ACCREDITATION
AGRÉMENT
CANADA
Qmentum

Accreditation Report

Northern Regional Health Authority

Flin Flon, MB

On-site survey dates: June 10, 2018 - June 15, 2018

Report issued: July 11, 2018

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 2018. 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

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 Client Engagement Lead 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,

Leslee Thompson
Chief Executive Officer

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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.

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.

About the On-site Survey

- **On-site survey dates: June 10, 2018 to June 15, 2018**

- **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. Gillam Hospital
10. Hope North
11. Northern Consultation Centre
12. Northern Spirit Manor
13. NRHA Flin Flon Regional Office
14. NRHA The Pas Regional Office
15. NRHA Thompson Regional Office
16. Rosaire House
17. Snow Lake Health Centre
18. St. Anthony's General Hospital
19. St. Paul's Personal Care Home
20. The Pas Clinic
21. The Pas Emergency Medical Station
22. The Pas Primary Health Care Centre
23. Thompson General Hospital

- **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. Governance
2. Infection Prevention and Control Standards
3. Leadership
4. Medication Management Standards

Population-specific Standards

5. Population Health and Wellness

Service Excellence Standards

6. Acquired Brain Injury Services - Service Excellence Standards
7. Ambulatory Care Services - Service Excellence Standards
8. Cancer Care - Service Excellence Standards
9. Community-Based Mental Health Services and Supports - Service Excellence Standards
10. Emergency Department - Service Excellence Standards
11. EMS and Interfacility Transport - Service Excellence Standards
12. Home Care Services - Service Excellence Standards
13. Inpatient Services - Service Excellence Standards
14. Long-Term Care Services - Service Excellence Standards
15. Mental Health Services - Service Excellence Standards
16. Obstetrics Services - Service Excellence Standards
17. Perioperative Services and Invasive Procedures - Service Excellence Standards
18. Public Health Services - Service Excellence Standards
19. Reprocessing of Reusable Medical Devices - Service Excellence Standards
20. Substance Abuse and Problem Gambling - Service Excellence Standards

- **Instruments**

The organization administered:

1. Canadian Patient Safety Culture Survey Tool
2. Governance Functioning Tool (2016)
3. Worklife Pulse
4. Client Experience Tool

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 (Work with my community to anticipate and meet our needs)	99	12	0	111
 Accessibility (Give me timely and equitable services)	127	4	0	131
 Safety (Keep me safe)	662	43	24	729
 Worklife (Take care of those who take care of me)	177	11	0	188
 Client-centred Services (Partner with me and my family in our care)	468	55	6	529
 Continuity (Coordinate my care across the continuum)	119	3	2	124
 Appropriateness (Do the right thing to achieve the best results)	876	117	20	1013
 Efficiency (Make the best use of resources)	64	14	0	78
Total	**2592**	**259**	**52**	**2903**

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	49 (100.0%)	0 (0.0%)	1	35 (100.0%)	0 (0.0%)	1	84 (100.0%)	0 (0.0%)	2
Leadership	49 (98.0%)	1 (2.0%)	0	93 (96.9%)	3 (3.1%)	0	142 (97.3%)	4 (2.7%)	0
Infection Prevention and Control Standards	40 (100.0%)	0 (0.0%)	0	29 (93.5%)	2 (6.5%)	0	69 (97.2%)	2 (2.8%)	0
Medication Management Standards	60 (82.2%)	13 (17.8%)	5	57 (93.4%)	4 (6.6%)	3	117 (87.3%)	17 (12.7%)	8
Population Health and Wellness	3 (75.0%)	1 (25.0%)	0	34 (97.1%)	1 (2.9%)	0	37 (94.9%)	2 (5.1%)	0
Acquired Brain Injury Services	38 (82.6%)	8 (17.4%)	0	72 (85.7%)	12 (14.3%)	4	110 (84.6%)	20 (15.4%)	4
Ambulatory Care Services	31 (70.5%)	13 (29.5%)	2	58 (74.4%)	20 (25.6%)	0	89 (73.0%)	33 (27.0%)	2
Cancer Care	77 (95.1%)	4 (4.9%)	0	100 (87.0%)	15 (13.0%)	0	177 (90.3%)	19 (9.7%)	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
	# (%)	# (%)	#	# (%)	# (%)	#	# (%)	# (%)	#
Community-Based Mental Health Services and Supports	35 (79.5%)	9 (20.5%)	0	88 (93.6%)	6 (6.4%)	0	123 (89.1%)	15 (10.9%)	0
Emergency Department	63 (88.7%)	8 (11.3%)	0	91 (85.8%)	15 (14.2%)	1	154 (87.0%)	23 (13.0%)	1
EMS and Interfacility Transport	100 (96.2%)	4 (3.8%)	10	113 (99.1%)	1 (0.9%)	6	213 (97.7%)	5 (2.3%)	16
Home Care Services	43 (89.6%)	5 (10.4%)	0	70 (93.3%)	5 (6.7%)	0	113 (91.9%)	10 (8.1%)	0
Inpatient Services	46 (76.7%)	14 (23.3%)	0	75 (89.3%)	9 (10.7%)	1	121 (84.0%)	23 (16.0%)	1
Long-Term Care Services	53 (98.1%)	1 (1.9%)	1	96 (99.0%)	1 (1.0%)	2	149 (98.7%)	2 (1.3%)	3
Mental Health Services	44 (88.0%)	6 (12.0%)	0	79 (85.9%)	13 (14.1%)	0	123 (86.6%)	19 (13.4%)	0
Obstetrics Services	68 (93.2%)	5 (6.8%)	0	78 (88.6%)	10 (11.4%)	0	146 (90.7%)	15 (9.3%)	0
Perioperative Services and Invasive Procedures	108 (95.6%)	5 (4.4%)	2	100 (93.5%)	7 (6.5%)	2	208 (94.5%)	12 (5.5%)	4
Public Health Services	45 (95.7%)	2 (4.3%)	0	68 (98.6%)	1 (1.4%)	0	113 (97.4%)	3 (2.6%)	0
Reprocessing of Reusable Medical Devices	81 (97.6%)	2 (2.4%)	5	38 (95.0%)	2 (5.0%)	0	119 (96.7%)	4 (3.3%)	5
Substance Abuse and Problem Gambling	38 (84.4%)	7 (15.6%)	0	71 (87.7%)	10 (12.3%)	1	109 (86.5%)	17 (13.5%)	1
Total	**1071 (90.8%)**	108 (9.2%)	26	1445 (91.3%)	137 (8.7%)	21	2516 (91.1%)	245 (8.9%)	47

* Does not includes ROP (Required Organizational Practices)

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			
Accountability for Quality (Governance)	Met	4 of 4	2 of 2
Patient safety incident disclosure (Leadership)	Met	4 of 4	2 of 2
Patient safety incident management (Leadership)	Met	6 of 6	1 of 1
Patient safety quarterly reports (Leadership)	Met	1 of 1	2 of 2
Patient Safety Goal Area: Communication			
Client Identification (Acquired Brain Injury Services)	Met	1 of 1	0 of 0
Client Identification (Ambulatory Care Services)	Met	1 of 1	0 of 0
Client Identification (Cancer Care)	Met	1 of 1	0 of 0
Client Identification (Emergency Department)	Met	1 of 1	0 of 0
Client Identification (EMS and Interfacility Transport)	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			
Client Identification (Home Care Services)	Met	1 of 1	0 of 0
Client Identification (Inpatient Services)	Met	1 of 1	0 of 0
Client Identification (Long-Term Care Services)	Met	1 of 1	0 of 0
Client Identification (Mental Health Services)	Met	1 of 1	0 of 0
Client Identification (Obstetrics Services)	Met	1 of 1	0 of 0
Client Identification (Perioperative Services and Invasive Procedures)	Met	1 of 1	0 of 0
Client Identification (Substance Abuse and Problem Gambling)	Met	1 of 1	0 of 0
Information transfer at care transitions (Acquired Brain Injury Services)	Unmet	4 of 4	0 of 1
Information transfer at care transitions (Ambulatory Care Services)	Unmet	4 of 4	0 of 1
Information transfer at care transitions (Cancer Care)	Met	4 of 4	1 of 1
Information transfer at care transitions (Community-Based Mental Health Services and Supports)	Met	4 of 4	1 of 1
Information transfer at care transitions (Emergency Department)	Met	4 of 4	1 of 1

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Communication			
Information transfer at care transitions (EMS and Interfacility Transport)	Met	4 of 4	1 of 1
Information transfer at care transitions (Home Care Services)	Met	4 of 4	1 of 1
Information transfer at care transitions (Inpatient Services)	Unmet	2 of 4	1 of 1
Information transfer at care transitions (Mental Health Services)	Unmet	4 of 4	0 of 1
Information transfer at care transitions (Obstetrics Services)	Met	4 of 4	1 of 1
Information transfer at care transitions (Perioperative Services and Invasive Procedures)	Met	4 of 4	1 of 1
Information transfer at care transitions (Substance Abuse and Problem Gambling)	Unmet	4 of 4	0 of 1
Medication reconciliation as a strategic priority (Leadership)	Met	4 of 4	2 of 2
Medication reconciliation at care transitions (Ambulatory Care Services)	Unmet	4 of 7	0 of 0
Medication reconciliation at care transitions (Cancer Care)	Met	7 of 7	0 of 0
Medication reconciliation at care transitions (Emergency Department)	Met	4 of 4	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 (Home Care Services)	Met	4 of 4	1 of 1
Medication reconciliation at care transitions (Inpatient Services)	Met	5 of 5	0 of 0
Medication reconciliation at care transitions (Long-Term Care Services)	Met	5 of 5	0 of 0
Medication reconciliation at care transitions (Mental Health Services)	Unmet	4 of 5	0 of 0
Medication reconciliation at care transitions (Obstetrics Services)	Met	5 of 5	0 of 0
Medication reconciliation at care transitions (Perioperative Services and Invasive Procedures)	Met	3 of 3	0 of 0
Medication reconciliation at care transitions (Substance Abuse and Problem Gambling)	Met	3 of 3	2 of 2
Safe Surgery Checklist (Obstetrics Services)	Met	3 of 3	2 of 2
Safe Surgery Checklist (Perioperative Services and Invasive Procedures)	Met	3 of 3	2 of 2
The “Do Not Use” list of abbreviations (Medication Management Standards)	Met	4 of 4	3 of 3

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Medication Use			
Antimicrobial Stewardship (Medication Management Standards)	Unmet	4 of 4	0 of 1
Concentrated Electrolytes (Medication Management Standards)	Met	3 of 3	0 of 0
Heparin Safety (Medication Management Standards)	Met	4 of 4	0 of 0
High-Alert Medications (EMS and Interfacility Transport)	Unmet	4 of 5	2 of 3
High-Alert Medications (Medication Management Standards)	Met	5 of 5	3 of 3
Infusion Pumps Training (Ambulatory Care Services)	Met	4 of 4	2 of 2
Infusion Pumps Training (Cancer Care)	Met	4 of 4	2 of 2
Infusion Pumps Training (Emergency Department)	Met	4 of 4	2 of 2
Infusion Pumps Training (EMS and Interfacility Transport)	Met	4 of 4	2 of 2
Infusion Pumps Training (Inpatient Services)	Met	4 of 4	2 of 2
Infusion Pumps Training (Obstetrics Services)	Met	4 of 4	2 of 2
Infusion Pumps Training (Perioperative Services and Invasive Procedures)	Met	4 of 4	2 of 2
Narcotics Safety (EMS and Interfacility Transport)	Met	3 of 3	0 of 0

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Medication Use			
Narcotics Safety (Medication Management Standards)	Met	3 of 3	0 of 0
Patient Safety Goal Area: Worklife/Workforce			
Client Flow (Leadership)	Met	7 of 7	1 of 1
Patient safety plan (Leadership)	Met	2 of 2	2 of 2
Patient 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 (EMS and Interfacility Transport)	Met	1 of 1	2 of 2
Hand-Hygiene Compliance (Infection Prevention and Control Standards)	Met	1 of 1	2 of 2
Hand-Hygiene Education and Training (EMS and Interfacility Transport)	Met	1 of 1	0 of 0
Hand-Hygiene Education and Training (Infection Prevention and Control Standards)	Met	1 of 1	0 of 0
Infection Rates (Infection Prevention and Control Standards)	Met	1 of 1	2 of 2

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Infection Control			
Reprocessing (EMS and Interfacility Transport)	Met	1 of 1	1 of 1
Patient Safety Goal Area: Risk Assessment			
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 (Cancer Care)	Met	3 of 3	2 of 2
Falls Prevention Strategy (Emergency Department)	Met	3 of 3	2 of 2
Falls Prevention Strategy (Home Care Services)	Met	3 of 3	2 of 2
Falls Prevention Strategy (Inpatient 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 (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 (Perioperative Services and Invasive Procedures)	Unmet	0 of 3	0 of 2
Home Safety Risk Assessment (Home Care 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 (Inpatient Services)	Unmet	0 of 3	1 of 2
Pressure Ulcer Prevention (Long-Term Care Services)	Met	3 of 3	2 of 2
Pressure Ulcer Prevention (Perioperative Services and Invasive Procedures)	Unmet	1 of 3	1 of 2
Skin and Wound Care (Home Care Services)	Met	7 of 7	1 of 1
Suicide Prevention (Community-Based Mental Health Services and Supports)	Met	5 of 5	0 of 0
Suicide Prevention (Emergency Department)	Met	5 of 5	0 of 0
Suicide Prevention (Long-Term Care Services)	Met	5 of 5	0 of 0
Suicide Prevention (Mental Health Services)	Met	5 of 5	0 of 0
Suicide Prevention (Substance Abuse and Problem Gambling)	Met	5 of 5	0 of 0
Venous Thromboembolism Prophylaxis (Inpatient Services)	Unmet	3 of 3	1 of 2
Venous Thromboembolism Prophylaxis (Perioperative Services and Invasive Procedures)	Met	3 of 3	2 of 2

Summary of Surveyor Team Observations

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

Summary of Observations

Northern Health Region (NHR) is the largest region in Manitoba, covering approximately two thirds of the province with a population of 72,000 residents. In addition, services are provided to approximately 8,000 Saskatchewan residents. There are 10 cities/towns, 25 First Nations communities and 16 Northern communities. In addition there are homes and cottages throughout the rural and remote areas. At the time of the last survey in 2014, NHR was only two years into the amalgamation of 2 former regions – Nor-Man and Burntwood.

NHR is again facing significant change due to changes announced by the provincial Ministry of Health, Seniors and Active Living in early 2018. Shared Health Manitoba has been formed to lead a transformation agenda. NHR representatives are actively participating on transformation teams and councils. The Board and leadership team are committed to ensuring that the voice of northern health care is heard. There is a positive attitude toward the process and the staff expressed appreciation for the timely communication provided through the CEO.

The NHR Community Health Assessment 2014 has guided the development of the Strategic Plan 2016-2021 through community engagement and priority setting. There is a strong integrated system of planning. The strategic plan includes four strategic directions, each with actions and performance indicators. The CEO's monthly reports to the Board uses the strategic plan as a framework. More recently, an operational planning and risk management approach has been integrated with the strategic directions.

Partnerships are important to the success of NHR. Community partners value their relationships with the region, particularly those that have formal agreements. It was identified that progress has been made in communication and collaboration within the last several years. It was suggested that additional attention be paid to communication, inter-provincial strategies and the northern patient transfer program.

NHR is very committed to quality and safety from the Board level to front line staff. Monthly quality reports are provided at each Board meeting as well as a patient or employee quality/safety story or video. Staff report that they experience a just culture and support from their supervisors.

A strong foundation has been built for Patient and Family Centred Care (PFCC) reflecting longstanding regional values. Patients, clients and residents report they are treated with dignity and respect. Strategies for co-design and collaboration at the regional level have been established including Local Health Involvement Groups reporting to the Board, Resident and Family Councils, a collaborative approach to patient concerns and critical incidents

In its quest for continuous improvement, the organization enthusiastically and effectively prepared for the accreditation survey. The organization is commended for integrating accreditation standards and priorities into its day to day operations. Against a background of system transformation, there will need to be continued vigilance on supporting the quality and safety agenda and advancing patient centered care.

Detailed Required Organizational Practices

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: Communication	
Information transfer at care transitions Information relevant to the care of the client is communicated effectively during care transitions.	· Inpatient Services 10.16 · Ambulatory Care Services 9.10 · Substance Abuse and Problem Gambling 9.10 · Acquired Brain Injury Services 9.11 · Mental Health Services 9.18
Medication reconciliation at care transitions Medication reconciliation is conducted in partnership with clients and families to communicate accurate and complete information about medications across care transitions.	· Ambulatory Care Services 8.5 · Mental Health Services 8.6
Patient Safety Goal Area: Medication Use	
Antimicrobial Stewardship There is an antimicrobial stewardship program to optimize antimicrobial use. NOTE: This ROP applies to organizations providing the following services: inpatient acute care, inpatient cancer, inpatient rehabilitation, and complex continuing care.	· Medication Management Standards 2.3
High-Alert Medications A documented and coordinated approach to safely manage high-alert medications is implemented.	· EMS and Interfacility Transport 13.10
Patient Safety Goal Area: Risk Assessment	
Falls Prevention Strategy To minimize injury from falls, a documented and coordinated approach for falls prevention is implemented and evaluated.	· Perioperative Services and Invasive Procedures 11.11 · Ambulatory Care Services 8.6

Unmet Required Organizational Practice	Standards Set
Pressure Ulcer Prevention Each client's risk for developing a pressure ulcer is assessed and interventions to prevent pressure ulcers are implemented.NOTE: This ROP does not apply for outpatient settings, including day surgery, given the lack of validated risk assessment tools for outpatient settings.	· Perioperative Services and Invasive Procedures 11.12 · Inpatient Services 9.9
Venous Thromboembolism Prophylaxis Medical and surgical clients at risk of venous thromboembolism (deep vein thrombosis and pulmonary embolism) are identified and provided with appropriate thromboprophylaxis.NOTE: This ROP does not apply for pediatric hospitals; it only applies to clients 18 years of age or older. This ROP does not apply to day procedures or procedures with only an overnight stay.	· Inpatient Services 9.10

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

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.

Priority Process: Governance

Meeting the demands for excellence in governance practice.

