ACCREDITATION
AGRÉMENT
CANADA
Qmentum

Accreditation Report

Interlake-Eastern Regional Health Authority

Selkirk, MB

On-site survey dates: June 18, 2023 - June 23, 2023

Report issued: August 23, 2023

About the Accreditation Report

Interlake-Eastern Regional Health Authority (referred to in this report as “the organization”) is participating in Accreditation Canada's Qmentum accreditation program. As part of this ongoing process of quality improvement, an on-site survey was conducted in June 2023. Information from the on-site survey as well as other data obtained from the organization were used to produce this Accreditation Report.

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

Confidentiality

This report is confidential and will be treated in confidence by Accreditation Canada in accordance with the terms and conditions as agreed between your organization and Accreditation Canada for the Assessment Program.

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

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

A Message from Accreditation Canada

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

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

Your Program Manager or Client Services Coordinator is available if you have questions or need guidance.

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

We look forward to our continued partnership.

Sincerely,

Leslee Thompson
Chief Executive Officer

Table of Contents

Executive Summary

Interlake-Eastern Regional Health Authority (referred to in this report as “the organization”) is participating in Accreditation Canada's Qmentum accreditation program. Accreditation Canada is an independent, not-for-profit organization that sets standards for quality and safety in health care and accredits health organizations in Canada and around the world.

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

This report shows the results to date and is provided to guide the organization as it continues to incorporate the principles of accreditation and quality improvement into its programs, policies, and practices.

The organization is commended on its commitment to using accreditation to improve the quality and safety of the services it offers to its clients and its community.

Accreditation Decision

Interlake-Eastern Regional Health Authority's accreditation decision is:

Accredited

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

About the On-site Survey

- **On-site survey dates: June 18, 2023 to June 23, 2023**

- **Locations**

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

1. Arborg and District Health Centre
2. Arborg Personal Care Home
3. Beausejour EMS
4. Beausejour Health Centre
5. Betel Home Foundation - Gimli
6. Betel Home Foundation - Selkirk
7. Fisher Personal Care Home and Community Health Office
8. Gimli Community Health Centre
9. IERHA AFM locations
10. Interlake-Eastern RHA Corporate Office
11. Kin Place Health Complex
12. Lac du Bonnet EMS
13. Lac du Bonnet Personal Care Home
14. Lakeshore General Hospital and Personal Care Home
15. Lundar Personal Care Home and Community Health Office
16. Pinawa EMS
17. Pinawa Hospital and Primary Health Care Centre
18. Pine Falls EMS
19. Pine Falls Health Complex
20. Rosewood Lodge
21. Selkirk Community Health Office
22. Selkirk EMS
23. Selkirk Quick Care Clinic
24. Selkirk Regional Health Centre

25. Stonewall and District Health Centre
26. Teulon Health Centre
27. Tudor House

- **Standards**

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

System-Wide Standards

1. Governance
2. Infection Prevention and Control Standards
3. Leadership

Population-specific Standards

4. Aboriginal Integrated Primary Care
5. Population Health and Wellness

Service Excellence Standards

6. Aboriginal Community Health and Wellness - Service Excellence Standards
7. Aboriginal Substance Misuse Services - Service Excellence Standards
8. Ambulatory Care Services - Service Excellence Standards
9. Cancer Care - Service Excellence Standards
10. Community-Based Mental Health Services and Supports - Service Excellence Standards
11. Emergency Department - Service Excellence Standards
12. EMS and Interfacility Transport - Service Excellence Standards
13. Home Care Services - Service Excellence Standards
14. Inpatient Services - Service Excellence Standards
15. Long-Term Care Services - Service Excellence Standards
16. Medication Management (For Surveys in 2021) - Service Excellence Standards
17. Obstetrics Services - Service Excellence Standards
18. Perioperative Services and Invasive Procedures - Service Excellence Standards
19. Primary Care Services - Service Excellence Standards
20. Public Health Services - Service Excellence Standards
21. Reprocessing of Reusable Medical Devices - Service Excellence Standards
22. Substance Abuse and Problem Gambling - Service Excellence Standards

- **Instruments**

  The organization administered:

  1. Governance Functioning Tool (2016)
  2. Client Experience Tool

Overview by Quality Dimensions

Accreditation Canada defines quality in health care using eight dimensions that represent key service elements. Each criterion in the standards is associated with a quality dimension. This table shows the number of criteria related to each dimension that were rated as met, unmet, or not applicable.

Quality Dimension	Met	Unmet	N/A	Total
Population Focus (Work with my community to anticipate and meet our needs)	106	17	0	123
Accessibility (Give me timely and equitable services)	155	1	0	156
Safety (Keep me safe)	735	31	15	781
Worklife (Take care of those who take care of me)	196	14	0	210
Client-centred Services (Partner with me and my family in our care)	552	37	0	589
Continuity (Coordinate my care across the continuum)	143	3	1	147
Appropriateness (Do the right thing to achieve the best results)	962	136	11	1109
Efficiency (Make the best use of resources)	80	1	1	82
Total	**2929**	**240**	**28**	**3197**

Overview by Standards

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

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

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

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

Standards Set	High Priority Criteria *			Other Criteria			Total Criteria (High Priority + Other)		
	Met	Unmet	N/A	Met	Unmet	N/A	Met	Unmet	N/A
	# (%)	# (%)	#	# (%)	# (%)	#	# (%)	# (%)	#
Governance	45 (91.8%)	4 (8.2%)	1	33 (91.7%)	3 (8.3%)	0	78 (91.8%)	7 (8.2%)	1
Leadership	48 (96.0%)	2 (4.0%)	0	88 (91.7%)	8 (8.3%)	0	136 (93.2%)	10 (6.8%)	0
Infection Prevention and Control Standards	38 (95.0%)	2 (5.0%)	0	27 (87.1%)	4 (12.9%)	0	65 (91.5%)	6 (8.5%)	0
Aboriginal Integrated Primary Care	60 (95.2%)	3 (4.8%)	0	98 (92.5%)	8 (7.5%)	1	158 (93.5%)	11 (6.5%)	1
Population Health and Wellness	4 (100.0%)	0 (0.0%)	0	34 (97.1%)	1 (2.9%)	0	38 (97.4%)	1 (2.6%)	0
Medication Management (For Surveys in 2021)	87 (90.6%)	9 (9.4%)	4	47 (97.9%)	1 (2.1%)	2	134 (93.1%)	10 (6.9%)	6
Aboriginal Community Health and Wellness	36 (90.0%)	4 (10.0%)	0	58 (92.1%)	5 (7.9%)	0	94 (91.3%)	9 (8.7%)	0
Aboriginal Substance Misuse Services	47 (90.4%)	5 (9.6%)	0	79 (90.8%)	8 (9.2%)	1	126 (90.6%)	13 (9.4%)	1

