ACCREDITATION CANADA

Driving Quality Health Services

Accreditation Report

Prepared for:

Burntwood Regional Health Authority

Thompson, MB

On-site Survey Dates:

April 25, 2010 - April 29, 2010

May 25, 2010

ACCREDITATION CANADA
AGRÉMENT CANADA

Accredited by ISQua

Accreditation Report

About this Report

The results of this accreditation survey are documented in the attached report, which was prepared by Accreditation Canada at the request of Burntwood Regional Health Authority.

This report is based on information obtained from the organization. Accreditation Canada relies on the accuracy of this information to conduct the survey and to prepare the report. The contents of this report is subject to review by Accreditation Canada. Any alteration of this report would compromise the integrity of the accreditation process and is strictly prohibited.

Confidentiality

This Report is confidential and is provided by Accreditation Canada to Burntwood Regional Health Authority only. Accreditation Canada does not release the Report to any other parties.

In the interests of transparency, Accreditation Canada encourages the dissemination of the information in this Report to staff, board members, clients, the community, and other stakeholders.

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About the Accreditation Report

The accreditation report describes the findings of the organization's accreditation survey. It is Accreditation Canada's intention that the comments and identified areas for improvement in this report will support the organization to continue to improve quality of care and services it provides to its clients and community.

Legend

A number of symbols are used throughout the report. Please refer to the legend below for a description of these symbols.

Items marked with a GREEN flag reflect areas that have not been flagged for improvements. Evidence of action taken is not required for these areas.

Items marked with a YELLOW flag indicate areas where some improvement is required. The team is required to submit evidence of action taken for each item with a yellow flag.

Items marked with a RED flag indicate areas where substantial improvement is required. The team is required to submit evidence of action taken for each item with a red flag.

Leading Practices are noteworthy practices carried out by the organization and tied to the standards. Whereas strengths are recognized for what they contribute to the organization, leading practices are notable for what they could contribute to the field.

Items marked with an arrow indicate a high risk criterion.

Accreditation Summary

Burntwood Regional Health Authority

This section of the report provides a summary of the survey visit and the status of the accreditation decision.

On-site survey dates	April 25 to 29, 2010
Report Issue Date:	May 25, 2010

Accreditation Decision	Accreditation with Condition (Report)

Locations

The following locations were visited during this survey visit:

1. Acquired Brain Injury Unit
2. BRHA Community Services
3. Burntwood Community Health Resource Centre
4. Gillam Hospital
5. Ilford Community Health Centre
6. Northern Consultation Centre
7. Northern Spirit Manor
8. Thompson General Hospital

Service areas

The following service areas were visited during this survey visit:

1. Acquired Brain Injury
2. Ambulatory Care
3. Community Health Services
4. Emergency Department
5. Emergency Medical Services
6. Home Care
7. Long Term Care
8. Managing Medications
9. Maternal/Perinatal
10. Medicine

11 Mental Health
12 Operating Room
13 Public Health
14 Sterilization and Reprocessing of Medical Equipment
15 Surgical Care

Surveyor's Commentary

The following global comments regarding the survey visit are provided:

1. Leadership Successes:
a. Executive leadership working towards ensuring a positive culture throughout the organization
b. New leadership team developing with recognition of community cultural issues
c. Growing culture of safety and an ethical conscience
d. Support leadership education and development

2. Leadership Challenges:
a. Clarification and education for the Board to ensure role clarity
b. Leadership gaps across the organization impact stability in programs
c. Increase focus and leadership on the Human Resources (HR) Plan as this impacts the entire organization's effectiveness

3. Areas of Risk:
a. The security system utilized for after-hours medication room is able to be bypassed and is considered in need of replacement
b. Consider unit dose system
c. Staff assigned on Medicine, Surgical, and Paediatric leads to increased chance of errors, particularly medication errors
d. Lack of reporting to Board of ongoing incidents and trends
e. Uncertified (for disinfection) Operating Room (OR) nurses cleaning scopes after hours
f. Lack of Home Care Support Worker, Home Health Aide direct supervision and follow up service evaluation
g. Mental Health policy related to "Seclusion" requires review with timelines defined
h. Consistency of Medication Reconciliation at admission, transfer and discharge is required throughout all areas of the organization (Acute, Long Term Care (LTC), Home Care, etc.)

4. Overall Strengths:
a. Car seat program implemented to keep newborns safe
b. Excellent response to the H1N1 in the fall of 2009 during which Burntwood Regional Health Authority (BRHA) was applauded for some models that were adopted provincially
c. Implementation and utilization of a Preventive Maintenance System
d. Early development of a strong cohesive leadership team
e. Beginning of strong ethical foundation will become the conscience of the organization
f. Successful transition through a difficult time and now beginning to establish an organizational identity
g. Utilization of telehealth is commended -- Telehealth utilized for Alcoholics Anonymous (AA) meetings and telehealth utilization overall
h. Physician initiation of Medication Reconciliation in Emergency Room (ER)
i. Trust growing between management and the Board
j. Implementation of regional communication officer role
k. Increase in visible and active interdisciplinary team approach throughout the region
l. Staff development
m. Regional orientation program
n. Staff recruitment – particularly the increase in the percentage of Aboriginal employees
o. Improved access at Burntwood Community Health Resource Centre
p. Palliative Care Program development and implementation

5. Need for improvement:
a. There is a lack of performance and outcome indicators throughout the organization
b. Lack of comprehensive Human Resource Plan which includes staff planning, performance reviews, labor management forums, etc.
c. Lack of alignment of values and beliefs of the community with its health care providers
d. Significant delays and inconsistencies of timely incident reporting, investigation and reporting. Need to investigate implementation of Root Cause process for system review (including near misses). Celebrate those near misses (Good Catches) that are reported.
e. Ongoing infusion pump training for staff
f. Limited options for individuals with behavioural problems who require Long Term Care
g. No formalized evaluation process for services and programs on an ongoing basis
h. Complaints process needs to be formalized and used consistently across the region

6. Community Relationships:
a. Organization and leaders are very visible and active in the community
b. It is apparent that there is a willingness to link with community partners
c. The organization is encouraged to continue to work on Federal/Provincial relationships and solutions at all levels
d. There is excellent collaboration with community partners in regard to disaster planning (Several examples including H1N1, forest fire planning, boil water, etc.)
e. The organization has a good relationship with the Addictions Foundation of Manitoba (AFM)
f. Multiple partnerships throughout the community to reach vulnerable populations
g. Strong community connections in smaller centres (i.e. Gillam, Ilford, etc.)
h. There is positive feedback on the communication and partnerships at the service provider level and many examples were cited regarding how the partners collaborate with program/staff throughout the Health Authority to provide services to the overall population/community (health promotion, return to work, parenting support, healthy school initiatives, student placements, disaster planning and chronic disease management, etc.)
i. Communities are appreciative of improved communication from the organization as it has enhanced relationships with the organization. Community partners encouraged strengthening communication at the corporate level.
j. Continue to build relationships with industry partners

7. Communication:
The organization utilizes a variety of methods to ensure ongoing communication among the various levels of the organization. Information from the Executive Team to the Regional Management team is primarily done through regular meetings to include members of both groups. This allows the opportunity for managers to provide information from front line staff to the Executive Team and ultimately to the governing body through the Chief Executive Officer (CEO) if required. It is noted that the CEO holds "open door" afternoons on a semi-regular basis to ensure that staff are able to access theCEO if it is their wish. Although not all departments utilize regular staff meetings, many departments utilize the staff meeting process to ensure effective communication and information transfer. Some departments utilize a more informal process such as daily "toolbox meetings" or impromptu staff gatherings to share necessary information. Communication books are also utilized in a number of departments and areas. Although staff do not currently have a formal comprehensive "intranet" site, there are electronic sites available to ensure e-access for staff to policies and information. Posters, bulletin boards, special e-mails directly to staff, regular newsletters and media are utilized to attempt to keep staff informed as much as possible. Minutes of Board meetings are posted to the Burntwood Regional Health Authority (BRHA) website and are accessible to staff.

Communication with stakeholders, communities, other agencies, the public, et cetera and the BRHA is done consistently and broadly through regular meetings, media (radio, newspaper), and newsletters. The region has recently redesigned and improved its public website which allows access to excellent information in regard to the region overall.

Organization's Commentary

The following comments were provided to Accreditation Canada post survey.

Burntwood Regional Health Authority
Organization Commentary
Accreditation Survey – April 2010

Comments: Re findings in Accreditation Report:

1. Fair assessment of our current status of compliance with Accreditation Canada standards.
2. A few technical and information inconsistencies that require correction:
a. Incomplete/inaccurate statement under Infection Prevention and Control in the Surveyor's Comments section ("IP&C 2.3. The Public Health Department has partners with the city Bylaws officers in relation.")
b. Under Surgical Procedures, Surveyor Comments, Surgical Pause, Surgical Site Marking and "Surgical Safety Check List" are being used for all procedures performed in the Operating Rooms
c. Ambulatory Care Services, Impact on Outcomes, Aboriginal Liaison Workers currently spend one hour with physicians during their orientation at the Burntwood Community Health Resource Centre.
d. Managing Medications, Criteria 10.3, Burntwood RHA does not have a computerized prescriber order entry (CPOE) system. The rating should be not applicable for this criteria
e. Emergency Department Services, Episode of Care, Surveyor Comments: "The team recently changed the Resuscitation policy to clearly reflect" (incomplete note).

The findings accurately captured our successes and challenges.

Organizational learning from assessment of compliance with Accreditation Canada standards:

1. Process enhanced with involvement of a broader organizational perspective, i.e. questionnaires completed by all levels of staff in all areas of the organization.
2. Added value of assessing compliance with standards from bottom to top of organization.
3. It is acceptable to acknowledge that we are not perfect in all areas and have room for improvement.
4. Accreditation goals are achievable.
5. Importance of continuing Quality Improvement Teams activities to maintain the momentum.
6. Accreditation standards need to be part of our every day work.
7. Staff appreciated the feeling of inclusiveness and transparency, and the positive feedback they received from surveyors.
8. The tracer process was felt to be more practical. Questions that the surveyors asked are those that we should ask ourselves every day.
9. Important to move forward and complete initiatives we have started.
10. Terminology used in Accreditation Canada questionnaires and instruments was difficult for staff to interpret. This resulted in the organization getting unwarranted "flags". "Neutral" responses may have skewed the results.

Actions currently underway to address identified areas for improvement:

1. Revised "Single Use" Policy on May 2010 agenda of Regional Infection Control Committee for discussion, and forwarded for approval and implementation.
2. Protocol for administration of prophylactic antibiotics for caesarean sections revised to comply with Accreditation Canada standard.

resident and provider safety went out in early April 2010 and are currently being received by the BRHA. Work expected to be completed by Fall 2010.

3. Request for tenders to improve access and/or egress at the Northern Spirit Manor to ensure resident and provider safety went out in early April 2010 and are currently being received by the BRHA. Work expected to be completed by Fall 2010.
4. Class "C" estimate for renovations to CSR department was completed at the end of March 2010 and drawings received as per required approval from Manitoba Health. Committee will review drawings to ensure compliance with CSA Standards. Next step is to proceed with request for approval of funding for renovations to CSR department as defined to Class 'C' estimate. This would enable the relocation of the cleaning of scopes to the CSR area and cleaning / disinfecting by certified staff.
5. Roll out of Medication Reconciliation at Admission to all areas of acute and long term care in the organization will be complete by the end of May 2010.
6. BRHA Board of Directors is working with the Manitoba Health Accountability Department and all provincial RHAs on education related to Board Governance. In addition, there is a provincial pilot project on Governance for Patient Safety. Results for Boards are expected in Fall 2010.

Actions to improve quality of care and diminish risks:

Immediate:

1. Complete rollout of Medication Reconciliation at admission and develop process for consistent auditing.
2. Proceed to develop and implement plan for Medication Reconciliation on transfer / discharge.
3. Infusion Pump training policy and procedure will be completed by June 4, 2010. Audits will be conducted quarterly.
4. Improve security system for after hours' medication room by June 30, 2010.
5. Communication focus group discussions
a. Hold staff focus groups sessions to discuss organizational communication.
b. Develop audit to measure uptake of distributed information by managers.
6. Increase frequency of system wide incident reporting to Board to quarterly, beginning September 2010.
7. Record minutes of In-camera sessions of the Board
8. Review / revise Mental Health policy relating to Seclusion by June 18, 2010.
9. Formalize a process to evaluate Home Care Services provided to clients by June 18, 2010.
10. Cultural awareness training program with inclusion of all cultures.
11. Develop an Annual Communication Plan by September 2010.
12. Two staff members will be taking "Train the Trainer" Root Cause Analysis training at the end of May 2010. Subsequent training sessions will be held for staff.
13. Human Resource Plan to be communicated at Regional Management meeting in June 2010. A Gant chart for implementation will be provided to CEO. Performance Review audits will be implemented in September 2010. The tool has been developed and circulated.
14. Strengthen incident reporting process including options to celebrate "Near Misses" that are reported. The "Big Catch" award will be implemented by December 2010.
15. Explore options to provide services to individuals with behavioural problems who require Long Term Care. We have a number of services available for a small area with many external reports. This needs to be more fully described. We have Long Term Care, Special Cognitively Impaired Unit and Acquired Brain Injury Unit.
16. Review process to evaluate programs and services.
17. Revise Complaints Policy and process.
18. Outcome Indicators will be developed for all Health Priorities as a contracted project using 120 Community Health Assessment indicators that have been completed as of May 2010 and will be published in September 2010. All Programs and Services will develop Outcome Indicators and submit to their Senior Executive report by December 2010.
19. Home Care program will develop a process to consistently collect information about the quality of its services and make timely improvements.

20. Home Care program will standardize verification processes.

Long term:

1. Establish Intranet to improve communication and facilitate more efficient and effective use of our current and future technologies.
2. Continue to request funding in annual Health Plan to purchase medication unit dose system.
3. Review of staffing on Medicine, Surgical, Paediatric nursing unit.
4. Implement a formalized process for Risk Management by January 2011.

Overview by Quality Dimension

The following table provides an overview of the organization's results by quality dimension. The first column lists the quality dimensions used. The second, third and fourth columns indicate the number of criteria rated as met, unmet or not applicable. The final column lists the total number of criteria for each quality dimension.

Quality Dimension	Met	Unmet	N/A	Total
Population Focus (Working with communities to anticipate and meet needs)	103	11	1	115
Accessibility (Providing timely and equitable services)	115	1	3	119
Safety (Keeping people safe)	449	49	37	535
Worklife (Supporting wellness in the work environment)	148	14	5	167
Client-centred Services (Putting clients and families first)	156	8	6	170
Continuity of Services (Experiencing coordinated and seamless services)	66	5	5	76
Effectiveness (Doing the right thing to achieve the best possible results)	603	79	26	708
Efficiency (Making the best use of resources)	61	8	4	73
Total	**1701**	**175**	**87**	**1963**

Overview by Standard Section

The following table provides an overview of the organization by standard section. The first column lists the standard section used. The second, third and fourth columns indicate the number of criteria rated as met, unmet or not applicable. The final column lists the total number of criteria for that standard section.

Standard Section	Met	Unmet	N/A	Total
Sustainable Governance	70	18	3	91
Effective Organization	83	21	0	104
Infection Prevention and Control	89	8	6	103
Public Health Services	97	12	6	115
Acquired Brain Injury Services	92	0	15	107
Ambulatory Care Services	106	1	13	120
Community Health Services	68	0	0	68
Emergency Department Services	86	17	2	105
Emergency Medical Services	135	17	8	160
Home Care	66	28	10	104
Long Term Care Services	114	2	3	119
Managing Medications	121	11	3	135
Medicine Services	95	7	2	104
Mental Health Services	103	3	3	109
Obstetrics/Perinatal Care Services	111	6	2	119
Operating Rooms	93	5	3	101
Reprocessing and Sterilization of Reusable Medical Devices	87	6	4	97
Surgical Care Services	85	13	4	102
Total	**1701**	**175**	**87**	**1963**

Overview by Required Organizational Practices (ROPs)

Based on the accreditation review, the table highlights each ROP that requires attention and its location in the standards.

Criteria	Required Organizational Practices
Effective Organization 6.4	The organization establishes a reporting system for sentinel events, adverse events, and near misses, including appropriate follow-up. The reporting system is in compliance with any applicable legislation, and within any protection afforded by legislation.
Effective Organization 6.8	The organization's leaders provide the governing body with quarterly reports on client safety, and include recommendations arising out of adverse incident investigation and follow-up, and improvements made.
Effective Organization 12.6	The organization has defined roles, responsibilities, and accountabilities of leaders, staff, service providers, and volunteers for client care and safety.
Infection Prevention and Control 1.2	The organization tracks infection rates, analyzes the information to identify clusters, outbreaks, and trends, and shares this information throughout the organization.
Emergency Department Services 10.5	The team reconciles medications with the client at referral or transfer and communicates information about the client's medications 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.
Emergency Department Services 10.8	The team transfers information effectively among service providers at transition points.
Home Care 7.4	The team reconciles the client's medications at the beginning of service with the involvement of the client.
Home Care 11.3	The team reconciles medications with the client at referral or transfer, and communicates information about the client's medications 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.
Home Care 11.4	The team transfers information effectively among service providers at transition points.
Home Care 15.5	The team implements verification processes and other checking systems for high-risk activities.
Long Term Care Services 7.4	The team reconciles the client's medications upon admission to the organization, and the involvement of the client.
Managing Medications 3.4	The organization standardizes and limits the number of medication concentrations available.
Managing Medications 19.4	Staff and service providers receive ongoing, effective training on infusion pumps.
Medicine Services 4.4	Staff and service providers receive ongoing, effective training on infusion pumps.
Medicine Services 11.3	The team reconciles medications with the client at referral or transfer, and communicates information about the client's medications 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.

Criteria	Required Organizational Practices
Mental Health Services 11.3	The team reconciles medications with the client at referral or transfer, and communicates information about the client's medications 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.
Mental Health Services 15.3	The team implements and evaluates a falls prevention strategy to minimize the impact of client falls.
Obstetrics/Perinatal Care Services 4.6	The team receives ongoing, effective training on all infusion pumps for staff and service providers.
Obstetrics/Perinatal Care Services 11.3	The team reconciles medications with the client at referral or transfer, and communicates information about the client's medications 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.
Surgical Care Services 4.4	Staff and service providers receive ongoing, effective training on infusion pumps.
Surgical Care Services 7.10	The team reconciles the client's medications upon admission to the organization, with the involvement of the client.
Surgical Care Services 11.4	The team reconciles medications with the client at referral or transfer, and communicates information about the client's medications 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.
Surgical Care Services 15.3	The team informs and educates its clients and families in writing and verbally about the client and family's role in promoting safety.

