



# Qmentum Program

## STANDARDS

### ***Community-Based Mental Health Services and Supports Standards***

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**ACCREDITATION CANADA  
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The following standards for Community-Based Mental Health Services and Supports are designed for organizations offering mental health services and supports in the community. This includes but is not limited to mental health promotion and education, early intervention services, crisis intervention, counselling and therapy, treatment, peer/self-help programs, diversion and court support, and social rehabilitation/recreation. Mental health services are provided in the individual's preferred environment whenever possible and safe, and could include a clinic, community agency, hospital, individual's or family's home, school, or workplace.

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

The standards contain the following sections:

- Investing in community-based mental health services and supports
- Engaging competent and proactive staff and service providers
- Providing safe and appropriate services and supports
- Maintaining accessible and efficient information systems
- Monitoring quality and achieving positive outcomes

For definitions of specific terms used in this document, please refer to the glossary in the Appendix.

## Glossary

**Individual:** Any person receiving mental health services and supports.

**Family:** Two or more persons who are related in any way - biologically, legally, or emotionally, including immediate relatives and individuals involved in the person's support network. Family includes not only relationships based on blood ties, but also an individual's extended family, their partners, friends, advocates, guardians, and other representatives. The individual receiving the services decides who their family is. Adapted from the Institute for Family Centered Care (<<http://www.ipfcc.org/faq.html>>) and The Mental Health Commission (<http://www.mhc.govt.nz>).

**Interdisciplinary team:** A team comprised of professionals from a variety of disciplines (e.g. social workers, family physicians, administrators, nurses, recreationists, interpreters, client advocates) that participates in the assessment, planning, and/or implementation of clients' or groups' services, with close interaction and integration among its members to achieve common goals.

**Psychosocial rehabilitation:** Psychosocial rehabilitation (also termed psychiatric rehabilitation or PSR) promotes personal recovery, successful community integration, and satisfactory quality of life for persons who have a mental illness or mental health concern. Psychosocial rehabilitation services and supports are collaborative, person-directed, and individualized, and an essential element of the human services spectrum. They focus on helping individuals develop skills and access resources needed to increase their capacity to be successful and satisfied in the living, working, learning, and social environments of their choice.

**Psychosocial Rehabilitation Canada:**

<<http://www.psrpscanada.ca/index.php?src=gendocs&ref=About&category=Quickstart>>

**Recovery:** Recovery is understood as a process in which people living with mental health problems and illnesses are empowered and supported to be actively engaged in their own journey of well-being. The recovery process builds on individual, family, cultural, and community strengths and enables people to enjoy a meaningful life in their community while striving to achieve their full potential.

Recovery does not necessarily mean 'cure,' although it does acknowledge that 'cure' is possible for many people. Recovery principles including hope, empowerment, self-determination, and responsibility, are relevant to everyone experiencing mental health problems or illnesses, but must also be adapted to the realities of the different stages of life.

**Mental Health Commission of Canada:**

[http://www.mentalhealthcommission.ca/SiteCollectionDocuments/boarddocs/15507\\_MHCC\\_EN\\_final.pdf](http://www.mentalhealthcommission.ca/SiteCollectionDocuments/boarddocs/15507_MHCC_EN_final.pdf)

**Service plan:** A document that identifies the client's or group's needs, their goals, and the resulting actions to



be taken and services to be provided by the organization and its partners. Also known as a care plan, nursing care plan, plan of service, integrated service plan, or treatment plan.

**Staff and service providers:** The range of workers, both paid and volunteer, who provide mental health services and supports in the community. These include but are not limited to psychiatrists, psychologists, occupational therapists, social workers, nurses, family physicians, family therapists and counsellors, peer support and community mental health workers, those involved in the education, justice, and corrections systems, and other provider groups that may emerge.



# Community-Based Mental Health Services and Supports Standards

## INVESTING IN COMMUNITY-BASED MENTAL HEALTH SERVICES AND SUPPORTS

### 1.0 The organization develops its services and supports to meet the needs of the individuals, families, and community it serves.



Effectiveness

- 1.1 The organization takes a person-centred, strengths-based, and individual-directed approach to services and supports.



Effectiveness

- 1.2 The organization's services and supports are recovery-oriented and focused on well-being.

#### **Guideline**

The concept of recovery is geared toward supporting individuals and families to establish a positive identity, build a meaningful life in the community of their choice, and feel in control of their illness and their life. Recovery must be accomplished using the individual's choice of services and supports. Principles of recovery orientation include harm reduction, fostering hope, enabling choice, encouraging responsibility, and promoting dignity and respect.



Client-centred  
Services

- 1.3 The organization works to support and engage the families of the individuals it serves.

#### **Guideline**

The Mental Health Commission of Canada has identified recognizing and strengthening the role of families in mental health services as a goal in its strategy for mental health. Enhancing the role of family caregivers, and supporting them in this role through information and education, can reduce hospitalization and delay relapse.

Families should be engaged and supported through programs such as parenting and sibling support, peer support, and respite care. Whenever possible, and while respecting consent and privacy, families should be involved in decisions regarding services.





Population  
Focus

- 1.4 The organization collects information about the individuals, families, and community it serves.

**Guideline**

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

If it is not within the organization's mandate to collect information, it knows how to access and use available information to inform decision making.



Population  
Focus

- 1.5 The organization uses the information it collects about the individuals, families, and community it serves to define the scope of services and supports, and to set priorities when multiple service needs are identified.

**Guideline**

When defining the scope of its services and supports, the organization considers the resources that are currently available in the community and those that are still needed.

The organization includes individuals, families, and community members in the process to determine priorities and service needs.



Effectiveness

- 1.6 The team's scope of services and supports is aligned with the organization's mission and strategic plan.

**Guideline**

Expectations regarding the organization's scope of services and supports may be outlined in federal, provincial or territorial legislation, regional directives, or contractual agreements with funders.



Population  
Focus

- 1.7 The organization makes information about service needs and identified priorities available to the public.





Client-centred  
Services

- 1.8 The organization has established processes and policies to meet the diverse needs of the community.