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

The Minister of Health, Seniors and Active Living is responsible for appointing the Chair and members of the Board. The qualifications and application process are posted on the ministry website.

Committees of the Board include Finance, Audit, Governance, Quality and Safety and Indigenous Health and Human Relations. The latter committee has developed an Indigenous Health Strategy and has community voting members. Two Local Health Involvement Groups (LHIGs) have been established to provide patient and family advice to the Board. Currently the groups are working together to develop a set of Patient Values based on feedback from patient surveys, concerns and comments.

Board members feel they have made a great deal of progress since the amalgamation of two regions just before the last survey. They express their role as being a voice for all of the people in the north and value partnerships and relationships in communities. Community connection is a standing agenda item where concerns and updates about respective communities are provided by each member. Throughout the many changes, board members feel they have succeeded by placing patients and families at the centre.

The Region is very conscious of the unique needs and health equity issues in their vast region. The board and leadership participate actively in the community health assessment activities. The board receives regular reports on key health issues and action plans. The Strategic Plan 2016- 2021 is a major achievement and provides the structure for performance indicators as well as monthly and annual reporting by the CEO. Annual Health Summits have been held the last five years. Key health topics are featured and both patient and public attendees are engaged. Community partners feel they are very worthwhile and informative.

The board is very committed to improving quality and ensuring the safety of patients, families, staff and communities. There are monthly quality updates including quality indicators on the board Dashboard and quarterly full reports via the Quality and Safety Committee of the Board. The Board is encouraged to continue with the practice of hearing patient stories at each meeting, both positive and learnings from adverse events.

In Manitoba there is a standard process for medical privileging. According to The region Bylaws physicians apply to the Manitoba Privilege Assessment Committee (MPAC) which has subdivisions for specialties. This committee recommends privileges. The recommendations go to the Region Medical Advisory Committee which makes recommendations to the Chief Medical Officer (CMO) on whether MPAC recommendations should be granted. The CMO then grants privileges and oversees the processes for on-boarding, education and appeals.

It is acknowledged by Community Partners and leaders that recruitment and retention of physicians is one of the biggest challenges faced by The Region. Rural and remote communities are particularly concerned about physicians vacancies and lack of consistency. A related challenge is that since not all physicians working in The Region are funded through the region and benefits and working arrangements vary.

Financial performance is reviewed monthly for operating budget and quarterly for capital. The Board is proud of the recent financial performance of the organization. At the end of the last fiscal year there was a small deficit, in spite of incorporating reductions in government funding. Financial issues and forecasts are discussed and addressed in cooperation with the CEO on a timely basis.

The Region Governance Manual is a comprehensive collection of information for board members posted on the public website that is much appreciated by Board members. The Manual includes community engagement, board education and orientation, the conduct of board meetings and evaluation methods as well as the Strategic Plan and Accreditation Canada governance standards.The Board also has access to a consultant who has provided guidance through the process of the second amalgamated strategic plan.

Board members participate in an assessment of meeting effectiveness after each meeting. Annually, they assess the Board Chair and provide self assessments to the Chair. A skills matrix is also updated annually. The performance of the CEO is evaluated annually by board feedback with a 360 process every two years.

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		
1.3	Client- and family-centred care is identified as a guiding principle for the organization.	!
1.5	Policies addressing the rights and responsibilities of clients are developed and implemented with input from clients and families.	

Surveyor comments on the priority process(es)

The organization is commended for its integrated service planning framework and process. Every five years a comprehensive Community Health Assessment (CHA) is conducted. Community and staff engagement is a key part of the CHA, followed by a prioritization session with executive and senior management. The 2016-2021 draft strategic plan, the first since amalgamation of two health regions, was then submitted to the Board where it was reviewed alignment ensured with the vision, mission and values. Following this review, comments were invited from staff and the Board passed a final approval. There are 4 strategic directions, each of which is associated with strategic priorities, key performance measures and links to the provincial priorities. A comprehensive operational planning process is being implemented, linking the Region operational plans and all relevant resources, data and documents to the strategic plan. Team/department based operational plans flow from the overall operational plan. Each includes risks, action plans and performance measures. Quality and safety plans are a key component.

Progress reports to the Board are completed using a monthly Indicator Dashboard and as part of the leadership report from the CEO. The staff receive regular Board and Executive Leadership highlights reports. The team is encouraged to continue with plans for regular one page reports on the Operational Plan. Annually, the community is updated through the Annual Report and Report to the Community.

For the first time, the 2014 CHA included information from First Nations communities. All providers are brought together quarterly to work together on solutions to identified priority health and cultural issues, overcoming jurisdictional problems in the process. Partnership agreements have been developed to use and share First Nations health data (Panorama) for example regarding immunization rates. Some First Nations communities still conduct their own community health assessments and allow access by the Region. One of the positive outcomes from the CHA was the establishment of a TB Coordinator to help clients navigate the complexities of their care.

Each year, further community engagement in planning is achieved through an Annual Summit, sponsored by the board. Attendance includes all community leaders including representatives of First Nations and

Northern Health Community groups as well as a patient panel. Key policy and cultural issues are addressed. Last year diabetes, a major northern health problem is being addressed.

Risks being addressed in integrated planning include ensuring data quality, connecting systems and choosing a reasonable number of KPIs that can be supported by a new decision support team approach.

The support from the Manitoba Centre for Health Policy has helped to ensure a robust process. The Region representatives are on a Need to Know team that ties research to front line users.

Reporting to the Board, Local Health Involvement Groups (LHIGs) have been created since the last survey in two main geographic areas to assist with planning and other collaborative initiatives. Currently the LHIGs are developing a patient and family feedback and survey data to create Patient Values for submission to the Board

Although client and family centered care is inherent in the vision, mission and values it is not a specific written principle. It is recommended that it be considered when the Local Health Involvement Group completes its work on identifying the Patient Values.

The Interest and commitment of The region senior leaders to participating in the Manitoba Health System Transformation teams and councils without additional resources is commended. Their positive approach and expertise in northern health issues should be an asset to the process and an inspiration to staff.

Priority Process: Resource Management

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

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

New budgeting and reporting tools (VIVID) have been successfully implemented and save time that can now be used for more financial planning, analysis and support of managers. The new tool pulls information from payroll and general ledger databases and displays actual expenditures for 3 years. In addition, a shift to more timely reporting and forecasting to Manitoba Health Seniors and Active Living has enhanced the organization's ability to make decisions and balance its budget. However the region continues to cope with the significant ongoing challenge of funding reductions without approval for some for some of its recommended actions..

The Region representatives are commended for their strong participation on provincial councils Including the CFO Council, Capital Planning Council and Safety & Security Council. The new Supply Chain Management Council is expected to create significant efficiencies in procurement and other standardized processes.

The Region has created a position to coordinate the use of the northern patient transport program (NPTP) from a clinical perspective to ensure the best and most consistent use of transfer related resources (especially medevac services). This initiative has started to reduce cost overruns. Community partners expressed frustration about the lack of funding for patients and those who accompany them back from larger centres as well as lack of interprovincial arrangements to manage Saskatchewan residents near Flin Flon. The organization is encouraged to continue to work with partners to solve issues related with the program and to evaluate the impact of new initiatives from both a clinical and financial perspective.

Operating budget financial challenges are being addressed strategically including sick time performance management and position control management. Physician overtime and travel costs are an outstanding issue. It is suggested that models for the use of designated EMS staff in remote areas continue to be investigated, looking to successes in other provinces.

Capital budgets are very limited and hampered by the absence of clinical engineers to develop strategies to maintain equipment. Information and communication technology budgets are also very limited which is currently affecting the need to fund ever-greening, license fees and new system implementation.

Priority Process: Human Capital

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

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

The organization has made progress in becoming “an employer of choice”. A psychological health and safety team is working on advancing psychological health and safety throughout the organization. The organization's Values have been incorporated into the code of conduct and the annual performance conversation process.

Recruitment and retention strategies are in place including a "Grow Your Own" initiative which offers financial incentives for staff to upgrade their education with a return of service agreement. The organization has developed on line learning modules for staff education and mandatory annual requirements have been identified to augment the annual Patient Safety Roadshow.

The organization has rolled out the violence prevention program and has made progress in creating a culture of respect with zero tolerance for bullying.
The new performance conversation system has been implemented but the department is encouraged to bring the number of staff having annual performance conversations up from the current estimate of 30% of staff.

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	
12.5 The effectiveness of the integrated risk management approach is regularly evaluated and improvements are made as necessary.	

Surveyor comments on the priority process(es)

Achieving healthy safe work environments are key priorities in the HR Operational Plan which is aligned with the Region Strategic Direction of Employer of Choice. The Quality and Risk Operational Plan identifies safety and quality priorities to achieve the Strategic Direction of Accessible, Quality Health Services. Department, Senior Management and Executive leads are designated for each priority initiative.

The approach of integrating risk management in operational plans using risk identification (heat maps), mitigation plans and performance indicators for each departmental priority is creative and efficient. The same framework also includes Quality and Safety plans and resources.It is recommended that an evaluation of the operational planning and risk management approach be undertaken. It is noted that many front line staff and some managers are not aware of the operational plans and where to find them.

The Patient Safety Collaborative networks key staff and managers together to address patient safety reporting, ROPs and other opportunities for improvement. The Patient Experience Collaborative is being refreshed and patient representatives are being, according to new Patient Advisor information from the province. The team is encouraged to make the best use of this unique approach to collaborate.

The Critical Incident process and related disclosure processes are very well planned and implemented. The collaboration with patients/families throughout the process is exemplary.

Patient experience CPES-IC survey in acute care are conducted in Manitoba by MHSAL using the Canadian Institute for Health Information (CIHI) and results shared with the region and all sites. In the last survey, The Region was able to add five additional questions focusing on patient safety. Results are used to inform priority setting. Home Care, Mental Health, Primary Care and Long Term Care have separate regionally generated surveys.

Patient Safety priorities included Accreditation Canada ROPs, integrating safety into practice using huddles and using the provincial patient safety framework, standardizing clinical technology and building safety competency with colleges and universities. Resources and information is gathered from the Provincial Quality & Safety Committee and the Manitoba Institute for Patient Safety. It is recommended that a

strategy be developed to replace the paper based incident reporting system. In addition, pushing out results at the unit level would increase staff engagement.

Quality Improvement priorities at the regional level include improving access to services, proactive health prevention and promotion as well as enhanced employee wellness, Falls and full implementation of Medication Reconciliation. Although the organization pays great attention to quality care and services on a continuous basis, it is suggested that all departments be encouraged to undertake smaller quality improvement or Lean initiatives using a QI approach. This would include identifying quality issues with the assistance of patients and families, measuring baseline data, making a change, measuring again and evaluating effectiveness.

Priority Process: Principle-based Care and Decision Making

Identifying and making decisions about ethical dilemmas and problems.

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

Efforts made by the Ethic Committee co-chairs and committee members are to be commended. The past framework process and policy have been fully reviewed and updated, with improvements such as a user friendly algorithm added. This will support and strengthen the framework allowing for ongoing learning and increased awareness/uptake of process and use. The committee and leaders have worked hard to raise awareness and participation. Actions include involvement of Board members, and having Ethics as a standing agenda item for the SMT, Board and the Nursing Practice Council. Other approaches included learning sessions presented by video conference to all areas. These highlighted an actual ethical dilemma from a Personal Care Home which was reviewed using the process and led by a community member-Spiritual Health. Another was Pharmacy leading a session on MAID. The Ethics committee now reviews policies as part of the Document Management process and this has already resulted in changes to policies such as Suicide assessment. Lastly, responsiveness of the committee was highlighted using an example of research review and approval needed on short notice. The committee was able to meet within 24 hours and their questions resulted in an improved research process with approval.
Next steps for the group will be to track and share impacts of improvements made which should include continued action or next steps. This could include reporting case data with resultant actions; and tracking of policies reviewed with changes made based on this work. This would also be an ideal committee to include patients, family or caregiver members as Person and Family Centred Care efforts progress.
Well done to this active group!

Priority Process: Communication

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

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

The Region Communication Plan, most recently revised in 2018, is aligned with the Board approved Community Engagement Strategy and the organization's mission, vision and values. The plan summarizes the communications objectives, key stakeholder groups strategic considerations, key messages, tactics and evaluation. The Communications Coordinator leads the implementation of external and internal communications work.

Due to the provincial transformation and an environment of change, communication priorities are being as timely as possible and using a variety of different methods. Message content is coordinated with MHSAL for announcements as well as the CEO office for responding to the needs and concerns of staff. Since the last survey, relationships with government and media have improved and a sense of trust is in evidence.

The team is commended on their social media strategy. Based on a survey of internal and external stakeholders, a social media presence was established on twitter and facebook. Posts are intended to celebrate accomplishments, provide information on health topics and notify the public regarding urgent issues such as outbreaks. Hit rates show that messages are reaching significant numbers of community residents and staff.

A variety of communication methods are used to reach external stakeholders, families and patients. Indigenous Liaison staff in the larger centres act as interpreters and arrangements have been made with the Winnipeg Regional Health Authority (WRHA) to access 260 languages through a telephone service. Where there is no internet or cell service, announcements are broadcast through NCI radio.

Staff and physicians have easy access to the intranet for all resources including all policies and procedures and education. A new external website is being launched soon to enable customization and timely changes.

Clinical information systems have been implemented sequentially but do not yet cover the full range of programs. A very successful EMR system has been implemented in most ambulatory services as well as public health and home care and is being planned for community mental health. An electronic patient record system for admission, discharge, transfer and registration functions went live in 2017. However, paper based charts are still used on inpatient units and in personal care homes. It is recommended that the Region advocate with MHSAL to plan for filling the gaps and connecting the systems, perhaps using a provincial approach.

Privacy and confidentiality policies and processes are in place and are used effectively to protect health information, under the direction of the Privacy Officer. This position also coordinates requests for information under FIPPA as well as through information requests.

A variety of communication methods are used to transfer knowledge from research into practice, including the Medical Staff Newsletter and the Clinical Effectiveness Collaborative.

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: EMS and Interfacility Transport		
11.3	Annual checks of the driving or operating records of team members' who operate transport vehicles are performed and documented.	!
Standards Set: Perioperative Services and Invasive Procedures		
3.1	The physical layout of the operating and/or procedure room(s) and equipment are designed to consider client flow, traffic patterns, the types of procedures performed, ergonomics, and equipment movement logistics.	
3.7	Rooms where surgical and invasive procedures are performed have at least 20 complete air exchanges per hour.	!

Surveyor comments on the priority process(es)

The NHR owns and operates 9 Ambulance services. Communities & First Nations operate 6 other ambulance services under Service Purchase Agreements. Staff are licensed at the Technician, Primary Care Paramedic (PCP), or Intermediate (ICP) levels. The Regional Management Site is in The Pas.

The onsite fleet vehicles and EMS are is well equipped for emergencies. The rural or remote roads are gravel and when accidents or breakdowns occur during any season, the satellite radio is able to transmit and receives clear and understandable voice communications at all times. Fleet vehicles are well equipped with first aid kits, jumper cables, shovel and other lifesaving supplies. A fire extinguisher is not part of the kit. The vehicle is used by staff, locum physicians and maintenance. All must sign they have a current license when first hired. Employees or Physicians who have access to fleet vehicles are not routinely requested annual checks of driving or operating records. They do however sign a Declaration of Qualifications for Operation of RHA Fleet Vehicles with Human Resources when they first start with the Region.

The facilities are well maintained, clean and clutter-free to support physical accessibility for those who use mobility aids such as wheelchairs, crutches, or walkers. The organizations meet and follow applicable laws regulations and codes. Backup generator exists, extra food stores and extra water supply close by at all sites; ready for emergencies. Maintenance and housekeeping take pride in their roles and are nicely connected with clinical staff. All seem to work well together, enjoying their roles. The laundry facility in Gillam is small and has clean passing dirty, but workflow strives to follow a circle one way flow for minimal cross contact.

HVAC infrastructure is old and renovating the system is costly and unwieldy. Humidity/ air exchanges are an issue at most sites especially in MDRD and Operating Rooms. Workarounds are in place but encourage pushing for funding opportunities to enable plans.

Skilled staff and project management are the organizations' strength.

Priority Process: Emergency Preparedness

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

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

An outstanding team in the region is charged with establishing emergency preparedness. the team has developed a comprehensive emergency response plan and has identified a wide variety of potential sources of emergency. The team has prepared a comprehensive binder which is placed in a variety of readily available across the region. The information on emergency preparedness and the necessary responses are also available on intranet.

Training in responding to emergency has been implemented and continues. Training involves all staff from executives to front line staff. Training for executives includes the optimal management of an emergency command centre.

A variety of exercises have been developed.Appropriate relationships have been developed with community organisations to proceed to more complex exercises.
Exercises are reviewed and lessons learned to further refine the process.
The team is encouraged to continue on the current path. it was a pleasure to meet them

Priority Process: People-Centred Care

Working with clients and their families to plan and provide care that is respectful, compassionate, culturally safe, and competent, and to see that this care is continuously improved upon.

Unmet Criteria		High Priority Criteria
Standards Set: Acquired Brain Injury Services		
1.3	Service-specific goals and objectives are developed, with input from clients and families.	
2.4	Space is co-designed with clients and families to ensure safety and permit confidential and private interactions with clients and families.	
3.13	Client and family representatives are regularly engaged to provide input and feedback on their roles and responsibilities, role design, processes, and role satisfaction, where applicable.	
15.3	Measurable objectives with specific timeframes for completion are identified for quality improvement initiatives, with input from clients and families.	!
Standards Set: Ambulatory Care Services		
1.1	Services are co-designed with clients and families, partners, and the community.	!
1.7	Barriers that may limit clients, families, service providers, and referring organizations from accessing services are identified and removed where possible, with input from clients and families.	
2.4	Space is co-designed with clients and families to ensure safety and permit confidential and private interactions with clients and families.	
3.3	A comprehensive orientation is provided to new team members and client and family representatives.	
3.11	Client and family representatives are regularly engaged to provide input and feedback on their roles and responsibilities, role design, processes, and role satisfaction, where applicable.	
Standards Set: Cancer Care		
1.1	Services are co-designed with clients and families, partners, and the community.	!

