ACCREDITATION CANADA



Driving Quality Health Services

Accreditation Report

Northern Regional Health Authority

Flin Flon, MB

On-site survey dates: June 15, 2014 - June 20, 2014

Report issued: July 15, 2014

ACCREDITATION CANADA
AGRÉMENT CANADA

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

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About the Accreditation Report

Northern 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 June 2014. 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.

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.

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

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 your organization on your participation in the Qmentum accreditation program. Qmentum is designed to integrate with your quality improvement program. By using Qmentum 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 the 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

Northern Regional Health Authority (referred to in this report as “the organization”) is participating in Accreditation Canada's Qmentum accreditation program. 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.

As part of the Qmentum accreditation program, the organization has undergone a rigorous evaluation process. Following a comprehensive self-assessment, external peer surveyors conducted an on-site survey during which they assessed this organization's leadership, governance, clinical programs and services against Accreditation Canada requirements for quality and safety. These requirements include national standards of excellence; required safety practices to reduce potential harm; and questionnaires to assess the work environment, patient safety culture, governance functioning and client experience. Results from all of these components are included in this report and were considered in the accreditation decision.

This 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.

The organization 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

Northern Regional Health Authority 's accreditation decision is:

Accredited (Report)

The organization has succeeded in meeting the fundamental requirements of the accreditation program.

1.2 About the On-site Survey

- **On-site survey dates: June 15, 2014 to June 20, 2014**

- **Locations**

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

1 Acquired Brain Injury Unit
2 Crisis Services for Youth
3 Flin Flon Clinic
4 Flin Flon Emergency Medical Station
5 Flin Flon General Hospital
6 Flin Flon Personal Care Home
7 Flin Flon Primary Health Care Centre
8 Flin Flon Primary Health Care Seniors
9 Leaf Rapids Health Centre
10 Lynn Lake Hospital
11 Northern Consultation Centre
12 Northern Lights Manor
13 Northern Spirit Manor
14 NRHA Thompson Regional Office
15 Rosaire House
16 Snow Lake Health Centre
17 St. Anthony's General Hospital
18 St. Paul's Personal Care Home
19 The Pas Clinic
20 The Pas Emergency Medical Station
21 The Pas Primary Health Care Centre
22 Thompson Clinic
23 Thompson General Hospital
24 Wabowden Community Health 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 Leadership
  2 Governance
  3 Medication Management Standards
  4 Infection Prevention and Control

  Population-specific Standards

  5 Populations with Chronic Conditions

  Service Excellence Standards

  6 Operating Rooms
  7 Surgical Care Services
  8 Emergency Department
  9 Home Care Services
  10 Acquired Brain Injury Services
  11 Ambulatory Care Services
  12 Community Health Services
  13 Long-Term Care Services
  14 Medicine Services
  15 Substance Abuse and Problem Gambling Services
  16 Emergency Medical Services
  17 Community-Based Mental Health Services and Supports Standards
  18 Obstetrics Services
  19 Mental Health Services
  20 Reprocessing and Sterilization of Reusable Medical Devices

- **Instruments**

  The organization administered:

  1 Governance Functioning Tool
  2 Patient Safety Culture Tool
  3 Worklife Pulse Tool
  4 Client Experience Tool

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 shows the number of criteria related to each dimension that were rated as met, unmet, or not applicable.

Quality Dimension	Met	Unmet	N/A	Total
 Population Focus (Working with communities to anticipate and meet needs)	90	18	0	108
 Accessibility (Providing timely and equitable services)	106	12	3	121
 Safety (Keeping people safe)	466	69	26	561
 Worklife (Supporting wellness in the work environment)	179	20	0	199
 Client-centred Services (Putting clients and families first)	212	14	8	234
 Continuity of Services (Experiencing coordinated and seamless services)	88	4	1	93
 Effectiveness (Doing the right thing to achieve the best possible results)	658	133	34	825
 Efficiency (Making the best use of resources)	49	21	1	71
Total	**1848**	**291**	**73**	**2212**

1.4 Overview by Standards

The Qmentum standards identify policies and practices that contribute to high quality, safe, and effectively managed care. Each standard has associated criteria that are used to measure the organization's compliance with the standard.

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

This table shows the sets of standards 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.

Accreditation decisions are based on compliance with standards. Percent compliance is calculated to the decimal and not rounded.

Standards Set	High Priority Criteria *			Other Criteria			Total Criteria (High Priority + Other)		
	Met	Unmet	N/A	Met	Unmet	N/A	Met	Unmet	N/A
	# (%)	# (%)	#	# (%)	# (%)	#	# (%)	# (%)	#
Governance	39 (88.6%)	5 (11.4%)	0	27 (79.4%)	7 (20.6%)	0	66 (84.6%)	12 (15.4%)	0
Leadership	35 (76.1%)	11 (23.9%)	0	66 (77.6%)	19 (22.4%)	0	101 (77.1%)	30 (22.9%)	0
Infection Prevention and Control	47 (94.0%)	3 (6.0%)	3	36 (83.7%)	7 (16.3%)	1	83 (89.2%)	10 (10.8%)	4
Medication Management Standards	52 (72.2%)	20 (27.8%)	6	46 (79.3%)	12 (20.7%)	6	98 (75.4%)	32 (24.6%)	12
Populations with Chronic Conditions	4 (100.0%)	0 (0.0%)	0	35 (100.0%)	0 (0.0%)	0	39 (100.0%)	0 (0.0%)	0
Acquired Brain Injury Services	22 (84.6%)	4 (15.4%)	1	68 (89.5%)	8 (10.5%)	0	90 (88.2%)	12 (11.8%)	1
Ambulatory Care Services	34 (97.1%)	1 (2.9%)	3	66 (89.2%)	8 (10.8%)	1	100 (91.7%)	9 (8.3%)	4
Community Health Services	12 (92.3%)	1 (7.7%)	0	55 (100.0%)	0 (0.0%)	0	67 (98.5%)	1 (1.5%)	0
Community-Based Mental Health Services and Supports Standards	14 (77.8%)	4 (22.2%)	0	95 (84.8%)	17 (15.2%)	0	109 (83.8%)	21 (16.2%)	0

Standards Set	High Priority Criteria *			Other Criteria			Total Criteria (High Priority + Other)		
	Met	Unmet	N/A	Met	Unmet	N/A	Met	Unmet	N/A
	# (%)	# (%)	#	# (%)	# (%)	#	# (%)	# (%)	#
Emergency Department	25 (80.6%)	6 (19.4%)	0	60 (70.6%)	25 (29.4%)	10	85 (73.3%)	31 (26.7%)	10
Emergency Medical Services	37 (97.4%)	1 (2.6%)	8	80 (87.0%)	12 (13.0%)	17	117 (90.0%)	13 (10.0%)	25
Home Care Services	36 (90.0%)	4 (10.0%)	0	46 (88.5%)	6 (11.5%)	0	82 (89.1%)	10 (10.9%)	0
Long-Term Care Services	24 (100.0%)	0 (0.0%)	0	65 (90.3%)	7 (9.7%)	0	89 (92.7%)	7 (7.3%)	0
Medicine Services	26 (100.0%)	0 (0.0%)	1	65 (94.2%)	4 (5.8%)	0	91 (95.8%)	4 (4.2%)	1
Mental Health Services	28 (90.3%)	3 (9.7%)	1	74 (84.1%)	14 (15.9%)	0	102 (85.7%)	17 (14.3%)	1
Obstetrics Services	57 (95.0%)	3 (5.0%)	3	64 (86.5%)	10 (13.5%)	1	121 (90.3%)	13 (9.7%)	4
Operating Rooms	65 (95.6%)	3 (4.4%)	1	23 (76.7%)	7 (23.3%)	0	88 (89.8%)	10 (10.2%)	1
Reprocessing and Sterilization of Reusable Medical Devices	36 (92.3%)	3 (7.7%)	1	54 (93.1%)	4 (6.9%)	1	90 (92.8%)	7 (7.2%)	2
Substance Abuse and Problem Gambling Services	20 (83.3%)	4 (16.7%)	3	58 (82.9%)	12 (17.1%)	1	78 (83.0%)	16 (17.0%)	4
Surgical Care Services	28 (96.6%)	1 (3.4%)	1	49 (75.4%)	16 (24.6%)	0	77 (81.9%)	17 (18.1%)	1
Total	**641 (89.3%)**	77 (10.7%)	32	1132 (85.3%)	195 (14.7%)	38	1773 (86.7%)	272 (13.3%)	70

* Does not includes ROP (Required Organizational Practices)

1.5 Overview by Required Organizational Practices

A Required Organizational Practice (ROP) is an essential practice that an organization must have in place to enhance client safety and minimize risk. Each ROP has associated tests for compliance, categorized as major and minor. All tests for compliance must be met for the ROP as a whole to be rated as met.

This table shows the ratings of the applicable ROPs.

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Safety Culture			
Adverse Events Disclosure (Leadership)	Met	3 of 3	0 of 0
Adverse Events Reporting (Leadership)	Met	1 of 1	1 of 1
Client Safety Quarterly Reports (Leadership)	Unmet	1 of 1	1 of 2
Client Safety Related Prospective Analysis (Leadership)	Met	1 of 1	1 of 1
Patient Safety Goal Area: Communication			
Client And Family Role In Safety (Acquired Brain Injury Services)	Met	2 of 2	0 of 0
Client And Family Role In Safety (Ambulatory Care Services)	Unmet	0 of 2	0 of 0
Client And Family Role In Safety (Community-Based Mental Health Services and Supports Standards)	Met	2 of 2	0 of 0
Client And Family Role In Safety (Home Care Services)	Met	2 of 2	0 of 0
Client And Family Role In Safety (Long-Term Care Services)	Met	2 of 2	0 of 0
Client And Family Role In Safety (Medicine Services)	Unmet	0 of 2	0 of 0

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Communication			
Client And Family Role In Safety (Mental Health Services)	Met	2 of 2	0 of 0
Client And Family Role In Safety (Obstetrics Services)	Unmet	1 of 2	0 of 0
Client And Family Role In Safety (Substance Abuse and Problem Gambling Services)	Met	2 of 2	0 of 0
Client And Family Role In Safety (Surgical Care Services)	Met	2 of 2	0 of 0
Dangerous Abbreviations (Medication Management Standards)	Unmet	3 of 4	2 of 3
Information Transfer (Acquired Brain Injury Services)	Met	2 of 2	0 of 0
Information Transfer (Ambulatory Care Services)	Met	2 of 2	0 of 0
Information Transfer (Community-Based Mental Health Services and Supports Standards)	Met	2 of 2	0 of 0
Information Transfer (Emergency Department)	Met	2 of 2	0 of 0
Information Transfer (Emergency Medical Services)	Met	2 of 2	0 of 0
Information Transfer (Home Care Services)	Met	2 of 2	0 of 0
Information Transfer (Long-Term Care Services)	Met	2 of 2	0 of 0
Information Transfer (Medicine Services)	Met	2 of 2	0 of 0
Information Transfer (Mental Health Services)	Met	2 of 2	0 of 0

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Communication			
Information Transfer (Obstetrics Services)	Met	2 of 2	0 of 0
Information Transfer (Substance Abuse and Problem Gambling Services)	Met	2 of 2	0 of 0
Information Transfer (Surgical Care Services)	Met	2 of 2	0 of 0
Medication reconciliation as a strategic priority (Leadership)	Met	4 of 4	2 of 2
Medication reconciliation at care transitions (Acquired Brain Injury Services)	Met	5 of 5	0 of 0
Medication reconciliation at care transitions (Ambulatory Care Services)	Unmet	6 of 7	0 of 0
Medication reconciliation at care transitions (Community-Based Mental Health Services and Supports Standards)	Unmet	2 of 4	1 of 1
Medication reconciliation at care transitions (Emergency Department)	Unmet	1 of 5	0 of 0
Medication reconciliation at care transitions (Home Care Services)	Met	4 of 4	1 of 1
Medication reconciliation at care transitions (Long-Term Care Services)	Met	5 of 5	0 of 0
Medication reconciliation at care transitions (Medicine Services)	Met	5 of 5	0 of 0

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Communication			
Medication reconciliation at care transitions (Mental Health Services)	Met	5 of 5	0 of 0
Medication reconciliation at care transitions (Obstetrics Services)	Met	5 of 5	0 of 0
Medication reconciliation at care transitions (Surgical Care Services)	Met	5 of 5	0 of 0
Safe Surgery Checklist (Obstetrics Services)	Met	3 of 3	2 of 2
Safe Surgery Checklist (Operating Rooms)	Unmet	1 of 3	1 of 2
Two Client Identifiers (Acquired Brain Injury Services)	Met	1 of 1	0 of 0
Two Client Identifiers (Ambulatory Care Services)	Met	1 of 1	0 of 0
Two Client Identifiers (Emergency Department)	Met	1 of 1	0 of 0
Two Client Identifiers (Emergency Medical Services)	Unmet	0 of 1	0 of 0
Two Client Identifiers (Home Care Services)	Met	1 of 1	0 of 0
Two Client Identifiers (Long-Term Care Services)	Met	1 of 1	0 of 0
Two Client Identifiers (Medicine Services)	Met	1 of 1	0 of 0
Two Client Identifiers (Mental Health Services)	Met	1 of 1	0 of 0
Two Client Identifiers (Obstetrics Services)	Met	1 of 1	0 of 0

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Communication			
Two Client Identifiers (Operating Rooms)	Met	1 of 1	0 of 0
Two Client Identifiers (Substance Abuse and Problem Gambling Services)	Met	1 of 1	0 of 0
Two Client Identifiers (Surgical Care Services)	Met	1 of 1	0 of 0
Patient Safety Goal Area: Medication Use			
Antimicrobial Stewardship (Medication Management Standards)	Unmet	0 of 4	0 of 1
Concentrated Electrolytes (Medication Management Standards)	Met	3 of 3	0 of 0
Heparin Safety (Medication Management Standards)	Unmet	2 of 4	0 of 0
High-Alert Medications (Emergency Medical Services)	Met	5 of 5	3 of 3
High-Alert Medications (Medication Management Standards)	Unmet	1 of 5	2 of 3
Infusion Pumps Training (Ambulatory Care Services)	Met	1 of 1	0 of 0
Infusion Pumps Training (Emergency Department)	Met	1 of 1	0 of 0
Infusion Pumps Training (Emergency Medical Services)	Met	1 of 1	0 of 0
Infusion Pumps Training (Medicine Services)	Met	1 of 1	0 of 0
Infusion Pumps Training (Obstetrics Services)	Met	1 of 1	0 of 0
Infusion Pumps Training (Operating Rooms)	Met	1 of 1	0 of 0

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Medication Use			
Infusion Pumps Training (Surgical Care Services)	Met	1 of 1	0 of 0
Narcotics Safety (Emergency Medical Services)	Met	3 of 3	0 of 0
Narcotics Safety (Medication Management Standards)	Met	3 of 3	0 of 0
Patient Safety Goal Area: Worklife/Workforce			
Client Safety Plan (Leadership)	Met	2 of 2	2 of 2
Client Safety: Education And Training (Leadership)	Met	1 of 1	0 of 0
Preventive Maintenance Program (Leadership)	Met	3 of 3	1 of 1
Workplace Violence Prevention (Leadership)	Met	5 of 5	3 of 3
Patient Safety Goal Area: Infection Control			
Hand-Hygiene Compliance (Emergency Medical Services)	Unmet	0 of 1	2 of 2
Hand-Hygiene Compliance (Infection Prevention and Control)	Unmet	0 of 1	1 of 2
Hand-Hygiene Education and Training (Emergency Medical Services)	Met	2 of 2	0 of 0
Hand-Hygiene Education and Training (Infection Prevention and Control)	Met	2 of 2	0 of 0
Infection Rates (Infection Prevention and Control)	Unmet	1 of 1	2 of 3
Pneumococcal Vaccine (Long-Term Care Services)	Met	2 of 2	0 of 0

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Infection Control			
Reprocessing (Emergency Medical Services)	Met	1 of 1	1 of 1
Reprocessing (Infection Prevention and Control)	Met	1 of 1	1 of 1
Patient Safety Goal Area: Falls Prevention			
Falls Prevention Strategy (Acquired Brain Injury Services)	Met	3 of 3	2 of 2
Falls Prevention Strategy (Ambulatory Care Services)	Unmet	0 of 3	0 of 2
Falls Prevention Strategy (Home Care Services)	Met	3 of 3	2 of 2
Falls Prevention Strategy (Long-Term Care Services)	Met	3 of 3	2 of 2
Falls Prevention Strategy (Medicine Services)	Met	3 of 3	2 of 2
Falls Prevention Strategy (Mental Health Services)	Met	3 of 3	2 of 2
Falls Prevention Strategy (Obstetrics Services)	Met	3 of 3	2 of 2
Falls Prevention Strategy (Surgical Care Services)	Met	3 of 3	2 of 2
Patient Safety Goal Area: Risk Assessment			
Home Safety Risk Assessment (Home Care Services)	Met	3 of 3	2 of 2
Pressure Ulcer Prevention (Long-Term Care Services)	Met	3 of 3	2 of 2
Pressure Ulcer Prevention (Medicine Services)	Met	3 of 3	2 of 2

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Risk Assessment			
Pressure Ulcer Prevention (Surgical Care Services)	Unmet	0 of 3	1 of 2
Suicide Prevention (Community-Based Mental Health Services and Supports Standards)	Met	5 of 5	0 of 0
Suicide Prevention (Mental Health Services)	Met	5 of 5	0 of 0
Venous Thromboembolism Prophylaxis (Medicine Services)	Met	3 of 3	2 of 2
Venous Thromboembolism Prophylaxis (Surgical Care Services)	Unmet	2 of 3	0 of 2

1.6 Summary of Surveyor Team Observations

The surveyor team made the following observations about the organization's overall strengths, opportunities for improvement, and challenges.

Northern Regional Health Authority (NRHA) is commended for participating in the accreditation program and demonstrating its dedication to ongoing quality improvement.

NRHA is an amalgamation of the two former health authorities of Burntwood and Nor-Man following a ministerial announcement in April 2012. The organization is now two years into amalgamation. A Board has been appointed and a governance model developed which will provide a solid foundation for the work of the Board. They have successfully developed a new vision, mission, values statement and logo to support branding a new identity and a strategic direction for the NRHA. The strategic plan is in its first year of implementation. They have developed a dashboard for performance measure quarterly reporting to the Board and communication strategies to deliver key messages internally and externally.

Data from two previous community health assessments has been used to create a new regional health profile; they are now preparing for the next assessment process. This information has been used in planning and community engagement. NRHA is commended for their innovative partnerships with First Nations communities such as the Opaskwayak partnership. These initiatives with First Nations have provided improved access to service and improved service. The development of the Local Health Involvement Groups (LHIGs) will provide a forum for broader community input and engagement in the planning processes.

The organization has restructured quality and risk management and has implemented a collaborative structure. These are in early stages of development but have helped align several initiatives and working groups with the strategic priorities, Manitoba Health goals, Accreditation Canada's Required Organizational Practices, and quality and risk management initiatives. A significant strength of NRHA is the development of the four pillars in the new collaboratives: patient safety, patient experience, clinical effectiveness and professional development. The organization has also supported training in Lean methodology and utilized these tools to streamline processes in several areas.

