from patient safety incidents. Outcomes and processes of care are improved in organizations where the governing body is engaged in patient safety.

TESTS FOR COMPLIANCE

Major	Quarterly patient safety reports are provided to the governing body.
Minor	The quarterly patient safety reports outline specific organizational activities and accomplishments in support of the organization's patient safety goals and objectives.
Minor	The governing body supports the patient safety activities and accomplishments and acts on the recommended actions in the quarterly patient safety reports.

REFERENCE MATERIAL

- Institute for Healthcare Improvement (2008). Getting Started Kit: Governance Leadership "Boards on Board" How-to Guide.
- Jiang, H. J., Lockee, C., Bass, K., & Fraser, I. (2009). Board oversight of quality: any differences in process of care and mortality? *J.Healthc.Manag.*, 54, 15-29.
- Reinertsen JL, Bisognano M, & Pugh MD (2008). Seven Leadership Leverage Points for Organization-Level Improvement in Health Care (Second Edition). IHI Innovation Series white paper.

CLIENT IDENTIFICATION

This ROP is found in most service-based sets of standards, see table on page 68.

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

GUIDELINES

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

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

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

TESTS FOR COMPLIANCE

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

REFERENCE MATERIAL

- Allworth, S., Lapse, P., Kelly, J (2008). Technology Solutions to Patient Misidentification - Report of Review. Australian Commission on Safety and Quality in Health Care. Sydney, Australia.
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- Parisi, L.L. (2003). Patient identification: the foundation for a culture of patient safety. Journal of Nursing Care Quality, 18, 73-79.
- Sandler, S. G., Langeberg, A., & Dohnalek, L. (2005). Bar code technology improves positive patient identification and transfusion safety. Developmental Biology, 120, 19-24.
- World Health Organization (2007). Patient Identification. Patient Safety Solutions.

THE "DO NOT USE" LIST OF ABBREVIATIONS

For the following standards: Independent Medical/Surgical Facilities, Medication Management

A list of abbreviations, symbols, and dose designations that are not to be used have been identified and implemented.

GUIDELINES

Medication errors are the largest identified source of preventable hospital medical error. From 2004-2006, more than 600,000 medication errors were reported to the United States Pharmacopeia (USP) MEDMARX program, with a total annual cost of $3.5 billion. Five percent of those errors were attributed to abbreviation use. Misinterpreted abbreviations can result in omission errors, extra or improper doses, administering the wrong drug, or giving a drug in the wrong manner. In return this can lead to an increase in the length of stay, more diagnostic tests and changes in drug treatment.

TESTS FOR COMPLIANCE

Major	The organization's Do Not Use list is inclusive of the abbreviations, symbols, and dose designations, as identified on the Institute of Safe Medication Practices (ISMP) Canada's "Do Not Use List".
Major	The Do Not Use List is implemented and applies to all medication-related documentation when hand written or entered as free text into a computer.
Major	Preprinted forms related to medication use do not include any abbreviations, symbols, and dose designations identified on the Do Not Use List.
Major	The dangerous abbreviations, symbols, and dose designations are not used on any pharmacy-generated labels and forms.
Minor	Team members are provided with education about the Do Not Use list at orientation and when changes are made to the list.
Minor	The Do Not Use list is updated and necessary changes are implemented to medication management processes.
Minor	Compliance with the Do Not Use List is audited and process changes are implemented based on identified issues.

REFERENCE MATERIAL

- Medication safety issue brief. Eliminating dangerous abbreviations, acronyms and symbols (2005). *Hosp.Health Netw*., 79, 41-42.
- Institute for Safe Medication Practices - Canada (2006). Eliminate Use of Dangerous Abbreviations, Symbols, and Dose Designations. ISMP Canada Safety Bulletin.
- Institute for Safe Medication Practices - Canada (2012). Do Not Use: List of Dangerous Abbreviations, Symbols, and Dose Designations. Institute for Safe Medication Practices – Canada.
- Koczmara, C., Jelincic, V., & Dueck, C. (2005). Dangerous abbreviations: "U" can make a difference! *Dynamics*., 16, 11-15.

THE "DO NOT USE" LIST OF ABBREVIATIONS – COMMUNITY ORGANIZATIONS

For the following standards: Medication Management for Community-Based Organizations and Community Pharmacy Services

The organization has identified and implemented a list of abbreviations, symbols, and dose designations that are not to be used in the organization.

GUIDELINES

Misinterpreted abbreviations can result in omission errors, extra or improper doses, administering the wrong drug, or giving a drug in the wrong manner.

TESTS FOR COMPLIANCE

Major	The organization's Do Not Use list is inclusive of the abbreviations, symbols, and dose designations, as identified on the Institute of Safe Medication Practices (ISMP) Canada's "Do Not Use List".
Major	The Do Not Use List is implemented and applies to all medication-related documentation when hand written or entered as free text into a computer.
Major	The dangerous abbreviations, symbols, and dose designations are not used on any pharmacy-generated labels and forms.
Minor	Team members are provided with education about the Do Not Use list at orientation and when changes are made to the list.
Minor	The Do Not Use list is updated and necessary changes are implemented to medication management processes.
Minor	Compliance with the Do Not Use List is audited and process changes are implemented based on identified issues.

REFERENCE MATERIAL

- Medication safety issue brief. Eliminating dangerous abbreviations, acronyms and symbols (2005). *Hosp.Health Netw*., 79, 41-42.
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INFORMATION TRANSFER AT CARE TRANSITIONS

This ROP is found in most service-based sets of standards, see table on page 68.

Information relevant to the care of the client is communicated effectively during care transitions.

GUIDELINES

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

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

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

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

TESTS FOR COMPLIANCE

Major	The information that is required to be shared at care transitions is defined and standardized for care transitions where clients experience a change in team membership or location: admission, handover, transfer, and discharge.
Major	Documentation tools and communication strategies are used to standardize information transfer at care transitions.
Major	During care transitions, clients and families are given information that they need to make decisions and support their own care.
Major	Information shared at care transitions is documented.
Minor	The effectiveness of communication is evaluated and improvements are made based on feedback received. Evaluation mechanisms may include: • Using an audit tool (direct observation or review of client records) to measure compliance with standardized processes and the quality of information transfer • Asking clients, families, and service providers if they received the information they needed • Evaluating safety incidents related to information transfer (e.g., from the patient safety incident management system).

REFERENCE MATERIAL

- Alvarado, K. et al. (2006). Transfer of accountability: transforming shift handover to enhance patient safety. Healthcare Quarterly, 9 Spec No, 75-79.
- American Medical Directors Association (2010). Transitions of care in the long-term care continuum clinical practice guideline. American Medical Directors Association. Columbia, MD.
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- Canadian Medical Protective Association (CMPA).). (2013) Patient Handovers. CMPA Risk Fact Sheet. CMPA. Ottawa, ON.
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- Fancott, C (2011). Interventions and measurement tools related to improving the patient experience through transitions in care: A summary of key literature. The Change Foundation. Toronto, ON.
- Kripalani, S., Jackson, A. T., Schnipper, J. L., & Coleman, E. A. (2007). Promoting effective transitions of care at hospital discharge: a review of key issues for hospitalists. Journal of Hospital Medicine, 2, 314-323.
- Kripalani, S., LeFevre, F., Phillips, C. O., Williams, M. V., Basaviah, P., & Baker, D. W. (2007). Deficits in communication and information transfer between hospital-based and primary care physicians: implications for patient safety and continuity of care. Journal of the American Medical Association, 297, 831-841. Naylor, M. D., Aiken, L. H., Kurtzman, E. T., Olds, D. M., & Hirschman, K. B. (2011). The care span: The importance of transitional care in achieving health reform. Health Affairs, 30, 746-754.
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- Provincial Council for Child and Maternal Health. (2013). Transition to Adult Healthcare Services. Provincial Council for Child and Maternal Health. Toronto, ON.
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- World Health Organization Collaborating Centre for Patient Safety Solutions (2007). Communication During Patient Handovers. Geneva, Switzerland: WHO Press.

MEDICATION RECONCILIATION AS A STRATEGIC PRIORITY

For the following standards: Leadership, Leadership for Aboriginal Health Services, and Leadership for Small Community-Based Organizations.

A documented and coordinated medication reconciliation process is used to communicate complete and accurate information about medications across care transitions.

GUIDELINES

Medication reconciliation is recognized as an important safety initiative by the World Health Organization. Medication reconciliation can be a cost-effective way to reduce medication errors (e.g., omissions, duplications, incorrect orders) and the re-work often associated with medication management.

Medication reconciliation is a three-step process, whereby the team (e.g., physicians, nurses, pharmacists) works in partnership with clients and families to generate a Best Possible Medication History (BPMH), identifies and resolves medication discrepancies, and communicates a complete and accurate list of medication to the client and their next care provider.

An organizational policy signals leadership's commitment to medication reconciliation and provides overarching guidance (e.g., an overview of the process, roles and responsibilities, care transitions where medication reconciliation is required, exemptions). Allocating resources to staffing, education, tools, information technology, etc., also demonstrates a commitment to medication reconciliation. Team education should include the rationale for and steps involved in medication reconciliation.

Implementing and sustaining medication reconciliation throughout an organization will be more successful if it is led by an interdisciplinary coordination team. Depending on the organization, the coordination team could include senior leaders (including clinical leaders representing medicine, nursing, and pharmacy); team members who are directly involved in the process; information technology staff; representatives from quality, risk, and safety committees; and clients and families.

It is important to monitor, in consultation with the coordination team and clinical team members, whether the medication reconciliation policy is being followed (e.g., Do clients receive medication reconciliation? Is the BPMH documented?) and the quality of the process (e.g., Is the BPMH complete? Are medication discrepancies identified and resolved?).

TESTS FOR COMPLIANCE

Major	There is a medication reconciliation policy and process to collect and use accurate and complete information about client medication at care transitions.
Major	Roles and responsibilities for completing medication reconciliation are defined.
Minor	An organizational plan to sustain medication reconciliation is led by an interdisciplinary coordination team.
Major	There is documented evidence that team members (including physicians) who are responsible for medication reconciliation are provided with relevant education.
Minor	Compliance with the medication reconciliation process is monitored and improvements are made when required.

REFERENCE MATERIAL

- Accreditation Canada, the Canadian Institute for Health Information, the Canadian Patient Safety Institute, and the Institute for Safe Medication Practices Canada. (2012). Medication Reconciliation in Canada: Raising The Bar – Progress to date and the course ahead. Ottawa, ON: Accreditation Canada. www.accreditation.ca/sites/default/files/med-rec-en.pdf
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MEDICATION RECONCILIATION AT CARE TRANSITIONS

Acute Care Services (Inpatient)

For the following standards: Acquired Brain Injury Services, Cancer Care Services, Correctional Services of Canada Health Services, Critical Care Services, Hospice Palliative End-of-Life Services, Inpatient Services, Mental Health Services, Obstetric Services, Perioperative Services and Invasive Procedures, Provincial Correctional Health Services, Rehabilitation Services, Spinal Cord Injury Acute Services, and Spinal Cord Injury Rehabilitation Services.

Medication reconciliation is conducted in partnership with clients and families to communicate accurate and complete information about medications across care transitions.

GUIDELINES

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

Medication reconciliation begins with generating a Best Possible Medication History (BPMH) that lists all the medications the client is taking including prescription, non-prescription, traditional, holistic, herbal, vitamins, and supplements. The BPMH also details how they are being taken including the dose, frequency, route of administration, and strength if applicable. Creating the BPMH involves interviewing the client, family, or caregivers, and consulting at least one other source of information such as the client's previous health record, or a community pharmacist. Once generated, the BPMH is an important reference tool for reconciling medications at care transitions.

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

At care transitions, in addition to the medications the client is currently receiving, it is important to also consider the medications that were taken prior to admission (as identified in the BPMH), which may be appropriate to continue, restart, discontinue, or modify. For example, medication reconciliation should happen at discharge or when medications are changed or reordered as part of a transfer involving a change in the service environment (e.g., from critical care to a medicine unit, or from one facility to another within an organization). Medication reconciliation is not required for bed relocation.

Clients should be regarded as active partners in the management of their medications and provided with information about the medications they should be taking in a format and language they understand. Clients should be encouraged to keep an up-to-date medication list and share it with their providers.

TESTS FOR COMPLIANCE

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

REFERENCE MATERIAL

- American Medical Association (2007). The physician's role in medication reconciliation. Retrieved from: www.ama-assn.org/resources/doc/cqi/med-rec-monograph.pdf
- American Society of Hospital Pharmacists (AHSP) SP) SP) Council on Pharmacy Practice. (2013). ASHP statement on the pharmacist's role in medication reconciliation. Am.J.Health.Syst.Pharm., 1: 453-6.
- Institute for Healthcare Improvement (2012). How-to Guide: Prevent Adverse Drug Events (Medication Reconciliation). Retrieved from: www.ihi.org/knowledge/Pages/Tools/HowtoGuidePreventAdverseDrugEvents.aspx
- Institute for Healthcare Improvement (2008). Reconcile medications at all transition points. Retrieved from: www.ihi.org/knowledge/Pages/Changes/ReconcileMedicationsatAllTransitionPoints.aspx
- MARQUIS Investigators. (2011). MARQUIS Implementation Manual: A guide for medication reconciliation quality improvement. Philadelphia, PA: Society of Hospital Medicine. http://tools.hospitalmedicine.org/resource_rooms/imp_guides/MARQUIS/marquis.html (registration required)
- World Health Organization Collaborating Centre for Patient Safety Solutions (2007). Assuring Medication Accuracy at Transitions in Care. Report No.: Solution 6.

