



**ACCREDITATION  
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**Qmentum**

## **STANDARDS**

### **Spinal Cord Injury Rehabilitation Services**

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## SPINAL CORD INJURY REHABILITATION SERVICES

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 patient- 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 patient and family as true partners in service delivery.

Patient- 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 patients and families they serve. Providing patient- and family-centred care means working collaboratively with patients 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 patient and family perspectives and choices. Patient 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 patients and families in ways that are affirming and useful. Patients 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 patients and families to participate in care and decision making to the extent that they wish.
- 4. Collaboration:** Collaborating with patients and families in policy and program development, implementation and evaluation, facility design, professional education, and delivery of care.

The Spinal Cord Injury Rehabilitation Services Standards were developed in response to a growing need for standards to specifically address the key safety and quality issues involved in the delivery of services to patients with spinal cord injury.

For the purposes of these standards, spinal cord injury includes both traumatic and non-traumatic injury. The standards address rehabilitation services that are provided both in an inpatient and outpatient setting.

Accreditation Canada's sector- and service-based standards help organizations assess quality at the point of service delivery. They are based on five key elements of service excellence: clinical leadership, people, process, information, and performance.

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**

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

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

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

**Co-design:** A process that involves the team and the patient 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 patient 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 patient's health information that is created and gathered cumulatively from all of the patient's health care providers. Information from multiple Electronic Medical Records is consolidated into the EHR.

**Electronic Medical Record (EMR):** A computerized record of a patient'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 patient's support network. Family includes a patient's extended family, partners, friends, advocates, guardians, and other individuals. The patient 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 patients 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 patient and family:** The team collaborates directly with each individual patient and their family to deliver care services. Patients 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, patient 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 patient. Types of patient safety incidents are:

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

**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 patients, 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 patients 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 patients and families:** Input from patients 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

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### 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

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### 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 patients and the community.**



Client-centred  
Services



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

##### **Guidelines**

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



Population  
Focus

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

##### **Guidelines**

New information may be solicited from patients 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 patients 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 patients and families.

**Guidelines**

Patients 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.



Efficiency

- 1.4 Services are reviewed and monitored for appropriateness, with input from patients and families.

**Guidelines**

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

1.5

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

**Guidelines**

Meeting the full range of needs of patients and a community is beyond the capabilities of one team or organization. Partnerships may be created to help patients 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 patients' needs.



Accessibility

- 1.6 Information on services is available to patients and families, partner organizations, and the community.

#### **Guidelines**

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

Patients 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

- 1.7 Barriers that may limit patients, families, service providers, and referring organizations from accessing services are identified and removed where possible, with input from patients 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 patient-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 patients, 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, patient tracking systems, wait list management systems, patient 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.



Appropriateness

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

**Guidelines**

Ensuring an appropriate and optimal mix of skill level and experience supports safe, effective, patient-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 patient groups.

Patients 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, patients 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 patients 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 patients and families).



Client-centred  
Services

**2.4**

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

**Guidelines**

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

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



Client-centred  
Services

- 2.5 Sufficient space is available to accommodate patients with spinal cord injury and to provide safe and effective services, including private space for patients and families.

#### Guidelines

Adequate space is available to meet the needs of spinal cord injury patients safely and comfortably. This includes adequate space for assistive devices and equipment, medication storage, and patient accessibility with specific requirements for persons with spinal cord injury. The team considers patient privacy, accessibility, and infection prevention and control when assessing sufficient space.



Appropriateness

- 2.6 The effectiveness of resources, space, and staffing is evaluated with input from patients 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 patients and families, the team, and stakeholders is gathered through surveys, focus groups, advisory committees, and informal feedback.



Accessibility

- 2.7 A universally-accessible environment is created with input from patients 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, patients, and families to support accessibility.



## BUILDING A PREPARED AND COMPETENT TEAM



Appropriateness



### 3.0 Team members are qualified and have relevant competencies.

#### 3.1 Required training and education are defined for all team members with input from patients and families.

##### Guidelines

The required training and education varies by role. They may be defined by a professional regulating body, may be formal or informal, and may include lived experience or work experience.

Patients and families can provide valuable input regarding education and training that could benefit team members and enhance services. For example, patients and families may identify a need for training on working with patients with diverse cultural backgrounds, religious beliefs, and care needs. Patients and families can also provide valuable input into where knowledge gaps may exist.

Input from patients 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.



Appropriateness



#### 3.2 Credentials, qualifications, and competencies are verified, documented, and up-to-date.

**Guidelines**

Requirements vary for different roles in the organization, including for regulated or unregulated team members.

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

Services are delivered within accepted scopes of practice. Team members have the appropriate training and capacities to provide patient-centred care and use equipment, devices, and supplies safely.



