



[Toolkit For]

The Steps to SCI Standards Accreditation





TOOLKIT FOR STEPS TO ACCREDITATION

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STEP 1

SELF-ASSESSMENT

The first step most organizations take when preparing for accreditation is to conduct a self-assessment of their programs in relation to the specific standards they are applying to be accredited for. Self-assessments are online surveys that ask teams to rate how their services and day to day practices meet Accreditation Canada requirements specific to an area of practice (i.e. SCI standards). This Toolkit refers to the SCI standards that have been developed by Accreditation Canada; however the process described in this document is the same for any set of Accreditation Canada standards.

It's about what you do every day

In order for the self-assessment to give the facility or team useful information, it should be inclusive of those people who touch patients' and families' lives every day, particularly front line staff and physicians. The more honest responses an organization can receive about how its day-to-day practices compare to the SCI standards, the better it can identify areas that require changing well in advance of the site visit by Accreditation Canada.

Self-assessment responses are anonymous, and Accreditation Canada does not share them with the accreditation surveyors. The results of the self-assessment belong to your organization as data for quality improvement. All responses are combined and rated according to a rating criteria set by Accreditation Canada. This process ensures no one person's responses can be identified.

How does my team participate?

The accreditation self-assessment is an online survey with privacy protection to ensure your anonymity. All that is needed is a willingness to take part and a computer that has internet access. Your accreditation lead will provide your team with a website address and login information for the self-assessment questionnaire specific to your team. Questionnaires can take between 30-45 minutes to complete. If your team is using more than one set of standards, i.e. SCI acute and Perioperative, your team may want to consider assigning sections of the questionnaires amongst staff to reduce the time requirements to complete the self-assessment.

The self-assessment questionnaire is worded exactly as the standards that apply to your team.

The questions ask about various aspects of how your team functions; some may apply to all team members, and some may be more discipline-specific. Your accreditation lead may recommend using the "not applicable" option for practices outside of one's role, rather than making a best guess, so as to not skew the results.

Get the How-To

Looking for some key messages to help you talk to your teams about participating in the self-assessment? Check out some [Frequently Asked Questions](#):

http://sci2.rickhanseninstitute.org/images/sci2/accreditation/resources/Self-Assessment_Frequently_Asked_Questions.pdf

Wondering what the online accreditation self-assessment survey looks like? [Download the User Guide: Completing the Accreditation Online Self-Assessment](#) to get detailed step-by-step instructions with screen prints:

http://sci2.rickhanseninstitute.org/images/sci2/accreditation/resources/Self-Assessment_Questionnaire_Instruction_Guide.pdf

Self-assessment completed: What happens next?

The online self-assessment for your team will stay open for responses until the deadline specified in the invite that you will receive from your team's accreditation leader. After the closing date, results will be automatically calculated into an aggregate report that your accreditation leader will share with your team.

The results will provide the basis for your team to identify and prioritize areas that require improvement or changes in preparation for the site visit by Accreditation Canada.

STEP 2: IDENTIFY AREAS FOR CHANGE

Learning from Self-Assessment Results

Once the self-assessment questionnaires are completed and the survey report is generated, the second step in accreditation begins: learning from the results and identifying areas that require improvement or changing. Teams receive their results, which summarizes how the teams' current practices meet Accreditation Canada standards as rated by the team. Typically, teams meet to discuss their results, explore which areas are feasible for the organization to change, and determine which areas that have the potential to make the highest impact on patient quality and safety.

How are self-assessment results calculated?

The algorithm that Accreditation Canada uses to calculate the flags is as follows:

Flag	Calculation
	The number of strongly agree and agree responses is equal to or greater than 75%.
	The number of strongly agree and agree responses is greater than 50% and less than 75%.
	The number of strongly agree and agree responses is equal to or less than 50%.

Responses of "don't know" and "not applicable" do not factor into the flag calculation.

Red, yellow, green... what does it all mean?

