ACCREDITATION CANADA

Driving Quality Health Services

Accreditation Report

NOR-MAN Regional Health Authority

Flin Flon, MB

On-site survey dates: November 20, 2011 - November 25, 2011

Report issued: December 19, 2011

ACCREDITATION CANADA
AGRÉMENT CANADA

Driving Quality Health Services
Force motrice de la qualité des services de santé

Accredited by ISQua

About the Accreditation Report

NOR-MAN Regional Health Authority (referred to in this report as "the organization") is participating in Accreditation Canada's Qmentum accreditation program. As part of this ongoing process of quality improvement, an on-site survey was conducted in November 2011. Information from the on-site survey as well as other data obtained from the organization were used to produce this Accreditation Report.

Accreditation results are based on information provided by the organization. Accreditation Canada relies on the accuracy of this information to plan and conduct the on-site survey and produce the Accreditation Report.

Any alteration of this Accreditation Report compromises the integrity of the accreditation process and is strictly prohibited.

Confidentiality

This report is confidential and is provided by Accreditation Canada to the organization only. Accreditation Canada does not release the report to any other parties.

In the interests of transparency and accountability, Accreditation Canada encourages the organization to disseminate its Accreditation Report to staff, board members, clients, the community, and other stakeholders.

Accreditation Canada is a not-for-profit, independent organization that provides health services organizations with a rigorous and comprehensive accreditation process. We foster ongoing quality improvement based on evidence-based standards and external peer review. Accredited by the International Society for Quality in Health Care, Accreditation Canada has helped organizations strive for excellence for more than 50 years.

A Message from Accreditation Canada's President and CEO

On behalf of Accreditation Canada's Board and staff, I extend my sincerest congratulations to your board, your leadership team, and everyone at NOR-MAN Regional Health Authority on your participation in the Qmentum accreditation program. Qmentum is designed to integrate with your quality improvement program. By using it to support and enable your quality improvement activities, its full value is realized.

This Accreditation Report includes your accreditation decision, the final results from your recent on-site survey, and instrument data that your organization has submitted. Please use the information in this report and in your online Quality Performance Roadmap to guide your quality improvement activities.

Your Accreditation Specialist is available if you have questions or need guidance.

Thank you for your leadership and for demonstrating your ongoing commitment to quality by integrating accreditation into your improvement program. We welcome your feedback about how we can continue to strengthen the program to ensure it remains relevant to you and your services.

We look forward to our continued partnership.

Sincerely,

Wendy Nicklin
President and Chief Executive Officer

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Section 1 Executive Summary

Accreditation Canada is an independent, not-for-profit organization that sets standards for quality and safety in health care and accredits health organizations in Canada and around the world. Organizations that are accredited by Accreditation Canada undergo a rigorous evaluation process. Following a comprehensive self-assessment, trained surveyors from accredited health organizations conduct an on-site survey to evaluate the organization's performance against Accreditation Canada's standards of excellence.

NOR-MAN Regional Health Authority (referred to in this report as "the organization") is participating in Accreditation Canada's Qmentum accreditation program. This Accreditation Report shows the results to date and is provided to guide the organization as it continues to incorporate the principles of accreditation and quality improvement into its programs, policies, and practices.

NOR-MAN Regional Health Authority is commended on its commitment to using accreditation to improve the quality and safety of the services it offers to its clients and its community.

1.1 Accreditation Decision

NOR-MAN Regional Health Authority has earned the following accreditation decision.

ACCREDITATION DECISION

Accreditation with Condition (Report)

Section 1 Executive Summary

1.2 About the On-site Survey

- **On-site survey dates: November 20, 2011 to November 25, 2011**

- **Locations**

  The following locations were assessed during the on-site survey. All sites and services offered by the organization are deemed accredited.

  1 Flin Flon General Hospital (FFGH)
  2 Flin Flon Personal Care Home
  3 Flin Flon Primary Health Care Centre
  4 Flin Flon Primary Health Care Seniors team
  5 Northern Lights Manor
  6 Rosaire House
  7 Snow Lake Health Centre
  8 St. Anthony's General Hospital
  9 St. Paul's Personal Care Home
  10 The Pas EMS Facility
  11 The Pas Primary Health Care Centre

- **Standards**

  The following sets of standards were used to assess the organization's programs and services during the on-site survey.

  System-Wide Standards

  1 Sustainable Governance
  2 Effective Organization

  Population-specific Standards

  3 Populations with Chronic Conditions

  Service Excellence Standards

  4 Managing Medications
  5 Operating Rooms
  6 Surgical Care Services
  7 Infection Prevention and Control
  8 Home Care Services
  9 Community Health Services
  10 Long Term Care Services
  11 Medicine Services

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12 Obstetrics/Perinatal Care Services
13 Substance Abuse and Problem Gambling Services
14 Emergency Medical Services
15 Mental Health Services
16 Emergency Department

- **Performance Measures**

  The organization submitted data related to the following performance measures.

  Instruments

  1 Governance Functioning Tool
  2 Patient Safety Culture Tool
  3 Worklife Pulse Tool

Section 1 Executive Summary

1.3 Overview by Quality Dimensions

Accreditation Canada defines quality in health care using eight dimensions that represent key service elements.

Each criterion in the standards is associated with a quality dimension. This table lists the quality dimensions and shows how many of the criteria related to each dimension were rated as met, unmet, or not applicable during the on-site survey.

Quality Dimension	Met	Unmet	N/A	Total
 Population Focus (Working with communities to anticipate and meet needs)	85	10	0	95
 Accessibility (Providing timely and equitable services)	95	1	2	98
 Safety (Keeping people safe)	374	57	25	456
 Worklife (Supporting wellness in the work environment)	139	10	2	151
 Client-centred Services (Putting clients and families first)	150	7	4	161
 Continuity of Services (Experiencing coordinated and seamless services)	62	1	0	63
 Effectiveness (Doing the right thing to achieve the best possible results)	513	83	16	612
 Efficiency (Making the best use of resources)	50	6	1	57
Total	**1468**	**175**	**50**	**1693**

Section 1 Executive Summary

1.4 Overview by Standards Sets

Qmentum standards of excellence identify policies and practices that contribute to high quality, safe, and effectively managed care. Each standard has associated criteria that contribute to achieving the standard as a whole.

System-wide standards address quality and safety at the organizational level in areas such as governance and leadership, while population-specific and service excellence standards address specific populations, sectors, and services. The sets of standards used to assess an organization's programs and services are based on the type of services it provides.

This table shows the standards sets used to evaluate the organization's programs and services, and the number and percentage of criteria that were rated met, unmet, or not applicable during the on-site survey.

Standards Set	High Priority Criteria			Other Criteria			Total Criteria (High Priority + Other)		
	Met	Unmet	N/A	Met	Unmet	N/A	Met	Unmet	N/A
	# (%)	# (%)	#	# (%)	# (%)	#	# (%)	# (%)	#
System-Wide Standards									
Sustainable Governance	21(91%)	2(9%)	0	59(88%)	8(12%)	1	80(89%)	10(11%)	1
Effective Organization	55(96%)	2(4%)	0	43(88%)	6(12%)	0	98(92%)	8(8%)	0
Population-specific Standards									
Populations with Chronic Conditions	3(75%)	1(25%)	0	33(94%)	2(6%)	0	36(92%)	3(8%)	0
Service Excellence Standards									
Infection Prevention and Control	50(88%)	7(12%)	0	38(86%)	6(14%)	2	88(87%)	13(13%)	2
Community Health Services	10(83%)	2(17%)	1	45(82%)	10(18%)	0	55(82%)	12(18%)	1
Emergency Department	33(97%)	1(3%)	1	71(88%)	10(12%)	5	104(90%)	11(10%)	6
Emergency Medical Services	29(91%)	3(9%)	6	98(84%)	19(16%)	5	127(85%)	22(15%)	11

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Standards Set	High Priority Criteria			Other Criteria			Total Criteria (High Priority + Other)		
	Met	Unmet	N/A	Met	Unmet	N/A	Met	Unmet	N/A
	# (%)	# (%)	#	# (%)	# (%)	#	# (%)	# (%)	#
Service Excellence Standards									
Home Care Services	48(100%)	0(0%)	0	49(94%)	3(6%)	2	97(97%)	3(3%)	2
Long Term Care Services	36(92%)	3(8%)	0	77(95%)	4(5%)	1	113(94%)	7(6%)	1
Managing Medications	75(94%)	5(6%)	3	49(98%)	1(2%)	2	124(95%)	6(5%)	5
Medicine Services	27(79%)	7(21%)	1	58(84%)	11(16%)	1	85(83%)	18(17%)	2
Mental Health Services	31(82%)	7(18%)	1	68(97%)	2(3%)	2	99(92%)	9(8%)	3
Obstetrics/Perinatal Care Services	39(87%)	6(13%)	6	59(87%)	9(13%)	2	98(87%)	15(13%)	8
Operating Rooms	63(93%)	5(7%)	4	22(76%)	7(24%)	1	85(88%)	12(12%)	5
Substance Abuse and Problem Gambling Services	26(81%)	6(19%)	0	67(94%)	4(6%)	1	93(90%)	10(10%)	1
Surgical Care Services	31(84%)	6(16%)	1	55(85%)	10(15%)	1	86(84%)	16(16%)	2
Total	**577(90%)**	**63(10%)**	**24**	**891(89%)**	**112(11%)**	**26**	**1468(89%)**	**175(11%)**	**50**

Section 1 Executive Summary

1.5 Overview by Required Organizational Practices

In Qmentum, a Required Organizational Practice (ROP) is defined as an essential practice that an organization must have in place to enhance client safety and minimize risk. Each ROP has associated tests for compliance, and all of the tests for compliance must be met for the ROP as a whole to be rated as met.

This table shows how the applicable ROPs were rated during the on-site survey.

Required Organizational Practice	Rating
Patient Safety Goal Area: Safety Culture	
Adverse Events Disclosure	Met
Adverse Events Reporting	Met
Client Safety As A Strategic Priority	Met
Client Safety Quarterly Reports	Met
Client Safety Related Prospective Analysis	Met
Patient Safety Goal Area: Communication	
Client And Family Role In Safety	Unmet
Dangerous Abbreviations	Unmet
Information Transfer	Met
Medication Reconciliation As An Organizational Priority	Met
Medication Reconciliation At Admission	Unmet
Medication Reconciliation at Transfer or Discharge	Unmet
Surgical Checklist	Unmet
Two Client Identifiers	Unmet
Verification Processes For High-Risk Activities	Met

Section 1 Executive Summary

Required Organizational Practice	Rating
Patient Safety Goal Area: Medication Use	
Concentrated Electrolytes	Met
Heparin Safety	Met
Infusion Pumps Training	Met
Medication Concentrations	Met
Narcotics Safety	Met
Patient Safety Goal Area: Worklife/Workforce	
Client Safety Plan	Met
Client Safety: Education And Training	Met
Client Safety: Roles And Responsibilities	Met
Preventive Maintenance Program	Met
Workplace Violence Prevention	Unmet
Patient Safety Goal Area: Infection Control	
Hand Hygiene Audit	Unmet
Hand Hygiene Education And Training	Met
Infection Control Guidelines	Met
Infection Rates	Met
Influenza Vaccine	Met
Pneumococcal Vaccine	Met
Sterilization Processes	Met
Patient Safety Goal Area: Falls Prevention	
Falls Prevention Strategy	Unmet

Section 1 Executive Summary

Required Organizational Practice	Rating
Patient Safety Goal Area: Risk Assessment	
Home Safety Risk Assessment	Met
Pressure Ulcer Prevention	Unmet
Suicide Prevention	Unmet
Venous Thromboembolism Prophylaxis	Unmet

Section 1 Executive Summary

1.6 Summary of Surveyor Team Observations

During the on-site survey, the surveyor team made the following observations about the organization's overall strengths, opportunities for improvement, and challenges.

The NOR-MAN Regional Health Authority (NRHA) underwent an extensive operational review in the winter of 2011 which resulted in some thirty five far reaching recommendations. The Board is highly engaged and has taken and developed an extensive work plan with an aggressive time line for implementation in response to the operational review. The Senior Leadership is committed to moving forward, using the operational review recommendations as a basis for positive change. In discussions with Community Partners, there was a desire for updates on progress to date. Having had an opportunity to view the accomplishments to date, it might be an opportune time for the leadership team to update both internal and external stakeholders. The leadership team is encouraged to follow a formal process to manage change, which needs to be monitored and adjusted as necessary. The leadership team is encouraged to continue the development of measurable strategic goals in support of the new strategic plan.

The leadership team clearly understands the cost drivers contributing to the financial burden on the RHA and is working with the Ministry to resolve the issues. The leadership team and Board are encouraged to pursue solutions to issues surrounding medical remuneration and Northern Patient Transportation with the appropriate funding agencies.

The leadership team is encouraged to closely monitor staff and service providers' fatigue and stress levels, and work to reduce safety issues associated with fatigue and stress. This is particularly true in areas where recruitment is difficult and span of control tends to increase. The NRHA is commended for the work completed on development of a respectful workplace program and may wish to review knowledge transfer to all programs and services. Performance appraisals are estimated at thirty percent (30%) complete. The team is encouraged to proceed with a simplified tool and might wish to consider a longer term target for completion.

The services provided to the communities appear to be appropriate given the population needs. A review of critical mass and availability of appropriate health care providers should be undertaken for the Snow Lake Health Centre in light of the future growth of the area.

Clients that were interviewed expressed much satisfaction with the care they received from the health care teams, and they reported a consistent level of compassion and caring.

Section 2 Detailed Required Organizational Practices Results

This section gives more information about unmet ROPs. It shows the patient safety goal area into which the ROP falls, the requirements of the ROP, and the set of standards where it can be found.

The patient safety goal areas are safety culture, communication, medication use, worklife/workforce, infection control, and risk assessment.