MEDICATION RECONCILIATION AT CARE TRANSITIONS

Ambulatory Care Services

For the following standards: Aboriginal Integrated Primary Care, Ambulatory Care Services, Cancer Care Services, and Remote/Isolated Health Services.

Medication reconciliation is conducted in partnership with clients and families to communicate accurate and complete information at ambulatory care visits when medication management is a major component of care.

GUIDELINES

Ambulatory care includes a wide range of services and client populations, thus it is important to focus medication reconciliation on clients for whom medication management is a major component of care. Organizations should identify and document which ambulatory care clinics meet the requirement for medication reconciliation, keeping in mind that clinical judgment should always be a consideration when managing client medications.

Medication reconciliation begins with generating a Best Possible Medication History (BPMH) that lists all the medications the client is taking including prescription, non-prescription, traditional, holistic, herbal, vitamins, and supplements. The BPMH also details how they are being taken including the dose, frequency, route of administration, and strength if applicable. Creating the BPMH involves interviewing the client, family, or caregivers, and consulting at least one other source of information such as the client's previous health record, or a community pharmacist. Once generated, the BPMH is an important reference tool for reconciling medications at care transitions.

The gathered lists of medications are compared, and when medication discrepancies are identified, they are resolved by the most responsible prescriber, either within the team or by referral. The prescriber indicates which medication(s) should be continued, discontinued, or modified and the reason(s) why.

Clients should be regarded as active partners in the management of their medications and provided with information about the medications they should be taking in a format and language they understand. Clients should be encouraged to keep an up-to-date medication list and share it with their providers.

TESTS FOR COMPLIANCE

Major	Ambulatory care clinics, where medication management is a major component of care, are identified by the organization. This designation is documented, along with the agreed upon frequency at which medication reconciliation should occur for clients of the clinic.
Major	During or prior to the initial ambulatory care visit, a Best Possible Medication History (BPMH) is generated and documented in partnership with the client, family, caregivers, and others, as appropriate.
Major	During or prior to subsequent ambulatory care visits, the BPMH is compared with the current medication list and any medication discrepancies are identified and documented. This is done as per the frequency required by the organization.
Major	Medication discrepancies are resolved in partnership with clients and families or medication discrepancies are communicated to the client's most responsible prescriber and actions taken to resolve medication discrepancies are documented.
Major	The client and the next care provider (e.g., primary care provider, community pharmacist, home care services) are provided with an accurate and up-to-date list of medications the client should be taking at the last visit or upon discharge from the clinic.

REFERENCE MATERIAL

- American Medical Association (2007). The physician's role in medication reconciliation.
- Institute for Healthcare Improvement (2012). How-to Guide: Prevent Adverse Drug Events (Medication Reconciliation).
- Institute for Safe Medication Practices - Canada (2012). Cross Country Med Rec Check-Up. Institute for Safe Medication Practices Canada. www.ismp-canada.org/medrec/map/
- Institute for Healthcare Improvement (2008). Reconcile medications at all transition points.
- World Health Organization Collaborating Centre for Patient Safety Solutions (2007). Assuring Medication Accuracy at Transitions in Care. Report No.: Solution 6.

MEDICATION RECONCILIATION AT CARE TRANSITIONS

Emergency Department

For the Emergency Department standard.

In partnership with clients, families, or caregivers (as appropriate), the medication reconciliation process is initiated for clients with a decision to admit and can be completed on the receiving unit.

GUIDELINES

Medication reconciliation begins with generating a Best Possible Medication History (BPMH) that lists all the medications the client is taking including prescription, non-prescription, traditional, holistic, herbal, vitamins, and supplements. The BPMH also details how they are being taken including the dose, frequency, route of administration, and strength if applicable. Creating the BPMH involves interviewing the client, family, or caregivers (as appropriate) and consulting at least one other source of information such as the client's previous health record, or a community pharmacist.

TESTS FOR COMPLIANCE

Major — Medication reconciliation is initiated for all clients with a decision to admit. A Best Possible Medication History (BPMH) is generated in partnership with clients, families, or caregivers, and documented. The medication reconciliation process may begin in the emergency department and be completed in the receiving inpatient unit.

REFERENCE MATERIAL

- American Medical Association (2007). The physician's role in medication reconciliation. Retrieved from: http://www.ama-assn.org/resources/doc/cqi/med-rec-monograph.pdf
- Institute for Healthcare Improvement (2012). How-to Guide: Prevent Adverse Drug Events (Medication Reconciliation). Retrieved from: www.ihi.org/knowledge/Pages/Tools/HowtoGuidePreventAdverseDrugEvents.aspx
- Institute for Healthcare Improvement (2008). Reconcile medications at all transition points. Retrieved from: www.ihi.org/knowledge/Pages/Changes/ReconcileMedicationsatAllTransitionPoints.aspx
- World Health Organization Collaborating Centre for Patient Safety Solutions (2007). Assuring Medication Accuracy at Transitions in Care. Report No.: Solution 6.

MEDICATION RECONCILIATION AT CARE TRANSITIONS

Home and Community Care Services

For the following standards: Aboriginal Substance Misuse Services, Case Management Services, Community-Based Mental Health Services and Supports, Home Care Services, and Substance Abuse and Problem Gambling.

Medication reconciliation is conducted in partnership with clients and families for a target group of clients when medication management is a component of care (or deemed appropriate through clinician assessment), to communicate accurate and complete information about medications.

GUIDELINES

Medication reconciliation is a structured process to communicate accurate and complete information about medications across care transitions.

Medication reconciliation should be considered for all clients when medication management is a component of care. If this is not possible, criteria need to be established to identify clients at risk of potential adverse drug events. A medication risk assessment tool can help identify clients for whom medication reconciliation is required. The rationale for selecting target clients must be documented.

Medication reconciliation begins with generating a Best Possible Medication History (BPMH) that lists all the medications the client is taking including prescription, non-prescription, traditional, holistic, herbal, vitamins, and supplements. The BPMH also details how they are being taken including the dose, frequency, route of administration, and strength if applicable.

Creating the BPMH involves interviewing the client, family, or caregivers, and consulting at least one other source of information such as the client's previous health record, or a community pharmacist. Once generated, the BPMH is an important reference tool for reconciling medications at care transitions. The gathered lists of medications are compared, and when medication discrepancies are identified, they are resolved by the most responsible prescriber, either within the team or by referral. The prescriber indicates which medication(s) should be continued, discontinued, or modified and the reason(s) why.

Clients should be regarded as active partners in the management of their medications and provided with information about the medications they should be taking in a format and language they understand. Clients should be encouraged to keep an up-to-date medication list and share it with their providers.

As care in the community is intermittent, the community care organization may not always be immediately aware that a client has been transferred or discharged. Keeping the medication list up-to-date and accurate is the best way to be prepared to communicate the client's medications to the client's circle of care or next provider of care.

TESTS FOR COMPLIANCE

Major	The types of clients who require medication reconciliation are identified and documented.
Major	At the beginning of service, a Best Possible Medication History (BPMH) is generated and documented in partnership with the client, family, health care providers, caregivers, and others, as appropriate.
Major	Medication discrepancies are resolved in partnership with clients and families or communicated to the client's most responsible prescriber, and the actions taken to resolve medication discrepancies are documented.
Minor	When medication discrepancies are resolved, the current medication list is updated and provided to the client or family (or primary care provider, as appropriate) along with clear information about the changes that were made.

REFERENCE MATERIAL

- American Medical Association (2007). The physician's role in medication reconciliation.
- Institute for Healthcare Improvement (2012). How-to Guide: Prevent Adverse Drug Events (Medication Reconciliation).
- Institute for Safe Medication Practices – Canada. (2012). Medication Reconciliation (MedRec). Institute for Safe Medication Practices Canada.
- Institute for Safe Medication Practices – Canada. (2012). Cross Country Med Rec Check-Up. Institute for Safe Medication Practices Canada.
- Institute for Healthcare Improvement (2008). Reconcile medications at all transition points.
- Safer Healthcare Now! (2012). Medication Reconciliation: Getting Started Kits.
- World Health Organization Collaborating Centre for Patient Safety Solutions (2007). Assuring Medication Accuracy at Transitions in Care. Report No.: Solution 6.

MEDICATION RECONCILIATION AT CARE TRANSITIONS

Long-Term Care Services

For the following standards: Long-Term Care Services, and Residential Homes for Seniors.

Medication reconciliation is conducted in partnership with the resident, family, or caregiver to communicate accurate and complete information about medications across care transitions.

GUIDELINES

Poor communication about medications is common as residents transfer between long-term care and other service environments (e.g., acute care, rehabilitation services, another long-term care facility, or home care). Medication reconciliation is a structured process to communicate accurate and complete information about the resident's medications across transitions of care.

Medication reconciliation begins with generating a Best Possible Medication History (BPMH) that lists all the medications the resident is taking including prescription, non-prescription, traditional, holistic, herbal, vitamins, and supplements. The BPMH also details how they are being taken including the dose, frequency, route of administration, and strength, if applicable. Creating the BPMH involves interviewing the resident, family, or caregivers, and consulting at least one other source of information such as the resident's previous health record, or a community pharmacist. Once generated, the BPMH is an important reference tool for reconciling medications at care transitions.

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

At care transitions, in addition to the medications the resident is currently receiving, it is important to also consider the medications that were taken prior to admission (as identified in the BPMH), which may be appropriate to continue, restart, discontinue, or modify. For example, medication reconciliation should happen at admission, re-admission back to long-term care from another service environment, or transfer out of long-term care.

Residents should be regarded as active partners in the management of their medications and provided with information about the medications they should be taking in a format and language they understand.

TESTS FOR COMPLIANCE

Major	Upon or prior to admission, a Best Possible Medication History (BPMH) is generated and documented in partnership with the resident, family, health care providers, or caregivers (as appropriate).
Major	The BPMH is used to generate admission medication orders or the BPMH is compared with current medication orders and any medication discrepancies are identified, resolved, and documented.
Major	Upon or prior to re-admission from another service environment (e.g., acute care), the discharge medication orders are compared with the current medication list and any medication discrepancies are identified, resolved, and documented.
Major	Upon transfer out of long-term care, the resident and next care provider (e.g., another long-term care facility or community-based health care provider) are provided with a complete list of medications the resident is taking.

REFERENCE MATERIAL

- American Medical Association. (2007). *The physician's role in medication reconciliation*. American Medical Association.
- Canadian Patient Safety Institute and Institute for Safe Medication Practices Canada (2012). *Medication Reconciliation in Long-term Care: Getting Started Kit.* Safer Healthcare Now!
- Institute for Healthcare Improvement. (2012). *How-to Guide: Prevent Adverse Drug Events (Medication Reconciliation).*
  Institute for Healthcare Improvement.
- Institute for Safe Medication Practices – Canada. (2012). *Medication Reconciliation (MedRec).* Institute for Safe MedicationPractices Canada.
- Institute for Safe Medication Practices – Canada. (2012). *Cross Country Med Rec Check-Up*. Institute for Safe MedicationPractices Canada.

SAFE SURGERY CHECKLIST

For the following standards: Independent Medical/Surgical Facilities, Obstetrics Services, Organ Donation for Living Donors, Organ and Tissue Transplant, and Perioperative Services and Invasive Procedures.

A safe surgery checklist is used to confirm that safety steps are completed for a surgical procedure performed in the operating room.

GUIDELINES

Surgical procedures are increasingly complex aspects of health services and carry a significant risk of potentially avoidable harm. Safe surgery checklists play an important role in improving the safety of surgical procedures. They can reduce the likelihood of complications following surgery and often improve surgical outcomes.

A safe surgery checklist is used to initiate, guide, and formalize communication among the team members conducting a surgical procedure and to integrate these steps into surgical workflow.

Safe surgery checklists have been developed by and are available from Canadian (Canadian Patient Safety Institute) and international (World Health Organization) sources. Each checklist has three phases:

i. Briefing – before the induction of anesthesia
ii. Time out – before skin incision
iii. Debriefing – before the patient leaves the operating room

TESTS FOR COMPLIANCE

Major	The team has agreed on a three-phase safe surgery checklist to be used for surgical procedures performed in the operating room.
Major	The checklist is used for every surgical procedure.
Major	There is a process to monitor compliance with the checklist.
Minor	The use of the checklist is evaluated and results are shared with the team.
Minor	Results of the evaluation are used to improve the implementation and expand the use of the checklist.

REFERENCE MATERIAL

- De Vries, E.N., Prins, H.A., Crolla, R.M.P.N, et al (2010). Effect of a Comprehensive Surgical Safety System on Patient Outcomes. N.Engl.J.Med., 363,20,1928-37.
- Haynes, A.B., Weiser, T.G., Berry, W.R., Lipsitz, S.R., Breizat, A.H., Dellinger, E.P. et al. (2009). A surgical safety checklist to reduce morbidity and mortality in a global population. New England Journal of Medicine, 360, 491-499.
- Panesar, S.S., Cleary, K., Sheikh, A., & Donaldson, L. (2009). The WHO checklist: A global tool to prevent errors in surgery. Patient Safety in Surgery, 3, 9.
- Russ, S., S., Rout, S., S., Sevdalis, N., et al (2013). Do safety checklists improve teamwork and communication in the operating room? A systematic review. Ann.Surg., 258,6,856-71.
- Semel, M.E., Resch, S., Haynes, A.B., Funk, L.M., Bader, A., Berry, W.R. et al. (2010). Adopting a surgical safety checklist could save money and improve the quality of care in U.S. hospitals. Health Affairs, 29, 1593-1599.
- World Alliance for Patient Safety (2008). Implementation Manual: Surgical Safety Checklist.
- World Alliance for Patient Safety (2009). Surgical Safety Checklist.

ANTIMICROBIAL STEWARDSHIP

For the Medication Management standard.

There is an antimicrobial stewardship program to optimize antimicrobial use.

