Required Organizational Practices

2024 HANDBOOK

Qmentum Global™

Effective: May 2024

People powered health™

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About ROPs

In the Accreditation Canada Qmentum Global™ program, a required organizational practice (ROP) is a criterion that describes a standardized practice that an organization must have in place to enhance client safety and minimize risk to deliver reliable and high-quality care to the population the organization serves. If the standardized practice is not in place, harm could result.

IMPORTANT

Not all ROPs collected in this handbook apply to all organizations. To determine which ROPs apply to your organization, refer to your customized assessment manuals in OnBoardQi or connect with your Accreditation Canada Client Engagement Team.

For your convenience and ease of use, this handbook contains all ROPs in the Accreditation Canada Qmentum Global™ program.

Most ROPs apply to more than one sector or service and therefore appear in multiple standards.

The standards in which the ROPs appear are identified in the *List of ROPs within Standards*.

ROPs are formatted using the following structure:

- **ROP statement**. A thematic statement that introduces the tests for compliance. The ROP statement specifies the objective of the ROP and who is accountable.
- **Tests for compliance**. Evidence-informed requirements that describe what actions people need to take to achieve the objective in the ROP statement. Each test for compliance outlines an action to be taken and who is accountable for the action.
- **Guidelines**. Additional information and evidence to support the implementation of each test for compliance.
- **Bibliography**. The published literature used to inform the content.

ROPs are categorized into the following six patient safety areas. The patient safety areas are being reviewed and may be updated in the future.

- **Safety Culture**. Create a culture of safety within the organization.
- **Communication**. Improve the effectiveness and coordination of communication among care and service providers and with the recipients of care and service across the continuum.
- **Medication Use**. Ensure the safe use of high-risk medications.
- **Work-life/Workforce**. Create a work-life and physical environment that supports the safe delivery of care and service.
- **Infection Prevention and Control**. Reduce the risk of health care-associated infections and their impact across the continuum of care/service.
- **Risk assessment**. Identify safety risks inherent in the client population.

What’s New in This Version of the Handbook

This handbook was published in May 2024.

In 2024, the following 10 ROPs were introduced to the Accreditation Canada Qmentum Global™ program and have been added to this handbook.

- HSO 5011:2024 Adhering to a Do-Not-Use List of Abbreviations, Symbols, and Dose Designations
- HSO 5055:2024 Cleaning and Low-Level Disinfecting Medical Equipment
- HSO 5050:2024 Improving Hand Hygiene Practices
- HSO 5035:2024 Limiting High-Concentration and High-Total-Dose Opioid Formulations
- HSO 5033:2024 Managing High-Alert Medications
- HSO 5014:2024 Maintaining an Accurate List of Medications during Care Transitions
- HSO 5063:2024 Optimizing Skin Integrity
- HSO 5060:2024 Preventing Falls and Reducing Injuries from Falls
- HSO 5065:2024 Preventing Venous Thromboembolism
- HSO A5064:2023 Suicide Prevention Program Required Organizational Practice

As demonstrated in the List of ROPs within Standards, these ROPs are an update and consolidation of former ROPs. There is only one net-new ROP (HSO 5055:2024 Cleaning and Low-Level Disinfecting Medical Equipment).

This consolidation has reduced the overall number of ROPs in the Accreditation Canada Qmentum Global™ program from 38 ROPs to 26 ROPs.

As ROPs are updated, a new structure is applied. Updated ROPs now include guidelines for each test for compliance, as well as a clear objective, accountability, and required actions. They also reflect a proactive, integrated, and team-based approach to standardized safety practices. This new approach is intended to encourage organizations to look beyond quality assurance and toward an organization-led continuous quality improvement model to prevent harm and improve outcomes.

How to Use the ROP Handbook

This handbook contains all the ROPs in the Accreditation Canada Qmentum Global™ program. However, not all ROPs apply to all organizations. The ROPs that apply to your organization depend on the services your organization provides and the standards your organization is being assessed against.

Organizations may also be at different points in the accreditation cycle. This means that different standards, and therefore different ROPs, will apply depending on where your organization is in its accreditation cycle.

The List of ROPs within Standards lists all the ROPs in the Accreditation Canada Qmentum Global™ program by patient safety area. As ROPs are updated, former ROPs will be phased out as organizations transitions to updated versions of standards.

Updated versions of ROPs **only apply if your organization is using the standard that the ROP is found in**. For example, the HSO 5000:**2021** *Accountability for Quality of Care* ROP only applies to organizations using the HSO A1001:**2022** *Governance* standard. Organizations using the HSO A1001:**2018** *Governance* standard will use the HSO 5000:**2018** *Accountability for Quality* ROP.

To determine which standards apply to your organization, refer to your customized assessment manuals in OnBoardQi or connect with your Accreditation Canada Client Engagement Team. You can use the checkboxes in the table below to make note of your applicable ROPs.

Required Organizational Practices

Safety Culture

Accountability for Quality of Care

HSO 5000:2021

Notes: This content is an update to HSO 5000:2018 Accountability for Quality. As organizations transition to the standards listed in the *List of ROPs within Standards* this ROP will become applicable.

ROP STATEMENT

The governing body demonstrates accountability for the quality of care provided by the organization.

TESTS FOR COMPLIANCE AND GUIDELINES

1. **The governing body applies a recognized framework for guiding the activities related to quality of care provided by the organization.**

   Guidelines

   The framework is adopted from existing jurisdictional or international frameworks such as the *Canadian Quality and Patient Safety Framework*. It includes a standardized approach that the governing body uses to address quality. The framework is tailored to the individuals and communities receiving services from the organization.

2. **The governing body provides its members with education and continuous learning on the topic of quality of care – quality frameworks, key quality principles, key quality indicators.**

   Guidelines

   The education and continuous learning helps governing body members understand the need for quality to be embedded in their service delivery.

   There are different ways the education and continuous learning can be undertaken. The education and continuous learning approach can use a combination of didactic or online training, community engagement, and reflective practice to increase the knowledge and skills. The governing body leverages resources available to provide this education and continuous learning.

3. **The governing body ensures the organization's executive leader(s), who report directly to the governing body, have an accountability for quality of care in their performance objectives.**

   Guidelines

   The governing body sets and evaluates performance objectives for the organization's executive leader(s), who report directly to it. By doing so, the governing body can hold the executive leader(s) accountable for achieving the established quality of care goals and associated quality indicators. Monitoring the executive leader(s) performance objectives will be an on-going activity of the governing body in addition to providing constructive and actionable feedback on the leader's performance.

4. **The governing body ensures there is an organizational action plan to address quality of care.**

   Guidelines

   The action plan is developed using a co-designed approach that includes recipients of care, community/system partners, the organization's workforce. The action plan identifies themes and priorities

the organization wants to address, the activities, roles and responsibilities of those involved and how the organization will measure change. A governing body action plan should include elements highlighted in the selected recognized framework.

5. **The governing body has quality of care as a standing agenda item in its regular meetings where it monitors the organization's action plan.**

Guidelines

The governing body demonstrates a clear commitment to quality of care by having it as a standing agenda item for each regular meeting and ensuring that sufficient time is allotted to review and discuss the organization's action plan to address quality of care.

Discussions need to be supported with indicator data that includes feedback from multiple stakeholders, including clients, families, and communities. Key quality indicators that measure quality at the organization level (i.e., 'big-dot' indicators) will help answer the questions "what does quality of care look like and how do we know it is improving?".

Examples of big-dot indicators can include:

- number of clients who were harmed
- number of complaints from clients
- timely access to care
- quality of worklife reported by the workforce, including measures of job engagement, retention and satisfaction that can influence the organization's clinical human resource capabilities
- client experience survey results

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Accountability for Quality

HSO 5000:2018

Notes: This ROP is being phased out and is replaced by HSO 5000:2021 Accountability for Quality of Care.

ROP STATEMENT

The governing body demonstrates accountability for the quality of care provided by the organization.

GUIDELINES

Governing bodies are accountable for the quality of care provided by their organizations. When governing bodies are engaged in overseeing quality, their organizations have better quality performance (better care, better client outcomes, better worklife, and reduced costs).

The members of the governing body need to be aware of key quality and safety principles if they are to effectively understand, monitor, and oversee the quality performance of the organization. Knowledge gaps among the membership can be addressed through targeted recruitment for specific competencies (e.g., quality assurance, risk management, quality improvement, and safety) from health care or other sectors (e.g., education or industry) or by providing education through workshops, modules, retreats, virtual networks, or conferences.

The governing body can demonstrate a clear commitment to quality when it is a standing agenda item at each meeting. Often the governing body overestimates the quality performance of an organization, so discussions need to be supported with indicator data and feedback from clients and families. A small number of easily understood performance indicators that measure quality at the system level (i.e., big-dot indicators) such as number of clients who died or were harmed by patient safety incidents, quality of worklife, number of complaints, and client experience results will help answer the question are the services we provide getting better?”

Quality performance indicators need to be directly linked to strategic goals and objectives and balanced across a number of priority areas. Knowledge gained from the review of quality performance indicators can be used to set the agenda, inform strategic planning, and develop an integrated quality improvement plan. It can also be used to set quality performance objectives for senior leadership and to determine whether they have met their quality performance objectives.

TESTS FOR COMPLIANCE

1. **The governing body is knowledgeable about quality and safety principles, by recruiting members with this knowledge or providing access to education. Defined criteria are used to determine when to initiate services with clients.**
2. **Quality is a standing agenda item at all regular meetings of the governing body.**
3. **The key system-level indicators that will be used to monitor the quality performance of the organization are identified.**
4. **At least quarterly, the quality performance of the organization is monitored and evaluated against agreed-upon goals and objectives.**
5. **Information about the quality performance of the organization is used to make resource allocation decisions and set priorities and expectations.**
6. **As part of their performance evaluation, leaders who report directly to the governing body (e.g., the CEO, Executive Director, Chief of Staff) are held accountable for the quality performance of the organization.**

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Patient Safety Incident Disclosure

HSO 5001:2018

ROP STATEMENT

A documented and coordinated approach to disclosing patient safety incidents to clients and families, that promotes communication and a supportive response, is implemented.

GUIDELINES

Disclosure of patient safety incidents is an ongoing discussion that includes the following core elements:

- Informing those affected that a patient safety incident has occurred and offering an apology
- Explaining what happened and why, as facts are known
- Discussing the immediate actions taken to care for the client and mitigate further harm
- Reviewing recommended actions to prevent future incidents
- Offering support to all involved

The support provided meets the needs of those involved (clients, families, and the team), and can be practical (e.g., reimbursement for out-of-pocket expenses) or emotional/psychological (e.g., helping with access to support groups or offering counselling).

Disclosing a patient safety incident that affects multiple clients (e.g., failures in sterilization, privacy breaches) includes additional elements, for example:

- Identifying which clients have been exposed to risk
- Deciding which clients should be contacted and how
- Locating and communicating with clients who have been affected
- Informing the community, other organizations, and the media

When asked for their feedback, clients and families are encouraged to speak from their own perspective and in their own words about their experience.

TESTS FOR COMPLIANCE

1. **There is a documented and coordinated process to disclose patient safety incidents to clients and families that identifies:**
    - Which patient safety incidents require disclosure
    - Who is responsible for guiding and supporting the disclosure process
    - What can be communicated and to whom about the incident
    - When and how to disclose
    - Where to document the disclosure

2. **The disclosure process is reviewed and updated, as necessary, with input from clients, families, and team members.**
3. **Those responsible for guiding and supporting the disclosure process are provided with training on disclosure.**
4. **Communication occurs throughout the disclosure process with clients, families, and team members involved in the patient safety incident. Communication is documented and based on their individual needs.**
5. **As part of the disclosure process, practical and emotional/psychological support is offered to clients, families, and team members involved in the patient safety incident.**
6. **Feedback is sought from clients, families, and team members about their experience with disclosure and this information is used to make improvements, when needed, to the disclosure process.**

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Patient Safety Incident Management

HSO 5002:2018

ROP STATEMENT

A patient safety incident management system that supports reporting and learning is implemented.

GUIDELINES

In a culture of patient safety, everyone is encouraged to report and learn from patient safety incidents, including harmful, no-harm, and near miss. A reporting system that is simple (few steps), clear (what needs to be reported, how to report, and to whom), confidential, and focused on system improvement is essential. Clients and families may report patient safety incidents differently than team members, but everyone needs to know how to report. Information about how to report can be tailored to the needs of team members or clients, and can be part of team member training and included in written and verbal communication to clients and families about their role in safety.

The immediate response to a patient safety incident is to address the urgent care and support needs of those involved. It is also important to secure any items related to the incident (for testing and review by the analysis team), report the incident using the approved process, begin the disclosure process (if required), and take action to reduce any risk of imminent recurrence.

Through incident analysis (also known as ‘root cause analysis'), contributing factors and recommended actions can be identified in order to make improvements. Analyzing similar patient safety incidents (such as near misses) together, to look for patterns or trends, can yield helpful information, as can analyzing incidents in isolation. Communicating incident analysis findings broadly (e.g., with clients and families, governance, leadership, clinical teams, and external partners) builds confidence in the incident management system and promotes learning from patient safety incidents.

Global Patient Safety Alerts is an on-line, searchable database where lessons learned from patient safety incidents are shared.

TESTS FOR COMPLIANCE

1. **A patient safety incident management system is developed, reviewed, and updated with input from clients, families, and team members, and includes processes to report, analyze, recommend actions, and monitor improvements.**
2. **Information is shared with clients, families, and team members so they understand what, when, and how to report patient safety incidents.**
3. **Training is provided, and documented, for team members on the immediate response to patient safety incidents.**
4. **There are procedures to review patient safety incidents and established criteria are used to prioritize those that will be analyzed further.**
5. **All recommended actions resulting from the analysis of patient safety incidents are reviewed and the rationale to accept, reject, or delay implementation is documented.**
6. **Information about recommended actions and improvements made following incident analysis is shared with clients, families, and team members.**
7. **The effectiveness of the patient safety incident management system is evaluated and improvements are made based on feedback received. Evaluation mechanisms may include:**

- Gathering feedback from clients, families, and team members about the system Monitoring patient safety incident reports by type and severity
- Examining whether improvements are implemented and sustained
- Determining whether team members feel comfortable reporting patient safety incidents

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Patient Safety Quarterly Reports

HSO 5003:2018

ROP STATEMENT

The governing body is provided with quarterly reports on patient safety that include recommended actions arising out of patient safety incident analysis, as well as improvements that were made.

GUIDELINES

The governing body is ultimately accountable for the quality and safety of the services delivered by the organization. It plays an important role in enabling an organizational culture that enhances patient safety.

An organization is more likely to make safety and quality improvement a central feature if the governing body is aware of patient safety issues and patient safety incidents, and leads the organization's quality improvement efforts. In addition, the governing body needs to be informed about and have input into follow-up actions or improvement initiatives resulting from patient safety incidents. Outcomes and processes of care are improved in organizations where the governing body is engaged in patient safety.

TESTS FOR COMPLIANCE

1. **Quarterly patient safety reports are provided to the governing body.**
2. **The quarterly patient safety reports outline specific organizational activities and accomplishments in support of the organization's patient safety goals and objectives.**
3. **The governing body supports the patient safety activities and accomplishments and acts on the recommended actions in the quarterly patient safety reports.**

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Communication

Adhering to a Do-Not-Use List of Abbreviations, Symbols, and Dose Designations

HSO 5011:2024

Notes: This content is an update to HSO 5011-1:2018 ‘Do Not Use’ list of abbreviations and HSO 5011-2:2018 ‘Do Not Use’ list of abbreviations – Community Pharmacy. As organizations transition to the standards listed in the *List of ROPs within Standards* this ROP will become applicable.

ROP STATEMENT

The organizational leaders ensure clinical teams adhere to a current do-not-use list of abbreviations, symbols, and dose designations in all medication-related communication.

TESTS FOR COMPLIANCE AND GUIDELINES

1. **The organizational leaders provide clinical teams with a current list of do-not-use abbreviations, symbols, and dose designations that applies to all medication-related communication.**

   Guidelines

   Misinterpreted abbreviations including drug name abbreviations, symbols, and dose designations can cause medication safety incidents such as incorrect medications, incorrect doses, or incorrect directions for use that may result in client harm.

   The organization’s do-not-use list is developed from research, evidence-informed safety practices, and error-reporting data at the organizational, jurisdictional, and national levels. The list is also informed by recommendations from professional regulatory bodies and jurisdictionally designated safety-focused organizations such as the Institute for Safe Medication Practices Canada.

   Examples of abbreviations, symbols, and dose designations that should be avoided in all medication-related communication include short forms of drug names; *u* for unit; symbols such as @, >, or <; and leading or trailing zeros.

2. **The organizational leaders ensure clinical teams follow the organization’s procedure to adhere to the do-not-use list of abbreviations, symbols, and dose designations in all medication-related communication.**

   Guidelines

   The organization’s procedure to adhere to the do-not-use list is developed from evidence-informed safety practices and reflects the type of care provided, the care setting, and the populations served. The organization’s procedure aims to prevent, detect, and resolve in a timely manner the use of listed abbreviations, symbols, and dose designations in all medication-related communication.

   The do-not-use list applies to all written and electronic medication-related communication throughout the medication management process. Medication-related communication includes handwritten prescriptions; medication and storage location labels; information in automated dispensing cabinets and smart infusion pumps; information in order entry systems including free text fields, standardized order sets, pharmacy master formulas, medication administration records, and health records; and continuous learning materials.

Resolving non-adherence to the do-not-use list may include a clarification of order note in the medical record that is signed off by the appropriate team member as defined in the organizational procedure. The resolution should not be a limiting factor to dispensing the medication, which could have a significant impact on the care outcome.

3. **The organizational leaders ensure the use of misinterpreted abbreviations, symbols, and dose designations that could have harmed or did harm a client are reported as medication safety incidents.**

Guidelines

An organizational culture of safety promotes and supports reporting of safety incidents to avoid harm, reduce errors, and lessen the impact of errors. Safety incidents are events or circumstances that could have harmed or did harm a client.

Medication safety incidents related to misinterpreted abbreviations, symbols, and dose designations are documented in the client's health record and the safety incident reporting system. The information is shared with the client and other authorized team members in a clear and accessible format as required by the organization's procedure.

Relevant safety incident reporting and analysis informs regular updates to the do-not-use list and associated safety practices.

Safety incidents inform the organization's medication management quality improvement plan.

Findings and recommendations from the analysis of safety incidents are communicated to clinical teams in the organization. The organizational leaders are encouraged to also communicate safety incident findings and recommendations to relevant partners, including professional regulatory bodies and jurisdictionally designated safety-focused organizations.

The do-not-use list is kept current to reflect changes to organizational practices and the introduction of new care practices. Changes to the list are communicated according to the organization's procedure to adhere to the do-not-use list.

4. **The organizational leaders provide clinical teams with continuous learning activities about the organization's procedure to adhere to the do-not-use list of abbreviations, symbols, and dose designations.**

Guidelines

Continuous learning helps clinical teams implement safety practices to prevent harm. Clinical teams include those who prescribe, prepare, dispense, and administer medications.

If the organization offers clinical practicums, students, residents, and fellows participate in the required learning activities before providing care.

Learning activities are provided in various ways to engage clinical team members with different educational backgrounds, abilities, and learning styles. Examples include in-person or virtual training and simulation sessions, awareness campaigns, reflective practice, and mentorship initiatives.

Clinical teams are involved in the development and evaluation of continuous learning activities. The lived experiences of clients and designated support persons also provide knowledge that is used to inform continuous learning activities.

Clinical teams are given time to participate in, reflect on, and share learnings and experiences. Learning activities are documented.

5. **The organizational leaders ensure the organization's medication management quality improvement plan includes activities to improve adherence to the do-not-use list of abbreviations, symbols, and dose designations.**

Guidelines

Quality improvement involves a team-based approach to understanding the organization's strengths, opportunities for improvement, risks, and challenges in delivering high-quality and safe care.

Quality improvement activities include collecting quantitative and qualitative data, engaging in reflective learning practices, and collecting feedback. Quality improvement activities also include identifying and implementing actions that improve adherence to the do-not-use list of abbreviations, symbols, and dose designations.

Aims, measures, and outcomes are documented in the organization's medication management quality improvement plan. Qualitative and quantitative measures may include

- observational activities and audits of medication-related communication to assess clinical teams' adherence to the do-not-use list;
- root cause analysis of safety incidents related to misinterpreted abbreviations, symbols, and dose designations;
- feedback from clinical teams on the do-not-use list and the organization's procedure to adhere to the do-not-use list; and
- feedback from the clinical team on the continuous learning activities provided by the organization on the do-not-use list.