Unmet Required Organizational Practice	Standards Set
Patient Safety Goal Area: Communication	
Client And Family Role In Safety The team informs and educates clients and families in writing and verbally about the client and family's role in promoting safety.	· Obstetrics/Perinatal Care Services 16.4
Medication Reconciliation At Admission The team reconciles the client's medications upon admission to the organization, with the involvement of the client, family or caregiver.	· Surgical Care Services 7.12 · Obstetrics/Perinatal Care Services 7.12 · Medicine Services 7.5 · Substance Abuse and Problem Gambling Services 7.5 · Mental Health Services 7.6
Medication Reconciliation at Transfer or Discharge The team reconciles the client's medications with the involvement of the client, family or caregiver at transition points where medication orders are changed or rewritten (i.e. internal transfer, and/or discharge).	· Medicine Services 11.3 · Obstetrics/Perinatal Care Services 11.3 · Substance Abuse and Problem Gambling Services 11.3 · Mental Health Services 11.3 · Surgical Care Services 11.4
Two Client Identifiers The team uses at least two client identifiers before providing any service or procedure.	· Medicine Services 9.7
Dangerous Abbreviations The organization has identified and implemented a list of abbreviations, symbols, and dose designations that are not to be used in the organization.	· Managing Medications 10.2
Surgical Checklist The team uses a safe surgery checklist to confirm safety steps are completed for a surgical procedure.	· Operating Rooms 6.8

Section 2 Detailed Required Organizational Practices Results

Unmet Required Organizational Practice	Standards Set
Patient Safety Goal Area: Worklife/Workforce	
Workplace Violence Prevention The organization implements a comprehensive strategy to prevent workplace violence.	· Effective Organization 8.5
Patient Safety Goal Area: Infection Control	
Hand Hygiene Audit The organization evaluates its compliance with accepted hand-hygiene practices.	· Infection Prevention and Control 6.5
Patient Safety Goal Area: Falls Prevention	
Falls Prevention Strategy The team implements and evaluates a falls prevention strategy to minimize client injury from falls.	· Surgical Care Services 15.2 · Medicine Services 15.2 · Obstetrics/Perinatal Care Services 16.2
Patient Safety Goal Area: Risk Assessment	
Pressure Ulcer Prevention The organization assesses each client's risk for developing a pressure ulcer and implements interventions to prevent pressure ulcer development.	· Long Term Care Services 8.4
Suicide Prevention The organization assesses and monitors clients for risk of suicide.	· Mental Health Services 7.3
Venous Thromboembolism Prophylaxis The team identifies medical and surgical clients at risk of venous thromboembolism (deep vein thrombosis and pulmonary embolism) and provides appropriate thromboprophylaxis.	· Medicine Services 7.4 · Surgical Care Services 7.7

Section 3 Detailed On-site Survey Results

This section shows detailed on-site results. When reviewing these results, it is important to review the service excellence and the system-wide results together, as they are complementary.

Accreditation Canada defines priority processes as critical areas and systems that have a significant impact on the quality and safety of care and services. Priority processes provide a different perspective from that offered by the standards, organizing the results into themes that cut across departments, services, and teams.

For instance, the patient flow priority process considers criteria from different sets of standards that each address various aspects of patient flow, from preventing infections to providing timely diagnostic or surgical services. This provides a comprehensive picture of how patients move through the organization and how services are delivered to them, regardless of the department they are in or the specific services they receive.

During the on-site survey, surveyors rate compliance with the criteria, provide a rationale for their rating, and comment on each priority process.

Priority process comments are shown in this report. The rationale for unmet criteria can be found in the organization's online Quality Performance Roadmap.

See Appendix B for a list of priority processes.

Interpreting the tables: The tables show all unmet criteria from each set of standards, identify high priority criteria, and list surveyor comments related to each priority process. High priority criteria are identified by the following symbols:

! High priority criterion

ROP Required Organizational Practice

3.1 Priority Process Results for System-wide Standards

The results in this section are categorized first by priority process and then by standards set.

Some priority processes in this section also apply to the service excellence standards. Where there are unmet criteria that also relate to services, those results should be shared with the relevant team.

Section 3 Detailed On-site Survey Results

3.1.1 Priority Process: Planning and Service Design

Developing and implementing infrastructure, programs, and services to meet the needs of the populations and communities served

Unmet Criteria		High Priority Criteria
Standards Set: Effective Organization		
4.7	The organization's leaders follow a formal process to manage change.	
Standards Set: Sustainable Governance		
2.3	When defining the organization's vision and strategic plan, the governing body considers the needs of the community and priorities set by government or other stakeholders.	!
2.5	The strategic plan includes measurable strategic goals and objectives.	
2.6	The governing body identifies timeframes and responsibility for achieving the strategic goals and objectives.	
4.3	The information received by the governing body is accurate, up-to-date, and in a format that is easy to understand.	
4.6	The governing body regularly reviews the available information to assess its appropriateness, and identify information needs and gaps.	
12.6	The governing body demonstrates that the organization achieves its strategic goals and objectives, and makes progress toward achieving its long term vision and direction.	!

Surveyor comments on the priority process(es)

The Board is highly engaged and the organization has undergone an extensive operational review from which the Board has taken and developed an extensive work plan with an aggressive time line for implementation. The Board and Senior Leadership are committed to moving forward with responding to the operational review.

The team is commented for its efforts to improve communication and become more transparent. The efforts to move forward on the operational review recommendations are noted with approval and encouraged to continue. The Senior Leadership is highly engaged and committed to the 'go forward' plan.

In discussion with community partners, some of the partners did not feel that needs of the community were considered.

Section 3 Detailed On-site Survey Results

Measurable strategic goals are in development, in support of a new strategic plan.

The Board is beginning to develop a plan to address its information needs and a dialogue is planned with Senior Leadership.
The Board is beginning to regularly review the available information to assess its appropriateness, and identify information needs and gaps. It is not evident to the Community Partners that community needs and gaps are assessed.

The Board has a plan that when complete will demonstrates that strategic goals and objectives are being achieved, and makes progress toward achieving its long term vision and direction

The NRHA is encouraged to continue to produce and share executive summaries of Community needs assessment with stakeholders.

The organization's leaders have just started to follow a formal process to manage change which needs to be monitored and adjusted as necessary.

Section 3 Detailed On-site Survey Results

3.1.2 Priority Process: Resource Management

Monitoring, administering, and integrating activities related to the allocation and use of resources

The organization has met all criteria for this priority process.
Surveyor comments on the priority process(es)
The leadership team clearly understands the cost drivers contributing to the financial burden on the NRHA and is working with the ministry to resolve the issues. The leadership team and the Board are encouraged to pursue with the appropriate funding agencies, solutions to issues surrounding medical remuneration and Northern Patient Transportation. There appropriate processes in place for the construction of operating and capital plans The Board is encouraged to continue the development of variance analysis reports as part of their ongoing monitoring responsibility. The organization is encouraged to share both financial challenges and successes with the stakeholders.

Section 3 Detailed On-site Survey Results

3.1.3 Priority Process: Human Capital

Developing the human resource capacity to deliver safe, high quality services

Unmet Criteria			High Priority Criteria
Standards Set: Effective Organization			
8.5	The organization implements a comprehensive strategy to prevent workplace violence.		ROP
	8.5.2	The policy is developed in consultation with staff, service providers, and volunteers.	
	8.5.4	The organization conducts risk assessments to ascertain the risk of workplace violence.	
8.8	The organization monitors the quality of its worklife culture using the Worklife Pulse Tool.		
	8.8.2	The organization does not have any unaddressed priority for action flags based on their most recent Worklife survey results.	
12.5	The organization's leaders develop and regularly update position profiles for each position.		
12.9	The organization's leaders implement policies and procedures to monitor performance.		

Surveyor comments on the priority process(es)

Although the Minister of Health appoints the members of the Board of Directors, there is recognition of the need to have a diversity of skills and to seek out individuals with the requisite skills and ask them to apply for membership. The governing body does not recruit anyone other than the chief executive officer (CEO) and the CEO selects the Chief Medical Officer (CMO) and the Chief Nursing Officer (CNO).

The organization's leaders are encouraged to closely monitor staff and service providers' fatigue and stress levels, and work to reduce safety issues associated with fatigue and stress. This is particularly true in areas where recruitment is difficult and span of control tends to increase.

The policy was not developed in consultation with staff, service providers and volunteers rather, a provincial framework was adopted.

The risk assessments to ascertain the risk of work place violence is in development and the team is encouraged to continue that process.

The organization is commended for the work completed on development of a respectful work place program

The organization does have unaddressed priority for action flags, based on their most recent work life survey.

Section 3 Detailed On-site Survey Results

Performance appraisals (PAs) are estimated at thirty percent (30%) complete. The team is encouraged to proceed with a simplified tool and might wish to consider a longer term target for performance appraisal completion.

It is the responsibility of managers to ensure regularly updated position profiles for each of the positions however, no data on completion is collected.

Section 3 Detailed On-site Survey Results

3.1.4 Priority Process: Integrated Quality Management

Using a proactive, systematic, and ongoing process to manage and integrate quality and achieve organizational goals and objectives

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

The client safety plan has been developed based on organizational activities and evidence based practice. The Patient Safety Committee has challenges around acquiring the requisite membership from the key departments thus, potentially negatively affecting the functioning of the group and its ability to meet the mandate and fulfil the client safety plan. It is recommended therefore, that the organization review the required membership and attendance for the Patient Safety group and facilitate support for their activities.

The organization identified a potential hazard around the new decontamination showers at the Pas site in that as by activating the shower there was a risk of contaminating the entire emergency department (ED), as well as the sterile medical supplies, resulting from unforeseen design flaws. The failure modes effects analysis (FMEA) resulted in correcting the structural design to eliminate the risk and provide some interim revisions until the capital funds required for structural changes were approved.

The Board has just developed a Quality and Patient Safety sub committee, which will drive more Board focus and attention on these issues. It is important to acknowledge that the development of the Client Safety plan began with identifying all required organizational practices (ROPs) as evidence based and developing the processes to ensure compliance was one of their initial client safety initiatives.

The current organizational score cards remain the same as was in place for the last accreditation cycle.

Staff are recognized in the organization's newsletters. The Board seems committed to its promise for transparency in all RHA activities to the community.

Section 3 Detailed On-site Survey Results

3.1.5 Priority Process: Principle-based Care and Decision Making

Identifying and making decisions about ethical dilemmas and problems

Unmet Criteria	High Priority Criteria
Standards Set: Sustainable Governance	
15.6 The governing body promotes access to research and evidence, and the value of evidence-informed decision-making and benchmarking in improving the quality of services.	

Surveyor comments on the priority process(es)

The Ethics Committee has been re established as an advisory committee to senior management and the policy was revised in July 2010.

An extensive "Ethics Week" at the end of March took place, with lunch and learns and posters and cafeteria table topics, Web site inclusion and an article in the staff newsletter. All of these events provoked much discussion and an increase in comfort and familiarity with the principles of ethical decision making. There is First Nations representation on this advisory committee. There exists ready and helpful access to the provincial ethics advisor. It might be worthwhile to have a representative from senior management on the advisory committee.

Section 3 Detailed On-site Survey Results

3.1.6 Priority Process: Communication

Communicating effectively at all levels of the organization and with external stakeholders

Unmet Criteria		High Priority Criteria
Standards Set: Effective Organization		
3.3	The organization's leaders develop and implement a communication plan to disseminate information to, and receive information from, stakeholders.	
Standards Set: Sustainable Governance		
11.3	The governing body works with the CEO to establish a communication plan.	
11.4	The communication plan includes strategies to communicate key messages to different groups and the community.	
11.7	The governing body regularly consults with and encourages input from stakeholders and the community about the organization and its services.	
Surveyor comments on the priority process(es)		

The Board and CEO have started the process to establish a communication plan.

Although the plan is not fully developed the intent is to include strategies to communicate key messages to different groups and the community.

The NRHA is encouraged to use encrypted devices to protect sensitive information and control access to and the flow of information across the organization, to the governing body, across sites or regional boundaries and to external partners and the community.

Section 3 Detailed On-site Survey Results

3.1.7 Priority Process: Physical Environment

Providing appropriate and safe structures and facilities to achieve the organization's mission, vision, and goals

Unmet Criteria		High Priority Criteria
Standards Set: Emergency Medical Services		
10.1	The team documents and maintains a record of the initial licenses and qualifications for all persons who drive an EMS vehicle.	
10.2	The team's vehicle operators participate in regular training on how to drive and operate EMS vehicles.	
10.3	The team conducts and documents annual checks of the driving records of all persons who drive an EMS vehicle.	!
10.4	Those driving vehicles report any and all changes to their driving or operating records.	

Surveyor comments on the priority process(es)

Flin Flon General Hospital site:

The team is challenged with managing the physical infrastructure of an aging building. Many redevelopment projects have been implemented and several more are either waiting for approval or have already been approved. Staff have become very creative at managing shortcomings such as storage issues, air flow, heat and cold. The organization is encouraged to continue to lobby for an appropriate physical infrastructure to support patient safety and excellent patient care.

Snow Lake site:

The facility is fortunate to be experiencing renovations to the acute and emergency (ED) areas including a new nursing station, medication room and sterilization areas. Given the state of the existing medication room, the organization is encouraged to ensure that these renovations are completed as soon as possible. A window replacement project is planned to commence soon in addition to installing additional insulation in the attic. While fire extinguishers are checked regularly by the Fire Department, the team should ensure that practice sessions are available for staff to actually use the extinguishers. The team should ensure that clutter is addressed as soon as possible to ensure safe patient care environments.

St. Anthony General Hospital site:

This organization is also challenged with an aging facility. There is clutter and storage issues and the team must continue to be creative to manage safety across all units and departments. The heat recovery system is impressive. The clean and dirty utility rooms in clinical areas must be evaluated, as national standards state that there should be separate spaces.

Section 3 Detailed On-site Survey Results

Northern Lights Manor site:

The elevator in Northern Lights Manor malfunctions frequently and can be out of service for up to 24 hours and occasionally 48 hours. When the elevator is out of service, dietary staff have to carry trays up and down the stairs, and housekeeping has to carry the linen up from the ground floor. Both of these activities present safety hazards. Plus, there is no back up generator at Northern Lights Manor. There is battery back up for basics such as lighting.

Emergency medical Services (EMS) at all NRHA sites:

The EMS staff would benefit from a safe driving program particularly in light of the road conditions in this northern rural community. The policies must be reviewed and updated to ensure that EMS drivers verify annual driving records and report any changes to driving status to the organization.

Section 3 Detailed On-site Survey Results

3.1.8 Priority Process: Emergency Preparedness

Planning for and managing emergencies, disasters, or other aspects of public safety

Unmet Criteria		High Priority Criteria
Standards Set: Effective Organization		
11.2	The organization's leaders align the organization's disaster and emergency plan with those of partner organizations and local, regional, and provincial governments.	
11.8	The organization's leaders regularly test the organization's disaster and emergency plans with drills and exercises.	!
Standards Set: Emergency Department		
2.6	The team participates in regular practice drills of the emergency preparedness plan.	!
Standards Set: Emergency Medical Services		
2.3	The team conducts regular disaster exercises at least once per year.	
2.6	The team works with partners and the community to develop plans, policies and procedures that integrate responses to pandemics, outbreaks, disasters, and emergencies.	
Standards Set: Infection Prevention and Control		
14.6	The organization coordinates its planning for pandemics and outbreaks with its overall planning for disasters and emergencies.	