Appropriateness

3.3

A comprehensive orientation is provided to new team members and patient and family representatives.

**Guidelines**

The orientation program covers, at minimum, the organization's mission, vision, and values; the team's mandate, goals, and objectives; the philosophy of patient-centred care and how to apply its principles to practice; roles, responsibilities, and performance expectations; policies and procedures, including confidentiality; worklife balance initiatives; and the organization's approach to integrated quality management (e.g., quality improvement, risk management, utilization management, efficient use of resources).

Orientation processes and activities are documented.



Safety

3.4

Specific training on assessment tools for spinal cord injury is provided to the team.

**Guidelines**

Team members are able to assess patients using tools. Where the scope of their role does not require assessment of patients, team members are able to review and understand assessment results. Assessment tools for spinal cord injury include: the International Standards for the Classification of Spinal Cord Injury, including the ASIA Impairment Scale (AIS), FIM (Functional Independence Measure), and SCIM (Spinal Cord Independence Measure).



Client-centred  
Services

3.5

Education and training are provided to team members on how to work respectfully and effectively with patients 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.



Client-centred  
Services

3.6

Education and training are provided on the organization's care delivery model.

**Guidelines**

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



Appropriateness

3.7 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 patients and family and/or team members, a patient's decision to withdraw care or to live at risk, and varying beliefs or practices.



Safety



3.8 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



3.9 **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 patient'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 patients.

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

- |              |  |
|--------------|--|
| <b>Major</b> | 3.9.1      Instructions and user guides for each type of infusion pump are easily accessible at all times. |
|--------------|--|

<b>Major</b>	3.9.2	<p>Initial and re-training on the safe use of infusion pumps is provided to team members:</p> <ul style="list-style-type: none"> <li>• Who are new to the organization or temporary staff new to the service area</li> <li>• Who are returning after an extended leave</li> <li>• When a new type of infusion pump is introduced or when existing infusion pumps are upgraded</li> <li>• When evaluation of competence indicates that re-training is needed</li> </ul> <p>When infusion pumps are used very infrequently, just-in-time training is provided.</p>
<b>Major</b>	3.9.3	<p>When patients are provided with patient-operated infusion pumps (e.g., patient-controlled analgesia, insulin pumps), training is provided, and documented, to patients and families on how to use them safely.</p>
<b>Major</b>	3.9.4	<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>
<b>Minor</b>	3.9.5	<p>The effectiveness of the approach is evaluated. Evaluation mechanisms may include:</p> <ul style="list-style-type: none"> <li>• Investigating patient safety incidents related to infusion pump use</li> <li>• Reviewing data from smart pumps</li> <li>• Monitoring evaluations of competence</li> <li>• Seeking feedback from patients, families, and team members.</li> </ul>
<b>Minor</b>	3.9.6	<p>When evaluations of infusion pump safety indicate improvements are needed, training is improved or adjustments are made to infusion pumps.</p>
	3.10	<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 patient information.



Worklife



3.11

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. Patient 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 patient-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 patient 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 patient-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.

Client-centred  
Services

3.12

Patient 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 patient 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 patient and family representatives are to remain independent from the organization, to ensure their opinions and recommendations remain unbiased.



Worklife



3.13

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

3.14

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.

4.0

**Services are provided within a collaborative team environment.**



Appropriateness



4.1

A collaborative approach is used to deliver services.

**Guidelines**

An interdisciplinary collaborative team needs to evolve and adapt to the changing needs of the patient. Depending on the needs and desires of the patient 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 patient 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 patient 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 patient safety and needs.



Appropriateness

- 4.2 Specialists who provide spinal cord injury rehabilitation services are accessible.

**Guidelines**

Specialists may include spinal surgeons, urologists, orthopedic surgeons, gastroenterologists, and plastic surgeons.



Appropriateness

- 4.3 The team works in collaboration with patients and families.

**Guidelines**

Patients and families are engaged in shared decision making and understand how care is provided. The patient 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

- 4.4 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, patient and family representatives).

Role clarity is essential in promoting patient 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



- 4.5 Standardized communication tools are used to share information about a patient'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

- 4.6 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, patients 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.

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

- 5.1 The workload of each team member is assigned and reviewed in a way that ensures patient 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 patient 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 patients 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.

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



Worklife



Worklife

**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 patient 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 patients 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

5.3

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

5.4

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



Safety



5.5

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



Safety



5.6

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

**Guidelines**

Training may include physical hazards; challenges with equipment; handling spills, waste, or infectious materials; working with patients 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



5.7

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 patients, 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 patients 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 patient'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



5.8

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 patient medical record depending on the nature of the incident.



## PROVIDING SAFE AND EFFECTIVE SERVICES

**6.0 Access to services for current and potential patients, families, teams, and referring organizations is provided in a timely and coordinated manner.**



Accessibility

6.1 There is a process to respond to requests for services in a timely way.

### Guidelines

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

Requests for service, the process to respond to requests, and the definition of timely will vary by type of service being offered.