Most reports will look like a traffic light gone awry, with some line items in green, others in red, and a fair bit of yellow thrown into the mix. Not to worry: this three-colour rainbow is perfectly normal. If your team's report is based on a small number of responses (i.e. under 10), you'll likely have more greens and red flags, and fewer yellow flags. That is also perfectly normal. What is important to keep in mind is results are intended to generate discussion, and to help teams prioritize where to focus their efforts in preparation for accreditation. Typically, flags suggest three different levels of compliance to the practice that is being assessed:



Likely high compliance – most respondents say we do this practice consistently, to best Practice standards



Likely inconsistent compliance – respondents either do not agree on how consistently we do this practice, or it's still a work in progress, with opportunities for improvement



Likely low compliance – most respondents say we do not do this practice to the extent described in the standards

Yellow and red flags alert teams to where there may be some gaps in practice compared to the SCI standards, which can help direct their attention to those areas. The flags by themselves do not provide qualitative information to help teams commit to and carry out a journey of improvement. Typically, teams will draw most of their learnings from this step in the accreditation process by meeting and discussing the flags in the context of their experiences.

What to focus on?

Accreditation Canada defines three tiers of in the standards that weigh into the overall accreditation award. These tiers can be very helpful to teams as they meet to review their self-assessment results and identify which areas they will focus on in preparation for their Accreditation site visit.

Required Organizational Practices, or ROPs – Required Organizational Practices, or ROPs, are the essential “must-have” practices that need to be in place because, without these practices, patients and/or staff safety or well-being may be at risk. Examples are medication reconciliation, pressure ulcer prevention, and educating patients/families about being active participants in care and safety. These items carry the most weight when surveyors evaluate the quality of services, and consequently, how Accreditation Canada assigns an accreditation award.

ROPs are a natural place to start identifying and prioritizing areas for improvement or changing. Typically, teams will start by discussing ROPs first, and prioritize any ROP that has been flagged with a yellow or red flag in their self-assessment report, before addressing other areas in the standards.

High-Priority Criteria – The next tier in the standards is the High-Priority criteria. Practices in this tier address patient safety, risk management, ethics, and a culture of quality improvement. While they still contribute greatly to the overall quality and safety of services, they tend to be more general statements as compared to ROPs, and have guidelines rather than specific tests for compliance.

High-priority criteria practices can make up more than half of a self-assessment’s total number of flags. To keep the number of areas that require changing for the purpose of accreditation manageable, many teams choose to focus on high-priority criteria only after they have ensured compliance to ROPs.

Other – The last tier is all the “Other” criteria in the standards that are neither ROPs nor high-priority criteria. While these criteria carry the least weight in Accreditation Canada’s algorithm when assigning an accreditation aware, they impact team functioning and culture – which tends to support teams in carrying out practices in the upper 2 tiers. Examples include having the right information systems, staffing mix, equipment and physical space.

Get the Tools

There is a great deal of content that is common between the SCI standards and the general population standards for acute and rehab settings, including the ROPs and their tests for compliance. There is also some specialized content in both the SCI and general-population standards that will allow teams to learn unique aspects of their practices.

In collaboration with Accreditation Canada, RHI has developed tools to help your team adopt the SCI standards for acute and rehab care as part of your organization's Qmentum preparation process, with as little impact as possible to your teams' workload.

Learn about key differences between [SCI Acute standards and general-population Perioperative standards](#):

http://sci2.rickhanseninstitute.org/images/sci2/accreditation/resources/Summary_of_Acute_SCI_Accreditation_Standards_vs_Periooperative_Standards.pdf

Learn about key differences between [SCI Rehab standards and general-population Rehab standards](#):

http://sci2.rickhanseninstitute.org/images/sci2/accreditation/resources/Summary_of_SCI_Rehab_Accreditation_Standards_vs_General_Rehab_Standards.pdf

Want the best of both worlds? If your team has chosen to use both the SCI and general population standards, the templates below can help you quickly and easily consolidate the self-assessment results from both sets of standards into a single worksheet. These worksheets are available through the secure login section of sci2.rickhanseninstitute.org. You can obtain your site's login and password information from your local RHSCIR coordinator, or by emailing clinical@rickhanseninstitute.org.