The amalgamation of a number of systems has occurred since the last survey including finance, payroll and e-mail. The intranet has been recently implemented. Funding has been received for some capital projects and upgrades. An information management plan has been developed to identify future needs in information management and technology. An electronic medical record (EMR) has been successfully implemented in community services and primary care at several sites. The adoption of an ethics framework is also noted. The need to utilize the framework in clinical and business decision-making is ongoing.

Progress has been made on standardizing processes such as the implementation of regional intravenous (IV) smart pumps. There also has been progress on packaging medications using a unit dose system. However, there is still wide variation across the regions and a need for standardization to provide consistency in quality and access to service delivery. The region is encouraged to share best practices across the region.

Patient safety initiatives including fall risk and pressure ulcer prevention programs have been developed and implemented.

Emergency medical services (EMS) has been restructured and is well-positioned to implement the changes recommended in the 2013 EMS provincial review.

NRHA has incorporated the MANIS program to ensure training and supports are in place for new and emerging leaders in the organization. This manager support, assistance and ability program is well received and is being operationalized. With the number of new managers in the organization, the support for this developmental opportunity is commendable. The workplace violence prevention program has been developed through significant consultation with provincial partners. The organization is commended on their plans to foster train-the-trainer development with an implementation plan for fall 2014.

A comprehensive critical occurrence reporting system is in place and has been disseminated and utilized by front-line staff.

The introduction of the clinical resource nurse on select units has provided additional support and liaison of front-line staff with management. This practice model is a valued resource across the region.

Several Lean initiatives have been implemented across the organization such as the project completed at the Flin Flon General Hospital medicine unit's clean supply room and redesign of the critical occurrence reporting system. Other initiatives are in development. Other Initiatives such as St. Anthony's General Hospital's upcoming designation as a baby friendly hospital and the regional tuberculosis program are innovative and progressive. In diabetes care, the addition of foot care, retinal screening and the introduction of innovative ways to address no-shows is commendable.

Currently, the region is in transition with regards to policy and procedure development. A number of policies and procedures exist across the region and there is an opportunity for standardization given that some are site-specific and others are regional. Many policies require updating with evidence-based information relevant to practice. It is recognized that the region has made an effort to draft a number of new policies for consistent practice; however, these are not widely understood or disseminated.

A number of risks have been identified in the region. NRHA would benefit from a risk assessment and mitigation plan. Safety and security risks were identified at all sites with some requiring priority for review including The Pas' community-based mental health services and security officer access at acute care facilities.

Currently a number of interdisciplinary team positions remain vacant. A regional recruitment and retention strategy and plan would be of significant value.

Subsequent to the NRHA’s completion of a strategic plan, department and service teams require formalized operational plans with measurable, goals and objectives. The region lacks a performance measurement framework inclusive of indicators, data collection and measurement. Data collection and capacity is a challenge with some audits requiring manual data collection.

Communication has been identified as a priority throughout the accreditation process and across the region internally and externally. Suggestions for improvement have included clarity of roles, responsibilities, and consistent dissemination of information. Broader community engagement is encouraged.

Several service areas identified access to professional development as a barrier. The region is encouraged to identify mechanisms and process to address this challenge such as the use of videoconferencing and webinars.

To ensure a population needs based approach is addressed, NRHA requires an enhanced focus on First Nations awareness training and education for all staff, including physicians.

The organization is encouraged to continue their efforts to create one region and increase standardization of processes and sharing the excellent practices that are found in pockets across the region.

Section 2 Detailed Required Organizational Practices Results

Each ROP is associated with one of the following patient safety goal areas: safety culture, communication, medication use, worklife/workforce, infection control, or risk assessment.

This table shows each unmet ROP, the associated patient safety goal, and the set of standards where it appears.

Unmet Required Organizational Practice	Standards Set
Patient Safety Goal Area: Safety Culture	
Client Safety Quarterly Reports The organization's leaders provide the governing body with quarterly reports on client safety, and include recommendations arising out of adverse incident investigation and follow-up, and improvements made.	· Leadership 15.11
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.	· Medicine Services 15.4 · Ambulatory Care Services 17.4 · Obstetrics Services 18.4
Two Client Identifiers The team uses at least two client identifiers before providing any service or procedure.	· Emergency Medical Services 16.8
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.	· Medication Management Standards 14.6
Safe Surgery Checklist The team uses a safe surgery checklist to confirm safety steps are completed for a surgical procedure.	· Operating Rooms 6.8

Unmet Required Organizational Practice	Standards Set
Medication reconciliation at care transitions With the involvement of the client, family, or caregiver (as appropriate), the team generates a Best Possible Medication History (BPMH) and uses it to reconcile client medications at ambulatory care visits where the client is at risk of potential adverse drug events*. Organizational policy determines which type of ambulatory care visits require medication reconciliation, and the how often medication reconciliation is repeated. *Ambulatory care clients are at risk of potential adverse drug events when their care is highly dependent on medication management OR the medications typically used are known to be associated with potential adverse drug events (based on available literature and internal data).	· Community-Based Mental Health Services and Supports Standards 12.4 · Emergency Department 8.4 · Ambulatory Care Services 8.4
Patient Safety Goal Area: Medication Use	
Heparin Safety The organization evaluates and limits the availability of heparin products to ensure that formats with the potential to cause harmful medication incidents are not stocked in client service areas.	· Medication Management Standards 9.3
Antimicrobial Stewardship The organization has a program for antimicrobial stewardship to optimize antimicrobial use. Note: Beginning in January 2013, this ROP will only apply to organizations that provide inpatient acute care services. For organizations that provide inpatient cancer, inpatient rehab, and complex continuing care services, evaluation of this ROP will begin in January 2014.	· Medication Management Standards 2.3
High-Alert Medications The organization implements a comprehensive strategy for the management of high-alert medications.	· Medication Management Standards 2.5
Patient Safety Goal Area: Infection Control	
Infection Rates The organization tracks infection rates; analyzes the information to identify clusters, outbreaks, and trends; and shares this information throughout the organization.	· Infection Prevention and Control 1.2

Unmet Required Organizational Practice	Standards Set
Hand-Hygiene Compliance The organization evaluates its compliance with accepted hand-hygiene practices.	· Infection Prevention and Control 6.5 · Emergency Medical Services 8.8
Patient Safety Goal Area: Falls Prevention	
Falls Prevention Strategy The team implements and evaluates a falls prevention strategy to minimize client injury from falls.	· Ambulatory Care Services 17.2
Patient Safety Goal Area: Risk Assessment	
Pressure Ulcer Prevention The team assesses each client's risk for developing a pressure ulcer and implements interventions to prevent pressure ulcer development.	· Surgical Care Services 7.9
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.	· Surgical Care Services 7.7

Section 3 Detailed On-site Survey Results

This section provides the detailed results of the on-site survey. When reviewing these results, it is important to review the service excellence and the system-wide results together, as they are complementary. Results are presented in two ways: first by priority process and then by standards sets.

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 includes criteria from a number of sets of standards that 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 IN THIS SECTION: The tables show all unmet criteria from each set of standards, identify high priority criteria (which include ROPs), and list surveyor comments related to each priority process.

High priority criteria and ROP tests for compliance are identified by the following symbols:

!	High priority criterion
ROP	Required Organizational Practice
MAJOR	Major ROP Test for Compliance
MINOR	Minor ROP Test for Compliance

3.1 Priority Process Results for System-wide Standards

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

Some priority processes in this section also apply to the service excellence standards. Results of unmet criteria that also relate to services should be shared with the relevant team.

3.1.1 Priority Process: Governance

Meeting the demands for excellence in governance practice.

Unmet Criteria		High Priority Criteria
Standards Set: Governance		
2.5	New members of the governing body receive an orientation before attending their first meeting.	
3.1	The governing body uses the ethics framework and evidence-informed criteria to guide decision making.	!
4.2	When developing or updating the mission statement, the governing body and the organization's leaders seek input from organization staff and stakeholders, including partners and clients.	
8.6	When reviewing and approving resource allocation decisions, the governing body assesses the risks and benefits to the organization.	!
8.7	When approving resource allocation decisions, the governing body evaluates the impact of the decision on quality and safety.	!
8.8	The governing body anticipates the organization's financial needs and potential risks, and develops contingency plans to address them.	
10.6	The governing body regularly consults with and encourages feedback from stakeholders and the community about the organization and its services.	
11.4	The governing body ensures that an integrated risk management approach and contingency plans are in place.	!
11.5	The governing body monitors and provides input into the organization's strategies to address client flow and variations in service demands.	
12.2	The governing body monitors data to assess the organization's performance and the achievement of the strategic plan.	
12.3	The governing body identifies opportunities for improvement and monitors the actions taken to address them.	

13.6	The governing body regularly evaluates the performance of the board chair based on established criteria.	!

Surveyor comments on the priority process(es)

The organization is to be commended on its efforts to create one region and implement the foundation for building the future. A Board has been appointed and members provided with education to support their role. They have clearly identified roles, responsibilities and by-laws, and a mandate to provide strategic direction to the organization.

A governance model has been adopted. The Board has developed a new vision, mission and value statement for the organization as well as a strategic plan. To provide regular reporting on performance measures, a dashboard has been implemented. Several board committees have been developed to support ongoing monitoring. The monitoring and evaluation processes are at very early stages of implementation.

The Board has adopted an ethics framework. They also have implemented a board evaluation process for self-evaluation.

The Board has identified several challenges. Jurisdictional issues with aboriginal health care funding and service delivery need to be addressed. Innovative partnerships and other efforts have been made to address aboriginal health issues. The organization has a Vice President of Aboriginal Affairs. This position will be very important to provide leadership to address issues of aboriginal health and cultural safety in the region.

There are financial pressures as well as other risks that will need to be addressed. A comprehensive risk assessment is needed to identify priorities and strategies developed to mitigate risk to the organization. High risk areas will need to be addressed with a degree of urgency.

There is a need and opportunity to communicate and engage more frequently with community partners. The organization needs to communicate the positive efforts and achievements to the community as well as engage them in mutually beneficial relationships.

There appears to be a wide variation in access and quality of service delivery across the region as well as service demands. The organization is encouraged to implement utilization reviews, monitor client flow, look at opportunities for reallocation of resources and develop alternate models of service delivery to address gaps in service and barriers.

The organization needs to continue with efforts to create one region and standardization across the services. A great deal has been achieved but many initiatives are in the early stages of implementation.

3.1.2 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: Leadership		
4.11	The organization's policies and procedures for all key functions, operations, and systems in the organization are documented, authorized, implemented, and up to date.	
6.1	The organization's leaders develop annual operational plans to support the achievement of the strategic plan, goals, and objectives, and to guide day-to-day operations.	!
6.2	When developing the operational plans, the organization's leaders seek input from staff, service providers, volunteers, and other stakeholders, and communicate the plans throughout the organization.	
6.3	The operational plans identify the resources, systems, and infrastructure needed to deliver services and achieve the strategic plan, goals and objectives.	
6.4	The organization's structures and services or program areas are designed, implemented, and adjusted as required to support service delivery and achievement of the operational plans.	
6.6	The organization's leaders select management systems and tools to monitor and report on the implementation of operational plans.	!
12.1	The organization's leaders use a structured process to identify and analyze actual and potential risks or challenges.	!

Surveyor comments on the priority process(es)

The organization is now two years into amalgamation and they have successfully developed a new vision, mission, values and logo to support branding a new identity and direction for Northern Regional Health Authority (NRHA). The work to date will provide the foundation for future initiatives and to improve service delivery and quality of care.

A collaborative structure has been implemented using four pillars of patient safety, patient experience, clinical effectiveness and professional development. This has helped align several initiatives and working groups with the NRHA strategic priorities, Manitoba Health goals, Accreditation Canada's Required Organizational Practices, and quality and risk management.

Data was utilized from two previous community health assessments to create a new regional health profile and NRHA is now preparing for the next assessment process. This information has been used in planning and community engagement. NRHA is commended for its innovative partnerships with aboriginal communities

such as with the Opaskwayak Cree Nation. The development of the Local Health Involvement Groups (LHIGs) will provide a forum for broader community input and engagement in the planning processes.

The change process has been challenging with a quick merger announcement; however, going forward, the planning and design of change processes is intended to be better anticipated and operationalized.

The leadership team is in early stages of implementation for many processes and has not fully developed operational plans with broad stakeholder input and identification of resource requirements to fully achieve the strategic plan, goals and objectives. The monitoring and evaluation of programs and progress on strategic goals and objectives is somewhat limited in current capacity for data collection and level of standardization.

NRHA established a transitional policy where existing policies are in place until there is an opportunity for review and adoption. Policy updating is very much a work in progress and will need to be a priority to support program delivery.

The development and implementation of operational plans and performance measurement is required at all levels of the organization.

Manitoba Health is formalizing the risk management reporting structure. In the interim, the organization is reporting to the Board on a number of complaints, occurrences, critical incidents, Manitoba Health reporting requirements on provincial initiatives, potential legal claims and service interruptions. Further development of risk assessment and prioritization is urgently required.

The team feels they have made progress in creating readiness for change, an increase in comfort in reporting of critical incidents, and a changing culture to support patient safety. The work on the collaboratives and Lean projects has created positive energy in the organization. There are challenges to supporting the change processes, continuing to build capacity in the organization in areas such as Lean methodology training, and having broad ownership of quality and risk management; however, NRHA is staged to address the challenges and lead forward successfully.

3.1.3 Priority Process: Resource Management

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

Unmet Criteria		High Priority Criteria
Standards Set: Leadership		
8.1	The organization's leaders, working with the governing body where applicable, make resource allocation part of the regular planning cycle.	
8.5	The organization's leaders follow set criteria to guide resource allocation decisions.	!
8.9	The organization's leaders monitor the budget and generate regular reports on financial performance.	

Surveyor comments on the priority process(es)

NRHA has completed the merger to one financial system and charter of accounts. The reporting systems are not yet in place. Variance reporting to managers is targeted to be implemented July 2014. Payroll system has just amalgamated and scheduling systems are still in development. This has challenged the regular budget planning cycle and budget monitoring.

There are appropriate financial policies and procedures in place as well as a robust budgeting process. A balanced budget is submitted and approved by the Board. There is limited contingency in place to offset unforeseen liabilities.

There is ongoing monitoring and reporting of the budget to the Board and managers. Capital planning is developed and submitted to Manitoba Health for approval. There are considerable financial challenges giving the ongoing program pressures, capital requirements and limited available funds to reallocate resources within.

There are no outstanding requirements from the financial audit. The current financial position is a concern to sustain program and services at the current funding level. Efforts to improve utilization and increase efficiency in operations is ongoing particularly in supply and support costs.

The organization is encouraged to review utilization and look at opportunities to increase efficiency and reallocate resources where needed. Staff vacancies and accounting systems have presented significant challenges over the last two years and staff are commended for their efforts to overcome the obstacles and provide appropriate support for resource management within the organization.

3.1.4 Priority Process: Human Capital

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

Unmet Criteria		High Priority Criteria
Standards Set: Leadership		
10.6	The organization's leaders ensure that position profiles for each position are developed and updated regularly.	
10.10	The organization's leaders implement policies and procedures to monitor staff performance that align with the organization's mission, vision, and values.	!
10.12	The organization's leaders conduct exit interviews and use this information to improve performance, staffing, and retention.	

Surveyor comments on the priority process(es)

There is a governance and leadership focus on the integration and amalgamation of the two former health entities, with a strong focus on the sensitivity of the staff and communities on becoming one health region. Some good examples of strategies and actions are a focus to form LHIGs and mechanisms to support virtual teams, such as the intranet.

The human resources strategic plan (2014-2019) has recently been completed by the human resources (HR) team. There is good alignment with NRHA's strategic directions as a "sustainable and innovative" organization, and as an employer of choice.

NRHA has identified a focus on retention and recruitment as a priority in the 2013-2016 strategic plan with the goal of "Being an Employer of Choice." Several key indicators have been selected including cultural awareness training, sick time, workers compensation rates and performance reviews completed/sustaining.

NRHA is commended for its interest in providing support, education and development for leadership capacity and capabilities throughout the organization. An advanced program for all managers is in the process of being rolled out for manager training (support and assistance program) and ability management as a result of the organization's survey and results. One significant area of concern was specific to "bullying in the workplace," noted by both managers and staff. A respectful workforce training program will be rolled out across the region with a planned effort to resurvey in early 2015.

The region has recently hired a nurse educator that is leading the development of education and eLearning.

The region and team are commended to the workplace assessment survey, completed in May 2013, which has provided them with several results to focus their strategic priorities. Some specific strategies and actions have been identified in the work plan for HR and the organization is encouraged to implement these as planned.

There is good development of policies as required; however, significant opportunity exists to collaborate and consult in their development, in addition to enhancing communication of the policies and education to

facilitate implementation, monitoring and evaluation. Many of the policies are draft and or very new requiring an implementation and communication plan.

Opportunity exists to ensure records are completed on a consistent basis with a checklist of documents completed that are current and stored with dates, including the completion of regular performance reviews for all staff.

Several key indicators have been developed, and are being tracked and reported in a dashboard format to the Board and posted for staff, including attendance, turnover, attraction and Workers Compensation Board of Manitoba rates. The team is encouraged in its efforts to continue to track these and address performance.

3.1.5 Priority Process: Integrated Quality Management

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

Unmet Criteria		High Priority Criteria
Standards Set: Leadership		
12.2	The organization's leaders implement an integrated risk management approach to mitigate and manage risk.	!
12.5	The organization's leaders evaluate the effectiveness of the integrated risk management approach and make improvements as necessary.	
12.6	As part of the integrated risk management approach, the organization's leaders follow established policies and procedures for selecting and negotiating contracted services.	
12.7	As part of the integrated risk management approach, the organization's leaders evaluate the quality of contracted services.	
15.11	The organization's leaders provide the governing body with quarterly reports on client safety, and include recommendations arising out of adverse incident investigation and follow-up, and improvements made. 15.11.3 There is evidence of the governing body's involvement in supporting the activities and accomplishments, and acting on the recommendations in the quarterly reports.	ROP **MINOR**
16.3	The organization's leaders require, monitor, and support service, unit, or program areas to monitor their own process and outcome measures that align with the broader organizational strategic goals and objectives.	!

Surveyor comments on the priority process(es)

The integrated quality management team has realigned positions and structures to support quality management in the new regional structure. The organization has merged cultures and developed four collaboratives, including patient safety, patient experience, clinical effectiveness and professional development, as pillars to support quality improvement (QI) initiatives. They have implemented quality boards in all departments across the organization to communicate and demonstrate ongoing improvements. Safety learning summaries have also been developed and disseminated.

NRHA has supported capacity building with two patient safety coordinators now in place, several staff trained in Lean methodology and engagement of staff in quality initiatives. Staff are proud of the progress made in increased understanding of patient safety and efforts to create a "just culture."

