ACCREDITATION CANADA



Driving Quality Health Services

Accreditation Report

North Eastman Health Association Inc.

Pinawa, MB

On-site survey dates: June 10, 2012 - June 15, 2012

Report issued: July 10, 2012

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

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About the Accreditation Report

North Eastman Health Association Inc. (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 2012. Information from the on-site survey as well as other data obtained from the organization were used to produce this Accreditation Report.

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

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

Confidentiality

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

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

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

A Message from Accreditation Canada's President and CEO

On behalf of Accreditation Canada's Board and staff, I extend my sincerest congratulations to your board, your leadership team, and everyone at North Eastman Health Association Inc. on your participation in the Qmentum accreditation program. Qmentum is designed to integrate with your quality improvement program. By using it to support and enable your quality improvement activities, its full value is realized.

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

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

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

We look forward to our continued partnership.

Sincerely,

Wendy Nicklin
President and Chief Executive Officer

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Section 1 Executive Summary

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

North Eastman Health Association Inc. (referred to in this report as “the organization”) is participating in Accreditation Canada's Qmentum accreditation program. This Accreditation Report shows the results to date and is provided to guide the organization as it continues to incorporate the principles of accreditation and quality improvement into its programs, policies, and practices.

North Eastman Health Association Inc. is commended on its commitment to using accreditation to improve the quality and safety of the services it offers to its clients and its community.

1.1 Accreditation Decision

North Eastman Health Association Inc. has earned the following accreditation decision.

Accredited (Report)

1.2 About the On-site Survey

- **On-site survey dates: June 10, 2012 to June 15, 2012**

- **Locations**

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

  1 Beausejour Health Centre
  2 East Gate Lodge
  3 Kin Place Health Complex
  4 Lac du Bonnet Personal Care Home
  5 Lac Du Bonnet Primary Health Care Centre
  6 North Eastman Health Association
  7 Pinawa Hospital and Primary Health Care Centre
  8 Pine Falls Health Complex
  9 Whitemouth District Health Centre

- **Standards**

  The following sets of standards were used to assess the organization's programs and services during the on-site survey. With the announcement in April 2012 of the amalgamation of the Manitoba Regional Health Authorities, the existing Board of Directors for all Manitoba Regional Health Authorities were dissolved May, 2012 and replaced by an interim Board of Directors consisting of three Manitoba Assistant Deputy Ministers. As a result of this change in governance structure the Sustainable Governance standards were not reviewed for the North Eastman survey in June 2012, nor the results of the Governance Functioning Tool completed by the former North Eastman Heatlh Association Board reported.

  System-Wide Standards

  1 Effective Organization

  Population-specific Standards

  2 Public Health Services

  Service Excellence Standards

  3 Operating Rooms
  4 Reprocessing and Sterilization of Reusable Medical Devices
  5 Primary Care Services
  6 Surgical Care Services
  7 Infection Prevention and Control
  8 Home Care Services
  9 Long-Term Care Services

10 Medicine Services
11 Emergency Medical Services
12 Customized Managing Medications
13 Community-Based Mental Health Services and Supports Standards
14 Emergency Department

- **Instruments**

  The organization administer:

  1 Patient Safety Culture Tool
  2 Worklife Pulse Tool

1.3 Overview by Quality Dimensions

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

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

Quality Dimension	Met	Unmet	N/A	Total
 Population Focus (Working with communities to anticipate and meet needs)	77	5	4	86
 Accessibility (Providing timely and equitable services)	69	2	8	79
 Safety (Keeping people safe)	337	30	65	432
 Worklife (Supporting wellness in the work environment)	105	6	13	124
 Client-centred Services (Putting clients and families first)	126	3	18	147
 Continuity of Services (Experiencing coordinated and seamless services)	58	1	8	67
 Effectiveness (Doing the right thing to achieve the best possible results)	409	38	76	523
 Efficiency (Making the best use of resources)	43	3	5	51
Total	**1224**	**88**	**197**	**1509**

1.4 Overview by Standards

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

System-wide standards address quality and safety at the organizational level in areas such as leadership, while population-specific and service excellence standards address specific populations, sectors, and services. The sets of standards used to assess an organization's programs 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
	# (%)	# (%)	#	# (%)	# (%)	#	# (%)	# (%)	#
Effective Organization	49 (86.0%)	8 (14.0%)	0	42 (85.7%)	7 (14.3%)	0	91 (85.8%)	15 (14.2%)	0
Public Health Services	47 (100.0%)	0 (0.0%)	0	62 (92.5%)	5 (7.5%)	1	109 (95.6%)	5 (4.4%)	1
Infection Prevention and Control	52 (96.3%)	2 (3.7%)	3	41 (95.3%)	2 (4.7%)	3	93 (95.9%)	4 (4.1%)	6
Customized Managing Medications	34 (89.5%)	4 (10.5%)	1	13 (100.0%)	0 (0.0%)	0	47 (92.2%)	4 (7.8%)	1
Community-Based Mental Health Services and Supports Standards	21 (95.5%)	1 (4.5%)	1	106 (94.6%)	6 (5.4%)	0	127 (94.8%)	7 (5.2%)	1
Emergency Department	31 (93.9%)	2 (6.1%)	2	63 (86.3%)	10 (13.7%)	13	94 (88.7%)	12 (11.3%)	15
Emergency Medical Services	25 (92.6%)	2 (7.4%)	11	88 (88.0%)	12 (12.0%)	22	113 (89.0%)	14 (11.0%)	33
Home Care Services	46 (97.9%)	1 (2.1%)	0	50 (96.2%)	2 (3.8%)	2	96 (97.0%)	3 (3.0%)	2
Long-Term Care Services	29 (90.6%)	3 (9.4%)	1	68 (95.8%)	3 (4.2%)	2	97 (94.2%)	6 (5.8%)	3

Standards Set	High Priority Criteria *			Other Criteria			Total Criteria (High Priority + Other)		
	Met	Unmet	N/A	Met	Unmet	N/A	Met	Unmet	N/A
	# (%)	# (%)	#	# (%)	# (%)	#	# (%)	# (%)	#
Medicine Services	31 (91.2%)	3 (8.8%)	1	64 (92.8%)	5 (7.2%)	1	95 (92.2%)	8 (7.8%)	2
Operating Rooms	51 (96.2%)	2 (3.8%)	19	24 (96.0%)	1 (4.0%)	5	75 (96.2%)	3 (3.8%)	24
Primary Care Services	33 (100.0%)	0 (0.0%)	1	63 (95.5%)	3 (4.5%)	0	96 (97.0%)	3 (3.0%)	1
Reprocessing and Sterilization of Reusable Medical Devices	36 (97.3%)	1 (2.7%)	3	53 (94.6%)	3 (5.4%)	3	89 (95.7%)	4 (4.3%)	6
Surgical Care Services			38	2 (100.0%)	0 (0.0%)	64	2 (100.0%)	0 (0.0%)	102
Total	**485 (94.4%)**	29 (5.6%)	81	739 (92.6%)	59 (7.4%)	116	1224 (93.3%)	88 (6.7%)	197

* includes ROP

1.5 Overview by Required Organizational Practices

In Qmentum, a Required Organizational Practice (ROP) is defined as an essential practice that an organization must have in place to enhance client safety and minimize risk. Each ROP has associated tests for compliance, 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 how the applicable ROPs were rated during the on-site survey.

Required Organizational Practice	Overall rating	Test of Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Safety Culture			
Adverse Events Disclosure (Effective Organization)	Met	3 of 3	0 of 0
Adverse Events Reporting (Effective Organization)	Met	1 of 1	1 of 1
Client Safety As A Strategic Priority (Effective Organization)	Met	1 of 1	1 of 1
Client Safety Quarterly Reports (Effective Organization)	Unmet	0 of 1	0 of 2
Client Safety Related Prospective Analysis (Effective Organization)	Unmet	1 of 1	0 of 1
Patient Safety Goal Area: Communication			
Client And Family Role In Safety (Community-Based Mental Health Services and Supports Standards)	Met	2 of 2	0 of 0
Client And Family Role In Safety (Home Care Services)	Met	2 of 2	0 of 0
Client And Family Role In Safety (Long-Term Care Services)	Met	2 of 2	0 of 0
Client And Family Role In Safety (Medicine Services)	Met	2 of 2	0 of 0
Dangerous Abbreviations (Customized Managing Medications)	Unmet	4 of 4	1 of 3

Required Organizational Practice	Overall rating	Test of Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Communication			
Information Transfer (Community-Based Mental Health Services and Supports Standards)	Met	2 of 2	0 of 0
Information Transfer (Emergency Department)	Met	2 of 2	0 of 0
Information Transfer (Home Care Services)	Met	2 of 2	0 of 0
Information Transfer (Long-Term Care Services)	Met	2 of 2	0 of 0
Information Transfer (Medicine Services)	Met	2 of 2	0 of 0
Medication Reconciliation As An Organizational Priority (Effective Organization)	Unmet	3 of 4	0 of 0
Medication Reconciliation At Admission (Community-Based Mental Health Services and Supports Standards)	Met	4 of 4	1 of 1
Medication Reconciliation At Admission (Emergency Department)	Met	4 of 4	1 of 1
Medication Reconciliation At Admission (Home Care Services)	Met	4 of 4	1 of 1
Medication Reconciliation At Admission (Long-Term Care Services)	Met	4 of 4	1 of 1
Medication Reconciliation At Admission (Medicine Services)	Met	4 of 4	1 of 1
Medication Reconciliation at Transfer or Discharge (Community-Based Mental Health Services and Supports Standards)	Unmet	2 of 3	1 of 2
Medication Reconciliation at Transfer or Discharge (Home Care Services)	Unmet	1 of 3	0 of 2

Required Organizational Practice	Overall rating	Test of Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Communication			
Medication Reconciliation at Transfer or Discharge (Long-Term Care Services)	Unmet	1 of 4	0 of 1
Medication Reconciliation at Transfer or Discharge (Medicine Services)	Unmet	3 of 4	1 of 1
Surgical Checklist (Operating Rooms)	Met	3 of 3	2 of 2
Two Client Identifiers (Customized Managing Medications)	Unmet	0 of 1	0 of 0
Two Client Identifiers (Emergency Department)	Unmet	0 of 1	0 of 0
Two Client Identifiers (Home Care Services)	Met	1 of 1	0 of 0
Two Client Identifiers (Long-Term Care Services)	Unmet	0 of 1	0 of 0
Two Client Identifiers (Medicine Services)	Unmet	0 of 1	0 of 0
Two Client Identifiers (Operating Rooms)	Met	1 of 1	0 of 0
Verification Processes For High-Risk Activities (Community-Based Mental Health Services and Supports Standards)	Met	2 of 2	1 of 1
Verification Processes For High-Risk Activities (Long-Term Care Services)	Met	2 of 2	1 of 1
Verification Processes For High-Risk Activities (Medicine Services)	Met	2 of 2	1 of 1

Required Organizational Practice	Overall rating	Test of Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Medication Use			
Concentrated Electrolytes (Customized Managing Medications)	Met	1 of 1	0 of 0
Heparin Safety (Customized Managing Medications)	Met	4 of 4	0 of 0
Infusion Pumps Training (Emergency Department)	Met	1 of 1	0 of 0
Infusion Pumps Training (Medicine Services)	Met	1 of 1	0 of 0
Narcotics Safety (Customized Managing Medications)	Unmet	2 of 3	0 of 0
Patient Safety Goal Area: Worklife/Workforce			
Client Safety Plan (Effective Organization)	Met	0 of 0	2 of 2
Client Safety: Education And Training (Effective Organization)	Met	1 of 1	0 of 0
Client Safety: Roles And Responsibilities (Effective Organization)	Met	1 of 1	2 of 2
Preventive Maintenance Program (Effective Organization)	Unmet	3 of 3	0 of 1
Workplace Violence Prevention (Effective Organization)	Unmet	4 of 5	1 of 3
Patient Safety Goal Area: Infection Control			
Hand Hygiene Audit (Infection Prevention and Control)	Met	1 of 1	2 of 2
Hand Hygiene Education And Training (Infection Prevention and Control)	Met	2 of 2	0 of 0
Infection Control Guidelines (Infection Prevention and Control)	Met	1 of 1	0 of 0

Required Organizational Practice	Overall rating	Test of Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Infection Control			
Infection Rates (Infection Prevention and Control)	Met	1 of 1	3 of 3
Influenza Vaccine (Infection Prevention and Control)	Met	3 of 3	0 of 0
Pneumococcal Vaccine (Long-Term Care Services)	Met	2 of 2	0 of 0
Sterilization Processes (Infection Prevention and Control)	Met	1 of 1	1 of 1
Patient Safety Goal Area: Falls Prevention			
Falls Prevention Strategy (Home Care Services)	Met	3 of 3	2 of 2
Falls Prevention Strategy (Long-Term Care Services)	Met	3 of 3	2 of 2
Falls Prevention Strategy (Medicine Services)	Met	3 of 3	2 of 2
Patient Safety Goal Area: Risk Assessment			
Home Safety Risk Assessment (Home Care Services)	Met	3 of 3	2 of 2
Pressure Ulcer Prevention (Long-Term Care Services)	Unmet	3 of 3	1 of 2
Suicide Prevention (Community-Based Mental Health Services and Supports Standards)	Met	5 of 5	0 of 0
Venous Thromboembolism Prophylaxis (Medicine Services)	Met	3 of 3	2 of 2

1.6 Summary of Surveyor Team Observations

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

The organization, North Eastman Health Association Inc. (NEHA) is commended on preparing for and participating in the Qmentum survey process. This accreditation survey occurred just after the announcement had been made regarding the merger of North Eastman and Interlake health regions, and appointment of the new chief executive officer (CEO). North Eastman is commended for its commitment to the accreditation process and positive view regarding the potential for the on-site survey to inform and contribute to the amalgamation process.