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The ‘Do Not Use’ List of Abbreviations

HSO 5011-1:2018

Notes: This ROP is being phased out and is replaced by HSO 5011:2024 Adhering to a Do-Not-Use List of Abbreviations, Symbols, and Dose Designations.

ROP STATEMENT

A list of abbreviations, symbols, and dose designations that are not to be used have been identified and implemented.

GUIDELINES

Medication errors are the largest identified source of preventable hospital medical error. From 2004-2006, more than 600,000 medication errors were reported to the United States Pharmacopeia (USP) MEDMARX program, with a total annual cost of $3.5 billion. Five percent of those errors were attributed to abbreviation use. Misinterpreted abbreviations can result in omission errors, extra or improper doses, administering the wrong drug, or giving a drug in the wrong manner. In return this can lead to an increase in the length of stay, more diagnostic tests and changes in drug treatment.

TESTS FOR COMPLIANCE

1. **The organization's ‘Do Not Use’ List is inclusive of the abbreviations, symbols, and dose designations, as identified by an Institute for Safe Medication Practices (ISMP) list of error-prone abbreviations, symbols, and dose designations.**
2. **The organization’s ‘Do Not Use’ List is implemented and applies to all medication-related documentation when hand written or entered as free text into a computer.**
3. **Pre-printed forms related to medication use do not include any abbreviations, symbols, and dose designations identified on the organization’s ‘Do Not Use’ List.**
4. **The dangerous abbreviations, symbols, and dose designations identified on the organization’s ‘Do Not Use’ List are not used on any pharmacy-generated labels and forms.**
5. **Team members are provided with education about the organization’s ‘Do Not Use’ List at orientation and when changes are made to the list.**
6. **The organization’s ‘Do Not Use’ List is updated and necessary changes are implemented to the medication management processes.**
7. **Compliance with the organization’s ‘Do Not Use’ List is audited and process changes are implemented based on identified issues.**

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The ‘Do Not Use’ List of Abbreviations – Community Pharmacy

HSO 5011-2:2018

Notes: This ROP is being phased out and is replaced by HSO 5011:2024 Adhering to a Do-Not-Use List of Abbreviations, Symbols, and Dose Designations.

ROP STATEMENT

The organization has identified and implemented a list of abbreviations, symbols, and dose designations that are not to be used in the organization.

GUIDELINES

Misinterpreted abbreviations can result in omission errors, extra or improper doses, administering the wrong drug, or giving a drug in the wrong manner.

TESTS FOR COMPLIANCE

1. **The organization’s ‘Do Not Use’ List is inclusive of the abbreviations, symbols, and dose designations, as identified by an Institute for Safe Medication Practices (ISMP) list of error-prone abbreviations, symbols, and dose designations.**
2. **The organization implements the ‘Do Not Use’ List and applies this to all medication-related documentation when hand written or entered as free text into a computer.**
3. **The dangerous abbreviations, symbols, and dose designations identified on the ‘Do Not Use’ List are not used on any pharmacy-generated labels and forms.**
4. **The organization educates staff about the ‘Do Not Use’ List during orientation and whenever changes are made to the list.**
5. **The organization updates the ‘Do Not Use’ List and implements necessary changes to the organization’s processes.**
6. **The organization audits compliance with the ‘Do Not Use’ List and implements process changes based on identified issues.**

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Client Identification

HSO 5010:2018

ROP STATEMENT

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

GUIDELINES

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

The person-specific identifiers used depends on the population served and client preferences. Examples of person-specific identifiers include the client's full name, home address (when confirmed by the client or family), date of birth, personal identification number, or an accurate photograph. In settings where there is long-term or continuing care and the team member is familiar with the client, one person-specific identifier can be facial recognition. The client's room or bed number, or using a home address without confirming it with the client or family, is not person-specific and should not be used as an identifier.

Client identification is done in partnership with clients and families by explaining the reason for this important safety practice and asking them for the identifiers (e.g., "What is your name?"). When clients and families are not able to provide this information, other sources of identifiers can include wristbands, health records, or government-issued identification. Two identifiers may be taken from the same source.

TESTS FOR COMPLIANCE

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

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Information Transfer at Care Transitions

HSO 5012:2018

ROP STATEMENT

Information relevant to the care of the client is communicated effectively during care transitions.

GUIDELINES

Effective communication is the accurate and timely exchange of information that minimizes misunderstanding.

Information relevant to the care of the client will depend on the nature of the care transition. It usually includes, at minimum, the client's full name and other identifiers, contact information for responsible providers, reason for transition, safety concerns, and client goals. Depending on the setting, information about allergies, medications, diagnoses, test results, procedures, and advance directives may also be relevant.

Using documentation tools and communication strategies (such as SBAR [Situation, Background, Assessment, Recommendation], checklists, discharge teaching materials and follow-up instructions, read-back, and teach-back) support effective communication, as does standardizing relevant information, and tools and strategies across the organization. The degree of standardization will depend on organizational size and complexity. Electronic medical records are helpful but not a substitute for effective communication tools and strategies.

Effective communication reduces the need for clients and families to repeat information. Clients and families need information to prepare for and improve care transitions; this may include written information or instructions, action plans, goals, signs or symptoms of declining health status, and contact information for the team.

TESTS FOR COMPLIANCE

1. **The information that is required to be shared at care transitions is defined and standardized for care transitions where clients experience a change in team membership or location: admission, handover, transfer, and discharge.**
2. **Documentation tools and communication strategies are used to standardize information transfer at care transitions.**
3. **During care transitions, clients and families are given information that they need to make decisions and support their own care.**
4. **Information shared at care transitions is documented.**
5. **The effectiveness of communication is evaluated and improvements are made based on feedback received. Evaluation mechanisms may include:**
    - Using an audit tool (direct observation or review of client records) to measure compliance with standardized processes and the quality of information transfer
    - Asking clients, families, and service providers if they received the information they needed
    - Evaluating safety incidents related to information transfer (e.g., from the patient safety incident management system).

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Maintaining an Accurate List of Medications during Care Transitions

HSO 5014:2024

Notes: This content is an update to HSO 5014-1:2018 Medication reconciliation at care transitions – Acute care services (inpatient); HSO 5014-2:2018 Medication reconciliation at care transitions – Ambulatory care services; HSO 5014-3:2018 Medication reconciliation at care transitions – Home and Community care services; HSO 5014-4:2018 Medication reconciliation at care transitions – Emergency department; and HSO 5014-5:2018 Medication reconciliation at care transitions – Long-term care services. As organizations transitions to the standards listed in the *List of ROPs within Standards* this ROP will become applicable.

ROP STATEMENT

The team follows the organization's medication reconciliation procedure to maintain an accurate list of medications during care transitions.

TESTS FOR COMPLIANCE AND GUIDELINES

1. **The team follows the organization's procedure to obtain a best possible medication history during care transitions.**

   Guidelines

   A best possible medication history is a complete and accurate list of medications the client is taking. Care transitions occur when a client moves from one care setting to another.

   The organization's procedure defines how to obtain a best possible medication history during care transitions, including at least the following:

   - Virtual or in-person conversations with the client or the person most responsible for medication management. These conversations are conducted in a way that encourages complete and accurate information about medication use, including prescription medications, over-the-counter medications, cannabis for medical purposes, supplements, and any traditional or alternative remedies.
   - Verifying the client's list of medications with at least one other reliable source of information. Sources of information may include a community pharmacy record, health record, hospital discharge medication list, or medication administration record.

   The organization's procedure is current and informed by evidence. The procedure identifies care transitions where a best possible medication history is completed. Examples include a client's transition to or from a hospital or long-term care home, an ambulatory care setting such as a cancer clinic, or a primary care setting where medication is being managed.

   The best possible medication history is documented in the client's health record. The information is shared with the client and other authorized team members in a clear and accessible format.

2. **The team follows the organization's procedure to resolve medication discrepancies during care transitions in a timely way.**

   Guidelines

   Unresolved medication discrepancies, both intentional and unintentional, can result in medication errors and cause harm to the client, unplanned clinical encounters, and related costs for the health system.

Medication discrepancies include errors related to inappropriate prescribing, duplication of therapies, and omitted medications.

Medication discrepancies are identified and documented by a designated and trained member of the team. The best possible medication history is compared with what has been recently prescribed or is intended to be prescribed.

Identified discrepancies are documented and communicated to the client's most responsible prescriber. Discrepancies are resolved in a timely way as defined in the organization's procedure.

Resolution of discrepancies can occur prospectively or retrospectively. However, the risk of medication discrepancies is significantly reduced when a best possible medication history is completed before a prescription is written. The use of interoperable information technology helps to make medication reconciliation more reliable and effective.

Medication changes are discussed with the client to ensure the changes reflect the client's goals, abilities, and preferences. These conversations help the client understand which medications need to be stopped or changed; potential interactions with over-the-counter medications, cannabis for medical purposes, supplements, and any traditional or alternative remedies; and how to dispose of unnecessary medications.

The accurate list of medications is documented in the client's health record. This information is shared with the client and other authorized team members in a clear and accessible format.

3. **The team follows the organization's procedure to report incidents that could have harmed or did harm a client related to maintaining an accurate list of medications during care transitions as safety incidents.**

Guidelines

An organizational culture of safety promotes and supports reporting of safety incidents to avoid harm, reduce errors, and lessen the impact of errors. Safety incidents are events or circumstances that could have harmed or did harm a client.

Incidents related to maintaining an accurate list of medications during care transitions include when medication reconciliation is not completed, is done incorrectly, or is not completed in a timely manner and could have harmed or did harm a client.

The organization's procedure to report incidents related to maintaining an accurate list of medications during care transitions as safety incidents is aligned with evidence-informed practices and jurisdictional requirements. The procedure outlines what types of incidents need to be reported and how to report them. The procedure is simple, clear, and focused on system improvement.

Safety incidents are documented in the client's health record and the safety incident reporting system. The information is shared with the client and other authorized team members in a clear and accessible format as required by the organization's procedure.

Safety incidents inform the organization's integrated quality improvement plan.

4. **The team participates in continuous learning activities about the medication reconciliation procedure to maintain an accurate list of medications during care transitions.**

Guidelines

Continuous learning helps the team implement safety practices to maintain an accurate list of medications during care transitions. As a member of the team, the client receives information and resources that enable them to play an active role in their care, make informed decisions, and manage their own health.

If the organization offers clinical practicums, students, residents, and fellows participate in required learning activities before providing care.

Learning topics relevant to team roles and responsibilities can include

- the importance of maintaining an accurate list of medications during care transitions as a safety practice;
- strategies to actively engage the client in maintaining an accurate list of medications during care transitions, including assessing the client's medication literacy;
- communicating medication changes during care transitions;
- training on the organization's medication reconciliation tools and interoperable technology; and
- reporting incidents related to maintaining an accurate list of medications during care transitions as safety incidents.

Learning activities are provided in various ways to engage team members with different educational backgrounds, abilities, and learning styles. Examples include in-person or virtual training and simulation sessions, awareness campaigns, reflective practice, and mentorship initiatives.

The team is involved in the development and evaluation of continuous learning activities. The team is given time to participate in, reflect on, and share learnings and experiences. Learning activities are documented.

5. **The team participates in activities to improve the medication reconciliation procedure to maintain an accurate list of medications during care transitions as part of the organization's integrated quality improvement plan.**

Guidelines

Quality improvement involves a team-based approach to understanding the organization's strengths, opportunities for improvement, risks, and challenges to delivering high-quality and safe care.

Participation in quality improvement activities includes supporting the collection of quantitative and qualitative data, engaging in reflective learning practices, and providing feedback. It also includes identifying and implementing actions that improve the organization's medication reconciliation procedure to maintain an accurate list of medications during care transitions.

Aims, measures, and outcomes are documented in the organization's integrated quality improvement plan. Qualitative and quantitative measures may include

- observational activities and audits of documentation to assess the team's adherence to the organization's medication reconciliation procedure, including assessing the reliability and accuracy of best possible medication histories and assessing medication discrepancy resolution rates and timeliness;
- root cause analysis of safety incidents related to maintaining an accurate list of medications during care transitions;
- feedback from the team, including the client, on the applicability of the organization's medication reconciliation procedure to maintain an accurate list of medications during care transitions; and
- feedback from the team, including the client, on the continuous learning activities provided by the organization on the medication reconciliation procedure to maintain an accurate list of medications during care transitions.

The team is given time to participate in, reflect on, and share quality improvement learnings and experiences.

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Medication Reconciliation at Care Transitions – Acute Care Services (Inpatient)

HSO 5014-1:2018

Notes: This ROP is being phased out and is replaced by HSO 5014:2024 Maintaining an Accurate List of Medications during Care Transitions.

ROP STATEMENT

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

GUIDELINES

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

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

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

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

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

TESTS FOR COMPLIANCE

1. **Upon or prior to admission, a Best Possible Medication History (BPMH) is generated and documented in partnership with clients, families, caregivers, and others, as appropriate.**
2. **The BPMH is used to generate admission medication orders or the BPMH is compared with current medication orders and any medication discrepancies are identified, resolved, and documented.**

3. **The prescriber uses the BPMH and the current medication orders to generate transfer or discharge medication orders.**
4. **The client, community-based health care provider, and community pharmacy (as appropriate) are provided with an accurate and up-to-date list of medications the client should be taking following discharge.**

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Medication Reconciliation at Care Transitions – Ambulatory Care Services

HSO 5014-2:2018

Notes: This ROP is being phased out and is replaced by HSO 5014:2024 Maintaining an Accurate List of Medications during Care Transitions.

ROP STATEMENT

Medication reconciliation is conducted in partnership with clients and families to communicate accurate and complete information at ambulatory care visits when medication management is a major component of care.

GUIDELINES

Ambulatory care includes a wide range of services and client populations, thus it is important to focus medication reconciliation on clients for whom medication management is a major component of care. Organizations should identify and document which ambulatory care clinics meet the requirement for medication reconciliation, keeping in mind that clinical judgment should always be a consideration when managing client medications.

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

The gathered lists of medications are compared, and when medication discrepancies are identified, they are resolved by the most responsible prescriber, either within the team or by referral. The prescriber indicates which medication(s) should be continued, discontinued, or modified and the reason(s) why.

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

TESTS FOR COMPLIANCE

1. **Ambulatory care clinics, where medication management is a major component of care, are identified by the organization. This designation is documented, along with the agreed upon frequency at which medication reconciliation should occur for clients of the clinic.**
2. **During or prior to the initial ambulatory care visit, a Best Possible Medication History (BPMH) is generated and documented in partnership with the client, family, caregivers, and others, as appropriate.**
3. **During or prior to subsequent ambulatory care visits, the BPMH is compared with the current medication list and any medication discrepancies are identified and documented. This is done as per the frequency required by the organization.**
4. **Medication discrepancies are resolved in partnership with clients and families or medication discrepancies are communicated to the client's most responsible prescriber and actions taken to resolve medication discrepancies are documented.**

5. **The client and the next care provider (e.g., primary care provider, community pharmacist, home care services) are provided with an accurate and up-to-date list of medications the client should be taking at the last visit or upon discharge from the clinic.**

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Medication Reconciliation at Care Transitions – Home and Community Care Services

HSO 5014-3:2018

Notes: This ROP is being phased out and is replaced by HSO 5014:2024 Maintaining an Accurate List of Medications during Care Transitions.

ROP STATEMENT

Medication reconciliation is conducted in partnership with clients and families for a target group of clients when medication management is a component of care (or deemed appropriate through clinician assessment), to communicate accurate and complete information about medications.

GUIDELINES

Medication reconciliation is a structured process to communicate accurate and complete information about medications across care transitions.

Medication reconciliation should be considered for all clients when medication management is a component of care. If this is not possible, criteria need to be established to identify clients at risk of potential adverse drug events. A medication risk assessment tool can help identify clients for whom medication reconciliation is required. The rationale for selecting target clients must be documented.

Medication reconciliation begins with generating a Best Possible Medication History (BPMH) that lists all the medications the client is taking including prescription, non-prescription, traditional, holistic, herbal, vitamins, and supplements. The BPMH also details how they are being taken including the dose, frequency, route of administration, and strength if applicable.

Creating the BPMH involves interviewing the client, family, or caregivers, and consulting at least one other source of information such as the client's previous health record, or a community pharmacist. Once generated, the BPMH is an important reference tool for reconciling medications at care transitions. The gathered lists of medications are compared, and when medication discrepancies are identified, they are resolved by the most responsible prescriber, either within the team or by referral. The prescriber indicates which medication(s) should be continued, discontinued, or modified and the reason(s) why.

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

As care in the community is intermittent, the community care organization may not always be immediately aware that a client has been transferred or discharged. Keeping the medication list up-to-date and accurate is the best way to be prepared to communicate the client's medications to the client's circle of care or next provider of care.

TESTS FOR COMPLIANCE

1. **The types of clients who require medication reconciliation are identified and documented.**
2. **At the beginning of service, a Best Possible Medication History (BPMH) is generated and documented in partnership with the client, family, health care providers, caregivers, and others, as appropriate.**

3. **Medication discrepancies are resolved in partnership with clients and families or communicated to the client's most responsible prescriber, and the actions taken to resolve medication discrepancies are documented.**

4. **When medication discrepancies are resolved, the current medication list is updated and provided to the client or family (or primary care provider, as appropriate) along with clear information about the changes that were made.**

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Medication Reconciliation at Care Transitions – Emergency Department

HSO 5014-4:2018

Notes: This ROP is being phased out and is replaced by HSO 5014:2024 Maintaining an Accurate List of Medications during Care Transitions.

ROP STATEMENT

In partnership with clients, families, or caregivers (as appropriate), the medication reconciliation process is initiated for clients with a decision to admit, and can be completed on the receiving unit.

GUIDELINES

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

TESTS FOR COMPLIANCE

1. **Medication reconciliation is initiated for all clients with a decision to admit. A Best Possible Medication History (BPMH) is generated in partnership with clients, families, or caregivers, and documented. The medication reconciliation process may begin in the emergency department and be completed in the receiving inpatient unit.**

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Medication Reconciliation at Care Transitions – Long-Term Care Services

HSO 5014-5:2018

Notes: This ROP is being phased out and is replaced by HSO 5014:2024 Maintaining an Accurate List of Medications during Care Transitions.

ROP STATEMENT

Medication reconciliation is conducted in partnership with the resident, family, or caregiver to communicate accurate and complete information about medications across care transitions.

GUIDELINES

Poor communication about medications is common as residents transfer between long-term care and other service environments (e.g., acute care, rehabilitation services, another long-term care facility, or home care). Medication reconciliation is a structured process to communicate accurate and complete information about the resident's medications across transitions of care.

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

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

At care transitions, in addition to the medications the resident is currently receiving, it is important to also consider the medications that were taken prior to admission (as identified in the BPMH), which may be appropriate to continue, restart, discontinue, or modify. For example, medication reconciliation should happen at admission, re-admission back to long-term care from another service environment, or transfer out of long-term care.

Residents should be regarded as active partners in the management of their medications and provided with information about the medications they should be taking in a format and language they understand.

TESTS FOR COMPLIANCE

1. **Upon or prior to admission, a Best Possible Medication History (BPMH) is generated and documented in partnership with the resident, family, health care providers, or caregivers (as appropriate).**
2. **The BPMH is used to generate admission medication orders or the BPMH is compared with current medication orders and any medication discrepancies are identified, resolved, and documented.**

3. **Upon or prior to re-admission from another service environment (e.g., acute care), the discharge medication orders are compared with the current medication list and any medication discrepancies are identified, resolved, and documented.**

4. **Upon transfer out of long-term care, the resident and next care provider (e.g., another long-term care facility or community-based health care provider) are provided with a complete list of medications the resident is taking.**

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Medication Reconciliation as a Strategic Priority

HSO 5013:2018

ROP STATEMENT

A documented and coordinated medication reconciliation process is used to communicate complete and accurate information about medications across care transitions.

GUIDELINES

Medication reconciliation is recognized as an important safety initiative by the World Health Organization. Medication reconciliation can be a cost-effective way to reduce medication errors (e.g., omissions, duplications, incorrect orders) and the re-work often associated with medication management.

Medication reconciliation is a three-step process, whereby the team (e.g., physicians, nurses, pharmacists) works in partnership with clients and families to generate a Best Possible Medication History (BPMH), identifies and resolves medication discrepancies, and communicates a complete and accurate list of medication to the client and their next care provider.