Responsiveness is monitored by setting and tracking times for responding to requests for services as well as through gathering feedback from patients and families, referring organizations, and other teams.



Accessibility

6.2 There is a procedure to facilitate timely communication with acute care services for notification of incoming patients with spinal cord injury.

### Guidelines

This may include an established intake procedure and/or providing an orientation to rehabilitation services while the patient is still receiving acute care.



Appropriateness

6.3 Information about the patient is gathered as part of the intake process and as required.

**Guidelines**

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

The intake process is adjusted as needed for patients and families with diverse needs such as language, culture, level of education, lifestyle, and physical or mental disability.



Accessibility

- 6.4 Defined criteria are used to determine when to initiate services with patients.

**Guidelines**

The needs of potential patients are assessed in relation to the capacity of the team to meet those needs.

Client-centred  
Services

- 6.5 The team works with acute care services to ensure effective patient transition to rehabilitation services.

**Guidelines**

This may include an established intake procedure and/or providing an orientation to rehabilitation services while the patient is still receiving acute care.



Accessibility

- 6.6 When the team is unable to meet the needs of a potential patient, access to other services is facilitated.

**Guidelines**

In the case where the organization is unable to meet the patient's needs, the rationale is explained and access to other services is facilitated. The information is documented for use in service planning.



Accessibility

- 6.7 Patients and families are made aware of the team member who is responsible for coordinating their service, and how to reach that person.

**Guidelines**

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

**7.0 Patients and families are partners in service delivery.**Client-centred  
Services

- 7.1 There is an open, transparent, and respectful relationship with each patient.

**Guidelines**

The team supports a respectful and transparent relationship with patients by introducing themselves and explaining their role; asking permission before performing tasks; explaining what they are doing; using a respectful tone; expressing concern or reassurance; providing an opportunity for questions, input, and feedback; respecting cultural and religious beliefs or lifestyle; and respecting confidentiality and privacy.

Client-centred  
Services

- 7.2 Patients and families are encouraged to be actively engaged in their care.

**Guidelines**

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



Client-centred  
Services

7.3

The capacity of each patient to be involved in their care is determined in partnership with the patient and family.

**Guidelines**

Each patient will have differing levels of ability to be involved in their own care. At each stage, the appropriate team member works with the patient, family, or substitute decision maker to determine how much and what type of information the patient or family requires to be meaningfully involved in their care. This information is documented in the patient record.



Client-centred  
Services

7.4

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

**Guidelines**

The team finds ways to include members of the patient's support network in the patient'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 patient and family.



Client-centred  
Services

7.5

Complete and accurate information is shared with the patient and family in a timely way, in accordance with the patient's desire to be involved.

### Guidelines

Sharing detailed and complete information is critical for informed choice and shared decision making between patients, families, and the team. Information is delivered according to individual needs and interests, as well as levels of understanding.

Patients and families are made aware of the risks and benefits of care; the patient's roles and responsibilities in service delivery; the benefits, limitations, and possible outcomes of proposed services or interventions; how to prepare for tests and treatments; the availability of counselling and support groups; and how to reach team members in an emergency or crisis.

Varying levels of information may be required at different points in the patient's care and are accommodated wherever possible. Similarly, different messages will require different delivery methods (e.g., serious topics require a more structured approach).



Client-centred  
Services

## 7.6

Information related to the consequences and complications associated with spinal cord injury, that is relevant to the patient, easy to understand, and accessible, is provided to each patient and family.

### Guidelines

Information is available in a variety of formats including written and oral. The team considers level of understanding, literacy, language, disability, and culture when providing information to patients.

Information is provided in a way that ensures patients and families understand the information provided and are given an opportunity to reflect and ask questions.

Suggested additional resources for patient information include:

- Spinal Cord Injury Canada (formerly Canadian Paraplegic Association)
- The Consortium for Spinal Cord Medicine Consumer Guides
- SCI-U
- Toronto Rehab's Spinal Cord Injury Essentials Toolkit.



Client-centred  
Services

- 7.7 The team verifies that the patient and family understand information provided about their care.

#### **Guidelines**

The level of understanding, literacy, language, disability, and culture are considered when providing information to patients and families.

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

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



Client-centred  
Services

- 7.8 Translation and interpretation services are available for patients and families as needed.

#### **Guidelines**

Written materials are available in the languages commonly spoken in the community, as required. Interpretation services are available when required by patients or families, wherever possible.



Client-centred  
Services

- 7.9 The patient's capacity to provide informed consent is determined.

**Guidelines**

The process of evaluating a patient'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, patients are involved to the greatest extent possible in making decisions about their services, and the team values their questions and input.