A strategic plan for the region was established for 2011-2016. This plan was informed by the Community Health Assessment and other information, leading to the establishment of four strategic priorities which are aligned with Manitoba Health goals. These priorities have been communicated across the region and unit/program action plans have been developed. This planning process has engaged many staff, although continued work will be needed to gain wider awareness of organizational priorities and to help all staff see the line of sight between their work and the organization's mission, vision and strategic priorities. There is a balanced budget and this demonstrates fiscal stewardship, with good internal controls for the region.

The organization has made a strong commitment to quality and patient safety. The new client safety framework and policy provide an excellent foundation for enhancing a culture of safety across the region. Staff members are aware of the occurrence reporting system. Processes are in place to review and learn from critical occurrences, although there are opportunities to further enhance this process. There is evidence of multiple areas engaging in local quality improvement. Examples include: releasing time to care, revision of the provincial triage form, medical device reprocessing and long term care (LTC) compliance with provincial standards. The Safety Month Annual review is a comprehensive annual educational program that is compulsory and tracked. The LTC pre-admission meeting is an innovative process whereby staff, family and friends are invited to learn about the LTC setting while their family member is still on the waiting list.

Services are provided as an integrated system. Co-location of many acute, LTC and/or community programs enhances that integration in many settings. Facilities are clean and well-maintained, illustrating staffs' pride in its buildings and grounds as part of the community. Several capital projects are underway including new, badly needed LTC beds in Lac du Bonnet and a new primary health care and Aboriginal healing centre in Powerview-Pine Falls.

The organization works collaboratively with Manitoba Health, other health regions and community agencies across the region. The province-wide approach to many policies, practices and programs is impressive and enables North Eastman to leverage and optimize its limited resources. There is much evidence of standardization, which is based on leading practices, enhances quality of care and elimination of defects. The single sheet that patients/families sign on admission to a NEHA facility is a well-worded, direct and impressive application of this standard.

There are some excellent examples of attention and consistency around working with vulnerable populations in the areas of suicide risk assessment and prevention. The organization has recently invested in training at the board and staff levels for the development of a region-wide patient safety educational program.

The NEHA is characterized by a strong values-based culture. Staff care about one other and the people and communities they serve. Despite many changes in senior leadership over the past several years, the leadership team has demonstrated a commitment to the organization and to continuous improvement.

The framework related to clinical ethics is well done. Staff members are aware of the framework, are applying this framework and seeking assistance in helping to resolve/discuss clinical ethics issues. Staff members are making use of this service.

The region-wide occurrence reporting system and associated escalation process link to the required reporting of critical incidents to the provincial government for critical incident review and to other required reporting, including protection for person's in care. The stated purpose of this occurrence reporting is to generate learning for improvement.

There is daily monitoring by clinical staff of symptoms of hospital acquired infections and this allows for early recognition of outbreaks.

The Safety Month Annual review is a comprehensive annual educational program that is compulsory and tracked.

There exist some overall challenges and opportunities for improvement. There are a number of local success stories but there is a challenge in spreading or maintaining these changes at a local area when they are meeting resistance in other clinical areas. As a region, the NEHA is under-resourced in the number of dedicated resources it has to support quality improvement. There is a lack of utilization management and capacity for decision support. Staff are measuring many performance indicators, most of which are process measures and primarily activity counts. The organization needs to further develop outcome measures and ways to effectively measure the effectiveness of its services across the region.

The patient safety culture survey identifies the need for some ongoing work relative to creating a just culture, not blame-free, but rather a culture of appropriate accountability. The disclosure policy is clear regarding NEHA's commitment to disclosure and there is evidence that disclosure is occurring. Staff members would benefit from additional and formal support to help them do this well. There are numerous well-written and intentioned policies relative to patient safety in place across the NEHA. There is inconsistency however, in how and if these policies are followed in each of clinical areas.

From time to time, staff and/or students will seek to study some aspect of care delivery. There is an opportunity for NEHA to help staff and students determine whether their particular project has ethical implications or not and if so, to help support internally some sort of ethical review. Reporting information is being used at a leadership/management level to generate new learning. When a report results in new learning and/or a change in practice, this information is not being published or otherwise shared with the general staff.

Physicians are not consistently supporting and at times working at cross-purposes with accepted and agreed to clinical practices. There appears to be an acceptance of and unwillingness to tackle this issue. Staff have established many 'workarounds' to mitigate these risks.

The organization has successfully recruited and managed to retain many qualified staff. International recruitment has assisted in filling hard-to-fill nursing and physician positions. The region however, is under-resourced in some areas such as in communications, infection control and quality improvement supports. Many physicians do not appear to be engaged with the region-wide focus on quality improvement and patient safety. Staff safety is an ongoing concern. Buildings do not have on-site security staff. Many staff members work in situations which pose a significant risk, despite region-wide policies and practices to manage this risk.

The organization has many strong partnerships with community partners across the region. Clients interviewed expressed a high level of satisfaction with services. However, the population served involves a large and growing Aboriginal community. Opportunities exist for enhanced relationships with the Aboriginal community and to also develop culturally competent services.

Section 2 Detailed Required Organizational Practices Results

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

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

Unmet Required Organizational Practice	Standards Set
Patient Safety Goal Area: Safety Culture	
Client Safety Quarterly Reports The organization's leaders provide the governing body with quarterly reports on client safety, and include recommendations arising out of adverse incident investigation and follow-up, and improvements made.	· Effective Organization 6.9
Client Safety Related Prospective Analysis The organization carries out at least one client safety-related prospective analysis and implements appropriate improvements.	· Effective Organization 6.7
Patient Safety Goal Area: Communication	
Medication Reconciliation at Transfer or Discharge The team reconciles the client's medications at interfaces of care where the client is at risk for medication discrepancies (circle of care, discharge) with the involvement of the client and family or caregiver when medication management is a component of care, or as deemed appropriate through clinician assessment.	· Home Care Services 11.2 · Medicine Services 11.3 · Long-Term Care Services 12.3 · Community-Based Mental Health Services and Supports Standards 14.3
Two Client Identifiers The team uses at least two client identifiers before providing any service or procedure.	· Customized Managing Medications 6.2 · Emergency Department 10.4 · Long-Term Care Services 8.8 · Medicine Services 9.8
Dangerous Abbreviations The organization has identified and implemented a list of abbreviations, symbols, and dose designations that are not to be used in the organization.	· Customized Managing Medications 1.10
Medication Reconciliation As An Organizational Priority The organization reconciles clients' medications at admission, and transfer or discharge.	· Effective Organization 6.6

Unmet Required Organizational Practice	Standards Set
Patient Safety Goal Area: Medication Use	
Narcotics Safety The organization evaluates and limits the availability of narcotic (opioid) products and removes high-dose, high-potency formats from patient care areas.	· Customized Managing Medications 1.7
Patient Safety Goal Area: Worklife/Workforce	
Preventive Maintenance Program The organization's leaders implement an effective preventive maintenance program for medical devices, medical equipment, and medical technology.	· Effective Organization 10.5
Workplace Violence Prevention The organization implements a comprehensive strategy to prevent workplace violence.	· Effective Organization 8.5
Patient Safety Goal Area: Risk Assessment	
Pressure Ulcer Prevention The team assesses each resident's risk for developing a pressure ulcer and implements interventions to prevent pressure ulcer development.	· Long-Term Care Services 8.4

Section 3 Detailed On-site Survey Results

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

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

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

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

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

See Appendix B for a list of priority processes.

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

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

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

3.1 Priority Process Results for System-wide Standards

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

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

3.1.1 Priority Process: Planning and Service Design

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

Unmet Criteria		High Priority Criteria
Standards Set: Effective Organization		
4.7	The organization's leaders follow a formal process to manage change.	
Standards Set: Public Health Services		
5.5	The organization regularly assesses the effectiveness of its communication strategy and uses this information to make improvements.	
9.4	The organization reviews position profiles annually, and updates them as required.	
9.6	Team leaders regularly evaluate and document each team member's performance in an objective, interactive, and positive way.	

Surveyor comments on the priority process(es)

The organization completes a community needs assessment every five years as required by Manitoba Health but refreshes it annually, informed by evidence gathered locally and provincially. There are close working relationships with many community stakeholders. A District Health Advisory Council meets quarterly and provides valuable input from communities. The organization participates in many initiatives which are coordinated at a provincial level.

Meeting community needs is challenging for a variety of reasons: isolation of some communities, especially in the north; health disparities with a higher burden of illness in some lower income and aboriginal communities; limited resources; and limited information systems.

The organization is encouraged to develop a formal change management strategy to guide the recently announced amalgamation. This will inevitably be a period of considerable stress and uncertainty which will need to be managed carefully and in ways which reflect the region's core values.

Many acute care beds are occupied by clients awaiting placement in long term care. Clients also identified the need for a walk in clinic or other facility to provide non urgent care and avoid inappropriate visits to the emergency department.

3.1.2 Priority Process: Resource Management

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

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

The region has a well-established process for development of its annual operating budget, which is developed collaboratively with managers, directors and the senior team. Guidelines are provided and the budget is normally developed as a status quo budget, with an opportunity for requests for funding to support new initiatives. The budget process is informed by the previous year's actual results and multi-year health plan, which is refreshed annually.

The organization has a position management system which also informs the budget process. Ministry approval is required for all but routine capital projects and expenditures. Regular reports are provided to the board finance, capital planning and audit committee and to the full board. An external auditor conducts an annual review of internal controls and confirms that the NEHA is providing appropriate systems and controls for financial and other resource management.

The new board may wish to examine the level of expenditure which requires board approval. Currently, thresholds are very low at $15,000 and involve the board in a level of operations that may not be appropriate. The amalgamation may provide opportunities to create economies of scale. It may also enable the new organization to enhance some resources such as communications staff, which will be important in managing the merger.

3.1.3 Priority Process: Human Capital

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

Unmet Criteria			High Priority Criteria
Standards Set: Effective Organization			
8.5	The organization implements a comprehensive strategy to prevent workplace violence.		ROP
	8.5.4	The organization conducts risk assessments to ascertain the risk of workplace violence.	**MAJOR**
	8.5.7	The organization's leaders review quarterly reports of incidents of workplace violence and use this information to improve safety, reduce incidents of violence, and make improvements to the workplace violence prevention policy.	**MINOR**
	8.5.8	The organization provides information and training to staff on the prevention of workplace violence.	**MINOR**
8.8	The organization monitors the quality of its worklife culture using the Worklife Pulse Tool.		
	8.8.2	The organization does not have any unaddressed priority for action flags based on their most recent Worklife survey results.	**MINOR**
12.5	The organization's leaders develop and regularly update position profiles for each position.		
12.8	The organization's leaders regularly evaluate reporting relationships and managers' span of control.		

Surveyor comments on the priority process(es)

The NEHA has a strong corporate culture built on its core values. The organization has developed a comprehensive human resource plan for the region. The NEHA monitors a number of human resource (HR) indicators and participates in benchmarking. The organization has demonstrated a commitment to staff safety. This includes a mandatory annual safety refresher for all staff that includes updates on workplace hazardous management information system (WHIMS), hand hygiene, occurrence reporting, and infection control.

A respectful workplace policy is in place, and a draft provincial policy on violence prevention is under review. The new policy will require increased occurrence reporting because of the expanded definition of workplace violence. Workplace violence incidents are rare but if they occurred they would be immediately reported to the appropriate senior leader.

Staff members interviewed expressed a high level of satisfaction with their jobs and a sense of pride and loyalty to NEHA. The organization has proven successful in filling some hard-to-fill positions using a variety of strategies, including bursaries and international recruitment. Partnerships are in place with Red River College

and other educational institutions to assist in meeting the HR needs. Staff turnover is within a reasonable range, although competition with Winnipeg is challenging, particularly in southern parts of the region. The organization has developed a comprehensive orientation for new staff. There are good relationships with unions and low grievance rates.

Workplace safety remains a challenge, particularly for staff working in high risk areas such as mental health and staff who work alone in the community. The organization is currently reviewing a new working alone/in-isolation policy. In the absence of in-house security staff, the organization is encouraged to continue to explore creative ways to enhance staff safety. There is a policy requiring formal performance reviews at least bi-annually however, many staff members interviewed had not received performance reviews during tist time frame. The amalgamation will provide both opportunities and challenges as the NEHA works with Interlake RHA to standardize policies and practices across the new amalgamated region, while wanting to retain many positive aspects of NEHA, including its strong corporate culture.

Concerns were expressed during the on-site survey regarding the lack of engagement and involvement by some physicians in the organization's quality and patient safety improvement work. This includes participation in the Regional Pharmacy and Therapeutics Committee and lack of co-operation by some physicians in medication reconciliation. There are examples of physician clinical practices relative to physician coverage, specifically during physician absences, and continuity of care such as for coverage of the emergency department and back-up for emergency medical services (EMS), that pose a significant risk to patients. Efforts to have physicians attend regional orientation have been largely unsuccessful and the organization may wish to consider making this mandatory for all physicians employed by the NEHA to assist in engaging them and clarifying expectations. Encouragement is offered to work with the physician community to develop and implement a physician engagement strategy and to address some aspects of physician practice and behaviour.

3.1.4 Priority Process: Integrated Quality Management

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

Unmet Criteria			High Priority Criteria
Standards Set: Effective Organization			
6.6	The organization reconciles clients' medications at admission, and transfer or discharge.		ROP
	6.6.2	Medication reconciliation is implemented in one client service area at transfer or discharge.	**MAJOR**
6.7	The organization carries out at least one client safety-related prospective analysis and implements appropriate improvements.		ROP
	6.7.2	The organization uses information from the analysis to make improvements.	**MINOR**
6.8	The organization monitors its client safety culture by using the Patient Safety Culture Instrument.		
	6.8.2	The organization does not have any unaddressed priority for action flags based on their most recent Patient Safety Culture survey results.	**MINOR**
6.9	The organization's leaders provide the governing body with quarterly reports on client safety, and include recommendations arising out of adverse incident investigation and follow-up, and improvements made.		ROP
	6.9.1	Quarterly client safety reports have been provided to the governing body.	**MAJOR**
	6.9.2	The reports outline specific organizational activities and accomplishments in support of client safety goals and objectives.	**MINOR**
	6.9.3	There is evidence of the governing body's involvement in supporting the activities and accomplishments, and acting on the recommendations in the quarterly reports.	**MINOR**

Surveyor comments on the priority process(es)

The organization has identified client safety as a written priority and has developed a well-articulated client safety framework. The establishment of a vice president (VP) position focused on quality and organizational development underscores the importance of this work across the organization. The client safety framework and associated quality management systems policy outline the organizational expectations for its operational leaders for quality and safety. The organization may want to consider whether there is an opportunity to establish dedicated positions to support and sustain the numerous new processes that this organizational focus will require.