Follow [the Instruction Guide](#) to load your team's results into the templates, and the results will be automatically mapped into a single cohesive set:

http://sci2.rickhanseninstitute.org/images/sci2/accreditation/resources/Self-Assessment_Worksheet_Template-How_To_Document.pdf

Your team can use the consolidated worksheet to discuss the results and identify opportunities for improvement that are both common and unique to their different populations.

Sites being visited in 2016 use version 10 of the standards, worksheet templates and ROP handbook; sites being visited in 2017 are expected to use the new [version 11 standards](#) that were released in January 2016, and the corresponding [worksheet templates](#) and [ROP handbook](#). Download them from the login section of this website:

<https://www.sci2.ca>

Self-assessment results have been reviewed: What happens next?

The process of learning from the self-assessment process and identifying/prioritizing areas that require change sets the stage for the next steps in the accreditation preparation process.

The next steps involve developing action plans and implementation plans for changing practices that have been identified in the self-assessment report as requiring improvement or change.

STEP 3: DEVELOP ACTION PLANS

Plotting the roadmap

Once teams have used their self-assessment results to identify improvement priorities, the work begins to move those priorities from paper into practice. During action planning sessions, teams will typically develop specific ideas for change and action steps for each area that has been identified as requiring improvement.

A tool for your team

Ultimately, the action plans are a tool for the team. They are not submitted to Accreditation Canada or shared with Accreditation Canada surveyors during the site visit. They are your team's internal roadmap to guide the implementation of changes leading up to the site visit - changes that will be maintained in the long term.

There is no right or wrong way to create an action plan: in fact, your team or organization may already have established processes for implementing changes in practice. As a general guideline in order for action plans to be specific enough to guide practice change, teams may want to consider the following:

- **Why:** the specific criterion in the standards, or test for compliance that is currently a gap that needs to be addressed
- **What:** the idea for change itself and action steps that the team is going to try to implement
- **Who:** the leads within the team that will ensure the action steps are done. A lead may not need a formal leadership title; sometimes they are the subject matter experts on the team
- **When:** specific timeframes for the major milestones in the action steps, which enables the team to gauge their progress over time
- **Measures/Indicators:** how the team is going to know their change is working and is being sustained. Think of measures/indicators that can be tracked, so that your team can evaluate progress based on more than a pre- and post-implementation snapshot. Also think of different types of Measures/indicators that can inform your team on:
 - Whether the agreed-upon process is being implemented consistently (i.e. the appropriate assessment is being done, the appropriate care plan is being triggered by the assessment), and
 - Whether the desired outcomes are being achieved (i.e. reduction in undesirable events, improved patient experience, etc.)

If your team does not have a preferred format for documenting its action plans, the downloadable document below is a [template for an action plan](http://sci2.rickhanseninstitute.org/images/sci2/accreditation/resources/Action_Plan_Template.doc) specific to Accreditation Canada planning that your team may find helpful when developing an action plan:

http://sci2.rickhanseninstitute.org/images/sci2/accreditation/resources/Action_Plan_Template.doc

What's next...

The majority of the work preparing for accreditation consists of embedding the standards into day-to-day practices and making them part of team processes. At this point, your team has likely completed the online self-assessment, which hopefully has assisted with identifying areas that require changing to comply with Accreditation Canada standards, and have developed ideas on how to implement those changes. Now the hands-on work begins, with change ideas being tested, adjusted, and scaled into practice. Now more than ever, staff and physician engagement is key to success.

STEP 4: IMPLEMENT PLANS

Thoughts to action

This step is the hands-on work of testing change ideas, adjusting them along the way to make sure the desired outcome is being achieved, and then integrating the changes into standard practice. Teams also need to consider how the new practices can be sustained in the long term after the accreditation process is completed.

