Required Organizational Practices
Handbook 2016
Accreditation Canada is an independent, not-for-profit organization that accredits health organizations in Canada and around the world. Its comprehensive accreditation program uses evidence-based standards and a rigorous peer review process to foster ongoing quality improvement. Accreditation Canada has been helping organizations improve health care quality and patient safety for more than 55 years.
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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.
WHO Classification for Patient Safety

Beginning January 2015, Accreditation Canada adopted the World Health Organization (WHO) Patient Safety Classification. “Adverse events, sentinel events, and near misses” are now referred to as a “patient* safety incident.”

As well, the term “client safety” has been changed to “patient* safety” throughout the standards, again to be consistent with WHO terminology.

WHO defines a patient safety incident as an event or circumstance that could have resulted, or did result, in unnecessary harm to a patient. It includes harmful incidents (formerly adverse or sentinel events), no harm incidents (that reach the patient but did not cause harm), and near misses (also known as close calls).


*Accreditation Canada recognizes that different health care sectors use different terms for the people they serve (e.g., patient, client, resident, etc.). While the term “patient safety” is used in the standards and ROPs, it is considered an all-inclusive concept that includes all types of clients.
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 (*formerly called Adverse events disclosure*)
- Patient safety incident management (*formerly called Adverse events reporting*)
- Patient safety quarterly reports (*formerly called Client safety quarterly reports*)
- Patient safety-related prospective analysis (*formerly called Client safety-related prospective analysis*)

## COMMUNICATION
- Client identification (*formerly called Two client identifiers*)
- The 'Do Not Use List' of abbreviations (*formerly called Dangerous abbreviations*)
- Information transfer at care transitions (*formerly called Information transfer*)
- 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 (*formerly called Infusion pumps training*)
- Narcotics safety

## WORKLIFE/WORKFORCE
- Client flow
- Patient safety: education and training (*formerly called Client safety: education and training*)
- Patient safety plan (*formerly called Client safety plan*)
- Preventive maintenance program
- Workplace violence prevention

## INFECTION CONTROL
- Hand-hygiene compliance
- Hand-hygiene education and training
- Infection rates
- Pneumococcal vaccine
- Reprocessing

## RISK ASSESSMENT
- Falls prevention
- Home safety risk assessment
- Pressure ulcer prevention
- Skin and wound care
- Suicide prevention
- Venous thromboembolism prophylaxis

◦ Revised for on-site surveys starting in 2016
ACCOUNTABILITY FOR QUALITY

For the Governance Standards.

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

PATIENT SAFETY INCIDENT DISCLOSURE

(Formerly called Adverse events disclosure)

For the following sets of 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 breeches) 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.

The Canadian Disclosure Guidelines and Guidelines for Informing the Media after an Adverse Event are resources for developing and implementing a transparent and supportive disclosure process.
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


PATIENT SAFETY INCIDENT MANAGEMENT

(Formerly called Adverse events reporting)

For the following sets of 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.

The Canadian Patient Safety Institute has developed resources for patient safety incident management. 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 is a documented process 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 on feedback 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 the Canadian Patient Safety Culture Survey Tool)

REFERENCE MATERIAL

PATIENT SAFETY QUARTERLY REPORTS
(Formerly called Client safety quarterly reports)

For the following sets of 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

PATIENT SAFETY-RELATED PROSPECTIVE ANALYSIS

(Formerly called Client safety-related prospective analysis)

For the following sets of standards: Independent Medical Surgical Facilities, Leadership, and Medical Imaging Centres.

At least one patient safety-related prospective analysis is carried out and appropriate improvements are implemented as a result.

GUIDELINES

Conducting systematic prospective analyses of potential patient safety incidents is an effective method to prevent or reduce errors. The intent is to eliminate unsafe actions and conditions that can lead to harmful incidents. For example, significant improvement was noted when a Failure Modes and Effects Analysis (FMEA) was applied to two high-risk situations—transcription of medication errors for inpatients and overcrowding in the emergency department.

There are numerous tools and techniques available to conduct a prospective analysis. FMEA is a team-based, systematic, and proactive approach that identifies the ways a process or design might fail, why it might fail, the effects of that failure, and how it can be made safer. Other methods to proactively analyze key processes include fault tree analysis, hazard analysis, simulations, and Reason’s Errors of Omissions model.

TESTS FOR COMPLIANCE

Major At least one prospective analysis has been completed within the past year.

Minor Results from the analysis have been used to make improvements.

REFERENCE MATERIAL

CLIENT IDENTIFICATION
(Formerly called Two client identifiers)

This ROP is found in most service-based sets of standards, see table on page 75.

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

THE “DO NOT USE” LIST OF ABBREVIATIONS
(Formerly called Dangerous abbreviations)

This ROP is found in the following standards: Independent Medical/Surgical Facilities, Medication Management, Medication Management for Community-Based Organizations, and Medication Management for Remote/Isolated Health 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

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 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 organization implements the Do Not Use List and applies this to all medication-related documentation when hand written or entered as free text into a computer.

Major The organization’s 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 The organization educates staff about the Do Not Use list at orientation and when changes are made to the list.

Minor The organization updates the Do Not Use list and implements necessary changes to the organization’s processes.

Minor The organization audits compliance with the Do Not Use List and implements process changes based on identified issues.

REFERENCE MATERIAL

INFORMATION TRANSFER AT CARE TRANSITIONS
(Formerly called Information transfer)

This ROP is found in most service-based sets of standards, see table on page 75.