There is a well-communicated policy and procedure for the disclosure of adverse events. Staff members interviewed were able to describe the organization's commitment to disclosure and there was clear evidence that in the event of an adverse event disclosure was indeed occurring.

Unit and program-based improvement activities are clearly connected to the organization's overall strategic plan.

The organization has a plan and in some areas, a process in place to ensure medication reconciliation at admission and transfer. There are plans for and some acknowledged challenges associated with ensuring medication reconciliation at discharge.

In reviewing the material related to integrated quality management, there was evidence of system level reporting on performance up to and including 2010. At some point in 2010, and reportedly following the departure of the CEO, the system level reporting ceased. Today, most data relative to performance is being managed at the program level. The exception to this would be the required reporting to Manitoba Health, although there is limited understanding of how these data are used internally by NEHA to evaluate performance.

Where the organization does have performance information, it is typically activity-based data, many of which are counts. The volume of data and counted measures may make it difficult for leaders to understand, based on these data, where action may be required. The organization should consider revisiting its performance measurement strategy. In particular, NEHA may wish to identify some key region-wide measures to track. Accountability to review these measures and take action as appropriate should be assigned to a member of the leadership team at the regional level. The organization should continue its practice as per the clinical indicators associated with the client safety framework, of establishing targets and measuring its progress against those targets.

Program leaders do provide updates to the board on their area's quality and safety events, describing specific concerns or achievements. There remains an opportunity to ensure that system level information related to quality and patient safety is also reported via the executive leadership of the region to the board.

With regard to disclosure there did not seem to be any support for clinicians to help them plan, do, or evaluate the effectiveness of their disclosure conversations. Further support may be required to help overcome some of the perceived barriers to disclosure, in particular staff concern or anxiety about engaging in these conversations. There may also need to be support for staff to help them navigate circumstances that are not entirely covered by the organization's disclosure policy and guideline. An example of this would relate to where one documents the disclosure conversation that occurs many months after a patient's death. The current guideline requires this documentation to be put into the clinical record. Staff were uncertain whether this meant that they needed to re-open a deceased patient's file to add a new note in the clinical record. As the organization becomes more familiar with disclosure it is inevitable that other issues will arise for example, ability to cover immediate expenses, multi-jurisdictional or multi-patient disclosures and a strategy to ensure that disclosure continues and improves would be beneficial to the organization and its staff.

Insofar as the organization's review of the frequency and severity of events and near misses identified by NEHA's occurrence reporting system, the organization may have conflicting goals. This is because the NEHA defines a target of decreasing occurrence reporting in their client safety framework at the same time as it suggests that it needs to focus on the acknowledged under reporting of these events. If the NEHA is successful in addressing the safety culture concerns the organization will likely see a net increase in reporting. The organization may also see this increase in reporting as a result of the releasing time to care work where groups of engaged staff are encouraged to identify and report occurrences for the purpose of learning. The organization is urged to revisit its clinical safety indicator target related to occurrence reporting to determine whether, as currently worded "decrease", it meets their needs. If the intent is to decrease the

number of actual occurrences rather than just reports of occurrences, then the organization is encouraged to explore other methods of capturing these occurrences. This could be accomplished with retrospective trigger tools, prospective clinical triggers, safety rounds/log books, and hospital acquired infection rates and so on to gain a better overall understanding of the safety status of the organization.

3.1.5 Priority Process: Principle-based Care and Decision Making

Identifying and decision making regarding ethical dilemmas and problems.

Unmet Criteria	High Priority Criteria
Standards Set: Effective Organization	
5.5 The ethics framework includes a process for reviewing the ethical implications of research.	!

Surveyor comments on the priority process(es)

The organization has a robust clinical ethical-decision making framework, policy and guideline. Staff at all levels, be the health care aides (HCA), licensed practical nurses (LPN), registered nurses (RN) or physicians (MD), could describe the process by which they could request assistance in working through an ethics issue or dilemma. There was evidence that this process was being utilized by staff and that expert advice was being provided to clinical areas to help in their care decisions.

The ethics committee is interdisciplinary and made up of individuals from many different NEHA programs and levels including the CEO, a member of the board and senior leadership. The recent revitalization of this committee and continued access to expert ethicist advice by way of a fee-for-service arrangement puts the organization in a good position to continue to enhance this service. One of the questions that NEHA will need to consider as a part of the recently announced merger is how the local committee works/interacts with the provincial ethics committee in which other regional health authorities participate.

The organization also has an opportunity to more clearly outline the requirements for ethical review and/or consideration for formal research projects and quality improvement projects. Although the organization does require an objective reviewer or body to review all formal research projects, this requirement is not supported by policy.

3.1.6 Priority Process: Communication

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

Unmet Criteria		High Priority Criteria
Standards Set: Effective Organization		
3.3	The organization's leaders develop and implement a communication plan to disseminate information to, and receive information from, stakeholders.	
13.1	The organization's leaders select and implement information management systems that meet the organization's current needs, and anticipate future needs.	

Surveyor comments on the priority process(es)

Recent efforts to enhance visibility of and communications with the senior team have been well-received by staff, particularly during a period of transition to the new amalgamated organization. At the unit level, a variety of formal and informal mechanisms are used to communicate among staff, including communications books, bulletin boards, staff meetings and informal discussions.

There are many excellent posters to inform about patient safety, including infection control and medication safety. Falling stars are used to identify clients at risk of falling. The organization has a very positive working relationship with the Manitoba Centre for Health Policy, which provides and interprets evidence that is used for health system planning and evaluation. The NEHA has a history of stellar use of evidence.

The organization has no dedicated communication staff or communications plan. With the new amalgamation, it will be important to enhance communications with staff and the public. Many staff were unaware of the strategic priorities for the region, although they were aware of the amalgamation. They expressed a desire to know more about what this will mean for them, their colleagues and their patients. Members of the public stated they sometimes hear about regional affairs via the media but receive little information directly from NEHA.

The organization has made some progress in enhancing its information systems for example, the electronic health record in primary care, but many gaps still exist. Its plans are largely dictated by the provincial e-health agency and funding from the ministry. In the new, larger organization, enhanced information systems, including development of an intranet site will be an important enabler for developing an integrated health system.

Telehealth is used for meetings, staff development and some clinical applications although there are many opportunities for further expansion, including support for remote Aboriginal communities.

3.1.7 Priority Process: Physical Environment

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

Unmet Criteria		High Priority Criteria
Standards Set: Emergency Medical Services		
10.2	The team's vehicle operators participate in regular training on how to drive and operate EMS vehicles.	
10.3	The team conducts and documents annual checks of the driving records of all persons who drive an EMS vehicle.	!

Surveyor comments on the priority process(es)

The organization has a large number of buildings located in several towns across the region. There are three acute care hospitals and several LTC homes. The acute care hospitals have been modified and are integrated facilities, sharing with the primary health care centre. In Pine Falls, there is a planned expansion of the primary care centre on the same site. There are also other buildings on some sites for supportive housing however, these are not NEHA's responsibility. A review of the physical environment for accreditation purposes involved a tour of the hospitals, several of the primary care units as well as many personal care homes. Overall, considering the age of some of the physical structures these buildings have been maintained extremely well, the mechanical aspects are working well and looking good and the interior environments are extremely clean.

Maintenance of the buildings is professionally done. The areas housing the heavy equipment such as generators, boilers, chillers and ventilation equipment is clean and well maintained. Testing of the generators under load is done on a regular basis. There have been issues with the back-up generators in Pine Falls since there were systems changes which accompanied the modifications made around the millennium scare in this regard. Some of these modifications are now causing problems, which may complicate the transfer of power when there is a utility failure. For the personal care facilities, a manual transfer of power supply is required when there is a utility failure where members of the maintenance staff are required to attend on site. This has not caused any safety issues as the organization has put procedures in place to mitigate risks but it is an inconvenience. Similar issues/risks however, do not exist in the hospital facilities as the initial transfer to generator power is automatic, but manual action is required to transfer back. The generator is small in Pine Falls but sufficient to provide emergency power. With the building of the new facility, more back-up potential will be installed and problematic switches replaced.

Recycling programs are in place where possible. Waste is disposed appropriately.

Environmental and dietary services are provided by NEHA staff but supervised by an employee of Aramark. Aramark policies and procedures are followed, with capital expenditures the responsibility of the NEHA. There are challenges with space in the individual laundry areas however, as noted in other areas of the accreditation report there is general satisfaction with these services.

Of note is the most recent move across the organization to a different system for cleaning, which does not require large amounts of water and detergents. The organization is now using microfiber towels, combined

with various chemicals which meets the requirements for cleaning and does not require the dumping of detergents down the drains. The new practice is stated to be kinder to the environment and is considered a green initiative.

Fire drills are conducted frequently in the various buildings, and drills requiring evacuation are projected to be done annually.

The team documents and maintains a record of the initial licenses and qualifications for all persons that drive an EMS vehicle. The team follows both a standard "Fleet" accident report process and NEHA's occurrence reporting procedure when an EMS vehicle is involved in a collision or other accident. The communications equipment is the property of and maintained by Manitoba Health however, the team has a role in liaising with that entity to resolve identified issues.

A preventive maintenance (PM) program is in place, and that which is required for medical equipment is done on a regular basis by the bio-engineering department from Brandon. The department visits bi-annually to perform PM and also whenever necessary to perform repairs. There is satisfaction with the service provided. The general maintenance and repairs of non-medical equipment is done by NEHA staff. Response time is good and staff are content with the service.

Requests for repairs are made in writing in a unit-specific maintenance book. This requires a member of the staff to visit the unit on a daily basis to know what repairs are required. No work orders are prepared and there is little information available to the staff as to timeliness of repairs, or what is wrong with the equipment. Information is kept in the maintenance department and the surveyor team suggests that even with the limited information system currently available, these processes could be expedited via an electronic PM system, accessible from the individual units.

Policies are in place that require all equipment to meet accepted standards such as those of the Canadian Standards Association (CSA) and this is done by purchasing department.

Appropriate codes are in place and well known and all staff members have codes on their identification (ID) tag.

3.1.8 Priority Process: Emergency Preparedness

Dealing with emergencies and other aspects of public safety.

Unmet Criteria		High Priority Criteria
Standards Set: Effective Organization		
11.8	The organization's leaders regularly test the organization's disaster and emergency plans with drills and exercises.	!
11.9	The organization's leaders use the results from post-drill analysis and debriefings to review, and revise if necessary, its disaster and emergency plans and procedures.	!
Standards Set: Emergency Department		
2.6	The team participates in regular practice drills of the emergency preparedness plan.	!
Standards Set: Emergency Medical Services		
2.3	The team conducts regular disaster exercises at least once per year.	
Standards Set: Infection Prevention and Control		
14.6	The organization coordinates its planning for pandemics and outbreaks with its overall planning for disasters and emergencies.	

Surveyor comments on the priority process(es)

The organization has some recent experience dealing with outbreaks and routinely conducts monthly fire drills and evacuation drills on a bi-annual basis at a facility level. There is good evidence of post-outbreak and post-drill reviews being conducted and recommendations for improvement being made. In general, while staff at a facility level are proud of their local efforts, they express some concern with the overall coordination and management of the system at a regional level.

The organization has a plan that describes all aspects of the regional emergency preparedness and response plans and has recently resurrected the disaster preparedness committee.

The organization has a pandemic plan in place dated 2008, which is consistent with the general education and procedures contained in the infection prevention and control manual. In an attempt to streamline and highlight the unique aspects of pandemic planning and response, the organization is revising the current pandemic plan. A 2012 updated manual has been produced and is currently awaiting final approval.

The disaster preparedness plan has not been updated in some time. The regional disaster response plan manual is dated 2009 and many sections of the manual are date-stamped 2008. Aspects of the plan that have not been applied in actual events have not been tested recently via planning and preparedness exercises. The

NEHA is required to conduct evacuation drills in its LTC facilities on an annual basis. It last conducted evacuation drills in facilities in 2010 and for a variety of reasons, did not complete the drills in 2011. There is a plan to complete these drills in all LTC facilities prior to a Manitoba Health inspection scheduled for August 2012.

There is little evidence of a regional approach to planning, testing and learning relative to emergency preparedness being in place. The director of EMS position is accountable for regional emergency preparedness and is currently attempting to re-establish a region-wide approach to disaster planning. However, competing priorities have resulted in some delays. Competing priorities include: a major provincial organizational review of EMS; complying within a three-month period with a recent external mandate to update the education and training status for all staff or risk loss of licensure for the entire NEHA EMS service; and the need to manage a very public critical incident involving EMS. The organization is urged to consider in the upcoming reorganization whether there is an opportunity to dedicate resources to the development, testing and maintenance of a regional disaster management plan. It is unlikely that continued use of the sole EMS director to support disaster planning for the facilities in the region can be sustained in the long term.

The regional disaster preparedness committee did not meet in 2011.

It is unclear what level of involvement the region's medical staff have in many aspects of disaster planning and testing, the exception being the medical officer of health whose role necessarily requires involvement in pandemic and outbreak responses.