Detailed Accreditation Results

System-Wide Processes and Infrastructure

This part of the report speaks to the processes and infrastructure needed to support service delivery. In the regional context, this part of the report also highlights the consistency of the implementation and coordination of these processes across the entire system. Some specific areas that are evaluated include: integrated quality management, planning and service design, resource allocation, and communication across the organization.

Findings

Following the survey, once the organization has the opportunity to address the unresolved criteria and provide evidence of action taken, the results will be updated to show that they have been addressed.

Planning and Service Design

Developing and implementing the infrastructure, programs and service to meet the needs of the community and populations served.

Surveyor Comments

The organization has a mission and vision statement that reflects their priorities. The values were developed in consultation with staff and reflect the focus and spirit of the mission and vision. At the last planning process there was an extensive stakeholder consultation, both internal and external, to provide input into the strategic planning process. There is a completed community needs assessment process which helps direct priorities for services within the communities. Both these processes are required by the Ministry and require regular updates.
The strategic plan is high level with broad overarching goals. The organization recognizes the need to develop some key measurable indicators with some targeted time lines for improvement. This will allow the organization to monitor and measure its improvements and goals over time as identified in the operational and strategic plan.
Operational planning is done through the Planning and Services committee and discussed with the leadership group and then presented to the Board. Operational planning is done on a needs base reviewing utilization data from previous years. Managers of various programs are encouraged to engage program staff and physicians in the operational planning and priority setting for service delivery.
While there are District Health Advisory Councils in several communities encouragement is given to find ways to support more engagement and input from the community. These Councils need to feel they have a community voice at the planning stage for the organization.
Most community partner organizations feel they have the opportunity to dialogue and provide input into the services and programs with the BRHA. While this process happens often informally there needs to be a documented and more formalized process to ensure partners are involved in establishing priorities. There is a Partnership Team that has been created, involving senior BRHA representatives and a variety of community partners which meets on a regular basis. This team was recognized as a good venue for open dialogue with the organization and for discussion about emerging issues, gaps and service needs. There are also examples of the BRHA and various community groups working together for improved services. Once services are planned and implemented in the operational plans community members hope to see more corporate information flowing to the community, providing information on programs and services as well as overall organizational information.
The community indicated BRHA senior representation was always apparent at community events.

This is something they viewed as key to improved relationships and partnering with the community. The region's 2009 Community Health Needs Assessment is currently in the printing process. Delay of printing was due to the H1N1 outbreak in fall 2009 and regions were given an extension for completion as a result. The community needs assessments were completed through consultation with various communities and agencies and included focus groups, public consultation, etc. A communication plan is to be developed in regard to release and distribution of the 2009 Community Health Needs Assessment. It is suggested that the team ensure there is an evaluation of the effectiveness of the communication strategy which can be used to make improvements in regard to communication into the future.
Community health assessments are completed every five years and are reviewed and updated about 1-2 years after completion. The organization has a plan to strive to do updates to community health assessments in a more timely manner (i.e. annually) and is encouraged to continue to work on this goal. Prominent issues identified in community health assessments are monitored and specific programming (i.e. Tuberculosis nurses) and/or resources are implemented. Evaluation of these programs with measurable targets and identified timelines is encouraged.
In order to address the operational needs of the organization encouragement is given to have an HR plan to address both immediate needs and plan for the future both in terms of operational issues and increasing demands on services. The HR plan should also be mindful of upcoming retirements with a retrospective view on resignations.
Governance and leadership are encouraged to include physician manpower planning as well as succession planning to ensure there is adequate supply of physicians to meet the community needs.
The organization needs to formalize the evaluation process to ensure tools and systems with quantitative data and outcomes are used to evaluate success of the operational plans. Without clear measurable targets and evidence success can only be viewed qualitatively. Evaluation needs to include both measures. Without identified goals that are measurable and within an identified timeline there is little objective evidence to allow the governing body and leadership to determine if they have achieved their strategic goals and if there is anything to realign.
While there is a very basic HR plan strong encouragement is given to proceed with the development of each area - including a staffing plan. The lack of a comprehensive HR plan and leadership to move it forward impacts the entire organization's ability to provide effective or quality service. This should be an immediate priority for this organization. A staffing workforce plan will assist the organization in planning for services. While position profiles are available there is encouragement to regularly update these profiles and communicate the profile and changes to respective staff. Ideally staff should have the opportunity to have input into the scope of their jobs. Currently staff are unaware of where these are and have not seen them.
There needs to be formal development, communication and implementation of a performance plan across the organization. Currently there is no formal performance evaluation for staff or managers.

The table below indicates the specific criteria that require attention, based on the accreditation review.

Criteria	Location	Priority for Action
Effective Organization		
The organization’s leaders follow a formal process to manage change.	4.7	

The organization's leaders select management systems and tools to monitor the implementation of operational plans.	4.8
Public Health Services	
The organization reviews the community health assessment every year and updates it as necessary	1.2
The organization has a documented process to work with partners to establish priorities.	4.4
The organization and partners develop a communication strategy based on evidence, best practices, research, and the community health assessment.	5.1
With its partners, the organization tailors the communication strategy to meet the needs of different target audiences and community groups.	5.2
The organization regularly assesses the effectiveness of its communication strategy and uses this information to make improvements.	5.5
The organization's goals and objectives for its services are measurable and specific.	8.6
The organization conducts a workforce assessment at least every three years to determine the capacity of its workforce and volunteers to meet community health needs.	9.1
The organization develops and implements a plan to address workforce gaps.	9.2
The organization reviews position profiles annually, and updates them as required.	9.4
Team leaders regularly evaluate and document each team member's performance in an objective, interactive, and positive way.	9.6
Team members have input on work and job design, including the definition of roles and responsibilities, and case assignments, where appropriate.	10.1

Team leaders regularly evaluate the effectiveness of staffing and use the information to make improvements.	10.2	
Sustainable Governance		
The strategic plan includes measurable strategic goals and objectives.	2.5	
The governing body identifies timeframes and responsibility for achieving the strategic goals and objectives.	2.6	
The governing body regularly reviews the available information to assess its appropriateness, and identify information needs and gaps.	4.6	
The governing body uses the information to make informed decisions and guide the organization's long-term direction.	4.7	
The governing body demonstrates that the organization achieves its strategic goals and objectives, and makes progress toward achieving its long term vision and direction.	12.6	↑

Resource Management

Monitoring, administration, and integration of activities involved with the appropriate allocation and use of resources.

Surveyor Comments

The Board has a mix of members many of whom have been in place for several years. There are also some Board members who have joint membership in the District Advisory Council in specific geographic areas. The Board operates under a Carver model but is moving towards a modified Carver with their inclusion of newly formed Board committees such as Audit and Finance and Policy. The Board receives information regarding resource requirements, priorities and risks to the organization from the senior team with explanation to ensure appropriate planning and process have occurred and resources are aligned appropriately. While the Board has done some recent governance education, encouragement is given to continue with this in light of the change to the modified Carver model. Board members need to have skills, abilities and confidence in their roles and responsibilities as Board members. When reviewing organizational health plan and resource requirements and understanding changing service programs and demands, the Board is encouraged to review and reflect on the priorities, health status and risks within the organization. A more comprehensive review at a high level will ensure the Board is aware of trends, impacts and potential risk.

There is a newly developed budgeting process that involves managers and has some involvement of their program staff. Managers are invited to the Senior team to speak to their past years successes and then outline goals for the upcoming year and the resources they will need to achieve these goals. The intent is that the program goals are linked to the strategic plan - this process should be formalized to ensure all programs directly impact the broader strategic goals.

There is then discussion with the Senior Leadership team and the Board to discuss the priorities the Senior team has set and associated resource requirements, based on the anticipated budget. Informal discussion with a focus on patient safety and security guide the resource discussion.

The Board receives a monthly financial report for information, showing the financial position in each program. Variance reporting is done by the Finance department and is provided to the Board. Encouragement is given to provide education regarding budgeting and financial management to the program managers. This will allow them to take greater responsibility for their financials and variance reporting and ultimately greater responsibility and accountability for their respective budgets and ultimately result in better resource management.

Despite lack of assurances of committed funds, the organization is encouraged to undertake a thoughtful and longer term plan to capital expenses, both new and replacement. This should include equipment and facility renovations and replacement. This will allow better planning and more accurate information to be shared with the MInistry through the submitted health plan.
In order to more accurately plan operational expenditures and more effectively manage the budget the issue of Northern Transportation funding should continue to be pursued and clarification sought.
Currently the system does not allow a joint report that aligns utilization and staff costs with available budget. This type of reporting would make resource planning more accurate and identify areas of program efficiency and actual resource needs.
Hours of care per patient day within units aligned against existing budget is useful to determine cost effectiveness and efficiencies.
In the previous fiscal year the organization ran in a deficit position. This however was supported by the Board and has been communicated. Part of the deficit is revenues not yet received.

The table below indicates the specific criteria that require attention, based on the accreditation review.

Criteria	Location	Priority for Action
Effective Organization		
The organization's leaders follow set criteria to guide resource allocation decisions.	9.2	↑
The organization's leaders regularly assess the impact of resource allocation decisions.	9.4	
The reports on financial performance include an analysis of the utilization of resources and opportunities to improve the efficient use of resources.	9.8	↑
The organization meets legal requirements for managing financial resources and financial reporting, i.e. audit, running a deficit.	9.9	

Sustainable Governance		
When reviewing and approving resource allocation decisions, the governing body identifies and assesses the associated risks to the organization.	10.2	
The governing body compares available resources to those required to meet needs and achieve the strategic goals and objectives.	10.3	
When making resource allocation decisions, the governing body considers ethics, values, social costs and benefits, and the potential impact on quality and safety.	10.5	↑
The governing body assesses and anticipates the impact of changing the level or type of service, and plans accordingly.	10.6	
The governing body anticipates financial needs and potential risks, and develops contingency plans.	13.2	↑

Human Capital

Developing the human resource capacity to deliver safe and high quality services to clients.

Surveyor Comments

Ongoing education of the Board is encouraged to further their understanding of their roles and responsibilities.
Further work needs to be completed to address human resource management processes and planning.
Although the Board has education related to services and programs more education related to the Board's role and responsibilities is encouraged.
A formal and proactive labour management process including regularly meeting is encouraged.
The organization has not developed a communication/action plan to address the results from the Work Life Pulse Tool.
Although the Board receives an annual quality report from each clinical program the Board needs to receive on a regular basis information related to performance indicators and patient safety.
Success in recruitment is noted, particularly the increase in recruitment of Aboriginal employees.
Although there is evidence that position profiles have been developed the majority of staff interviewed do not acknowledge that they have a position description. It is suggested that HR develop a process for communicating and updating position profiles.
A performance management process has not been implemented. There is evidence of informal feedback on performance. Performance evaluation is required at all levels in the organization.
Client safety is addressed in newsletters, orientation and handout materials. The organization is encouraged to include client safety in position profiles and performance evaluations.
The organization is encouraged to conduct exit interviews more frequently.

The table below indicates the specific criteria that require attention, based on the accreditation review.

Criteria	Location	Priority for Action
Effective Organization		
The organization's leaders identify and monitor process and outcome measures related to worklife and the working environment.	8.6	↑
The organization monitors the quality of its worklife culture using the Worklife Pulse Tool.	8.7	
The organization does not have any unaddressed priority for action flags based on their most recent Worklife survey results.	8.7.2	
The organization's leaders share the results of the Worklife Pulse Tool and use the results to make improvements.	8.8	↑
The organization's leaders develop and regularly update position profiles for each position.	12.5	
The organization has defined roles, responsibilities, and accountabilities of leaders, staff, service providers, and volunteers for client care and safety.	12.6	↑
Attention to client safety is demonstrated by defining roles and responsibilities for client safety in position profiles, performance appraisals, handbooks, orientation material, and by addressing client safety on regular basis in newsletters and client safety committee minutes.	12.6.2	
The organization's leaders implement policies and procedures to monitor performance.	12.9	
The organization's leaders conduct exit interviews with individuals and use this information to improve staffing and retention strategies.	12.11	

Integrated Quality Management

Continuous, proactive and systematic process to understand, manage and communicate quality from a system-wide perspective to achieve goals and objectives.

Surveyor Comments

There is a Quality Council formed from chairs of individual program quality committees. There is good senior representation on this committee as well. Although this committee is relatively new the commitment of the members to quality and patient safety is evident.

Issues may be identified by the organization or program staff and can be discussed at this Council.
Issues are brought forward to this group, discussion occurs and then any direction set and recommendations go back to individual areas for implementation. There is written presentation to the Governance Board around trends and summary numbers of incidents, complaints, etc. once a year. While there are quality reports that go monthly to the Board, with each month being on a specific program, there is no quarterly summary report to the Board. Trends and key indicators in a summary quarterly report should be provided to the Board for increased awareness.There needs to be an organizational summary on a quarterly basis to the Board to ensure any trends emerging across the organization are noted. This will allow the Board and Senior team to develop strategies and set targets to address these. Additionally program front line staff should be involved with establishing indicators, setting targets and time lines and actions to address the improvements. Regular reporting done at the department or unit level would encourage ownership and pride in the improvements.

There appears to be a significant time lag between when incidents are reported and when appropriate review occurs. There needs to be a formalized process for incident reports in terms of time lines for initial review, with thirty and sixty day follow up to the appropriate bodies. Additionally recommendations that have been an outcome of the incident need to have a formalized process in place to ensure implementation and follow up occurs. Regular risk reports and trending regarding incident reports needs to be reviewed at the Board level and this information needs to be utilized when aligning resources. Staff injury trends also need to be reported at the Board level to ensure Board members are aware of and are able to use this information when priorizing safety concerns for both workers and clients.

Any sentinel events or critical events are discussed verbally in-camera to the Board. Due to the sensitivity of these issues the in- camera discussion is supported. The summary and any record of decision on these issues needs to be documented in in-camera minutes or record of decision written documentation. This will ensure Corporate memory and records of decisions are clearly documented. The organization is strongly encouraged to avoid any potential liability in the future, with in-camera meetings of the Board having written minutes or documentation recording decisions that are made.

As with many similar organizations there are challenges managing the jurisdictional issues. Encouragement is given to the organization to continue to explore options to further clarify roles and responsibilities for each partner and to seek joint solutions for patient care as needed.

There has been a recent Quality Newsletter developed and distributed to staff to increase awareness of patient safety. The news letters highlight a variety of patient safety successes and give kudos to programs. Posters of quality improvement (QI) and safety initiative are developed by programs and these posters are displayed in the facilities as a means of public recognition.

There is a good beginning of measuring indicators and highlighting improvements and areas for further work. While there has been some early work begun in indicator development and implementation, the team is encouraged to go beyond outputs such as counting participants and attendees and begin to focus on the outcome and results of the indicators.

If patient education is highlighted as a result of the indicator then education is organized and funding is available to staff and physicians to attend as needed.

Some safety reports including wait times for service and reports on falls with regular monitoring of specific indicators are provided to the Board on an annual basis through the Quality team reporting process. Encouragement is given to create a high level quarterly summary document for Board review that can assure the Board things are on track between the annual program specific reporting.

There has been an incident reporting process formalized that also includes disclosure with identified time lines. While time lines are identified in the policy there appears to be lack of adherence to this. Reporting occurs at times with a very long time lag following the incident and there appears to be an absence of follow up reports on incidents that have occurred. Disclosure training has occurred for some physicians and is being offered again to more physicians and some staff, although many staff were unaware of the process of disclosure. Further education needs to occur to ensure staff and physicians are all aware of the disclosure process and the steps they may need to be involved in.

There is a formal Patient Safety plan developed in alignment with Accreditation Canada required organizational practices (ROPs). The organization is encouraged to move to the next steps to try and expand this work to include other operational and organizational areas of priorities.

Management of contracts is delegated to respective managers in each area and not overseen by either HR or the Governance.

The table below indicates the specific criteria that require attention, based on the accreditation review.

Criteria	Location	Priority for Action
Effective Organization		
The organization establishes a reporting system for sentinel events, adverse events, and near misses, including appropriate follow-up. The reporting system is in compliance with any applicable legislation, and within any protection afforded by legislation.	6.4	↑
Improvements are made following investigation and follow-up.	6.4.2	
The organization monitors its client safety culture by using the Patient Safety Culture Instrument.	6.7	
The organization does not have any unaddressed priority for action flags based on their most recent Patient Safety Culture survey results.	6.7.2	
The organization's leaders provide the governing body with quarterly reports on client safety, and include recommendations arising out of adverse incident investigation and follow-up, and improvements made.	6.8	↑
Quarterly client safety reports have been provided to the governing body.	6.8.1	
The reports outline specific organizational activities and accomplishments in support of client safety goals and objectives.	6.8.2	

There is evidence of the governing body's involvement in supporting the activities and accomplishments, and acting on the recommendations in the quarterly reports.	6.8.3	
The organization has a positive worklife culture as a strategic priority.	8.1	
The organization's leaders select and monitor process and outcome measures to evaluate the organization's performance.	14.5	↑
The organization's leaders require service or program areas to monitor their own process and outcome indicators, and monitor and support their efforts to do so.	14.6	
Sustainable Governance		
The governing body selects and monitors performance measures to assess the organization's performance and the achievement of the strategic plan.	12.2	
The governing body establishes how often it will receive reports about the organization's performance, and analyzes trends in performance.	12.4	↑
The governing body identifies opportunities for improvement and monitors the actions taken to address them.	12.5	
The governing body regularly reviews the frequency and severity of near misses and adverse events.	15.3	↑
The governing body monitors organization-level measures of client safety.	16.4	↑

Principle Based Care and Decision Making

Identifying and decision making regarding ethical dilemmas and problems.

Surveyor Comments

There is a well organized Ethics Committee. Membership includes front line staff with good representation across the organization, including managers and Board member representation, which meets regularly to discuss both clinical issues and research issues.The Board member on the Ethics Committee acts as a liaison to the Board, ensuring the Board is aware of challenges and issues arising. The Committee functions well with a sense of equal representation by all members. Based on the high First Nations populations it would be beneficial for an Elder and another spiritual leader to be added to the Committee.