An organizational policy signals leadership's commitment to medication reconciliation and provides overarching guidance (e.g., an overview of the process, roles and responsibilities, care transitions where medication reconciliation is required, exemptions). Allocating resources to staffing, education, tools, information technology, etc., also demonstrates a commitment to medication reconciliation. Team education should include the rationale for and steps involved in medication reconciliation.

Implementing and sustaining medication reconciliation throughout an organization will be more successful if it is led by an interdisciplinary coordination team. Depending on the organization, the coordination team could include senior leaders (including clinical leaders representing medicine, nursing, and pharmacy); team members who are directly involved in the process; information technology staff; representatives from quality, risk, and safety committees; and clients and families.

It is important to monitor, in consultation with the coordination team and clinical team members, whether the medication reconciliation policy is being followed (e.g., Do clients receive medication reconciliation? Is the BPMH documented?) and the quality of the process (e.g., Is the BPMH complete? Are medication discrepancies identified and resolved?).

TESTS FOR COMPLIANCE

1. **There is a medication reconciliation policy and process to collect and use accurate and complete information about clients' medication at care transitions.**
2. **Roles and responsibilities for completing medication reconciliation are defined.**
3. **An organizational plan to sustain medication reconciliation is led by an interdisciplinary coordination team.**
4. **There is documented evidence that team members (including physicians) who are responsible for medication reconciliation are provided with relevant education.**
5. **Compliance with the medication reconciliation process is monitored and improvements are made when required.**

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Safe Surgery Checklist

HSO 5021:2018

ROP STATEMENT

A safe surgery checklist is used to confirm that safety steps are completed for a surgical procedure performed in the operating room.

GUIDELINES

Surgical procedures are increasingly complex aspects of health services and carry a significant risk of potentially avoidable harm. Safe surgery checklists play an important role in improving the safety of surgical procedures. They can reduce the likelihood of complications following surgery and often improve surgical outcomes.

A safe surgery checklist is used to initiate, guide, and formalize communication among the team members conducting a surgical procedure and to integrate these steps into surgical workflow.

Safe surgery checklists have been developed by and are available from various sources. Each checklist has three phases:

i. Briefing – before the induction of anesthesia

ii. Time out – before skin incision

iii. Debriefing – before the patient leaves the operating room

TESTS FOR COMPLIANCE

1. **The team has agreed on a three-phase safe surgery checklist to be used for surgical procedures performed in the operating room.**
2. **The checklist is used for every surgical procedure.**
3. **There is a process to monitor compliance with the checklist.**
4. **The use of the checklist is evaluated and results are shared with the team.**
5. **Results of the evaluation are used to improve the implementation and expand the use of the checklist.**

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Medication Use

Antimicrobial Stewardship

HSO 5030:2018

Notes: This ROP applies only to organizations that provide acute inpatient care, cancer treatment services or inpatient rehabilitation services.

The HSO standard Antimicrobial Stewardship Program (HSO 5030:2020) is developed as a resource document for the Qmentum Global™ program, to support the implementation of the existing Antimicrobial Stewardship ROP. This resource document specifies requirements for organizations to develop, implement, communicate, maintain, and evaluate activities related to antimicrobial use and antimicrobial resistance at the organizational level. This resource document is intended for use by organizations who wish to place explicit focus on building a strong and resilient antimicrobial stewardship program. In doing so, organizations are encouraged to use this resource document hand-in-hand with the Antimicrobial Stewardship ROP. The Antimicrobial Stewardship Program standard is available as a resource in the resource section of AMS 2.0.

ROP STATEMENT

There is an antimicrobial stewardship program to optimize antimicrobial use.

GUIDELINES

The use of antimicrobial agents is a valuable health intervention, yet may result in unintended consequences including toxicity, the selection of pathogenic organisms, and the development of organisms resistant to antimicrobial agents. Antibiotic-resistant organisms have a substantial impact on the health and safety of clients and the resources of the health care system.

Antimicrobial stewardship is an activity that includes appropriate selection, dosing, route, and duration of antimicrobial therapy. The primary focus of an antimicrobial stewardship program is to optimize antimicrobial use to achieve the best patient outcomes, reduce the risk of infections, reduce or stabilize levels of antibiotic resistance, and promote patient safety.

Effective antimicrobial stewardship in combination with a comprehensive infection control program has been shown to limit the emergence and transmission of antimicrobial-resistant bacteria. Studies indicate that antimicrobial stewardship programs are cost-effective and provide savings through reduced drug costs and avoidance of microbial resistance.

A comprehensive, evidence-informed antimicrobial stewardship program may include a number of interventions. Organizations are encouraged to tailor an approach to antimicrobial stewardship that is consistent with their size, service environment, and patient population, and to establish processes for ongoing monitoring and improvement of the program. A successful antimicrobial stewardship program requires collaboration between the antimicrobial stewardship, pharmacy, and infection control teams. The support of hospital administrators, medical staff leadership, and health care providers is essential.

TESTS FOR COMPLIANCE

1. **An antimicrobial stewardship program has been implemented.**
2. **The program specifies who is accountable for implementing the program.**

3. **The program is interdisciplinary, involving pharmacists, infectious diseases physicians, infection control specialists, physicians, microbiology staff, nursing staff, hospital administrators, and information system specialists, as available and appropriate.**
4. **The program includes interventions to optimize antimicrobial use, such as audit and feedback, a formulary of targeted antimicrobials and approved indications, education, antimicrobial order forms, guidelines and clinical pathways for antimicrobial utilization, strategies for streamlining or de-escalation of therapy, dose optimization, and parenteral to oral conversion of antimicrobials (where appropriate).**
5. **The program is evaluated on an ongoing basis and results are shared with stakeholders in the organization.**

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Infusion Pump Safety

HSO 5034:2018

ROP STATEMENT

A documented and coordinated approach for infusion pump safety that includes training, evaluation of competence, and a process to report problems with infusion pump use is implemented.

GUIDELINES

Infusion pumps, used to deliver fluids into a client's body in a controlled manner, are used extensively in health care, including in the home environment, and are associated with significant safety issues and harm to clients.

This ROP focuses on parenteral delivery (i.e., routes other than the digestive tract or topical application) of fluids, medications, blood and blood products, and nutrients. It includes stationary and mobile intravenous infusion pumps, patient-controlled analgesia, epidural pumps, insulin pumps, and large-volume pumps. It excludes gastric feeding pumps.

Team members need training and education to maintain their competence in using infusion pumps safely, given the variety of pump types and manufacturers, the movement of team members between services, and the use of temporary staff. Safety is best achieved when organizations have a comprehensive approach that combines training and evaluation with the appropriate selection, procurement, and standardization of infusion pumps across an organization.

When evaluations reveal problems with infusion pump design, organizations can work with manufacturers to make improvements. Organizations are encouraged to report problems externally so that other organizations can implement safety improvements.

TESTS FOR COMPLIANCE

1. **Instructions and user guides for each type of infusion pump are easily accessible at all times.**
2. **Initial and re-training on the safe use of infusion pumps is provided to team members:**
    - Who are new to the organization or temporary staff new to the service area
    - Who are returning after an extended leave
    - When a new type of infusion pump is introduced or when existing infusion pumps are upgraded
    - When evaluation of competence indicates that re-training is needed
    - When infusion pumps are used very infrequently, just-in-time training is provided
3. **When clients are provided with client-operated infusion pumps (e.g., patient-controlled analgesia, insulin pumps), training is provided, and documented, to clients and families on how to use them safely.**
4. **The competence of team members to use infusion pumps safely is evaluated and documented at least every two years. When infusion pumps are used very infrequently, a just-in-time evaluation of competence is performed.**
5. **The effectiveness of the approach is evaluated. Evaluation mechanisms may include:**

- Investigating patient safety incidents related to infusion pump use
- Reviewing data from smart pumps
- Monitoring evaluations of competence
- Seeking feedback from clients, families, and team members

6. **When evaluations of infusion pump safety indicate improvements are needed, training is improved or adjustments are made to infusion pumps.**

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Limiting High Concentration and High Total Dose Opioid Formulations

HSO 5050:2024

Notes: This content is an update to HSO 5035:2018 Narcotics safety. As organizations transitions to the standards listed in the *List of ROPs within Standards* this ROP will become applicable.

ROP STATEMENT

The organizational leaders implement a risk mitigation strategy to limit the availability of and access to high-concentration and high-total-dose opioid formulations.

TESTS FOR COMPLIANCE AND GUIDELINES

1. **The organizational leaders provide clinical teams with a current list of high-concentration and high-total-dose opioid formulations available in the organization.**

   Guidelines

   Pharmaceutical formulations with high-concentration and high-total-dose opioid can increase the risk of harm due to their potency, the total amount of opioid in the package, and the frequent requirement for calculation and dilution steps before the formulation is administered to a client.

   A risk assessment is conducted to identify and create a list of opioid formulations available in the organization that pose a risk to clients. The risk assessment takes into consideration the high-concentration and the high-total-dose of opioid; the type of care provided; the care setting, such as surgical care, palliative care, acute care, long-term care, or home care; and the populations served, such as newborns, children, youth, adults, or older adults.

   The list of high-concentration and high-total-dose opioid formulations available in the organization is developed from research, evidence-informed safety practices, and error-reporting data at the organizational, jurisdictional, and national levels. The list is also informed by recommendations from professional regulatory bodies and jurisdictionally designated safety-focused organizations such as the Institute for Safe Medication Practices Canada.

   Examples of high total dose opioid formulations for acute and long-term care settings include

   - fentanyl ampoules or vials with total dose greater than 100 mcg,
   - HYDROmorphone ampoules or vials with total dose greater than 2 mg,
   - morphine ampoules or vials with total dose greater than 15 mg per formulation in adult care settings and 2 mg in pediatric care settings, and
   - opioid infusion bags and cassettes.

   Examples of high concentration opioid formulations for acute and long-term care settings include

   - HYDROmorphone 50 mg/mL vials,
   - morphine 50 mg/mL vials, and
   - methadone 10 mg/mL oral concentrate.

Examples of dispensing high volume opioid formulations for home care settings include

- HYDROmorphone long-acting 30 mg tablet minimally limited to a one-month supply,
- fentanyl transdermal patch 100 mcg/hr in a carton of 5 patches,
- prefilled syringes each containing 5 mg of morphine in an envelope of 10 syringes, and
- methadone oral solution 1 mg/mL in 100 mL bottles.

2. **The organizational leaders ensure clinical teams follow the organization's procedure to limit the availability of and access to high-concentration and high-total-dose opioid formulations.**

   Guidelines

   The organization's procedure to limit the availability of and access to high-concentration and high-total-dose opioid formulations is developed from evidence-informed safety practices and reflects the type of care provided, the care setting, and the populations served. The organization's procedure aims to mitigate the risk of harm and ensure proper opioid availability and access.

   The organization's procedure incorporates safety practices such as

   - avoiding storage of high total dose opioid formulations in the client care setting;
   - limiting inventory of high concentration opioids in the client care setting;
   - providing opioids in ready-to-use formats to avoid the need for calculations at the point-of-care or the need to dilute the product;
   - dispensing opioids in the community setting in limited quantities, such as four-day supplies rather than monthly;
   - providing opioids in unit-dose packaging;
   - providing a lockbox for opioid storage in client homes; and
   - ensuring timely and effective disposal or removal of unneeded and wasted opioids.

3. **The organizational leaders ensure the list of high-concentration and high-total-dose opioid formulations available in the organization is regularly updated to incorporate learnings from all opioid-related medication safety incident reporting and analysis.**

   Guidelines

   An organizational culture of safety promotes and supports reporting of safety incidents to avoid harm, reduce errors, and lessen the impact of errors. Safety incidents are events or circumstances that could have harmed or did harm a client.

   Medication safety incidents related to the availability of and access to high-concentration and high-total-dose opioid formulations are documented in the client's health record and the safety incident reporting system. The information is shared with the client and other authorized team members in a clear and accessible format as required by the organization's procedure.

   Opioid-related safety incident reporting and analysis informs regular updates to the list of high-concentration and high-total-dose opioid formulations available in the organization and associated safety practices.

   Safety incidents inform the organization's medication management quality improvement plan.

Findings and recommendations from the analysis of opioid-related safety incidents are communicated to clinical teams in the organization. The organizational leaders are encouraged to also communicate safety incident findings and recommendations to relevant partners, including professional regulatory bodies and jurisdictionally designated safety-focused organizations.

The list of high-concentration and high-total-dose opioid formulations available in the organization is kept current to reflect changes to organizational practices, the introduction of new care practices, and newly available formulations. Changes to the list are communicated according to the organization's procedure to limit the availability of and access to high-concentration and high-total-dose opioid formulations.

4. **The organizational leaders provide clinical teams with continuous learning activities about the organization's risk mitigation strategy to limit the availability of and access to high-concentration and high-total-dose opioid formulations.**

Guidelines

Continuous learning helps clinical teams implement safety practices to prevent harm. Clinical teams include those who prescribe, prepare, dispense, and administer high-concentration and high-total-dose opioid formulations.

If the organization offers clinical practicums, students, residents, and fellows participate in the required learning activities before providing care.

Learning activities are provided in various ways to engage clinical team members with different educational backgrounds, abilities, and learning styles. Examples include in-person or virtual training and simulation sessions, awareness campaigns, reflective practice, medication safety rounds, and mentorship initiatives.

Clinical teams are involved in the development and evaluation of continuous learning activities. The lived experiences of clients and designated support persons also provide knowledge that is used to inform continuous learning activities.

Clinical teams are given time to participate in, reflect on, and share learnings and experiences. Learning activities are documented.

5. **The organizational leaders ensure the organization's medication management quality improvement plan includes activities to improve safety practices related to the availability of and access to high-concentration and high-total-dose opioid formulations.**

Guidelines

Quality improvement involves a team-based approach to understanding the organization's strengths, opportunities for improvement, risks, and challenges in delivering high-quality and safe care.

Quality improvement activities include collecting quantitative and qualitative data, engaging in reflective learning practices, and collecting feedback. Quality improvement activities also include identifying and implementing actions that improve safety practices related to the availability of and access to high-concentration and high-total-dose opioid formulations.

Aims, measures, and outcomes are documented in the organization's medication management quality improvement plan. Qualitative and quantitative measures may include

- observational activities and audits of medication storage areas to assess adherence to the organization's procedure to limit the availability of and access to high-concentration and high-total-dose opioid formulations,
- root cause analysis of safety incidents related to the availability of and access to high-concentration and high-total-dose opioid formulations,

- feedback from clinical teams on the organization's procedure to limit the availability of and access to high-concentration and high-total-dose opioid formulations and the list of high-concentration and high-total-dose opioid formulations available in the organization, and
- feedback from clinical teams on the continuous learning activities provided by the organization on opioid safety.

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Narcotics Safety

HSO 5035:2018

Notes: This ROP is being phased out and is replaced by HSO 5035:2024 Limiting High Concentration and High Total Dose Opioid Formulations.

ROP STATEMENT

The availability of narcotic products is evaluated and limited to ensure that formats with the potential to cause patient safety incidents are not stocked in client service areas.

GUIDELINES

Narcotics (or opioids) have been identified as high-alert medications. Limiting their availability and ensuring that high dose formats are not stocked in client service areas are effective strategies to minimize the risk of death or disabling injury associated with these agents.

For specific care circumstances, it may be necessary for narcotic products to be available in select client service areas, for example:

- Fentanyl: ampoules or vials with total dose greater than 100 mcg per container
- HYDROmorphone: 10 mg/mL ampoules or vials may be provided based on the following criteria and must be removed when no longer required: intermittent intravenous, subcutaneous or intramuscular doses greater than 4 mg

In these cases, an interdisciplinary committee for medication management (e.g., Pharmacy and Therapeutics Committee and Medical Advisory Secretariat) reviews and approves the rationale for availability and safeguards are put in place to minimize the risk of error.

Organizations serving pediatric populations are encouraged to implement practice recommendations specific to their patient population, including the use of standardized concentrations for opioid infusions.

To optimize the safe use of narcotic products, organizations may also consider establishing a pain management team.

TESTS FOR COMPLIANCE

1. **An audit of the following narcotic products in client service areas is completed at least annually:**
    - Fentanyl: ampoules or vials with total dose greater than 100 mcg per container
    - HYDROmorphone: ampoules or vials with total dose greater than 2 mg
    - Morphine: ampoules or vials with total dose greater than 15 mg in adult care areas and 2 mg in paediatric care areas.
2. **Stocking the following narcotic products is avoided in client service areas:**
    - Fentanyl: ampoules or vials with total dose greater than 100 mcg per container
    - HYDROmorphone: ampoules or vials with total dose greater than 2 mg

- Morphine: ampoules or vials with total dose greater than 15 mg in adult care areas and 2 mg in paediatric care areas.

3. **When it is necessary for narcotic (opioid) products to be available in select client service areas, an interdisciplinary committee for medication management reviews and approves the rationale for availability, and safeguards are put in place to minimize the risk of error.**

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Managing High Alert Medications

HSO 5033:2024

Notes: This content is an update to HSO 5033-1:2018 High-alert medications; HSO 5033-2:2018 High-alert medications – Community pharmacy; HSO 5031:2018 Concentrated electrolytes; and HSO 5032:2018 Heparin safety. As organizations transitions to the standards listed in the *List of ROPs within Standards* this ROP will become applicable.

ROP STATEMENT

The organizational leaders implement a risk mitigation strategy to safely manage high-alert medications.

TESTS FOR COMPLIANCE AND GUIDELINES

1. **The organizational leaders provide clinical teams with a current list of high-alert medications available in the organization.**

   Guidelines

   High-alert medications are drugs that can cause significant harm to clients if they are administered incorrectly.

   A risk assessment is conducted to identify and create a list of high-alert medications available in the organization. The risk assessment takes into consideration, at a minimum, anticoagulants, insulins, chemotherapeutic agents, opioids, neuromuscular-blocking agents, and concentrated electrolytes. The risk assessment also considers the type of care provided; the care setting, such as surgical care, palliative care, acute care, long-term care, or home care; and the populations served, such as newborns, children, youth, adults, or older adults.

   The list of high-alert medications available in the organization is developed from research, evidence-informed safety practices, and error-reporting data at the organizational, jurisdictional, and national levels. The list is also informed by the latest versions of high-alert medication lists developed by professional regulatory bodies or jurisdictionally designated safety-focused organizations such as the Institute for Safe Medication Practices Canada.

2. **The organizational leaders ensure clinical teams follow the organization's procedure to safely manage high-alert medications.**

   Guidelines

   The organization's procedure to safely manage high-alert medications is developed from evidence-informed safety practices and reflects the type of care provided, the care setting, and the populations served. The organization's procedure aims to mitigate the risk of harm and optimize the safe use of high-alert medications.

   The organization's procedure to safely manage high-alert medications includes the following safety practices:

   Procuring

   - Informing clinical teams about changes to the organization's drug formulary, including updated guidance for safe prescribing and administering.

   Storing

- Using assistive technologies such as bar coding to identify when medications are received, stored, or returned to stock.
- Limiting access to high alert medications in the care setting.
- Conducting routine audits, including identifying medications such as insulin, concentrated electrolytes, or high concentration or high total amount heparin that are safely stored in the care setting.
- Implementing additional safety practices when a decision is made to store high alert medications in the care setting.

Prescribing

- Using predefined order sets and standardized protocols to support the safe use of high alert medications.

Dispensing

- Using commercially available or pharmacy-prepared premixed products or prefilled syringes.
- Providing premixed products or prefilled syringes, where feasible, to make available ready-to-use products at the point of care.
- Adding auxiliary warning labels to high alert medications if bar coding technology is not used at point of care.

Administering

- Using programmable pumps with drug libraries that incorporate limits for dosing and/or infusion volume.
- Using programmable pump automated alerts that are consistent with predefined order sets and standardized protocols.
- Employing independent double checks, including the use of bar-coding technology.

Monitoring

- Integrating monitoring parameters into predefined order sets and standardized protocols.
- Considering the potential of a medication error or adverse drug reaction when a client's clinical status significantly changes.

3. **The organizational leaders ensure the list of high-alert medications available in the organization is regularly updated to incorporate learnings from medication safety incident reporting and analysis.**

Guidelines

An organizational culture of safety promotes and supports reporting of safety incidents to avoid harm, reduce errors, and lessen the impact of errors. Safety incidents are events or circumstances that could have harmed or did harm a client.

