Emergency Department

For Surveys Starting After: September 05, 2012
Accreditation Canada's sector and service-based standards help organizations assess quality at the point of service delivery. They are based upon five key elements1 of service excellence: clinical leadership, people, process, information, and performance. These standards contain the following subsections:

- Investing in Emergency Department services
- Engaging prepared and proactive team
- Providing safe and appropriate services
- Maintaining accessible and efficient clinical information systems
- Monitoring quality and achieving positive outcomes

Emergency Department

INVESTING IN EMERGENCY DEPARTMENT SERVICES

1.0 The team develops its emergency department services to meet the needs of clients, families, and referring organizations.

1.1 The team collects information about its clients and the community.

Guideline

Information includes the types of clients served by the organization and their service needs, and trends that could have an impact on the community and its health service needs. Service needs are influenced by health status, capacities, risks, and determinants of health such as lifestyle, education, and housing. Information can come from internal and external sources such as the Canadian Institute for Health Information (CIHI), census data, end of service planning reports, wait list data, and community needs assessments.

If it is not within a team's mandate to collect information, it knows how to access and use information that is available.

1.2 The team collects information about its referring organizations and providers.

1.3 The team uses the information it collects about clients and the community to define the scope of its services and set priorities when multiple service needs are identified.

Guideline

When defining the scope of its services, the team considers the resources that are currently available and those that are still needed for urban, rural or remote centres or clients with special considerations, e.g. screening elderly clients for cognition, mobility, home safety, and establishing processes to avoid inappropriate admissions.
1.4 The team's scope of services is aligned with the organization's strategic direction.

**Guideline**
Expectations regarding the team's scope of services may be outlined in provincial or territorial legislation.

1.5 The team identifies barriers that prevent clients, families, providers, and referring organizations from accessing services in the Emergency Department.

**Guideline**
Access may be compromised by internal barriers that are under the team's control (e.g. overcrowding as a result of break-downs in patient flow and transfer of clients to in-patient units, physical and language barriers, lack of or inefficient over-capacity protocol) and barriers that are outside of the team's control (e.g. overcrowding as a result of a high volume of clients presenting in the Emergency Department, transportation, ambulance diversion from another organization, lack of in-patient beds).

1.6 The team collaborates with its partners to provide access to the full spectrum of emergency services.

**Guideline**
Other emergency health service providers may include local ambulance service operators and dispatchers, fire departments, and community groups. The community may have access to emergency health services via 911 or a local access telephone number.

1.7 The team collaborates with its partners to inform the community, clients, families, service providers, and referring organizations about how to access emergency health services, including the Emergency Department.

1.8 The team collaborates with its partners to develop resource-sharing arrangements to offer safe and effective services for each client and family.
1.9 The team regularly reviews its services and makes changes as needed.

**Guideline**

The team reviews the appropriateness of its current services as well as the need for new services.

2.0 The team has access to leadership to provide effective services in the Emergency Department and support client flow.

2.1 The team works together to develop goals and objectives.

**Guideline**

Staff and service providers have input into the development of team goals and objectives. Community partners, clients, and families may also be involved in developing team goals and objectives.

The team's goals and objectives provide the foundation for delivering services.

2.2 The team's goals and objectives are linked to benchmarking of bed availability in the Emergency Department, time to admission, client diversion to other facilities, and wait times.

2.3 The team has strategies in place to effectively manage overcrowding and surges in the Emergency Department.

**Guideline**

Access to the emergency department may be compromised as a result of barriers to in-patient units.

Strategies to address overcrowding and sudden surges in the emergency department may include the assessment and release of select clients by emergency medical services to community health services or primary care, proactive communication about the use and access to telehealth resources in the community, improved information technology to assist with client distribution decisions, a process at triage for the efficient offload of emergency medical services clients, and Transfer of Care agreements.
2.4 The team's strategies to manage overcrowding include plans to manage clients when in-patient beds are unavailable.

**Guideline**
The team may explore other referral or service options, e.g. transferring clients to another hospital or determining if a client is willing to remain in the Emergency Department if discharge to other health care services and programs is not feasible.

2.5 The team has an emergency preparedness plan and is trained and equipped to manage disasters and emergencies.

**Guideline**
The plan describes the role of the Emergency Department and available resources, and is cohesive with that of the overall organization.

The team's training addresses specific situations that may be included in the emergency preparedness plan, e.g. extended period of power loss, service interruptions, terrorist, or hostage situations.

2.6 The team participates in regular practice drills of the emergency preparedness plan.

2.7 When delivering Emergency Department services, the team has access to equipment and supplies appropriate to the needs of the community or catchment area.
2.8 The team has access to equipment and supplies appropriate for pediatric clients.

**Guideline**

Standard size equipment and supplies are normally inappropriate for pediatric clients. Neonatal and pediatric sizes of all relevant equipment and supplies may be provided in the emergency department or shared with other inpatient services (e.g., pediatric ward, nursery).

A recommended list of equipment for monitoring, airway management, vascular access, fracture management, and general equipment with recommended sizes can be found in the appendix of these standards. The Canadian Association of Emergency Physicians also provides a list of recommended minimum equipment for emergency departments in rural communities. See http://www.caep.ca/template.asp?id=31556A066C23444794351894AE1023F0.

2.9 The team has the workspace needed to deliver effective services in the Emergency Department.
ENGAGING PREPARED AND PROACTIVE TEAM

3.0 The team uses an interdisciplinary approach to deliver Emergency Department services.

3.1 The organization identifies an interdisciplinary team to deliver Emergency Department services.

Guideline
The interdisciplinary team includes people with different roles and from various disciplines. Depending on the needs of clients and families, the team may include primary care staff including physicians, nurses, and nurse practitioners; emergency medical services staff; trauma specialists; social workers; respite care workers; respiratory therapists; care planners; administrators; translators; security staff; or representatives from community partner organizations.

3.2 The interdisciplinary team includes consultants and referring medical professionals who work with staff and service providers in the Emergency Department to coordinate services or transfers.

3.3 The team has timely access to specialists with expertise in pediatric health.

Guideline
Specialists with expertise in pediatric health may include pediatricians, pediatric emergency physicians, pediatric radiologists, and pediatric surgeons. Access to specialists can either be provided on-site or using virtual technologies such as telehealth.