Standards Set	High Priority Criteria *			Other Criteria			Total Criteria (High Priority + Other)		
	Met	Unmet	N/A	Met	Unmet	N/A	Met	Unmet	N/A
	# (%)	# (%)	#	# (%)	# (%)	#	# (%)	# (%)	#
Ambulatory Care Services	42 (91.3%)	4 (8.7%)	1	71 (91.0%)	7 (9.0%)	0	113 (91.1%)	11 (8.9%)	1
Cancer Care	81 (100.0%)	0 (0.0%)	0	110 (96.5%)	4 (3.5%)	0	191 (97.9%)	4 (2.1%)	0
Community-Based Mental Health Services and Supports	41 (91.1%)	4 (8.9%)	0	89 (95.7%)	4 (4.3%)	1	130 (94.2%)	8 (5.8%)	1
Emergency Department	64 (88.9%)	8 (11.1%)	0	98 (91.6%)	9 (8.4%)	0	162 (90.5%)	17 (9.5%)	0
EMS and Interfacility Transport	97 (85.8%)	16 (14.2%)	1	104 (86.7%)	16 (13.3%)	0	201 (86.3%)	32 (13.7%)	1
Home Care Services	41 (85.4%)	7 (14.6%)	0	71 (94.7%)	4 (5.3%)	0	112 (91.1%)	11 (8.9%)	0
Inpatient Services	54 (90.0%)	6 (10.0%)	0	78 (91.8%)	7 (8.2%)	0	132 (91.0%)	13 (9.0%)	0
Long-Term Care Services	50 (89.3%)	6 (10.7%)	0	97 (99.0%)	1 (1.0%)	1	147 (95.5%)	7 (4.5%)	1
Obstetrics Services	67 (94.4%)	4 (5.6%)	2	84 (95.5%)	4 (4.5%)	0	151 (95.0%)	8 (5.0%)	2
Perioperative Services and Invasive Procedures	100 (89.3%)	12 (10.7%)	3	102 (94.4%)	6 (5.6%)	1	202 (91.8%)	18 (8.2%)	4
Primary Care Services	54 (91.5%)	5 (8.5%)	0	84 (92.3%)	7 (7.7%)	0	138 (92.0%)	12 (8.0%)	0
Public Health Services	44 (93.6%)	3 (6.4%)	0	64 (92.8%)	5 (7.2%)	0	108 (93.1%)	8 (6.9%)	0
Reprocessing of Reusable Medical Devices	80 (95.2%)	4 (4.8%)	4	34 (87.2%)	5 (12.8%)	1	114 (92.7%)	9 (7.3%)	5
Substance Abuse and Problem Gambling	42 (93.3%)	3 (6.7%)	1	78 (96.3%)	3 (3.7%)	1	120 (95.2%)	6 (4.8%)	2
Total	**1222 (91.7%)**	111 (8.3%)	17	1628 (93.1%)	120 (6.9%)	9	2850 (92.5%)	231 (7.5%)	26

* Does not includes ROP (Required Organizational Practices)

Overview by Required Organizational Practices

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

This table shows the ratings of the applicable ROPs.

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Safety Culture			
Accountability for Quality (Governance)	Met	4 of 4	2 of 2
Patient safety incident disclosure (Leadership)	Met	4 of 4	2 of 2
Patient safety incident management (Leadership)	Met	6 of 6	1 of 1
Patient safety quarterly reports (Leadership)	Met	1 of 1	2 of 2
Patient Safety Goal Area: Communication			
Client Identification (Aboriginal Integrated Primary Care)	Met	1 of 1	0 of 0
Client Identification (Ambulatory Care Services)	Met	1 of 1	0 of 0
Client Identification (Cancer Care)	Met	1 of 1	0 of 0
Client Identification (Emergency Department)	Unmet	0 of 1	0 of 0
Client Identification (EMS and Interfacility Transport)	Met	1 of 1	0 of 0

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Communication			
Client Identification (Home Care Services)	Met	1 of 1	0 of 0
Client Identification (Inpatient Services)	Met	1 of 1	0 of 0
Client Identification (Long-Term Care Services)	Met	1 of 1	0 of 0
Client Identification (Obstetrics Services)	Met	1 of 1	0 of 0
Client Identification (Perioperative Services and Invasive Procedures)	Met	1 of 1	0 of 0
Client Identification (Substance Abuse and Problem Gambling)	Met	1 of 1	0 of 0
Information transfer at care transitions (Aboriginal Integrated Primary Care)	Met	4 of 4	1 of 1
Information transfer at care transitions (Aboriginal Substance Misuse Services)	Unmet	2 of 4	0 of 1
Information transfer at care transitions (Ambulatory Care Services)	Met	4 of 4	1 of 1
Information transfer at care transitions (Cancer Care)	Met	4 of 4	1 of 1
Information transfer at care transitions (Community-Based Mental Health Services and Supports)	Met	4 of 4	1 of 1
Information transfer at care transitions (Emergency Department)	Met	4 of 4	1 of 1

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Communication			
Information transfer at care transitions (EMS and Interfacility Transport)	Met	4 of 4	1 of 1
Information transfer at care transitions (Home Care Services)	Met	4 of 4	1 of 1
Information transfer at care transitions (Inpatient Services)	Met	4 of 4	1 of 1
Information transfer at care transitions (Long-Term Care Services)	Unmet	3 of 4	1 of 1
Information transfer at care transitions (Obstetrics Services)	Met	4 of 4	1 of 1
Information transfer at care transitions (Perioperative Services and Invasive Procedures)	Met	4 of 4	1 of 1
Information transfer at care transitions (Substance Abuse and Problem Gambling)	Met	4 of 4	1 of 1
Medication reconciliation as a strategic priority (Leadership)	Met	3 of 3	2 of 2
Medication reconciliation at care transitions (Aboriginal Integrated Primary Care)	Met	5 of 5	0 of 0
Medication reconciliation at care transitions (Aboriginal Substance Misuse Services)	Met	3 of 3	1 of 1
Medication reconciliation at care transitions (Ambulatory Care Services)	Met	5 of 5	0 of 0

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Communication			
Medication reconciliation at care transitions (Cancer Care)	Met	5 of 5	0 of 0
Medication reconciliation at care transitions (Community-Based Mental Health Services and Supports)	Met	3 of 3	1 of 1
Medication reconciliation at care transitions (Emergency Department)	Met	1 of 1	0 of 0
Medication reconciliation at care transitions (Home Care Services)	Met	3 of 3	1 of 1
Medication reconciliation at care transitions (Inpatient Services)	Met	4 of 4	0 of 0
Medication reconciliation at care transitions (Long-Term Care Services)	Unmet	2 of 4	0 of 0
Medication reconciliation at care transitions (Obstetrics Services)	Met	4 of 4	0 of 0
Medication reconciliation at care transitions (Perioperative Services and Invasive Procedures)	Met	4 of 4	0 of 0
Medication reconciliation at care transitions (Substance Abuse and Problem Gambling)	Met	3 of 3	1 of 1

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Communication			
Safe Surgery Checklist (Obstetrics Services)	Met	3 of 3	2 of 2
Safe Surgery Checklist (Perioperative Services and Invasive Procedures)	Met	3 of 3	2 of 2
The "Do Not Use" list of abbreviations (Medication Management (For Surveys in 2021))	Unmet	3 of 4	2 of 3
Patient Safety Goal Area: Medication Use			
Antimicrobial Stewardship (Medication Management (For Surveys in 2021))	Met	4 of 4	1 of 1
Concentrated Electrolytes (Medication Management (For Surveys in 2021))	Met	3 of 3	0 of 0
Heparin Safety (Medication Management (For Surveys in 2021))	Met	4 of 4	0 of 0
High-Alert Medications (EMS and Interfacility Transport)	Unmet	1 of 5	0 of 3
High-Alert Medications (Medication Management (For Surveys in 2021))	Unmet	4 of 5	1 of 3
Infusion Pumps Training (Ambulatory Care Services)	Met	4 of 4	2 of 2
Infusion Pumps Training (Cancer Care)	Met	4 of 4	2 of 2

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Medication Use			
Infusion Pumps Training (Emergency Department)	Met	4 of 4	2 of 2
Infusion Pumps Training (EMS and Interfacility Transport)	Met	4 of 4	2 of 2
Infusion Pumps Training (Inpatient Services)	Met	4 of 4	2 of 2
Infusion Pumps Training (Obstetrics Services)	Met	4 of 4	2 of 2
Infusion Pumps Training (Perioperative Services and Invasive Procedures)	Met	4 of 4	2 of 2
Narcotics Safety (EMS and Interfacility Transport)	Met	3 of 3	0 of 0
Narcotics Safety (Medication Management (For Surveys in 2021))	Met	3 of 3	0 of 0
Patient Safety Goal Area: Worklife/Workforce			
Client Flow (Leadership)	Met	7 of 7	1 of 1
Patient safety plan (Leadership)	Met	2 of 2	2 of 2
Patient safety: education and training (Leadership)	Met	1 of 1	0 of 0
Preventive Maintenance Program (Leadership)	Met	3 of 3	1 of 1
Workplace Violence Prevention (Leadership)	Met	5 of 5	3 of 3