Surveyor comments on the priority process(es)

To date, exercises around disaster preparedness has focused only on fire drills. There is no evidence of the plan being tested or exercised. The Emergency Medical Services (EMS) team participated in a disaster exercise that was hosted by the local mining company. The organization's disaster and pandemic plans do not strongly acknowledge the presence and role of the EMS team.
There was no evidence in this survey that the EMS team had participated in these activities.

To date, it does not seem to be a requirement that paramedics wear safety footwear specifically, steel toe shoes. Although this is not a standard, [paramedics are vulnerable to a number of potential injuries.

There is no evidence of any significant effort on the part of the organization to align its disaster plan with that of partner organizations. This was evident during the Community Partners' session. Sharing of the new plan, which has yet to be implemented, reflected a one day opportunity for community stakeholders to

Section 3 Detailed On-site Survey Results

attend a workshop and learn about the plan. Currently, the organization is working from the old plan. The new disaster plan will be rolled out in January 2012.This new plan is very clear, specific and user friendly. The education plan for the roll out is comprehensive and targets all 1000 staff, with 30 sessions planned over one year.

Only fire plans appear to be tested with any regularity. Pandemic planning has been done separately from the Emergency Preparedness plan. The pandemic plan was developed as a separate exercise from that of the organization's disaster planning process.

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3.1.9 Priority Process: Patient Flow

Assessing the smooth and timely movement of clients and families through service settings

The organization has met all criteria for this priority process.
Surveyor comments on the priority process(es)

The major barrier occurs as a result of bed blocking with alternate level of care (ALC) patients occupying acute care beds. The organization has, and continues to address ALC/LTC placement strategies.

The organization has identified some challenges involving a lack of understanding of the Emergency Department triage process by local Aboriginal citizens. The organization's Aboriginal Liaison person has worked with this group and attempts to educate.

Emergency Department overcrowding is not an issue within this region and given that there are only two emergency departments (1.5 hours drive apart), diverting ambulances is not an option for them. NRHA does not have 'bed managers' or patient flow coordinators within the organization as positions; and patient placement coordination is usually done by the Emergency Department frontline nurses as required during busy periods.

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3.1.10 Priority Process: Medical Devices and Equipment

Obtaining and maintaining machinery and technologies used to diagnose and treat health problems

Unmet Criteria		High Priority Criteria
Standards Set: Emergency Medical Services		
11.4	The team's cleaning and disinfection procedures outline the cleaning schedule, the choice of cleaners or disinfectants and their proper dilution and effective contact time, and protocols to wash cleaning equipment.	
11.6	The team follows specific procedures for additional cleaning and disinfection of EMS vehicles after transporting patients with a known or suspected communicable disease or contaminant.	
Standards Set: Infection Prevention and Control		
12.2	For each contaminated device and piece of equipment, a trained staff person uses a recognized classification system to determine whether sterilization is required.	!
Standards Set: Operating Rooms		
12.1	For each contaminated device and piece of equipment, a trained staff person uses a recognized classification system to determine whether sterilization is required.	!

Surveyor comments on the priority process(es)

All Sites:

The organization does not implement a recognized classification system to determine whether sterilization is required. Best practices should be investigated and a documented policy written. There was a review completed and a report provided to the organization in September 2011 concerning Decontamination Practices in NRHA. The team is encouraged to review and implement the recommendations suggested by this review.

The quality control program for cleaning, disinfection and the sterilization of reusable medical devices should be reviewed against best practice standards and ensure that it is comprehensive. Indicators are monitored and tracked but additional strategies could be implemented.

All EMS sites:

Evidence of cleaning procedures exist for only the in hospital activities however, these do not address and/or adjust for decontamination of ambulances.

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Flin Flon General Hospital site:

While there is a plan in place for replacement of old equipment and the purchase of new equipment, a longer term strategy such as a five year replacement plan is encouraged to be considered.

St Anthony General Hospital site:

No site specific comments.

Snow Lake site:

The location of the sterilization/reprocessing (CSR) area does not meet standards. There is a newly renovated area being constructed that will separate clean equipment from soiled equipment and will house a new sterilizer. However, the staff that perform these functions do not have the proper certifications and official training to safely reprocess and sterilize reusable equipment and instruments. The organization is strongly encouraged to consider alternate strategies for reprocessing and sterilizing the equipment and instruments at this site. Also, consider introducing disposable equipment/instruments or having this service provided by either Flin Flon or The Pas sites.

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3.2 Priority Process Results for Population-specific Standards

The results in this section are categorized first by standards set and then by priority process.

Priority processes specific to population-specific standards are:

Chronic Disease Management

- Integrating and coordinating services across the continuum of care for populations with chronic conditions

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3.2.1 Standards Set: Populations with Chronic Conditions

Unmet Criteria		High Priority Criteria
Priority Process: Chronic Disease Management		
2.1	The organization sets measurable and specific goals and objectives for its services for populations with chronic conditions.	
6.4	The organization works with primary care providers, partners, and other organizations to integrate information systems.	
7.1	The organization identifies and monitors performance measures for chronic disease management.	!

Surveyor comments on the priority process(es)

Priority Process: Chronic Disease Management

Strengths

An enthusiastic and dedicated group of providers and health developers who work well together and are passionate about what they do. They operate a number of specific programs e.g. One Step Ahead, Protect Your Pairs (for which they won an innovation award), Get Better Together (a chronic disease self-management program), Tobacco Tackle. They work well with and are very inclusive of aboriginal populations and their specific health challenges. They are very responsive to community needs, for example they developed a homeless shelter committee with community partners and established a shelter, and they are active participants in the Moose Lake Healthy Community Committee. The region is often used to pilot provincial programs as they are seen to be innovative.

Areas for improvement

One challenge will be for NRHA to sustain their innovative and inclusive multi-faceted multi-disciplinary chronic disease management and prevention programs with their limited fiscal resources. The diabetic program in The Pas currently has only two diabetic nurse educators (one is away on medical leave of absence) and they no longer have a foot care nurse; they are providing care in 7 communities up to 3 hours away, and have difficulty getting patients' lab results and contacting their physicians to get medication.

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3.3 Service Excellence Standards Results

The results in this section are categorized first by standards set and then by priority process.

Priority processes specific to service excellence standards are:

Clinical Leadership

- Providing leadership and direction to teams providing services

Competency

- Developing a skilled, knowledgeable, interdisciplinary team that can manage and deliver effective programs and services

Episode of Care

- Providing clients with coordinated services from their first encounter with a health care provider through their last contact related to their health issue

Decision Support

- Using information, research, data, and technology to support management and clinical decision making

Impact on Outcomes

- Identifying and monitoring process and outcome measures to evaluate and improve service quality and client outcomes

Medication Management

- Using interdisciplinary teams to manage the provision of medication to clients

Organ Donation

- Providing organ donation services for deceased donors and their families, including identifying potential donors, approaching families, and recovering organs

Infection Prevention and Control

- Implementing measures to prevent and reduce the acquisition and transmission of infection among staff, service providers, clients, and families

Surgical Procedures

- Delivering safe surgical care, including preoperative preparation, operating room procedures, postoperative recovery, and discharge

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3.3.1 Standards Set: Community Health Services

Unmet Criteria		High Priority Criteria
Priority Process: Clinical Leadership		
2.2	The team's goals and objectives for community health services are measurable and specific.	
Priority Process: Competency		
3.7	The interdisciplinary team follows a formal process to regularly evaluate its functioning, identify priorities for action, and make improvements.	
4.6	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.	
5.1	The organization uses defined criteria that are used to assign team members to responsibilities in a fair and equitable manner.	
5.3	Team leaders regularly evaluate the effectiveness of staffing and use the information to make improvements.	
Priority Process: Episode of Care		
8.1	The team maintains accurate and up-to-date records for each community-based program.	
Priority Process: Decision Support		
10.2	The team reviews its guidelines to make sure they are up-to-date and reflect current research and best practice information.	!
10.3	The team's guideline review process includes seeking input from staff and service providers about the applicability of the guidelines and their ease of use.	
Priority Process: Impact on Outcomes		
11.2	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.	!
11.5	The team identifies and monitors process and outcome measures for its community health services.	

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11.9	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.	

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

There is a well organized multidisciplinary team that is very active, flexible and very community focused and based. Programs are geared to specific needs of populations for example, First Nations. Recognition is given to innovative programs such as the Mighty Bubbles hand washing program to reduce lead levels in children.

The team needs to institute formal specific measurable goals and objectives then document their achievements and measure progress year over year. The only measurable statistics the team is obtaining now are from the provincially mandated programs in which it participates.

Priority Process: Competency

The team is small in number, highly productive, innovative, flexible and enthusiastic.

A formalized process for measuring and tracking team functioning, performance and training is needed, along with the appropriate tools and systems to facilitate this.

Priority Process: Episode of Care

Very client focused care is being provided. However, better tracking of the extent of services provided, ideally computer based and even tablet based is suggested to facilitate easy and complete recording and statistical generation of data and analysis.

Priority Process: Decision Support

The organization needs to establish a mechanism to regularly review and update as necessary, guidelines and best practice information.

Priority Process: Impact on Outcomes

The Community Health Services is achieving positive outcomes in many areas, as has been previously mentioned in other report sections for this service.

Encouragement is offered to develop specific indicators to measure achievements, and this needs to include quality indicators.

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3.3.2 Standards Set: Emergency Department

Unmet Criteria		High Priority Criteria
Priority Process: Clinical Leadership		
The organization has met all criteria for this priority process.		
Priority Process: Competency		
The organization has met all criteria for this priority process.		
Priority Process: Episode of Care		
6.7	The team measures ambulance offload response times, and sets and achieves target times for clients brought to the Emergency Department by EMS.	
6.8	The team monitors ambulance offload response times and uses this information to improve its services.	
6.11	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.	
Priority Process: Decision Support		
The organization has met all criteria for this priority process.		
Priority Process: Impact on Outcomes		
The organization has met all criteria for this priority process.		
Priority Process: Organ Donation		
9.1	The team works with the ICU, organ recovery centre, or tissue recovery team to establish time frames for the timely transfer of potential organ and tissue donors from the emergency department.	
9.2	The organization has established clinical referral triggers to identify potential organ and tissue donors.	
9.3	The team receives training and education on the definition of imminent death, the use of clinical referral triggers, who to contact when potential organ and tissue donation opportunities arise, how to approach families about donation and other donation issues.	
9.4	The organization has a policy on neurological determination of death (NDD).	

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9.5	The team follows a written protocol for NDD that includes accessing the people qualified to determine neurological death.	
9.7	The team provides the family with the appropriate information about the implications of neurological death.	
9.9	The team checks the provincial donor registry, where one exists, to determine if the patient is a registered donor.	

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

Although The Pas site has been recently renovated, the emergency department (ED) in Flin Flon remains small and is not conducive to patient flow or care. It is understood that there is a renovation planned for Flin Flon.

Collaboration with the Winnipeg Regional Health Authority (WPRHA) is suggested for protocols and procedure sharing, and with various other hospitals to obtain special care protocols that may help patient service delivery, including the Canadian Association of Emergency Physicians (CAEP) and Critical Care Nursing Association.

The organization is encouraged to develop a special care unit advisory committee, reflecting many different disciplines.

Priority Process: Competency

Strengths in this area include completed performance appraisals and the employee of the month program.

Priority Process: Episode of Care

There was no evidence or witness that supports the standard of measuring off load delays. There is no evidence that this indicator is measured. These measurements would have to be completed manually as there is not an electronic option.

Currently, there is a patient handout to better inform patients.

Concentrated Electrolytes: High dose Potassium is still present on the unit, locked in the narcotic cabinet.

The team relies only on a verbal mode of transferring information among providers at patient care transition points. There is no published expectation that clearly identifies the content of the information exchange, nor any measure to ensure effectiveness and compliance. The organization would benefit from formalizing this process and developing a useful operational structure around it.

The patient that was interviewed and brought in by EMS was interviewed here. Staff promptly assessed the patient, diagnostic imaging was conducted. All elements of positive patient safety concerns relative to this case were observed. Assessment, treatment, diagnosis and decision making on behalf of this patient was well done.

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Another patient Interview concerned the mother of a four year old boy that uses the ED to receive his Factor VIII. The mother's impression is that staff know the child and are well informed on his disease and care plans. This is a young mother that appears grateful and acknowledges the efforts on the part of the ED staff to educate her and look after her son.

Priority Process: Decision Support

The team is encouraged to seek out and obtain care plans from the Winnipeg Regional Health Authority (WRHA) for acute coronary syndrome (ACS) for example. (14.1).

To date, the team has not undertaken any clinical research trials. (14.4)

Priority Process: Impact on Outcomes

The team has received feedback on the quality and comfort of the waiting room experience for clients and it was not positive. Adjustments such as engagement by receptionists are being considered. Also, the team is looking at education video screens via television. (16.4)

Priority Process: Organ Donation

There is no formal process in place, and organ donation is currently performed as an ad hoc process.

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3.3.3 Standards Set: Emergency Medical Services

Unmet Criteria		High Priority Criteria
Priority Process: Clinical Leadership		
4.9	The medical oversight team regularly follows-up with referring and accepting physicians at local hospitals and alternate level of care facilities to identify issues, and review and improve patient care.	
Priority Process: Competency		
The organization has met all criteria for this priority process.		
Priority Process: Episode of Care		
12.7	The team secures and restrains all patient care equipment in EMS vehicles.	
13.10	The dispatch team provides the geographical location and directions should the EMS team require travel instructions.	
17.2	The EMS crew secures and positions the patient correctly for transport.	!
17.4	When using chemical or physical restraints the EMS crew follows medical policies or restraint protocols.	
Priority Process: Decision Support		
The organization has met all criteria for this priority process.		
Priority Process: Impact on Outcomes		
21.1	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.	!
22.1	The team collects information about the quality of its services to identify successes and opportunities for improvement, and makes improvements in a timely way.	
22.3	The team's quality improvement activities have a defined reporting process.	
22.4	The team monitors stakeholder, patient and family perspectives on the quality of its services.	
22.5	The team identifies and monitors structure, process, and outcome measures for its services.	

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

Priority Process: Infection Prevention and Control

8.1	The organization designates an individual or group to lead and coordinate the infection prevention and control program.	
8.4	The infection prevention and control program educates staff about infection control practices to reduce their risk of exposure.	
8.5	Staff and service providers from all departments in the organization are represented and participate in the infection prevention and control program.	

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

Transfer skills that focus on acute coronary syndrome (ACS) and high numbers of diabetes rates have identified and added to the scope of practice and both of these complement observations on population health in the community. The emergency service modifies services as required to meet health needs ranging from addressing personal protective equipment (PPE) needs and high cardiovascular disease. Since their introduction, service has increased their scope of practice to better address ACS patients. As well, the service has instituted intravenous therapy (IV), and "D50" administration to address increased rates of diabetes identified in First Nations communities.