“Timely” refers to the timelines set by the organization's policy for emergency department services.
3.4 Team members have position profiles that define roles, responsibilities, and scope of practice.

**Guideline**

Position profiles include a position summary, specify qualifications and minimum requirements for the position, state the nature and scope of the work, and clarify reporting relationships.

Role clarity is essential in promoting client and staff 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 individuals.

3.5 The interdisciplinary team communicates regularly to coordinate services, roles, and responsibilities.

**Guideline**

Miscommunication or a lack of communication among interdisciplinary team members often compromises client safety. Making accurate and timely communication a priority promotes continuity of care and helps prevent adverse events.

Communication mechanisms can include meetings, teleconferences, or virtual technologies such as telehealth or webconferencing, and may involve the client, family, caregiver, or client advocate.

3.6 The interdisciplinary team follows a formal process to regularly evaluate its functioning, identify priorities for action, and make improvements.

**Guideline**

The team's process to evaluate its functioning includes a review of its services, processes and outcomes. This may include administering a team functioning or climate questionnaire to team members to stimulate discussion about areas for improvement.

The team evaluates its functioning at least annually, and whenever there is a significant change in the structure of the team.
4.0 The team’s staff and service providers are educated, trained, qualified, and competent.

4.1 Each team member has the necessary credentials or license from the appropriate professional college or association.

Guideline
The team has a process to verify that team member credentials or licenses are appropriate and up-to-date.

4.2 The team orients new team members about their roles and responsibilities, the team goals and objectives, and the organization as a whole.

Guideline
The orientation program covers the organization’s mission, vision, and values; the team’s mandate, goals, and objectives; roles, responsibilities, and expectations regarding performance; policies and procedures, including confidentiality; initiatives that support worklife balance; and the organization’s approach to integrated quality management, e.g. quality improvement, risk management, and utilization management/efficient use of resources.

4.3 The team orients new staff and service providers about the unique work environment in the Emergency Department.

Guideline
The orientation includes the specific nature of the Emergency Department; the triage process; the value of linking with team members beyond the Emergency Department e.g. Emergency Medical Services, consultants, trauma services, and alternative levels of care; emergency disaster planning; the protocols to address high volume and surges in the Emergency Department; and the process to address wait times.

4.4 New team members are trained on the safe use, storage, and operation of equipment, devices, and supplies used in delivering Emergency Department services, as well as preventive maintenance and what to do in case of breakdown.

Guideline
The training includes the safe use and operation of cardiac monitoring equipment, ventilators, CPAP and BiPAP machines, and fluid warmers.
4.5 REQUIRED ORGANIZATIONAL PRACTICE: Staff and service providers receive ongoing, effective training on infusion pumps.

Guideline
The more types of infusion pumps there are within an organization, the more chance there is for serious error. To minimize risk staff and service providers receive ongoing, effective training on infusion pumps, covering client clinical needs, staff competency, staff continuity, infusion pump technology, and the location of the pumps (e.g. hospital, community, home). This training is particularly important given that many service providers often work at more than one health service organization, meaning they need to be competent in using many different types of infusion pumps.

Organizations are also encouraged to standardize infusion pumps to the greatest possible extent.

Test(s) for Compliance

Major 4.5.1 There is documented evidence of ongoing, effective training on infusion pumps.

4.6 The team receives specific education and training to deliver Emergency Department services.

Guideline
Training may include triage policies, process, and documentation; decision support software for Canadian Triage and Acuity Scale (CTAS); managing violence and security breaches; care maps; assessing clients for physical, sexual or psychological abuse; end of life issues, including advance directives, and do not resuscitate (DNR); use of least restraint policies.

An interdisciplinary approach to education and training may be used to encourage collaboration across disciplines.

4.7 The team receives training specific to providing emergency health services to pediatric clients.

Guideline
Training addresses the unique needs of pediatric clients including developmental stages, pediatric reference values, interaction with families, informed consent, Pediatrics Canadian Triage and Acuity Scale (P-CTAS), resuscitation and life support for infants and children, weight-based dose adjustment of medications, safe use of pediatric medical equipment, pain management, care protocols for common pediatric conditions, pediatric radiology protocols, and children and youth maltreatment.
4.8 The organization trains the team on how to prevent workplace violence.

**Guideline**
Acts of violence include abuse, aggression, threats, and assaults. Workplace violence includes acts committed by clients (or their families) or other staff and service providers, domestic violence in the workplace, and random violence that occurs as a result of a criminal act.
The training and education addresses the following core competencies: identifying triggers; recognizing signs of agitation and aggression; responding to and managing violence (e.g. de-escalation techniques, conflict resolution and mediation, and self defense); communication; and change management.

4.9 The organization trains the team on how to report incidents of workplace violence.

**Guideline**
Reporting includes perceived, potential, or actual incidents of violence.

4.10 The team monitors and meets each team member's ongoing education, training, and development needs.

**Guideline**
The process to monitor and meet each team member's ongoing learning needs may include performance evaluations, or regular assessment of team needs. It also identifies when specific training is required, such as when new technology, equipment, or skills are introduced, or after a team member has been away for an extended period of time.

4.11 Team leaders promote the Emergency Department as a career opportunity.

**Guideline**
Team leaders may promote the Emergency Department as a career opportunity by providing financial support for required courses and relevant conferences; and through enhanced orientation and mentorship programs for new staff in the Emergency Department.
4.12 The team supports student and volunteer placement on the Emergency Department team.

**Guideline**
If students or volunteers are placed with the team, the team provides adequate resources and supervision, and evaluates the student or volunteer placement regularly.

4.13 Team leaders regularly evaluate and document each team member’s performance in an objective, interactive, and positive way.

**Guideline**
Team leaders use the organization's established process to evaluate each team member's performance.

When evaluating performance, team leaders review the individual's ability to carry out responsibilities, and consider the individual's strengths, areas for improvement, and contributions regarding client safety, worklife, and other areas described in the position profile. They may also seek client or peer input.

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

5.0 Team leaders promote the team's well-being and worklife balance.

5.1 The organization has defined criteria that are used to assign team members to clients and other responsibilities in a fair and equitable manner.