NOTE: This ROP applies to organizations providing the following services: inpatient acute care, inpatient cancer, inpatient rehabilitation, and complex continuing care.

GUIDELINES

The use of antimicrobial agents is a valuable health intervention, yet may result in unintended consequences including toxicity, the selection of pathogenic organisms, and the development of organisms resistant to antimicrobial agents. Antibiotic-resistant organisms have a substantial impact on the health and safety of clients and the resources of the health care system.

Antimicrobial stewardship is an activity that includes appropriate selection, dosing, route, and duration of antimicrobial therapy. The primary focus of an antimicrobial stewardship program is to optimize antimicrobial use to achieve the best patient outcomes, reduce the risk of infections, reduce or stabilize levels of antibiotic resistance, and promote patient safety.

Effective antimicrobial stewardship in combination with a comprehensive infection control program has been shownto limit the emergence and transmission of antimicrobial-resistant bacteria. Studies indicate that antimicrobial stewardship programs are cost-effective and provide savings through reduced drug costs and avoidance of microbial resistance.

A comprehensive, evidence-informed antimicrobial stewardship program may include a number of interventions. Organizations are encouraged to tailor an approach to antimicrobial stewardship that is consistent with their size, service environment, and patient population, and to establish processes for ongoing monitoring and improvement of the program. A successful antimicrobial stewardship program requires collaboration between the antimicrobial stewardship, pharmacy, and infection control teams. The support of hospital administrators, medical staff leadership, and health care providers is essential.

TESTS FOR COMPLIANCE

Major	An antimicrobial stewardship program has been implemented.
Major	The program specifies who is accountable for implementing the program.
Major	The program is interdisciplinary, involving pharmacists, infectious diseases physicians, infection control specialists, physicians, microbiology staff, nursing staff, hospital administrators, and information system specialists, as available and appropriate.
Major	The program includes interventions to optimize antimicrobial use, such as audit and feedback, a formulary of targeted antimicrobials and approved indications, education, antimicrobial order forms, guidelines and clinical pathways for antimicrobial utilization, strategies for streamlining or de-escalation of therapy, dose optimization, and parenteral to oral conversion of antimicrobials (where appropriate).
Minor	The program is evaluated on an ongoing basis and results are shared with stakeholders in the organization.

REFERENCE MATERIAL

- American Hospital Association (2014). Appropriate Use of Medical Resources: Antimicrobial Stewardship Toolkit.
- Canadian Antibiotic Awareness Partnership (2012). Antibiotic Awareness - Health Care Providers.
- Centers for Disease Control and Prevention (2010). Get Smart for Healthcare - Evidence to Support Stewardship.
- Coenen, S., Ferech, M., Haaijer-Ruskamp, F. M., Butler, C. C., Vander Stichele, R. H., Verheij, T. J. et al. (2007). European Surveillance of Antimicrobial Consumption (ESAC): quality indicators for outpatient antibiotic use in Europe. Qual.Saf Health Care, 16, 440-445.
- Del Arco, A., Tortajada, B., de la Torre, J., Olalla, J, Prada, J.L., Fernández, F., Rivas, F., Gracía-Alegría, J., Faus, V., & Montiel, N. (2014). The impact of an antimicrobial stewardship programme on the use of antimicrobials and the evolution of drug resistance. Eur J Clin Microbiol Infect Dis. (Aug).
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- Joint Commission Resources (2012). Antimicrobial Stewardship Toolkit.
- Morris, A. M., Brener, S., Dresser, L., Daneman, N., Dellit, T. H., Avdic, E. et al. (2012). Use of a structured panel process to define quality metrics for antimicrobial stewardship programs. Infect.Control Hosp.Epidemiol., 33, 500-506.
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CONCENTRATED ELECTROLYTES

For the following standards: Medication Management and Medication Management for Community-Based Organizations

The availability of concentrated electrolytes is evaluated and limited to ensure that formats with the potential to cause patient safety incidents are not stocked in client service areas.

GUIDELINES

Ensuring that concentrated electrolytes are not stocked in client service areas can minimize the risk of death or disabling injury associated with these agents. It is also recommended that the packaging of concentrated electrolytes is in line with their intended use.

For specific care circumstances, it may be necessary to have concentrated electrolytes available in select client service areas, for example:

- Calcium: pre-filled syringes (1 g in 10 mL) in emergency carts or boxes only
- Sodium chloride (concentrations greater than 0.9%): bags are segregated from non-medicated intravenous solutions in select areas (e.g., neurology, emergency departments, critical care)

In these cases, an interdisciplinary committee for medication management (e.g., Pharmacy and Therapeutics Committee and Medical Advisory Secretariat) reviews and approves the rationale for availability, and safeguards are put in place to minimize the risk of error.

TESTS FOR COMPLIANCE

Major — An audit of the following concentrated electrolytes in client service areas is completed at least annually:
- Calcium (all salts): concentrations greater than or equal to 10%
- Magnesium sulfate: concentrations greater than 20%
- Potassium (all salts): concentrations greater than or equal to 2 mmol/mL (2 mEq/mL)
- Sodium acetate and sodium phosphate: concentrations greater than or equal to 4 mmol/mL
- Sodium chloride: concentrations greater than 0.9%.

Major — Stocking the following concentrated electrolytes is avoided in client service areas:
- Calcium (all salts): concentrations greater than or equal to 10%
- Magnesium sulfate: concentrations greater than 20%
- Potassium (all salts): concentrations greater than or equal to 2 mmol/mL (2 mEq/mL)
- Sodium acetate and sodium phosphate: concentrations greater than or equal to 4 mmol/mL
- Sodium chloride: concentrations greater than 0.9%.

Major — When it is necessary to make concentrated electrolytes available in select client service areas, an interdisciplinary committee for medication management reviews and approves the rationale for availability, and safeguards are put in place to minimize the risk of error.

REFERENCE MATERIAL

- Hyland, S. & U, D. (2002). Medication Safety Alerts. Institute for Safe Medication Practices Canada.
- Institute for Healthcare Improvement (IHI) (2012). Adverse Drug Events Involving Electrolytes.
- Institute for Safe Medication Practices Canada (2001). Reported Error With Sodium Chloride 3% Reminds Us Of The Need For Added System Safeguards With This Product. ISMP Canada Safety Bulletin.
- Institute for Safe Medication Practices Canada (2003). More on Potassium Chloride. ISMP Canada Safety Bulletin.
- Institute for Safe Medication Practices Canada (2004). Concentrated Potassium Chloride - A Recurring Danger. ISMP Canada Safety Bulletin.
- Institute for Safe Medication Practices Canada (2006). Safety Strategies for Potassium Phosphates Injection. ISMP Canada Safety Bulletin.
- World Health Organization (2007). Control of Concentrated Electrolyte Solutions. World Health Organization.

HEPARIN SAFETY

For the following standards: Medication Management and Medication Management for Community-Based Organizations

The availability of heparin products is evaluated and limited to ensure that formats with the potential to cause patient safety incidents are not stocked in client service areas.

GUIDELINES

Heparin is a high-alert medication. Limiting its availability and ensuring that high-dose formats are not stocked in client service areas are effective strategies to minimize the risk of death or disabling injury associated with these agents.

For specific care circumstances, it may be necessary for heparin products to be available in select client service areas. In these cases, an interdisciplinary committee for medication management (e.g., Pharmacy and Therapeutics Committee and Medical Advisory Secretariat) reviews and approves the rationale for availability and safeguards are put in place to minimize the risk of error.

For flushing intravenous lines, organizations are encouraged to consult best practice guidelines to explore options other than heparin. Additional strategies to ensure the safe use of heparin may be found in the Accreditation Canada ROP about high-alert medications.

TESTS FOR COMPLIANCE

Major	An audit of unfractionated and low molecular weight heparin products in client service areas is completed at least annually.
Major	High dose unfractionated heparin (50,000 units total per container) is not stocked in client service areas.
Major	Steps are taken to limit the availability of the following heparin products in client service areas: • Low molecular weight heparin: use of multi-dose vials is limited to critical care areas for treatment doses. • Unfractionated heparin (high dose): greater than or equal to 10,000 units total per container (e.g., 10,000 units/1 mL; 10,000 units/10 mL; 30,000 units/30 mL) is provided on a client-specific basis when required. • Unfractionated heparin for intravenous use (e.g., 25,000 units/500 mL; 20,000 units/500 mL) is provided on a client-specific basis when required.
Major	When it is necessary for the previous heparin products to be available in select client service areas, an interdisciplinary committee for medication management reviews and approves the rationale for availability, and safeguards are put in place to minimize the risk of error.

REFERENCE MATERIAL

- Harder, K. A., Bloomfield, J. R., Sendelbach, S. E., Shepherd, M. F., Rush, P. S., Sinclair, J. S. et al. (2005). Improving the Safety of Heparin Administration by Implementing a Human Factors Process Analysis.
- Joint Commission on Accreditation of HealthCare Organizations. (2001). Patient Safety Alert: 'High-alert' medications and patient safety. International Journal for Quality in Health care. 13(4), 339-340.
- Institute for Healthcare Improvement. (2012). How-to Guide: Prevent Harm from High-Alert Medications.
- Institute for Safe Medication Practices Canada (2004). A Need to "Flush" Out High Concentration Heparin Products. ISMP Canada Safety Bulletin.
- Institute for Safe Medication Practices Canada (2005). Heparin Induced Thrombocytopenia - Effective Communication Can Prevent a Tragedy. ISMP Canada Safety Bulletin.
- Institute for Safe Medication Practices Canada (2008). Enhancing Safety with Unfractionated Heparin: A National and International Area of Focus. ISMP Canada Safety Bulletin.
- Institute for Safe Medication Practices - Canada (2008). Enhancing Safety with Unfractionated Heparin: A National and International Area of Focus. ISMP Canada Safety Bulletin.
- MacKinnon, N., Koczmara, C., & U, D. (2008). Medication Incidents Involving Heparin in Canada: "Flushing" Out the Problem. Institute for Safe Medication Practices Canada.
- Schneider, P. (2008). Improving Heparin Safety. CareFusion Center for Safety and Clinical Excellence.

HIGH-ALERT MEDICATIONS

For the following standards: EMS and Interfacility Transport, Independent Medical Surgical Facilities and Medication Management.

A documented and coordinated approach to safely manage high-alert medications is implemented.

GUIDELINES

High-alert medications may cause significant harm when they are administered in error. A coordinated and documented approach to safely manage high-alert medications enhances patient safety and reduces the possibility of harm. High-alert medications include but are not limited to antithrombotic agents, adrenergic agents, chemotherapy agents, concentrated electrolytes, insulin, narcotics (opioids), neuromuscular blocking agents, and sedation agents. The Institute for Safe Medication Practices (ISMP) has developed lists of high-alert medications for acute care and community/ambulatory settings.

A documented and coordinated approach to safely manage high-alert medications identifies them based on an organization's medication formulary and takes into consideration organizational, provincial, or national medication error data. Each high-alert medication or class of medication is evaluated, procedures to improve safe use are identified, and an action plan is established. Procedures for the safe use of high-alert medications may include but are not limited to:

- Standardizing high-alert medication concentrations and volume options
- Using pre-mixed solutions (commercially available and pharmacy prepared)
- Using programmable pumps with dosing limits and automated alerts
- Applying warning labels to products as soon as they are received in the pharmacy
- Using visible warning and auxiliary labels according to the organization's policy
- Using patient-specific labelling for unusual concentrations
- Limiting access to high-alert medications in client service areas and auditing routinely to assess for items that should be removed
- Standardizing the ordering, storage, preparation, administration, and dispensing of these products through the use of protocols, guidelines, dosing charts, and orders sets (pre-printed or electronic)
- Segregating and providing directed access to reduce the likelihood of selection errors (e.g., use of automated dispensing cabinets in client service areas)
- Providing training about high-alert medications
- Employing redundancies such as automated or independent double checks

The approach may place additional emphasis on strategies for high-risk client populations including the elderly, pediatrics, and neonates, as well as on transition points including admission, transfer, and discharge.

TESTS FOR COMPLIANCE

Major	There is a policy for the management of high-alert medications.
Minor	The policy names the role or position of individual(s) responsible for implementing and monitoring the policy.
Major	The policy includes a list of high-alert medications identified by the organization.
Major	The policy includes procedures for storing, prescribing, preparing, administering, dispensing, and documenting each identified high-alert medication.
Major	Concentrations and volume options for high-alert medications are limited and standardized.
Minor	Client service areas are regularly audited for high-alert medications.
Minor	The policy is updated on an ongoing basis.
Major	Information and ongoing training is provided to team members on the management of high-alert medications.

REFERENCE MATERIAL

- U, D. (2006) High-alert medications: the need for awareness and safeguards to prevent patient harm. Hospital News.
- Institute for Healthcare Improvement (IHI) (2012). High-Alert Medication Safety.
- Institute for Safe Medication Practices (ISMP) P) (2013). Your high-alert medication list – relatively useless without associated risk-reduction strategies. ISMP Medication Safety Alert – Acute Care. Institute for Safe Medication Practices. April 4.
- Institute for Safe Medication Practices (ISMP) (2012). List of High-Alert Medications.
- Institute for Safe Medication Practices (ISMP) (2011). ISMP List of High-Alert Medications in Community/Ambulatory Healthcare.

HIGH-ALERT MEDICATIONS – COMMUNITY ORGANIZATIONS

For the following standards: Community Pharmacy Services, and Medication Management for Community-Based Organizations

The organization implements a comprehensive strategy for the management of high-alert medications.

GUIDELINES

Implementing a comprehensive strategy for the management of high-alert medications is a valuable use of resources to enhance patient safety, and to reduce the possibility of serious harm.