3.1.9 Priority Process: Patient Flow

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

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

Staff members across the region work extremely collaboratively. The arrangement of integrated facilities, which co-locate a variety of services such as emergency, in-patient, community programs, and/or long term care facilitate communications, flow and continuity of care. Communications binders/doctors' boards are used to communicate with physicians regarding in-patient orders, reports or concerns.

Two observation beds are available at Beausejour site for periods when no in-patient beds are available and patients need to be admitted/observed for 24 hours.

The provincial emergency triage system (MTCC) appears to work well in coordinating emergency ambulance response. Mutual support arrangements are in place with two other health regions to cope with busy periods of ambulance transfers.

The major challenge with regard to patient flow is the severe shortage of LTC beds. Many patients in acute care are 'panelled' patients awaiting access to long term care. This sometimes prevents the NEHA from accepting patients ready for discharge from Winnipeg hospitals. Access to care in Winnipeg is sometimes delayed, because of system pressures at the tertiary care facilities.

3.1.10 Priority Process: Medical Devices and Equipment

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

Unmet Criteria		High Priority Criteria
Standards Set: Effective Organization		
10.5	The organization's leaders implement an effective preventive maintenance program for medical devices, medical equipment, and medical technology.	ROP
10.5.3	The organization's leaders have a process to evaluate the effectiveness of the preventive maintenance program.	**MINOR**
Standards Set: Emergency Medical Services		
12.6	The team locks and secures all medications, sharps, and syringes when the vehicle is not in use or is unattended.	
Standards Set: Reprocessing and Sterilization of Reusable Medical Devices		
1.1	The organization collects information at least annually about service volumes and patterns of medical device use.	
2.4	Supervisors and staff members involved in reprocessing have completed a recognized course in reprocessing and sterilization.	
5.1	The medical device reprocessing department is equipped with hand hygiene facilities at entrances to and exits from the reprocessing areas, including personnel support areas.	
5.2	The medical device reprocessing department's hand hygiene facilities are equipped with faucets supplied with foot-, wrist-, or knee-operated handles, or electric eye controls.	!

Surveyor comments on the priority process(es)

The medical device reprocessing staff members and manager are commended for the well-organized department. The coordinator has made many improvements to processes over the past six months since receiving certification. There have been many areas of quality improvement implemented to meet best practices.

Sterile supplies in the medical device reprocessing area are stored in a restricted access atmosphere, which is best practice.
Flexible scope reprocessing is performed using excellent reprocessing practices.

A record of devices disinfected is required with documentation. The machine tubing is soaked in a disinfectant and this process needs to be documented daily with name of item and disinfectant. The channels need to be flushed with medical air for drying after disinfection and rinsing.

The staffing mix is one permanent full-time and a number of part-time casuals. As the part-time allotment is more than another equivalent full time equivalent (EFT), consideration could be given to two permanent staff in the medical device department in light of the increase in endoscope procedures.

All sites send their re-usable medical devices to Beausejour for reprocessing. The staff at each of the sites namely, ward clerk, registered nurse or health care aide, hand-wash these devices in the procedure room using personnel protective equipment (PPE), then contain and ship the devices to Beausejour for reprocessing. This is also done for used patient utensils. It is suggested that an examination be done of the cost of this process including staff time for cleaning and containing the device, decontamination, packaging, reprocessing and sterilization, transport costs and material used to sterilize the device with chemical indicators and packaging costs. There are excellent single use trays and instruments available which meet quality in structure and sterility. These items are cost effective, and will eliminate the transportation of contaminated medical devices, and staff exposure at the sites to clean these devices which is performed in the patient procedure rooms. This practice has been implemented in Saskatchewan and Northern Ontario. Disposable utensils of a good quality could be considered for these sites.

Ongoing education is important and the use of on-line and Telehealth education sessions could be explored to assist staff in maintaining education and practice. With the increase in endoscope procedures, future plans for medical device reprocessing design may want to consider expansion of the decontamination area as currently, this is of a small size. Future purchase of an automated endoscope, Telehealth may want to consider the pass through model for better flow, or a separate room for the automated reprocessing machines.

Relative humidity in the medical device reprocessing is required to be maintained to specific levels due to infection control issues. The organization is experiencing problems maintaining humidity to the required levels and has identified this problem. Manitoba Health has hired a company to review the systems. If this review does not provide a solution, action is required to solve this issue. The reprocessing department packages all sterile products in plastic dust covers for any product being transported to another site, and between May and September for all products, due to humidity levels in the Beausejour facility. This is a precautionary measure due to high humidity during this period.

All surfaces in the decontamination area are required to be non-porous. Wood shelving and a wood cabinet are located in this area and do not meet the requirement so should be replaced. Further, the pass through window is left open for long periods, which affects the negative pressure in the decontamination area so therefore, needs to be closed immediately after it is opened.

The quality of surgical linen drapes being used for procedures needs to be assessed, as the CSA standard is level 3 minimum and level 1 is being used at this time. Reusable gowns are used as PPE and it is required that a quality system be followed as per the CSA standard Z314.10.2. This process is not being performed and therefore, this is an occupational health and safety issue.

Laundry facilities at some sites are using the same door for the entry of contaminated linen and exit of the clean linen, which is an infection control concern. Also, while no physical separation occurs between clean and dirty the surveyor observed good practice being performed. The design and layout of the laundry could be reviewed.

Storage of reprocessed or clean supplies should not be in the decontamination area. Cleaned sterile utensils should be moved to the clean sterile storage area. The decontamination area should only have storage of supplies required to perform processes in the decontamination area and only volume required for a short period.

Reprocessing of single use medical devices does not occur, but at Oakbank, a used single use medical device was discovered in the clean cupboard. This was brought to the director's attention. There was immediate follow-up and action taken to correct this within 48 hours and education provided to the nurse practitioners and physicians.

An external review occurred in 2011. It is suggested that a yearly internal review occurs as well as a periodic external review so that opportunities for improvement occur and are acted on.

The washer disinfector does not meet the CSA standard Z314.8, which requires a print-out to ensure that the temperature has been met for the devices that are reprocessed using this equipment. It is suggested that a quality program including testing for cleanliness and temperature should be considered.

3.2 Priority Process Results for Population-specific Standards

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

Priority processes specific to population-specific standards are:

Population Health and Wellness

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

3.2.1 Standards Set: Public Health Services

Unmet Criteria		High Priority Criteria
Priority Process: Population Health and Wellness		
16.3	The organization shares its knowledge of public health research, best practices and evidence with its partners.	
17.7	The team regularly completes utilization reviews to ensure resources have been used appropriately.	
Surveyor comments on the priority process(es)		
Priority Process: Population Health and Wellness		

This is a very committed and collegial team. Public health staff participate in development of the Community Health Assessment and use these data to inform program planning and delivery.

Community groups at higher risk of health problems are identified, including use of standard assessment tools to determine eligibility for the Home Visitors program. There is evidence of many programs which are evidence based, some of which are part of the Healthy Child Manitoba provincial programs such as Healthy Baby and Families First. NEHA has initiated a self assessment for Baby Friendly designation. There is a significant focus on promoting breast feeding, including information for grandparents.

Public health inspection has recently been transferred to health from another government department.

There is evidence of many partnerships with external agencies, including school (e.g. Passport to Health program). This community development approach is creating creative solutions to underlying determinants of health in small rural communities such as plans for the new outdoor rink in Lac du Bonnet. Focus on health promotion includes water safety, car seat and crib safety.

Many indicators are tracked, including client satisfaction with programs. The region is encouraged to focus on a fewer number of outcomes measures, with comparison of results to evidence-based targets. The region's staff immunization rates are low and the region is encouraged to examine ways to increase these rates, informed by successful practices in other jurisdictions.

3.3 Service Excellence Standards Results

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

Priority processes specific to service excellence standards are:

Episode of Care - Primary Care

- Includes all elements of the primary care encounter in the clinical setting from accessing primary care services to how the encounter is completed to integration and coordination of services.

Clinical Leadership - Primary Care

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

Competency - Primary Care

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

Impact on Outcomes - Primary Care

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

Decision Support - Primary Care

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

Clinical Leadership

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

Competency

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

Episode of Care

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

Decision Support

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

Impact on Outcomes

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

Medication Management

- Interdisciplinary provision of medication to clients.

Organ Donation

- Donation services provided from identification of a potential donor to donor management and organ recovery.

Infection Prevention and Control

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

Surgical Procedures

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

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

Unmet Criteria			High Priority Criteria
Priority Process: Clinical Leadership			
The organization has met all criteria for this priority process.			
Priority Process: Competency			
4.10	Team leaders regularly evaluate and document each staff member's performance in an objective, interactive, and positive way.		
Priority Process: Episode of Care			
14.3	The team reconciles the client's medications at interfaces of care where the client is at risk for medication discrepancies (circle of care, discharge) with the involvement of the client and family or caregiver when medication management is a component of care, or as deemed appropriate through clinician assessment.		ROP
	14.3.2	The team updates the client's medication list following each clinician consultation or visit to a health care practitioner within the client's circle of care.	**MAJOR**
	14.3.3	The team provides the client with a copy of the up-to-date medication list, clear information about the changes, and educates the client to share the list when encountering providers in the client's circle of care.	**MINOR**
14.5	Following a transition or at the end of service, the team contacts individuals, families, and referring organizations to evaluate the effectiveness of the transition, and uses this information to improve its transition and end-of-service planning.		
Priority Process: Decision Support			
The organization has met all criteria for this priority process.			

Priority Process: Impact on Outcomes		
19.2	The team regularly monitors process and outcome measures.	
19.3	The team regularly monitors individuals' and families' perspectives on the quality of its services.	
19.4	The team compares its results with other similar interventions, programs, or organizations.	
19.6	The team shares evaluation results with staff, individuals, and families.	

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

The mental health staff demonstrate a strong commitment to client and family-centred care. They genuinely care about the people and communities they serve. They find creative ways to provide services to meet community needs, within available resources. There is a strong sense of teamwork and respect for what each team member contributes.

The mental health program includes coordinated intake and client assessment, crisis intervention, ongoing case management and rehabilitation, as well as public education and health promotion. Services are evaluated using a variety of mechanisms, including client feedback. There are partnerships with many community agencies. There is also collaboration with other health regions. The proctor program is particularly notable as a way to support mental health clients, while optimizing limited mental health professional resources.

Given the strong focus on community programs, safety of staff working in these settings needs to continue to be an area of focus. There are opportunities to streamline the provincial assessment process for clients awaiting long term care (LTC) to avoid inappropriate demands on scarce mental health staff when other care providers such as home care staff may be in a better position to assess client needs.

Priority Process: Competency

There is a strong sense of teamwork. All staff members are required to participate in non-violence crisis intervention training (CPI) bi-annually. There is good communication and cooperation between mental health staff and family physicians. The regional mental health team is supported by psychiatric staff based in Winnipeg, and it includes access via Telehealth. Staff are supported in ongoing professional development.

A new working alone/in-isolation policy is being finalized and will need to be consistently implemented to enhance staff safety.

Many staff reported they do not receive bi-annual formal performance reviews as required under NEHA policy.

Telehealth is used but could be expanded to improve access to specialists in larger centres and enhance services in remote communities.

Priority Process: Episode of Care

Staff demonstrate a respectful compassionate relationship with their clients. Staff were aware of supports available to deal with ethics issues. Services are tailored to meet individual needs, with a high degree of flexibility in terms of where and how those services were delivered. In some cases, given the stigma associated with mental illness, staff meet with clients in alternative settings. Many services are provided in collaboration with other agencies.

A crisis intervention service is available and clients are made aware of how to access this service. Written materials are almost exclusively in English, although some translation services are available. Standardized processes are used for client assessment. This assessment includes identification of suicide risk.

Although medication administration is not part of this program, generating a medication history is part of the initial assessment process. Information regarding changes in medications may be communicated by the family physician although this is not done consistently and it appears that patients are not provided an updated list. In these circumstances, the mental health nurse may rely on the patient to inform of these changes. The further development of the electronic health records has the potential to ensure more timely and accurate communication of medication changes during the entire course of care.

Priority Process: Decision Support

A new electronic health record for mental health services was recently implemented across the region. Mental health services are informed by evidence of leading practices, including suicide risk assessment and prevention, treatment of delirium and re-assessment and treatment of depression.

The program is informed by the National Guidelines for Seniors Mental Health. Some initiatives are done at a provincial level in collaboration with Manitoba Health and other regions. Staff demonstrate an interest in and commitment to continuously improve their services, based on new knowledge and feedback on their services.

The region has identified the need to further develop processes to share benchmarking and leading practice information with partner organizations and clients.

Priority Process: Impact on Outcomes

Mental health services prepares an annual action plan aligned with the regional strategic plan. A logic model has been developed to identify program components and short, medium and long-term outcomes. The mental health program monitors an extensive list of performance indicators, which largely focus on measuring activity.

Opportunities exist to reduce the number of metrics and focus more on outcome measures. Some client outcomes are tracked informally by care staff but a more formal approach, including measurement of client satisfaction would provide more information regarding program effectiveness.

The organization is encouraged to implement its plans to reactivate surveys of clients and referring agencies to evaluate satisfaction and effectiveness of its services. These surveys have not been done for several years. This would provide important information to help prioritize quality improvement initiatives. This information should also be shared with staff and program clients.

Staff were aware of the occurrence reporting policy and practice. The organization is encouraged to further enhance its focus on staff safety across the region, particularly for staff working alone in potentially high-risk circumstances.