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Infection Control			
Hand-Hygiene Compliance (EMS and Interfacility Transport)	Unmet	0 of 1	0 of 2
Hand-Hygiene Compliance (Infection Prevention and Control Standards)	Met	1 of 1	2 of 2
Hand-Hygiene Education and Training (EMS and Interfacility Transport)	Met	1 of 1	0 of 0
Hand-Hygiene Education and Training (Infection Prevention and Control Standards)	Met	1 of 1	0 of 0
Infection Rates (Infection Prevention and Control Standards)	Met	1 of 1	2 of 2
Reprocessing (EMS and Interfacility Transport)	Met	1 of 1	1 of 1
Patient Safety Goal Area: Risk Assessment			
Falls Prevention Strategy (Cancer Care)	Met	2 of 2	1 of 1
Falls Prevention Strategy (Inpatient Services)	Met	2 of 2	1 of 1
Falls Prevention Strategy (Long-Term Care Services)	Met	5 of 5	1 of 1
Falls Prevention Strategy (Obstetrics Services)	Met	2 of 2	1 of 1
Falls Prevention Strategy (Perioperative Services and Invasive Procedures)	Met	2 of 2	1 of 1

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Risk Assessment			
Home Safety Risk Assessment (Home Care Services)	Met	3 of 3	2 of 2
Pressure Ulcer Prevention (Inpatient Services)	Met	3 of 3	2 of 2
Pressure Ulcer Prevention (Long-Term Care Services)	Met	3 of 3	2 of 2
Pressure Ulcer Prevention (Perioperative Services and Invasive Procedures)	Met	3 of 3	2 of 2
Skin and Wound Care (Home Care Services)	Met	7 of 7	1 of 1
Suicide Prevention (Aboriginal Community Health and Wellness)	Met	5 of 5	0 of 0
Suicide Prevention (Aboriginal Integrated Primary Care)	Met	5 of 5	0 of 0
Suicide Prevention (Aboriginal Substance Misuse Services)	Met	5 of 5	0 of 0
Suicide Prevention (Community-Based Mental Health Services and Supports)	Met	5 of 5	0 of 0
Suicide Prevention (Emergency Department)	Met	5 of 5	0 of 0
Suicide Prevention (Long-Term Care Services)	Met	5 of 5	0 of 0
Suicide Prevention (Substance Abuse and Problem Gambling)	Met	5 of 5	0 of 0

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Risk Assessment			
Venous Thromboembolism Prophylaxis (Inpatient Services)	Unmet	2 of 3	2 of 2
Venous Thromboembolism Prophylaxis (Perioperative Services and Invasive Procedures)	Met	3 of 3	2 of 2

Summary of Surveyor Team Observations

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

Board of Directors

The 11-member Board of Directors is commended for the leadership provided to the organization across all aspects of its operation. Their clear focus is evident through the development of a new Strategic Plan, with strong oversight, as well as a keen eye on the operational priorities—like quality and risk mitigation. This ensures that the Board remains focused on leading the organization. Like all healthcare organizations, the Interlake-Eastern Regional Health Authority (IERHA) Board faces many issues and is making every effort to support the organization in addressing them. Through six clear strategic priorities, the Board is guiding the organization to focus on strategies that balance excellent care today with innovation for tomorrow.

The Board is recognized for its leadership in advancing partnerships and identifying areas of focus that strengthen the organization. An example of this leadership is the introduction of an Indigenous Health Advisory Committee. Looking ahead, the Board will also be required to address a number of significant needs in the organization, including the introduction of a more compassionate and caring culture, will greatly contribute to the organization’s growth and its ability to meet the changing needs of the population it serves.

Community and Community Partnerships

Members of the community who were involved in the accreditation process demonstrated remarkable support for the organization, particularly appreciating its open and transparent approach to engagement. People felt valued and respected, and despite the challenging decisions that needed to be made on an ongoing basis, they believed that the organization was making every effort to provide the highest quality of care to those in need. There was a clear recognition that the community also had a role to play in assisting the organization in fulfilling its mandate. Whether it was helping with physician recruitment, acting as a communication channel to community members, or advocating for essential services like housing, everyone agreed that working together, regardless of the clinical service reality, was the most responsible course of action.

Significant discussions took place regarding the importance of education and supporting local individuals in pursuing careers in healthcare. IERHA received commendation for its active presence in schools and was encouraged to expand its efforts. Furthermore, the organization was praised for introducing programs aimed at developing local talent, including the upcoming launch of the Uncertified Health Care Aide Mobile Training.

Participants also emphasized the significance of cultural sensitivity and expressed support for the organization's approach to engage with Indigenous Peoples on their own terms. By fostering a more inclusive and discrimination-free environment, the quality of life for everyone would improve.

Leadership

Leadership at IERHA is passionate, engaged, and focused on doing what is right for all served. The past three years have been very challenging for leaders; however, like everyone else, they have stepped forward in any way possible to support the organization, those served, and each other. In fact, during surveys, a number of managers regularly and willingly took on clinical shifts to maintain services at sites, without complaint.

Feedback from across the organization highlighted the importance of visibility and appreciated activities such as huddles. Connecting with leaders from different parts of the organization strengthens the culture and ensures awareness of the key issues that need to be addressed. Recent surveys have provided a clear pathway forward to ensure that leadership remains focused on the organization's current priorities, such as increasing efforts to address systemic racism.

Given the presence of many novice leaders in the organization, it is crucial to prioritize and provide adequate leadership development opportunities. Current efforts are commendable; however, the organization is urged to ensure that necessary support is provided not only for team members to perform their current jobs but also to enable them to advance their careers.

The organization faces numerous key priority issues, and strong leadership will be essential in achieving much of what is planned. Supporting the provision of existing services, which comes with various operational and financial pressures, including staffing, is one aspect that requires attention. Additionally, leadership needs to ensure that the necessary tools are in place to support the team and the community. Finally, and perhaps most importantly, leadership must continue to drive innovation. It is only through proactive and deliberate change that we can overcome the challenges of the present and create a future that improves the quality of life of those served and of those serving.

Staffing and Worklife

The past three-plus years have posed remarkably challenges for everyone, particularly for healthcare workers who face the pandemic day in and day out. The strain, stress, and heartache that followed have greatly impacted everyone and have shifted many people's perspectives on life priorities. Against this backdrop, IERHA deserves commendation for its efforts in promoting engagement and creating a supportive work environment for the team.

The recent staff survey has clearly revealed the workforce's passion and their strong desire to see continuous improvement in working conditions. The heightened focus on workplace safety, including the recent completion of the Manitoba Association of Safety in Health Certification, has been well-received. Staff members are eager to voice their concerns, and the organization is committed to addressing them through an increased focus emphasis on occurrence reporting.

Staffing shortages and uncertainties have resulted in strains throughout the organization. Ongoing negotiations have also created tensions, but everyone remains dedicated to resolving them in a manner that prioritizes the highest level of patient care. A strong comradery exists within the organization, and it will be crucial to maintain this as integration standardization progress.

Delivery of Care and Services

Despite the ongoing challenges faced, the delivery of high-quality care remains paramount. All surveyors noted examples of caring service delivery and were remarkably impressed with the commitment to quality that existed throughout the organization. Significant recent efforts have been made to improve access to diagnostic and surgical procedures, resulting in an immediate and positive impact on wait times across the region. Locally offered new services—such as ECHO—have helped address the perennial challenge faced by all healthcare systems, namely patient flow. Ongoing collaborations with partners upstream and downstream continue to facilitate smooth patient flow, and the introduction of expanded access to the Quick Care Clinic, including protected slots for triage 4/5 patients on a daily basis, is yet another example of the organization's commitment to innovation.