1.8	Barriers that may limit clients, families, service providers, and referring organizations from accessing services are identified and removed where possible, with input from clients and families.	
2.4	Space is co-designed with clients and families to ensure safety and permit confidential and private interactions with clients and families.	
8.12	Client and family representatives are regularly engaged to provide input and feedback on their roles and responsibilities, role design, processes, and role satisfaction, where applicable.	
27.3	Measurable objectives with specific timeframes for completion are identified for quality improvement initiatives, with input from clients and families.	!
Standards Set: Community-Based Mental Health Services and Supports		
1.2	Services are co-designed with clients and families, partners, and the community.	!
4.10	Client and family representatives are regularly engaged to provide input and feedback on their roles and responsibilities, role design, processes, and role satisfaction, where applicable.	
16.7	Patient safety incidents are analyzed to help prevent recurrence and make improvements, with input from clients and families.	!
17.3	Measurable objectives with specific timeframes for completion are identified for quality improvement initiatives, with input from clients and families.	!
Standards Set: Emergency Department		
1.1	Services are co-designed with clients and families, partners, and the community.	!
4.15	Client and family representatives are regularly engaged to provide input and feedback on their roles and responsibilities, role design, processes, and role satisfaction, where applicable.	
18.3	Measurable objectives with specific timeframes for completion are identified for quality improvement initiatives, with input from clients and families.	!
Standards Set: EMS and Interfacility Transport		
27.3	Measurable objectives with specific timeframes for completion are identified for quality improvement initiatives, with input from patients and families.	!

Standards Set: Home Care Services		
15.3	Measurable objectives with specific timeframes for completion are identified for quality improvement initiatives, with input from clients and families.	!
Standards Set: Inpatient Services		
1.1	Services are co-designed with clients and families, partners, and the community.	!
2.5	Space is co-designed with clients and families to ensure safety and permit confidential and private interactions with clients and families.	
3.12	Client and family representatives are regularly engaged to provide input and feedback on their roles and responsibilities, role design, processes, and role satisfaction, where applicable.	
9.5	Goals and expected results of the client's care and services are identified in partnership with the client and family.	
11.1	Clients and families are actively engaged in planning and preparing for transitions in care.	!
15.9	Patient safety incidents are analyzed to help prevent recurrence and make improvements, with input from clients and families.	!
16.3	Measurable objectives with specific timeframes for completion are identified for quality improvement initiatives, with input from clients and families.	!
Standards Set: Leadership		
10.4	Education and training are provided throughout the organization to promote and enhance a culture of client- and family-centred care.	
Standards Set: Mental Health Services		
2.4	Space is co-designed with clients and families to ensure safety and permit confidential and private interactions with clients and families.	
3.15	Client and family representatives are regularly engaged to provide input and feedback on their roles and responsibilities, role design, processes, and role satisfaction, where applicable.	
14.7	Patient safety incidents are analyzed to help prevent recurrence and make improvements, with input from clients and families.	!

15.3	Measurable objectives with specific timeframes for completion are identified for quality improvement initiatives, with input from clients and families.	!
Standards Set: Obstetrics Services		
1.1	Services are co-designed with clients and families, partners, and the community.	!
2.4	Space is co-designed with input from clients and families to ensure safety and permit confidential and private interactions with clients and families.	
3.13	Client and family representatives are regularly engaged to provide input and feedback on their roles and responsibilities, role design, processes, and role satisfaction, where applicable.	
18.3	Measurable objectives with specific timeframes for completion are identified for quality improvement initiatives, with input from clients and families.	!
Standards Set: Perioperative Services and Invasive Procedures		
1.1	Services are co-designed with clients and families, partners, and the community.	!
2.4	Space is co-designed with clients and families to ensure safety and permit confidential and private interactions with clients and families.	
6.12	Client and family representatives are regularly engaged to provide input and feedback on their roles and responsibilities, role design, processes, and role satisfaction, where applicable.	
25.3	Measurable objectives with specific timeframes for completion are identified for quality improvement initiatives, with input from clients and families.	!
Standards Set: Public Health Services		
16.3	Measurable objectives with specific timeframes for completion are identified for quality improvement initiatives, with input from clients and families.	!
Standards Set: Substance Abuse and Problem Gambling		
1.1	Services are co-designed with clients and families, partners, and the community.	!

3.10	Client and family representatives are regularly engaged to provide input and feedback on their roles and responsibilities, role design, processes, and role satisfaction, where applicable.	
14.8	Patient safety incidents are analyzed to help prevent recurrence and make improvements, with input from clients and families.	!
15.3	Measurable objectives with specific timeframes for completion are identified for quality improvement initiatives, with input from clients and families.	!

Surveyor comments on the priority process(es)

The Region is committed to person centred care and this is shown on a daily basis in the way the organizational values guide service to patients, families, residents and clients.

At the organizational level, The Region has developed several excellent strategies and structures to facilitate collaboration and co-design including Local Health Improvement Groups and their work on patient values, patient stories at board meetings, robust critical incident process involving patients at every step, co-design of a new Flin Flon Emergency Department, well functioning LTC Resident and Family Councils and a new Mental Health Patient Involvement Group. The recruitment of Patient Advisors is in the planning stages. Some of the potential roles are membership on the Patient Safety Collaborative and the Patient Experience Collaborative.

Input and feedback is gathered routinely through major surveys - CIHI acute care survey plus other surveys in Home Care, Primary Care, Long Term Care and Mental Health. This feedback is taken into account in the planning and implementation of new or redesigned programs.

At the care delivery level, patients and families are highly involved according to the patients wishes and patients feel well informed. Patients and families who were interviewed are very pleased.

There has been less progress at the departmental and site level and less awareness of the rationale.
Available patient and family feedback does not seem to be used to make improvements
It is suggested that opportunities be offered to patients and families to be involved in local QI initiatives or conversations.

Priority Process: Patient Flow

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

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

The organization is very aware of and sensitive to issues around capacity and patient flow. The Emergency Departments in the Region have established processes to manage instances where unscheduled demand exceeds capacity. There is a very collegial relationship within the facilities visited which was evidenced by the willingness of other areas to band together to address this surge demand for service. It is not uncommon for clinicians from other areas to not only create capacity within their own areas but to also come down to the Emergency Room (ER) to assist with care in that setting. Anecdotally, we were also advised that staff members will even come in from home to assist when demand is high.

It is well understood by the organization that a high degree of the ER demand can be linked to challenges related to resources in primary care areas. A significant portion of the population does not have a family Physician due, in most part, to the limited number of available Primary Care Doctors as a result of historical under funding of positions based on population and panel size standards. This results in reduced availability of walk in and scheduled clinic time. The result is that the ER becomes the default healthcare solution for many low acuity clinical issues that could otherwise have been managed at a clinic.

At this time the types of surgeries performed within the Region jurisdiction are not 'wait list' type electives and surgery services does not appear to be oversubscribed.

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: Reprocessing of Reusable Medical Devices		
3.1	The layout of the MDR department is designed based on service volumes, range of reprocessing services, and one way flow of medical devices.	
3.4	The MDR department has an area for decontamination that is physically separate from other reprocessing areas and the rest of the facility.	!
3.6	The MDR department has floors, walls, ceilings, fixtures, pipes, and work surfaces that are easy to clean, non-absorbent, and will not shed particles or fibres.	!
4.1	Reprocessing equipment is purchased based on service volumes, input from team members, and considerations for maintenance, cleaning, and infection prevention and control.	

Surveyor comments on the priority process(es)

The reprocessing department is a dedicated, committed collaborative team that has been cross-trained to all roles in the department. This flexibility allows for cross-coverage when required to meet the needs of the organization. There are strong partnerships with the Operating Room (OR) and Emergency Department, their two largest customers. The MDR team is knowledgeable in all aspects of reprocessing and aware of the importance of their job for both patients and the organization.

There is a clear separation of dirty and clean areas in the reprocessing area in The Pas with demarcation of areas where additional gowning is required. In Thompson there is a need to review the dirty and clean separation. At the Thompson site scopes are cleaned in the OR area and the hospital might consider moving this to the MDR department which would free up OR space for storage or other needs. They do not flash sterilize at The Pas or Thompson and have no scoping services at The Pas site.

They have a good incident review process at The Pas and provided examples of working with the OR to uncover an post-op infection issue and with issues inside their department. Their training consists of on-line courses for certifications as well as LMS modules (Absorb)for completion. The staff indicate they enjoy their work and that they work well together and are proud of their contribution to care.

The physical plant is less than ideal in both The Pas and Thompson - cramped in Thompson, clean but old in all sites. There is some wooden counters in The Pas, Flin Flon and the Thompson reprocessing areas with exposed wood and wooden doors on entry in some sites and some wooden cabinets. The hospital

sites are encourage to continue to update the work areas to infection control standards. All sites of MDR should be reviewed and update in both physical plant and equipment as needed as a non-functioning area is a risk to the organizations work.

They continue to review expired packs to downsize in areas in the hospital as required and monitor the needs of the organizations to ensure they have the right and enough equipment to meet the demands. They send out broken equipment or discard depending on the state of the returned equipment/instruments.

They collect and review data to support quality improvement and continue to work as a team to increase efficiencies and their support to the organization.
Overall this is a well committed staff team work in less than optimal conditions doing good work with a fantastic attitude to their work and support of patient care.

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:

Population Health and Wellness

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

Standards Set: Population Health and Wellness - Horizontal Integration of Care

Unmet Criteria		High Priority Criteria
Priority Process: Population Health and Wellness		
1.3	The organization seeks input from members of its priority population(s) to identify service needs.	
5.3	The organization reviews its guidelines to make sure they are up to date and reflect current research and best practice.	!
Surveyor comments on the priority process(es)		
Priority Process: Population Health and Wellness		

This multidisciplinary team is made up of public health representatives, medical officers of health, health promotion staff... They are public health staff with a population health focus and demonstrate strong leadership and engagement. The team have a "can do" attitude where they have been able to get things done without new resources. They take an approach where they meet the client where they are, to ensure enhanced compliance.

They know the community and its' population well. The organization also completes a Community Health Assessment every 5 yrs as part of the strategic planning process. The assessment was last done in 2014 and work has begun on one for this planning cycle.

The public health team has a good sense of the community needs however the input process should be formalized to include surveys containing patient feedback and other forms of communication.

The team has set priorities to align with the overall strategic plan for the Northern Health Region. These priorities make up their operational plan. The team is encouraged to continue to define and monitor indicators to ensure their resources are being applied appropriately across the populations.

The team has been able to complete a number of health promotion projects with little or no new resource input. One example is their focus on increasing the breastfeeding numbers.
This region moved breastfeeding rates from 70% to 89% which is a very good outcome. They have trained lactation consultants and have been accredited by BFI, as a part of the breastfeeding strategy for Manitoba.

Self-managed care is available for some priority populations including for diabetes, other chronic diseases, sexual health, TB, living with stroke...to note a few. The team is encouraged to evaluate the data and make improvements or changes where necessary.
There is a service coordination committee for diabetes for example.
The team is encouraged to continue to share the data and results with other partners and stakeholders, as well as clients and staff.

There are some research projects underway including prenatal and the focus on improving access to prenatal care.

The region is moving to a Health Equity Approach where resources will be aligned with the areas of greatest need.
For example, they are working to ensure new babies are receiving their immunizations. They address reasons why Mothers may not take their babies for immunizations including transportation barriers, multiple children at home and no day care available....

There are a number of projects underway based on the Community Health Assessment results but driven by the community including Tobacco Tackle, to address smoking.

Another interesting and successful project is the Youth Leadership Project, started 10 yrs ago, where youth are educated and participate in leadership. It is youth focused and community based.

There are regular newsletters and educational opportunities, like the Summit and boot camp.
There is wonderful participation by youth and they undertake successful and meaningful projects. The goal is that this will expand across the North to ensure the future populations will make good decisions around health promotion and services required.
I suggested the team consider presenting this project as a Leading Practise to Accreditation Canada.

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 direction to teams providing services.

Competency

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

Episode of Care

- Partnering with clients and families to provide client-centred services throughout the health care encounter.

Decision Support

- Maintaining efficient, secure information systems to support effective service delivery.

Impact on Outcomes

- Using evidence and quality improvement measures to evaluate and improve safety and quality of services.

Medication Management

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

Organ and Tissue Donation

- Providing organ and/or tissue donation services, from identifying and managing potential donors to recovery.

Infection Prevention and Control

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

Public Health

- Maintaining and improving the health of the population by supporting and implementing policies and practices to prevent disease, and to assess, protect, and promote health.

Standards Set: Acquired Brain Injury Services - Direct Service Provision

Unmet Criteria			High Priority Criteria
Priority Process: Clinical Leadership			
2.5	The effectiveness of resources, space, and staffing is evaluated with input from clients and families, the team, and stakeholders.		
Priority Process: Competency			
4.5	Standardized communication tools are used to share information about a client's care within and between teams.		!
9.7	Access to spiritual space and care is provided to meet clients' needs.		
Priority Process: Episode of Care			
9.11	Information relevant to the care of the client is communicated effectively during care transitions.		ROP
	9.11.5	The effectiveness of communication is evaluated and improvements are made based on feedback received. Evaluation mechanisms may include: • Using an audit tool (direct observation or review of client records) to measure compliance with standardized processes and the quality of information transfer • Asking clients, families, and service providers if they received the information they needed • Evaluating safety incidents related to information transfer (e.g., from the patient safety incident management system).	**MINOR**
10.5	The transition plan is documented in the client record.		
10.7	The client's risk of readmission is assessed, where applicable, and appropriate follow-up is coordinated.		!
10.9	The effectiveness of transitions is evaluated and the information is used to improve transition planning, with input from clients and families.		
Priority Process: Decision Support			
11.3	Policies and procedures to securely collect, document, access, and use client information are followed.		!
11.6	Policies and procedures for securely storing, retaining, and destroying client records are followed.		!

Priority Process: Impact on Outcomes		
13.2	The procedure to select evidence-informed guidelines is reviewed, with input from clients and families, teams, and partners.	
13.3	There is a standardized process, developed with input from clients and families, to decide among conflicting evidence-informed guidelines.	!
13.4	Protocols and procedures for reducing unnecessary variation in service delivery are developed, with input from clients and families.	!
15.6	New or existing indicator data are used to establish a baseline for each indicator.	
15.7	There is a process to regularly collect indicator data and track progress.	
15.8	Indicator data is regularly analyzed to determine the effectiveness of the quality improvement activities.	!
15.10	Information about quality improvement activities, results, and learnings is shared with clients, families, teams, organization leaders, and other organizations, as appropriate.	
15.11	Quality improvement initiatives are regularly evaluated for feasibility, relevance, and usefulness, with input from clients and families.	

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

This is a strong and knowledgeable interdisciplinary team. They are focused on positive resident outcomes and celebrate their successes.
The neuro psychologist who was a part of the original planning and design, still comes to the centre every 5-6 weeks for 3 days to provide resident assessment and treatment, support to residents and families by phone, helps to develop rehabilitation strategies, to develop behavioural management programs, and to provide education to the staff.

The facility was built 10 yrs ago for ABI pts.. They did not put in a treatment or assessment area which would be helpful.
There is limited input from clients and families into the space, staffing....The team would benefit from having a pt and /or family rep as part of their clinical team for these types of discussions, as well as Quality Improvement activities..

Priority Process: Competency

The team consists of a social worker, manager, transition workers, program OT and a neuro psychiatrist. They also can consult with the hospital for medical needs, nutrition services...
The team meet monthly as a group. At the monthly meetings, ethics is on the agenda as a standing item.
The team has had a number of different managers so they will benefit from the consistency of having an ongoing manager.

The staff use the learning management system, Absorb , which provides online education, for the majority of their courses and training. These include Food Safe Handling, Indigenous courses, hand hygiene, WHMIS, ethics, fire safety, disaster planning, Violence prevention...to note a few.
The staff require Food Safe Handling as part of their programming with the residents is meal preparation.

The psychologist has developed and implemented a Staff Training Manual for Acquired Brain Injury (ABI) that is provided to the staff. It is a very inclusive manual to educate, train and guide the work specific to Acquired Brain Injury.

Priority Process: Episode of Care

The Northern Health Region Acquired Brain Injury Neuro-Rehabilitation Residence is a 5 bed unit in Thompson. It is a voluntary residence where they can stay up to one year.
It is the only one available in the North so they receive applications from all over.
The team is multidisciplinary and very committed to the residents. The team is made up of social worker, manager, transition workers, neuro psychologist... You can sense the enthusiasm they feel when a resident is discharged or transitioned to a permanent home. They maintain contact with some residents after discharge and are pleased to hear of their progress. They share those successes among the team.

The staff do a falls risk assessment on each resident to identify their risk level to fall. They implement a plan to help reduce the risk for falling. For one resident they were able to reduce the risk of falling by 50%, great results.

The occupational therapist (OT) develops and evaluates the programs for each resident to ensure the program continues to meet their needs. The programs are diversified and run throughout the day. All programs are aligned with the residents care and recovery plan.

The staff are trained in Food Safe Handling as the residents participate in meal preparation with the staff, as a apart of their programming.

Medications are not administered by the staff. The staff store the medications and note when they take them or when they refuse them.

If a resident requires medical care, support for pain, they would be taken to the emergency dept or referred to a physician. The residence does not provide this level of acute care.

The environment at the residence is warm, sunny, welcoming, and colorful with one of the residents' creative puzzles hung throughout the building. They are wonderful additions to this facility and I want to commend the resident for the great work and contribution she has made.

The family members I spoke to were very positive about the improvements and progress their son has made since entering the program, They find the staff respectful, knowledgeable, caring and responsive to their questions. The requests the family shared with me were noted by the manager for followup.
The staff always strive to make improvements for the residents" to improve their overall quality of life.

The team have some descriptive and colorful handouts for residents and families to offer explanation and an overview of the services.
There is a Guide for Families to help them understand brain injury and a pamphlet on what the residence is and the objectives of the program.
There is a standardized application process as well as a discharge plan.
There is also a client handbook to outline the program. The staff have done some good work on developing this documentation.

Priority Process: Decision Support

Policies and procedures specific to clinical area need to be developed and implemented. These need to be reviewed and updated regularly, as outlined in the regions' policy.
Administrative policies are available for the staff.

It would appear that the administrative policies and procedures are completed but not always well communicated to all the staff across the region. There seems to be a gap between the Regional office and the front line staff.