The Institute for Safe Medication Practices has produced a list of high-alert medications specifically for community/ambulatory settings which can be found online. To prevent harm from medication errors, a policy for the management of high-alert medications is required. Strategies for the safe use of high-alert medications may include but are not limited to:

- Applying warning labels to products as soon as they are received in the pharmacy
- Using visible warning and auxiliary labels according to the organization's policy
- Providing training about high-alert medications
- Employing automated or independent double checks

A policy for the management of high-alert medications may place additional emphasis on strategies for high-risk client/resident populations including the elderly, paediatrics, and neonates. Organizations should systematically evaluate each high-alert medication or class of medications and establish an action plan to improve the safe use of these medications.

TESTS FOR COMPLIANCE

Major	There is a policy for the management of high-alert medications.
Minor	The policy names the role or position of individual(s) responsible for implementing and monitoring the policy.
Major	The policy includes a list of high-alert medications identified by the organization.
Major	The policy includes procedures for storing, prescribing, preparing, administering, dispensing, and documenting each identified high-alert medication.
Minor	The policy is updated on an ongoing basis.
Major	Information and ongoing training is provided to team members on the management of high-alert medications.

REFERENCE MATERIAL

- Institute for Healthcare Improvement (IHI) (2012). High-Alert Medication Safety.
- Institute for Safe Medication Practices (ISMP) (2012). List of High-Alert Medications.

INFUSION PUMP SAFETY

This ROP is found in most service-based sets of standards, see table on page 68.

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

GUIDELINES

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

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

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

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

TESTS FOR COMPLIANCE

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

Major — Initial and re-training on the safe use of infusion pumps is provided to team members:

- Who are new to the organization or temporary staff new to the service area
- Who are returning after an extended leave
- When a new type of infusion pump is introduced or when existing infusion pumps are upgraded
- When evaluation of competence indicates that re-training is neededWhen infusion pumps are used very infrequently, just-in-time training is provided.

Major — When clients are provided with client-operated infusion pumps (e.g., patient-controlled analgesia, insulin pumps), training is provided, and documented, to clients and families on how to use them safely.

Major — The competence of team members to use infusion pumps safely is evaluated and documented at least every two years. When infusion pumps are used very infrequently, a just-in-time evaluation of competence is performed.

Minor The effectiveness of the approach is evaluated. Evaluation mechanisms may include:

- Investigating patient safety incidents related to infusion pump use
- Reviewing data from smart pumps
- Monitoring evaluations of competence
- Seeking feedback from clients, families, and team members

Minor When evaluations of infusion pump safety indicate improvements are needed, training is improved or adjustments are made to infusion pumps.

REFERENCE MATERIAL

- Association for the Advancement of Medical Instrumentation (AAMI). 2010. Infusing Patients Safely: priority issues from the AAMI/FDA Infusion Device Summit. AAMI. Arlington, VA.
- ECRI Institute. (2014) Top 10 Health Technology Hazards for 2014. ECRI Institute. Plymouth Meeting, PA.
- Health Canada (2004). Health risks associated with use of INFUSION PUMPS - Notice to Hospitals. Health Canada.
- Institute for Safe Medication Practices (ISMP) (2009). Proceedings from the ISMP summit on the use of smart infusion pumps: guidelines for safe implementation and use.
- Institute for Safe Medication Practices - Canada (2003). Infusion Pumps – Opportunities for Improvement. ISMP Canada Safety Bulletin. ismp-
- Institute for Safe Medication Practices - Canada (2004). Infusion Pump Project: Survey Results and Time for Action. ISMP Canada Safety Bulletin. ismp-
- Medicines and Healthcare Products Regulatory Agency (MHRA). (2013). Infusion systems v2.1. MHAR. London, UK.
- Reston, J. (2013). Smart Pumps and Other Protocols for Infusion Pumps: Brief Review. In: Making Health Care Safer II: an updated critical analysis of the evidence for patient safety practices. Agency for Healthcare Research and Quality. AHRQ Evidence Report No. 211. Rockville, MD.
- Scroggs, J. (2008). Improving patient safety using clinical needs assessments in IV therapy. British Journal of Nursing, 17, S22-S28.
- Trbovich PL, Jeon J, Easty A. (2009) Smart Medication Delivery Systems: Infusion Pumps. University Health Network. Toronto, ON.

NARCOTICS SAFETY

For the following standards: EMS and Interfacility Transport, Independent Medical Surgical Facilities, Medication Management and Medication Management for Community-Based Organizations

The availability of narcotic products is evaluated and limited to ensure that formats with the potential to cause patient safety incidents are not stocked in client service areas.

GUIDELINES

Narcotics (or opioids) have been identified as high-alert medications. Limiting their availability and ensuring that high dose formats are not stocked in client service areas are effective strategies to minimize the risk of death or disabling injury associated with these agents.

For specific care circumstances, it may be necessary for narcotic products to be available in select client service areas, for example:

- Fentanyl: ampoules or vials with total dose greater than 100 mcg per container
- HYDROmorphone: 10 mg/mL ampoules or vials may be provided based on the following criteria and must be removed when no longer required: intermittent intravenous, subcutaneous or intramuscular doses greater than 4 mg

In these cases, an interdisciplinary committee for medication management (e.g., Pharmacy and Therapeutics Committee and Medical Advisory Secretariat) reviews and approves the rationale for availability and safeguards are put in place to minimize the risk of error.

Organizations serving pediatric populations are encouraged to implement recommendations from the Canadian Association of Paediatric Health Centres and the Institute for Safe Medication Practices Canada (ISMP Canada) Paediatric Opioid Safety Resource Kit, including the use of standardized concentrations for opioid infusions.

To optimize the safe use of narcotic products, organizations may also consider establishing a pain management team.

TESTS FOR COMPLIANCE

Major — An audit of the following narcotic products in client service areas is completed at least annually:
- Fentanyl: ampoules or vials with total dose greater than 100 mcg per container
- HYDROmorphone: ampoules or vials with total dose greater than 2 mg
- Morphine: ampoules or vials with total dose greater than 15 mg in adult care areas and 2 mg in paediatric care areas.

Major — Stocking the following narcotic products is avoided in client service areas:
- Fentanyl: ampoules or vials with total dose greater than 100 mcg per container
- HYDROmorphone: ampoules or vials with total dose greater than 2 mg
- Morphine: ampoules or vials with total dose greater than 15 mg in adult care areas and 2 mg in paediatric care areas.

Major — When it is necessary for narcotic (opioid) products to be available in select client service areas, an interdisciplinary committee for medication management reviews and approves the rationale for availability, and safeguards are put in place to minimize the risk of error.

REFERENCE MATERIAL

- Colquhoun, M., Koczmara, C., & Greenall, J. (2006). Implementing system safeguards to prevent error-induced injury with opioids (narcotics): an ISMP Canada collaborative. Healthc.Q., 9 Spec No, 36-42.
- Institute for Healthcare Improvement. (2012). High-alert medication safety.
- Institute for Healthcare Improvement. (2012). How-to Guide: Prevent Harm from High-Alert Medications. [On-line].
- Institute for Safe Medication Practices - Canada (2005). Narcotic (Opioid) Medication Safety Initiative. Institute for Safe Medication Practices - Canada.
- Institute for Safe Medication Practices Canada (2003).Safeguard Against Errors with Long-Acting Oral Narcotics. ISMP Canada Safety Bulletin.
- Institute for Safe Medication Practices - Canada (2012). A National Collaborative: Advancing Medication Safety in Paediatrics. Institute for Safe Medication Practices - Canada.
- Institute for Safe Medication Practices Canada (2013). Safeguards for HYDROmorphone–results of a targeted demonstration project. ISMP Canada Safety Bulletin. 13(10).
- The Joint Commission. (2012). Safe use of opioids in hospital. The Joint Commission Sentinel Event Alert. 49.

CLIENT FLOW

For the Leadership standard.

Client flow is improved throughout the organization and emergency department overcrowding is mitigated by working proactively with internal teams and teams from other sectors.

NOTE: This ROP only applies to organizations with an emergency department that can admit clients.

GUIDELINES

Emergency department (ED) overcrowding is a system-wide challenge. Its root cause is usually poor client flow (e.g., unavailability of inpatient beds, inappropriate admissions, delays in the decision to admit, delays in discharge, and lack of timely access to diagnostic services and care in the community) stemming from a mismatch between capacity and demand. By evaluating client flow data and considering all sources of demand (such as emergency and planned admissions, outpatient and follow-up care), organizations can understand the pattern of demand and develop strategies to meet variations in demand, reduce barriers to client flow, and prevent overcrowding. The approach should be aligned with existing provincial and territorial indicators and strategies.

The approach specifies the role of clinical and non-clinical teams within the hospital (e.g., medicine, surgery, infection control, diagnostics, housekeeping, admitting, discharge planning, and transportation) and across the health system (e.g., long-term care, home care, palliative care, rehabilitation, and primary care).

Possible interventions to address variations in demand and barriers to flow include developing clear criteria for admission, reducing the length of stay (especially for those with extended lengths of stay), improving access to ambulatory services (diagnostics, laboratory, and consults), improving discharge planning, and partnering with the community to improve placement times. To know whether the intervention(s) led to an improvement, organizations need to continue to analyze client flow.

Improving client flow requires strong leadership support. The accountability of senior leaders, including physicians, can be demonstrated through policy, through their specified roles and responsibilities, or through performance evaluation.

TESTS FOR COMPLIANCE

Major	The organization's leaders, including physicians, are held accountable for working proactively to improve client flow and mitigate emergency department overcrowding.
Major	Client flow data (e.g., length of stay, turnaround times for labs or imaging, community placement times, consultant response times) is used to identify variations in demand and barriers to delivering timely emergency department services.
Major	There is a documented and coordinated approach to improve client flow and address emergency department overcrowding.
Major	The approach specifies the role of teams within the hospital and other sectors of the health system to improve client flow.
Major	The approach specifies targets for improving client flow (e.g., time to transfer clients to an inpatient bed following a decision to admit, emergency department length of stay for non-admitted clients, transfer of care times from emergency medical services to the emergency department).
Major	Interventions to improve client flow that address identified barriers and variations in demand are implemented.

Major	When needed, short-term actions to manage overcrowding, that mitigate risks to client and team members (e.g., over-capacity protocols), are implemented.
Minor	Client flow data is used to measure whether the interventions prevent or reduce overcrowding in the emergency department, and improvements are made when needed.

REFERENCE MATERIAL:

- Canadian Association of Emergency Physicians (2013).Position Statement on Emergency Department Overcrowding and Access Block. Canadian Association of Emergency Physicians (CAEP). Ottawa, ON.
- Canadian Nurses Association (2009). Overcapacity protocols and capacity in Canada's health system. CAN Position Statement. Ottawa, ON.
- Guttmann, A., Schull, M.J., Vermeulen, M.J., Stukel,T.A. (2011) Association between waiting times and short term mortality and hospital admission after departure from emergency department: population based cohort study from Ontario, Canada. BMJ. 342:d2983.
- De Grood, J., Bota, M., Zwicker, K., et al (2012). Overview of interventions to mitigate emergency department overcrowding. In: Quality of care and safety of patients requiring access to emergency department care and cancer surgery and the role and process of physician advocacy. p247-321.Health Quality Council of Alberta. Edmonton, AB.
- Forero, R., Hillman, K. (2008) Access block and overcrowding: a literature review. Prepared for the Australasian College for Emergency Medicine. Simpson Centre for Health Services Research, South Western Sydney Clinical School, University of New South Wales. Sydney, Australia
- The Health Foundation (2013). Improving patient flow: How two trusts focused on flow to improve the quality of care and use available capacity effectively. The Health Foundation. London, UK.

PATIENT SAFETY: EDUCATION AND TRAINING

For the following standards: Independent Medical Surgical Facilities, Leadership, Leadership for Aboriginal Health Services, Leadership for Small Community-Based Organizations, and Medical Imaging Centres.

Patient safety training and education that addresses specific patient safety focus areas are provided at least annually to leaders, team members, and volunteers.

GUIDELINES

Annual education on patient safety is made available to the organization's leaders, team members, and volunteers. Specific patient safety focus areas such as safe medication use, reporting patient safety incidents, human factors training, techniques for effective communication, equipment and facility sterilization, hand washing and hand hygiene, and infection prevention and control are identified.

TESTS FOR COMPLIANCE

Major There is annual patient safety training tailored to the organization's needs and specific patient safety focus areas.

REFERENCE MATERIAL

- The Australian Council for Safety and Quality in Health Care (2005). The National Patient Safety Framework. Canberra, Australia: Commonwealth of Australia.
- Committee on the Health Professions Education Summit Board on Health Care Services IoM (2003). Health Professions Education: A Bridge to Quality. Washington, DC: National Academic Press.
- Frank JR, Brien S, (Editors) on behalf of The Safety Competencies Steering Committee. (2008). The Safety Competencies: Enhancing Patient Safety Across the Health Professions. Canadian Patient Safety Institute. Ottawa, ON.
- Haxby, E., Higton, P., & Jaggar, S. (2007). Patient safety training and education: who, what and how? Clinical Risk, 13, 211-215.
- McKeon, L.M., Cunningham, P.D., & Oswaks, J.S. (2009). Improving patient safety: patient-focused, high-reliability team training. Journal of Nursing Care Quality, 24, 76-82.
- Walton, M.M. & Elliott , S.L.(2006). Improving safety and quality: how can education help? Medical Journal of Australia, 184(10 Suppl), S60-S64.
- World Health Organization (2012). WHO Patient Safety Curriculum Guide.
- Yassi, A. & Hancock, T. (2005). Patient safety--worker safety: building a culture of safety to improve healthcare worker and patient well-being. Healthcare Quarterly, 8 Spec No, 32-38.