**Guideline**
The criteria are based on accepted standards of practice, legal requirements, knowledge, experience and other qualifications, volume or complexity of the caseload, changes in workload, and client safety and needs.

This process also applies to students and volunteers, with adjustments made as required.
5.2 The team assesses workload and reassigns team members as required during periods of high volume and surges in the Emergency Department.

**Guideline**
The process to assess workload and reassign team members during periods of high volume and surges is monitored, and the data used to develop criteria to ensure fairness and equity.

5.3 The team has a process for identifying and reducing risks to team members while delivering Emergency Department services.

**Guideline**
Common risks may include aggressive and violent behaviour or security breaches in the Emergency Department and subsequent risk to clients, families, and staff; infectious disease; and using unsafe equipment. The team works with their leaders and the organization to reduce risks. Team members feel comfortable raising concerns about their safety when delivering Emergency Department services.

5.4 Team members have input on work and job design, including the definition of roles and responsibilities, and case assignments, where appropriate.

**Guideline**
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. Effective job design helps staff manage time, fatigue, stress, and worklife balance.

5.5 Team leaders regularly evaluate the effectiveness of staffing and use the information to make improvements.

**Guideline**
The evaluation covers job design, position profiles, practice roles, and case assignments.
The team has a fair and objective process to recognize team members for their contributions.

**Guideline**

Recognition activities may be individual, such as service awards based on years of service, or team-based, such as team activities.
6.0 The team coordinates timely access to services for current and potential clients, families, service providers, and referring organizations.

6.1 Emergency Department users can find the Emergency Department easily.

Guideline
The Emergency Department is identified through appropriate signage. This may include “H” signs posted on major roadways; clear directions to the emergency department and hospital for ambulatory clients, emergency vehicles, and client vehicles; signs inside the hospital indicating where to find emergency services such as the Emergency Department or the 24-hour on-call physician; and clearly marked helipads for hospitals that use air emergency medical services.

6.2 The team works to ensure that clients and families can access Emergency Department services 24 hours a day, seven days a week.

Guideline
The team works with other providers, organizations, and the community to ensure emergency services are available through other locations or groups when there is a high volume of emergencies.

6.3 The team quickly recognizes overcrowding in the Emergency Department and follows protocols to move clients elsewhere within the organization.

Guideline
In addition to limiting access to timely and appropriate care, overcrowding is a safety risk. In the event of overcrowding, the team follows protocols to improve in-patient utilization and move the right client to the right bed within the right time frame using mutually-agreed upon transfers of care with other parts of the organization. The team also identifies clients for an alternate level of care (ALC) including chronic care, chronic complex care, transition care, respite care, and palliative care, and begins the process to transfer ALC clients.
6.4 The team follows its protocols to manage overcrowding and surges before requesting aid from alternative health care sites or diverting ambulances.

**Guideline**
Access to the Emergency Department may be compromised when clients cannot be moved to other locations. The team uses strategies to address continued overcrowding or surges in the Emergency Department, e.g. assessment and release of clients by emergency medical services to community health services or primary care, proactive communication about the use and access to telehealth resources in the community, improved information technology to assist with client distribution decisions, a process at triage to ensure efficient offload of emergency medical services clients, and Transfer of Care agreements with other health care organizations in the community.

6.5 The team has a process to respond to all clients who present at the Emergency Department.

**Guideline**
The process may include a method to prioritize or triage clients by level of urgency, relocating clients with less urgent needs to waiting rooms, and specific sub-processes of care for particular client symptoms including point-of-care testing and rapid diagnostics.

6.6 A nurse or other medical personnel offloads clients from Emergency Medical Services (EMS) and conducts timely initial assessments.

6.7 The team measures ambulance offload response times, and sets and achieves target times for clients brought to the Emergency Department by EMS.

**Guideline**
Data for ambulance offload times is tracked to allow the team to identify patterns over time. The team has a process to update and synchronize clocks.

6.8 The team monitors ambulance offload response times and uses this information to improve its services.
The team records client information obtained from EMS.

**Guideline**
Pre-hospital information may include proposed triage categories or priority categories; basic or advanced assessment; medical directives; client-specific orders; client history, records, progress notes, or verbal reports; telephone advice; medico-legal issues such as police cases, e.g. indications of domestic violence and abuse; animal bites; consent to treatment; involuntary clients; client refusals; withdrawal of life support; clients who are dead on arrival (DOA); confidentiality of information; safety and security of client identification, valuables, and belongings.

The team shares relevant information about the client with Emergency Medical Services (EMS).

The team sets, tracks, and benchmarks data related to waiting times for services and information, and the length of stay (LOS) in the Emergency Department.

**Guideline**
The data is cross-tabulated according to Canadian Triage and Acuity Scale (CTAS) levels. LOS data is collected for clients who are admitted or not admitted.

The team triages clients in the Emergency Department in a timely way.

The team uses the Canadian Triage and Acuity Score (CTAS) to conduct the triage assessment.

**Guideline**
The CTAS is used to define client needs and improve timely access to emergency care and services. Emergency Medical Services (EMS) may, in some cases, release CTAS level 4 or 5 clients to primary care or Urgent Care Facilities before and as an alternative to presenting to the Emergency Department. If several clients are waiting to be triaged, the team may conduct a visual triage assessment.
7.2 The team uses the Pediatric-CTAS to conduct the triage assessment of pediatric clients.

7.3 The team conducts a triage assessment for each client within CTAS timelines.

**Guideline**
Clients receive a complete triage assessment regardless of how they arrive in the Emergency Department.

7.4 The team conducts a triage assessment for each pediatric client within P-CTAS timelines.

7.5 With the client's permission, the team gathers health history information to determine the need for service.

**Guideline**
When prioritizing and managing services for the client, the team takes into consideration information from other health service providers such as physicians, paramedics, Emergency Medical Technicians, Emergency Medical Responders, nurses, nurse practitioners, and social workers.

7.6 In addition to CTAS, the team follows set criteria and gathers input from the client's other service providers to identify immediate and urgent needs and decide on priorities of service.