**Guideline**

Diversity includes but is not limited to language, gender, sexual orientation, ethno-cultural background, different abilities, socio-economic status, and spiritual or religious beliefs.

The organization's acceptance of the diversity of the individuals and families it serves is evident in its policies and procedures. This may include having materials available in different languages and suitable for the hearing or sight impaired, access to interpretation services, and awareness programs and committees to understand different cultures and age groups.

Staff and service providers are encouraged to deliver services and supports in a manner that takes into account the social, political, linguistic, and spiritual realities of the individuals and families with whom they are working.



Effectiveness

- 1.9 The organization regularly reviews service demands and utilization, and makes adjustments as necessary.

**Guideline**

The organization reviews the appropriateness of its current services and supports, and whether to discontinue or change them, as well as the need to introduce new services and supports.

**2.0 The organization has goals and objectives for its mental health services and supports that are reflective of the needs of the individuals, families, and community it serves.**



Effectiveness

- 2.1 The organization uses a team approach to develop goals and objectives for its services and supports.

**Guideline**

Staff, service providers, service partners, individuals, and families have a primary role in developing goals and objectives.



Population  
Focus

- 2.2 The organization's goals and objectives are based on the needs of the community it serves.

**Guideline**

The organization uses the results of community needs assessments and other information about the community's needs to develop its goals and objectives.





Effectiveness

- 2.3 The organization's goals and objectives are linked to its strategic direction(s), mission, values, and the principles of person-centred care.



Effectiveness

- 2.4 The organization's goals and objectives are specific and measurable.

**Guideline**

Goals and objectives have measurable outcomes and success factors, and are realistic and time-specific.



Efficiency

- 2.5 The organization identifies the resources needed to meet its goals and objectives.

**Guideline**

Resources may be human, financial, structural, or informational.

The availability of resources may depend on the continuity of funding, as well as opportunities to pool resources or work with other organizations and partners.



Effectiveness

- 2.6 Staff and service providers have access to the supplies and equipment needed to deliver mental health services and supports.

**Guideline**

Equipment and supplies are selected based on the needs of the community or populations served, e.g. supplies associated with physical assessment (e.g. blood pressure cuffs) and intramuscular injections (IM), and non-medical supplies such as car safety kits, cell phones, personal protective equipment (PPE), and telehealth equipment.



Worklife

- 2.7 Staff and service providers are supported to provide quality mental health services and supports.

**Guideline**

Support can include organizational policies that encourage worklife balance, learning and development opportunities, quality improvement activities, recognition programs, training in community safety and risk management, and employee assistance programs (EAP).



### 3.0 The organization works to promote optimal mental health and reduce the stigma of mental illness and concurrent disorders.



Population  
Focus

- 3.1 The organization has a strategy to promote optimal mental health and reduce the stigma of mental illness and concurrent disorders.



Population  
Focus

- 3.2 The strategy includes working with other services, groups, programs, and organizations in the community (e.g. social services, justice, etc.) to raise awareness of the resources and supports available to individuals and families.

**Guideline**

Strategies to raise awareness of the resources and supports available may include responding to inquiries in a timely manner, having access to translation services, establishing a formal process for interacting with the media and monitoring media coverage, and listing services in local directories, e.g. telephone books and online equivalents.



Population  
Focus

- 3.3 The organization delivers, or partners with other organizations to deliver, mental health promotion sessions in the community.

**Guideline**

Mental health promotion helps build awareness and understanding of mental health issues and educate people about the signs and symptoms of emerging issues. Initiatives should be directed at families, schools, and workplaces, and can include education, screening, and wellness sessions.



Population  
Focus

- 3.4 The organization participates in community events to raise awareness about mental health, mental illness, and concurrent disorders.

**Guideline**

Raising community awareness includes working at public events, participating in school programs, and participating in community health committees.



Population  
Focus

- 3.5 The organization participates in activities to build the community's capacity to support individuals and families seeking mental health services.



## ENGAGING COMPETENT AND PROACTIVE STAFF AND SERVICE PROVIDERS

### **4.0 The organization's staff and service providers are educated, trained, qualified, and competent.**



Effectiveness

#### **4.1 The organization recruits and hires qualified and diverse personnel.**

##### **Guideline**

Qualifications include an approved program of study, work experience, lived experience, provincial licensure, and credentials related to the organization's scope of care and population served.

The organization should seek a range of regulated and unregulated personnel, which may include psychiatrists, psychologists, occupational therapists, social workers, nurses, family physicians, family therapists and counsellors, peer support and community mental health workers, those with training in addictions treatment, those involved in the education, justice, and corrections systems, and other provider groups that may emerge.



Effectiveness

#### **4.2 Staff and service providers maintain current competencies and credentials to fulfill the requirements of their job.**

##### **Guideline**

Credentials for interdisciplinary team members include those from professional associations (e.g. psychologists, social workers, Registered Psychiatric Nurses) and mental health certification, which may be national or provincial.

Staff, service providers, and managers should demonstrate competencies in recovery-oriented practices, including harm reduction and psychosocial rehabilitation, cultural sensitivity, and other identified treatment and support modalities for the specific population served.



Effectiveness

#### **4.3 The organization maintains up-to-date and accurate records of all staff and service providers' credentials, and reviews the records on a regular basis.**

##### **Guideline**

Proof of licensure is obtained annually for professions where it is required.

A record of credentials is also kept for volunteers.





Worklife

- 4.4 The organization supports the placement of students and volunteers on the team, where applicable.

**Guideline**

Organizations have formal agreements with educational institutions when placing students on the team. If students or volunteers are placed on the team, the organization provides adequate resources and supervision, and regularly evaluates the placement.



Effectiveness

- 4.5 The team orients new staff members, volunteers, and peer support workers about their roles and responsibilities, and the goals and objectives of the organization.

**Guideline**

Staff is oriented to the code of ethics, individual rights, the work environment, protocols, policies, procedures, standards relating to the employee, and the position for which they were hired.



Worklife

- 4.6 Staff and service providers receive specific education and training to deliver mental health services.