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

<table>
<thead>
<tr>
<th>Major</th>
<th>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.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Major</td>
<td>Documentation tools and communication strategies are used to standardize information transfer at care transitions.</td>
</tr>
<tr>
<td>Major</td>
<td>During care transitions, clients and families are given information that they need to make decisions and support their own care.</td>
</tr>
<tr>
<td>Major</td>
<td>Information shared at care transitions is documented.</td>
</tr>
<tr>
<td>Minor</td>
<td>The effectiveness of communication is evaluated and improvements are made based on feedback received. Evaluation mechanisms may include:</td>
</tr>
<tr>
<td></td>
<td>▪ Using an audit tool (direct observation or review of client records) to measure compliance with standardized processes and the quality of information transfer</td>
</tr>
<tr>
<td></td>
<td>▪ Asking clients, families, and service providers if they received the information they needed</td>
</tr>
<tr>
<td></td>
<td>▪ Evaluating safety incidents related to information transfer (e.g., from the patient safety incident management system).</td>
</tr>
</tbody>
</table>
REFERENCE MATERIAL

MEDICATION RECONCILIATION AS A STRATEGIC PRIORITY

For the following sets of standards: Leadership, Leadership for Aboriginal Health Services, Leadership for Small Community-based Organizations.

There is a documented and coordinated approach to partner with clients and families to collect accurate and complete information about client medications and utilize this information during transitions of care.

NOTE: Accreditation Canada will move towards full implementation of medication reconciliation in two phases.

For on-site surveys between 2014 and 2017, medication reconciliation should be implemented in ONE service (or program) that uses a Qmentum standard containing the Medication Reconciliation at Care Transitions ROP. Medication reconciliation should be implemented as per the tests for compliance for each ROP.

For on-site surveys in 2018 and beyond, medication reconciliation should be implemented in ALL services (or programs) that use Qmentum standards containing the Medication Reconciliation at Care Transitions ROP. Medication reconciliation should be implemented as per the tests for compliance for each ROP.

GUIDELINES

Medication reconciliation is widely recognized as an important safety initiative. In Canada, Safer Healthcare Now! identifies medication reconciliation as a patient safety priority. The World Health Organization (WHO) has also developed a Standard Operating Protocol for medication reconciliation as one of its interventions designed to enhance patient safety. Properly conducted medication reconciliation reduces the possibility that medications will be inadvertently omitted, duplicated, or incorrectly ordered at transitions of care. Medication reconciliation can be a cost-effective way to reduce medication errors and can reduce the re-work that can be associated with managing client medications.

Safer Healthcare Now! offers a “Getting Started Kit” for various sectors (including acute care, long-term care, and home care) at www.saferhealthcarenow.ca.

Medication reconciliation is a structured, shared process whereby health care professionals:

1. Partner with clients, families, or caregivers (as appropriate), and at least one other source of information, to generate a Best Possible Medication History (BPMH). A BPMH is a list of all medications (including prescription, non-prescription, traditional, holistic, herbal, vitamins, and supplements) the client is actually taking.
2. Identify and resolve differences (discrepancies) between the BPMH and medications ordered at transition points.
3. Document and communicate up-to-date information about client medications to the client (and their next service provider, as appropriate).

Success at medication reconciliation requires clear commitment and direction from organization leaders. An organization policy signals commitment to medication reconciliation and provides guiding principles (e.g., an overview of the process, roles and responsibilities, transitions where medication reconciliation is required, exemptions, etc.). Organization commitment to medication reconciliation also requires investment, with resources allocated towards staffing, education, tools, information technology, etc.
Implementing and sustaining medication reconciliation throughout an organization will be more successful when 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.

For organizations that are just starting, it can be helpful to develop the necessary forms and tools and implement them in one service area to gain expertise. As monitoring indicates implementation is successful, a plan can be developed to implement medication reconciliation throughout the organization, continuing to monitor and make improvements as required. As medication reconciliation is successfully implemented, organizations need to consider the sustainability of the process, continuing to monitor and make improvements as required.

Team education about medication reconciliation should include the rationale for and steps involved in medication reconciliation. The Agency for Healthcare Research and Quality’s MATCH toolkit provides more information about medication reconciliation training. Evidence of education can include orientation checklists, a list of education sessions offered, attendance lists, competency evaluation forms, sign-off sheets for having read policies/procedures, etc.

It is important to monitor, in consultation with the coordination team and front-line staff, the extent to which the medication reconciliation policy and process are being followed. Monitoring should assess compliance with the overall medication reconciliation process (e.g., the quality of the collection of the BPMH, whether the BPMH is documented, and whether medication discrepancies are identified and resolved). The Safer Healthcare Now! “Getting Started Kit” also has useful resources to monitor implementation. ISMP Canada and the Canadian Patient Safety Institute (CPSI) have developed an audit tool that can be used to help assess the quality of an established medication reconciliation process.

### TESTS FOR COMPLIANCE

<table>
<thead>
<tr>
<th>Requirement</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Major</td>
<td>There is a medication reconciliation policy and process to collect and utilize accurate and complete information about client medication at transitions of care.</td>
</tr>
<tr>
<td>Major</td>
<td>Roles and responsibilities for completing medication reconciliation are defined.</td>
</tr>
<tr>
<td>Major</td>
<td>There is a plan to implement and sustain medication reconciliation that specifies services/programs, locations and timelines.</td>
</tr>
<tr>
<td>Minor</td>
<td>The organizational plan is led and sustained by an interdisciplinary coordination team.</td>
</tr>
<tr>
<td>Major</td>
<td>There is documented evidence that team members, including physicians, who are responsible for medication reconciliation are provided with education.</td>
</tr>
<tr>
<td>Minor</td>
<td>Compliance with the medication reconciliation process is monitored and improvements are made when required.</td>
</tr>
</tbody>
</table>
REFERENCE MATERIAL

MEDICATION RECONCILIATION AT CARE TRANSITIONS

Acute Care Services

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

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

GUIDELINES

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

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

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

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

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

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

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

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

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

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** A current medication list is retained in the client record.