**Guideline**
Teams may label this process registration, admission, intake, pre-admission, or screening. Immediate and urgent needs may include an older adult's age-related changes, e.g. atypical presentation, wandering; indicators of high risk for client's repeat injury or homicide from an intimate or formerly intimate partner. The process may need to be adjusted for clients and families with diverse needs, e.g. language, culture, level of education, lifestyles, prior experiences of physical, sexual, or psychological abuse, and physical or mental disability.
7.7 The team informs clients in the waiting area of wait times for assessment and treatment.

7.8 After the initial triage assessment, the team advises clients who are waiting for service to return to triage if their condition changes.

7.9 The team monitors possible progression of illness for clients waiting in the Emergency Department.

7.10 The team has a policy and process to ensure that client CTAS scores are re-assessed.

**Guideline**

Clients who initially appear stable may deteriorate as illnesses progress. The team re-assesses all clients (e.g. clients in hallways, waiting rooms, ambulance bays) according to policy, and staff and service provider responsibilities for re-assessment are defined. The team's process includes measuring the timeliness of the re-assessments and setting targets based on CTAS re-assessment guidelines.

7.11 The team has a policy and process to ensure pediatric client P-CTAS scores are re-assessed.

**Guideline**

Pediatric clients require more frequent re-assessments than adults since the health condition of this age group is more likely to deteriorate rapidly. The team is encouraged to have a pediatric-specific triage protocol that defines P-CTAS re-assessment timelines.
The team assesses the client's physical and psychosocial health.

**Guideline**

Building on information collected from the triage process, elements of physical health include medical history, allergies, medication profile, health status; personal safety and the home environment, including exposure to physical, psychological or sexual abuse; and nutritional status and special dietary needs. Elements of psychosocial health include functional and emotional status, including client's communication and self-care abilities; mental health status, including personality and behavioural characteristics; socioeconomic situation; spiritual orientation; and cultural beliefs.
REQUIRED ORGANIZATIONAL PRACTICE: The team reconciles medications for clients with a decision to admit, with the involvement of the client, family or caregiver.

**Guideline**

Medication reconciliation is a structured process in which healthcare professionals partner with clients, families and caregivers for accurate and complete transfer of medication information at transitions of care.

The medication reconciliation process involves generating a comprehensive list of all medications the client has been taking prior to admission – the Best Possible Medication History (BPMH). The BPMH is compiled using a number of different sources, and includes information about prescription medications, non-prescription medications, vitamins, and supplements, along with detailed documentation of drug name, dose, frequency, and route of administration.

Medication reconciliation at admission generally fits into two models - the proactive process, the retroactive process, or a combination of the two:

- In the proactive process, the prescriber uses the BPMH to create admission medication orders. This process includes verification that every medication in the BPMH has been assessed by the prescriber.
- In the retroactive process, the BPMH is generated after the admission medication orders are written. This process requires a timely comparison of the BPMH against the admission medication orders, with any discrepancies identified and resolved with the prescriber.

Medication reconciliation is widely recognized as an important safety initiative. Evidence shows medication reconciliation reduces potential for medication discrepancies such as omissions, duplications, and dosing errors. In Canada, Safer Healthcare Now! identifies medication reconciliation as a safety priority. The World Health Organization (WHO) has also developed a Standard Operating Protocol for medication reconciliation as one of its interventions designed to enhance patient safety.

Medication reconciliation is a shared responsibility which must involve the client or family. Liaison with the primary care provider and community pharmacist may be required.

**Test(s) for Compliance**

**Major**

8.3.1 There is a demonstrated, formal process to reconcile client medications for clients with a decision to admit.

8.3.2 The team generates a Best Possible Medication History (BPMH) for clients with a decision to admit.

8.3.3 Depending on the model, the prescriber uses the BPMH to create admission medication orders (proactive), OR, the team makes a timely comparison of the BPMH against the admission medication orders (retroactive).
### Accessibility

#### 8.6

The team has priority access to diagnostic imaging and laboratory testing, results, and expert consultation and advice to manage clients with life-threatening or urgent conditions.

#### 8.5

The team has 24-hour access to diagnostic imaging and laboratory testing and results.

**Guideline**

Based on the organization’s resources, 24-hour access to diagnostic imaging and laboratory testing and results may be available on an on-call basis for life-threatening situations only.

#### 8.4

**INDICATOR:** Medication reconciliation for clients with a decision to admit.

While there is no longer a requirement to submit indicator data using the client portal, Accreditation Canada encourages organizations to continue to monitor the rate of medication reconciliation at the beginning of service. A new process to receive indicator results is being developed.

**Guideline**

Accreditation Canada has developed definitions and data collection protocols based on research, literature reviews, and input from leading experts. These are available on the portal for organizations that wish to use them.

**Indicator Information**

- **8.4.1** The team follows Accreditation Canada’s protocols and definitions to collect and submit data on medication reconciliation.
- **8.4.2** The team does not have any unaddressed priority for action flags based on their medication reconciliation indicator results.

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- **Accessibility**

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**Indicator Information**

- **8.4.1** The team follows Accreditation Canada’s protocols and definitions to collect and submit data on medication reconciliation.
- **8.4.2** The team does not have any unaddressed priority for action flags based on their medication reconciliation indicator results.

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### Major

- **8.3.4** The team documents that the BPMH and admission medication orders have been reconciled; and appropriate modifications to medications have been made where necessary.

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### Minor

- **8.3.5** The process is a shared responsibility involving the client and one or more health care practitioner(s), such as nursing staff, medical staff, pharmacists, and pharmacy technicians, as appropriate.
8.7 The team uses evidence-based protocols to select diagnostic imaging services for pediatric clients.

Guideline
Inappropriate use of diagnostic imaging may increase costs and expose pediatric clients to unnecessary radiation. The team is encouraged to collaborate with diagnostic imaging services to develop evidence-based radiology protocols.

8.8 The team follows a process for staff and service providers to communicate and validate client diagnoses when there is discrepancy between the initial diagnosis and diagnostic imaging or laboratory results.

8.9 The team regularly reviews the client assessment and updates it if the client's health status changes significantly.

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

9.0 The team identifies and refers potential organ and tissue donors in a timely and effective manner.

9.1 The team works with the ICU, organ recovery centre, or tissue recovery team to establish time frames for the timely transfer of potential organ and tissue donors from the emergency department.