The redevelopment of the occurrence reporting system and use of the Lean process to streamline and improve reporting is commended. Efforts have been made to promote patient advocacy and involve patients and staff in the processes. Additional efforts to close the loop of reporting and ensure there is feedback on incidents reported by staff and families are noted.

The QI work plan as well as indicator development across programs are in early development. The team is aligning their work with the work of Manitoba Health in performance measure reporting. Some comparison is done with other regions using the Manitoba RHA Indicators Atlas.

Data collection and reporting capacity is with antiquated systems and, in many cases, manual data collection is challenging. There are limited resources to support audit collections and analysis. Culture and language barriers are challenged to develop regional processes in areas such as staff and patient engagement.

The organization is strongly encouraged to complete a comprehensive risk assessment, identify priorities, develop action plans to mitigate risks, and develop target time frames for completion. There needs to be an urgent response to some risk areas identified.

The team is commended for their efforts to support QI in the organization.

3.1.6 Priority Process: Principle-based Care and Decision Making

Identifying and decision making regarding ethical dilemmas and problems.

Unmet Criteria		High Priority Criteria
Standards Set: Leadership		
1.6	The organization's leaders assign and monitor accountability for the ethics framework and the processes to address ethics issues.	
1.8	The organization's leaders have a process for gathering and reviewing information about trends in ethics issues, challenges, and situations.	

Surveyor comments on the priority process(es)

A well-established ethics committee is in place whose main role is to support the development and utilization of the ethics framework, increase awareness of ethical issues and build ethics capacity in the organization.

Several strategies, such as Lunch and Learn presentations, ethics as a standing agenda at staff meetings, and ethics workshops with an external ethicist, are in place to support their goals.

The committee is encouraged to look at methods to monitor progress on the operationalization and utilization of the ethics framework, and to assess the level of awareness and trends in ethical issues across the organization in both clinical and administrative situations.

The committee is now reviewing research projects as requested.

The committee is commended for their work to date on increasing dialogue on ethical issues in the organization.

3.1.7 Priority Process: Communication

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

Unmet Criteria		High Priority Criteria
Standards Set: Leadership		
7.5	The organization's leaders seek input from stakeholders on a regular basis to evaluate the effectiveness of their relationships with them.	
11.6	The organization's leaders regularly assess the quality and usefulness of the organizations' data and information, and improve the organization's information systems.	

Surveyor comments on the priority process(es)

As NRHA has evolved, there has been a strategic focus on communications, key messaging and utilization of various tools and strategies to disseminate information internally and externally to stakeholders. Key stakeholders, such as local media, have been identified in their efforts to build relationships and ensure timely messages get to the community. Summaries of Board meetings are distributed to staff and partners.

Various communication tools such as newsletters, monthly communiqués from the CEO ("Hello its Helga"), the website, intranet, e-mails, press releases, and updates to executive and managers have been developed. Some tools, such as the intranet and website, are in the early days of development.

Feedback from staff and the community has recognized an increase in communication in some areas. However, there are other areas that feel communication is not adequate and stakeholders do not know what is going on both internally and externally.

A new Privacy and Access Officer has been established to support privacy and confidentiality legislation.

An Information Management Plan (2013-2018) has been developed to identify information needs, including system and process development required for the future.

During this time of significant change, staff are commended for their efforts to address communication challenges and information management in the region with limited resources. Although there are continued challenges to provide timely and effective communication, organizational branding and foundation elements have been put in place. The organization is encouraged to continue to focus on communication as a priority.

Two focus group meetings were held with community partners representing various organizations within the broader community. Partners express that they would like more invitations and ongoing communication about programs they may be able to access throughout the region. They are appreciative of the invitations they receive to attend education and training sessions hosted by NRHA.

NRHA has partnered with the City of Thompson to share space in a civic building with for the purpose of offering wellness and rehabilitation programs to citizens in a location that is easily accessible. The working relationship between health region frontline staff and staff from other community agencies is described by community partners as respectful and professional. The support from a mental health nurse to assess clients in the cell block is very much appreciated.

Partners express concern about the lack of consistency and standardization in services provided. Access to family physicians and primary health care is also a voiced concern. However, others' experience is more positive and they see improvements in access. Partners identify language and cultural awareness as barriers to quality care. International physicians and health care providers who speak English as a second language are often difficult to understand.

Partners would like to see more collaboration and consultation with citizens and communities. Partners believe there is more opportunity for collaboration, community focus groups, and regular communication and reporting by NRHA on services being offered and regional improvements. There is some consensus among participants that the health care system should focus more on the patient experience. They identify jurisdictional issues and the northern transportation program as a barrier to access and quality care. Increased focus on aboriginal health is identified as a need.

There was a request for education to increase the understanding of clinician roles and responsibilities as there appears to be discrepancy in the role dependent upon the site, especially in public health nursing.

Interpretation of the privacy act has caused frustration and appears to vary across the province. An opportunity to dialogue on this issue with the RCMP would be mutually beneficial.

The process for making a complaint is not widely known by community partners or by community members. It is thought that the process should be more widely publicized.

The participation of NRHA in community events is appreciated.

3.1.8 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		
10.3	The team conducts and documents annual checks of the driving records of all persons who drive an EMS vehicle.	!

Surveyor comments on the priority process(es)

There is a committed facility maintenance staff to maintain an aging infrastructure, and provide preventive and ongoing maintenance for equipment in a timely manner. There are processes in place to identify and address occupational and worklife issues related to the built environment. There appears to be a positive and supportive relationship with clinical programs and staff.

The acute care experience survey identified the provision of a clean and quiet environment as area for improvement which was validated by the observations of surveyors. The cleanliness of facilities varied from site to site and from unit to unit.

There are space challenges across the region, particularly in waiting areas, which impact infection prevention and control, privacy and confidentiality. The corridors in Thompson General Hospital's emergency department (ED) are lined with stretchers and supply carts making navigation difficult. There are also challenges in medical device reprocessing with current plans to renovate in order to meet current standards.

Specifically at Thompson General Hospital, there are challenges to provide appropriate air handling with the breakdown of chillers. Ventilation accommodations have been implemented to support smudging in the chapel. Negative pressure capacity and isolation rooms are available for infection prevention and control risk in several areas. However, there is no isolation room in the Thompson ED, although there is an isolation room in the adjacent special care unit with shared staffing between the two units. The ED waiting room is very crowded with risk of cross-infection. Generally, the building is showing its age, and clutter and storage issues negatively impact the ability to clean which influences the overall patient care environment and experience. The level of cleanliness could be improved.

At St. Anthony's Hospital, the ED is congested, supply carts are in the short hall between the ambulance door and the main ER, and there are combined clean and dirty utility rooms in the ED.

At Flin Flon General Hospital, the ED ramp has been deemed unsafe for car traffic and EMS has to use an alternative access and elevator. This situation has been going on for approximately two years. Plans are in place to address the issue; however, in the interim, strategies to mitigate risk need to be implemented.

Several long-term care facilities were noted to be well maintained and clean. At the emergency medical services (EMS) site in The Pas, the garage and crew quarters are in a newer, modern building that is heated and cooled using a geothermal system. The environment is very clean and neat. The EMS garage and crew quarters in Flin Flon is clean and well organized.

Efforts have been made in the region to recycle where possible and reduce the impact on the environment. Accessibility has been assessed and, where possible, addressed to meet barrier-free standards.

Infection control processes are in place as part of any maintenance or capital project to meet current standards.

Current signage is from the previous health authorities. There is a process in place to develop a proposal with costs for updated signage for the region.

The physical environment department is encouraged to do a comprehensive infrastructure risk assessment of facilities, identify priorities and create a long-term plan for projected capital upgrades. The department is commended for their efforts to date to secure funding for capital projects and upgrades in a tight fiscal environment.

3.1.9 Priority Process: Emergency Preparedness

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

Unmet Criteria		High Priority Criteria
Standards Set: Emergency Department		
2.6	The team participates in regular practice drills of the emergency preparedness plan.	!
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.	
Standards Set: Leadership		
14.1	The organization's leaders develop and implement plans for preventing and mitigating potential disasters and emergencies.	!
14.2	The organization's leaders develop, implement, and evaluate an all-hazard disaster and emergency response plan to address the risk of disasters and emergencies.	!
14.3	The organization's leaders align the organization's all-hazard disaster and emergency response plan with those of partner organizations and local, regional, and provincial governments.	!
14.9	The organization's leaders develop and implement a business continuity plan to continue critical operations during and following a disaster or emergency.	
14.10	The business continuity plan addresses back-up systems for essential utilities and systems during and following emergency situations.	!

Surveyor comments on the priority process(es)

A regional disaster management coordinator position was created and filled one year ago. Since that time, efforts have focused on consolidating and modifying emergency plans already in existence into a regional emergency response plan.

The international emergency colour code and incident management system for responding to emergencies have been reaffirmed as important parts of the regional plan. The organization is encouraged to give thought to regional coordination in a scenario where multiple sites are involved in a disaster response and where there could conceivably be multiple incident command systems operating.

An overall plan to exercise emergency plans at facilities and sites within the region is in the beginning stage of development. Exercises of emergency response up to now have largely been limited to fire drills and mock code blues in some locations. A code green evacuation at a long-term care facility has also recently taken place. NRHA is encouraged to develop a multi-year plan to exercise all major emergency plans and involve facilities in those emergency response exercises.

The organization already demonstrates a good understanding of the QI process in its disaster responses and its exercises. Responses are documented, stakeholders and staff are involved in debriefing, areas of improvement are identified, and improvements are carried out.

The organization is encouraged to continue its collaborative work with stakeholders, including public health, to review and update its outbreak and pandemic plan.

Encouragement is given to continue to work on its risk assessment for emergencies and how risk can be minimized or prevented.

The organization is encouraged to continue to develop business continuity plans.

It is recommended the organization exercise its incident management system (IMS) when opportunities arise in order for key members of the IMS and senior leaders to gain familiarity with the IMS.

3.1.10 Priority Process: Patient Flow

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

Unmet Criteria		High Priority Criteria
Standards Set: Emergency Department		
2.4	The team's strategies to manage overcrowding include plans to manage clients when in-patient beds are unavailable.	
6.4	The team follows its protocols to manage overcrowding and surges before requesting aid from alternative health care sites or diverting ambulances.	
Standards Set: Emergency Medical Services		
19.4	The team has timely access to the patient's health record.	
Standards Set: Leadership		
13.1	The organization's leaders collect and analyze client flow information to identify barriers to optimal client flow, their causes, and the impact on client experience and safety.	
13.2	The organization's leaders use information about barriers to client flow to develop a strategy to build the organization's capacity to meet the demand for service and improve client flow throughout the organization.	
13.5	The organization evaluates the effectiveness and impact of the client flow strategy.	
Standards Set: Operating Rooms		
11.5	The operating room team contacts clients or follow-up service providers to help evaluate the effectiveness of the procedure and the post-surgical transition, and makes improvements to its services as appropriate.	!
Standards Set: Surgical Care Services		
6.7	The team uses a standardized process to prioritize and schedule elective procedures.	
Surveyor comments on the priority process(es)		

Optimizing patient flow in the facilities surveyed will require a more focused approach. Data should be collected to identify where bottlenecks exist in the system. Identifying targeted lengths of stay and wait times will help the organization set goals and measure where and when goals are being met or not being met. Barriers to meeting targets can then be identified and improvement plans developed to optimize patient flow. Staff should be included in this work and in sharing results.

There were examples of patients in stretchers in ED hallways and one patient did indicate he had received IV therapy in the ED waiting room.

It is recommended the organization develop written protocols for actions to take in the event of ED overcrowding and/or in-patient overcapacity. For example, pre-determined occupancy or numbers of emergency cases in the ED might be used to trigger an urgent meeting of stakeholders to problem-solve the situation.

Home intravenous (IV) therapy and dressing changes that could be carried out by home care are being done in the ED in Flin Flon and Thompson. EDs in all communities have a high percentage of low acuity visits that could be seen in a physician's office or primary health clinic. Access to family physicians or primary care providers such as nurse practitioners continues to be a gap identified by ED staff as well as patients and community partners.

Although staff identify they have a process for prioritizing elective surgery, there is no written protocol or procedure for how this is done and no written protocol on how to guide decision-making in the event of a problem or conflict.

Community partners identified concerns related to long wait times to see family physicians to the point that some are seeking primary health care outside the community.

3.1.11 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		
11.6	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		
13.1	The organization has written requirements for education, qualification, and competency of staff involved in the reprocessing of endoscopy devices.	!
Standards Set: Reprocessing and Sterilization of Reusable Medical Devices		
1.6	The organization has the right number and mix of staff to carry out its reprocessing and sterilization activities.	
3.3	The medical device reprocessing department is designed to prevent cross-contamination of sterilized and contaminated devices or equipment, isolate incompatible activities, and clearly separate different work areas.	!
3.5	The organization regulates the air quality, ventilation, temperature, and relative humidity, and lighting in decontamination, reprocessing, and storage areas.	
3.6	The organization selects materials for the floors, walls, ceilings, fixtures, pipes, and work surfaces that limit contamination, promote ease of washing and decontamination, and will not shed particles or fibres.	
5.1	The medical device reprocessing department is equipped with hand hygiene facilities at entrances to and exits from the reprocessing areas, including personnel support areas.	
5.2	The medical device reprocessing department's hand hygiene facilities are equipped with faucets supplied with foot-, wrist-, or knee-operated handles, or electric eye controls.	!
9.1	The team uses its most complex or challenging pack or container to verify that all devices can be sterilized.	!

The medical reprocessing units of the NRHA were assessed including The Pas, Flin Flon and Thompson. The physical space provided was adequate in all units, but not laid out according to strict criteria for medical reprocessing. In all units, the configuration was such that the pathways for unprocessed materials crossed with the sterile areas. This deficiency may be corrected with the proposed new site at Thompson. There are some areas not up to standard with defects in floor coverings and wall covering.

Flin Flon General Hospital has only one functioning reprocessor. It is due to be replaced soon. If it should malfunction, it would essentially shut down the hospital until repairs or alternate arrangements can be made.

The reprocessing staff is all properly certified. The only exception is at Flin Flon where the endoscopes are reprocessed by OR staff, which are not properly certified for reprocessing scopes, although they have demonstrated competence in dealing with the scopes. Personnel issues are adequately dealt with. Continuing medical education is ongoing. It is felt that more staff would be useful at Flin Flon General Hospital. Proper techniques and quality monitoring are followed. No major issues with technique or policies were identified.

3.2 Priority Process Results for Population-specific Standards

The results in this section are grouped 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

3.2.1 Standards Set: Populations with Chronic Conditions

Unmet Criteria	High Priority Criteria
Priority Process: Chronic Disease Management	
The organization has met all criteria for this priority process.	

Surveyor comments on the priority process(es)
Priority Process: Chronic Disease Management
NRHA is challenged with high rates of chronic disease, some of the rates being five to six times greater than other parts of the province. Other challenges include a population of people who may not be motivated to manage their condition, who do not show up for appointments, live in poverty and lack basic amenities. Despite these barriers, staff are positive and continue to look for innovative ways to help their clients. For example, the diabetic educators quickly noticed that individuals living with diabetes have a much higher attendance rate at retinal screening appointments so they arrange to meet with those clients after the drops are placed in their eyes and they need to wait for them to dilate. They realized the client is then a captive audience for approximately twenty minutes so they use this time to do education and monitoring. The tuberculosis (TB) program is another success story and Manitoba Health notes that the program is the best in the province outside of Winnipeg. Clients interviewed from these services (diabetes and TB) feel they are treated with respect by staff, included in care planning and very much appreciate the care they receive. The electronic medical record (EMR) has been a welcome addition and the team notes that they are now able to set tasks for monitoring which assists to practice to guidelines. In terms of improvements, the team needs to formalize their framework. There has been discussion about using the Expanded Chronic Care Model; the team is encouraged to use this model as it would provide excellent guidance. Finally, the team needs to formalize their goals at a program level and communicate those to all staff.

3.3 Service Excellence Standards Results

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

Priority processes specific to service excellence standards are:

Clinical Leadership

- Providing leadership and overall goals and direction to the team of people 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 and Tissue 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

3.3.1 Standards Set: Acquired Brain Injury 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 acquired brain injury services are measurable and specific.	
Priority Process: Competency		
4.10	Team leaders regularly evaluate and document each team member's performance in an objective, interactive, and positive way.	
Priority Process: Episode of Care		
3.5	The team develops standardized processes and procedures to improve teamwork and minimize duplication.	
10.5	The team has a process to evaluate client requests to bring in or self-administer their own medication.	
11.2	The team works with the client and family, other teams, services, and organizations to develop a comprehensive follow-up plan.	
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 acquired brain injury 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 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		
15.3	Staff and service providers participate in regular safety briefings to share information about potential safety problems, reduce the risk of error, and improve the quality of service.	!
15.5	The team identifies, reports, records, and monitors in a timely way sentinel events, near misses, and adverse events.	!

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

The acquired brain injury (ABI) program is one of two in the province that takes individuals with acquired brain injuries who are likely to show improvement with rehabilitation. The majority of staff do not have professional training but the manager is developing an internal education program that will give them recognized skills and provide them with some pride in achieving a more formal recognition of their knowledge of their program. The manager is a neuropsychologist. There is a 0.2 full-time equivalent (FTE) occupational therapist, a social worker, and a clinical neuropsychologist. The facility has five inpatient beds and clients receive rehabilitation for an average of 285 days.

There are definite criteria to be met before admission to the program; individuals must have potential for rehabilitation, no substance abuse and be medically stable. The program goal is to provide clients with the skills needed for independent living. Even though this is not always achieved, it is the goal.

Priority Process: Competency

The team provides 24/7 care to clients who have acquired brain injuries. During the day, an occupational therapist is on-site for one to two hours. An neuropsychologist is also available most days.

Priority Process: Episode of Care

The overall care provided by the ABI team is excellent. There is an aggressive occupational therapy program that has proven to be effective in improving care of these clients. There appears to be an effective partnership between the Thompson Clinic physicians and the ABI program. Acute care is immediately available at Thompson General Hospital. The clinical leader of the ABI program is working to develop learning opportunities for staff. A review of services is currently under way.

Consideration should be given to the development of a follow-up plan for all residents to better assess the success of the program.

Priority Process: Decision Support

The program provides excellent care but should consider applying clinical practice guidelines to assure best care.

Priority Process: Impact on Outcomes

The team may want to consider being more proactive in collecting successes and opportunities, and sharing them with staff, clients and families.