**Major** The prescriber uses the Best Possible Medication History (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 a complete list of medications the client should be taking following discharge.
REFERENCE MATERIAL

MEDICATION RECONCILIATION AT CARE TRANSITIONS

Ambulatory Care

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

A Best Possible Medication History (BPMH) is generated in partnership with clients, families, or caregivers (as appropriate), and used to reconcile client medications at ambulatory care visits where the client is at risk of potential adverse drug events. Organizational policy determines which type of ambulatory care visits require medication reconciliation, and how often medication reconciliation is repeated.

GUIDELINES

Medication reconciliation is a structured process to communicate accurate and complete information about client medications at interfaces of care. Ambulatory care includes a wide range of services and client populations, thus targeting medication reconciliation to clients or populations who are at risk of potential adverse drug events is encouraged. Ambulatory care clients are at risk of potential adverse drug events when their care is highly dependent on medication management OR the medications typically used are known to be associated with potential adverse drug events (based on available literature and internal data). Organizations apply a risk assessment approach, working with team members to identify client groups who are at most risk of adverse drug events and are most likely to benefit from medication reconciliation. Medication reconciliation should be repeated periodically as appropriate for the client or population receiving services.

Targets may begin with a small group of clients at risk of adverse drug events, and then expand as success with medication reconciliation is achieved. The rationale for the target(s) and the frequency of medication reconciliation is documented, and any factors that influence the decision (e.g., client flow when designing their medication reconciliation process) are considered. Medication reconciliation may be targeted to all clients receiving selected ambulatory care services, or to selected clients in any ambulatory care service.

Medication reconciliation begins with generating a Best Possible Medication History (BPMH) for each client. The BPMH lists all medications (prescription, non-prescription, traditional, holistic, herbal, vitamins, and supplements) the client is actually taking, and captures the name, dose, frequency, and route of administration for each. Creating the BPMH involves interviewing the client, family, or caregivers (as appropriate), and consulting at least one other source of information such as the client’s previous health record, the community pharmacist, or a provincial database. Once it has been generated, the BPMH follows the client through their health care journey and is an important reference tool for reconciling medications. For example, interfaces of care were clients are at risk potential adverse drug events include beginning of service, transfer of care between sites within the same organization, transfer to another service environment (e.g., client moves from a renal program to a long-term care facility), or end of service.

When a client has been receiving services for an extended period of time, the up-to-date current medication list may be used as a BPMH. The period of time must be specified in organizational policy. In these instances, every effort should be made to account for medications the client may have been taking prior to the beginning of services that may not be
Included on the up-to-date medication list. Safer Healthcare Now! Communities of Practice provide a number of BPMH tools and forms.

Once the BPMH is generated, the goal of medication reconciliation is to identify and communicate what medications should be continued, discontinued, or modified, and the reasons why. Any discrepancies identified between what the client is prescribed, and what they are actually taking, will be resolved at the clinic or referred to their most responsible prescriber. The end result of medication reconciliation is a complete list of medications clients should be taking. Whenever possible, and always at the end of service, clients and the clients’ community providers (e.g. primary care provider, community pharmacist, home care provider) are provided with the up-to-date BPMH. Clients should be provided with information about the medications they should be taking in a format and language they can easily understand.

TESTS FOR COMPLIANCE

<table>
<thead>
<tr>
<th>Major</th>
<th>The type of ambulatory care visits where medication reconciliation is required are identified and documented.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Major</td>
<td>For ambulatory care visits where medication reconciliation is required, the frequency at which medication reconciliation should occur is identified and documented.</td>
</tr>
<tr>
<td>Major</td>
<td>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, or caregiver (as appropriate).</td>
</tr>
<tr>
<td>Major</td>
<td>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 documented by the organization.</td>
</tr>
<tr>
<td>Major</td>
<td>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.</td>
</tr>
<tr>
<td>Major</td>
<td>When medication discrepancies are resolved, the current medication list is updated and retained in the client record.</td>
</tr>
<tr>
<td>Major</td>
<td>The client and the next care provider (e.g., primary care provider, community pharmacist, home care services) are provided with a complete list of medications the client should be taking following the end of service.</td>
</tr>
</tbody>
</table>

REFERENCE MATERIAL

MEDICATION RECONCILIATION AT CARE TRANSITIONS

Emergency Department

For the Emergency Department Standards.

In partnership with clients, families, or caregivers (as appropriate), medication reconciliation is initiated for clients with a decision to admit and a target group of clients without a decision to admit who are at risk for potential adverse drug events (organizational policy specifies when medication reconciliation is initiated for clients without a decision to admit).

GUIDELINES

Medication reconciliation is a structured process to communicate accurate and complete information about client medications at care transitions. The medication reconciliation process is initiated for clients with a decision to admit and for a target group of non-admitted clients who are identified as being at risk for adverse drug events. Organizations use a risk assessment approach, working with team members to identify client groups who are at most risk for adverse drug events and are most likely to benefit from medication reconciliation.

Targets may begin with a small group of clients, expanding as success with medication reconciliation is achieved. The rationale for the target group(s) is documented and takes into account factors that may affect the process (e.g., client flow).

Medication reconciliation begins with generating a Best Possible Medication History (BPMH). The BPMH lists all medications (prescription, non-prescription, traditional, holistic, herbal, vitamins, and supplements) the client is actually taking and shows the name, dose, frequency, and route of administration for each. 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, a community pharmacist, or a provincial database.