Similar to developing action plans, there is more than one way to implement changes in practice, and some organizations may already have established processes. As a general guideline, we encourage teams to consider the following key principles:

- Identify and engage stakeholders
- Plan, Do, Study, Act... then do it all again!
- It's really hard to evaluate what you can't measure

Identifying and engaging stakeholders

When trying to improve a process or implement a new practice, every person who will be impacted by the changes should be consulted. The people who touch patients' and families' lives every day, frontline staff and physicians, will often have the most practical and efficient solutions because they are grounded in hands-on experience. In addition to staff, we encourage your team to also consider providing patients and families opportunities to give their input as your partners in care. Surveyors will look at processes from the patients' perspective when they conduct the site visit. Knowing how patients and families experience processes that are being evaluated for accreditation will give your team/organization a definite advantage!

Plan, Do, Study, Act... then do it all again!

Testing out your change idea with a number of different scenarios and variables increases confidence the process or practice change will have the intended outcomes and be sustainable. This step will also help your team anticipate any unforeseen effects, both upstream and downstream of the process your team is trying to implement or improve.

The Plan-Do-Study-Act (PDSA) model for improvement is a simple, yet powerful tool for accelerating improvement. The PDSA model is not meant to replace change models that organizations may already be using, but rather to accelerate improvement. By doing multiple quick rounds of PDSA tests that build sequentially onto each other, your team will be able to generate knowledge quickly and refine the process. Further information on the PDSA model can be found on the Institute for Healthcare Improvement website:

<http://www.ihl.org/resources/Pages/HowtoImprove/ScienceofImprovementHowtoImprove.aspx>

It's really hard to manage what you can't measure

Health indicators can be used when evaluating a practice change. A health indicator is a single measure that provides relevant and actionable information about population health and/or health system performance and characteristics. An indicator can track progress and performance over time.

As your team starts testing different change ideas, think of indicators that will inform your team on outcomes of the practice/process changes that are being implemented:

- How will your team know the right processes are being followed consistently? I.e. are the right assessments being performed at the right time? Are the right care plans initiated? Do we document consistently?
- How will your team know the changes being implemented are causing the intended outcomes? I.e. has the incidence of patient falls decreased? Are patients more satisfied with their care? Has readmission to hospital rates decreased?

Also think of how your team currently talks about the quality of patient care and patient safety. By regularly reviewing and discussing your process and outcome measures as a team implementing practice or process changes, your team can learn in-the-moment and course-correct as necessary.

SCI Practice Improvement Resources

Most teams will have at least one ROP or High-Priority Criteria item that will require improvement on their action plan that is not unique their team or organization, but is actually a common challenge in other centres. By participating in the Rick Hansen Spinal Cord Injury Registry your facility has access to the Clinical Liaison Team at the Rick Hansen Institute, which can link you with other RHSCIR SCI centres across Canada are also working on implementing the SCI standards into practice – or with centres who have already been awarded the SCI standards by Accreditation Canada. This linkage can facilitate sharing knowledge, tools and resources that can benefit all SCI programs in Canada.

Below is a list of resources that can help your team address specific criteria in the SCI standards and draw from the experiences of other teams who have been awarded the SCI standards from Accreditation Canada. This list will be updated periodically by the Clinical Liaison Team at RHI as new information becomes available, to help your organization translate Accreditation Canada SCI standards into practice:

<http://sci2.rickhanseninstitute.org/accreditation-canada/resources>

Download [ROP fact sheets](#) (one double-sided page each):

- [Falls Prevention ROP](#)
<http://sci2.rickhanseninstitute.org/images/sci2/accreditation/resources/ROPs/ROPFallsPrevention.pdf>
- [Information Transfer at Transition Points ROP](#)
<http://sci2.rickhanseninstitute.org/images/sci2/accreditation/resources/ROPs/ROPTInfoTransfer.pdf>
- [Medication Reconciliation at Care Transitions ROP](#)
<http://sci2.rickhanseninstitute.org/images/sci2/accreditation/resources/ROPs/ROPMedRec.pdf>
- [Patient's Role in Safety ROP](#)
<http://sci2.rickhanseninstitute.org/images/sci2/accreditation/resources/ROPs/ROPPatientRoleinSafety.pdf>
- [Pressure Ulcer Prevention ROP](#)
<http://sci2.rickhanseninstitute.org/images/sci2/accreditation/resources/ROPs/ROPPressureUlcerPrevention.pdf>
- [Surgical Safety Checklist ROP](#)
<http://sci2.rickhanseninstitute.org/images/sci2/accreditation/resources/ROPs/ROPSurgicalSafetyChecklist.pdf>
- [Two Patient Identifiers ROP](#)
<http://sci2.rickhanseninstitute.org/images/sci2/accreditation/resources/ROPs/ROPTwoidentifiers.pdf>
- [VTE Prevention ROP](#)
<http://sci2.rickhanseninstitute.org/images/sci2/accreditation/resources/ROPs/ROPVTEPrevention.pdf>