Guideline
The team transfers potential organ and tissue donors to the ICU, organ recovery centre, tissue recovery area or morgue in a timely way to appropriately manage the donor and recover the organ or tissue. Transferring potential donors is particularly important in organizations without critical care facilities.
9.2 The organization has established clinical referral triggers to identify potential organ and tissue donors.

**Guideline**
The organization should establish clinical referral triggers that define criteria for imminent death. For organ donation, these clinical triggers should address patients requiring mechanical ventilation; having clinical findings consistent with a score on the Glasgow Coma Scale less than or equal to an agreed-upon threshold; being evaluated for a diagnosis of neurological death; having withdrawal of life-sustaining therapies ordered by a physician; or lacking of brain stem reflexes. For tissue donation, these triggers address patients with cardiac death who are under 85 years of age.

9.3 The team receives training and education on the definition of imminent death, the use of clinical referral triggers, who to contact when potential organ and tissue donation opportunities arise, how to approach families about donation and other donation issues.

**Guideline**
Team members, e.g. nurses, physicians, or respiratory therapists should be educated on when and how to make referrals to physicians qualified to determine neurological death or how to link with donation services such as Organ Procurement Organizations.

9.4 The organization has a policy on neurological determination of death (NDD).

**Guideline**
To allow for organ donation, policies for NDD should cover but are not limited to vital signs body such as temperature, clinical NDD and ancillary testing, qualifications of physicians conducting NDD, and verification of NDD by a second qualified physician.

9.5 The team follows a written protocol for NDD that includes accessing the people qualified to determine neurological death.

**Guideline**
Determining neurological death does not require a particular level of specialty certification, only that physicians have the requisite skills and knowledge necessary to determine neurological death. In instances where access to physicians that are qualified to determine death is limited, team members should have a protocol in place to access centres capable of NDD and organ recovery or critical care lines.
9.6 The team checks the provincial donor registry, where one exists, to determine if the patient is a registered donor.

**Guideline**

In every province that has legislation on organ and tissue donation such as The Human Tissue Gift Act, the law prohibits physicians determining neurological death from participating in transplant procedures. This includes association with potential recipients and is intended to prevent influences in physicians’ judgements.

9.7 The team provides the family with the appropriate information about the implications of neurological death.

**Guideline**

Materials such as pamphlets or booklets on neurological death may help the family to better understand the nature or gravity of neurological death and what has happened to their family member.

9.8 The team notifies the Organ Procurement Organization (OPO) in a timely manner when death is imminent or established for potential donors.

**Guideline**

Rapid notification of potential donors to the OPO increases the likelihood of organ and tissue donation.

In many jurisdictions, legislation specifies procedures to be followed when death is imminent. In those provinces, team members are required by law to notify their OPO when a patient has died or a physician has made an NDD.

9.9 The team checks the provincial donor registry, where one exists, to determine if the patient is a registered donor.
9.10 Before approaching the family, the team and the donation coordinator discuss how they will approach the family about donation.

**Guideline**
The team, e.g. physicians, attending physician, intensivists, spiritual advisors, nurses, and donation coordinator, should quickly meet to discuss how they will approach the family about donation and how to support the family and meet their needs during the process. The organization should have a process to establish where potential donors are best managed and where the family will be approached.

The team may discuss the family's understanding of the situation, when the best time to discuss donation would be, the best person to approach the family, and how the OPO staff and the donor coordinator will be introduced to the family.

The organization should have a policy that describes those circumstances under which the potential donor's family is approached or the donor is managed in the emergency department.

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9.11 When approaching families about donation, the team uses a decoupling approach.

**Guideline**
A decoupling approach is approaching the family about donation only after they have had the opportunity to grasp the confirmed or imminent death of their loved one.

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9.12 The most qualified team member follows a written process when approaching families about organ and tissue donation.

**Guideline**
Discussions regarding organ and tissue donation and determining if the family is interested in donation should be handled by the person that the team identifies as the most skilled, capable and experienced. This professional could be a nurse, physician, social worker, spiritual advisor, or a representative from an OPO.

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9.13 When approaching the family, the team is sensitive to the situation, and respects the clients and family's culture, beliefs, and decisions about organ and tissue donation.

**Guideline**
This may include using interpreters where necessary so that the family understands the information being provided.
9.14 The team records all aspects of the donation process including the family's decision about organ and tissue donation in the client record.

**Guideline**

The client record includes that the client was identified as a potential donor, the family was approached for donation, the OPO was contacted and the decision about organ and tissue donation.

**10.0 The team effectively manages clients who come to the Emergency Department for service.**

10.1 During registration, an appropriate team member explains to the client, and family if available, the anticipated sequence of events, locations where services will be provided, and by whom.

**10.2 The team follows hospital policy to obtain the client's informed consent to treatment or investigation.**

**Guideline**

Informed consent consists of reviewing service information and the consent form with the client; informing the client about the available options and providing time to reflect and ask questions before asking for consent; respecting the client's rights, culture, and values as they relate to informed consent, including the right to refuse consent at any time; and recording the client's decision in the client record.

Implied consent occurs when providing services where written consent is not needed, such as when clients willingly present themselves to the Emergency Department registration desk, are brought for service through Emergency Medical Services (EMS), or present with life-threatening or emergent condition(s) and require immediate resuscitation.

When dealing with minors such as children and youth, the team's consent process includes involving the minors as much as possible in decision-making about their service, intervention, or treatment, and valuing their questions and input.
When clients are incapable of giving informed consent, the team refers to the client's advance directives if available or obtains consent using a substitute decision maker.

**Guideline**

Clients who are incapable of providing consent may have advance directives to guide certain or all decisions. The team records advance directives in the client record and shares this information with service providers in and outside of the organization, as appropriate.

The team may also consult with a substitute decision maker when clients are unable to make their own decisions. In these cases, the team provides the substitute decision maker with information on the roles and responsibilities involved in being a substitute decision maker, and discusses questions, concerns, and options. A substitute decision maker may be specified in legislation or may be an advocate, family member, legal guardian, or caregiver.

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

**REQUIRED ORGANIZATIONAL PRACTICE:** The team uses at least two client identifiers before providing any service or procedure.