**Guideline**

The team receives training on the unique issues and risks in mental health services, such as recovery-oriented practices; knowledge of mental illnesses; knowledge of medication and substance abuse; monitoring individuals for risk of self-harm or suicide; sensitivity to ethnic, cultural, and gender specific issues; family-related issues; and high-risk issues such as harassment reduction, non-violent crisis intervention, and de-escalation techniques.



Safety

- 4.7 The organization trains staff and service providers on how to prevent workplace violence.

**Guideline**

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





Effectiveness

- 4.8 Staff and service provider training and education are documented in personnel files.

**Guideline**

Staff are expected to maintain their professional association licensure records and provide copies to the organization for their personnel files.



Worklife

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

**Guideline**

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



Effectiveness

- 4.10 Team leaders regularly evaluate and document each staff member's performance in an objective, interactive, and positive way.

**Guideline**

The organization's established process is used to evaluate each staff member's performance.

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

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



Worklife

- 4.11 The organization provides staff members with opportunities for additional training and education to improve their competency, skills and performance.

**Guideline**

Remedial training or education may be given based on the staff member's performance evaluation. Training may include recovery-oriented practices; knowledge of mental illnesses; knowledge of medication and substance abuse; monitoring individuals for risk of self-harm or suicide; sensitivity to ethnic, cultural, and gender-specific issues; family-related issues; and high-risk issues such as harassment reduction, non-violent crisis intervention, and de-escalation techniques.



## 5.0 The organization promotes the well-being and worklife balance of each of its staff and service providers.



Worklife

- 5.1 The organization ensures equitable and fair division of responsibilities to staff and service providers.

### Guideline

Staff assignments take into consideration accepted standards of practice, legal requirements, knowledge, experience and other qualifications, service volume or complexity of the service mix, committee work, changes in workload, individual needs, and safety.



Worklife

- 5.2 Staff and service providers have input on work and job design, including case assignments, and the definition of roles and responsibilities, where appropriate.

### Guideline

Job design refers to how a group of tasks or an entire job is organized. Job design addresses all factors that affect the work, including job rotation, work breaks, and working hours. Effective job design helps staff manage time, fatigue, stress, and worklife balance.



Effectiveness

- 5.3 The organization regularly evaluates the effectiveness of staffing and uses the information collected to make improvements.

### Guideline

The evaluation covers job design, position profiles, practice roles, and case assignments.



Safety

- 5.4 The team has a process for identifying, managing, and reducing safety risks to staff and service providers while delivering services.

### Guideline

Common risks include but are not limited to working alone, managing aggressive and violent behaviour, lack of training on safety issues, and using unsafe equipment. Staff members work with their leaders and the organization to reduce these risks and develop appropriate strategies, such as carrying cell phones, home visit protocols, building alarms, in-and-out boards, and flexible extended hours for staff security.





Worklife

- 5.5 Staff and service providers are aware of relevant occupational health and safety legislation.

**Guideline**

Occupational health and safety legislation cover the rights and responsibilities of workers and employers, including the right to refuse unsafe work, and the right to know about potential dangers in the workplace.



Worklife

- 5.6 Staff and service providers have access to counselling services.

**Guideline**

Access to mental health counselling assists staff to identify existing and potential mental health issues, including compassion fatigue and burnout; informs them of relevant resources; and promotes personal mental health.



Worklife

- 5.7 The organization has processes in place to assist staff and service providers to resolve conflicts.

**Guideline**

Conflict resolution is done through intermediaries who approach conflict from an independent, fair, and neutral perspective in order to help parties work through their difficulties. The conflict resolution process may include input from all members of the interdisciplinary team and personnel outside the organization.



Worklife

- 5.8 The organization has a fair and objective process to recognize staff members for their contributions.

**Guideline**

Recognition activities may be individual, such as awards based on years of service, or team-based, such as team activities.



## 6.0 The organization delivers mental health services and supports using an interdisciplinary approach.



Continuity of  
Services

- 6.1 The organization uses an interdisciplinary team to deliver mental health services and supports.

### Guideline

The interdisciplinary team includes regulated and unregulated professionals with different roles and from various disciplines and backgrounds, depending on the needs of the individuals and families. The organization may create linkages with community partners to help individuals and families access a range of service providers.



Worklife

- 6.2 Each team member has a position profile that defines his or her role, responsibility, and scope of practice.

### Guideline

Role clarity is essential in promoting a safe and positive work environment. Understanding roles and responsibilities, and being able to work to one's full scope of practice helps create meaning and purpose for individuals.

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



Safety

- 6.3 The interdisciplinary team regularly communicates with providers across the service continuum to coordinate services, roles, and responsibilities to support continuity of care.

### Guideline

Miscommunication or a lack of communication among interdisciplinary team members can compromise safety. Making accurate and timely communication a priority promotes continuity of care and helps prevent adverse events. The team is responsible for communicating with other providers throughout service provision; in particular, primary care providers.

Communication mechanisms can include meetings, teleconferences, or virtual technologies such as telehealth or webconferencing, and may involve the individual, family, caregiver, or advocate working on the individual's behalf.





Worklife

- 6.4 The organization encourages all team members to develop skills to improve the interdisciplinary approach and overall team functioning.

**Guideline**

Skills to improve interdisciplinary and team functioning may differ from required technical skills, and may include building trust, increasing cooperation and collaboration, effective communication, leadership, and responsibility.



Effectiveness

- 6.5 The interdisciplinary team evaluates its functioning at least annually, identifies priorities for action based on the evaluation, and makes improvements.

**Guideline**

The team should also evaluate its functioning whenever there is a significant change in the structure of the team.

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



## PROVIDING SAFE AND APPROPRIATE SERVICES AND SUPPORTS

### 7.0 The organization is person-centred and supports family engagement.



Client-centred  
Services

- 7.1 The team develops an open, transparent, and respectful relationship with each individual and/or family.

**Guideline**

The team works to actively engage the family during service provision.



Client-centred  
Services

- 7.2 The team informs individuals and families of their rights and responsibilities.

**Guideline**

Individual and family rights include the right to have privacy and confidentiality protected, be treated with respect and care, maintain cultural practices, pursue spiritual beliefs, live at risk, and be free from abuse, exploitation, and discrimination.

