# Required Organizational Practices
## Resources for the 2017 Survey

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| **CLIENT IDENTIFICATION**  
Working in partnership with residents/clients and families, at least two person-specific identifiers are used to confirm that clients receive the service or procedure intended for them. | ➢ At least two person-specific identifiers are used to confirm that residents/clients receive the service or procedure intended for them, in partnership with clients and families. | ➢ Staff must be aware of the Patient Identification policy and its requirements.  
   o What person-specific identifiers are accepted in your practice setting?  
   o What identifiers are not considered to be person-specific and should not be accepted?  
➢ What processes do you have in place in your specific program area to educate staff on this patient safety measure:  
   o Orientation  
   o In-services  
   o Posters  
➢ How does staff educate resident/client and families about how and why we include them in the verification process?  
➢ What processes do you have in place to validate that patients are being appropriately identified?  
➢ How do you share audit results with staff?  
➢ What improvement activities have been implemented as a result of audit findings? | Policies:  
   - Patient Identification Policy VIIB-25  
Audit Tools:  
   - Two Patient Identifiers Observation Audit  
   - Two Patient Identifiers Audit: Staff Interview Questions  
Poster:  
   Expect to Check Poster |
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<th>MEDICATION RECONCILIATION AT CARE TRANSITIONS</th>
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| **Palliative Hospice End of Life** | 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. | Is staff familiar with the MedRec process? | Policy:  
| | 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. | What is in place to educate staff about the MedRec process? | Poster:  
The 5 Questions to ask about your medication when you see your Doctor, nurse or Pharmacist  
Institute for Safe Medication Practices Canada Website:  
[http://www.ismp-canada.org/index.htm](http://www.ismp-canada.org/index.htm) |
| | A current medication list is retained in the client record. | Are staff familiar with where and how to access resources? | CompassionNet Resources:  
- What is MedRec  
- Why Do We Need MedRec  
- MedRec Implementation  
- MedRec Education  
- MedRec on Admission resources  
- MedRec at Transfer Resources  
- MedRec at Discharge Resources  
- MedRec Evaluation & Measurement  
- MedRec Tools  
- Other MedRec Resources  
- MedRec News & Updates  
| | The prescriber uses the BPMH and the current medication orders to generate transfer or discharge medication orders. | What processes are in place to report, resolve, document and discuss errors? |  |
| | The client, community-based health care provider, and community pharmacy (as appropriate) are provided with a complete list of medications the client should be taking following discharge. | Are forms filled out completely and appropriately? |  |
| **LTC & Residential Care** | Upon or prior to admission, a BPMH is generated and documented in partnership with the resident, family, health care providers, or caregivers (as appropriate). | What processes are in place to validate that MedRec is occurring at all transitions? |  |
| | The BPMH is compared with the admission orders and any medication discrepancies are identified, resolved and documented. | How are audit results shared with staff? |  |
| | The reconciled admission orders are used to generate a current medication list that is kept in the resident’s record. | What improvement initiatives have occurred as a result of audit findings? |  |
| | Upon or prior to re-admission from another service environment (e.g., acute care), the discharge medication orders are compared with the current medication list and any medication discrepancies are identified, resolved, and documented. |  |  |
| | Upon transfer out of LTC, the resident and next care providers are provided with a complete list of medications the resident is taking. |  |  |
### INFUSION PUMP SAFETY

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.

- Instructions and user guides for each type of infusion pump are easily accessible at all times.
- Initial and retraining on the safe use of infusion pumps is provided to team members:
  - Who are new to the organization or temporary staff new to the service area
  - Who are returning after an extended leave
  - When a new type of infusion pump is introduced or when existing infusion pumps are upgraded
  - When evaluation of competence indicates that re-training is needed
  - When infusion pumps are used very infrequently, just-in-time training is provided.
- When residents/clients are provided with resident/client-operated infusion pumps (e.g., patient-controlled analgesia, insulin pumps), training is provided, and documented, to residents/clients and families on how to use them safely.
- 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.
- The effectiveness of the approach is evaluated. Evaluation mechanisms may include:
  - Investigating patient safety incidents related to infusion pump use
  - Reviewing data from smart pumps
  - Monitoring evaluations of competence
  - Seeking feedback from clients, families, and team members
- When evaluations of infusion pump safety indicate improvements are needed, training is improved or adjustments are made to infusion pumps.