Providing culturally sensitive care is also a clear priority across the Authority, and ongoing efforts to enhance the Indigenous voice in decision-making processes will further advance this goal. Throughout the report, surveyors have highlighted examples of service delivery that set the tone for the organization, and IERHA is encouraged to continue advancing innovation and implementing best practices delivery in the years to come.

Client Satisfaction

The organization collects client satisfaction data from numerous sources and has a robust process to ensure feedback is addressed in a timely and responsible manner. While most feedback is certainly positive, the organization has clear processes in place to promptly address and involve the appropriate personnel. All clients engaged during the survey were highly complimentary of the team providing care, which is particularly valuable feedback for healthcare professionals during this stressful time. Patients are well-informed about the available channels to engage with the organization and readily share feedback on all aspects of care and treatment. Like all regions across the country,
the organization remains focused on ensuring timely access to care and has made significant progress in this area, which is acknowledged and appreciated by those it serves.

IERHA has a lot to be proud of, is well-positioned for future advancement, and was a pleasure to survey—here's to continued success!

Detailed Required Organizational Practices

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

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

Unmet Required Organizational Practice	Standards Set
Patient Safety Goal Area: Communication	
Information transfer at care transitions Information relevant to the care of the client is communicated effectively during care transitions.	· Long-Term Care Services 9.19 · Aboriginal Substance Misuse Services 9.9
Client Identification Working in partnership with clients and families, at least two person-specific identifiers are used to confirm that clients receive the service or procedure intended for them.	· Emergency Department 12.6
The Do Not Use list of abbreviations A list of abbreviations, symbols, and dose designations that are not to be used have been identified and implemented.	· Medication Management (For Surveys in 2021) 15.6
Medication reconciliation at care transitions Medication reconciliation is conducted in partnership with the resident, family, or caregiver to communicate accurate and complete information about medications across care transitions.	· Long-Term Care Services 8.5
Patient Safety Goal Area: Medication Use	
High-Alert Medications A documented and coordinated approach to safely manage high-alert medications is implemented.	· Medication Management (For Surveys in 2021) 2.5 · EMS and Interfacility Transport 13.10
Patient Safety Goal Area: Infection Control	
Hand-Hygiene Compliance Compliance with accepted hand-hygiene practices is measured.	· EMS and Interfacility Transport 8.7

Unmet Required Organizational Practice	Standards Set
Patient Safety Goal Area: Risk Assessment	
Venous Thromboembolism Prophylaxis Medical and surgical clients at risk of venous thromboembolism (deep vein thrombosis and pulmonary embolism) are identified and provided with appropriate thromboprophylaxis.NOTE: This ROP does not apply for pediatric hospitals; it only applies to clients 18 years of age or older. This ROP does not apply to day procedures or procedures with only an overnight stay.	· Inpatient Services 9.10

Detailed On-site Survey Results

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

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

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

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

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

See Appendix B for a list of priority processes.

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

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

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

Priority Process Results for System-wide Standards

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

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

Priority Process: Governance

Meeting the demands for excellence in governance practice.

Unmet Criteria		High Priority Criteria
Standards Set: Governance		
1.3	The governing body approves, adopts, and follows the ethics framework used by the organization.	!
3.1	The ethics framework and evidence-informed criteria are used by the governing body to guide decision making.	!
3.4	The governing body has processes in place to oversee the functions of audit and finance, quality and safety, and talent management.	!
7.9	The governing body oversees the development of the organization's talent management plan.	!
11.3	The governing body works with the CEO to establish, implement, and evaluate a communication plan for the organization.	
11.4	The communication plan includes strategies to communicate key messages to clients and families, team members, stakeholders, and the community.	
Surveyor comments on the priority process(es)		

Interlake-Eastern Regional Health Authority (IERHA) is governed by a Board of 11 Members appointed by the Manitoba Government. All Board members participated in a stimulating discussion regarding accountability, structure, planning, quality, and oversight.

Despite being an appointed Board, the focus on addressing the specific needs of IERHA is evident. A Skills Matrix is utilized to identify the diverse skills required at the Board Table, and strong efforts are made to ensure a balance that aligns with the unique needs of the region. The presence of an Indigenous Board Member is a significant reflection of this commitment, considering the high percentage of First Nations individuals supported by the Authority.

Internal Board controls are commendable. The Education, Policy, and Planning Committee provides support in this area and consistently explores different methods to ensure internal integrity and accountability. The Board employs several evaluation tools, such as a Board Self-Assessment tool, strategic evaluations, CEO evaluation, and ongoing evaluation tools for the Chair. Additionally, active participation in broader meetings, such as Bilateral Meetings with the province, facilitates the exchange of best practice approaches to governance. IERHA has built a strong reputation in this regard.

The onboarding process appears comprehensive, including sessions with the Chair and Vice-Chair. Extensive materials are prepared and shared, including access to an application called Diligent Boards. Two newly appointed members expressed satisfaction with the provided information and conveyed confidence in their ability to contribute to board deliberation from the beginning.

The Board's commitment to ensuring alignment with the unique needs of First Nation populations is commendable. The catchment area encompasses 17 First Nation Communities, and the Board actively collaborates with their leadership. The establishment of an Indigenous Health Advisory Committee exemplifies this commitment and demonstrates the Board's willingness to reassess priorities continuously. The Health Involvement Groups are also praiseworthy as they provide an excellent platform for obtaining broader community input in setting priorities.

The Board's dedication to delivering the highest quality care is evident. Quality issues are addressed by the Board's Quality & Patient Safety Committee, which includes all Committee Members. Areas of focus, such as Critical Incident Review, are effectively managed, and the provided dashboards ensure the Board remains informed about all issues impacting the quality of care provided across the organization. However, it is important to ensure the Board has a full understanding and engagement with the Chief Medical Officer around the privileging of Physicians. While not directly accountable for privileging, the Board is responsible for ensuring the quality of care and fiscal integrity of the organization.

Fiscal integrity is a key focus for the Board, and robust controls are in place. It should be noted that the per capita funding of the IERHA is lower than that of other Regional Health Authorities (RHAs) in the province. The Board is urged to consistently raise this fact during bilateral meetings with the province. Nevertheless, the Board's vigilance in this area is commendable, and ongoing support for identifying key investment needs, including strategies to address them, is crucial to ensure the Authority continues to progress and adequately meets the care needs of the population and staff. A prime example of this is the necessity for a well-defined information technology strategy.

The infrastructure supporting ethics requires attention, as highlighted by the Survey Team. Although the Regional Ethics Advisory Council has recently been reinstated, there is a need to emphasize ethics education, training, and processes. Setting the tone for ethical practices at the Board level is essential and should be given due consideration.

The Board's oversight of the 2021–2028 Strategic Plan is commendable. The establishment of six Strategic Action Groups, responsible for advancing the six priority areas as expected, demonstrates clear accountability for the Plan. The IERHA's approach to strategic oversight is among the most comprehensive observed.

Client engagement is a clear priority for the organization. There are opportunities at the Board Table to enhance engagement in broader planning and decision-making processes. The role played by Shared Health in identifying patient advisors was acknowledged, and the Board should actively promote interest in this important area throughout the Authority.

The Board should take pride in its role in advancing and supporting the health and wellness of the population it serves.

Priority Process: Planning and Service Design

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

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

IERHA is commended for its 2021–2028 Strategic Plan, including the inclusive manner in which it was developed. While it is recognized that Manitoba Health allowed for the extension of existing plans, IERHA is commended for advancing a refresh unique to the region. The approach taken to engage is also noted, with sessions held with the community to discuss challenges, strengths, priorities, and mission, vision, and values. The plan was subsequently shared with staff through a Town Hall.