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



Client-centred  
Services

- 7.3 The team encourages individuals to involve others in their care, but recognizes and upholds their right to choose not to.

**Guideline**

The involvement of an individual's family, whether made up of relatives or other people of the individual's choosing, can promote well-being and encourage recovery.

Families may also require support to help in providing care to the individual. Wherever possible, families should be partners in the treatment process, and included in decision making in a way that respects consent and privacy.



Client-centred  
Services

- 7.4 Individuals and/or families are involved in their own care, including service planning.





Client-centred  
Services

- 7.5 To the extent allowed by legislation, individuals and/or their families have the right to refuse care, treatment, or services.

**Guideline**

The team is familiar with legislation regarding the refusal of services, and uses harm reduction and effective outreach techniques with individuals who choose to refuse services.



Client-centred  
Services



- 7.6 The team investigates and resolves any claims that an individual's or family's rights have been violated.



Client-centred  
Services

- 7.7 The team complies with relevant professional and legislative confidentiality requirements.

**Guideline**

Applicable legislation may be provincial/territorial or federal, e.g. Personal Information Protection and Electronic Documents Act (PIPEDA).



Client-centred  
Services

- 7.8 Services are provided in a manner that protects the privacy of individuals and families.





Client-centred  
Services



7.9

The team has a process to obtain informed consent from the individual and/or family before delivering services or supports and on an ongoing basis, which includes determining the individual's and/or family's capacity to provide informed consent.

#### Guideline

Informed consent consists of reviewing service information and the consent form with the individual and/or family; informing the individual and/or family about the available options and allowing time to reflect and ask questions before asking for consent; respecting the individual's and family's rights, culture, and values including the right to refuse consent at any time; recording the individual's and/or family's decisions in the client record; and informing the individual about who is on the service team and who can access their information. Clients are made aware that they can withdraw their consent.

Implied consent occurs when service is provided and written consent is not needed, such as when individuals and/or families ask to take part in a particular community service or mental health program.

When dealing with minors, the team's consent process includes involving the minors as much as possible in decision making about their service, intervention, or treatment, and valuing their questions and input.

An informal assessment may be used to determine an individual's and/or family's capacity to provide informed consent.



Effectiveness



7.10

When an individual is incapable of giving informed consent, the team refers to the individual's advance directives, if available, or obtains consent using a substitute decision maker.

#### Guideline

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

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

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





Effectiveness



- 7.11 The team follows a process to identify, address, and record all ethics-related issues.

**Guideline**

Ethics-related issues include decisions about informed consent for those with diminished capacity, the right to live at risk, and the choice to refuse or withdraw treatment, e.g. medications.

The process is established at the organizational level, and staff and service providers receive training on how to recognize ethical issues; making ethical decisions, including guidelines for handling disagreements between individuals, families, and their service providers, or among service providers about ethics-related questions; and mechanisms to share information with individuals and families and identify individual needs resulting from ethical questions.

Ethics-related issues may be addressed by an ethics committee or consultation team which may include health service professionals, clergy, or ethicists. In addition to clinical consultation, the ethics committee may be involved in policy review and ethics education.

Client-centred  
Services

- 7.12 The team informs individuals and families of the process to bring forward complaints or concerns.

Client-centred  
Services

- 7.13 The organization has a protocol to respond to individuals' and families' complaints in an open, fair, and timely way.

**Guideline**

Individuals and families should feel comfortable raising concerns or issues. For example, the organization may provide access to a neutral, objective resource person from whom individuals and families can seek advice or consultation.

Client-centred  
Services

- 7.14 The organization records and tracks its response to complaints.



## 8.0 The organization collaborates with community partners and other sectors to help ensure equitable and timely access to appropriate and effective services and supports for individuals and families.



Client-centred  
Services

- 8.1 The team works to ensure individuals and families receive the appropriate services and supports as quickly as possible.

### Guideline

Individuals and families seeking services should have timely access to appropriate and effective programs, services, and supports in their community, and be able to enter the system through any organization.



Client-centred  
Services

- 8.2 If the organization does not offer the services or supports required, it facilitates and supports access to the appropriate services.



Continuity of  
Services

- 8.3 The team collaborates with other services, programs, providers, and organizations to identify, address, coordinate, and deliver services.

### Guideline

Meeting the full range of the service needs of the community or population served is beyond the capabilities of any one team or organization. Collaboration with partners facilitates coordination across sectors.

The organization identifies partnerships and works collaboratively with partners to enhance the efficiency and effectiveness of its services, provide access across the continuum of care, and make it easier for individuals and families to move through the system. Partnerships for mental health services include primary care, public health, home care, acute care, other community health services, education, addictions services, housing, employment, social services, and justice.



Accessibility

- 8.4 The team identifies and works to minimize and mitigate barriers that prevent individuals, families, service providers, and referring organizations from accessing services.

### Guideline

Potential barriers to be considered include wait lists, hours of operation, physical or language barriers, transportation, and funding.





Accessibility

- 8.5 The organization's hours of operation are flexible and address the needs of the individuals and families it serves.

**Guideline**

The organization has the flexibility to respond to urgent clients and walk-ins.

Client-centred  
Services

- 8.6 The team strives to provide services in individuals' and families' choice of locations.

**Guideline**

Individuals and/or families choose the location where services and supports are to be delivered, keeping in mind the safety and security of the service provider. Locations can include a clinic or hospital, community agency, the individual's or family's home, workplace, or school, or public spaces such as restaurants, coffee shops, or public parks.



Accessibility

- 8.7 During their first contact with the organization, individuals and/or families are informed of the process to access services and what they can expect.



Accessibility

- 8.8 Individuals and/or families are informed on how to access 24-hour emergency or crisis services.

**Guideline**

Services include the emergency department and after-hours crisis lines.



Accessibility

- 8.9 The team responds to requests for services and information in a timely way.

**Guideline**

The team is encouraged to set benchmarks for response times, and monitor its responsiveness by tracking response times.





Effectiveness

- 8.10 The team gives individuals, families, service providers, and referring organizations information about the organization and the services and supports it offers.