PATIENT SAFETY PLAN

For the following standards: Independent Medical Surgical Facilities, Leadership, Leadership for Aboriginal Health Services, Leadership for Small Community-Based Organizations, and Medical Imaging Centres.

A patient safety plan is developed and implemented for the organization.

GUIDELINES

There is an important connection between excellence in care and safety. Ensuring services are provided safely is one of an organization's primary obligations to clients and team members. Patient safety can be improved when organizations develop a targeted patient safety plan.

Patient safety plans need to consider safety issues in the organization, the delivery of services, and the needs of clients and families. They may include a range of topics and approaches, such as mentoring team members, the role of leadership (e.g., patient safety leadership walkabouts), implementing organization-wide patient safety initiatives, accessing evidence and best practices, and recognizing team members for innovations to improve patient safety.

TESTS FOR COMPLIANCE

Major	Patient safety issues for the organization are assessed.
Minor	There is a plan and process in place to address identified patient safety issues.
Major	The plan includes patient safety as a written strategic priority or goal.
Minor	Resources are allocated to support the implementation of the patient safety plan.

REFERENCE MATERIAL

- Botwinick L, Bisognano M, & Haraden C. (2006). Leadership Guide to Patient Safety. IHI Innovation Series White Paper.
- Canadian Patient Safety Institute (2012). Quality and Safety Plan.
- World Health Organization. (2008). World Alliance for Patient Safety Forward Program 2008-2009. Geneva, Switzerland.
- Zimmerman, R., Ip, I., Christoffersen, E., & Shaver, J. (2008). Developing a patient safety plan. Healthc.Q., 11, 26-30.

PREVENTIVE MAINTENANCE PROGRAM

For the following standards: Independent Medical Surgical Facilities, Leadership, Leadership for Aboriginal Health Services, Leadership for Small Community-Based Organizations, and Medical Imaging Centres.

A preventive maintenance program for medical devices, medical equipment, and medical technology is implemented.

GUIDELINES

An effective preventive maintenance program helps ensure medical devices, medical equipment, and medical technology are safe and functional. It also helps identify and address potential problems with medical devices, medical equipment, or medical technology that may result in injury to team members or clients.

TESTS FOR COMPLIANCE

Major	There is a preventive maintenance program for all medical devices, medical equipment, and medical technology.
Major	There are documented preventive maintenance reports.
Minor	There is a process to evaluate the effectiveness of the preventive maintenance program.
Major	There is documented follow up related to investigating incidents and problems involving medical devices, equipment, and technology.

REFERENCE MATERIAL

- Brewin, D. (2001). Effectively utilizing device maintenance data to optimize a medical device maintenance program. *Biomed.Instrum.Technol*. 35(6):383-90.
- Ridgway, M. (2001). Classifying medical devices according to their maintenance sensitivity: a practical, risk-based approach to PM program management. *Biomed.Instrum.Technol*., 35, 167-176.
- Taghipour, S., Banjevic, D., & Jardine, A. (2010). Prioritization of medical equipment for maintenance decisions. *J.Operational.Res.Soc.*, 1-22.

WORKPLACE VIOLENCE PREVENTION

For the following standards: Independent Medical Surgical Facilities, Leadership, Leadership for Aboriginal Health Services, and Leadership for Small Community-Based Organizations.

A documented and coordinated approach to prevent workplace violence is implemented.

GUIDELINES

Workplace violence is more common in health care settings than in many other workplaces, with one-quarter of all incidents of workplace violence occurring at health services organizations. It is an issue that affects staff and health providers across the health care continuum.

This ROP has adopted the modified International Labour Organization definition of workplace violence, as follows: "Incidents in which a person is threatened, abused or assaulted in circumstances related to their work, including allforms of harassment, bullying, intimidation, physical threats, or assaults, robbery or other intrusive behaviours. These behaviours could originate from customers or co-workers, at any level of the organization."

A strategy to prevent workplace violence should be in compliance with applicable provincial or territorial legislation, and is an important step to respond to the growing concern about violence in health care workplaces.

TESTS FOR COMPLIANCE

Major	There is a written workplace violence prevention policy.
Major	The policy is developed in consultation with team members and volunteers as appropriate.
Major	The policy names the individual(s) or position responsible for implementing and monitoring adherence to the policy.
Major	Risk assessments are conducted to ascertain the risk of workplace violence.
Minor	There are procedures for team members to confidentially report incidents of workplace violence.
Major	There are procedures to investigate and respond to incidents of workplace violence.
Minor	The organization's leaders review quarterly reports of incidents of workplace violence and use this information to improve safety, reduce incidents of violence, and improve the workplace violence prevention policy.
Minor	Information and training is provided to team members on the prevention of workplace violence.

REFERENCE MATERIAL

- Gacki-Smith, J., Juarez, A. M., Boyett, L., Homeyer, C., Robinson, L., & MacLean, S. L. (2010). Violence against nurses working in US emergency departments. *J.Healthc.Prot.Manage.*, 26, 81-99.
- Gates, D., Fitzwater, E., & Succop, P. (2005). Reducing assaults against nursing home caregivers. *Nurs.Res.*, 54, 119-127.
- Kling, R. N., Yassi, A., Smailes, E., Lovato, C. Y., & Koehoorn, M. (2009). Characterizing violence in health care in British Columbia. *J.Adv.Nurs.*, 65, 1655-1663.
- Nursing Health Services Research Unit (2008). A review and evaluation of workplace violence prevention programs in the health sector. Nursing Health Services Research Unit.
- Peek-Asa, C., Casteel, C., Allareddy, V., Nocera, M., Goldmacher, S., Ohagan, E. et al. (2009). Workplace violence prevention programs in psychiatric units and facilities. *Arch.Psychiatr.Nurs.*,23,166-176.

- Public Services Health and Safety Association (2010). Addressing Domestic Violence in the Workplace.
- Registered Nurses Association of Ontario (2009). Preventing and Managing Violence in the Workplace. Registered Nurses Association of Ontario.
- Worksafe BC (2000). Preventing violence in health care: Five steps to an effective program. Worksafe BC.

HAND-HYGIENE COMPLIANCE

For the following standards: Assisted Reproductive Technology Standards for Clinical Services, EMS and Interfacility Transport, Independent Medical/surgical Facilities, Infection Prevention and Control, Infection Prevention and Control for Aboriginal Substance Misuse Services, Infection Prevention and Control for Community-based Organizations, and Medical Imaging Centres.

Compliance with accepted hand-hygiene practices is measured.

GUIDELINES

Hand hygiene is considered the single most important way to reduce health care-associated infections, but compliance with accepted hand-hygiene practices is often poor. Measuring compliance with hand-hygiene practices allows organizations to improve education and training about hand hygiene, evaluate hand-hygiene resources, and benchmark compliance practices across the organization. Studies show that improving compliance with hand-hygiene practices decreases health care-associated infections.

Direct observation (audits) is the best method to measure compliance with hand-hygiene practices. This involves watching and recording the hand-hygiene behaviours of team members and observing the work environment. Observation can be done by a trained observer within an organization, by two or more health care professionals working together, or by clients and families in the organization or in the community. *Safer Healthcare Now!* offers a variety of tools for measuring hand-hygiene compliance in different settings. Ideally, direct observation measures compliance with all four of the moments for hand hygiene:

1. Before initial contact with the client or their environment
2. Before a clean/aseptic procedure
3. After body fluid exposure risk
4. After touching a client or their environment

Direct observation should be used by all organizations working out of a fixed location (i.e., clients come to them). Organizations that provide services in clients' homes and find that direct observation is not possible may consider alternative methods. As these alternatives are not as robust as direct observation, they should be used in combination (two or more) to give a more accurate picture of compliance with hand-hygiene practices.

TESTS FOR COMPLIANCE

Major — Compliance with accepted hand-hygiene practices is measured using direct observation (audit). For organizations that provide services in clients' homes, a combination of two or more alternative methods may be used, for example:

- Team members recording their own compliance with accepted hand-hygiene practices (self-audit)
- Measuring product use
- Questions on client satisfaction surveys that ask about team members' hand-hygiene compliance
- Measuring the quality of hand-hygiene techniques (e.g., through the use of ultraviolet gels or lotions)

Minor — Hand-hygiene compliance results are shared with team members and volunteers.

Minor — Hand-hygiene compliance results are used to make improvements to hand-hygiene practices.

REFERENCE MATERIAL

- Bryce, E. A., Scharf, S., Walker, M., & Walsh, A. (2007). The infection control audit: the standardized audit as a tool for change. *Am.J.Infect.Control*, 35, 271-283.
- Canada's Hand Hygiene Challenge (2012). Hand Hygiene Toolkit. Canada's Hand Hygiene Challenge.
- Eveillard, M., Hitoto, H., Raymond, F., Kouatchet, A., Dube, L., Guilloteau, V. et al. (2009). Measurement and interpretation of hand hygiene compliance rates: importance of monitoring entire care episodes. *J.Hosp.Infect*., 72, 211-217.
- Gould, D. J., Moralejo, D., Drey, N., & Chudleigh, J. H. (2010). Interventions to improve hand hygiene compliance in patient care. *Cochrane.Database.Syst.Rev*., CD005186.
- Howard, D. P., Williams, C., Sen, S., Shah, A., Daurka, J., Bird, R. et al. (2009). A simple effective clean practice protocol significantly improves hand decontamination and infection control measures in the acute surgical setting. *Infection*, 37, 34-38.
- Lederer, J. W., Jr., Best, D., & Hendrix, V. (2009). A comprehensive hand hygiene approach to reducing MRSA health care-associated infections. *Jt.Comm J.Qual.Patient Saf*, 35, 180-185.
- Stewardson, A.J., Allegranzi, B., Perneger, T.V., et al (2013). The Joint Commission (2009). Measuring Hand Hygiene Adherence: Overcoming the Challenges.
- The Joint Commission (2009). Measuring Hand Hygiene Adherence: Overcoming the Challenges.

HAND-HYGIENE EDUCATION AND TRAINING

For the following standards: Assisted Reproductive Technology Standards for Clinical Services, EMS and Interfacility Transport, Independent Medical/surgical Facilities, Infection Prevention and Control, Infection Prevention and Control for Aboriginal Substance Misuse Services, Infection Prevention and Control for Community-based Organizations, and Medical Imaging Centres.

Hand-hygiene education is provided to team members and volunteers.

GUIDELINES

Hand hygiene is critical to infection prevention and control programs, but adherence to accepted hand-hygiene protocols is often poor. It has been shown that the costs of health care-associated infections significantly exceed those related to implementing and monitoring hand-hygiene programs.

Training on hand hygiene is multimodal and addresses the importance of hand hygiene in preventing the transmission of microorganisms, factors that have been found to influence hand-hygiene behaviour, and proper hand-hygiene techniques. Training also includes recommendations about when to clean one's hands, based on the four moments for hand hygiene:

1. Before initial contact with the client or their environment
2. Before a clean/aseptic procedure
3. After body fluid exposure risk
4. After touching a client or their environment.

TESTS FOR COMPLIANCE

Major Team members and volunteers are provided with education about the hand-hygiene protocol.

REFERENCE MATERIAL

- Infection Prevention and Control Canada (2012). Information about Hand Hygiene. Community and Hospital Infection Control Association – Canada.
- Hilburn, J., Hammond, B. S., Fendler, E. J., & Groziak, P. A. (2003). Use of alcohol hand sanitizer as an infection control strategy in an acute care facility. Am.J.Infect.Control, 31, 109-116.
- Huber, M. A., Holton, R. H., & Terezhalmy, G. T. (2006). Cost analysis of hand hygiene using antimicrobial soap and water versus an alcohol-based hand rub. J.Contemp.Dent.Pract., 7, 37-45.
- Pittet, D., Sax, H., Hugonnet, S., & Harbarth, S. (2004). Cost implications of successful hand hygiene promotion. Infect.Control Hosp.Epidemiol., 25, 264-266.
- Stone, P. W., Hasan, S., Quiros, D., & Larson, E. L. (2007). Effect of guideline implementation on costs of hand hygiene.
- Nurs.Econ., 25, 279-284.
- World Health Organization (2009). WHO Guidelines on Hand Hygiene in Health Care. World Health Organization.
- World Health Organization (2012). Hand Hygiene in Outpatient and Home-based Care and Long-term Care Facilities. A Guide to the Application of the WHO Multimodal Hand Hygiene Improvement Strategy and the "My Five Moments for Hand Hygiene" Approach.

INFECTION RATES

For the following standards: Infection Prevention and Control, and Infection Prevention and Control for Community-Based Organizations.

Health care-associated infections are tracked, information is analyzed to identify outbreaks and trends, and this information is shared throughout the organization.

NOTE: This ROP only applies to locations that have beds and provide nursing care.

GUIDELINES

The health care-associated infections most common to the organization's services and client populations are identified and tracked. These could include Clostridium difficile (C. difficile), surgical site infections, seasonal influenza, noroviruses, urinary tract infections, and other reportable diseases and antibiotic-resistant organisms. Tracking methods for health care-associated infections may focus on a particular infection or service area or may be organization- or system-wide. They may include data analysis techniques to help detect previously unrecognized outbreaks. Tracking may include frequencies and changes in frequencies over time, associated mortality rates, and attributed costs.

Teams that are well informed about health care-associated infection rates are better equipped to prevent and manage them. The role or position responsible for receiving information about health care-associated infection rates is identified and a plan is established to regularly disseminate information (e.g., quarterly reports to all departments). In addition to team members, the governing body needs to be informed about health care-associated infection rates and associated infection prevention and control issues. This may be done directly through senior management or a medical advisory committee.