STEP 5: SITE VISIT

What to expect when you're expecting... surveyors

The site visit is your organization's time in the spotlight. It's an opportunity to showcase the great work your teams do every day. However, the date of the site visit gets closer, it is quite normal to start feeling a mix of excitement and nervousness... sometimes more of the latter than the former!

Those who are familiar with the former method, AIM, that was used by Accreditation Canada during the site visits recall the surveyors spent the majority of the site visit meeting with program leadership, and only had a limited glimpse into what happened at the bedside or in treatment areas. The meetings were the main source of information for surveyors during site visits, along with our carefully compiled self-assessment documents and evidence binders that were compiled by the organization. This method required limited involvement of staff, patients and their family.

In 2008 Accreditation Canada adopted the Qmentum system of accreditation, which is significantly different than the previous evaluation method. Qmentum focuses on clinical team practices and the patient's journey through the program. Surveyors spend minimal time meeting with organizational leaders, as the majority of their evaluation comes from spending time at the point of care, interacting with staff, physicians, patients and their families, through a process Accreditation Canada has termed "tracers".

Tracers: A Tool for You

Tracers are the method used in the Qmentum program to evaluate the standards during the on-site survey. Surveyors trace the path of a clinical or an administrative process to gather evidence about an organization's quality and safety of care and services. Surveyors also tour the facilities where care is provided, and may approach patients and their support people to engage in conversations about their experience as partners in care.

A tracer is meant to be interactive, grounded in daily practice and reality, and is often a rewarding and validating experience for those involved. Tracers are unscripted and flexible to what is happening in the moment, allowing surveyors to see "a day in the life of" your team. However, tracers always refer back to the standards because the surveyors rate each criterion in the standards as either met or unmet based on their observations during the site visit.

Tracers are not just the method by which surveyors will evaluate your organization's services. They can also be a useful quality improvement tool independent of the accreditation process that can help teams identify practices and processes that are working well, as well as areas that require improvement that considers patient perspectives. Tracers can help your team develop action plans to initiate changes, track progress over time, and validate your team's practices against Accreditation Canada standards.

A list of [common themes](#) for accreditation tracers can be downloaded at the following website:

http://sci2.rickhanseninstitute.org/images/sci2/accreditation/resources/Common_Tracer_Themes.pdf

Our team is hosting a tracer... now what?

As mentioned previously, the Qmentum evaluation process primarily involves direct observation of clinical practices, so while there is no need for teams to compile evidence binders, there are a few things your team can prepare to ensure the site visit goes smoothly, and the surveyors have access to all the information that they may need to conduct their tracers.

During the site visit, surveyors will want to:

- Tour the facility
- Review patient medical records (electronic and paper charts)
- Speak to patients and their families as appropriate (on premises or by phone)
- Speak to frontline staff and physicians
- Review documentation such as practice guidelines, manuals, referral forms, etc.
- If appropriate, phone other partners involved in the traced patient care

To help surveyors access the information they require for their tracers, your team may need to provide:

- A site host
- Access to a maximum of five patient medical records (electronic or paper charts). Prior to the site visit, patients must consent to have their medical records reviewed by the surveyors. The chosen patients should represent the typical patient profile on the program
- Access to front line staff and physicians to interact with the surveyors
- Access upon request to any documentation that your team refers to in the course of delivering care, such as practice guidelines, manuals, forms, pathways, patient education materials, policies, etc. Surveyors will mainly want to ascertain that team members have ready access to the tools, resources and information supports that they need, when they need them in the course of delivering care. Therefore, the kinds of information requests that surveyors are most likely to make will be pertinent to the patient journeys that they are tracing, and in the context of how team members would normally access the information as part of the work they do every day.
- Examples of quality improvements our team has made, i.e. indicators that your team tracks, recent practice changes your team has implemented, initiatives your team is working on, etc.
- A quiet space where surveyors can review documentation, make phone calls, eat lunch, etc.