**Guideline**

The information includes the scope of the organization's services, supports, and costs, if any; and the effectiveness and outcomes of its services.



Continuity of Services

- 8.11 Staff and service providers are aware of the range of other applicable services, supports, and resources available to individuals, families, and the community.



Continuity of Services

- 8.12 Staff and service providers support individuals and families to navigate the health care system, based on their knowledge of other applicable services and supports available in the community.



Client-centred Services

- 8.13 Service information provided to individuals, families, and referring organizations is in writing, easy to understand, and available in languages commonly spoken by the populations served.

**9.0 The organization carries out accurate, appropriate, and timely assessments to determine individuals' and families' needs.**



Accessibility



- 9.1 A timely assessment of the individual's and/or family's needs is completed in collaboration with the individual and family.

**Guideline**

The team is encouraged to set and track timeframes for completing the initial assessment, and to work in partnership with other service providers and organizations to avoid duplication.





Accessibility

- 9.2 Staff and service providers have access to the appropriate expert consultation and advice as needed to complete a comprehensive assessment.

**Guideline**

Access to these services can be obtained from within the organization, or by working with a community partner. Access to previous test results may also be obtained from a previous provider organization, or through primary care, with the individual's permission.

Client-centred  
Services

- 9.3 During the assessment process, the team engages the individual's family in support of the individual, at the discretion of the individual.

**Guideline**

Assessment of family and caregiver involvement includes evaluating the availability of family and community support. The team also assesses the family and caregivers for support or services they may require during or after the individual's involvement with the organization, including emotional support, counselling, and respite services.

The individual defines the makeup of their family.



Effectiveness

- 9.4 The assessment is completed using a holistic approach by assessing the individual's and family's physical, psychological, spiritual, and social needs.

**Guideline**

Elements of physical health include medical history, allergies, medication profile, health status including previous mental health problems and history of communicable diseases (e.g. HIV/AIDS, hepatitis C, STIs), history of substance abuse or addictions, nutritional status, and special dietary needs.

Elements of psychosocial health include functional and emotional status, including suicidal or self-harming behaviours; personality and behavioural characteristics; communication and self-care abilities; history of abuse or neglect; legal history and current legal status; level of risk presented to the individual and others by the individual; socio-economic situation, housing, employment history, and level of education; spiritual orientation; and cultural beliefs.





Effectiveness

- 9.5 The assessment process identifies the individual's and/or family's strengths, needs, and expectations, and family and caregiver involvement.

**Guideline**

Assessment takes into account how the individual and/or family perceive their strengths, needs, desired outcomes, and expectations of service, as well as their awareness of health issues and how to prevent health problems. The assessment process establishes what 'recovery' entails for the individual and/or family and identifies steps to achieve it.



Safety

- 9.6 The team assesses and monitors individuals for risk of self-harm.



Safety



- 9.7 **REQUIRED ORGANIZATIONAL PRACTICE:** The organization assesses and monitors individuals for risk of suicide.

**Guideline**

Suicide is a global health concern. In 2006, the Public Health Agency of Canada reported that suicide accounted for 1.7 percent of all deaths in Canada. Risk assessment can help prevent suicide through early recognition of the signs of suicidal thinking and appropriate intervention.

Test(s) for Compliance

- 9.7.1 The organization assesses each individual for risk of suicide at regular intervals, or as needs change.
- 9.7.2 The organization identifies individuals at risk of suicide.
- 9.7.3 The organization addresses the immediate safety needs of individual's who are identified as being at risk of suicide.
- 9.7.4 The organization identifies treatment and monitoring strategies to ensure individual safety.
- 9.7.5 The organization documents the implementation of the treatment and monitoring strategies in individual's health record.



Continuity of  
Services

- 9.8 The assessment is shared openly with everyone involved in the process, including the team, individual, family, and other service providers in a timely and easy-to-understand way.

**Guideline**

Sharing the assessment with the individual and family as well as service providers and other organizations improves clarity and prevents duplication.

The individual's consent should be obtained before sharing assessment results with the family.



Effectiveness

- 9.9 The team and individual and/or family jointly review the assessment on an ongoing basis.

**Guideline**

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

## 10.0 The team and each individual and/or family work together to develop the service plan.

Client-centred  
Services

- 10.1 The team and individual and/or family develop an integrated and comprehensive service plan.

**Guideline**

The service plan includes the roles and responsibilities of the team, other service providers and organizations, and individuals and their families. The plan addresses where and how frequently service will be delivered; timelines for starting services, reaching service goals and expected results, and completing services; how the team will monitor achievement of service goals and expected results; and plans for transition or follow-up once the individual leaves the organization, if applicable.

The service plan incorporates meeting elements of the individual and family's psychosocial health, which include functional and emotional status, including suicidal or self-harming behaviours; personality and behavioural characteristics; communication and self-care abilities; history of abuse or neglect; legal history and current legal status; level of risk presented to the individual and others by the individual; socio-economic situation, housing, employment history, and level of education; spiritual orientation; and cultural beliefs.

The service plan also addresses education, emotional support, counselling, and information on prevention and health promotion to be provided, including a component that promotes self-care, independence, health, and well-being. The plan is completed providing as much choice as possible to the individual and family.





Client-centred  
Services

- 10.2 The service plan addresses the individual's and/or family's goals and objectives for services.

**Guideline**

Goals include the individual's and/or family's goals for vocation, education, home, friendship, leisure, and social life.



Effectiveness

- 10.3 The service plan includes strategies to manage symptoms, including identification of early warning signs of relapse and appropriate action.

**Guideline**

The team consults with experts and uses research and evidence to understand and use methods to manage symptoms.



Effectiveness

- 10.4 The service plan includes an initial crisis intervention plan, as appropriate.



Continuity of  
Services

- 10.5 The team shares the service plan with other service providers in a timely manner, in accordance with privacy legislation, and with the consent of the individual and/or family.

**Guideline**

As required to meet the service goals, the team shares the service plan with service providers in and outside of the organization. Wherever possible, the individual and/or family should be encouraged to share the service plan with their other service providers.



Effectiveness

- 10.6 Staff and service providers follow the service plan when delivering services.