TESTS FOR COMPLIANCE

Major	Health care-associated infection rates are tracked.
Minor	Outbreaks are analyzed and recommendations are made to prevent recurrences.
Minor	Information about relevant health care-associated infections and recommendations from outbreak reviews are shared with team members, senior leadership, and the governing body.

REFERENCE MATERIAL

- Infection Prevention and Control Canada (2012). Surveillance and Statistics. Community and Hospital Infection Control Association – Canada.
- Humphreys, H. & Cunney, R. (2008). Performance indicators and the public reporting of healthcare-associated infection rates. *Clin.Microbiol.Infect*., 14, 892-894.
- Jarvis, W. R. (2003). Benchmarking for prevention: the Centers for Disease Control and Prevention's National Nosocomial Infections Surveillance (NNIS) system experience. *Infection*, 31 Suppl 2, 44-48.
- O'Neill, E. & Humphreys, H. (2009). Use of surveillance data for prevention of healthcare-associated infection: risk adjustment and reporting dilemmas. *Curr.Opin.Infect.Dis*., 22, 359-363.
- Public Health Agency of Canada (2012). The Canadian Nosocomial Infection Surveillance Program. Public Health Agency of Canada.

REPROCESSING

For the following standards: EMS and Interfacility Transport, Independent Medical/surgical Facilities, Infection Prevention and Control, Infection Prevention and Control for Community-based Organizations, and Medical Imaging Centres.

Processes for cleaning, disinfecting, and sterilizing medical devices and equipment are monitored and improvements are made when needed.

GUIDELINES

The processes for cleaning, disinfecting, and sterilizing are collectively known as reprocessing. Organizations reprocess equipment based on the Spaulding classification and according to manufacturers' instructions. Monitoring reprocessing helps to identify areas for improvement and reduce health care-associated infections. The effectiveness of cleaning and disinfection can be measured by monitoring: water quality and washer function, whether appropriate concentrations of disinfectants are available, and whether disinfectants are used according to manufacturers' instructions. The effectiveness of sterilization can be monitored by measuring organic residuals, ATP (adenosine triphosphate), and total viable count; and by using test strips to confirm that devices/equipment are sterilized. If the organization does not reprocess equipment, it has a process to ensure equipment has been appropriately reprocessed prior to use.

TESTS FOR COMPLIANCE

Major There is evidence that processes and systems for cleaning, disinfection, and sterilization are effective.

Minor Action has been taken to examine and improve processes for cleaning, disinfection, and sterilization where indicated.

REFERENCE MATERIAL

- Ontario Agency for Health Protection and Promotion (Public Health Ontario) (2013). Provincial Infectious Diseases Advisory Committee. Best practices for cleaning, disinfection and sterilization of medical equipment/devices. 3rd ed.
- Rutala, W. A. & Weber, D. J. (2011). Sterilization, high-level disinfection, and environmental cleaning. *Infect.Dis.Clin North Am.*, 25, 45-76.

FALLS PREVENTION AND INJURY REDUCTION

Inpatient Services

For the following standards: Acquired Brain Injury Services, Cancer Care Services, Critical Care Services, Hospice, Palliative, End-of-Life Services, Inpatient Services, Mental Health Services, Obstetric Services, Organ and Tissue Transplant, Perioperative Services and Invasive Procedures, Rehabilitation Services, Spinal Cord Injury Acute Services, and Spinal Cord Injury Rehabilitation Services.

To prevent falls and reduce the risk of injuries from falling, universal precautions are implemented, education and information are provided, and activities are evaluated.

GUIDELINES

Clients admitted to hospital are at greater risk of falling and injuring themselves as they find themselves in an unfamiliar environment while also adjusting to a change in their physical or cognitive functioning (Stephenson et al., 2016). Reducing injuries from falls can increase quality of life, prevent loss of mobility and pain for clients, and reduce length of stay and costs.

Effective fall prevention and injury reduction requires an interdisciplinary approach and support from all levels of an organization. It is helpful to implement a coordinated approach to fall prevention and injury reduction within the organization, while recognizing the unique needs across different services, and to designate individuals to facilitate its implementation.

Organizations should identify and adopt precautions for all clients, regardless of risk of falling. The acronym S.A.F.E. (Safe environment; Assist with mobility; Fall-risk reduction; and Engage client and family) describes the key strategies for universal fall precautions. The Institute for Clinical Systems Improvement guideline (2012) also recommends the following universal interventions: familiarize the client to the environment; keep call buttons within reach at all times and observe clients demonstrate their use; keep clients' personal possessions within reach; have sturdy handrails in bathrooms, rooms, and hallways; keep the bed in low position with brakes locked; provide non slip, well-fitting footwear to clients; use night lights or supplemental lighting; keep floor surfaces clean and dry; clean up all spills promptly; keep care areas uncluttered. It is important to identify precautions that align with the clinical setting and needs of clients in that setting.

Education about the importance of fall prevention and injury reduction, universal precautions and strategies to prevent falls and reduce injuries from falling is provided regularly to team members and volunteers. Clients, families, and caregivers are provided with easy to understand information that empowers them to play an active role in fall reduction and injury prevention.

It is important to regularly evaluate whether or not current precautions to prevent falls and reduce injuries from falling are having the desired impact and are meeting client, family, and team member needs. Effectiveness can be evaluated through a variety of means, whether informal discussions, interviews, surveys, audits, or evaluation processes. Measurement for improvement initiatives and post-fall debriefings may also help identify safety gaps and prevent the recurrence of falls or reduce injuries from falling.

TESTS FOR COMPLIANCE

Major	Universal fall precautions, applicable to the setting, are identified and implemented to ensure a safe environment that prevents falls and reduces the risk of injuries from falling.
Major	Team members and volunteers are educated, and clients, families, and caregivers are provided with information to prevent falls and reduce injuries from falling.
Minor	The effectiveness of fall prevention and injury reduction precautions and education/information are evaluated, and results are used to make improvements when needed.

REFERENCE MATERIAL

- Beard, J., Rowll, D., Scott, D., van Beurden, E., Barnett, L., Hughes, K. & Newman, B. (2006). Economic analysis of a community-based falls prevention program. Public Health, 120, 742-751.
- Cusimano, M. D., Kwok, J. & Spadafora, K. (2008). Effectiveness of multifaceted fall-prevention programs for the elderly in residential care. Injury Prevention, 14, 113-122.
- Local Health Integration Network Collaborative (2011). Integrated Provincial Falls Prevention Framework & Toolkit. Local Health Integration Network Collaborative. http://c.ymcdn.com/sites/www.alphaweb.org/resource/collection/822ec60d-0d03-413e-b590-afe1aa8620a9/LHIN_report_IntegratedProvincialFallsPreventionFrameworkToolkit_07-07-2011.pdf
- National Center for Injury Prevention and Control (2015). Preventing Falls: A Guide to Implementing Effective Community-based Fall Prevention Programs. 2nd ed. Centers for Disease Control and Prevention. Atlanta, GA. http://www.cdc.gov/homeandrecreationalsafety/falls/programs.html
- Oliver, D., Killick, S., Even, T., & Willmott, M. (2008). Do falls and falls-injuries in hospital indicate negligent care -- and how big is the risk? A retrospective analysis of the NHS Litigation Authority Database of clinical negligence claims, resulting from falls in hospitals in England 1995 to 2006. Quality & Safety in Health Care, 17, 431-436.
- World Health Organization (2007). WHO Global Report on Falls Prevention in Older Age. Retrieved from: www.who.int/ageing/projects/falls_prevention_older-age/

FALLS PREVENTION AND INJURY REDUCTION

Long-Term Care Services

For the Long-Term Care Services standard.

To prevent falls and reduce the risk of injuries from falling, a risk assessment is conducted for each resident and interventions are implemented.

GUIDELINES

Reducing falls and injuries from falls can increase quality of life, prevent loss of mobility and pain for residents, and reduce costs.

Effective fall prevention and injury reduction requires an interdisciplinary approach and support from all levels of an organization. It is helpful to implement a coordinated approach to fall prevention and injury reduction within the organization, while recognizing the unique needs of different settings or sites, and to designate individuals to facilitate its implementation.

A wide range of risk assessment tools are available to identify specific risk profiles of residents in order to create individualized targeted fall prevention plans. Examples of risk assessment tools appropriate for long-term care include:

- Area Ellipse of Postural Sway
- Berg Balance Test
- Mobility Fall Chart

Common serious injuries that occur as a result of a fall in the elderly are hip fractures (Fuller, 2000). Recommendations for preventing fracture in long-term care can include vitamin D supplementation, use of hip protectors, exercise, multifactorial interventions, and pharmacologic therapies (Papaioannou et al., 2015).

It is important to identify and adopt assessment tools and interventions that align with the type of clinical setting and individual needs of residents, including their right to live at risk.

Education about the risk assessment, protocol, and procedures to prevent falls and reduce injuries from falling is provided regularly to team members and volunteers. Residents, families, and caregivers are provided with easy to understand information that empowers them to play an active role in fall prevention and injury reduction.

It is important to regularly evaluate whether or not current activities to prevent falls and reduce injuries from falling are having the desired impact and are meeting resident, family, and team member needs. Effectiveness can be evaluated through a variety of means, whether informal discussions, interviews, surveys, or audits. Measurement for improvement initiatives and post-fall debriefings may also help identify safety gaps and to prevent the recurrence of falls or reduce injuries from falling.

TESTS FOR COMPLIANCE

Major	An initial fall prevention and injury reduction risk assessment is conducted for residents upon admission, using a standardized tool.
Major	A standardized process is followed to reassess residents at regular intervals and when there is a significant change in their health status.
Major	Protocols and procedures (based on best practice guidelines when available and applicable to the setting) are implemented to prevent falls and reduce injuries from falling.
Major	Interventions to prevent falls and reduce injuries from falling are documented in the resident record and communicated to the team.
Major	Team members and volunteers are educated, and residents, families, and caregivers are provided with information to prevent falls and reduce injuries from falling.
Minor	The effectiveness of fall prevention and injury reduction activities (e.g., risk assessment process and tools, protocols and procedures, documentation, education, and information) are evaluated, and results are used to make improvements when needed.

REFERENCE MATERIAL

- Beard, J., Rowell, D., Scott, D., van Beurden, E., Barnett, L., Hughes, K. & Newman, B. (2006). Economic analysis of a community- based falls prevention program. Public Health, 120, 742-751.
- Cusimano, M. D., Kwok, J. & Spadafora, K. (2008). Effectiveness of multifaceted fall-prevention programs for the elderly in residential care. Injury Prevention, 14, 113-122.
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- RNAO's Long-Term Care Best Practices Initiative Team. (2015). Resources for long-term care homes: Falls and injury prevention. Registered Nurses Association of Ontario. Toronto, ON. rnao.ca/bpg/guidelines/prevention-falls-and-fall-injuries-older-adult
- World Health Organization (2007). WHO Global Report on Falls Prevention in Older Age Retrieved from: www.who.int/ageing/projects/falls_prevention_older_age/

HOME SAFETY RISK ASSESSMENT

For the following standards: Home Care Services and Home Support Services.

A safety risk assessment is conducted for clients receiving services in their homes.

GUIDELINES

Health services provided in a client's home present challenges for clients, families, and team members. Some of these include the unique characteristics of each client's home, the intermittent presence of team members, and the role played by families or caregivers in providing health services.

While home care agencies may have little direct control over risks in a client's home environment, a home safety risk assessment can enhance the safety of clients, families, and team members involved in home health services. Assessment results can be used to select priority service areas, identify safety strategies to include in service plans, and communicate with clients, families, caregivers, and partner organizations.

TESTS FOR COMPLIANCE

Major	A home safety risk assessment is conducted for each client at the beginning of service.
Major	The home safety risk assessment includes a review of internal and external physical environments; chemical, biological, fire and falls hazards; medical conditions requiring special precautions; client risk factors; and emergency preparedness.
Major	Information from the home safety risk assessment is used when planning and delivering client services, and shared with partners who may be involved in care planning.
Minor	The home safety risk assessment is regularly updated and used to improve services provided to the client.
Minor	Clients and families are educated on home safety issues identified in the risk assessment.

REFERENCE MATERIAL

- Doran, D. M., Hirdes, J., Blais, R., Ross, B. G., Pickard, J., & Jantzi, M. (2009). The nature of safety problems among Canadian homecare clients: evidence from the RAI-HC reporting system. J.Nurs.Manag., 17, 165-174.
- European Agency for Safety and Health at Work. (2008). Risk Assessment for Care Workers: E-Facts 35. (Sept). Bilbao, Spain.
- Lang, A., Edwards, N., & Fleiszer, A. (2008). Safety in home care: a broadened perspective of patient safety. Int.J.Qual.Health Care, 20, 130-135.
- Public Services Health and Safety Association (2009). Assessing Violence in the Community: A Handbook for the Workplace.
- Public Services Health and Safety Association (2010). Tips for Guarding Your Personal Safety on Home Visits.

PRESSURE ULCER PREVENTION

For the following standards: Cancer Care, Critical Care, Hospice, Palliative, and End-of-Life Services, Long-term Care Services, Inpatient Services, Perioperative Services and Invasive Procedures, Rehabilitation Services, Spinal Cord Injury Acute Services, and Spinal Cord Injury Rehabilitation Services.

Each client's risk for developing a pressure ulcer is assessed and interventions to prevent pressure ulcers are implemented.

NOTE: This ROP does not apply for outpatient settings, including day surgery, given the lack of validated risk assessment tools for outpatient settings.

GUIDELINES

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

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

Effective pressure ulcer prevention starts with a validated risk assessment scale, such as:

- The Braden Scale for Predicting Pressure Sore Risk
- The Norton Pressure Sore Risk Assessment Scale
- interRAI Pressure Ulcer Risk Scale (long-term care)
- The Waterlow Score
- The Gosnell Scale
- The Knoll Scale
- SCIPUS (Spinal Cord Injury Pressure Ulcer Scale)

A number of best practice guidelines are also available to inform the development of pressure ulcer prevention and treatment strategies, including risk assessments, reassessments, interventions, education, and evaluation.