Download [Preparing for Hosting the Accreditation Site Visit](#) at the following website:

http://sci2.rickhanseninstitute.org/images/sci2/accreditation/resources/Site_Visit_Logistics_Overview.pdf

While surveyors will only trace one to two patient journeys in detail, they can, and quite often will, approach other patients and families that may be on the premises at the time of the site visit for a brief conversation about their experiences with your organization. The two poster templates below can be customized with your team's site visit date and time, to notify people on the premises that they may be approached by a surveyor.

Site visit notification poster

Landscape orientation

http://sci2.rickhanseninstitute.org/images/sci2/accreditation/resources/SiteVisitNotice_Template_Landscape.ppt

Portrait orientation

http://sci2.rickhanseninstitute.org/images/sci2/accreditation/resources/SiteVisitNotice_Template_Portrait.ppt

The Site Host

The site host is the “go-to” person for the surveyors while they are visiting your team and conducting tracers. Often the program director or leader will accompany the surveyor to the tracer location, then hand-off the surveyors to a site host who is a staff member of the team who has extensive knowledge of how the team functions. Managers, educators, care coordinators, team leads all make excellent site hosts. If you are selected to be the site host, your role will be to:

- Greet the surveyors at your site/unit, and show them around the premises
- Describe the highlights of your team: mandate, volume of patients served, staff mix, diagnoses that are treated by your team, key partners the team work with, etc.
- Provide the surveyor with access to consented patient files for the tracer
- Introduce the surveyors to front line staff members
- Provide access to other documents as requested (i.e. manuals, forms...)
- Allow the surveyors to direct the tracers

Below is a list of frequently requested documentation that your surveyors may want to see during the site visit. Rather than compiling these documents into a single binder, think of how your team currently accesses them.

- Transfer documents, both into and out of your team's care
- Assessment tools and their related care plans, flowsheets
- Clinical Practice Documents like guidelines, policies, pathways,
- Standard Operating Procedures
- Training/orientation manuals for new team members (staff, physicians, volunteers)

- Patient education materials and resources
- Sources of feedback from your patients/families: patient experience survey results, compliments and complaints, examples of patient/family engagement, etc.
- Indicators that your team tracks for ongoing improvement: think of both process and outcome measures, how they are discussed as a team and used for improvement
- Corporate policies and other information resources (i.e. how to access
- Risk management, Ethics support, etc.)

Making the best first impression

RHI has developed a [customizable visual prep tool](#) with tips to help your team prepare for welcoming surveyors. The tool can be downloaded at the following website:

**[http://sci2.rickhanseninstitute.org/images/sci2/accreditation/resources/
Making_a_first_impression_for_your_site_visit_Visual_Prep.doc](http://sci2.rickhanseninstitute.org/images/sci2/accreditation/resources/Making_a_first_impression_for_your_site_visit_Visual_Prep.doc)**

The Word document is customizable so that your team can add information, examples or images to meet your team's needs.

Site visit completed... what happens next?

Following the site visit, your organization will receive the surveyors' feedback and observations. The next section reviews ways to learn from the surveyors' report and keep the momentum alive for continuous improvement at your organization. The accreditation team at RHI will continue to provide updates on changes to the standards, as well as facilitate opportunities for sharing and developing support resources for future quality improvement work through consultation with SCI experts, administrators and clinicians.

STEP 6: SUSTAINMENT

They came, they saw, they evaluated... Now what?

