



**ACCREDITATION
AGRÉMENT**
CANADA
Qmentum

STANDARDS

Organ and Tissue Transplant Standards

For Surveys Starting After:
January 01, 2019

Date Generated: January 22, 2019
Ver. 14

IMPORTANT: PLEASE READ THE FOLLOWING CAREFULLY. USE OF THIS PUBLICATION IS SUBJECT TO THE TERMS AND CONDITIONS SET OUT BELOW.

This publication is provided by Accreditation Canada. This publication, and all content contained herein, is owned by Accreditation Canada and/or its licensors and is protected by copyright and other intellectual property rights in Canada and around the world.

You are entitled to use this publication internally within your organization for information purposes only. You may reproduce, retransmit, and redistribute this publication internally within your organization (physically or on a digital network) solely for such limited purpose as long as the copyright notice and proper citations and permissions are included. Internal use is limited to a network of up to 30 personnel. **All other use and all other exploitation are expressly prohibited without the express permission of Accreditation Canada.**

Except as otherwise specifically provided above (or except as expressly permitted by Accreditation Canada otherwise), you may not: (i) use this publication for any other purpose (including without limitation, for commercial purposes), (ii) reproduce, retransmit, reprint or distribute this publication to any other person or entity, (iii) modify, amend or translate this publication, (iv) remove, modify or obscure any trade names, trademarks or copyright notices included in this publication, (v) combine this publication (in whole or in part) with any other materials (or software).

This publication is provided “as is” without warranty of any kind, whether express or implied, including without limitation any warranties of suitability or merchantability, fitness for purpose, the non-infringement of intellectual property rights or that this publication and the contents thereof is complete, correct, up to date, and does not contain any errors, defects, deficiencies or omissions. In no event shall Accreditation Canada and/or its licensors be liable to you or any other person or entity for any direct, indirect, incidental, special or consequential damages whatsoever arising out of or in connection with this publication and/or the use or other exploitation thereof (including lost profits, anticipated or lost revenue, loss of data, loss of use of any information system, failure to realize expected savings or any other economic loss, or any third party claim), whether arising in negligence, tort, statute, equity, contract (including fundamental breach), common law, or any other cause of action or legal theory even if advised of the possibility of those damages.

If you do not accept these terms and conditions (in whole or in part) you may not use this publication. Your failure to comply with any of these terms and conditions shall entitle Accreditation Canada to terminate your right to use this publication.

Nothing in these terms and conditions shall be construed or deemed as assigning or transferring to you or your organization any ownership, title or interest in this publication and any content thereof, or any intellectual property rights therein.

For permission to reproduce or otherwise use this publication or the contents thereof for any other purpose, including commercial purposes, please contact standards@accreditation.ca.

© 2017, Accreditation Canada and its licensors

ORGAN AND TISSUE TRANSPLANT STANDARDS

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

Accreditation is one of the most effective ways for organizations to regularly and consistently examine and improve the quality of their services. The standards provide a tool for organizations to embed accreditation and quality improvement activities into their daily operations with the primary focus being on including the client and family as true partners in service delivery.

Client- and family-centred care is an approach that guides all aspects of planning, delivering and evaluating services. The focus is always on creating and nurturing mutually beneficial partnerships among the organization's team members and the clients and families they serve. Providing client- and family-centred care means working collaboratively with clients and their families to provide care that is respectful, compassionate, culturally safe, and competent, while being responsive to their needs, values, cultural backgrounds and beliefs, and preferences (adapted from the Institute for Patient- and Family-Centered Care (IPFCC) 2008 and Saskatchewan Ministry of Health 2011).

Accreditation Canada has adopted the four values that are fundamental to this approach, as outlined by the IPFCC, and integrated into the service excellence standards. The values are:

- 1. Dignity and respect:** Listening to and honouring client and family perspectives and choices. Client and family knowledge, values, beliefs, and cultural backgrounds are incorporated into the planning and delivery of care.
- 2. Information sharing:** Communicating and sharing complete and unbiased information with clients and families in ways that are affirming and useful. Clients and families receive timely, complete, and accurate information in order to effectively participate in care and decision-making.
- 3. Partnership and participation:** Encouraging and supporting clients and families to participate in care and decision making to the extent that they wish.
- 4. Collaboration:** Collaborating with clients and families in policy and program development, implementation and evaluation, facility design, professional education, and delivery of care.

The Organ and Tissue Transplant Standards apply to acute care organizations that provide transplant services. The standards cover the transplant continuum from caring for recipients prior to surgery to long-term follow up care.

These standards include references to the Canadian Standards Association (CSA) standards entitled Cells,

Tissues, and Organs for Transplantation and Assisted Reproduction: General Requirements (Z900.1-03) and two subset standards: Tissues for Transplantation (Z900.2.2-03) and Perfusable Organs for Transplantation (Z900.2.3-03).

The Organ and Tissue Transplant Standards comply with Health Canada's Safety of Human Cells, Tissues and Organs for Transplantation Regulations.

This set of standards contains the following sections:

- **Investing in quality services**
- **Building a prepared and competent team**
- **Providing safe and effective services**
- **Maintaining accessible and efficient information systems**
- **Monitoring quality and achieving positive outcomes**

In alignment with provincial laws and regulations, certain functions and requirements addressed in these standards fall under the jurisdiction of provincial Organ Procurement Organizations. In some provinces, legislation outlines that the Organ Procurement Organization is designated and authorized to carry out specific responsibilities related to the coordination of organ and tissue donation and transplant. As part of the accreditation process, it is important for organizations to involve their donation and transplant stakeholders and partners in order to meet the standards.

The following is a list of Organ Procurement Organizations in Canada:

British Columbia Transplant
 HOPE Program North, Alberta
 Southern Alberta Organ and Tissue Donation Program, Alberta
 Saskatchewan Transplant Program, Saskatchewan
 Transplant Manitoba, Gift of Life, Manitoba
 Trillium Gift of Life Network, Ontario
 Québec-Transplant, Québec
 Organ and Tissue Procurement Program, Department of Health, New Brunswick
 Critical Care Organ Donation Program, Nova Scotia
 Organ Procurement Exchange Network, Newfoundland

All Accreditation Canada standards are developed through a rigorous process that includes a comprehensive literature review, consultation with a standards working group or advisory committee comprised of experts in the field, and evaluation by resident organizations and other stakeholders. If you would like to provide feedback on the standards, please complete the feedback form in this document.

Glossary - List of standard terms for all services

Care delivery model: A conceptual model that broadly outlines the way services are delivered. It is based on a thorough assessment of client needs, involving a collaborative approach and stakeholder input, which considers the best use of resources and services that are culturally appropriate. The benefits of using a care delivery model include improving access to services, providing safe, quality care, promoting a client-centred continuum of care, providing access to a balanced range of services, supporting a highly skilled and dedicated workforce, and reducing inequities in health status.

Care plan: May also be known as the service plan, plan of care, or treatment plan. It is developed in collaboration with the client and family and provides details on the client history as well as the plan for services including treatments, interventions, client goals, and anticipated outcomes. The care plan provides a complete picture of the client and their care and includes the clinical care path and information that is important to providing client-centred care (e.g., client wishes, ability/desire to partner in their care, the client's family or support network). The care plan is accessible to the team and used when providing care.

Client: The recipient of care. May also be called a patient, consumer, individual, or resident. Depending on the context, client may also include the client's family and/or support network when desired by the client. Where the organization does not provide services directly to individuals, the client refers to the community or population that is served by the organization.

Client representative or client advisor: Client representatives work with the organization and often individual care teams. They may be involved in planning and service design, recruitment and orientation, working with clients directly, and gathering feedback from clients and team members. Integrating the client perspective into the system enables the organization to adopt a client- and family- centred approach.

Co-design: A process that involves the team and the client and family working in collaboration to plan and design services or improve the experience with services. Co-design recognizes that the experience of and input from the client and family is as important as the expertise of the team in understanding and improving a system or process.

Electronic Health Record (EHR): An aggregate, computerized record of a client's health information that is created and gathered cumulatively from all of the client's health care providers. Information from multiple Electronic Medical Records is consolidated into the EHR.

Electronic Medical Record (EMR): A computerized record of a client's health information that is created and managed by care providers in a single organization.

Family: Person or persons who are related in any way (biologically, legally, or emotionally), including immediate

relatives and other individuals in the client's support network. Family includes a client's extended family, partners, friends, advocates, guardians, and other individuals. The client defines the makeup of their family, and has the right to include or not include family members in their care, and redefine the makeup of their family over time.

Indicator: A single, standardized measure, expressed in quantitative terms, that captures a key dimension of individual or population health, or health service performance. An indicator may measure available resources, an aspect of a process, or a health or service outcome. Indicators need to have a definition, inclusion and exclusion criteria, and a time period. Indicators are typically expressed as a proportion, which has a numerator and denominator (e.g., percentage of injuries from falls, compliance with standard procedures, team satisfaction). Counts, which do not have a denominator, may also be used (e.g., number of complaints, number of clients harmed as a result of a preventable error, number of policies revised). Tracking indicator data over time identifies successful practices or areas requiring improvement; indicator data is used to inform the development of quality improvement activities. Types of indicators include structure measures, process measures, outcome measures, and balancing measures.

In partnership with the client and family: The team collaborates directly with each individual client and their family to deliver care services. Clients and families are as involved as they wish to be in care delivery.

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

Medical devices and equipment: An article, instrument, apparatus or machine used for preventing, diagnosing, treating, or alleviating illness or disease; supporting or sustaining life; or disinfecting other medical devices. Examples include blood pressure cuffs, glucose meters, breathalyzers, thermometers, defibrillators, scales, foot care instruments, client lifts, wheelchairs, syringes, and single-use items such as blood glucose test strips.

Medical equipment: A subset of medical devices, considered to be any medical device that requires calibration, maintenance, repair, and user training.

Partner: An organization or person who works with another team or organization to address a specific issue by sharing information and/or resources. Partnership can occur at the organization level, team level, or through individual projects or programs.

Patient safety incident: An event or circumstance that could have resulted, or did result, in unnecessary harm to a client. Types of patient safety incidents are:

- *Harmful incident:* A patient safety incident that resulted in harm to the client. Replaces adverse event and sentinel event.
- *No harm incident:* A patient safety incident that reached a client but no discernible harm resulted.
- *Near miss:* A patient safety incident that did not reach the client.

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

Population: Also known as community. A specific group of people, often living in a defined geographical area who

may share common characteristics such as culture, values, and norms. A population may have some awareness of their identity as a group, and share common needs and a commitment to meeting them.

Procedure: A written series of steps for completing a task, often connected to a policy.

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

Scope of practice: The procedures, actions, and processes that are permitted for a specific health care provider. In some professions and regions, scope of practice is defined by laws and/or regulations. In these cases, licensing bodies use the scope of practice to determine the education, experience, and competencies that are required for health care providers to receive a license to practice.

Self-efficacy: A person's estimate or judgment of his or her ability to cope with a given situation, or to succeed in completing tasks by attaining specific or general goals. An example of achieving a specific goal includes quitting smoking, whereas achieving a general goal includes continuing to remain at a prescribed weight level.

Team: The group of the care professionals who work together to meet the complex and varied needs of clients, families and the community. Teams are collaborative, with different types of health care professionals working together in service provision. The specific composition of a team depends on the type of service provided.

Team leader: Person(s) responsible for the operational management of a team. Duties include identifying needs, staffing, and reporting to senior management. Team leaders may be formally appointed or take a role naturally within the team.