3.3.2 Standards Set: Customized Managing Medications

Unmet Criteria			High Priority Criteria
Priority Process: Medication Management			
1.7	The organization evaluates and limits the availability of narcotic (opioid) products and removes high-dose, high-potency formats from patient care areas.		ROP
	1.7.2	The organization has removed the following products (exceptions include palliative care): hydromorphone ampoules or vials with concentration greater than 2 mg/ml, and morphine ampoules or vials with concentrations greater than 15mg/ml.	**MAJOR**
1.10	The organization has identified and implemented a list of abbreviations, symbols, and dose designations that are not to be used in the organization.		ROP
	1.10.6	The organization updates the list and implements necessary changes to the organization's processes.	**MINOR**
	1.10.7	The organization audits compliance with the Do Not Use List and implements process changes based on identified issues.	**MINOR**
3.5	Team members document in the client record verbal or written information about medication that is provided to the client.		!
6.2	The team uses at least two client identifiers before administering medication.		ROP
	6.2.1	The team uses at least two client identifiers before administering medications.	**MAJOR**
Surveyor comments on the priority process(es)			
Priority Process: Medication Management			

Pharmacy services in the organization are provided by an external vendor (Alentex). The service is supported with one full-time pharmacist via contract and 2.3 equivalent full time (EFT) pharmacy technicians who are employees of the organization. Staff interviewed indicated that response and support from these resources is readily available.

The pharmacy program is also required to participate in a bi-annual review by the Manitoba Pharmaceutical Association. This review was conducted in fall 2011.

All medication storage areas are well-defined and well-organized.

At sites that have ward clerks in place, these clerks are accountable for transcribing all orders, which are checked by the nurse before being implemented. Ward clerks are required to be appropriately certified before transcribing medication orders. All appropriate safety checks are in place and consistently applied. Kudos!

All medication related occurrences in the organization are reviewed. Those in long term care (LTC) are reviewed quarterly via the pharmacy and therapeutics committee. Those in community care are reviewed by the program. Those in acute care are reviewed by site-specific medication occurrence report committees. Meetings of this group have been inconsistent, likely due to the broad scope of the pharmacist. The team is considering changing this forum to region, versus site-specific.

Evidence was noted to support that improvement is made as a result of reviewing medication related occurrences. Application and documentation processes for fentanyl and nitro patches were revised at East Gate Lodge to support safer medication practice.

Primarily, with regard to medication related performance measures, the organization monitors medication occurrences only. Occasionally, there are "one off" medication related processes that are monitored as required.

3.3.3 Standards Set: Emergency Department

Unmet Criteria		High Priority Criteria
Priority Process: Clinical Leadership		
2.2	The team's goals and objectives are linked to benchmarking of bed availability in the Emergency Department, time to admission, client diversion to other facilities, and wait times.	
2.8	The team has the workspace needed to deliver effective services in the Emergency Department.	
Priority Process: Competency		
3.5	The interdisciplinary team follows a formal process to regularly evaluate its functioning, identify priorities for action, and make improvements.	
4.2	The team orients new team members about their roles and responsibilities, the team goals and objectives, and the organization as a whole.	
4.3	The team orients new staff and service providers about the unique work environment in the Emergency Department.	
4.12	Team leaders regularly evaluate and document each team member's performance in an objective, interactive, and positive way.	
Priority Process: Episode of Care		
6.7	The team measures ambulance offload response times, and sets and achieves target times for clients brought to the Emergency Department by EMS.	
6.8	The team monitors ambulance offload response times and uses this information to improve its services.	
Priority Process: Decision Support		
The organization has met all criteria for this priority process.		
Priority Process: Impact on Outcomes		
10.4	The team uses at least two client identifiers before providing any service or procedure.	ROP
10.4.1	The team uses at least two client identifiers before providing any service or procedure.	**MAJOR**
16.1	The team identifies and monitors process and outcome measures for its Emergency Department services.	

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

Priority Process: Organ Donation

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

The Emergency department uses information about patient and community needs from the Community Health Assessment, wait lists, population demographics as well as historic Emergency Department usage data such as the Canadian Triage Acuity Scale (CTAS) score and type of care provided to patients, to plan and stratify their service delivery and education. An example is ensuring paediatric advanced life support (PALS) training for staff in Pinawa.

Although not dedicated to the emergency specifically, the availability of a clinical resource nurse in the emergency department was viewed by staff as a big benefit, particularly in the orientation process.

The clinical skills required to provide effective emergency care require unique skills in addition to those used for acute care provision. A dedicated focus on emergency department skills beyond sending staff to commercially available courses for ACLS, PALS, trauma nursing core course (TNCC), would help ensure maintenance of competency in the emergency department. At this time, the organization has not developed an emergency specific educational or maintenance of competency program, and does not currently have mock or other drills related to clinical care. Therefore, there exists an opportunity to formalize the emergency department and Emergency Medical Services (EMS) relationship to allow inter-team education and training. For example, have a joint training and education with the emergency department and EMS staff around codes.

Physicians new to the region and who are expected to provide emergency care do not receive an orientation to the emergency department's processes or practices. In particular, there is no joint training, case review or other educational offerings involving physicians and other emergency department staff.

Priority Process: Competency

The orientation and mentorship program that exists in the acute care facilities for staff has resulted in tremendous alignment of purpose and function around care. In the emergency department setting the orientation to CTAS, the ethics framework and other processes has helped ensure consistent care. There is financial support to ensure the maintenance of core courses related to emergency patient needs including TNCC, PALS and ACLS.

The emergency department team will contact EMS for assistance in the event of a critical patient requiring additional care such as seizures or arrests.

Some training for example, non-violent crisis intervention is only offered on a trial and/or periodic basis, partly due to funding implications. Although staff are appreciative of these opportunities, NEHA is encouraged to determine whether these sorts of programs are beneficial to both staff and to patient care and if so, to seek out opportunities to fund these programs.

Priority Process: Episode of Care

The emergency department team works across sites to identify priorities and to develop new practice. The revision to the triage form is an example of this collaborative approach whereby all staff that would be expected to use the form become involved in the design and trial of these forms.

Staff at all levels work together to ensure ongoing care to patients and families, follow a common plan and support one another in their activities. The EMS and emergency department staff work together to facilitate routine transfers to and from other facilities for advanced diagnostics and consultation.

There is a process in place to ensure that diagnostic imaging (DI) reports are reviewed by both registered nurses and physicians, and any discrepancies are reviewed prior to these reports being placed on the client file.

There are challenges with providing in-patient services to patients being held in the observation area of the emergency department. These patients require in-patient services as well as scheduled medications, nutritional services, physician rounds; however, the area of the emergency department that they are held is not set up to routinely house in-patients. In one circumstance, a patient that was being held in the observation area did not have an identification or allergy wrist band and was not 'rounded' on by the responsible physician, although reportedly, this was an atypical occurrence. Staff did acknowledge that they do have challenges relative to care when patients are being held in emergency department space for prolonged periods.

The emergency department is expected to provide care 24/7/365 however, after hours some key diagnostics are available on an on-call basis only. This would include electrocardiogram (ECG). In the Pine Falls emergency department, it was reported that if the patient requires an ECG after hours that someone on-call must come in to provide the team with that ECG. As the team develops processes to review the performance of its key clinical process and outcomes measures, for example chest pain protocol, ST segment evaluation myocardial infarction (STEMI), the degree to which this lack of access contributes to outcomes could be evaluated.

Priority Process: Decision Support

The organization does have access to some information technology (IT) in the emergency department, for example picture archiving and communication system (PACS) in diagnostic imaging (DI), and develops processes to ensure these technologies are being utilized.

The staff in the emergency department routinely work across sites and programs to develop, review and revise protocols and associated education.

In a care environment where physicians are often not available on site - the physician in the community being on-call after hours and on weekends - the emergency staff frequently have to begin care while waiting for physician orders.

The organization should consider having physician leaders involved at a regional level in the development and maintenance of emergency department specific protocols.

Priority Process: Impact on Outcomes

The team utilizes available data and occurrence reporting to help redesign care processes. Non-violent crisis intervention training was made available to staff on a voluntary basis.

Nursing managers have access to and utilize the Manitoba Health Nurse Recruitment and Retention fund to support staff education and training.

As the organization continues to develop its electronic documentation, it is encouraged to consider prior to implementation, how these systems could be built to support the evaluation and improvement of clinical processes.

Priority Process: Organ Donation

Given the type of services available in the organization, there is little opportunity to engage in organ donation processes. The one case that could be recalled was related to a family's strong desire to donate and in this case, NEHA was able to arrange for bone donation. The organization does have a policy that is available to help guide these rare circumstances.

3.3.4 Standards Set: Emergency Medical Services

Unmet Criteria		High Priority Criteria
Priority Process: Clinical Leadership		
3.1	The team has a communications policy for sharing information and raising awareness about emergency medical services.	
4.2	The medical oversight team includes physicians, paramedics, nurses, clinical educators, and clinical performance managers.	!
4.8	The team has a policy and a process to address continuous physician responsibility and availability during all phases of the patient's care in the field and during transport.	
4.9	The medical oversight team regularly follows-up with referring and accepting physicians at local hospitals and alternate level of care facilities to identify issues, and review and improve patient care.	
Priority Process: Competency		
5.10	The organization regularly evaluates and documents each team member's performance in an objective, interactive, and positive way.	
6.4	The interdisciplinary team evaluates its functioning annually, identifies priorities for action, and makes improvements.	
Priority Process: Episode of Care		
The organization has met all criteria for this priority process.		
Priority Process: Decision Support		
20.5	The team communicates the evidence-based guidelines, research, and best practice information to patients, families, and the public receiving services.	
Priority Process: Impact on Outcomes		
22.4	The team monitors stakeholder, patient and family perspectives on the quality of its services.	
22.5	The team identifies and monitors structure, process, and outcome measures for its services.	
Priority Process: Infection Prevention and Control		
9.2	The team properly uses personal precautions and personal protective equipment.	
Surveyor comments on the priority process(es)		

Priority Process: Clinical Leadership

The team does receive some information about its clients and the community through community health assessment activities and has used this information to help plan for new stations. The organization has successfully secured funding to develop new and/or renovate existing stations in the region. The team also has access to information related to its responses. The organization is using these data to set targets such as to ensure a 70th percentile response compliance better than the provincial average and is monitoring progress towards these targets at a regional level.

The Emergency Medical Services (EMS) team has recently put in place a clinical audit process for the purpose of learning. This routine non-occurrence based review if conducted in a transparent manner with the involvement of EMS practitioners, has the potential to greatly influence the EMS culture in the organization. Prior to the introduction of the clinical audit process, practitioners often completed occurrence variance reports to which they rarely received feedback or responses. The only formal feedback that staff received about clinical events was usually as a result of more formal provincial level critical incident reviews, which usually carried with them a negative connotation.

The EMS team has a lead role in internal disaster and emergency preparedness planning and serves as the primary contact for the organization, with numerous other health and non-health based disaster response stakeholders in Manitoba. Involving EMS in this planning is viewed as a noted strength, however, if the organization would like EMS to lead this work it needs to ensure EMS is provided with sufficient time and resources to deliver on this commitment.

The EMS performance data are available to the leadership team in EMS but not shared routinely with staff.

The EMS medical director funding is insufficient to support routine involvement of the medical director in medical oversight matters. The small amount of funded medical director time is often consumed by basic physician administration and other regional responsibilities.

Priority Process: Competency

The EMS team has put a number of initiatives in place to help support practitioner competency. A major achievement was the ability to retrain all of the organization's EMS staff in a three-month period to meet provincial ambulance service licensure requirements at the end of the past calendar year. The organization authorized the establishment of temporary positions to help support this training and is in the process of trying to establish some level of permanent educational position in the region.

There are likely additional opportunities to be explored related to joint training involving EMS personnel and other staff in the organization. This would include infection prevention and control (IPAC) staff, occupational health and safety (OHS) staff and emergency department personnel. In addition, the EMS staff report that they used to help out in other clinical settings on a regular basis, and that in recent years this practice of helping out has decreased. The organization should explore whether there are opportunities to better integrate EMS skills and personnel into the overall organization care delivery model.

The EMS team is expected as per Manitoba Health, to fund 10 EMS units on a 24/7/365 basis. The EMS has historically struggled to meet this requirement and most recently, only able to meet its staffing requirements 53 percent of the time. Recent changes to the staffing plan have resulted in a significant increase in compliance with the staffing model.

The current, flat staffing model does not match the significant variability in EMS demand across the region in particular, the increased demand during summer months with a significant influx of residents into the region. It is not clear how the staffing model was determined, whether based on average activity, peak activity, however, it does not appear to be paired or adjusted, based on demand.

There are opportunities for EMS to utilize other programs within the organization and resources to support the EMS mandate; there is evidence that EMS practitioners are taking advantage of this benefit of regionalization. Every EMS practitioner file does clearly identify that practitioner's role and transfer of functions.

There are position profiles for EMS practitioners. These job descriptions have not been reviewed since 2008 and paramedic roles including transfer of function possibilities for these positions have changed.

Priority Process: Episode of Care

The organization does utilize provincially developed medical control protocols and guidelines and has a clinical audit program in place to assess protocol/guideline compliance. The audit information is being used to address individual learning needs and will be used in the future to assess overall EMS practice in the region.

The EMS team members have access to basic Personal Protective Equipment (PPE) and have been fit-tested for N95 masks. Only N95 masks of a single 'regular' size were available on the ambulances inspected. Staff members were unclear on how they would access N95 masks of the appropriate fit. Staff need access to N95 masks that match the results of their fit test. Staff members are scheduled to repeat their fit testing later this year.

The EMS leadership have identified a need to better support practitioners with regional protocols and ongoing education and funding requests have been submitted to help support continued improvement of the EMS services. There appears to be a limited ability for local medical direction to modify or update EMS protocols to reflect local service needs. Conceptually, the EMS team can work with their medical director to create new protocols but in practice, this has not happened. This lack is in part due to the lengthy approval process with Manitoba Health and in part because of the paucity of funded physician time. In the absence of assess, treat and refer or treat and release protocols and with no access to real time online medical consultation, the EMS team has had very little flexibility to modify their care according to patient needs.

The clinical care that is available for each ambulance varies as a result of variability of staff credentials and transfers of function. There may be opportunities to look at ensuring that a standard level of care is provided to all patients that require EMS services.

Priority Process: Decision Support

The team, in response to direction from Manitoba Health was able to provide overdue education to all EMS practitioners in the organization over a three month time frame. The requirement to focus on training has resulted in a proposal for ongoing funding to ensure ongoing compliance with governmental standards.