Attention to communication is important for services that are on their own to ensure they are aware of the regions priorities and direction. Having a regular manager will help greatly with that.

Priority Process: Impact on Outcomes

There is a process to select evidence based guidelines for the region however the team are not selecting guidelines using this process. This will be helpful as they develop their policies and procedures.

The quality improvement activities need to be formalized for development of indicators, evaluation and tracking to make improvements. All results should be shared back with the team, patients (pts) and their families. The pts and families could be involved where possible.
The OT on staff would be a great resource for indicator definition and tracking, similar to what he is doing with falls.

Standards Set: Ambulatory Care Services - Direct Service Provision

Unmet Criteria		High Priority Criteria
Priority Process: Clinical Leadership		
1.2	Information is collected from clients and families, partners, and the community to inform service design.	
1.3	Service-specific goals and objectives are developed, with input from clients and families.	
1.4	Services are reviewed and monitored for appropriateness, with input from clients and families.	
2.3	An appropriate mix of skill level and experience within the team is determined, with input from clients and families.	
2.6	The effectiveness of resources, space, and staffing is evaluated with input from clients and families, the team, and stakeholders.	
Priority Process: Competency		
3.10	Team member performance is regularly evaluated and documented in an objective, interactive, and constructive way.	!
3.12	Team members are supported by team leaders to follow up on issues and opportunities for growth identified through performance evaluations.	!
4.2	The team works in collaboration with clients and families.	
4.4	Standardized communication tools are used to share information about a client's care within and between teams.	!
4.5	The effectiveness of team collaboration and functioning is evaluated and opportunities for improvement are identified.	
Priority Process: Episode of Care		
7.10	When clients are incapable of giving informed consent, consent is obtained from a substitute decision maker.	!
7.11	Clients and families are provided with opportunities to be engaged in research activities that may be appropriate to their care.	
7.13	Clients and families are provided with information about their rights and responsibilities.	!

8.5	Medication reconciliation is conducted in partnership with clients and families to communicate accurate and complete information about 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 how often medication reconciliation is repeated.	ROP
8.5.1	The type of ambulatory care visits where medication reconciliation is required are identified and documented.	**MAJOR**
8.5.5	Medication discrepancies are resolved in partnership with clients and families OR medication discrepancies are communicated to the client's most responsible prescriber and actions taken to resolve medication discrepancies are documented.	**MAJOR**
8.5.7	The client and the next care provider (e.g., primary care provider, community pharmacist, home care services) are provided with a complete list of medications the client should be taking following the end of service.	**MAJOR**
8.6	To minimize injury from falls, a documented and coordinated approach for falls prevention is implemented and evaluated.	ROP
8.6.1	A documented and coordinated approach to falls prevention is implemented.	**MAJOR**
8.6.2	The approach identifies the populations at risk for falls.	**MAJOR**
8.6.3	The approach addresses the specific needs of the populations at risk for falls.	**MAJOR**
8.6.4	The effectiveness of the approach is evaluated regularly.	**MINOR**
8.6.5	Results from the evaluation are used to make improvements to the approach when needed.	**MINOR**
9.1	The client's individualized care plan is followed when services are provided.	
9.10	Information relevant to the care of the client is communicated effectively during care transitions.	ROP

9.10.5	The effectiveness of communication is evaluated and improvements are made based on feedback received. Evaluation mechanisms may include: • Using an audit tool (direct observation or review of client records) to measure compliance with standardized processes and the quality of information transfer • Asking clients, families, and service providers if they received the information they needed • Evaluating safety incidents related to information transfer (e.g., from the patient safety incident management system).	**MINOR**
10.8	The effectiveness of transitions is evaluated and the information is used to improve transition planning, with input from clients and families.	
Priority Process: Decision Support		
11.8	There is a process to monitor and evaluate record-keeping practices, designed with input from clients and families, and the information is used to make improvements.	!
Priority Process: Impact on Outcomes		
13.1	There is a standardized procedure to select evidence-informed guidelines that are appropriate for the services offered.	!
13.2	The procedure to select evidence-informed guidelines is reviewed, with input from clients and families, teams, and partners.	
13.3	There is a standardized process, developed with input from clients and families, to decide among conflicting evidence-informed guidelines.	!
13.4	Protocols and procedures for reducing unnecessary variation in service delivery are developed, with input from clients and families.	!
13.5	Guidelines and protocols are regularly reviewed, with input from clients and families.	!
15.1	Information and feedback is collected about the quality of services to guide quality improvement initiatives, with input from clients and families, team members, and partners.	
15.4	Indicator(s) that monitor progress for each quality improvement objective are identified, with input from clients and families.	
15.5	Quality improvement activities are designed and tested to meet objectives.	!
15.7	There is a process to regularly collect indicator data and track progress.	

15.8	Indicator data is regularly analyzed to determine the effectiveness of the quality improvement activities.	!
15.10	Information about quality improvement activities, results, and learnings is shared with clients, families, teams, organization leaders, and other organizations, as appropriate.	
15.11	Quality improvement initiatives are regularly evaluated for feasibility, relevance, and usefulness, with input from clients and families.	

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

The Ambulatory clinics held at Flin Flon, Gilliam, Northern Consultation Centre, The Pas Clinic and Thompson General are led by dedicated staff that are caring and engaged in health teaching, and the delivery of safe patient care. The Clinics are run with Nurse Practitioners, Physicians Assistants, and Contract Physicians. The recruitment of skilled staff is a huge strain on the organizations of the region. The key challenge the region in rural areas is facing is the physician shortage. Their on-going efforts to find creative ways to work within that context are encouraged.

The sites are also now considering ways to involve clients and families in decisions affecting them. Encourage leadership to become more engaged with involving clients and families in the decisions of the organization.

Unit annual goals and objectives are not formally done at the sites to align with the corporate overarching plans.

The Pas clinic team members include RN's, LPN's and Healthcare Aides as well as doctor and surgeon. It does not appear that these nursing professions are used at the top of their skill levels other than to assist the doctors by recording patient vitals or assisting with minor procedures and clerical duties: there are opportunities to give them more significant scope of practice. This could also assist the other rural remote areas.

The effectiveness of resources, space, and staffing is evaluated however without input from clients and families, the team, and stakeholders.

Priority Process: Competency

The staffing consists of a multidisciplinary group of regulated and unregulated professionals. There is good collaboration among the group and a commitment to optimizing client care.

The organization supports and offers opportunities for training and education via on line programs, webinars, conferences and via telehealth or Lync.
Staff receives regular infusion pump training and annual reviews.

When an ethical dilemma arises the staff are aware of the process to seek the expertise of the ethicist. Performance appraisals are not routinely completed. Performance appraisals are an essential tool to motivate staff and provide them performance feedback. Some position profiles have also not been reviewed for several years and should be updated.

The staff at Thompson General Hospital are very culturally aware and take any training provided to them. Approximately 95% of their patients are indigenous.
There is significant variability of paper versus electronic charts, and how users actually use the system, leading to variable communication tools. It is encouraged to inform all sites of the plan for standardization across the region.

Priority Process: Episode of Care

The key issue with the Ambulatory Clinics is wait times for clinic appointments and leadership is looking at creative ways to improve access. Falls risk assessment and medication reconciliation could be strengthened. The falls risk assessment was being done at most sites, but has fallen off and needs to be reinstated.

Ambulatory care includes a wide range of services and client populations, thus targeting medication reconciliation to clients or populations that are at risk of adverse drug events is encouraged. Ambulatory care clients are at risk when their care is highly dependent on medication management or if the medications typically used are known to be associated with adverse drug events. Evaluation of effectiveness of transitional care is recommended.

Two person specific identifiers are used to confirm that the correct client receive the appropriate treatment.

Patients and families interviewed confirmed they are informed of the next steps in their care and the information is important for their well-being and conditions.

Priority Process: Decision Support

The patient record in Ambulatory care is mostly electronic and provides a good overview of client information. An identified opportunity is the development of standardized approaches across the region to the release of health information.

A concern with clinics that utilize Locum physicians was the ordering of tests need to be referred to the Most Responsible Physician so the continuum of care is provided. Some lab results waited weeks before a “ordering Locum” returned. Some locums may not ever return. This is a gap in service and should be resolved.
Policies and procedures are documented, reviewed and updated in Winnipeg.

Priority Process: Impact on Outcomes

The Gillam Ambulatory Clinic is informally aligned with corporate quality initiatives and health teaching. The program could benefit from the expansion of family and patient input in education material,as well as the privacy and confidentiality project of the new registration/ triage are. Adverse events, near misses are reported reviewed and shared back with the staff.

The Flin Flon clinic is aligned to the corporate quality initiatives however, opportunities exist to identify and select manageable quality improvement projects relevant to the ambulatory care service. An identified opportunity is development of evidence-based protocols to guide clinicians across the region.

Overall all sites could benefit from learning more from the data on performance metrics, how they are systemically tracked and used for performance improvement initiatives.

The site are all in the initial stages of involving patients and families in quality improvement strategies.

NCC site highly individualized to physician preferences.....the centre is highly dependent on locums and the variability of practice among physicians causes unnecessary hardship and workload for staff. The use of the EMR is highly individualized and variable.

In Thompson, they do hand hygiene audits and physician order reviews.

The Manitoba Renal Program does not track infection rates for their satellite sites. There is no quarterly report required to Winnipeg.
The team is encouraged to review this and move to formal QI activities, to evaluate their services and make improvements.

Standards Set: Cancer Care - Direct Service Provision

Unmet Criteria		High Priority Criteria
Priority Process: Clinical Leadership		
1.2	Information is collected from clients and families, partners, and the community to inform service design.	
1.3	Service-specific goals and objectives are developed, with input from clients and families.	
1.4	Services are reviewed and monitored for appropriateness, with input from clients and families.	
Priority Process: Competency		
The organization has met all criteria for this priority process.		
Priority Process: Episode of Care		
24.4	Technologies, systems, and software are interoperable.	
Priority Process: Decision Support		
The organization has met all criteria for this priority process.		
Priority Process: Impact on Outcomes		
25.2	The procedure to select evidence-informed guidelines is reviewed, with input from clients and families, teams, and partners.	
27.7	There is a process to regularly collect indicator data and track progress.	
27.9	Data are collected on treatment-related toxicity outcomes.	
27.11	Client-reported outcomes are collected and reviewed as part of the cancer program's quality improvement initiatives.	
27.12	Data about disease control and survival outcomes are collected.	
27.13	Indicator data are compared to available benchmarks.	
27.14	Indicator data is regularly analyzed to determine the effectiveness of the quality improvement activities.	!
27.15	Quality improvement activities that were shown to be effective in the testing phase are implemented broadly throughout the organization.	!

27.16	Information about quality improvement activities, results, and learnings is shared with clients, families, teams, organization leaders, and other organizations, as appropriate.	
27.17	Quality improvement initiatives are regularly evaluated for feasibility, relevance, and usefulness, with input from clients and families.	

Priority Process: Medication Management

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

The cancer care program in the Region is established primarily as a service delivery of chemotherapy to enable clients to receive their chemotherapy closer to home and avoid the arduous trip to Winnipeg. Cancer Care Manitoba has partnered with a number of regional health authorities for the benefit of patients and also to relieve the pressure on space restricted cancer care facilities.

I met with staff and one of the "family doctor oncologists" as well as a number of patients.
All expressed a high level of satisfaction with both the training and the service as well as the exceptional availability of the oncologists of Cancer Care to answer questions and assist with issues.

The Region could benefit greatly from a better degree of data sharing.

Priority Process: Competency

All staff are well trained in the administration of chemotherapy and the management of side effects. Clients expressed a high degree of satisfaction with the service. Ongoing education and training is provided regularly. The team works well together.

Priority Process: Episode of Care

The Regional team works well with Cancer Care Manitoba to coordinate and deliver care to patients as close to home as possible. The team has access to the Cancer Care EMR (ARIA) and chemotherapy prescriptions are electronically ordered.Comprehensive patient information is available on every client and the full extent of the treatment plan and anticipated goals are evident.

Patients expressed a high degree of satisfaction with the services provided.

Of concern however, is the ongoing use of printed and faxed material going from the chemo suite to the pharmacy. While chemo orders are electronic,it seems redundant for the nurse to print the orders off and fax them to pharmacy when pharmacy also has access to Aria.

Pharmacy also has access to Aria but receives a faxed requisition from the nurse and then enters that order manually into the pharmacy system. When asked about this the answer seemed to be "that's always how we've done it" which is not really acceptable.

Patients are assessed for a wide variety of needs including psychosocial care, pain, quality of life etc.

Mention will be made in the pharmacy section of the dreadful state of the chemotherapy preparation room and hood. This facility is beyond antiquated and needs urgent upgrading. Patient and staff safety must be paramount values and the lack of attention to this area is not in my view consistent with the stated organisational values

Priority Process: Decision Support

Cancer Care Manitoba uses the 'Aria' electronic medical record system. Staff at regional chemotherapy delivery and care sites have access to Aria. Cancer Care Manitoba has a robust set of evidence based treatment protocols which can be readily accessed. A comprehensive set of client data is collected and shared.

Priority Process: Impact on Outcomes

Cancer Care Manitoba may have a well functioning system for collecting data on patient outcomes in terms of survival, recurrence rates etc., but this is of little value to a regional hospital providing community oncology services.Much greater attention needs to be paid to the outcomes of regional oncology services as it relates to the clients and population being served and the staff providing that service. With appropriate use of Aria, much greater detail could be collected, analyzed and used in a proactive way to improve service delivery.
Patient reported outcomes are a key indicator of cancer services and are missing.
The organisation and its clients would be well served by fosussing some effort here

Priority Process: Medication Management

see the notes in a previous section regarding the lack of interactivity between the Aria ordering system and the regional pharmacy systems

Standards Set: Community-Based Mental Health Services and Supports - Direct Service Provision

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		
13.8	There is a process to monitor and evaluate record-keeping practices, designed with input from clients and families, and the information is used to make improvements.	!
Priority Process: Impact on Outcomes		
15.1	There is a standardized procedure to select evidence-informed guidelines that are appropriate for the services offered.	!
15.2	The procedure to select evidence-informed guidelines is reviewed, with input from clients and families, teams, and partners.	
15.3	There is a standardized process, developed with input from clients and families, to decide among conflicting evidence-informed guidelines.	!
15.4	Protocols and procedures for reducing unnecessary variation in service delivery are developed, with input from clients and families.	!
17.1	Information and feedback is collected about the quality of services to guide quality improvement initiatives, with input from clients and families, team members, and partners.	
17.2	The information and feedback gathered is used to identify opportunities for quality improvement initiatives and set priorities, with input from clients and families.	
17.5	Quality improvement activities are designed and tested to meet objectives.	!

17.8	Indicator data is regularly analyzed to determine the effectiveness of the quality improvement activities.	!
17.10	Information about quality improvement activities, results, and learnings is shared with clients, families, teams, organization leaders, and other organizations, as appropriate.	
17.11	Quality improvement initiatives are regularly evaluated for feasibility, relevance, and usefulness, with input from clients and families.	

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

Flin Flon
The Community Mental Health Service in Flin Flon has established a recovery-focused, trauma-informed approach to service delivery. They are moving in the direction of adopting Wellness Recovery Action Planning (WRAP) to further enhance a patient-centred approach that includes peer support. They also have three mental health promotion specialists who work in schools, provide community anti stigma education etc. The program has identified two individuals to serve as patient advisers who will provide the patient's voice to inform the team in planning and decision-making.

Crisis Services for Youth
There is a Mobile Crisis Team for youth under 18 yrs of age. They provide service within 110 km radius from Thompson and to all youth aged 17 and younger living in Northern Manitoba, 12 hrs per day, 7 days per week, 12 noon to 12 midnight. Outside the 110 km radius, they can do assessments via telehealth or by phone.
As well they provide triage and follow-up Monday to Friday, 830 am - 430 pm. The service is very accessible. The assessments are done by two staff, a crisis worker and a clinician.
Staff respond to requests for assessment, support and consultation for youth in crisis due to mental health issues, suicide or addictions.
The multidisciplinary team is knowledgeable and committed to youth and their well being.
The staff are aware of the needs of the youth in the area and have engaged in projects through Healthy Child Manitoba. These projects have provided them additional resources for NEW positions to better meet the needs.

Hope North
The Crisis Stabilization Unit is a safe environment for youth to take a break from current life circumstances where they receive support, encouragement and life skills. They focus on enhancing protective factors to decrease stress, reduce risk factors for suicide and address mental health issues. The youth stay 4-7 days and access the unit through the Mobile Crisis team.
Youth, families and communities will be involved in ongoing support for youth.
The team is multidisciplinary, focused on recovery and provides a home environment for the youth in their care.

Priority Process: Competency

Flin Flon

A dedicated and committed team consists of wellness and recovery workers, proctors, housing specialists, mental health promotion specialists, psychiatrists, and others.

Crisis Services for Youth

The team receives education through the Learning Management System online, Absorb.
Some staff are in new roles and they are required to take additional education and training.

Hope North

The team have access to professional development and education both through online learning management, Absorb , as well as other means.
Some staff continue to complete online professional development as well as university courses.

Priority Process: Episode of Care

Flin Flon

The team works with clients to establish goals and treatment plans. Their services are culturally sensitive, holistic and focused on patient and family-centred care. They have received very positive responses from clients in their recent patient satisfaction survey.

Crisis Services for Youth and Hope North

Hope North Recovery Centre for Youth is a new facility, almost one year old, the setting was chosen for the trees, green space, tranquility and to align with Indigenous culture. The facility was designed with input from the youth of the area. It is a beautiful facility with good security, homelike setting, environmentally friendly, accessible, has outside space, private rooms, access to telehealth, meeting rooms and so much more. There is a central room they use as a spiritual space with circular layout for inclusiveness and beautiful murals with indigenous theme by a indigenous artist.

Youth go through the Mobile Crisis Unit assessment to access the Crisis Stabilization Unit. There is programming available on the Stabilization unit. The youth can also assist with meal preparation as that is provided by staff onsite. The staff have completed the Food Safe Handling program offered online.

There are a number of good pamphlets and booklets available as a source of information.

The Mobile Crisis Team have a mobile unit that they take around the community to where the kids gather. They provide information on their services, hand out business cards and get more familiar with the youth.

The team also provide education and information in the schools to youth, teachers, families, and to community groups.