Medication safety incidents related to high-alert medications are documented in the client's health record and the safety incident reporting system. The information is shared with the client and other authorized team members in a clear and accessible format as required by the organization's procedure.

Safety incident reporting and analysis related to high-alert medications informs regular updates to the list of high-alert medications used in the organization and associated safety practices.

Safety incidents inform the organization's medication management quality improvement plan.

Findings and recommendations from the analysis of safety incidents are communicated to clinical teams in the organization. The organizational leaders are encouraged to also communicate safety incident findings and recommendations to relevant partners, including professional regulatory bodies and jurisdictionally designated safety-focused organizations.

The list of high-alert medications used in the organization is kept current to reflect changes to organizational practices, the introduction of new care practices, and newly available drugs in the formulary. Changes to the list are communicated according to the organization's procedure to safely manage high-alert medications.

4. **The organizational leaders provide clinical teams with continuous learning activities about the organization's risk mitigation strategy to safely manage high-alert medications.**

   Guidelines

   Continuous learning helps clinical teams implement safety practices to prevent harm. Clinical teams include those who prescribe, prepare, dispense, and administer high-alert medications.

   If the organization offers clinical practicums, students, residents, and fellows participate in the required learning activities before providing care.

   Learning activities are provided in various ways to engage clinical team members with different educational backgrounds, abilities, and learning styles. Examples include in-person or virtual training and simulation sessions, awareness campaigns, reflective practice, medication safety rounds, and mentorship initiatives.

   Clinical teams are involved in the development and evaluation of continuous learning activities. The lived experiences of clients and designated support persons also provide knowledge that is used to inform continuous learning activities.

   Clinical teams are given time to participate in, reflect on, and share learnings and experiences. Learning activities are documented.

5. **The organizational leaders ensure the organization's medication management quality improvement plan includes activities to improve safety practices related to high-alert medications.**

   Guidelines

   Quality improvement involves a team-based approach to understanding the organization's strengths, opportunities for improvement, risks, and challenges in delivering high-quality and safe care.

   Quality improvement activities include collecting quantitative and qualitative data, engaging in reflective learning practices, and gathering feedback. Quality improvement activities also include identifying and implementing actions that improve safety practices related to high-alert medications.

   Aims, measures, and outcomes are documented in the organization's medication management quality improvement plan. Qualitative and quantitative measures may include

   - observational activities and audits of medication storage areas to assess clinical teams' adherence to the organization's procedure to safely manage high-alert medications,
   - root cause analysis of safety incidents related to high-alert medications,

- feedback from clinical teams on the list of high-alert medications used in the organization and the organization's procedure to safely manage high-alert medications, and
- feedback from clinical teams on the continuous learning activities provided by the organization on high-alert medication safety.

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High-Alert Medications

HSO 5033-1:2018

Notes: This ROP is being phased out and is replaced by HSO 5033:2024 Managing High Alert Medications.

ROP STATEMENT

A documented and coordinated approach to safely manage high-alert medications is implemented.

GUIDELINES

High-alert medications may cause significant harm when they are administered in error. A coordinated and documented approach to safely manage high-alert medications enhances patient safety and reduces the possibility of harm. High-alert medications include but are not limited to antithrombotic agents, adrenergic agents, chemotherapy agents, concentrated electrolytes, insulin, narcotics (opioids), neuromuscular blocking agents, and sedation agents.

A documented and coordinated approach to safely manage high-alert medications identifies them based on an organization's medication formulary and takes into consideration organizational, provincial, or national medication error data. Each high-alert medication or class of medication is evaluated, procedures to improve safe use are identified, and an action plan is established. Procedures for the safe use of high-alert medications may include but are not limited to:

- Standardizing high-alert medication concentrations and volume options
- Using pre-mixed solutions (commercially available and pharmacy prepared)
- Using programmable pumps with dosing limits and automated alerts
- Applying warning labels to products as soon as they are received in the pharmacy
- Using visible warning and auxiliary labels according to the organization's policy
- Using patient-specific labelling for unusual concentrations
- Limiting access to high-alert medications in client service areas and auditing routinely to assess for items that should be removed
- Standardizing the ordering, storage, preparation, administration, and dispensing of these products through the use of protocols, guidelines, dosing charts, and orders sets (pre-printed or electronic)
- Segregating and providing directed access to reduce the likelihood of selection errors (e.g., use of automated dispensing cabinets in client service areas)
- Providing training about high-alert medications
- Employing redundancies such as automated or independent double checks

The approach may place additional emphasis on strategies for high-risk client populations including the elderly, pediatrics, and neonates, as well as on transition points including admission, transfer, and discharge.

TESTS FOR COMPLIANCE

1. **There is a policy for the management of high-alert medications.**

2. **The policy names the role or position of individual(s) responsible for implementing and monitoring the policy.**
3. **The policy includes a list of high-alert medications identified by the organization.**
4. **The policy includes procedures for storing, prescribing, preparing, administering, dispensing, and documenting each identified high-alert medication.**
5. **Concentrations and volume options for high-alert medications are limited and standardized.**
6. **Client service areas are regularly audited for high-alert medications.**
7. **The policy is updated on an ongoing basis.**
8. **Information and ongoing training is provided to team members on the management of high-alert medications.**

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High-Alert Medications – Community Pharmacy

HSO 5033-2:2018

Notes: This ROP is being phased out and is replaced by HSO 5033:2024 Managing High Alert Medications.

ROP STATEMENT

The organization implements a comprehensive strategy for the management of high-alert medications.

GUIDELINES

Implementing a comprehensive strategy for the management of high-alert medications is a valuable use of resources to enhance patient safety, and to reduce the possibility of serious harm.

The Institute for Safe Medication Practices has produced a list of high-alert medications specifically for community/ambulatory settings which can be found online. To prevent harm from medication errors, a policy for the management of high-alert medications is required. Strategies for the safe use of high-alert medications may include but are not limited to:

- Applying warning labels to products as soon as they are received in the pharmacy
- Using visible warning and auxiliary labels according to the organization's policy
- Providing training about high-alert medications
- Employing automated or independent double checks

A policy for the management of high-alert medications may place additional emphasis on strategies for high-risk client/resident populations including the elderly, paediatrics, and neonates. Organizations should systematically evaluate each high-alert medication or class of medications and establish an action plan to improve the safe use of these medications.

TESTS FOR COMPLIANCE

1. **The organization has a policy for the management of high-alert medications.**
2. **The policy names the role or position of individual(s) responsible for implementing and monitoring the policy.**
3. **The policy includes a list of high-alert medications identified by the organization.**
4. **The policy includes procedures for storage, prescribing, preparation, administration, dispensing, and documentation for each high-alert medication, as appropriate.**
5. **The organization establishes a mechanism to update the policy on an ongoing basis.**
6. **The organization provides information and ongoing training to staff on the management of high-alert medications.**

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Concentrated Electrolytes

HSO 5031:2018

Notes: This ROP is being phased out and is replaced by HSO 5033:2024 Managing High Alert Medications.

ROP STATEMENT

The availability of concentrated electrolytes is evaluated and limited to ensure that formats with the potential to cause patient safety incidents are not stocked in client service areas.

GUIDELINES

Ensuring that concentrated electrolytes are not stocked in client service areas can minimize the risk of death or disabling injury associated with these agents. It is also recommended that the packaging of concentrated electrolytes is in line with their intended use.

For specific care circumstances, it may be necessary to have concentrated electrolytes available in select client service areas, for example:

- Calcium: pre-filled syringes (1 g in 10 mL) in emergency carts or boxes only
- Sodium chloride (concentrations greater than 0.9%): bags are segregated from non-medicated intravenous solutions in select areas (e.g., neurology, emergency departments, critical care)

In these cases, an interdisciplinary committee for medication management (e.g., Pharmacy and Therapeutics Committee and Medical Advisory Secretariat) reviews and approves the rationale for availability, and safeguards are put in place to minimize the risk of error.

TESTS FOR COMPLIANCE

1. **An audit of the following concentrated electrolytes in client service areas is completed at least annually:**
    - Calcium (all salts): concentrations greater than or equal to 10%
    - Magnesium sulfate: concentrations greater than 20%
    - Potassium (all salts): concentrations greater than or equal to 2 mmol/mL (2 mEq/mL)
    - Sodium acetate and sodium phosphate: concentrations greater than or equal to 4 mmol/mL
    - Sodium chloride: concentrations greater than 0.9%
2. **Stocking the following concentrated electrolytes is avoided in client service areas:**
    - Calcium (all salts): concentrations greater than or equal to 10%
    - Magnesium sulfate: concentrations greater than 20%
    - Potassium (all salts): concentrations greater than or equal to 2 mmol/mL (2 mEq/mL)
    - Sodium acetate and sodium phosphate: concentrations greater than or equal to 4 mmol/mL
    - Sodium chloride: concentrations greater than 0.9%

3. **When it is necessary to make concentrated electrolytes available in select client service areas, an interdisciplinary committee for medication management reviews and approves the rationale for availability, and safeguards are put in place to minimize the risk of error.**

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Heparin Safety

HSO 5032:2018

Notes: This ROP is being phased out and is replaced by HSO 5033:2024 Managing High Alert Medications.

ROP STATEMENT

The availability of heparin products is evaluated and limited to ensure that formats with the potential to cause patient safety incidents are not stocked in client service areas.

GUIDELINES

Heparin is a high-alert medication. Limiting its availability and ensuring that high-dose formats are not stocked in client service areas are effective strategies to minimize the risk of death or disabling injury associated with these agents.

For specific care circumstances, it may be necessary for heparin products to be available in select client service areas. In these cases, an interdisciplinary committee for medication management (e.g., Pharmacy and Therapeutics Committee and Medical Advisory Secretariat) reviews and approves the rationale for availability and safeguards are put in place to minimize the risk of error.

For flushing intravenous lines, organizations are encouraged to consult best practice guidelines to explore options other than heparin.

TESTS FOR COMPLIANCE

1. **An audit of unfractionated and low molecular weight heparin products in client service areas is completed at least annually.**
2. **High dose unfractionated heparin (50,000 units total per container) is not stocked in client service areas.**
3. **Steps are taken to limit the availability of the following heparin products in client service areas:**
    - Low molecular weight heparin: use of multi-dose vials is limited to critical care areas for treatment doses
    - Unfractionated heparin (high dose): greater than or equal to 10,000 units total per container (e.g., 10,000 units/1 mL; 10,000 units/10 mL; 30,000 units/30 mL) is provided on a client-specific basis when required
    - Unfractionated heparin for intravenous use (e.g., 25,000 units/500 mL; 20,000 units/500 mL) is provided on a client-specific basis when required
4. **When it is necessary for the previous heparin products to be available in select client service areas, an interdisciplinary committee for medication management reviews and approves the rationale for availability, and safeguards are put in place to minimize the risk of error.**

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Worklife and Workforce

Client Flow

HSO 5040:2021

Notes: This content is an update to HSO 5040:2018 Client flow. As organizations transition to the standards listed in the *List of ROPs within Standards* this ROP will become applicable.

ROP STATEMENT

Organizational leaders optimize client flow within their organization.

TESTS FOR COMPLIANCE AND GUIDELINES

1. **Organizational leaders ensure there is an organization-wide client flow strategy that aligns with the needs of the populations it serves.**

   Guidelines:

   Client flow considers the movement of individuals into an organization, within the organization, out of the organization, and between organizations. It is critical to consider client flow from an end-to-end perspective, as barriers at various points can have significant impacts on other aspects of service.

   The organization's client flow strategy is co-designed with clients, community and partners, its workforce, and other stakeholders. To optimize safety, the client flow strategy includes inter-organizational and intra-organizational perspectives.

   In designing the client flow strategy, the organization should consider the following:

   - Sources of demand (e.g., emergency, unplanned and planned admissions, outpatient, follow-up care)
   - Patterns and volume of demand
   - Variations in demand
   - Availability of capacity to address excessive demand
   - Enablers and barriers to client flow
   - Risk and consequences of overcrowding (e.g., adverse events)

   The client flow strategy should define specific outcomes. The client flow strategy should align with existing jurisdictional indicators, measures, and requirements.

2. **Organizational leaders ensure there is an operational action plan that aligns with the organization's client flow strategy.**

   Guidelines

   The operational action plan identifies tactics on how the organization proactively prevents and manages client flow issues, the roles and responsibilities of those involved in taking action, and how change will be measured.

Roles and responsibilities should also extend to the organization's health and social services partners, to facilitate seamless transition of clients to the most appropriate type and level of care (e.g., long-term care, home care, community care, rehabilitation, primary care).

The operational action plan identifies targets for client flow that are evidence informed, based on internal and external benchmarks, and aligned with best practices and the client flow targets of comparable organizations. Targets may be specified for client flow data such as time to transfer clients to an inpatient bed following a decision to admit; emergency department length of stay for non-admitted clients; transfer of clients to long- term care homes; and wait times for surgery, home care services, mental health and addiction services. Indicators should be regularly evaluated for appropriateness.

The organization collects client flow data on how often and how long clients wait for services, which may include data on wait lists, length of stay, turnaround times for lab or diagnostic imaging results, community placement times, or consultant response times.

The organization improves client flow by using client flow data to implement interventions that address barriers and changes in demand.

3. **The team implements protocols to effectively manage client flow.**

   Guidelines

   In addition to a client flow strategy, the organization has protocols to effectively manage client flow. The protocols may include how to work with external organizations to ensure smooth and timely transitions in care.

   The protocols should monitor and provide guidance on how to manage backlogs, barriers, and surges. In acute care settings, this may include emergency department surges and bed flow. In community settings, this may include wait list management, case load and capacity management, and length of stay based on needs.

4. **Organizational leaders ensure there are mechanisms to monitor and adjust the client flow strategy.**

   Guidelines

   Data are continually collected, outcomes are reviewed, and the strategy is updated as needed. Monitoring is continuous and organizational leaders are informed of any significant or sudden changes in the data.

   The organization has continuous quality improvement initiatives based on client flow targets.

   The governing body is made aware of key quality and safety principles, to help the members effectively understand, monitor, and oversee the organization's quality performance.

5. **Organizational leaders regularly report on progress against the client flow strategy to the governing body, workforce, clients and families, community, and other stakeholders.**

   Guidelines

   Reports on progress against the client flow strategy are regularly made available.

   Reporting includes sharing experiences with other health and social services organizations to provide opportunities to learn from each other.

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Client Flow

HSO 5040:2018

Notes: This ROP is being phased out and is replaced by HSO 5040:2021 Client flow.
This ROP only applies to organizations with an emergency department that can admit clients.

ROP STATEMENT

Client flow is improved throughout the organization and emergency department overcrowding is mitigated by working proactively with internal teams and teams from other sectors.

GUIDELINES

Emergency department (ED) overcrowding is a system-wide challenge. Its root cause is usually poor client flow (e.g., unavailability of inpatient beds, inappropriate admissions, delays in the decision to admit, delays in discharge, and lack of timely access to diagnostic services and care in the community) stemming from a mismatch between capacity and demand. By evaluating client flow data and considering all sources of demand (such as emergency and planned admissions, outpatient and follow-up care), organizations can understand the pattern of demand and develop strategies to meet variations in demand, reduce barriers to client flow, and prevent overcrowding. The approach should be aligned with existing provincial and territorial indicators and strategies.

The approach specifies the role of clinical and non-clinical teams within the hospital (e.g., medicine, surgery, infection control, diagnostics, housekeeping, admitting, discharge planning, and transportation) and across the health system (e.g., long-term care, home care, palliative care, rehabilitation, and primary care).

Possible interventions to address variations in demand and barriers to flow include developing clear criteria for admission, reducing the length of stay (especially for those with extended lengths of stay), improving access to ambulatory services (diagnostics, laboratory, and consults), improving discharge planning, and partnering with the community to improve placement times. To know whether the intervention(s) led to an improvement, organizations need to continue to analyze client flow.

Improving client flow requires strong leadership support. The accountability of senior leaders, including physicians, can be demonstrated through policy, through their specified roles and responsibilities, or through performance evaluation.

TESTS FOR COMPLIANCE

1. **The organization's leaders, including physicians, are held accountable for working proactively to improve client flow and mitigate emergency department overcrowding.**
2. **Client flow data (e.g., length of stay, turnaround times for labs or imaging, community placement times, consultant response times) is used to identify variations in demand and barriers to delivering timely emergency department services.**
3. **There is a documented and coordinated approach to improve client flow and address emergency department overcrowding.**
4. **The approach specifies the role of teams within the hospital and other sectors of the health system to improve client flow.**
5. **The approach specifies targets for improving client flow (e.g., time to transfer clients to an inpatient bed following a decision to admit, emergency department length of stay for non-admitted clients, transfer of care times from emergency medical services to the emergency department).**

6. **Interventions to improve client flow that address identified barriers and variations in demand are implemented.**
7. **When needed, short-term actions to manage overcrowding, that mitigate risks to client and team members (e.g., over-capacity protocols), are implemented.**
8. **Client flow data is used to measure whether the interventions prevent or reduce overcrowding in the emergency department, and improvements are made when needed.**

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Patient Safety Education and Training

HSO 5041:2018

ROP STATEMENT

Patient safety training and education that addresses specific patient safety focus areas are provided at least annually to leaders, team members, and volunteers.

GUIDELINES

Annual education on patient safety is made available to the organization's leaders, team members, and volunteers. Specific patient safety focus areas such as safe medication use, reporting patient safety incidents, human factors training, techniques for effective communication, equipment and facility sterilization, handwashing and hand hygiene, and infection prevention and control are identified.

TESTS FOR COMPLIANCE

1. **There is annual patient safety training tailored to the organization's needs and specific patient safety focus areas.**

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Patient Safety Plan

HSO 5042:2018

ROP STATEMENT

A patient safety plan is developed and implemented for the organization.

GUIDELINES

There is an important connection between excellence in care and safety. Ensuring services are provided safely is one of an organization's primary obligations to clients and team members. Patient safety can be improved when organizations develop a targeted patient safety plan.

Patient safety plans need to consider safety issues in the organization, the delivery of services, and the needs of clients and families. They may include a range of topics and approaches, such as mentoring team members, the role of leadership (e.g., patient safety leadership walkabouts), implementing organization-wide patient safety initiatives, accessing evidence and best practices, and recognizing team members for innovations to improve patient safety.

TESTS FOR COMPLIANCE

1. **Patient safety issues for the organization are assessed.**
2. **There is a plan and process in place to address identified patient safety issues.**
3. **The plan includes patient safety as a written strategic priority or goal.**
4. **Resources are allocated to support the implementation of the patient safety plan.**

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Preventive Maintenance Program

HSO 5043:2018

ROP STATEMENT

A preventive maintenance program for medical devices, medical equipment, and medical technology is implemented.

GUIDELINES

An effective preventive maintenance program helps ensure medical devices, medical equipment, and medical technology are safe and functional. It also helps identify and address potential problems with medical devices, medical equipment, or medical technology that may result in injury to team members or clients.

TESTS FOR COMPLIANCE

1. **There is a preventive maintenance program for all medical devices, medical equipment, and medical technology.**
2. **There are documented preventive maintenance reports.**
3. **There is a process to evaluate the effectiveness of the preventive maintenance program.**
4. **There is documented follow up related to investigating incidents and problems involving medical devices, equipment, and technology.**

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Workplace Violence Prevention

HSO 5044:2018

ROP STATEMENT

A documented and coordinated approach to prevent workplace violence is implemented.

GUIDELINES

Workplace violence is more common in health care settings than in many other workplaces, with one-quarter of all incidents of workplace violence occurring at health services organizations. It is an issue that affects staff and health providers across the health care continuum.

This ROP has adopted the modified International Labour Organization definition of workplace violence, as follows: “Incidents in which a person is threatened, abused or assaulted in circumstances related to their work, including all forms of harassment, bullying, intimidation, physical threats, or assaults, robbery or other intrusive behaviours. These behaviours could originate from customers or co-workers, at any level of the organization.”

A strategy to prevent workplace violence should be in compliance with applicable regional or national legislation, and is an important step to respond to the growing concern about violence in health care workplaces.