The EMS has the opportunity to work with other health colleagues in the organization to develop new EMS protocols or guidelines.

Priority Process: Impact on Outcomes

Traditional EMS measurement has been focused on computer aided dispatch data and is related to the movement and response intervals of EMS staff. The team's new continuous quality improvement and continuous quality assurance processes coupled with the learning approach demonstrated by the new leadership team, positions this group to engage in future conversations about their care delivery and outcomes.

The EMS team is well-integrated with the organization in the area of event analysis and occurrence reporting. The organization has the opportunity to use the occurrence reporting information to help identify issues or opportunities with care processes that cross between the facilities/community and EMS.

As EMS continues to utilize data to evaluate their performance and seeks to look at processes of care that include non-EMS resources such as stroke and/or STEMI protocols, EMS will have the ability to start collecting and utilizing patient outcome data to help refine their care processes.

Priority Process: Infection Prevention and Control

Education and training around infection prevention and control (IPAC) including routine and terminal cleaning on ambulances are well established across the EMS.

3.3.5 Standards Set: Home Care Services

Unmet Criteria			High Priority Criteria
Priority Process: Clinical Leadership			
The organization has met all criteria for this priority process.			
Priority Process: Competency			
4.10	The organization regularly evaluates and documents each staff member's performance in an objective, interactive, and positive way.		
Priority Process: Episode of Care			
11.2	The team reconciles the client's medications at interfaces of care where the client is at risk for medication discrepancies (circle of care, discharge) with the involvement of the client and family or caregiver when medication management is a component of care, or as deemed appropriate through clinician assessment.		ROP
	11.2.1	There is a demonstrated, formal process to reconcile client medications at interfaces of care where the client is at risk of medication discrepancies (circle of care, discharge).	**MAJOR**
	11.2.3	The team provides the client with a copy of the up-to-date medication list, clear information about the changes, and educates the client to share the list when encountering providers in the client's circle of care.	**MINOR**
	11.2.4	Upon notification that a client has been transferred or discharged, the community care organization communicates the most recent medication list to the next provider of care.	**MAJOR**
	11.2.5	The process is a shared responsibility involving the client or family, and one or more health care practitioner(s), such as nursing staff, medical staff, and pharmacy staff, as appropriate.	**MINOR**
Priority Process: Decision Support			
The organization has met all criteria for this priority process.			
Priority Process: Impact on Outcomes			
3.7	The organization follows a formal process to regularly evaluate the functioning of the team annually, identify priorities for action, and make improvements.		

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

The home care (HC) team offers a full range of services at each of the five sites. Services include: direct service assistance with personal care; congregate meal programs; nursing services; therapy services; adult day program and supply and equipment services. The HC program also has the capacity to coordinate programs including palliative care, respite care, home oxygen, self or family managed care, services to seniors and supportive housing.

In an effort to support effective service planning, the HC team depends primarily on information gleaned from the provincially mandated Community Halth Assessment. This is conducted every five years. Other resources include census data and population reports. The team is planning extensively and looking forward to an enhanced provision of services with the addition of the Aboriginal Health Centre in Pine Falls.

The team is commended for its collaborative relationships which support client care planning. Of particular note is the support provided by the on-site personal care home (PCH). These teams work together to provide bathing services for community clients when the bath suites are not required for PCH residents. This is a great example of innovative client centred care. Kudos!

The HC team has developed a more program-specific team action plan to support the organization's strategic plan. The development of this plan includes representation from all levels of the HC portfolio.

The team offers a full array of written brochures which define their services for current and potential clients.

Staff comment that leaders are responsive and attentive to any expressed concerns.

Priority Process: Competency

Staff members indicate that they receive opportunities and support to develop their skills. All staff receive a two-day regional orientation followed by a program-specific orientation of a duration that varies according to past skills and experience. Mentors are sometimes used to support orientation processes. Staff also describe receiving training in non-violent crisis intervention.

The team leaders, staff and clients have been particularly challenged in recent months due to union negotiations. This has required the conversion of casual HC staff positions to full-time equivalencies. This has contributed to the incapacity of teams to provide the level of client-centred care to which they were accustomed. Leaders comment that this conversion process in and of itself has been rather resource intensive causing some degree of incapacity to advance other program goals and initiatives.

The team's leadership is commended for its will and intent to develop a business case advocating for the client, and the continued capacity of the team to ensure that client-centred service is indeed maintained.

Priority Process: Episode of Care

The team has a well-established process to ensure that clients are aware of the complaints or quality care management concerns process. This is well-communicated in the admission package. Also included is an explanation of privacy (PHIA) legislation and the client bill of rights, responsibilities of clients and/or family guardians. Clients acknowledge awareness of these processes. Clients also comment that they are aware of the person coordinating their care, and express great satisfaction with the services and true care provided by their care givers. After hours care related issues are managed via the telephone service 1-800 Health Links, which is a provincial systems support.

The team currently uses verbal mechanisms only to transfer client information at transition points. To date, the team leadership cites no adverse events as a result and that these informal processes work well. The team may want to consider establishing more formal, written communication for transfer of information processes.

The team conducts client satisfaction surveys for both the home care and palliative care client groups on an annual basis and demonstrated commitment to an appropriate action plan.

Numerous and various tools are used to communicate various awareness needs to clients and/or team members. These include newsletters namely: Regional Home Care Newsletter, the Client Safety Information sheet, Advance Care Planning Guide, and Guide for Care Givers. Of particular note is the Palliative Care Information folder. It is comprehensive in content regarding pain management, drug access program, advance care planning and other matters. There is also the booklet entitled: "Safety It Matters" for staff.

A review of the hand-hygiene audits shows a decrease in compliance.

Priority Process: Decision Support

All decision support criteria have been successfully met.

Priority Process: Impact on Outcomes

Performance measures via the corporate scorecard include measures such as: number of cases due for and not reassessed; number of clients waiting for supportive housing per site; cumulative number of staff trained in non-violent crisis intervention; number of times there is an error in discharge information and other measure.

The team also tracks various medication related occurrences such as: number of omissions; incorrect; lost/found and refusals. The team is encouraged to consider greater integration of rate-based measures, and to keep the number of measures monitored at a number with which the team can actually use these measures to improve quality and/or safety outcomes.

3.3.6 Standards Set: Infection Prevention and Control

Unmet Criteria		High Priority Criteria
Priority Process: Infection Prevention and Control		
8.2	The organization stores and handles linen, supplies, devices, and equipment in a manner than protects them from contamination.	!
12.1	The organization verifies the qualifications and competencies of staff involved in reprocessing reusable medical devices.	
13.2	The organization reviews and verifies the education, qualification, and competency of staff involved in reprocessing of endoscopy devices.	!
Surveyor comments on the priority process(es)		
Priority Process: Infection Prevention and Control		

Infection prevention and control (IPAC) is supported with the commitment of a regional steering and at a program level; each of the three clinical educators have accountabilities as IPAC leads. Locally, each of the sites is supported by an infection control nurse who receives additional education and training to support the IPAC program, as a special assignment in addition to their regular nursing duties. From a leadership perspective, the director in each of the three programs is accountable for IPAC activities in their respective programs.

The IPAC leads are members of the provincial network. By way of this forum, and via access to other expertise such as the provincial infectious diseases advisory committee (PIDAC), the Community Hospital Infection Control Association (CHICA), and the Winnipeg Regional Health Authority, the organization is able to access evidence-based practices to support program-specific IPAC interventions across the region.

The team maximizes opportunities to engage the general public in IPAC awareness via efforts such as: government funded vaccination programs; a health forum held during the organization's annual general meeting; home care newsletters; local newspaper advertisements, as well as via the organization's website.

The team is commended for its comprehensive education program. Education on IPAC is reinforced in many and varied forums across the organization. Education includes such activities as: orientation education for employees and volunteers; the respiratory protection program education module and quiz to support fit testing; introduction of and education about routine practices; the booklet entitled: "Risk Assessment Algorithm, Safety First"; IPAC related education sessions for acute care in June and a core competencies booklet. Of particular note is the 'safety month annual review', which is held every November. This annual mandatory review requires that every employee including leadership participate. Though annual mandatory education/reviews are not necessarily a unique practice, this initiative is commendable in that the review requires a self-test. The IPAC committee then reviews the test results and incorporates action plans for any identified gaps into annual program-specific goals.

Hand sanitizers are readily accessible across the organization. Compliance with use of sanitizers was noted consistently in the organization. The team is committed to improving compliance with hand-hygiene audit results, particularly for the poorest performers, which is the physician group. A hand-hygiene presentation

was made at a recent medical advisory committee meeting. Outcomes to date are encouraging. Kudos is given to the medical device reprocessing department for attaining 100 percent hand-hygiene compliance. Inconsistencies were noted with regard to visitor awareness and compliance with hand hygiene and observation. All food preparation areas demonstrated compliance with various aspects of IPAC. All food service workers are certified in food handling and are re-certified as required.

The team has a comprehensive post exposure prophylaxis protocol, treatment package and response algorithm. This was developed as a resource to staff that have had an exposure. Kudos!

The physical plant team did have an opportunity recently to exercise its IPAC related processes during the recent installation of a new steam sterilizer. Lessons learned were gained from the extensive renovations and experiences at Pinawa. The team describes it as a great collaboration, resulting in effective planning and outcome. Kudos!

By way of regular preventive maintenance (PM) of the heating and ventilating (HVAC) system, the humidex temperature was noted to be higher than normal. The system is currently being re-commissioned by an external vendor. This is a great example of action resulting from effective PM processes.

The housekeeping team is commended for its recent transition to a microfiber cleaning system. During recent education sessions, housekeeping staff identified that they had difficulty discerning isolation signage. The team has revised these posters to help bring needed clarity and understanding. This is a great example of leadership responsiveness.

The materials services team is commended for their diligence in IPAC interventions. Every item coming into the organization via this department is wiped with VIROX before it goes into the supply rooms. The supply area has a dedicated secure space for any sterile items.

The organization learned much from the influenza pandemic. The team has recently revised its pandemic plan. It will be tabled for approval at the next IPAC committee meeting.

The identification of the endoscope and re-processor are placed on the patient's chart only. No record is maintained in the medical device reprocessing department for re-call purposes. For efficiency of tracking, the organization is encouraged to maintain a central registry. This could be easily accomplished by duplicating the current form.

Inconsistencies were noted in the practices regarding decanting of disinfectants. On several occasions, disinfectants were observed not to be labelled with either the name of the product or the concentration.

The organization is encouraged to provide opportunity for the IPAC leads to obtain infection control practitioner certification (CHICA). Additionally, there did not appear to be a clear understanding of who in the organization had ultimate accountability for IPAC. If not clearly articulated, attention and action is warranted.

3.3.7 Standards Set: Long-Term Care Services

Unmet Criteria			High Priority Criteria
Priority Process: Clinical Leadership			
The organization has met all criteria for this priority process.			
Priority Process: Competency			
3.7	The team follows a formal process to regularly evaluate its functioning, identify priorities for action, and make improvements.		
4.7	The organization trains the team on how to prevent workplace violence.		
Priority Process: Episode of Care			
8.4	The team assesses each resident's risk for developing a pressure ulcer and implements interventions to prevent pressure ulcer development.		ROP
	8.4.5	The team has a system in place to measure the effectiveness of pressure ulcer prevention strategies, and uses results to make improvements.	**MINOR**
12.3	The team reconciles the resident's medications with the involvement of the resident, family, or caregiver at transition points where medication orders are changed or rewritten (i.e., internal transfer, and/or discharge).		ROP
	12.3.1	There is a demonstrated, formal process to reconcile resident medications at transition points where medication orders are changed or rewritten (i.e. internal transfer, and/or discharge).	**MAJOR**
	12.3.2	The team makes a timely comparison of the up-to-date, complete medication list, and new medication orders or recent changes.	**MAJOR**
	12.3.3	The team documents that the up-to-date, complete medication list and new medication orders or recent changes have been reconciled; and appropriate modifications to medications have been made where necessary.	**MAJOR**
	12.3.5	The process is a shared responsibility involving the resident or family, and one or more health care practitioner(s), such as nursing staff, medical staff, and pharmacy staff, as appropriate.	**MINOR**
Priority Process: Decision Support			
The organization has met all criteria for this priority process.			
Priority Process: Impact on Outcomes			

8.8	The team uses at least two resident identifiers before providing any service or procedure.	ROP
8.8.1	The team uses at least two resident identifiers before providing any service or procedure.	**MAJOR**
16.4	The organization shares benchmark and best practice information with its partners and other organizations.	

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

Long term care (LTC) services are provided at five sites in the organization. Sites visited included Lac du Bonnet Personnal Care Home (PCH), Sunnywood Manor, a PCH part of the Pine Falls Health Complex, and East Gate Lodge. Wait lists are extensive. The team and community are much looking forward to a new home that has been approved for Lac du Bonnet, with a 50-person capacity increase. The new home is scheduled to open in 2016.

Great inter-program collaboration was observed. This was particularly noted at those sites offering full integrated services such as for Pine Falls. Select clients from the community health program are able to access the bathing suites at Sunnywood Manor when not being used by residents at that site. Additionally, some residents requiring more extensive physiotherapy support are able to access this service in the adjacent acute care site. Though not necessarily new practices, these examples of client/resident-centred collaboration is commendable.

Staff report that if/when new equipment needs to support care are identified, leaders certainly endeavour to address those needs as much as they are able, recognizing obvious fiscal restraints.

The sites that were visited have varying degrees of volunteer support, but state that where volunteers are not readily available, family members are encouraged to and do quite willingly participate in recreation and social activities to support the residents, and Sunnywood Manor is one example. Local school students are also integrated into the volunteer effort and offered academic credit in lieu. With staff support, student volunteers recently developed a regional family newsletter. Kudos!