The teams are aware of ethical framework however would benefit from additional and ongoing education.

The team would benefit from more input and feedback from clients and families. They told me that they can access the youth readily in the areas if they require their input, similar to what they did with facility design.

All clients have goals and discharge plans following collaboration with the client.
Upon discharge, the clients are followed by the Mobile Crisis team. The youth are assessed by Mobile Crisis team to access the Crisis Stabilization unit and then followed up by same team after discharge.

Priority Process: Decision Support

Flin Flon

The team uses evidence-based assessments and guidelines. They will soon be moving to an enhanced electronic health record which provides an opportunity for report writing to provide decision support for program planning and development.

Crisis Services for Youth

Policies and procedures are in place. Some programs mandated through Healthy Child Manitoba have very focused policies and procedures. For example they have implemented Brief Services, a goal directed collaborative approach to positive change and have hired a coordinator to lead this program. The program is 6-8 sessions designed to build on existing strengths /skills and focus on solutions/ goal setting.
There are paper as well as electronic files leading to duplication. The files are very well written and organized however there would be huge benefits to moving to electronic health record (EHR).

Hope North

Policies and procedures need to be developed, implemented, reviewed and updated. The files are paper and again this area would benefit from EHR.
The area would benefit from policies and procedures around safe storage, retention and destroying records.

Priority Process: Impact on Outcomes

Flin Flon

The team has developed a client survey to provide input to the quality improvement planning process.

Crisis Services for Youth and Hope North

There is nothing available on evidence based guidelines to direct selection of or to settle discrepencies.

The team measures indicators that are required through Healthy Child Manitoba or the region, however they would benefit from formalizing Quality Improvement activities, selecting meaningful indicators that are tracked and those results reported back to the staff, clients and families to make improvements. There is no feedback loop back to the staff.

Standards Set: Emergency Department - Direct Service Provision

Unmet Criteria		High Priority Criteria
Priority Process: Clinical Leadership		
1.2	Information is collected from clients and families, partners, and the community to inform service design.	
1.3	Specific goals and objectives regarding wait times, length of stay (LOS) in the emergency department, client diversion to other facilities, and number of clients who leave without being seen are established, with input from clients and families.	
2.6	Seclusion rooms and/or private and secure areas are available for clients.	!
2.9	The effectiveness of resources, space, and staffing is evaluated with input from clients and families, the team, and stakeholders.	
Priority Process: Competency		
4.11	Education and support to work with clients with mental health and addictions are provided to team members.	
4.13	Education and training are provided on how to identify palliative and end-of-life care needs.	!
4.14	Team member performance is regularly evaluated and documented in an objective, interactive, and constructive way.	!
4.16	Team members are supported by team leaders to follow up on issues and opportunities for growth identified through performance evaluations.	!
12.12	Access to spiritual space and care is provided to meet clients' needs.	
Priority Process: Episode of Care		
7.1	Entrance(s) to the emergency department are clearly marked and accessible.	!
Priority Process: Decision Support		
10.12	Evidence-based protocols are used to select diagnostic imaging services for pediatric clients.	
Priority Process: Impact on Outcomes		
18.10	Indicator data is regularly analyzed to determine the effectiveness of the quality improvement activities.	!

Priority Process: Organ and Tissue Donation		
11.1	There are established protocols and policies on organ and tissue donation.	
11.2	There is a policy on neurological determination of death (NDD).	
11.3	There is a policy to transfer potential organ donors to another level of care once they have been identified.	
11.4	There are established clinical referral triggers to identify potential organ and tissue donors.	
11.5	Training and education on organ and tissue donation and the role of the organization and the emergency department is provided to the team.	
11.6	Training and education on how to support and provide information to families of potential organ and tissue donors is provided to the team, with input from clients and families.	
11.7	When death is imminent or established for potential donors, the OPO or tissue centre is notified in a timely manner.	
11.8	All aspects of the donation process are recorded in the client record, including the family's decision about organ and tissue donation.	

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

The NRHA Emergency Departments (EDs) are well established in the region and are an important part of the communities they serve. The organization is blessed with having talented and innovative people who are committed to quality care. Despite challenges with space and infrastructure these teams have found ways to provide quality care. The EDIS system is a good first step

Opportunities:
Space issues continue to be major challenges for most areas. This lack of space extends to create issues with things like clean/dirty utility rooms and triage areas.

Recruitment and retention of physicians is a major contributor to ED congestion. The lack of primary care MDs contributes to primary care access issues as clinics back up and, at times, close completely resulting in a steady stream of patients going to EDs to address minor medical needs that could otherwise have been managed in a clinic setting.

Priority Process: Competency

The NRHA does provide unique development opportunities for new employees. These new practitioners can come north and be exposed to many different clinical settings and gain significant experience in a short time.

Opportunities:
The constant in-flow of inexperienced people who need guidance to become proficient is a challenge. Informally this falls on experienced staff which can have an impact on burnout. A formal mentorship program may offer some mitigation to these concerns.

Expansion of areas of excellence such as palliative care could be exploited to raise overall capacity within the region in areas that currently are without these resources.

Priority Process: Episode of Care

The care provided for patients is excellent.

Opportunities:
Charting consolidation would continue to be an important initiative as mentioned previously.

Priority Process: Decision Support

The organization is developing enhanced ability to communicate at a distance. The IT infrastructure is relatively solid.

Opportunity:
Expansion of the EDIS system to being a fully electronic solution. The current hybrid system of paper/electronic reporting is awkward and can be confusing with opportunities to lose or miss important information.

Priority Process: Impact on Outcomes

The NRHA is well positioned to be a leader in enhancing quality care provincially. The combination of size and infrastructure make it an ideal place to conduct research and advance quality initiatives.

Priority Process: Organ and Tissue Donation

There is a tremendous opportunity for the Region to participate in expanding a program that would support a larger provincial transplant program that could impact many lives. However at this time identification of potential donors or approaching the family of potential donors is not done. NRHA could develop overarching policies,awareness and education for Organ and Tissue donation and retrieval. All sites could participate.

Every year many people die while waiting for an organ donation and small sites could participate by helping develop an awareness of the Canadian Transplant society. Smaller sites could be trained to retrieve tissue and eyes. If larger organs could be harvested than the body could be flown out.

Standards Set: EMS and Interfacility Transport - Direct Service Provision

Unmet Criteria	High Priority Criteria
Priority Process: Clinical Leadership	
The organization has met all criteria for this priority process.	
Priority Process: Competency	
5.6 A formal mentoring or coaching program is included in the organization's orientation process.	
Priority Process: Episode of Care	
18.4 The team ensures that patients are properly secured when being assisted or lifted, and positioned onto the stretcher, during any travel to the transport vehicle, throughout transport, and when leaving the transport vehicle.	!
Priority Process: Decision Support	
The organization has met all criteria for this priority process.	
Priority Process: Impact on Outcomes	
The organization has met all criteria for this priority process.	
Priority Process: Medication Management	
13.10 A documented and coordinated approach to safely manage high-alert medications is implemented.	ROP
13.10.6 Client service areas are regularly audited for high-alert medications.	**MINOR**
13.10.8 Information and ongoing training is provided to team members on the management of high-alert medications.	**MAJOR**
Priority Process: Infection Prevention and Control	
9.9 Linen, supplies, devices, and equipment are stored and handled appropriately.	!
Surveyor comments on the priority process(es)	
Priority Process: Clinical Leadership	
The NRHA EMS group is lead by a dedicated and passionate group of leaders. They have integrated in to the system well and continue to establish relationships and seek opportunities to improve. They are well	

aware of the challenges they face as a northern community and seek out innovative solutions to challenges around geography, recruitment and retention and funding. They are well connected to organization as well as the government oversight team and work hard to address compliance to all areas. It appears that there is a strong culture of organizational trust (Just Culture). Staff stated they would have no hesitation in reporting risks or errors for fear being reprimanded.

Opportunities:

Succession planning and an aggressive recruitment and retention program would help the organization continue to grow and advance.

There is currently no Medical First Response (MFR) programs with local agencies such as Fire Departments or other groups. With a large remote geographic footprint the NRHA EMS team may want to consider expanding an MFR program to enhance opportunities for care in locations where EMS response is delayed.

Priority Process: Competency

The NRHA EMS group does a good job of monitoring competency and providing training opportunities. The online ABSORB learning program is an example of using technology to enhance training and competency. Infusion pump training is in place as part of the overall competency profile for Paramedics. Staff feel that they are afforded good opportunities for growth. Employee mental health is clearly on the radar of leadership.

Opportunities:
Future plans are being contemplated to formalize a mentoring program that would extend 1-3 years. This would likely have a positive effect on overall engagement for new employees and could enhance retention issues.

There is an opportunity to enhance programs related to employee mental health as part of an employee engagement and retention initiative.

Priority Process: Episode of Care

The provincial dispatch system does a good job of supporting pre-hospital care in NRHA. The service is well connected and respected by other areas of healthcare. Overall it appears that NRHA EMS has dedicated and passionate employees who are proud of the service. They are considered an important partner of the healthcare system. Care is guided by the provincial government office of the Manitoba Health EMS Medical Director. The care guidelines used by paramedics comes from this office and is consistent with other jurisdictions.

Opportunities:
Enhance the relationship with the Government office of the EMS Medical Director in order to participate in provincial initiatives. Special considerations for remote pre-hospital care will need to be vetted through this office.

An overall assessment of organizational compliance to policies should be contemplated, especially around patient restraint during transport and the use of the 5 point stretcher harness.

Priority Process: Decision Support

The organization has good infrastructure to enhance EMS responses. The provincial dispatch system enhances continuity of EMS services provincially. This is important for effective and efficient system status management for the service.

Opportunities:
A electronic Patient Care Record (ePCR) should be a consideration for future enhancement. This would enhance integration with other healthcare areas as well as providing rapid access to large quantities of data which would enhance QA/QI initiatives. Opportunities for enhanced care and safety is the result.

Priority Process: Impact on Outcomes

The NHRA EMS group is well positioned to be leaders

Priority Process: Medication Management

Controlled substance management is well established by the team. Ongoing audit ensures the efficacy of the controls in place.

A review of all High Alert Medications should be done. Enhanced and awareness of dangerous medications and improved labeling will enhance patient safety in this regard.

Look alike medications with dose variation was identified. Solu-Medrol 40 mg and 125 mg vials are stored together in the medication kits. The packaging is similar (exact same shape…one had a white top and one an orange top). They were stored together in the bottom of a medication kit with no differentiation. Also Acetaminophen and ASA are stored together with similar packaging. These presentations are risks to patient safety and needs to be corrected.

Priority Process: Infection Prevention and Control

The team has good integration with the NRHA IPAC program. Overall the units are well maintained and there are processes for cleaning and maintaining units.

Opportunities:
Some of the units inspected were clean and well maintained overall but there was some dirt accumulations in hard to reach corners and window edges.

A review of how 'clean' equipment is stored would help to enhance overall patient safety and reduce risks for infections for patients.

Standards Set: Home Care Services - Direct Service Provision

Unmet Criteria		High Priority Criteria
Priority Process: Clinical Leadership		
The organization has met all criteria for this priority process.		
Priority Process: Competency		
4.6	The effectiveness of team collaboration and functioning is evaluated and opportunities for improvement are identified.	
Priority Process: Episode of Care		
10.7	The effectiveness of transitions is evaluated and the information is used to improve transition planning, with input from clients and families.	
Priority Process: Decision Support		
11.8	There is a process to monitor and evaluate record-keeping practices, designed with input from clients and families, and the information is used to make improvements.	!
Priority Process: Impact on Outcomes		
15.2	The information and feedback gathered is used to identify opportunities for quality improvement initiatives and set priorities, with input from clients and families.	
15.4	Indicator(s) that monitor progress for each quality improvement objective are identified, with input from clients and families.	
15.5	Quality improvement activities are designed and tested to meet objectives.	!
15.8	Indicator data is regularly analyzed to determine the effectiveness of the quality improvement activities.	!
15.9	Quality improvement activities that were shown to be effective in the testing phase are implemented broadly throughout the organization.	!
15.11	Quality improvement initiatives are regularly evaluated for feasibility, relevance, and usefulness, with input from clients and families.	

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

Home care takes advantage of a multidisciplinary team and relationships within the region and communities. Teams may include OT, Diabetes educators, Nurses, Mental Health Clinicians and the Community Health Developer. Flin Flon also highlighted Mental Health as a team member with assistance for dementia as well as the regularly visiting psychiatry service.

All members of the teams are utilized to maximize services provided. There are some challenges with navigation of dual systems (nursing stations, treaty area logistics) or with resource gaps such as the absence of those who would assist the Public Trustee office processes to support clients. There may be some solutions to this as the region works together (ie) the Flin Flon site has navigated service issues with the Public Trustee that fall outside of regional service provision and this might assist The Pas.
The NP is a valuable team member in Flin Flon and provides home visits if needed. The Pas is also interested in NP use and efforts to secure NP's for additional sites should continue. The current Flin Flon NP supports the PCH, HC and PH. She was part of the 'Grow your Own' program.

The Home Independence Program has issues with housing environments and getting needed equipment to isolated areas. Lack of suitable seniors and assisted living housing was shared in both communities as a gap, which increases demands on the home care team as they navigate challenging settings.
The HC staff drive their own vehicles and work alone. Safety processes should be added to ensure staff are finished and safe at the end of the day. Both sites had committed and caring teams providing effective services to their communities.

Priority Process: Competency

All staff confirm that the new education platform Absorb offers training that is required and needed. At the same time staff are supported to take additional education when needed. The Best Practice educator is a valuable team member who is able to share best practice and increase access to needed information using regional and provincial networks.

The Home Care teams are large with staff vacancies. A client reports that staffing can impact the length of visit at times. An effort is being made to introduce high school students to the HCA program in their last year. In this way they understand the work and are able to graduate with school credit and qualify as HCA. Great idea and partnership!

Priority Process: Episode of Care

Access to service is excellent with an intake call within 2 days of referral. All services are free to clients, except for some major equipment items that are not available for loan. Clients shared their appreciation for the care and support they get. It is evident that at both sites that this attention has helped seniors (and those with support needs) stay in their homes or in supported housing successfully longer. Feedback regarding transitions may have been collected within the Home Care survey yet evaluation of effectiveness (success) or use of information for planning was not seen. This would be a next step with the data collected.

Challenges to service do include the number of clients with a Public Trustee and the expectation that Home Care fulfill duties that are outside of home care role. Some other sites in the region had shared this problem and found solutions. It would be valuable for LTC and HC to discuss this topic, outline potential solutions or approaches, and raise as needed to regional Leaders.

Priority Process: Decision Support

A strong intake process was reviewed for home care. With the number of staff and number of clients, record keeping, follow up and processes is a priority for care success. There is an opportunity to review processes/charting in the field and consider any identified areas of improvement.

Priority Process: Impact on Outcomes

Specific quality improvement activities for improvement, with action and ongoing evaluation of efforts, were not seen. This is an opportunity for this strong service.

Standards Set: Infection Prevention and Control Standards - Direct Service Provision

Unmet Criteria		High Priority Criteria
Priority Process: Infection Prevention and Control		
5.2	Team members, clients and families, and volunteers are engaged when developing the multi-faceted approach for IPC.	
14.3	Input is gathered from team members, volunteers, and clients and families on components of the IPC program.	
Surveyor comments on the priority process(es)		
Priority Process: Infection Prevention and Control		

The organisation is fortunate in having a highly functioning, well organised, focussed and knowledgeable team leading the infection prevention and control program. The team is well integrated and multi-disciplinary and engages well with the various departments and sectors of the region as well as with the necessary community partners.
The team has a well coordinated hand hygiene program with regular audits and responsive efforts to improve hand hygiene. All units are involved. THe team has responded well to the likelihood of hand sanitizer being removed from the premises with the installation of more protective covers.
Thee team is fully engaged in monitoring antimicrobial usage and has engaged relevant partners in further refining and defining appropriate situations for antimicrobial use.
The team collaborates well with community partners to identify potential outbreaks and has developed appropriate response plans.
The team robustly encourages engagement of all staff and clients in regular vaccination programs.
Data is used to direct future program directions.
It was a pleasure to meet the team. Resources for the team are restrictive and additional resources would yield further improvements for the organisation

Standards Set: Inpatient Services - Direct Service Provision

Unmet Criteria		High Priority Criteria
Priority Process: Clinical Leadership		
1.2	Information is collected from clients and families, partners, and the community to inform service design.	
1.3	Services are co-designed to meet the needs of an aging population, where applicable.	
Priority Process: Competency		
3.11	Team member performance is regularly evaluated and documented in an objective, interactive, and constructive way.	!
3.13	Team members are supported by team leaders to follow up on issues and opportunities for growth identified through performance evaluations.	!
Priority Process: Episode of Care		
8.7	Translation and interpretation services are available for clients and families as needed.	
8.9	The client's informed consent is obtained and documented before providing services.	!
8.10	When clients are incapable of giving informed consent, consent is obtained from a substitute decision maker.	!
8.12	Ethics-related issues are proactively identified, managed, and addressed.	!
8.13	Clients and families are provided with information about their rights and responsibilities.	!
8.14	Clients and families are provided with information about how to file a complaint or report violations of their rights.	!
8.15	A process to investigate and respond to claims that clients' rights have been violated is developed and implemented with input from clients and families.	!
9.9	Each client's risk for developing a pressure ulcer is assessed and interventions to prevent pressure ulcers are implemented. NOTE: This ROP does not apply for outpatient settings, including day surgery, given the lack of validated risk assessment tools for outpatient settings.	ROP

	9.9.1	An initial pressure ulcer risk assessment is conducted for clients upon admission, using a validated, standardized risk assessment tool.	**MAJOR**
	9.9.2	The risk of developing pressure ulcers is assessed for each client at regular intervals and when there is a significant change in the client's status.	**MAJOR**
	9.9.3	Documented protocols and procedures based on best practice guidelines are implemented to prevent the development of pressure ulcers. These may include interventions to prevent skin breakdown; minimize pressure, shear, and friction; reposition; manage moisture; optimize nutrition and hydration; and enhance mobility and activity.	**MAJOR**
	9.9.4	Team members, clients, families, and caregivers are provided with education about the risk factors and protocols and procedures to prevent pressure ulcers.	**MINOR**
9.10	Medical and surgical clients at risk of venous thromboembolism (deep vein thrombosis and pulmonary embolism) are identified and provided with appropriate thromboprophylaxis. NOTE: This ROP does not apply for pediatric hospitals; it only applies to clients 18 years of age or older. This ROP does not apply to day procedures or procedures with only an overnight stay.		ROP
	9.10.5	Information is provided to clients and team members about the risks of VTE and how to prevent it.	**MINOR**
10.16	Information relevant to the care of the client is communicated effectively during care transitions.		ROP
	10.16.2	Documentation tools and communication strategies are used to standardize information transfer at care transitions.	**MAJOR**
	10.16.4	Information shared at care transitions is documented.	**MAJOR**

Priority Process: Decision Support

The organization has met all criteria for this priority process.