3.3.2 Standards Set: Ambulatory Care 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 ambulatory care services are measurable and specific.	
Priority Process: Competency		
3.5	The organization provides sufficient workspace to support interdisciplinary team functioning and interaction.	
3.7	The interdisciplinary team follows a formal process to regularly evaluate its functioning, identify priorities for action, and make improvements.	
4.9	Team leaders regularly evaluate and document each team member's performance in an objective, interactive, and positive way.	
Priority Process: Episode of Care		
3.4	The team develops standardized processes and procedures to improve teamwork and minimize duplication.	
7.1	When scheduling services, the team follows set criteria and gathers input from service providers so clients with the most urgent needs are seen first.	
8.4	With the involvement of the client, family, or caregiver (as appropriate), the team generates a Best Possible Medication History (BPMH) and uses it to reconcile client medications at ambulatory care visits where the client is at risk of potential adverse drug events*. Organizational policy determines which type of ambulatory care visits require medication reconciliation, and the how often medication reconciliation is repeated. *Ambulatory care clients are at risk of potential adverse drug events when their care is highly dependent on medication management OR the medications typically used are known to be associated with potential adverse drug events (based on available literature and internal data).	ROP
8.4.1	The organization identifies and documents the type of ambulatory care visits where medication reconciliation is required.	**MAJOR**
8.6	The team uses standardized clinical measures to evaluate the client's pain.	
Priority Process: Decision Support		

16.4	The team's research activities for ambulatory care services meet applicable research and ethics protocols and standards.	!
Priority Process: Impact on Outcomes		
17.2	The team implements and evaluates a falls prevention strategy to minimize client injury from falls.	ROP
17.2.1	The team implements a falls prevention strategy.	**MAJOR**
17.2.2	The strategy identifies the populations at risk for falls.	**MAJOR**
17.2.3	The strategy addresses the specific needs of the populations at risk for falls.	**MAJOR**
17.2.4	The team establishes measures to evaluate the falls prevention strategy on an ongoing basis.	**MINOR**
17.2.5	The team uses the evaluation information to make improvements to its falls prevention strategy.	**MINOR**
17.4	The team informs and educates clients and families in writing and verbally about the client and family's role in promoting safety.	ROP
17.4.1	The team develops written and verbal information for clients and families about their role in promoting safety.	**MAJOR**
17.4.2	The team provides written and verbal information to clients and families about their role in promoting safety.	**MAJOR**
Surveyor comments on the priority process(es)		
Priority Process: Clinical Leadership		

Ambulatory care services are quite different in patient populations. Both chemotherapy and dialysis care report through provincial agencies whose structures are well suited to ensuring that patients receive the right care at the right time. Both CancerCare Manitoba (CCMB) and the Manitoba Renal Program provide medical and interprofessional care to patients excluding chemotherapy.

The primary care hospital-based clinics are well run by enthusiastic managers who are committed to advanced access for patients to have family physicians by 2015. The regional manager provides exceptional mentoring and guidance. There is a medical director at the Flin Flon Clinic that works closely with the manager to develop the program.

The larger team should work to develop common goals and objectives that are specific and measurable that can be monitored quarterly and reported up to the senior leadership team.

Priority Process: Competency

Workspace and clinical space is cramped and uninviting in some areas in ambulatory care services. The Flin Flon Clinic is nicely renovated and has generous clinic space. Staff are trained on a regular basis in the operating of infusion pumps. The staff in dialysis and chemotherapy are trained in Winnipeg prior to coming to the The Pas clinic for location-specific training. It would benefit staff in this area to receive performance reviews. As the ambulatory program evolves, it is important for leadership to evaluate and understand the effectiveness of staffing patterns in providing these specialized programs.

Priority Process: Episode of Care

The surveyors visited a variety of ambulatory care services including cancer care, renal care, primary care, rehabilitation, pain management and audiology services. The chemotherapy programs are small ones that are staffed by one or two nurses; they are satellites of the CCMB program. All patient care is started in Winnipeg where the patient is diagnosed and a treatment plan is agreed upon. Staff follow CCMB protocols related to chemotherapy.

Haemodialysis is part of the provincial renal program. Nephrology support is in Winnipeg. All patients undergoing dialysis are initially assessed and on-boarded in Winnipeg. The team in each program in Winnipeg obtain a best possible medication history (BPMH).

On transfer to NRHA for either service, the teams send all relative information including lab test results, BPMH, physical and psychosocial assessment records, and any treatment received prior to chemotherapy or dialysis being started. Patients are triaged to ensure the wait time is within the target set and there has been no change in the patient's health status that warrants an earlier visit.

Primary care sites were also surveyed using the ambulatory care standards. The clinic setting in The Pas is not well suited to primary care. The exam rooms are open and voices carry easily. Until renovations are approved, the manager may want to investigate using white noise to help limit information being easily overheard. Flin Flon Clinic is a newly renovated space in the Flin Flon General Hospital. It has been designed appropriately. There is an electronic medical record in use in Flin Flon. As more data is entered and analyzed, it will become easier to look at patient flow and chronic disease management from a performance perspective. The community engagement group interview by other surveyors expressed concern about the availability of family physicians in Thompson. Under the leadership of their Director, the team is actively working on the Ministry's mandate for advanced access and the audacious goal to have a family physician for everyone person who wants one by 2015.

The ambulatory care clinic at The Pas is designed as both a specialist- and procedure-based service. The clinic provides short-term IV therapy, and the removal of lumps and bumps for family medicine.

Priority Process: Decision Support

Flin Flon Clinic has fully implemented a new electronic medical record. Currently, it is not interfaced with the hospital's laboratory information system. All lab tests must be scanned into the system. In some cases the full hard copy chart has been scanned into the electronic chart. The physicians and staff interviewed are very happy with the implementation outcome.

The cancer care and renal teams collect a lot of data but do not see the analyzed results coming back from CCMB and the Manitoba Renal Program respectively.

Work needs to be started to establish an interprofessional team to identify best practices in primary care and apply the concepts to quality improvement initiatives including producing policies and procedures to guide practice.

Priority Process: Impact on Outcomes

In most of the sites, there is a lack of written goals and objectives in any form. The teams understand the work they need to do and how it is aligned with organizational and provincial mandates but it is not documented. Consistently the information is held by one or two people on the team. The risk here is that it is difficult to maintain momentum if that particular person leaves and the wisdom and knowledge goes with them. In speaking with a number of the managers and staff, guidance in setting up goals and objectives with specific and measurable outcome indicators is most welcome. Falls prevention is not in place in most of the ambulatory settings in spite of the fact that those patients receiving chemotherapy or renal therapy often feel dizzy and unwell.

Analysis and investigation of near misses and critical events seem superficial. Providing training to the managers in how to conduct root cause analyses would be helpful in finding more sustainable solutions. Any recommendations that come forward should be shared with staff.

3.3.3 Standards Set: Community Health Services

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	
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	
13.1 The team is trained to identify, reduce, and manage risk.	!

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

The organization conducts a survey of the community every five years and it is due for 2014. The NRHA 2014 Community Survey can be completed in hard copy or online. As well, focus groups will be held. NRHA uses this information for planning purposes.

The team has many partners and they work well together to improve the lives and health of residents. There is some good work being done around HIV care, TB and increasing breastfeeding rates. The team is excited that the board recently approved harm reduction policies. NRHA may be the first region outside of Winnipeg to offer harm reduction supply distribution programs and the team is quite proud of this work.

Priority Process: Competency

Staff have the required education and credentials to do their work. They appreciate the recognition from their managers and provided the example of the "Big Catch" award. Team members believe their workload is fair. The organization needs to continue to get the job descriptions regionalized and share them with staff.

Priority Process: Episode of Care

The team works very hard to ensure they are successful in reaching clients. Clients are provided with taxi slips or bus passes. Snacks and bottled water are available for TB patients. Staff have been quite innovative in ensuring TB patients consistently take their medications for six to twelve months (depends on treatment regime).

There are some significant community challenges in terms of transportation, motivation, poverty and homelessness. The team is innovative in their ways to address some of these challenges. There is client advocacy on a daily basis, and a passion to improve and deliver high quality services.

Priority Process: Decision Support

An area of strength for the organization is that community staff are participating in a number of research initiatives such as "Towards Flourishing." Staff discussed the ethics approval process that needs to occur prior to data collection. Participation in research is valued by staff, and they need to be encouraged to publish results when possible.

The EMR has been a positive impact on staff and they look forward to completing implementation. One of the ways it benefits staff and clients is that staff can build-in clinical practice guideline monitoring in the form of tasks, which greatly enhance programs. One such program is the TB program.

Priority Process: Impact on Outcomes

The team has added safety as an agenda item in their regular team meetings. This has assisted to identify risks and strategize how to mitigate them; however, there could be improvements in the training provided to identify areas of risk.

3.3.4 Standards Set: Community-Based Mental Health Services and Supports Standards

Unmet Criteria		High Priority Criteria
Priority Process: Clinical Leadership		
1.3	The organization works to support and engage the families of the individuals it serves.	
1.8	The organization has established processes and policies to meet the diverse needs of the community.	
1.9	The organization regularly reviews service demands and utilization, and makes adjustments as necessary.	
2.5	The organization identifies the resources needed to meet its goals and objectives.	
Priority Process: Competency		
4.5	The team orients new staff members, volunteers, and peer support workers about their roles and responsibilities, and the goals and objectives of the organization.	
4.10	Team leaders regularly evaluate and document each staff member's performance in an objective, interactive, and positive way.	
4.11	The organization provides staff members with opportunities for additional training and education to improve their competency, skills and performance.	
5.3	The organization regularly evaluates the effectiveness of staffing and uses the information collected to make improvements.	
5.4	The team has a process for identifying, managing, and reducing safety risks to staff and service providers while delivering services.	
Priority Process: Episode of Care		
8.13	Service information provided to individuals, families, and referring organizations is in writing, easy to understand, and available in languages commonly spoken by the populations served.	
9.2	Staff and service providers have access to the appropriate expert consultation and advice as needed to complete a comprehensive assessment.	

12.4	When medication management is a component of care (or deemed appropriate through clinician assessment), and with the involvement of the individual, family, or caregiver (as appropriate), the organization generates a Best Possible Medication History (BPMH) and uses it to reconcile individual's medications.	ROP
12.4.1	The organization identifies and documents the types of individuals who require medication reconciliation.	**MAJOR**
12.4.2	At the beginning of service the organization generates and documents a Best Possible Medication History (BPMH), with the involvement of the individual, family, health care providers, and caregivers (as appropriate).	**MAJOR**
Priority Process: Decision Support		
18.1	The organization has a process to select evidence-based guidelines for its mental health services and supports.	!
18.2	The organization reviews its guidelines to make sure they are up-to-date and reflect current research and leading practice information.	!
18.3	The organization's process for guideline selection includes seeking input from staff, service providers, individuals, and families about the applicability of guidelines and their ease of use.	
Priority Process: Impact on Outcomes		
17.2	The team has procedures in place for reporting safety risks and trending and analyzing this information to improve safety.	
17.4	The organization's leaders encourage staff members to report concerns about safety.	
17.5	Staff and service providers participate in regular safety briefings to share information about potential safety problems, reduce the risk of error, and improve the quality of service.	!
17.8	The team identifies high-risk activities and implements verification processes to mitigate risk.	!
18.5	The organization shares benchmark and leading practice information with its partners and other organizations.	
20.2	The team regularly monitors process and outcome measures.	
20.6	The team shares evaluation results with staff, individuals, and families.	

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

Staff within community-based mental health services focus on client engagement and a strengths-based approach with assessment and care. Several good examples of a recovery orientation are evident in this service such as the overall philosophy of care and innovation with services delivery to coordinate with community agencies and programs, such as the RCMP, Rosaire House Addiction Centre in The Pas, aboriginal services and organizations, as well as others.

NRHA is incorporating information and data collected from the 2009-2010 community health assessment needs report with the former region(s), looking at mental health specific data including deaths from suicide and potential years of life lost.

A focus of the team and new leadership is to develop processes to identify, incorporate, utilize and evaluate care and services with evidence-based information. These actions are encouraged to further develop this service area.

Opportunity exists to review the services and program overall to identify priorities for program development. Staff report the need for aboriginal awareness training and access to aboriginal holistic approaches to care.

Priority Process: Competency

The program's leadership team is commended for their interest in developing a model and competencies for mental health that are based on evidence-based practices.

The organization provides opportunities for professional development; however, most team members report that additional training specific to mental health and treatment modalities is required. In addition, staff consistently report their interest and request to have clinical supervision built into the program.

Staff report current difficulties with large caseloads and a lot of stress with current responsibilities and expectations, posing an opportunity for an overall service and utilization review.

At The Pas Primary Health Care Centre, the environment is crowded, and staff counsel clients in their small, cramped offices as no other counselling space is available on-site. Staff are alone with clients and identify the significant safety risk present. There are no call buttons or distress line to access; no windows for colleagues to assess safety and risk; and, no clinical supervision of care. As this team is assessing very complex, and often acute walk-in clients, the organization is strongly encouraged to address this as an urgent safety risk.

Priority Process: Episode of Care

There is excellent incorporation of suicide assessment training and skill development to enhance community capacity in the team and throughout the region. Examples include Applied Suicide Intervention Skills Training (ASIST), mental health first aid and Safe TALK (reflected in NRHA's Annual Report (2012-13)).

The team has excellent processes and supports in place to ensure clients are transitioned to services as required. For example, in The Pas, for clients assessed as high-risk or suicidal, the team has access to assessment and triage services at the emergency unit and acute inpatient mental health unit. Community outreach staff are also on the team and community proctors provide assistance to clients.

With the high number of aboriginal clients in the region, opportunity exists for the region and/or teams to develop culturally appropriate services and supports, including the provision of information in languages spoken by the population.

Priority Process: Decision Support

This team does not have a process in place to review or incorporate evidence-based practices into care or service. Opportunity exists to review the program overall to introduce new processes, mechanisms and practices.

Priority Process: Impact on Outcomes

A focus of the team and new leadership is to develop processes to identify, incorporate, use and evaluate care and services with evidence-based information. These actions are encouraged to develop this service area. A significant opportunity for this team overall is the identification of performance and outcome measurements and processes.

The team has identified several high-risk safety concerns at The Pas Primary Health Care Centre, as previously mentioned. The organization is encouraged to address these concerns and implement mitigating strategies.

3.3.5 Standards Set: Emergency Department

Unmet Criteria		High Priority Criteria
Priority Process: Clinical Leadership		
1.3	The team uses the information it collects about clients and the community to define the scope of its services and set priorities when multiple service needs are identified.	
1.8	The team collaborates with its partners to develop resource-sharing arrangements to offer safe and effective services for each client and family.	
1.9	The team regularly reviews its services and makes changes as needed.	
2.1	The team works together to develop goals and objectives.	
2.2	The team's goals and objectives are linked to benchmarking of bed availability in the Emergency Department, time to admission, client diversion to other facilities, and wait times.	
2.8	The team has access to equipment and supplies appropriate for pediatric clients.	!
2.9	The team has the workspace needed to deliver effective services in the Emergency Department.	
15.2	The team identifies, manages, and isolates clients with known or suspected infectious diseases.	!
Priority Process: Competency		
3.6	The interdisciplinary team follows a formal process to regularly evaluate its functioning, identify priorities for action, and make improvements.	
4.8	The organization trains the team on how to prevent workplace violence.	
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.	

8.4	With the involvement of the client, family, or caregiver (as appropriate), the team generates a Best Possible Medication History (BPMH) and uses it to reconcile client medications at transitions of care.	ROP
8.4.1	Upon or prior to admission, the team generates and documents a Best Possible Medication History (BPMH), with the involvement of the client, family, or caregiver (and others, as appropriate).	**MAJOR**
8.4.2	The team uses the BPMH to generate admission medication orders OR compares the Best Possible Medication History (BPMH) with current medication orders and identifies, resolves, and documents any medication discrepancies.	**MAJOR**
8.4.4	The prescriber uses the Best Possible Medication History (BPMH) and the current medication orders to generate transfer or discharge medication orders.	**MAJOR**
8.4.5	The team provides the client, community-based health care provider, and community pharmacy (as appropriate) with a complete list of medications the client should be taking following discharge.	**MAJOR**
8.5	The team has 24-hour access to diagnostic imaging and laboratory testing and results.	
Priority Process: Decision Support		
12.3	Staff and service providers have timely access to the client record.	
14.1	The organization has a process to select evidence-based guidelines for Emergency Department 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		
14.5	The team shares benchmark and best practice information with its partners and other organizations.	
15.1	The team is trained to identify and manage physically threatening or violent clients in the Emergency Department.	!
16.1	The team identifies and monitors process and outcome measures for its Emergency Department services.	!
16.2	The team monitors clients' perspectives on the quality of Emergency Department services.	

16.3	The team compares its results with other similar interventions, programs, or organizations.	!
16.5	The team shares evaluation results with staff, clients, and families.	

Priority Process: Organ and Tissue 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).	

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

The development of the clinical resource nurse position has been a success in the larger emergency departments (EDs). Staff and physicians have identified that communication and addressing of minor issues has improved.

There is a need for strong medical leadership in the region's emergency services. The current structure does not appear to be effective as questions and concerns regarding clinical practice issues are going un-addressed. It is unclear to staff which certifications physicians must have to work in the ED.

There are also gaps noted in the overall leadership of emergency services, the development of goals and objectives, monitoring of service outcomes and client satisfaction with the services.

Priority Process: Competency

There is strong evidence of a good relationship between EMS and the EDs surveyed. Relationships with staff on inpatient units is also positive.

Nursing staff receive orientation and certification in advanced cardiovascular life support (ACLS), pediatric advanced life support (PALS), the Trauma Nursing Core Course (TNCC) and pediatric emergency nursing. Certifications are documented and kept in personnel files.

The organization is encouraged to look at ways to promote medical participation in multidisciplinary planning and decision-making.

Priority Process: Episode of Care

Patients are expected to register first at admitting in Flin Flon General Hospital and The Pas. They are then are seen by a registered nurse (RN) who triages them following an initial assessment and the assignment of a Canadian Triage and Acuity Scale (CTAS) score. The areas where triage is occurring lack privacy and there is a risk of confidentiality being breached.

Space in the three largest EDs is not conducive to patient care. There is not enough storage space therefore hallways are used to store equipment and supplies. Clean and dirty utility rooms are co-located.

The large yellow sharps containers used in the EDs do not have an acceptably secure lid. Lids can be easily removed and sharps accessed. It is recommended that materials management source a sharps container with a lid that is secured with the inability to reach in and remove sharps.

Priority Process: Decision Support

The organization is encouraged to promote the review and use of evidence-based care guidelines for use in the EDs. This work would be best carried out by an interdisciplinary team that includes medical staff representation. There is an opportunity to take a regional approach to the development of these guidelines.

Priority Process: Impact on Outcomes

It is recommended the team work together with EMS and admitting and health records to establish a regional policy and procedure for determining how to identify clients who are unable to verify their identity. For example, gender, patient number plus an admission number could be used on admission records and wristbands until actual identity can be confirmed.

It is recommended the team work on a strategy to evaluate the quality and safety of the services being delivered in the EDs.

Priority Process: Organ and Tissue Donation

NRHA has worked with Transplant Manitoba and it has been determined that the region's sites are too remote for organ donation to be considered. In addition, testing for brain death is not available.