There is also a formalized ethics framework that has been implemented within the organization. Staff education regarding the ethics framework and the role and function of the ethics committee occurs in several ways. General orientation for new staff and discussion by committee members on the unit is done. As well regularly scheduled Lunch and Learn sessions are done with a variety of appropriate and timely ethical topics. Guest speakers and physicians are asked to present. There was a well received Ethics week event, with contests, displays and education sessions.

There is a formal process for review of research proposals within the organization. Any research proposals follow the formalized research policy. The University of Manitoba conducts the ethics research review prior to it being brought forward to this ethics group. There have been three recent research projects that have been done.

The Ethics committee receives education as a committee through external education sessions, telehealth sessions and linkage with the Manitoba Provincial Health Ethics Network (PHEN).

There was lively discussion about an ethical issue and it was obvious the group is well functioning and is respectful of each others expertise and knowledge. This group clearly understands their role as bringing the conscience of the organization to greater awareness for the improvement of patient care.

No Unmet Criteria for this Priority Process.

Communication

Communication among various layers of the organization, and with external stakeholders.

Surveyor Comments

Although the Information Management Team does have a five-year action plan, the organization does not currently have a formal regional annual communication plan. It is suggested that the organization develop an annual communication plan to include strategies, identification of all audiences, outlining of outcome measure for the year, etc.

This organization is commended for the excellent work that has been achieved in the area of communication over the past year or so. Good Work! Much good work has been achieved in regard to communication by the BRHA over the past several years. In 2008 the organization implemented the position of communication coordinator. The organization sends annual newsletters to all households and stakeholder partners; has re-developed the BRHA public website; resurrection of the staff newsletter is under review; and there are regular e-mail newsletters from the CEO to staff.

During an impromptu staff group conversation held during the visit in regard to organizational communication, staff clearly stated that they valued the former staff newsletter and during the meeting advised the Information Management Team of their the desire to see this resurrected. The group felt that it would be helpful if the communication coordinator could be the facilitator and they felt that staff would volunteer to provide consistent and regular information. Currently the region does not have an internal website (intranet). Staff from external locations, as well as others, expressed the need for such a resource if at all possible. Currently there are two systems that allow access to all policies, etc. electronically by staff. The organization may wish to investigate the possibility of an internal (intranet) website accessible to all management and staff throughout the region to improve and ensure information sharing (post events, highlight regional information for staff, etc.).

The regional communication officer attends regular board meetings and is occasionally invited to participate at Senior Management meetings as issues arise. The organization may wish to consider having the communication coordinator participate regularly at Executive meetings in order to ensure that communication planning is an ongoing part of all discussions.

The organization regularly utilizes local radio and BRHA also regularly purchases advertising in the local weekly newspaper to highlight important public health messaging.

Due to the relative remoteness of the organization, BRHA is faced with some communication issues (i.e. cell phone coverage, internet and other type of access, etc.). Staff at Thompson General Hospital has access to policies etc. through the New Technologies (NT) User site. Off site locations do not appear to have the same type of access due to telephone coverage challenges and therefore have access to policies, etc., through their public folders in Outlook.

It was observed during review of the governing body's minutes, records and decisions that currently the organization develops and retains copies of minutes of its regular meetings with the exception of the in-camera portions of the meetings. It is strongly encouraged to ensure that minutes/notes of in-camera decisions and discussions are recorded and maintained to ensure the organization meets its legal requirements.

The organization is encouraged to review its confidentiality policy and agreements at all levels to include Board, management and staff confidentiality agreements to ensure consistency of practice.

The support given by the organization to a young Aboriginal woman's (Chantelle's Promise) goal to increase the number of Aboriginal individuals on the One Match bone marrow registry is commendable and is an excellent example of the region's broad vision of health care and excellent communication with partner organizations. As a result of "Chantelle's Promise", with the region's assistance, in the first year of the campaign fifty Aboriginal people throughout Manitoba registered on the OneMatch Network and Chantelle's Promise is continuing to increase those numbers and improve odds for Aboriginal patients requiring bone marrow transplantation.

The region's mascot CAREibou was developed to enhance visibility and to promote health care for the children in the communities. CAREibou is a caribou with "hand-like" antlers depicting the region's motto, "Northern Health in Northern Hands".

The table below indicates the specific criteria that require attention, based on the accreditation review.

Criteria	Location	Priority for Action
Effective Organization		
The organization’s leaders develop and implement a communication plan to disseminate information to, and receive information from, stakeholders.	3.3	

Sustainable Governance		
The organization maintains records of the governing body's activities and decisions that are easy to access and meet legal requirements.	4.5	↑
The governing body works with the CEO to establish a communication plan.	11.3	
The communication plan includes strategies to communicate key messages to different groups and the community.	11.4	

Physical Environment

Providing appropriate and safe structures and facilities to successfully carry out the mission, vision, and goals.

Surveyor Comments

Despite the age of some of the Thompson General Hospital facility (built about 1960), the facility is well maintained and environmental service staff are commended for the cleanliness of the facilities. The environmental services department constantly experiences employee turnover and find it difficult to maintain a consistent staffing complement.

The organization is involved in projects/programs to lessen the organizations environmental impact. Namely, the Energy Efficiency Program, to switch heating from steam to an electric hot water boiler to reduce propane costs is currently being considered. Also a Water Usage reduction project has been rejuvenated. The organization is encouraged to continue on these paths. The organization is actively involved in recycling programs and are encouraged to continue and to expand these.

The maintenance department is commended for the quick response to department requests and for the neatness of the grounds and equipment.

The organization is applauded for having implemented the Micro Main Preventative Maintenance Program. The region is encouraged to continue to work to involve all levels of staff and to utilize the program to its fullest capacity.

Some areas in the older portion of the facility (mainly basement) are not wheelchair accessible and it is reported that an architectural review is planned sometime in the 2010-11 fiscal year to determine future capital planning needs.

Recently the entire building operating system has been replaced and other sites may also be monitored directly from the main location.

It is reported that there continues to be asbestos flooring in the basement of the facility. The organization has reportedly submitted proposals for replacement.

It is noted that the exits at the Northern Spirit Manor will require improved access and/or egress (only wooden walks outside exits) to ensure resident and provider safety. The organization is strongly encouraged to investigate solutions as soon as possible.

No Unmet Criteria for this Priority Process.

Emergency Preparedness

Dealing with emergencies and other aspects of public safety.

Surveyor Comments

It is evident through tracer activity, staff and leadership interviews, documentation review and conversations with various partners that the organization has worked diligently over the past several years to develop and test components of its Emergency Preparedness. In 2008 the region undertook a mock "code green" exercise. The region is commended on its diligence and teamwork in developing its plan. It is suggested that the organization continue to test components of the plan on a regular basis and continue to undertake mock exercises whenever possible.

Fire drills are held at all facilities on a regular (monthly) basis. Drills are recorded and records are retained as required.

With the National H1N1 outbreak in late 2009, the region was able to test and continue to develop its regional Pandemic Plan. This region was among the hardest hit area. The region was commended provincially and was recognized as developing some model practices that were utilized elsewhere in the province.

Several excellent communication practices for the public were utilized during the H1N1 outbreak to highlight important public processes. The region developed T-shirts emblazoned with a "Cover your Cough" message to drive home the message. Also, members of the disaster planning team were visible throughout the event, both to staff and out in the public domain. The Chief of Medical Staff was available to the Hydro project (Wuskwatim) employees to provide valuable information to the company's employees. It was estimated that 200 to 300 employees accessed the event. Regular radio communication for the public was provided. Communication and collaboration with various partners was strengthened through these events.

The organization has held at least one mock disaster event and is currently planning another mock event to include numerous other partners. It is anticipated that the event will take place sometime in 2010. Information from the Code Green mock disaster was utilized to improve and enhance future planning.

In meeting with the disaster planning team it was clear that this is an enthusiastic group with an excellent cross-section of health professionals (managers, physicians, nursing, CEO, etc.) on the team. The team is encouraged to continue to develop and to further expand to include other agencies/stakeholders to augment planning for disaster events that could impact the community (forest fires, etc.).

It was evident that the team had considered various ethical issues, and is encouraged to continue discussion.

Ongoing education for all staff in regard to the disaster plan and emergency response is encouraged. Education should be ongoing, consistent and regular.

Regional name tags outline the disaster response codes on the reverse side and are therefore available to all staff at any time.

The region is commended for its recognition and celebration of its staff following the H1N1 outbreak.

No Unmet Criteria for this Priority Process.

Patient Flow

Smooth and timely movement of clients and their families through appropriate service and care settings.

Surveyor Comments

There are good processes in place when overcrowding occurs. The processes and procedures are informal in nature which tends to lead to some inconsistency in practice. It is suggested the organization formalize key processes and procedures related to overcrowding in the Emergency Department. The ER works closely with the inpatient units to effect the smooth transfer of patients. The transfer process has improved significantly with the clinical resource nurse positions in ER and on the inpatient unit. In addition, for patients who are discharged but are required to wait for transportation, medications or lodging, the Keewatin Tribal Council (KTC) is able to facilitate and assist with the discharge and discharge planning process.

Surgical services uses a well functioning block booking system. There is an ability to move patients on the operating room slate to facilitate optimal patient flow. In addition, when there are available slots on the OR slate, there is a mechanism in place for short call to patients for their procedure.

There is strong cooperation between the ER and inpatient units when overcrowding situations arise. Discharge planning on the inpatient unit is good. There is good cooperation between the unit staff, Social Worker and Home Care, when required.

Laboratory results are returned to the inpatient unit in an irregular fashion which can cause delays in discharges. In the ER patients are seen first by Registration and then by the Triage Nurse. Best practice would have the patients seen by Triage first and then if medically stable seen at Registration. It is recommended the ER address the assessment order of patients who present to the Emergency Department.

No Unmet Criteria for this Priority Process.

Medical Devices and Equipment

Machinery and technologies designed to aid in the diagnosis and treatment of healthcare problems.

Surveyor Comments

There is consistent evidence of staff monitoring of disinfecting solutions, shelf life, etc.

Staff were observed after they received some new equipment as they organized the manufacturers recommended instructions for each piece of equipment for easy reference.

A year ago there was an incident of grass mites infesting the sterile processing department (SPD).

Once this was identified the organization quickly took action and closed the SPD, identified the items that needed to be reprocessed, arranged an alternate source to do the reprocessing, managed the OR cases, identified and eliminated the source of the mites, decreased the risk that they would return and sealed the windows. The situation is now resolved.

The staff make changes in a resource binder to the standard operating procedure lists of specific bundles to be used in the OR to be sterilized.

The organization has a contract with the company that supplied the sterilizers to do preventative maintenance and the company comes regularly.

The OR Nurses clean the scopes after hours as the OR technician is not available. The OR Nurses are not trained in cleaning the scopes according to standards.

In talking to the manager of the OR there is no deliberate approach to monitor the use of medical devices such as endoscope devices. They are used in the order they are stored and are cleaned as they are used. They know how many scopes they do in a year and how many scopes they own so they then factor how often each scope is used by a calculation.

It was discussed with the Managers and staff that the cleaning of scopes, which is done outside the SPD, is done by the OR RN's after hours. There is one OR technician who is certified and does the majority of the cleaning but the OR RN's are not certified in this procedure.

The decontamination unit has a stainless steel cart that is located in the archway from the sterile area to identify to staff that they are not to cross over to that area. There is a renovation plan that is desired for that area and it will be corrected with the new renovations if renovations are approved. In the meantime the decontamination door is locked to the outside and is restricted to authorized staff only.

The sinks in the decontamination area within the SPD that are used to wash the instruments has tap water faucets that have to be turned on with your wrist, but the staff use their hands.

The policy on Reuse of Single Devices is not clear. It states "the BRHA recognizes that any single use (disposable) medical device used in this region shall not be reprocessed unless listed in this policy and that medical devices opened or unused or those devices which have an expiry date that has passed are not addressed in this policy." The written policy then goes on to list a number of items that can be reprocessed. There is no policy or direction to address the issues that are not addressed in the policy. On discussion with the manager, it was acknowledged that this policy needs to be reworded for clarity for the staff and it was hoped she would have it completed by the end of the week. It was her intent to phrase the policy to more strongly prevent the reuse.

Some standard operating procedures (e.g. list of instruments used for specific OR bundles) are listed clearly in a scribbler and not in a word document for the SPD supervisor to easily update them as needed. The manager is aware and this will be changed to assist the supervisor. This move to a word document will facilitate the ability to easily track the required changes to standard operating procedures and manufactories instructions as needed.

As discussed with Emergency Medical Services (EMS), they have paediatric ambu bags but no broselow bags in each EMS vehicle.

The SPD currently does not own the process in OR for disinfecting the scopes. The OR currently does not record the results of each cleaning of the scopes so this needs to change.

There is a plan to renovate the SPD area which will allow the transfer of the cleaning of the scopes to be moved from the OR to the SPD area. The organization is encouraged to ensure the funding is secured to make this happen for the organization. Funding will need to be secured from the government. There will be an operational impact of this renovation so it will be important for the leadership to ensure there is an accompanying business case to ensure it matches the structural changes.

The table below indicates the specific criteria that require attention, based on the accreditation review.

Criteria	Location	Priority for Action
Effective Organization		
The organization's leaders follow a plan for maintaining, upgrading, and replacing medical devices and equipment.	10.4	
Emergency Medical Services		
Paediatric medical equipment is carried on all EMS vehicles.	12.3	↑
Operating Rooms		
If disinfection is required, a trained and competent team member follows the organization's detailed procedures for cleaning and disinfecting the reusable device or equipment.	12.2	↑
Reprocessing and Sterilization of Reusable Medical Devices		
The organization collects information at least annually about service volumes and patterns of medical device use.	1.1	
The organization designates a trained and competent individual with the accountability for coordinating all reprocessing and sterilization activities across the organization, including those performed outside the reprocessing unit or area.	1.4	
The physical space has a specific, closed area for decontamination that is separate from other areas of the processing unit or area and the rest of the organization.	3.4	↑
The team tracks changes to policies, SOPs, standards of practice, and manufacturers' instructions using a document control procedure.	4.10	

The team prevents the on-site reprocessing or sterilization of single-use devices (SUDs).	8.1	↑
The team verifies and documents the quality of reprocessing services provided in other areas, or by contracted services or subsidiaries.	12.6	

Horizontal Integration of Care

Findings

Following the survey, once the organization has the opportunity to address the unresolved criteria and provide evidence of action taken, the results will be updated to show that they have been addressed.

Population Health and Wellness

Promoting and protecting the health of the populations and communities served, through leadership, partnership, innovation, and action.

Surveyor Comments

Recent examples of region wide health promotion programs include such things as the influenza shot "the best defence against Pandemic H1N1 flu virus". Numerous opportunities were created to ensure information was provided to partner organizations, communities, staff and individuals to ensure public awareness of issues such as influenza and specifically H1N1. Diabetes education, non-smoking campaigns, hand hygiene, suicide education, etc. are other examples of region wide campaigns. The region has used a variety of methods to assess the impacts of its health promotion activities on the intended outcomes. The free blue light for non smoking homes is a very positive initiative in some communities. Many of these measures are reflected in the five year community health needs assessment documents required to be produced by the organization.

Building relationships is a first priority in building capacity in population health. The leadership demonstrates this in all facets of population health programming. In September 2009 the region implemented a Risk Factor Coach in the organization to enhance its efforts to prevent chronic disease and promote healthy lifestyles. Individuals with risk factors such as heart disease and stroke, Type 2 diabetes, kidney disease, lung disease, cancer, etc. have access to the services provided. Through this initiative individuals have recognized the importance of changing lifestyles.

Breastfeeding is also a priority within BRHA and the Thompson General Hospital is working toward being designated as a Baby Friendly Hospital. This is a global program initiated by the World Health Organization (WHO) to encourage and recognize hospitals and maternity facilities that offer an optimal level of care for mothers and infants. Approximately 900 babies were delivered over the past year and the impact of the program is currently being measured. Public health is responding to this indicator change, and has developed a plan which includes two additional lactation trained public health nurses and a widespread focus on connecting with every mother prenatally to softly encourage, through education, the need to breastfeed.

The region is commended for organizing a recent Youth Suicide Prevention Forum held in Thompson in April 2010. Approximately 250 individuals turned out to hear speaker Dr. Martin Brokenleg speak about a model which integrates Aboriginal philosophies on child rearing, the heritage of early pioneers in education and youth work, and contemporary resilience research.

The organization regularly pays for advertising in the weekly newspaper to provide health information consistently to the public. Newsletters to the public and other public health information is produced and is provided to each household in the RHA (i.e. H1N1 information). The local radio stations are utilized consistently to ensure public information is available to communities region wide.

Public Health Inspection is not part of the service provided by BRHA. Rather inspection is provided to the region by the Province. Water and other samples required to be sent to Provincial Laboratory are the responsibility of the Province and are not under the direction of the RHA.

The BRHA does not currently have a Medical Officer of Health (MOH) located directly in the region. However, the services of an MOH are regularly available to the region through a contract arrangement. Staff and physicians are very aware of the availability and responsibilities of the MOH and the service is utilized very well.

No Unmet Criteria for this Priority Process.

Direct Service Provision

This part of the report provides information on the delivery of high quality, safe services. Some specific areas that are evaluated include: the episode of care, medication management, infection control, and medical devices and equipment.

Findings

Following the survey, once the organization has the opportunity to address the unresolved criteria and provide evidence of action taken, the results will be updated to show that they have been addressed.

Acquired Brain Injury Services

Clinical Leadership

Providing leadership and overall goals and direction to the team of people providing services.

Surveyor Comments

This service is provided in a transitional home for up to five brain injured adults.
It utilizes a non medical model using non professional staff.
There are consultative services through a neurological psychologist from out of region. There are also the services of an occupational therapist (OT) from the RHA.
There is a full time social worker assigned to this program.
The clinical leader is also the program manager of the Mental Health Program. She is a psychiatric nurse and a social worker.
Students have worked in this program.

No Unmet Criteria for this Priority Process.

Competency

Developing a highly competent interdisciplinary team with the knowledge, skills and abilities to develop, manage, and deliver effective and efficient programs, services, and care.