Effectiveness

- 10.7 The team and individual and/or family work together to update the service plan as needs change.

## 11.0 The team supports individuals and/or families to actively participate in service delivery to achieve goals.

Client-centred  
Services

- 11.1 The team helps the individual and/or family make informed choices by providing timely, complete, and accurate information about service options.

### Guideline

The information gives details on how and when services will be provided; opportunities to participate in service delivery and make choices regarding services; the individual's and family's roles and responsibilities in service delivery, including safety; the limitations and possible outcomes of the proposed services or interventions; possible side effects and risks; the availability of counselling and support groups; and how to reach service providers after hours or in an emergency or crisis situation.

The information may also include security measures or legal restrictions as applicable. These may be imposed to meet legal requirements, e.g. criminal justice system.

Client-centred  
Services

- 11.2 The team engages individuals and/or families in education related to their service needs.

### Guideline

The education focuses on coaching and teaching individuals and/or families to manage their health needs and health-related issues, helps them develop the skills necessary to meet their own needs and become as independent as possible, and enables them to participate in service delivery and decision making. It also teaches self-care techniques, how to follow the service plan and achieve service goals and expected results, and how to use medications, supplies, and equipment safely and effectively.

When providing education, the team considers the individual's and family's beliefs, values, literacy level, language, and functional abilities.



Client-centred  
Services

- 11.3 Staff and service providers verify that the individual and/or family understand the service information provided to them.

**Guideline**

To help the individual and family understand the service information, it is made available in the appropriate language wherever possible, in a simple and easy-to-understand format, and in a way that is respectful of cultural beliefs and preferences.

The team member providing the information documents the verification in the client record.

Client-centred  
Services

- 11.4 The team works with the individual and/or family to identify service goals and expected results.

**Guideline**

The team considers physical, psychosocial, cultural, occupational, and spiritual needs; informed choices; and preferences as identified in the individual assessment.

Service goals and expected results should suit the individual's and family's unique capacities, be achievable, measurable, and complement those developed by other service providers and organizations with which the individual and/or family is involved.

**12.0 The organization provides effective services and supports to individuals and/or families.**

Client-centred  
Services

- 12.1 The team assists individuals and/or families in securing arrangements to meet their basic needs (e.g. income, food, clothing, shelter, etc.), as identified by the individual and their family.

**Guideline**

The team can assist individuals and families in securing their basic needs by providing information, advocating on their behalf, or referring them to other services or organizations.



Effectiveness

- 12.2 The organization has a policy that identifies staff's and service providers' roles in medication monitoring or medication management, if any.

**Guideline**

Medication management includes prescribing and administering medications.





Safety



12.3

**REQUIRED ORGANIZATIONAL PRACTICE:** The team reconciles the client's medication at the beginning of service with the involvement of the client and family or caregiver when medication management is a component of care.

**Guideline**

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

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

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

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

Test(s) for Compliance

- 12.3.1 There is a demonstrated, formal process to reconcile client medications at each visit if medications have been discontinued, altered or changed.
- 12.3.2 The team generates a Best Possible Medication History (BPMH) at the beginning of service when medication management is a component of care.
- 12.3.3 The team conducts a timely comparison of the BPMH with medications prescribed, ordered, dispensed, or administered during service.
- 12.3.4 The team communicates the BPMH and discrepancies requiring resolution to the appropriate health care provider, and documents actions taken in the client record.
- 12.3.5 The process is a shared responsibility involving the client and one or more health care practitioner(s), such as nursing staff, medical staff, pharmacists, and pharmacy technicians, as appropriate.





Effectiveness



- 12.4 Staff and service providers adhere to applicable legislation, organizational policies, accepted standards of practice, and codes of ethical practice when delivering services.



Effectiveness

- 12.5 The team documents all services received by the individual and/or family in their client record.



Effectiveness

- 12.6 The team and individual and/or family work together to evaluate whether the individual and/or family is achieving their service goals and expected results, and uses this information to identify and address barriers that are preventing goal achievement.

**Guideline**

The team is encouraged to collaboratively track progress using both qualitative and quantitative methods.



Effectiveness

- 12.7 The team has processes to follow up with high-risk individuals and/or families who do not appear for scheduled appointments.

**Guideline**

The organization defines 'high-risk' for the purposes of identifying when follow-up is required.

Teams may use assertive outreach techniques, such as frequent contact, particularly when dealing with hard-to-reach populations, such as homeless individuals.

**13.0 The team provides safe and effective crisis intervention services.**



Accessibility

- 13.1 Crisis intervention services are available to any individual or family that contacts the organization.

**Guideline**

Services may be provided in partnership with other organizations.





Effectiveness

- 13.2 Staff and service providers receive training in crisis intervention techniques.



Effectiveness

- 13.3 The team encourages individuals and/or families to share their crisis intervention plan with others who may have contact with them in a crisis situation.

#### 14.0 **Staff and service providers facilitate the individual's and/or family's transition to another service team or setting, service provider, or at the end of service.**

Client-centred  
Services

- 14.1 The team shares information with individuals and families about what to expect during a transition or at the end of service.

##### **Guideline**

Continuity of care is enhanced when individuals and families have comprehensive information about transitions and end of service. Information provided to the individual and family includes the service plan, goals, and preferences; a summary of the services provided; an updated list of any outstanding issues, clinical or otherwise; what to expect during transition or at end of service; and contact information for the team and details on when to contact the team, e.g. if individuals or families notice any warning signs or symptoms of adverse reactions.

Transitions are particularly important for individuals and families who are high-risk for readmission or medication non-compliance. The team involves the individual's family and informal caregivers as much as possible to facilitate end of service and successful management in the community.





Continuity of Services

- 14.2 The team works with the individual, family, and other teams, services, and organizations to determine the appropriate transition to other services and to develop a comprehensive follow-up plan.

#### Guideline

The team remains connected to the individual and/or family until service has officially ended or the individual and/or family has transitioned to another team, service, or organization.

Note that not all individuals or families need a comprehensive follow-up plan, such as those engaged in counselling services only.