The service would benefit from strategically utilizing the "Supervisor Support/Command SUV" in their deployment plan for first response, intercept and perhaps mobile coverage. The service does not perform mobile postings, resulting in respiratory therapy (RT) of at least one hour to respond. Smaller communities have nurses from local clinics attend in the interim in a fleet vehicle.

The service participated and led a region wide AED program, which included partnering with a local community college.

The service would benefit from taking advantage of being a hospital based service whose Medical Director has privileges and use this opportunity to follow through on the patients that are transported. Specifically, measure outcomes to reconciling the EMS providers clinical impression with final diagnosis for example, pneumonia versus congestive heart failure (CHF), Sepsis recognition and ACS versus other causes and so on.

The service uses the emergency management school in Brandon for unique hazardous scenarios.

Currently, the EMS services Medical Director does not follow up on patient care with physicians and hospital staff on the quality of EMS care.

Priority Process: Competency

The remedial training provided does not include operation of a vehicle. To date, there is no mechanism/plan to support staff members that do not demonstrate the competencies required to safely operate the ambulance.

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Priority Process: Episode of Care

The EMS does not currently carry or utilize a shoulder harness restraint device on their stretchers. Restraint is limited to thigh, hip and chest only and does not afford the patient the safety required to adequately restrain them. Shoulder harness restraints have become a standard practice across the industry. Without them, patients stand a very high probability of severe or fatal injury when the vehicle must stop suddenly, perform collision avoidance, or become involved in a collision.

The NRHA EMS service does not provide its own emergency call taking and ambulance dispatch services. These services are provided by Manitoba Health out of the Ambulance Communications Centre in Brandon. Paper maps are in the ambulance, as no automatic vehicle location (AVL) is currently available.

The NRHA EMS does not have a treat and release policy as part of their services. All patients that request service are transported unless they refuse.

High risk medication administration was witnessed during the episode of care, all competencies surrounding this were witnessed.

As already observed and noted in the earlier standard around restraint devices, the EMS does not utilize a shoulder harness concurrently with their restraint devices on their stretcher. Without adequate restraint devices inclusive of shoulder harnesses, patients cannot be adequately restrained and are subject to risk and injury. The EMS service does not have physical or chemical restraint policies or procedures in their practice/operations.

The surveyor engaged in an interview with a patient that had been brought in to the ED by EMS. The patient spoke positively of the care received by the Paramedics in terms managing injury and pain. The patient was later prepared and transferred to Winnipeg.

Priority Process: Decision Support

The EMS does not currently partake in research. (20.4)

Priority Process: Impact on Outcomes

The EMS service has not had opportunity nor has it been included in risk identification activities in the organization. Currently, there is no formal forum or mechanism in place for such briefings. (21.1)

Although this is done for the RHA as a whole, there is no specific area to collect EMS feedback. (22.1)

The clinical measurements that EMS utilizes focus on transfer skills and appropriate application and protocol compliance. The service would benefit greatly from more outcome measurements such as survival from cardiac arrest, multiple trauma management, congestive obstructive pulmonary disease (COPD) and so on.

The service does not collect this information (22.4). The NRHA does an exercise corporately, but it does not identify satisfaction with EMS services.

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The service does not have any formal structured reporting process. The clinical data collected addresses only the number and type of treatment such as transfer skill protocol used and number of chief complaints. The EMS service does not measure the accuracy of the assessment completed by Paramedics to validate the protocol/treatment selected, the appropriateness and success rate of the skill(s) performed, or the appropriateness of medications including narcotics administered. The service does not track any resuscitation, mortality or morbidity data. (22.3-22.5)

There is no evidence that the service benchmarks its current performance activities with other services or standards in the industry. (22.6)

Priority Process: Infection Prevention and Control

The organization has not identified the infection prevention and control (IPAC) risks specific to EMS, nor has it developed procedures to address some of the differences inherent in the environment. (8.1) Although this is done across the NRHA, EMS has not been a beneficiary. (8.4) The Emergency Medical Services area does not appear to have been included or is actively participating in the organization's IPAC program. (8.5)

It was hard to identify whether or not such cleaning followed IPAC recommendations, as IPAC policy and procedure focused only on in hospital areas and there were no clear directions or procedures for EMS workers to follow that fit their environment. (11.5)

The EMS vehicles are well equipped with personal protective equipment (PPE), hand washing solution and gloves. These items are strategically located and easily accessed from inside the vehicle.

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3.3.4 Standards Set: Home Care Services

Unmet Criteria		High Priority Criteria
Priority Process: Clinical Leadership		
2.3	The organization's goals and objectives are measurable and specific.	
Priority Process: Competency		
4.10	The organization regularly evaluates and documents each staff member's performance in an objective, interactive, and positive way.	
Priority Process: Episode of Care		
The organization has met all criteria for this priority process.		
Priority Process: Decision Support		
The organization has met all criteria for this priority process.		
Priority Process: Impact on Outcomes		
3.7	The organization follows a formal process to regularly evaluate the functioning of the team annually, identify priorities for action, and make improvements.	

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

Home Care is well organized, using a software program to provide detailed tracking of services to clients.

Encouragement is offered to develop a comprehensive body of specific and measurable goals and objectives to provide an objective measure of successes, achievements and needs.

Priority Process: Competency

Staff are well selected, appropriately trained, enthusiastic and flexible.

The organization needs to update performance appraisals and schedule and perform them at regular intervals.

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Priority Process: Episode of Care

There exist comprehensive well organized responsive comprehensive services, with detailed computer based records. Clients were uniformly very happy with services provided.

Priority Process: Decision Support

Please refer to earlier comments made about Home Care Services.

Priority Process: Impact on Outcomes

There is capability to measure specific client outcomes via the software.

It is suggested that a formal annual structured process to evaluate team functioning would be worthwhile in terms of assessing efficiency and pointing to changes that could enhance services in the future.

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3.3.5 Standards Set: Infection Prevention and Control

Unmet Criteria		High Priority Criteria
Priority Process: Infection Prevention and Control		
1.6	The organization shares trends in infections and significant findings with other organizations, public health agencies, and the community.	
5.1	The organization develops an IPAC education program that is tailored to the organization, its services, and client populations.	
5.4	Staff, service providers, and volunteers attend the IPAC education program at orientation and regularly thereafter.	
5.5	The organization offers IPAC education and training to partners, other organizations, and the community.	
6.2	The organization's senior leaders encourage and support implementation of education and training on hand hygiene for staff, service providers, and volunteers.	!
6.5	The organization evaluates its compliance with accepted hand-hygiene practices.	ROP
6.5.2	The organization shares results from the audits with staff, service providers, and volunteers.	
7.2	The information and education provided to clients and families about IPAC covers hand hygiene and respiratory etiquette, e.g. coughing and sneezing.	
7.3	Information provided to clients and families is documented in the client record.	!
12.10	The organization transports contaminated items separately from clean or sterilized items, and away from client service and high-traffic areas.	!
13.3	All endoscope reprocessing areas are physically separate from client care areas.	!
13.4	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.	!
Surveyor comments on the priority process(es)		
Priority Process: Infection Prevention and Control		

Currently, the organization has invested in a 0.25 position for each facility to coordinate and provide infection prevention and control (IPAC) leadership for approximately 1000 employees. This is a very dedicated and capable individual however, it would behove the organization to consider and research what

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an adequate full time equivalent (FTE) position would be considered for an organization of this size and geographical spread. This surveyor thinks current allocation is more than a little lean here. (1.1)
Reports are shared in the organization to department heads and/or Manitoba Health but not with the community. (1.6)

This activity is not carried out by the IPAC program, but similar activities have been carried out by the Patient Safety Coordinator. (2.2)

The organization makes use of provincial IPAC groups as well as the Canadian Hospital Infection Control Association (CHICA). (2.3)

There is an IPAC manual however, the target area for these policies address only "in hospital" activities and do not address the unique needs of the NRHA's EMS service. (4.1)

The IPAC education does not include the risks and special requirements of the EMS service. Policies address in hospital IPAC activities and do not take into consideration the environment(s) within which the EMS staff function. The unique risks around IPAC have not been formally addressed by the organization to date. (5.1)

High risk IPAC activities have not been identified or adjusted for the EMS service delivery area. (5.3)

There is a program for initial orientation for new staff. But there is currently no formal follow up or review of the education evident in the organizations operations. (5.4)

The NRHA has only offered training in its own organization. (5.5)

Due to limited staffing of an infection control specialist, compliance issues are mostly addressed when there is an adverse event or incident. (5.7)

There is no evidence of the senior management team intervention or participation in encouraging good hand hygiene practices, and no evidence of walk arounds of staff engagement. (6.2)
Hand hygiene audits are shared with department managers. No evidence that hand hygiene results are posted for staff review. (6.5.2)

The information provided in the NRHA and the resistant germs document does not really focus on these messages. Clear direction and education for this group is not strong. (7.2)
Currently, there is no expectation of staff to carry this out. (7.3)

Reprocessing is carried out in the recovery room, which is a patient care area. (13.3)
The dirty and final process is in a shared dirty utility room. Endoscopes however, are stored correctly. (13.4)

The IPAC cleaning and disinfection policies do not adequately address EMS service delivery. (10.1)

The dirty utility and clean utility rooms are shared as one in the Emergency Department at The Pas site. (11.2)

The dirty and clean utility share the same room and this was noted in the Emergency Department and the obstetrics areas. A plastic curtain is all that is separating the two functions. (12.11)

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3.3.6 Standards Set: Long Term Care Services

Unmet Criteria	High Priority Criteria
Priority Process: Clinical Leadership	
2.2 The team's goals and objectives for its long term care services are measurable and specific.	
Priority Process: Competency	
5.5 The team has a fair and objective process to recognize team members for their contributions.	
Priority Process: Episode of Care	
7.7 The team uses standardized clinical measures to evaluate the client's pain.	
8.4 The organization assesses each client's risk for developing a pressure ulcer and implements interventions to prevent pressure ulcer development. 8.4.1 The organization conducts an initial pressure ulcer risk assessment at admission, using a standardized risk assessment tool. 8.4.2 The organization reassesses each client for risk of developing pressure ulcers at regular intervals. 8.4.3 The organization implements documented protocols and procedures to prevent the development of pressure ulcers, which include interventions to prevent skin breakdown, reduce pressure, reposition, manage moisture, maximize nutrition, and enhance mobility and activity. 8.4.4 The organization educates staff on risk factors for pressure ulcers and strategies for the prevention of pressure ulcers. 8.4.5 The organization monitors its success in preventing the development of pressure ulcers and makes improvements to its prevention strategies and processes.	ROP
9.6 The team follows the organization's established policies on storing and disposing of medications safely and securely.	!
Priority Process: Decision Support	

The organization has met all criteria for this priority process.

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Priority Process: Impact on Outcomes		
16.3	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.	!
17.1	The team identifies and monitors process and outcome measures for its long term care services.	

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

There is overall strong leadership in the long term care (LTC) services.

As mentioned for the Community Health Services, the team needs to develop specific, measurable goals and objectives.

Priority Process: Competency

Regular resident satisfaction reports are completed. There needs to be a more active system for recognizing employee contributions. Regular safety briefings occur.

Priority Process: Episode of Care

There is a very extensive pre admission assessment and education for the resident and family.

The organization must ensure that narcotics are double locked. Steps should be taken to expedite wound care prevention and management protocol approval.

Priority Process: Decision Support

There is an identified need to act on the desirability of an electronic medical record.

Priority Process: Impact on Outcomes

The LTC services undertake communication with clients/residents and their families via a newsletter.

There is an identified need to develop specific measurable process and outcome indicators for services.

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3.3.7 Standards Set: Managing Medications

Unmet Criteria			High Priority Criteria
Priority Process: Medication Management			
2.5	The organization defines and lists available high-risk/high-alert medications.		!
3.11	The pharmacy has a policy and process to identify and resolve problems with medication shipments.		!
10.2	The organization has identified and implemented a list of abbreviations, symbols, and dose designations that are not to be used in the organization.		ROP
	10.2.2	The organization implements the Do Not Use List and applies this to all medication-related documentation when hand written or entered as free text into a computer.	
	10.2.3	The organization's preprinted forms, related to medication-use, do not include any abbreviations, symbols, and dose designations identified on the Do Not Use List.	
	10.2.7	The organization audits compliance with the Do Not Use List and implements process changes based on identified issues.	
10.9	The pharmacy and other service providers accept verbal orders for medication only in emergencies.		!
11.7	The pharmacy contacts the prescribing medical professional if there are concerns or changes with a medication order and documents the results of the discussion in the client record.		!
12.1	The organization provides workspace to pharmacy staff to support safe and effective preparation of medications.		
Surveyor comments on the priority process(es)			
Priority Process: Medication Management			

The pharmacy at St. Anthony's Hospital site is bright and for the most part spacious, neat, tidy, clean and well organized.

Laminar flow hood inspections are up to date.

There are high risk/high alert stickers on all medications as appropriate, including both those considered to be high risk/high alert, as well as any for which there has been a medication error.

Medication Kardexes on the units of personal care homes have the patients' photos attached.

The pharmacy at Flin Flon General Hospital site was not reviewed.

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Narcotics were not double locked at the Northern Lights Personal Care Home facility. The drug room door was locked, but the narcotic drawers were not locked.

There are concentrated electrolyte vials, either potassium chloride or potassium phosphate, in the emergency department and on the medicine unit at St. Anthony's Hospital. Although these are controlled like narcotics, they nonetheless need to be removed from the areas and kept in the pharmacy. The cytotoxic drug preparation room should have a clean vestibule and a computer and label printer available.