Surveyor Comments

The multidisciplinary team referenced above is primarily consultative in nature. A neuro psychologist from Winnipeg is a consultant. She does a portion of the initial assessment. An OT from the RHA provides consultant service as well but also does some groups work. A full time social worker is assigned to this program. The three of these individuals and the transition support workers are the team led by the program manager.
Regular case conferencing is done.
The program manager is a social worker and a psychiatric nurse.
Performance appraisals are carried out by the program manager.
Staffing is assessed in light of the needs of the clients and adjusted accordingly. At the time of the visit to the centre, as a result of bouts of aggression by one client, a security person was in the facility.

No Unmet Criteria for this Priority Process.

Episode of Care

Healthcare services provided for a health problem from the first encounter with a health care provider through the completion of the last encounter related to that problem.

Surveyor Comments

This is a transition house. It is a community based model. It is supported by a multidisciplinary team however the primary day to day work is carried out by non professional staff who are transition support workers.
There is no service array in the RHA with respect to brain injury.
Emergency services would be provided by the ER at the Thompson General Hospital.
To date there have been no wait lists for this service.
Physical health is not assessed by the service but rather by family physicians in the community.
There is a goal orientated service plan for each client. Community living is a common goal. Goal achievement is assessed daily.
Good planning processes are in place for transitioning clients to community living arrangements.

No Unmet Criteria for this Priority Process.

Decision Support

Information, research and evidence, data, and technologies that support and facilitate management and clinical decision-making.

Surveyor Comments

Paper files are utilized. These files are separate and are not part of a hospital chart.
There is limited use of technology by this program.

No Unmet Criteria for this Priority Process.

Impact on Outcomes

The identification and monitoring of process and outcome measures to evaluate and improve the quality of services to clients and the impact on client outcomes.

Surveyor Comments

The program has changed its admission criteria to include those who have acquired brain injury as a result of stroke.

No Unmet Criteria for this Priority Process.

Ambulatory Care Services

Clinical Leadership

Providing leadership and overall goals and direction to the team of people providing services.

Surveyor Comments

Burntwood Community Health Resource Centre:
This Health Centre has strong leadership in both the program manager and the physician leader.
There are many examples of improvements based on what is known about the population served, such as diabetes education and cultural sensitive programs.
There are good examples of partnerships particularly with the Manitoba Addictions Service.
The physical space is well kept with ample space to provide appropriate services.
A preventive maintenance program is in place.
There has been an excellent review of barriers to timely access with appropriate actions taken to address same.
A number of physicians are being supported to get advanced training in relevant areas.

Northern Consultation Centre:
They have a very client centred program.
Providers know their patients well.
There is good collaboration with community partners.
There is a well laid out area with private areas. There are some space challenges for a growing program.
There is a strong program manager.
There is good use of medical students. This is a new initiative.

No Unmet Criteria for this Priority Process.

Competency

Developing a highly competent interdisciplinary team with the knowledge, skills and abilities to develop, manage, and deliver effective and efficient programs, services, and care.

Surveyor Comments

Burntwood Community Health Resource Centre:
Professionals and para professionals work to full scope of practice in this program.
The physician leader has a plan to creatively use nurses in this program.
There are monthly team meetings.
There are meetings of physicians every two weeks.
There are corridor meetings with the front desk staff twice per week.
Excellent processes have been implemented to improve access.
A good orientation for new physicians has recently been implemented.
Performance appraisals have not been routinely conducted on all staff. This is an area for improvement.
There is a good understanding by the management of the number of patients that each physician has.

Northern Consultation Centre:
The team is comprised of physicians, a nurse practitioner, licensed practical nurses (LPN's), and clinic assistants.
There are regular meetings among the medical services staff.
There are regular meetings among the support staff.
There is good team spirit.
There is good involvement of medical students.

The table below indicates the specific criteria that require attention, based on the accreditation review.

Criteria	Location	Priority for Action
Team leaders regularly evaluate and document each team member's performance in an objective, interactive, and positive way.	4.9	

Episode of Care

Healthcare services provided for a health problem from the first encounter with a health care provider through the completion of the last encounter related to that problem.

Surveyor Comments

Burntwood Community Health Resource Centre:
Timely access has improved significantly of late. There is a need to continue work to improve access to counselling services.
Good work has been completed to minimize the number of no shows.
Clients say there is still work to be done about wait times once they arrive for their appointment.
Crises services are provided after hours by the ER.
Family physicians do have a care plan for each of their assigned patients.
Physicians assigned to walk in clinics only address the presenting issue.
Services to young adults are provided under the rule of emancipated minors.
There are good forms to transfer information between the walk in clinic physician and the assigned family physician.
There are good processes for making physicians aware that a patient has called requesting information.

Northern Consultation Centre:
Obstetrical patients can self refer.
There are still a significant number of no shows however physicians do monitor no shows and develop strategies regarding recall.

Dialysis:
Beautiful environment.
Good interdisciplinary team - newly developed.
Strong provincial program.

Chemotherapy:

Well developed provincial program.
Caring, flexible staff committed to the patients that are served.

Audiology:
Good work on reducing wait list by focusing on services to children.

No Unmet Criteria for this Priority Process.

Decision Support

Information, research and evidence, data, and technologies that support and facilitate management and clinical decision-making.

Surveyor Comments

There is good use of technology for scheduling in both the Burntwood Community Health Resource Centre and the Northern Consultation Centre.
An electronic health record is used in the chemotherapy program.
There is good use of telemedicine in the chemotherapy program.
There is good use of technology for staff education in the chemotherapy program.
There are examples of technology use for patient teaching in the audiology program.

No Unmet Criteria for this Priority Process.

Impact on Outcomes

The identification and monitoring of process and outcome measures to evaluate and improve the quality of services to clients and the impact on client outcomes.

Surveyor Comments

Burntwood Community Health Resource Centre:
There is innovative use of a risk factor coach to assist patients with behaviours that put their health at risk.
There is good use of Aboriginal liaison workers.
Aboriginal liaison workers currently spend one hour with physicians during the orientation of physicians to the Burntwood Community Health Resource Centre. There would be benefit from involving Aboriginal liaison workers in a comprehensive cultural orientation for professionals.

No Unmet Criteria for this Priority Process.

Community Health Services

Clinical Leadership

Providing leadership and overall goals and direction to the team of people providing services.

Surveyor Comments

The community health team uses the health assessment documents to create a team service delivery plan. In public health there has been significant effort in leadership to keep multiple sites well informed with each feeling that they have input into the broader public health plan and that they are part of a larger support network. Sharing of workload through strategically planned committee involvement, biweekly case conferencing, and unit meetings has instilled a sense of program and health promotion ownership in staff. Population health promotion focuses

are structured and planned ahead for every month of the year. This enables sharing of resources with central support and local diversification to meet the needs of the communities. There are several examples of intersectoral delivery of programs, such as the public health nurse position expanding from one day a week to three days a week in the high school, combined with a nurse practitioner one day a week for healthy lifestyle support. The families first program supports families through the joys and challenges of parenting, and is another example of a program that connects families to intersectoral community resources such as the Hello Parent Network of Thompson.

Their is a strong system of orientation of new staff to new positions and evidence that the staff have input into the roles and responsibilities and job design in the new public health nurse position in Ilford. The service delivery team in Ilford is one year old. It has well established links with the community members, a systematic chronic disease follow up system that decreases numbers of trips to the clinic (all in one service) and a solid support network for timely attended referral for additional service (minimized no show rate activity). Building community linkages will facilitate public health policy in the future.

No Unmet Criteria for this Priority Process.

Competency

Developing a highly competent interdisciplinary team with the knowledge, skills and abilities to develop, manage, and deliver effective and efficient programs, services, and care.

Surveyor Comments

The agenda of action plan review, team work, and collaborative practice discussion at unit meetings demonstrates strong support for interdisciplinary team functioning and leads to a well coordinated service delivery plan. Respectful workplace education along with the staff recognition activities in place add to team cohesiveness. Ongoing quality improvement is evident in the practices visited. The staff know the terms and are quite comfortable in the continuous state of change as the result of continually trying to improve the service. Performance reviews are timely and are positively received. Appropriate licensure is in place. Orientation is structured and geared to meet the needs of the new employee. An example of this is the three month mentoring of the public health nurse for Ilford. Performance reviews are completed in a timely manner and are positively viewed by staff. Recognition of contributions occurs regularly at the staff unit meetings.

No Unmet Criteria for this Priority Process.

Episode of Care

Healthcare services provided for a health problem from the first encounter with a health care provider through the completion of the last encounter related to that problem.

Surveyor Comments

The client charting systems are standardized with numerous regionally standardized flow sheets in a well organized chart. The teams have well written program description brochures that are shared with the public, other organizations and providers at every opportunity. There is a very strong informal follow up system, in that when there is a need to make a contact, the team is able to do it consistently because of their efforts to build relationships and their networking system. The philosophy within the service is capitalized 'on the here and now ' for the population served. When someone walks in with questions or is requesting a specific service, the team does

all it is able to at the time instead of booking into the future. Relationship building is a priority and thus services delivery is coordinated with a multitude of community partners in multiple communities. This is especially evident in the smaller communities of Gillam and Ilford. The team is very aware of the resources available in the community and actively initiates program connections with the clients. Community partnership work on public policy would add another dimension to the population health plan.

No Unmet Criteria for this Priority Process.

Decision Support

Information, research and evidence, data, and technologies that support and facilitate management and clinical decision-making.

Surveyor Comments

The data collection for the Manitoba Immunization Management System (MIMS) is entered by a single individual for clerical accuracy but is accessible and used by all the public health nurses. Best practice guidelines are available in written and electronic versions. Best practice is part of the biweekly care conferences. Because of the availability of information from multiple sources, the director has a very structured role out of new guidelines all at the same time in all communities. This consistency also applies to changes in baseline teaching information that goes to the public. The staff are appreciative of this practice. The public health leadership is part of the provincial working groups on best practice guidelines.

No Unmet Criteria for this Priority Process.

Impact on Outcomes

The identification and monitoring of process and outcome measures to evaluate and improve the quality of services to clients and the impact on client outcomes.

Surveyor Comments

The community service team excels at responding to community needs. When asked for help the team does all it can and this includes responding to large scale requests when multiple communities sought help to immunize for H1N1. Jurisdiction was not an issue. It also includes the single individual seeking personal health information. There is a culture of being very proud of the programs and service offered in community services.

There is a process in place to identify risk and near misses in the department. It is evidenced by the higher number of near misses reporting than incidents. Because of the needs of family first clients, a process was developed provincially with active regional involvement to identify criteria for the level of risk of families during unexpected events such as a pandemic. Guidelines are now in place detailing a specify response plan. The information about potential safety problems is discussed at unit meetings with the plan of reduction of risk. The team has several program process measures and outcome measures for several programs (i.e. immunization, diabetes outcome measures). Benchmarking occurs mainly with the larger urban region in the south. Additional data may be obtained from other community partner quality of service discussion.

No Unmet Criteria for this Priority Process.

Emergency Department Services

Clinical Leadership

Providing leadership and overall goals and direction to the team of people providing services.

Surveyor Comments

The Emergency Department (ED) team has not done any formal strategic planning in relation to its review of information about its clients in order to define the scope of service.
There is no formal strategic planning process for ED that was evident.
There does not appear to be a bed flow issue in the ED.
The ED has designated specific hallway spaces that are used with specific criteria for minor procedures, short stay, minimum privacy required, etc. Patients using this space were interviewed and felt that staff made them comfortable and respected their privacy.

The table below indicates the specific criteria that require attention, based on the accreditation review.

Criteria	Location	Priority for Action
The team uses the information it collects about clients and the community to define the scope of its services and set priorities when multiple service needs are identified.	1.3	
The team regularly reviews its services and makes changes as needed.	1.9	
The team has the workspace needed to deliver effective services in the Emergency Department.	2.8	

Competency

Developing a highly competent interdisciplinary team with the knowledge, skills and abilities to develop, manage, and deliver effective and efficient programs, services, and care.

Surveyor Comments

The ED has a complete team with RN's, physicians, clerks, diabetic coordinator, respiratory therapist, social worker, physiotherapist, occupational therapist, pharmacy, Consultation clinic and Baby program. These services are all available to the ED as needed.

No Unmet Criteria for this Priority Process.

Episode of Care

Healthcare services provided for a health problem from the first encounter with a health care provider through the completion of the last encounter related to that problem.

Surveyor Comments

The organization has data on wait times for ED but they don't display them for the staff, physicians or team. The wait time data is available but is not in an organized manner that is easy to see and understand quickly. The team now needs to set a benchmark and monitor their results against the targets.

The team recently changed the resuscitation policy to clearly reflect the individual roles for each member of the Code team.

The transfer of information (handoffs) from ED to the floor is done nurse to nurse in an informal manner without a standard approach that is documented. There is evidence in Home Care and LTC that this information back to those areas is slow and sometimes difficult to get when they return to the LTC or Home Care system.

The table below indicates the specific criteria that require attention, based on the accreditation review.

Criteria	Location	Priority for Action
The team sets, tracks, and benchmarks data related to waiting times for services and information, and the length of stay (LOS) in the Emergency Department.	6.11	
The team adheres to assigned roles and responsibilities during the resuscitation of clients.	9.7	↑
The team reconciles medications with the client at referral or transfer and communicates information about the client's medications 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.	10.5	
There is a demonstrated, formal process to reconcile client medications at referral or transfer.	10.5.1	
The process includes generating a comprehensive list of all medications the client has been taking prior to referral or transfer.	10.5.2	
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.	10.5.3	
The process requires documentation that differences between the two lists have been identified, discussed, and resolved, and that appropriate modifications to the new medications have been made.	10.5.4	
The process makes it clear that medication reconciliation is a shared responsibility involving the client, nursing staff, medical staff and pharmacists, as appropriate.	10.5.5	
The team transfers information effectively among service providers at transition points.	10.8	↑
The team uses mechanisms for timely transfer of information at transition points (e.g. transfer forms, checklists) that result in proper information transfer.	10.8.1	
Staff is aware of the organizational mechanisms used to transfer information.	10.8.2	

There is documented evidence that timely transfer of information occurs.	10.8.3

Decision Support

Information, research and evidence, data, and technologies that support and facilitate management and clinical decision-making.

Surveyor Comments

The team does not have a systematic approach to share client data back to the LTC and Home Care as needed after the client has left the ED.
There has been recent installation of computers in the ED where they can now have access to "Up to Date" information to assist them in best practice protocols.
There is no information technology system for client information such as laboratory results, medication administration record, etc. All systems are manual. The picture archiving and communication system (PACS) for Diagnostic Imaging (DI) is coming soon. The radiologist in Winnipeg reads the DI results and the ED gets the results days later.
The ED has identified the need for an electronic triage system.
Although the team is close knit and works well together there is no formal structure to get together to review evidence based guidelines. There are pre printed order sets for acute coronary syndrome, diabetic ketoacidosis, deep vein thrombosis, and heparin but there is no formal process for review.
There is no research conducted in the ED at this time.

The table below indicates the specific criteria that require attention, based on the accreditation review.

Criteria	Location	Priority for Action
The team shares client information and coordinates its flow among service providers, other teams, and other organizations, as required.	11.4	
Staff and service providers use information technology to share information with the interdisciplinary team.	12.2	
The organization has a process to select evidence-based guidelines for Emergency Department services.	13.1	
The team reviews its guidelines to make sure they are up-to-date and reflect current research and best practice information.	13.2	
The team's guideline review process includes seeking input from staff and service providers about the applicability of the guidelines and their ease of use.	13.3	

Impact on Outcomes

The identification and monitoring of process and outcome measures to evaluate and improve the quality of services to clients and the impact on client outcomes.

Surveyor Comments

The staff have only had one staff meeting in the last six months. There is no formal process to gather the entire ED team together to discuss patient safety issues such as reducing risks and improving quality.

The team has data about utilization which has not yet been shared with staff or physicians. They have not yet evolved to the identification of clinical outcome best practices to share with staff and its partners. The specific benchmarks have not yet been defined or measured but the manager will discuss this with the team in the future.

The ED team has a process to receive regular and confidential feedback on its clients.

The ED has utilization data on the activity and acuity of patients arriving to the ED by the hour. This information is very helpful to the ED team in planning services and monitoring activity. Looking at the ED as a system, it is recommended that the ED team review the data being collected, ensure that the specific data is what is most important to them to collect, and then share the data with the ED staff and the partners. They have input data. They now need to look at through put and out flow data and then share that with staff and the organization as a whole.

The table below indicates the specific criteria that require attention, based on the accreditation review.

Criteria	Location	Priority for Action
The team shares benchmark and best practice information with its partners and other organizations.	13.5	
The team identifies and monitors process and outcome measures for its Emergency Department services.	15.1	↑
The team compares its results with other similar interventions, programs, or organizations.	15.3	↑
The team uses the information it collects about the quality of its services to identify successes and opportunities for improvement, and makes improvements in a timely way.	15.4	↑
The team shares evaluation results with staff, clients, and families.	15.5	

Emergency Medical Services

Clinical Leadership

Providing leadership and overall goals and direction to the team of people providing services.

Surveyor Comments

Emergency medical services (EMS) delivery within the BRHA is complex. There is a new EMS Coordinator who has been in the role for approximately eight months. The funding arrangements for the EMS services within the BRHA are complex. The BRHA accountabilities and the accountabilities of the EMS organizations are not clear or consistent. This lack of clarity results in a number of jurisdictional challenges. There are inconsistencies with operational policies and procedures as a result of some of the jurisdictional challenges and unclear accountabilities.

Mutual aid exists between multiple EMS providers and Emergency Service providers, however these are informal in nature. It is strongly encouraged the organization formalize its mutual aid agreements between various EMS providers and between EMS and other emergency service providers.

There is good medical oversight present. There is movement away from random patient call records (PCRs) reviews to an audit system looking at all PCRs with predetermined criteria for each PCR review. It is unclear how critical incidents are managed within the EMS system. It was stated there were no critical incidents in the past two years. If there was a critical incident, EMS would use the BRHA critical incident forms and utilize the processes from BRHA. However, due to the multiple funding arrangements and jurisdictional challenges, there may not be consistency in how critical incidents are managed. It is suggested the BRHA develops and implements a critical incident review process for EMS.

There is no formal mass causality plan, however due to the nature of the service and community nature of Thompson, there is an informal understanding of what would occur. It is suggested the organization develop and implement a formal mass casualty plan for EMS in cooperation with key external stakeholders.

The table below indicates the specific criteria that require attention, based on the accreditation review.