Manitoba Health has released various strategies in the interim, which have included a focus on seniors, First Nations, Métis and Inuit Manitobans, and mental health. These province-wide strategies, along with updated health status information, have helped complement and reinforce the IERHA's plan, enabling the advancement of several contemplated strategies.

The phrase "nothing about us without us" is foundational to IERHA's thinking when it comes to overall planning and service design. The Authority is very responsible in engaging with populations and quick to acknowledge where strategies may fall short. A good example of this is Indigenous relations, where in 2018, heartfelt stories clearly indicated that the IERHA was not meeting the needs of the Indigenous populations it supported and that a different approach was required. As a result, the Indigenous Health Advisory Committee was established as a Committee of the Board, significantly improving relations, and ensuring care is provided in a sensitive manner. This has also included a specific policy on Indigenous Procurement, allowing the Authority to responsibly support local businesses in its operation.

One of the strongest areas noted during the survey was the approach being taken to oversee the roll-out of the Strategic Plan. Strategic Steering Committees have been established for all six priority areas of focus, meeting monthly and engaging the Board. This ensures that not only are the articulated strategies advanced responsibly, but also provides a clear framework for adjusting the Plan if necessary, due to changing local priorities or province-wide directives from Manitoba Health. It also enables the organization to break down the Plan into manageable pieces to ensure results are achieved.

Specific operational areas noted with approval include the Diagnostic and Surgical Recovery Task Force initiative, as well as the enhanced investments available to support the Mental Health and Addictions population.

Community and client engagement, as well as ensuring a robust data stream, are key to the success of any Plan. The organization is making investments, including an engagement position, to strengthen in these areas. Manual data collection systems pose a barrier to the organization's ability to advance priorities, and addressing this moving forward needs to be a priority. However, the organization is committed to being an early adopter and takes advantage of provincial programs when offered. This positive attitude is one of the best ways to stabilize the organization as it deals with the inevitable changes that lie ahead.

Supporting the team and the community through these changes is vital. IERHA has provided strong Change Management training and has a library with resources supporting the same. Ensuring the capacity necessary to support change is important, and the organization needs to be mindful of supporting its leaders, many of whom are new in this important area. All leaders need to be comfortable with change, and the organization is making strides to ensure this occurs, including investing in process improvement facilitators.

After being in the organization for a short period of time, it is clear that the leadership culture has changed and is now very supportive of driving positive improvements. A collaborative, genuinely inquisitive culture that is accountable and committed to strong relationships can significantly impact positive change. IERHA appears poised to do this and is commended for the leadership role it is taking in this, arguably the most important space in healthcare in Canada today.

Priority Process: Resource Management

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

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

The surveyors met with members of the IERHA team responsible for resource oversight and received detailed updates on the processes followed to ensure fiscal integrity throughout the organization.

Both operating and capital plans are developed with the active involvement of the organization. However, capital planning follows a slightly different approval process that involves external entities. This dual accountability means that both the Board of Directors (operational planning) and Shared Health/Manitoba Government (major capital) are engaged in ultimate oversight. The prioritization of capital projects follows a responsible set of criteria, led by life safety, with endorsed lists from the senior leadership forwarded to Shared Health. Approved projects are expected to be completed within three years, and the organization takes care of the necessary logistics. Investments in areas such as HVAC for Personal Care Homes, fire life safety, generators and nurse call systems are considered priorities and enjoy strong support.

Operational planning involves the leadership team and is largely based on actual figures from the previous year. The organization has a Briefing Report process in place, which allows funds to be reallocated to priority areas. The organization is commended for its ability to align funding with priorities, and a recent example of this is the efforts to improve access to selected surgeries by strategically utilizing available resources.

One of the areas that received approval is the introduction of financial education during the onboarding process. Ultimately, one of the best ways to control costs is to ensure that organization members who contribute to costs through their actions have a good understanding of the budgeting process. It is recommended to expand this type of education, as it will yield significant benefits.

Bottom-up involvement in budget setting is encouraged, as is starting the planning process early for the next year. The organization acknowledges the “zero-based” budget philosophy and provides managers with templates for staffing to facilitate focused discussions. Shared Health assists in developing budgets through a logistics document that outlines anticipated increases. These areas of focus instill confidence in the organization’s budget-setting process.

Budget monitoring throughout the year is thorough, including at the Board level. Monthly variance reports are prepared and evaluated within the organization, and program leads are responsible for identifying opportunities for necessary and appropriate cost savings. Addressing coding discrepancies and ensuring that budgets align with programs have contributed significantly to this effort.

An area of opportunity, , relates to utilization and standardization. Achieving consistency across the province in resource allocation and utilization will contribute to cost certainty. Furthermore, continued advocacy with the province for a more equitable, population-based funding model is crucial. Lastly, there is a presenting need to establish an Information Management Strategy for technology investment. Without it, the organization's current reliance on paper-based systems will increasingly hinder recruitment and retention of essential personnel.

Clearly, the organization benefits from a highly competent team that is dedicated to acting in the best interest of the organization. While enhanced flexibility in staff utilization would be beneficial, the current team demonstrates remarkable responsiveness and collaboration, making them a valuable asset to the organization.

Priority Process: Human Capital

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

Unmet Criteria	High Priority Criteria
Standards Set: Leadership	
10.5 There is a talent management plan that includes strategies for developing leadership capacity and capabilities within the organization.	

Surveyor comments on the priority process(es)

A highly engaged team met with the surveyors through the process and clearly exhibited a passion for supporting the human needs across the organization.

Recent changes within Shared Health, specifically the centralization of seven staff from IERHA to Shared Health, are an area of focus for the team. Role clarity and accountability are crucial, and it will be important for the new Program Director to ensure strong and clear communication lines exist, allowing the Authority to fully benefit from Shared Health programs and services.

The enhanced focus on safety, including the recent certification obtained through the Manitoba Association of Safety in Healthcare, was noted with approval. The organization's efforts to address burnout, racism, and bullying though the establishment of a working group were evident from the recent staff surveys and have had a very positive impact. Targeted initiatives, such as the Respectful Workplace Policy, were also well-received, and the organization's shift in how it handles discipline has effectively conveyed a strong message of respect and engagement. Training support is available to team members in areas such as de-escalation, and significant efforts are being made to meet broader training needs for employees.

Recruitment and retention remain major priorities for the organization, as they are everywhere. Innovative "grow your own" initiatives, including the creation of the Uncertified Healthcare Aide Mobile Training Program Pilot starting in June, will greatly contribute to stabilizing the workforce. However, ensuring that all necessary supports are in place for staff to realize their potential will continue to be a priority. Onboarding is recognized as one of the best ways to ensure retention, and the team is commended for their approaches in this area. Regional orientation is complemented by site-specific efforts to ensure local comfort and awareness. Visibility and the provision of clear avenues of support, particularly for novice staff, will remain important.

Recognition is a clear priority for the organization, as demonstrated by initiatives such as Years of Service Recognition, the Customer Service Award from the Chair of the Board, the Safety Superstar Award (selected by site), Wednesday Wave, Infection Prevention and Control Awards, and the Physician Emeritus Award. The recent "You're Appreciated a CHOCO-lot" initiative had a significant impact. Expressing a simple thank you is easy, yet it often does not happen frequently enough in our lives, so this particular initiative deserves recognition as a job well done.

Healthy labour relations are a strong focus for the organization, with recently settled collective agreements serving as a good example. Respectful relations are evident, and the organization is committed to supporting team members and ensuring maximum performance and support. The focus on Performance Improvement Plans is acknowledged, as it helps support team members in a positive and proactive manner, while also identifying areas where there may be a lack of fit. Although the full implementation of Performance Appraisals and Performance Conversations is not currently occurring, considering the numerous and varied pressures on team members, this is understandable. However, the organization is committed to providing ongoing and consistent feedback to all team members, including physicians.