The goal of medication reconciliation is to identify and communicate what medications should be continued, discontinued, or modified, and the reasons why.

Safer Healthcare Now! Communities of Practice provide BPMH tools and forms.

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.

Major The criteria for a target group of non-admitted clients who are eligible for medication reconciliation are identified and the rationale for choosing those criteria is documented.

Major When medications are adjusted for non-admitted clients in the target group, a BPMH is generated, in partnership with clients, families, or caregivers, and documented.

Major For non-admitted clients in the target group, medication changes are communicated to the primary health care provider.
REFERENCE MATERIAL

MEDICATION RECONCILIATION AT CARE TRANSITIONS

Home and Community Care

For the following sets of standards: Case Management Services, Community-Based Mental Health Services and Supports, and Home Care Services.

When medication management is a component of care (or deemed appropriate through clinician assessment), a Best Possible Medication History (BPMH) is generated in partnership with clients, families, or caregivers (as appropriate) and used to reconcile client medications.

GUIDELINES

More than ever before, health care in Canada is being provided in the home environment and community-based care is responding to more complex client needs. It has been demonstrated that nearly 50 percent of adults transitioning from a hospital to home care have medication discrepancies. Many of these can lead to serious consequences for the client. Clients are extremely vulnerable during the transition from institutional care to home care. Medication reconciliation is a structured process to communicate accurate and complete information about client medications at interfaces of care.

Safer Healthcare Now! offers a ‘Getting Started Toolkit’ for medication reconciliation in the community setting. Medication reconciliation should be considered for all home care clients where medication management is a component of care, but when this is not possible, criteria need to be established to identify home care clients at risk of potential adverse drug events. A medication risk assessment tool can help identify clients for whom medication reconciliation is required. Safer Healthcare Now! offers a sample medication risk assessment tool in its ‘Getting Started Toolkit’. The rationale for selecting target clients must be documented.

Medication reconciliation begins with generating a Best Possible Medication History (BPMH) for the client. The BPMH lists all medications (prescription, non-prescription, traditional, holistic, herbal, vitamins, and supplements) the client is actually taking, and captures the name, dose, frequency, and route of administration for each. The best time to generate the BPMH is during the initial visit, but this may not be possible in all cases. Therefore, acceptable timelines for generating the BPMH need to be defined. Creating the BPMH involves interviewing the client, family, or caregivers (as appropriate), and consulting at least one other source of information such as the client’s previous health record, the community pharmacist, or a provincial database.

When a client has been receiving services for an extended period of time and did not receive a BPMH at the beginning of service, the current medication list may be used as a BPMH. The period of time must be specified in organizational policy. In these instances, every effort should be made to account for medications the client may have been taking prior to the beginning of services that may not be included on the current medication list.

Once the BPMH is generated, the goal of medication reconciliation is to identify and communicate what medications should be continued, discontinued, or modified. Any discrepancies identified between what the client is prescribed and what they are actually taking, are communicated to the client (and their circle of care, as appropriate) and resolved by the appropriate prescriber.
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 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, and caregivers (as appropriate).

**Major** Medication discrepancies are resolved in partnership with clients and families OR communicated to the client’s most responsible prescriber, and 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.

**Major** Clients and families are educated on how to share the complete medication list when encountering health care providers within the client’s circle of care.

### REFERENCE MATERIAL


MEDICATION RECONCILIATION AT CARE TRANSITIONS

Long-term Care

*For the following sets of standards: Long-term Care Services, and Residential Homes for Seniors.*

A Best Possible Medication History (BPMH) is generated in partnership with the resident, family, or caregiver (as appropriate) and used to reconcile resident medications at care transitions.

GUIDELINES

Poor communication about medications is common as residents transfer between other service environments (e.g., acute care, rehabilitation services, or home care) and long-term care. This is a significant patient safety issue as it can lead to adverse drug events that have the potential to cause serious consequences for the resident. Medication reconciliation is a structured process to communicate accurate and complete information about resident medications across transitions of care. *Safer Healthcare Now!* offers a ‘Getting Started Toolkit’ for medication reconciliation in the long-term care setting.

Medication reconciliation begins with generating a Best Possible Medication History (BPMH) for each resident. The BPMH lists all medications (prescription, non-prescription, traditional, holistic, herbal, vitamins, and supplements) the resident is currently taking, even though it may be different from what was actually prescribed. The BPMH captures the name, dose, frequency, and route of administration for each medication. Creating the BPMH involves interviewing the resident, family, or caregivers (as appropriate), and consulting at least one other source of information such as the resident’s previous health record, the community pharmacist, or a provincial database. *Safer Healthcare Now!* Communities of Practice provide a number of BPMH tools and forms.

Medication reconciliation at admission or re-admission can be achieved using one of two models. The proactive model is used most commonly in long-term care, where the BPMH is used to create admission medication orders. In the retroactive model, the BPMH is generated after admission medication orders have been written and a timely comparison of the BPMH against the admission medication orders is made. Regardless of the model used, it is important to identify, resolve, and document medication discrepancies.

After the BPMH is generated, the goal of medication reconciliation at admission is to identify and resolve discrepancies between what medications the resident was taking prior to admission with those ordered by the prescriber. Medication reconciliation is not required for bed relocation. When a resident moves from long-term care to another service environment (e.g., acute care) and returns to long-term care, the resident’s medications need to be reconciled at re-admission to account for any changes made in the other service environment.

At all times a current medication list (often called a medication administration record or MAR) is retained in the resident record.