Criteria	Location	Priority for Action
The team has formal mutual aid policies and agreements with neighbouring emergency medical services that describe how to initiate and respond to mutual aid requests.	2.1	
The medical oversight team makes sure the results of ongoing retrospective case reviews are applied to the organization.	4.5	↑
The medical oversight team has formal agreements for accessing and consulting with health service providers in areas of practice where the team does not have expertise.	4.7	

Episode of Care

Healthcare services provided for a health problem from the first encounter with a health care provider through the completion of the last encounter related to that problem.

Surveyor Comments

The organization would be encouraged to develop and implement a mass casualty plan in cooperation with its external stakeholders and partner agencies. The development and implementation of treatment protocols is encouraged.

The table below indicates the specific criteria that require attention, based on the accreditation review.

Criteria	Location	Priority for Action
The communication centre provides call updates to the EMS team and monitors the movement and safety of the EMS team at the incident scene and throughout transfer.	13.9	
The EMS crew uses the results of the assessment and CTAS scores or other priority codes to identify the patient's immediate and urgent needs, make care decisions, and select the best destination setting.	14.4	
The EMS crew follows an established process to manage and triage patients at mass casualty incidents.	14.6	
The EMS crew uses set criteria to determine when to contact the Communication Centre for additional resources.	14.7	
The EMS crew follows guidelines when verbal or written authorization is required for a treatment protocol, including which treatment protocols require authorization, who is permitted to give authorization, and acceptable standing orders to be used.	15.4	
When written authorization is required for a treatment protocol, the EMS crew documents the authorization in a consistent location in the patient record.	15.5	
The EMS crew provides education to patients and families about emergency medical services and their rights, and tests and treatments included under implied consent.	15.12	

Impact on Outcomes

The identification and monitoring of process and outcome measures to evaluate and improve the quality of services to clients and the impact on client outcomes.

Surveyor Comments

There is no formal disclosure policy for EMS.
A community needs survey is underway, but it does not include EMS.

The table below indicates the specific criteria that require attention, based on the accreditation review.

Criteria	Location	Priority for Action
The team identifies, reports, records, and monitors in a timely way sentinel events, near misses, and adverse events.	20.2	↑
The team follows the organization's policy and process to disclose adverse events to patients and families.	20.3	↑
The team monitors stakeholder, patient and family perspectives on the quality of its services.	21.4	

Home Care

Clinical Leadership

Providing leadership and overall goals and direction to the team of people providing services.

Surveyor Comments

The team is aware that the regional needs assessment will be completed shortly and broad community information and determinant of health information will be available from this source. The home care department does not have a database of cumulative data from their assessments. The implementation of the Procura Electronic medical record by March 2011 will address this need for a service data base. The scope of service is based on demand for service. The goals and objectives are defined within the strategic directions. The communication around the goals within the department is unclear. The team collaborates well with long term care and community services. Acute services connections are in place with twice a week discharge planning visits to acute care.

One contract has defined expectations. A second purchased service does not have a defined contract. A brochure of home care programs is available to all clients to define the service available.

The professional and coordinating office staff have input into their roles and responsibilities through office meetings. The home care health aides and home care service workers do not have this same process available to them. Involving these staff in organized team care meetings would be an option to explore.

The Director of Health Services position responsible for home care is vacant, so support to management of home care is limited by this vacancy.

The table below indicates the specific criteria that require attention, based on the accreditation review.

Criteria	Location	Priority for Action
When the organization purchases client services from an external organization, it establishes written contracts or memoranda of understanding.	1.5	
The team works together to develop goals and objectives.	2.1	
The team's goals and objectives for its home care services are measurable and specific.	2.2	

Competency

Developing a highly competent interdisciplinary team with the knowledge, skills and abilities to develop, manage, and deliver effective and efficient programs, services, and care.

Surveyor Comments

The process of interdisciplinary functioning review is an informal process of communication within the team that occurs with client reassessment. Concerns from home care office staff and professional staff are brought to staff meetings and addressed. Interdisciplinary two way communication about clients is positive (social work assessment, primary care nurse, and occupational therapist). Case conferences with the palliative care physician occur.

The manager supports teamwork. Formalized teamwork skill development is not in place.

Performance reviews are valued but currently they are not done on a regular basis. The workspace for home care is limited with two to three staff in a small space. A process is underway to review/revise the filing storage to help relieve some of the congestion in the work area. A formal interdisciplinary team review process is not in place, but the informal process is there facilitating consultations about client care.

Professionals have the necessary licensure in place. There is a regional orientation process in place. The orientation process is not formalized in the home care department. The buddy system is used for orientation, specifically with the unregulated workers. A significant portion of home health aides and home care service workers are trained on the job by others that have been in the role for a period of time. The time varies dependant on the employee. Structured orientation to standards of service for this employee group is suggested.

There is no formal process for orientation to transfers and lifts. Recently the occupational therapist provided a workshop for some of the staff on this topic and it was well received. There are no intravenous (IV) services in Home Care, thus no pumps. There are training programs available for education of staff, such as palliative care and employee personal safety with aggressive clients. The organization is encouraged to ensure that a formal process is in place to ensure specific education in a timely manner for unregulated service workers.

The staff turn over rate is significant and the hiring process into these positions is on going. Because of the geographical locations where some of the staff are hired, the interview and hiring process is by phone and the resource coordinators (that hire) may not meet the employee for a significant period of time. This practice is a risk for the organization and should be reviewed.

The regular education of these employees and documented performance review are not in place. Encouragement is given to ensure all HR practices are in place.

The assignment of clients is based on task lists, and occurs based on staff availability and if possible the client /staff compatibility match. Formal criteria need to be put in place.

The resource coordinators call the clients on a non structured informal basis to see if the clients are happy with the service. They would prefer to go to the homes in follow up on a regular basis to visually audit the service delivery. This process is not in place. There is a plan in place to have a casual staff member replace the resource coordinator to enable some of this auditing to occur. There needs to be a formalized evaluation of the service provided.

Email messaging is used as a form of recognition of each other for a job well done along with a designated location for written notes to one another.

While there is good intent to coordinate services between professionals and other service providers, the organization is encouraged to formalize a collaborative process between all caregivers.

The table below indicates the specific criteria that require attention, based on the accreditation review.

Criteria	Location	Priority for Action
The organization provides sufficient workspace to support interdisciplinary team functioning and interaction.	3.5	
The interdisciplinary team follows a formal process to regularly evaluate its functioning, identify priorities for action, and make improvements.	3.7	
The team orients new team members about their roles and responsibilities, the team goals and objectives, and the organization as a whole.	4.2	
The team orients new team members about the safe use of equipment, devices, and supplies used in delivering home care services.	4.3	↑
The team receives specific education and training to deliver home care services.	4.5	
The team monitors and meets each team member’s ongoing education, training, and development needs.	4.7	

Team leaders regularly evaluate and document each team member's performance in an objective, interactive, and positive way.	4.8
The organization has defined criteria that are used to assign team members to clients and other responsibilities in a fair and equitable manner.	5.1
Team leaders regularly evaluate the effectiveness of staffing and use the information to make improvements.	5.3

Episode of Care

Healthcare services provided for a health problem from the first encounter with a health care provider through the completion of the last encounter related to that problem.

Surveyor Comments

The team uses standardized assessment and reassessment forms, as well as task sheets defining the service to be provided. Clients know how to reach the person that coordinates their care from the time of assessment. The team uses a contracted service to provide after hour scheduling of essential services. Home care services are currently trialling an "on call home support worker" to replace this contracted service. Barriers to service are explained to clients. If the service is beyond the scope of the home care service the client is advised to seek service in the emergency department.

The team responds to service requests in a timely manner and detailed standard histories are completed with the clients. There is no waiting list for service and clients with urgent/emergent needs are prioritized for service. Wait times from referral to assessment are monitored (one day average).

The home care referral forms from other providers are standardized. The accurate completion of the form is a significant issue for the assessment staff as they often have minimal information. This requires review and completion in the home care office before the referral assessment can start. Accurate completion of these forms needs to addressed.

Part of the assessment process includes referral to another agency/facility if the client's needs are beyond the scope of home care. The Primary Care Nurse position that includes intake assessment is new with minimal similar examples to benchmark to. The position is case management and nursing service combined.

The process for medication reconciliation is not formal or standardized but the initial home care assessment includes medication reconciliation with various sources. The medication list on referral forms are often incomplete. The pharmacy, physician and family are consulted, along with a Drug Program Information Network (DPIN) review. There is a comparison of the medication before admission to those on admission, but no structured process in place to define the process to all nursing staff. The process of reconciliation is initiated by the home care staff, and validated with others in consultation. A defined structured medication reconciliation process has not been rolled out in home care.

The team has access to general practice medical staff and a palliative care specialist visits bimonthly. The staff use the 0-10 pain scale. The assessor/primary care provider shares the assessment with the client before the start of service as well as the reviews. Clients and families are aware of the service available and are supported. Client rights discussion, investigation process and resolving of any claims is not a standard process in all home care services. This needs to addressed. Clients do call the resource worker and or the assessor with concerns and have sent their complaints directly to administration. The process within home care is not clearly defined for the client but as concerns are brought to the resource coordinators, low level resolution appears to be working in an informal manner.

The services provided by the home care aide and home care support worker are not documented. A documentation process will increase accountability. If there is a change in service there is an expectation that the worker let the Resource Coordinator know. Validation of this process does not occur.

Through reassessment by the primary care nurse or social worker assessor, the clients are reassessed and monitored dependant on need, but a minimum of yearly. The primary care nurses monitor service goals and expected results with the clients with nursing needs on an ongoing basis.

There is limited medication administration by home care staff. It is a client/ family responsibility other than general monitoring of bubble pack usage. Medication lists are forwarded to long term care regularly and acute care on request. Structured medication reconciliation specifically with acute services admission is not a standardized process. The flag is present on the admission electronic system to alert all that this is a home care client, so that home care can be called for additional information, sharing the responsibility on transition. This does not happen on a regular basis and would improve continuity .

The clients that may require long term care services in the future are designated to the social worker assessor. The process of application to long term care is facilitated by this prior knowledge at transition time. Transition of service process evaluation is not in place.

The table below indicates the specific criteria that require attention, based on the accreditation review.

Criteria	Location	Priority for Action
The team reconciles the client's medications at the beginning of service with the involvement of the client.	7.4	↑
There is a demonstrated, formal process to reconcile client medications at the beginning of service.	7.4.1	
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 where necessary.	7.4.4	
The process makes it clear that medication reconciliation is a shared responsibility involving the client, nursing staff, medical staff, and pharmacists, as appropriate.	7.4.5	

Medication Reconciliation at the Beginning of Service.	7.5	
The team follows Accreditation Canada's protocols and definitions to collect and submit data on medication reconciliation.	7.5.1	
The team does not have any unaddressed priority for action flags based on their medication reconciliation indicator results.	7.5.2	
The team educates clients and families about their rights, and investigates and resolves any claims that these rights have been violated.	8.7	↑
The team responds to client and family complaints in an open, fair, and timely way.	8.9	
The team documents all services received by the client in the client record.	9.8	
The team reconciles medications with the client at referral or transfer, and communicates information about the client's medications 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.	11.3	
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.	11.3.3	
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.	11.3.4	
The process makes it clear that medication reconciliation is a shared responsibility involving the client, nursing staff, medical staff and pharmacists, as appropriate.	11.3.5	
The team transfers information effectively among service providers at transition points.	11.4	↑
The team uses mechanisms for timely transfer of information at transition points (e.g. transfer forms, checklists) that result in proper information transfer.	11.4.1	
There is documented evidence that timely transfer of information occurs.	11.4.3	
Following transition or end of service, the team contacts clients, families, or referral organizations to evaluate the effectiveness of the transition, and uses this information to improve its transition and end of service planning.	11.5	↑

Decision Support

Information, research and evidence, data, and technologies that support and facilitate management and clinical decision-making.

Surveyor Comments

The charts are in place for each client. The location of charted information is different from chart to chart, thus not as easily accessible as it could be for the professionals that have access. Procura electronic medical records (EMR) is the plan to correct this issue. There is generally no documentation at the client's home, with exceptions on occasion where there are some log books if clients have changing providers. A summary of client care in an in home binder would improve continuity, and may be sent to the ER with the client.

New technology has been decided on in the form of an EMR. Education for same will start soon but is not in place at this time. Best practice guidelines are in place for wound care and palliative care, which is significant progress since the last accreditation process. The team has the services of a palliative care physician from Winnipeg who comes out for a day every second month. She is available for consultation, case conference, specific client follow up and has done significant education with home care staff. This expertise is also available for physician update and support in palliative care management across the continuum of service.

The table below indicates the specific criteria that require attention, based on the accreditation review.

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

Impact on Outcomes

The identification and monitoring of process and outcome measures to evaluate and improve the quality of services to clients and the impact on client outcomes.

Surveyor Comments

The team identifies the resources needed to deliver the individual service goals. The assessment includes risk assessment for team members. The team uses the client health number and the name on the task sheets for client identification. There is not a structured process in place to always use the identifiers but staff address the client by name and if this does not match, they access office staff for verification of site and name. A standard identification process is suggested.

Information will be provided to other services such as acute care if asked. There is a client identifier in the system that identifies clients as home care clients. The outpatient/ER staff then can call home care and they will provide the information (or next day if after hours).

The staff are aware of the benchmarking data process but do not actively use the information.

Profession staff are aware of risks and develop a care plan to minimize the risk to clients. There is a formal fall prevention strategy in home care. Not all home care health aides and service workers are aware of the specific process but are aware that client risks are part of every assessment completed. Structured orientation would address this issue as well.

There are no specific safety briefings in home care. Client safety is discussed as part of every assessment and reassessment. A client satisfaction survey has been established to evaluate the quality of service from the client's perspective. The organization is commended for undertaking a home care client survey.

There is a process in place where home care aides and home service workers alert the resource coordinator when they are going to homes that may have some risk. They call the coordinator back on leaving. Formalizing this verification process as a protocol will solidify the process.

Staff know that incident forms are to be completed. Staff understanding of near misses is inconsistent. Quality review of nursing service and palliative care is in place as part of nursing practice. Benchmarking with other services on palliative care practice does occur. The follow up on home health aide service is limited.

The table below indicates the specific criteria that require attention, based on the accreditation review.

Criteria	Location	Priority for Action
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.	15.3	↑
The team implements verification processes and other checking systems for high-risk activities.	15.5	↑
The team has implemented verification processes for high-risk activities.	15.5.1	
The team identifies, reports, records, and monitors in a timely way sentinel events, near misses, and adverse events.	15.6	↑
The team monitors clients' perspectives on the quality of its home care services.	16.2	
The team compares its results with other similar interventions, programs, or organizations.	16.3	↑
The team uses the information it collects about the quality of its services to identify successes and opportunities for improvement, and makes improvements in a timely way.	16.4	↑
The team shares evaluation results with staff, clients, and families.	16.5	

Infection Prevention and Control

Infection Prevention and Control

Measures practiced by healthcare personnel in healthcare facilities to decrease transmission and acquisition of infectious agents.

Surveyor Comments

The infection control team is diverse in its membership of physicians, nurses, nutrition, acute care, sterile processing department (SPD), LTC, OR, Medical Health Officer, public health, etc.

There are numerous posters in the hospital on hand washing and coughing etiquette. Alcohol based rubs are readily accessible. Hand washing sinks are located in each patient room.

The committee acknowledged that the patient pamphlet they had previously was complicated and not easy to read. They have since re-designed it and tested it on patients and family in the hospital before delivering them out to the appropriate communities.

The staff do the internal and external check for damage to endoscopes but the OR nurses do it in an emergency and they are not qualified as designated certification to the disinfection process.

The organization has an epidemiologist who is an active member of the infection control team. She works out of Winnipeg but is part of the team.

The Public Health Department partners with city bylaw officers in relation to the tuberculosis patients who leave without medical authority or do not comply with social isolation practices. The city bylaw staff look for these patients and try to bring them back to the hospital for education and treatment if needed.

The routine for cleaning of mobile equipment such as IV pumps, IV poles, wheelchairs, etc. is done by the nursing department when a patient is discharged. The nurse or aide is expected to wipe down the device and move it to an equipment storage area.

The staff and physician whom surveyors spoke to in the obstetrics department did not know the infection rates for the obstetrics area, specifically the post operative caesarean section rates. On observation of the unit there was no posting of the information that was easily seen.

At the operating room in the hospital, staff state that if disinfection is required, it is not always the case that a trained and competent staff member follows detailed procedures for cleaning or disinfecting of reusable devices as OR nurses who are not necessarily trained clean endoscope equipment between emergency cases. The OR technician, however, assigned for regular cleaning for days they do endoscopes, has the required certification. All the staff in Central Sterilization Room (CSR) are required to get the training within one year of starting work in that area.

At the operating room, the endoscope reprocessing area is not physically separated from the client care area as the reprocessing occurs directly outside the room where patients are transferred in and out. The disinfecting is then completed in a device adjacent to the corridor in a common area centrally located in the OR.

At the operating room in Burntwood Regional Health Authority the reprocessing space where the endoscope equipment is used was not found to be in a separated area with dedicated plumbing, piping, or air ventilation.

There is no record of endoscope device reprocessing. The only documentation is the daily check of the Cidex OPA viability. This issue has been brought to the attention of the manager of Infection Control and the OR manager and it is their intent to institute a record as soon as possible.

The table below indicates the specific criteria that require attention, based on the accreditation review.

Criteria	Location	Priority for Action
The organization tracks infection rates, analyzes the information to identify clusters, outbreaks, and trends, and shares this information throughout the organization.	1.2	↑
Staff and service providers know the infection rates.	1.2.2	
The organization verifies the qualifications and competencies of staff involved in reprocessing reusable medical devices.	12.1	
If disinfection is required, a trained and competent staff member follows detailed procedures for cleaning or disinfecting the reusable device.	12.3	↑
The organization prevents the on-site reprocessing or sterilization of single-use devices (SUD).	12.15	↑
All endoscope reprocessing areas are physically separate from client care areas.	13.3	↑
All endoscope reprocessing areas are equipped with separate clean and decontamination work areas as well as storage, dedicated plumbing and drains, and proper air ventilation.	13.4	↑
For each scope, the organization maintains a permanent record of endoscopy device reprocessing.	13.12	
The record of endoscopy device reprocessing includes the identification number and type of endoscope, the identification of the automated endoscope reprocessor (AED) if applicable, date and time of the clinical procedure, the name or unique identifier of the client, results of the individual inspection and leak test, and the name of the person reprocessing the endoscope.	13.13	

Long Term Care Services

Clinical Leadership

Providing leadership and overall goals and direction to the team of people providing services.