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3.3.8 Standards Set: Medicine Services

Unmet Criteria			High Priority Criteria
Priority Process: Clinical Leadership			
2.1	The team works together to develop goals and objectives.		
2.2	The team's goals and objectives for its medicine services are measurable and specific.		
2.4	The team has access to the supplies and equipment needed to deliver medicine services.		
Priority Process: Competency			
3.7	The interdisciplinary team follows a formal process to regularly evaluate its functioning, identify priorities for action, and make improvements.		
4.8	Team leaders regularly evaluate and document each team member's performance in an objective, interactive, and positive way.		
Priority Process: Episode of Care			
7.4	The team identifies medical and surgical clients at risk of venous thromboembolism (deep vein thrombosis and pulmonary embolism) and provides appropriate thromboprophylaxis.		ROP
	7.4.1	The organization has a written thromboprophylaxis policy or guideline.	
	7.4.2	The team identifies clients at risk for venous thromboembolism (VTE), [(deep vein thrombosis (DVT) and pulmonary embolism (PE)] and provides appropriate evidence-based, VTE prophylaxis.	
	7.4.3	The team establishes measures for appropriate thromboprophylaxis, audits implementation of appropriate thromboprophylaxis, and uses this information to make improvements to their services.	
	7.4.4	The team identifies major orthopaedic surgery clients (hip and knee replacements, hip fracture surgery) who require post-discharge prophylaxis and has a mechanism in place to provide appropriate post-discharge prophylaxis to such clients.	
	7.4.5	The team provides information to health professionals and clients about the risks of VTE and how to prevent it.	
7.5	The team reconciles the client's medications upon admission to the organization, with the involvement of the client, family or caregiver.		ROP

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7.5.3	Depending on the model, the prescriber uses the BPMH to create admission medication orders (proactive), OR, the team makes a timely comparison of the BPMH against the admission medication orders (retroactive).	
7.5.4	The team documents that the BPMH and admission medication orders have been reconciled; and appropriate modifications to medications have been made where necessary.	
11.3	The team reconciles the client's medications with the involvement of the client, family or caregiver at transition points where medication orders are changed or rewritten (i.e. internal transfer, and/or discharge).	ROP
11.3.2	Depending on the model, the prescriber uses the Best Possible Medication History (BPMH) and the active medication orders to generate transfer or discharge medication orders (proactive), OR, the team makes a timely comparison of the BPMH, the active medication orders, and the transfer or discharge medication orders (retroactive).	
11.3.3	The team documents that the BPMH, the active medication orders, and the transfer or discharge medication orders have been reconciled; and appropriate modifications to medications have been made where necessary.	
11.3.4	Depending on the transition point, an up-to-date medication list is retained in the client record (internal transfer), OR, the team generates a Best Possible Medication Discharge Plan (BPMDP) that is communicated to the client, community-based physician or service provider, and community pharmacy, as appropriate (discharge).	
11.6	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.	
Priority Process: Decision Support		
14.1	The organization has a process to select evidence-based guidelines for medicine services.	!
14.2	The team reviews its guidelines to make sure they are up-to-date and reflect current research and best practice information.	!
14.3	The team's guideline review process includes seeking input from staff and service providers about the applicability of the guidelines and their ease of use.	
Priority Process: Impact on Outcomes		
9.7	The team uses at least two client identifiers before providing any service or procedure.	ROP
9.7.1	The team uses at least two client identifiers before providing any service or procedure.	

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14.5	The team shares benchmark and best practice information with its partners and other organizations.	
15.2	The team implements and evaluates a falls prevention strategy to minimize client injury from falls.	ROP
15.2.4	The team establishes measures to evaluate the falls prevention strategy on an ongoing basis.	
15.2.5	The team uses the evaluation information to make improvements to its falls prevention strategy.	
16.1	The team identifies and monitors process and outcome measures for its medicine services.	
16.2	The team monitors clients' perspectives on the quality of its medicine services.	
16.3	The team compares its results with other similar interventions, programs, or organizations.	

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

Flin Flon General Hospital site:

There have been some informal goals identified for the team such as implementation of medication reconciliation at transfer and discharge. However, there are no formal goals and objectives for this team. Formal unit based goals should be developed so that all team members are made aware of their priorities. There is new leadership on this unit and it is making excellent improvements for both staff and patients. The unit has no patient lifts, which impacts the team's ability to provide safe patient care. There is some bariatric equipment such as the stretchers that can not be effectively used because the team might not be able to get a patient out of bed.

St. Anthony General Hospital site:

There have been no goals and objectives formalized for this team.

All sites:

The leadership team needs to strengthen the culture of safety by way of effective communications with staff members, role modelling and education. While the patient safety team provides staff with education and resources, the unit leadership and staff are responsible for living out a culture of safety on a daily basis. Staff members would benefit from continued education around risk mitigation and reduction activities on the unit, as well as encouragement to educate patients on their role in patient safety.

Priority Process: Competency

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Flin Flon General Hospital site:

There is a new orientation program in place, which is based on newly defined needs for "orientees". A preceptorship model is highly valued by staff. .

All Sites:

While there are education opportunities available for team members, there is an identified need for pediatric education to maintain staff competencies. Investigation of courses such as Pediatric Advanced Life Support (PALS) or Emergency Nursing Pediatric Course (ENPC) is a potential strategy to address this issue for staff. Staff would also benefit from becoming certified in appropriate Canadian Nurses Association (CNA) specialities. Staff performance assessments are encouraged to be a priority for the teams.

It is essential for all team members to work together in a respectful way and to be considered equal members of the interdisciplinary team. Physicians and the rest of the team should investigate ways to improve collaboration and appreciate the contributions made by every team member towards excellent patient outcomes. The goal of every member should be the improvement of quality care and patient safety at NRHA.

Priority Process: Episode of Care

Flin Flon General Hospital site:

The interdisciplinary team is very passionate and proud of the care it provides to their patients. This was validated by patients during interviews with them. Patients reported that they felt staff maintained confidentiality particularly given the smallness of the community. The team includes nurses, physicians, occupational (OT) and physiotherapy (PT) but there is not a social work position. Such a position would be useful to address the many "at risk" patients and complex patient needs that present themselves to this team. There is a clinical resource nurse role new to this unit, which is a modified worker position and it has proven very beneficial to the needs of this unit. Education and best practice including patient safety initiatives have been the focus of this position and commendation is given for the outcomes. The team is also commended for the implementation of medication reconciliation. The tool is useful, complete and reviewed.

The organization must be very creative in managing resources for patients that it does not provide in the community. Patients undergo significant travel to access needed services. There are challenges for Saskatchewan patients versus Manitoba patients vis-a-vis consultation appointments and travel arrangements. This often proves to be challenging for staff to manage in addition to their work. There is an opportunity for the team to continue to investigate Telehealth opportunities for patients requiring consultation appointments for services unavailable in the community versus the requirement to travel far distances to access these services.

Patients were able to articulate their discharge plans and expected outcomes however, the team would benefit from earlier discharge planning and include physicians in these discussions.

Snow Lake Health Centre site:

The team provides care to acute in-patients in two (2) beds, four (4) LTC residents, and emergency patients. The team must provide care to both adults and pediatrics. Patients report a high level of satisfaction with the care they receive. Strengthening pediatric knowledge and ensuring that appropriate paediatric equipment is available were some verbalized concerns. This team was fortunate to receive funding for a Braslow cart, which is for paediatric patients.

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Charts that were reviewed did not demonstrate that the component of medication reconciliation on admission or discharge was occurring consistently. There was no evidence that physicians were ordering medications from the best possible medication list. This team is strongly encouraged to comply with this requirement for medication reconciliation.

St. Anthony General Hospital site:

The interdisciplinary team provides care to both medical, surgical and pediatric patients. The team is encouraged to consistently implement medication reconciliation with all patients. There are discharge rounds that include various disciplines that would benefit from physician attendance. This unit provides care to a variety of patient types including surgical, medical, paediatric and palliative. This facility is encouraged to consider bed rounds in the morning given their pressures for availability of beds and ALC numbers. Increased collaboration amongst the clinical leaderships will be extremely important to improve the quality of patient care and patient safety initiatives. There is no evidence of complete and consistent medication reconciliation being performed on admission, transfer and discharge.

All Sites:

The organization should consider reviewing the interdisciplinary team composition from a regional perspective. It needs to be assured that there equal access by the community to various clinical specialties such as speech language pathology (SLP), social work (SW) and dieticians to specify a few. The teams uses long established methods such as taped report and verbal report to transfer accountability from unit to unit and shift to shift, although there is no check list used for ensuring consistency in this regard. The organization is encouraged to investigate best practices in this issue of transfer of accountability and then consider implementing a documentation tool or check list to formalize this process.

The teams are able to identify how they would access resources for ethics issues. Education regarding the organization's ethical framework is encouraged to provide a consistent approach for all staff. All teams would benefit from additional education and reinforcement of a culture of patient safety and quality improvement strategies, selecting and monitoring of indicators. The teams do not conduct follow up contacts with other organizations or patients/families following a discharge home or transition to the community. While there has been discussions related to how this could be accomplished in the organization, it would be beneficial to investigate how follow up contacts could be conducted to ascertain outcomes. Results could be used to improve care provided in the organization.

All sites are commended for the education they provide to their patients regarding their health conditions and general knowledge. Attention needs to be paid to educating patients and their families on their role in contributing to patient safety and medications. Both of these educational areas need to have enhanced documentation in the health record. Discussions related to medication education must be carefully documented in addition to information about safety and risk reduction activities. The organization is also encouraged to educate all staff on identifying potential risks in the clinical areas and strategies to reduce, eliminate and/or mitigate them.

Education related to quality improvement activities would improve the working knowledge of front line staff and managers.

Priority Process: Decision Support

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Flin Flon General Hospital site:

The patient health record is very thorough, complete and impressive.

Snow Lake Health Centre site:

This site is encouraged to evaluate the documentation in the health record. Unapproved forms were found in at least one chart with no patient identifier, date or full signature of staff member. Policies and procedures must be approved by the most appropriate individual and the team is encouraged to review the need for site specific policies and discuss who provides final approval for safety and consistency.

St Anthony General Hospital site:

Patient teaching must be thoroughly documented on the health teaching and discharge form.

All Sites:

The organization should consider reviewing all clinical policies and procedures and "regionalize" them as much as possible to ensure best practices are implemented, as this would result in an increased consistency of care. There is need to evaluate all policies to determine that they are up to date and to have current references within the last three years. All teams should ensure that they are benchmarking quality care indicators against one another and other appropriate organizations.

There have been some standing pre printed orders developed, which help to improve patient safety. There is an Acute Coronary Syndrome (ACS) care map that has been developed for the region. The team is encouraged to work together to identify additional case mix groups (CMGs) that would benefit from standing orders/protocols and care maps. While the team reports that it has developed guidelines based on best practice, there is a need to develop a more formal and objective process to access, review and select evidence based guidelines. Since resources are so valuable, it is critical to ensure that the appropriate guidelines are being selected, based on patient/organizational priority needs.

Priority Process: Impact on Outcomes

Snow Lake site:

Patients are not provided with arm bands and therefore, appropriate two patient identifiers are not being used. This is a critical patient safety initiative that must be addressed immediately.

All Sites:

The Falls management program has been implemented and the teams are encouraged to evaluate outcomes with Patient Safety staff. While formalized safety briefings do not occur, discussions about patient safety are incorporated into team meetings and there are ad hoc discussions as well.

The teams report on the appropriate process to report sentinel events adverse events. The organization needs to continue to reinforce the need to report and discuss near misses, disclosure and follow up following debriefing and case reviews.

The teams monitor very few indicators that specifically relate to quality of patient care. The indicators are more process oriented than outcome oriented. Benchmarking against other organizations will be more useful

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if they can measure quality of care. Careful selection of meaningful indicators will enable benchmarking to occur to make necessary improvements or refinements, as well as sharing of best practice with these organizations. Once these quality indicators are selected, they should be shared with staff and patients.

There is an organization survey that evaluates patient satisfaction but the results do not drill down to the unit level. It is extremely important for the teams to obtain specific satisfaction results for their care and quality outcomes. All teams must ensure that they discuss the role that patients play in patient safety with families and patients. While patients reported that they know about the importance of hand hygiene and some discussed checking arm bands, more can be done to improve their knowledge. Teams should post more posters and information about patient safety.

The teams are encouraged to review the handbook that is given patients with patients and families and ensure that this teaching is documented for every patient.

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3.3.9 Standards Set: Mental Health Services

Unmet Criteria	High Priority Criteria
Priority Process: Clinical Leadership	
2.2 The team's goals and objectives for its mental health services are measurable and specific.	
Priority Process: Competency	
4.9 The team monitors and meets each team member's ongoing education, training, and development needs.	
5.5 The team is aware of the process to initiate the work refusal policy.	!
Priority Process: Episode of Care	
7.3 The organization assesses and monitors clients for risk of suicide. 7.3.4 The organization identifies treatment and monitoring strategies to ensure client safety.	ROP
7.6 The team reconciles the client's medications upon admission to the organization, with the involvement of the client, family or caregiver. 7.6.4 The team documents that the BPMH and admission medication orders have been reconciled; and appropriate modifications to medications have been made where necessary.	ROP
8.10 The team follows the organization's process to identify, address, and record all ethics-related issues.	!
11.3 The team reconciles the client's medications with the involvement of the client, family or caregiver at transition points where medication orders are changed or rewritten (i.e. internal transfer, and/or discharge). 11.3.3 The team documents that the BPMH, the active medication orders, and the transfer or discharge medication orders have been reconciled; and appropriate modifications to medications have been made where necessary.	ROP
Priority Process: Decision Support	
14.1 The organization has a process to select evidence-based guidelines for mental health populations.	!
14.2 The team reviews its guidelines to make sure they are up-to-date and reflect current research and best practice information.	!

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Priority Process: Impact on Outcomes

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

This is a highly engaged team doing its level best in very challenging circumstances.

The team is responsive to client needs.

The clients interviewed expressed support of the team and the level of professionalism. Clients stated they felt respected by the team.

The team expressed a lack of knowledge about goals and objectives and/or associated measurement.

There are studen nurses on the mental health team, but no volunteer placement.

Team members expressed a strong desire to have input to their work and job design, including the definition of roles and responsibilities and case assignments, where appropriate. Role clarity was a major concern.

Priority Process: Competency

The psychiatric unit nurses do not do IV therapy, only provides Intria-Muscualr medications.

The team expressed a lack of knowledge regarding each of the team member's ongoing education, training, and development needs. There were concerns expressed about inconsistent application of a corporate education policy.

The team is not aware of the process to initiate the work refusal policy.

Priority Process: Episode of Care

The addiction services team expressed concern that the treatment and monitoring strategies were not adequate to ensure the safety of addictions' clients that the team identified as being at risk.

The team expressed some confusion that the best possible medication history (BPMH) and admission medication orders have been reconciled and appropriate modifications to medications have been made where necessary.

The team did not understand the organization's process to address ethics related issues.

The organization was instructed it did not have to follow Accreditation Canada's protocols and definitions to collect and submit data on medication reconciliation at admission.

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Priority Process: Decision Support

The team felt there was not adequate support in the selection of evidence based guidelines for mental health populations

There were no research activities noted for this service.

Priority Process: Impact on Outcomes

The team identifies the resources needed to achieve its goals and objectives.

The mental health team has processes for identifying and reducing risks to team members while delivering mental health services.

While the team is trained to identify, reduce, and manage risks to client and staff safety it did express some concern about the availability of ongoing educational opportunities.