An organization's first opportunity to receive surveyors' feedback and observations will typically be on the final day of the site visit. Surveyors may start their debrief with a closed-doors session with the organization's governing board and senior leadership, which is typically followed by an open debrief session for all staff and physicians. This provides staff with an opportunity to hear the surveyors' findings in four broad areas of focus that are in the accreditation standards:

- Patient safety
- Quality improvement culture
- Ethics framework and supports
- Risk management

While surveyors do not usually give team-specific feedback during the on-site debrief session, they will often present a summary of the overall standards ratings, including met and unmet ROPs. Surveyors will then review areas of excellence as well as areas requiring improvement in each of the four key themes listed above that they observed at the organization level.

The onsite debrief can also be an opportunity for the organization to express appreciation for all the work teams did to prepare for and host the accreditation site visit, and to celebrate the continuing improvement journey and commitment to quality patient care.

Before leaving the site visit, surveyors will typically present the organization with a copy of their preliminary report, which has detailed ratings and specific findings for each of the standards that were assessed. The organization will then have between five and seven business days to review the content of the report, and provide feedback to Accreditation Canada about any factual inaccuracies (i.e. wrong names of programs or locations). Corrections provided within this timeframe can be incorporated into the final report.

Organizations will usually receive the surveyors' final report and notice of the forecasted accreditation award between two to three weeks after the site visit, once the surveyors' preliminary findings have been reviewed by Accreditation Canada's own independent review body, the Accreditation Decision Committee. The Accreditation Decision Committee, and not the surveyors, assign the accreditation award level and determine which, if any, unmet criteria require formal follow-up and by which timelines.

There are four possible levels of accreditation decision awards. Accreditation Canada defines the level as follows:

- **Accredited with Exemplary Standing:** for organizations that go beyond the requirements of Accreditation Canada and demonstrate excellence in quality improvement. This is the highest level of accreditation.
- **Accredited with Commendation:** for organizations that go beyond the requirements of Accreditation Canada and are commended for their commitment to quality improvement.
- **Accredited:** for organizations that meet the requirements of Accreditation Canada and show a commitment to quality improvement.
- **Not Accredited:** the organization must make significant improvements to meet the requirements of the accreditation program.

To arrive at the accreditation award level fairly and objectively, the Accreditation Decision Committee uses the algorithm below, which considers compliance with ROPs and High-Priority Criteria, as well as whether the organization conducted surveys of staff and providers’ Patient Safety Culture and Work/Life Pulse (referred to as “Instruments” below) at least once every four years, with a sufficient response rate to be a representative sample.

Accreditation Decision Levels

Decision Level	Instrument Thresholds	Criteria		ROP Tests for Compliance
		High priority criteria in each grouping	All other criteria in each grouping	
Accredited	Not met	Met 84% or less	Met 84% or less	Two or more major tests unmet at onsite survey
Accredited with Commendation	Met	Met 85% to 94%	Met 85% to 94%	One major test unmet at onsite survey
Accredited with Exemplary Standing*	Met at onsite survey	Met 95% or more at onsite survey	Met 95% or more at onsite survey	All tests met at onsite survey

*Cannot be achieved if an organization has had its Board dismissed and/or is under supervision at the time of the on-site survey.

Not Accredited: An organization receives a decision of Not Accredited if it has met less than 80 percent of all criteria and less than 70 percent of high-priority criteria/ROPs in any one or more sets of standards. These organizations have the opportunity to improve their accreditation rating by undergoing a supplementary survey.

The same algorithm is applied to all organizations undergoing accreditation, regardless of whether they are single site, a single-service organization (i.e. independent rehabilitation facilities) or a full-continuum, regionally integrated system (i.e. Alberta Health Services, BC health authorities). To find out more about accreditation decision levels, [Accreditation Canada’s algorithm](#) can be downloaded from the following website:

http://sci2.rickhanseninstitute.org/images/sci2/accreditation/resources/DecisionGuidelines_directivesrelativesDec2015EN.pdf

The accreditation award itself is typically not finalized for approximately five months after the site visit. This provides an opportunity for organizations that have unmet criteria to submit status updates to Accreditation Canada to prove unmet standards have been addressed and resolved. If, upon reviewing the status updates, the Accreditation Decision Committee deems there is sufficient evidence to consider those unmet criteria as being satisfied, the final accreditation award will take those new ratings into account. It is therefore possible for an organization to be upgraded from a forecasted decision of “Accredited” to a final decision of “Accredited with Commendation”.