3.3.6 Standards Set: Emergency Medical Services

Unmet Criteria		High Priority Criteria
Priority Process: Clinical Leadership		
3.1	The team has a communications policy for sharing information and raising awareness about emergency medical services.	
3.3	The team delivers injury prevention and health promotion sessions.	
3.4	The team meets cultural and language diversity within the community it serves.	
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		
7.1	The team leaders regularly evaluate the effectiveness of staff scheduling and make improvements.	
Priority Process: Episode of Care		
16.8	The team uses at least two client identifiers before providing any service or procedure.	ROP
16.8.1	The team uses at least two client identifiers before providing any service or procedure.	**MAJOR**
16.11	The EMS team members administering medications demonstrate competence to achieve the desired level of sedation, monitor patients to maintain level of sedation, and use resuscitation equipment.	
Priority Process: Decision Support		
	The organization has met all criteria for this priority process.	
Priority Process: Impact on Outcomes		
23.1	The team collects information about the quality of its services to identify successes and opportunities for improvement, and makes improvements in a timely way.	
23.4	The team monitors stakeholder, patient and family perspectives on the quality of its services.	
23.5	The team identifies and monitors structure, process, and outcome measures for its services.	

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

Priority Process: Medication Management

The organization has met all criteria for this priority process.

Priority Process: Infection Prevention and Control

8.8	The organization evaluates its compliance with accepted hand-hygiene practices.	ROP
8.8.1	The organization audits its compliance with hand hygiene practices.	**MAJOR**

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

In March 2013, the province released the findings of a comprehensive review of its EMS. All fifty-four recommendations identified in the Report were accepted by the government and implementation has begun. Ten working groups were established under the overall supervision of a provincial implementation task force.

The Provincial Office of the Medical Director has recently been established to provide medical oversight for standardizing training requirements, medical care, continuing education and quality improvement. NRHA is well-represented on a variety of committees reporting to the Provincial Medical Director, including the Clinical Practice Committee and the Operations Liaison Committee. The organizational structure for EMS is designed to support operations and implement new protocols and change.

There are two EMS dispatch systems within the geographical boundaries of the health region. The local dispatch service in Thompson is not linked to the provincial dispatch or Medical Transportation Coordination Centre (MTCC) and is a local historical system. EMS is provided in Thompson by a municipally owned and operated fire/EMS service. The plan is to migrate all EMS services in NRHA to the provincial dispatch system. Access to EMS is through a 911 or a 7-digit emergency number that connects the caller to the provincial dispatch centre.

In addition to the eight ambulance stations directly run by the region, there are eight stations in the region that have service purchase agreements with the organization.

Ambulance stations and vehicles surveyed are clean and well-organized. Staff believe they have sufficient and appropriate equipment to do their work safety and effectively. Processes are in place for inventory tracking and stocking. Medications are stored and tracked appropriately.

The organization is encouraged to continue to work on those policies and procedures staff need to carry out their work in a consistent and safe way. Regional policies that are intended for all services should identify any variations EMS may require. For example, the regional policy on two client identifiers is appropriate for facility-based care; however, community-based services such as EMS will need different processes in non-transfer types of calls. It is recommended that EMS, EDs and admitting/health records meet to decide on a standard and consistent way of identifying patients without document identification who are verbally unable to identify themselves.

EMS has a clear direction on where they are going and staff and managers within the service are looking forward to the changes that have started and are to come. Implementation of evidence-based care protocols that will be used province-wide is one major improvement that will enhance quality of EMS service in the region.

Data collection and analysis to evaluate quality and safety will be simplified following the implementation of the electronic patient care report; however, implementation does not appear to be imminent.

EMS staff are appreciated by community partners for the work they do. Partners also indicate that the participation of EMS in local community activities is valued.

Priority Process: Competency

EMS has a strict system of tracking continuing education and competencies. Staff are required to submit evidence of training and education in order to secure their provincial license.

It is recommended the organization continue its work on developing and implementing a comprehensive orientation program, complete with a mentoring component as a quality improvement initiative to improve staff orientation.

Priority Process: Episode of Care

The MTCC is not under the jurisdiction of the health region; however, EMS staff were able to provide some information on how the Centre operates and its protocols for dispatch and deployment of vehicles.

Work is ongoing at a regional and provincial level with respect to upgrading and enhancing treatment protocols and standardizing other aspects of EMS such as training, dispatch, deployment and quality assurance.

The EMS services visited in the survey voice commitment to their communities and providing an efficient safe quality service.

EMS management is committed to evaluating their services from a utilization perspective as well as from a quality perspective. The EMS review and work being done at the provincial level are giving momentum to the improvement work being done in EMS.

It is important to provide cultural awareness and sensitivity training for EMS staff and include this in the new orientation program being developed.

Priority Process: Decision Support

The province has taken the lead in developing evidence-based, best practice care protocols. This standardized approach to decision support is viewed by EMS as a progressive and welcome development.

Priority Process: Impact on Outcomes

The lack of an electronic patient care report does make analysis of outcomes difficult. The team is aware of the expectation that the quality of their service be monitored and improved where evidence indicates improvement is needed.

It is recommended that the team develop a continuous QI program that would focus improvement efforts on identified gaps in service or gaps in other aspects of its operation.

Priority Process: Medication Management

The team maintains a small number of controlled medications at doses that follow accreditation guidelines. These medications are kept in safes or locked cupboards within locked cupboards and there are several levels of oversight to ensure accurate tracking of the medications. Waste is witnessed and double-signed on the tracking record.

Priority Process: Infection Prevention and Control

EMS has a regional infection prevention and control (IPC) resource person to advise them on cleaning and disinfecting protocols for their vehicles and equipment.

It is recommended that the team draft IPC policies and procedures to support unique requirements of the EMS service equipment and vehicles.

The organization is encouraged to replace straps for long boards and other materials that are difficult to clean with equipment that can be more easily cleaned. The orange straps seen at the Flin Flon ambulance station are easy to clean and superior to the black straps with respect to cleaning.

3.3.7 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		
4.1	Each staff member has the necessary skills and training to perform their duties.	!
4.8	Staff members are trained to prevent and safely manage aggressive or violent client behavior.	!
4.9	The organization monitors and meets each staff member's ongoing education, training, and development needs.	
Priority Process: Episode of Care		
2.1	The organization uses a team approach to develop its goals and objectives.	
7.8	The organization follows a process to identify, address, and record all ethics-related issues.	!
8.7	Staff members wear an identity card when delivering services.	!
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.	
16.1	The organization identifies and monitors process and outcome measures for its services.	
16.5	The organization shares evaluation results with staff, clients, and families.	
Surveyor comments on the priority process(es)		
Priority Process: Clinical Leadership		
A community health assessment is completed every five years and is used to inform the organization about the trends and needs of the population. Information gathered at the local level is used to identify new		

services or programs required and/or the need to enhance or expand existing services. For example, rehabilitation aides have been added to the team to address the high need for clients to have physiotherapy.

The services provided in the home care program are in line with the organization's strategic directions of providing accessible quality health services and contributing to population health. The teams have contracted with Healthy Business Solutions to provide group exercises or one-on-one sessions with clients to improve their mobility.

The team has developed good relationships with internal and external partners. A close relationship has been established with First Nations leadership to ensure that clients receive service in a timely manner. There are opportunities to access services through telehealth that are not available in the local area such as speech language pathology services from Winnipeg.

The team is encouraged to identify measurable goals and objectives for home care with specific targets.

The home care team has a strong interdisciplinary focus. Teams in some areas are not as developed in the interdisciplinary team approach as others and are encouraged to continue to develop this model. Case conferences are held regularly with all members of the team involved in the client's service delivery. Regular team meetings are held to review and share information and plan for the service.

Staff report good support for their role development with access to professional development. Opportunities for input are supported, such as the involvement of the nursing case coordinator position in the development and implementation of the provincial guidelines for seniors' care in home care.

Clients and families are provided with verbal and written information about the services provided. Clients indicate that they are pleased with the information provided and indicate that they receive clarification of any questions.

There are standard assessments completed in all areas. A home care client assessment form and Kardex is completed as well as a home risk assessment on all clients. Clients are provided with a copy of the Safety First booklet. All incidents are reported via an occurrence report which is passed on to the manager. Staff indicate that they receive feedback on occurrences.

Safety for both staff and clients was identified as a priority. Staff indicate that any safety concerns are addressed in a timely manner and processes are in place to deal with aggressive clients. Clients indicate that corrective measures are taken to deal with any safety issues identified in the home.

Priority Process: Competency

Role descriptions are currently being reviewed and updated. Staff are aware of their roles and responsibilities; however, the managers indicate that performance reviews have not been done on a regular basis. The organization is encouraged to set a deadline to have job descriptions in place and work towards having performance reviews completed.

Case conferences are held with the interdisciplinary team to discuss client care.

Mandatory education is provided to staff annually. Staff receive non-violent crisis intervention training; however, it is not mandatory in all areas within the region. It is recommended that this be mandatory and that all staff be trained as this poses a risk to both staff and clients. Learning Essential Approaches to Palliative and End of Life Care (LEAP) and P.I.E.C.E.S. training for dementia is available. Currently, only

nurses receive CPR training. The team is encouraged to proceed with the plan to have health care aides complete CPR training.

There is a comprehensive orientation program for staff that includes orientation to home care service as well as a general organization orientation. The manager and staff identify training and education needs. There is no standardized written record of staff education that staff have completed. It is recommended that a record of staff education be kept on file and become part of the employee's file. Staff indicate that they are supported to attend training.

Mansis training for performance reviews has been completed by managers and coordinators. It is recommended that a plan to complete performance reviews on staff be implemented.

Staff are recognized through recognition lunches, employee of the month, acknowledgement for perfect attendance, recognition for individual achievements and an annual long service recognition event.

Staff complete assessments in the home to determine the level of client risk. Assessments completed include a home safety assessment, falls risk assessment and medication reconciliation. Two client identifiers are used. Many staff are trained in non-violent crisis intervention.

Priority Process: Episode of Care

The team has access to provincial standards of care which are assisting in the development of services, particularly as it relates to relates to seniors' care. There are no formal goals and objectives developed by the team for the home care service. The team follows the strategic directions from the organization but they are not specific to home care. It is recommended that the team develop goals and objectives for the home care service that are in line with the organization's strategic directions and, are measurable and time-specific.

There is excellent coordination of the interdisciplinary team on home visits for seniors with chronic disease. For example, coordination of care is provided by the nursing case coordinator, RN staff for insulin administration, and the health care aide for home supports and cleaning; in addition, consultation is provided by the dietician and diabetic team.

There is a case conference held with all members of the team providing service to the client to discuss care and share information. Information is shared among the team members on a regular basis to ensure the plan of care is coordinated and meets the client’s needs.

Service care plans are being introduced in the home, with medication records and progress notes of all visit encounters. This is in place in parts of the region. The team is encouraged to roll this out throughout the region.

The implementation of the case coordinator role was identified by the team as a significant improvement which resulted in having someone available to provide advice and address issues and coordinate the team to prevent gaps and avoid duplication.

Clients indicate that when they have issues, they are dealt with promptly and adequately. There is good client feedback specific to discharge planning and meeting with the home care staff in hospital, and subsequently in the client's home to assess and provide nursing care and support services.

A best possible medication history is generated on all clients in home care receiving medication. When the client receives services or is transferred for service, medications are reconciled on transfer.

Consents are obtained from the client's substitute decision maker when the client is unable to provide consent. Clients and families are actively involved and included throughout the assessment and service delivery. Support is provided to clients and their families to help them adjust. There is an on-call system in place after hours if clients have issues. A copy of the bill of rights and information on who to contact is provided to the family and client.

There is a regional ethics committee with representation from the various sites. There is an ethical framework for the organization; however, the team has not used it to deal with ethical issues and does not appear to have a clear understanding of their role and potential involvement with the service.

There is a standardized safety risk assessment conducted for all clients receiving home care services. Safety for clients and staff is a priority for the team. The team uses a photo of the client and name verification for identification. Clients indicate that they have been provided with written information around safety. When issues were identified regarding safety, staff explained the reason for and importance of taking measures to reduce the risk to the client and to the staff. One client identified the benefits of using a transfer belt to protect her safety and the staffs.

There is a policy that requires staff to wear identification (ID) cards. The region is in the process of updating cards and all managers and staff did not have the new ID cards and/or were observed to be not wearing them. It is recommended that ID cards be made available in a timely manner to ensure that staff are identifying themselves to clients and families.

Staff are aware of the policy to report incidents and indicate that they have completed occurrence reports. There are a low number of near misses reported in the home care service; however, it is not known if this is due to under-reporting or a low number. It is recommend that education on the importance of reporting near misses be provided to staff.

There is a standard transfer form that is completed on clients when they are moving from the home care service to another service. A telephone call is often used as well to discuss the client and follow-up after transfer.

Satisfaction surveys have been completed however managers and staff were not aware of the results. It is recommended that the results be shared with managers and staff.

Priority Process: Decision Support

The team follows legislation and NRHA's policy for protecting clients privacy and confidentiality. An incident involving a breech of client information was identified that resulted in a review and change in policy. The incident was disclosed to the clients impacted.

There are limited technology and information systems available in the home care services areas. Telehealth is used and enables specialists to consult regarding wound care, speech language pathology, and psychogeriatric assessments.

The team identified the need for technology to enhance the ability to document care in the home and for sharing among the team. The team is encouraged to develop a plan to introduce technology and information systems.

The team has access to provincial standards of care which are assisting in the development of services, particularly as it relates to seniors' care.

Priority Process: Impact on Outcomes

The home care team has developed a strategic plan and recognizes the need to address priorities and overall effectiveness. It is recommended that the team evaluate their effectiveness.

Case conferences are held regularly to review clients with staff and the client and/or family present. Safety and ways to reduce risks are discussed.

The chart is shared with the team providing care to the client. The care plan and progress notes are available online. A chart with information regarding the daily care provided is left with the client in areas; this has been implemented in some location and greater roll out is underway.

The home care teams coordinate services with the community mental health team and public health team.

The home care service has not identified outcome measures that they are monitoring to understand the impact of their services. It is recommended that outcome measures be identified, monitored and reported on regularly.

Information on occurrences is collected by the organization and is analyzed by site. This information has just recently been shared with the sites via the intranet; however, some managers and staff are not aware of this. It is recommended that information on critical indicators be shared with staff and used to identify areas for improvement.

The team has identified clear linkages with acute care and transition protocols are used to facilitate discharge planning to the community.

3.3.8 Standards Set: Infection Prevention and Control

Unmet Criteria			High Priority Criteria
Priority Process: Infection Prevention and Control			
1.2	The organization tracks infection rates; analyzes the information to identify clusters, outbreaks, and trends; and shares this information throughout the organization.		ROP
	1.2.3	Staff and service providers are aware of the infection rates and recommendations from outbreak reviews.	**MINOR**
1.3	The organization uses standard definitions and accepted statistical techniques to share and compare information about infections.		
1.4	The organization shares trends in infections and significant findings with other organizations, public health agencies, and the community.		
4.7	The organization reviews and updates its policies and procedures at least every three years, and as new information becomes available.		
5.1	The organization develops an IPAC education program that is tailored to the organization, its services, and client populations.		
5.5	The organization offers IPAC education and training to partners, other organizations, and the community.		
6.5	The organization evaluates its compliance with accepted hand-hygiene practices.		ROP
	6.5.1	The organization audits its compliance with hand hygiene practices.	**MAJOR**
	6.5.2	The organization shares results from the audits with staff, service providers, and volunteers.	**MINOR**
7.3	Information provided to clients and families is documented in the client record.		!
13.3	All endoscope reprocessing areas are physically separate from client care areas.		!
14.4	The organization's policies and procedures address how to manage new, rare, or problematic organisms, including antibiotic-resistant organisms.		
Surveyor comments on the priority process(es)			
Priority Process: Infection Prevention and Control			

Infection prevention and control (IPC) concerns report through a regional manager to a director and then to a vice president. This structure supports NRHA's commitment to keeping patients and families safe, and the workplace a safe environment for staff and physicians.

The organization tracks infection rates, and identifies clusters and outbreaks.The information is not widely shared and some managers who do receive the statistics are not sure how to interpret them in the context of patient care. At Thompson General Hospital, there is reporting of rates related to C/S infection, hand hygiene and housekeeping cleaning effectiveness, for example. Staff at Thompson is aware of infection rates.

The organization follows direction from Manitoba Health with regard to current and emerging IPC issues. Current hand hygiene posters do not reflect best current practices that staff, physicians, patients and visitors are taught to follow. The issue was identified by the IPC nurse months ago. There is an understanding that a consensus between sites must be reached before the posters can be changed.

When invited to attend staff meetings, the team shares current IPC research and best practices with frontline staff. The organization does not use medical or interprofessional teaching rounds where a focus on IPC could be undertaken. When asked for information, the team provides it enthusiastically. Presentations to the Board or senior management could prove very helpful. Public health plays a key role in educating the public with regard to communicable diseases and the importance of hand hygiene.

Using best practice as a guide, the IPC team is reviewing, revising or archiving policies and procedures in an effort to begin to standardize procedures across the region. It is recommended that the team continue to focus on getting all policies that are currently in draft approved and rolled out to the hospital staff and physicians as soon as possible.

It is recommended that the IPC nurses train managers and clinical resource nurses to conduct hand hygiene audits within their own or in other departments. The process and audit results need to be regularly discussed and owned by the appropriate clinician groups and departments in order to ensure accountability. Hand hygiene compliance could be an indicator that is reported on to the senior team on a quarterly basis. The team should distribute the analyzed results of hand hygiene practices to managers or in management forums. There are no medical teaching rounds where the results can be discussed. The results are discussed at the new IPC team meetings. The intranet is a new addition with the organization and would be a good vehicle to post results.

Some written information is at a very high literacy level.

Any person entering a NRHA location should be encouraged to self-screen for cough, fever, runny nose and aches. A sign in English and any other key language such as Cree should direct a person with these symptoms to wash their hands and put on a mask before entering the facility. For visitors, there is a sign asking them not to enter. It is recommended that permanent hand hygiene stations be placed at every entrance to the locations. At Thompson General Hospital, there are hand hygiene stations are entrances to the hospital.

The dietary staff receive leadership support from Aramark, a leader in the field of institutional food preparation and serving. All of the processes and procedures follow best practices such as monitoring of temperature of fridges and freezers, monitoring temperature of dishwasher water in cleaning cycle and cool down cycle, hand hygiene, hair coverage, cooling audits for high risk foods, and contracted vent hood cleaning. The dietary staff at each location follow procedures to the letter. All dietary staff must successfully complete a food safety course at a community college within six months of hire.

Laundry is done onsite at each hospitals visited. In each case, the clean and dirty functions are appropriately separated. The machines have regular preventive service to ensure the temperature meets the target levels. If the temperatures go out of range, there is an alarm. Laundry soaked with blood or body fluids is washed separately from regular soiled laundry to ensure there is no contamination.

Staff has been trained to immediately report and isolate patients complaining of recurrent diarrhea, unexplained or unexpected fever, and respiratory symptoms. The IPC nurse is then notified and the process of investigation begins as to whether a patient has a hospital-acquired infection.

There are designated isolation rooms on most hospital sites. Not all isolation rooms have negative pressure or HEPA air filters. In the event there is no designated isolation room, the patient is placed in a single room until IPC nurses determine if isolation must continue or the patient can be cohorted with another like patient.