Client-centred  
Services



7.10

The patient's informed consent is obtained and documented before providing services.

**Guidelines**

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

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



Appropriateness



7.11

When patients are incapable of giving informed consent, consent is obtained from a substitute decision maker.

**Guidelines**

A substitute decision maker is consulted when patients are unable to make their own decisions, and an advance directive is used, where available, to ensure decisions are in line with the patient's wishes. In these cases, the substitute decision maker is provided with information about the roles and responsibilities involved in being a substitute decision maker, and given the opportunity to discuss questions, concerns, and options. Selecting the appropriate substitute decision maker is done in consideration of the applicable legislation and may be an advocate, family member, legal guardian, or caregiver.

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

When working with children and youth, informed consent is received and documented from the child, youth, family or legal guardian before providing services. The consent process includes involving them as much as possible in the decisions about their service, intervention, or treatment, and valuing their questions and input.



Client-centred  
Services

7.12

Patients and families are provided with opportunities to be engaged in research activities that may be appropriate to their care.

**Guidelines**

There is an ethical review process to determine when to involve a patient in a research activity. Research activities may include clinical trials, assessments of new protocols, or changes to existing protocols. Patients and families are included in participatory research project design and implementation where appropriate, (e.g., gathering qualitative data for quality improvement initiatives).



Appropriateness



7.13

Ethics-related issues are proactively identified, managed, and addressed.

**Guidelines**

Ethics-related issues are ones in which values may be in conflict, making it hard to reach a decision. The issues may be very serious, life-and-death matters, or related to day-to-day activities. Examples include conflicts of interest; respecting a patient's choice to live at risk; triaging community members during an emergency; requests to withdraw or end services, including life-sustaining supports or treatments; and end-of-life care.

The organization's ethics framework is used to manage and address ethic-related issues. They may be addressed by an ethics committee or consultation team that may include health service professionals, clergy, or ethicists. In addition to clinical consultation, the ethics committee may be involved in policy review and ethics education.

Ethics-related issues involving particular patients are documented in the patient record.



Client-centred  
Services



7.14

Patients and families are provided with information about their rights and responsibilities.

**Guidelines**

Patient and family rights include the right to have privacy and confidentiality protected; be aware of how patient information is used; have access to their record and information about them; be treated with respect and care; maintain cultural practices; pursue spiritual beliefs; live at risk; and be free from abuse, exploitation, and discrimination.

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

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

The information is provided at intake or admission and is adapted to meet diverse needs such as language, culture, level of education, lifestyles, and physical or mental disability. When the information cannot be provided to the patient and family on intake, it is provided at the earliest opportunity.



Client-centred  
Services



7.15

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



Client-centred  
Services



7.16

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

**Guidelines**

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

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

**8.0 Care plans are developed in partnership with the patient and family based on a comprehensive assessment.**

**8.1** Each patient's physical and psychosocial health is assessed and documented using a holistic approach, in partnership with the patient and family.

**Guidelines**

Elements of physical health include:

- Medical history
- Allergies
- Medication profile
- Health status
- Nutritional status
- Palliative care needs
- Dietary needs

Elements of psychosocial health include:

- Functional and emotional status family and caregiver involvement
- Communication and self-care abilities and strengths
- Mental health status, including personality and behavioural characteristics
- Cognitive status
- Socio-economic status
- Cultural and spiritual beliefs and needs.



Appropriateness





Client-centred  
Services

- 8.2 The assessment process is designed with input from patients and families.

#### **Guidelines**

The assessment process is as streamlined and straightforward as possible, so that patients are not required to repeat information to multiple providers or team members. Where applicable, an interdisciplinary or collaborative assessment may be completed with the patient, family, and appropriate team members.



Client-centred  
Services

- 8.3 Goals and expected results of the patient's care and services are identified in partnership with the patient and family.

#### **Guidelines**

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



Client-centred  
Services

- 8.4 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 patient 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 patient and the care provider.

The standardized assessment tools used will vary depending on the needs of the patient 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.



Safety



8.5

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

## Guidelines

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

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

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

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

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

**Test(s) for Compliance**

- Major**      8.5.1      Upon or prior to admission, a Best Possible Medication History (BPMH) is generated and documented in partnership with clients, families, caregivers, and others, as appropriate.
- Major**      8.5.2      The BPMH is used to generate admission medication orders or the BPMH is compared with current medication orders and any medication discrepancies are identified, resolved, and documented.
- Major**      8.5.3      The prescriber uses the BPMH and the current medication orders to generate transfer or discharge medication orders.
- Major**      8.5.4      The client, community-based health care provider, and community pharmacy (as appropriate) are provided with an accurate and up-to-date list of medications the client should be taking following discharge.