Transfer out of long-term care is a transition that puts residents at risk of potential adverse drug events. This includes transitions out of the facility (e.g., transfer to acute care for short term treatment), transfers between long-term care facilities, and a move from long-term care facility to community-based care or home. The goal of medication reconciliation when a resident transfers out of long-term care is to communicate a complete list of the resident’s current medications to the next health care provider.
A systematic process needs to be followed to ensure this information is documented and shared with the resident, family, and subsequent care providers. Ideally, information about resident medications is part of a Best Possible Medication Discharge Plan (BPMDP) that also includes a medication information transfer letter to the next care provider, a structured discharge prescription to the next care provider or community pharmacist, and clear information for the resident about the medications the resident should be taking (in plain language that the resident and family can 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 compared with the admission orders and any medication discrepancies are identified, resolved, and documented.
- **Major** The reconciled admission orders are used to generate a current medication list that is kept in the resident record.
- **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), as appropriate, are provided with a complete list of medications the resident is taking.

**REFERENCE MATERIAL**

MEDICATION RECONCILIATION AT CARE TRANSITIONS

Substance Misuse

For the following sets of standards: Aboriginal Substance Misuse Services, and Substance Abuse and Problem Gambling Services.

Client medications are reconciled in partnership with the client, family, or personal support system at care transitions.

GUIDELINES

In many settings, medication reconciliation is a structured process in which team members partner with clients, families, and other caregivers for accurate and complete transfer of medication information at transitions of care. Due to the unique service environments and staff mix of treatment centres, key elements of the medication reconciliation process have been customized to ensure the accurate tracking and communication of medication information in this setting. These important steps are designed to enhance patient safety and minimize the risk of medication errors or adverse drug events.

Client medication information should include prescribed medications, over-the-counter medications, vitamins, supplements, herbal remedies, and traditional medicines, along with detailed documentation of drug name, dose, frequency, and route of administration.

Medication reconciliation is a shared responsibility that is done in partnership with the client, family, or other personal support system. Liaison with the primary care provider, community pharmacist, healer, and other community partners may be required.

TESTS FOR COMPLIANCE

Major There is a formal process to track and communicate information about client medications over the duration of treatment.

Major A comprehensive list of all medications the client is taking (Best Possible Medication History) is generated in partnership with clients, families, or personal support systems at the beginning of service.

Major Any changes to the medication list over the duration of treatment (e.g. medications discontinued, added, altered, or changed during a physician visit, prescriptions completed during treatment) are documented.

Minor Upon transfer to another service provider or end of service, the client and their providers of care (e.g. family physician) are provided with a copy of the updated medication list.

Minor The process is a shared responsibility, undertaken in partnership with the client, service providers, family physician, and community pharmacists, as appropriate.
REFERENCE MATERIAL

SAFE SURGERY CHECKLIST

For the following sets of 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

ANTIMICROBIAL STEWARDSHIP

For the Medication Management Standards.

The organization has a program for antimicrobial stewardship 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

Use of antimicrobial agents is an important 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 may have a substantial impact on the health and safety of clients, and the resources of 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 the use of antimicrobials 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 shown to limit the emergence and transmission of antimicrobial-resistant bacteria. Studies also indicate that antimicrobial stewardship programs are cost effective, and provide savings through reduced drug costs and avoidance of microbial resistance.

A comprehensive, evidence-based antimicrobial stewardship program may include a number of interventions based on local antimicrobial use and available resources. Possible interventions include:

- Prospective audit and feedback
- Formulary of targeted antimicrobials and approved indications
- Education
- Guidelines and clinical pathways
- Antimicrobial order forms
- Streamlining or de-escalation of therapy
- Dose optimization
- Parenteral to oral conversion

Organizations are encouraged to tailor an approach to antimicrobial stewardship consistent with their size, service environment, and patient population, and to establish processes for ongoing monitoring and improvement of the program over time.

A successful antimicrobial stewardship program requires an inter-disciplinary approach, with collaboration between the antimicrobial stewardship team, pharmacy, and hospital infection control. The involvement and support of hospital administrators, medical staff leadership, and health care providers is essential.
REQUIRED ORGANIZATIONAL PRACTICES 2016

TESTS FOR COMPLIANCE

Major  The organization implements an antimicrobial stewardship program.

Major  The program includes lines of accountability for implementation.

Major  The program is inter-disciplinary 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 that may include 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 organization establishes mechanisms to evaluate the program on an ongoing basis, and shares results with stakeholders in the organization.

REFERENCE MATERIAL

CONCENTRATED ELECTROLYTES

For the following sets of standards: Medication Management, Medication Management for Community-Based Organizations, and Medication Management for Remote/Isolated Health Services.

The organization evaluates and limits the availability of concentrated electrolytes to ensure that formats with the potential to cause harmful medication incidents are not stocked in client service areas.

GUIDELINES

There are reports of accidental death from the inadvertent administration of concentrated sodium chloride solution. Avoiding stocking concentrated electrolytes in client service areas is a valuable use of resources to minimize the risk of death or disabling injury associated with these agents. It also recommended that the packaging of concentrated electrolytes is in line with their intended use.

Concentrated electrolytes to be the focus of audit and removal from client service areas include:

- 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 phosphate): concentrations greater than or equal to 4 mmol/mL
- Sodium chloride: concentrations greater than 0.9%

For specific care circumstances, it may be necessary for concentrated electrolytes to be available in selected client service areas.

Possible Examples:

- 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 selected areas (e.g. Neurology, Emergency Departments, Critical Care)

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

Additional strategies to ensure the safe use of high-alert medications such as concentrated electrolytes may be found in Accreditation Canada’s High-Alert Medications ROP.
TESTS FOR COMPLIANCE

Major The organization completes an audit of the following concentrated electrolytes in client service areas 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 The organization avoids stocking the following concentrated electrolytes 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 for concentrated electrolytes to be available in selected client service areas, the organization’s interdisciplinary committee for medication management reviews and approves the rationale for availability and safeguards put in place to minimize the risk of error.