The hospitals appear to provide a very clean environment in patient rooms, staff work and rest spaces, waiting areas and even in basement support areas. Patients interviewed voice their agreement with the cleaning of their rooms and bathrooms on a regular basis.

3.3.9 Standards Set: Long-Term Care 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 long-term care services are measurable and specific.	
Priority Process: Competency		
3.7	The team follows a formal process to regularly evaluate its functioning, identify priorities for action, and make improvements.	
4.11	Each team member's performance is regularly evaluated and documented in an objective, interactive, and positive way.	
Priority Process: Episode of Care		
8.10	The team monitors whether residents' service goals and expected results are achieved, and uses this information to identify and address barriers that are preventing achievement of goals.	
Priority Process: Decision Support		
The organization has met all criteria for this priority process.		
Priority Process: Impact on Outcomes		
16.4	The organization shares benchmark and best practice information with its partners and other organizations.	
18.3	The team compares its results with other similar interventions, programs, or organizations.	

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

The team has access to a community health needs assessment that is completed every five years. Information is reviewed on the demographic and care needs of the population as well as from wait lists to determine the type of services required to meet their needs.

The management team identified the need for a clinical coordinator position at The Pas. This has been implemented and there is positive feedback on the nursing leadership being provided to the team.

There are no formalized goals and objectives for the long-term care service across the region. Some facility managers have informal goals. It is recommended that the process for setting goals and objectives for the service as well as each site be formalized, shared with staff and monitored for progress.

There is good equipment available at the long-term care (LTC) sites to meet the residents' needs. Equipment identified as necessary to provide care is purchased either by the facility or through donated funds. For example, a new wheelchair accessible vehicle was purchased through donated funds for Northern Spirit Manor.

Student placements are supported in LTC. Licensed practical nurses (LPNs) and health care aides do their practicuums at several of the facilities. Nurses provide preceptorship for the LPNs and the LPNs for the health care aides.

Priority Process: Competency

Job descriptions are currently under redevelopment. Staff indicate that they are aware of their roles and responsibilities.

Teams work together; however, there is no formal process in place to evaluate services or outcomes. The team is encouraged to establish the proposed collaboratives which include patient experience and effectiveness, and clinical education and effectiveness.

The health care aides are required to have certification. Student placements are supported.

There is a comprehensive orientation for staff in LTC. A separate orientation process is in place for agency nurses.

Infusion pumps are not used in LTC.

Staff receive training on non-violent crisis education every two years and is required for all new employees. The facility has a violence flagging system for patients displaying aggressive behaviour. P.I.E.C.E.S. training is offered to staff.

Training is provided to staff on pressure ulcers, restraint/least restraint usage and falls prevention.

Clinical staff indicate they have had performance reviews but they have not been completed consistently. A new process for standardization of the review process is being developed. It is recommended that performance reviews be completed in a timely manner to provide feedback to staff.

Priority Process: Episode of Care

A comprehensive process is in place to provide information to families and residents. Clients and families interviewed during the tracer indicated they were aware of who was responsible for their care and knew who to contact if they had an issue or concern.

Feedback from residents and families across the sites visited was positive regarding response to requests for service or information. A comprehensive package of information is provided to families and residents on admission and it is reviewed during orientation to the site. When new information needs to be shared, there are mechanisms established for the site that are effective in reaching residents, families and other organizations. Family and resident councils are used frequently to share information and get feedback.

A comprehensive assessment is completed on admission within the first 24 to 72 hours. The interdisciplinary team including nursing, physicians, social work, recreation, physiotherapy, occupational therapy and dieticians complete assessments. An initial care conference is held with the family and resident within six months and then annually thereafter. Medication reviews are completed quarterly.

Residents and families are involved in assessments and the plan of care. Residents indicate they have a choice in how and when their care is provided.

The team uses a facial expressions pain assessment tool as well as monitors behaviours and expressions of residents that are cognitively impaired to identify pain.

The Eden model of care has been adopted. The plan of care for the resident is developed around a resident-centred philosophy which identifies what the resident wishes to achieve. This has replaced the goals and objectives approach to care planning.

The Bates-Jensen Wound Assessment Tool as well as the Braden Pressure Ulcer Risk Scale Tool are used. The team also uses pictures to monitor progress with treatment, and share with team members and wound specialists for advice regarding treatment. Any stage three ulcers has to be reported to Manitoba Health through the critical incident reporting process.

The interdisciplinary team records treatments and services in the residents' records. It is recommended that the team explore the possibility of moving to an electronic documentation system.

There is a policy on self-medication; however, the experience has been that residents have not requested to self-administer medications. There is a process for certain topical ointments and drops to be self-administered if the resident requests and is deemed capable.

The team explains cardiopulmonary arrest as part of the admission process. Residents are asked to identify the level of intervention they wish to have administered. This is documented and updated should the resident's condition change.

Consent is obtained prior to providing care. Separate consent is obtained for immunization and other invasive treatments. Implied consent is used for general care provision. All residents have an advanced directive completed which identifies the level of intervention desired on admission. The resident and/or family is educated on advance care planning and the goals of care. Regular reviews are done with the primary decision maker and/or resident.

All residents and families are provided with a copy of the bill of rights which outlines what residents can expect. Elders are consulted at the resident council meeting.

There is an ethical framework in place and a regional ethics committee with representatives from the sites. Ethical issues are discussed with the team and, if necessary, the manager is consulted.

There is a policy around least restraint use. Families and residents are provided with a copy of the policy on restraints and families are asked to sign when they wish for a restraint to be used.

There are recreation staff that provide a program of activities that meet the residents' needs. There are a variety of activities, both individual and group, to address the needs of the diverse population. There are volunteers who participate in the recreation program to assist with activities. Efforts are made by the team to engage families and the community in activities.

A server model is in place for food delivery in the larger facilities. There is a plan to move to an entrée model that will give residents more choice over their portions. A relaxed dining model has been adopted which allows residents to have a more leisurely dining experience. Overall, residents and family indicate that the food is good. First Nations residents are unable to access tradition meals such as moose and other wild game at the facility as there are provincial rules that prohibit the organization from cooking this type of meal. Families and friends are encouraged to bring in traditional meals for the residents and a space is provided for preparation.

Priority Process: Decision Support

The team has limited access to computers. Most information is shared manually. Some laboratory and diagnostic reports from Winnipeg are received electronically.

The team has access to Mosby's online for clinical practice guidelines and other research from the library and internet. Guidelines are reviewed to ensure they are current and updated. Resources from the region are used to update clinical practice guidelines for areas such as wound care.

An initiative from Manitoba Health to implement the MDS-RAI assessment tool electronically was temporarily put on hold due to resources.

Priority Process: Impact on Outcomes

The team identifies the appropriate staffing to meet residents' needs. Staffing levels were increased to address the level of care the residents required. A charge nurse position was put in place to provide oversight on the unit level and the help support the team.

Education and training is provided on equipment and appropriate techniques for handling and transferring residents.

Two client identifiers are used including a photo and confirmation by the resident of their name. If a resident is unable to identify themselves by name, staff confirm their identity through either knowing the resident or checking with another staff member for verification.

Benchmarking is not done with other facilities outside of the region. Northern Spirit Manor measures their progress on the Manitoba standards; however, this does not appear to occur in the other four long-term care homes that were visited.

There is a falls prevention strategy in place which has been adopted across the region. A falls risk assessment is completed on residents upon admission and, if interventions are put in place, they are documented in the care plan.

Residents and families are provided with an orientation on admission. A package of information around safety and the resident and family role in this is also explained face-to-face.

There are policies in place around near misses, sentinel events and adverse events. There are occurrence reports filed and reports are generated and provided back to the manager to share with staff.

The team is doing amazing work to maintain a high level of care. Benchmarking with similar organizations outside of the region would be beneficial.

3.3.10 Standards Set: Medication Management Standards

Unmet Criteria		High Priority Criteria
Priority Process: Medication Management		
2.3	The organization has a program for antimicrobial stewardship to optimize antimicrobial use. Note: Beginning in January 2013, this ROP will only apply to organizations that provide inpatient acute care services. For organizations that provide inpatient cancer, inpatient rehab, and complex continuing care services, evaluation of this ROP will begin in January 2014.	ROP
2.3.1	The organization implements an antimicrobial stewardship program.	**MAJOR**
2.3.2	The program includes lines of accountability for implementation.	**MAJOR**
2.3.3	The program is inter-disciplinary involving pharmacists, infectious diseases physicians, infection control specialists, physicians, microbiology staff, nursing staff, hospital administrators, and information system specialists, as available and appropriate.	**MAJOR**
2.3.4	The program includes interventions to optimize antimicrobial use that may include audit and feedback, a formulary of targeted antimicrobials and approved indications, staff training, antimicrobial order sets, guidelines and clinical pathways for antimicrobial utilization, strategies for streamlining or de-escalation of therapy, dose optimization, and parenteral to oral conversion of antimicrobials (where appropriate).	**MAJOR**
2.3.5	The organization establishes mechanisms to evaluate the program on an ongoing basis, and shares results with stakeholders in the organization.	**MINOR**
2.4	The interdisciplinary committee establishes procedures for each step of the medication management process.	!
2.5	The organization implements a comprehensive strategy for the management of high-alert medications.	ROP
2.5.1	The organization has a policy for the management of high-alert medications.	**MAJOR**
2.5.2	The policy names the individual(s) responsible for implementing and monitoring the policy.	**MINOR**
2.5.3	The policy includes a list of high-alert medications identified by the organization.	**MAJOR**
2.5.4	The policy includes procedures for storage, prescribing, preparation, administration, dispensing, and documentation for each high-alert medication, as appropriate.	**MAJOR**

	2.5.8 The organization provides information and ongoing training to staff on the management of high-alert medications.	**MAJOR**
2.15	The interdisciplinary committee develops a process to determine which medications can be stored in client service areas.	
2.16	The interdisciplinary committee monitors compliance with each step of the medication management process.	
3.4	The interdisciplinary committee ensures that there is a process in place to inform staff and service providers about any changes to the formulary.	!
4.2	If required, the organization provides training on a new medication before it is used.	!
5.2	The organization provides staff and service providers with timely access to the client's medication profile and essential client information.	
6.2	The organization provides staff and service providers with access in the pharmacy and clinical service areas to information on high alert medications including current protocols, guidelines, dosing recommendations, checklists, and standard order sets.	!
8.1	The organization has a process for determining the type and level of alerts required by the pharmacy computer system which include, at minimum, alerts for medication interactions, drug allergies, and minimum and maximum doses for high-alert medications.	!
8.2	The organization has a policy for when and how to override alerts by the pharmacy computer system.	!
8.4	The organization regularly tests the pharmacy computer system to make sure that the built in alerts are working.	!
8.5	The organization manages alert fatigue by regularly evaluating the type of alerts required by the pharmacy computer system based on best practice information and input from staff and service providers.	
9.3	The organization evaluates and limits the availability of heparin products to ensure that formats with the potential to cause harmful medication incidents are not stocked in client service areas.	ROP
	9.3.1 The organization completes an audit of unfractionated and low molecular weight heparin products in client service areas at least annually.	**MAJOR**

	9.3.3	The organization is taking steps to limit the availability of the following heparin products in client service areas: • Low molecular weight heparin: use of multi-dose vials is limited to critical care areas for treatment doses • Unfractionated heparin (high dose): greater than or equal to 10,000 units total per container (e.g. 10,000 units/1 mL; 10,000 units/10 mL; 30,000 units/30 mL) is provided on a client-specific basis when required • Unfractionated heparin for intravenous use: E.g. 25,000 units/500 mL; 20,000 units/500 mL is provided on a client-specific basis when required.	**MAJOR**
11.2	The organization has a policy for when and how to override smart infusion pump alerts.		!
11.4	The organization regularly tests the limits set for soft and hard doses to make sure they are working in the smart infusion pump.		!
12.2	The organization regularly cleans and organizes its medication storage areas.		
12.6	The organization separates look-alike, sound-alike medications; different concentrations of the same medication; and high-alert medications in the pharmacy and client service areas.		!
13.3	The organization stores chemotherapy medications in a separate negative pressure room with adequate ventilation segregated from other supplies.		!
14.2	The organization has criteria for how written medication orders are sent to the pharmacy.		!
14.5	The organization helps provide minimal distractions, interruptions and noise for prescribing, writing and verifying medication orders either manually or electronically.		
14.6	The organization has identified and implemented a list of abbreviations, symbols, and dose designations that are not to be used in the organization.		ROP
	14.6.2	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.	**MAJOR**
	14.6.7	The organization audits compliance with the Do Not Use List and implements process changes based on identified issues.	**MINOR**
14.9	The organization regularly audits a sample of medication orders to verify compliance with existing criteria and makes improvements as needed.		!
15.1	The pharmacist reviews prescription and medication orders within the organization prior to administration of the first dose.		!
15.4	The pharmacist contacts the prescriber if there are concerns or changes required with a medication order and documents the results of the discussion in the client record.		!

16.1	The organization regularly cleans and organizes its medication preparation areas.	
16.3	The organization has a separate negative pressure area with a 100 percent externally-vented biohazard hood for preparing chemotherapy medications.	!
16.4	The organization has a separate area with a certified laminar air flow hood for preparing sterile products and intravenous admixtures.	!
17.1	The organization labels all medication packages/units in a standardized manner.	!
17.4	Unit dose oral medications remain in the manufacturer's or pharmacy's packaging until they are administered.	!
18.3	The pharmacy team dispenses emergency, urgent, and routine medications within the timelines set by the organization.	
21.2	Service providers provide clients and families with information on how to prevent medication errors.	!
27.2	Where medication management processes are contracted to external providers, the organization establishes and maintains a contract with each provider that requires consistent levels of quality and adherence to accepted standards of practice.	
27.4	The interdisciplinary committee regularly completes a comprehensive evaluation of its medication management system.	
27.5	The interdisciplinary committee monitors process and outcome indicators for medication management.	
27.6	The interdisciplinary committee prioritizes and completes medication use evaluations.	

Surveyor comments on the priority process(es)

Priority Process: Medication Management

The organization is commended for regional standardization of smart infusion pumps for the region. This is a significant achievement for patient safety.

CCM provides excellent support to the pharmacies by training both pharmacy technicians and pharmacists on-site in Winnipeg on cancer treatment and chemotherapy compounding.

Since regionalization, the three main pharmacy sites have not had a pharmacy director to oversee operations on a regional level. There is considerable standardization and work to be done on the medication system as a whole and a pharmacy director is critical to providing leadership over and above the current staff. The current staff manage well within their own sites but processes and available services are varied. There is opportunity for centralization, automation and standardization, led by a pharmacy director for the region. Regional goals and objectives need to be set.

Since the last survey, the pharmacies have made significant progress in moving towards unit dose packaging.

Most sites have all oral dosages packaged and Flin Flon has a partial CIVA program. No IV preparation (other than chemotherapy) is done at Thompson General Hospital; this is a risk as there is a high volume of medication prepared by nurses in a non-sterile environment. Continued progress in this area is recommended.

Overall medication information is relayed to patients and medication reconciliation seems to be very well done. Having the medication list at discharge given to both the patient and the retail pharmacy is excellent. Some additional work needs to be done on providing information to the patient on their role in medication safety while in the hospital.

In most of the areas, nurses take the unit dose packaged medication to the patient prior to administration. At St. Anthony's General Hospital, the medication cart stays in the medication room and medications are pre-poured into medication cups. This practice should be eliminated.

The organization has taken steps to limit the availability of high dose heparin and should continue to review this on an ongoing basis especially when exceptions are made. Snow Lake Health Centre was an exception to this. Auditing is not formally done and the outlying sites have not been reviewed at all.

A dangerous abbreviations list has been adopted in the organization and further work is required to audit compliance to this list. This could be combined with auditing medication order writing practices to reduce overall work associated with auditing.

The recording of medication incidents is well done in the organization and specific initiatives to address medication safety issues as a result have occurred. This is a significant improvement in addressing medication safety.

Each medication distribution system is different at each site, varying from almost full unit dose at Flin Flon General Hospital to extensive wardstock at Thompson General Hospital. Provision of service at all sites should be standardized to best practice of full unit dose. Options to provide this economically could look at the centralization or automation of some functions.

Pharmacists at all sites have very limited time to carry out clinical work. A permanent full-time pharmacist is required at Flin Flon General Hospital. Once pharmacy technicians are regulated, more medication distribution work could be done by technicians, allowing pharmacists to do clinical work that is currently not being done.

The pharmacy computer systems are not integrated and provide minimal pharmacy, medical and nursing support for a well-functioning medication management system. The systems should be on one platform and offer essential pharmacy functionality including interfacing with ADT and lab systems.

The physical plant of the Flin Flon General Hospital pharmacy is excellent and helps to provide the level of service that is currently in place. The pharmacies at St. Anthony's and Thompson General Hospitals currently do not meet standards and prevent the provision of service that they should. At St. Anthony's General Hospital, the space for the entire pharmacy is adequate but needs renovation to allow for a proper sterile compounding area for both chemotherapy and sterile IV admixtures while the space at Thompson General Hospital is inadequate to allow for expansion.

The hours of services at all pharmacies are limited to weekdays with no evening or weekend service. Providing 24/7 service would be unattainable; however, offering technology to allow for remote order entry at any site could provide the ability to enter or verify orders in a centralized hub model. Also, a formalized, rotating, centralized on-call service would be feasible to provide on-call service rather than having this provided by every site.

There is limited access by nursing to the pharmacy when medications cannot be found in the night medication cart or room. This should be eliminated by reviewing the medications that are being accessed to add those medications to the night medication cart. Until that occurs, a pharmacist should be called with a reason for entering when a nurse needs to access the pharmacy.

3.3.11 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.		
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			
3.4	The team develops standardized processes and procedures to improve teamwork and minimize duplication.		
Priority Process: Decision Support			
The organization has met all criteria for this priority process.			
Priority Process: Impact on Outcomes			
15.4	The team informs and educates clients and families in writing and verbally about the client and family's role in promoting safety.		ROP
	15.4.1	The team develops written and verbal information for clients and families about their role in promoting safety.	**MAJOR**
	15.4.2	The team provides written and verbal information to clients and families about their role in promoting safety.	**MAJOR**

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

Medicine staff at all sites make up strong teams. The units have seen multiple changes over the years that staff have embraced. Consideration should be given to having formalized goals and objectives to guide the direction of the medicine units and the region.

Students and volunteers are welcome and mentored in specific locations.

The integration of the clinical resource nurse (CRN) role in The Pas, Flin Flon and Thompson has provided strong clinical leadership and a clear liaison between frontline staff and management. Communication between the medical units in the region is lacking. Regularly scheduled meetings between the CRNs and managers would assist to implement the regionalized philosophy.

Priority Process: Competency

Medicine staff are well-trained. Staff take training in the use of infusion pumps as well as a CPR course; they have access to multiple other educational programs. The introduction of the intranet and the Mosby staff/patient teaching program has provided a best practice tool for reference. Staff are encouraged to follow their areas of interest to implement change, for example, enhanced falls prevention education resulting in a falls program for the facility then region. Interdisciplinary teams are very well integrated.