Safety



- 8.6**      **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**      8.6.1      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**      8.6.2      Team members and volunteers are educated, and clients, families, and caregivers are provided with information to prevent falls and reduce injuries from falling.
- Minor**      8.6.3      The effectiveness of fall prevention and injury reduction precautions and education/information are evaluated, and results are used to make improvements when needed.



Safety



- 8.7**      **REQUIRED ORGANIZATIONAL PRACTICE:** Each patient's risk for developing a pressure ulcer is assessed and interventions to prevent pressure ulcers are implemented.

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

## Guidelines

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

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

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

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

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

## Test(s) for Compliance

### Major

- 8.7.1 An initial pressure ulcer risk assessment is conducted for patients upon admission, using a validated, standardized risk assessment tool.

<b>Major</b>	8.7.2	The risk of developing pressure ulcers is assessed for each patient at regular intervals and when there is a significant change in the patient's status.
<b>Major</b>	8.7.3	Documented protocols and procedures based on best practice guidelines are implemented to prevent the development of pressure ulcers. These may include interventions to prevent skin breakdown; minimize pressure, shear, and friction; reposition; manage moisture; optimize nutrition and hydration; and enhance mobility and activity.
<b>Minor</b>	8.7.4	Team members, patients, families, and caregivers are provided with education about the risk factors and protocols and procedures to prevent pressure ulcers.
<b>Minor</b>	8.7.5	The effectiveness of pressure ulcer prevention is evaluated, and results are used to make improvements when needed.



Safety



**8.8**      **REQUIRED ORGANIZATIONAL PRACTICE:** Medical and surgical patients 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 patients 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 patient 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**

<b>Major</b>	8.8.1	There is a written venous thromboembolism (VTE) prophylaxis policy or guideline.
<b>Major</b>	8.8.2	Patients at risk for VTE are identified and provided with appropriate, evidence-informed VTE prophylaxis.
<b>Minor</b>	8.8.3	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** 8.8.4 Major orthopedic surgery patients (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** 8.8.5 Information is provided to patients and team members about the risks of VTE and how to prevent it.



Appropriateness

8.9 Where clinically indicated, an autonomic assessment of patients with spinal cord injury is completed and documented in partnership with the patient and family.

**Guidelines**

Examples of autonomic assessment include management of cardiovascular stability, respiratory, sudomotor, bladder, bowel, and sexual function.



Appropriateness



8.10 Functional assessments using standardized and valid assessment tools are completed and documented.

**Guidelines**

Valid assessment tools include the Functional Independence Measure (FIM), Spinal Cord Independence Measure (SCIM), and the International Standards for the Neurological Classification of Spinal Cord Injury (ISNCSCI). For more information please refer to Spinal Cord Injury Rehabilitation Evidence (SCIRE).

Team members are knowledgeable and know how to work with the results of functional assessments and interpret their scores.



Appropriateness



8.11 A comprehensive and ongoing assessment of patients is completed and documented which includes the ASIA Impairment Scale (AIS) for patients where clinically indicated.

### Guidelines

The International Standards for the Neurological Classification of Spinal Cord Injury (ISNCSCI) are used to conduct the assessment. The results produce overall sensory and motor scores and are used in combination with evaluation of anal contraction as a basis for the determination of ASIA Impairment Scale (AIS) classification. Typically the ASIA Impairment Scale is used for patients with traumatic spinal cord injury; other assessments may be used for non-traumatic patients.



Appropriateness

- 8.12 Where clinically indicated, a cognitive screening of patients is completed and documented at admission and throughout treatment.



Client-centred  
Services

- 8.13 In partnership with the patient and family, the need for assistive devices is evaluated and prescribed to maximize the patient's function and quality of life.

### Guidelines

This may include conducting a seating assessment as well as assessing the need for mobility aids, or accessibility equipment. Where services or equipment are not immediately available, team members work with partners and make referrals where necessary.

Many organizations customize assistance devices on-site. If this service is not available, access to partner organizations or community partners who are able to provide customized assistive devices for patients is provided.

Customization may include custom seating, motor controls, or physical supports to protect skin quality.



Appropriateness

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

**Guidelines**

The patient's expressed needs, preferences and the options for care and service are discussed with the patient and family. The team and patient engage in shared-decision making that considers patient 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 patient 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.



Appropriateness



8.15 Timely access to the necessary diagnostic services and expert consultation or advice is provided to complete a comprehensive assessment.



Continuity

8.16 The results of the assessment are shared with the patient and other team members in a timely and easy-to-understand way.

**Guidelines**

Sharing assessment results as applicable improves clarity and prevents duplication. In order to provide information that is easy to understand, information is tailored to the patient's literacy level, language, and culture.



Continuity



8.17 A comprehensive and individualized care plan is developed and documented in partnership with the patient and family.