REFERENCE MATERIAL

HEPARIN SAFETY

For the following sets of standards: Emergency Medical Services, Medication Management, Medication Management for Community-Based Organizations, and Medication Management for Remote/Isolated Health Service

The organization evaluates and limits the availability of heparin products to ensure that formats with the potential to cause harmful medication incidents are not stocked in client service areas.

GUIDELINES

Heparin has been identified as a high-alert medication that is an area of focus for safety. Limiting availability and ensuring that high-dose formats of heparin are not stocked in client service areas are effective strategies to minimize the risk of death or disabling injury associated with these agents.

Heparin products to be the focus of audit to ensure that they are not stocked in client service areas include:
- Unfractionated heparin (high dose, high potency): 50,000 units total per container (e.g. 50,000 units/5 mL; 50,000 units/2 mL)

Heparin products to be the focus of audit with the goal to limit availability in client service areas include:
- 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

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

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

Major The organization completes an audit of unfractionated and low molecular weight heparin products in client service areas at least annually.

Major The organization does not stock high dose unfractionated heparin (50,000 units total per container) in client service areas.

Major The organization is taking steps 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 selected client service areas, the organization’s interdisciplinary committee for medication management reviews and approves the rationale for availability and safeguards put in place to minimize the risk of error.

REFERENCE MATERIAL

HIGH-ALERT MEDICATIONS

For the following sets of standards: Emergency Medical Services, Independent Medical Surgical Facilities, Medication Management, Medication Management for Community-Based Organizations, and Medication Management for Remote/Isolated Health Services.

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

GUIDELINES

High-alert medications have an increased risk of causing significant client harm when they are administered in error. Implementing a comprehensive strategy for the management of high-alert medications is a valuable use of resources to enhance client safety, and to reduce the possibility of serious 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. A detailed list of high-alert medications developed by the Institute for Safe Medication Practices (United States) can be found online and is a valuable starting point for the identification of high-alert medications. ISMP has also produced a list of high-alert medications specifically for community/ambulatory settings.

To prevent harm from medication errors, a policy for the management of high-alert medications is required. High-alert medications policies identify a list of high-alert medications based on an organization’s medication formulary and informed by available organizational, provincial, or national medication error data. Strategies 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
A policy for the management of high-alert medications may place additional emphasis on strategies for high-risk client populations including the elderly, paediatrics, and neonates, as well as on transition points including admission, transfer, and discharge. 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. Specific strategies for the safe use of concentrated electrolytes, heparin products, and narcotics (opioids) should be developed in accordance with Accreditation Canada’s medication safety ROPs.

TESTS FOR COMPLIANCE

Major  The organization has a policy for the management of high-alert medications.
Minor  The policy names the 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 storage, prescribing, preparation, administration, dispensing, and documentation for each high-alert medication, as appropriate.
Major  The organization limits and standardizes concentrations and volume options available for high-alert medications.
Minor  The organization regularly audits client service areas for high-alert medications.
Minor  The organization establishes a mechanism to update the policy on an ongoing basis.
Major  The organization provides information and ongoing training to staff on the management of high-alert medications.

REFERENCE MATERIAL

INFUSION PUMP SAFETY

(Formerly called Infusion pumps training)

This ROP is found in most service-based sets of standards, see table on page 75.

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

GUIDELINES

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

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

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

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

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 needed

When 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
NARCOTICS SAFETY

For the following sets of standards: Emergency Medical Services, Independent Medical Surgical Facilities, Medication Management, Medication Management for Community-Based Organizations, and Medication Management for Remote/Isolated Health Services.

The organization evaluates and limits the availability of narcotic (opioid) products to ensure that formats with the potential to cause harmful medication incidents are not stocked in client service areas.

GUIDELINES

Opioids have been identified as high-alert medications that are an area of focus for safety. Limiting availability and ensuring that high dose formats of opioid products are not stocked in client service areas is an effective strategy to minimize the risk of death or disabling injury associated with these agents.

Narcotic (opioid) products to be the focus of audit to ensure that they are not stocked in client service areas include:

- Fentanyl: ampoules or vials with total dose greater than 100 mcg per container
- HYDROmorphine: 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

For specific care circumstances, it may be necessary for narcotic (opioid) products to be available in selected client service areas.

Possible Examples:

- Fentanyl: ampoules or vials with total dose greater than 100 mcg per container
- HYDROmorphine: 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, the organization reviews and approves the rationale for availability and safeguards put in place to minimize the risk of error.

To optimize the safe use of narcotic (opioid) products, organizations may also consider the implementation of a pain management team. Organizations serving paediatric 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. Additional strategies to ensure the safe use of high-alert medications such as narcotics (opioids) may be found in the Accreditation Canada ROP about high-alert medications.
TESTS FOR COMPLIANCE

Major The organization completes an audit of the following narcotic (opioid) products in client service areas 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 The organization avoids stocking the following narcotic (opioid) products 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 selected client service areas, the organization’s interdisciplinary committee for medication management reviews and approves the rationale for availability and safeguards put in place to minimize the risk of error.

REFERENCE MATERIAL

CLIENT FLOW

For the Leadership Standards.