TESTS FOR COMPLIANCE

Major	An initial pressure ulcer risk assessment is conducted for clients upon admission, using a validated, standardized risk assessment tool.
Major	The risk of developing pressure ulcers is assessed for each client at regular intervals and when there is a significant change in the client's status.
Major	Documented protocols and procedures based on best practice guidelines are implemented to prevent the development of pressure ulcers. These may include interventions to prevent skin breakdown; minimize pressure, shear, and friction; reposition; manage moisture; optimize nutrition and hydration; and enhance mobility and activity.
Minor	Team members, clients, families, and caregivers are provided with education about the risk factors and protocols and

procedures to prevent pressure ulcers.

Minor The effectiveness of pressure ulcer prevention is evaluated, and results are used to make improvements when needed.

REFERENCE MATERIAL

- European Pressure Ulcer Advisory Panel and the American National Pressure Ulcer Advisory Panel (2009). Pressure Ulcer Prevention.
- Institute for Healthcare Improvement (2012). Prevent Pressure Ulcers.
- Perry, D., Borchert, K., Burke, S., et al. .(2012) Pressure Ulcer Prevention and Treatment Protocol. Institute for Clinical Systems Improvement. Bloomington, MN.
- Royal College of Nursing (2001). Pressure ulcer risk assessment and prevention.
- Woodbury, M. G. & Houghton, P. E. (2004). Prevalence of pressure ulcers in Canadian healthcare settings. *Ostomy.Wound.Manage*., 50, 22-28.

SKIN AND WOUND CARE

For the Home Care Services standard.

An interprofessional and collaborative approach is used to assess clients who need skin and wound care and provide evidence-informed care that promotes healing and reduces morbidity and mortality.

GUIDELINES

Wound healing is a complex process that depends on the client (e.g., co-morbidities, age, nutritional status, etc.), the type of skin and wound, the client's environment (e.g., cleanliness, social support, mobility aids, etc.), and what type of care is provided. Many wounds can be prevented through proper skin care and preventive measures.

Once they have occurred, most wounds can be healed through proper assessment, accurate diagnosis, appropriate treatment, and proper self-care. Appropriate care can reduce client suffering (e.g., intractable pain, infection, amputation, hospital admission, reduced quality of life) and save lives. Clients who need skin and wound care are a high-volume service (more than one-third of all home care clients need wound care) and wounds cost the Canadian health care system $3.9 billion dollars annually (or 3 percent of total health care expenditures). Effective skin and wound care programs result in better client outcomes and lower costs.

Comprehensive interprofessional collaboration using standardized, evidence-informed protocols is the most effective way to provide skin and wound care. A wide range of expertise is needed, and interprofessional collaboration can be achieved in different ways (e.g., interdisciplinary teams, rounds, virtual networks, telehealth). It is important to identify when and how care providers can access expertise to ensure accurate diagnosis of the wound(s) and seamless skin and wound care. To support interprofessional collaboration, the team, clients, families and caregivers need information and education that is tailored to their roles in providing appropriate care.

Effective skin and wound care starts with a comprehensive assessment to obtain an accurate diagnosis of the wound. It includes assessing the client's skin and wound and reviewing client factors, the client's environment, and the care the client has already received. Canadian evidence-informed best practice guidelines for skin and wound care are available (e.g., Canadian Association for Wound Care, Registered Nurses Association of Ontario). Adopting guidelines helps organizations strengthen the skin and wound care they provide through proper assessment, accurate diagnosis, appropriate products and treatments, appropriate interdisciplinary referrals, and ongoing monitoring. Given the plethora of wound care products available, care is strengthened when organizations have a standardized product list that includes criteria for use. A standardized approach for accurate and comprehensive documentation of all aspects of care is needed for professionals to communicate effectively.

Giving providers timely access to information about wounds has been shown to dramatically improve client outcomes and healing time, so organizations need a process to share complete information as the client moves between providers and services. Indicator data related to care processes and client outcomes can help evaluate the effectiveness of the approach to skin and wound care. Possible indicators include home care data (e.g., length of stay, wound dimensions, number of visits)

TESTS FOR COMPLIANCE

Major	There is a documented and coordinated approach to skin and wound care that supports physicians, nurses, and allied health care providers to work collaboratively and provides access to the range of expertise that is appropriate for the client population.
Major	Team members have access to education on appropriate skin and wound care, including products and technologies, assessment, treatment, and documentation.
Major	Clients, families, and caregivers are provided with information and education about skin and wound self-care, in a format that they can understand.
Major	An evidence-informed assessment of new clients is used to determine or confirm the diagnosis of the wound and develop an individualized care plan that addresses the cause(s) of the wound.
Major	Standardized skin and wound care that optimizes skin health and promotes healing is delivered.
Major	Standardized documentation is implemented to create a comprehensive record of all aspects of the client's skin and wound care (including assessment, treatment goals, treatment provided, and outcomes).
Major	There is a process to share information between providers, especially at care transitions, about the client's skin and wound care.
Minor	The effectiveness of the skin and wound care program is monitored by measuring care processes (e.g., accurate diagnosis, appropriate treatment, etc.) and outcomes (e.g., healing time, pain, etc.) and this information is used to make improvements.

REFERENCE MATERIAL:

- Best Practice Recommendations. Canadian Association of Wound Care. Toronto, ON.
- Best Practice Guidelines. Registered Nurses Association of Ontario; Toronto, ON.
- Bolton, L., McNees, P., van Rijswijk, L., et al (2004). Wound-healing outcomes using standardized assessment and care in clinical practice. J.Wound.Ostomy.Continence.Nurs. 31(2):65-71.
- Canadian Home Care Association (2012). An ehealth evidence-based approach to wound care: target, measure, report and improve equals enhanced client outcomes and cost savings. High Impact Practices.
- Canadian Institute for Health Information (2013). Compromised Wounds in Canada. Analysis in Brief. f. Canadian Institute for Health Information.
- Harris, C., Shannon, R (2008). An innovative enterostomal therapy nurse model of community wound care delivery: a retrospective cost-effectiveness analysis. J.Wound.Ostomy.Continence.Nurs. 35(2):169-83.
- Lareforet, K., Allen, J.O., McIssac, C. (2012) Evidence-based wound care: home care perspective. Canadian Home Care Association; Mississauga, ON.
- Medical Advisory Secretariat. (2009) Community-based care for chronic wound management: an evidence-based analysis. Ontario Health Technology Assessment Series; 9(18).
- Wound Care Alliance Canada. (2012) Wounds: National Stakeholder Round-table. Report of the June 27 2012 Meeting.

SUICIDE PREVENTION

For the following standards: Aboriginal Community Health and Wellness Services, Aboriginal Integrated Primary Care Services, Aboriginal Substance Misuse Services , Child , Youth and Family Services, Community-Based Mental Health Services and Supports, Correctional Service of Canada Health Services, Emergency Department, Long-Term Care, Mental Health Services, Provincial Correctional Health Services, Remote/Isolated Health Services, Residential Homes for Seniors, and Substance Abuse and Problem Gambling.

Clients are assessed and monitored for risk of suicide.

GUIDELINES

Suicide is a global health concern. Every year more than 800,000 people die by suicide, according to the World Health Organization. Many of these deaths could be prevented by early recognition of the signs of suicidal thinking and offering appropriate intervention.

TESTS FOR COMPLIANCE

Major	Clients at risk of suicide are identified.
Major	The risk of suicide for each client is assessed at regular intervals or as needs change.
Major	The immediate safety needs of clients identified as being at risk of suicide are addressed.
Major	Treatment and monitoring strategies are identified for clients assessed as being at risk of suicide.
Major	Implementation of the treatment and monitoring strategies is documented in the client record.

REFERENCE MATERIAL

- Health Canada (2009). Suicide Prevention. Health Canada.
- Lynch, M. A., Howard, P. B., El-Mallakh, P., & Matthews, J. M. (2008). Assessment and management of hospitalized suicidal patients. J.Psychosoc.Nurs.Ment.Health Serv., 46, 45-52.
- Steele, M. M. & Doey, T. (2007). Suicidal behaviour in children and adolescents. Part 2: treatment and prevention. Can.J.Psychiatry, 52, 35S-45S.
- Suicide Prevention Resource Center. (2015). The Role of Senior Living Community Professionals in Preventing Suicide. Suicide Prevention Resource Center. Washinton, DC.
- World Health Organization (2012). Preventing Suicide: A Resource Series. World Health Organization
- World Health Organization. (2014). Preventing Suicide: A Global Imperative. Geneva, Switzerland.

VENOUS THROMBOEMBOLISM PROPHYLAXIS

For the following standards: Cancer Care, Critical Care, Inpatient Services, Organ and Tissue Transplant, Organ Donation for Living Donors, Perioperative Services and Invasive Procedures, Spinal Cord Injury Acute Services, and Spinal Cord Injury Rehabilitation Services.

Medical and surgical clients at risk of venous thromboembolism (deep vein thrombosis and pulmonary embolism) are identified and provided with appropriate thromboprophylaxis.

NOTE: This ROP does not apply for pediatric hospitals; it only applies to clients 18 years of age or older**.**
This ROP does not apply to day procedures or procedures with only an overnight stay.

GUIDELINES

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

VTE isa serious and common complication for those in hospital or undergoing surgery. The incidence of VTE can be reduced or prevented by identifying clients at risk and providing appropriate, evidence-informed thromboprophylaxis.

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

There are many evidence-based clinical practice guidelines that recommend thromboprophylaxis for large groups of clients (e.g. the American College of Chest Physicians Evidence-Based Clinical Practice Guidelines, 9th edition) or for specific subgroups (e.g. American Society of Clinical Oncology, Society of Obstetricians and Gynaecologistsof Canada). These guidelines are very useful resources and generally reflect the accepted standard of practice.

TESTS FOR COMPLIANCE

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

REFERENCE MATERIAL

- Geerts, W. (2009). Prevention of venous thromboembolism: a key patient safety priority. Journal of Thrombosis and Haemostasis, 7 Suppl 1, 1-8.
- Geerts, W. H., Bergqvist, D., Pineo, G. F., Heit, J. A., Samama, C. M., Lassen, M. R. et al. (2008). Prevention of venous thromboembolism: American College of Chest Physicians Evidence-Based Clinical Practice Guidelines (8th MacDougall, D.A., Feliu, A.L., Boccuzzi, S.J., & Lin, J. (2006). Economic burden of deep-vein thrombosis, pulmonary embolism, and post-thrombotic syndrome. American Journal of Health-System Pharmacy, 63, S5-15.
- Kahn, S.R., Lim, W., Dunn, A.S., et al. (2012) Prevention of VTE in nonsurgical patients: antithrombotic therapy and prevention of thrombosis, 9th ed: American College of Chest Physicians Evidence-Based Clinical Practice Guidelines. *Chest*. 141(Suppl):e195S-e226S.
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- Qaseem, A., Chou, R., Humphrey, L.L., et al. (2011). Venous thromboembolism prophylaxis in hospitalized patients: a clinical practice guideline from the American College of Physicians. Ann.Intern.Med. 155(9);625-32.
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- Stein, J., Maynard, G. Preventing Hospital-Acquired Venous-Thromboembolism: A Guide for Effective Quality Improvement, Version 3.3. Prepared by the Society of Hospital Medicine..Agency for Healthcare Research and Quality. Rockville, MD.
- Thirugnanam, S., Pinto, R., Cook, D.J., Geerts, W.H., Fowler, R.A.. (2012) Economic analyses of venous thromboembolism prevention strategies in hospitalized patients: a systematic review. Critical.Care. 16:R43.
- Zeidan, A.M., Streiff, ff, ff, M.B., .B., Lau, u, B. B. D, et al. (2013) Impact of venous thromboembolism prophylaxis “smart order set”: improved compliance, fewer events. Am.J. Hematol.88:545-549.