Surveyor Comments

Northern Spirit Manor is the first long term care facility in the Burntwood Health Region. The community came together and raised significant funding to start the project. The community continues to actively support the facility in a recent donation to purchase a handi-van for the facility. The team collects utilization data and statistical information on community needs working in partnership with the Home Care program. The development of a daycare program is an example of a need identified. Further information is being collected around the possibility of this programming. There are weekly team meetings in Northern Spirit Manor. The team meetings to coordinate services are very inclusive including a member of every staff group: housekeeping, laundry, health care aide, licensed practical nurse, registered nurse, clinical resource leader, activity worker, activity coordinator, therapist, dietician, and social worker. The facility, being new, has all private rooms complete with lift tracks in every room and well furnished lounges. The equipment is all new: quality tubs, lifts, chairs, etc.

The team has input into their roles within their scope. The clientele are First Nations, Aboriginal and non Aboriginal and there is a need for interpretive services which is handled predominantly by Cree speaking staff in housekeeping, nursing and social work. This is an example of roles that can vary dependant on need and willingness. Dene interpretation remains an unmet need.

No Unmet Criteria for this Priority Process.

Competency

Developing a highly competent interdisciplinary team with the knowledge, skills and abilities to develop, manage, and deliver effective and efficient programs, services, and care.

Surveyor Comments

For the facility size the number of disciplines available on site is significant. The clinical resource leader is full time (RN) in addition to the nursing staff on duty. As a result of these significant human resources, the clients needs are addressed in a very timely manner. The client daily activities options are well organized. The medical care follow up of the clients is streamlined, with elimination of duplication through the work of the clinical resource leader. The workplace culture is positive.

The majority of staff including leadership are new to long term care. The team is learning together with experience and changing processes together. All health care aides in long term care must have the six month program to work in the facility. All staff must have the lift use training and training to deal with aggressive behaviour. As the training is not always available on the employee start date, training through buddying occurs until the formal training is available. The lift use policy requires that two people be present at all times preventing inexperienced staff from injury. Orientation is structured and performance reviews are completed.

No Unmet Criteria for this Priority Process.

Episode of Care

Healthcare services provided for a health problem from the first encounter with a health care provider through the completion of the last encounter related to that problem.

Surveyor Comments

There is a need to define the clients financial situation prior to admission to long term care. Contact with families and/or establishment of the power of attorney can be a significant barrier to admission. The home care staff and the long term care social worker work together in outreach to family/other parties to prevent delay of service and to remove this barrier when a bed is available. There are clients with behavioural problems that are determined to be beyond the scope of the facility that do not have a resource to meet their needs in the Burntwood Health Region.

The regulations require 24/7 RN coverage. RN's are on days and evening shifts. They are unable to recruit enough RN's to cover the night shift and so to meet the standard LPN's work the night shift with an RN on call.
From initial contact the clients know the team member to contact for their care coordination. The Handbook available to clients and families is comprehensive and easy to understand. Families verified their understanding of services and rights in English and through a Cree interpreter.

Medication reconciliation on admission is in place awaiting the next admission to start the process.
The facility is adjacent to the hospital so access to diagnostic service is not an issue. Medical coverage of the LTC facility has been reviewed and for continuity a coverage pattern acceptable to all has been defined.

With the support of the clinical resource leader the care plans are comprehensive and are reviewed in a timely manner.The family is encouraged to be part of the care plan development with the client.
The facility has adopted a best practice protocol for preventing ulcer development with success. Medication security is in place, and 24/7 medication needs are met. There is one self administration of an inhaler in LTC.

Advanced directive options are reviewed with every client and family on admission. All staff are annually trained in cardiopulmonary resuscitation (CPR). There are a significant number of clients that have not decided and/or are young in age. The process of resuscitation includes ambulance to hospital for safety and continuity even though the buildings are side by side.

The Manor operates on the Eden concept of care with a focus on wellness and independence. As an example, the First Nations individual spoken to had cooked a duck in the facilities available (with support) the day before the accreditation visit .

The resident council is active, has a 37% attendance rate and is currently chaired by a resident. Policies and procedures are in place. Minimal restraint related to safety is used. Cognitively sound choices made to live at some risk are respected. There is both a church service weekly and a regular traditional smudge in a room specifically designed to accomplish this without setting off alarms. A palliative care program is in place with symptom management protocols, and death and dying learned processes to support the clients and families prior to and after death.

Transfer of information to acute services is a structured process which includes medication reconciliation. There is continued work on having the information returned in a timely manner to the long term care facility. There is follow up to ensure clarification of the plan on return transfers.

The table below indicates the specific criteria that require attention, based on the accreditation review.

Criteria	Location	Priority for Action
The team reconciles the client's medications upon admission to the organization, and the involvement of the client.	7.4	↑
There is a demonstrated, formal process to reconcile client medications upon admission.	7.4.1	
The process includes generating a comprehensive list of all medication the client has been taking prior to admission.	7.4.2	
The process includes a timely comparison of the prior-to-admission medication list with the list of new medications ordered at admission.	7.4.3	
The process requires documentation that the two lists have been compared; differences have been identified, discussed and resolved; and that appropriate modifications to the new medications have been made where necessary.	7.4.4	
The process makes it clear that medication reconciliation is a shared responsibility involving the client, nursing staff, medical staff, and pharmacists, as appropriate.	7.4.5	
The organization has a documented plan to implement throughout the organization, and before the next accreditation survey, a medication reconciliation process upon admission.	7.4.6	

Decision Support

Information, research and evidence, data, and technologies that support and facilitate management and clinical decision-making.

Surveyor Comments

Charts are complete, orderly, up to date and accessible to the team providing service. Sharing of information to coordinate service is ongoing, is fluid in an informal manner as well as written. The electronic version of assessment and work loading is being considered. Email is an effective way to share information with staff as most use this form of communication. Best practice articles and new information are shared in this manner as well as the use of a communication book. The clinical resource leader is available to help staff when there is a question as well as to evaluate the changes made.

No Unmet Criteria for this Priority Process.

Impact on Outcomes

The identification and monitoring of process and outcome measures to evaluate and improve the quality of services to clients and the impact on client outcomes.

Surveyor Comments

The team continually assesses risk while delivering services in long term care. Risk reduction practices are in place. The team accesses information available from established best practices for benchmarks. A fall prevention strategy is in place and safety is discussed at staff meetings and case conferences. Stand alone safety briefings are not currently in practice. Families and clients are aware of the importance of safety and their role and responsibility in safety. This safety information starts before admission in written form and is reviewed at every regularly scheduled case conference and as needed. There is a verification for high risk process in place with clients choosing to live at risk.

Incidents are recorded, reviewed and the data is shared with the team and used to make improvements.

The table below indicates the specific criteria that require attention, based on the accreditation review.

Criteria	Location	Priority for Action
Staff and service providers participate in regular safety briefings to share information about potential safety problems, reduce risk of error, and improve the quality of service.	16.3	↑

Managing Medications

Medication Management

Interdisciplinary provision of medication to clients.

Surveyor Comments

The Burntwood Health Region has two pharmacists functioning in the Pharmacy located at Thompson General Hospital. Pharmacy also provides services to Northern Spirit Manor. Pharmacists are available during the hours of 0800 to 1700 weekdays, Monday to Friday. On weekends nursing staff is required to access the Supervisor's Room and in the event that consultation by a pharmacist is urgently required, pharmacists are on-call to assist.

The region has an active Pharmacy and Therapeutics (P &T) Committee comprised of various disciplines including physician, Chief Medical Officer, pharmacist, nursing, etc. When selecting medications, through the P & T Committee, the organization considers the needs of clients, staff, other providers and prescribing medical professionals, as well as safety, effectiveness, cost, etc.

A regional formulary has been developed. Copies of the formulary are provided to all service areas. Updates are provided to the staff via memorandum. The P & T Committee indicate that the formulary is updated "about 3 times annually". Information regarding newly available medication is provided via memorandum to managers.

It is noted that the organization plans to begin its Medication Reconciliation on Admission process in its long term care facility shortly. The organization will implement the new process and review it in six to eight weeks to determine effectiveness and to identify any issues prior to finalizing implementation of the new medication reconciliation process in LTC.

The LTC facility is currently in the process of reviewing its Standing Orders for LTC with a view to increasing the items for which standing orders are available. This review and implementation are planned to be completed and implemented shortly.

Two tracer reviews in regard to client medication incidents were conducted. The tracers included conversations with clients to discuss client notification of incidents. It was noted however that two of the medication incidents provided for review occurred three months earlier and the Quality Improvement Coordinator and the Pharmacist were just now being made aware of the potential issues. In part the breakdown of the process may be attributed to the shortage of consistent management staff for the area. It is strongly recommended that the reporting of adverse medication events be reviewed and strengthened to ensure consistent and timely reporting of all medication incidents.

Due to the remoteness and isolation of several communities in the region, transport of medication to some of the sites may be difficult. It is suggested that the region may wish to undertake a Failure Modes and Effects Analysis (FMEA) process to consider safe medication transport given adverse conditions to ensure the chain of signature process, etc. Due to the difficulty accessing medications in remote areas, all clients leaving the hospital and services are clearly and consistently reminded to fill prescriptions prior to leaving the city of Thompson.

Some cross-jurisdictional issues in regard to filling medications by other jurisdictions were identified. It is suggested that the region continue to identify opportunities to discuss cross-jurisdictional issues with partner organizations (i.e. Grand Medicine).

In June 2008 the BRHA launched its "It's Safe to Ask" campaign. This is a health literacy initiative of the Manitoba Institute for Patient Safety. It was created based on the belief that patients and families can play an important role in enhancing the safety and quality of their health care by becoming active, informed members of the care team. The initiative offers practical information and tips for both providers and patients to assist with clear communication. A patient medication card is provided as part of the initiative.

The recommendation from the organization's 2007 Accreditation in regard to development of a process to regularly check for outdated drug samples in Ambulatory Care has been addressed. The process initiated with quarterly reporting of outdated medications; outdated medications are sent to pharmacy for disposal. A form and a process are in place.

Although the organization has developed an interdisciplinary group to investigate/review adverse drug events, it is strongly suggested that the region could benefit from review of adverse events utilizing a system review (Root Cause) type analysis. It is further suggested that the system/incident review then include frontline care providers together with other multidisciplinary team members, managers and supervisors to ensure the addressing of system change issues. This process is an excellent process to ensure valuable frontline staff input into identifying system issues and also to create the opportunity for staff buy-in. The organization may wish to contact the Canadian Patient Safety Institute for opportunities for root cause analysis training, etc.

Although the organization is required to report adverse drug events, it is suggested that the organization ensure regular and consistent education about adverse drug events for its staff and service providers.

Quiet work areas where medication orders may be written, transcribed and entered are available only for physicians. It is suggested that areas for other health professionals would also be of benefit in reducing transcription errors.

Regarding criteria 11.5, although a policy for weight based dosing in paediatrics exists, the organization is strongly encouraged to ensure that pharmacy is regularly and consistently made aware of patient weights at the time of admission by nursing staff.

At this time the organization does not consistently ensure that staff and service providers receive ongoing, effective training on infusion pumps.

The organization is encouraged to provide staff and service providers with regular feedback about adverse drug events, hazardous situations and risk reduction strategies.

The table below indicates the specific criteria that require attention, based on the accreditation review.

Criteria	Location	Priority for Action
The organization educates staff and service providers about adverse drug events (ADEs).	1.8	↑
The organization standardizes and limits the number of medication concentrations available.	3.4	↑
Medication concentrations are standardized and limited across the organization.	3.4.1	
The organization uses alerts to inform staff and service providers about problematic labelling, packaging, and nomenclature.	4.2	↑
Medications are stored in secure areas accessible only by authorized staff.	6.3	↑
The organization separates or isolates look-alike, sound-alike medications; different concentrations of the same medication; high-risk/high-alert medications; and discontinued, expired, damaged, and contaminated medications pending removal.	6.5	↑
Medications for client service areas are stored in labelled, unit dose packaging.	7.4	↑
The organization provides quiet work areas where medication orders are written, transcribed, and entered into computer systems.	10.12	
The pharmacy dispenses medications using a unit dose packaging system.	13.3	↑

Staff and service providers receive ongoing, effective training on infusion pumps.	19.4	↑
There is documented evidence of ongoing, effective training on infusion pumps.	19.4.1	
The organization uses the findings of adverse drug event investigations to identify and implement improvements.	21.8	↑
The organization provides staff and service providers with regular feedback about adverse drug events, hazardous situations, and risk reduction strategies that are being implemented.	21.9	

Medicine Services

Clinical Leadership

Providing leadership and overall goals and direction to the team of people providing services.

Surveyor Comments

This service has not had a program manager for almost one year. This has had an impact on services.
There is good access to educational opportunities for staff.
Changes to service, specifically the inclusion of paediatric patients on this unit, were done as a result of service review.

No Unmet Criteria for this Priority Process.

Competency

Developing a highly competent interdisciplinary team with the knowledge, skills and abilities to develop, manage, and deliver effective and efficient programs, services, and care.

Surveyor Comments

There is a multidisciplinary team however processes for inclusion of all team members in the provision of service needs to be reviewed.
Some roles have developed by chance rather than by design (i.e. social worker, clincial resource nurse (CRN)).
The only area where staff can congregate is the nursing station.
Orientation processes for agency nurses need to be reviewed.
Ongoing training with respect to the use of infusion pumps is not provided.
The CRN is responsible for the assignment of nurses to patients. The assignment of allied health professionals to patients is ad hoc and there is inconsistent use of referrals.
As there has been no program manager for approximately one year performance appraisals have not been done in this time period.

The table below indicates the specific criteria that require attention, based on the accreditation review.

Criteria	Location	Priority for Action
The interdisciplinary team communicates regularly to coordinate services, roles, and responsibilities.	3.6	↑
The interdisciplinary team follows a formal process to regularly evaluate its functioning, identify priorities for action, and make improvements.	3.7	
Staff and service providers receive ongoing, effective training on infusion pumps.	4.4	↑
There is documented evidence of ongoing, effective training on infusion pumps.	4.4.1	
Team leaders regularly evaluate the effectiveness of staffing and use the information to make improvements.	5.3	

Episode of Care

Healthcare services provided for a health problem from the first encounter with a health care provider through the completion of the last encounter related to that problem.

Surveyor Comments

There is a need to review processes related to multidisciplinary involvement.
The House Medical Officers do a good job at transfer of care every ten days.This includes a crossover half day and written information.
Pharmacy uses manual systems. The use of automation and technology in this area is strongly recommended.
Some professionals report that not all medication errors are reported.
One of the most significant challenges for social work is affordable housing.
Operationalizing follow up plans can be extremely challenging for some individuals who will be returning to Aboriginal communities.

The table below indicates the specific criteria that require attention, based on the accreditation review.

Criteria	Location	Priority for Action
The team develops standardized processes and procedures to improve teamwork and minimize duplication.	3.4	

The team reconciles medications with the client at referral or transfer, and communicates information about the client's medications 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.	11.3
There is a demonstrated, formal process to reconcile client medications at referral or transfer.	11.3.1
The process includes generating a comprehensive list of all medications the client has been taking prior to referral or transfer.	11.3.2
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.	11.3.3
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.	11.3.4
The process makes it clear that medication reconciliation is a shared responsibility involving the client, nursing staff, medical staff and pharmacists, as appropriate.	11.3.5
The organization has a documented plan to implement throughout the organization, and before the next accreditation survey, a medication reconciliation process at referral and transfer.	11.3.6

Decision Support

Information, research and evidence, data, and technologies that support and facilitate management and clinical decision-making.

Surveyor Comments

There are paper charts in this program area.
At certain times of the day when the physicians are doing rounds charts are inaccessible by other team members (e.g.. allied health professionals).
There is a good relationship with the ER.
A falls prevention strategy has been initiated. Its continued implementation and monitoring is encouraged.
Implementation of isolation protocols need to be reviewed and there needs to be consideration to making education regarding infection control more user friendly.

No Unmet Criteria for this Priority Process.

Impact on Outcomes

The identification and monitoring of process and outcome measures to evaluate and improve the quality of services to clients and the impact on client outcomes.

Surveyor Comments

Disclosure is just beginning to role out in this organization using a train the trainer model.
The number of admissions and lengths of stay are being monitored.

Patient satisfaction surveys are conducted.

The table below indicates the specific criteria that require attention, based on the accreditation review.

Criteria	Location	Priority for Action
The team identifies, reports, records, and monitors in a timely way sentinel events, near misses, and adverse events.	15.6	↑

Mental Health Services

Clinical Leadership

Providing leadership and overall goals and direction to the team of people providing services.

Surveyor Comments

The mental health team provides support (debriefing and counselling) to other staff in the organization.
This team has a good understanding of the clients they serve.

Work needs to be done in relation to understanding the teen suicide rate so that interventions can be specific and the effect of interventions can be evaluated over time.
This team needs to engage in community development activities specifically with the first nations communities and to partner to comprehensively address the mental health challenges that the population faces specifically the child and youth.
A regular meeting of the acute unit staff, the community mental health team and the consultative group is encouraged.
Community health team members are well integrated into Aboriginal communities.

Staff on the unit say they have job descriptions.
Nurses on the unit have had performance appraisals.
There is good multidisciplinary involvement in all of the mental health team.
There is good collaboration with schools, the Canadian Mental Health Association, AFM and the Salvation Army.

No Unmet Criteria for this Priority Process.

Competency

Developing a highly competent interdisciplinary team with the knowledge, skills and abilities to develop, manage, and deliver effective and efficient programs, services, and care.

Surveyor Comments

While education for team members is offered there are challenges in replacing staff so that they can attend day long events.
Nurses have received performance appraisals.The recreation staff has a performance appraisal planned in the near future.
The community mental health team has a process for assigning clients to clinicians.

No Unmet Criteria for this Priority Process.

Episode of Care

Healthcare services provided for a health problem from the first encounter with a health care provider through the completion of the last encounter related to that problem.