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3.3.10 Standards Set: Obstetrics/Perinatal Care Services

Unmet Criteria			High Priority Criteria
Priority Process: Clinical Leadership			
2.1	The team works together to develop team goals and objectives.		
2.2	The team's goals and objectives for its obstetrics/perinatal care services are measurable and specific.		
Priority Process: Competency			
3.7	The interdisciplinary team follows a formal process to regularly evaluate its functioning, identify priorities for action, and make improvements.		
Priority Process: Episode of Care			
7.12	The team reconciles the client's medications upon admission to the organization, with the involvement of the client, family or caregiver.		ROP
	7.12.3	Depending on the model, the prescriber uses the BPMH to create admission medication orders (proactive), OR, the team makes a timely comparison of the BPMH against the admission medication orders (retroactive).	
	7.12.4	The team documents that the BPMH and admission medication orders have been reconciled; and appropriate modifications to medications have been made where necessary.	
11.3	The team reconciles the client's medications with the involvement of the client, family or caregiver at transition points where medication orders are changed or rewritten (i.e. internal transfer, and/or discharge).		ROP
	11.3.2	Depending on the model, the prescriber uses the Best Possible Medication History (BPMH) and the active medication orders to generate transfer or discharge medication orders (proactive), OR, the team makes a timely comparison of the BPMH, the active medication orders, and the transfer or discharge medication orders (retroactive).	
	11.3.3	The team documents that the BPMH, the active medication orders, and the transfer or discharge medication orders have been reconciled; and appropriate modifications to medications have been made where necessary.	
	11.3.4	Depending on the transition point, an up-to-date medication list is retained in the client record (internal transfer), OR, the team generates a Best Possible Medication Discharge Plan (BPMDP) that is communicated to the client, community-based physician or service provider, and community pharmacy, as appropriate (discharge).	

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11.5	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.	
Priority Process: Decision Support		
15.1	The team has a process to access, review, and select which evidence-based guidelines it will use.	!
15.2	The team reviews its guidelines to make sure they are up-to-date and reflect current research and best practice information.	!
15.3	The team's guideline review process includes seeking input from staff and service providers about the applicability of the guidelines and their ease of use.	
Priority Process: Impact on Outcomes		
15.5	The team shares benchmark and best practice information with its partners and other organizations.	
16.2	The team implements and evaluates a falls prevention strategy to minimize client injury from falls. 16.2.4 The team establishes measures to evaluate the falls prevention strategy on an ongoing basis. 16.2.5 The team uses the evaluation information to make improvements to its falls prevention strategy.	ROP
16.4	The team informs and educates clients and families in writing and verbally about the client and family's role in promoting safety. 16.4.1 The team develops written and verbal information for clients and families about their role in promoting safety. 16.4.2 The team provides written and verbal information to clients and families about their role in promoting safety.	ROP
17.1	The team identifies and monitors process and outcome measures for its obstetrics/perinatal care services.	
17.2	The team monitors clients and families' perspectives the quality of its obstetrics/perinatal care services.	
17.3	The team compares its results with other similar interventions, programs, or organizations.	

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Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

Flin Flon General Hospital site:

The team has received funding for some new equipment for example, Bilirubin Light Therapy and has electronic fetal monitors for patients in labour. The team reports that it does not perform flash sterilization under any circumstances. There is no equipment on the unit available to perform this activity. The leadership team collaborates with partners in the health authority.

St. Anthony General Hospital site:

This team also reports that it does not perform flash sterilization.

All Sites:

There have been some informal goals identified for the team such as improving breastfeeding rates at Flin Flon General Hospital however, there are no formal goals and objectives for this team. Formal unit based goals should be developed so that all team members are aware of their priorities. Specific objectives will allow for the identification of indicators that will measure outcomes.

Priority Process: Competency

Flin Flon General Hospital site:

The team is commended for the focus on staff education such as the Neonatal Resuscitation Program (NRP). Several of the staff members are certified NRP instructors. There has also been fetal health education via the Surveillance Course. The team is fairly small in number and discusses patient care concerns during rounds.

St Anthony General Hospital site.

This team is also commended for its emphasis on staff education although there are challenges with staffing that sometimes limit the team's availability to attend sessions.

All Sites:

There is no formal process in place that allows for team members to evaluate their performance as an interdisciplinary team and to find ways to improve their functioning. The team is encouraged to work with their organizational and educational supports to develop an effective process for team evaluation.

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Priority Process: Episode of Care

Flin Flon General Hospital site:

The team not only provides care to the obstetrical/newborn population but also to surgical patients and off service patients. The team members are passionate about the care they provide and are proud of their outcomes. The staff are challenged with maintaining competency, with only approximately 150 births annually. There are several educational courses in which staff are required to participate and it is essential to continue to address competency issues. Collaboration with The Pas Health Centre is essential to ensure consistency of patient care, guidelines and education with a focus on regionalization of these clinical supports.

The medication reconciliation form is comprehensive and is used appropriately by all pertinent teams during the patient's admission, transfer/discharge. Documentation in the patient's health record is comprehensive The team has worked to increase breast feeding rates and the hospital is in the process of becoming designated as a Baby Friendly Hospital. When this occurs, it will become the first hospital in Manitoba with this designation. This team is also passionate about the care it provides and is committed to being family centred. There was no evidence that medication reconciliation is being consistently implemented. The team is encouraged to look to their fellow staff at Flin Flon for best practices in this safety initiative to assist with improvements.

All Sites:

The staff can identify the process they would involve should they encounter an ethical situation in their practice. However, there seemed to be limited knowledge about a 'corporate' ethical framework to help guide decision making. Encouragement is offered to continue to enable staff discussions and education related to ethics. There is a process in place to review medication incidents and to make recommendations for improvements.

There were some examples of quality improvements that have been implemented as a direct result of medication incidents. The teams are encouraged to document disclosure to the patient/family in the patient chart on a regular basis according to organizational policies. The team uses traditional methods to transfer accountability from unit to unit and shift to shift, although there is no check list used to ensure consistency. The organization is encouraged to investigate best practices on this issue of transfer of accountability and consider implementing a documentation tool to formalize this process.

The teams do not currently conduct follow up contacts with other organizations or patients/families following discharge home or transition to the community. While there has been discussions related to how this could be accomplished in the organization, it would be beneficial to investigate how follow- p contacts could be conducted to ascertain outcomes. Results could be used to improve care provided in the organization.

All sites are commended for the education they provide to their patients regarding their health conditions and general knowledge. Attention needs to be paid to educating patients and their families on their role in contributing to patient safety and medications. Both of these educational areas need to have enhanced documentation in the health record. Discussions related to medication education must be carefully documented in addition to information about safety and risk reduction activities. The organization is also encouraged to educate all staff on identifying potential risks in the clinical areas and strategies to reduce, eliminate and/or mitigate them.

Education on quality improvement activities would improve the working knowledge of front line staff and managers.

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Priority Process: Decision Support

Flin Flon General Hospital site:

Client health records are extremely comprehensive and thoroughly done. Information is shared between care providers. The leadership team collaborates with other obstetrical care providers in the region and this strategy should continue in order to develop region wide guidelines, as well as standing pre-printed orders and policies as much as possible to ensure consistency of care and best practices.

All Sites:

The team reports that it has developed guidelines based on best practice however, there is a need to develop a more formal and objective process to access, review and select evidence based guidelines. Since resources are so valuable, it is critical to ensure that the appropriate guidelines are being selected based on patient/organizational priority needs.

While there are some policies and procedures in place, which is the terminology used by the organization although they are clinical guidelines in many cases, there needs to be a formal review process of existing guidelines to ensure that the most up to date practice and research studies are being used. Development of a formal best practice guideline development and review process would address these standards.

Insofar as standards (15.1 and 15.2), since there is no formal review process for best practices, there is not a specific strategy to seek input from the interdisciplinary team. This is not to say that staff and physicians are not asked for input and feedback on these guidelines. There simply is not a formal process to ensure this feedback occurs consistently. Additionally, there does not appear to be a standardized process for the development, approval, implementation, evaluation and review of policies and procedures at this organization. Many policies are being held up in draft form for long periods because people are unclear as to what to do with them to gain approval, provide feedback and so on. It is highly recommended to develop a process to address this issue.

Priority Process: Impact on Outcomes

All Sites:

Staff participate in meetings that discuss safety issues in addition to other topics, although they are not specifically referred to as safety briefings. Staff were able to identify some risks and then find ways to mitigate these risks for this patient population. It would be worthwhile for the organization to investigate the managing obstetrical risk (MoreOB) program or a formal risk assessment program with its insurance provider to ensure that all risks are identified and appropriately addressed. Additional education regarding risk mitigation for this patient population is suggested.

The teams report that they do not document evidence of patient teaching relative to their role in patient safety. This could be incorporated into the admission assessment tool. It is essential for all staff to provide the same information to patients to ensure consistency of patient teaching particularly as it relates to safety.

The teams monitor very few indicators that specifically relate to quality of patient care. The indicators are more process oriented than outcome oriented. Benchmarking against other organizations will be more useful if they can measure quality of care. There is an organizational survey that evaluates patient satisfaction but the results do not drill down to the unit level. It is extremely important for the teams to obtain specific satisfaction results for their care and quality outcomes.

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3.3.11 Standards Set: Substance Abuse and Problem Gambling Services

Unmet Criteria		High Priority Criteria
Priority Process: Clinical Leadership		
2.4	The team has access to the supplies and equipment needed to deliver substance abuse and problem gambling services.	
2.5	The organization provides support to the team to deliver quality substance abuse and problem gambling services.	
Priority Process: Competency		
3.5	The organization provides sufficient workspace to support interdisciplinary team functioning and interaction.	
5.3	Team leaders regularly evaluate the effectiveness of staffing and use the information to make improvements.	
Priority Process: Episode of Care		
7.5	The team reconciles the client's medications upon admission to the organization, with the involvement of the client, family or caregiver.	ROP
	7.5.1 There is a demonstrated, formal process to reconcile client medications upon admission.	
	7.5.2 The team generates a Best Possible Medication History (BPMH) for the client upon admission.	
	7.5.3 Depending on the model, the prescriber uses the BPMH to create admission medication orders (proactive), OR, the team makes a timely comparison of the BPMH against the admission medication orders (retroactive).	
	7.5.4 The team documents that the BPMH and admission medication orders have been reconciled; and appropriate modifications to medications have been made where necessary.	
10.2	Before dispensing medication, a qualified team member reviews each prescription for completeness and accuracy.	!
10.3	A qualified team member fills the prescription and dispenses the medication in a timely and accurate way.	!
11.3	The team reconciles the client's medications with the involvement of the client, family or caregiver at transition points where medication orders are changed or rewritten (i.e. internal transfer, and/or discharge).	ROP

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11.3.1	There is a demonstrated, formal process to reconcile client medications at transition points where medication orders are changed or rewritten (i.e. internal transfer, and/or discharge).	
11.3.2	Depending on the model, the prescriber uses the Best Possible Medication History (BPMH) and the active medication orders to generate transfer or discharge medication orders (proactive), OR, the team makes a timely comparison of the BPMH, the active medication orders, and the transfer or discharge medication orders (retroactive).	
11.3.3	The team documents that the BPMH, the active medication orders, and the transfer or discharge medication orders have been reconciled; and appropriate modifications to medications have been made where necessary.	
11.3.4	Depending on the transition point, an up-to-date medication list is retained in the client record (internal transfer), OR, the team generates a Best Possible Medication Discharge Plan (BPMDP) that is communicated to the client, community-based physician or service provider, and community pharmacy, as appropriate (discharge).	
11.3.5	The process is a shared responsibility involving the client or family, and one or more health care practitioner(s), such as nursing staff, medical staff, and pharmacy staff, as appropriate.	
Priority Process: Decision Support		
14.2	The team reviews its guidelines to make sure they are up-to-date and reflect current research and best practice information.	!
Priority Process: Impact on Outcomes		
5.4	The team has a process for identifying and reducing risks to team members while delivering substance abuse and problem gambling services.	!

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

The team is in need of security upgrades both inside the building and at key access points to better protect staff and client safety.

Facility infrastructure and equipment needs to be reviewed to determine if the team has the space and equipment necessary to deliver quality services in a safe manner.

There are gaps in organizational support for the team when it needs to deliver quality substance abuse services. These include housekeeping, laundry and clinical support.

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Priority Process: Competency

The team would benefit from having clinical expertise.

A number of staffing deficits were identified by the team but have not been addressed by the organization.

Priority Process: Episode of Care

This is a highly engaged team doing its level best in very challenging circumstances.

The team has a process to evaluate client requests to bring in or self administer their own medication, as this is the only option and the team handles it to the best of their ability.

The team follows a risk reduction strategy in very challenging circumstances.

Given the nature of the population and the challenging geography, the team is commended for doing its best to work with the client and family, other teams, services, and organizations to develop a comprehensive and integrated follow up plan.

The team lacks the clinical support necessary to reconcile medication upon admission.

The team requires clinical support for ensuring that a qualified team member reviews every prescription for completeness and accuracy before dispensing medication.

Apparently, the organization was instructed it did not have to follow Accreditation Canada's protocols and definitions to collect and submit data on medication reconciliation at admission.

Priority Process: Decision Support

There is evidence that the team maintains an accurate and up to date record for every client.

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

The team identifies its needs for new technology and information systems and would benefit from its introduction when possible.

The team would benefit from assistance as it reviews its guidelines to make sure they are up to date and reflect current research and best practice information.

Priority Process: Impact on Outcomes

The Team have identified a number of strategies but felt they need additional support to better deliver services.

Section 3 Detailed On-site Survey Results

3.3.12 Priority Process: Surgical Procedures

Delivering safe surgical care, including preoperative preparation, operating room procedures, postoperative recovery, and discharge

Unmet Criteria		High Priority Criteria
Standards Set: Operating Rooms		
1.1	The team's composition reflects the operating room's case mix, case acuity, service volumes and workload.	
1.3	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.	
1.8	The interdisciplinary team follows a formal process to regularly evaluate its functioning, identify priorities for action, and make improvements.	
3.2	The organization designs the operating room to promote the appropriate use of all utilities.	
3.9	The team uses technology to effectively manage operating room resources, including staff/service providers and equipment.	
6.8	The team uses a safe surgery checklist to confirm safety steps are completed for a surgical procedure. 6.8.2 The team uses the checklist for every surgical procedure in the operating room. 6.8.4 The team evaluates the use of the checklist and shares results with staff and service providers. 6.8.5 The team uses results of the evaluation to improve the implementation of and expand the use of the checklist.	ROP
6.9	Immediately prior to the procedure, the team conducts a preoperative pause to confirm the client's identity and nature, site, and side of the procedure.	!
6.10	The team documents the preoperative pause.	!
14.3	The team selects and monitors specific performance indicators for the operating room and its services.	!
14.4	The team sets performance goals and objectives and measures their achievement.	