TESTS FOR COMPLIANCE

1. **There is a written workplace violence prevention policy.**
2. **The policy is developed in consultation with team members and volunteers as appropriate.**
3. **The policy names the individual(s) or position responsible for implementing and monitoring adherence to the policy.**
4. **Risk assessments are conducted to ascertain the risk of workplace violence.**
5. **There are procedures for team members to confidentially report incidents of workplace violence.**
6. **There are procedures to investigate and respond to incidents of workplace violence.**
7. **The organization's leaders review quarterly reports of incidents of workplace violence and use this information to improve safety, reduce incidents of violence, and improve the workplace violence prevention policy.**
8. **Information and training is provided to team members on the prevention of workplace violence.**

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Infection Control

Cleaning and Low-Level Disinfection of Medical Equipment

HSO 5055:2024

DEFINITIONS

Medical device. An article, instrument, apparatus, or machine used for prevention, diagnosis, treatment, monitoring, rehabilitation, or palliation. Medical devices range from simple thermometers to complex surgical instruments and implantable devices and are classified as critical, semi-critical, or non-critical.

Medical equipment. A non-invasive medical apparatus, appliance, or material that comes in contact with a client's intact skin and is used in the provision of care. Examples include wheelchairs, IV poles, and commodes. Medical equipment requires cleaning and low-level disinfection procedures and may require preventive maintenance and repair. Some medical equipment, such as blood pressure cuffs and medical imaging equipment, could also require calibration.

ROP STATEMENT

Teams ensure medical equipment is cleaned and low-level disinfected to minimize cross-contamination and mitigate the risk of transmission of health care associated infections.

TESTS FOR COMPLIANCE AND GUIDELINES

1. **Teams follow the organization's procedure to clean and low-level disinfect medical equipment.**

   Guidelines

   Effective cleaning and low-level disinfection of medical equipment is a critical part of the organization's infection prevention and control program. Each type of medical equipment has specific requirements for cleaning and low-level disinfecting between each use, when visibly soiled, and on a regular basis.

   The organization's procedure and other supportive materials such as manufacturer's instructions are available at the point of use. These materials provide guidance on the activities, supplies, and chemical agents required to properly clean and low-level disinfect medical equipment according to standardized practices.

   The organization's procedure to clean and low-level disinfect medical equipment includes

   - roles and responsibilities of in-house and contracted teams;
   - the type and frequency of cleaning and low-level disinfection required for medical equipment, classified according to risk of infection; the care setting, such as acute care, long-term care, or home care; or the service setting, such as a diagnostic imaging centre, laboratory, or rehabilitation gym;
   - specific instructions for medical equipment that is difficult to clean and low-level disinfect, including disassembly and reassembly;
   - the required activities to identify, handle, transport, and store medical equipment that needs cleaning and low-level disinfection;

- the required activities to identify, handle, transport, and store medical equipment that has been cleaned and low-level disinfected and is ready for reuse;
- appropriate areas and required precautions for cleaning and low-level disinfecting medical equipment;
- proper storage, preparation, and use of chemical agents for cleaning and low-level disinfecting medical equipment; and
- periodic assessments of compliance and evaluation methods such as visual observation.

2. **Teams coordinate activities to ensure medical equipment is effectively cleaned and low-level disinfected.**

   Guidelines

   Roles and responsibilities for cleaning and low-level disinfecting medical equipment are clearly defined, including for contracted teams, as well as alternate team members responsible for these activities as part of contingency planning.

   The required activities are communicated, coordinated, and completed according to the organization's procedure. For example, medical equipment that requires cleaning and low-level disinfection is identified with a visual cue and placed in the appropriate area for cleaning and low-level disinfection by the responsible team member. The cleanliness of medical equipment is validated, and discrepancies are reported and addressed with the appropriate person or group.

   Clients and designated support persons are encouraged to ask questions, share concerns, and participate in conversations about the cleanliness of medical equipment.

3. **Teams use proper cleaning and low-level disinfection equipment and supplies in an appropriate area.**

   Guidelines

   Equipment and supplies include chemical agents, dilution and concentration testing materials, and personal protective equipment.

   Medical equipment is cleaned and low-level disinfected in appropriate areas with the required precautions, according to the organization's procedure.

   Equipment and supplies are stored appropriately, safely transported, and disposed of according to manufacturers' instructions and jurisdictional requirements for workplace hazardous materials.

4. **Teams participate in continuous learning activities about cleaning and low-level disinfection of medical equipment.**

   Guidelines

   Continuous learning helps teams ensure medical equipment is effectively cleaned and low-level disinfected, stored appropriately, and made ready for reuse, according to the organization's procedure.

   Learning activities are provided during orientation, when products or procedures change, and on a regular basis. If the organization offers clinical practicums, students, residents, and fellows participate in the required learning activities before providing care.

   Learning topics relevant to team roles and responsibilities can include

   - the importance of cleaning and low-level disinfecting medical equipment as a safety practice;

- understanding the Globally Harmonized System of Classification and Labelling of Chemicals (GHS) and the Workplace Hazardous Materials Information System (WHIMS);
- appropriate selection and use of cleaning and low-level disinfection chemicals, methods, and technologies for different areas and surfaces; and
- reporting medical equipment that has not been properly cleaned and low-level disinfected as a safety incident.

Learning activities are provided in various ways to engage team members with different educational backgrounds, abilities, and learning styles. Examples include in-person or virtual training and simulation sessions, awareness campaigns, reflective practice, and mentorship initiatives.

Teams are involved in the development and evaluation of continuous learning activities. Teams are given time to participate in, reflect on, and share learnings and experiences. Learning activities are documented.

5. **Teams participate in activities to improve the organization's procedure to clean and low-level disinfect medical equipment.**

Guidelines

Quality improvement involves a team-based approach to understanding the organization's strengths, opportunities for improvement, risks, and challenges in delivering high-quality and safe care.

Participation in quality improvement activities includes supporting the collection of quantitative and qualitative data, engaging in reflective learning practices, and providing feedback.

Examples include

- observational activities and audits to assess teams' adherence to the organization's procedure to clean and low-level disinfect medical equipment, such as walk arounds to ensure proper identification and storage of clean and soiled medical equipment;
- root cause analysis of safety incidents related to cleaning and low-level disinfecting medical equipment;
- feedback from teams, including clients, on the organization's procedure to clean and low-level disinfect medical equipment; and
- feedback from teams on the continuous learning activities provided by the organization on cleaning and low-level disinfecting medical equipment.

Aims, measures, and outcomes are used to improve the organization's procedure to clean and low-level disinfect medical equipment.

Teams are given time to participate in, reflect on, and share quality improvement learnings and experiences.

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Improving Hand Hygiene Practice

HSO 5050:2024

Notes: This content is an update to HSO 5050:2018 Hand-hygiene compliance and HSO 5051:2018 Hand-hygiene education and training. As organizations transitions to the standards listed in the *List of ROPs within Standards* this ROP will become applicable.

ROP STATEMENT

The organizational leaders are accountable to demonstrate improvement in hand hygiene practices as part of the organization's infection prevention and control program.

TESTS FOR COMPLIANCE AND GUIDELINES

1. **The organizational leaders define an aim for improving hand hygiene practices.**

   Guidelines

   Hand hygiene can significantly reduce the risk of transmission of infections and enhance client and workforce safety when performed correctly and consistently.

   A clear and measurable aim to improve hand hygiene practices for the organization is defined and documented in the hand hygiene quality improvement plan. The aim is a statement that is focused on the outcome and articulates the targeted improvement over a specified time frame.

   The aim takes into consideration improving hand hygiene practices in all care, administrative, and public settings across the organization.

   The aim is defined collaboratively with partners and informed by baseline data on hand hygiene compliance.

2. **The organizational leaders invest in resources to improve hand hygiene practices.**

   Guidelines

   Investing in resources demonstrates commitment to improvement and supports the achievement of the hand hygiene aim.

   Resources include people, finances, infrastructure, equipment, and information.

   The resources needed to support the improvement of hand hygiene practices will depend on the defined aim. Examples of resources include

   - a person or team that has the responsibility and protected time to improve the organization's hand hygiene practices;
   - infrastructure to support hand hygiene practices, including accessible equipment such as sinks and dispensers, and just-in-time supplies such as alcohol-based hand rub, soap, and paper towels; and
   - an established methodology for collecting and analyzing data on hand hygiene compliance such as direct observation or electronic monitoring systems.

3. **The organizational leaders ensure that a hand hygiene quality improvement plan is developed.**

   Guidelines

A quality improvement plan provides essential information about how hand hygiene improvement activities will be implemented, managed, and evaluated.

Activities to improve hand hygiene practices require a multi-faceted and multidisciplinary approach that is tailored to the setting and populations served.

Examples of hand hygiene improvement activities include

- innovative approaches to quickly identifying where supplies are needed such as visual indicator tags or quick response (QR) codes;
- just-in-time supplies such as alcohol-based hand rub, soap, and paper towels;
- multimodal continuous learning activities for teams that are developed in collaboration with clients, designated support persons, visitors, and external partners on the importance of hand hygiene and correct techniques;
- innovative approaches for hand hygiene auditing such as electronic monitoring systems; and
- multimodal performance feedback such as on-the-spot feedback, team huddles, visual displays, and electronic dashboards.

For each of the selected activities, the person or team responsible and allocated resources are identified and documented in the hand hygiene quality improvement plan.

4. **The organizational leaders monitor hand hygiene improvement activities over time based on identified indicators.**

Guidelines

The systematic collection and analysis of qualitative and quantitative indicators enables organizational leaders to ensure resources for improving hand hygiene practices are allocated properly and activities are achieving results.

Indicators are selected according to the hand hygiene improvement activities and may include

- structural indicators relating to hand hygiene infrastructure and the availability of hand hygiene supplies and equipment such as sinks and alcohol-based hand rub dispensers;
- process indicators such as compliance with the organization’s procedures on performing hand hygiene at key moments; and
- outcome indicators such as the use of alcohol-based hand rub and soap, improved hand hygiene practices, decreased infection rates, and qualitative feedback on the user experience.

The results are documented in the organization’s hand hygiene quality improvement plan.

5. **The organizational leaders ensure the infection prevention and control program is informed by learnings from hand hygiene improvement activities.**

Guidelines

A learning organization recognizes that quality improvement affects all parts of the organization. Sharing and implementing learnings also helps the organization promote a culture of safety and quality, rather than a culture of blame.

Learnings from the hand hygiene quality improvement activities are shared in a timely manner and in a format that is clear and appropriate for each audience. Quality improvement activities that demonstrate positive change are implemented, sustained, and spread as part of the infection prevention and control

program. These efforts include adjusting policies and procedures, clinical decision support tools, and other resources.

Sharing of learnings through established networks, communities of practice, publications, and at conferences is encouraged to further improve the spread and scale of hand hygiene practices.

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Hand-Hygiene Compliance

HSO 5050:2018

Notes: This ROP is being phased out and is replaced by HSO 5050:2024 Improving Hand Hygiene Practices.

ROP STATEMENT

Compliance with accepted hand-hygiene practices is measured.

GUIDELINES

Hand hygiene is considered the single most important way to reduce health care-associated infections, but compliance with accepted hand-hygiene practices is often poor. Measuring compliance with hand-hygiene practices allows organizations to improve education and training about hand hygiene, evaluate hand-hygiene resources, and benchmark compliance practices across the organization. Studies show that improving compliance with hand-hygiene practices decreases health care-associated infections.

Direct observation (audits) is the best method to measure compliance with hand-hygiene practices. This involves watching and recording the hand-hygiene behaviours of team members and observing the work environment. Observation can be done by a trained observer within an organization, by two or more health care professionals working together, or by clients and families in the organization or in the community. Ideally, direct observation measures compliance with all four of the moments for hand hygiene:

i. Before initial contact with the client or their environment

ii. Before a clean/aseptic procedure

iii. After body fluid exposure risk

iv. After touching a client or their environment

Direct observation should be used by all organizations working out of a fixed location (i.e., clients come to them). Organizations that provide services in clients' homes and find that direct observation is not possible may consider alternative methods. As these alternatives are not as robust as direct observation, they should be used in combination (two or more) to give a more accurate picture of compliance with hand-hygiene practices.

TESTS FOR COMPLIANCE

1. **Compliance with accepted hand-hygiene practices is measured using direct observation (audit). For organizations that provide services in clients' homes, a combination of two or more alternative methods may be used, for example:**
    - Team members recording their own compliance with accepted hand-hygiene practices (self-audit)
    - Measuring product use
    - Questions on client satisfaction surveys that ask about team members' hand-hygiene compliance
    - Measuring the quality of hand-hygiene techniques (e.g., through the use of ultraviolet gels or lotions)
2. **Hand-hygiene compliance results are shared with team members and volunteers.**
3. **Hand-hygiene compliance results are used to make improvements to hand-hygiene practices.**

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Hand-Hygiene Education and Training

HSO 5051:2018

Notes: This ROP is being phased out and is replaced by HSO 5050:2024 Improving Hand Hygiene Practices.

ROP STATEMENT

Hand-hygiene education is provided to team members and volunteers.

GUIDELINES

Hand hygiene is critical to infection prevention and control programs, but adherence to accepted hand-hygiene protocols is often poor. It has been shown that the costs of health care-associated infections significantly exceed those related to implementing and monitoring hand-hygiene programs.

Training on hand hygiene is multimodal and addresses the importance of hand hygiene in preventing the transmission of microorganisms, factors that have been found to influence hand-hygiene behaviour, and proper hand-hygiene techniques. Training also includes recommendations about when to clean one's hands, based on the four moments for hand hygiene:

i. Before initial contact with the client or their environment.

ii. Before a clean/aseptic procedure.

iii. After body fluid exposure risk.

iv. After touching a client or their environment.

TESTS FOR COMPLIANCE

1. **Team members and volunteers are provided with education about the hand-hygiene protocol.**

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Infection Rates

HSO 5052:2018

Notes: This ROP only applies to organizations that have beds and provide nursing care.

ROP STATEMENT

Health care-associated infections are tracked, information is analyzed to identify outbreaks and trends, and this information is shared throughout the organization.

GUIDELINES

The health care-associated infections most common to the organization's services and client populations are identified and tracked. These could include Clostridium difficile (C. difficile), surgical site infections, seasonal influenza, noroviruses, urinary tract infections, and other reportable diseases and antibiotic-resistant organisms. Tracking methods for health care-associated infections may focus on a particular infection or service area or may be organization- or system-wide. They may include data analysis techniques to help detect previously unrecognized outbreaks. Tracking may include frequencies and changes in frequencies over time, associated mortality rates, and attributed costs.

Teams that are well informed about health care-associated infection rates are better equipped to prevent and manage them. The role or position responsible for receiving information about health care-associated infection rates is identified and a plan is established to regularly disseminate information (e.g., quarterly reports to all departments). In addition to team members, the governing body needs to be informed about health care-associated infection rates and associated infection prevention and control issues. This may be done directly through senior management or a medical advisory committee.

TESTS FOR COMPLIANCE

1. **Health care-associated infection rates are tracked.**
2. **Outbreaks are analyzed and recommendations are made to prevent recurrences.**
3. **Information about relevant health care-associated infections and recommendations from outbreak reviews are shared with team members, senior leadership, and the governing body.**

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Reprocessing

HSO 5054:2018

ROP STATEMENT

Processes for cleaning, disinfecting, and sterilizing medical devices and equipment are monitored and improvements are made when needed.

GUIDELINES

The processes of cleaning, disinfecting, and sterilizing are collectively known as reprocessing, and the level of reprocessing depends on the risk of infection (according to the Spaulding classification). Organizations reprocess equipment based on the Spaulding classification and according to manufacturers' instructions.

Monitoring reprocessing helps to identify areas for improvement and reduce health care-associated infections. The effectiveness of cleaning and disinfection can be measured by monitoring: water quality and washer function, whether appropriate concentrations of disinfectants are available, and whether disinfectants are used according to manufacturers' instructions. The effectiveness of sterilization can be monitored by measuring organic residuals, ATP (adenosine triphosphate), and total viable count; and by using test strips to confirm that devices/equipment are sterilized.

If the organization does not reprocess equipment, it has a process to ensure equipment has been appropriately reprocessed prior to use.

TESTS FOR COMPLIANCE

1. **There is evidence that processes and systems for cleaning, disinfection, and sterilization are effective.**
2. **Action has been taken to examine and improve processes for cleaning, disinfection, and sterilization where indicated.**

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Risk Assessment

Home Safety Risk Assessment

HSO 5061:2018

ROP STATEMENT

A safety risk assessment is conducted for clients receiving services in their homes.

GUIDELINES

Health services provided in a client's home present challenges for clients, families, and team members. Some of these include the unique characteristics of each client's home, the intermittent presence of team members, and the role played by families or caregivers in providing health services.

While home care agencies may have little direct control over risks in a client's home environment, a home safety risk assessment can enhance the safety of clients, families, and team members involved in home health services. Assessment results can be used to select priority service areas, identify safety strategies to include in service plans, and communicate with clients, families, caregivers, and partner organizations.

TESTS FOR COMPLIANCE

1. **A home safety risk assessment is conducted for each client at the beginning of service.**
2. **The home safety risk assessment includes a review of internal and external physical environments; chemical, biological, fire and falls hazards; medical conditions requiring special precautions; client risk factors; and emergency preparedness.**
3. **Information from the home safety risk assessment is used when planning and delivering client services and shared with partners who may be involved in care planning.**
4. **The home safety risk assessment is regularly updated and used to improve services provided to the client.**
5. **Clients and families are educated on home safety issues identified in the risk assessment.**

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Optimizing Skin Integrity

HSO 5063:2024

Notes: This content is an update to HSO 5062:2018 Pressure ulcer prevention and HSO 5063:2018 Skin and wound care. As organizations transitions to the standards listed in the *List of ROPs within Standards* this ROP will become applicable.

ROP STATEMENT

The team participates in the organization's evidence-informed program to optimize skin integrity.

TESTS FOR COMPLIANCE AND GUIDELINES

1. **The team follows the organization's procedure to conduct screening for risk of impaired skin integrity.**

   Guidelines

   Screening is a brief, evidence-informed process to proactively identify a client's health needs and risks that may require further assessment.

   The organization's procedure identifies the selected screening tools to determine a client's risk of impaired skin integrity. The selected tools are evidence-informed and appropriate for the care setting and populations served. The organization's procedure also defines when screening is conducted and repeated, such as when care begins and when a client's health status changes.

   In some care settings it may be appropriate to screen all clients for impaired skin integrity. Selective screening of clients, as defined in the organization's procedure, may be more appropriate for other care settings. If appropriate, clients may use the tools to screen themselves.

   The screening results are documented in the client's health record and individualized care plan. The information is shared with the client and other authorized team members in a clear and accessible format. The information is also shared during care transitions.

2. **The team follows the organization's procedure to ensure a comprehensive assessment is conducted for a client who screens positive for risk of impaired skin integrity.**

   Guidelines

   When screening results are positive, indicating that the client may be at risk of impaired skin integrity, a comprehensive assessment is conducted to determine appropriate interventions.

   The assessment is timely and complete as defined in the organization's procedure. If the team does not have the required competencies to conduct the assessment, a referral may be made to a specialized health care professional outside of the organization or team.

   The assessment is conducted using evidence-informed tools that reflect the services being provided, the care setting, and the populations served.

   The selected assessment tools may include methods for assessing

   - skin colour, moisture, temperature, texture, elasticity, and presence of lesions or tears;
   - the client's sensory perception, degree of physical activity, mobility, and exposure to friction, shear, moisture, and environmental risk factors;

- the client's ability to manage their own skin integrity, including maintaining good hygiene, nutrition, and hydration; and
- associated risks from co-morbidities, such as diabetes, or planned interventions, such as surgery or cancer therapies.

The information collected during the assessment is documented in the client's health record and individualized care plan. The information is shared with the client and other authorized team members in a clear and accessible format. The information is also shared during care transitions.

3. **The team implements interventions to optimize skin integrity as part of the client's individualized care plan.**

Guidelines

Interventions to optimize skin integrity are informed by the assessment results and the client's decisions about their care. Interventions may include

- implementing strategies to optimize skin integrity, such as movement, hydration, nutrition, and use of topical protectants;
- conducting safety checks and reassessments;
- reviewing medications that may impact skin integrity; and
- providing equipment or devices such as lifts, pressure-reduction cushions, or mattresses.

The selected interventions are documented in the client's health record and individualized care plan. The information is shared with the client and other authorized team members in a clear and accessible format. The interventions are regularly assessed. Client progress is measured and documented. The information is also shared during care transitions.

4. **The team follows the organization's procedure to report health care associated impaired skin integrity as a safety incident.**

Guidelines

An organizational culture of safety promotes and supports reporting of safety incidents to avoid harm, reduce errors, and lessen the impact of errors. Safety incidents are events or circumstances that could have harmed or did harm a client.

Health care associated impaired skin integrity is when a skin tear, infection, pressure, or other skin injury is caused by a care intervention or unintended variation in care.