Surveyor Comments

The adolescent community mental health team is well know and well integrated in the community.
Work needs to be done in promoting adult mental health services.
The community mental health team has an information package it gives clients and potential clients.The acute care service is developing a package.
Services are accessed through the ER.
There are short wait lists for service. Clients interviewed said they wait less than three weeks for community services.
There was a good example of case conferencing prior to start of intervention in the adolescent mental health team.
Goal orientated therapy is operationalized in the adult community mental health program.
Medication reconciliation on admission has just been implemented on the mental health unit.

Good consent processes in place.
There is a good process in place for clients on the mental health unit to understand their role in keeping themselves safe.
It is strongly encouraged that the use of, and policies related to the use of seclusion be reviewed, particularly as it relates to consent and timelines for use.

Service plans are developed for each client.
Paper charts are utilized.
The multidisciplinary team including representatives from the community mental health team are involved in discharge planning.
Comprehensive follow up processes should be developed and implemented.
There are no acute care psychiatric beds in the region for children or adolescents.
Planning for the implementation of a Youth Crises Stabilization Unit as a stand alone facility is underway. There is a significant need for this in this region.
Clients say that the time from assessment in the ER to placement on the unit is short.
A wide variety of groups are offered on the unit from 9 AM to 3 PM daily.
The one psychiatrist in the BRHA provides a regional service.

The table below indicates the specific criteria that require attention, based on the accreditation review.

Criteria	Location	Priority for Action
The team reconciles medications with the client at referral or transfer, and communicates information about the client's medications 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.	11.3	
There is a demonstrated, formal process to reconcile client medications at referral or transfer.	11.3.1	

The process includes generating a comprehensive list of all medications the client has been taking prior to referral or transfer.	11.3.2	
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.	11.3.3	
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.	11.3.4	
The process makes it clear that medication reconciliation is a shared responsibility involving the client, nursing staff, medical staff and pharmacists, as appropriate.	11.3.5	
The organization has a documented plan to implement throughout the organization, and before the next accreditation survey, a medication reconciliation process at referral and transfer.	11.3.6	
Following transition or end of service, the team contacts clients, families, or referral organizations to evaluate the effectiveness of the transition, and uses this information to improve its transition and end of service planning, as appropriate.	11.5	↑

Decision Support

Information, research and evidence, data, and technologies that support and facilitate management and clinical decision-making.

Surveyor Comments

Paper client records are utilized.
Clients have access to their charts through clinical records. All third party information is removed.

No Unmet Criteria for this Priority Process.

Impact on Outcomes

The identification and monitoring of process and outcome measures to evaluate and improve the quality of services to clients and the impact on client outcomes.

Surveyor Comments

Client satisfaction questionnaires are being filled out by clients and are then reviewed by the program manager.
A falls assessment is not completed on each client on the unit. An assessment is only done when a team member(s) believes a particular individual is at risk for falls.
Monitoring of the seclusion room is carried out by the use of cameras as well as physical checks.

The table below indicates the specific criteria that require attention, based on the accreditation review.

Criteria	Location	Priority for Action
The team implements and evaluates a falls prevention strategy to minimize the impact of client falls.	15.3	↑
The team has implemented a falls prevention strategy.	15.3.1	
The strategy identifies the populations at risk for falls.	15.3.2	
The strategy addresses the specific needs of the populations at risk for falls.	15.3.3	
The team evaluates the falls prevention strategy on an ongoing basis to identify trends, causes, and degree of injury.	15.3.4	
The team uses the evaluation information to make improvements to its falls prevention strategy.	15.3.5	

Obstetrics/Perinatal Care Services

Clinical Leadership

Providing leadership and overall goals and direction to the team of people providing services.

Surveyor Comments

Obstetrical services are well organized and well run. There is good clinical care and strong commitment by the staff and physicians to providing excellent patient care. The organization would be encouraged to be more inclusive in its service planning and goal setting exercises.

The table below indicates the specific criteria that require attention, based on the accreditation review.

Criteria	Location	Priority for Action
The team works together to develop team goals and objectives.	2.1	

Competency

Developing a highly competent interdisciplinary team with the knowledge, skills and abilities to develop, manage, and deliver effective and efficient programs, services, and care.

Surveyor Comments

There is initial education of staff on the use of infusion pumps and all new staff are oriented to the pumps on the floor. However, there is no consistent ongoing education on the various infusion pumps used on the unit. It is suggested the organization under take a formal process to ensure ongoing education related to infusion pumps. This education should include physicians, such as anaesthesiologists, in the education program.

The table below indicates the specific criteria that require attention, based on the accreditation review.

Criteria	Location	Priority for Action
The team receives ongoing, effective training on all infusion pumps for staff and service providers.	4.6	↑
There is documented evidence of ongoing, effective training on infusion pumps.	4.6.1	

Episode of Care

Healthcare services provided for a health problem from the first encounter with a health care provider through the completion of the last encounter related to that problem.

Surveyor Comments

In the neonatal intensive care unit (NICU) we would suggest the use of the Broslow Tape and the associated colour cart drawers to minimize the chances of an error when caring for ill and unstable neonates and children. Medication reconciliation is a challenge for many organizations and this is the case at BRHA. There is early work underway and the organization is encouraged to continue with their medication reconciliation strategy and where possible accelerate to full implementation.

The table below indicates the specific criteria that require attention, based on the accreditation review.

Criteria	Location	Priority for Action
The team reconciles medications with the client at referral or transfer, and communicates information about the client's medications 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.	11.3	
There is a demonstrated, formal process to reconcile client medications at referral or transfer.	11.3.1	
The process includes generating a single documented, comprehensive list all medications the client has been taking prior to referral or transfer.	11.3.2	
The process includes a timely comparison of the prior-to-referral or transfer medication list with the list of new medications ordered at referral or transfer.	11.3.3	
The process requires documentation that differences between the two lists have been identified, discussed, and resolved, and that appropriate modifications to the new medications have been made.	11.3.4	
The process makes it clear that medication reconciliation is a shared responsibility involving the client, nursing staff, medical staff and pharmacists, as appropriate.	11.3.5	

The organization has a documented plan to implement throughout the organization, and before the next accreditation survey, a medication reconciliation process at referral and transfer.	11.3.6

Impact on Outcomes

The identification and monitoring of process and outcome measures to evaluate and improve the quality of services to clients and the impact on client outcomes.

Surveyor Comments

The use of safety briefings on a regular basis is encouraged.

The table below indicates the specific criteria that require attention, based on the accreditation review.

Criteria	Location	Priority for Action
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.	16.2	↑
The team identifies, reports, records, and monitors in a timely way sentinel events, near misses, and adverse events.	16.5	↑
The team shares evaluation results with staff, clients, and families.	17.5	

Public Health Services

Clinical Leadership

Providing leadership and overall goals and direction to the team of people providing services.

Surveyor Comments

Strong team, strong leadership, every individual involved in improving quality.

No Unmet Criteria for this Priority Process.

Episode of Care

Healthcare services provided for a health problem from the first encounter with a health care provider through the completion of the last encounter related to that problem.

Surveyor Comments

Consents and adverse event documentation is clear for all

No Unmet Criteria for this Priority Process.

Surgical Procedures

Delivery of safe surgical care to clients, from preparation and the actual procedure in the operating room, to the post-recovery area and discharge.

Surveyor Comments

The surgical team is to be commended for its progress since the last survey. Surgical services are well organized. They are progressive and are ahead of many departments of similar size and complexity. The incorporation of the Surgical Pause, Surgical Site Marking, preoperative antibiotic administration and the Surgical Safety Check List is to be commended.

There are some process indicators for the surgical services, however greater use of outcome measures with predetermined targets would enhance the team's ability to understand their clinical activities. It is encouraged for staff to have regular staff performance reviews. There is some early discussion regarding the use of clinical pathways. The formal use of clinical pathways would be encouraged. The department is encouraged to continue to use research to direct clinical practice. Its use of research in relation to the use of surgical masks is to be commended. Data collection is predominately manual. It is suggested consideration be given to automating data collection where possible.

The table below indicates the specific criteria that require attention, based on the accreditation review.

Criteria	Location	Priority for Action
Operating Rooms		
The team uses evidence-based client care maps or pathways to guide them through steps in the procedure, promote efficient care and achieve optimal client outcomes.	1.3	
The team sets performance goals and objectives and measures their achievement.	14.4	
The team benchmarks or compares its results with other similar interventions, programs, or organizations.	14.5	↑
The team uses the information it collects about safety, risk, and performance to identify successes and opportunities for improvement, and makes improvements as needed.	14.6	
Surgical Care Services		
The team’s goals and objectives for its surgical care services are measurable and specific.	2.2	

Staff and service providers receive ongoing, effective training on infusion pumps.	4.4	↑
There is documented evidence of ongoing, effective training on infusion pumps.	4.4.1	
Team leaders regularly evaluate and document each team member's performance in an objective, interactive, and positive way.	4.8	
Team members have input on work and job design, including the definition of roles and responsibilities, and case assignments, where appropriate.	5.2	
The team uses a procedure-specific care map to guide the client through preparation for and recovery from the procedure.	7.1	
The team reconciles the client's medications upon admission to the organization, with the involvement of the client.	7.10	↑
There is a demonstrated, formal process to reconcile client medications upon admission.	7.10.1	
The process includes a timely comparison of the prior-to-admission medication list with the list of new medications ordered at admission.	7.10.3	
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 where necessary.	7.10.4	
The process makes it clear that medication reconciliation is a shared responsibility involving the client, nursing staff, medical staff, and pharmacists, as appropriate.	7.10.5	
The organization has a documented plan to implement throughout the organization, and before the next accreditation survey, a medication reconciliation process upon admission.	7.10.6	
Medication Reconciliation at Admission	7.11	
The team follows Accreditation Canada's protocols and definitions to collect and submit data on medication reconciliation at admission.	7.11.1	
The team does not have any unaddressed priority for action flags based on their medication reconciliation at admission indicator results.	7.11.2	

The team reconciles medications with the client at referral or transfer, and communicates information about the client's medications 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.	11.4	
There is a demonstrated, formal process to reconcile client medications at referral or transfer.	11.4.1	
The process includes generating a comprehensive list of all medications the client has been taking prior to referral or transfer.	11.4.2	
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.	11.4.3	
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.	11.4.4	
The process makes it clear that medication reconciliation is a shared responsibility involving the client, nursing staff, medical staff and pharmacists, as appropriate.	11.4.5	
The organization has a documented plan to implement throughout the organization, and before the next accreditation survey, a medication reconciliation process at referral and transfer.	11.4.6	
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.	15.2	↑
The team informs and educates its clients and families in writing and verbally about the client and family's role in promoting safety.	15.3	↑
Written and verbal information is provided to clients and families about their role in promoting safety.	15.3.1	
Staff uses written and verbal approaches to inform and educate clients about their role in promoting safety.	15.3.2	
Clients indicate that they have received written and verbal communication about their role in promoting safety.	15.3.3	
The team identifies and monitors process and outcome measures for its surgical care services.	16.1	↑
The team monitors clients' perspectives on the quality of its surgical care services.	16.2	
The team compares its results with other similar interventions, programs, or organizations.	16.3	↑

Performance Measure Results

The following section provides an overview of the performance measures collected for the entire organization. These measures consist of both instrument and indicator results, which are valuable components of evaluation and quality improvement.

Instrument Results

The instruments are questionnaires completed by a representative sample of clients, staff, leadership and/or other key stakeholders that provide important insight into critical aspects of the organization's services. The following tables summarize the organization's results and highlight each item that requires attention. Results are presented in three main areas: governance functioning, patient safety culture and worklife.

Governance Functioning Tool

The Governance Functioning Tool is intended for members of the governing body to assess their own structures and processes and identify areas for improvement. The results reflect the perceptions and opinions of the governing body regarding the status of its internal structures and processes.

Summary of Results

	Governance Structures and Processes	% Agree	% Neutral	% Disagree	Priority for Action
		Organization	Organization	Organization	
1	We actively recruit, recommend and/or select new members based on needs for particular skills, background, and experience.	60	0	40	⚠
2	We have explicit criteria to recruit and select new members.	70	0	30	⚠
3	Our renewal cycle is appropriately managed to ensure continuity on the governing body.	83	0	17	
4	The composition of our governing body allows us to meet stakeholder and community needs.	100	0	0	
5	Clear written policies define term lengths and limits for individual members, as well as compensation.	100	0	0	
6	We regularly review, understand, and ensure compliance with applicable laws, legislation and regulations.	100	0	0	
7	Governance policies and procedures that define our role and responsibilities are well-documented and consistently followed.	100	0	0	
8	We review our own structure, including size and sub-committee structure.	83	0	17	
9	We have sub-committees that have clearly-defined roles and responsibilities.	92	0	8	
10	Our roles and responsibilities are clearly identified and distinguished from those delegated to the CEO and/or senior management. We do not become overly involved in management issues.	100	0	0	
11	We each receive orientation that helps us to understand the organization and its issues, and supports high-quality decision-making.	100	0	0	

12	Disagreements are viewed as a search for solutions rather than a “win/lose”.	100	0	0
13	Our meetings are held frequently enough to make sure we are able to make timely decisions.	100	0	0
14	Individual members understand and carry out their legal duties, roles and responsibilities, including sub-committee work (as applicable).	100	0	0
15	Members come to meetings prepared to engage in meaningful discussion and thoughtful decision-making.	100	0	0
16	Our governance processes make sure that everyone participates in decision-making.	100	0	0
17	Individual members are actively involved in policy-making and strategic planning.	92	0	8
18	The composition of our governing body contributes to high governance and leadership performance.	100	0	0
19	Our governing body’s dynamics enable group dialogue and discussion. Individual members ask for and listen to one another’s ideas and input.	100	0	0
20	Our ongoing education and professional development is encouraged.	100	0	0
21	Working relationships among individual members and committees are positive.	100	0	0
22	We have a process to set bylaws and corporate policies.	92	0	8
23	Our bylaws and corporate policies cover confidentiality and conflict of interest.	100	0	0
24	We formally evaluate our own performance on a regular basis.	91	0	9
25	We benchmark our performance against other similar organizations and/or national standards.	82	0	18
26	Contributions of individual members are reviewed regularly.	100	0	0
27	As a team, we regularly review how we function together and how our governance processes could be improved.	100	0	0
28	There is a process for improving individual effectiveness when non-performance is an issue.	100	0	0

29	We regularly identify areas for improvement and engage in our own quality improvement activities.	100	0	0
30	As a governing body, we annually release a formal statement of our achievements that is shared with the organization's staff as well as external partners and the community.	100	0	0
31	As individual members, we receive adequate feedback about our contribution to the governing body.	91	0	9
32	We have a process to elect or appoint our chair.	100	0	0
33	Our chair has clear roles and responsibilities and runs the governing body effectively.	100	0	0

Patient Safety Culture Survey

The patient safety culture survey results provide valuable insight into staff perceptions of patient safety, as well as an indication of areas of strength, areas of improvement, and a mechanism to monitor changes within the organization.

Summary of Results

Number of survey respondents = 353 respondents

A. Patient Safety: Activities to avoid, prevent, or correct adverse outcomes which may result from the delivery of health care	% Disagree	% Neutral	% Agree	Priority for Action
	Organization	Organization	Organization	
1 Patient safety decisions are made at the proper level by the most qualified people	8	18	73	▲
2 Good communication flow exists up the chain of command regarding patient safety issues	18	18	64	▲
3 Reporting a patient safety problem will result in negative repercussions for the person reporting it	67	18	15	▲
4 Senior management has a clear picture of the risk associated with patient care	15	22	63	▲
5 My unit takes the time to identify and assess risks to patients	11	16	73	▲
6 My unit does a good job managing risks to ensure patient safety	7	16	77	
7 Senior management provides a climate that promotes patient safety	12	21	67	▲
8 Asking for help is a sign of incompetence	89	5	6	
9 If I make a mistake that has significant consequences and nobody notices, I do not tell anyone about it	93	4	3	
10 I am sure that if I report an incident to our reporting system, it will not be used against me	18	21	61	▲
11 I am less effective at work when I am fatigued	13	11	76	
12 Senior management considers patient safety when program changes are discussed	7	30	63	▲
13 Personal problems can adversely affect my performance	28	16	56	▲
14 I will suffer negative consequences if I report a patient safety problem	76	15	8	

15	If I report a patient safety incident, I know that management will act on it	11	22	67	⚠
16	I am rewarded for taking quick action to identify a serious mistake	20	42	37	✖
17	Loss of experienced personnel has negatively affected my ability to provide high quality patient care	33	34	34	✖
18	I have enough time to complete patient care tasks safely	11	26	63	⚠
19	I am not sure about the value of completing incident reports	62	18	20	⚠
20	In the last year, I have witnessed a co-worker do something that appeared to me to be unsafe for the patient in order to save time	51	17	31	⚠
21	I am provided with adequate resources (personnel, budget, and equipment) to provide safe patient care	19	18	63	⚠
22	I have made significant errors in my work that I attribute to my own fatigue	75	13	12	⚠
23	I believe that health care error constitutes a real and significant risk to the patients that we treat	10	17	73	⚠
24	I believe health care errors often go unreported	23	23	54	✖
25	My organization effectively balances the need for patient safety and the need for productivity	12	26	62	⚠
26	I work in an environment where patient safety is a high priority	9	16	75	
27	Staff are given feedback about changes put into place based on incident reports	27	29	44	✖
28	Individuals involved in patient safety incidents have a quick and easy way to report what happened	13	30	56	⚠
29	My supervisor/manager says a good word when he/she sees a job done according to established patient safety procedures	13	17	69	⚠
30	My supervisor/manager seriously considers staff suggestions for improving patient safety	9	20	71	⚠
31	Whenever pressure builds up, my supervisor/manager wants us to work faster, even if it means taking shortcuts	71	18	11	⚠
32	My supervisor/manager overlooks patient safety problems that happen over and over	66	20	13	⚠

33	On this unit, when an incident occurs, we think about it carefully	8	19	74	⚠
34	On this unit, when people make mistakes, they ask others about how they could have prevented it	11	22	67	⚠
35	On this unit, after an incident has occurred, we think about how it came about and how to prevent the same mistake in the future	6	16	78	
36	On this unit, when an incident occurs, we analyze it thoroughly	12	24	64	⚠
37	On this unit, it is difficult to discuss errors	64	20	16	⚠
38	On this unit, after an incident has occurred, we think long and hard about how to correct it	12	27	60	⚠
	B. These questions are about your perceptions of overall patient safety	**% Good/ Excellent**	**% Acceptable**	**% Poor/ Failing**	**Priority for Action**
		Organization	Organization	Organization	
39	Please give your unit an overall grade on patient safety	67	29	5	⚠
40	Please give the organization an overall grade on patient safety	54	38	8	⚠
	C. These questions are about what happens after a Major Event	**% Disagree**	**% Neutral**	**% Agree**	**Priority for Action**
		Organization	Organization	Organization	
41	Individuals involved in major events contribute to the understanding and analysis of the event and the generation of possible solutions	9	29	63	⚠
42	A formal process for disclosure of major events to patients/families is followed and this process includes support mechanisms for patients, family, and care/service providers	8	37	55	⚠
43	Discussion around major events focuses mainly on system-related issues, rather than focusing on the individual(s) most responsible for the event	18	38	43	✖
44	The patient and family are invited to be directly involved in the entire process of understanding: what happened following a major event and generating solutions for reducing re-occurrence of similar events	11	48	41	✖

45	Things that are learned from major events are communicated to staff on our unit using more than one method (e.g. communication book, in-services, unit rounds, emails) and / or at several times so all staff hear about it	12	31	57	
46	Changes are made to reduce re-occurrence of major events	9	24	67	

Worklife Pulse

The concept of 'quality of worklife' is central to Accreditation Canada's accreditation program. The Pulse Survey enables health service organizations to monitor key worklife areas. The survey takes the 'pulse' of quality of worklife, providing a quick and high level snapshot of key work environment factors, individual outcomes, and organizational outcomes. Organizations can then use the findings to identify strengths and gaps in their work environments, engage stakeholders in discussions of opportunities for improvement, plan interventions to improve the quality of worklife, and develop a clearer understanding of how quality of worklife influences the organization's capacity to meet its strategic goals.