The absence of a formal Talent Management Plan is noticeable, and the organization is urged to develop one, potentially in collaboration with Shared Health. Nevertheless, most of the components of a good plan are already in place, including a clear understanding of the workforce, gaps, opportunities, skills requirements, and leadership training. Leadership training is an area of focus since the organization includes a significant number of novice leaders who are gaining experience during a challenging time. Ensuring that support systems are in place for these individuals to advance their careers will be crucial for IERHA's continued success in the future.

Few areas within an organization have the impact of a strong human resources team, and IERHA unquestionably possesses a great team. While there are key areas that require attention—such as strengthening training and development, addressing systemic racism, clarifying accountability with Shared Health, and emphasizing visibility and personal connections—the team has made tremendous progress throughout and beyond the pandemic. They are commended for their passion and commitment to excellence. Well done, and may their success continue.

Priority Process: Integrated Quality Management

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

Unmet Criteria		High Priority Criteria
Standards Set: Leadership		
3.8	The spread and sustainability of quality improvement results is promoted and supported.	
16.3	The organization's leaders require, monitor, and support service, unit, or program areas to monitor their own process and outcome measures that align with the broader organizational strategic goals and objectives.	!

Surveyor comments on the priority process(es)

IERHA has a highly dedicated and focused team that supports quality improvement, risk mitigation, and engagement. The team places great emphasis on identifying and eliminating risks and has robust processes to achieve this objective.

Organizational quality oversight is carried out through the Board Quality Committee, which convenes on a quarterly basis and includes all Board members. The Board is highly active and supportive of Quality Improvement activities. Members actively assess trends, including occurrence reporting, and regularly review and provide input on organizational balanced scorecards. Meetings commence with patient stories, and the organization is commended for its hands-on approach to involving clients in their care.

The Region has been adding Clinical Process Improvement Leads to assist with improving the quality and efficiency of client care. The organization also has Physicians who contribute their insights to specific Quality Improvement initiatives. A notable example of this is the Emergency Rural Childbirth Project, which has had strong physician input and engagement through the Regional Medical Advisory Committee.

The organization’s approach to Critical Incidents and Disclosure is outstanding. The proactive processes they have identified and follow ensure comprehensive involvement of patients and their families in the process, with results that benefit everyone involved. Process improvements are identified and implemented as necessary. In fact, during the recent Canadian Patient Safety Week, the IERHA was one of only three organizations nationally selected to present their process.

Prior to Accreditation, the organization participated in the combined Worklife Pulse/Patient Safety Survey, which yielded results largely similar to previous reports. It is unsurprising that, given the recent experience with the pandemic, needs were identified in Occupational Health, and one in five respondents acknowledged witnessing unfair treatment towards a client/patient or their family member. The resulting Action Plan focuses on cultural and psychological safety and aims to provide appropriate supports to address address systemic racism, which unfortunately appears to be prevalent across the country.

To support these efforts, the organization deliberately focuses on building capacity within the organization through orientation, personal engagement, and doubling their efforts to encourage staff to submit occurrence reports when concerns arise. IERHA actively promotes a blame-free culture, and while reporting declined during the pandemic, ongoing efforts to increase engagement are yielding positive results. Incident tracking is currently done manually, and the organization has acknowledged Occurrence Reporting Fatigue. Given the high number of events, which can reach upwards of 3,000 per year, having a robust process to ensure follow-up is crucial. Quarterly Occurrence Reports are distributed to all sites, staff are briefed on issues, and leaders are expected to close the loop with relevant staff regarding safety concerns.

Managers are expected to regularly visit their patients to address any concerns raised in the moment. Received feedback is triaged and addressed by the appropriate individuals.

An increased emphasis on closing the feedback loop has resulted in a decrease in the time it takes to close a complaint, from a recent 13.6 days to the current 9.6 days. The organization is commended for its dedication to this focus, and it is expected that the recently hired Patient Relations & Engagement Coordinator will further enhance engagement with a positive impact. Shared Health is also involved if their services are mentioned in feedback concerns, and they are responsive and proactive in triaging.

When it has been determined there has been a Critical Incident, the organization engages in a comprehensive and timely process, approaching it with warmth and empathy. While processes are mandated through the province, the local approach employed by the organization builds capacity, with each incident handled by a specifically identified team on a case-by-case basis. Supporting this approach is a disclosure culture that promotes ongoing and proactive engagement with patients whenever issues arise.

A Corporate Risk Registry is in place, and all risks are reviewed with Directors twice a year. Risks are shared with Manitoba Health, with provincial risks shared among the CEOs. The organization also incorporates aspects of the Risk Registry in Briefing Notes, linking the top three risks to the report to ensure that risk mitigation and minimization remain at the forefront of all decisions.

The four-year Patient Safety Plan consolidates information from multiple sources to identify the appropriate areas of focus. It builds upon previous plans, with the most recent plan prioritizing the existence of capacity across programs and the necessary and appropriate integration. Throughout the survey, the Survey Team noted a clear corporate commitment to Quality Improvement activities, but limited activity at the frontlines. Given the organization's current bandwidth and other patient-centred efforts, including improving access to surgical and diagnostic procedures, these initiatives did not receive the appropriate priority. However, moving forward, this is expected to change.

Looking ahead, the organization is eager to implement RL6, an automated Occurrence Management tracking system. A reduction in the planned 18-month window would be viewed favourably by all stakeholders. Efforts to address racism will continue, and the organization aims to ensure broader Indigenous representation, including in quality initiatives. Continued capacity building and mindfulness of bandwidth will be key to achieving these objectives.

The key to success in any quality initiative lies in the commitment and passion of the staff, and IERHA has an exceptional team in this regard. The strong relationship with leadership and the ongoing efforts to expand engagement are highly commendable and will have a significantly positive impact. Kudos to everyone involved.

Priority Process: Principle-based Care and Decision Making

Identifying and making decisions about ethical dilemmas and problems.

Unmet Criteria		High Priority Criteria
Standards Set: Leadership		
1.10	Support is provided to build the capacity of the governing body, leaders, and teams to use the ethics framework.	
1.11	There is a process for gathering and reviewing information about trends in the organization's ethics issues, challenges, and situations.	
1.12	Information about trends in ethics issues, challenges, and situations is used to improve the quality of services.	
1.13	The ethics framework includes a process for reviewing the ethical implications of any research activity that the organization leads or participates in.	!

Surveyor comments on the priority process(es)

An Ethics Committee had been established within the IERHA, but it was disbanded during the pandemic. However, it has recently been reinstated with approximately twenty committee members. Much of the membership consists of leadership staff from IERHA. Nevertheless, the committee is encouraged to include representation from frontline staff and external partners such as legal, religious, and Indigenous representatives. There is a member of the board on the Ethics Committee who also represents the Local Health Involvement Group. The Ethics Committee convenes approximately five to six times per year, as well as on an ad hoc basis as required.

The IERHA possesses a Clinical Ethics Framework along with a supporting working document. If there is a need for consultation, staff members must complete an Ethics Consultation request form. All non-urgent requests must be submitted to the Administrative Assistant of Medical Services, who will then forward them to the Co-Chairs of the Ethics Consultation Service Team. The Co-Chairs assess whether the request is appropriate for the consultation service, and if not, it may be returned to the individual(s) who submitted it. If the request is deemed necessary, the Ethics Consultation Service Team Committee convenes to discuss the ethical matter. In urgent cases, the Co-Chairs of the Ethics Committee meet with as many members of the committee as possible, as quickly as possible. The Ethics Committee is encouraged to review the processes to ensure the timely and concise handling of ethical requests. IERHA does not currently have a contract with an ethicist. The organization is encouraged to explore and advocate for options for accessing an ethicist and making this service available as needed.

The Ethics Consultation Service Team has not received enough submissions to identify trends. However, and safe changes that support staff and the people they serve. This committee does not engage with research processes or projects, and the Clinical Ethics Framework does not prioritize research as a focus. Currently, the committee is collecting information on ethical issues and challenges within the community, and their efforts are commendable.