The organization's procedure to report health care associated impaired skin integrity as a safety incident is aligned with evidence-informed practices and jurisdictional requirements. The procedure outlines what types of incidents need to be reported and how to report them. The procedure is simple, clear, and focused on system improvement.

Safety incidents are documented in the client's health record and the safety incident reporting system. The information is shared with the client and other authorized team members in a clear and accessible format as required by the organization's procedure.

Safety incidents inform the organization's integrated quality improvement plan.

5. **The team participates in continuous learning activities about the program to optimize skin integrity.**

Guidelines

Continuous learning helps the team implement safety practices to prevent harm and optimize skin integrity. As a member of the team, the client receives information and resources that enable them to play an active role in their care, make informed decisions, and manage their own health.

If the organization offers clinical practicums, students, residents, and fellows participate in the required learning activities before providing care.

Learning topics relevant to team roles and responsibilities can include

- the importance of optimizing skin integrity as a safety practice;
- identification of preventable and non-preventable risks to skin integrity;
- the importance of assessing surfaces and devices that are in contact with the skin;
- the importance of assessing devices that cross the skin barrier, such as intravenous lines; and
- reporting health care associated impaired skin integrity as a safety incident.

Learning activities are provided in various ways to engage team members with different educational backgrounds, abilities, and learning styles. Examples include in-person or virtual training and simulation sessions, awareness campaigns, reflective practice, and mentorship initiatives.

The team is involved in the development and evaluation of continuous learning activities. The team is given time to participate in, reflect on, and share learnings and experiences. Learning activities are documented.

6. **The team participates in activities to improve the program to optimize skin integrity as part of the organization's integrated quality improvement plan.**

Guidelines

Quality improvement involves a team-based approach to understanding the organization's strengths, opportunities for improvement, risks, and challenges in delivering high-quality and safe care.

Participation in quality improvement activities includes supporting the collection of quantitative and qualitative data, engaging in reflective learning practices, and providing feedback. It also includes identifying and implementing actions that improve the organization's program to optimize skin integrity.

Aims, measures, and outcomes are documented in the organization's integrated quality improvement plan. Qualitative and quantitative measures may include

- observational activities and audits of documentation to assess the team's adherence to the organization's procedures to optimize skin integrity;
- assessing the impact of interventions to prevent injury and optimize skin integrity;
- root cause analysis of safety incidents related to health care associated impaired skin integrity;
- feedback from the team, including the client, on the organization's program to optimize skin integrity; and
- feedback from the team, including the client, on the continuous learning opportunities provided by the organization on optimizing skin integrity.

The team is given time to participate in, reflect on, and share quality improvement learnings and experiences.

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Pressure Ulcer Prevention

HSO 5062:2018

Notes: This ROP does not apply for outpatient settings, including day surgery, given the lack of validated risk assessment tools for outpatient settings.
This ROP is being phased out and is replaced by HSO 5063:2024 Optimizing Skin Integrity.

ROP STATEMENT

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

GUIDELINES

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

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

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

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

A number of best practice guidelines are also available to inform the development of pressure ulcer prevention and treatment strategies, including risk assessments, reassessments, interventions, education, and evaluation.

TESTS FOR COMPLIANCE

1. **An initial pressure ulcer risk assessment is conducted for clients upon admission, using a validated, standardized risk assessment tool.**
2. **The risk of developing pressure ulcers is assessed for each client at regular intervals and when there is a significant change in the client's status.**
3. **Documented protocols and procedures based on best practice guidelines are implemented to prevent the development of pressure ulcers. These may include interventions to prevent skin breakdown; minimize pressure, shear, and friction; reposition; manage moisture; optimize nutrition and hydration; and enhance mobility and activity.**

4. **Team members, clients, families, and caregivers are provided with education about the risk factors and protocols and procedures to prevent pressure ulcers.**
5. **The effectiveness of pressure ulcer prevention is evaluated, and results are used to make improvements when needed.**

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Skin and Wound Care

HSO 5063:2018

Notes: This ROP is being phased out and is replaced by HSO 5063:2024 Optimizing Skin Integrity.

ROP STATEMENT

An interprofessional and collaborative approach is used to assess clients who need skin and wound care and provide evidence-informed care that promotes healing and reduces morbidity and mortality.

GUIDELINES

Wound healing is a complex process that depends on the client (e.g., co-morbidities, age, nutritional status, etc.), the type of skin and wound, the client's environment (e.g., cleanliness, social support, mobility aids, etc.), and what type of care is provided. Many wounds can be prevented through proper skin care and preventive measures.

Once they have occurred, most wounds can be healed through proper assessment, accurate diagnosis, appropriate treatment, and proper self-care. Appropriate care can reduce client suffering (e.g., intractable pain, infection, amputation, hospital admission, reduced quality of life) and save lives. Clients who need skin and wound care are a high-volume service (more than one-third of all home care clients need wound care) and wounds are costly to health care systems. Effective skin and wound care programs result in better client outcomes and lower costs.

Comprehensive interprofessional collaboration using standardized, evidence-informed protocols is the most effective way to provide skin and wound care. A wide range of expertise is needed, and interprofessional collaboration can be achieved in different ways (e.g., interdisciplinary teams, rounds, virtual networks, telehealth). It is important to identify when and how care providers can access expertise to ensure accurate diagnosis of the wound(s) and seamless skin and wound care. To support interprofessional collaboration, the team, clients, families and caregivers need information and education that is tailored to their roles in providing appropriate care.

Effective skin and wound care starts with a comprehensive assessment to obtain an accurate diagnosis of the wound. It includes assessing the client's skin and wound and reviewing client factors, the client's environment, and the care the client has already received. Evidence-informed best practice guidelines for skin and wound care are available. Adopting guidelines helps organizations strengthen the skin and wound care they provide through proper assessment, accurate diagnosis, appropriate products and treatments, appropriate interdisciplinary referrals, and ongoing monitoring. Given the plethora of wound care products available, care is strengthened when organizations have a standardized product list that includes criteria for use. A standardized approach for accurate and comprehensive documentation of all aspects of care is needed for professionals to communicate effectively.

Giving providers timely access to information about wounds has been shown to dramatically improve client outcomes and healing time, so organizations need a process to share complete information as the client moves between providers and services. Indicator data related to care processes and client outcomes can help evaluate the effectiveness of the approach to skin and wound care. Possible indicators include home care data (e.g., length of stay, wound dimensions, number of visits).

TESTS FOR COMPLIANCE

1. **There is a documented and coordinated approach to skin and wound care that supports physicians, nurses, and allied health care providers to work collaboratively and provides access to the range of expertise that is appropriate for the client population.**
2. **Team members have access to education on appropriate skin and wound care, including products and technologies, assessment, treatment, and documentation.**

3. **Clients, families, and caregivers are provided with information and education about skin and wound self-care, in a format that they can understand.**
4. **An evidence-informed assessment of new clients is used to determine or confirm the diagnosis of the wound and develop an individualized care plan that addresses the cause(s) of the wound.**
5. **Standardized skin and wound care that optimizes skin health and promotes healing is delivered.**
6. **Standardized documentation is implemented to create a comprehensive record of all aspects of the client's skin and wound care (including assessment, treatment goals, treatment provided, and outcomes).**
7. **There is a process to share information between providers, especially at care transitions, about the client's skin and wound care.**
8. **The effectiveness of the skin and wound care program is monitored by measuring care processes (e.g., accurate diagnosis, appropriate treatment, etc.) and outcomes (e.g., healing time, pain, etc.) and this information is used to make improvements.**

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Preventing Falls and Reducing Injuries from Falls

HSO 5060:2024

Notes: This content is an update to HSO 5060-1:2018 Fall prevention and injury reduction and HSO 5060-2:2018 Fall prevention and injury reduction – Long-term care services. As organizations transitions to the standards listed in the *List of ROPs within Standards* this ROP will become applicable.

ROP STATEMENT

The team participates in the organization's evidence-informed program to prevent falls and reduce injuries from falls.

TESTS FOR COMPLIANCE AND GUIDELINES

1. **The team follows the organization's procedures for providing a safe physical environment to prevent falls and reduce injuries from falls.**

   Guidelines

   A safe and barrier-free indoor and outdoor physical environment is essential to preventing falls and reducing injuries from falls.

   The organization's procedures are current, informed by evidence, and aligned with jurisdictional requirements. The procedures identify how to provide a safe physical environment, such as

   - keeping floors clean and dry and cleaning up spills promptly;
   - providing mobility aids and furniture that are appropriate for the population served;
   - ensuring structural features that enhance safety and accessibility are in place and in good working order, such as ramps, handrails, grab bars, non-slip flooring, and adequate lighting;
   - minimizing overcrowding and reducing clutter; and
   - conducting ongoing safety checks of the care setting and public spaces such as the cafeteria, entrance, and parking areas.

   The client, as a member of the team, is encouraged to ask questions, share concerns, and participate in conversations about the safety of the physical environment.

2. **The team follows the organization's procedure to conduct screening for risk of falls and injuries from falls.**

   Guidelines

   Screening is a brief, evidence-informed process to proactively identify a client's health needs and risks that may require further assessment.

   The organization's procedure identifies the selected screening tools to determine a client's risk of falls and injuries from falls. The selected tools are evidence-informed and appropriate for the care setting and populations served. The organization's procedure also defines when screening is conducted and repeated, such as when care begins and when a client's health status changes.

   In some care settings it may be appropriate to screen all clients for risk of falls and injuries from falls. Selective screening of clients, as defined in the organization's procedure, may be more appropriate for other care settings. If appropriate, clients may use the tools to screen themselves.

The screening results are documented in the client's health record and individualized care plan. The information is shared with the client and other authorized team members in a clear and accessible format. The information is also shared during care transitions.

3. **The team follows the organization's procedure to ensure a comprehensive assessment is conducted for a client who screens positive for risk of falls or injuries from falls.**

   Guidelines

   When screening results are positive, indicating that the client may be at risk of falls or injuries from falls, a comprehensive assessment is conducted to determine appropriate interventions.

   The assessment is timely and complete as defined in the organization's procedure. If the team does not have the required competencies to conduct the assessment, a referral may be made to a specialized health care professional outside of the organization or team.

   The assessment is conducted using evidence-informed tools that reflect the services being provided, the care setting, and the populations served. The selected tools may include methods for assessing gait, balance, mood, vision, cognition, medication history, co-morbidity, fall history, management of daily activities, and use of assistive devices.

   The information collected during the assessment is documented in the client's health record and individualized care plan. The information is shared with the client and other authorized team members in a clear and accessible format. The information is also shared during care transitions.

4. The team implements interventions to prevent falls and reduce injuries from falls as part of the client's individualized care plan.

   Guidelines

   Interventions to prevent falls and reduce injuries from falls are informed by the assessment results and the client's decisions about their care. Interventions may include

   - organizing the client's environment to minimize clutter and placing necessary items within reach;
   - client self-management techniques to protect against falls such as improving strength and balance and learning to fall safely;
   - reviewing medications that may increase risk of falls; and
   - providing equipment or devices to improve the client's safety and mobility.

   The selected interventions reflect the organization's procedure on the use of least restraint. The interventions are documented in the client's health record and individualized care plan. The information is shared with the client and other authorized team members in a clear and accessible format. The interventions are regularly assessed. Client progress is measured and documented. The information is also shared during care transitions.

5. **The team follows the organization's procedure to report falls and injuries from falls as safety incidents.**

   Guidelines

   An organizational culture of safety promotes and supports reporting of safety incidents to avoid harm, reduce errors, and lessen the impact of errors. Safety incidents are events or circumstances that could have harmed or did harm a client. Falls and injuries from falls that occur in the care setting or public space are reported as safety incidents.

The organization's procedure to report falls and injuries from falls as a safety incident is aligned with evidence-informed practices and jurisdictional requirements. The procedure outlines what types of incidents need to be reported and how to report them. The procedure is simple, clear, and focused on system improvement.

Safety incidents are documented in the client's health record and the safety incident reporting system. The information is shared with the client and other authorized team members in a clear and accessible format as required by the organization's procedure.

Safety incidents inform the organization's integrated quality improvement plan.

6. **The team participates in continuous learning activities about the program to prevent falls and reduce injuries from falls.**

Guidelines

Continuous learning helps the team implement safety practices to prevent falls and reduce injuries from falls. As a member of the team, the client receives information and resources that enable them to play an active role in their care, make informed decisions, and manage their own health.

If the organization offers clinical practicums, students, residents, and fellows participate in the required learning activities before providing care.

Learning topics relevant to team roles and responsibilities can include

- the importance of fall prevention and injury reduction as a safety practice;
- prevention strategies that engage the interdisciplinary team, such as sharing the client's mobility status on the client's communication board;
- strategies for team members to reduce their risk of falls and injuries when supporting clients; and
- what to do when a fall or injury from a fall occurs in the care setting or public space, including reporting it as a safety incident.

Learning activities are provided in various ways to engage team members with different educational backgrounds, abilities, and learning styles. Examples include in-person or virtual training and simulation sessions, awareness campaigns, reflective practice, and mentorship initiatives.

The team is involved in the development and evaluation of continuous learning activities. The team is given time to participate in, reflect on, and share learnings and experiences. Learning activities are documented.

7. **The team participates in activities to improve the program to prevent falls and reduce injuries from falls as part of the organization's integrated quality improvement plan.**

Guidelines

Quality improvement involves a team-based approach to understanding the organization's strengths, opportunities for improvement, risks, and challenges in delivering high-quality and safe care.

Participation in quality improvement activities includes supporting the collection of quantitative and qualitative data, engaging in reflective learning practices, and providing feedback. It also includes identifying and implementing actions that improve the organization's program to prevent falls and reduce injuries from falls.

Aims, measures, and outcomes are documented in the organization's integrated quality improvement plan. Qualitative and quantitative measures may include

- observational activities and audits of documentation to assess the team's adherence to the organization's procedures to prevent falls and reduce injuries from falls;
- assessing the impact of interventions to prevent falls and reduce injuries from falls;
- root cause analysis of safety incidents related to falls and injuries from falls;
- feedback from the team, including the client, on the organization's program to prevent falls and reduce injuries from falls; and
- feedback from the team, including the client, on the continuous learning activities provided by the organization on preventing falls and reducing injuries from falls.

The team is given time to participate in, reflect on, and share quality improvement learnings and experiences.

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Falls Prevention and Injury Reduction – Inpatient Services

HSO 5060-1:2018

Notes: This ROP is being phased out and is replaced by HSO 5060:2024 Preventing Falls and Reducing Injuries from Falls.

ROP STATEMENT

To prevent falls and reduce the risk of injuries from falling, universal precautions are implemented, education and information are provided, and activities are evaluated.

GUIDELINES

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

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

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

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

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

TESTS FOR COMPLIANCE

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

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Fall Prevention and Injury Reduction – Long-Term Care Services

HSO 5060-2:2018

Notes: This ROP is being phased out and is replaced by HSO 5060:2024 Preventing Falls and Reducing Injuries from Falls.

ROP STATEMENT

To prevent falls and reduce the risk of injuries from falling, a risk assessment is conducted for each resident and interventions are implemented.

GUIDELINES

Reducing falls and injuries from falls can increase quality of life, prevent loss of mobility and pain for residents, and reduce costs.

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

A wide range of risk assessment tools are available to identify specific risk profiles of residents in order to create individualized targeted fall prevention plans. Examples of risk assessment tools appropriate for long-term care include:

- Area Ellipse of Postural Sway
- Berg Balance Test
- Mobility Fall Chart

Common serious injuries that occur as a result of a fall in the elderly are hip fractures (Fuller, 2000). Recommendations for preventing fracture in long-term care can include vitamin D supplementation, use of hip protectors, exercise, multifactorial interventions, and pharmacologic therapies (Papaioannou et al., 2015).

It is important to identify and adopt assessment tools and interventions that align with the type of clinical setting and individual needs of residents, including their right to live at risk.

Education about the risk assessment, protocol, and procedures to prevent falls and reduce injuries from falling is provided regularly to team members and volunteers. Residents, families, and caregivers are provided with easy to understand information that empowers them to play an active role in fall prevention and injury reduction.

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

TESTS FOR COMPLIANCE

1. **An initial fall prevention and injury reduction risk assessment is conducted for residents upon admission, using a standardized tool.**

2. **A standardized process is followed to reassess residents at regular intervals and when there is a significant change in their health status.**
3. **Protocols and procedures (based on best practice guidelines when available and applicable to the setting) are implemented to prevent falls and reduce injuries from falling.**
4. **Interventions to prevent falls and reduce injuries from falling are documented in the resident record and communicated to the team.**
5. **Team members and volunteers are educated, and residents, families, and caregivers are provided with information to prevent falls and reduce injuries from falling.**
6. **The effectiveness of fall prevention and injury reduction activities (e.g., risk assessment process and tools, protocols and procedures, documentation, education, and information) are evaluated, and results are used to make improvements when needed.**

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Preventing Venous Thromboembolism

HSO 5065:2024

Notes: This content is an update to HSO 5065:2018 Venous thromboembolism (VTE) prophylaxis. As organizations transitions to the standards listed in the *List of ROPs within Standards* this ROP will become applicable.

ROP STATEMENT

The team participates in the organization's evidence-informed program to prevent venous thromboembolism.

TESTS FOR COMPLIANCE AND GUIDELINES

1. **The team follows the organization's procedure to conduct screening for risk of venous thromboembolism.**

   Guidelines

   Screening is a brief, evidence-informed process to proactively identify a client's health needs and risks that may require further assessment.

   The organization's procedure identifies the selected screening tools to determine a client's risk of venous thromboembolism. The selected tools are evidence-informed and appropriate for the care setting and populations served. The organization's procedure also defines when screening is conducted and repeated, such as when care begins and when a client's health status changes.

   The selected screening tools identify risk factors for venous thromboembolism such as the client's history of venous thromboembolism, decreased mobility, advanced age, health conditions, and specified surgical and interventional procedures.

   In some care settings, it may be appropriate to screen all clients receiving care for risk of venous thromboembolism. Selective screening of clients, as defined in the organization's procedure, may be more appropriate for other care settings. If appropriate, clients may use the tools to screen themselves.

   The screening results are documented in the client's health record and individualized care plan. The information is shared with the client and other authorized team members in a clear and accessible format. The information is also shared during care transitions.

2. **The team follows the organization's procedure to use clinical decision support tools to determine appropriate interventions for a client who screens positive for risk of venous thromboembolism.**

   Guidelines

   Clinical decision support tools provide the team, including the client, with evidence-informed information to support decision-making. Clinical decision support tools may be embedded in order sets.

   When screening results are positive, indicating that the client may be at risk of venous thromboembolism, evidence-informed clinical decision support tools are used to determine appropriate interventions. If the team does not have the required competencies to determine appropriate interventions, a referral may be made to a specialized health care professional outside of the organization or team.

   The information collected from the use of the clinical decision support tools is documented in the client's health record and individualized care plan. The information is shared with the client and other authorized team members in a clear and accessible format. The information is also shared during care transitions.

3. **The team implements interventions to prevent venous thromboembolism as part of the client's individualized care plan.**

   Guidelines

   Interventions to prevent venous thromboembolism are informed by the clinical decision support tools and the client's decisions about their care. Interventions may include

   - daily strategies such as hydration, mobilization, positioning, and wearing loose-fitting clothing;
   - longer-term strategies such as maintaining a healthy weight and avoiding a sedentary lifestyle;
   - pharmacological thromboprophylaxis; and
   - mechanical thromboprophylaxis, such as using an intermittent pneumatic device.

   The timing of initiation, duration, and monitoring requirements for thromboprophylaxis interventions are specified and tailored to the characteristics of the client. Client characteristics include risk of bleeding, weight, physiological functions, and risk factors such as falls and skin integrity.

   The selected interventions are documented in the client's health record and individualized care plan. The information is shared with the client and other authorized team members in a clear and accessible format. The interventions are regularly assessed. Client progress is measured and documented. The information is also shared during care transitions.

4. **The team follows the organization's procedure to report health care associated venous thromboembolism as a safety incident.**

   Guidelines

   An organizational culture of safety promotes and supports reporting of safety incidents to avoid harm, reduce errors, and lessen the impact of errors. Safety incidents are events or circumstances that could have harmed or did harm a client.

   Health care associated venous thromboembolism is when a blood clot in a vein or in the lungs is caused by a care intervention.