Section 3 Detailed On-site Survey Results

14.5	The team benchmarks or compares its results with other similar interventions, programs, or organizations.	
Standards Set: Surgical Care Services		
2.1	The team works together to develop goals and objectives.	
2.2	The team's goals and objectives for its surgical care services are measurable and specific.	
3.7	The interdisciplinary team follows a formal process to regularly evaluate its functioning, identify priorities for action, and make improvements.	
7.1	The team uses a procedure-specific care map to guide the client through preparation for and recovery from the procedure.	
7.7	The team identifies medical and surgical clients at risk of venous thromboembolism (deep vein thrombosis and pulmonary embolism) and provides appropriate thromboprophylaxis. 7.7.1 The organization has a written thromboprophylaxis policy or guideline. 7.7.2 The team identifies clients at risk for venous thromboembolism (VTE), [(deep vein thrombosis (DVT) and pulmonary embolism (PE)] and provides appropriate evidence-based, VTE prophylaxis. 7.7.3 The team establishes measures for appropriate thromboprophylaxis, audits implementation of appropriate thromboprophylaxis, and uses this information to make improvements to their services. 7.7.4 The team identifies major orthopaedic surgery clients (hip and knee replacements, hip fracture surgery) who require post-discharge prophylaxis and has a mechanism in place to provide appropriate post-discharge prophylaxis to such clients. 7.7.5 The team provides information to health professionals and clients about the risks of VTE and how to prevent it.	ROP
7.12	The team reconciles the client's medications upon admission to the organization, with the involvement of the client, family or caregiver. 7.12.3 Depending on the model, the prescriber uses the BPMH to create admission medication orders (proactive), OR, the team makes a timely comparison of the BPMH against the admission medication orders (retroactive). 7.12.4 The team documents that the BPMH and admission medication orders have been reconciled; and appropriate modifications to medications have been made where necessary.	ROP

Section 3 Detailed On-site Survey Results

11.4	The team reconciles the client's medications with the involvement of the client, family or caregiver at transition points where medication orders are changed or rewritten (i.e. internal transfer, and/or discharge). 11.4.2 Depending on the model, the prescriber uses the Best Possible Medication History (BPMH) and the active medication orders to generate transfer or discharge medication orders (proactive), OR, the team makes a timely comparison of the BPMH, the active medication orders, and the transfer or discharge medication orders (retroactive). 11.4.3 The team documents that the BPMH, the active medication orders, and the transfer or discharge medication orders have been reconciled; and appropriate modifications to medications have been made where necessary. 11.4.4 Depending on the transition point, an up-to-date medication list is retained in the client record (internal transfer), OR, the team generates a Best Possible Medication Discharge Plan (BPMDP) that is communicated to the client, community-based physician or service provider, and community pharmacy, as appropriate (discharge).	ROP
11.6	Following transition or end of service, the team contacts clients, families, or referral organizations or teams to evaluate the effectiveness of the transition, and uses this information to improve its transition and end of service planning.	
14.1	The organization has a process to select evidence-based guidelines for surgical care services.	!
14.2	The team reviews its guidelines to make sure they are up-to-date and reflect current research and best practice information.	!
14.3	The team's guideline review process includes seeking input from staff and service providers about the applicability of the guidelines and their ease of use.	
14.5	The team shares benchmark and best practice information with its partners and other organizations.	
15.2	The team implements and evaluates a falls prevention strategy to minimize client injury from falls. 15.2.5 The team uses the evaluation information to make improvements to its falls prevention strategy.	ROP
16.1	The team identifies and monitors process and outcome measures for its surgical care services.	
16.2	The team monitors clients' perspectives on the quality of its surgical care services.	

Section 3 Detailed On-site Survey Results

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

Surveyor comments on the priority process(es)

Flin Flon General Hospital site:

This team excels at providing patient specific education both pre-operatively and post-operatively. The rights and dignity of patients were maintained at all times during the tracer. Assessments were extremely thorough and appropriate and well documented throughout all aspects of the surgical process. The staff were extremely responsive to patient needs and requests. The team is commended for the attention to patient centred care.

The team has experienced an increase in the number of surgical cases over the past year. The pre-operative clinic is truly a part of the day surgery area and assessments are conducted on the same day of the operating room (OR) booking. This has resulted in cancellations of surgery if contraindications to surgery are identified. Best practices should be considered by the team for evaluation of effective strategies for timing of the pre-operative assessments.

The team composition is made up of regulated health professionals that report receiving a variety of educational opportunities. However, the team is strongly encouraged to investigate educational opportunities for peri operative nursing practices. This would ensure that all staff have the requisite knowledge and skills related to peri operative best practices. A review of staffing patterns is also suggested. The OR suite is old and dated and the team is very aware of there need for a more updated clinical environment. There has been a request submitted for an improvement project.

All documentation and booking processes are manually completed. For long range planning, the organization is encouraged to consider electronic OR scheduling to streamline resources. Consideration for additional uses for information technology (IT) in the OR is suggested. The post operative surgical team is also responsible for obstetrical patient care on the same unit. Please refer to that report section for comments about the Obstetrics/Perinatal Care Service.

During the pre-operative pause process, all members of the team should cease performing any activities related to patient care to ensure complete attention to the safety checks. A review of best practices regarding marking surgical side/sites is encouraged to reduce risk of 'wrong side' surgeries. Positive patient identification was witnessed at every stage of the surgical process.

St. Anthony General Hospital site:

The surgical check list is a regional tool and has been developed with three phases. This team was witnessed to implement only phase one of the check list and not phases two and three. The surgical count was not completed before some aspects of the first phase was initiated. The check list itself was kept with all of the patient health record papers and therefore, was not used to guide the discussion. It was not signed in a timely manner. Phase two and three of the check list was not witnessed during the surgery tracers. This team is encouraged to review best practices regarding implementation of the surgical check list and then take steps to ensure that all three phases are observed. The check list should be physically used and checked at the time that the criteria are being assessed with the team. While there is a slight pause when the patient is brought into the OR and the first stage of the surgical check list is partially completed, a formal "pause" immediately before cutting the skin, with completion of the second phase of the surgical check list, was not

Section 3 Detailed On-site Survey Results

witnessed on at least two occasions. The team must ensure that these safety activities are performed to be in compliance with best practice initiatives.

Procedure specific care maps have not been developed and implemented by this team. Best practices and efficient care processes are ensured when these structured and based on evidence tools are used for patients. The team is encouraged to consider developing care maps for priority procedures to implement region wide for consistent care. This will also address any issues associated with variations in surgeons' practices and preferences. This team does a great job of marking surgical sites with appropriate markers.

Medication reconciliation forms are inconsistently completed in the reconciliation component for admission, transfer and discharge. Medication reconciliation is an essential component of a patient safety program and all members of the team need to and must collaborate together to ensure this initiative is consistently implemented.

All Sites:

There have been some informal goals identified for the teams however, there are no formal goals and objectives developed and evaluated. Formal unit based goals should be developed so that all team members are aware of their priorities. However, the team does consider the resources it needs to address their informally identified goals such as medication reconciliation and renovation projects.

To update the current guidelines in place, a thrombo embolism policy has been developed but it is still in draft form. However, it is in the process of being approved and then it will be implemented. The organization is encouraged to ensure these processes continue as soon as possible, given the risks associated with this 'at risk' patient population. The teams use a long established method of taped and verbal reports to transfer accountability from unit to unit and shift to shift, although there is no check list used to ensure consistency. The organization is encouraged to investigate best practices into the issue of transfer of accountability and to consider implementing a documentation tool to formalize this process.

Clinical pathways have not been developed by this team. Higher risk and higher frequency surgical procedures would benefit from a consistent care approach, using best practice research. Audit results of the surgical check list should be shared with staff and senior leaders as this is such an important safety initiative. Audits for the implementation of the surgical pause process should be completed at both St. Anthony and Flin Flon sites to identify processes that are proceeding well and also to identify areas for improvements.

Section 4 Performance Measures Results

Under Qmentum, client organizations collect performance measure data using instruments.

- **Instruments (or tools)** are surveys related to areas such as governance, patient safety culture, and quality of worklife. They are completed by a representative sample of clients, staff, senior leaders, board members, and other stakeholders.

The information in this section shows some of the performance measure results at the organizational level.

4.1 Instruments

4.1.1 Governance Functioning Tool

The Governance Functioning Tool enables members of the governing body to assess board structures and processes, provide their perceptions and opinions, and identify priorities for action. The four aspects of the governing body that it is designed to measure are:

- Board composition and membership
- Scope of authority (roles and responsibilities)
- Meeting processes
- Evaluation of performance

Accreditation Canada provided the organization with detailed results from its Governance Functioning Tool prior to the on-site survey, through the Quality Performance Roadmap on the client organization portal. The organization then had the opportunity to address challenging areas.

Data collection period: February 15, 2011 to March 9, 2011

Number of respondents: 9

Governance Functioning Tool: Results by Aspect of Governing Body

Governance Structures and Processes	% Agree	% Neutral	% Disagree	%Agree * Canadian Average
	Organization	Organization	Organization	
1 We actively recruit, recommend and/or select new members based on needs for particular skills, background, and experience.	0	0	100	94
2 We have explicit criteria to recruit and select new members.	33	0	67	86
3 Our renewal cycle is appropriately managed to ensure continuity on the governing body.	78	0	22	93

Section 4 Performance Measures Results

Governance Structures and Processes	% Agree	% Neutral	% Disagree	%Agree * Canadian Average
	Organization	Organization	Organization	
4 The composition of our governing body allows us to meet stakeholder and community needs.	67	0	33	96
5 Clear written policies define term lengths and limits for individual members, as well as compensation.	100	0	0	96
6 We regularly review, understand, and ensure compliance with applicable laws, legislation and regulations.	100	0	0	93
7 Governance policies and procedures that define our role and responsibilities are well-documented and consistently followed.	100	0	0	96
8 We review our own structure, including size and sub-committee structure.	89	0	11	94
9 We have sub-committees that have clearly-defined roles and responsibilities.	100	0	0	97
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	96
11 We each receive orientation that helps us to understand the organization and its issues, and supports high-quality decision-making.	89	0	11	93
12 Disagreements are viewed as a search for solutions rather than a “win/lose”.	100	0	0	95
13 Our meetings are held frequently enough to make sure we are able to make timely decisions.	100	0	0	98
14 Individual members understand and carry out their legal duties, roles and responsibilities, including sub-committee work (as applicable).	100	0	0	97
15 Members come to meetings prepared to engage in meaningful discussion and thoughtful decision-making.	89	0	11	95

Section 4 Performance Measures Results

Governance Structures and Processes	% Agree	% Neutral	% Disagree	%Agree * Canadian Average
	Organization	Organization	Organization	
16 Our governance processes make sure that everyone participates in decision-making.	100	0	0	95
17 Individual members are actively involved in policy-making and strategic planning.	100	0	0	93
18 The composition of our governing body contributes to high governance and leadership performance.	100	0	0	94
19 Our governing body's dynamics enable group dialogue and discussion. Individual members ask for and listen to one another's ideas and input.	89	0	11	95
20 Our ongoing education and professional development is encouraged.	100	0	0	91
21 Working relationships among individual members and committees are positive.	89	0	11	97
22 We have a process to set bylaws and corporate policies.	100	0	0	97
23 Our bylaws and corporate policies cover confidentiality and conflict of interest.	100	0	0	98
24 We formally evaluate our own performance on a regular basis.	78	0	22	83
25 We benchmark our performance against other similar organizations and/or national standards.	44	0	56	75
26 Contributions of individual members are reviewed regularly.	63	0	38	72
27 As a team, we regularly review how we function together and how our governance processes could be improved.	67	0	33	83
28 There is a process for improving individual effectiveness when non-performance is an issue.	88	0	13	66
29 We regularly identify areas for improvement and engage in our own quality improvement activities.	75	0	25	84

Section 4 Performance Measures Results

Governance Structures and Processes	% Agree	% Neutral	% Disagree	%Agree * Canadian Average
	Organization	Organization	Organization	
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	88
31 As individual members, we receive adequate feedback about our contribution to the governing body.	63	0	38	73
32 We have a process to elect or appoint our chair.	80	0	20	96
33 Our chair has clear roles and responsibilities and runs the governing body effectively.	100	0	0	97

*Canadian average: Percentage of Accreditation Canada client organizations surveyed from January to June, 2011 that agreed with the instrument item.

Section 4 Performance Measures Results

4.1.2 Patient Safety Culture Tool

The Patient Safety Culture Tool provides insight into staff perceptions of patient safety, allowing the organization to identify successes and challenges in a number of areas related to patient safety and worklife.

Accreditation Canada provided the organization with detailed results from its Patient Safety Culture Tool prior to the on-site survey, through the Quality Performance Roadmap on the client organization portal. The organization then had the opportunity to address challenging areas. During the on-site survey, surveyors reviewed progress made in those areas.