Summary of Results

Number of survey respondents = 367 respondents

How would you rate your work environment	% Disagree	% Neutral	% Agree	Priority for Action
	Organization	Organization	Organization	
1 I am satisfied with communications in this organization.	28	23	48	✕
2 I am satisfied with communications in my work area.	23	19	59	△
3 I am satisfied with my supervisor.	12	19	69	△
4 I am satisfied with the amount of control I have over my job activities.	12	16	71	△
5 I am clear about what is expected of me to do my job.	7	12	82	
6 I am satisfied with my involvement in decision making processes in this organization.	19	27	55	△
7 I have enough time to do my job adequately.	18	18	64	△
8 I feel that I can trust this organization.	16	26	58	△
9 This organization supports my learning and development.	10	18	72	△
10 My work environment is safe.	13	14	73	△
11 My job allows me to balance my work and family/personal life.	10	17	73	△

Individual Outcomes	% Not Stressful	% A bit Stressful	% Quite or Extremely Stressful	Priority for Action
	Organization	Organization	Organization	
12 In the past 12 months, would you say that most days at work were…	24	50	26	

	% Very Good/ Excellent	% Good	% Fair/ Poor	Priority for Action
	Organization	Organization	Organization	
13 In general, would you say your health is…	53	39	8	
14 In general, would you say your mental health is…	63	31	7	
15 In general, would you say your physical health is…	50	39	12	

	% Very Satisfied	% Somewhat Satisfied	% Not Satisfied	Priority for Action
	Organization	Organization	Organization	
16 How satisfied are you with your job?	90	7	2	

	% < 10	% 10 - 15	% > 15	Priority for Action
	Organization	Organization	Organization	
17 In the past 12 months, how many days were you away from work because of your own illness or injury? (counting each full or partial day as 1 day)	86	7	7	
18 During the past 12 months, how many days did you work despite an illness or injury because you felt you had to (counting each full or partial day as 1 day)?	82	11	7	

	% Never/ Rarely	% Sometimes	% Often/ Always	Priority for Action
	Organization	Organization	Organization	
19 How often do you feel you can do your best quality work in your job?	2	19	79	

	% Disagree	% Neutral	% Agree	Priority for Action
	Organization	Organization	Organization	
20 Overall, I am satisfied with this organization.	13	22	65	⚠
21 Working conditions in my area contribute to patient safety.	7	22	71	⚠

Indicator Results

Indicators collect data related to important aspects of patient safety and quality care. The tables in this section show the indicator data that has been submitted by the organization.

Surgical Site Infection

Post-surgical infection rate is a key outcome measure that reflects process interventions.

The thresholds for this performance indicator are currently in development. Performance ratings will be provided when the thresholds are finalized.

Surgical Site Infection: Post-Surgical Infection - Colorectal Surgery

Flag	Location	Team Name (standard section)	Dates (dd/mm/yyyy)	% post-surgical infections
	Thompson General Hospital (Infection Prevention and Control)	Infection Prevention and Control (Infection Control Committee)	01/04/2009 30/06/2009	0
	Thompson General Hospital (Infection Prevention and Control)	Infection Prevention and Control (Infection Control Committee)	01/07/2009 30/09/2009	0
	Thompson General Hospital (Infection Prevention and Control)	Infection Prevention and Control (Infection Control Committee)	01/10/2009 31/12/2009	0

The thresholds for this performance indicator are currently in development. Performance ratings will be provided when the thresholds are finalized.

Surgical Site Infection: Post-Surgical Infection - Hysterectomy				
Flag	Location	Team Name (standard section)	Dates (dd/mm/yyyy)	% post-surgical infections
	Thompson General Hospital (Infection Prevention and Control)	Infection Prevention and Control (Infection Control Committee)	01/07/2009 30/09/2009	0
	Thompson General Hospital (Infection Prevention and Control)	Infection Prevention and Control (Infection Control Committee)	01/10/2009 31/12/2009	0

The thresholds for this performance indicator are currently in development. Performance ratings will be provided when the thresholds are finalized.

Surgical Site Infection: Post-Surgical Infection - C-Section				
Flag	Location	Team Name (standard section)	Dates (dd/mm/yyyy)	% post-surgical infections
	Thompson General Hospital (Infection Prevention and Control)	Infection Prevention and Control (Infection Control Committee)	01/04/2009 30/06/2009	5.4
	Thompson General Hospital (Infection Prevention and Control)	Infection Prevention and Control (Infection Control Committee)	01/07/2009 30/09/2009	15
	Thompson General Hospital (Infection Prevention and Control)	Infection Prevention and Control (Infection Control Committee)	01/10/2009 31/12/2009	2.6

Threshold for Flags
RED: < 80/100
YELLOW: >= 80/100 AND < 90/100
GREEN: >= 90/100

Surgical Site Infection

Timeliness of administering antibiotic prophylaxis is a universal process measure applicable to many surgical procedures and with widely recognized benefits in reducing post-surgical infections in selected high risk procedures.

Surgical Site Infection: Prophylactic Antibiotics - Colorectal Surgery				
Flag	Location	Team Name (standard section)	Dates (dd/mm/yyyy)	% timely administrations of antibiotics
RED	Thompson General Hospital (Infection Prevention and Control)	Infection Prevention and Control (Infection Control Committee)	01/04/2009 30/06/2009	0
GREEN	Thompson General Hospital (Infection Prevention and Control)	Infection Prevention and Control (Infection Control Committee)	01/07/2009 30/09/2009	100
GREEN	Thompson General Hospital (Infection Prevention and Control)	Infection Prevention and Control (Infection Control Committee)	01/10/2009 31/12/2009	100

Threshold for Flags
RED: < 80/100
YELLOW: >= 80/100 AND < 90/100
GREEN: >= 90/100

Surgical Site Infection: Prophylactic Antibiotics - Hysterectomy				
Flag	Location	Team Name (standard section)	Dates (dd/mm/yyyy)	% timely administrations of antibiotics
RED	Thompson General Hospital (Infection Prevention and Control)	Infection Prevention and Control (Infection Control Committee)	01/07/2009 30/09/2009	33

Surgical Site Infection: Prophylactic Antibiotics - Hysterectomy				
Flag	Location	Team Name (standard section)	Dates (dd/mm/yyyy)	% timely administrations of antibiotics
RED	Thompson General Hospital (Infection Prevention and Control)	Infection Prevention and Control (Infection Control Committee)	01/10/2009 31/12/2009	67

Threshold for Flags
RED: < 80/100
YELLOW: >= 80/100 AND < 90/100
GREEN: >= 90/100

Surgical Site Infection: Prophylactic Antibiotics - C-Section				
Flag	Location	Team Name (standard section)	Dates (dd/mm/yyyy)	% timely administrations of antibiotics
RED	Thompson General Hospital (Infection Prevention and Control)	Infection Prevention and Control (Infection Control Committee)	01/04/2009 30/06/2009	11
RED	Thompson General Hospital (Infection Prevention and Control)	Infection Prevention and Control (Infection Control Committee)	01/07/2009 30/09/2009	30
RED	Thompson General Hospital (Infection Prevention and Control)	Infection Prevention and Control (Infection Control Committee)	01/10/2009 31/12/2009	21

Threshold for Flags
RED: < 80/100
YELLOW: >= 80/100 AND < 90/100
GREEN: >= 90/100

Health Care Associated Infection Rates

Health care associated C. difficile and MRSA infections represent a significant risk to the individuals receiving care and are a substantial resource burden to organizations and the health care system. Measuring infection control performance measures has the additional benefit of informing and shaping the staff's view of safety. Evidence suggests that as staff become more aware of infection control rates and the evidence related to infection control there is a change in behaviour to reduce the perceived risk.

Health Care-Associated MRSA & C. difficile - C. difficile

Flag	Location	Team Name (standard section)	Dates (dd/mm/yyyy)	# cases of infection / 1000 patient days
GREEN	Gillam Hospital (Infection Prevention and Control)	Infection Prevention and Control (Infection Control Committee)	01/04/2009 30/06/2009	0
GREEN	Gillam Hospital (Infection Prevention and Control)	Infection Prevention and Control (Infection Control Committee)	01/07/2009 30/09/2009	0
GREEN	Gillam Hospital (Infection Prevention and Control)	Infection Prevention and Control (Infection Control Committee)	01/10/2009 31/12/2009	0
GREEN	Lynn Lake Hospital (Infection Prevention and Control)	Infection Prevention and Control (Infection Control Committee)	01/04/2009 30/06/2009	0
GREEN	Lynn Lake Hospital (Infection Prevention and Control)	Infection Prevention and Control (Infection Control Committee)	01/07/2009 30/09/2009	0

Health Care-Associated MRSA & C. difficile - C. difficile				
Flag	Location	Team Name (standard section)	Dates (dd/mm/yyyy)	# cases of infection / 1000 patient days
GREEN	Lynn Lake Hospital (Infection Prevention and Control)	Infection Prevention and Control (Infection Control Committee)	01/10/2009 31/12/2009	0
GREEN	Northern Spirit Manor (Infection Prevention and Control)	Infection Prevention and Control (Infection Control Committee)	01/04/2009 30/06/2009	0
GREEN	Northern Spirit Manor (Infection Prevention and Control)	Infection Prevention and Control (Infection Control Committee)	01/07/2009 30/09/2009	0
GREEN	Northern Spirit Manor (Infection Prevention and Control)	Infection Prevention and Control (Infection Control Committee)	01/10/2009 31/12/2009	0
GREEN	Thompson General Hospital (Infection Prevention and Control)	Infection Prevention and Control (Infection Control Committee)	01/04/2009 30/06/2009	0
GREEN	Thompson General Hospital (Infection Prevention and Control)	Infection Prevention and Control (Infection Control Committee)	01/07/2009 30/09/2009	0
GREEN	Thompson General Hospital (Infection Prevention and Control)	Infection Prevention and Control (Infection Control Committee)	01/10/2009 31/12/2009	0

Threshold for Flags
RED: > 8/1000
YELLOW: >= 6/1000 AND < 8/1000
GREEN: <= 6/1000

Health Care-Associated MRSA & C. difficile - MRSA

Flag	Location	Team Name (standard section)	Dates (dd/mm/yyyy)	# cases of infection + colonization / 1000 patient days
GREEN	Gillam Hospital (Infection Prevention and Control)	Infection Prevention and Control (Infection Control Committee)	01/04/2009 30/06/2009	0
GREEN	Gillam Hospital (Infection Prevention and Control)	Infection Prevention and Control (Infection Control Committee)	01/07/2009 30/09/2009	0
GREEN	Gillam Hospital (Infection Prevention and Control)	Infection Prevention and Control (Infection Control Committee)	01/10/2009 31/12/2009	2.1
GREEN	Lynn Lake Hospital (Infection Prevention and Control)	Infection Prevention and Control (Infection Control Committee)	01/04/2009 30/06/2009	0
GREEN	Lynn Lake Hospital (Infection Prevention and Control)	Infection Prevention and Control (Infection Control Committee)	01/07/2009 30/09/2009	0
GREEN	Lynn Lake Hospital (Infection Prevention and Control)	Infection Prevention and Control (Infection Control Committee)	01/10/2009 31/12/2009	0

Health Care-Associated MRSA & C. difficile - MRSA				
Flag	Location	Team Name (standard section)	Dates (dd/mm/yyyy)	# cases of infection + colonization / 1000 patient days
GREEN	Thompson General Hospital (Infection Prevention and Control)	Infection Prevention and Control (Infection Control Committee)	01/04/2009 30/06/2009	0.71
GREEN	Thompson General Hospital (Infection Prevention and Control)	Infection Prevention and Control (Infection Control Committee)	01/07/2009 30/09/2009	0.39
GREEN	Thompson General Hospital (Infection Prevention and Control)	Infection Prevention and Control (Infection Control Committee)	01/10/2009 31/12/2009	1.2

Threshold for Flags
RED: > 8/1000
YELLOW: >= 6/1000 AND < 8/1000
GREEN: <= 6/1000

Next Steps

Congratulations! You have just completed your Qmentum on-site survey visit. Please note the following check list items that you need to attend to in the coming days and months.

- ☐ We ask that you review this report within the next five days for errors in titles of names of services. This will help ensure the report and our records are accurate. Once you have reviewed, please send your requested changes to your Accreditation Specialist.

- ☐ In 10 business days, a letter outlining your accreditation decision and requirements will be e-mailed to your Chief Executive Officer. If revisions to the report were required, a copy of a revised report will be sent along with that letter.

- ☐ You are required to submit your quarterly reports on indicators on May 31st, every year. If you have any questions regarding this submission, please contact your Accreditation Specialist.

Appendix A – Accreditation Decision Guidelines

Quality improvement continues to be a key principle of Accreditation Canada's Qmentum program. Accreditation Canada's standards assess the quality of services provided by an organization and are constructed around eight dimensions of quality:

1. Population focus
2. Accessibility
3. Safety
4. Worklife
5. Client-centred services
6. Continuity of services
7. Effectiveness
8. Efficiency

Each standard criterion is related to a quality dimension. Organizations participating in Accreditation Canada's Qmentum program are eligible for the recognition awards: Accreditation; Accreditation with Condition (Report and/or Focused Visit) and Non-accreditation.

Under the Qmentum accreditation program, Accreditation Canada High Priority Criteria and Required Organization Practices (ROPs) are the two main factors that are considered in determining the appropriate recognition award.

Accreditation Canada High Priority Criteria

Accreditation Canada identifies high priority criteria by their alignment with several key areas:

- Quality Improvement
- Safety
- Risk
- Ethics

Required Organization Practices (ROPs)

A Required Organizational Practice is defined as an essential practice that organizations must have in place to enhance patient/client safety and minimize risk. It is a specific requirement for healthcare organizations in the accreditation program.

Based on the above, the three accreditation decisions for 2010 Qmentum surveys are:

Option 1: Accreditation
An organization is eligible for full accreditation (with a resurvey in three years) if all of the following criteria are met:

(a) 90% or more of high priority criteria met per standard section, AND
(b) Compliance with all of the Required Organizational Practices, AND
(c) Compliance with collection of all the performance measures,

If the organization is a CSSS, participating in the Joint Program with Conseil québecois d'agrément (CQA) and Accreditation Canada, the following additional criteria are required, which are specific CQA indicators relating to customer service and worklife:

(d) Compliance with ≥66.6% of Client Satisfaction Indicators AND
(e) Compliance with ≥66.6% of Employees Mobilization Indicators

Option 2: Accreditation with Condition: Report and/or Focused Visit
An organization will receive Accreditation with Condition: Report and/or Focused Visit if any of following criteria is met:

(a) More than 10% and less than 30% of high priority criteria unmet in any standard section,
OR
(b) Non-compliance with any one of the Required Organizational Practices
OR
(c) Non-compliance with the collection of any one of the performance measures

If the organization is a CSSS, participating in the Joint Program with CQA and Accreditation Canada, the following addition criteria apply:

(d) Compliance with less than 66.6% of Client Satisfaction Indicators,
OR
(e) Compliance with less than 66.6% of Employees Mobilization Indicators

The condition, i.e. submission of a report or focused visit; and timeframe, i.e. 6 months or 12 months; is based upon the nature of the recommendations. If the organization is a CSSS, and their compliance with the Client Satisfaction Indicators OR Employees Mobilization Indicators is less than 66.6%, they must conduct the survey(s) again within 18 months following the onsite visit as a condition of accreditation.

Organizations are required to submit follow-up reports as a condition of maintaining accreditation status. If a satisfactory report is not submitted within the required timeline, Accreditation Canada may grant a one-time extension of 6 months, based on surveyor input, proof of progress, and a plan to meet the conditions. Failure to comply with these requirements within the maximum allotted time extension will result in removal of accreditation status, at the discretion of Accreditation Canada.

For organizations that fail to complete a satisfactory focused visit within the required timeline, Accreditation Canada may grant a one-time extension of 6 months, based on surveyor input, proof of progress and a plan to meet the conditions. Failure to comply with these requirements within the maximum allotted time extension will result in removal of accreditation status, at the discretion of Accreditation Canada.

Option 3: Non-accreditation
An organization will NOT be accredited if the following conditions exist:

(a) One or more ROPs not in place
AND
(b) 30% or more high priority criteria unmet in one or more standards sections
AND
(c) 20% or more criteria unmet overall for all standards applied to the organization

Should an organization wish to have their non-accreditation status reviewed within 6 months post survey, they are required to complete a focused visit within 5 months. Organizations that fail to complete a satisfactory focused visit within the required timeframe will maintain a non-accreditation status.

If the organization is a CSSS, and their compliance with the Client Satisfaction Indicators OR Employees Mobilization Indicators is less than 66.6%, they must conduct the survey(s) again within 18 months following the onsite visit as a condition of accreditation.