**Guidelines**

The care plan is based on the results of the assessment and the patient's service goals and expected results. It includes the roles and responsibilities of the team, other organizations, and patients and their families. It includes detailed information about the patient'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.



Client-centred Services

- 8.18 Planning for care transitions, including end of service, are identified in the care plan in partnership with the patient 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 patients for the end of service. Patient involvement in end-of-service planning ensures the patient and family are prepared and know what to expect.

Discussions about the patient'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.

- 9.0 **Care plans are implemented in partnership with patients and families.**



Appropriateness

- 9.1 The patient's individualized care plan is followed when services are provided.



Safety



9.2

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

**Guidelines**

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

The person-specific identifiers used depends on the population served and patient preferences. Examples of person-specific identifiers include the patient's full name, home address (when confirmed by the patient 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 patient, one person-specific identifier can be facial recognition. The patient's room or bed number, or using a home address without confirming it with the patient or family, is not person-specific and should not be used as an identifier.

Patient identification is done in partnership with patients and families by explaining the reason for this important safety practice and asking them for the identifiers (e.g., "What is your name?"). When patients 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**

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



Appropriateness

9.3

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

**Guidelines**

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



Appropriateness



9.4

Treatment protocols are consistently followed to provide the same standard of care in all settings to all patients.



Appropriateness



9.5

The patient's health status is reassessed in partnership with the patient, and updates are documented in the patient 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 patient's condition, are significant barriers to safe and effective care and services. Changes in the patient's health status are documented accurately, in a timely manner, and communicated to all team members.

Client-centred  
Services

9.6

The care plan includes prevention, management, care, and consideration of secondary complications and conditions for patients with spinal cord injury.

**Guidelines**

Examples of secondary complications and conditions related to spinal cord injury may include autonomic dysfunction, venous thromboembolism, bladder management, bowel management, urinary tract infection, pressure ulcers, respiratory impairment, pain, spasticity, and sexual and reproductive health issues.



Client-centred  
Services

- 9.7 The care plan includes a community integration plan developed in partnership with the patient and family.

#### **Guidelines**

The care plan includes appropriate measures toward work reintegration, education, leisure activities, domestic activities, and housing planning.



Client-centred  
Services

- 9.8 A long-term pain management plan is developed in partnership with the patient and family.

#### **Guidelines**

The plan considers pain management post-discharge, sustainability of treatment, and quality of life. Strategies to manage pain may include analgesics, including opioids or adjuvants when needed, along with physical, behavioural, and psychological interventions. Information is collected from experts, research and evidence to understand the best ways to manage pain for patients with spinal cord injury.



Appropriateness

- 9.9 Patient progress toward achieving goals and expected results is monitored in partnership with the patient, 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 patient and family. It may include the use of standardized assessment tools, discussion with patients and families, and observation.



Client-centred  
Services

- 9.10 Access to spiritual space and care is provided to meet patients' needs.

**Guidelines**

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

The patient'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

- 9.11 Patients and families have access to psychosocial and/or supportive care services, as required.

**Guidelines**

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



Client-centred  
Services

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

**Guidelines**

Services are initiated by the team, patient, 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 patients served. Where palliative and end-of-life care is not provided by the team, patients are connected with the appropriate services.



Client-centred  
Services

9.13

Support for the family, team members, and other patients is provided throughout and following the death of a patient.

#### Guidelines

Relevant information is shared with patients 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 patient'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 patients, families, team members, and volunteers, including volunteer support or professional services.



Safety



9.14

**REQUIRED ORGANIZATIONAL PRACTICE:** Information relevant to the care of the patient 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 patient will depend on the nature of the care transition. It usually includes, at minimum, the patient's full name and other identifiers, contact information for responsible providers, reason for transition, safety concerns, and patient 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 patients and families to repeat information. Patients 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**

- |              |        |  |
|--------------|--------|--|
| <b>Major</b> | 9.14.1 | The information that is required to be shared at care transitions is defined and standardized for care transitions where patients experience a change in team membership or location: admission, handover , transfer, and discharge. |
| <b>Major</b> | 9.14.2 | Documentation tools and communication strategies are used to standardize information transfer at care transitions.   |

- Major** 9.14.3 During care transitions, patients and families are given information that they need to make decisions and support their own care.
- Major** 9.14.4 Information shared at care transitions is documented.
- Minor** 9.14.5 The effectiveness of communication is evaluated and improvements are made based on feedback received. Evaluation mechanisms may include:
  - Using an audit tool (direct observation or review of patient records) to measure compliance with standardized processes and the quality of information transfer
  - Asking patients, 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).

**10.0 Patients and families are partners in planning and preparing for transition to another service or setting.**

- 10.1** Patients and families are actively engaged in planning and preparing for transitions in care.