Priority Process: Episode of Care

The Medicine units often have combined services including paediatrics care, surgical care, palliative care and care of bariatric patients. The unit recently underwent a review to identify challenges and opportunities. Staff are eager to fill the gaps identified in the review. For example, capacity has been built with clinical resource nurses added to the rotation. This role provides the consistency for staff, physicians and patients as an educator, mentor and overall skilled team member.

There are multiple standard order sheets in place including venous thromboembolism (VTE) prophylaxis, falls risk reduction and suicide risk prevention. A multidisciplinary team approach was noted including services provided by a First Nations wellness coordinator, spiritual health coordinator, respiratory therapist, dietician and full-scope LPNs. There is a conflict resolution process in place that is used with feedback returning to the caregiver or patient. An ethical process is in place but staff recognize ethical issues as a part of their everyday work.

Team consultation is standard practice. Patients receive a full assessment on admission and are continuously assessed as per changes in condition.

Staff transfer information very well between services. Safety measures, such as the transfer checklist, ensure staff are gathering relevant information including the identification of resources. Physician staffing at Flin Flon and The Pas is consistent and physicians are strong members of the team. The advanced care planning process is done according to a provincial goals of care model.

Priority Process: Decision Support

The medicine team provides a detailed health record for each patient. Communication and flow between team members is consultative resulting in a collaborative care plan and communication exchange. The team is encouraged to regionalize the exchange of evidence-based guidelines for consistency.

Priority Process: Impact on Outcomes

Although there are no formal goals and objectives, medicine service teams (The Pas, Flin Flon and Thompson) did identify a staffing and resource issue that was brought forward to the senior team. A complete review of medicine services was done resulting in a reorganization of the staffing and care delivery model.

Consideration should be given to benchmarking indicators with similar service facilities across the country. Although statistics are collected, meaningful indicators linked to patient outcomes would provide clear guidance for service delivery to the team.

3.3.12 Standards Set: Mental Health Services

Unmet Criteria		High Priority Criteria
Priority Process: Clinical Leadership		
2.2	The team's objectives for mental health services are specific and measurable.	
4.9	The organization has a strategy to reduce stigma of mental illness among staff and service providers.	
Priority Process: Competency		
3.4	Team leaders support and evaluate interdisciplinary team functioning regularly, and use the information to make improvements.	
Priority Process: Episode of Care		
8.2	The team informs clients and families of their rights and responsibilities.	!
9.6	The client's service plan includes strategies to manage psychological and physical symptoms, including strategies to prevent relapse.	
10.7	The team uses standardized clinical processes to minimize service duplication.	
12.6	The team follows a process to evaluate the effectiveness of transitions, and uses this information to improve transition and end of service planning.	
Priority Process: Decision Support		
15.1	The organization has a process to select and update evidence-based guidelines to inform its mental health service delivery.	!
15.2	The organization's process for selecting guidelines includes seeking input from clients, families, staff, and service providers about the applicability of the guidelines to client recovery.	
Priority Process: Impact on Outcomes		
16.3	The organization's leaders trend and analyze safety data, and use this information to make improvements.	!
18.1	The team has processes in place to regularly monitor the quality of its services.	
18.2	The team regularly monitors clients' perspectives on the quality of its mental health services.	

18.3	The team identifies and monitors process and outcome measures for its mental health services.	
18.4	The team compares its process and outcome measure results with those of other similar interventions, programs, or organizations, as available.	
18.5	The team shares leading practice information with its partners and other organizations.	
18.6	The team uses the evaluation information it collects to identify strengths and weaknesses, and make improvements in a timely way.	
18.7	The team shares evaluation information with staff, clients, and families.	

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

Significant leadership and program planning is underway for mental health services, and the team is focused to address next steps, operational planning, priorities and strategies. This leadership team is relatively new in its formation at the director and manager levels, and is very committed to advancing the program to enhance the provision of an optimal level of care and service.

The focus of the acute care mental health services is on the level of acuity and presenting needs as well as the opportunity to collect additional information to define services and scope such as occupancy data. Opportunity may exist to define alternate levels of care and service such as a step down unit.

Staff and management are working to align their service and roles with the organizational priorities such as defining core competencies in mental health and bringing in evidence-based best practices throughout the program.

This team is currently challenged with a number of vacancies of key positions in psychology, occupational therapy, recreational therapy, nursing and permanent psychiatry.

There is an excellent focus on discharge planning and transition to community services and primary care. As this function is primarily led by nursing staff, an opportunity for improvement identified by this team is the introduction of a social work/transition role in The Pas.

Stigma has been identified by several staff and clients involved in service, specifically in the ED where clients are triaged for assessment and admission. Opportunity exists to develop and implement a strategy with education and support for staff throughout the organization and program areas.

Overall, the region is commended on their early efforts to regionalize this service with the intent to address standardization of practices. The team is also encouraged to coordinate mental heath services across the continuum, and focus on the integration of addiction and mental health in programming to better address client population needs in this community.

Priority Process: Competency

The team incorporates an interdisciplinary focus in care. In The Pas, the team is currently struggling to recruit several key positions that are funded vacancies.

With the new leadership structure established, opportunity exists to introduce a review of services, processes and outcomes to support and evaluate the team.

Specific to competencies, processes exist upon hiring individuals and the team is commended on their current focus to develop a competency framework/model for mental health services by incorporating the NHS Education for Scotland model.

Support for leadership development is identified as a strength with NRHA. An opportunity for improvement identified by frontline staff includes the request for access to more education and professional development specific to mental health and best practices. It is anticipated that access through the new Lync and LIME system and webinars will facilitate in meeting this identified need.

Priority Process: Episode of Care

The inpatient acute care mental health unit at The Pas is spacious, open and welcoming. Excellent safety and security measures are in place for clients and staff. The unit is locked and appropriate physical measures have been undertaken to promote client safety such as installed beds, appropriate window frames, locked doors, medication storage and regular safety audits that are conducted by management and staff.

It is evident that many renovations have been completed at Thompson General Hospital's acute care inpatient unit. The team is encouraged to continue to review and address any perceived safety risks such as the removal of unsecured tables from client rooms. Several good examples of the team's focus to protect the physical security of clients and staff exist. The acute unit is locked and a comprehensive suicide/risk assessment is completed on triage prior to being admitted to the inpatient program.

There is good access to service through the ED. Clients are medically cleared and a mental health nursing assessment is completed by either the inpatient program staff or the intake worker affiliated with the community-based mental health services.

Opportunity exists to review, monitor and evaluate utilization to optimize access and use of this service with low occupancy rates.

Inconsistent practice and a lack of staff awareness of their responsibility to inform clients of rights and responsibilities were noted.

Opportunity exists to identify evidence-based practices and standardization across the regional services and units with the interdisciplinary team. For example, currently the team does not provide follow-up on clients discharged from acute care services, and the team is encouraged to identify processes and mechanisms to address this as an evidence-based practice.

Priority Process: Decision Support

This team does not have a process in place to review or incorporate evidence-based practices into care or service. Opportunity exists to review the program overall to introduce new processes, mechanisms and new practices such as cognitive behavioural therapies, group programming, treatment modalities, family assessment and approaches overall.

The management and team are keen to learn and participate in selecting evidence-based guidelines.

Priority Process: Impact on Outcomes

A focus of the team and new leadership is to develop processes to identify, incorporate, use and evaluate care and services with evidence-based information. These actions are encouraged to develop this service area.

A significant opportunity for this team overall is the identification of performance and outcome measurement and processes to review and evaluate services and care overall.

3.3.13 Standards Set: Obstetrics Services

Unmet Criteria		High Priority Criteria
Priority Process: Clinical Leadership		
2.1	The team works together to develop goals and objectives specific to obstetrics services.	
2.2	The team's goals and objectives for obstetrics services are measurable and specific.	
2.9	The team has access to the resources and infrastructure needed to clean and reprocess obstetrics devices within the service area, as required.	
13.4	The team retains preventive maintenance records for at least two years.	!
Priority Process: Competency		
3.7	The organization provides sufficient workspace to support interdisciplinary team functioning and interaction.	
3.9	The interdisciplinary team follows a formal process to regularly evaluate its functioning, identify priorities for action, and make improvements.	
Priority Process: Episode of Care		
12.5	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		
17.1	The team has a process to access, review, and select which evidence-based guidelines it will use.	
17.2	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		
17.5	The team shares benchmark and best practice information with its partners and other organizations.	
18.4	The team informs and educates clients and families in writing and verbally about the client and family's role in promoting safety.	ROP
18.4.1	The team develops written and verbal information for clients and families about their role in promoting safety.	**MAJOR**
20.1	The team identifies and monitors performance measures for its obstetrics services.	!

20.5	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.	!
20.6	The team shares evaluation results with staff, clients, and families.	

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

The obstetrics team works hard to provide good patient care. Nursing leadership is not consistent across sites. Staff are unaware of goals and objectives for the units. Although there is a clear preventive maintenance process, staff are unaware of the policy and formalized process.

Priority Process: Competency

The team works in a strong interdisciplinary environment.

Strong clinical nursing leadership is an asset. Performance appraisals should be annualized. Although staff receive a lot of training in maternity and newborn care, clear, documented, annual priorities for education should be understood for each employee and done on a measurable cycle. There is no formal process in place to identify unit priorities and evaluate improvements.

Priority Process: Episode of Care

There is a baby-friendly and "Breast is Best" initiative in place. Although a MOREOB program may be of benefit, clinicians identify the need for more staff as a priority. The team identifies under-staffing as the main cause for nurse fatigue but is cognizant of patient and personal safety. The implementation of the clinical resource nurse in Flin Flon, The Pas and Thompson has provided a liaison between staff and management.

Policies are in place but require updating and considerable regionalization. Physicians orders are often contain detailed descriptions of procedures therefore staff have clinical direction. Clinical standards are in the planning process at some locations.

Physicians are key members of the healthcare team and identified as readily available. There is a process in place for lack of capacity and consent. Consideration should be given to a case study regarding an ethical issue.

Discharge surveys provide patient feedback and provide direction for care.

Priority Process: Decision Support

The obstetrics team is well-trained and knowledgeable. Policies and procedures would benefit from an update and best practice reference. A regionalized approach to evidence-based guidelines would provide consistency between services.

Priority Process: Impact on Outcomes

Staff are passionate about providing safe, quality care. Although obstetrics collects statistics, they are not linked to outcomes and care improvements across the facilities. Benchmarking with regional and other similar facilities across Canada is suggested. Input from staff on measurable goals and objectives would provide direction for the services provided. The team should work towards creating a no-blame culture that encourages staff to report near misses without fear of retribution.

3.3.14 Standards Set: Substance Abuse and Problem Gambling Services

Unmet Criteria		High Priority Criteria
Priority Process: Clinical Leadership		
1.6	The team regularly reviews its services and makes changes as needed.	
2.2	The team's goals and objectives for its substance abuse and problem gambling services are measurable and specific.	
Priority Process: Competency		
3.1	The organization identifies an interdisciplinary team to deliver substance abuse and problem gambling services.	
3.2	Team members have position profiles that define roles, responsibilities, and scope of practice.	
3.5	The organization provides sufficient workspace to support interdisciplinary team functioning and interaction.	
3.7	The interdisciplinary team follows a formal process to regularly evaluate its functioning, identify priorities for action, and make improvements.	
4.3	The team receives specific education and training to deliver substance abuse and problem gambling services.	
4.8	The team leaders regularly evaluate and document each team member's performance in an objective, interactive, and positive way.	
Priority Process: Episode of Care		
7.1	The team completes a timely assessment for clients and families.	!
7.4	During assessment the team determines family and caregiver support needs.	
8.9	The team follows the organization's process to identify, address, and record all ethics-related issues.	!
9.2	The team develops an integrated and comprehensive service plan for clients and families.	
9.8	The team monitors whether clients achieve their service goals and expected results, and uses this information to identify and address barriers that are preventing clients from achieving their goals.	
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 team has a process to access, review and select which evidence-based guidelines it will use.	!
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		

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

Rosaire House is the only centre for substance abuse in NRHA as Addictions Foundation Manitoba provides the majority of programs and services. Currently the manager of The Pas Addictions Foundation Manitoba is the acting manager at this site, with the region's and Foundation's intent to address the opportunity to transition this provincial service to the Foundation.

A current review is underway, and several changes and opportunities for improvement have been identified such as education, the introduction of best practices, staffing composition and levels, security, space requirements and capital upgrades.

The region's plan to transition this service to the provincial arm of Addictions Foundation Manitoba is perceived by management, staff and clients as a positive move to address standards of care, staffing and programming for clients in this 28-day residential program, best practices, and evaluation.

Rosaire House has good linkages and partnerships with referring organizations that are also accessed with transition from care. Opportunity exists in the region to partner with existing regional services such as mental health and rehabilitation.

Priority Process: Competency

The team consists of unregulated professionals,addiction counsellors and resident case workers. Opportunity to enhance the interdisciplinary focus with mental health, nursing, rehabiliation (occupational therapy and respiratory therapy) and physician involvement is encouraged.

An opportunity for a review of the programming exists to introduce evidence-based practices, and evaluation and monitoring. Staff report minimal access to professional development opportunities and evidence based practices.

Staffing assignments to the residential program, particularly on evening and night shifts, have been reviewed with management and staff, and concerns have been raised regarding the personal safety of staff working alone.

Priority Process: Episode of Care

The team is commended on its strength to remove barriers for access to service wherever possible. This service has an excellent focus on First Nations awareness, ways of being and learning. Client feedback is very positive regarding the First Nations focus of the service and team on cultural traditions, awareness and holistic practice. This includes a focus on spirituality, prayer, smudging and access to sweat lodge ceremony practices.

Staff are very committed and caring with clients as is evident in client interactions and feedback.

Opportunities for improvement identified include support to families; the introduction of female- and male-centred groups; access to the interdisciplinary team, inclusive of physicians; and mechanisms to ensure client safety and security is protected.

An additional area of focus that is suggested for this program is with the transition of service to the referring source, and follow-up care and evaluation specific to effectiveness and outcomes.

Priority Process: Decision Support

Client records are maintained throughout the residential program and counselling services, and meet applicable legislative requirements for storage and confidentiality.

Several evidence-based guidelines have been identified, and staff are eager to learn more and incorporate these into future programming.

Priority Process: Impact on Outcomes

The team/service is often accessed for their excellent focus on the First Nations culture and the incorporation of traditional healing.

The focus of this team is primarily linked to process and utilization indicators. An identified opportunity for improvement of this service is evaluation and an enhanced focus on outcome measurement.

3.3.15 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		
1.3	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.	
2.4	Team leaders monitor and meet each team member's ongoing education, training, and development needs.	
2.8	The team leaders regularly evaluate and document each team member's performance in an objective, interactive, and positive way.	
3.1	When planning and designing the operating room layout, the organization considers client flow, traffic patterns, ergonomics, and equipment movement logistics.	
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.	ROP
	6.8.2 The team uses the checklist for every surgical procedure in the operating room.	**MAJOR**
	6.8.3 The team has developed a process for ongoing monitoring of compliance with the checklist.	**MAJOR**
	6.8.5 The team uses results of the evaluation to improve the implementation of and expand the use of the checklist.	**MINOR**
12.6	The organization transports contaminated items separate from clean or sterilized items, away from client service and high-traffic areas.	!
14.1	The team carries out regular safety briefings to share information about potential safety problems, reduce the risk of error, and improve the service quality.	!
14.4	The team sets performance goals and objectives and measures their achievement.	
14.5	The team benchmarks or compares its results with other similar interventions, programs, or organizations.	

Standards Set: Surgical Care Services		
2.2	The team's goals and objectives for its surgical care services are measurable and specific.	
2.5	The organization provides support to the team to deliver quality surgical care services.	
3.3	The organization encourages all team members to develop skills to improve the interdisciplinary approach and overall team functioning.	
4.7	The team monitors and meets each team member's ongoing education, training, and development needs.	
4.8	Team leaders regularly evaluate and document each team member's performance in an objective, interactive, and positive way.	
5.1	The organization has defined criteria that are used to assign team members to clients and other responsibilities in a fair and equitable manner.	
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.	ROP
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.	**MAJOR**
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.	**MINOR**
7.7.5	The team provides information to health professionals and clients about the risks of VTE and how to prevent it.	**MINOR**
7.9	The team assesses each client's risk for developing a pressure ulcer and implements interventions to prevent pressure ulcer development.	ROP
7.9.1	The team conducts an initial pressure ulcer risk assessment at admission, using a validated, standardized risk assessment tool.	**MAJOR**
7.9.2	The team reassesses each client for risk of developing pressure ulcers at regular intervals, and with significant change in client status.	**MAJOR**
7.9.3	The team implements documented protocols and procedures based on best practice guidelines to prevent the development of pressure ulcers, which may include interventions to: prevent skin breakdown; minimize pressure, shear, and friction; reposition; manage moisture; optimize nutrition and hydration; and enhance mobility and activity.	**MAJOR**

7.9.5	The team has a system in place to measure the effectiveness of pressure ulcer prevention strategies, and uses results to make improvements.	**MINOR**
9.2	The team continues to monitor and provide bedside care to clients on a one-to-one basis as they recover from anaesthetic.	
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.	
13.1	The team identifies its needs for new technology and information systems.	
13.2	Team members receive education and training on information systems and other technology.	
15.3	Staff and service providers participate in regular safety briefings to share information about potential safety problems, reduce the risk of error, and improve the quality of service.	!
16.2	The team monitors clients' perspectives on the quality of its surgical care services.	
16.3	The team compares its results with other similar interventions, programs, or organizations.	
16.4	The team uses the information it collects about the quality of its services to identify successes and opportunities for improvement, and makes improvements in a timely way.	
16.5	The team shares evaluation results with staff, clients, and families.	

Surveyor comments on the priority process(es)

The NRHA sites of The Pas, Flin Flon and Thompson were assessed for surgical services. The surgeries done in these centres are mainly day care procedures with few post-operative surgical admissions. General surgery and obstetrics and gynaecology are the main areas represented. All other procedures are referred out to more major centres. Most of the surgeries and anaesthetics in this region are done by locum surgeons and anaesthetists.

All sites were found to have appropriate staff who met the criteria for training. There is some concern at The Pas and Flin Flon regarding under-staffing. Continuing medical education (CME) of staff is appropriate. All staff receive appropriate support and training, although there is some concern about the lack of training and CME for staff in Flin Flon.

The operating room (OR) layouts in Flin Flon and The Pas are dated. The OR in Thompson is more modern and functions better from a physical point of view. The appropriate surgical devices are available for the surgeries done. All appropriate emergency systems are in place.

The VTE protocol is not being followed in Flin Flon. The pressure ulcer protocol is being followed completely only in Thompson.

All routine surgical nursing is done to appropriate standards. All OR and equipment use and maintenance is appropriate.

Care is taken to ensure the patient is aware and understands his/her surgical care. Care is also taken to ensure the patient is aware of his/her rights and responsibilities.