The team promotes alignment between the individual's and/or family's after-care needs and services provided by other organizations or services. With the consent of the individual and/or family, agreement is sought from the referral organization to identify risks and warning signs, and to direct the individual and/or family back to referring organization for evaluation and re-assessment.

To ensure individuals and families receive the most seamless and continuous care possible, the process for planning transitions and follow up includes steps to follow when a transition or end of service does not occur as planned, or is unplanned.



Safety



- 14.3 **REQUIRED ORGANIZATIONAL PRACTICE:** The team reconciles medications with the client at referral or transfer, and communicates information about the client's medication to the next provider of service at referral or transfer to another setting, service, service provider, or level of care within or outside the organization.

#### Guideline

Medication reconciliation is a way to collect and communicate accurate information about client medication, including over-the-counter medications, vitamins, and supplements. Evidence shows medication reconciliation can lead to reduced medication discrepancies on admission such as omissions, duplications, and dosing errors, and a reduction in discrepancies in drug frequency and dose at the time of discharge.

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

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

#### Test(s) for Compliance

- 14.3.1 There is a demonstrated, formal process to reconcile client medications at referral or transfer.
- 14.3.2 The process includes generating a comprehensive list of all medications the client has been taking before referral or transfer.



- 14.3.3 The process includes a timely comparison of the prior-to-referral or prior-to-transfer medication list with the list of new medications ordered at referral or transfer.
- 14.3.4 The process requires documentation that the two lists have been compared; differences have been identified, discussed, and resolved; and appropriate modifications to the new medications have been made.
- 14.3.5 The process makes it clear that medication reconciliation is a shared responsibility involving the client, nursing staff, medical staff and pharmacists, as appropriate.



Safety



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

**Guideline**

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

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

Test(s) for Compliance

- 14.4.1 The team has established mechanisms for timely and accurate transfer of information at transition points.
- 14.4.2 The team uses the established mechanisms to transfer information.



Effectiveness

- 14.5 Following a transition or at the end of service, the team contacts individuals, families, and referring organizations to evaluate the effectiveness of the transition, and uses this information to improve its transition and end-of-service planning.

**Guideline**

The team contacts individuals, families, or referring organizations to monitor the results of the transition or end of service, and follow-up plans. The team verifies that individual and/or family needs have been met; where they have not, the team uses this information to make improvements to its transition and end-of-service planning.



## MAINTAINING ACCESSIBLE AND EFFICIENT INFORMATION SYSTEMS

### 15.0 The organization keeps client records accurate, up-to-date, and secure.



Effectiveness

- 15.1 The organization maintains an accurate and up-to-date record for each individual and/or family.

**Guideline**

The client record includes the individual's and/or family's referral information, consent form(s), assessment results, service goals, treatment plan, discharge and transition plan, and crisis plan.



Client-centred  
Services



- 15.2 The organization meets applicable legislation for protecting the privacy, security, and confidentiality of client records.

**Guideline**

Applicable legislation may be national or provincial/territorial.



Client-centred  
Services

- 15.3 Individuals and/or families have opportunities to access their records.

**Guideline**

Individuals and/or families have the right to read and comment on information about them that is recorded by the organization, in accordance with applicable privacy legislation.



Accessibility

- 15.4 Staff and service providers have timely access to client records.

**Guideline**

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

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

The team retains client records after end of service for information sharing and coordination, and to facilitate transitions if individuals or families re-access services.





Continuity of  
Services



- 15.5 The organization shares information and coordinates its flow among service providers, other teams, and other organizations, as required.

**Guideline**

While protecting the individual's and family's right to privacy, information is shared, as required, to facilitate transitions and to reduce duplication in obtaining information.

**16.0 The team has access to information technology which assists in the delivery of services and supports.**



Effectiveness

- 16.1 The team identifies its needs for technology and information systems.

**Guideline**

Examples of technology include intake and diagnosis systems, wait list management systems, electronic health records (EHRs), personal digital assistants (PDAs), cell phones, telemedicine, and decision support tools. Innovative information technology is used to support the work of the service area.



Worklife

- 16.2 Staff and service providers receive education and training on information systems and other technologies necessary to do their jobs.

**Guideline**

Required skills may include knowledge of computer applications, word processing software, and how to use the Internet, personal digital assistants (PDAs), and cell phones.



## MONITORING QUALITY AND ACHIEVING POSITIVE OUTCOMES

### 17.0 The team regularly monitors safety and addresses areas of risk.



Safety



- 17.1 Staff and service providers are trained to identify, reduce, and manage risks to individual, family, and staff safety.

#### Guideline

Risks include physical hazards; meeting individuals and/or families at home or at other ambulatory settings; individual and family behaviour that may lead to injury; suicidal and self-harming behaviour; family violence and threats of violence to staff or other individuals; falls; multiple dependency issues; and overdose or problems with handling, storing, or dispensing medications.



Safety

- 17.2 The team has procedures in place for reporting safety risks and trending and analyzing this information to improve safety.



Safety

- 17.3 The organization has guidelines to protect staff and service providers that work alone.

#### Guideline

Guidelines may include information about how to reach other staff or a supervisor when working alone, safe driving tips, and staff and service providers' rights to not enter a premises where they feel unsafe.



Safety

- 17.4 The organization's leaders encourage staff members to report concerns about safety.





Safety



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

**Guideline**

Regular opportunities to share information about potential problems and actual incidents can reduce risk and the likelihood of reoccurrence.



Safety

- 17.6 The organization responds to staff members' concerns about safety issues in an open, fair, and timely way.



Safety



- 17.7 **REQUIRED ORGANIZATIONAL PRACTICE:** The team informs and educates individuals and families in writing and verbally about the individual and family's role in promoting safety.

**Guideline**

Individuals and families play an important role in preventing adverse events. Their questions and comments are often a good source of information about potential risks, errors, or safety issues. Individuals and families are able to fulfill this role when they are included and actively involved in the process of care.

Many organizations have developed materials that relate to client safety-related issues and provide guidance and direction for questions and topics to address during care. Examples of client safety educational materials include the Manitoba Institute of Patient Safety's "It's Safe to Ask," and the Ontario Hospital Association's "Your Healthcare – Be Involved."