Client-centred  
Services



**Guidelines**

Patients and families are involved in all transition planning. The team, patient and family discuss the patient's care plan, goals, and preferences; the care provided; outstanding issues, clinical or otherwise; what to expect during transition; follow-up appointments; exercise and nutrition plans, where applicable; contact information for the team members and details on when they should be contacted.

Continuity of care is improved when patients participate in transition planning and preparation and have comprehensive information about transitions and end of service.

Examples of key transition moments include rounds, shift changes, handoffs, moving in or out of an organization, to another community provider or at end of service.

Talking with the patient and family about transitions helps them understand the process and provides an opportunity to ask any questions. It also helps ensure all information is accurate and complete, and that the patient's wishes are respected.



Client-centred  
Services

10.2

The patient'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 patient 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

10.3

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

**Guidelines**

Education that promotes empowerment and helps patients 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 patients to self-manage and are tailored to each patient's needs. For example, tools and resources can be modified based on level of understanding, literacy, language, disability, and culture.



Continuity

10.4

Each patient's post-discharge destination and documented comprehensive follow up and/or ongoing care plan is developed in partnership with the patient and family, other teams, services, and partner organizations.

**Guidelines**

The team remains responsible for the patient until service has officially ended or the patient has been transferred to another team, service, or organization.

Working together to establish proper placement for the patient helps to ensure the patient receives the most appropriate services in the most appropriate setting, and minimizes temporary solutions where possible.

To ensure patients receive the most seamless and continuous care possible, the process for determining placement and follow up includes steps to follow when transfers or end of service do not occur as planned, or are unplanned.



Continuity

10.5

The transition plan is documented in the patient record.



Client-centred  
Services

- 10.6 A patient's wish to end or limit services, transfer to another service, or transition home, is respected.

#### Guidelines

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

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



Client-centred  
Services



- 10.7 The patient'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 patient contact, or reminding the patient of an appointment. It also includes patient 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.



Appropriateness

10.8

The effectiveness of transitions is evaluated and the information is used to improve transition planning, with input from patients and families.

**Guidelines**

At regular intervals, a sample of patients, families, or referral organizations is contacted to determine the effectiveness of the transition or end of service, monitor patient perspectives and concerns after the transition, and monitor follow-up plans. Evaluating transitions is an opportunity to verify that patient and family needs were met and concerns or questions addressed.

Patient feedback and the overall results of the evaluation are shared with the organization's leaders and the governing body and the information is used to improve transitions.

## MAINTAINING ACCESSIBLE AND EFFICIENT INFORMATION SYSTEMS



Appropriateness



- 11.0**      **Patient records are kept accurate, up-to-date, and secure.**
- 11.1      An accurate, up-to-date, and complete record is maintained for each patient, in partnership with the patient and family.

**Guidelines**

Patient 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 patient information is prominently displayed.

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

Organizational and professional standards are followed when determining what information is needed for the patient 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.

Patients and families are involved in providing and documenting information, and ensuring the information captured is accurate and complete. The team may partner with the patient 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 patient and family. This is not always possible in all care settings, particularly if the patient 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 patient record with the patient and family is not possible, the team works to include the patient 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

**11.2**

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

**Guidelines**

Collecting standardized information applies whether the patient 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 patient.



Appropriateness



11.3

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

**Guidelines**

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

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

Client-centred  
Services

11.4

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

**Guidelines**

Patient 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 patient-centred and support patients to access their information. Patients have opportunities to discuss the information, ask questions, provide feedback.



Client-centred  
Services

- 11.5 Information is documented in the patient's record in partnership with the patient and family.

**Guidelines**

Patients 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. Patients 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 patient as part of their care, or access to their records may be provided electronically.



Appropriateness



- 11.6 Policies and procedures for securely storing, retaining, and destroying patient 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

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

**Guidelines**

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

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



Appropriateness



11.8

There is a process to monitor and evaluate record-keeping practices, designed with input from patients 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.

12.0

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



Appropriateness

12.1

Training and education about legislation to protect patient privacy and appropriately use patient 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

12.2

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

**Guidelines**

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

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



Appropriateness

12.3

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 patient privacy is maintained (e.g., by de-identifying or aggregating data prior to disclosure). Where identifiable or re-identifiable data is requested, the team follows an ethics approval process and assesses risk prior to disclosure.



## MONITORING QUALITY AND ACHIEVING POSITIVE OUTCOMES

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



Appropriateness



13.1 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.



Client-centred  
Services

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

**Guidelines**

A collaborative approach is used to select guidelines that are appropriately linked to improved patient 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 patient care and experience, organizations gather and consider input from patients and families when reviewing the procedure to select evidence-informed guidelines. Although patients and families may not be involved in a technical or scientific review, their perspectives on patients' experiences of care are valuable. Patient 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



13.3

There is a standardized process, developed with input from patients 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.