ROPS FOUND IN MOST SERVICE-BASED SETS OF STANDARDS

Name of Standards	Client identification	Information transfer at care transitions	Infusion pump safety
Aboriginal Community Health and Wellness Services			
Aboriginal Integrated Primary Care Services	✓	✓	
Aboriginal Substance Misuse Services		✓	
Acquired Brain Injury Services	✓	✓	
Ambulatory Care Services	✓	✓	✓
Assisted Reproductive Technology for Clinical Services	✓	✓	✓
Biomedical Laboratory Services	✓		
Cancer Care Services	✓	✓	✓
Case Management Services		✓	
Child, Youth and Family Services			✓
Community-Based Mental Health Services and Supports		✓	
Correctional Service of Canada Health Services	✓	✓	✓
Critical Care Services	✓	✓	✓
Dental Services	✓	✓	
Diagnostic Imaging Services	✓		
Emergency Department	✓	✓	✓
EMS and Interfacility Transport	✓	✓	✓
Home Care Services	✓	✓	✓
Home Support Services	✓	✓	
Hospice Palliative and End-of-Life Services	✓	✓	✓
Independent Medical/Surgical Facilities	✓		✓
Inpatient Services	✓	✓	✓
Intellectual and Developmental Disabilities		✓	✓
Long-term Care Services	✓	✓	✓
Medical Imaging Centres	✓		
Mental Health Services	✓	✓	✓
Obstetrics Services	✓	✓	✓
Organ and Tissue Transplant	✓	✓	✓
Organ Donation for Living Donors	✓	✓	✓
Perioperative Services and Invasive Procedures	✓	✓	✓
Point-of-Care Testing	✓		
Provincial Correctional Health Services	✓	✓	✓
Rehabilitation Services	✓	✓	✓
Remote/Isolated Health Services	✓	✓	✓
Residential Homes for Seniors		✓	
Spinal Cord Injury Acute Services	✓	✓	✓
Spinal Cord Injury Rehabilitation Services	✓	✓	✓
Substance Abuse and Problem Gambling Services	✓	✓	
Transfusion Services	✓		

ROP DEVELOPMENT OVER THE YEARS

(Pre–Qmentum)

- Adverse events disclosure
- Adverse events reporting
- Client and family role in safety
- Patient safety as a strategic priority
- Concentrated electrolytes
- Hand-hygiene education and training
- Infection control guidelines
- Infection rates
- Information transfer
- Infusion pumps training
- Medication concentrations
- Medication reconciliation (admission)
- Medication reconciliation (transfer or discharge)
- Patient safety plan
- Patient safety quarterly reports
- Patient safety related prospective analysis
- Patient safety: Education and training
- Patient safety: Roles and responsibilities
- Preventive maintenance
- Sterilization processes
- Verification processes for high-risk activities

2008 (Qmentum)

- Falls prevention
- Influenza vaccine
- Pneumococcal vaccine
- Two client identifiers

2009

- Dangerous abbreviations
- Hand-hygiene audit
- Heparin safety
- Narcotics safety
- Pressure ulcer prevention (for long-term care)
- Suicide prevention

2010

- Medication reconciliation as an organizational priority

2011

- Home safety risk assessment
- Safe surgery checklist
- Venous thromboembolism prophylaxis
- Workplace violence prevention

2012

No changes

2013

New ROPs

- Antimicrobial stewardship (for acute care)

2014

New ROPs

- Antimicrobial stewardship (for inpatient rehabilitation, cancer care, complex continuing care)

Major revisions

- Medication reconciliation ROPs
- Medication use ROPs: Concentrated electrolytes, Heparin safety, High-alert medications (formerly Medication concentrations), Narcotics safety

2015

New ROPs

- Accountability for quality
- Client flow
- Skin and wound care

Major revisions

- Infection Control ROPs: Hand-hygiene education and training, Hand-hygiene compliance (formerly Hand-hygiene audit)

2016

Major revisions

- Information transfer at care transitions
- Infusion pump safety (formerly Infusion pumps training)
- Patient safety incident disclosure (formerly Adverse event disclosure)
- Patient safety incident management (formerly Adverse event reporting)

Removed

- Client and family role in safety (program-wide focus on client- and family-centred care)

2017

Transitioned to high-priority criteria

- Patient safety-related prospective analysis
- Pneumococcal vaccine

2019

Major revisions

- Medication Reconciliation as a Strategic Priority
- Medication Reconciliation at Care Transitions
- Falls Prevention and Injury Reduction

2020

No changes

- Pressure ulcer prevention (added to six acute care standards sets)

Transitioned to high-priority criteria

- Patient safety as a strategic priority (integrated into the Client safety plan ROP)
- Patient safety: Roles and responsibilities
- Infection control guidelines
- Influenza vaccine
- Verification processes

ROPs are listed according to the year that on-site evaluation begins. Typically, ROPs are released one year prior to being evaluated during on-site surveys.

ROPs in the Standards

Patient Safety Area	ROP	Standards
Safety Culture	*Accountability for quality*	▪ Governance for Health Services ▪ Governance for Aboriginal Health Services
	Patient safety incident management	▪ Diagnostic Imaging Services ▪ Independent Medical/ Surgical Facilities ▪ Leadership ▪ Leadership for Aboriginal Health Services ▪ Medical Imaging Centres
	Patient safety quarterly reports	▪ Independent Medical/ Surgical Facilities ▪ Leadership for Aboriginal Health Services
	Patient safety incident disclosure	▪ Independent Medical/ Surgical Facilities ▪ Leadership ▪ Leadership for Aboriginal Health Services ▪ Leadership for Small Community-Based Organizations ▪ Medical Imaging Centres

ROPs in the Standards

Patient Safety Area	ROP	Standards
Communication	*Client identification*	▪ Aboriginal Integrated Primary Care Services ▪ Acquired Brain Injury Services ▪ Ambulatory Care Services ▪ Assisted Reproductive Technology for Clinical Services ▪ Biomedical Laboratory Services ▪ Cancer Care ▪ Community Pharmacy Services ▪ Correctional Health Services ▪ Correctional Services of Canada Health Services ▪ Critical Care Services ▪ Dental Services ▪ Diagnostic Imaging Services ▪ Emergency Department ▪ Emergency Medical Services and Interfacility Transport ▪ Home Care Services ▪ Home Support Services ▪ Hospice, Palliative, and End-of-Life Services ▪ Independent Medical/ Surgical Facilities ▪ Inpatient Services ▪ Long-term Care Services ▪ Medical Imaging Centres ▪ Mental Health Services ▪ Obstetrics Services ▪ Organ and Tissue Transplant ▪ Organ Donation Living Donors ▪ Perioperative Services and Invasive Procedures ▪ Point-of-care Testing ▪ Rehabilitation Services ▪ Remote/Isolated Health Services ▪ Spinal Cord Injury Acute Services ▪ Spinal Cord Injury Rehabilitation Services ▪ Substance Abuse and Problem Gambling ▪ Transfusion Services
	'Do Not Use' list of abbreviations	▪ Independent Medical/ Surgical Facilities ▪ Medication Management
	'Do Not Use' list of abbreviations – Community Pharmacy	▪ Community Pharmacy Services ▪ Medication management for Community-Based Organization

ROPs in the Standards

Patient Safety Area	ROP	Standards
Communication	*Medication reconciliation as a strategic priority*	▪ Leadership ▪ Leadership for Aboriginal Health Services ▪ Leadership for Small Community-Based Organizations
	Medication reconciliation at care transitions – Acute care services (inpatient)	▪ Acquired Brain Injury Services ▪ Cancer Care ▪ Correctional Health Services ▪ Correctional Services of Canada Health Services ▪ Critical Care Services ▪ Hospice, Palliative, and End-of-Life Services ▪ Inpatient Services ▪ Mental Health Services ▪ Obstetrics Services ▪ Perioperative Services and Invasive Procedures ▪ Rehabilitation Services ▪ Spinal Cord Injury Acute Services ▪ Spinal Cord Rehabilitation Services
	Medication reconciliation at care transitions – Ambulatory care services	▪ Aboriginal Integrated Primary Care Services ▪ Ambulatory Care Services ▪ Cancer Care ▪ Remote/Isolated Health Services
	Medication reconciliation at care transitions – Home and Community care services	▪ Aboriginal Substance Misuse Services ▪ Case Management Services ▪ Community-Based Mental Health Services and Supports ▪ Home Care Services ▪ Substance Abuse and Problem Gambling
	Medication reconciliation at care transitions – Long-term care services	▪ Long-term Care Services ▪ Residential Homes for Seniors
	Medication reconciliation at care transitions – Emergency department	▪ Emergency Department
	Safe surgery checklist	▪ Independent Medical/ Surgical Facilities ▪ Obstetrics Services ▪ Organ and Tissue Transplant ▪ Organ Donation for Living Donors ▪ Perioperative Services & Invasive Procedures

ROPs in the Standards

Patient Safety Area	*ROP*	*Standards*
Communication	*Information transfer at care transitions*	▪ Aboriginal Integrated Primary Care Services ▪ Aboriginal Substance Misuse Services ▪ Acquired Brain Injury Services ▪ Ambulatory Care Services ▪ Assisted Reproductive Technology for Clinical Services ▪ Cancer Care ▪ Case Management ▪ Community-Based Mental Health Services and Supports ▪ Correctional Health Services ▪ Correctional Services of Canada Health Services ▪ Critical Care Services ▪ Dental Services ▪ Emergency Department ▪ Emergency Medical Services and Interfacility Transport ▪ Home Care Services ▪ Home Support Services ▪ Hospice, Palliative, and End-of-Life Services ▪ Inpatient Services ▪ Intellectual and Developmental Disabilities Services ▪ Long-term Care Services ▪ Mental Health Services ▪ Obstetrics Services ▪ Organ and Tissue Transplant ▪ Organ Donation for Living Donors ▪ Perioperative Services and Invasive Procedures ▪ Rehabilitation Services ▪ Remote/Isolated Health Services ▪ Residential Homes for Seniors ▪ Spinal Cord Injury Acute Services ▪ Spinal Cord Injury Rehabilitation Services ▪ Substance Abuse and Problem Gambling

ROPs in the Standards

Patient Safety Area	ROP	Standards
Medication Use	*Antimicrobial stewardship*	▪ Medication Management
	Concentrated electrolytes	▪ Medication Management ▪ Medication Management for Community-Based Organizations
	Heparin safety	▪ Medication Management ▪ Medication Management for Community-Based Organizations
	High-alert medications	▪ Emergency Medical Services and Interfacility Transport ▪ Independent Medical/ Surgical Facilities ▪ Medication Management
	High-alert medications – Community-based Organizations	▪ Community Pharmacy Services ▪ Medication Management for Community-Based Organizations
	Infusion pump safety	▪ Correctional Service of Canada Health Services ▪ Emergency Medical Services and Interfacility Transport ▪ Independent Medical/ Surgical Facilities ▪ Organ and Tissue Transplant ▪ Organ Donation for Living Donors ▪ Service Excellence
	Narcotics safety	▪ Emergency Medical Services and Interfacility Transport ▪ Independent Medical/ Surgical Facilities ▪ Medication Management ▪ Medication Management for Community-Based Organizations

ROPs in the Standards

Patient Safety Area	ROP	Standards
Worklife/ Workforce	*Preventive maintenance program*	▪ Independent Medical/ Surgical Facilities ▪ Leadership ▪ Leadership for Aboriginal Health Services ▪ Leadership for Small Community-Based Organizations ▪ Medical Imaging Centres
	Patient safety: education and training	▪ Independent Medical/ Surgical Facilities ▪ Leadership ▪ Leadership for Aboriginal Health ▪ Leadership for Small Community-Based Organizations ▪ Medical Imaging Centres
	Workplace violence prevention	▪ Independent Medical/ Surgical Facilities ▪ Leadership ▪ Leadership for Aboriginal Health Services ▪ Leadership for Small Community-Based Organizations
	Client flow	▪ Leadership
	Patient safety plan	▪ Independent Medical/ Surgical Facilities ▪ Leadership ▪ Leadership for Aboriginal Health Services ▪ Leadership for Small Community-Based Organizations ▪ Medical Imaging Centres

ROPs in the Standards

Patient Safety Area	ROP	Standards
Infection Control	*Hand-hygiene compliance*	▪ Assisted Reproductive Technology (ART) Clinical Services ▪ Emergency Medical Services and Interfacility Transport ▪ Independent Medical/ Surgical Facilities ▪ Infection Prevention and Control ▪ Infection Prevention and Control for Aboriginal Substance Misuse Services ▪ Infection Prevention and Control for Community-Based Organizations ▪ Medical Imaging Centres
	Hand-hygiene education and training	▪ Assisted Reproductive Technology (ART) Clinical Services ▪ Emergency Medical Services and Interfacility Transport ▪ Independent Medical/ Surgical Facilities ▪ Infection Prevention and Control ▪ Infection Prevention and Control for Aboriginal Substance Misuse Services ▪ Infection Prevention and Control for Community-Based Organizations ▪ Medical Imaging Centres
	Infection rates	▪ Infection Prevention and Control ▪ Infection Prevention and Control for Community-Based Organizations
	Reprocessing	▪ Emergency Medical Services and Interfacility Transport ▪ Independent Medical/ Surgical Facilities ▪ Infection Prevention and Control ▪ Infection Prevention and Control for Community-Based Organizations ▪ Medical Imaging Centres

ROPs in the Standards

Patient Safety Area	ROP	Standards
Risk Assessment	*Fall prevention and injury reduction*	▪ Acquired Brain Injury Services ▪ Cancer Care ▪ Critical Care ▪ Inpatient Services ▪ Mental Health Services ▪ Obstetrics Services ▪ Organ and Tissue Transplant ▪ Perioperative Services & Invasive Procedures ▪ Rehabilitation Services ▪ Spinal Cord Injury Acute Services ▪ Spinal Cord Injury Rehabilitation Services
	Fall prevention and injury reduction – Long-term care services	▪ Long-term Care Services
	Home safety risk assessment	▪ Home Care Services ▪ Home Support Services
	Pressure ulcer prevention	▪ Cancer Care ▪ Critical Care Services ▪ Hospice, Palliative and End-of-Life Services ▪ Inpatient Services ▪ Long-term Care Services ▪ Perioperative Services and Invasive Procedures ▪ Rehabilitation Services ▪ Spinal Cord Injury Acute Services ▪ Spinal Cord Injury Rehabilitation Services
	Suicide prevention	▪ Aboriginal Community Health and Wellness ▪ Aboriginal Integrated Primary Care Services ▪ Aboriginal Substance Misuse Services ▪ Child, Youth and Family Services ▪ Community-Based Mental Health Services and Supports ▪ Provincial Correctional Health Services ▪ Correctional Service of Canada Health Services ▪ Emergency Department ▪ Long-term Care Services ▪ Mental Health Services ▪ Remote/Isolated Health Services ▪ Residential Homes for Seniors ▪ Substance Abuse and Problem Gambling

	Venous thromboembolism (VTE) prophylaxis	▪ Cancer Care ▪ Critical Care ▪ Inpatient Services ▪ Organ and Tissue Transplant ▪ Organ Donation for Living Donors ▪ Perioperative Services & Invasive Procedures ▪ Spinal Cord Injury Acute Services ▪ Spinal Cord Injury Rehabilitation Services
	Skin and wound care	▪ Home Care Services