Status updates for unmet criteria or ROPs can be submitted as a concise (under 4,000 characters) narrative summary. Below are some ideas for what can be included in a status update:

- Specific unmet criteria or tests for compliance and surveyor rationale the status update addresses
- A full description of the actions and activities that have been completed after the on-site survey to meet the above
- When the actions were completed
- Impact of the actions, and how the actions will be maintained and evaluated
- Planned activities are useful (“we will be...”) but not deemed to be evidence that the standard is met
- If the standard is unmet at multiple locations or in more than one program, provide evidence for each location or program, prefaced by the location or program name as a header
- Please spell out acronyms or abbreviations the first time they are used

Keep the standards alive

After the site visit, the work to sustain the changes that have been made in preparation for accreditation should be continued. After all, the standards describe the evidence-based practices that make services excellent for every patient.

We encourage sites to continue using the SCI standards as a guide for achieving a “constant state of readiness”. This toolkit and additional resources are available SCI2 website (<https://www.sci2.ca>). The practices described in the SCI standards are just a portion of what your site does every day for patient care, and ideally should be integrated into your practices regardless of when your next accreditation site visits are.

Another way to keep the momentum alive is to stay abreast of changes to accreditation standards and requirements as they are introduced. Every January, Accreditation Canada publishes updated standards, which may include revised criteria or ROP definitions and tests for compliance. The latest version of the standards, version 11, which applies to site visits in 2016 onwards, was released in January 2016. The newest version has greater emphasis on patient and family centred care as an underlying philosophy, as well as revisions to a number of ROPs with the goal of making the tests for compliance more robust and observable. Download the new [Version 11](#) standards at the website listed below. If your site visit is in 2016, you will continue to use version 10, which is also available for download on the website:

<https://www.sci2.ca>

We encourage your team to take the opportunity to disseminate the standards within your organization and proactively identify what changes in practices may be required in order to successfully build the standards into day to day processes, well in advance of your next site visits.

Make accreditation better

Accreditation Canada regularly reviews and updates various components of its Qmentum accreditation program and standards to ensure that the content is current and relevant, and to continually raise the bar for patient care and safety. Typically, each set of standards is revised every three years. The SCI standards were released in 2012, therefore a revision to the standards is expected to occur in 2015 and 2018.

Input on subject matter from SCI experts as well as process experts is crucial to ensure that the revisions not only accurately reflect current best practice, but are also realistic and objectively assessable. Therefore Accreditation Canada actively seeks out representation and feedback from client organizations into the revision process by reaching out to surveyors, accreditation leaders, and experts who were involved in the working group that developed the standards.

RHI worked in partnership with Accreditation Canada to develop the SCI standards. As such, RHI will continue to be involved in any future revisions of the SCI standards, and will reach out to the SCI community of care to solicit input along the way. If you or your team receives an invitation to provide feedback on revisions to the SCI standards, we hope that you will take the opportunity to participate.

To find out more about how you can be involved, contact accreditation@rickhanseninstitute.org.

Become a surveyor

Are you a health care leader with a passion for advancing best practices in SCI care? Do you enjoy travelling, exchanging knowledge with like-minded professionals within and outside of Canada, and bringing that knowledge home to benefit your organization? Then RHI and Accreditation Canada want you to consider becoming a surveyor.

Surveying is a great opportunity to network with other health care professionals and broaden your skills, while bringing a wealth of ideas and practical resources to help your organization and the SCI community of care to continuously improve their practices. Surveyors are health care professionals from a diverse range of expertise, both clinical and administrative, who volunteer their time with Accreditation Canada to conduct accreditation site visits and advise on the accreditation program. As an accreditation surveyor with subject matter expertise in SCI care, you will participate in surveys twice a year, which involves visiting organizations that provide care to SCI patients both within Canada and around the world.

To learn more about becoming a surveyor, visit Accreditation Canada's [Surveyor Recruitment page](#):

<http://www.accreditation.ca/surveying-accreditation-canada>



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