### Tests for Compliance

- Staff must be trained on all pumps used to administer medications (includes PCA pumps).
- While enteral feeding pumps are not included in the ROP standardized training on the use of these pumps is important.
- Are the instructions and user guides for each type of pump used easily accessible?
- What process are in place to educate all staff:
  - Orientation
  - Ongoing certification
- Are checklists used to ensure consistency?
- Surveyors will request to see evidence of how managers and/or educators validate that all staff have received the appropriate education.
- How do you determine that the education you have provided is effective?
- What processes are in place to address infusion pump incidents, data library updates etc.? 
- Have improvements been made based on RLS data or feedback?
- Have you standardized your training that is provided to residents/clients and family members on how to use the patient-operated infusion pumps?
- Do we use teach-back to ensure that our patients understand the information we have taught them?

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<td>When to Use an Infusion Pump – Decision Guide</td>
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<td>CompassionNet Link: Provincial Infusion Pump Education</td>
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<td>✓ Who are new to the organization or temporary staff new to the service area</td>
<td>Are the instructions and user guides for each type of pump used easily accessible?</td>
<td>*<strong>CLiC modules:</strong></td>
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<td>✓ Who are returning after an extended leave</td>
<td>What process are in place to educate all staff:</td>
<td>- Infusion Pump Education Module</td>
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<td>✓ When a new type of infusion pump is introduced or when existing infusion pumps are upgraded</td>
<td>✓ Orientation</td>
<td>- Standardized Medication Concentrations for Parenteral Infusion</td>
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**When to Use an Infusion Pump – Decision Guide**

CompassionNet Link: Provincial Infusion Pump Education

**CLiC modules:**
- Infusion Pump Education Module
- Standardized Medication Concentrations for Parenteral Infusion
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| INFORMATION TRANSFER AT CARE TRANSITIONS | Information relevant to the care of the resident/client is communicated effectively during care transitions. | The information that is required to be shared at care transitions is defined and standardized for care transitions where clients experience a change in team membership or locations: admission, handover, transfer, and discharge. | Policies:  
- Transfer of Information Accountability Policy VII-B-255  
Tools:  
- Internal Transfer Report  
- Path to Home Resources  
  o Bedside shift report  
  o Shift introduction  
- InterFacility Transfer Form Resource |
|             | Documentation tools and communication strategies are used to standardize information transfer at care transitions. | During care transitions, clients and families are given information that they need to make decisions and support their own care. | **Have you identified all handover points for your area?**  
- Break coverage  
- Shift exchange  
- When the resident/client leaves your unit/facility for a test or procedure  
- When transferring to another unit or facility  
- At discharge |
|             | Information shared at care transitions is documented. | Information shared at care transitions is documented. | **Does your area have a standardized consistent process that staff follows for each transition point?**  
**Does your area have a written guideline for the process that staff is to use?**  
**How are staff orientated to the process and tools used on your unit?**  
**Is information transferred in a timely manner?**  
**How do you validate that the process is adhered to?**  
**Do you follow up with any RLS incidents that are related to information transfer?**  
**Have any changes been made to improve current processes?**  
**Have you ever communicated with partners who receive the information you provide to ensure they are receiving the information they need for continuity of care?**  
**How do you include the patient/family when communicating information at transfer or discharge?** |
|             | The effectiveness of communication is evaluated and improvements are made based on feedback received. Evaluation mechanisms may include: | The effectiveness of communication is evaluated and improvements are made based on feedback received. Evaluation mechanisms may include: | **Have your area a written guideline for the process that staff is to use?**  
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**How do you validate that the process is adhered to?**  
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**Have any changes been made to improve current processes?**  
**Have you ever communicated with partners who receive the information you provide to ensure they are receiving the information they need for continuity of care?**  
**How do you include the patient/family when communicating information at transfer or discharge?** |
|             | - Using an audit tool (direct observation or review of client records) to measure compliance with standardized processes and the quality of information transfer  
- Asking clients, families, and service providers if they received the information they needed  
- Evaluating safety incidents related to information transfer | - Using an audit tool (direct observation or review of client records) to measure compliance with standardized processes and the quality of information transfer  
- Asking clients, families, and service providers if they received the information they needed  
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**Have any changes been made to improve current processes?**  
**Have you ever communicated with partners who receive the information you provide to ensure they are receiving the information they need for continuity of care?**  
**How do you include the patient/family when communicating information at transfer or discharge?** |
|             | | | **Available Resources** |