   The organization's procedure to report health care associated venous thromboembolism as a safety incident is aligned with evidence-informed practices and jurisdictional requirements. The procedure outlines what types of incidents need to be reported and how to report them. The procedure is simple, clear, and focused on system improvement.

   Safety incidents are documented in the client's health record and the safety incident reporting system. The information is shared with the client and other authorized team members in a clear and accessible format as required by the organization's procedure.

   Safety incidents inform the organization's integrated quality improvement plan.

5. **The team participates in continuous learning activities about the program to prevent venous thromboembolism.**

   Guidelines

   Continuous learning helps the team implement safety practices to prevent venous thromboembolism. As a member of the team, the client receives information and resources that enable them to play an active role in their care, make informed decisions, and manage their own health.

   If the organization offers clinical practicums, students, residents, and fellows participate in the required learning activities before providing care.

Learning topics relevant to team roles and responsibilities can include

- the importance of venous thromboembolism prevention as a safety practice;
- current guidance on identifying a client's risk of venous thromboembolism and appropriate preventive strategies including pharmacological and mechanical interventions; and
- reporting health care associated venous thromboembolism incidents as safety incidents.

Learning activities are provided in various ways to engage team members with different educational backgrounds, abilities, and learning styles. Examples include in-person or virtual training and simulation sessions, awareness campaigns, reflective practice, and mentorship initiatives.

The team is involved in the development and evaluation of continuous learning activities. The team is given time to participate in, reflect on, and share learnings and experiences. Learning activities are documented.

6. **The team participates in activities to improve the program to prevent venous thromboembolism as part of the organization's integrated quality improvement plan.**

Guidelines

Quality improvement involves a team-based approach to understanding the organization's strengths, opportunities for improvement, risks, and challenges in delivering high-quality and safe care.

Participation in quality improvement activities includes supporting the collection of quantitative and qualitative data, engaging in reflective learning practices, and providing feedback. It also includes identifying and implementing actions that improve the organization's program to prevent venous thromboembolism.

Aims, measures, and outcomes are documented in the organization's integrated quality improvement plan. Qualitative and quantitative measures may include

- observational activities and audits of documentation to assess the team's adherence to the organization's procedures to prevent venous thromboembolism;
- assessing the impact of interventions to prevent venous thromboembolism;
- root cause analysis of safety incidents related to health care associated venous thromboembolism;
- feedback from the team, including the client, on the organization's program to prevent venous thromboembolism; and
- feedback from the team, including the client, on the continuous learning opportunities provided by the organization on venous thromboembolism prevention.

The team is given time to participate in, reflect on, and share quality improvement learnings and experiences.

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Venous Thromboembolism (VTE) Prophylaxis

HSO 5065:2018

Notes: This ROP is being phased out and is replaced by HSO 5065:2024 Preventing Venous Thromboembolism. This ROP does not apply for pediatric hospitals; it only applies to clients 18 years of age or older. This ROP does not apply to day procedures or procedures with only an overnight stay.

ROP STATEMENT

Medical and surgical clients at risk of venous thromboembolism (deep vein thrombosis and pulmonary embolism) are identified and provided with appropriate thromboprophylaxis.

GUIDELINES

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

VTE is a serious and common complication for those in hospital or undergoing surgery. The incidence of VTE can be reduced or prevented by identifying clients at risk and providing appropriate, evidence-informed thromboprophylaxis.

The widespread human and financial impact of thromboembolism is well documented. VTE is associated with increased client mortality; it is the most common preventable cause of hospital death. Appropriate evidence-informed thromboprophylaxis reduces cost and median length of stay.

There are many evidence-based clinical practice guidelines that recommend thromboprophylaxis for large groups of clients or for specific subgroups that are very useful and generally reflect the accepted standard of practice.

TESTS FOR COMPLIANCE

1. **There is a written venous thromboembolism (VTE) prophylaxis policy or guideline.**
2. **Clients at risk for VTE are identified and provided with appropriate, evidence-informed VTE prophylaxis.**
3. **Measures for appropriate VTE prophylaxis are established, the implementation of appropriate VTE prophylaxis is audited, and this information is used to make improvements to services.**
4. **Major orthopedic surgery clients (i.e., those having hip and knee replacements or hip fracture surgery) who require post-discharge prophylaxis are identified and there is a process to provide them with appropriate post-discharge prophylaxis.**
5. **Information is provided to clients and team members about the risks of VTE and how to prevent it.**

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Suicide Prevention Program

HSO A5064:2023

Notes: This content is an update to HSO 5064:2018 Suicide prevention. As organizations transition to the standards listed in the *List of ROPs within Standards* this ROP will become applicable.
The HSO A5064:2023 Suicide Prevention Program Required Organizational Practice (ROP) is a derivative of the CAN/HSO 5064:2023 Suicide Prevention Program standard.

ROP STATEMENT

The team leadership ensures the team demonstrates the required competencies to follow organizational procedures to prevent suicide.

TESTS FOR COMPLIANCE

1. **The team leadership ensures the team follows organizational procedures to minimize safety risks and ensure a secure environment for all.**

   Guidelines

   The team conducts regular safety checks of the physical environment to minimize risks to clients, designated support persons, and the workforce, regardless of the care settings.

   Clients and their designated support persons are involved in identifying risks and determining what needs to be done to keep themselves safe irrespective of care settings. The individualized safety plan should include client-specific measures to minimize risk.

   The safety checks are conducted transparently and the results are made available to the relevant stakeholders. The team works towards the maintenance of a safe environment for all.

2. **The team leadership ensures the team receives appropriate training and education to deliver safe suicide prevention services.**

   Guidelines

   Training and education are fundamental to enabling a team to conduct screening, assessment and provide safety planning for suicide prevention including care planning for populations experiencing potential risk for suicide. Having the appropriate skills, behaviours and attitudes is important to deliver suicide risk assessment, appropriate interventions and postvention services.

   The team is provided with culturally safe training to deliver suicide prevention and support services that match the goals, abilities, and preferences of the population they serve.

3. **The team leadership ensures the team conducts standardized routine screening for suicide risk, using evidence-informed tools provided by the organizational leaders.**

   Guidelines

   The team conducts suicide risk screening as an initial step to determine the need for a suicide risk assessment and intervention. It then implements the appropriate follow-up in the event of positive screens. The information that is collected during the suicide risk screening is recorded and documented in the client record so appropriate team members can easily access the information.

   The suicide risk screening tools are evidence-informed and appropriate to the care setting in which the screening is conducted. In some care settings, universal screening (i.e., screening of all clients who are in contact with the organization) may be appropriate when needing to identify those who may not have

otherwise self-identified as suicidal or experiencing potential risk for suicide. However, selective screening of clients with warning signs and/or risk factors for suicide or who are in physical or mental distress may be more appropriate for other settings.

4. **The team leadership ensures the team refers clients who screen positive for suicide risk to a person with the competencies to do a suicide risk assessment and put the necessary safety plan in place.**

   Guidelines

   When the screening identifies a risk for suicide, the client is kept safe, a timely suicide risk assessment is conducted, and a safety plan is developed with the client. The team may refer the client to a person with the competencies, either within or outside the organization, to conduct a suicide risk assessment. The person is a competent team member who has the skills, attitudes, and behaviours to conduct the suicide risk assessment. The team follows appropriate guidelines for the referral to ensure it is timely and complete and based on the level of risk identified during the screening.

   The risk of suicide is higher during transitions of care and is a possible deficiency in the delivery of safe care. When a care transition is necessary, the team ensures information relevant to the care of the client is communicated effectively. There is a potential safety risk during care transition when relevant information is not transferred appropriately.

5. **The team leadership ensures the team develops an individualized safety plan, based on the goals, abilities and preferences of the person.**

   Guidelines

   Based on the result of the suicide risk screening and/or assessment, the team develops an individualized safety plan for suicide prevention that:

   - Includes reasons for living (“What is important to the client?”)
   - Is culturally safe
   - Addresses imminent behaviours that can cause harm to self or others
   - Includes personal warning signs
   - Ensures the person is being provided with the care in the safest care setting
   - Identifies the designated support person, caring contact or most relevant care provider to call in case of an emergency or when help is needed
   - Provides information on accessing local crisis services
   - Focuses on reducing access to lethal means (could include medication overdose, dangerous chemicals and weaponry)

   The individualized safety plan is based on the needs and level of risk of the client that may include a care transition recommendation. The underlying objective of the safety plan is to ensure the ongoing support and safety of the client.

   The individualized safety plan is documented and shared with the client and the appropriate team members and could be accessible to the designated support person and/or caring contact with the client’s consent. The individualized safety plan includes any care transition planning. The individualized safety plan is regularly re-assessed. When possible and coherent with care-setting, in addition to safety planning, developing an intervention plan that includes the client’s goal for recovery as an integrated practice, that mitigates risks of recurring suicidal ideation.

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Suicide Prevention

HSO 5064:2018

Notes: This ROP is being phased out and is replaced by HSO A5064:2023 Suicide Prevention Program Required Organizational Practice.

ROP STATEMENT

Clients are assessed and monitored for risk of suicide.

GUIDELINES

Suicide is a global health concern. Every year more than 800,000 people die by suicide, according to the World Health Organization. Many of these deaths could be prevented by early recognition of the signs of suicidal thinking and offering appropriate intervention.

TESTS FOR COMPLIANCE

1. **Clients at risk of suicide are identified.**
2. **The risk of suicide for each client is assessed at regular intervals or as needs change.**
3. **The immediate safety needs of clients identified as being at risk of suicide are addressed.**
4. **Treatment and monitoring strategies are identified for clients assessed as being at risk of suicide.**
5. **Implementation of the treatment and monitoring strategies is documented in the client record.**

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List of ROPs within Standards

Most up-to-date ROPs	Standards	ROPs that will be phased out	Standards
Safety Culture: Create a culture of safety within the organization.			
☐ **HSO 5000:2021 Accountablity for quality of care**	HSO A1001:2022 Governance	☐ **HSO 5000:2018 Accountability for quality**	HSO A1001:2018 Governance HSO 1002:2018 Governance for Aboriginal Health Services
☐ **HSO 5001:2018 Patient safety incident disclosure**	HSO A42002:2019 Diagnostic Imaging HSO A42002:2024 Diagnostic Imaging HSO A34010:2018 Independent Medical/ Surgical Facilities HSO A34010:2024 Independent Medical/ Surgical Facilities HSO A2001:2020 Leadership HSO A2002:2018 Leadership for Aboriginal Health Services HSO A42003:2018 Medical Imaging Centres HSO A42003:2024 Medical Imaging Centres		
☐ **HSO 5002:2018 Patient safety incident management**	HSO A42002:2019 Diagnostic Imaging Services HSO A42002:2024 Diagnostic Imaging Services HSO A34010:2018 Independent Medical/ Surgical Facilities HSO A34010:2024 Independent Medical/ Surgical Facilities HSO A2001:2020 Leadership		

Most up-to-date ROPs	Standards	ROPs that will be phased out	Standards
	HSO A2002:2018 Leadership for Aboriginal Health Services HSO A42003:2018 Medical Imaging Centres HSO A42003:2024 Medical Imaging Centres		
☐ **HSO 5003:2018 Patient safety quarterly reports**	HSO A34010:2018 Independent Medical/ Surgical Facilities HSO A34010:2024 Independent Medical/ Surgical Facilities HSO A2002:2018 Leadership for Aboriginal Health Services		
Communication: Improve the effectiveness and coordination of communication among care and service providers and with the recipients of care and service across the continuum.			
☐ **HSO 5011:2024 Adhering to a Do-Not-Use List of Abbreviations, Symbols, and Dose Designations**	HSO A41001:2024 Emergency Medical Services and Interfacility Transport HSO A34010:2024 Independent Medical/ Surgical Facilities HSO A42003:2024 Medical Imaging Centres HSO A3001:2024 Medication Management HSO A34014:2024 Medication Management for Community-Based Organizations	☐ **HSO 5011-1:2018 'Do Not Use' list of abbreviations**	HSO A34010:2018 Independent Medical/ Surgical Facilities HSO A3001:2019 Medication Management HSO A34015:2020 Primary Health Care Services
		☐ **HSO 5011-2:2018 'Do Not Use' list of abbreviations – Community Pharmacy**	HSO A51001:2018 Community Pharmacy Services HSO A34014:2019 Medication Management for Community-Based Organizations
☐ **HSO 5010:2018 Client identification**	HSO A34002:2018 Aboriginal Integrated Primary Care Services HSO A34002:2024 Aboriginal Integrated Primary Care Services HSO A34003:2018 Acquired Brain Injury Services		

Most up-to-date ROPs	Standards	ROPs that will be phased out	Standards
	HSO A34003:2024 Acquired Brain Injury Services		
	HSO A34004:2018 Ambulatory Care Services		
	HSO A34004:2024 Ambulatory Care Services		
	HSO A34101:2018 Assisted Reproductive Technology (ART) Clinical Services		
	HSO A34101:2024 Assisted Reproductive Technology (ART) Clinical Services		
	HSO A42001:2018 Biomedical Laboratory Services		
	HSO A42001:2024 Biomedical Laboratory Services		
	HSO A34005:2018 Cancer Care		
	HSO A34005:2024 Cancer Care		
	HSO A51001:2018 Community Pharmacy Services		
	HSO A34008:2018 Correctional Service of Canada Health Services		
	HSO A11001:2018 Critical Care		
	HSO A11001:2024 Critical Care		
	HSO A32001:2018 Dental Services		
	HSO A32001:2024 Dental Services		
	HSO A42002:2019 Diagnostic Imaging Services		
	HSO A42002:2024 Diagnostic Imaging Services		
	HSO A11002:2018 Emergency Department		
	HSO A11002:2024 Emergency Department		

Most up-to-date ROPs	Standards	ROPs that will be phased out	Standards
	HSO A41001:2018 Emergency Medical Services and Interfacility Transport		
	HSO A41001:2024 Emergency Medical Services and Interfacility Transport		
	HSO A35001:2018 Home Care Services		
	HSO A35001:2024 Home Care Services		
	HSO A35002:2018 Home Support Services		
	HSO A35002:2024 Home Support Services		
	HSO A34010:2018 Independent Medical/ Surgical Facilities		
	HSO A34010:2024 Independent Medical/ Surgical Facilities		
	HSO A11004:2018 Inpatient Services		
	HSO A11004:2024 Inpatient Services		
	HSO A21001:2020 Long-term Care Services		
	HSO A21001:2023 Long-Term Care Services		
	HSO A42003:2018 Medical Imaging Centres		
	HSO A42003:2024 Medical Imaging Centres		
	HSO A34019:2018 Mental Health Services		
	HSO A11005:2018 Obstetrics Services		
	HSO A11005:2024 Obstetrics Services		
	HSO A11007:2018 Organ and Tissue Transplant		
	HSO A11007:2024 Organ and Tissue Transplant		
	HSO A11008:2018 Organ Donation for Living Donors		
	HSO A11008:2024 Organ Donation for Living Donors		

Most up-to-date ROPs	Standards	ROPs that will be phased out	Standards
	HSO A13001:2024 Palliative Care Services		
	HSO A11009:2018 Perioperative Services & Invasive Procedures		
	HSO A11009:2024 Perioperative Services & Invasive Procedures		
	HSO A42004:2018 Point-of-care Testing		
	HSO A34015:2020 Primary Health Care Services		
	HSO A34015:2024 Primary Health Care Services		
	HSO A34017:2018 Provincial Correctional Health Services		
	HSO A34017:2024 Provincial Correctional Health Services		
	HSO A11010:2018 Rehabilitation Services		
	HSO A11010:2024 Rehabilitation Services		
	HSO A34018:2018 Remote/Isolated Health Services		
	HSO A34018:2024 Remote/Isolated Health Services		
	HSO S3401:2018 Spinal Cord Injury Acute Services		
	HSO S3402:2018 Spinal Cord Injury Rehabilitation Services		
	HSO A22004:2018 Substance Abuse and Problem Gambling		
	HSO A42005:2018 Transfusion Services		
☐ **HSO 5012:2018 Information transfer at care transitions**	HSO A34002:2018 Aboriginal Integrated Primary Care Services		

Most up-to-date ROPs	Standards	ROPs that will be phased out	Standards
	HSO A34002:2024 Aboriginal Integrated Primary Care Services		
	HSO A22001:2018 Aboriginal Substance Misuse Services		
	HSO A22001:2024 Aboriginal Substance Misuse Services		
	HSO A34003:2018 Acquired Brain Injury Services		
	HSO A34003:2024 Acquired Brain Injury Services		
	HSO A34004:2018 Ambulatory Care Services		
	HSO A34004:2024 Ambulatory Care Services		
	HSO A34101:2018 Assisted Reproductive Technology (ART) Clinical Services		
	HSO A34101:2024 Assisted Reproductive Technology (ART) Clinical Services		
	HSO A34005:2018 Cancer Care		
	HSO A34005:2024 Cancer Care		
	HSO A71002:2018 Case Management Services		
	HSO A71002:2024 Case Management Services		
	HSO A34007:2018 Community-Based Mental Health Services and Supports		
	HSO A34008:2018 Correctional Service of Canada Health Services		
	HSO A11001:2018 Critical Care		
	HSO A11001:2024 Critical Care		
	HSO A32001:2018 Dental Services		
	HSO A32001:2024 Dental Services		

Most up-to-date ROPs	Standards	ROPs that will be phased out	Standards
	HSO A42002:2019 Diagnostic Imaging Services		
	HSO A42002:2024 Diagnostic Imaging Services		
	HSO A11002:2018 Emergency Department		
	HSO A11002:2024 Emergency Department		
	HSO A41001:2018 Emergency Medical Services and Interfacility Transport		
	HSO A41001:2024 Emergency Medical Services and Interfacility Transport		
	HSO A35001:2018 Home Care Services		
	HSO A35001:2024 Home Care Services		
	HSO A35002:2018 Home Support Services		
	HSO A35002:2024 Home Support Services		
	HSO A11004:2018 Inpatient Services		
	HSO A11004:2024 Inpatient Services		
	HSO A34009:2018 Intellectual and Developmental Disabilities Services		
	HSO A34009:2024 Intellectual and Developmental Disabilities Services		
	HSO A21001:2020 Long-term Care Services		
	HSO A21001:2023 Long-Term Care Services		
	HSO A34019:2018 Mental Health Services		
	HSO A11005:2018 Obstetrics Services		
	HSO A11005:2024 Obstetrics Services		
	HSO A11007:2018 Organ and Tissue Transplant		
	HSO A11007:2024 Organ and Tissue Transplant		

Most up-to-date ROPs	Standards	ROPs that will be phased out	Standards
	HSO A11008:2018 Organ Donation for Living Donors		
	HSO A11008:2024 Organ Donation for Living Donors		
	HSO A13001:2024 Palliative Care Services		
	HSO A11009:2018 Perioperative Services & Invasive Procedures		
	HSO A11009:2024 Perioperative Services & Invasive Procedures		
	HSO A34015:2020 Primary Health Care Services		
	HSO A34015:2024 Primary Health Care Services		
	HSO A34017:2018 Provincial Correctional Health Services		
	HSO A34017:2024 Provincial Correctional Health Services		
	HSO A11010:2018 Rehabilitation Services		
	HSO A11010:2024 Rehabilitation Services		
	HSO A34018:2018 Remote/Isolated Health Services		
	HSO A34018:2024 Remote/Isolated Health Services		
	HSO A29001:2018 Residential Homes for Seniors		
	HSO A29001:2024 Residential Homes for Seniors		
	HSO S3401:2018 Spinal Cord Injury Acute Services		
	HSO S3402:2018 Spinal Cord Injury Rehabilitation Services		