Data collection period: September 14, 2009 to October 23, 2009

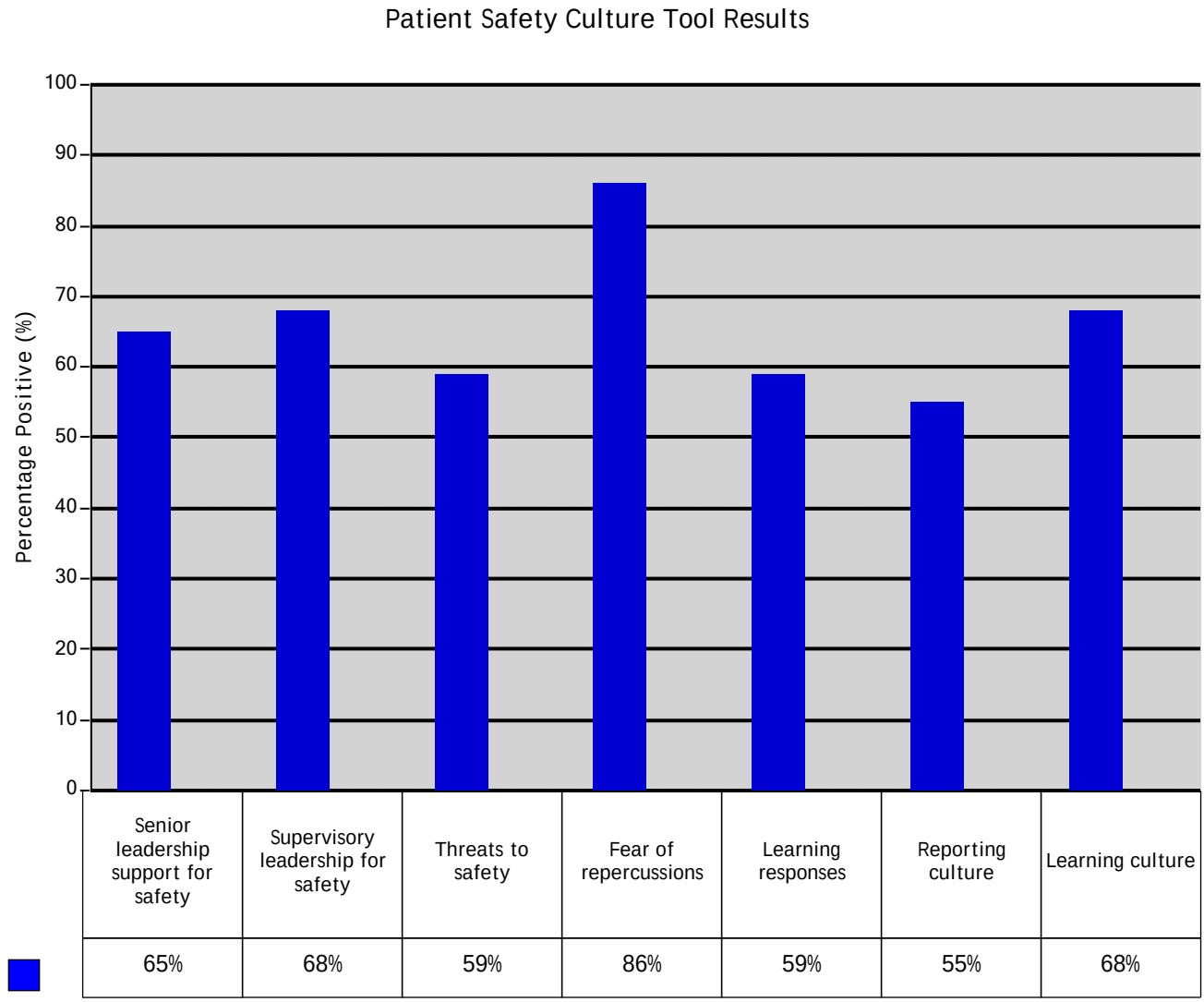
Minimum response rate (based on the number of employees): 275

Number of respondents: 324

Minimum response rate MET

Section 4 Performance Measures Results

Patient Safety Culture: Results by Patient Safety Culture Dimension



Legend

NOR-MAN Regional Health Authority

Section 4 Performance Measures Results

4.1.3 Worklife Pulse Tool

The Worklife Pulse Tool enables organizations to take the "pulse" of the quality of worklife by monitoring staff perceptions of various aspects of worklife, such as on-the-job communication, staff health and well-being, and job satisfaction. It collects information related to 11 aspects of the work environment that are known to contribute to individual quality of worklife and organizational performance.

Accreditation Canada provided the organization with detailed results from its Worklife Pulse Tool prior to the on-site survey, through the Quality Performance Roadmap on the client organization portal. The organization then had the opportunity to address challenging areas. During the on-site survey, surveyors reviewed progress made in those areas.

Data collection period: October 24, 2010 to December 10, 2010

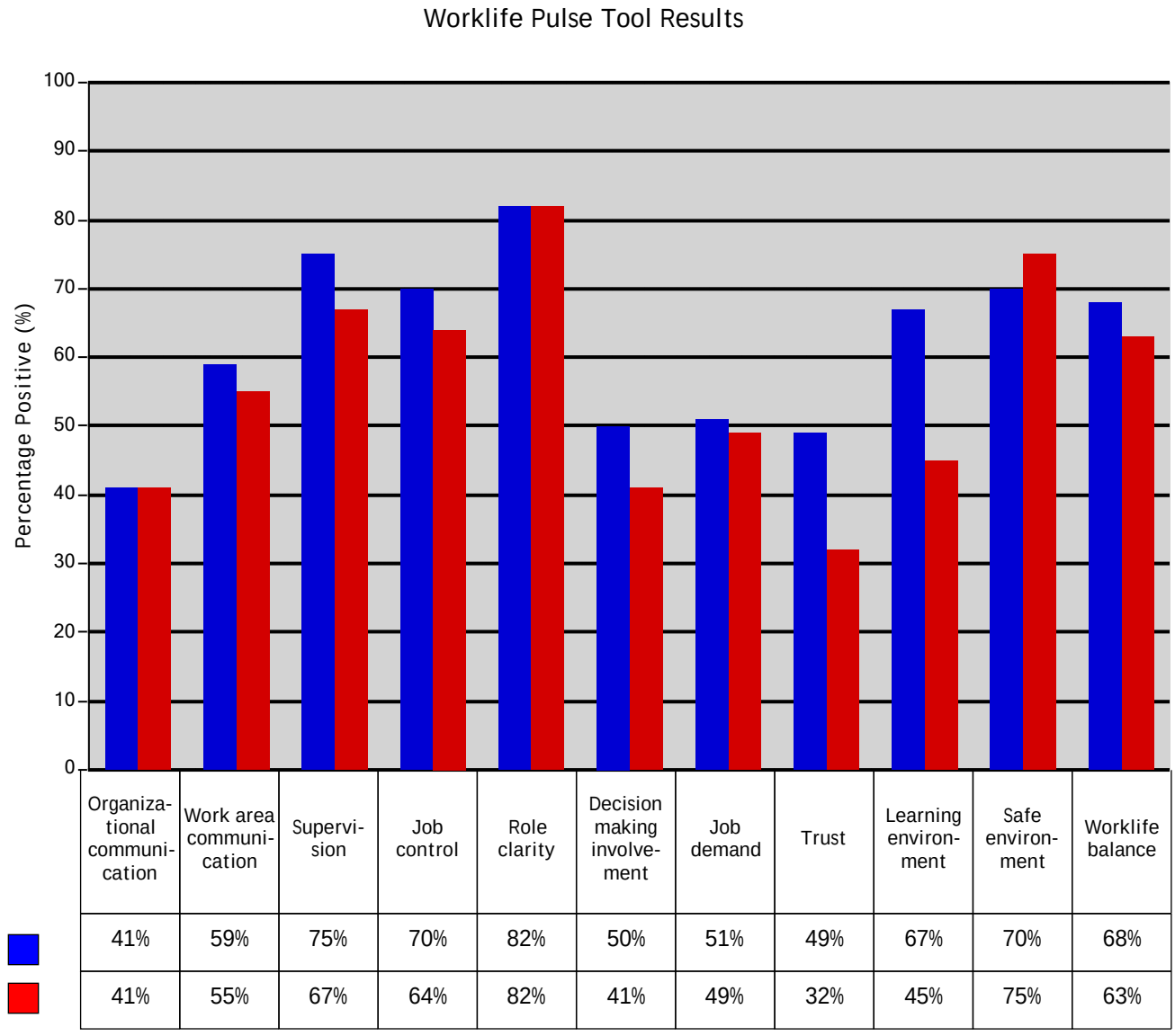
Minimum response rate (based on the number of employees): 275

Number of respondents: 389

Minimum response rate MET

Section 4 Performance Measures Results

Worklife Pulse Tool: Results of Work Environment



	Organizational communication	Work area communication	Supervision	Job control	Role clarity	Decision making involvement	Job demand	Trust	Learning environment	Safe environment	Worklife balance
	41%	59%	75%	70%	82%	50%	51%	49%	67%	70%	68%
	41%	55%	67%	64%	82%	41%	49%	32%	45%	75%	63%

Legend

NOR-MAN Regional Health Authority

* Canadian Average

*Canadian average: Percentage of Accreditation Canada client organizations surveyed from July to December, 2010 that agreed with the instrument item.

Section 5 Organization's Commentary

After the on-site survey, the organization was invited provide comments to be included in this report about its experience with Qmentum and the accreditation process.

Accreditation Canada On Site Visit November 2011

NOR-MAN Regional Health Authority Organizational Commentary

The 2011 Accreditation Canada On Site visit was the NRHA's second time participating in the Qmentum Program. The resulting report from the On Site visit provided a more balanced summary of our successes and areas of improvement than the previous 2008 report. The Survey team clearly recognized and understood the successes and challenges of the NRHA. The feedback that the surveyors provided in the report is more succinct than in 2008 which enables us to be focused in our improvement initiatives.

There is a synergy between this report and the Journey Forward Initiative that the NRHA has embarked on in the past few months. With the feedback provided we will be able to link the recommendations of the Accreditation Canada report to the work already in progress in the region.

During the On Site visit the surveyors not only assessed the NRHA but were very open with sharing their wealth of knowledge with our staff. Preliminary feedback from staff has been very positive regarding their interactions with the surveyors. The surveyors' comments also provided very positive feedback on successes of the NRHA and recognized staff for their hard work and dedication.

In terms of unmet criteria, there are plans in place already to address several of these areas:
1. Medication Reconciliation at Admission, Transfer or Discharge – There is a regional plan in place for moving forward with medication reconciliation. We currently have it in place in all three stages in Flin Flon General Hospital with a plan to role it out regionally.
2. Concentrated Electrolytes – have already been removed from the two areas in which they were located.
3. Hand Hygiene Audits – Audits are occurring and results shared with managers. A process for sharing the results consistently with staff will be developed.
4. Falls Prevention Strategy – A team has been pulled together to review the falls prevention strategy and to participate in the Safer Healthcare Now Falls Learning Series.
5. Pressure Ulcer Prevention- Policy is developed and will be moving forward.
6. Venous Thromboembolism Prophylaxis- An update has been completed on our current policy to ensure it follows best practice. Once approval from the key stakeholders is received it will be put into practice.

Section 5 Organization's Commentary

Areas of concern:

1. Workplace Violence Prevention – The comment was made that there was little consultation with staff on the development of the policy and was based on a provincial template. It is actually our policy and was developed in consultation with a local Violence Prevention Working Group that was created to develop the policy and the Workplace Safety & Health Committees; membership on these committees includes front-line staff. We participate on a provincial working group that will be making recommendations in regards to policy and training. In addition, provincial standard signage has been adopted by all RHAs across the province.

2. On Page 53 of the report there is a comment made regarding that there are no indicators telehealth sessions conducted annually broken down in to Administrative use, education, and clinical; this is reported on our Scorecard to the Board.

As the NRHA moves ahead with the Journey Forward initiative, many of the actions contained with in it will have direct results on Accreditation recommendations. We will be able to integrate the Accreditation recommendations to operational plans which will ensure integration into daily activities.

Appendix A Qmentum

Health care accreditation contributes to quality improvement and patient safety by enabling a health organization to regularly and consistently assess and improve its services. Accreditation Canada's Qmentum accreditation program offers a customized process aligned with each client organization's needs and priorities.

As part of the Qmentum accreditation process, client organizations complete self-assessment questionnaires, submit performance measure data, and undergo an on-site survey during which trained peer surveyors assess their services against national standards. The surveyor team provides preliminary results to the organization at the end of the on-site survey. Accreditation Canada reviews these results and issues the Accreditation Report within 15 business days.

An important adjunct to the Accreditation Report is the online Quality Performance Roadmap, available to client organizations through their portal. The organization uses the information in the Roadmap in conjunction with the Accreditation Report to ensure that it develops comprehensive action plans.

Throughout the three-year cycle, Accreditation Canada provides ongoing liaison and support to help the organization address issues, action plan, and monitor progress.

Action Planning

Following the on-site survey, the organization uses the information in its Accreditation Report and Quality Performance Roadmap to develop action plans to address areas identified as needing improvement. The organization provides Accreditation Canada with evidence of the actions it has taken to address these conditions.

Progress Review and Ongoing Improvement

Five months after the on-site survey, Accreditation Canada evaluates the evidence submitted by the organization. If the evidence shows that a sufficient percentage of previously unmet criteria are now met, a new accreditation decision that reflects the organization's progress may be issued.

Appendix B Priority Processes

Priority processes associated with system-wide standards

Priority Process	Description
Planning and Service Design	Developing and implementing infrastructure, programs, and services to meet the needs of the populations and communities served
Resource Management	Monitoring, administering, and integrating activities related to the allocation and use of resources
Human Capital	Developing the human resource capacity to deliver safe, high quality services
Integrated Quality Management	Using a proactive, systematic, and ongoing process to manage and integrate quality and achieve organizational goals and objectives
Principle-based Care and Decision Making	Identifying and making decisions about ethical dilemmas and problems
Communication	Communicating effectively at all levels of the organization and with external stakeholders
Physical Environment	Providing appropriate and safe structures and facilities to achieve the organization's mission, vision, and goals
Emergency Preparedness	Planning for and managing emergencies, disasters, or other aspects of public safety
Patient Flow	Assessing the smooth and timely movement of clients and families through service settings
Medical Devices and Equipment	Obtaining and maintaining machinery and technologies used to diagnose and treat health problems

Priority processes associated with population-specific standards

Priority Process	Description
Chronic Disease Management	Integrating and coordinating services across the continuum of care for populations with chronic conditions
Population Health and Wellness	Promoting and protecting the health of the populations and communities served through leadership, partnership, and innovation

Priority processes associated with service excellence standards

Appendix B Priority Processes

Priority Process	Description
Point-of-care Testing Services	Using non-laboratory tests delivered at the point of care to determine the presence of health problems
Organ Transplant	Providing organ transplant services, from initial assessment of transplant candidates to providing follow-up care to recipients
Episode of Care - Primary Care	Providing primary care in the clinical setting, including making primary care services accessible, completing the encounter, and coordinating services
Organ Donation (Living)	Providing organ donation services for living donors, including supporting potential donors to make informed decisions, conducting donor suitability testing, and carrying out donation procedures
Clinical Leadership	Providing leadership and direction to teams providing services
Competency	Developing a skilled, knowledgeable, interdisciplinary team that can manage and deliver effective programs and services
Episode of Care	Providing clients with coordinated services from their first encounter with a health care provider through their last contact related to their health issue
Decision Support	Using information, research, data, and technology to support management and clinical decision making
Impact on Outcomes	Identifying and monitoring process and outcome measures to evaluate and improve service quality and client outcomes
Medication Management	Using interdisciplinary teams to manage the provision of medication to clients
Organ Donation	Providing organ donation services for deceased donors and their families, including identifying potential donors, approaching families, and recovering organs
Infection Prevention and Control	Implementing measures to prevent and reduce the acquisition and transmission of infection among staff, service providers, clients, and families
Surgical Procedures	Delivering safe surgical care, including preoperative preparation, operating room procedures, postoperative recovery, and discharge
Diagnostic Services: Imaging	Ensuring the availability of diagnostic imaging services to assist medical professionals in diagnosing and monitoring health conditions
Diagnostic Services: Laboratory	Ensuring the availability of laboratory services to assist medical professionals in diagnosing and monitoring health conditions

Appendix B Priority Processes

Priority Process	Description
Blood Services	Handling blood and blood components safely, including donor selection, blood collection, and transfusions