The Clinical Ethics framework is included in staff orientation procedures. However, there are no education opportunities provided at the clinical level for staff or physicians to familiarize themselves with the ethical framework. The organization is encouraged to enhance capacity-building efforts and provide tabletop exercises that employ relevant scenarios to facilitate staff's understanding and application of the ethics framework.

The Ethics Committee members are urged to continue their vital work and provide support to staff, patients, and families during ethical dilemmas.

Priority Process: Communication

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

Unmet Criteria	High Priority Criteria
Standards Set: Leadership	
7.5 There is an organization communication plan that addresses disseminating information to and receiving information from internal and external stakeholders.	

Surveyor comments on the priority process(es)

IERHA has a Communication Manager and a Communication Associate. Tools used for internal communication include the hospital's intranet, email, Twitter, Facebook, the Wednesday Wave newsletter, Visboards, huddles, staff meetings, staff whiteboards, corkboards and Safety Talks memos. Monthly leadership meetings take place, and information is expected to flow from leadership to frontline staff through the Directors and Managers. Memos are sent on an as-needed basis.

It was noted that there is a good relationship between IERHA and social medial, radio, and newspaper businesses. External communications include the website, a newsletter called "In Good Health," an Annual General Meeting, and an Annual Report—currently available only in English. The organization is encouraged to publish the Annual Report in French as well. There is leadership presence at the Elected Briefing Meetings, Regional Health Advisory Council, and Strategic Steering Committee meetings. It was felt that there are good rapport and relationships with provincial partners, key regional stakeholders, and the communities. However, there is no formalized communication plan for IERHA, and the organization is encouraged to develop a plan that identifies and addresses action plans, accountabilities, resources, and tasks within the organization.

IERHA has a Privacy Officer who is responsible for facilitating compliance with the Personal Health Information Act and dealing with requests from individuals who want a copy of personal health information. Patients may access their health information through the Health Information Services Department. The organization's website provides information to the community on privacy and patient advocate agreement processes.

There are two designated bilingual facilities within the IERHA the leaders are encouraged to take this into consideration when providing wayfinding signage, education materials, or handouts to patients or the public. IERHA has contracted a Language Interpreter Service, available by phone and through Telehealth, which provides interpretation services in Indigenous languages, French, American Sign Language, and refugee languages. The Patient Relations & Engagement Coordinator is accessible to support and assist patients with care needs, concerns, and complaints. Clear processes and timelines are in place to enable follow-ups. Patient Relations & Engagement Coordinator tracks complaints by themes, and quarterly reports are provided to the board.

The organization is commended for the strategies they have in place to communicate with internal and external partners. Speaking to frontline staff, the majority felt that they had good communication from their leaders and were informed and aware of information that affected them in their roles. With over 30 facilities spread over a large area, one can never communicate too much.

Priority Process: Physical Environment

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

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

There is a dedicated facilities management team that oversees 26 sites, including leased sites. These sites encompass a range of infrastructure, from older buildings dating back to the 1950s to newer ones from the 1990s. The Facilities Management Team is responsible for the day-to-day maintenance of these sites, which includes preventative maintenance, scheduling contract maintenance, managing acute and personal care homes, and addressing urgent facility issues. Additionally, they have developed a five-year plan for necessary projects, upgrades, and equipment. Shared Health receives a list of requirements, determines provincial needs, and provides recommendations accordingly. The aging infrastructure in many personal care homes is evident.

Given the mix of older and newer infrastructure, it is recommended to pay particular attention to detail at the older locations, such as groundskeeping and storage.

A preventative maintenance program is in place, and work orders are received and monitored through a Computerized Maintenance Management System (CMMS) called Hippo.

Annually, over 16,000 work orders are received, with a combination of Hippo and manual records used across the sites. Standardizing the Hippo program throughout the region would be beneficial. Facilities management faces human resource challenges, and recruitment and hiring initiatives are currently underway.

Selkirk Regional Health Centre has been operational since 2017. The centre is bright, welcoming, and clean. Currently, there is an ongoing project to add 30 acute care beds to the centre, along with plans for additional waiting room space for the Emergency Room (ER) and the installation of computerized tomography (CT) scanners.

Storage space is limited at many locations, including community offices and personal care homes. It is recommended to conduct regular audits and declutter equipment. There is a high reliance on paper for communication on the walls and in the hallways, particularly at the personal care homes. It is important to be mindful of the impact of Infection Prevention and Control (IPAC) practices in this area. While the paper provides information to residents, families, and patients, it is advisable to consistently review the messaging, consider the audience, and minimize clutter to create a clean and tidy environment. Inclusion and input from residents, families, and patients in communication messaging is recommended. For example, it would be valuable to understand what they read and what information they find important.

Priority Process: Emergency Preparedness

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

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

An up-to-date Emergency Response Plan is in place. The organization adopts an all-hazard approach and utilizes the Incident Management System framework to define roles, as well as prepare and respond to the diverse risks that may trigger a response at any time.

The response to COVID-19 pushed the Authority into a state of emergency, resulting in significant personnel changes and alterations in business operations. Due to turnover in staff and leadership—as well as adjustments to hybrid work arrangements—there is a need to catch up on testing and training through mock and tabletop exercises. However, efforts are underway to regain momentum. In the meantime, it is evident that plans and emergency response kits have been updated and standardized, with consideration given to making them easily identifiable by colour. Facility staff, including temporary and agency personnel, can recognize these kits and discuss the steps they would take in the event of an emergency.

The pandemic response necessitated a specific focus on identifying and responding to public health emergencies, including the role of IPAC procedures.

A process and schedule for regular fire drills are in place. Drills are conducted following an initiate, practice, review, and approve approach.

Collaboration with partners in communities throughout the region is fostered. These communities are at various stages of readiness and recovery from the peak of the pandemic. The IERHA values partnerships and assumes a leading role in supporting communities in the development and implementation of their programs.

Policies and procedures exist for the identification and management of outbreaks, as well as the handling of biohazardous materials.

Priority Process: People-Centred Care

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

Unmet Criteria		High Priority Criteria
Standards Set: Aboriginal Community Health and Wellness		
13.3	Measurable objectives with specific timeframes for completion are identified for quality improvement initiatives, with input from clients and families.	!
Standards Set: Aboriginal Integrated Primary Care		
2.4	Space is co-designed with clients and families to ensure safety and permit confidential and private interactions with clients and families.	
Standards Set: Aboriginal Substance Misuse Services		
1.1	Services are co-designed with clients and families, partners, and the community.	!
2.4	Space is co-designed with clients and families to ensure safety and permit confidential and private interactions with clients and families.	
Standards Set: Ambulatory Care Services		
1.1	Services are co-designed with clients and families, partners, and the community.	!
2.4	Space is co-designed with clients and families to ensure safety and permit confidential and private interactions with clients and families.	
Standards Set: Cancer Care		
2.4	Space is co-designed with clients and families to ensure safety and permit confidential and private interactions with clients and families.	
Standards Set: Community-Based Mental Health Services and Supports		
1.2	Services are co-designed with clients and families, partners, and the community.	!
3.4	Space is co-designed with clients and families to ensure safety and permit confidential and private interactions with clients and families.	

17.3	Measurable objectives with specific timeframes for completion are identified for quality improvement initiatives, with input from clients and families.	!
Standards Set: Emergency Department		
1.1	Services are co-designed with clients and families, partners, and the community.	!
2.5	Space is co-designed with clients and families to ensure safety and permit confidential and private interactions with clients and families.	
18.3	Measurable objectives with specific timeframes for completion are identified for quality improvement initiatives, with input from clients and families.	!
Standards Set: Governance		
2.3	The governing body includes clients as members, where possible.	
Standards Set: Home Care Services		
1.1	Services are co-designed with clients and families, partners, and the community.	!
2.4	Space is co-designed with clients and families to ensure safety and permit confidential and private interactions with clients and families.	
15.3	Measurable objectives with specific timeframes for completion are identified for quality improvement initiatives, with input from clients and families.	!
Standards Set: Inpatient Services		
1.1	Services are co-designed with clients and families, partners, and the community.	!
16.3	Measurable objectives with specific timeframes for completion are identified for quality improvement initiatives, with input from clients and families.	!
Standards Set: Leadership		
3.3	Teams, clients, and families are supported to develop the knowledge and skills necessary to be involved in quality improvement activities.	
4.3	Services are planned with input from clients, families, and the broader community.	