**Guideline**

Failure to correctly identify clients may result in a range of adverse events such as medication errors, transfusion errors, testing errors, wrong person procedures, and the discharge of infants to the wrong families. Client misidentification was identified in more than 100 individual root cause analyses by the US Department of Veterans Affairs National Center for Patient Safety from January 2000 to March 2003. The UK National Patient Safety Agency reported 236 incidents and near misses related to missing wristbands or wristbands with incorrect information between 2003 and 2005. Evidence has shown decreases in client identification errors when revised client identification systems are used.

The team uses means of identification that are appropriate to the type of services provided and population served. The information obtained needs to be specific to the client, and examples include person-specific identification number such as a registration number; client identification cards such as the health card with name, address, date of birth; client barcodes; double witnessing; or a client wristband. Two client identifiers may be taken from a single source, such as the client wristband. The client's room number is not to be used as a client identifier.

**Test(s) for Compliance**

**Major**

10.4.1 The team uses at least two client identifiers before providing any service or procedure.
10.5 The team evaluates and manages the client's pain.

**Guideline**

The team uses standardized clinical measures to determine pain intensity, quality, location, alleviating and contributing factors, and impact on usual activities. Examples for adults include Numerical Rating Scale (NRS) for pain intensity and relief (0-10), and the Brief Pain Inventory for functional ability. Examples for infants and children include Stevens' Premature Infant Pain Profile and the Faces Pain Scale – Revised (FPS-R). Examples for non-verbal and/or cognitively impaired persons include Feldt's Checklist of Nonverbal Pain Indicators and McGrath's behavioural and physiological indicators.

Pain may also be assessed in combination with other symptoms using a comprehensive assessment tool such as the Edmonton Symptom Assessment Scale (ESAS).

Strategies to manage pain may include analgesics, including opioids and adjuvants when needed, along with physical, behavioural, and psychological interventions. The team consults with experts, and uses research and evidence to understand the best ways to manage pain and other symptoms.

10.6 The team uses evidence-based care protocols when providing emergency department services to clients.

**Guideline**

Use of evidence-based care protocols assists staff and service providers to effectively identify, address, and manage health care needs of pediatric clients, and minimizes treatment variations.

Pediatric care protocols for emergency departments may include anaphylaxis, asthma, croup, febrile neutropenia, gastroenteritis and dehydration, pain, suspected neonatal sepsis, septic shock, seizures and status epilepticus, procedural sedation, and radiology.

Since evidence-based care protocols are normally developed in an urban setting, organizations in rural communities need to evaluate the applicability of these protocols to ensure they meet the needs of their emergency department.

10.7 Before dispensing medication, a qualified team member reviews each prescription for completeness and accuracy.

**Guideline**

At a minimum, each prescription shows the client's name, the name of the medication, dosage and frequency, and the name of the prescribing medical professional. The prescription review assesses the appropriateness of the medication being prescribed, the use of multiple medications, and medication interactions.
Guideline
The transfer of care criteria may include sufficient control of pain, nausea, or vomiting, and appropriateness and safety of discharge destination.

10.9 The team administers medications to pediatric clients using weight-based pediatric dosages and appropriately sized equipment.

10.10 The team adheres to assigned roles and responsibilities during the resuscitation of clients.

Guideline
The team knows its roles and responsibilities, including leadership roles, enabling it to work and communicate effectively as a team during resuscitation.

10.11 The team identifies and manages medico-legal issues in the Emergency Department.

Guideline
The team provides training to staff in the Emergency Department on the identification and management of medico-legal issues such as police cases (e.g. indications of domestic violence and abuse), consent to treatment, involuntary clients, client refusals, withdrawal of life support, clients who are dead on arrival (DOA); safety, security and confidentiality of client identification.

11.0 The team prepares clients and families for transition to another service team or setting, service provider, or end of service.

11.1 The team applies standardized criteria to determine whether a client is fit for transfer of care.

Guideline
The transfer of care criteria may include sufficient control of pain, nausea, or vomiting, and appropriateness and safety of discharge destination.
11.2 The team coordinates the client's services within the organization's in-patient health care services and with other health services outside the organization.

**Guideline**

Health services outside the organization include community health services, primary care, other primary health care services or community-based services, home care, social services, specialized treatment centres, and long term care.

11.3 The team follows standardized processes and procedures to coordinate timely inter-facility client transfers and transfers to other units within the organization.

**Guideline**

Processes to improve client flow to other facilities and within the organization may include a client flow strategy or diagram, a time series model to predict in-patient resource requirements generated by admission to the Emergency Department, or an Emergency Department Full Capacity Protocol to facilitate the admission of clients held in the Emergency Department awaiting bed assignment.

11.4 The team collaborates with a discharge planner or bed manager to evaluate clients for referral to other health care services and programs when an in-patient bed is not available.

**Guideline**

Other health care services and programs may include community-based health care or social services programs.

The team may explore the option of transferring clients to another hospital, or determine if a client is willing to remain in the emergency department if discharge to other health care services and programs is not feasible.

11.5 REQUIRED ORGANIZATIONAL PRACTICE: The team reconciles the client's medications with the involvement of the client, family or caregiver at transition points where medication orders are changed or rewritten (i.e. internal transfer, and/or discharge).

**Guideline**

Medication reconciliation is a structured process in which healthcare professionals partner with clients, families and caregivers for accurate and complete transfer of medication information at transitions of care. The ‘Medication Reconciliation at Transfer or Discharge ROP’ is designed to complement Accreditation Canada’s ‘Medication Reconciliation at Admission ROPs’.

The medication reconciliation process involves generating a comprehensive list of all medications the client has been taking prior to admission – the Best Possible Medication History (BPMH). The BPMH is compiled using a number of different sources, and includes information about prescription medications, non-prescription medications, vitamins, herbal remedies, and supplements, along with detailed
11.5 documentation of drug name, dose, frequency, and route of administration.

Throughout a client's health care journey, the BPMH serves as an important reference for reconciling medications at transitions of care. In instances where a client has been in a service environment for an extended period and did not receive a BPMH upon admission, the up-to-date, complete medication list may be used as a BPMH (the period of time should be determined by organizational policy). In these instances, every effort should be made to account for medications the patient may have been taking prior to admission that may not be included on the up-to-date medication list.