Test(s) for Compliance

- 17.7.1 The team develops written and verbal information for individuals and families about their role in promoting safety.
- 17.7.2 The team provides written and verbal information to individuals and families about their role in promoting safety.





Safety



17.8

**REQUIRED ORGANIZATIONAL PRACTICE:** The team implements verification processes and other checking systems for high-risk activities.

**Guideline**

Processes and checking systems for high-risk care or service activities are important to client safety. To identify high-risk activities the team reviews their services and uses this information to develop and implement checking systems to prevent and reduce risk of harm to clients.

Across the care continuum, systems will vary depending on services. Examples may include but are not limited to:

- Safe surgery checklists and procedural pauses
- Repeat back or read back processes for diagnostics or verbal orders
- Checking systems for water temperature for client bathing
- Standardized tracking sheets for clients with complex medication management needs
- Automated alert systems for communication of critical test results
- Computer-generated reminders for follow-up testing in high-risk patients
- Two person verification process for blood transfusions
- Critical interventions related to drug orders
- Independent double checks for the dispensing/administration of high-risk medications
- Medication bar coding systems for drug dispensing, labeling, and administration
- Decision support software for order entry and/or drug interaction checking
- Safety monitoring systems for service providers in community-based organizations, or for clients in high-risk environments
- Standardized protocols for the monitoring of fetal heart rate during medical induction/augmentation of labour, or in high-risk deliveries
- System for monitoring of vaccine fridge temperatures
- Standardized protocols for the use of restraints
- Standardized screening processes for allergies to contrast media

Test(s) for Compliance

17.8.1 The team identifies high-risk activities.

17.8.2 The team develops and implements verification processes for high-risk activities.

17.8.3 The team evaluates the verification processes and uses information to make improvements.





Safety



17.9

The organization investigates all sentinel events, adverse events, and near misses.

**Guideline**

This includes investigating all incidents (e.g. sentinel and adverse events, and near misses), taking action to minimize the risk of the same situation reoccurring, monitoring incidents, and translating case-based lessons learned into improvements. Examples of incidents in mental health services include suicide or self-harm, aggression, falls, and other patient accidents.

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

Staff and service providers delivering mental health services are responsible for implementing the organization's process.



Safety



17.10

Staff and service providers follow the organization's policy and process to disclose adverse events to the individuals and families affected.

**Guideline**

This criterion is linked to the Required Organizational Practice in Accreditation Canada's Effective Organization Standards that requires organizations to have a formal process to disclose adverse events to individuals and families. The process for disclosure includes support and counselling for individuals and families, as well as for staff and service providers in the organization.



## 18.0 The organization uses current research, evidence-based guidelines, and leading practice information to improve the quality of its services.



Effectiveness



- 18.1 The organization has a process to select evidence-based guidelines for its mental health services and supports.

### Guideline

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

Guidelines from other organizations or associations may be adopted by the team. The process for selecting guidelines is standardized and formalized. It may include using content experts, a consensus panel, or the Appraisal of Guidelines Research and Evaluation (AGREE) instrument, which allows organizations to evaluate the methodological development of clinical practice guidelines from six perspectives: scope and purpose, stakeholder involvement, rigour of development, clarity and perspective, applicability, and editorial independence.

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



Effectiveness



- 18.2 The organization reviews its guidelines to make sure they are up-to-date and reflect current research and leading practice information.

### Guideline

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



Effectiveness

- 18.3 The organization's process for guideline selection includes seeking input from staff, service providers, individuals, and families about the applicability of guidelines and their ease of use.





Effectiveness



- 18.4 The team's research activities for mental health services meet applicable research and ethics protocols and standards.

**Guideline**

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

Research and ethics protocols and standards include individuals' and families' consent to participate in research activities.



Effectiveness

- 18.5 The organization shares benchmark and leading practice information with its partners and other organizations.

**19.0 The team makes ongoing improvements to its mental health services and supports.**



Effectiveness

- 19.1 The team has processes in place to regularly monitor the quality of its services and supports.

**Guideline**

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

Examples of events and processes to monitor include reasons for individuals leaving the service, sentinel event occurrences, and patient safety reviews.



Effectiveness

- 19.2 The team regularly monitors process and outcome measures.

**Guideline**

Performance measures should be reliable and relevant to the things the team wants to improve. Examples of process measures include therapy compliance rates, period of time from first contact with the organization to first appointment, individual falls, and number of visits to the emergency department. Examples of outcome measures include satisfaction rates and clinical outcomes.

Data quality is maintained to ensure that the information is useful.





Client-centred  
Services

- 19.3 The team regularly monitors individuals' and families' perspectives on the quality of its services.

**Guideline**

The team may seek individuals' and families' perspectives through surveys, focus groups, interviews, or meetings. This may include family or informal caregiver proxies if individuals are unable to provide their perspective.



Effectiveness

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

**Guideline**

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



Effectiveness

- 19.5 The team uses the information it collects to identify successes and make ongoing improvements.

**Guideline**

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



Population  
Focus

- 19.6 The team shares evaluation results with staff, individuals, and families.

**Guideline**

Sharing the results of evaluations and improvements helps staff to become familiar with the philosophy and benefits of quality improvement. It also increases individuals' and families' awareness of the organization's commitment to quality for its mental health services, and its commitment to ongoing quality improvement.



## Legend:

### Dimensions:



**Population Focus**

Working with communities to anticipate and meet needs



**Accessibility**

Providing timely and equitable services



**Safety**

Keeping people safe



**Worklife**

Supporting wellness in the work environment



**Client-centred Services**

Putting clients and families first



**Continuity of Services**

Experiencing coordinated and seamless services



**Effectiveness**

Doing the right thing to achieve the best possible results



**Efficiency**

Making the best use of resources

### Criterion Types



**Required Organizational Practices**

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



**Performance Measures**

Performance measures are evidence-based instruments and indicators that are used to measure and evaluate the degree to which an organization has achieved its goals, objectives, and program activities.

### Priority



**High Priority**

High priority criteria are criteria related to safety, ethics, risk management, and quality improvement. They are identified in the standards.