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



Appropriateness



13.4

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

**Guidelines**

Selected guidelines and evidence are used to develop procedures and protocols to improve service delivery and provide standardized care to patients. The procedures and protocols may enhance patient safety, improve inter-team collaboration, increase efficiency, and minimize variation in service delivery. Patient and family perspectives are considered when evaluating improvements due to guidelines. 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



13.5

Guidelines and protocols are regularly reviewed, with input from patients 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 patients and families may not be involved in a technical or scientific review, their perspectives on patients' experiences while receiving care driven by guidelines and protocols are valuable to the review process.



Safety

13.6

Up-to-date information on spinal cord injury rehabilitation is accessible.

### Guidelines

Information is updated on an ongoing basis or anytime there is a significant change in best-practice, process, or service delivery. Up-to-date clinical information on treatments, standards of care, and research is available and easily accessible. This information is stored in an easily accessible location either in hard copy or electronically. All team members know how and where to access this information.

Information includes both national and international sources. Suggested sources include:

- Spinal Cord Injury Rehabilitation Evidence (SCIRE)
- Toronto Rehab's Spinal Cord Injury Essentials Toolkit
- Rick Hansen Institute
- SCI-U
- Consortium for Spinal Cord Medicine
- American Spinal Cord Injury Association (ASIA) Learning Centre
- The International Spinal Cord Society (ISCOs).



Appropriateness



13.7

There is a policy on ethical research practices that outlines when to seek approval, developed with input from patients 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



14.0

**Patient and team safety is promoted within the service environment.**

14.1

A proactive, predictive approach is used to identify risks to patient and team safety, with input from patients 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 patients, 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



14.2

There is a process to identify and reduce risks to team members during the delivery of services.

**Guidelines**

Common risks may include lack of training on safety issues, performing improper lifts, unfamiliarity with mobilization and equipment and techniques used to support safe mobilization of patients, using unsafe equipment, or working alone. Leaders and team members work together to reduce these risks.

Team members feel comfortable raising concerns about their safety when delivering spinal cord injury rehabilitation services.



Safety



14.3

Verification processes are used to mitigate high-risk activities, with input from patients 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 patients 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 patients with complex medication management needs
- Automated alert systems for communication of critical test results
- Computer-generated reminders for follow-up testing in high-risk patients
- Two person verification process for blood transfusions
- Independent double checks for 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 patients 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



14.4

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

#### Guidelines

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



Safety



14.5

Patient safety incidents are reported according to the organization's policy and documented in the patient 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

14.6

Patient safety incidents are disclosed to the affected patients 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 patients and families as well as team members affected by a patient safety incident.



Safety



14.7

Patient safety incidents are analyzed to help prevent recurrence and make improvements, with input from patients 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 patient 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/](http://www.patientsafetyinstitute.ca/).

## 15.0 Indicator data is collected and used to guide quality improvement activities.

- 15.1 Information and feedback is collected about the quality of services to guide quality improvement initiatives, with input from patients 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 patient 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.

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



Appropriateness

**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 patients and families, patient-reported outcomes, risk, volume, or cost.



Appropriateness



15.3

Measurable objectives with specific timeframes for completion are identified for quality improvement initiatives, with input from patients 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

15.4

Indicator(s) that monitor progress for each quality improvement objective are identified, with input from patients 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



15.5

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

15.6

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

15.7

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



15.8

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



15.9

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

15.10

Information about quality improvement activities, results, and learnings is shared with patients, 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

15.11

Quality improvement initiatives are regularly evaluated for feasibility, relevance, and usefulness, with input from patients 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

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Rick Hansen Institute [www.rickhanseninstitute.org](http://www.rickhanseninstitute.org)

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*Safer Healthcare Now!* Patient Safety Metrics: Measuring to Reduce Harm. [www.saferhealthcarenow.ca](http://www.saferhealthcarenow.ca)

SCI-U [www.spinalcordconnections.ca](http://www.spinalcordconnections.ca)

Spinal Cord Injury Canada [www.spinalcordinjurycanada.ca](http://www.spinalcordinjurycanada.ca) - formerly Canadian Paraplegic Association.

Spinal Cord Injury Pressure Ulcer Scale (SCIPUS) Measure [www.scireproject.com](http://www.scireproject.com)

Spinal Cord Injury Rehabilitation Evidence (SCIRE) [www.scireproject.com](http://www.scireproject.com)

Toronto Rehab's Spinal Cord Injury Essentials Toolkit [www.torontorehab.com](http://www.torontorehab.com)

**INTERNATIONAL RESOURCES:**

American Spinal Cord Injury Association (ASIA) Learning Centre [www.asia-spinalinjury.org](http://www.asia-spinalinjury.org)

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**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."*

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