The LTC program has a great connection with the local media. The media highlights various events and happenings in the local paper on a regular basis and serves as a great communication medium to increase public awareness of programs and services.

Professional and non-professional student opportunities are made available; this is a great recruitment strategy.

Priority Process: Competency

Consistently, work spaces are well defined, tidy and very well-organized.

Staff members interviewed at all three sites report receiving regular performance reports.

The team plans to introduce an enhanced module-based orientation program for registered nurses. These modules reflect comprehensive content that is specific to LTC.

Consistently, staff members report that their orientation processes were comprehensive and consisted of content to support their roles. They also report being provided with support to attend pertinent education sessions.

Priority Process: Episode of Care

The LTC team is commended for the pre-admission meeting process. This session, lead by the management team is currently offered once yearly to family members and their relatives that have been panelled for admission to any of the PCHs in the organization. Having had the opportunity to attend this session, it was very well-attended, with approximately 70-80 persons in attendance. Family members commented that this session was well worth the time and most beneficial in helping them to understand the various aspects of and considerations when moving into long term care. Additionally, family information nights are held twice yearly as a forum to keep families aware of system changes and other things. Kudos!

Various aspects of the admission assessment process have completion timelines identified. Admission checklists with timelines noted are maintained in every health record to monitor compliance with ensuring all assessment processes are complete. The resident care plan is formally reviewed and updated every three months and more often as required.

It is noteworthy to acknowledge that since the organization's previous survey, this team was the first in the province to be 100 percent successful in meeting the 26 standards required of Manitoba Health. This team is currently providing support to a local federally funded PCH in this same process. This standards review is conducted every two years and is due early this fall 2012.

Advance care planning processes are well-established at all sites. The team recently identified a gap in this process when families were on social passes, needing to ensure Emergency Medical Services had a written verification of the plan. The team quickly developed an effective resolution.

Complaints and compliments forms are made readily available at all sites. Family members interviewed are aware of this communication tool and state they would have no hesitation to complete one if necessary, but that on most occasions they are able to address any concerns at the immediate time.

Residents' personal spaces are well-appointed. Residents are encouraged to personalize their rooms to make their space as home like as is possible and the only exception being if items compromise resident or employee safety. The maintenance team is exceptionally responsive to address any identified resident room repairs before new residents are admitted. This includes re-painting the rooms if required. Again, kudos!

Secure, beautifully groomed outdoor garden spaces are readily available for residents and their families. The inclusion of resident supported herb gardens is a lovely touch. It was great to see the children's play equipment at the East Gate Lodge, which is innovative and home-like. This site is also able to avail of inter-generational programming with local school children's visits.

Residents and family members interviewed appreciate the efforts of all team members including food services, housekeeping, maintenance and recreation. Residents are able to influence meal offerings and activity options. Staff are quite receptive to these suggestions and are more than willing to go above and beyond to enhance these quality-of-life issues. There is a real sense of community in all sites. Great team work was observed.

Priority Process: Decision Support

All health records are well-maintained and in a consistent order and format across all sites. All tools are standardized. At this time, all aspects of the health record are paper-based.

Leaders avail of provincial networks, the regional projects leader, Manitoba Health and other reputable sources to ensure best practices in the care areas.

Priority Process: Impact on Outcomes

Satisfaction surveys are distributed eight weeks after admission, and annually thereafter. The team uses results to make improvements. Additionally, feedback and contributions to service delivery are available from the monthly residents' council meetings coordinated by the recreation department.

There are various pamphlets/tools available to help to ensure residents and families are educated on their role in promoting safety. These include pamphlets entitled: "It's Safe to Ask", "Falls Information", "Your Safety Our Priority" as well as resident/family information sheets, patient safety week focus groups on resident safety, and information sharing during family information nights. There are inconsistencies however, in the degree of awareness which residents/family members report. While some report being very informed, some of those interviewed report never having received any such information. This feedback was not site-dependant. The team may want to consider an evaluation process to determine whether current processes/tools are indeed effective.

3.3.8 Standards Set: Medicine Services

Unmet Criteria			High Priority Criteria
Priority Process: Clinical Leadership			
The organization has met all criteria for this priority process.			
Priority Process: Competency			
3.7	The interdisciplinary team follows a formal process to regularly evaluate its functioning, identify priorities for action, and make improvements.		
Priority Process: Episode of Care			
11.3	The team reconciles the client's medications with the involvement of the client, family or caregiver at transition points where medication orders are changed or rewritten (i.e. internal transfer, and/or discharge).		ROP
	11.3.1	There is a demonstrated, formal process to reconcile client medications at transition points where medication orders are changed or rewritten (i.e. internal transfer, and/or discharge).	**MAJOR**
11.6	Following transition or end of service, the team contacts clients, families, or referral organizations to evaluate the effectiveness of the transition, and uses this information to improve its transition and end of service planning.		
Priority Process: Decision Support			
14.1	The organization has a process to select evidence-based guidelines for medicine services.		!
14.3	The team's guideline review process includes seeking input from staff and service providers about the applicability of the guidelines and their ease of use.		
Priority Process: Impact on Outcomes			
9.8	The team uses at least two client identifiers before providing any service or procedure.		ROP
	9.8.1	The team uses at least two client identifiers before providing any service or procedure.	**MAJOR**
14.5	The team shares benchmark and best practice information with its partners and other organizations.		
16.3	The team compares its results with other similar interventions, programs, or organizations.		

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

The medicine service is part of the Acute Care Division. Emergency services and surgery are similar, and all services except for surgery are delivered at the three hospital sites by the same staff who circulate between the various services. All staff members work under the same policies and procedures.

The Community Health Assessment is considered the main source of information, which the organization uses to collect information about the community it serves, and to determine what programs are required within their respective facilities. The individual programs will also collect information from their individual clients, from program statistics and community partners.

On an annual basis, the acute care quality team whose members include patient care managers and directors, will review their action plan identifying what progress has been made to their priorities and strategic objectives since the previous review and will identify and document new priorities for the coming year.

Priority Process: Competency

Rounds are held in the various sites on a regular basis. Rounds occur two times per week. Attendees include the Nurse Managers, Clinical Resource Nurse, home care staff and others. All patients are reviewed and issues around discharge discussed. Separate rounds are held weekly to discuss ongoing patient care needs. Physicians attend these rounds infrequently. Physicians usually make rounds daily.

Staffing is a challenge for the region both for nursing and physician positions. At this time, staffing in the various facilities is considered adequate. However, there are occasions when due to unforeseen circumstances such as ambulance runs, staff illness, services are interrupted due to staff unavailability.

Training on infusion pumps with competency testing is included in the initial orientation program. There is an expectation that all staff who use pumps that is, all nurses, will annually complete a further training program with a partner. This recertification includes a competency examination. Documentation of their participation in recertification is automatically saved.

Staff are encouraged to attend regional education programs. Educational events out of the region are not supported to a large degree but will be considered if staff are doing committee work and meetings are appropriate, for example for infection control. All staff members receive a stipend from their union to participate in continuing education. The Aboriginal Liaison Interpreter is not able to be supported by the organization with time or funding to avail of ongoing education, however she takes annual leave and pays her own way. This is commendable! All nursing staff that work on the units have certification in ACLS, PALS and TNCC. Monitoring is done by staff development.

Performance appraisals are expected every two years. These are done, however compliance is varied.

Following recent occurrences which have created significant stress to employees, the involved staff were counselled by senior staff and being offered stress debriefing. The need to access this debriefing is determined by the involved staff member and in these situations neither accepted the offer. The surveyor team was advised that in those situations supervisory staff stay in contact with the staff member to assure they are okay.

Priority Process: Episode of Care

Acute care beds in all facilities have a significant number of medically discharged but panelled patients. In some facilities the number exceeds 30 percent. Overall, occupancy remains at around 85 percent however, in some situations where occupancy is high, acute care patients are required to stay in the observation unit on stretchers. It is reported this situation may continue over three days and at times, patients are actually discharged from the observation unit. Occurrences such as these are not conducive to optimum care.

There are plans to build an 80-bed LTC unit in Pine Falls which will add 50 extra beds to the region and this will relieve the pressure on acute care beds. This will not happen for some time and it is expected the pressure on the acute beds will continue.

Discharge planning is ongoing however, there is little evidence of any utilization review with the units visited by the surveyor team. Encouragement is offered to improve utilization and to work to avoid extended time between the decision to admit and a patient moving into an acute care bed. This will require that utilization review commence.

Patients who need admission to the hospital can be accommodated if necessary in one of the other facilities within the region, if the facility closer to home is full. This does occur, particularly when patients are being transferred back from out of the region hospitals.

The venous thrombo embolism (VTE) protocol has recently been implemented. This is used most often for patients that have been transferred back from Winnipeg after having orthopaedic surgery and now that it is available, all patients will be assessed for risk.

Medication reconciliation is being done on admission. Medication reconciliation forms were found on all charts. The process however involves the nursing staff and pharmacy staff, with little if any input or participation of the medical staff. The acute care team leaders have been making attempts to engage with the medical staff but have yet to succeed.

Frequent attempts are made to involve patients and families in their care. Meetings with families are facilitated.

Formal consent is obtained for conscious sedation and any invasive procedures.

Ethics consultations are available when required. There is a formal board ethics committee as well with appropriate membership. This group meets quarterly.

Pharmacy services is provided by a contract with an outside pharmacy. The in-hospital medication is provided by the services of a pharmacy technician who is an employee of the hospital.

On occasion, patients may be on medications which are not available in the organization. On these occasions, the patient may bring in their own medications. Self-administration of any medication is monitored/observed.

Rounds that occur weekly are attended by Home Care so any required follow-up by them is anticipated. Appointments are also made for the primary care clinic where necessary.

On transfer, the appropriate documents such as the Transfer Referral Form are prepared, which contain appropriate patient information including medication reconciliation.

Priority Process: Decision Support

A number of medical charts were reviewed, and several of these charts did not have history and physicals completed and verbal orders which were many, were not in any case co-signed by the ordering or attending physician. Signatures were illegible and appeared to not be completed in English. Physician signatures are not included in the list of signatures on the front of the chart. It might be beneficial if individuals were requested to print their name legibly on the file or use a name stamp.

Every chart has a plasticized document that indicates a number of abbreviations that are not to be used. Chart review demonstrates that these abbreviations are being used widely.

On one occasion, it was noted that even though the attending physician had gone on holiday there was no formal transfer order or acceptance of care. It is standard physician practice that when absent from the community for an extended period, usually 48 hours, formal transfer and acceptance of care occurs.

Mortality and morbidity rounds are not being done.

Guidelines have been implemented for the care of patients with certain diagnoses such as chest pain, Myocardial infarction (MI), STEMI and non-STEMI recent VTE guidelines. Policy on methicillin resistant staphylococcus aureus (MRSA) is in place.

While it is recognised that chart audits have been done, it appears this was an audit of nursing notes and there are no comments related to physician entries. The organization is encouraged to develop clear expectations for the timeliness and completion of the medical record.

Priority Process: Impact on Outcomes

Resources required is considered when creating the action plan

All patients who are admitted are now briefed by staff regarding their role in safety. A document, which is signed by the patient, is put on the patients file.

A number of high-risk activities have been identified relative to intravenous (IV) insulin and heparin and for these activities a verification process has been implemented.

Adverse events and complaints are reported and collated however, the process of resolution and the development of a plan to mitigate further risk is less clear. The organization is encouraged to develop a clear process that will see adverse events reviewed with a clear plan to assure future risk is mitigated.

Indicators are in place to review outputs and outcomes, however, they are mostly statistical in nature; for example, LOS; triage levels; audits; occurrences and restraint audits. The team is encouraged to look at the development of indicators which are more clinically based.

3.3.9 Standards Set: Primary Care Services

Unmet Criteria	High Priority Criteria
Priority Process: Clinical Leadership - Primary Care	
3.2 The clinic's funding or payment models create incentives to deliver the best possible primary care services.	
Priority Process: Competency - Primary Care	
The organization has met all criteria for this priority process.	
Priority Process: Episode of Care - Primary Care	
6.4 The clinic's out-of-office and after-hours care process includes how to respond to requests for medication refills and medication information after hours and in emergencies.	
Priority Process: Decision Support - Primary Care	
13.2 The team follows a process to monitor the consistent use of guidelines in the delivery of primary care services.	
Priority Process: Impact on Outcomes - Primary Care	
The organization has met all criteria for this priority process.	

Surveyor comments on the priority process(es)

Priority Process: Decision Support - Primary Care

Electronic records are now kept on all patients. Previous written hard copy records are being entered into the EMR. The EMR is accessible by any authorized health care provider across the region.

Evidence-based guidelines are being used in the clinic. Certain members of the group have access to: "Up to Date", which is used to search and develop appropriate guidelines. Guidelines are not being used by all members of the clinic. Management is encouraged to promote the development of guidelines and protocols for all of the primary care clinics in the region and to encourage all professionals to follow them.

Priority Process: Impact on Outcomes - Primary Care

Clinic staff meet to discuss the functioning of the clinic, with meetings of the senior team occurring quarterly. It is within these meetings that quality of service is discussed. Action plans are reviewed and changed as appropriate, annually.

The primary care clinics follow the regional policy on reporting adverse events and disclosure.

Sentinel events are reported across the organization as well as for those mandated by Manitoba. The circumstances of some events were specifically discussed with appropriate follow-up including disclosure to the patient.

Clinic results can be compared across the various individual clinics however, there is no comparison at this time with other PCCs in other regions. It is reported that with the implementation of 'advance access' that has funding associated with it, there is an expectation that all results will be reviewed centrally. This should then facilitate comparison.

Priority Process: Clinical Leadership - Primary Care

The network of Primary Care Clinics (PCCs) within NEHA are recipients of the information gleaned by the mandatory Community Health Assessment, which is conducted on a regular basis. This analysis is mandated by the Government of Manitoba. The PCCs however collect further information from their connections in the community, as well as information that they obtain from reviewing their own client load. They have also used information from a recent survey of the health needs of local youth. They use this information to enhance their services in specific areas. Most recently, they have been working on improving access for their clients. Their aim is to provide same-day access for the services they provide. Within certain clinics, they have successfully met this goal and overall have reduced the wait time substantially. The team is applauded for the work it has done and is encouraged to continue to promote this initiative.