Section 4 Instrument Results

As part of Qmentum, organizations administer instruments. Qmentum includes three instruments (or questionnaires) that measure governance functioning, patient safety culture, and quality of worklife. They are completed by a representative sample of clients, staff, senior leaders, board members, and other stakeholders.

4.1 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. It does this by asking questions about:

- 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 client organization portal. The organization then had the opportunity to address challenging areas.

- **Data collection period: August 30, 2013 to November 1, 2013**
- **Number of responses: 11**

Governance Functioning Tool Results

	% Disagree	% Neutral	% Agree	%Agree * Canadian Average
	Organization	Organization	Organization	
1 We regularly review, understand, and ensure compliance with applicable laws, legislation and regulations.	0	0	100	89
2 Governance policies and procedures that define our role and responsibilities are well-documented and consistently followed.	9	0	91	93
3 We have sub-committees that have clearly-defined roles and responsibilities.	0	0	100	93
4 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.	0	0	100	90
5 We each receive orientation that helps us to understand the organization and its issues, and supports high-quality decision-making.	18	0	82	89

	% Disagree	% Neutral	% Agree	%Agree * Canadian Average
	Organization	Organization	Organization	
6 Disagreements are viewed as a search for solutions rather than a “win/lose”.	0	0	100	92
7 Our meetings are held frequently enough to make sure we are able to make timely decisions.	9	0	91	94
8 Individual members understand and carry out their legal duties, roles and responsibilities, including sub-committee work (as applicable).	9	27	64	93
9 Members come to meetings prepared to engage in meaningful discussion and thoughtful decision-making.	0	9	91	92
10 Our governance processes make sure that everyone participates in decision-making.	0	18	82	90
11 Individual members are actively involved in policy-making and strategic planning.	0	0	100	88
12 The composition of our governing body contributes to high governance and leadership performance.	0	9	91	89
13 Our governing body’s dynamics enable group dialogue and discussion. Individual members ask for and listen to one another’s ideas and input.	9	0	91	92
14 Our ongoing education and professional development is encouraged.	0	0	100	87
15 Working relationships among individual members and committees are positive.	9	9	82	96
16 We have a process to set bylaws and corporate policies.	0	0	100	91
17 Our bylaws and corporate policies cover confidentiality and conflict of interest.	0	0	100	95
18 We formally evaluate our own performance on a regular basis.	36	36	27	78
19 We benchmark our performance against other similar organizations and/or national standards.	27	36	36	66
20 Contributions of individual members are reviewed regularly.	64	27	9	61

	% Disagree	% Neutral	% Agree	%Agree * Canadian Average
	Organization	Organization	Organization	
21 As a team, we regularly review how we function together and how our governance processes could be improved.	36	27	36	77
22 There is a process for improving individual effectiveness when nonperformance is an issue.	27	27	45	53
23 We regularly identify areas for improvement and engage in our own quality improvement activities.	18	9	73	78
24 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.	9	0	91	81
25 As individual members, we receive adequate feedback about our contribution to the governing body.	27	45	27	64
26 Our chair has clear roles and responsibilities and runs the governing body effectively.	9	0	91	92
27 We receive ongoing education on how to interpret information on quality and patient safety performance.	9	27	64	78
28 As a governing body, we oversee the development of the organization's strategic plan.	27	0	73	92
29 As a governing body, we hear stories about clients that experienced harm during care.	9	0	91	81
30 The performance measures we track as a governing body give us a good understanding of organizational performance.	18	9	73	88
31 We actively recruit, recommend and/or select new members based on needs for particular skills, background, and experience.	60	20	20	84
32 We have explicit criteria to recruit and select new members.	56	11	33	79
33 Our renewal cycle is appropriately managed to ensure continuity on the governing body.	0	9	91	86

		% Disagree	% Neutral	% Agree	%Agree * Canadian Average
		Organization	Organization	Organization	
34	The composition of our governing body allows us to meet stakeholder and community needs.	0	20	80	91
35	Clear written policies define term lengths and limits for individual members, as well as compensation.	0	0	100	92
36	We review our own structure, including size and sub-committee structure.	20	10	70	86
37	We have a process to elect or appoint our chair.	44	11	44	90

*Canadian average: Percentage of Accreditation Canada client organizations that completed the instrument from July to December, 2013 and agreed with the instrument items.

4.2 Patient Safety Culture Tool

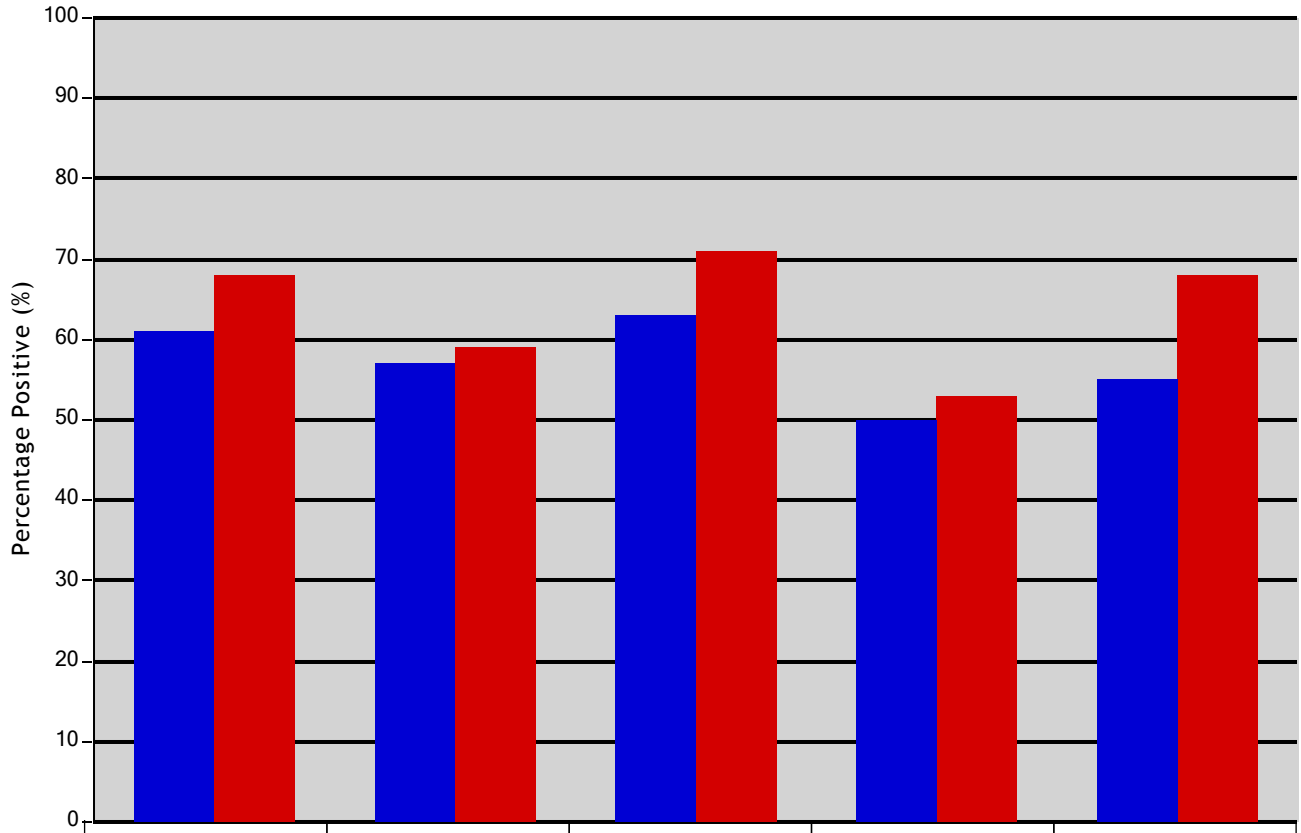
Organizational culture is widely recognized as a significant driver in changing behavior and expectations in order to increase safety within organizations. A key step in this process is the ability to measure the presence and degree of safety culture. This is why Accreditation Canada provides organizations with the Patient Safety Culture Tool, an evidence-informed questionnaire that provides insight into staff perceptions of patient safety. This tool gives organizations an overall patient safety grade and measures a number of dimensions of patient safety culture.

Results from the Patient Safety Culture Tool allow the organization to identify strengths and areas for improvement 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 client organization portal. The organization then had the opportunity to address areas for improvement. During the on-site survey, surveyors reviewed progress made in those areas.

- **Data collection period: June 24, 2013 to September 27, 2013**
- **Minimum responses rate (based on the number of eligible employees): 274**
- **Number of responses: 577**

Patient Safety Culture Tool: Results by Patient Safety Culture Dimension



	Senior leadership support for safety (valuing safety)	Supervisory leadership support for safety	Patient safety learning culture	Communication barriers/talking about errors	Overall perception of patient safety
	61%	57%	63%	50%	55%
	68%	59%	71%	53%	68%

Legend

Northern Regional Health Authority

* Canadian Average

*Canadian average: Percentage of Accreditation Canada client organizations that completed the instrument from July to December, 2013 and agreed with the instrument items.

4.3 Worklife Pulse

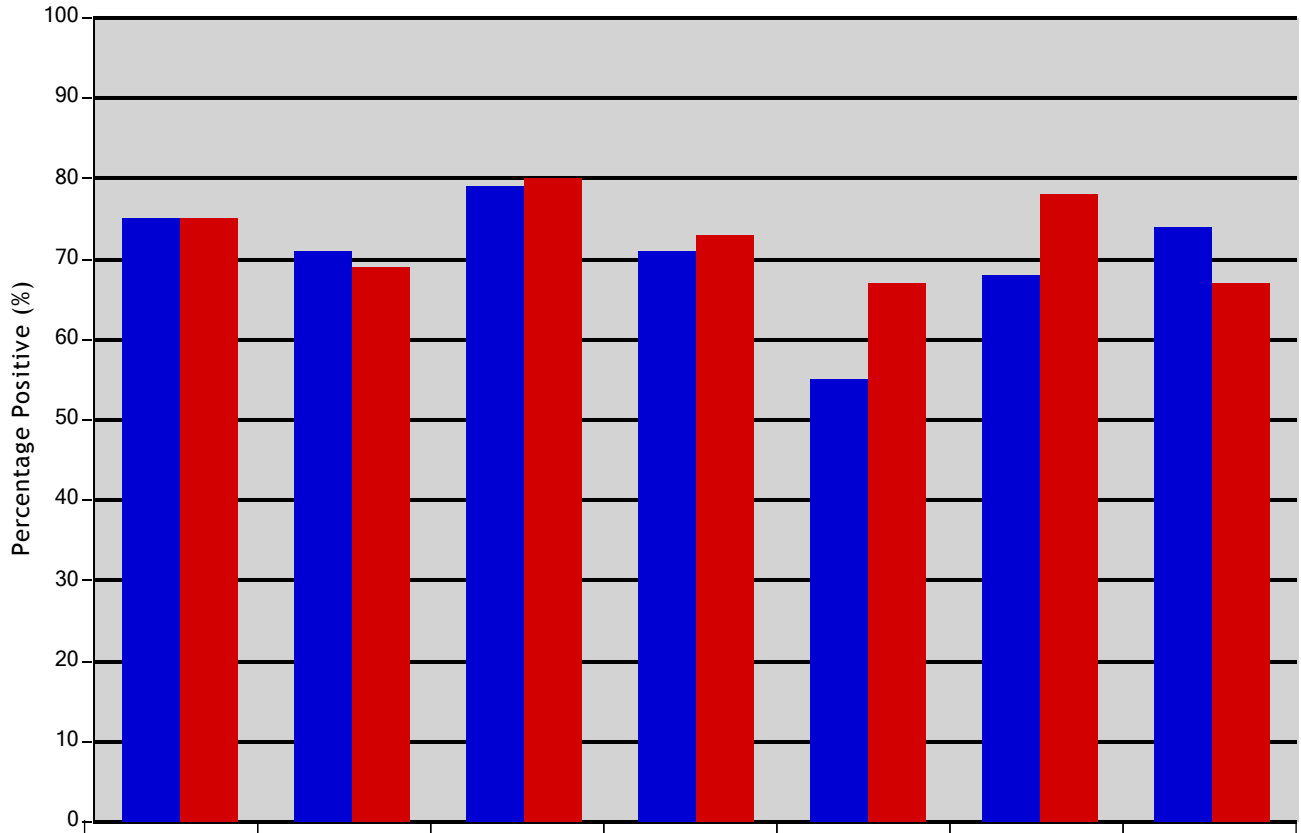
Accreditation Canada helps organizations create high quality workplaces that support workforce wellbeing and performance. This is why Accreditation Canada provides organizations with the Worklife Pulse Tool, an evidence-informed questionnaire that takes a snapshot of the quality of worklife.

Organizations can use results from the Worklife Pulse Tool to identify strengths and gaps in the quality of worklife, engage stakeholders in discussions of opportunities for improvement, plan interventions to improve the quality of worklife and develop a clearer understanding of how quality of worklife influences the organization's capacity to meet its strategic goals. By taking action to improve the determinants of worklife measured in the Worklife Pulse tool, organizations can improve outcomes.

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

- **Data collection period: June 23, 2013 to September 27, 2013**
- **Minimum responses rate (based on the number of eligible employees): 295**
- **Number of responses: 520**

Worklife Pulse: Results of Work Environment



	Job	Training and Development	Coworkers	Immediate Supervisor	Senior Management	Safety and Health	Overall Experience
	75%	71%	79%	71%	55%	68%	74%
	75%	69%	80%	73%	67%	78%	67%

Legend

Northern Regional Health Authority

* Canadian Average

*Canadian average: Percentage of Accreditation Canada client organizations that completed the instrument from July to December, 2013 and agreed with the instrument items.

Client Experience Tool

Measuring client experience in a consistent, formal way provides organizations with information they can use to enhance client-centred services, increase client engagement, and inform quality improvement initiatives.

Prior to the on-site survey, the organization conducted a client experience survey that addressed the following dimensions:

Respecting client values, expressed needs and preferences,including respecting client rights, cultural values, and preferences; ensuring informed consent and shared decision-making; and encouraging active participation in care planning and service delivery.

Sharing information, communication, and education,including providing the information that people want, ensuring open and transparent communication, and educating clients and their families about the health issues.

Coordinating and integrating services across boundaries,including accessing services, providing continuous service across the continuum, and preparing clients for discharge or transition.

Enhancing quality of life in the care environment and in activities of daily living,including providing physical comfort, pain management, and emotional and spiritual support and counselling.

The organization then had the chance to address opportunities for improvement and discuss related initiatives with surveyors during the on-site survey.

Client Experience Program Requirement	
Conducted a client experience survey using a survey tool and approach that meets accreditation program requirements	Met
Provided a client experience survey report(s) to Accreditation Canada	Met

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.

The 2014 Accreditation Canada on-site visit is the first survey of the amalgamated Northern Regional Health Authority (NRHA).

The on-site visit by Accreditation Canada surveyors is the second step in the review of the NRHA to measure compliance with Accreditation Canada standards of services provided to the population of the region. Over the previous year, the NRHA undertook a self-assessment process to identify opportunities for improvement and teams were assigned responsibility for developing and implementing action plans to address the areas that were identified. Much of this work involved regionalizing policies, processes and procedures. During the self-assessment process it became very evident that even though the former RHAs had many similarities, there was a lot of variation in processes and care delivery models.

The report by the Accreditation Canada surveyors validated the information that was garnered from the self-assessment and the organization was not “surprised” by the surveyors’ findings. With the feedback provided we will be able to link the recommendations of Accreditation Canada with 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. The organization was commended for its progress to-date as a region in recognition of all the challenges this entails.

In terms of unmet criteria, there are plans in place already to address the majority of these areas:

1. Organizational Risk Assessment: This process is being rolled out to be in line with work that is being undertaken on a provincial basis.

2. Performance Measurement/Indicators/Benchmarking: A monitoring and reporting structure has been developed to align with the strategic directions/priorities of the region in four pillars; Patient Safety, Patient Experience, Clinical Effectiveness and Professional Development.

3. Space/Physical Environment Challenges: Work is ongoing through the Health Planning process to communicate and negotiate these issues with the funding body.

4. Performance Reviews and Job Descriptions: This process has been regionalized, managers and staff are being orientated to the new process and it is being adopted. This will be an ongoing process that will be monitored.

5. Safe Surgery Checklist: This is completed at all three sites that have operating rooms and audits of compliance are done. Processes will be put in place to ensure that audits are done on a routine basis with documentation of the audit results shared with staff.

Areas of Concern:

1. Limited participation in the Community Partners Discussion Group sessions may mean that a true regional perspective may not be represented in the comments received.

2. Some comments reflected as regional issues may actually only be relevant to individual programs and/or sites.

Overall, the NRHA is satisfied with the survey findings and will use this information as a point of focus as we Journey Forward on the road to Healthy People, Healthy North.

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 four-year cycle, Accreditation Canada provides ongoing liaison and support to help the organization address issues, develop action plans, 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 required follow ups.

Evidence 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
Communication	Communicating effectively at all levels of the organization and with external stakeholders
Emergency Preparedness	Planning for and managing emergencies, disasters, or other aspects of public safety
Governance	Meeting the demands for excellence in governance practice.
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
Medical Devices and Equipment	Obtaining and maintaining machinery and technologies used to diagnose and treat health problems
Patient Flow	Assessing the smooth and timely movement of clients and families through service settings
Physical Environment	Providing appropriate and safe structures and facilities to achieve the organization's mission, vision, and goals
Planning and Service Design	Developing and implementing infrastructure, programs, and services to meet the needs of the populations and communities served
Principle-based Care and Decision Making	Identifying and decision making regarding ethical dilemmas and problems.
Resource Management	Monitoring, administration, and integration of activities involved with the appropriate allocation and use of resources.

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, innovation, and action.

Priority processes associated with service excellence standards

Priority Process	Description
Blood Services	Handling blood and blood components safely, including donor selection, blood collection, and transfusions
Clinical Leadership	Providing leadership and overall goals and direction to the team of people providing services.
Competency	Developing a skilled, knowledgeable, interdisciplinary team that can manage and deliver effective programs and services
Decision Support	Using information, research, data, and technology to support management and clinical decision making
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
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
Impact on Outcomes	Identifying and monitoring process and outcome measures to evaluate and improve service quality and client outcomes
Infection Prevention and Control	Implementing measures to prevent and reduce the acquisition and transmission of infection among staff, service providers, clients, and families
Medication Management	Using interdisciplinary teams to manage the provision of medication to clients
Organ and Tissue Donation	Providing organ donation services for deceased donors and their families, including identifying potential donors, approaching families, and recovering organs
Organ and Tissue Transplant	Providing organ transplant services, from initial assessment of transplant candidates to providing follow-up care to recipients
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
Point-of-care Testing Services	Using non-laboratory tests delivered at the point of care to determine the presence of health problems

Priority Process	Description
Primary Care Clinical Encounter	Providing primary care in the clinical setting, including making primary care services accessible, completing the encounter, and coordinating services
Surgical Procedures	Delivering safe surgical care, including preoperative preparation, operating room procedures, postoperative recovery, and discharge