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

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

With input from clients and families: Input from clients and families is sought collectively through advisory committees or groups, formal surveys or focus groups, or informal day-to-day feedback. Input can be obtained in a number of ways and at various times and is utilized across the organization.

Legend

Dimensions



Population Focus: Work with my community to anticipate and meet our needs



Accessibility: Give me timely and equitable services



Safety: Keep me safe



Worklife: Take care of those who take care of me



Client-centred Services: Partner with me and my family in our care



Continuity: Coordinate my care across the continuum



Appropriateness: Do the right thing to achieve the best results



Efficiency: Make the best use of resources

Criterion Types



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



Required Organizational Practices Required Organizational Practices (ROPs) are essential practices that an organization must have in place to enhance client safety and minimize risk.

Tests for Compliance

Minor Minor tests for compliance support safety culture and quality improvement, yet require more time to be implemented.

Major Major tests for compliance have an immediate impact on safety.



Performance Measures Performance measures are evidence-based instruments and indicators that are used to measure and evaluate the degree to which an organization has achieved its goals, objectives, and program activities.

INVESTING IN QUALITY SERVICES

1.0 **Services are designed collaboratively to meet the needs of clients and the community.**



Client-centred
Services



1.1 Services are co-designed with clients and families, partners, and the community.

Guidelines

Collaboration with clients, partners, and the community in service design is achieved through client advocacy groups, community advisory committees, and client experience surveys. Gaps in services are identified and addressed where possible.



Population
Focus

1.2 Information is collected from clients and families, partners, and the community to inform service design.

Guidelines

New information may be solicited from clients and families, partners, and the community, or existing information may be used when it is still relevant. If it is not within the team's mandate to collect information, the team knows how to access and use information that is available. Information can come from internal and external sources such as the Canadian Institute of Health Information (CIHI), census data, end-of-service planning reports, wait list data, and community needs assessments.

The information includes the expressed needs of clients served by the organization as well as trends that could have an impact on the community and its health service needs.

Health service needs are influenced by health status, capacities, risks, and determinants of health (i.e., income, social support networks, education and literacy, employment/working conditions, access to health services, gender, and culture).



Appropriateness

- 1.3 Service-specific goals and objectives are developed, with input from clients and families.

Guidelines

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

Goals and objectives are meaningful to the team. They are reviewed annually or as needed and their achievement is evaluated.

Goals and objectives align with federal and provincial/territorial objectives as required.



Appropriateness

- 1.4 There is a written policy that clearly specifies which organs and tissues may be transplanted.

Guidelines

Some organizations may do only certain types of transplant, e.g., some only do kidney transplants while others may do a variety such as kidney, heart, lung, and liver transplants.



Efficiency

- 1.5 Services are reviewed and monitored for appropriateness, with input from clients and families.

Guidelines

Monitoring and evaluating its services allows the team to examine what services are being offered to and used by clients, and identify areas for improvement. The type of information gathered about services is determined with input from clients and families.

Monitoring the use of services can make internal processes more efficient by identifying service gaps, either within the organization or in the community. Services are assessed to determine whether they are being offered and used as intended, are of appropriate quality, and whether there are opportunities to improve the service design and range of services.

This information is used to improve efficiency by minimizing duplication, evaluating cost-effectiveness of technologies and interventions, and increasing consistency across the organization.

Choosing Wisely Canada (<http://www.choosingwiselycanada.org>) provides information on services for various areas of service that may be unnecessary or inappropriate.



Continuity

1.6

Partnerships are formed and maintained with other services, programs, providers, and organizations to meet the needs of clients and the community.

Guidelines

Meeting the full range of needs of clients and a community is beyond the capabilities of one team or organization. Partnerships may be created to help clients navigate services across the continuum of care, or to fill service gaps.

Partnerships may be formed with primary care, acute care, community organizations, mental health services, education, housing, or social services. The organization may also partner or establish linkages with federal, provincial, or territorial organizations as well as non-governmental organizations.

Linkages and partnerships vary depending on the range of services provided by the organization and clients' needs.



Appropriateness

1.7 Written agreements are established with Organ Procurement Organizations (OPO), tissue banks, and donor referral centres to coordinate transplant services across the continuum.

Guidelines

Open communication and collaboration with OPOs, tissue banks, and donor referral centres facilitates better patient care flow and more efficient donation referral and transfers.



Efficiency

1.8 There is a written policy and procedures for collaborating with OPOs.

Guidelines

The OPO plays an important role in facilitating and coordinating donation and transplant by assisting in the procurement, distribution and delivery of donated organs and tissues as well as communicating and making arrangements with the transplant teams.



Safety



1.9 A list of all health care professionals who are authorized to accept and receive donated organs is maintained.
CSA Reference: Z900.2.3-03, 18.3, 18.4.



Safety



1.10 The OPO is provided annually with a list of transplant surgeons qualified and authorized to perform organ recovery procedures.



Accessibility

- 1.11 Information on services is available to clients and families, partner organizations, and the community.

Guidelines

The information addresses, at minimum, the scope of the organization's services; costs to the client, if any; how to access services; contact points; the effectiveness and outcomes of services; other services available to address the client's needs; and any partner organizations.

Clients and families, partner organizations, and the community are engaged to determine what information is required or desired, and to evaluate whether the information provided meets their needs.



Accessibility

- 1.12 Barriers that may limit clients, families, service providers, and referring organizations from accessing services are identified and removed where possible, with input from clients and families.

Guidelines

There is a process to identify, report, and try to remove barriers to access.

Barriers to access may include the proximity and distribution of services, the physical environment, the cultural acceptability of services, wait times, the types of services available, language barriers, financial barriers, availability of transportation, and access to 24-hour emergency services.

Where barriers are beyond the control of the organization or team, they work with partners and/or the community to minimize them.

- 2.0 **Sufficient resources are available to provide safe, high-quality, and client-centred services.**



Appropriateness

- 2.1 Resource requirements and gaps are identified and communicated to the organization's leaders.

Guidelines

The resources needed to provide safe, effective, and high quality care are determined by team members and the organization. Resources may be human, financial, structural, informational, or technological.

Identifying resource requirements is a collaborative process between the team and the organization's leaders. It includes criteria to determine where resources are required, potential risks to the team and clients, gaps in services, service bottlenecks, or barriers to service delivery or access.

The team and the organization's leaders work together to determine how to effectively use available resources or where additional resources are required.



Appropriateness

- 2.2 Technology and information systems requirements and gaps are identified and communicated to the organization's leaders.

Guidelines

Technology includes electronic medical/health records (EMR/EHR), decision tools, client tracking systems, wait list management systems, client self-assessment tools, or access to service-specific registries and/or databases. Depending on the organization, the need for systems could be complex (e.g., advanced software to increase interoperability) or support basic operation (e.g., newer computer systems).

As much as possible, innovative information technology is used to support the work of the service area.



Efficiency

- 2.3 Communication devices such as pagers and cell phones are provided to the appropriate team members for the rapid relay and coordination of transplant activities.



Appropriateness

- 2.4 An appropriate mix of skill level and experience within the team is determined, with input from clients and families.

Guidelines

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

Optimal evidence-based ratios of skills and experience are determined. Team members have a broad range of knowledge, skills, and experience working with various client groups.

Clients and families have a unique perspective on the skills level and experience available on their team. They may be able to point to services that were not available through their care team as well as individual skills and knowledge that could improve the client experience. For example, clients and families may be well positioned to recognize a resource or knowledge gap on the team (e.g., knowledge of community resources; experience working with clients and families with certain conditions, barriers, levels of understanding, or languages) as well as areas to improve communication (e.g., between teams, between providers, when and how the team communicates with clients and families).



Appropriateness

- 2.5 There are a sufficient number of staff members across all relevant disciplines to prevent organ offers from being declined and transplants from being cancelled when donated organs are available.

Guidelines

To prevent transplant cancellations, team members are available to accept, recover, and transplant organs 24 hours per day, 365 days per year.

Team members include transplant coordinators, transplant surgeons, physicians, nurses, dietitians, pharmacists, lab technicians, psychologists or psychiatrists, social workers, and rehabilitation therapists.



Appropriateness

- 2.6 There are a sufficient number of team members to complete data reporting requirements.

Guidelines

In addition to data that may be tracked by the organization for quality improvement purposes, data reporting requirements also include data submitted to the Canadian Institute for Health Information's Canadian Organ Replacement Register (CORR).



Efficiency

- 2.7 Standards for timely access to the diagnostic and consultative services required to complete evaluation and testing throughout the transplant process are followed and monitored.

Guidelines

Diagnostic and consultative services may include radiology, labs or blood banks, and cardiac support services from other departments.

Client-centred
Services

- 2.8 Space is co-designed with clients and families to ensure safety and permit confidential and private interactions with clients and families.

Guidelines

To the extent possible, the physical space is designed to be safe and to respect privacy and confidentiality. Clients and families are involved in planning and designing the layout and use of space to meet their needs. Client dignity; respect, privacy, and confidentiality; accessibility; infection prevention and control; and other needs specific to the clients and community served are considered in space use and design.

When services are provided outside the organization (e.g., in a client's home or a community partner organization), the team works with the client or partner to maintain safety and privacy.



Efficiency

- 2.9 Throughout the transplant process, operating rooms, ICU beds, and ward care are accessible in a timely manner.



Appropriateness

- 2.10 The effectiveness of resources, space, and staffing is evaluated with input from clients and families, the team, and stakeholders.

Guidelines

Evaluating resources, space, and staffing helps determine the extent to which effective services are being provided and identifies opportunities for improvements. Input from clients and families, the team, and stakeholders is gathered through surveys, focus groups, advisory committees, and informal feedback.



Efficiency

- 2.11 The appropriate space and team members are available to manage recipients post-transplant.

Guidelines

Resources to manage recipients post-transplant may include outpatient clinics or other follow-up services.



Appropriateness

- 2.12 Team members and clients have access to information about community services, including palliative and end-of-life care.

Guidelines

Written and verbal information is provided as needed, and may include information about rehabilitation, community mental health, and primary care, depending on the population served and the resources available. The level of understanding, literacy, language, disability, and culture of the client population are considered when developing and providing information.

Information on palliative and end-of-life care includes information for clients and families as well as resources for the team.



Accessibility

- 2.13 A universally-accessible environment is created with input from clients and families.

Guidelines

The service environment is kept clean and clutter-free to support physical accessibility for those who use mobility aids such as wheelchairs, crutches, or walkers. The environment is also accessible for those with language, communication, or other requirements, such as those who have auditory, visual, cognitive, or other impairments.

Where team members work outside the organization (e.g., delivering care in the community, home care) they work with partners, clients, and families to support accessibility.

- 3.0 There are standard operating procedures (SOPs) for all aspects of the transplant process.**



Appropriateness

- 3.1 An SOP manual is available to all members of the transplant team. CSA Reference: Z900.1-03, 6.1.



Appropriateness

- 3.2 The SOP manual is dated and signed by the Medical Director. CSA Reference: Z900.1-03, 6.1.



Appropriateness

- 3.3 Each SOP contains the title and purpose, a unique identification number, the date it was implemented or revised, the signature of the authorizing person(s) and the date of authorization, the steps to be followed in the procedure, and who is responsible for checking, reviewing, and approving the SOP. CSA Reference: Z900.1-03, 6.2.



Appropriateness

- 3.4 There are SOPs on the qualifications and responsibilities of team members; the recipient assessment process; patient care protocols; immunosuppressant methods and medications; infection control procedures; wait list management including those authorized to make changes to the wait list; allocation algorithms; recipient record keeping; consent procedures; individuals who may act as a designate for the Medical Director of the transplant program; exceptional distribution; and harmful incidents and recalls. CSA Reference: Z900.1-03, 6.3.