Priority Process: Impact on Outcomes

15.5	Protocols to move clients elsewhere within the organization during times of overcrowding are followed by the team.	!

16.4	Indicator(s) that monitor progress for each quality improvement objective are identified, with input from clients and families.	
16.6	New or existing indicator data are used to establish a baseline for each indicator.	
16.7	There is a process to regularly collect indicator data and track progress.	
16.8	Indicator data is regularly analyzed to determine the effectiveness of the quality improvement activities.	!

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

The staff at all sites are extremely dedicated and work the best they can with the difficulties they face, particularly when there is no stable medical staff. The staff are proud of the services they provide and feel they can adapt to the needs of the clients they care for.
There are opportunities at all sites to have local input from clients and families to help with service design ("co-design") and develop site specific programming that is responsive to the local needs but also fits under the Region's overall umbrella.

Priority Process: Competency

Nursing and support staff at all sites have their credentials checked by HR. Staff have a sound on-boarding orientation process which includes mandatory completion of training modules on the ABSORB online site. Completion rates are monitored and those employees who are not up to date are followed-up.
The exception seems to be with medical staff: some sites like The Pas indicate physicians are not good at reviewing the mandatory modules while at other sites like Thompson their uptake is considered satisfactory.
Staff at all sites are content in their jobs and many have been there for many years. There is good camaraderie and the teams work well.
Janitorial staff are also well trained in the types of clean-up they must perform in the patient rooms: (particular mention of the sisters at Flin Flon ("Salt" and "Pepper").
The Quality Boards are new and have been received differently at the different sites. It seems that when the educator 'blitzes' the Quality Borad with short educational moments with opportunities for staff to sign off on the learning, then there is better uptake: this is true at Flin Flon.
It might be helpful to communicate these education opportunities to the nurses at Snow Lake who may not have such in depth access.

Priority Process: Episode of Care

In-patient staff at all the sites visited are providing excellent care and it is clear they take their duties responsibly and with respect.
All in-patients interviewed were very satisfied with the service they received from the units they were on.

Several complemented the smaller hospitals in comparison to the one they had been to in Winnipeg.

The process of documenting improvements to services, and monitoring and proving the effectiveness of the services being delivered are the places where there are some opportunities to demonstrate the valuable contributions of all staff members to their in-patient floors.

Some simple tweaks to the Required Organizational Practices which may have already been implemented include handing out educational pamphlets to clients when they are admitted, thus acting as a memory aid to the patient that in fact this is what these discussions are about.

In the same vein, clients and families should be given the pamphlets describing their rights and responsibilities and the Patient Experience brochure, so those that are quiet or afraid to speak up, also have a chance to express their input into the patient experience.

These very patients may also be recruited to form an ad hoc consulting group when the site staff are thinking about a new initiative to improve service, and thus document input from clients and families.

The transfer of care documentation has been reviewed and is in the process of being implemented. Once this is done there should be compliance with the transfer safety check requirements.

Priority Process: Decision Support

Generally staff are knowledgeable on record keeping practices and have learned most of the privacy and other training from the ABSORB website.
The computerization of health records and transfer to EPR is not consistent within the hospitals but the same EPR is used, when it is used, in the Emergency rooms at some sites.
The gaps identified include the patchwork of computer systems available.
Some sites have computerized EPR in Emergency but not on In-patient unit so the documents are printed off the EPR when the patient is admitted to the floor. This has led to confusion finding the necessary patient information data as the layout is different. As staff get used to it they are learning where to find the information. There does not seem to have been any talk of making the EPR software viewable from the in-patient unit if clarification is needed.
Some staff members and locum doctors indicate the EPR is not user friendly as there are too many fields that require click yes/no input rather than narrative.
Orders and prescriptions and Medication Management are not included in the EPR.
Other concerns that have been brought forward is the Intranet search engine is not user friendly when looking up a procedure as only certain key words are indexed.

Priority Process: Impact on Outcomes

The inpatient nursing staff, allied staff and support staff at all sites perform like well oiled machines. They like their jobs and have a considerable degree of autonomy within their site.

The issue of bed crowding at one site, while another site is under capacity could be something senior staff may wish to review and consider developing a procedure for patient transfer at times of over-crowding, or possibly reviewing which services are provided where: keep in mind the strong advice to include input from clients and families as well as team members, when deliberating such a proposition.

Managers at all sites are performing important Quality Improvement initiatives but have not identified them as such, nor developed measurable baseline and outcome indicators.The initiatives at each site are very well thought out and designed, with best practice input from nursing continuing ed systems, with good objectives in mind.
Most of these initiatives 'fly under the radar' as they are not identified and monitored as QI initiatives.

Special note of the Nursing Practice Committee at Thompson, which is a small off-shoot of the larger Nursing Committee. This group meets for about an hour weekly and has come up with several initiatives within their unit, including ID tags that remind what information to give at shift change handovers, also they have instituted bedside nursing handover and have noted time savings - note also that Flin Flon has also done this and The Pas has followed Flin Flon's lead. Unfortunately they have not been measuring indicator data such as patient satisfaction or saved time/better recall for bedside handover. Another initiative soon to be assessed is for the Med nurse to wear a bib or sash to request no interruptions, and the staff should consider measuring a couple of indicators such as number of interruptions before and after and number of near misses.

Snow Lake and Gillam are small units that have multiple services within them. Staff there would benefit from being included in Tele-health meetings when discussing quality improvement initiatives with the bigger sites.

Standards Set: Long-Term Care Services - Direct Service Provision

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	
12.7 The effectiveness of transitions is evaluated and the information is used to improve transition planning, with input from residents and families.	
Priority Process: Decision Support	
The organization has met all criteria for this priority process.	
Priority Process: Impact on Outcomes	
17.5 Quality improvement activities are designed and tested to meet objectives.	!

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

It was clear that across the region, the Personal Care Homes work closely with each other and associated services such as Home Care and Acute care.
Service planning considers elder and family needs, wishes, and input as well as information sharing from those partners in the region and relationships across the province. The Home settings have input from elders and families. This may include layout, colours, and even additional team members like a cat or dog!

Priority Process: Competency

The interprofessional teams include nursing at all levels as well as OT, adn support services. All work toward common goals and approaches of care for elders regardless of their position. Staff are trained with regional orientation as well as PCH specific orientation to meet the needs of elders. This includes philosophies of care and approaches such as PIECES or Pallium.

Priority Process: Episode of Care

It was a pleasure to visit 3 PCH sites. All demonstrated care and commitment to elders and families. Each site excelled in different and unique ways.

Sites shared stories which highlighted relationship and a person and family centred approach. In The Pas, staff members went to an elder's family members house to inform them of the elder death when they could not be reached. In Flin Flon, report was observed. As the team gave report, they problem solved, advocated for elders, shared approaches, key assessment information and acknowledgement of a department who had helped them in a tough situation (in this case it was maintenance). In Thompson, they are able to provide telehealth for elders which allow for long distance appointments without travel or special face to face connections with families far away. All sites were well cared for and felt like a home. Elders gave feedback which included "staff are awesome"; they go "above and beyond"; and "the meals are good and I get to choose" to name a few.
Staff shared their pleasure and even "joy" of coming to work which is not often heard. Well done!

Priority Process: Decision Support

All teams work to ensure common communication methods, screens and processes are in place for the benefit of elders in the PCH and in the event of a transfer. Unique assessments, needs and decisions or choices made by the elders are captured and shared.

Priority Process: Impact on Outcomes

All sites surveyed gather significant information regarding care needs assessments, screens and about the elders in their work. At the same time the Best Practice Educators work to complete audits and support needed learning at the site. Often information is reported and entered into a data base, such as occurrences and audit results. In addition there is an operational work plan. All of this provides an excellent foundation for next steps. These would include specific desired outcomes or improvements; activities to accomplish this; and how success is measured.
Some sites may be doing excellent QI work and not capturing it to share and learn from. For example The Pas noted that their hard work on education for behaviour management for aggression and agitation had changed the area significantly. "We used to call codes here all the time. We don't call them anymore". This is a result of well trained staff who are able to diffuse situations which before may have escalated. This is improvement which is anecdotal and could be measured and now monitored to ensure the gains are sustained.

Standards Set: Medication Management Standards - Direct Service Provision

Unmet Criteria		High Priority Criteria
Priority Process: Medication Management		
2.3	There is an antimicrobial stewardship program to optimize antimicrobial use. NOTE: This ROP applies to organizations providing the following services: inpatient acute care, inpatient cancer, inpatient rehabilitation, and complex continuing care.	ROP
2.3.5	The program is evaluated on an ongoing basis and results are shared with stakeholders in the organization.	**MINOR**
3.3	The interdisciplinary committee regularly reviews and updates the formulary.	
6.5	Teams can access an on-site or on-call pharmacist at all times to answer questions about medications or medication management.	!
8.1	There is a process for determining the type and level of alerts required by the pharmacy computer system including, at minimum: alerts for medication interactions, drug allergies, and minimum and maximum doses for high-alert medications.	!
8.2	A policy on when and how to override alerts by the pharmacy computer system is developed and implemented.	!
8.3	The medication information stored in the pharmacy computer system is regularly updated.	!
8.4	The pharmacy computer system is regularly tested to make sure the alerts are working.	!
11.2	A policy that specifies when and how to override smart infusion pump alerts is developed and implemented.	!
12.6	Look-alike, sound-alike medications; different concentrations of the same medication; and high-alert medications are stored separately, both in the pharmacy and client service areas.	!
14.5	Steps are taken to reduce distractions, interruptions, and noise when team members are prescribing, writing, and verifying medication orders.	
14.9	Compliance with the policies and procedures regarding medication orders is regularly monitored, and improvements are made as needed.	!

15.1	The pharmacist reviews all prescription and medication orders within the organization prior to administration of the first dose.	!
15.2	When preparing medications for pediatric patients, the pharmacist double checks the dosing calculations of weight-based protocols.	!
16.2	Appropriate ventilation, temperature, and lighting are maintained in the medication preparation areas.	
16.3	There is a separate negative pressure area with a 100 percent externally vented biohazard hood for preparing chemotherapy medications.	!
16.6	Accurate and up-to-date records are maintained for all medications compounded and repackaged in the pharmacy.	!
17.2	All compounds and intravenous admixture containers are labelled, at a minimum, with: the name of the medication, base solution, total amount of drug additives, and total volume of solution in the container.	!
27.1	Resources needed to support quality improvement activities for medication management are provided.	

Surveyor comments on the priority process(es)

Priority Process: Medication Management

The Region is fortunate in having a highly functional team of pharmacists and technicians and support staff dedicated to providing a safe and comprehensive medication management service to the Region's clients.
Unfortunately, the systems that support such a highly functioning team are hugely inadequate.

There is no standardized formulary across the region. Surely this is unacceptable after so many years of attempted integration. The reason, or reasons, for the lack of standardization must be identified as a priority and addressed. Clearly there is a lack of senior admin support in addressing the issues at hand. The region now has essentially three different formularies largely representing the previously existing health authorities.

Additions to the various formularies occur regularly and the process appears fair and systematic. Yet somehow, physicians are regularly accommodated in circumventing the system and either providing inadequate background supporting evidence or even worse having the decisions of the P&T committee overturned. What is the point of having an evidence based process?

I heard reports of physician bullying and disrespectful behaviour which is either tolerated or even worse condoned. This seemed to me to be not in keeping with the stated value of a "respectful workplace".
I spent all my time at the Thompson site. Within the Thompson Regional Hospital, there is an outdated and non-supported pharmacy system. Even the manufacturer of the system no longer supports this legacy product.

Also within the Thompson Hospital, the interactive medication checking system no longer functions. This inadequacy presents an unacceptable level of patient risk.

Across the Region, there are now three different pharmacy systems in place, none of which appear to be connected to the provincial system.
THere is an unacceptably difficult process to remove items from any formulary.
There have been critical incidents involving the use of calcium and morphine. Lessons should be learned from such incidents.
There is widespread variation in prescribing practice across the region. Variation in practice leads to variation in outcome. There is an opportunity for major data to be collected on this issue.

Finally, it should be more clear as to whom the P&T committee actually reports. P&T should provide reports to the MAC but it is not appropriate for P&T to be subject to MAC.
The pharmacy at Thompson Regional Hospital is clearly inadequate for the job it is required to do. The space is too small, there are no quiet areas for staff to work, there is no space for personal belongings and lunch bags, the chemotherapy prep area is utterly outdated and totally.
I congratulate the team in the pharmacy for the Herculean effort they make to keep patients safe.

Standards Set: Mental Health Services - Direct Service Provision

Unmet Criteria		High Priority Criteria
Priority Process: Clinical Leadership		
1.5	Service-specific goals and objectives are developed, with input from clients and families.	
2.5	The effectiveness of resources, space, and staffing is evaluated with input from clients and families, the team, and stakeholders.	
5.2	Work and job design, roles and responsibilities, and assignments are determined with input from team members, and from clients and families where appropriate.	
Priority Process: Competency		
3.13	Education and training are provided on information systems and other technology used in service delivery.	
Priority Process: Episode of Care		
2.7	The physical environment is safe, comfortable, and promotes client recovery.	
8.2	The assessment process is designed with input from clients and families.	
8.6	Medication reconciliation is conducted in partnership with clients and families to communicate accurate and complete information about medications across care transitions.	ROP
8.6.5	The client, community-based health care provider, and community pharmacy (as appropriate) are provided with a complete list of medications the client should be taking following discharge.	**MAJOR**
9.18	Information relevant to the care of the client is communicated effectively during care transitions.	ROP

9.18.5	The effectiveness of communication is evaluated and improvements are made based on feedback received. Evaluation mechanisms may include: • Using an audit tool (direct observation or review of client records) to measure compliance with standardized processes and the quality of information transfer • Asking clients, families, and service providers if they received the information they needed • Evaluating safety incidents related to information transfer (e.g., from the patient safety incident management system).	**MINOR**
10.9	The effectiveness of transitions is evaluated and the information is used to improve transition planning, with input from clients and families.	
Priority Process: Decision Support		
11.8	There is a process to monitor and evaluate record-keeping practices, designed with input from clients and families, and the information is used to make improvements.	!
Priority Process: Impact on Outcomes		
13.2	The procedure to select evidence-informed guidelines is reviewed, with input from clients and families, teams, and partners.	
13.3	There is a standardized process, developed with input from clients and families, to decide among conflicting evidence-informed guidelines.	!
14.1	A proactive, predictive approach is used to identify risks to client and team safety, with input from clients and families.	!
14.2	Strategies are developed and implemented to address identified safety risks, with input from clients and families.	!
15.2	The information and feedback gathered is used to identify opportunities for quality improvement initiatives and set priorities, with input from clients and families.	
15.4	Indicator(s) that monitor progress for each quality improvement objective are identified, with input from clients and families.	
15.7	There is a process to regularly collect indicator data and track progress.	
Surveyor comments on the priority process(es)		
Priority Process: Clinical Leadership		

Acute mental health services are offered in the Pas where they have eight beds and in Thompson where

they have ten beds. Both sites are within the hospital and provide service to patients over 18 years of age. There are seclusion rooms on each inpatient unit.
There is one psychiatrist in the Pas and two in Thompson. The services are well coordinated across the region and between acute and community care.

Hope North is a crisis stabilization unit for youth under 18 years of age.
There is also a Mobile Crisis Response Unit in Thompson for youth.

Thompson:
The inpatient mental health team consist of nursing, OT, social worker, psychiatry, transition workers and they also have access to pharmacy, nutrition....The team has a very good sense of their community and the mental health needs.
The model of care is based on the recovery model, one of hope and resilience.
Wait times to see a psychiatrist are reasonable albeit the team continually try to improve those wait times.

The environment at the Thompson Hospital would benefit from some attention to paint, wall coverings, furnishings...

The team are working to reduce the mental health stigma; however, they are encouraged to ensure clients and families are included in this process.
There is a mental health promotion specialist that is working to reduce the stigma to mental health by educating the community, and facilitating programs in the schools.
There are also mental health support workers in the community to support clients in their homes.

They use universal falls screening assessment. If at risk of falling, this may include a sign on the bed, a sticker on the chart, being placed closer to nursing desk for observation. Patients at risk of falls are monitored and reassessed regularly.

The Pas....The manager who has been in place for just over a year is gathering data on client admissions and lengths of stay in an effort to better understand the requirements of the patient population and to inform service design moving forward. It is suggested that service-specific goals for Mental Health be established annually with input from patients and families.

Priority Process: Competency

The team use a transfer form to communicate and share information however it is not standardized at this point. The team would benefit from a standardized approach to sharing pt information.

IV infusion pump education is not required as pts are only admitted if they are stable.

Seclusion and restraints are used as a last resort to protect the patient from harm and /or the staff from injury. There are seclusion rooms on the units.

The team is encouraged to include pts and families when defining and evaluating services, education, environment....

The staff access the online Learning Management system, Absorb, for ongoing education.
A competency model is in place for mental health services and includes core competencies for each staff role.
Mental health is implementing the Wellness Recovery Action Plan (WRAP) which will be provided through certified trainors.

The team is just setting up a Patient Involvement Group that will be made up of pts and family. They will provide their perspective on the services, care delivery and after care planning.

The Pas team demonstrate teamwork and good collaboration in the provision of patient-centred care. They consult one another frequently when dealing with challenging situations. It is suggested that more education on the use of the hospital's ethical framework would be beneficial with the complexities of managing the inpatient mental health population.

Priority Process: Episode of Care

Thompson
The team is interdisciplinary and serve as strong advocates for their pts. The pts report that they feel respected and that they receive good care at the unit. I spoke to one of two psychiatrists who has very good insight into the needs of the pts they serve and the options for those pts in the North.

In Thompson, the physical environment needs some attention. The unit is not conducive for recovery. I would suggest some attention to painting, furnishings, wall hangings... With the seclusion rooms and it being a locked unit, it would appear that it is safe however some alignment with a home environment would better support the pts. journey to recovery.

The medication room is small and cluttered and could pose risk for medication preparation. This needs to be assessed, move unnecessary items from there and overall, ensure least interruption for the staff preparing the medications.

In Thompson
I have concern a concern of a pt maintained on the unit who poses a safety risk to staff and other pts.. All pts should be assessed and reassessed for appropriateness to any unit.

There is a suicide assessment tool in place to assess pts risk level. The staff work to ensure the pts are safe from self harm.

In Thompson, there is ongoing OT program delivery and support for the pts which they find very beneficial to their recovery. These programs are closely monitored by OT and changes made when needed.

The inpatient nursing staff also provide injections for those pts that come into the Community Mental Health Clinic and require that service. That is a great service for those pts..

The Thompson Hospital Leadership is encouraged to ensure that the medications purchased are kept by the in house pharmacy, rather than ordering from retail pharmacy. All medications should be ordered through the onsite pharmacy and distributed accordingly.

The Pas
The team at The Pas provides a patient and family centred approach to care working collaboratively with the patient on treatment planning and goals.

It is suggested that a standardized evidence-based suicide risk assessment be implemented within the region.

St Anthony's General Hospital...Medication reconciliation on discharge requires further attention to ensure that the client, community-based health care provider, and community pharmacy (as appropriate) are provided with a complete list of medications the client should be taking following discharge.

Across the region, an opportunity exists to evaluate the effectiveness of communication upon discharge in order to improve quality of care at this important transition.

For charting the staff across region have access to the electronic system, Accuro, however everyone records on paper with some information on Accuro. The emergency dept uses EDIS. It would be beneficial for the region to consider one electronic system for continuity of care and real time access to client information. I understand that is in planning.

Priority Process: Decision Support

Information is documented in the clients record however there is limited partnership with the client and family.

The pamphlet " Know Your Rights" , is available plus there is a Mental Health Review Board to support clients.
The team has also developed and implemented a booklet which describes the Adult Psychiatric Acute Care Unit at the hospital in Thompson. It outlines confidentiality, privileges and passes, pt behaviour, visiting hours....to note a few.

There was no evidence of a process to monitor and evaluate record-keeping practices. This will be particularly important when the new electronic record is introduced.
Presently, the staff chart on paper however they have access to electronic system that physicians use, Accuro. The Emergency dept uses EDIS. There are several different systems available and I saw alot of duplication in documentation which again will benefit from introduction of regional EHR.

Priority Process: Impact on Outcomes

Quality improvement is beginning however the team would benefit from defining their QI initiatives and setting priorities based on input from pts and families. This would guide their priorities into the future and help them make improvements.

There is an ethics committee in place to support staff however most have not used the process, but were aware. It would benefit staff to have some exercises where the ethics process could be applied for learning and education.

There is a solid research process to follow. By the time the research gets to the region, it has usually been vented through the University of Manitoba ethics process. There are no research projects going on at this time.

The team is encouraged to include pts and families more in planning and design to ensure they capture what the pt feels would be most appropriate. It is important to select the right representation but that input would be very valuable in their work as they identify strategies and approaches to improve care delivery and service. The Pt Involvement Group is a start.

A major issue for their pts is safe, affordable housing however there is a portable housing benefit that they can apply for. As well, there is a Housing coordinator in the Pas and Flin Flon to support them in this process.

There is a depot medication clinic available in Thompson and the Pas for pts.. The staff do what they can to ensure the pt can maintain their goals following discharge. The teams are encouraged to provide followup and evaluation on their transition process to make improvements and adjustments where needed.

An opportunity exists to include patients and families in the identification of indicators that monitor progress towards meeting quality improvement objectives.

Standards Set: Obstetrics Services - Direct Service Provision

Unmet Criteria		High Priority Criteria
Priority Process: Clinical Leadership		
1.2	Information is collected from clients and families, partners, and the community to inform service design.	
1.3	Service-specific goals and objectives are developed, with input from clients and families.	
1.4	Services are reviewed and monitored for appropriateness, with input from clients and families.	
2.5	The effectiveness of resources, space, and staffing is evaluated with input from clients and families, the team, and stakeholders.	
Priority Process: Competency		
9.12	Access to spiritual space and care is provided to meet clients' needs.	
Priority Process: Episode of Care		
13.8	The effectiveness of transitions is evaluated and the information is used to improve transition planning, with input from clients and families.	
Priority Process: Decision Support		
The organization has met all criteria for this priority process.		
Priority Process: Impact on Outcomes		
16.2	The procedure to select evidence-informed guidelines is reviewed, with input from clients and families, teams, and partners.	
16.3	There is a standardized process, developed with input from clients and families, to decide among conflicting evidence-informed guidelines.	!
16.5	Guidelines and protocols are regularly reviewed, with input from clients and families.	!
17.1	A proactive, predictive approach is used to identify risks to client and team safety, with input from clients and families.	!
18.4	Indicator(s) that monitor progress for each quality improvement objective are identified, with input from clients and families.	

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

The environment meets the standard of care for rooming-in and supporting care on the units for vaginal, v-back and c-section deliveries. There seems to be a lack of information about the populations and cultural needs of their patients that could inform their goals and objectives and design of a unique delivery experience for each patient. The have good connections with the community through social work and aboriginal liaison staff. MDR handles all reprocessing at the sites.

Priority Process: Competency

At all sites there are well-trained and dedicated staff that are focused on ensuring a supportive birth experience. They have both on-line and group in servicing to review their pre, delivery and post care routines and protocols. There is a good orientation program for new staff and ongoing support from more senior staff.

Recruitment and retention in this specialty area is an ongoing concern. There is no dedicated spiritual care area and the La Pas site and the leadership is encouraged to dedicate a space at this site and recommend a review of any cultural needs to make clients and families feel more at home and to support the social issues that arise.

The midwives are well integrated into the obstetrical service and are present on the unit. Skills drills occur yearly and ad hoc to keep staff up to date on care needs and emergency situations. As staff are trained in all areas of care there is a good team spirit to help where needed on each shift.

Priority Process: Episode of Care

There is a very knowledgeable team at both the The Pas and Thompson site to support the birth experience and birthing emergencies. The care is supported by a comprehensive client record and supportive staff.There is a falls assessment completed on each patient and mom's are encouraged to use the wheeling bassinet to move their new babies around the unit area. The units are locked with video cameras at the entrances to protect against abductions. When necessary child protective services are used to support the care of the newborn.

All assessments of both mom and the unborn baby during the birth experiences are documented and reported to the most responsible physician. Treatment protocols are used consistently and pain management is provided to the birthing client. In the case of the death of a newborn there is a protocol for support of the family and their needs. Skin to skin in encouraged along with breast feeding. There is a process for labeling and storing breast milk for new moms who want to bottle feed.

Health teaching in delivered for mom and baby care and discharge plans and follow-up care is discussed, documented and actioned as required. It is recommended that the units look at an evaluation post transition to home to support teaching needs at the hospital and patient experience feedback.
A shortage of physicians at the Flin Flon site is impacting the ability for clients to deliver at that hospital

and patients are being transferred to the The Pas site for care. A shortage of specialized nursing at The Pas in Obstetrics has also been identified as an ongoing struggle.

Priority Process: Decision Support

There is an accurate and up to date record to support client care. A standard set of documents are used to capture the client information and it is kept securely on each area. The staff are knowledgeable about patient privacy especially in this area where there may be many inquiries about the birth of a new baby. There is a good flow of information on clients who plan to deliver at the hospital site and a process for and Emergency Department client who has not been identified in the pregnancy process.

Priority Process: Impact on Outcomes

There is a need to formalize a process for client and family input into the service at all sites given the new patient and family centered care standards. The use of formal goals and objectives in aspects of care would enable client and family input and evaluation of the changes made. Patient safety occurrences are reviewed with the team and mitigation strategies are implemented. Protocols and procedures are in place to support safe care. There is a need to develop indicators that are reported and shared at the staff/physician level to benchmark care to other organizations and any obstetrical standards - e.g. c-section rate, tear and birth trauma, infections, vacuum deliveries, etc. There is also an opportunity to share quality improvement initiatives more formally with clients and families.

Standards Set: Perioperative Services and Invasive Procedures - Direct Service Provision

Unmet Criteria			High Priority Criteria
Priority Process: Clinical Leadership			
1.3	Service-specific goals and objectives are developed, with input from clients and families.		
1.4	Services are reviewed and monitored for appropriateness, with input from clients and families.		
Priority Process: Competency			
12.8	Access to spiritual space and care is provided to meet clients' needs.		
Priority Process: Episode of Care			
11.11	To minimize injury from falls, a documented and coordinated approach for falls prevention is implemented and evaluated.		ROP
	11.11.1	A documented and coordinated approach to falls prevention is implemented.	**MAJOR**
	11.11.2	The approach identifies the populations at risk for falls.	**MAJOR**
	11.11.3	The approach addresses the specific needs of the populations at risk for falls.	**MAJOR**
	11.11.4	The effectiveness of the approach is evaluated regularly.	**MINOR**
	11.11.5	Results from the evaluation are used to make improvements to the approach when needed.	**MINOR**
11.12	Each client's risk for developing a pressure ulcer is assessed and interventions to prevent pressure ulcers are implemented. NOTE: This ROP does not apply to outpatient settings, including day surgery, given the lack of validated risk assessment tools for outpatient settings.		ROP
	11.12.1	An initial pressure ulcer risk assessment is conducted for clients upon admission, using a validated, standardized risk assessment tool.	**MAJOR**
	11.12.2	The risk of developing pressure ulcers is assessed for each client at regular intervals and when there is a significant change in the client's status.	**MAJOR**

11.12.5	The effectiveness of pressure ulcer prevention is evaluated, and results are used to make improvements when needed.	**MINOR**

Priority Process: Decision Support

The organization has met all criteria for this priority process.

Priority Process: Impact on Outcomes

23.2	The procedure to select evidence-informed guidelines is reviewed, with input from clients and families, teams, and partners.	
23.3	There is a standardized process, developed with input from clients and families, to decide among conflicting evidence-informed guidelines.	!
23.4	Protocols and procedures for reducing unnecessary variation in service delivery are developed, with input from clients and families.	!

Priority Process: Medication Management

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

There is strong leadership in the Operating Room from both management and staff who are focused on the needs of the patient. There is a focus on continued improvement in their service. There is a need to determine how to set service goals and objectives with clients and families and the community to plan service needs now and in the future. This would allow for physician recruitment in areas of growth or new needs as required. Resource requirement and gaps are identified and have line of site at the leadership level.

Priority Process: Competency

The staff are well trained and enthusiastic about their work and the work of the team. They have or are working towards certifications and are trained to all areas of the pre, intra-op and post-op areas. They are respectful of their clients needs and try to decrease their anxiety by answering questions and reassuring them throughout their stay. As the team learns all areas of the service they are supportive of sharing the workload as required to make the client experience a smooth one.

There is a continual focus on recruitment and retention of staff especially at The Pas site. The staff preceptor nurses from the nursing schools and both students and staff enjoy the experience. Ongoing professional development and education is in place whether a formal certification, skills drills or on-line learning (Absorb).

Priority Process: Episode of Care

There is a good process at all sites to accept referrals, book, pre-assess and execute on surgical service needs. There is a standard approach at all sites for patient pre-op preparation including the use of the surgical safety checklist, DVT prophylaxis, and pre=op antibiotics where required. There is a good process for falls and pressure injury assessment and formal documentation on all surgical patients at the Flin Flon site, the Thompson and The Pas sites are encouraged to use a similar formal process on all patients to meet the required organizational practice. There is strong team approach to the surgical experience on the day of surgery with flexibility in staffing due to the cross-training of staff for all areas of care. Diagnostics and lab services are available at all sites and can be accessed as required. If specimens are taken for pathology they are sent to the lab for send out services.
At all the sites surveyed there is a need to look at the physical space, patient flow, supplies management and storage to de-clutter the OR area and make it more usable. This is most evident at the Thompson site where some rooms are being used for cases, others for storage and cross-flow of dirty and clean equipment in some areas that may jeopardize safety and infection control management.
At all the sites surveyed there seems to be a temperature and humidity management issue and steps should be taken to review HVAC needs and remediation plans.
There are still some wooden surfaces and doors at all sites which should be reviewed from an infection control standpoint. At some sites wooden surfaces has been decreased since the last survey and this is applauded.
The clients and families are well educated and informed in the pre, during and post operative phase and indicate appreciation of the staff and physicians who provide care.

Priority Process: Decision Support

There is no electronic health record at any of the three sites surveyed however they have a robust peri-operative records which includes forms, checklists and progress notes. The staff work with the patient to ensure they are well informed about their procedure.In response to an ethical issue regarding parental consent not being available they have developed an responsibility consent and use this form when required.
At the Thompson site there is need for considering of using the pre-op area of the OR for patient/family/physician interviews rather that the waiting area even for the most minor surgery. This would require a re-work of the care areas to support large volume surgery days.

Priority Process: Impact on Outcomes

There is a need to determine how best to use clients and families in the selection of evidence-informed guidelines and those that have conflicting evidence. There are indicators in the area that are monitored including wait time for surgery, no-shows, surgical infections etc. There is a new process to be trialed at the Thompson site to reduce the no-show rate of clients especially for scoping procedures. Safety incidents are reported and reviewed. A surgical site checklist is used at all sites and has been tailored to population need at the Thompson site for scoping and pediatric dental cases.
The staff at all sites have ideas on quality improvement activities that would support continued improvement in care and staff/physician experience.

Priority Process: Medication Management

Medication are managed in the OR and post-op areas. There is standard process used which includes double-checks, locked stock and narcotic counts. Expiration of medications are managed with the pharmacy to minimize waste. Emergency equipment is readily available for both pediatric and adult patients and a Code team lead by the ED will attend Code calls from the OR area.

Standards Set: Public Health Services - Direct Service Provision

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: Impact on Outcomes		
The organization has met all criteria for this priority process.		
Priority Process: Public Health		
1.7	As part of the population health assessment, information about the physical or built environment and its health implications is accessed and analyzed.	
3.10	There is access to sufficient laboratory capacity in the community to meet the needs of the local public health system.	!

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

Public Health staff state they have significant input into job design and roles because of the unique needs of the communities they serve. They appreciate the flexibility and encouragement of management to find creative ways to maintain and improve the health of their communities. Concern was expressed by staff based in very remote communities about the effects of isolation on quality of life and staff retention.

Priority Process: Competency

Education and training is provided effectively to staff in a wide variety of ways. There is a comprehensive 6 week orientation and within a year, a funded week in Winnipeg to learn about communication with parents and teens. On an on going basis there is access to tele-health sessions, on line learning modules, monthly public health meetings and email notifications about new legislation, standards and events. Staff feel very well informed.

Concern was expressed by staff who are permanently based in very remote communities about the effects of isolation on quality of life and staff retention. They feel they are recognized for the quality of work they do but that there should be greater understanding at senior and provincial levels about what it is like to work in rural and remote communities with little support and recruitment challenges.

Priority Process: Impact on Outcomes

Evaluation is built into all public health initiatives and includes input from clients and communities, even though it may not be recognized as a quality improvement project. For example, when falls data at one of the clinics showed a significant increase, it was identified by staff and clients that the steps to the front door were heaving and irregular, causing a risk. After repairs, the number of falls decreased dramatically.

On example of many excellent community engagement and health related quality initiatives is the Elders Grief project in the small community of Wabowden. The Mayor noticed the effects of grief due to a cluster of deaths and asked for help. Since the mental health worker travels in every other Monday into the community, the public health team supported the Mayor's suggestion of a town forum to come up with solutions. The outcome was a peer supported grief group that has had a positive impact. The group also decided to hold a women's wellness weekend that was half traditional practices such as a grief sweat lodge and have western practices including spa treatments and yoga. Additional benefits included greater understanding by persons of different cultures, including young people. The team is encouraged to present this project nationally.

Priority Process: Public Health

The public health team is a highly creative multidisciplinary group of staff that is committed to making a difference in the health of the individuals and unique communities served by NHR.

Soon to be updated, the Community Health Assessment of 2014 not only includes information to set public health priorities, it was an opportunity for community and client engagement. Other important sources of information include the Compendium of Health Indicators from the Manitoba Centre for Health and First Nations data. Creative ways to assess needs on a continuous basis are being investigated. The Annual Health Summits are an annual opportunity to engage with communities and work collaboratively on a particular health problem such as diabetes.

Transportation and communication can be major challenges for staff and clients. Some communities have lost bus and/or rail service or the service is infrequent and many people do not have their own vehicles. Some do not have cellular service or wifi so rely on radio, mail, and home visits. Newsletters are effective means of communicating health promotion information and may be delivered door to door by staff who are checking on their clients. The NPTP can be used to support trips for urgent medical care or testing but community partners note that there is seldom funding for trips home again. Lab services are not accessible in many small remote communities resulting in costly and stressful trips to a larger centre for tests. The teams encouraged to continue to work with partners to address these challenges.

Partnerships and good relationships with many groups are essential to the success of the public health team. Several partnerships are used to address the recent TB outbreak. Led by the TB Coordinator, the public health team is working with the Winnipeg Regional Health Authority, First Nations and Inuit Health

Branch, the MOH, physicians, medevac companies, schools and communities such as the Shematawa First Nations to trace contacts and provide treatment. The team is commended for not only ensuring that effective treatment is provided for each individual, but that supports such as toys, food, games and transportation are provided using a health equity approach.

Another example of a creative approach to health prevention and promotion is the Sexual Health Team's response to the increased prevalence of syphilis. Among other strategies to reach affected cases and prevent new ones, the team worked with youth to create art that is used on t-shirts and posters as well as a graphic novel. A move was developed with high school students and more are planned. A Health festival was held in some communities including the Manitoba Hydro camp at Gillam.