INTERNAL TRANSFER
Internal transfer is defined as an interface of care within a facility where medication orders are changed or rewritten. Internal transfers where medication reconciliation should occur include a change in responsible medical service, a change in level of care, post-operatively, and/or transfer between units when one of the previous three conditions is present. Bed relocation or transitions of care where the responsible health care provider does not change should not be considered an internal transfer for the purpose of medication reconciliation.

The goal of medication reconciliation at internal transfer is to consider not only what the patient was receiving on the transferring/sending unit, but also medications they were taking at home that may be appropriate to continue, restart, discontinue, or modify.

DISCHARGE
Discharge is defined as a critical interface of care where clients are at risk of medication discrepancies as they transition out of a facility. Discharge includes external transfers to another service environment or community-based service provider, or the end of service. Examples may include but are not limited to acute care to long term care, acute care to home care, acute care to rehab, and acute care to self-care.

The goal of discharge medication reconciliation is to reconcile the medications the patient was taking prior to admission, and those initiated in hospital, with the medications they should be taking post-discharge.

Medication reconciliation at internal transfer and discharge generally fits into two models – the proactive process or the retroactive process.
• In the proactive process, the prescriber uses the BPMH and the active medication orders to generate transfer or discharge medication orders. This process includes verification that every medication in the BPMH has been assessed by the prescriber.
• In the retroactive process, the team makes a timely comparison of the BPMH, the active medication orders, and the transfer or discharge medication orders to identify discrepancies and resolve with the prescriber.

At discharge, this information should be used to generate a Best Possible Medication Discharge Plan (BPMDP). The BPMDP includes all detailed medication information outlined in the BPMH description above, and should be communicated to the client and/or caregiver, community-based physician or service, community pharmacy, and alternative care facility or service, as appropriate.

Note: For emergency departments, medication reconciliation at internal transfer or discharge is only expected for patients who have been admitted.

Medication reconciliation is a widely recognized as an important safety initiative. In Canada, Safer Healthcare Now! identifies medication reconciliation as a safety priority. The Institute for Safe Medication Practices Canada has developed a Standard Operating Protocol for medication reconciliation which has been endorsed by the World Health Organization as one of its interventions designed to enhance patient safety.

Medication reconciliation is a shared responsibility which must involve the client or family. Liaison with the primary care provider and community pharmacist may be required.
### Major 11.5.1
There is a demonstrated, formal process to reconcile client medications at transition points where medication orders are changed or rewritten (i.e. internal transfer, and/or discharge).

### Major 11.5.2
Depending on the model, the prescriber uses the Best Possible Medication History (BPMH) and the active medication orders to generate transfer or discharge medication orders (proactive), OR, the team makes a timely comparison of the BPMH, the active medication orders, and the transfer or discharge medication orders (retroactive).

### Major 11.5.3
The team documents that the BPMH, the active medication orders, and the transfer or discharge medication orders have been reconciled; and appropriate modifications to medications have been made where necessary.

### Major 11.5.4
Depending on the transition point, an up-to-date medication list is retained in the client record (internal transfer), OR, the team generates a Best Possible Medication Discharge Plan (BPMDP) that is communicated to the client, community-based physician or service provider, and community pharmacy, as appropriate (discharge).

### Minor 11.5.5
The process is a shared responsibility involving the client or family, and one or more health care practitioner(s), such as nursing staff, medical staff, and pharmacy staff, as appropriate.

### Major 11.6
The team tells clients and families what to expect during transition or end of service.

**Guideline**
Continuity of care is enhanced when clients have comprehensive information about transitions and end of service. Information provided to the client and family includes the client’s service plan, goals, and preferences; a summary of the care provided; an updated list of outstanding issues, clinical or otherwise; what to expect during transition or at end of service; and contact information for the team and details on when clients should contact the team, e.g. if clients notice any warning signs or symptoms of adverse reactions.
11.7  The team transfers the information obtained from Emergency Medical Services (EMS), triage, assessment, and admissions to service providers in the next setting.

11.8  REQUIRED ORGANIZATIONAL PRACTICE: The team transfers information effectively among service providers at transition points.

Guideline
Effective communication has been identified as a critical element in improving client safety, particularly with regard to transition points such as shift changes, end of service, and client movement to other health services or community-based providers.

Effective communication includes transfer of information within the organization, between staff and service providers, with the client and family, and to other services outside the organization, such as primary care providers. Examples of mechanisms to ensure accurate transfer of information may include transfer forms and checklists.

Test(s) for Compliance

Major  11.8.1  The team has established mechanisms for timely and accurate transfer of information at transition points.

Major  11.8.2  The team uses the established mechanisms to transfer information.
MAINTAINING ACCESSIBLE AND EFFICIENT CLINICAL INFORMATION SYSTEMS

12.0 The team keeps client records accurate, up-to-date, and secure.

12.1 The team maintains an accurate and up-to-date record for each client.

12.2 The team meets applicable legislation for protecting the privacy and confidentiality of client information.

Guideline
Applicable legislation may be national or provincial/territorial.

12.3 Staff and service providers have timely access to the client record.

Guideline
The organization has policies outlining who may access client information, and how and when they may do so.

Team members make it a priority to read and understand client records. Failing to be aware of information contained in the client record can lead to breakdowns in the continuity of care and services, and create unnecessary gaps or duplication.

12.4 The team shares client information and coordinates its flow among service providers, other teams, and other organizations, as required.

Guideline
While maintaining an awareness of the client's right to privacy, the team shares information as required to facilitate transfers, and to reduce duplication in obtaining client information.
13.0 The team has access to information technology to deliver Emergency Department services.

13.1 The team has timely access to information technology that impacts client care.

13.2 Staff and service providers use information technology to share information with the interdisciplinary team.

**Guideline**
To enhance communication, the team uses appropriate information technology to communicate with other services which may include primary health care providers, emergency medical services, pharmacy, diagnostic imaging services, and alternative levels of care (ALC).

13.3 The team identifies its needs for new technology and information systems.

**Guideline**
Examples of technology include electronic health records (EHR), client tracking systems, and waiting list management systems. Innovative information technology is used to support the work of the service area.

13.4 Team members receive education and training on information systems and other technology.

**Guideline**
Required skills may include knowledge of computer applications, word-processing software, and how to use the Internet.
14.0 The team uses evidence-based guidelines and best practice information to improve the quality of its services.