Guidelines

Some of the required SOPs may be developed and maintained by the OPO and some by the hospital.



Appropriateness

- 3.5 Training is provided to the team before implementing a new or revised SOP. CSA Reference: Z900.1-03, 6.4.



Appropriateness

3.6 The training provided to the team on the SOPs is documented.



Appropriateness

3.7 Compliance with SOPs is monitored regularly.



Appropriateness

3.8 The effectiveness of the SOPs is annually reviewed and evaluated. Based on the results, the SOPs, training activities, or monitoring processes are changed as necessary.



Appropriateness

3.9 Relevant SOPs are reviewed following patient safety incidents, changes in regulatory or legal requirements, internal or external audits, and other situations as defined in the program's policies.



Appropriateness

3.10 All changes to the SOPs are tracked and version numbers are documented.



Appropriateness

3.11

New or revised SOPs are approved by the Medical Director or designate.
CSA Reference: Z900.1-03, 6.4.

BUILDING A PREPARED AND COMPETENT TEAM



Appropriateness

4.0 Team members are qualified and have relevant competencies.

4.1 The transplant program is supervised by a qualified Medical Director.
CSA Reference: Z900.2.3-03, 4.2.

Guidelines

The qualified Medical Director is a transplant physician or surgeon.



Appropriateness

4.2 Team members have the necessary credentials and licensing.
CSA Reference: Z900.2.3-03, 4.2.

Guidelines

Transplant physicians and surgeons who are appointed as medical staff at the transplant centre are licensed medical doctors certified through the Royal College of Physicians and Surgeons of Canada [FRCP (Fellow of the Royal College of Physicians), or FRCS (Fellow of the Royal College of Surgeons)] or equivalent.

Physicians and surgeons caring for transplant patients have at least one year of formal transplant training, during the course of which they have had responsibility for all aspects of transplant, i.e. donor and recipient management, and post-operative care such as immunosuppressive management.



Appropriateness

4.3 Depending on the type of organ or tissue transplanted, transplant coordinators are qualified physicians, registered nurses, or health care professionals with one year of experience in organ retrieval, clinical transplant work, or organ-specific work.
CSA Reference: Z900.2.3-03, 4.2.

Guidelines

The transplant coordinators are responsible for coordinating pre-operative care of the recipients.



Client-centred
Services

- 4.4 Transplant physicians and surgeons are regularly educated about when and how to add candidates to transplant wait lists and organ allocation.

Guidelines

The Canadian Society of Transplantation (CST) reviews its policies on adding clients to organ-specific wait lists annually and makes recommendations for changes. Information about CST reviews and recommendations is regularly communicated to transplant teams.



Appropriateness

- 4.5 Newly-recruited transplant coordinators participate in an orientation and training period which addresses the standard operating procedures and the transplant program.
CSA Reference: Z900.2.3-03, 4.2.



Appropriateness

- 4.6 At the end of orientation and training, newly-recruited transplant team members demonstrate theoretical and practical knowledge.
CSA Reference: Z900.2.3-03, 4.2.

Guidelines

Theoretical and practical knowledge is included in the SOPs and is determined by the Medical Director or designate.



Worklife

- 4.7 Regular training and education about providing transplant services are provided to the team.
CSA Reference: Z900.1-03, 4.2.2.3.

Guidelines

Team members are educated about all phases of the transplant process, including pre- and post-operative recipient care as well as familiarity with standards, best practices, laws and regulations, and delivering client-centred care.

Client-centred
Services

- 4.8 Education and training are provided to team members on how to work respectfully and effectively with clients and families with diverse cultural backgrounds, religious beliefs, and care needs.

Guidelines

Cultural education and training build the skills, knowledge, and attitudes that are required to safely and appropriately deliver interventions and services to culturally diverse populations. The training may cover topics such as disability, level of understanding, or mental health.

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



Appropriateness

- 4.9 Education and training are provided on the organization's ethical decision-making framework.

Guidelines

Training and support to handle ethical issues is provided to team members. Ethics-related issues include conflicts of interest, conflicting perspectives between clients and family and/or team members, a client's decision to withdraw care or to live at risk, and varying beliefs or practices.



Safety



4.10

Education and training are provided on the safe use of equipment, devices, and supplies used in service delivery.

Guidelines

Information about the safe use of equipment is provided to all team members. They are trained on how to use existing and new equipment, devices, and supplies. Retraining may be requested or required if a team member does not feel prepared to use the equipment, device, or supplies, or has not used the equipment or device for a long time.

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



Safety



4.11

REQUIRED ORGANIZATIONAL PRACTICE: 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.

Test(s) for Compliance

Major	4.11.1	Instructions and user guides for each type of infusion pump are easily accessible at all times.
--------------	--------	---

Major	4.11.2	<p>Initial and re-training on the safe use of infusion pumps is provided to team members:</p> <ul style="list-style-type: none"> • 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 <p>When infusion pumps are used very infrequently, just-in-time training is provided.</p>
Major	4.11.3	<p>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.</p>
Major	4.11.4	<p>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.</p>
Minor	4.11.5	<p>The effectiveness of the approach is evaluated. Evaluation mechanisms may include:</p> <ul style="list-style-type: none"> • 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	4.11.6	<p>When evaluations of infusion pump safety indicate improvements are needed, training is improved or adjustments are made to infusion pumps.</p>
	4.12	<p>Education and training are provided on information systems and other technology used in service delivery.</p>



Appropriateness

Guidelines

Education and training may cover topics such as knowledge of computer applications, word processing, software, time management tools, communication tools, research applications, cell phone use, and protecting the privacy of client information.



Continuity



4.13

Education and training are provided on how to identify palliative and end-of-life care needs.

Guidelines

Training includes information on the organization's process to provide or facilitate access to palliative care and end-of-life services, communicating with families about end-of-life issues, and how and when to initiate discussions about palliative and end-of-life care.

Federal, provincial, and territorial legislation and regulations regarding consent and substitute decision making are followed.



Worklife



4.14

Team member performance is regularly evaluated and documented in an objective, interactive, and constructive way.

Guidelines

An established process to evaluate each team member's performance is followed. Client and/or peer input is part of the evaluation process.

The evaluation may consider the team member's ability to carry out responsibilities, apply the principles of client-centred care, and contribute to the values of the organization. It may also consider the individual's strengths; opportunities for growth; contributions toward patient safety, worklife, and respecting client wishes; or specific competencies described in the position profile. The evaluation may identify issues that require follow up such as unprofessional or disruptive behaviour or challenges adopting client-centred care practices.

A performance evaluation is usually done before the probationary period is completed and annually thereafter, or as defined by the organization. An evaluation may also be completed after retraining or when new technology, equipment, or skills are introduced.



Appropriateness

4.15

A demonstration of competence is included as part of the performance evaluation.

CSA Reference: Z900.1-03, 4.2.



Client-centred
Services

4.16

Client and family representatives are regularly engaged to provide input and feedback on their roles and responsibilities, role design, processes, and role satisfaction, where applicable.

Guidelines

Regular communication between team members/leaders and client and family representatives ensures that the relationship is mutually beneficial. Discussions include opportunities for increased collaboration and role satisfaction.

Though an open and transparent dialogue is encouraged, team leaders recognize that client and family representatives are to remain independent from the organization, to ensure their opinions and recommendations remain unbiased.



Worklife



4.17

Team members are supported by team leaders to follow up on issues and opportunities for growth identified through performance evaluations.

Guidelines

Issues may be identified by the team member or the team leaders and are used to develop an action plan or professional development plan.



Worklife

4.18

Ongoing professional development, education, and training opportunities are available to each team member.

Guidelines

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

5.0

Services are provided within a collaborative team environment.



Appropriateness



5.1

A collaborative approach is used to deliver services.

Guidelines

An interdisciplinary collaborative team needs to evolve and adapt to the changing needs of the client. Depending on the needs and desires of the client and family, the team may consist of specialized roles (e.g., care providers) and support roles (e.g., care planners, translators, security staff, or representatives from community partner organizations). Students, volunteers, and client representatives or advisors may also be included as part of the team.

A team leader (or leaders) is defined and the role of each team member is made clear to the client and family.

The collaborative team is established based on defined criteria such as accepted standards of practice; legal requirements; knowledge, experience, and other qualifications; volume or complexity of caseload; changes in workload; and client safety and needs.



Appropriateness

5.2

The team works in collaboration with clients and families.

Guidelines

Clients and families are engaged in shared decision making and understand how care is provided. The client defines the makeup of their family, and has the right to include or not include family members of their choice in their care, and the right to redefine the makeup of their family over time. Family includes an individual's extended family, their partners, friends, advocates, guardians, and other representatives.



Worklife

5.3

Position profiles with defined roles, responsibilities, and scope of employment or practice exist for all positions.

Guidelines

Position profiles include a position summary, qualifications and minimum requirements, the nature and scope of the work, and reporting relationships. They are developed for all team members including those who are not directly employed by the organization (e.g., contracted team members, partners, client and family representatives).

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



Safety



5.4

Standardized communication tools are used to share information about a client's care within and between teams.

Guidelines

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

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



Appropriateness

5.5

The effectiveness of team collaboration and functioning is evaluated and opportunities for improvement are identified.

Guidelines

The process to evaluate team functioning and collaboration may include a review of its services, processes, and outcomes. This could be done by administering a team functioning questionnaire to team members, clients and families, and partners to stimulate discussion about areas for improvement.

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



Worklife

6.0 Well-being and worklife balance is promoted within the team.

6.1 The workload of each team member is assigned and reviewed in a way that ensures client and team safety and well-being.

Guidelines

Appropriate criteria are used for determining workload depending on the environment and the unique demands of different services areas, including hours of work, caseload, role complexity, complexity of client care, physical or emotional demands, repetitive nature of tasks, and level of responsibility. The preferences and availability of each team members are also considered.

In some cases teams may designate a maximum workload for team members. The process of assigning and reviewing workload includes monitoring and tracking hours and clients and when additional measures are needed (e.g., staffing transfers or team re-design).

An environment where team members are comfortable discussing demands and stress levels in the workplace is promoted by the organization and leaders. Measures are taken to alleviate these pressures as much as possible. These can include scheduling strategies, workload sharing, and scheduled time for documentation.



Worklife

6.2 There are specific measures in place to avoid excessive consecutive hours of work and fatigue.

Guidelines

Measures to avoid fatigue and consecutive hours of work may include having back-up staff to relieve people that feel fatigued and encouraging a culture where staff feel comfortable admitting when they are fatigued.



Worklife

- 6.3 Work and job design, roles and responsibilities, and assignments are determined with input from team members, and from clients and families where appropriate.

Guidelines

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

When developing and reviewing job design, roles, responsibilities, and assignments, team member and client and family input and feedback is considered. They can all provide unique insight into areas of job design that directly impact them. The flexibility of job design, roles, responsibilities, and assignments will vary depending on the type of services being delivered, the clients being served, and the individual team members involved. Assignments include who each provider cares for, as well as other elements of the team members' roles (e.g., participation in quality improvement activities, training new staff members).



Worklife

- 6.4 Team members are recognized for their contributions.

Guidelines

Recognition activities may be individual, such as awards for years of service or special achievements, or they may involve team recognition or activities.

Recognition can be formal or informal and may be verbal, written, or focus on promoting an atmosphere where team members feel appreciated for their contributions.



Worklife

- 6.5 There is a policy that guides team members to bring forward complaints, concerns, and grievances.



Safety



6.6

Education and training on occupational health and safety regulations and organizational policies on workplace safety are provided to team members.



Safety



6.7

Education and training are provided on how to identify, reduce, and manage risks to client and team safety.

Guidelines

Training may include physical hazards; challenges with equipment; handling spills, waste, or infectious materials; working with clients who may pose a risk to themselves or others; and challenges with handling, storing, or dispensing medications.

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



Safety



6.8

Education and training are provided to team members on how to prevent and manage workplace violence, including abuse, aggression, threats, and assaults.

Guidelines

Acts of violence include abuse, aggression, threats, and assaults. They may be committed by clients, their families, teams, or anyone else in the workplace.

Where possible, team members use de-escalation techniques as a preventive measure. De-escalation techniques are minimally intrusive and the least restrictive way to manage violence. Some training programs on how to safely work with clients who are at risk of or who exhibit aggressive or responsive behaviors include:

- CPI Training (Crisis Prevention and Intervention)
- GPA (Gentle Persuasive Approach)
- U-First!

Training and education include the use of a standardized risk assessment tool such as the Hamilton Anatomy of Risk Management (HARM) tool. Training may address:

- Identifying triggers
- Assessing and communicating a client's potential for violence and recognizing signs of agitation and aggression
- Reducing harassment
- Responding to and managing violence (e.g., non-violent crisis intervention, emergency code response guidelines, conflict resolution and mediation, and self-defense)
- The trauma-informed approach
- Communication techniques

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



Safety



6.9

The organization's policy on reporting workplace violence is followed by team members.

Guidelines

Perceived, potential, or actual incidents of physical or verbal violence are reported to the appropriate authorities in accordance with applicable legislation, and may be reported in the client medical record depending on the nature of the incident.

PROVIDING SAFE AND EFFECTIVE SERVICES

7.0 A comprehensive assessment of each potential transplant candidate is conducted, in partnership with candidates and their families, to determine if they should be placed on the wait list.



Client-centred
Services

7.1 Clients and families are encouraged to be actively engaged in their care.

Guidelines

The environment encourages clients and families to be active participants in their care, ask questions, and provide input at all stages of the care process.



Client-centred
Services

7.2 The client's wishes regarding family involvement in their care are respected and followed.

Guidelines

The team finds ways to include members of the client's support network in the client's care.

Applicable legislation when a substitute decision maker or family is involved in decision-making is respected. There is a process to resolve conflicts regarding level of desired involvement between the client and family.



Continuity

7.3 Diagnostic and laboratory testing and expert consultation are available in a timely way to support a comprehensive assessment.



Safety



7.4

The assessment for each potential transplant candidate, conducted in partnership with the candidate and their family, includes a medical history and physical exam; diagnosis of organ disease and illness; previous surgeries and medications; vital signs; testing for infectious diseases; and indications and contraindications to transplant.

CSA Reference: Z900.2.3-03, 18.5.

Client-centred
Services

7.5

A psychosocial evaluation of each potential transplant candidate is conducted in partnership with the candidate and their family.

Client-centred
Services

7.6

Goals and expected results of potential transplant candidate's care and services are identified in partnership with the potential transplant candidate and their family.

Guidelines

The potential transplant candidate's physical and psychosocial needs, choices, and preferences as identified in the potential transplant candidate assessment are used to develop service goals. Service goals and expected results suit the potential transplant candidate's individual circumstances, are achievable, measurable, and complement those developed by other team members and organizations with which the client is involved.

Client-centred
Services

7.7

Standardized assessment tools are used during the assessment process.

Guidelines

Tools are standardized and adopted across the team, and where applicable, across the organization. Assessment tools are designed to assist the team to systematically collect and interpret all of the information gathered during the assessment process. Benefits of using standardized tools for the client and the care provider include being more efficient, collecting more accurate information, consistency of assessment, and reliability of results and improved opportunity for communication between the client and the care provider.

The standardized assessment tools used will vary depending on the needs of the client and the type and range of services provided. Examples of standardized assessment tools are the Glasgow Coma Scale, the Clinical Frailty Scale, the Beck Depression Inventory, or the InterRAI tool. The standardized assessment tools used are evidence-informed and meaningful for the services provided.



Appropriateness

7.8

Each client's preferences and options for services are discussed as part of the assessment, in partnership with the client and family.

Guidelines

The client's expressed needs, preferences and the options for care and service are discussed with the client and family. The team and client engage in shared-decision making that considers client preferences, expected outcomes, and risks and benefits of the options.

For example, various strategies to manage pain—such as analgesics including opioids and adjuvants, as well as physical, behavioural, and psychological interventions—may be discussed and the client is able to select the preferred option.

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



Client-centred
Services

7.9

An assessment of the client's palliative and end-of-life care needs is completed, where appropriate, in partnership with the client and family.

Guidelines

The need for a palliative care assessment may be expressed by the client or family or identified by the team. The types of services that may be required are identified. Early identification of palliative care needs allows clients and families to be involved in care planning and can improve the quality of care and family satisfaction throughout the process.

In an organization or service area that does not provide palliative and end-of-life care, the assessment identifies the need to connect the client and family to the appropriate services.



Appropriateness



7.10

The results of the assessment are recorded in the potential transplant candidate's medical record.
CSA Reference: Z900.2.3-03, 18.5.



Client-centred
Services



7.11

The results of the assessment and the outcome are communicated to the potential transplant candidate in an easily understandable and timely manner.

Guidelines

Based on the results of the assessment, the potential transplant candidate is informed whether or not they will be added to the wait list. The definition of the potential transplant candidate's status and what it means to be “ready” versus “non-ready” or “on hold” for transplant is explained.



Continuity



7.12

A comprehensive and individualized care plan is developed and documented in partnership with the potential transplant candidate and their family.

Guidelines

The care plan is based on the results of the assessment and the potential transplant candidate's service goals and expected results. It includes the roles and responsibilities of the team, other organizations, and potential transplant candidates and their families. It includes detailed information about the potential transplant candidate's history, assessments, diagnostic results, allergies, and medication, including any medication issues or adverse drug reactions.

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



Appropriateness



7.13

There is a process to review and approve all new listings and urgent cases.

Guidelines

The process may include having “listing conferences” where each organ-specific transplant team meets to discuss new people added to the wait list, changes in status (e.g., changes to high status or urgent cases).



Appropriateness

7.14

National guidelines for determining the suitability of potential transplant candidates and listing criteria for placing them on the transplant wait list are adhered to.

Guidelines

The organ-specific national guidelines cover minimum testing criteria.

Client-centred
Services

7.15

Decision-making processes and policies for placing potential transplant candidates on transplant wait lists are made available to the public.



Client-centred
Services

- 7.16 Planning for care transitions, including end of service, are identified in the care plan in partnership with the client and family.

Guidelines

Including information in the care plan about transition planning, whether to home, another team, an alternate level of care, or end of service, enhances coordination among teams or partner organizations and helps prepare clients for the end of service. Client involvement in end-of-service planning ensures the client and family are prepared and know what to expect.

Discussions about the client's transition and post-care needs and preferences are part of developing the care plan. The discussion may include post-care follow up, ability to perform self-care, referrals to community supports, or other anticipated needs or challenges.



Client-centred
Services



- 8.0 **Accurate and confidential transplant wait lists are maintained in a manner that is sensitive to those waiting for transplant.**

- 8.1 The meaning of wait list status, how organs are allocated, and how and when they will be kept informed is explained to potential recipients.



Client-centred
Services



- 8.2 Potential recipients on the wait list and their referring physician are kept informed of their status at least annually.



Client-centred
Services

- 8.3 Wait lists are regularly reviewed and updated, including promptly removing the names of deceased individuals and individuals with contraindications.



Client-centred
Services

- 8.4 The medical status of potential recipients on wait lists is kept current.

Guidelines

Keeping potential recipients' medical status or readiness for transplant current may include reviewing and updating their medical condition, blood work, and other work up.



Client-centred
Services



- 8.5 Potential recipients are promptly notified when their status on the wait list changes.



Client-centred
Services

- 8.6 Organizations that maintain national lists are promptly notified when a potential recipient's status changes or when that potential recipient becomes an urgent case.



8.7

Wait lists are kept secure and access is limited to authorized team members.
CSA Reference: Z900.2.3-03, 18.5.



8.8

There is a written procedure for receiving updates and making changes to the wait lists.
CSA Reference: Z900.2.3-03, 18.3.



8.9

Changes to transplant wait lists are made by authorized team members only.
CSA Reference: Z900.2.3-03, 18.3.

Guidelines

The team members that are authorized to make changes to transplant wait lists are listed in the SOP.



8.10

Access to emotional support and counselling is provided to those who are removed from the wait list.

9.0

Organs are allocated in an equitable and transparent manner.



9.1

Organs are allocated using an established, transparent algorithm.

Guidelines

The algorithm may be local or regional and may contain factors such as medical urgency, age-matching, HLA matching sensitization status, the possibility of combined organ transplant, or length of wait time.

The algorithm guidelines take into account the short amount of time some organs can remain viable and the need to assign organs to the most suitable recipient.



Client-centred
Services

- 9.2 Candidates are promptly notified when an organ is available and they are being considered as potential recipients.

Guidelines

More than one potential recipient may be notified in order to prepare a “back-up” candidate in the event that one of the potential recipients has last minute contraindications.



Client-centred
Services

- 9.3 Access to emotional support and counselling services for the candidate or for any of the “back-up” candidates who did not receive the organ is provided.

Guidelines

To assist with the difficult prospect of not receiving a transplant, those who were informed that an organ was available but who did not receive the organ are given access to emotional support and counselling.



Client-centred
Services



- 9.4 The algorithm guideline that was used for each organ that is transplanted is documented.



Client-centred
Services



9.5

When organ allocation deviates from the recommended algorithm guidelines, documented criteria for decision making are followed.



Client-centred
Services



9.6

When organ allocation deviates from the algorithm guidelines, the medical reasons and rationale for the deviation are documented.

Guidelines

An organ may be allocated for medical reasons that do not align with the established algorithm guidelines. When this happens, the medical reasons and rationale for allocating the organ and deviating from the guidelines are documented.



Appropriateness

9.7

Exceptions to the algorithm guidelines are regularly reviewed and analyzed, peer-to-peer accountability reviews are conducted, and corrective action is taken to adjust the guidelines as appropriate.



Appropriateness

9.8

Algorithms are promptly reviewed and changes are made based on recommendations by experts and decision makers.

Guidelines

Advancements in the donation and transplant field may influence changes to organ allocation policies and algorithms. An analysis of exceptions to the guidelines that the team has experienced on-site may also influence changes.



Client-centred
Services

9.9 Algorithm guidelines used to allocate organs are made available to the public.



Client-centred
Services

10.0 Recipients are provided with information about the transplant procedure and all of their concerns are responded to.

10.1 Recipients and their families are provided with information about the transplant procedure, its risks, and potential outcomes so they can make an informed choice.

Guidelines

Recipients are provided with information about the risks (medical, surgical, psychosocial and financial) and possible outcomes of the transplant in a language understood by the recipient. Information about the requirements of the pre-operative assessment and availability of emotional support, counselling, and rehabilitation post-transplant are also provided.



Client-centred
Services

10.2 Information about the transplant is communicated in a manner that is easy for those without medical training to understand.

Guidelines

Communication is free of jargon and complex medical terminology, increasing the likelihood that the recipient will understand the information provided.



Client-centred
Services

10.3 The client's capacity to provide informed consent is determined.

Guidelines

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

Federal, provincial, and territorial legislation are followed when working with children and youth. When dealing with the elderly, minors, or those deemed incapable of consenting, clients are involved to the greatest extent possible in making decisions about their services, and the team values their questions and input.



Client-centred
Services



10.4 Informed consent is obtained and documented prior to performing the transplant.

Guidelines

Informed consent is documented in the medical record, including the identity of the person giving consent.



Client-centred
Services



10.5 When recipients are incapable of giving informed consent, the client's advance directives are referred to, if available, or consent is obtained from a substitute decision maker.

Guidelines

Clients who are incapable of providing consent may have advance directives to guide certain or all decisions. Advance directives are documented in the medical record and this information is shared with service providers in and outside of the organization, as appropriate.

A substitute decision maker may be consulted when clients are unable to make their own decisions. In these cases, the substitute decision maker is provided with information on their role and responsibilities as a substitute decision maker, and their questions, concerns, and options are discussed. A substitute decision maker may be specified in legislation or may be an advocate, family member, legal guardian, or caregiver.

If consent is given by a substitute decision maker, the name of the substitute decision maker, the relationship to the client, and the decision made is documented in the medical record.



Client-centred
Services



10.6

Prior to the transplant, each recipient is provided with information about their rights.

Guidelines

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

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



Appropriateness



10.7

Organizational processes to identify and address ethical issues are followed.

Guidelines

Ethics-related issues include decisions about providing, forgoing, or withdrawing life-sustaining treatment; obtaining consent for transplant in a way that is free of coercion; and exceptional distribution of organs and tissues from donors based on set criteria, multiple transplants per recipient, exclusionary criteria, and client noncompliance.

The process is established at the organization level and teams receive training about making ethical decisions.

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

Client-centred
Services

10.8

Clients and families are provided with information about how to file a complaint or report violations of their rights.

Client-centred
Services

10.9

A process to investigate and respond to claims that clients' rights have been violated is developed and implemented with input from clients and families.

Guidelines

An environment where clients, families, and team members feel comfortable raising concerns or issues is promoted. The organization may provide access to a neutral, objective person from whom clients and families can seek advice or consultation. Where electronic health records are used, there is a process to receive and respond to client complaints and questions regarding the privacy of the electronic record.

Claims brought forward by team members or other teams are also addressed.

11.0 Requests for exceptional distribution of organs or tissues are made only under those circumstances where it is appropriately justified.



Safety



- 11.1 Requests for exceptional distribution may only be made by the Medical Director or designate of the transplant program to the Medical Director or designate of the donation program.
CSA Reference: Z900.1-03, 17.3.

Guidelines

Health Canada defines exceptional distribution as the distribution of tissues or organs to a transplant program from a donor in whom the donor suitability assessment has identified an increased risk for disease transmission. Exceptional distribution may be permitted only in those circumstances where it is medically justified and the potential benefit outweighs the potential risk to the recipient.



Client-centred
Services



- 11.2 The recipient is informed about the exceptional distribution, its risks, and potential outcomes so they can make an informed choice.
CSA Reference: Z900.2.3-03, 17.3.

Guidelines

Recipients need information about the absolute risks (e.g., of disease transmission) and possible outcomes of proceeding with exceptional distribution in a language understood by them. The information shared should be specific to the exceptional distribution case but also include standard information provided in every exceptional distribution situation.

- | | | | |
|---|---|------|---|
| 
Client-centred
Services | ! | 11.3 | The recipient or substitute decision maker's informed consent to exceptional distribution is recorded in the medical record.
CSA Reference: Z900.2.3-03, 17.3.4. |
| 
Safety | ! | 11.4 | The reasons that justify the exceptional distribution; the organ or tissue name; tests not completed or the conditions not met; the name of the donor organization, the signature of the transplant physician or surgeon authorizing the organ or tissue distribution; and the date of the authorization are recorded in the medical record.
CSA Reference: Z900.2.3-03, 17.3. |
| 
Safety | ! | 11.5 | The exceptional distribution form is completed and returned to the donation team within 48 hours of the donation procedure. |
| 
Client-centred
Services | | 11.6 | Following the exceptional distribution of the organs or tissues and the transplant, the completed results of the donor testing are received and the recipient is informed of the results. |



Client-centred
Services



- 11.7 Recipients that have exceptional distribution transplants are provided with follow up.

Guidelines

Following up on exceptional distribution recipients may involve tracking follow-up testing and results.

- 12.0 **Once the recipient is confirmed, an immediate pre-operative assessment is completed by the transplant team, and they collaborate with the donation team and the operating room to prepare for the procedure.**



Safety



- 12.1 REQUIRED ORGANIZATIONAL PRACTICE: 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 depends 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.

Test(s) for Compliance

Major 12.1.1 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.



Population
Focus



12.2 **REQUIRED ORGANIZATIONAL PRACTICE:** To prevent falls and reduce the risk of injuries from falling, universal precautions are implemented, education and information are provided, and activities are evaluated.

Guidelines

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

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

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

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

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

Test(s) for Compliance

- Major** 12.2.1 Universal fall precautions, applicable to the setting, are identified and implemented to ensure a safe environment that prevents falls and reduces the risk of injuries from falling.
- Major** 12.2.2 Team members and volunteers are educated, and clients, families, and caregivers are provided with information to prevent falls and reduce injuries from falling.
- Minor** 12.2.3 The effectiveness of fall prevention and injury reduction precautions and education/information are evaluated, and results are used to make improvements when needed.



Safety



12.3 **REQUIRED ORGANIZATIONAL PRACTICE:** Medical and surgical clients at risk of venous thromboembolism (deep vein thrombosis and pulmonary embolism) are identified and provided with appropriate thromboprophylaxis.

NOTE: This ROP does not apply for pediatric hospitals; it only applies to clients 18 years of age or older.

This ROP does not apply to day procedures or procedures with only an overnight stay.

Guidelines

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

VTE 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.

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

Test(s) for Compliance

Major	12.3.1	There is a written venous thromboembolism (VTE) prophylaxis policy or guideline.
Major	12.3.2	Clients at risk for VTE are identified and provided with appropriate, evidence-informed VTE prophylaxis.
Minor	12.3.3	Measures for appropriate VTE prophylaxis are established, the implementation of appropriate VTE prophylaxis is audited, and this information is used to make improvements to services.

Major 12.3.4 Major orthopedic surgery clients (i.e., those having hip and knee replacements or hip fracture surgery) who require post-discharge prophylaxis are identified and there is a process to provide them with appropriate post-discharge prophylaxis.

Minor 12.3.5 Information is provided to clients and team members about the risks of VTE and how to prevent it.



Appropriateness



12.4 To minimize the time between organ recovery and transplant, i.e., cold ischemia times, there is collaboration and regular communication between the donation coordinator, operating room booking staff, and the anesthesiology team.

Guidelines

To minimize time between organ recovery and transplant, effective communication and coordination between donation, operating room and transplant recipient teams is critical. Regular updates are provided on progress and any delays due to travel or operating room scheduling.



Efficiency

12.5 There is a policy and procedure that allows for prompt access to the operating room and the anesthesiology team.

Guidelines

Respecting the timeframes between organ recovery and transplant and having prompt access to the operating room contributes to the viability of the organ and the long term health of the recipient.



Safety



12.6 Transplant Fellows who are sent to another facility to recover organs are appropriately qualified and supervised.



Safety



12.7

When using ex-vivo perfusion pumps, manufacturers' guidelines for their proper use are followed.



Safety



12.8

The proper use of perfusion pumps is regularly monitored and their contribution to organ viability is analyzed.



Appropriateness



12.9

A pre-operative assessment of the potential recipient is conducted in partnership with the recipient and their family to rule out new contraindications.

CSA Reference: Z900.2.3-03, 18.5.4.3, 18.6.1.

Guidelines

The pre-operative assessment includes reconfirming the elements of the assessment that were carried out in the initial potential candidate assessment.

Client-centred
Services

12.10

If new contraindications to transplant arise for the recipient and there is no back-up recipient, a written procedure for reallocation that includes reapplying the algorithm guidelines and documenting the results is followed.

13.0

Transplant procedures are carried out safely and effectively.



Safety



13.1

REQUIRED ORGANIZATIONAL PRACTICE: 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.

Test(s) for Compliance

Major	13.1.1	The team has agreed on a three-phase safe surgery checklist to be used for surgical procedures performed in the operating room.
Major	13.1.2	The checklist is used for every surgical procedure.
Major	13.1.3	There is a process to monitor compliance with the checklist.
Minor	13.1.4	The use of the checklist is evaluated and results are shared with the team.

Minor 13.1.5 Results of the evaluation are used to improve the implementation and expand the use of the checklist.



Appropriateness



13.2 Organs are transplanted within the acceptable amount of time after recovery, depending on the type of organ.



Safety



13.3 The recipient's identity is confirmed, and an intra-operative assessment is conducted to make sure the right organ is being transplanted to the right recipient and that the donor's blood type and suitability assessment results are as expected for the recipient.

CSA Reference: Z900.2.3-03, 18.6.1, 18.6.1.

Guidelines

The assessment includes tissue and blood typing, serological and infectious disease testing, and biopsy results, if included. In some instances the donor and recipient may intentionally be mismatched.



Safety



13.4 If errors, accidents, patient safety incidents, or recalls are found, they are documented and the donation team or OPO is promptly notified.



Safety



13.5 The results of the intra-operative assessment, including the donor identification, blood type, test results and any other elements of the suitability assessment, are documented.



13.6

The surgical transplant procedures are properly documented.

Guidelines

Cold ischemia times, warm ischemia times, which perfusion solution was used, and which surgical techniques were used are documented. Any complications that arise during the procedure are also recorded.



13.7

The organ donor identification number is recorded in the medical record.



13.8

When transplanting tissues, instructions on the package and the supplier or source establishment instructions are followed.

Guidelines

Supplier or source establishment instructions may include thawing procedures or specific instructions on how to use or place the tissue.



13.9

When transplanting tissues, the integrity, safety and sterility of the allograft is verified.

Guidelines

Verifying the integrity and sterility of the allograft means checking the product, expiry date, packaging, label and storage temperature.



13.10

When transplanting tissues, the transplant locations, tissue types, and unique tissue identifiers are recorded in the medical record.



13.11

There is a process to provide feedback to the donation team on the entire process including the quality of the organ recovered, preservation, package, label, and donor information.

14.0

Recipients are provided with immediate follow up care after the transplant procedure.



14.1

The client's individualized care plan is followed when services are provided.



14.2

Recipients are provided with prompt access to the appropriate interdisciplinary services following the transplant.

Guidelines

Interdisciplinary services may include nutrition, rehabilitation, emotional support, and counselling.



14.3

The client's health status is reassessed in partnership with the client, and updates are documented in the client record, particularly when there is a change in health status.

Guidelines

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



Safety



14.4

There are written protocols for immunosuppression therapy, infectious prophylaxis, and monitoring rejections.



Safety



14.5

Transplant rejections, infections, and adverse reactions are prevented, monitored, and promptly diagnosed and treated.



Safety



14.6

In the event of a suspected adverse reaction as a result of a transplanted organ or tissue, the donor identification codes are determined and the source establishment is notified.

Guidelines

Adverse reactions may include malignancy or infectious disease transmission.



Appropriateness



14.7

The recipient's identification is provided to the donation team.



Appropriateness

14.8

Client progress toward achieving goals and expected results is monitored in partnership with the client, and the information is used to adjust the care plan as necessary.

Guidelines

Documenting progress toward goals is done using both qualitative and quantitative methods and includes the client and family. It may include the use of standardized assessment tools, discussion with clients and families, and observation.

Client-centred
Services

14.9

Access to spiritual space and care is provided to meet clients' needs.