Most up-to-date ROPs	Standards	ROPs that will be phased out	Standards
	HSO A22004:2018 Substance Abuse and Problem Gambling		
☐ **HSO 5014:2024 Maintaining an Accurate List of Medications during Care Transitions**	HSO A34001:2024 Aboriginal Community Health and Wellness HSO A34002:2024 Aboriginal Integrated Primary Care Services HSO A22001:2024 Aboriginal Substance Misuse Services HSO A34003:2024 Acquired Brain Injury Services HSO A34004:2024 Ambulatory Care Services HSO A34101:2024 Assisted Reproductive Technology (ART) Clinical Services HSO A34005:2024 Cancer Care HSO A71002:2024 Case Management HSO A82001:2024 Child, Youth and Family Services HSO A34006:2024 Community Health Services HSO A11001:2024 Critical Care Services HSO A32001:2024 Dental Services HSO A42002:2024 Diagnostic Imaging Services HSO A11002:2024 Emergency Department HSO A41001:2024 Emergency Medical Services and Interfacility Transport HSO A35001:2024 Home Care Services HSO A35002:2024 Home Support Services	☐ **HSO 5014-1:2018 Medication reconciliation at care transitions – Acute care services (inpatient)**	HSO A34003:2018 Acquired Brain Injury Services HSO A34005:2018 Cancer Care HSO A34017:2018 Provincial Correctional Health Services HSO A34008:2018 Correctional Service of Canada Health Services HSO A11001:2018 Critical Care HSO A11004:2018 Inpatient Services HSO A34019:2018 Mental Health Services HSO A11005:2018 Obstetrics Services HSO A11009:2018 Perioperative Services & Invasive Procedures HSO A11010:2018 Rehabilitation Services HSO S3401:2018 Spinal Cord Injury Acute Services HSO S3402:2018 Spinal Cord Rehabilitation Services
		☐ **HSO 5014-2:2018 Medication reconciliation at care transitions – Ambulatory care services**	HSO A34002:2018 Aboriginal Integrated Primary Care Services HSO A34004:2018 Ambulatory Care Services HSO A34005:2018 Cancer Care HSO A34018:2018 Remote/Isolated Health Services

Most up-to-date ROPs	Standards	ROPs that will be phased out	Standards
	HSO A34010:2024 Independent Medical/Surgical Facilities HSO A11004:2024 Inpatient Services HSO A34009:2024 Intellectual and Developmental Disabilities Services HSO A21001:2023 Long-Term Care Services HSO A42003:2024 Medical Imaging Centres HSO A22004:2023 Mental Health and Addictions Services HSO A11005:2024 Obstetrics Services HSO A11007:2024 Organ and Tissue Transplant HSO A11008:2024 Organ Donation for Living Donors HSO A13001:2024 Palliative Care Services HSO A11009:2024 Perioperative Services & Invasive Procedures HSO A34015:2024 Primary Health Care Services HSO A34017:2024 Provincial Correctional Health Services HSO A11010:2024 Rehabilitation Services HSO A34018:2024 Remote/Isolated Health Services HSO A29001:2024 Residential Homes for Seniors	☐ **HSO 5014-3:2018 Medication reconciliation at care transitions – Home and Community care services**	HSO A22001:2018 Aboriginal Substance Misuse Services HSO A71002:2018 Case Management Services HSO A34007:2018 Community-Based Mental Health Services and Supports HSO A35001:2018 Home Care Services HSO A22004:2018 Substance Abuse and Problem Gambling
		☐ **HSO 5014-4:2018 Medication reconciliation at care transitions – Emergency department**	HSO A11002:2018 Emergency Department
		☐ **HSO 5014-5:2018 Medication reconciliation at care transitions – Long-term care services**	HSO A21001:2020 Long-term Care Services HSO A29001:2018 Residential Homes for Seniors
☐ **HSO 5013:2018 Medication reconciliation as a strategic priority**	HSO A2001:2020 Leadership HSO A2002:2018 Leadership for Aboriginal Health Services		

Most up-to-date ROPs	Standards	ROPs that will be phased out	Standards
☐ **HSO 5021:2018 Safe surgery checklist**	HSO A34010:2018 Independent Medical/Surgical Facilities HSO A34010:2024 Independent Medical/Surgical Facilities HSO A11005:2018 Obstetrics Services HSO A11005:2024 Obstetrics Services HSO A11007:2018 Organ and Tissue Transplant HSO A11007:2024 Organ and Tissue Transplant HSO A11008:2018 Organ Donation for Living Donors HSO A11008:2024 Organ Donation for Living Donors HSO A11009:2018 Perioperative Services & Invasive Procedures HSO A11009:2024 Perioperative Services & Invasive Procedures		
Medication Use: Ensure the safe use of high-risk medications.			
☐ **HSO 5030:2018 Antimicrobial stewardship**	HSO A3001:2019 Medication Management HSO A3001:2024 Medication Management		
☐ **HSO 5034:2018 Infusion pump safety**	HSO A34008:2018 Correctional Service of Canada Health Services HSO A41001:2018 Emergency Medical Services and Interfacility Transport HSO A41001:2024 Emergency Medical Services and Interfacility Transport HSO A34010:2018 Independent Medical/ Surgical Facilities		

Most up-to-date ROPs	Standards	ROPs that will be phased out	Standards
	HSO A34010:2024 Independent Medical/ Surgical Facilities HSO A11007:2018 Organ and Tissue Transplant HSO A11007:2024 Organ and Tissue Transplant HSO A11008:2018 Organ Donation for Living Donors HSO A11008:2024 Organ Donation for Living Donors HSO A0001:2020 Service Excellence HSO A0001:2024 Service Excellence		
☐ **HSO 5035:2024 Limiting High Concentration and High Total Dose Opioid Formulations**	HSO A41001:2024 Emergency Medical Services and Interfacility Transport HSO A34010:2024 Independent Medical/ Surgical Facilities HSO A42003:2024 Medical Imaging Centres HSO A3001:2024 Medication Management HSO A34014:2024 Medication Management for Community-Based Organizations	☐ **HSO 5035:2018 Narcotics safety**	HSO A41001:2018 Emergency Medical Services and Interfacility Transport HSO A34010:2018 Independent Medical/ Surgical Facilities HSO A3001:2019 Medication Management HSO A34014:2019 Medication Management for Community-Based Organizations
☐ **HSO 5033:2024 Managing High Alert Medications**	HSO A41001:2024 Emergency Medical Services and Interfacility Transport HSO A34010:2024 Independent Medical/ Surgical Facilities HSO A42003:2024 Medical Imaging Centres HSO A3001:2024 Medication Management HSO A34014:2024 Medication Management for Community-Based Organizations	☐ **HSO 5033-1:2018 High-alert medications**	HSO A41001:2018 Emergency Medical Services and Interfacility Transport HSO A34010:2018 Independent Medical/ Surgical Facilities HSO A3001:2019 Medication Management
		☐ **HSO 5033-2:2018 High-alert medications – Community pharmacy**	HSO A51001:2018 Community Pharmacy Services

Most up-to-date ROPs	Standards	ROPs that will be phased out	Standards
			HSO A34014:2019 Medication Management for Community-Based Organizations
		☐ **HSO 5031:2018 Concentrated electrolytes**	HSO A3001:2019 Medication Management HSO A34014:2019 Medication Management for Community-Based Organizations
		☐ **HSO 5032:2018 Heparin safety**	HSO A3001:2019 Medication Management HSO A34014:2019 Medication Management for Community-Based Organizations
Work-life/Workforce: Create a work-life and physical environment that supports the safe delivery of care and service.			
☐ **HSO 5040:2021 Client flow**	HSO A2001:2020 Leadership	☐ **HSO 5040:2018 Client flow**	HSO A2001:2018 Leadership
☐ **HSO 5041:2018 Patient safety: education and training**	HSO A34010:2018 Independent Medical/ Surgical Facilities HSO A34010:2024 Independent Medical/ Surgical Facilities HSO A2001:2020 Leadership HSO A2002:2018 Leadership for Aboriginal Health Services HSO A42003:2018 Medical Imaging Centres HSO A42003:2024 Medical Imaging Centres		
☐ **HSO 5042:2018 Patient safety plan**	HSO A34010:2018 Independent Medical/ Surgical Facilities HSO A34010:2024 Independent Medical/ Surgical Facilities		

Most up-to-date ROPs	Standards	ROPs that will be phased out	Standards
	HSO A2002:2018 Leadership for Aboriginal Health Services HSO A42003:2018 Medical Imaging Centres HSO A42003:2024 Medical Imaging Centres		
☐ **HSO 5043:2018 Preventive maintenance program**	HSO A34010:2018 Independent Medical/ Surgical Facilities HSO A34010:2024 Independent Medical/ Surgical Facilities HSO A2001:2020 Leadership HSO A2002:2018 Leadership for Aboriginal Health Services HSO A42003:2018 Medical Imaging Centres HSO A42003:2024 Medical Imaging Centres		
☐ **HSO 5044:2018 Workplace violence prevention**	HSO A34010:2018 Independent Medical/ Surgical Facilities HSO A34010:2024 Independent Medical/ Surgical Facilities HSO A2001:2020 Leadership HSO A2002:2018 Leadership for Aboriginal Health Services		
Infection Prevention and Control: Reduce the risk of health care-associated infections and their impact across the continuum of care/service.			
☐ **HSO 5055:2024 Cleaning and Low-Level Disinfection of Medical Equipment**	HSO A41001:2024 Emergency Medical Services and Interfacility Transport HSO A34010:2024 Independent Medical/Surgical Facilities HSO A4001:2024 Infection Prevention and Control		

Most up-to-date ROPs	Standards	ROPs that will be phased out	Standards
	HSO A22002:2024 Infection Prevention and Control for Aboriginal Substance Misuse Services HSO A34011:2024 Infection Prevention and Control for Community-Based Organizations HSO A42003:2024 Medical Imaging Centres		
☐ **HSO 5050:2024 Improving Hand Hygiene Practice**	HSO A41001:2024 Emergency Medical Services and Interfacility Transport HSO A34010:2024 Independent Medical/Surgical Facilities HSO A4001:2024 Infection Prevention and Control HSO A22002:2024 Infection Prevention and Control for Aboriginal Substance Misuse Services HSO A34011:2024 Infection Prevention and Control for Community-Based Organizations HSO A42003:2024 Medical Imaging Centres	☐ **HSO 5050:2018 Hand-hygiene compliance**	HSO A34101:2018 Assisted Reproductive Technology (ART) Clinical Services HSO A41001:2018 Emergency Medical Services and Interfacility Transport HSO A34010:2018 Independent Medical/ Surgical Facilities HSO A4001:2018 Infection Prevention and Control HSO A22001:2018 Infection Prevention and Control for Aboriginal Substance Misuse Services HSO A34011:2018 Infection Prevention and Control for Community-Based Organizations HSO A42003:2018 Medical Imaging Centres HSO A34015:2020 Primary Health Care Services
		☐ **HSO 5051:2018 Hand-hygiene education and training**	HSO A34101:2018 Assisted Reproductive Technology (ART) Clinical Services HSO A41001:2018 Emergency Medical Services and Interfacility Transport HSO A34010:2018 Independent Medical/ Surgical Facilities

Most up-to-date ROPs	Standards	ROPs that will be phased out	Standards
			HSO A4001:2018 Infection Prevention and Control HSO A22001:2018 Infection Prevention and Control for Aboriginal Substance Misuse Services HSO A34011:2018 Infection Prevention and Control for Community-Based Organizations HSO A42003:2018 Medical Imaging Centres
☐ **HSO 5052:2018 Infection rates**	HSO A4001:2018 Infection Prevention and Control HSO A34011:2018 Infection Prevention and Control for Community-Based Organizations		
☐ **HSO 5054:2018 Reprocessing**	HSO A41001:2018 Emergency Medical Services and Interfacility Transport HSO A34010:2018 Independent Medical/ Surgical Facilities HSO A4001:2018 Infection Prevention and Control HSO A34011:2018 Infection Prevention and Control for Community-Based Organizations HSO A42003:2018 Medical Imaging Centres		
Risk Assessment: Identify safety risks inherent in the client population.			
☐ **HSO 5061:2018 Home safety risk assessment**	HSO A35001:2018 Home Care Services HSO A35001:2024 Home Care Services HSO A35002:2018 Home Support Services HSO A35002:2024 Home Support Services		

Most up-to-date ROPs	Standards	ROPs that will be phased out	Standards
☐ **HSO 5063:2024 Optimizing Skin Integrity**	HSO A34001:2024 Aboriginal Community Health and Wellness HSO A34002:2024 Aboriginal Integrated Primary Care Services HSO A22001:2024 Aboriginal Substance Misuse Services HSO A34003:2024 Acquired Brain Injury Services HSO A34004:2024 Ambulatory Care Services HSO A34101:2024 Assisted Reproductive Technology (ART) Clinical Services HSO A34005:2024 Cancer Care HSO A71002:2024 Case Management HSO A82001:2024 Child, Youth and Family Services HSO A34006:2024 Community Health Services HSO A11001:2024 Critical Care Services HSO A32001:2024 Dental Services HSO A42002:2024 Diagnostic Imaging Services HSO A11002:2024 Emergency Department HSO A41001:2024 Emergency Medical Services and Interfacility Transport HSO A35001:2024 Home Care Services HSO A35002:2024 Home Support Services HSO A34010:2024 Independent Medical/Surgical Facilities HSO A11004:2024 Inpatient Services	☐ **HSO 5062:2018 Pressure ulcer prevention**	HSO A34005:2018 Cancer Care HSO A11001:2018 Critical Care HSO A11004:2018 Inpatient Services HSO A21001:2020 Long-term Care Services HSO A11009:2018 Perioperative Services & Invasive Procedures HSO A11010:2018 Rehabilitation Services HSO S3401:2018 Spinal Cord Injury Acute Services HSO S3402:2018 Spinal Cord Injury Rehabilitation Services
		☐ **HSO 5063:2018 Skin and wound care**	HSO A35001:2018 Home Care Services HSO A21001:2020 Long-term Care Services HSO A34015:2020 Primary Health Care Services

Most up-to-date ROPs	Standards	ROPs that will be phased out	Standards
	HSO A34009:2024 Intellectual and Developmental Disabilities Services HSO A21001:2023 Long-Term Care Services HSO A42003:2024 Medical Imaging Centres HSO A22004:2023 Mental Health and Addictions Services HSO A11005:2024 Obstetrics Services HSO A11007:2024 Organ and Tissue Transplant HSO A11008:2024 Organ Donation for Living Donors HSO A13001:2024 Palliative Care Services HSO A11009:2024 Perioperative Services & Invasive Procedures HSO A34015:2024 Primary Health Care Services HSO A34017:2024 Provincial Correctional Health Services HSO A11010:2024 Rehabilitation Services HSO A34018:2024 Remote/Isolated Health Services HSO A29001:2024 Residential Homes for Seniors		
☐ **HSO 5060:2024 Preventing Falls and Reducing Injuries from Falls**	HSO A34001:2024 Aboriginal Community Health and Wellness HSO A34002:2024 Aboriginal Integrated Primary Care Services HSO A22001:2024 Aboriginal Substance Misuse Services	☐ **HSO 5060-1:2018 Fall prevention and injury reduction**	HSO A34003:2018 Acquired Brain Injury Services HSO A34005:2018 Cancer Care HSO A11001:2018 Critical Care HSO A11004:2018 Inpatient Services HSO A34019:2018 Mental Health Services

Most up-to-date ROPs	Standards	ROPs that will be phased out	Standards
	HSO A34003:2024 Acquired Brain Injury Services HSO A34004:2024 Ambulatory Care Services HSO A34101:2024 Assisted Reproductive Technology (ART) Clinical Services HSO A34005:2024 Cancer Care HSO A71002:2024 Case Management HSO A82001:2024 Child, Youth and Family Services HSO A34006:2024 Community Health Services HSO A11001:2024 Critical Care Services HSO A32001:2024 Dental Services HSO A42002:2024 Diagnostic Imaging Services HSO A11002:2024 Emergency Department HSO A41001:2024 Emergency Medical Services and Interfacility Transport HSO A35001:2024 Home Care Services HSO A35002:2024 Home Support Services HSO A34010:2024 Independent Medical/Surgical Facilities HSO A11004:2024 Inpatient Services HSO A34009:2024 Intellectual and Developmental Disabilities Services HSO A21001:2023 Long-Term Care Services HSO A42003:2024 Medical Imaging Centres HSO A22004:2023 Mental Health and Addictions Services		HSO A11005:2018 Obstetrics Services HSO A11007:2018 Organ and Tissue Transplant HSO A11009:2018 Perioperative Services & Invasive Procedures HSO A11010:2018 Rehabilitation Services HSO S3401:2018 Spinal Cord Injury Acute Services HSO S3402:2018 Spinal Cord Injury Rehabilitation Services
		☐ **HSO 5060-2:2018 Fall prevention and injury reduction – Long-term care services**	HSO A21001:2020 Long-term Care Services

Most up-to-date ROPs	Standards	ROPs that will be phased out	Standards
	HSO A11005:2024 Obstetrics Services HSO A11007:2024 Organ and Tissue Transplant HSO A11008:2024 Organ Donation for Living Donors HSO A13001:2024 Palliative Care Services HSO A11009:2024 Perioperative Services & Invasive Procedures HSO A34015:2024 Primary Health Care Services HSO A34017:2024 Provincial Correctional Health Services HSO A11010:2024 Rehabilitation Services HSO A34018:2024 Remote/Isolated Health Services HSO A29001:2024 Residential Homes for Seniors		
☐ **HSO 5065:2024 Preventing Venous Thromboembolism**	HSO A34001:2024 Aboriginal Community Health and Wellness HSO A34002:2024 Aboriginal Integrated Primary Care Services HSO A22001:2024 Aboriginal Substance Misuse Services HSO A34003:2024 Acquired Brain Injury Services HSO A34004:2024 Ambulatory Care Services HSO A34101:2024 Assisted Reproductive Technology (ART) Clinical Services HSO A34005:2024 Cancer Care HSO A71002:2024 Case Management	☐ **HSO 5065:2018 Venous thromboembolism (VTE) prophylaxis**	HSO A34005:2018 Cancer Care HSO A11001:2018 Critical Care HSO A11004:2018 Inpatient Services HSO A11007:2018 Organ and Tissue Transplant HSO A11008:2018 Organ Donation for Living Donors HSO A11009:2018 Perioperative Services & Invasive Procedures HSO S3401:2018 Spinal Cord Injury Acute Services HSO S3402:2018 Spinal Cord Injury Rehabilitation Services

Most up-to-date ROPs	Standards	ROPs that will be phased out	Standards
	HSO A34006:2024 Community Health Services		
	HSO A11001:2024 Critical Care Services		
	HSO A32001:2024 Dental Services		
	HSO A42002:2024 Diagnostic Imaging Services		
	HSO A11002:2024 Emergency Department		
	HSO A41001:2024 Emergency Medical Services and Interfacility Transport		
	HSO A35001:2024 Home Care Services		
	HSO A35002:2024 Home Support Services		
	HSO A34010:2024 Independent Medical/Surgical Facilities		
	HSO A11004:2024 Inpatient Services		
	HSO A34009:2024 Intellectual and Developmental Disabilities Services		
	HSO A21001:2023 Long-Term Care Services		
	HSO A42003:2024 Medical Imaging Centres		
	HSO A22004:2023 Mental Health and Addictions Services		
	HSO A11005:2024 Obstetrics Services		
	HSO A11007:2024 Organ and Tissue Transplant		
	HSO A11008:2024 Organ Donation for Living Donors		
	HSO A13001:2024 Palliative Care Services		
	HSO A11009:2024 Perioperative Services & Invasive Procedures		

Most up-to-date ROPs	Standards	ROPs that will be phased out	Standards
	HSO A34015:2024 Primary Health Care Services HSO A34017:2024 Provincial Correctional Health Services HSO A11010:2024 Rehabilitation Services HSO A34018:2024 Remote/Isolated Health Services HSO A29001:2024 Residential Homes for Seniors		
☐ **HSO A5064:2023 Suicide Prevention Program**	HSO A82001:2024 Child, Youth and Family Services HSO A41001:2024 Emergency Medical Services and Interfacility Transport HSO A34010:2024 Independent Medical/Surgical Facilities HSO A34009:2024 Intellectual and Developmental Disabilities Services HSO A42003:2024 Medical Imaging Centres HSO A11008:2024 Organ Donation for Living Donors HSO A11007:2024 Organ and Tissue Transplant HSO A0001:2024 Service Excellence	☐ **HSO 5064:2018 Suicide prevention**	HSO A34001:2018 Aboriginal Community Health and Wellness HSO A34002:2018 Aboriginal Integrated Primary Care Services HSO A22001:2018 Aboriginal Substance Misuse Services HSO A82001:2018 Child, Youth and Family Services HSO A34007:2018 Community-Based Mental Health Services and Supports HSO A34017:2018 Provincial Correctional Health Services HSO A34008:2018 Correctional Service of Canada Health Services HSO A11002:2018 Emergency Department HSO A21001:2020 Long-term Care Services HSO A34019:2018 Mental Health Services HSO A34018:2018 Remote/Isolated Health Services

Most up-to-date ROPs	Standards	ROPs that will be phased out	Standards
			HSO A29001:2018 Residential Homes for Seniors HSO A22004:2018 Substance Abuse and Problem Gambling

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