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:


PATIENT SAFETY: EDUCATION AND TRAINING
(Formerly called Client safety: education and training)

For the following sets of 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
PATIENT SAFETY PLAN
(Formerly called Client safety plan)

For the following sets of 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

PREVENTIVE MAINTENANCE PROGRAM

For the following sets of 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

<table>
<thead>
<tr>
<th>Level</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Major</td>
<td>There is a preventive maintenance program for all medical devices, medical equipment, and medical technology.</td>
</tr>
<tr>
<td>Major</td>
<td>There are documented preventive maintenance reports.</td>
</tr>
<tr>
<td>Minor</td>
<td>There is a process to evaluate the effectiveness of the preventive maintenance program.</td>
</tr>
<tr>
<td>Major</td>
<td>There is documented follow up related to investigating incidents and problems involving medical devices, equipment, and technology.</td>
</tr>
</tbody>
</table>

REFERENCE MATERIAL

WORKPLACE VIOLENCE PREVENTION

For the following sets of 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 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.

Accreditation Canada 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 all forms 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.”

The Registered Nurses Association of Ontario describes four classifications of workplace violence:

- **Type I (Criminal Intent):** Perpetrator has no relationship to the workplace.
- **Type II (Client or Customer):** Perpetrator is a client, visitor, or family member of a client at the workplace who becomes violent toward a worker or another client.
- **Type III (Worker-to-worker):** Perpetrator is an employee or past employee of the workplace.
- **Type IV (Personal Relationship):** Perpetrator has a relationship with an employee (e.g., domestic violence in the workplace).

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 is a documented process for team members to confidentially report incidents of workplace violence.
- **Major** There is a documented process 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

HAND-HYGIENE COMPLIANCE
(Formerly called Hand-hygiene audit)

For the following sets of standards: Emergency Medical Services, Independent Medical/surgical Facilities, Infection Prevention and Control, Infection Prevention and Control for Community-based Organizations, and Medical Imaging Centres.

The organization measures its compliance with accepted hand-hygiene practices.

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 facilities, and benchmark compliance practices across the organization. Studies have shown that improvements in compliance with hand-hygiene practices have decreased the number of health care-associated infections.

The best method for measuring compliance with accepted hand-hygiene practices is to use direct observation (audits). Direct observation involves watching and recording the hand-hygiene behaviours of staff and observing the work environment. Observation can be done by a trained observer within an organization, using a buddy system when two or more health care professionals work together, or by patients/families within an organization or in the community. Safer Healthcare Now! offers a variety of tools for measuring hand-hygiene compliance in different settings. Ideally, direct observation should measure compliance in all 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

Direct observation should be used by all organizations working out of a fixed location (i.e., clients come to them). For organizations providing services in clients’ homes, direct observation is still the best method of measuring hand-hygiene compliance. Such organizations may wish to consider having clients (and their families) measure staff compliance with accepted hand-hygiene practices – tools are available at www.handhygiene.ca. Organizations that provide services in clients’ homes, and find that direct observation is not possible, can consider alternative methods such as:

- Staff recording their own compliance with accepted hand-hygiene practices (self-audit)
- Measuring product use
- Questions on client satisfactions surveys that ask about staff’s hand-hygiene compliance
- Measuring the quality of hand-hygiene techniques (e.g., through the use of ultraviolet gels or lotions)

Since 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 organizational compliance with accepted hand-hygiene practices.
TESTS FOR COMPLIANCE

Major  The organization measures its compliance with accepted hand-hygiene practices using direct observation methods (e.g., audit). For organizations that provide services in clients’ homes, a combination (two or more) of alternative methods may be used.

Minor  The organization shares the results of measuring hand-hygiene compliance with staff, service providers, and volunteers.

Minor  The organization uses the results of measuring hand-hygiene compliance to make improvements to its hand-hygiene practices.

REFERENCE MATERIAL

HAND-HYGIENE EDUCATION AND TRAINING

For the following sets of standards: Assisted Reproductive Technology Standards for Clinical Services, Emergency Medical Services, 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.

The organization provides hand-hygiene education to staff, service providers, and volunteers.

GUIDELINES

Hand hygiene is a critical component of an effective infection prevention and control program in health care settings. However, adherence to proper hand-hygiene protocols is often poor. Cost estimates of health care-associated infections significantly exceed those related to hand hygiene.

Training on hand hygiene is multimodal and addresses the importance of hand hygiene in 1) preventing the transmission of microorganisms, 2) factors that have been found to influence hand-hygiene behaviour, and 3) 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

The organization provides staff, service providers, and volunteers with education about the hand-hygiene protocol.

REFERENCE MATERIAL

INFECTION RATES

For the following sets of standards: Infection Prevention and Control, and Infection Prevention and Control for Community-Based organizations.

The organization tracks health care-associated infections, analyzes the information to identify outbreaks and trends, and shares this information throughout the organization.

GUIDELINES

Tracking methods may focus on a particular health care-associated infection or service area, or may be organization- or system-wide. They may include data analysis techniques to help detect previously unrecognized outbreaks.

The organization identifies the health-care associated infections most common to its services and client populations, such as *Clostridium difficile* (*C. difficile*), surgical site infections, seasonal influenza, noroviruses, or urinary tract infections as well as other reportable diseases and antibiotic-resistant organisms. The organization tracks these as well as other reportable diseases and antibiotic-resistant organisms. The information tracked may include frequencies and changes in frequencies over time, associated mortality rates, and attributed costs.

Staff and service providers who are well informed about health care-associated infection rates are usually better equipped to prevent and manage them. The organization identifies who is responsible for receiving information about health care-associated infection rates (e.g., the governing body, senior management, staff, and service providers) and establishes plans to disseminate information appropriately and in a regular and timely way (e.g., quarterly reports to all departments).

In addition to staff and service providers, the organization also keeps the governing body up-to-date about health care-associated infection rates and associated IPC issues. This may be done directly through senior management and/or a medical advisory committee.