Guidelines

Spiritual care is available to meet the needs of clients, as required. It includes access to a spiritual leader appropriate to the client's beliefs (e.g., a chaplain, imam, rabbi, or non-denominational counsellor). Clients and families have access to a designated space to observe spiritual practice.

The client's spiritual needs and preferences are seen as integral to the care and healing process, and are discussed when making care decisions that may involve an ethical or spiritual component.

Client-centred
Services

14.10

There is a process for initiating palliative and end-of-life care, as required.

Guidelines

Services are initiated by the team, client, or family, and take into consideration the assessment results. Involvement in palliative and end-of-life care will differ depending on the services provided by the team and the clients served. Where palliative and end-of-life care is not provided by the team, clients are connected with the appropriate services.



Client-centred
Services

- 14.11 Support for the family, team members, and other clients is provided throughout and following the death of a client.

Guidelines

Relevant information is shared with clients and families about the dying process, such as the signs and symptoms of imminent death; coping strategies; how to provide support and comfort during the final hours; and grief and bereavement services.

The client's family and friends are encouraged to use community support systems. When these are insufficient, or when family and friends are identified as being at risk for complex grief reactions, access is facilitated to bereavement services for clients, families, team members, and volunteers, including volunteer support or professional services.



Appropriateness

- 14.12 All services received by the client, including changes and adjustments to the care plan, are documented in the client record.

Guidelines

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

- 15.0 **Timely and comprehensive education is provided to recipients.**



Appropriateness

- 15.1 There are specific team members responsible for educating organ recipients.

Guidelines

Education is interactive. Resources may include information about recipient and caregiver information sessions (individual or group), written materials on community resources, peer support groups, accessing home care services, and rehabilitation.

Client-centred
Services

- 15.2 Education is provided to recipients, families, and caregivers about living with a transplant and identifying and addressing potential changes in lifestyle.

Guidelines

After transplant, recipients, families and caregivers may experience changes in their life roles, e.g. partner relationships, returning to work, caregiver support needed. Information should be provided on possible issues or changes, potential strategies to address these changes, and resources and contact information.

Client-centred
Services

- 15.3 Depending on the type of transplant, nutritional assessments and diet counselling are provided to recipients, families and caregivers post-transplant.

Guidelines

If these services are not provided, recipients, families, and caregivers are referred to the appropriate service providers.

Client-centred
Services

- 15.4 Emotional support and counselling are provided to recipients, families, and caregivers to help them adjust to life post-transplant.

Guidelines

If these services are not provided, recipients, families, and caregivers are referred to the appropriate provider.



Client-centred
Services

- 15.5 The education and resources provided are appropriate to the recipient's type of transplant, readiness, and needs.

Guidelines

Education and resources are provided in a variety of languages and formats (written, oral, group, counselling approach), and specific to recipient, family, and caregiver needs.



Client-centred
Services

- 15.6 Education that was provided prior to discharge is documented in the recipient's record.

Guidelines

The documentation describes the timing of the education, the type of education provided, materials shared and content reviewed, family members that were present, duration of session and who provided the education.

- 16.0 Recipients are prepared for transition to another service team or setting, service provider, or end of service.**



Client-centred
Services

- 16.1 The client's physical and psychosocial readiness for transition, including their capacity to self-manage their health, is assessed.

Guidelines

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



Client-centred Services

16.2

Clients are empowered to self-manage conditions by receiving education, tools, and resources, where applicable.

Guidelines

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

Tools and resources made available to help clients to self-manage and are tailored to each client's needs. For example, tools and resources can be modified based on level of understanding, literacy, language, disability, and culture.



Safety



16.3

REQUIRED ORGANIZATIONAL PRACTICE: 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.

Test(s) for Compliance

Major	16.3.1	The information that is required to be shared at care transitions is defined and standardized for care transitions where clients experience a change in team membership or location: admission, handover, transfer, and discharge.
Major	16.3.2	Documentation tools and communication strategies are used to standardize information transfer at care transitions.

Major	16.3.3	During care transitions, clients and families are given information that they need to make decisions and support their own care.
Major	16.3.4	Information shared at care transitions is documented.
Minor	16.3.5	<p>The effectiveness of communication is evaluated and improvements are made based on feedback received. Evaluation mechanisms may include:</p> <ul style="list-style-type: none"> • Using an audit tool (direct observation or review of client records) to measure compliance with standardized processes and the quality of information transfer • Asking clients, families, and service providers if they received the information they needed • Evaluating safety incidents related to information transfer (e.g., from the patient safety incident management system).



Client-centred Services



16.4 The client's risk of readmission is assessed, where applicable, and appropriate follow-up is coordinated.

Guidelines

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

A standardized assessment tool (e.g., the LACE Index Scoring Tool). is used to assess risk of readmission after the end of service.



Client-centred Services

16.5 A post-operative care plan is developed in partnership with the recipient and their family.

Guidelines

The post-operative care plan includes post-operative care that the recipient will receive while in hospital.



Continuity

16.6

A post-transplant immediate and long-term follow-up care plan is developed in partnership with the recipient and their family.

Guidelines

Recipients are provided with information about follow-up and how to access services once they have left the facility, including how and when to contact the transplant team (e.g. if they have questions) and when to contact or visit their primary care provider, referring specialist or rehabilitation therapist for immediate and long-term follow-up.

Transplant recipients may also require follow-up emotional and psychosocial support services from social workers or psychologists. If these services are not provided, recipients are assisted in accessing them.



Appropriateness

16.7

Recipients are advised of what to expect during transition or discharge.

Guidelines

Continuity of care is enhanced when recipients have comprehensive information about transitions and end of service. Information provided to the recipient and family includes the recipient's service plan, goals, and preferences; a summary of the care provided; an updated list of outstanding issues, clinical or otherwise; what to expect during transition or at end of service; and contact information for the team and details on when recipients should contact the team, e.g. if they notice any warning signs or symptoms of adverse reactions.

Recipients are provided with information about follow up and how to access services such as emotional and psychosocial supports once they have left the facility.



Appropriateness

16.8

Following transition, the recipient or referral centre are contacted to evaluate the effectiveness of the transition and follow up on the transplant.

Guidelines

Transplant follow-up occurs at regular, frequent intervals as established by the transplant program.

MAINTAINING ACCESSIBLE AND EFFICIENT INFORMATION SYSTEMS

17.0 Recipient records are kept accurate, up-to-date, and secure.



Appropriateness

- 17.1 Accurate, up-to-date records for each recipient are maintained.
CSA Reference: Z900.2.3-03, 7.3.

Guidelines

The recipient's record includes (but is not limited to) recipient identification (name, transplant centre, health number, race, age, sex, date of birth, blood typing, height and weight); person giving consent; preoperative clinical exercises (medical history and physical exam, diagnosis of organ disease and illness, previous surgeries and medications, and vital signs); preoperative evaluation (primary disease, anaesthetic and operative risk, lab reports); and organ and tissue donor information (identification number, suitability assessment, donor blood type, abnormalities or anomalies).



Appropriateness



- 17.2 Each recipient is assigned a unique identifier.

Guidelines

The unique identifier maintains recipient confidentiality and traceability between donors, donated organs and tissues, and recipients.



Appropriateness

- 17.3 Records allow any organ or tissue to be traced among the recipient, the donor, or the tissue bank.

Guidelines

The use of comprehensive documentation and unique identification numbers maintains traceability of donated and transplanted organs and tissues.



Appropriateness



17.4

Recipient information is shared with service providers, other teams, and organizations.

Guidelines

Other organizations include primary care providers and providers of psychosocial and emotional support services. The sharing of recipient information respects the applicable provincial privacy legislation.



Appropriateness

17.5

Recipient records are retained for a minimum of 10 years after transplant.



Appropriateness

**18.0****Client records are kept accurate, up-to-date, and secure.**

18.1

An accurate, up-to-date, and complete record is maintained for each client, in partnership with the client and family.

Guidelines

Client records are accessible and up-to-date. Information is easy to find and identify, and is organized for ease of use. The record includes the dates of service, is signed by the appropriate authority, and is legible.

Only recognized abbreviations are used in the record, and critical client information is prominently displayed.

The client record is updated whenever there is a change in health status, the care plan, the client's medications, or when the client is transitioned to another level of care or service.

Organizational and professional standards are followed when determining what information is needed for the client record to be considered complete. These include significant changes in condition, diagnostic results, alert notations, progress notes, significant events or patient safety incidents, and others.

Clients and families are involved in providing and documenting information, and ensuring the information captured is accurate and complete. The team may partner with the client and family in various ways depending on the service setting and individual circumstances. For example, in community settings or primary care, documentation can often be completed in the room, with the client and family. This is not always possible in all care settings, particularly if the client record is maintained in a central location, concurrent documentation detracts from the care or service being delivered, or urgent care is being delivered.

When documenting in the client record with the client and family is not possible, the team works to include the client and family in the process as much as possible (e.g., taking notes with them, confirming information) to ensure that what is documented is accurate and reflects the nature of the service provided, intervention, or conversation.



Appropriateness

18.2

A standardized set of health information is collected to ensure client records are consistent and comparable.

Guidelines

Collecting standardized information applies whether the client records are paper-based or electronic.

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



Appropriateness



18.3

Policies and procedures to securely collect, document, access, and use client information are followed.

Guidelines

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

The team is aware of and knows how to comply with applicable legislation to protect the privacy and confidentiality of client information. Applicable legislation may be provincial, territorial, or federal.

Client-centred
Services

18.4

Clients are able to access information in their records, including electronic medical/health records, in a routine, client-centred, and timely way.

Guidelines

Client access to their records is facilitated in a proactive way, according to the organization's policy and applicable legislation. The processes to access records are client-centred and support clients to access their information. Clients have opportunities to discuss the information, ask questions, provide feedback.



Client-centred Services

18.5 Information is documented in the client's record in partnership with the client and family.

Guidelines

Clients are the owners of their health information. They are included in the process of documenting information in their record and can provide input on the information being documented. Clients are given the right to read and comment on information that is recorded. The charting or documentation process may be conducted in partnership with the client as part of their care, or access to their records may be provided electronically.



Appropriateness



18.6 Policies and procedures for securely storing, retaining, and destroying client records are followed.

Guidelines

Relevant legislation, including the federal Privacy Act and the federal Personal Information Protection and Electronic Documents Act, are followed, where applicable. Each province and territory refers to their respective privacy laws, and laws governing health information protection, where relevant.



Continuity

18.7 The flow of client information is coordinated among team members and other organizations, in partnership with the client and in accordance with legislation.

Guidelines

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

Clients are involved in sharing information (e.g., maintaining and sharing a current list of medications, or providing a discharge summary to appropriate providers).



Appropriateness



18.8

There is a process to monitor and evaluate record-keeping practices, designed with input from clients and families, and the information is used to make improvements.

Guidelines

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

Evaluation may be done for a sample of records on an irregular or regular basis. Where record-keeping is electronic, evaluation can be triggered based on certain events, such as unusual activity, attempt to retrieve certain data, or unmasking of data.

All electronic activities are linked to a unique user identifier, date and time stamped, and an activity log is maintained to ensure practices can be appropriately monitored.

19.0

Health information is managed to support the effective delivery of services.



Appropriateness

19.1

Training and education about legislation to protect client privacy and appropriately use client information are provided.

Guidelines

Training is provided to all team members and may be formal or informal. Further training or education is provided when there are changes to legislation or after an extended period of time.



Appropriateness

19.2

Policies on the use of electronic communications and technologies are developed and followed, with input from clients and families.