14.1 The organization has a process to select evidence-based guidelines for Emergency Department services.

**Guideline**

Evidence-based guidelines may be established internally by a committee, a council, or an individual who develops tools and makes recommendations to the team.

Guidelines from other organizations or associations may be adopted by the team. The process for selecting guidelines is standardized and formalized. It may include using content experts, a consensus panel, or the Appraisal of Guidelines Research and Evaluation (AGREE) 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.

Comprehensive documents that synthesize evidence from several guidelines are also available. For example, the Cochrane Collaboration conducts systematic reviews of the available evidence; this can help service providers and organizations with their review process. Where synthesized information is not available, the organization has a process to deal with and decide among conflicting guidelines or multiple recommendations.

Evidence-based guidelines for Emergency Departments include the Canadian Association of Emergency Physician policies, position statements, or clinical guidelines, all or which are designed to enhance service delivery in Emergency Departments.

14.2 The team reviews its guidelines to make sure they are up-to-date and reflect current research and best practice information.

**Guideline**

The team's review process includes ways to access the most up-to-date research and information, e.g., through literature reviews, content experts, national organizations or associations, or the Cochrane Collaboration. Research information may include intervention research, program evaluations, and clinical trials.

14.3 The team's guideline review process includes seeking input from staff and service providers about the applicability of the guidelines and their ease of use.
14.4 The team's research activities for Emergency Department services meet applicable research and ethics protocols and standards.

**Guideline**
The team may participate in research initiatives to improve the quality of care to Emergency Department clients, e.g. clinical trials, assessments of new interventions, or changes to existing ones.

Research and ethics protocols and standards include those for client consent to participate in research activities.

14.5 The team shares benchmark and best practice information with its partners and other organizations.

15.0 **The team promotes safety in the service environment.**

15.1 The team is trained to identify and manage physically threatening or violent clients in the Emergency Department.

**Guideline**
The team uses strategies such as verbal de-escalation or non-violent crisis intervention, or resources such as security guards to mitigate risks and ensure the safety of others.

15.2 The team identifies, manages, and isolates clients with known or suspected infectious diseases.

15.3 Staff and service providers participate in regular safety briefings to share information about potential safety problems, reduce the risk of error, and improve the quality of service.

**Guideline**
Regular opportunities to share information about potential problems and actual incidents can reduce risk and the likelihood of an incident recurring.
The team identifies, reports, records, and monitors in a timely way sentinel events, near misses, and adverse events.

**Guideline**

Investigating sentinel events, near misses, and adverse events includes taking action to prevent the same situation from recurring, monitoring incidents, and using lessons learned to make improvements.

This criterion is linked to the Required Organizational Practice in Accreditation Canada's Standards for an Effective Organization that requires organizations to have a reporting system consistent with applicable legislation for near misses, and sentinel and adverse events.

Staff and service providers delivering Emergency Department services are responsible for implementing the organization's process. In addition, information about sentinel events, near misses and adverse events is tracked for Emergency Department services specifically and reported in a manner that is consistent with others across the organization so that the information may be summarized at the organization level.

The team follows the organization's policy and process to disclose adverse events to clients and families.

**Guideline**

This criterion is linked to the Required Organizational Practice in Accreditation Canada's Standards for an Effective Organization that requires organizations to have a formal process to disclose adverse events to clients and families.

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The team makes ongoing improvements to its Emergency Department services.

The team identifies and monitors process and outcome measures for its Emergency Department services.

**Guideline**

The team uses its quality improvement process to examine how services can be improved and makes changes to achieve better results.

Process and outcome measures should include bed availability, client diversion to other facilities, time to admission, length of stay (LOS) for admitted and non-admitted clients of the emergency department, wait times, and rates of re-admission within 72 hours for pediatric clients.
16.2 The team monitors clients' perspectives on the quality of Emergency Department services.

Guideline
The team may seek clients' perspectives through surveys, focus groups, interviews, or meetings.

16.3 The team compares its results with other similar interventions, programs, or organizations.

Guideline
The team may participate in benchmarking opportunities and comparisons with peer organizations to assess its performance and identify opportunities for improvement. The team also identifies and shares leading practices.

16.4 The team uses the information it collects about the quality of its services to identify successes and opportunities for improvement, and makes improvements in a timely way.

Guideline
Ongoing quality improvement initiatives are part of a broader organizational philosophy of quality improvement. The team's work to monitor and improve the quality of its services is integrated with the organization's overall work on quality improvement, risk management and client safety, and utilization management, i.e. the efficient use of resources.

Areas for improvement are prioritized based on criteria such as high risk, high volume, and cost.

16.5 The team shares evaluation results with staff, clients, and families.

Guideline
Sharing the results of evaluations and improvements helps staff to become familiar with the philosophy and benefits of quality improvement. It also increases clients' and families' awareness of the organization's commitment to quality for its Emergency Department services and its commitment to ongoing quality improvement.
**Legend:**

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<thead>
<tr>
<th>Dimensions</th>
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<tr>
<td>Population Focus</td>
<td>Working with communities to anticipate and meet needs</td>
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<td>Accessibility</td>
<td>Providing timely and equitable services</td>
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<td>Safety</td>
<td>Keeping people safe</td>
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<td>Worklife</td>
<td>Supporting wellness in the work environment</td>
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<tr>
<td>Client-centred Services</td>
<td>Putting clients and families first</td>
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<td>Continuity of Services</td>
<td>Experiencing coordinated and seamless services</td>
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<td>Effectiveness</td>
<td>Doing the right thing to achieve the best possible results</td>
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<td>Efficiency</td>
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**Criterion Types**

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

- **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.

**Priority**

- **High Priority**: High priority criteria are criteria related to safety, ethics, risk management, and quality improvement. They are identified in the standards.
**ROP Tests for Compliance**

<table>
<thead>
<tr>
<th>Type</th>
<th>Description</th>
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<tbody>
<tr>
<td>Minor</td>
<td>Minor tests for compliance support safety culture and quality improvement, yet require more time to be implemented.</td>
</tr>
<tr>
<td>Major</td>
<td>Major tests for compliance have an immediate impact on safety.</td>
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References: