ACCREDITATION
AGRÉMENT
CANADA
Qmentum

Accreditation Report

Interlake-Eastern Regional Health Authority

Selkirk, MB

On-site survey dates: June 23, 2019 - June 28, 2019

Report issued: August 28, 2019

About the Accreditation Report

Interlake-Eastern 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 2019. 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 Program Manager or Client Services Coordinator 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

Interlake-Eastern 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

Interlake-Eastern 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 23, 2019 to June 28, 2019**

- **Locations**

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

1. Arborg and District Health Centre
2. Beausejour Health Centre
3. Beausejour Office Highway 302
4. Betel Home Foundation - Gimli
5. Betel Home Foundation - Selkirk
6. E. M. Crowe Memorial Hospital and Personal Care Home
7. East Gate Lodge
8. Eriksdale Wellness Centre
9. Gimli Community Health Centre
10. HEW Building - Primary Health Clinic
11. Kin Place Health Complex
12. Lac du Bonnet Personal Care Home
13. Lakeshore General Hospital and Personal Care Home
14. People Centre Care
15. Pinawa Hospital and Primary Health Care Centre
16. Rosewood Lodge
17. Selkirk Community Health Office
18. Selkirk Community Mental Health Office
19. Selkirk Crisis Unit
20. Selkirk Regional Health Centre
21. Stonewall and District Health Centre
22. Teulon Community Health Office
23. Teulon - Goodwin Lodge PCH
24. Corporate Office

- **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. Cancer Care - Service Excellence Standards
  7. Community-Based Mental Health Services and Supports - Service Excellence Standards
  8. Emergency Department - Service Excellence Standards
  9. EMS and Interfacility Transport - Service Excellence Standards
  10. Home Care Services - Service Excellence Standards
  11. Inpatient Services - Service Excellence Standards
  12. Long-Term Care Services - Service Excellence Standards
  13. Obstetrics Services - Service Excellence Standards
  14. Perioperative Services and Invasive Procedures - Service Excellence Standards
  15. Primary Care Services - Service Excellence Standards
  16. Public Health Services - Service Excellence Standards
  17. Reprocessing of Reusable Medical Devices - Service Excellence Standards

- **Instruments**

  The organization administered:

  1. Worklife Pulse
  2. Canadian Patient Safety Culture Survey Tool
  3. Governance Functioning Tool (2016)
  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)	97	5	0	102
 Accessibility (Give me timely and equitable services)	106	5	0	111
 Safety (Keep me safe)	634	24	13	671
 Worklife (Take care of those who take care of me)	158	5	0	163
 Client-centred Services (Partner with me and my family in our care)	389	27	1	417
 Continuity (Coordinate my care across the continuum)	102	2	1	105
 Appropriateness (Do the right thing to achieve the best results)	787	67	10	864
 Efficiency (Make the best use of resources)	71	3	0	74
Total	**2344**	**138**	**25**	**2507**

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	48 (96.0%)	2 (4.0%)	0	34 (97.1%)	1 (2.9%)	1	82 (96.5%)	3 (3.5%)	1
Leadership	48 (96.0%)	2 (4.0%)	0	89 (92.7%)	7 (7.3%)	0	137 (93.8%)	9 (6.2%)	0
Infection Prevention and Control Standards	40 (100.0%)	0 (0.0%)	0	31 (100.0%)	0 (0.0%)	0	71 (100.0%)	0 (0.0%)	0
Medication Management Standards	61 (85.9%)	10 (14.1%)	7	51 (82.3%)	11 (17.7%)	2	112 (84.2%)	21 (15.8%)	9
Population Health and Wellness	4 (100.0%)	0 (0.0%)	0	35 (100.0%)	0 (0.0%)	0	39 (100.0%)	0 (0.0%)	0
Cancer Care	78 (96.3%)	3 (3.7%)	0	106 (93.0%)	8 (7.0%)	0	184 (94.4%)	11 (5.6%)	0
Community-Based Mental Health Services and Supports	45 (100.0%)	0 (0.0%)	0	93 (98.9%)	1 (1.1%)	0	138 (99.3%)	1 (0.7%)	0
Emergency Department	67 (93.1%)	5 (6.9%)	0	99 (92.5%)	8 (7.5%)	0	166 (92.7%)	13 (7.3%)	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
	# (%)	# (%)	#	# (%)	# (%)	#	# (%)	# (%)	#
EMS and Interfacility Transport	106 (93.0%)	8 (7.0%)	0	110 (91.7%)	10 (8.3%)	0	216 (92.3%)	18 (7.7%)	0
Home Care Services	46 (95.8%)	2 (4.2%)	0	70 (93.3%)	5 (6.7%)	0	116 (94.3%)	7 (5.7%)	0
Inpatient Services	54 (91.5%)	5 (8.5%)	1	78 (92.9%)	6 (7.1%)	1	132 (92.3%)	11 (7.7%)	2
Long-Term Care Services	56 (100.0%)	0 (0.0%)	0	98 (100.0%)	0 (0.0%)	1	154 (100.0%)	0 (0.0%)	1
Obstetrics Services	61 (87.1%)	9 (12.9%)	3	81 (94.2%)	5 (5.8%)	2	142 (91.0%)	14 (9.0%)	5
Perioperative Services and Invasive Procedures	102 (91.1%)	10 (8.9%)	3	96 (88.9%)	12 (11.1%)	1	198 (90.0%)	22 (10.0%)	4
Primary Care Services	58 (98.3%)	1 (1.7%)	0	91 (100.0%)	0 (0.0%)	0	149 (99.3%)	1 (0.7%)	0
Public Health Services	47 (100.0%)	0 (0.0%)	0	68 (98.6%)	1 (1.4%)	0	115 (99.1%)	1 (0.9%)	0
Reprocessing of Reusable Medical Devices	86 (98.9%)	1 (1.1%)	1	38 (95.0%)	2 (5.0%)	0	124 (97.6%)	3 (2.4%)	1
Total	**1007 (94.6%)**	58 (5.4%)	15	1268 (94.3%)	77 (5.7%)	8	2275 (94.4%)	135 (5.6%)	23

* 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 (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
Client Identification (Home Care Services)	Met	1 of 1	0 of 0
Client Identification (Inpatient Services)	Met	1 of 1	0 of 0

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Communication			
Client Identification (Long-Term Care 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
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
Information transfer at care transitions (EMS and Interfacility Transport)	Unmet	2 of 4	0 of 1
Information transfer at care transitions (Home Care Services)	Met	4 of 4	1 of 1
Information transfer at care transitions (Inpatient Services)	Met	4 of 4	1 of 1
Information transfer at care transitions (Long-Term Care Services)	Met	4 of 4	1 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

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Communication			
Medication reconciliation as a strategic priority (Leadership)	Met	3 of 3	2 of 2
Medication reconciliation at care transitions (Cancer Care)	Met	5 of 5	0 of 0
Medication reconciliation at care transitions (Community-Based Mental Health Services and Supports)	Met	3 of 3	1 of 1
Medication reconciliation at care transitions (Emergency Department)	Met	1 of 1	0 of 0
Medication reconciliation at care transitions (Home Care Services)	Met	3 of 3	1 of 1
Medication reconciliation at care transitions (Inpatient Services)	Met	4 of 4	0 of 0
Medication reconciliation at care transitions (Long-Term Care Services)	Met	4 of 4	0 of 0
Medication reconciliation at care transitions (Obstetrics Services)	Met	4 of 4	0 of 0
Medication reconciliation at care transitions (Perioperative Services and Invasive Procedures)	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			
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
Patient Safety Goal Area: Medication Use			
Antimicrobial Stewardship (Medication Management Standards)	Met	4 of 4	1 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)	Met	5 of 5	3 of 3
High-Alert Medications (Medication Management Standards)	Unmet	4 of 5	3 of 3
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

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Medication Use			
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
Narcotics Safety (Medication Management Standards)	Unmet	2 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

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Infection Control			
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
Reprocessing (EMS and Interfacility Transport)	Met	1 of 1	1 of 1
Patient Safety Goal Area: Risk Assessment			
Falls Prevention Strategy (Cancer Care)	Met	2 of 2	1 of 1
Falls Prevention Strategy (Inpatient Services)	Met	2 of 2	1 of 1
Falls Prevention Strategy (Long-Term Care Services)	Met	5 of 5	1 of 1
Falls Prevention Strategy (Obstetrics Services)	Met	2 of 2	1 of 1
Falls Prevention Strategy (Perioperative Services and Invasive Procedures)	Met	2 of 2	1 of 1
Home Safety Risk Assessment (Home Care Services)	Met	3 of 3	2 of 2
Pressure Ulcer Prevention (Inpatient 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 (Long-Term Care Services)	Met	3 of 3	2 of 2
Pressure Ulcer Prevention (Perioperative Services and Invasive Procedures)	Met	3 of 3	2 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
Venous Thromboembolism Prophylaxis (Inpatient Services)	Met	3 of 3	2 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.

The Interlake-Eastern Regional Health Authority (IERHA) is commended for its commitment and participation in the accreditation process. The organization is led by an enthusiastic Chief Executive Officer (CEO) and dedicated leadership team, many whom are new to their roles. Manitoba is undergoing significant change in health care delivery and the impact on the organization is noticeable. The team has embraced the potential for shifting directions and feel that the right people are now placed within the leadership team to support ongoing change and improvement.

IERHA is a large diverse region mix of small urban, rural, northern and northern remote communities with 129,000 residents and 17 Indigenous Communities. The population swells to 290,000 in the summer causing significant pressure on the organization's services. There are 3350 staff including 133 physicians.

The strategic plan was developed in 2016 – 2021 primarily with Board and Leadership input. Minimal stakeholder feedback was solicited. The planning process for the refreshed plan, which will soon begin, is intended to include a broader range of stakeholder input, including how to include the patient and families' voice. While there are many information groups and stakeholder engagement sessions, the team heard repeatedly that information was given, and limited feedback was sought.

Recently there has been a shift to align with the four (4) provincial goals of improving access, the health service experience, safety and affordability and sustainable health spending. A provincial dashboard for reporting was created in February 2019. The IERHA is awaiting further direction from Manitoba Health on the next steps in the health innovation model.

A strong committed Board provides oversight to the organization. There is a good skill mix and they have a solid understanding of the organization and the challenges. Members are appointed by Manitoba Health.

Since the last accreditation survey there has been attention on mental health (focusing on patient and family engagement), integration and amalgamation of services, and standardization of processes.

Significant challenges include the lack of inpatient mental health beds, an ALC population of 50 percent, emergency department operations, and the inequity in health access. The organization has managed to turn a 23-million-dollar budget deficit into a balanced budget. Other success includes focused recruitment of physicians, a new MRI and a beautiful new facility in Selkirk.

The IERHA does not have a well-defined strategy to promote People Centred Care. While they have identified tactics and some initiatives are in place, they may want to consider developing formal expectations and processes for the organization, such as a patient advisory committee. There are many opportunities to include the voice of the patient and family as they move forward on addressing the complex needs within

their region.

Patients spoke positively about the care they received in the region. Staff also indicated that they were supported and the IERHA was a good place to work.

The Community Partners was a diverse group of individuals who have varied working relationships with IERHA. For the most part, individuals stated that they had a very good working relationships with the organization. They were treated with respect and many used the word trust. There has been work on breaking down the silos. Information updates varied, and non-profits felt marginalized. Organizations that donated money did not have donations acknowledged. Some of the partners had participated in the Local Health Involvement Groups (LHIGs) and have chosen not to continue as there is little or no opportunity to have their voices heard. Agendas were set by the Board and feedback was not solicited. There was an overwhelming agreement that providing updates on activities and changes would be appreciated, especially from the CEO and Leadership team.

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 patient is communicated effectively during care transitions.	· EMS and Interfacility Transport 22.1
Patient Safety Goal Area: Medication Use	
Narcotics Safety The availability of narcotic products is evaluated and limited to ensure that formats with the potential to cause patient safety incidents are not stocked in client service areas.	· Medication Management Standards 9.4
High-Alert Medications A documented and coordinated approach to safely manage high-alert medications is implemented.	· Medication Management Standards 2.5

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.

Unmet Criteria	High Priority Criteria
Standards Set: Governance	
4.2 When developing or updating the mission statement, input is sought from team members and external stakeholders, including clients, families, and partners.	

Surveyor comments on the priority process(es)

The Board consists of 12 members who provide oversight to the IERHA. Monthly meetings are aligned with the subcommittee meetings which are chaired by a Board member along with a member of the Senior Leadership Team. Manitoba Health appoints all members and there is no opportunity to request new members based on required skills. Members spoke of their understanding of the role of governance. Board evaluation takes place and looks at individual performance as well as board performance. As a result, subcommittees were changed to add education and a focus on Indigenous Community.

The monthly CEO report provides an update, along with the detailed board packages that are prepared for each meeting. In February 2019, a new Provincial Dashboard was created and is now part of the Board package. Members have found this helpful in understanding organizational performance. The Board was instrumental in identifying Big Dot initiatives such as access and safety which are reviewed quarterly. Patients have come to the Board to tell their story or patient stories are read at the meeting. Patients who come do not stay for the meeting to hear the discussion.

CEO performance expectations are discussed with the Executive Committee and there is a succession plan for the CEO.

The Board understands the importance of quality and as per the Provincial focus, look at safety within the organization. Critical incidents are reported, and the Board ensures that recommendations are followed up and implemented. An Ethical Frameworks has been used to discuss challenging situations.

There is uncertainty about the future of health in the region and they are waiting for further direction. Areas of concern are rural access to services and physician shortages in the emergency and the need for additional long-term care beds.

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		
1.5	Policies addressing the rights and responsibilities of clients are developed and implemented with input from clients and families.	
1.6	Input is sought from clients and families during the organization's key decision-making processes.	
4.10	Goals and objectives at the team, unit, or program level align with the strategic plan.	

Surveyor comments on the priority process(es)

The current strategic plan will be refreshed with the planning process in the fall. The organization recognizes the opportunity to more extensively engage with a broad range of stakeholders. The Community Assessment Plan is a key source of information for IERHA. Leaders have begun a renewed process and will have numerous indicators and data to share with their zones and districts. Access to Provincial data is also available for areas such as Home Care and Mental health. Provincial healthcare transformation in Manitoba Health will set the direction for change. The organization is awaiting more information, and this is making it difficult to move forward. There are some areas where they must wait and put moving forward on hold.

The organization is training leaders in change management and the expectation is that regional leadership will all participate in the training. Leaders recognize the challenge to stay focused on meeting regional needs alongside provincial planning. For example, Shared Health will be developed Clinical and Preventative Service plan for 11 clinical streams that regions will address in the future. My Health Team development is a provincial initiative, reviewing clinical decision making and identifying gaps in service. The organization will have a team in Selkirk and one in Ashern/Hudson. The values were reviewed in 2016 and cultural sensitivity was added. An online module is available and to date over 800 staff members have completed the course. Key challenges include urban and rural sustainability, long term bed capacity and human resources costs.

Priority Process: Resource Management

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

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

The organization is to be commended on having a balanced budget for the past 3 years after having a 23-million-dollar deficit. There has been focused attention on home care optimization, reducing or removing unfunded positions and surgical scheduling reviews. These initiatives have led to cost savings. Shared Health will be developing new processes and templates for use in the province.

There are standard processes for all resource management functions. The Board approves and monitors the budget. Finance provides support and monitors variances with all managers. Manitoba Health provides global funding. Activity or performance-based funding is not used. Budget drivers include health care status, the elderly, and population growth in the Indigenous population, supply costs and human resources. Supply costs in the surgical program are increasing. There is no Product Standardization Committee. The leaders may want to include the physicians on surgical supply costs discussions.

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 Human Resources (HR) department supports all the key functions of the organization. An Indigenous Recruiter has been added to the HR team. The IERHA does recruiting through schools, universities and advertisements. Some positions are specifically targeted. Potential employees are encouraged to use the website and apply on line. A standardized process is in place to bring new employees into the organization. The orientation program has been revised with day 1 occurring before the employee starts in their workplace. Day 2 does not take place for 30 days due to room availability. The organization may want to consider looking at opportunities to have Day 2 immediately follow Day 1 to ensure that critical content, such as infection prevention and violence prevention, is available to the employee before they begin work. It is important to have ethics education as part of general orientation. Mandatory requirements are repeated every three years or as significant changes occur. Professional development and ongoing education are entered into a Learning Management System.

The organization has made a concerted effort to support and educate managers. There is a Leading for Organizational Impact Program that all managers are required to attend. The IERHA is now partnering with Prairie Mountain Health to implement education for front line staff. Each of these programs will undergo evaluation and provide feedback to a Sustainability Working Group.

There is no formal IERHA Talent Management Plan. The organization uses the Shared Health Plan that was developed from the WRHA. Performance reviews are required every 2 years and a review of staff files indicated that they were not completed consistently. The model is moving from a lengthy review process to a performance conversation.

The HR staff spoke of positive relations with the unions and work to resolve grievances in a timely manner. There is a defined back to work process that is supported by legislation, best practices and work safe. Common injuries include musculoskeletal injury prevention (MSIP), violence, slips trips and falls. Violence incidents are mostly without injury and a proactive approach is in place. Joint Occupational Health and Safety Committees are responsible for auditing workplaces. Approaches by each of the committees is different and the organization is looking to standardize the processes.

Employee Assistance Program (EAP) is available to staff. There are defined recognition programs dependent on years of service. There are instances when mandatory overtime may occur. There is an opportunity for staff to identify whether they can work safely.

Recruitment for some professions is challenging and agency nurses are used more in the summer months when the population of the region doubles. The organization has made gains in absent management.

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	
15.3 A strategy to prevent the abuse of clients is developed and implemented.	!

Surveyor comments on the priority process(es)

There are numerous documents addressing quality in the organization. A quality framework was developed in 2014 and revised in 2017 supported by an action plan. The Manitoba Quality and Learning Framework released in May 2019 is to guide healthcare quality improvement for all Manitobans. At this time, it is not clear how all the plans will be linked. The organization may want to develop an overarching quality plan that outlines their quality priorities, along with a supporting structure, with clear linkages to the strategic plan.

A 20 plus member Quality Steering Committee has been in place since 2015. The terms of reference indicate quarterly meetings, but given competing priorities, the committee only met twice last year. The Quality Council structure for programs is not consistent, with some programs having a Quality Council and others having Leadership or Practice Councils.

Program and Service Committees, at the Director level, have the responsibility of developing and implementing processes, forms, and indicators to meet the standards such as ROPs. While there are examples of quality indicators in the framework, it is left up to the responsibility of each program to identify quality performance measures. The IERHA may want to have the Quality Department take a leadership role in assisting programs to identify and monitor such indicators based on the strategic plan. It will also be important to ensure that selected indicators are used measures and trended. There may be some indicators that are not providing the organization with meaningful information.

IERHA monitors provincial indicators such as access, safety, patient experience, and affordability. Significant improvement has been noted in HSMR results.

There is a well-defined process for reporting incidents. Reviews feedback and implementation of recommendations are tracked and monitored. Learnings are shared across the organization. There were some excellent examples of incidents and reviews were shared. The reporting system is paper-based and makes trending and follow up cumbersome. The organization may want to consider investing in an online safety reporting system.

The risk register is coming to the end of year four (4). It will be refreshed in the fall. There have been learning and improvements will be incorporated into the new version. The organization will be using the HIROC database.

It is apparent that the quality team is committed to working with the staff at all levels to make improvements. They are energetic and passionate in their work. Improvements have been made at the front line regarding regular safety briefing, team daily huddles, and vis boards.

Priority Process: Principle-based Care and Decision Making

Identifying and making decisions about ethical dilemmas and problems.

Unmet Criteria	High Priority Criteria
Standards Set: Leadership	
1.7 An ethics framework to support ethical practice is developed or adopted, and implemented with input from clients and families.	!

Surveyor comments on the priority process(es)

An Ethics Committee has been in place since 2014. There are 19 members and meetings are held quarterly. Each meeting starts with a video or education session. The most recent work plan was developed in 2017 and members agree that little progress has been made. For example, the intent was to set up ethics champions in the organization and this has not begun. The Committee has used resources provided by the Manitoba Provincial Health Ethics Network until it was disbanded 18 months ago. Up until recently, the committee approved clinical research. A new committee has been created to take over this function.

The organization has developed an ethics framework for clinical decision making in 2015. Members were able to identify how the framework helped work through challenging issues. They are looking at another framework for non-clinical decision making which has less of bioethical focus. The draft has been used to consider resource allocation with some success. The committee would like to revise both frameworks to include the values.

Staff learn about ethics through their manager during unit orientation. There is no ethics content provided during the orientation and the organization should look at ways of adding the content to ensure that all staff are familiar with the concepts. The Ethics Committee provides ethics consultation and advise. There have been no consultations requested for this year which supports the need for ongoing education.

The Patient Bill of Rights was not posted at all sites. These documents were developed without input from patients and families. The organization could look at how to get input from stakeholders on developing meaningful documents.

The committee monitors current trends in ethics such as medical marijuana, MAID and the implication of Bill 5. As issues come forward, they will have to provide a forum for ongoing ethics education.

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 Communication Plan is updated on an annual basis and incorporates key messages from Manitoba Health. The plan is regional and incorporates Provincial Integration Initiatives. With Manitoba Health transformation, the organization finds it challenging to keep stakeholders and others up to date, such as information from Shared Health.

Document Central is a repository for all policies, guidelines and procedures. It has a good searchable function and staff use it extensively. Policies are reviewed every 3 years. Privacy educations is ongoing, starting at orientation. As new changes come forward, such as Bill 5, education is targeted to the key areas.

The Provincial Services Strategy is now responsible for reviewing and approving all requests for information systems or software. IERHA currently has a request in for an on-line incident reporting system.

Patients and or families are currently not involved in providing feedback on written materials. The organization may want to consider developing a process to include their input on educational materials, brochures or a review of the Bill of Rights.

Records are all paper based except in Primary Health and Public Health. Some aspects of the emergency patient record are electronic. A document management system scans all patient files at discharge. Older files have all been scanned into the system. There is a defined process for patients to access their files.

The Regional Health Foundation Coordinator is now working to consolidate and align donations and other fund-raising activities within the region. There are numerous donation accounts that have not been used, nor had the donation acknowledged.

Provincial reports that have an impact on communication include KPMG and the Peachy Report. Local Health Involvement Groups have been in place since 2017. Agendas are set by the board and some participants have left as they do not feel that their voice was heard. Some described the process as one-way communication from IERHA.

The organization has a good relationship with the media. Leaders who need to engage with the media are prepared.

Priority Process: Physical Environment

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

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

The Selkirk Regional Health Centre is brand new. It is a well-lit, bright facility making use of natural light. Patient rooms are single for the most part. Each room has a window that can open and allow fresh air. Staff are pleased with the layout of the rooms which provides ample space to work. Each unit has an overflow room and negative pressure rooms. The new facility has many automatic features and alarms and was built to the Gold Leed Standard. Systems are tested regularly with minimal or no interruption. There is minimal overhead paging and Voicera is used with adherence to privacy and confidentiality.

Facility maintenance looks after equipment that does not have a service contract. Alarms are linked to facilities 24 hours a day. Biomedical support is provided through a contract with Prairie Mountain Health. All maintenance requests are tracked through the HIPPO system.

The organization participated in recycling and other green initiatives such as reusable sharps container. Other facilities in the region were noted to be clean and well maintained regardless of their age. Linen services are contracted through WRHA.

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)

There is a comprehensive and detailed emergency preparedness plan for the organization that is integrated with the various community partners. There is an overall standardized plan with modifications that are site specific.

The regional committee meets twice a year working with different stakeholders in designing and revising the plan.

There is education for all staff during their orientation and ongoing opportunities for mock drills of the codes and annual tabletop exercise.

The resource manual for codes and signage are visible throughout the organization.

There is a culture of ongoing learning and making improvements to ensure the safety and security of staff and clients, e.g. installing a panic alarm system. Debriefing post-incident management is a regular practice for the organization where input and feedback from staff and stakeholders are used for making improvements.

Staff acknowledged and appreciated the onboarding and ongoing training and support they receive to prepare themselves for handling emergencies and outbreaks.

The emergency management team shared many examples where they have implemented the incident management system successfully, e.g. Pinawa boiler electrical incident where patients were evacuated to the local school within 45 minutes and the code white incident at the Pine Falls site to name a few.

The disaster management team is very knowledgeable and committed to supporting staff during emergencies.

There are opportunities for improvement which includes, more involvement of clients and families in planning and education of emergency preparedness plan at the regional and local level; and more frequent mock training for staff on those emergency codes that occur less frequently (e.g. housekeeping staff on code brown).

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: Cancer Care		
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.	
27.3	Measurable objectives with specific timeframes for completion are identified for quality improvement initiatives, with input from clients and families.	!
Standards Set: Emergency Department		
2.5	Space is co-designed with clients and families to ensure safety and permit confidential and private interactions with clients and families.	
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.	
17.7	Patient safety incidents are analyzed to help prevent recurrence and make improvements, with input from clients and families.	!
Standards Set: EMS and Interfacility Transport		
5.3	A comprehensive orientation is provided to new team members and patient and family representatives.	
26.8	Patient safety incidents are analyzed to help prevent recurrence and make improvements, with input from patients and families.	!
27.3	Measurable objectives with specific timeframes for completion are identified for quality improvement initiatives, with input from patients and families.	!
Standards Set: Governance		
5.3	The governing body provides oversight of the organization's efforts to build meaningful partnerships with clients and families.	!

5.4	The governing body monitors and evaluates the organization's initiatives to build and maintain a culture of client- and family-centred care.	!
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		
16.3	Measurable objectives with specific timeframes for completion are identified for quality improvement initiatives, with input from clients and families.	!
Standards Set: Leadership		
4.3	Services are planned with input from clients, families, and the broader community.	
6.2	When developing the operational plans, input is sought from team members, clients and families, and other stakeholders, and the plans are communicated throughout the organization.	
9.2	There are mechanisms to gather input from clients and families in co-designing new space and determining optimal use of current space to best support comfort and recovery.	
10.4	Education and training are provided throughout the organization to promote and enhance a culture of client- and family-centred care.	
Standards Set: Obstetrics Services		
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.	
17.9	Patient safety incidents are analyzed to help prevent recurrence and make improvements, with input from clients and families.	!
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		
24.7	Patient safety incidents are analyzed to help prevent recurrence and make improvements, with input from clients and families.	!

25.3 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 organization has made efforts to put patients at the centre of their care, improve their experience and enable more connected care. An overall strategy for people-centered care at the regional level with clear consistent accountabilities at the local level is recommended. The organization is encouraged to develop metrics to measure their people centre approach.

At the corporate level, there are three geographical Local Health Involvement Group (LHIG) meetings held 5 – 6 times per year and a newly formed region-wide Patient Experience Council. The organization will want to ensure that there is ample time on the agenda so that patient and family members can provide meaningful feedback and input.

There are several programs that have made a strong effort to incorporate and embed patient and family advisors into the culture of their program, including the Mental Health Program, Palliative Care and Long-Term Care. These patient and family advisors feel they are contributing in a meaningful way and that their voice is heard. They shared examples of how their input and feedback have led to improvements in the quality of services. At the same time, the staff from these programs believe that the input from these patient and family advisors are meaningful and add value to their respective programs.

There is currently no corporate structure to support the recruitment of patient and family advisors. There is no established recruitment; hiring and selection process, nor is there any formal training program. The organization is encouraged to develop formal training materials; one tailored to patient and family advisors and the other to staff and physicians.

Input from patients is currently obtained through various mechanisms, such as storytelling, surveys, complaint process, and informal interactions. Storytelling is a tool currently being used as a reminder to keep the patient experience at the centre of discussions, at Board and program team meetings.

There is a desire to hear feedback from patients and families to improve care and services. While the feedback process is posted on the website and envelopes with a letter enclosed in various areas at each site encouraging patients to provide feedback, this should be more visible and readily available to all throughout the organization (e.g. at elevators, registration desks and inpatient rooms). While there is information on the website, it was not felt to be clear to individuals that they could access it. While there is a poster in patient rooms inviting patients to ask questions and share their concerns with the staff, it does not include the option of communicating with the manager or a member of the Quality Office at their discretion. It may be worthwhile to engage your patient and family advisors to assist in determining how to improve the visibility and consistency in receiving feedback.

There was a wide variation on the visibility of the patient's "Bill of Rights". Some were well-developed with individual and family input, for example in the Mental Health Program, Primary Health Care,

Palliative and Long-Term Care. The organization in collaboration with patient and family advisors is encouraged to develop a corporate "Bill of Rights and Responsibilities" for patients and families to ensure that it is readily and consistently visible throughout the organization.

Most organizations have moved away from visiting hours and are much more liberal about the family presence and open visiting hours. This may be another worthwhile area to seek the input of patient and family advisors on this practice.

Even when recruiting for key leadership or professional positions, patient and family advisors may be active members of an interview panel.

Whiteboards located in patients' rooms are standardized and consistently completed with pertinent information or information that are useful to the patient and family. Patients and families were aware that they could use the board, for example, to write questions to the physician or other care providers.

The organization has been working on moving the change of shift report away from the communication station to the bedside where patients and families may participate in their report. The organization is encouraged to continue this journey so that patients and families' voices are heard, and relevant safety checks are completed at shift change (e.g. armbands, IV solutions, allergies, etc.).

Relevant patient education handouts organized at the different locations are well organized and readily accessible.

The patients we met experienced good care overall. There were involved in their care plans, goal setting and collaborated with their health care team. Families are invited to be partners in the care with their loved one. There was mention by patients and family members that there are still silos in the system and navigation is challenging at times, especially with referrals outside of the region. There is hope that the upcoming new transformation by the region and province will alleviate issues surrounding access and equity to care and improve collaboration and unnecessary complications.

Some patients had a very positive experience with telehealth and look forward to the continued expansion of this program.

As the organization continues the journey to incorporate the voice of the patient and family members as full members of committees across all sites and at all level of the organization, you will likely require a larger pool of patients and family members to ensure proper feedback is captured in terms of diversity and special needs.

When asked to describe their experience at Interlake-Eastern Regional Health Authority, the patients and family members in the focus group used the following words: caring, feel staff and physicians truly listen, compassionate, grateful for the care close to home and treated with respect.

Priority Process: Patient Flow

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

Unmet Criteria	High Priority Criteria
Standards Set: Emergency Department	
3.4 There is access to the emergency department 24 hours a day, seven days a week.	!

Surveyor comments on the priority process(es)

The Interlake-Eastern RHA has a repatriation agreement and protocol with WRHA. This process includes a standardized form to ensure client information is transferred safely.

There is a strong patient flow strategy in IERHA. Daily bed flow huddles and an overcapacity bed management plan is in place and used to optimize bed spacing. However, most of the smaller blended Emergency Room and inpatient wards are filled over 50 percent with patients designated ALC awaiting home care of personal care bed/long-term care bed. Given the large geographic distribution, placement in beds across the region is often refused by patients in favor of staying closer to home in an acute care bed. Lack of access to home care or PHC beds significantly limits flow through the Emergency rooms and Inpatient units. Acute care treatment is often delivered in hallways. Staff across the smaller sites would like to renovate to accommodate the need for acute private care spaces to meet the needs of short stay and acute ER patients requiring treatment. The organization is encouraged to consider alternative options for both discharge planning of ALC designated patients such as wait at home programs or respite care beds. There is clearly a need for more PCH beds in the region given the aging population.

Various emergency rooms are "closed" across the rural northern region of IERHA. This is a result of lack of physician coverage. However, these ER departments stay open and operate a nurse triage resource. Acute patients must then be transferred to an open ER department with an on-call physician available for a phone consultation or in-person assessment. This does pose a risk to the organization as best practice treatment times for STEMI and Stroke should be considered if patients continue to access "closed" rural emergency departments. Despite significant physician recruitment to the IERHA, there exists a physician shortage to cover the Emergency Departments in the more rural areas as these physicians are also expected to provide outpatient primary care. As there are seasonal increases to the population, consideration to extra locum coverage should be considered in the rural areas to ensure that access and flow are not limited for patients.

The temporary closure of rural ER departments has an impact, including EMS redirect increasing patients at open and fully serviced ER departments such as that in Selkirk. Given data collected by flow directors and site directors, it would be highly recommended to re-evaluate the physician model given higher volumes year over year in Selkirk. The organization could consider recruiting Primary Care Nurse

Practitioners to help with physician shortage in rural areas. The organization is encouraged to have a robust rural locum coverage plan if the plan is to continue to keep the small emergency rooms open as full-service emergency departments. In addition, some thought, and advocacy should be considered by leadership to increase physician complement to other rural hospitals in the region as other sites are "closed" as well as Selkirk ED. Special consideration should be given to Selkirk ED. The organization and leadership are encouraged to review the ED patient data for Selkirk, which receives more unstable patients from rural sites. Additional Emergency physicians working during peak hours would improve patient flow in Selkirk. The organization is encouraged to examine the opportunities to redirect unused call stipends to help with adding physicians to redirected Emergency Rooms.

There exists a need to repatriate patients both from Winnipeg Regional Health Authority as in order to allow flow between IERHA and the specialty services provided at WRHA. The organization is encouraged to continue to work with this partner in order to facilitate timely access to specialized services in IERHA. Opening of the special care unit may improve flow as it would add 4 more acutely monitored beds to the region. This would improve the repatriation of patients from specialty services at WHRA and improve ED flow.

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		
15.1	There is a quality improvement program for reprocessing services that integrates the principles of quality control, risk management, and ongoing improvements.	
15.4	Measurable objectives with specific timeframes for completion are identified for quality improvement initiatives with input from stakeholders.	!
15.12	Quality improvement initiatives are regularly evaluated for feasibility, relevance, and usefulness, with input from stakeholders.	

Surveyor comments on the priority process(es)

The Medical Devices and Equipment (MDE) and Endoscopy at the Selkirk and at the Beauséjour sites were visited during this survey.

Initial discussions began with members of the leadership teams including the site managers and the director for both sites. From a regional perspective the goal is to standardize MDE processes across IERHA and to acquire full online access to MDE reports at any time. This plan will also be an excellent opportunity to review all maintenance contracts. The organization is encouraged to support these efforts and to provide teams with regular updates on objectives, specific timeframes and deliverables.

Staff have the necessary credentials to provide reprocessing services and are aware of the expected cleaning procedures defined by the manufacturers. There are no wooden cabinets and counters in MDE.

Policies and procedures guide their practice and processes are in place to manage recalls for equipment when a problem is observed.

The staff take great pride in performing quality work to keep patients safe. Given that MDE is key in the prevention of hospital-associated infections, the organization is encouraged to include MDE managers on the Infection Control Committee (IPC). This opportunity would support both newly hired managers as they acquire the necessary skills to appropriately lead their services.

From a risk management and quality improvement perspective huddle boards are in the preliminary stage of development at Selkirk and data is collected regarding hand washing compliance and to compliance with environmental standards.

MDE areas are clean and well organized. At Selkirk access to MDE is appropriately restricted and there is a clear separation between dirty and clean activities. During the onsite visit it was noticed that at Selkirk there could be a tendency to over supply areas. The organization may wish to consider introducing a lean approach to equipment storage.

While touring MDE at Beauséjour it was noticed that humidity levels are controlled by two monitors placed in two different locations and that both provide different readings. Given the importance to monitor humidity in MDE the organization is encouraged to identify one monitor and to place it in an adequate location in the department. As the unit engages in quality improvement projects there may be an opportunity to invest efforts in humidity control monitoring.

During the on-site visit at MDE at Beauséjour there did not seem to be an adequate documentation to ensure that quality and safety aspects of the equipment are maintained. The organization may wish to review the preventative maintenance schedules and establish mechanisms to ensure adequate and timely service maintenance for all equipment and devices.

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	
The organization has met all criteria for this priority process.	

Surveyor comments on the priority process(es)
Priority Process: Population Health and Wellness

Population health and wellness is a priority for the team and leaders. A strong inter-disciplinary team supports the needs of priority populations. The team and leaders are passionate and committed to improving programs and services for clients, families, and partners. The team spoke highly of the education and training provided. They described feeling safe at work and that the organization provided a safe working environment.

The team and leaders have identified four program pillars including; physical fitness, mental health, healthy eating, and tobacco reduction. Population Health strategies and Actions helps guide the work of the team and leaders. Community wellness grants provide funding for community members. A recent initiative was a grant for funding to lead a physical activity program.

A comprehensive Community Health Assessment was completed in 2014. This is reviewed and revised every five years. Work is ongoing on the development of a Community Health Assessment for September 2019. The leaders are encouraged to develop a robust strategy to share the plan with staff, clients, families, and partners and to seek input into the actions arising from the Community Health Assessment.

The team and leaders are committed to providing programs for their high-risks populations. This includes using a health equity lens to address systemic issues that influence health disparities in the under-serviced populations. Training for the team on health equity is planned with webinars and a workshop to be scheduled with health enquiry specialist in September 2019. Indigenous awareness and cultural

sensitivity training are also a priority. The leaders are encouraged to continue to provide education and training to the team on this important work.

There are several new initiatives that have been implemented to meet the needs of priority populations. The Rapid Access to Addictions Medicine (RAAM) Clinic was opened in Selkirk November 2019 in partnership with Addictions Foundation of Manitoba. The walk-in's clinics for adults improve access by providing help with substance use without an appointment of formal referral. A physician, nurse, social worker, and administrative support provides interdisciplinary care. The team uses the input and guidance of peers who are clients for the program to help inform program delivery. It was stated that they felt they were treated with care, dignity and respect and the all suggestions are valued by the team. Furthermore, the clinic felt welcoming and comfortable. The are for improvements includes the establishment of a safe injection site and opportunities to address homelessness. Additionally, a drop-in harm reduction clinic is held which provides harm reduction supply kits. Peers stated that they provide input into the program and that their opinions matter to the team and leaders. The team provides outstanding and compassionate care and are to be acknowledged for their commitment to the RAAM and Harm Reduction Clinics. The team and leaders are encouraged to continue to seek input from peers, clients, families, and partners into the design, implementation, and evaluation of programs and services.

The team and leaders are commended for their commitment to reducing the impact of sexually transmitted blood-borne infections. This has included policy development, staff education and training, communications, resource development, and partnership collaborations.

Partnerships are a strong focus of the team and leaders. This includes partners such as the Quality Childhood Coalition, Justice, RCMP, Addiction Foundation of Manitoba, Interlake Regional Tribal Council, Manitoba Harm Reduction network to name just a few. The partnerships were viewed as an important method to furthering the reach of population health and wellness initiatives.

A variety of communication processes are used to share information with clients, families and partners. This includes a Facebook page for the Teen Clinic, Community Wellness newsletter, website, newspapers, and meetings with stakeholders. Feedback on programs and services is received by client satisfaction surveys, feedback from peers, partners meeting, program evaluations, focused questions using peers, and educational session evaluations. The leaders are encouraged to continue to seek feedback from peers, clients, families and partners on programs and services to assist in quality improvement.

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: Cancer Care - 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		
8.6	Education and training are provided on the organization's ethical decision-making framework.	
11.5	The effectiveness of team collaboration and functioning is evaluated and opportunities for improvement are identified.	
Priority Process: Episode of Care		
The organization has met all criteria for this priority process.		
Priority Process: Decision Support		
The organization has met all criteria for this priority process.		
Priority Process: Impact on Outcomes		
25.6	There is a policy on ethical research practices that outlines when to seek approval, developed with input from clients and families.	!
27.4	Indicator(s) that monitor progress for each quality improvement objective are identified, with input from clients and families.	
27.5	Quality improvement activities are designed and tested to meet objectives.	!
27.13	Indicator data are compared to available benchmarks.	
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

Interlake-Eastern Regional Health Authority (IERHA) chemotherapy satellites work in collaboration with Cancer Care Manitoba (CCM).

During this survey two cancer satellites clinics were surveyed namely Selkirk and Gimli.

At both sites the clinical teams are engaged and passionate about the care they provide to their patients. Patients and families expressed praise and positive comments about the quality of care they receive. Significant efforts are made to reach underserved populations, new comers and elderly oncology patients.

The approach to care is inter-professional and a great amount of support is provided to the teams by managers and directors.

A comprehensive problem and symptom screening tool (COMPASS) are completed by every patient and is an effective tool to guide clinical care.

At the Selkirk site the new chemotherapy department is bright, uncluttered, and well-lit with natural light. The number of treatment chairs in the new cancer care unit increased from 4 to 9, as such, the number of outpatient treatments increased by 15 percent over the past year.

Wait times are closely monitored and efforts are made to begin chemotherapy treatments as soon as a diagnosis is confirmed. The addition of 2 nurse navigators to the oncology team optimizes cancer management and patient and family support.

In contrast, at Gimli, cancer care is delivered in a room that is cluttered with limited space to move between treatment chairs. Patients and staff expressed their concerns regarding the risk of infections, errors, falls, noise and to confidential issues. There is an urgent need for the organization to assess the space constraints in the cancer care unit at this site and their impact on quality, safety, risk and on patient experience.

Patients' voice is captured by the creation of patient advisors and this led to the enhancements in surgical oncology programs. The organization may wish to develop recruitment strategies to attract and involve more patients in that role.

Priority Process: Competency

Cancer Care Manitoba is responsible for providing cancer care in multiple sites throughout the region.

A robust orientation program is offered, and clinicians have access to a variety of educational opportunities; they take pride in their knowledge and skills regarding the oncology population. To ensure

a high level of standards of practice and excellence, competency maintenance and training opportunities are offered to front line staff. Guidelines and safety protocols are taken seriously and practiced with every patient. Staff are recognized during huddles and on an individual basis for their engagement in the excellent care they provide.

Regarding the use of the ethical decision-making framework, the organization recognizes opportunities for improvement in that area.

Support is offered to staff when they experience stress following an incident or a death.

Priority Process: Episode of Care

Employees have yearly performance reviews and skills and competencies are maintained. In both satellite sites, physician engagement is critical to higher patient experience and staff satisfaction. Throughout both satellite cancer centers, initiatives are taken to minimize risks. In one center a patient's fall resulted in a change in the environment to minimize risks (an extension cord was added to an existing one).

In addition to providing excellent care, efforts are made to minimize patients' displacements for blood work. Many patients who live far from the chemo center can receive pre-treatment blood work close to their home. Transition efforts are also initiated when a patient is stable enough to shift from an acute care team to primary care.

Medication reconciliation continues to be an area to improve. At Selkirk, the oncology nurse will identify a list of medications that the patient is taking, and the oncologist will review and update the list but not all general practitioners provide a decision on whether the medications that the patient is taking should be 'stopped, modified or continued' during the chemotherapy treatments. The organization is encouraged to engage all members of the inter-professional team to comply with the medication reconciliation policy.

Priority Process: Decision Support

Except for the community cancer program (CCP) at Gimli documentation in all CCP'S is computerized. The organization is aware of the benefits of implementation of an electronic medical record (EMR) across all CCP sites and is encouraged to execute this plan in a very near future.

Due to the increasing demand for acute cancer care efforts are put in place to begin transitioning patients from an acute cancer care setting to a primary one. Clinicians involved in this initiative have expressed the challenges both from a patient perspective and from a caregiver perspective of engaging in transition modalities. The organization is encouraged to pursue this necessary goal. Understanding transition readiness will prove to be useful in ensuring patient centered-care and in minimizing fears and concerns that can be associated with this shift. It will also be an opportunity to engage patients and families in care delivery and in transition planning.

Priority Process: Impact on Outcomes

Multiple audits are conducted by Cancer Care Manitoba or by the individual satellite centers and data are displayed on huddle boards. Daily, front line clinical and non-clinical staff review data and engage in discussions on ways to improve safety, quality, and patient experiences. Involvement of front-line staff is leveraged, and the organization may wish to include patients and families in this safety improvement initiative.

A variety of indicators are being tracked and discussed at leadership meetings; new patient referrals, outpatient treatment numbers and nurse-patient visits per year are collected and the data are compared to previous year's performance. The organization may wish to consolidate reports and benchmark them against centers of excellence. This exercise would serve as an excellent strategy to promote communication, innovation, and change regarding patient care and services.

Although staff attends mock codes on a regular basis at Selkirk, a need was expressed to reactivate unit based mock code exercises.

Priority Process: Medication Management

Cancer Care Manitoba offers a rigorous orientation program as well as ongoing teaching opportunities to maintain and to enhance medication management standards of care throughout the satellite community care programs. Best practice guidelines and safety protocols for administering systemic chemotherapy are followed.

Complete and documented instructions and safety measures are taught to patients and families who wish to pursue their chemotherapy treatments in their home.

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

Unmet Criteria	High Priority Criteria
Priority Process: Clinical Leadership	
1.4 Service-specific goals and objectives are developed, with input from clients and families.	
Priority Process: Competency	
The organization has met all criteria for this priority process.	
Priority Process: Episode of Care	
The organization has met all criteria for this priority process.	
Priority Process: Decision Support	
The organization has met all criteria for this priority process.	
Priority Process: Impact on Outcomes	
The organization has met all criteria for this priority process.	

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

It is clear that the leadership through the regional and program committees have focused on standardizing policies, procedures, protocols and practices across the regional health authority to ensure an integrated and coordinated system of mental health services for the communities that it serves. The leadership spoke about the value and importance of their partnerships in an effort wherever possible to avoid transfers to hospital emergency department or admission to hospital wherever possible.

A raised awareness and prioritization of patient safety is evident. A revised violence prevention and suicide assessment protocols are examples where evidenced based, best practices have been implemented across the mental health system. As a result, staff demonstrated consistent understanding and practice in their documentation including assessments, progress notes, and discharge planning.

There has been a focused effort since the last Accreditation to address patient and family concerns and complaints in an ongoing and meaningful way. Two years ago, the Recovery Champions Group was formed which provides an excellent opportunity for patients and family members with lived experiences to provide feedback and input into the Mental Health Program in a meaningful way. The Recovery Champions Group has been actively engaged in reviewing the website, suicide protocol and development

of the program patients' rights and responsibilities, just to name a few. One of the patient representatives of the Recovery Champion Group expressed how they felt their input was meaningful and valued. There is an opportunity to optimize the Recovery Champion Group by engaging them for their input on the program strategic goals, objectives and action plan.

Priority Process: Competency

The staff are highly skilled with strong interprofessional collaboration. Staff highlighted the value of their training in crisis intervention, cultural sensitivity and diversity, violence assessment and management, suicide assessment and prevention. Staff discussed the risk associated with their work and provided positive comments about the culture of staff safety and the measures that have been put in place when they are working. The violence risk assessment, personal alarm buttons that goes directly to the local RCMP office and using a buddy system are examples provided by staff that have been effective measures put in place for ensuring their safety. Overall staff feel positive about the changes that have been made and are proud of their working relationships both internally within their teams and externally with their community partners.

Priority Process: Episode of Care

Although there are no acute inpatient psychiatric beds in the region, the current services available across the region are comprehensive and include the crisis stabilization unit, centralized intake, mobile crisis, intensive case management, shared care program, community wellness and housing, child and adolescent and elderly programs just to name a few. These programs are evidence of the strong continuum of care in the mental health system. There are strong collaborative partnerships with the different sectors across the region.

Staff highlighted the value of the electronic documentation that is integrated with some partner organizations, i.e., some primary care providers, chronic disease program, Quick Care Clinic. Staff highlighted the value of the ability to access and share information across the sectors. Staff look forward to the upcoming plan for the mobile crisis team and CSU to go live with electronic documentation within the next 6 months. This will avoid charting duplication and repeated questions for clients and families.

Priority Process: Decision Support

Being able to provide feedback is highly valued by clients and families. It was observed that although this is one of the quality indicators, some programs are not consistently or regularly measuring this. It is recommended that a mechanism to consistently measure client and family feedback be undertaken. For example, in the crisis stabilization program, follow up discharge phone call within two weeks was highly valued and appreciated by the patients and family member. There is an opportunity to do more patient and family surveys on a consistent and ongoing basis across the mental health programs.

Priority Process: Impact on Outcomes

All staff highlighted the importance of building a therapeutic relationship with the individual and family and through their Recovery Model, empowering the individual to set their own goals and treatment plans. Individuals and family members all felt very positive about their experience and believed that the services they received played a key role in transforming their lives. There were several stories where individuals received services from multiple aspects of the program and community partners and were very grateful for receiving care close to home and genuinely felt that they were treated in a caring and respectful manner. Many wished that they had known sooner about the services offered. The program may want to explore strategies for promoting the education training sessions available for clients and their families.

Standards Set: Emergency Department - Direct Service Provision

Unmet Criteria		High Priority Criteria
Priority Process: Clinical Leadership		
2.9	The effectiveness of resources, space, and staffing is evaluated with input from clients and families, the team, and stakeholders.	
Priority Process: Competency		
4.7	Education and training are provided on the organization's ethical decision-making framework.	
Priority Process: Episode of Care		
9.14	Clients and families are provided with information about their rights and responsibilities.	!
9.15	Clients and families are provided with information about how to file a complaint or report violations of their rights.	!
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.	
16.4	Protocols and procedures for reducing unnecessary variation in service delivery are developed, with input from clients and families.	!
18.2	The information and feedback gathered is used to identify opportunities for quality improvement initiatives and set priorities, 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.	
18.13	Quality improvement initiatives are regularly evaluated for feasibility, relevance, and usefulness, with input from clients and families.	
Priority Process: Organ and Tissue Donation		
The organization has met all criteria for this priority process.		

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

The organization is encouraged to continue its education of staff on Indigenous cultural values and traditions. Particularly in locations where there are patients from First Nations, the organization is encouraged to continue working with Chiefs and Indigenous persons to find innovative and culturally appropriate solutions to care, emergency access and discharge planning. Providing on-reserve primary care may help to decrease CTAS 4+5 visits to local emergency department and improve population health outcome through continued preventative care and chronic disease management.

There is a strong educational component to this organization's approach to care. The Medical Director at Selkirk emergency room (ER) department provides ER training and orientation for all new primary care physicians that work in the rural ER and blended units. Selkirk emergency department employs physicians with significant experience or EM training as a reflection on the patient acuity. The organization should be commended for the hard work that is done to provide continued clinical education. Managers and Directors enable staff to attend additional educational opportunities notably sessions in palliative care, emergency practice, mental health, and addiction.

Ethics is not part of the orientation, but the staff is aware of how to manage an ethical dilemma. Most locations did not host educational sessions regarding the ethical decision-making framework. The organization is encouraged to ensure that this is part of orientation and continuing education programs.

Most sites are still paper-based charting, but all staff has had training on using e-chart and EMR for primary care. Electronic medical records are used in Selkirk Emergency Department and training on these systems is part of orientation.

The clinical leadership should be commended for their commitment to ensuring that staff remains clinical competent in the reflection of emergency department patient acuity.

Priority Process: Competency

The Medical Director at Selkirk ER department provides ER training and orientation for all new primary care physicians that work in the rural ER and blended units. Selkirk emergency department employs physicians with significant experience or EM training as a reflection on the patient acuity.

Priority Process: Episode of Care

Front line staff is committed to excellence in care. Staff is open to safety huddles and critical incidences are used to evaluate processes and change if indicated. Standard evidence-based tools are used in the emergency department across the region.

Staff are committed to ensuring patients are seen in a timely manner. Selkirk emergency staff have identified gaps in the new space for waiting room and triage in the emergency department. Leadership is encouraged to help staff mediate these gaps.

In rural sites, attention to the impact of overcapacity on the delivery of acute care services needs to be considered as hallway delivery of services is difficult for both staff and patients. In the rural sites, the addition of a dedicated ER/Inpatient ward clerk would positively impact care and clinician workflow.

Priority Process: Decision Support

The IERHA should be commended in the amalgamation of forms across the regional health authority. Standard templates are used across the organization for patient information and communication. The use of validated standard tools for assessment is exceptional. Although paper-based, the charts are accurate and up to date. The organization could consider in the future ensuring that an EMR that auto-populates these tools would improve nursing workflow and physician standard work. The organization could also consider leveraging the Nursing Advisory Council to review some of the transfer forms to eliminate unnecessary duplication of documentation.

Priority Process: Impact on Outcomes

Standardized processes are used across the health authority. The IERHA is commended for its implementation of standardization of transfer information across the region. There is a variation in service delivery based on limited resources including remote location and physician resources. There does not appear to be input from clients and families regarding protocols. The organization is strongly encouraged to engage patients, families, and communities in identifying the limitations in resources across the region and be included in setting priorities and quality initiatives. The leaders of the organization have performed exceptionally well in the implementation of vis board or quality boards.

Priority Process: Organ and Tissue Donation

There is no advertisement visible for organ or tissue donation in the smaller emergency room sites.

Standards Set: EMS and Interfacility Transport - Direct Service Provision

Unmet Criteria		High Priority Criteria
Priority Process: Clinical Leadership		
1.4	Transport planning is undertaken with input from patients, families, and partners.	
3.3	Awareness is raised about the organization's role in the community through team participation in community and outreach events.	
4.5	The MOT provides input on and approval for clinical staff training and education.	
4.10	The MOT completes follow-ups with sending and receiving teams to identify and address issues and improve patient care.	
Priority Process: Competency		
5.1	Required training and education are defined for all team members with input from patients and families.	!
5.5	Team members have access to a variety of teaching and training methods.	
5.8	Education and training are provided on the organization's ethical decision-making framework.	
5.9	Education and training are provided on the safe use of equipment, devices, and supplies used in service delivery.	!
5.16	Vehicle-specific orientation is provided to non-permanent members of the team.	!
5.17	Remedial or supplementary training and education is provided to team members to improve their skills and performance.	
5.21	Patient and family representatives are regularly engaged to provide input and feedback on their roles and responsibilities, role design, processes, and role satisfaction, where applicable.	
Priority Process: Episode of Care		
14.1	When communication centre functions are provided through an external provider, the organization ensures that service meets requirements for the safety of patients and team members.	!
19.11	Ethics-related issues are proactively identified, managed, and addressed.	!

20.4	Established contact precautions are followed when treating patients with possible communicable diseases.	!
20.18	Established guidelines or frameworks are used to provide respectful and compassionate end-of-life care to patients and families.	
22.1	Information relevant to the care of the patient is communicated effectively during care transitions.	ROP
22.1.1	The information that is required to be shared at care transitions is defined and standardized for care transitions where patients experience a change in team membership or location: admission, handover , transfer, and discharge.	**MAJOR**
22.1.2	Documentation tools and communication strategies are used to standardize information transfer at care transitions.	**MAJOR**
22.1.5	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 patient records) to measure compliance with standardized processes and the quality of information transfer • Asking patients, 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**

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

The organization has met all criteria for this priority process.

Priority Process: Infection Prevention and Control

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)
Priority Process: Clinical Leadership
IERHA has created leading practice champions in infection prevention and control. The organization should be applauded for initiatives like this that provide depth of evaluation audit and quality improvement processes.
Priority Process: Competency
Training and Education in EMS is an opportunity for IERHA due to the geographic spread of this organization. There is one training staff member for the whole EMS division and staff do not see him as often as they would like. IERHA has many strong and interested clinicians that if allowed could add some bench strength to the distribution of the training initiatives that are required.
Priority Process: Episode of Care
Paramedics in IERHA are working hard to provide exemplary service to the communities they serve. They are passionate about the work and compassionate about the people and locations they serve.
Priority Process: Decision Support
IERHA has a very comprehensive policy suite that supports EMS staff well. Paramedics do not use the intranet unless directed to this document collection. Opportunities to share access in additional media formats would help to share the supportive work completed.
Priority Process: Impact on Outcomes
IERHA audits and evaluates many aspects of care practice both for practitioners and clients. Often this important work helps to drive good change in organizations and provides proof for the right change at the right time for leaders and decision-makers.
Priority Process: Medication Management
IERHA manages and controls high alert medications very well and stores these medications in each station under a double lock system. These same medications appropriately are carried by EMS Paramedics in a pouch on their person. Documentation and practice are identical for the stations witnessed.
Priority Process: Infection Prevention and Control
There is an opportunity to engage like practice in the EMS division of this organization. EMS to date has not received the same attention that the rest of the organization has in IPC. The organization has good data for Hand Hygiene but does not evaluate EMS in their care setting. EMS is evaluated in the facility during hand over only. EMS does not have adequate supply in each facility to complete a post-call clean and does not at present have a deep clean of EMS Unit schedule. Access to hand sanitizer is not evident in all EMS units.

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		
The organization has met all criteria for this priority process.		
Priority Process: Episode of Care		
The organization has met all criteria for this priority process.		
Priority Process: Decision Support		
The organization has met all criteria for this priority process.		
Priority Process: Impact on Outcomes		
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.	
15.6	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.	!
15.11	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 home care team is a well-established and experienced team. The leaders and the care providers are experienced and have been in place for several years. They are dedicated, are well informed, familiar with the needs of their clients, the organizational range of services, to be able to advocate on behalf of their clients to maximize and optimize services and client outcomes.

There are multiple opportunities for the team to meet, exchange information, learn, and collaborate with each other.

The organization has a robust safety assessment mechanism to avoid risk and harm to both clients and staff, however as incidents occur, a process for reporting and follow up exist. Opportunities exist in further evaluating and assessing current resources to determine and meet the changing client needs, such as additional allied health resources, mainly occupational therapist, social worker, and dietitian.

As the population continues to age, the need for psychosocial support will continue to increase to meet the needs of the elderly with mental health disorders and needs. The involvement of clients and families in designing services and developing service level goals and objectives is done informally, and the team would benefit from a formal process to solicit additional feedback and information from their clients.

Priority Process: Competency

The organization provides extensive and on-going education to all staff members, in the form of online education, as well as in person. Much of the education is focused on enhancing the competency, knowledge, and skills of the providers, to ensure that their exposure to harm and risk is minimized. Safety education, such as MSIP training and education is reviewed on a regular basis. Training on the correct use of the equipment and other relevant devices is also reviewed on a regular basis. The role of client and family in safety is reviewed with clients and their significant others and feedback solicited on a regular basis.

There is Home Care Best Practices manual that is reviewed and updated by the corporate educators and shared with all staff.

Probationary performance reviews are done on a regular basis for newly hired staff, as are the regular performance reviews for all permanent and regular staff. Opportunities exist in the way information is documented and shared among the care team and would certainly improve the efficiency and effectiveness for communicating, sharing, and relaying pertinent client information.

The client chart is in a paper format, comprised of three potential sections/parts, depending on the services that are delivered, and is not as seamless and integrated as it may be. It may be beneficial to explore on-line documentation formats to suit the specific care environment and service delivery, as well as improve timeliness of communication and accuracy. It would also be beneficial to explore a standardized communication tools/formats to help with transfer of information in times of transition, mainly during hand over times from one provider to another.

Priority Process: Episode of Care

The home care team is a high functioning and appreciated team. Most of the staff have been part of the team for many years and are significantly involved and aware of their clients' needs and can anticipate

some of the requirements ahead of time. They are excellent client advocates and are highly responsive. In discussion with clients, it was evident that the team is client and family centric in their approach, works in partnership with client and family, and consider their wishes in designing the care plan and service delivery.

A robust home safety and client safety assessment are completed on each client and shared with the care providers as relevant and appropriate, before the provision of care, to reduce and avoid risk situations. Working in a smaller community may create situations where ethical dilemmas may arise, however staff are aware of the ethical decision-making framework and are supported by the leadership of the program appropriately.

Incidents and complaints are followed up in a timely fashion and are managed appropriately to avoid further escalations and complications. Opportunities may exist in the allocation of additional resources to support front line staff and the team.

The home care team may further benefit from re-evaluating the availability and increased need of allied health professionals, such as additional occupational therapists' resources, social work and dietitian, especially as it comes to comes to management of complex client needs and complicated psychosocial and physiological conditions. Other opportunities exist in the composition and structure of the chart and the use of electronic documentation for communication and information management. This would specifically be applicable and beneficial during care transition times, such as, handover instances.

Priority Process: Decision Support

The organization maintains appropriate and relevant record-keeping practices. Charts are audited on a regular basis and reviewed for accuracy. Client records are maintained according to health record policies and procedures and follow organizational guidelines. Client chart consists of, potentially, three parts: medication recording, nursing chart for nursing clients, and a complete chart kept by the case coordinator), an opportunity may exist to combine all sections of the chart into a one complete and integrated chart, to enhance and streamline communication and information sharing.

Priority Process: Impact on Outcomes

Home care staff rely on the support of corporate educators and local leadership, such as the case coordinator and the resource coordinator for education and skills optimization. On-line education services, as well as in person educational opportunities are offered to all staff and are monitored for completion at regular intervals and during performance reviews. A home care best practice manual is available to all home care staff for reference and is reviewed and updated by the corporate educators.

Opportunities exist in the identification, use, and integration of clinical and quality indicators to monitor, evaluate, and sustain service delivery. It is recommended that specific quality indicators are identified and consequently shared and discussed to guide and evaluate the efficacy and efficiency of service delivery.

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

Unmet Criteria	High Priority Criteria
Priority Process: Infection Prevention and Control	
The organization has met all criteria for this priority process.	

Surveyor comments on the priority process(es)
Priority Process: Infection Prevention and Control
IERHA IPC program is managed well. Policies and supporting documents are evident. In facilities, IPC education and awareness are very apparent and found in multiple locations. Safety huddles have been incorporated at shift changes that include good IPC messaging.

Standards Set: Inpatient Services - Direct Service Provision

Unmet Criteria		High Priority Criteria
Priority Process: Clinical Leadership		
2.8	A universally-accessible environment is created with input from clients and families.	
Priority Process: Competency		
3.6	Education and training are provided on the organization's ethical decision-making framework.	
Priority Process: Episode of Care		
8.7	Translation and interpretation services are available for clients and families as needed.	
8.13	Clients and families are provided with information about their rights and responsibilities.	!
Priority Process: Decision Support		
The organization has met all criteria for this priority process.		
Priority Process: Impact on Outcomes		
14.3	There is a standardized process, developed with input from clients and families, to decide among conflicting evidence-informed guidelines.	!
14.5	Guidelines and protocols are regularly reviewed, with input from clients and families.	!
16.2	The information and feedback gathered is used to identify opportunities for quality improvement initiatives and set priorities, with input from clients and families.	
16.4	Indicator(s) that monitor progress for each quality improvement objective are identified, with input from clients and families.	
16.9	Information and data on bed availability is collected and used for quality improvement initiatives in collaboration with organizational leaders, and with input from clients and families.	!
16.12	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

Since their last accreditation, the organization has been focused on ensuring that patients feel informed about their care plans. They have implemented standardized whiteboards in all the patient rooms, bedside shift reporting and improved patient information available about their safety and encouraging patients to ask questions about their care (poster called “Its Safe to Ask”). There exist blended ER/Inpatient units across the rural hospitals that often operate at overcapacity largely due to ALC patients. The staff works well in teams to work to full clinical scope. In Selkirk, the largest inpatient unit, there is a dedicated hospitalist model. While this model helps with patient flow, the admissions often exceed the physician capacity. The addition of a physician assistant may help with patient flow but staff across the organization express the need for more access to physicians.

As the rural inpatient units are covered by the primary care physicians that also cover the ER departments, the leadership is encouraged to engage physicians to help with the design of patient flow and repatriation plan.

Priority Process: Competency

The organization is committed to continued education for staff. Any new physicians to the rural sites have training in Selkirk ED to ensure a smooth transition to rural communities. Managers at all site encourage continued training for staff reflective of the changing needs of the patient population. The organization should include the ethics framework into training.

The nursing practice council could be leveraged to include education, particularly with high priority initiatives. Further, the organization could consider adding patient representatives to councils and leadership forums.

Priority Process: Episode of Care

Standardized processes are used across the health authority. The IERHA is commended for its implementation of standardization of transfer information across the region. There is a variation in service delivery based on limited resources including remote location and physician resources. There does not appear to be input from clients and families regarding protocols. The organization is strongly encouraged to engage patients, families, and communities in identifying the limitations in resources across the region and be included in setting priorities and quality initiatives. The leaders of the organization have performed exceptionally well in the implementation of vis board or quality boards.

The organization is highly encouraged to include patients and families in designing quality improvement initiatives.

Priority Process: Decision Support

The organization should be commended for using standard validated tools and templates across the organization. Paper charting does make audits and quality reviews more difficult but many of the indicators are reported regionally or provincially. The organization should be commended for its use of e-chart and EMR for primary care as this does allow timely access to patient information.

Priority Process: Impact on Outcomes

The organization should be commended for the dedication of staff to patient care. Patients and families speak highly of the medical and clinical staff. Staff feel supported by management.

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	
The organization has met all criteria for this priority process.	
Priority Process: Decision Support	
The organization has met all criteria for this priority process.	
Priority Process: Impact on Outcomes	
The organization has met all criteria for this priority process.	

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

The leadership and care team, are a very involved group of individuals, involved in providing quality care and advocating on behalf of the residents and the families. The team demonstrates significant levels of collaboration and partnerships to ensure that the care delivery and range of services meets the needs of the residents and families.

The team has access to relevant and appropriate resources and best practices to support the delivery of quality and safe care. There is significant evidence of collaboration and partnership between the regional teams and the affiliate organization. This ensures that standards are applied evenly and consistently, and that residents and families experience a consistent approach to care delivery and services. Opportunities exist in additional and formal involvement of families and residents in designing care delivery and range of services, as well as sharing information and soliciting feedback to inform care delivery and quality improvement opportunities.

Priority Process: Competency

The long-term care team in general is built on the strength, resilience, and compassion of its collective team members. In all the sites, the teams are comprised of veteran employees, with significant level of experience and knowledge. Although staffing needs are not unique to this service delivery line, some

areas experience additional difficulties in recruitment and retention of staff, due to the remoteness of the locations, and often because on unavailability of full-time positions.

The team maintains its competence and currency through on-going education and training both through the on-line training opportunities, as well as in person education opportunities delivered by the regional clinical educators.

The collaborative approach is evident, although allied health resources are limited and stretched to cover a significant number of residents with complex needs. The current HPRD ranges between 3.6 -3.8, which is considerable when compared nationally. A greater need exists to support residents with complex mental health and other pathological/physiological needs, and yet is limited throughout the region (such as social work, dietitians, and OT to name a few).

A strong community involvement is evident through the active volunteer program, and yet opportunities exist to further strengthen the relationship, communication, and collaboration with residents and families to inform service delivery and enhance quality of care. Much of the communication is limited to informal communication, the team may consider the use of other communication means, such as newsletter, billing invoices and so on, to share and solicit information.

The use of a paper-based chart may introduce challenges in communicating and sharing information, consideration for electronic means would greatly improve and mitigate any such challenges, allowing for enhanced transparency, access, and sharing of information throughout the region. A discussion with residents and family members, confirmed that the team delivers quality care, is attentive, and is significantly involved and aware of resident needs, in a caring and compassionate manner, it is recommended that additional focus is given to continuously evaluate the use of available resources, programming, and services to meet the changing needs of residents and families. For example, the opportunity may exist in reviewing the current structure and method of delivering recreational services, mostly focusing on format and times of recreational programs (consider recreational programs after hours and weekend).

There is significant evidence of collaboration and partnership between the regional teams and the affiliate organization. The ability to share and access resources at the regional level is commendable and demonstrates focus on the needs of the residents, families, and staff. It is recommended that additional attention is given to increase and diversify opportunities and venues to solicit and involve residents and families in a range of activities related to care delivery and operational structures, such as committees, task forces and so on.

Priority Process: Episode of Care

The team's orientation and focus on the delivery of quality care are commendable. The program leaders are dedicated to support the staff, residents, and families, throughout their experience transitioning from the community to LTC homes and help identify care needs in a collaborative and supportive manner. Despite limited resources, the residents and families communicate high levels of satisfaction with their

care and the staff.

Some of the opportunities to improve service delivery and satisfaction may include, but not limited to, further enhancing communication and information sharing with families and residents, and expanding the means of communication, making information sharing timelier and more available.

There is significant evidence of collaboration and partnership between the regional teams and the affiliate organization. There is open communication and supportive relationship to help staff achieve optimal resident outcomes and satisfaction. It was evident that the staff and leaders are engaged in significant informal communication and are very attentive and responsive to the needs of the residents of the families, however opportunities exist in formalizing some of the communication channels in soliciting formal feedback to guide improvement activities and information sharing, and to ensure that information is shared and assimilated the most effective and efficient manner. This will further allow for an optimal Integration of best practices and align services with changing resident needs.

Further integration of quality indicators to inform service delivery is recommended, and additional evaluation of services would be beneficial to assess the impact on resident outcomes, and the ability to meet individual goals and objectives. This can be achieved through the establishment of formal processes and structures involving residents and families highlighting specific indicators as they may relate to care delivery and outcomes and asking for formal feedback on their impact and experience at the "bedside".

Although no significant concerns were expressed by residents or families, concerns were expressed over the availability of LTC beds, and in some areas of the region, long wait times in acute care may be detrimental to quality care and outcomes for the older adult. Suggestions were also raised with regards to the recreational activities and programming and the benefit of evaluating the possibility of delivering recreational programs/activities during off hours and weekends, as well as the availability of other non-nursing support services such as social work, OT, MH workers/support, and Dietitian. Overall a very supportive, involved, and engaged team of staff and leaders.

Priority Process: Decision Support

A dedicated team focused on the delivery of quality care. there are significant levels of collaboration both inter and intra team, to achieve optimal resident outcomes. Documentation is completed through a paper-based chart, some consideration may be given to explore electronic solutions, to help with streamlining documentation, accessibility, and sharing of information.

Priority Process: Impact on Outcomes

The delivery of quality care is achieved through on-going collaboration and information gathering. Quality indicators and improvement opportunities are discussed at the team level quarterly. The team relies on the work of corporate support and local leaders, which demonstrates high levels of awareness, involvement, and commitment to the delivery of quality and safe care.

Quality boards exist in public areas and include a range of information in relation to quality and quality indicators, such as falls, medication incidents, and hand hygiene compliance rates. The quality boards contain a range of information, consideration may be given to improve the visibility of the quality indicators through a dedicated board and larger formats. Quality teams exist and meet quarterly, to further discuss and review quality indicators and other quality measures, however, opportunities exist in further and additional communication and education of residents and families, on the significance of these indicators, and their impact on the delivery of care.

Standards Set: Medication Management Standards - Direct Service Provision

Unmet Criteria		High Priority Criteria
Priority Process: Medication Management		
2.5	A documented and coordinated approach to safely manage high-alert medications is implemented. 2.5.8 Information and ongoing training is provided to team members on the management of high-alert medications.	ROP **MAJOR**
2.8	The interdisciplinary committee standardizes critical information found in medication orders, medication labels, and medication administration records.	
2.15	The interdisciplinary committee develops a process to determine which medications can be stored in client service areas.	
2.16	The interdisciplinary committee monitors compliance with each step of the medication management process.	
4.4	The effectiveness of training activities for medication management is regularly evaluated and improvements are made as needed.	
6.5	Teams can access an on-site or on-call pharmacist at all times to answer questions about medications or medication management.	!
8.4	The pharmacy computer system is regularly tested to make sure the alerts are working.	!
9.4	The availability of narcotic products is evaluated and limited to ensure that formats with the potential to cause patient safety incidents are not stocked in client service areas. 9.4.2 Stocking the following narcotic products is avoided in client service areas: • Fentanyl: ampoules or vials with total dose greater than 100 mcg per container • HYDROmorphone: ampoules or vials with total dose greater than 2 mg • Morphine: ampoules or vials with total dose greater than 15 mg in adult care areas and 2 mg in paediatric care areas.	ROP **MAJOR**
11.3	The medication information stored in the smart infusion pumps is regularly updated.	!

11.4	The limits set for soft and hard doses are regularly tested to make sure they are working in the smart infusion pump.	!
11.5	The limits set for soft and hard doses are regularly reviewed and changes are made as required.	
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.	!
15.3	The pharmacist double checks the dosing calculations for chemotherapeutic agents that are dosed according to weight or body surface area.	!
16.4	Sterile products and intravenous admixtures are prepared in a separate area with a certified laminar air flow hood.	!
18.2	Medications are dispensed in unit dose packaging.	!
21.5	At the end of service transfer of service, written information is shared with each client about who to contact for questions about medications and when that person can be reached.	
22.1	There are criteria for determining which medications can be self-administered by clients.	
22.2	Established criteria are used to assess whether a client is able to self-administer medications.	
27.1	Resources needed to support quality improvement activities for medication management are provided.	
27.5	The interdisciplinary committee monitors process and outcome indicators for medication management.	
27.6	The interdisciplinary committee prioritizes and completes medication use evaluations.	

Surveyor comments on the priority process(es)

Priority Process: Medication Management

The pharmacy service team at Interlake-Eastern Regional Health Authority is composed of 9.6 equivalent full-time pharmacists and 10.2 equivalent full-time pharmacy technicians. This team coordinates the medication dispensing and the clinical pharmaceutical services for 237 acute beds dispersed in 10

facilities. They also provide the chemotherapy sterile preparation services for the cancer care units at Selkirk and Gimli. The central pharmacy is situated at Selkirk Regional Health Centre with operating hours from 8 am to 4 pm, 7 days per week. A clinical pharmacist is available onsite in 9 other facilities with coverage that varies from 1 to 5 days per site. This team of pharmacists and pharmacy technician is very devoted and implicated throughout the organization. The pharmacist's role in the interdisciplinary team is very well established and the pharmacists are recognized for their essential contribution to patient care.

Pharmacy and Therapeutics and Medication Safety are interdisciplinary committees that are actively responsible for medication management. These committees have accomplished major work to ensure the implementation of policies and procedures for each step of the medication management process. They also analyze different safety and quality data and improve the medication management process continuously. The medication formulary is well managed, and many treatment protocols have been implemented by the Pharmacy and Therapeutics committee. The medication errors reports are analyzed promptly and discussed at the Medication Safety committee. These committees are rigorous and significantly contribute to improving safety medication use throughout the organization.

A unit dose dispensing model has been implemented at Selkirk Regional Health Centre with access to medication dispensing cabinets on units. Selkirk is the only facility with this model. A multidose dispensing model is in place in 9 other acute facilities with no access to medication dispensing cabinets. All the medication is stocked on the units and can be administered before the prescriptions are verified by the pharmacist. Most of the prescriptions are not validated by a pharmacist prior to administration of the first dose and the prescriptions from the emergency department are not entered in the patient's pharmacy profile. The intravenous medication, except for chemotherapy, is prepared on the units. Most of the medication profiles are handwritten by the nursing staff. This type of dispensing model is at high risk for medication errors and wastage. The organization could benefit from a reassessment of the resources allocated to pharmacy practices in the acute setting. The medication management process could include the implementation of a unit dose dispensing model throughout all the facilities, the validation of most prescriptions by a pharmacist prior to administration, the double-checking of pediatric and chemotherapy prescriptions, the use of a printed medication profile generated by the pharmacy computer system, ready to administer intravenous medication and a pharmacist on call service. Adding automated pharmacy technology (medication dispensing cabinets, automated packaging system), remote validation of prescriptions and prolonged operating hours may be considered.

The medication dispensing and clinical pharmaceutical services of the long-term facilities are coordinated by an external provider (MediSystem). The medication is dispensed on a client-specific basis through individualized medication pouches which is adequate.

The organization has a high alert medication policy, the heparin and concentrated electrolytes available in client service areas are limited and monitored. Some aspects of the high alert medication policy are not applied and should be reinforced. High concentrated narcotics are stocked on some units and are accessible before prescriptions are validated by a pharmacist. The dispensing process for high concentrated narcotics could be reviewed to ensure that high concentrated narcotics are dispensed on a client-specific basis.

A list of abbreviations, symbols and dose designations that are not to be used is implemented and is well monitored through auditing. We encourage the organization to continue the reinforcement and evaluation of compliance with the list.

The acute setting antimicrobial stewardship program consists of the restriction use of selected antibiotics. The antibiotic stewardship subcommittee is not active (no meetings) and the effectiveness of the program is not monitored. There is no antimicrobial stewardship program in the long term setting. The organization would benefit from an expansion of the antimicrobial stewardship program by conducting other activities and including the long term setting.

Because of limited resources, medication use evaluations are limited. A reassessment of pharmacists designated to clinical activities that improve medication usage optimization and safety may be considered.

Standards Set: Obstetrics 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		
7.14	Clients and families are provided with information about their rights and responsibilities.	!
7.16	Clients and families are provided with information about how to file a complaint or report violations of their rights.	!
7.17	A process to investigate and respond to claims that clients' rights have been violated is developed and implemented 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.	!
16.4	Protocols and procedures for reducing unnecessary variation in service delivery are developed, with input from clients and families.	!
16.5	Guidelines and protocols are regularly reviewed, with input from clients and families.	!
17.4	Safety improvement strategies are evaluated 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.	

18.11	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 obstetric leadership team shares a role with the peri-operative team and there is considerable crossover of responsibilities. With the opening of the new facility there has been some expansion of service and the establishment of an epidural program. This was encouraged by the communities and has led to the repatriation of some cases.

There are appropriate resources to provide the services, but these would have to be enhanced if there is to be further expansion. The human resource is stable but there is a need for better C-section (emergency) coverage.

There is some evidence of patient/family/community involvement but there needs to be more and with increased formality. Satisfaction surveys and the complaint process provide the bulk of "external" input to the program. The organization is encouraged to formalize and enhance the input from patients and families.

Priority Process: Competency

There are specific educational requirements for those working within the obstetrics program. These may be provided by the organization both internally and externally. Ongoing educational opportunities are made available and there is an electronic platform to record all educational events. Orientation is provided both regionally and unit based with appropriate time exposure to ensure both competence and confidence.

Performance appraisals are done according to the organizational policy but with the advent of a number of new leaders there has been some laxity and they are encouraged to get this process "on track" for the benefit of both the employee and the organization.

Priority Process: Episode of Care

Obstetrical services for the Region are offered only at the Selkirk site, low-risk cases only, 400 deliveries last year. Many pregnancies within the region are delivered in Winnipeg--the result of proximity and legacy contractual arrangements with Indigenous communities.

Those done locally have all prenatal care provided by the family practice groups or an obstetric group in the city. All education, risk assessment and information are collated here and sent as is appropriate to the birthing unit. On admission for delivery all procedures and processes are appropriate with adequately trained staff to manage the volumes. (there is time when c-section availability is limited necessitating transfer of some cases, if volumes are to expand this issue will have to be solved).

Patient information and education materials are available but could be of more use if given and explained on admission rather than after delivery, maybe these materials could be provided in sections as relevant. There was no evidence of any distribution of the “Patient Handbook”.

Several patients were interviewed and were extremely happy with their experience here. They were very pleased with the space and environment and praiseworthy of the staff attention and care. None were aware of any form of possible input into program planning or design, nor quality improvement initiatives.

The addition of an epidural service has improved the wellbeing of patients. However, the overall obstetric program would appear to have reached its limit at present and any expansion or enhancement would require considerable planning and resources.

Priority Process: Decision Support

All patients’ records are in a paper format. Some information generated in the emergency room is on an electronic platform and is accessible via a computer console. The charting is succinct and timely and demonstrates participation by the patient and/or family.

The charts are kept in the nursing station and are available to all as necessary.

Priority Process: Impact on Outcomes

Clinical practice guidelines, protocols and procedures are all in place and predominantly based upon those developed by the Society of Obstetricians and Gynecologists. There is some mild local nuance and reviews are done according to policy. There is no evidence of local consumer input into the development, review or communication of these guidelines.

Quality improvement initiatives are developed and monitored but there is no consumer input into this process. Communication of this quality improvement is done at the staff level with some "public" display but there could be improved education to the consumer group.

Standards Set: Perioperative Services and Invasive Procedures - 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.	
2.5	The effectiveness of resources, space, and staffing is evaluated with input from clients and families, the team, and stakeholders.	
2.7	A universally-accessible environment is created with input from clients and families.	
Priority Process: Competency		
6.1	Required training and education are defined for all team members with input from clients and families.	!
6.6	Education and training are provided on the organization's ethical decision-making framework.	
Priority Process: Episode of Care		
14.4	Procedure-specific care maps or guidelines are used to guide the client through preparation for and recovery from the procedure.	
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.	!
23.5	Guidelines and protocols are regularly reviewed, with input from clients and families.	!
24.1	A proactive, predictive approach is used to identify risks to client and team safety, with input from clients and families.	!
24.2	Strategies are developed and implemented to address identified safety risks, with input from clients and families.	!
24.3	Verification processes are used to mitigate high-risk activities, with input from clients and families.	!
24.4	Safety improvement strategies are evaluated with input from clients and families.	!
25.2	The information and feedback gathered is used to identify opportunities for quality improvement initiatives and set priorities, with input from clients and families.	
25.4	Indicator(s) that monitor progress for each quality improvement objective are identified, with input from clients and families.	
25.11	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 perioperative team provides oversight for obstetrics, endoscopy and surgical services. Eighty percent of the volume is done as day-care cases in a well-organized collaborative fashion. The implementation of central intake and central booking will further enhance efficiencies and flow.

There is some evidence of patient/family/community involvement but there needs to be more and with increased formality. Satisfaction surveys and the complaint process provide the bulk of "external" input to the program. The organization is encouraged to formalize and enhance the input from patients and families.

Priority Process: Competency

All staff are well trained and have ongoing educational opportunities.

Performance appraisals are lacking within the organizational policy but the "new" managers and directors plan to complete these soon.

Ethical framework education needs to be incorporated in the orientation program.

Priority Process: Episode of Care

All aspects of the surgical care journey, preoperative, perioperative and postoperative are managed very well. There is consistency of practice and patients and families are pleased with their access and care provided.

The flow in the operating room is controlled and smooth with excellent entry and exit for both inpatients and day surgery patients. The follow-up phone calls to discharged day surgery patients is working very well and greatly appreciated by the consumers.

Priority Process: Decision Support

Charting is all paper-based. There is some information available from the emergency room that is computer accessible but is then where necessary copied for the paper chart. Upon discharge, all patient information is scanned for possible later retrieval on an electronic platform!

The organization is encouraged to implement total electronic charting in the future to enable the complete transfer of information throughout the region.

Priority Process: Impact on Outcomes

The program has some practice guidelines, safety initiatives and quality improvement initiatives however there is no evidence of consumer input into any of these processes. Satisfaction surveys have provided some feedback but not in a formalized fashion.

The organization is encouraged to proceed with their plans to have "patient" representatives embedded in the program committees.

Priority Process: Medication Management

Medication management within the operating room and on the surgical floor meets all requirements.

Standards Set: Primary 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	
3.10 Team member performance is regularly evaluated and documented in an objective, interactive, and constructive way.	!
Priority Process: Episode of Care	
The organization has met all criteria for this priority process.	
Priority Process: Decision Support	
The organization has met all criteria for this priority process.	
Priority Process: Impact on Outcomes	
The organization has met all criteria for this priority process.	

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

The leadership team has set a strong direction and vision for primary health care for the Interlake-Eastern Regional Health Authority. The leaders and team are passionate about primary health care and the potential to improve health for clients, families, and communities. There is a strong commitment to improving the health status of marginalized populations. The importance of a social determinants approach was described by the team and leaders. The leaders and teamwork from a strength-based approach. They are to be commended for their significant progress in furthering the reach of primary health care. They have established and fostered robust, comprehensible services in a focused, deliberative manner. The leaders and team are flexible, creative and adaptable in developing and implementing primary health care.

The ability to develop and foster partnerships is evident. They have significant comprehensive relationships with internal and external stakeholders. The commitment of the leaders to inter-sectorial collaboration has supported primary health care. The leaders have developed strong partnerships with First Nations leaders, justice, community agencies, not-for-profit organizations, and governmental agencies. The leaders are continuing to work with their federal colleagues on an area of shared jurisdiction and are encouraged to continue with this important work.

The leaders have used a variety of methods to obtain information from clients, families, partners and the community to inform the design of primary health care. This has included questionnaires, focus groups, partner consultations, and statistical data review. A comprehensive Community Health Assessment was completed in 2014. Work is ongoing on the development of a Community Health Assessment for September 2019. The leaders are encouraged to continue to use this important information to inform program design and set priorities.

Priority Process: Competency

Primary health care is support by a strong competent team and leaders. There is a strong commitment from the leaders to support the education and training needs of the team. This commitment extends to the education and training needs of partners and stakeholders. The team spoke highly of the professional development, education and training opportunities available. The team spoke highly of the support provided by the leaders. There is a strong orientation process. The team spoke highly of the value of the orientation in their daily work. The student learners described the importance of the orientation in supporting their student experience. The leaders are encouraged to continue to support innovative educational opportunities. Performance appraisals are not consistently completed across primary health care sites. The leaders are encouraged to continue with the plan to complete performance appraisals for the team which will assist in identifying opportunities for professional growth.

The team stated that they are aware of the process to follow if ethical concerns arise. The leaders are encouraged to continue to support ethics education for the team. The safety of clients and team members is a priority. The team members stated that they feel safe at work and that their safety is a priority of the organization. A team member described the support of the leaders in addressing workplace issues.

Priority Process: Episode of Care

Primary Health Care is a strategic direction of the Interlake-Eastern Regional Health Authority (IERHA). The leaders and team are committed to providing primary health care in a consistent and coordinated way to the needs of clients, families, and communities. There are twenty primary care sites/teams operated by IERHA and fifteen operated by private providers. There are six primary care sites on First Nations communities. An engaged interdisciplinary team comprised of Indigenous Health Engagement Communications Coordinators, Physicians, Nurse Practitioners, Primary Care Nurses, Chronic Disease Nurses, Traditional Healers, and Dieticians.

Wellness facilitators support the primary health care teams and work with communities to provide innovative health promotion programs. A monthly Community Wellness newsletter is distributed. The team is supported by administrative support professionals who are client-centered and often the first point of contact for clients and families. There are strong linkages with Acute Care, Public Health and Community Based Mental Health Services.

The primary health care sites visited were bright, clean, inviting and accessible. The client bill of rights was displayed in the waiting rooms and offices. There is adequate waiting room space with information for

clients. There are hand hygiene stations and products available. There are spaces to have private interactions with clients and families. The clients and families stated that they felt welcome and comfortable when attending primary health care sites.

Software is being developed on medication reconciliation to add to the Electronic Medical Record. This process is under development and consideration. The leaders are encouraged to implement the proposed medication reconciliation changes to the Electronic Medical Record.

The leaders and team are passionate about their work in primary health care. They are excited to be a part of the primary health care team. They clearly articulated the importance of providing primary health care "closer to home." They are committed to working effectively as a team to deliver excellent primary health care services. There are strong engagement and collaboration with partners, communities, clients, and families. The team offers a comprehensive array of programs. Exciting initiatives include the development and implementation of My Health Teams, Home Clinic development, and improving primary health care access for unserved and marginalized populations. The implementation of a shared electronic medical record has facilitated shared care and communications across the team.

The leaders and team members are to be commended for their commitment to quality primary health care. Clients and families report high satisfaction with the care received. Primary Health Care Engagement Surveys are completed. The May 2019 survey indicated that 85 percent of respondents ranked primary health care services as eight or higher on the overall experience score. A client noted, "This is an excellent clinic. The staff is excellent. I know what to expect when I go home." The clients stated that they were treated with care, dignity, and respect. There were many examples of excellent clinical interactions with the team. Clients and families did not offer any suggestions for improvement for primary health care. However, several clients spoke of the need to have the local emergency rooms always open. The leaders are encouraged to continue to involve clients, families, and partners in the development, implementation, and evaluation of primary health care.

There are strong working relationships developed with community groups and agencies. This includes First Nations Leaders, Cancer Care Manitoba, Addiction Foundation of Manitoba, Manitoba Health, and Justice, to name just a few. There is a strong commitment to addressing the social determinants of health and improving population health. The leaders and team members work hard to increase the accessibility of primary health care for under-serviced and marginalized populations. Priorities include primary care addictions services capacity development, indigenous health service delivery partnership development and primary care access to under-serviced populations. The leaders and team are encouraged to continue with this important work and to continue to engage clients, families, partners, and communities.

Priority Process: Decision Support

The team and leaders are committed to using decision support to enable quality primary health care services. Education and training are provided to the team on the use of technology.

An electronic medical record is used by the primary health care team with public health, occupational

therapy, speech therapy, community mental health, and primary care physicians sharing the electronic medical record. A clinical applications specialist supports the implementation of the electronic medical record. The electronic medical record is described by members of the team as critical for their work as primary health care providers.

E-Chart supports the accessibility of prescription, laboratory and diagnostic imaging results for the primary health care team. The organization is encouraged to continue to implement plans to enable viewing access to the electronic medical health record for other health care providers.

Standardized client information is collected. Comprehensive and up to date information is collected with the input of clients and families. Care plans are developed and updated with the input of clients and families.

A Continuous Quality Improvement Program works with the Primary Care Teams to leverage relevant data to support quality improvement plans. Recording keeping practices are monitored and evaluated. A data integrity analyst completes regular audits of the electronic medical record. A recent example was an audit of the registry process. Monthly reports are generated. The leaders are encouraged to continue to audit their record keeping practices and to share results with clients, families, and stakeholders.

Priority Process: Impact on Outcomes

The leaders and team are acknowledged for their commitment to quality improvement. Quality boards are visible and are used to share quality improvement activities with clients and families. Additionally, forums such as partner meetings are used to provide feedback and to support safety and quality initiatives. Patient Satisfaction Surveys are completed with the results shared with the team and clients. The primary health care teams are engaged with quality improvement initiatives. The leaders are encouraged to continue to seek team, client and partner input and suggestions for continuous quality improvement.

The team and leaders are to be commended for their commitment to best practices and quality improvement. The leaders and team have access to evidence-based guidelines to support care. Primary Care Quality Indicators are collected and shared with the goal of improving health status. The leaders and team are encouraged to continue to develop and implement evidence-based guidelines with the input of clients, families and partners.

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	
16.11 Quality improvement initiatives are regularly evaluated for feasibility, relevance, and usefulness, with input from clients and families.	
Priority Process: Public Health	
The organization has met all criteria for this priority process.	

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

The leaders and team are passionate about enhancing Public Health Services. This includes the recent implementation of a Harm Reduction Program and prevention work on Sexually Transmitted Blood Borne Infections. The work assignments are determined with input from the team to meet the needs of clients. The organization is responsive to the needs of the community by offering such programs as extended hours for harm reduction initiatives.

Priority Process: Competency

There is a strong commitment from the leaders to support education and training. The team spoke highly of the education and training opportunities available. The team members spoke highly of the support from colleagues. Opportunities for learning about culturally competent and safe care are provided. There is a strong orientation process available for the team. The team spoke highly of the value of the orientation process. The leaders are encouraged to continue to support innovative educational opportunities.

The team members noted that they are aware of the process to follow if ethical concerns arise. The leaders are encouraged to continue to support ethics education for team members.

The leaders are to be acknowledged for their commitment to completing performance appraisals. The leaders are encouraged to continue to complete performance appraisals for the team which will assist in identifying opportunities for professional growth.

Priority Process: Impact on Outcomes

The leaders and team members are committed to selecting evidence-based guidelines to support care. Recent initiatives include the development of Provincial Standards for Prenatal Postpartum and Early Childhood 2019, and Public Health Nursing Newborn Nursing Care Pathway 2019. Community Capacity Building and Community Development Collaborative Practice 2019, a collaboration through Manitoba Public Health and the RHAs have partnered in to increase the efficiency and effectiveness of health promotion initiatives by creating common tools and processes. There has been significant progress in developing and implementing standardized programs.

Client satisfaction surveys are completed. The leaders and team members are responsive to client feedback and have made improvements based on the surveys. There are several examples of changes made to the program and services based on client feedback including changes to the hours of service for some programs.

Information is shared with clients, families, and partners at partner meetings, Teen Clinic through Facebook, Wellness newsletters, and through peer meetings. Quality Boards are not located at the Selkirk Public Health site. The leaders are encouraged to implement Quality Boards for team members, clients and families to visualize quality improvement activities and data in a transparent way. The leaders are encouraged to continue to evaluate quality improvement initiatives with the input of clients and families and to implement successful initiatives across Public Health.

Priority Process: Public Health

The Public Health Service is provided at seventeen sites throughout the Interlake-Eastern Regional Health Authority. The Selkirk Community Health Office is bright, clean and inviting. There is waiting room space with information for clients. There are hand hygiene products available. There are spaces to have private interactions with clients and families. The clients and families stated that they felt welcome and comfortable when attending the Selkirk Community Health Office.

The leaders and team are passionate about enhancing public health. They are committed to working effectively as a team to deliver responsive public health services. There are strong engagement and collaboration with the Medical Officers of Health. Public health programs and services are supported by a strong interdisciplinary team. The team is supported by administrative support professionals who are client-centered. The team offers a comprehensive array of programs including; Families First, Key Worker Program, communicable disease control program, Healthy Baby, Fetal Alcohol Spectrum Disorder, Unified Referral Intake System, immunization program, maternal child health and reproductive health services, sexually transmitted infections, disease prevention and health promotion activities and programs, travel immunization program, teen clinics, breastfeeding support, school immunization clinics, and mobile clinic.

The leaders and team members are to be commended for their commitment to quality public health services. Clients and families report high satisfaction with the care received. A client noted, “This program has helped my daughter thrive.” They stated being treated with care, dignity, and respect. Clients

and families did not offer any suggestions for improvement. The public health program was described by team members as a “Great place to work.” The organization is encouraged to continue to involve clients, families, and partners in the development, implementation, and evaluation of public health services.

A comprehensive Community Health Assessment was completed in 2014. This is reviewed and revised every five years. Work is ongoing on the development of a Community Health Assessment for September 2019. The leaders are encouraged to develop a robust strategy to share the plan with staff, clients, families, and partners and to seek input into the actions arising from the Community Health Assessment.

The team and leaders have prioritized program developed based on the needs of priority populations. An action plan for Sexually Transmitted Blood Borne Infections has been developed and implemented to meet the needs of this high-risk population. This has included policy development, staff education and training, communications, resource development, and partnership collaboration. The team and leaders are to be commended for their flexibility in rapidly responding to this important health issue.

There is support for community wellness with a community wellness team including wellness facilitators, dieticians, and exercise consultants trained to help motivate people to live a healthier life. Example of programs includes; Get Better Together, Craving Change, and smoking cessation. Clients and partners are involved in setting priorities for wellness activities. A monthly Community Wellness newsletter is distributed.

There are strong working relationships developed with community groups and agencies. This includes First Nations leaders, Public Health Agency of Canada, Addiction Foundation of Manitoba, Justice, mental health, and RCMP to name just a few. There is a strong commitment to addressing the social determinants of health and to improve population health and reduce health inequities. The leaders and team members are encouraged to continue the work of strengthening public health programs and services through reducing health inequities.

The leaders and team members work hard to increase the accessibility of public health programs and services. Strategies are developed to facilitate access to programs and services such as extending hours, Teen Clinics, travel health satellite services, and locating the Harm Reduction Program in an accessible location.

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: November 22, 2018 to November 29, 2018**
- **Number of responses: 1**

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.	0	0	100	94
2. Governance policies and procedures that define our role and responsibilities are well documented and consistently followed.	0	0	100	95
3. Subcommittees need better defined roles and responsibilities.	100	0	0	70
4. As a governing body, we do not become directly involved in management issues.	0	0	100	85
5. Disagreements are viewed as a search for solutions rather than a “win/lose”.	0	0	100	95

	% 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.	0	0	100	96
7. Individual members understand and carry out their legal duties, roles, and responsibilities, including subcommittee work (as applicable).	0	0	100	96
8. Members come to meetings prepared to engage in meaningful discussion and thoughtful decision making.	0	0	100	94
9. Our governance processes need to better ensure that everyone participates in decision making.	100	0	0	59
10. The composition of our governing body contributes to strong governance and leadership performance.	0	0	100	95
11. Individual members ask for and listen to one another's ideas and input.	0	0	100	97
12. Our ongoing education and professional development is encouraged.	0	0	100	86
13. Working relationships among individual members are positive.	0	0	100	98
14. We have a process to set bylaws and corporate policies.	0	0	0	95
15. Our bylaws and corporate policies cover confidentiality and conflict of interest.	0	0	100	98
16. We benchmark our performance against other similar organizations and/or national standards.	0	0	100	77
17. Contributions of individual members are reviewed regularly.	0	0	100	71
18. As a team, we regularly review how we function together and how our governance processes could be improved.	0	0	100	84
19. There is a process for improving individual effectiveness when non-performance is an issue.	0	0	100	60
20. As a governing body, we regularly identify areas for improvement and engage in our own quality improvement activities.	0	0	100	84

	% 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.	100	0	0	44
22. We receive ongoing education on how to interpret information on quality and patient safety performance.	0	0	100	81
23. As a governing body, we oversee the development of the organization's strategic plan.	0	0	100	97
24. As a governing body, we hear stories about clients who experienced harm during care.	0	0	100	86
25. The performance measures we track as a governing body give us a good understanding of organizational performance.	0	0	100	91
26. We actively recruit, recommend, and/or select new members based on needs for particular skills, background, and experience.	0	0	0	86
27. We lack explicit criteria to recruit and select new members.	0	0	0	77
28. Our renewal cycle is appropriately managed to ensure the continuity of the governing body.	0	100	0	89
29. The composition of our governing body allows us to meet stakeholder and community needs.	0	0	100	94
30. Clear, written policies define term lengths and limits for individual members, as well as compensation.	0	0	100	93
31. We review our own structure, including size and subcommittee structure.	0	0	100	87
32. We have a process to elect or appoint our chair.	0	0	0	86

*Canadian average: Percentage of Accreditation Canada client organizations that completed the instrument from July to December, 2017 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	0	0	100	80
34. Quality of care	0	0	100	81

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

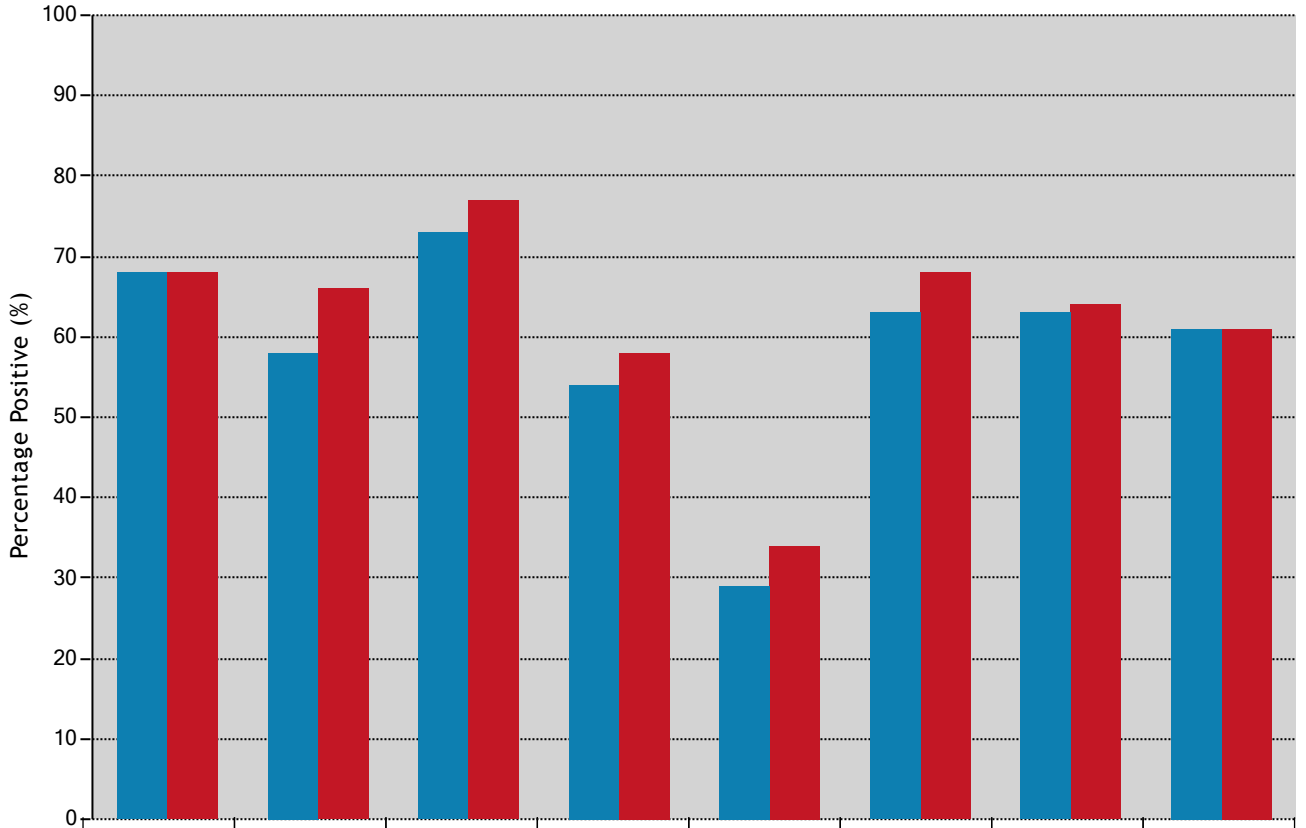
Canadian Patient Safety Culture Survey Tool

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: October 6, 2017 to November 27, 2017**
- **Minimum responses rate (based on the number of eligible employees): 331**
- **Number of responses: 400**

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%	58%	73%	54%	29%	63%	63%	61%
	68%	66%	77%	58%	34%	68%	64%	61%

Legend

Interlake-Eastern Regional Health Authority

* Canadian Average

*Canadian average: Percentage of Accreditation Canada client organizations that completed the instrument from July to December, 2018 and agreed with the instrument items.

Worklife Pulse

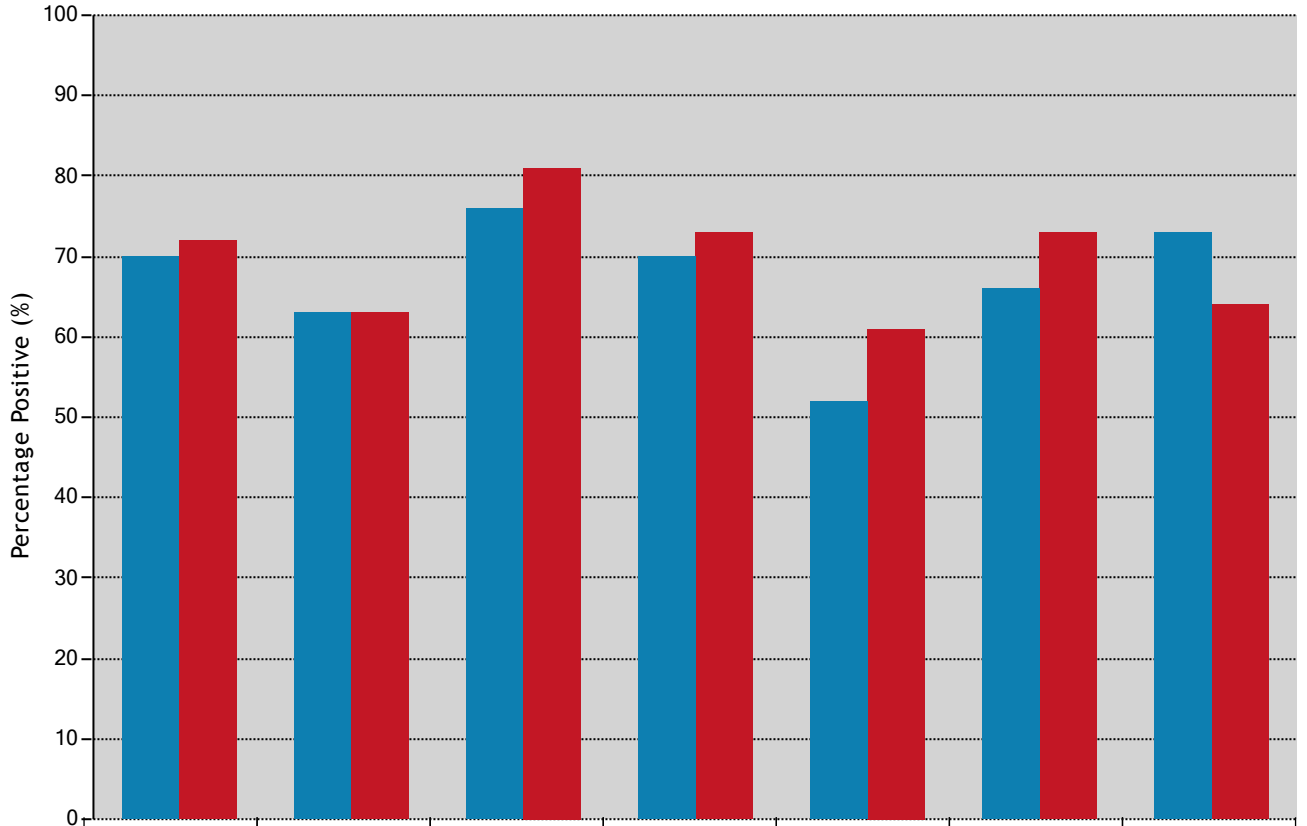
Accreditation Canada helps organizations create high quality workplaces that support workforce wellbeing and performance. This is why Accreditation Canada provides organizations with the Worklife Pulse Tool, an evidence-informed questionnaire that takes a snapshot of the quality of worklife.

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.

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

- **Data collection period: October 6, 2017 to November 27, 2017**
- **Minimum responses rate (based on the number of eligible employees): 334**
- **Number of responses: 749**

Worklife Pulse: Results of Work Environment



	Job	Training and Development	Coworkers	Immediate Supervisor	Senior Management	Safety and Health	Overall Experience
	70%	63%	76%	70%	52%	66%	73%
	72%	63%	81%	73%	61%	73%	64%

Legend

Interlake-Eastern Regional Health Authority

* Canadian Average

*Canadian average: Percentage of Accreditation Canada client organizations that completed the instrument from July to December, 2018 and agreed with the instrument items.

Client Experience Tool

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

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

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

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

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

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

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

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

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 Interlake-Eastern Regional Health Authority has now completed its second accreditation cycle as an amalgamated region. We appreciate the participation of our affiliate organization Betel Home Foundation. The survey report highlights the significant improvements made over the past four years. Examples include recruitment of new leaders, standardization of processes, a balanced budget and enhancements to mental health services.

During the survey visit, our patients, staff and physicians reported very positive interactions with the survey team members while discussing the care provided, and receiving input and insight into further improvements. The report validates our self-assessment findings. We will be able to move forward, using the report to work towards increasing our overall compliance with the standards. Of note, a patient engagement strategy will be developed to ensure the voice of the patient is at the heart of everything we do.

During this time of health care transition, these results will provide guidance as we proceed together with provincial partners. There are four provincial goals currently being monitored – reduced emergency department wait times, improved positive in-patient ratings, reduced hospital deaths and sustainable health spending.

We welcome the external feedback on our compliance with national standards, and thank the survey team and Accreditation Canada. Our participation in the accreditation process is rich in reflection and continuous quality improvement.

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.