Guidelines

Policies regarding the use of electronic mail, texting, web applications and social media are determined using the perspectives of clients and families. This may include inter-team communication, communication with clients, or communication with partners and potential clients.

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



Appropriateness

19.3

Policies and procedures for disclosing health information for secondary use are developed and followed.

Guidelines

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

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

MONITORING QUALITY AND ACHIEVING POSITIVE OUTCOMES

20.0 **Current research, evidence-informed guidelines, and best practice information is used to improve the quality of services.**



Appropriateness



20.1 There is a standardized procedure to select evidence-informed guidelines that are appropriate for the services offered.

Guidelines

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

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



Safety



20.2 Health Canada's Safety of Human Cells, Tissues and Organs for Transplantation Regulations are followed.



Client-centred
Services

20.3 The procedure to select evidence-informed guidelines is reviewed, with input from clients and families, teams, and partners.

Guidelines

A collaborative approach is used to select guidelines that are appropriately linked to improved client experience and outcomes.

Organizations will use a comprehensive procedure to select evidence-informed guidelines. Depending on the scope of the project, this may include a comprehensive literature review, an environmental scan, consulting other organizations about their practices, and an evaluation with partners and stakeholders.

As with any activity that affects client care and experience, organizations gather and consider input from clients and families when reviewing the procedure to select evidence-informed guidelines. Although clients and families may not be involved in a technical or scientific review, their perspectives on clients' experiences of care are valuable. Client and family perspectives can be gathered through their attendance at procedural review committees, their review of procedural documents, and by shadowing the use or implementation of the procedure in practice.



Appropriateness



20.4

There is a standardized process, developed with input from clients and families, to decide among conflicting evidence-informed guidelines.

Guidelines

Comprehensive documents that synthesize the evidence from several guidelines may be used. For example, the Cochrane Collaboration conducts systematic reviews of the available evidence that can help teams and organizations with their review process.

Clients and families are consulted to determine whether the method of deciding among guidelines follows a client-centred approach (e.g., helping to determine which guideline is more client-centred, reviewing whether a guideline was developed with the client perspective).



Appropriateness



20.5

Protocols and procedures for reducing unnecessary variation in service delivery are developed, with input from clients and families.

Guidelines

Selected guidelines and evidence are used to develop procedures and protocols to improve service delivery and provide standardized care to clients. The procedures and protocols may enhance patient safety, improve inter-team collaboration, increase efficiency, and minimize variation in service delivery. Client and family perspectives are considered when evaluating improvements. As the recipients of care, clients and families are often best positioned to help identify unnecessary variations or duplications in service.

Research knowledge is adapted and applied to each unique care setting.



Appropriateness



20.6

Guidelines and protocols are regularly reviewed, with input from clients and families.

Guidelines

The review process includes accessing the most up-to-date research and information and determining its relevance (e.g., through literature reviews, content experts, or national organizations or associations). Research information may include intervention research, program evaluations, or clinical trials.

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

Although clients and families may not be involved in a technical or scientific review, their perspectives on clients' experiences while receiving care driven by guidelines and protocols are valuable to the review process.



Appropriateness



20.7

There is a policy on ethical research practices that outlines when to seek approval, developed with input from clients and families.

Guidelines

The need for ethics approval is evaluated and, if necessary, sought, prior to undertaking research or activities (including quality improvement activities), where information is collected.



Safety



21.0 Client and team safety is promoted within the service environment.

21.1 A proactive, predictive approach is used to identify risks to client and team safety, with input from clients and families.

Guidelines

A proactive, predictive approach is designed to address potential issues by mitigating a risk or hazard before it occurs. While it may not be possible to identify all risks in a service setting, a comprehensive process is used to identify the most probable risks.

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

Information is gathered to determine the causes of potential problems and strategize possible solutions. These activities include conducting audits, talking to clients, talking to team members, monitoring areas for risk, identifying interruptions, participating in safety briefings, and addressing areas where there is a high margin of error.

Regular opportunities to share information about potential problems and actual incidents can reduce risk and the likelihood of an incident occurring or recurring.



Safety



21.2 Strategies are developed and implemented to address identified safety risks, with input from clients and families.

Guidelines

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



Safety



21.3

Verification processes are used to mitigate high-risk activities, with input from clients and families.

Guidelines

To identify high-risk activities, the team may review its services and use this information to develop and implement checking systems to reduce the risk of harm to clients and team members.

Across the care continuum, verification systems vary depending on services. Examples may include but are not limited to:

- Repeat back or read back processes for diagnostics or verbal orders
- Checking systems for water temperature, especially for bathing
- Standardized tracking sheets for clients with complex medication management needs
- Automated alert systems for communication of critical test results
- Computer-generated reminders for follow-up testing in high-risk clients
- Two person verification process for blood transfusions
- Independent double checks for dispensing and administering high-risk medications
- Medication bar coding systems for drug dispensing, labeling, and administration
- Decision support software for order entry or drug interaction checking
- Safety monitoring systems for teams in community-based organizations or for clients in high-risk environments
- Standardized protocols to monitor vital signs (e.g., fetal heart rate during medical induction/augmentation of labour, or in high-risk deliveries)
- Systems to monitor vaccine fridge temperatures
- Standardized protocols for the use of restraints
- Standardized screening processes for allergies to contrast media.



Safety



21.4

Safety improvement strategies are evaluated with input from clients and families.

Guidelines

Adjustments are made as needed to ensure positive change is sustained.



Safety



21.5

Patient safety incidents are reported according to the organization's policy and documented in the client and the organization record as applicable.

Guidelines

Reporting and recording is done in a timely way. Patient safety incidents include harmful incidents, no harm incidents, and near misses, as per the World Health Organization International Classification for Patient Safety.

Client-centred
Services

21.6

Patient safety incidents are disclosed to the affected clients and families according to the organization's policy, and support is facilitated if necessary.

Guidelines

The Canadian Patient Safety Institute (CPSI) publishes a guide to disclosing patient safety incidents, for health care providers, interdisciplinary teams, organizations, and regulators who are developing and implementing disclosure policies, practices, and training methods.

Support following a patient safety incident is an important part of the process. Support is provided to clients and families as well as team members affected by a patient safety incident.



Safety



21.7

Timely investigations and notifications are conducted following patient safety incidents and adverse reactions.

Guidelines

If the patient safety incident or adverse reaction relates to the donated organs or tissues, the donor identification code is identified and communicated to the donation centre so that the donation centre can quarantine other implicated organs and tissues and notify the donation team.



Safety



21.8

Patient safety incidents and adverse reactions related to donated organs or tissues are investigated and reported to the donation program or tissue supplier as soon as they occur.

Guidelines

All patient safety incidents and adverse reactions related to donated organs and tissues are investigated.

This criterion reflects Health Canada's Regulations for the Safety of Human Cells, Tissues and Organs for Transplantation.

The team delivering transplant services is responsible for implementing the organization's monitoring and reporting processes. In addition, information about patient safety incidents and adverse reactions related to transplant is tracked and reported in a manner that is consistent with others across the organization so that the information may be summarized at the organization level.



Safety



21.9

Patient safety incidents are analyzed to help prevent recurrence and make improvements, with input from clients and families.

Guidelines

Analyzing patient safety incidents includes determining the contributing factors, taking action to prevent the same situation from recurring, and monitoring the effectiveness of those actions. Organizations use this information when developing strategies to proactively anticipate and address risks to client and team safety.

The Canadian Patient Safety Institute offers a framework for incident management. It provides an in-depth description of the process of analyzing and managing patient safety incidents. An online Incident Analysis Learning Program series is available to assist organizations to apply the principles of incident analysis at www.patientsafetyinstitute.ca/.

22.0 **Indicator data is collected and used to guide quality improvement activities.**

- 22.1 Information and feedback is collected about the quality of services to guide quality improvement initiatives, with input from clients and families, team members, and partners.



Client-centred
Services

Guidelines

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

- 22.2 **!** As part of the quality improvement program, every transplant case is reviewed to identify opportunities for improvement.



Appropriateness

Guidelines

Reviewing every transplant case may include reviewing the transplant process or surgical report.



Appropriateness

- 22.3 To obtain long-term outcomes data, there is collaboration with the recipient's primary care providers or follow-up centre.



Appropriateness

- 22.4 The information and feedback gathered is used to identify opportunities for quality improvement initiatives and set priorities, with input from clients and families.

Guidelines

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



Appropriateness



- 22.5 Measurable objectives with specific timeframes for completion are identified for quality improvement initiatives, with input from clients and families.

Guidelines

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

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



Appropriateness

22.6 Indicator(s) that monitor progress for each quality improvement objective are identified, with input from clients and families.

Guidelines

Indicators are used to monitor whether the activities resulted in change and if the change is an improvement. Primarily, indicators are selected based on their relevance and whether they can accurately monitor progress. When there are multiple potential indicators, criteria such as scientific validity and feasibility are used to select them.

If there are difficulties selecting indicators, it may mean the quality improvement objective needs clarification.



Appropriateness



22.7 Quality improvement activities are designed and tested to meet objectives.

Guidelines

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

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



Appropriateness

22.8 New or existing indicator data are used to establish a baseline for each indicator.

Guidelines

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



Appropriateness

22.9 There is a process to regularly collect indicator data and track progress.

Guidelines

How indicator data will be collected and how often is determined. Regularly collecting data allows the team to track its progress and understand the normal variation of values.



Appropriateness



22.10 Indicator data is regularly analyzed to determine the effectiveness of the quality improvement activities.

Guidelines

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

Analyzing data helps identify trends and may reveal areas that could be considered for future quality improvement initiatives. Indicator data can be displayed in a run chart or control chart, both of which are valid means of data analysis.

Safer Healthcare Now! offers Patient Safety Metrics, a web-based tool where organizations can submit data on various interventions, analyze results, and generate reports.

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



Appropriateness



22.11

Quality improvement activities that were shown to be effective in the testing phase are implemented broadly throughout the organization.

Guidelines

The way in which activities are implemented broadly will vary based on the scope and scale of the team's services and the timeframe (e.g., an effective activity is implemented in more than one area of care and for a longer period of time).

Population
Focus

22.12

Information about quality improvement activities, results, and learnings is shared with clients, families, teams, organization leaders, and other organizations, as appropriate.

Guidelines

Information is tailored to the audience and considers the messaging and language that is appropriate for each audience.

Sharing the results of evaluations and improvements helps familiarize stakeholders with the philosophy and benefits of quality improvement and engage them in the process. It is also a way for organization to spread successful quality improvement activities and demonstrate its commitment to ongoing quality improvement.

Among other benefits, sharing indicator data externally allows for comparisons with organizations offering similar services.



Appropriateness

22.13

Quality improvement initiatives are regularly evaluated for feasibility, relevance, and usefulness, with input from clients and families.

Guidelines

The evaluation of quality improvement initiatives includes activities, objectives, and indicators. Results are used to plan future quality improvement initiatives including how and when to sustain or spread existing initiatives.

Outcomes of the quality improvement initiatives are considered with respect to how they align with the organization's overall quality improvement plan, goals and objectives, mission and values, and strategic plan. The team evaluates whether objectives were met within the timeframes and whether the timeframes are still relevant.

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

Resources

Association of Public Health Observatories (APHO). (2008). *The Good Indicators Guide: Understanding how to use and choose indicators*. NHS Institute for Innovation and Improvement.

Audet, A.M. (2006). Adoption of Patient-Centered Care Practices by Physicians: Results From a National Survey. *Arch Intern Med*, 166(7):754-9.

Balik, B. (2011). Leaders' role in patient experience: Hospital leadership must drive efforts to better meet patients' needs. *Healthcare Executive*. 26(4):76-78.