The immunization team is congratulated on the achievement of higher than provincial average immunization rates. Routine immunization is provided to all children at different ages and adults are offered pertussis immunization at postpartum visits. For at risk individuals many strategies including health fairs, mobile clinics and home visits are used to insure that transportation and other barriers are overcome. In Thompson, a Health Circus is held for pre-shcool children, their siblings and parents. In addition to immunization, it is an opportunity to offer other assessments and services such as hearing, speech, dental hygiene and nutrition while having fun. Although staff influenza rates are lower than previous years, approximately 65% of staff were vaccinated.

The electronic medical record system Accuro is now region wide and is reported by staff and providers to be user friendly, efficient and a good source of data. The provincial Panorama system is still used for immunization records and has many good features such as production of a mass clinic coverage list by community. Team members can determine who has not been immunized and contact each person, whether by text, satellite/phone or email, depending on the community.

Provincial protocols and standards are adopted and used to ensure up to date practice. Managers and staff have input to their development and revision.

Standards Set: Substance Abuse and Problem Gambling - Direct Service Provision

Unmet Criteria			High Priority Criteria
Priority Process: Clinical Leadership			
1.3	Service-specific goals and objectives are developed, with input from clients and families.		
1.7	Awareness campaigns are conducted with partners to raise awareness of substance abuse and problem gambling services available in the community.		
Priority Process: Competency			
The organization has met all criteria for this priority process.			
Priority Process: Episode of Care			
9.10	Information relevant to the care of the client is communicated effectively during care transitions.		ROP
	9.10.5	The effectiveness of communication is evaluated and improvements are made based on feedback received. Evaluation mechanisms may include: • Using an audit tool (direct observation or review of client records) to measure compliance with standardized processes and the quality of information transfer • Asking clients, families, and service providers if they received the information they needed • Evaluating safety incidents related to information transfer (e.g., from the patient safety incident management system).	**MINOR**
10.8	The effectiveness of transitions is evaluated and the information is used to improve transition planning, with input from clients and families.		
Priority Process: Decision Support			
11.8	There is a process to monitor and evaluate record-keeping practices, designed with input from clients and families, and the information is used to make improvements.		!

Priority Process: Impact on Outcomes		
13.2	The procedure to select evidence-informed guidelines is reviewed, with input from clients and families, teams, and partners.	
13.3	There is a standardized process, developed with input from clients and families, to decide among conflicting evidence-informed guidelines.	!
15.1	Information and feedback is collected about the quality of services to guide quality improvement initiatives, with input from clients and families, team members, and partners.	
15.2	The information and feedback gathered is used to identify opportunities for quality improvement initiatives and set priorities, with input from clients and families.	
15.4	Indicator(s) that monitor progress for each quality improvement objective are identified, with input from clients and families.	
15.5	Quality improvement activities are designed and tested to meet objectives.	!
15.6	New or existing indicator data are used to establish a baseline for each indicator.	
15.7	There is a process to regularly collect indicator data and track progress.	
15.8	Indicator data is regularly analyzed to determine the effectiveness of the quality improvement activities.	!
Surveyor comments on the priority process(es)		
Priority Process: Clinical Leadership		

Rosaire House
A new manager of Rosaire House is in place who also oversees the inpatient mental health service which provides an opportunity for collaboration on issues of mutual concern. Rosaire House uses a strength-based, patient-centred approach to treatment planning. Meaningful partnerships have been formed with addiction and drug programs in the First Nations communities which facilitates effective communication and transition planning. Establishing goals and objectives for the balance of the year is recommended. Addiction counsellors and residential care workers constitute the care team with some consideration being given to including other health care professionals to augment the service. Clients express appreciation for the care provided and identify increased recreational services as an opportunity for improvement.
The program operates in an aging physical plant. Opportunities for improvement include enhancing the physical environment.

Hope North Recovery for Youth: Youth Addiction Stabilization
Youth Addiction Stabilization is a new program situated in the beautiful Hope North facility. They are still in start-up mode having only served a small number of clients/families so far. A client and family focused philosophy has been established using the Circle of Courage framework and the team is using a trauma-informed approach to recovery. Specific goals have not yet been established but marketing the program to all stakeholders and the wider community is being planned with an emphasis on education of families and the Indigenous community about the court mandate aspect to ensure parents are comfortable with the process.

Priority Process: Competency

Rosaire House
Addiction Counsellors and Residential Care Workers constitute the team currently. Consideration is being given to other skills required to meet the needs of residents. Staff are committed to their work and indicate that educational opportunities for their own professional growth are available to them.

Hope North Recovery for Youth: Youth Addiction Stabilization
The team consists of RNs, Recovery Support Workers and Recovery Support Navigators. This is a team that works well together to optimize the client experience. Training and education has been offered and staff recognize the importance of this and have identified further areas for learning and growth to enhance their roles in youth drug stabilization.

Priority Process: Episode of Care

The Rosaire team offers comprehensive treatment and counselling services in this 28 day residential treatment program. Connections with community partners particularly in the First Nations communities are well established. Staff are committed and patient focused. Previous security concerns related to working off site from the hospital have been alleviated by the availability of 24/7 security services. A more structured approach to transition planning would strengthen this critical component of the episode of care. On a practical note, it is suggested that old medication records and expired medications could be removed from the patient medication storage area.

Hope North Recovery for Youth: Youth Addiction Stabilization
The client's episode of care has been thoughtfully mapped out from the point of intake to discharge over the 7 day stabilization period. Staff involve clients and parents in the treatment planning process. The transition/discharge process could be strengthened by auditing and evaluating the effectiveness of communication to external partners.

Priority Process: Decision Support

Rosaire House
Mental Health and Addictions services will soon be able to access electronic documents. Staff are aware of privacy and confidentiality policies and are careful to ensure that consent is obtained in order to share client information. Currently data on wait lists are being compiled to assist with wait list management and an efficient intake process.

Hope North Recovery for Youth: Youth Addiction Stabilization
Program Leaders have sought out validated and evidence-based tools for risk assessment. They are encouraged to share these tools and work with regional and provincial partners towards a standardized approach to risk assessment.
Currently all documentation is paper-based but soon will be replaced by an electronic health record which is a good step forward in regard to potential for report writing that supports planning and decision-making,

Priority Process: Impact on Outcomes

Rosaire House:
The program uses evidence-based tools in alignment with provincial/industry standards. Although staff continuously engage with clients to understand and enhance the client experience, staff are not involved in any quality improvement projects at the program level. It is suggested that undertaking a simple project involving outcome indicator tracking and trending would engage staff and promote a culture of continuous quality improvement at R
Rosaire House.

Hope North Recovery for Youth: Youth Addiction Stabilization
The program has established validated evidence-based tools for risk assessment. Although staff continuously engage with clients to understand and enhance the client experience, staff are not involved in any quality improvement projects at the program level. It is suggested that undertaking a simple project involving outcome indicator tracking and trending would engage staff and promote a culture of continuous quality improvement in the Youth Addiction Stabilization Program.

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.

Governance Functioning Tool (2016)

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: April 19, 2017 to May 12, 2017**
- **Number of responses: 8**

Governance Functioning Tool Results

	% Strongly Disagree / Disagree	% Neutral	% Agree / Strongly Agree	%Agree * Canadian Average
	Organization	Organization	Organization	
1. We regularly review and ensure compliance with applicable laws, legislation, and regulations.	25	0	75	94
2. Governance policies and procedures that define our role and responsibilities are well documented and consistently followed.	13	0	88	95
3. Subcommittees need better defined roles and responsibilities.	63	0	38	72
4. As a governing body, we do not become directly involved in management issues.	13	13	75	81
5. Disagreements are viewed as a search for solutions rather than a “win/lose”.	13	13	75	94

	% Strongly Disagree / Disagree	% Neutral	% Agree / Strongly Agree	%Agree * Canadian Average
	Organization	Organization	Organization	
6. Our meetings are held frequently enough to make sure we are able to make timely decisions.	25	25	50	96
7. Individual members understand and carry out their legal duties, roles, and responsibilities, including subcommittee work (as applicable).	13	0	88	96
8. Members come to meetings prepared to engage in meaningful discussion and thoughtful decision making.	13	0	88	95
9. Our governance processes need to better ensure that everyone participates in decision making.	50	13	38	64
10. The composition of our governing body contributes to strong governance and leadership performance.	13	13	75	91
11. Individual members ask for and listen to one another's ideas and input.	13	0	88	95
12. Our ongoing education and professional development is encouraged.	13	13	75	92
13. Working relationships among individual members are positive.	25	0	75	97
14. We have a process to set bylaws and corporate policies.	13	25	63	95
15. Our bylaws and corporate policies cover confidentiality and conflict of interest.	13	0	88	99
16. We benchmark our performance against other similar organizations and/or national standards.	25	13	63	76
17. Contributions of individual members are reviewed regularly.	13	38	50	69
18. As a team, we regularly review how we function together and how our governance processes could be improved.	13	13	75	80
19. There is a process for improving individual effectiveness when non-performance is an issue.	25	13	63	62
20. As a governing body, we regularly identify areas for improvement and engage in our own quality improvement activities.	13	13	75	85

	% Strongly Disagree / Disagree	% Neutral	% Agree / Strongly Agree	%Agree * Canadian Average
	Organization	Organization	Organization	
21. As individual members, we need better feedback about our contribution to the governing body.	25	13	63	50
22. We receive ongoing education on how to interpret information on quality and patient safety performance.	13	13	75	84
23. As a governing body, we oversee the development of the organization's strategic plan.	25	0	75	95
24. As a governing body, we hear stories about clients who experienced harm during care.	13	0	88	78
25. The performance measures we track as a governing body give us a good understanding of organizational performance.	25	0	75	90
26. We actively recruit, recommend, and/or select new members based on needs for particular skills, background, and experience.	29	29	43	88
27. We lack explicit criteria to recruit and select new members.	63	13	25	77
28. Our renewal cycle is appropriately managed to ensure the continuity of the governing body.	25	25	50	88
29. The composition of our governing body allows us to meet stakeholder and community needs.	25	25	50	93
30. Clear, written policies define term lengths and limits for individual members, as well as compensation.	13	0	88	93
31. We review our own structure, including size and subcommittee structure.	25	38	38	88
32. We have a process to elect or appoint our chair.	29	43	29	89

*Canadian average: Percentage of Accreditation Canada client organizations that completed the instrument from January to June, 2016 and agreed with the instrument items.

Overall, what is your assessment of the governing body's impact over the past 12 months, in terms of driving improvements to:	% Poor / Fair	% Good	% Very Good / Excellent	%Agree * Canadian Average
	Organization	Organization	Organization	
33. Patient safety	43	14	43	81

Overall, what is your assessment of the governing body's impact over the past 12 months, in terms of driving improvements to:	% Poor / Fair	% Good	% Very Good / Excellent	%Agree * Canadian Average
	Organization	Organization	Organization	
34. Quality of care	38	25	38	82

*Canadian average: Percentage of Accreditation Canada client organizations that completed the instrument from January to June, 2016 and agreed with the instrument items.

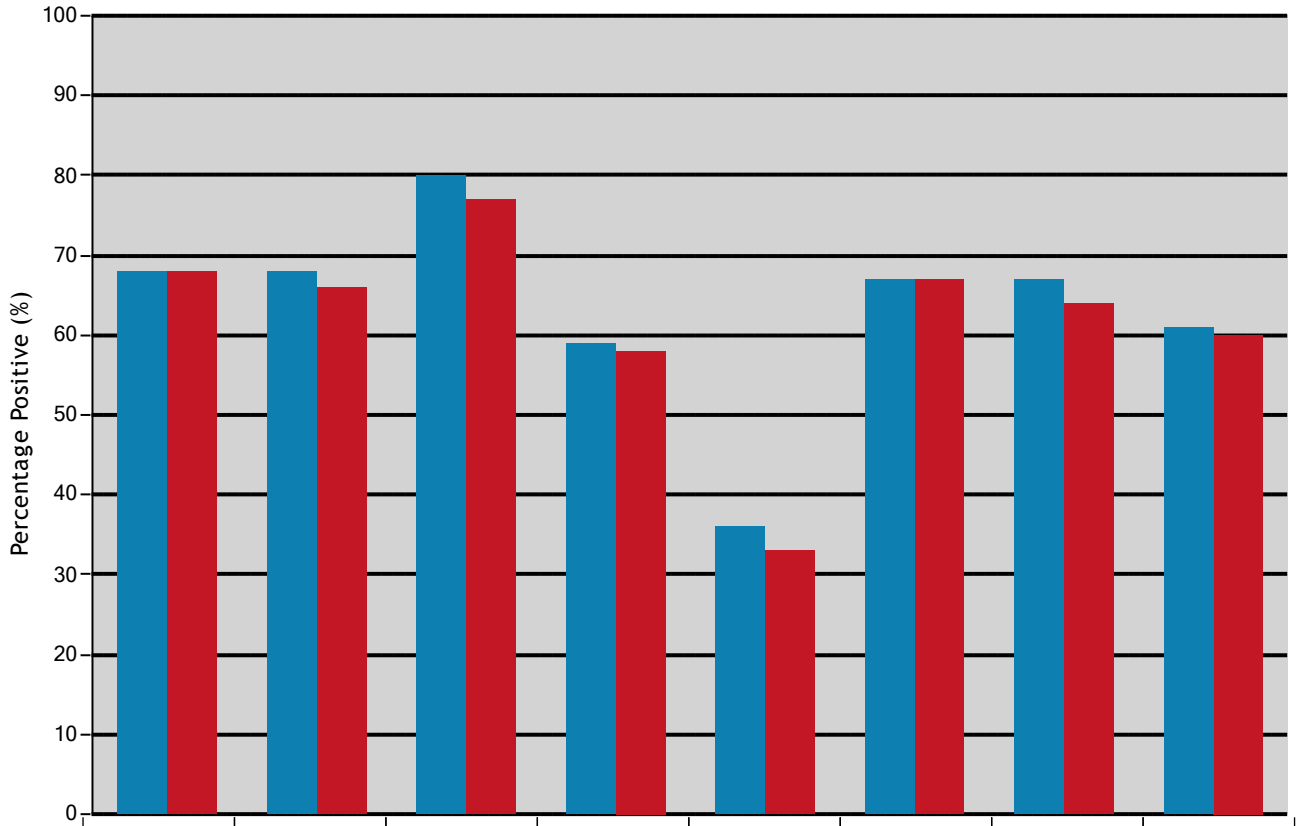
Canadian Patient Safety Culture Survey Tool

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: September 25, 2017 to December 29, 2017**
- **Minimum responses rate (based on the number of eligible employees): 274**
- **Number of responses: 408**

Canadian Patient Safety Culture Survey Tool: Results by Patient Safety Culture Dimension



	Organizational (senior) leadership support for safety	Supervisory leadership for safety	Unit learning culture	Enabling Open Communication I: judgment-free environment	Enabling Open Communication II: job repercussions of error	Incident follow up	Stand-alone items	Overall Perceptions of Client Safety
	68%	68%	80%	59%	36%	67%	67%	61%
	68%	66%	77%	58%	33%	67%	64%	60%

Legend

Northern Regional Health Authority

* Canadian Average

*Canadian average: Percentage of Accreditation Canada client organizations that completed the instrument from July to December, 2017 and agreed with the instrument items.

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.

The organization used an approved substitute tool for measuring quality of Worklife. The organization has provided Accreditation Canada with results from its substitute tool and had the opportunity to identify strengths and address areas for improvement. During the on-site survey, surveyors reviewed actions the organization has taken.

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

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 2018 Accreditation Canada on-site visit is the second survey of the Northern Regional Health Authority (the Region) since amalgamating in 2012; the first survey occurred in 2014.

The on-site visit by Accreditation Canada surveyors is the second step in the review of the Region to measure compliance with Accreditation Canada standards of services provided to the population of the region. Over the previous year, the Region 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 further regionalizing policies, processes and procedures and gaining regional service practice and delivery consistency. During the self-assessment process it became very evident that significant progress had been made since the last survey and in the 6 years since amalgamation. This is in the face of substantial jurisdictional challenges, recruitment and retention difficulties and financial reduction directives from government.

During the on-site visit, the surveyors not only assessed the Region 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 Region and recognized staff for their innovation, creativity, 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. Patient, client and family engagement has become a focus of the Region from the Board to front-line providers and teams. We recognize we have work to do in this area and are eagerly moving down this very positive road to ensuring our care is informed by those we serve. We particularly appreciated the input from the surveyors on their experiences from their work places in terms of experiences they have gained. They willingly shared those.

2. Quality Improvement at front-line is a priority of the organization. It is observed that staff are regularly engaging in "improvement projects", however not connecting this to the quality, patient safety and continuous improvement mandate of the Region.

3. Medication Management: Our challenges admittedly exist and work is yet to be done, particularly in identified areas is recognized; work is being undertaken to meet this expectation.

4. Space/Physical Environment Challenges: Work is ongoing through the Health Planning process to communicate and negotiate these issues with the funding body. There is recognition at the funding body (MHSAL) that grave concerns regarding infrastructure exist in areas such as MDRD, Pharmacy and Operating Rooms; this information has been inputted into the Provincial Clinical and

Preventive Services Planning process and teams.

5. Performance Conversations and Respectful Workplace: as an Employer of Choice, we will continue to work tirelessly on ensuring Managers support their direct reports in ensuring they are encouraged and corrected to maximize their performance in the roles. We have taken courageous steps in creating a more respectful workplace and will continue to do so. Our refreshed performance conversation framework for supporting the performance of employees is being well received and we expect compliance with this expectation to increase.

6. Participation in the Community Partners Discussion Group session was relatively well attended and we believe is a testament to the community engagement that occurs and is a strategic focus of the Region.

The report by the Accreditation Canada surveyors validated the information that was garnered from the self-assessments. The organization agreed with the surveyors findings; the comments from the team were supportive of our own self-assessment and did not come as a surprise. With the feedback provided we will be able to link the recommendations of Accreditation Canada, accept with gratitude the encouragement and progress with confidence in the work already well underway in the region.

Overall, the Region is very satisfied with the survey findings and will use this information as a point of focus as we move forward.

We thank the surveyor team and Accreditation Canada for conducting this survey; it will aid us greatly as we continue in our quest to provide accessible, quality health care services in Northern Manitoba.

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.

Appendix B - Priority Processes

Priority processes associated with system-wide standards

Priority Process	Description
People-Centred Care	Working with clients and their families to plan and provide care that is respectful, compassionate, culturally safe, and competent, and to see that this care is continuously improved upon.