**Policies:**
- Transfer of Information Accountability Policy VII-B-255

**Tools:**
- Internal Transfer Report
- Path to Home Resources
  - Bedside shift report
  - Shift introduction
- InterFacility Transfer Form Resource
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| FALLS PREVENTION | To minimize injury from falls, a documented and coordinated approach for falls prevention is implemented and evaluated. | ➢ What processes are in place on your unit to assess a patient's risk for falls on admission and on an ongoing basis?  
➢ How is staff educated about falls prevention on your unit?  
➢ How do you include patients and families in the conversation about falls risk and prevention?  
➢ Do you use visual identifiers to indicate a patient's risk for falls?  
➢ How do you communicate between members of the interdisciplinary team, patient, and family, the patient's falls risk and intervention strategies?  
➢ How do you determine that appropriate interventions are in place to reduce the risk of falls?  
➢ Is staff clear of all steps to follow when a patient falls?  
➢ Are post falls huddles occurring consistently on your unit (the surveyors may ask to see post fall huddle documentation)?  
➢ Are falls consistently being entered into RLS?  
➢ Does your unit use the RLS data to analyze fall trends on your unit?  
➢ What processes are in place on your unit to validate that falls risk assessments and interventions are appropriately being completed?  
➢ Is staff aware of the number of falls occurring on your unit?  
➢ What improvement activities have occurred on your unit as a result of information/data obtained about falls in your area (change in admission practice, improved RLS reporting etc.)? | Falls Risk Management Policy: [http://www.compassionnet.ca/Policies/vii-b-435.pdf](http://www.compassionnet.ca/Policies/vii-b-435.pdf)  
Fall Risk Management Resources on CompassionNet [http://www.compassionnet.ca/Page1421.aspx](http://www.compassionnet.ca/Page1421.aspx)  
General Resources:  
Education PowerPoint  
Fall Prevention High Risk Medication Reference Table  
Ask-3 Patient Poster  
Ask-3 Resident Poster  
Ask-3 Lanyard Card  
Universal Fall Protocol (SAFE) Patient Poster  
Universal Fall Protocol (SAFE) Resident Poster  
Universal Fall Protocol (SAFE) Patient Poster – be LITE  
Universal Fall Protocol (SAFE) Resident Poster – be LITE  
Take Action – Prevent a Fall before it happens brochure  
Anyone Can Fall brochure  
Poster: Think Falls – Spring  
Poster: Think Falls – Summer  
Poster: Think Falls – Fall  
Poster: Think Falls - Winter  
In-patient Adult:  
Fred’s Patient Journey  
Adult Inpatient Fall Risk Algorithm  
Schmid Fall Risk Assessment Tool  
Post Fall Report  
Continuing Care (Supportive Living & Long Term Care)  
Fall Risk Management Algorithm  
Scott Fall Risk Screen  
Post-Fall Clinical Pathway Document  
Post-Fall Neurovital Signs Sheet |
### PRESSURE INJURY PREVENTION

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

- An initial pressure ulcer risk assessment is conducted for clients at admission, using a validated, standardized risk assessment tool.
- The risk of developing pressure ulcers is assessed at regular intervals, and when there is a significant change in the client’s status.
- 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.
- Team members, clients, and families or caregivers are provided with education about the risk factors and protocols and procedures to prevent pressure ulcers.
- The effectiveness of pressure ulcer prevention is evaluated, and results are used to make improvements when needed.