The PCCs have prepared informational pamphlets for the individual clinics. There is also a newsletter and posters which are put in various areas. Members of the team will attend various events and have poster presentations demonstrating their services as well as to promote healthily lifestyle. They work with multiple partners.

Staffing is multidisciplinary and includes: nurse practitioners that provide direct patient care; primary care nurses that provide assistance in the treatment and care of chronic disease; wellness coordinators and physicians that provide direct care to their patients. The PCCs have implemented an electronic medical record (EMR), which is accessible by staff across all of the PCCs in the region.

The clinics that were seen during the on-site survey process had adequate space for appropriate care. There is a new clinic proposed and in development for Pine Falls, which will add even more capacity.

The current EMR is a major advance in assuring continuity of care and information exchange. The addition of a diagnostic services interface, allowing integration with any proposed hospital information system will enhance the advantages of this EMR.

An enhanced partnership with the physicians and sharing of patients may provide more appropriate care.

Priority Process: Competency - Primary Care

The primary care team members meet to develop their action plan, which lists the strategic priorities and operational strategies. These are reviewed at least annually, highlighting their success and challenges.

Education is offered to staff on conflict resolution as well as professional activities.

Job descriptions exist for all staff. There is some duplication of competencies between various professionals which offers some redundancy however, work is not duplicated.

Licences and credentials are reviewed annually.

Priority Process: Episode of Care - Primary Care

Same day access is not yet available in all clinics however, in urgent situations, same day access is available. Screening is done by the clerk at registration.

Feedback from clients has suggested access will improve with additional hours of services and as a result, certain clinics are offering after hour clinics to meet the need of clients and families.

Telehealth is a provincial program and is being used in a limited way in the region. The potential for expanding the service is being reviewed.

Screening is done in the clinic for risk factors such as breast check; cervix check; glucose; A1C and others.

Consent for consultation is implied however, for an invasive examination informed consent is obtained.

Reminders known as 'ticklers' regarding the need for client follow-up is done via the EMR system.

Diagnostic results are forwarded to the originating clinic. There is an ad hoc process in place to ensure that the attending health care provider is informed as soon as possible about critical results. Diagnostic results do not automatically appear on the clinic EMR. An effective interface, which would see critical and routine results reported automatically on the EMR would decrease risk and improve care.

3.3.10 Priority Process: Surgical Procedures

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

Unmet Criteria		High Priority Criteria
Standards Set: Operating Rooms		
1.3	The team uses evidence-based client care maps or pathways to guide them through steps in the procedure, promote efficient care and achieve optimal client outcomes.	
3.4	The surgical suite has three levels of increasingly restricted access: accessible areas, semi-restricted areas, and restricted areas.	!
3.5	The operating room has a protected area for sterile storage of medical equipment, devices and supplies.	!

Surveyor comments on the priority process(es)

The surgical service at NEHA specifically at the hospital in Beausejour, is limited to the use of the operating room (OR) and post-operative recovery room (PORR) area as an endoscopy area. There are no other surgical procedures done in the hospital other than the occasional 'lump' in the ER department. There is no in-patient surgical services or anaesthesia, other than local anaesthesia for skin lesions and conscious sedation for endoscope and occasionally for reduction of dislocations.

The surgical services criteria therefore have almost all been identified as not-applicable (N/A), and many of the criteria listed for a full service operating room are also accordingly considered not applicable. Many of the criteria that relate to the team and general hospital administration are similar to the other services in the organization, particularly to acute care.

In response to an ever increasing waiting list, NEHA implemented an endoscopy program approximately three years ago. One of the general practitioners completed the prescribed training program and was granted endoscopy privileges by the appropriate credentials committee. The hospital in Beausjour which has previously had an OR and PORR area was selected to house the service. Nurses were sent to Sterling for training in endoscopy. Endoscopes and other required equipment was purchased. This program has proven successful in decreasing the wait list for diagnostic endoscopy. Time allocation has increased from one day per week to two in 2011 and is now increasing to three days per week. It is hoped that with the increased time the service will be able to do some of the 180 patients, which are on the elective/non-urgent list.

All patients are reviewed pre-operatively by the physician usually in the office and then scheduled for the procedure. All patients follow the same process and receive the appropriate information about the procedure pre-operatively. They are all called to confirm that it is their continued intention to have the procedure performed.

The operating room suite with co-located PORR make a excellent and purpose built environment for this service. The suite has two levels of increasingly restricted access as there is no need for a sterile area for this service.

An appropriate surgical checklist and pause is used for all cases.

Appropriate guidelines are in place for conscious sedation.

Section 4 Instrument Results

As part of Qmentum, client organizations administer instruments. Instruments (or tools) are surveys related to areas such as patient safety culture, and quality of worklife. They are completed by a representative sample of clients, staff, senior leaders, board members, and other stakeholders.

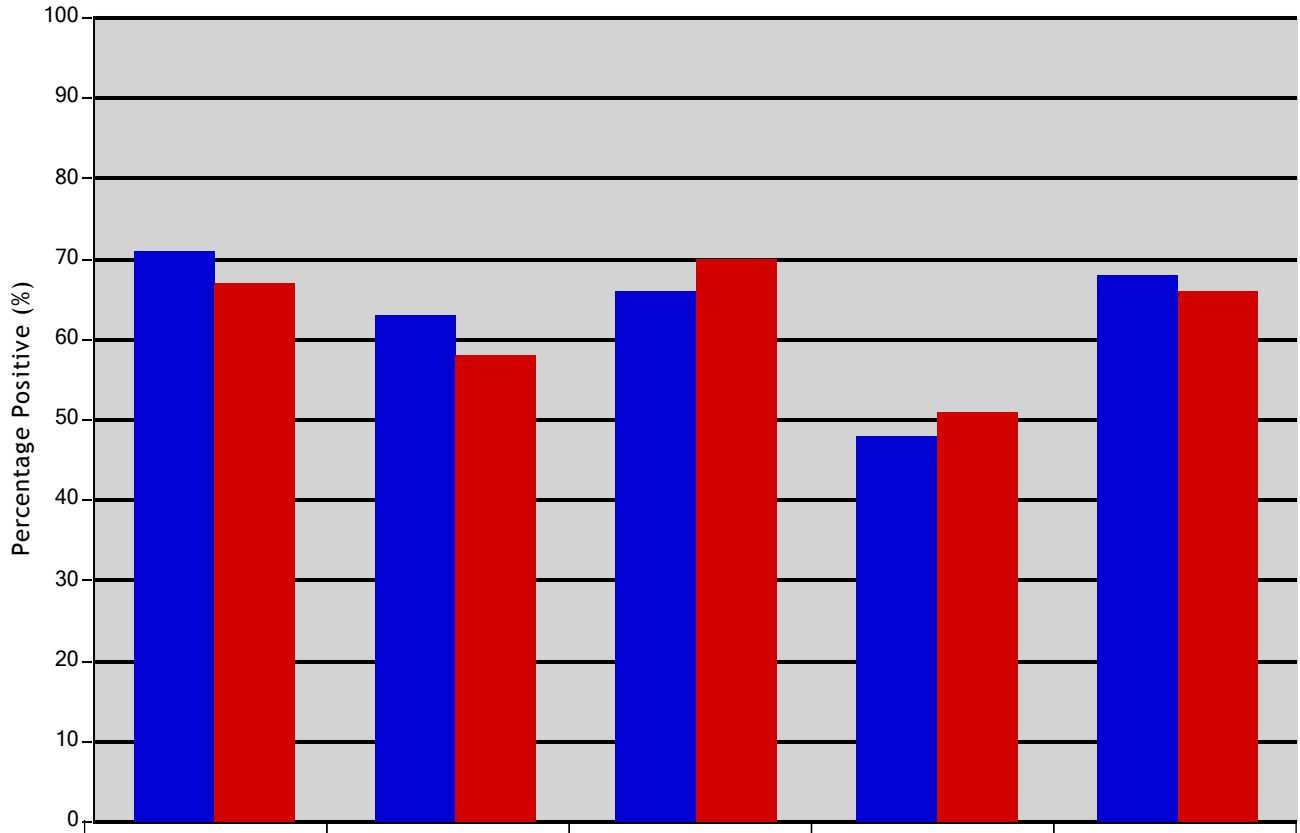
4.1 Patient Safety Culture Tool

The Patient Safety Culture Tool provides insight into staff perceptions of patient safety, allowing 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 Quality Performance Roadmap on 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: February 6, 2012 to June 7, 2012**
- **Minimum response rate (based on the number of employees): 285**
- **Number of respondents: 297**

Patient Safety Culture: Results by Patient Safety Culture Dimension



	Senior leadership support for safety (valuing safety)	Supervisory leadership support for safety	Patient safety learning culture	Communication barriers/talking about errors	Overall perception of patient safety
	71%	63%	66%	48%	68%
	67%	58%	70%	51%	66%

Legend

North Eastman Health Association Inc.

* Canadian Average

*Canadian average: Percentage of Accreditation Canada client organizations that completed the instrument from July to December, 2011 and agreed with the instrument items.

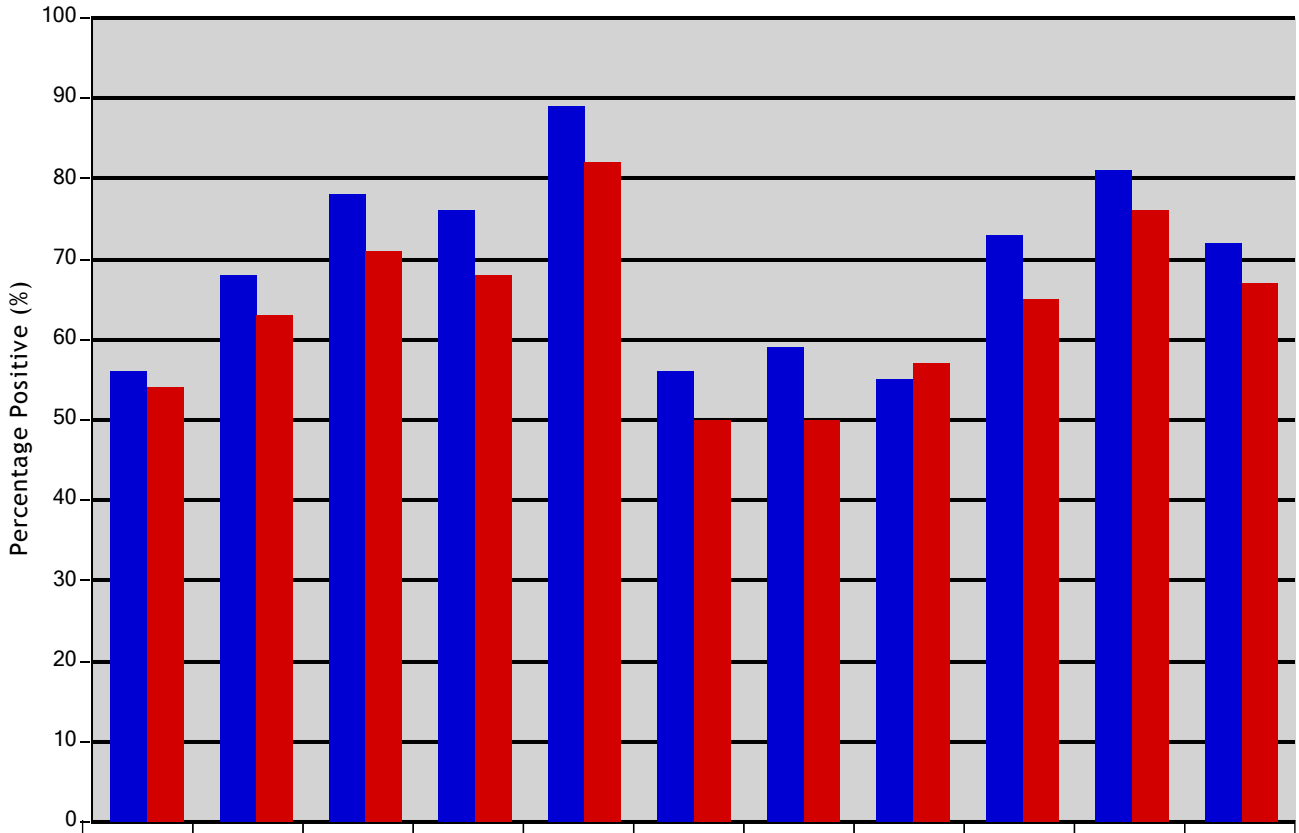
4.2 Worklife Pulse Tool

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

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

- **Data collection period: February 6, 2012 to June 7, 2012**
- **Minimum response rate (based on the number of employees): 271**
- **Number of respondents: 310**

Worklife Pulse Tool: Results of Work Environment



	Organizational communication	Work area communication	Supervision	Job control	Role clarity	Decision making involvement	Job demand	Trust	Learning environment	Safe environment	Worklife balance
	56%	68%	78%	76%	89%	56%	59%	55%	73%	81%	72%
	54%	63%	71%	68%	82%	50%	50%	57%	65%	76%	67%

Legend

North Eastman Health Association Inc.

* Canadian Average

*Canadian average: Percentage of Accreditation Canada client organizations that completed the instrument from July to December, 2011 and agreed with the instrument items.

Appendix A Qmentum

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

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

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

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

Action Planning

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

Evidence Review and Ongoing Improvement

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

Appendix B Priority Processes

Priority processes associated with system-wide standards

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

Priority processes associated with population-specific standards

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

Priority processes associated with service excellence standards

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

Priority Process	Description
Surgical Procedures	Delivering safe surgical care, including preoperative preparation, operating room procedures, postoperative recovery, and discharge