Balik, B. (2012). Patient- and Family-Centredness: Growing a Sustainable Culture. *Healthcare Quarterly* 15: 10-12.

Balik, B., J. Conway, L. Zipperer & J. Watson. (2011). *Achieving an Exceptional Patient and Family Experience of Inpatient Hospital Care*. IHI Innovation Series White Paper. Cambridge, Massachusetts: Institute for Healthcare Improvement.

Bate, P., & Robert, G. (2006). Experience-based design: from redesigning the system around the patient to co-designing services with the patient. *Qual Saf Health Care*, 15: 307-310.

BC Patient Safety & Quality Council. (2010) *Measurement strategies for improving the quality of care: A review of best practice*. Vancouver BC.

Bergeson, S.C. (2006). A Systems Approach to Patient-Centered Care. *JAMA*, 296 (23): 2848-51.

Black, N. (2013). Patient reported outcome measures could help transform healthcare. *BMJ*, 346: f167.

British Columbia Ministry of Health (2011). *Integrated primary and community care patient and public engagement Framework*. www.impactbc.ca

Canadian Foundation for Health care Improvement (2013). *On Call Webinars - Patient Engagement Series*. www.cfhi-fcass.ca

Canadian Institutes of Health Research (2011). News Release. Government of Canada puts patients first with new research strategy. August 22, 2011. www.cihr-irsc.gc.ca

Canadian Malnutrition Task Force (2014). *Canadian Malnutrition Task Force Screening Tool*. June 2014. www.nutritioncareincanada.ca

Canadian Medical Association (2007). Putting Patients First: Patient-Centred Collaborative Care, A Discussion Paper. July 2007. www.cma.ca

Canadian Medical Association (2010). Health care transformation, *Change that Works. Care that Lasts.* Building a culture of patient-centred care. Charter for Patient-Centred Care. www.cma.ca

Cancer Quality Council of Ontario (2013). Environmental Scan: Patient and Family Experience June 2013.

Centers for Disease Control and Prevention (2003). *Prevention Works: CDC Strategies for a Heart-Healthy and Stroke-Free America.* Atlanta, GA: U.S. Department of Health and Human Services. www.cdc.gov

Chan, & Wood (2010). Preparing Tomorrow's Healthcare Providers for Interprofessional Collaborative Patient-Centred Practice Today. *UBCMJ* 1(2).

Change Foundation (2011). Winning Conditions to improve patient experiences: integrated healthcare in Ontario. www.changefoundation.ca

Chow, S., Teare, G., & Basky, G. (2009). Shared decision making: Helping the system and patients make quality health care decision. Saskatoon: Health Quality Council. www.hqc.sk.ca

Conway, et al. (2006). Partnering with Patients and Families To Design a Patient- and Family-Centered Health Care System, A Roadmap for the Future. www.ipfcc.org

Coulter, A. (2012). Leadership for patient engagement. The King's Fund. London: UK. www.kingsfund.org.uk

Coulter, A. (2012). Patient Engagement-What Works? *J Ambulatory Care Manage*, 35(2): 80-89.

Davis, R., Sevdalis, N., & Vincent, C. (2010). Patient involvement in patient safety: How willing are patients to participate? *BMJ Quality and Safety*, 20: 108-114.

Dentzer, S. (2013). Rx for the 'Blockbuster Drug' of Patient Engagement. *Health Affairs*, 32(2):202.

Epstein, R.M., & Street, R.L. (2011). The values and value of patient-centered care. *Annals of Family Medicine*, 9(2): 100-103.

Epstein, R.M., Fiscella, K., Lesser C.S., & Stange, KC. (2010). Why The Nation Needs A Policy Push On Patient-Centered Health Care. *Health Affairs*, 29(8): 1489-1495.

- Frampton, S., Charmel, P. Eds. (2009) *Putting Patients First: Best Practices in Patient-Centered Care*, Second edition. San Francisco: Planetree, Inc.
- Frampton, S., Guastello, S., Brady, C., Hale, M., Horowitz, S., Bennett Smith, S., & Stone, S (2008). *Patient-Centered Care Improvement Guide*. Derby, Connecticut: Planetree. www.ihl.org
- Frankel, et al (2011). Crossing the Patient-Centered Divide: Transforming Health Care Quality Through Enhanced Faculty Development, *Academic Medicine*, 86(4), 445-452.
- Hall, J., Peat, M., Birks, Y., Golder, S. et al (2010). Effectiveness of interventions designed to promote patient involvement to enhance safety: A systematic review. *BMJ Quality and Safety in Health Care*, 19(5):e10.
- Hibbard, J.H., Greene, J., & Overton, V. (2013). Patients with Lower Activation Associated with Higher Costs; Delivery Systems Should Know Their Patients' 'Scores'. *Health Affairs*, 32(2): 216-222.
- Hudon, et al (2011). Measuring Patients' Perceptions of Patient-Centered Care: A Systematic Review of Tools for Family Medicine, *Annals of Family Medicine*, 9:155-164.
- Institute for Healthcare Improvement (IHI) (2012). How to Improve. www.ihl.org
- Institute for Healthcare Improvement, the National Initiative of Children's Healthcare Quality, the Institute for Patient and Family-Centered Care (2011). *Patient- and Family-Centered Care Organizational Self-Assessment Tool*. www.ihl.org
- Institute for Healthcare Improvement (2004). Strategies for Leadership: Patient-and Family-Centred Care: A Hospital Self-Assessment Inventory. www.ihl.org
- Johnson, et al (2008). Partnering with Patients and Families to Design a Patient and Family-Centered Health Care System: Recommendations and Promising Practices. The Institute for Patient- and Family-Centered Care. www.ipfcc.org
- Kingston General Hospital (2012). Press Release: KGH wins patient-centred care award from NRC Picker. www.kgh.on.ca
- Langley, G.L., Nolan, K.M., Nolan, T.W., Norman, C.L., & Provost, L.P. (2009). *The Improvement Guide: A Practical Approach to Enhancing Organizational Performance* (2nd edition). San Francisco: Jossey-Bass Publishers.

Levinson, W. (2011). Patient-centred communication: a sophisticated procedure. *British Medical Journal of Quality and Safety*, 20(10): 823-825.

Lewis, S. (2009). Patient-Centered Care: An Introduction to What It Is and How to Achieve It: A Discussion Paper for the Saskatchewan Ministry of Health. www.health.gov.sk.ca

Lloyd, R. (2004) *Quality healthcare: A guide to developing and using indicators*. Sudbury MA. Jones and Bartlett Publishers.

Longtin, Y., Sax, H., Leape, L., Sheridan, S., Donaldson, L., & Pittet, D (2010). Patient Participation: Current Knowledge and Applicability to Patient Safety. *Mayo Clinic Proceedings*, 85: 53-62.

Luxford, et al. (2011). Promoting Patient-centred care: a qualitative study of facilitators and barriers in healthcare organizations with a reputation for improving patient experience, *International Journal for Quality in Health Care*, 23(5): 510-15.

National Committee for Quality Assurance. The Patient-Centred Medical Home: Health Care that Revolves Around You. An Established Model of Care Coordination. www.ncqa.org

New Brunswick Health Council (2010). Our Health. Our Perspectives. Our Solutions. Results of our First Engagement Initiative with New Brunswick Citizens. www.nbhc.ca

Ontario Medical Association (2010). Patient-Centred Care, Ontario Medical Review, Policy Paper, June 2010. www.oma.org

Picker Institute (2012). Always Events: Health Care Solutions Book. Publications. www.alwaysevents.pickerinstitute.org/?p=1759

Raleigh, V.S., & Foot, C. (2010). *Getting the Measure of Quality: Opportunities and Challenges*. London: The King's Fund.

Safer Healthcare Now! (2011). Improvement Frameworks Getting Started Kit. Canadian Patient Safety Institute. www.saferhealthcarenow.ca

Safer Healthcare Now! Patient Safety Metrics: Measuring to Reduce Harm. www.saferhealthcarenow.ca

Saint Elizabeth Health Care (2011). Client-Centred Care in the Canadian Home and Community Sector: A Review of Key Concepts. September 2011. www.saintelizabeth.com

Saskatchewan Ministry of Health (2011). Patient- and Family-Centred Care in Saskatchewan: A Framework for Putting Patients and Families First. www.health.gov.sk.ca

Shaller, D., & Darby, C. (2009). High-Performing Patient and Family-Centered Academic Medical Centers: Cross-Site Summary of Six Case Studies. The Picker Institute.

Shaller, D. (2007). Patient-Centered Care: What Does it Take? The Commonwealth Fund. www.commonwealthfund.org

Smith, et al (2011). Behaviorally Defined Patient-Centered Communication-A Narrative Review of the Literature, *Journal of General Internal Med* 26(2): 185-91.

Spragins, & Lorenzetti (2008). Public Expectation and Patient Experience of Integration of Health Care: A Literature Review. The Change Foundation. www.changefoundation.ca

Stange, K.C., Nutting, P.A., et al (2010). Defining and Measuring the Patient-Centered Medical Home. *Journal of General Internal Med*, 25(6): 601-12. www.commonwealthfund.org

The Australian Council on Healthcare Standards (ACHS) (2010). The ACHS Equip5 Guide: Book 2- Accreditation, Standards, and Guidelines-Support and Corporate Functions. Sydney, Australia: ACHS.

The Australian Commission on Safety and Quality of Health Care (2010). Patient-Centred Care: Improving Quality and Safety by Focusing Care on Patients and Consumers, Discussion paper. www.safetyandquality.gov.au

The Health Council of Canada (2008). How Engaged are Canadians in their Primary Care? Results from the 2010 Commonwealth Fund International Health Policy Survey. Canadian Health Care Matters. Bulletin 5. www.healthcouncilcanada.ca

The Health Council of Canada (2012). Turning what we know into action: A commentary on the National Symposium on Patient Engagement. www.healthcouncilcanada.ca

The Health Foundation (2013). Evidence Scan: Involving patients in improving safety. The Evidence Centre. London: UK. www.health.org.uk

The King's Fund (2013). Patient Centred Leadership: Rediscovering our Purpose. www.kingsfund.org.uk

Wagner, et al (2012). Guiding Transformation: How Medical Practices Can Become Patient-Centred Medical Homes. The Commonwealth Fund. February 2012. www.commonwealthfund.org

Wasson, & Baker (2009). Balanced Measures for Patient-Centered Care. *J Ambulatory Care Manage*, 32(1), 44-55.

Weingard, S.N. (2013). Patient Engagement and Patient Safety: Perspective on Safety. Agency for Healthcare Research and Quality: WebM&M. www.webmm.ahrq.gov

WIHI. Recognizing Person- and Family-Centered Care: Always Events at IHI Radio Broadcast. September 26, 2013. www.ihl.org

World Health Organization (2007). People-Centred Health Care: A Policy Framework. Geneva. www.who.int

Wynia, & Matiasek (2006). Promising Practices for Patient-Centred Communication with Vulnerable Populations: examples from eight hospitals. The Commonwealth Fund. August 2006. www.commonwealthfund.org

Accreditation Canada would appreciate your feedback on these standards

Your Name: _____

Organization Name: _____

Email address or telephone number: _____

(A Product Development Specialist may contact you about your feedback.)

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

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

You may also submit your feedback online [HERE](#)

[YOUR COMMENTS HERE]

Thank you for your input! Please send this page to:

Program Development, Accreditation Canada, 1150 Cyrville Road, Ottawa, ON K1J 7S9

Fax: 1-800-811-7088, Email: ProgramDevelopment@accreditation.ca