### Tests for Compliance

- The Braden risk assessment tool is being used for all inpatient adults and continuing care residents.
- Does your nursing assessment and care record booklet include the Braden assessment tool?
- If you do not have a nursing assessment and care booklet does you use a stand-alone Braden form?
- Is your staff aware of when a reassessment is required?
- How do you orientate members of your team to the approach used for pressure ulcer prevention (at orientation and ongoing)?
- How is the information obtained from the assessment and interventions required communicated among team members?
- How do you communicate to residents/clients and families strategies for pressure ulcer prevention?
- How do you document the information that is provided to residents/clients and families?
- Is your team completing an RLS if a patient develops a hospital acquired pressure ulcer?
- What processes are in place to collect data about pressure ulcer rates on your unit?
- Have any improvement strategies been implemented as a result of pressure ulcer trends on your unit?

### Things to Consider

- A Covenant Health Pressure Ulcer Prevention Policy is currently in DRAFT (anticipate before Christmas). A webpage for Pressure Injury Prevention on CompassionNet is also under development.

### Available Resources

- A Covenant Health Pressure Ulcer Prevention Policy
- Braden risk assessment tool
- Does your nursing assessment and care record booklet include the Braden assessment tool?
- If you do not have a nursing assessment and care booklet does you use a stand-alone Braden form?
- Is your staff aware of when a reassessment is required?
- How do you orientate members of your team to the approach used for pressure ulcer prevention (at orientation and ongoing)?
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<td><strong>SUICIDE PREVENTION</strong>&lt;br&gt;Clients are assessed and monitored for risk of suicide.</td>
<td>➢ Clients at risk of suicide are identified. &lt;br&gt;➢ The risk of suicide for each client is assessed at regular intervals or as needs change. &lt;br&gt;➢ The immediate safety needs of clients identified as being at risk of suicide are addressed. &lt;br&gt;➢ Treatment and monitoring strategies are identified for clients assessed as being at risk of suicide. &lt;br&gt;➢ Implementation of the treatment and monitoring strategies is documented in the client record.</td>
<td>➢ Is all staff (including physicians) aware of current policies and guidelines? &lt;br&gt;➢ Does staff know where/how to access information? &lt;br&gt;➢ What type of education do staff receive about suicide prevention at orientation? &lt;br&gt;➢ What ongoing education is provided to staff and physicians? &lt;br&gt;➢ Is staff able to identify risk factors for suicide? &lt;br&gt;➢ What is the screening process for suicide risk in high risk individuals? &lt;br&gt;➢ Are there consistent practices in place on your unit to address patients who have been identified at risk? &lt;br&gt;➢ Are treatment and monitoring strategies clearly documented in the patients chart? &lt;br&gt;➢ Can staff easily locate the treatment and monitoring information? (surveyors may look for how this information is communicated among staff) &lt;br&gt;➢ What audit strategies are in place to ensure that risk assessments and checklists are completed appropriately? &lt;br&gt;➢ How are audit results shared with staff? &lt;br&gt;➢ Have any improvement strategies been implemented based on results of audits?</td>
<td>Policies:&lt;br&gt;• Suicide Risk Assessment and Management VII-B-200&lt;br&gt;• Inpatient Attempted Suicide VII-B-205&lt;br&gt;• Inpatient Death by Suicide VII-B-210&lt;br&gt;• Environmental Risk Assessment Mental Health VII-B-220&lt;br&gt;• Observation Levels Mental Health VII-B-215&lt;br&gt;• Search of Patient Property Mental Health VOO-B-225&lt;br&gt;Additional Resources:&lt;br&gt;• AHS Resource: Suicide Awareness and Prevention&lt;br&gt;• Canadian Coalition for Seniors Mental Health&lt;br&gt;• RNAO Best Practice Guideline.pdf&lt;br&gt;• Ontario Hospitals Suicide Risk Assessment Guide.pdf</td>
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<td><strong>PNEUMOCOCCAL VACCINE</strong>&lt;br&gt;A policy and procedure for administration of the pneumococcal vaccine is developed and implemented.</td>
<td>➢ There is a policy and protocol to administer the pneumococcal vaccine. &lt;br&gt;➢ The policy and protocol includes identifying populations at risk for complications from pneumococcal disease.</td>
<td>➢ What is the process on admission to determine if a resident has current immunizations? &lt;br&gt;➢ What is the process for ensuring that residents receive a re-vaccination when necessary (after 5 years from the initial vaccination)? &lt;br&gt;➢ What is the process for administering vaccinations?</td>
<td>Resident Immunizations</td>
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