TESTS FOR COMPLIANCE

Major  The organization tracks health care-associated infection rates.

Minor  The organization analyzes outbreaks and makes recommendations to prevent recurrences.

Minor  The organization shares 1) information about relevant health care-associated infections and 2) recommendations from outbreak reviews with staff, service providers, senior leadership, and the governing body.
REFERENCE MATERIAL

REQUIRED ORGANIZATIONAL PRACTICES 2016

INFECTION CONTROL

PNEUMOCOCCAL VACCINE

For the following sets of standards: Correctional Service of Canada Health Services, Long-term Care, and Residential Homes for Seniors.

A policy and procedure for administration of the pneumococcal vaccine is developed and implemented.

GUIDELINES

Populations at risk of complications from pneumococcal disease may include clients and team members. Immunizing high-risk clients can improve morbidity and mortality rates and reduce health care system costs.

TESTS FOR COMPLIANCE

Major There is a policy and protocol to administer the pneumococcal vaccine.
Major The policy and protocol includes identifying populations at risk of complications from pneumococcal disease.

REFERENCE MATERIAL

REPROCESSING
(Formerly called Sterilization processes)

For the following sets of standards: Emergency Medical Services, Independent Medical/surgical Facilities, Infection Prevention and Control, Infection Prevention and Control for Community-based Organizations, and Medical Imaging Centres.

The organization monitors its processes for reprocessing equipment, and makes improvements as appropriate.

GUIDELINES

Reprocessing includes the processes for cleaning, disinfecting, and sterilizing, and the level of reprocessing used depends on the risk of infection associated with the use of medical devices/equipment (Spaulding classification). Monitoring their reprocessing processes helps organizations identify areas for improvement and reduce health care-associated infections. Examples of methods to measure the effectiveness of reprocessing include: monitoring water quality and washer function; and measuring organic residuals, adenosine triphosphate (ATP), and total viable count.

Organizations reprocess equipment according to manufacturers’ instructions. 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 reprocessing processes and systems are effective.

Minor Action has been taken to examine and improve reprocessing processes where indicated.

REFERENCE MATERIAL

FALLS PREVENTION

This ROP is found in most service-based sets of standards, see table on page 75.

To minimize injury from falls, a documented and coordinated approach for falls prevention is implemented and evaluated.

GUIDELINES

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

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

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

TESTS FOR COMPLIANCE

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

REFERENCE MATERIAL

HOME SAFETY RISK ASSESSMENT

For the following sets of standards: Case Management Services, 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


PRESSURE ULCER PREVENTION

For the following sets of standards: Cancer Care and Oncology Services, Critical Care, Hospice, Palliative, and End-of-Life Services, Long-term Care Services, Medicine 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.

GUIDELINES

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

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

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

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

SKIN AND WOUND CARE

For the Home Care Services Standards.

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 care1 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) as well as tools such as Health Outcomes for Better Information and Care (HOBIC) and the interRAI Community Health Assessment (interRAI-CHA).
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 Guidelines. Registered Nurses Association of Ontario; Toronto, ON. www.rnao.ca
SUICIDE PREVENTION

For the following sets of standards: Aboriginal Community Health and Wellness Services, Aboriginal Integrated Primary Care Services, Aboriginal Substance Misuse Services, Child Welfare 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

Every year close to 3,700 people in Canada commit suicide. Many of these deaths could be prevented by early recognition of the signs of suicidal thinking and offering appropriate intervention.

TESTS FOR COMPLIANCE

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

REFERENCE MATERIAL

VENOUS THROMBOEMBOLISM PROPHYLAXIS

For the following sets of standards: Cancer Care and Oncology Services, Critical Care, Independent Medical/surgical Facilities, Medicine 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 is not a requirement for pediatric hospitals. The ROP applies to clients 18 years of age or older.

GUIDELINES

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

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

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

TESTS FOR COMPLIANCE

<table>
<thead>
<tr>
<th>Major</th>
<th>There is a written venous thromboembolism (VTE) prophylaxis policy or guideline.</th>
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<tbody>
<tr>
<td>Major</td>
<td>Clients at risk for VTE are identified and provided with appropriate, evidence-informed VTE prophylaxis.</td>
</tr>
<tr>
<td>Minor</td>
<td>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.</td>
</tr>
<tr>
<td>Major</td>
<td>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.</td>
</tr>
<tr>
<td>Minor</td>
<td>Information is provided to clients and team members about the risks of VTE and how to prevent it.</td>
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</tbody>
</table>
REFERENCES

## ROPs FOUND IN MOST SERVICE-BASED SETS OF STANDARDS

<table>
<thead>
<tr>
<th>Name of Standards</th>
<th>Client identification</th>
<th>Falls prevention</th>
<th>Information transfer at care transitions</th>
<th>Infusion pump safety</th>
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<tr>
<td>Aboriginal Community Health and Wellness Services</td>
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<tr>
<td>Aboriginal Integrated Primary Care Services</td>
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<tr>
<td>Aboriginal Substance Misuse Services Standards</td>
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<td>Acquired Brain Injury Services</td>
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<td>Ambulatory Care Services</td>
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<td>Assisted Reproductive Technology for Clinical Services</td>
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<td>Case Management Services</td>
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<td>Community-Based Mental Health Services and Supports</td>
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<td>Transfusion Services</td>
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*Added to standards for on-site surveys starting in January 2016.
## 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

### 2013
**New ROPs**
- Antimicrobial stewardship (for acute care)
- 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

### 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)

**Minor revision**
- Client identification (formerly Two client identifiers)

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

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.