Standards Set: Long-Term Care Services		
1.1	Services are co-designed with residents and families, partners, and the community.	!
17.3	Measurable objectives with specific timeframes for completion are identified for quality improvement initiatives, with input from residents and families.	!
Standards Set: Obstetrics Services		
1.1	Services are co-designed with clients and families, partners, and the community.	!
2.4	Space is co-designed with input from clients and families to ensure safety and permit confidential and private interactions with clients and families.	
18.3	Measurable objectives with specific timeframes for completion are identified for quality improvement initiatives, with input from clients and families.	!
Standards Set: Perioperative Services and Invasive Procedures		
1.1	Services are co-designed with clients and families, partners, and the community.	!
2.4	Space is co-designed with clients and families to ensure safety and permit confidential and private interactions with clients and families.	
25.3	Measurable objectives with specific timeframes for completion are identified for quality improvement initiatives, with input from clients and families.	!
Standards Set: Primary Care Services		
1.1	Services are co-designed with clients and families, partners, and the community.	!
2.5	Space is co-designed with clients and families to ensure safety and permit confidential and private interactions with clients and families.	
16.3	Measurable objectives with specific timeframes for completion are identified for quality improvement initiatives, with input from clients and families.	!
Standards Set: Substance Abuse and Problem Gambling		
1.1	Services are co-designed with clients and families, partners, and the community.	!

2.4	Space is co-designed with clients and families to ensure safety and permit confidential and private interactions with clients and families.	
15.3	Measurable objectives with specific timeframes for completion are identified for quality improvement initiatives, with input from clients and families.	!

Surveyor comments on the priority process(es)

Surveyors assessed the engagement of patients and clients in the organization across most priority process areas and were impressed with the strong relationships that existed between providers and those receiving care. In all instances where clients were engaged in discussions, the caring and compassion of the team were noted, as was the client's comfort in being part of the decision-making process in relation to goals of care for their specific situation. Clients felt that they had access to the level and detail of information necessary to make informed decisions, and all felt that their privacy was respected throughout.

Shared Health has established a Patient Advisory Network whose goal is to provide support to the regions. Further clarity and direction on how to ensure IERHA can contribute and benefit from the provincial networks is in-progress, and is important as IERHA seeks to establish its own network for local initiatives.

The Board has an opportunity to set the tone with Patient Advisors by formally engaging them in the committee structures that exist. Best practice across the industry has the voice at the Board Table as well as at all Committees of the Board, including the Medical Advisory Committee. In saying this, the Board is commended for the inclusion of patient stories at the Board and for supporting the introduction of an IERHA Team Member focused on engagement.

With clear Board priority, further involvement of clients at the program and service level with planning and service delivery will be an option. While this exists in some areas, there are further opportunities to strengthen these voices, and the organization is commended for its efforts and leadership in ensuring the same.

Priority Process: Patient Flow

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

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

Surveyor comments on the priority process(es)

Patient Flow is a priority process that IERHA is addressing in a proactive and innovative manner. The goal is to ensure that the right person is in the right location at the right time for the care and support required, and the team is laser-focused on this reality.

The establishment of a dedicated Patient Flow Team, including a Regional Manager, sets this Authority apart. It has committed the necessary resources to do all that it can in this area, a fact supported during Bilateral Meetings with the province. It is acknowledged that the various sectors across the RHA—acute care, home care, long-term care, mental health, and addictions—all have unique flow challenges. However, they intersect in numerous ways and are therefore assessed as a whole.

Daily and weekly meetings aimed at understanding the situation across all programs and sites are very helpful in facilitating flow. Knowing who is waiting, the reason for their wait, and being able to marshal available resources to support them are key aspects in this area. In saying this, IERHA is also very aware that there are numerous factors influencing flow, some under their control and some not. The Authority appears to be addressing all in a responsible manner. These factors include transportation, access to upstream and downstream services, repatriation, service availability locally (ECHO being a good example), and intersection with other programs and services. A notable example of the latter is the organization's focus, through its Emergency Departments (EDs), on moving Triage Level 4/5 patients into primary care setting. For instance, two slots are protected every day at the same day Quick Care Clinic for patients in the ED who could be off-loaded. Good processes and protocols exist, as they do with other primary care locations, to ensure that appropriate care is provided in the right location.

The challenge most healthcare organizations face today is that they are always overcapacity in one way or another. This can include patients having to receive care in unconventional spaces, patients waiting excessively long for care (including in EDs), and patients being cared for in the wrong environments, such as Alternate Level of Care Patients. IERHA is aware of all of these challenges and has employed strategies to address them, including pull strategies, for example, from Acute Care to Home Care. The team has established a number of responsible goals focusing on areas such as preferred occupancy rates, wait times for transfers to other locations, and service investments needed to address current "chokepoints" when considering the movement of people.

Opportunities exist, as they always do, to assist in patient flow. Access to more robust information regionally and provincially, enhanced wait-time systems, and a best practice focus in areas such as Length of Stay will all contribute. Broader integration and accountability, including in the area of moving patients requiring access to mental health beds from emergency departments, continue to need focus for the organization. Clarifying roles and accountabilities with Shared Health and Manitoba Health will also be important moving forward. Access to diagnostics is a good example of this, as is fully implementing the Seniors Strategy to better support access to care at home and closer to home.

The Patient Flow team and the organization are commended for the tremendous emphasis they are placing on this important systemwide challenge. The survey team would be hard-pressed to identify further structures the team could put in place, with the exception of ensuring that supports for effective flow are available seven days a week.

Kudos to all involved for their passion and commitment.

Priority Process: Medical Devices and Equipment

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

Unmet Criteria		High Priority Criteria
Standards Set: Reprocessing of Reusable Medical Devices		
15.4	Measurable objectives with specific timeframes for completion are identified for quality improvement initiatives with input from stakeholders.	!
15.5	Indicator(s) that monitor progress for each quality improvement objective are identified, with input from stakeholders.	
15.6	Quality improvement activities are designed and tested to meet objectives.	!
15.7	New or existing indicator data are used to establish a baseline for each indicator.	
15.8	There is a process to regularly collect indicator data and track progress.	
15.9	Indicator data is regularly analyzed to determine the effectiveness of the quality improvement activities.	!
15.10	Quality improvement activities that were shown to be effective in the testing phase are implemented broadly throughout the organization.	!
15.11	Information about quality improvement activities, results, and learnings is shared with stakeholders, teams, organization leaders, and other organizations, as appropriate.	
15.12	Quality improvement initiatives are regularly evaluated for feasibility, relevance, and usefulness, with input from stakeholders.	

Surveyor comments on the priority process(es)

The Medical Devices Reprocessing (MDR) departments at the Selkirk Regional Health Centre and the Beausejour Hospital provide reprocessing, high-level disinfection, and sterilization for the IERHA community, including affiliated partners such as personal care homes, Selkirk Mental Health Centre, and physician offices. The MDR services support all programming areas of IERHA, including endoscopy, acute care, clinics, primary care, and community programs. Interfacility transport is used to facilitate the movement of medical devices and equipment throughout the regions.

The MDR team is commended for expanding the endoscopy services and increasing the services at Selkirk both locations. The team has embraced the challenge and opportunity to increase the number of Regional Health Centre and Beausejour Hospital. The program has doubled the number of procedures at both locations. The team has embraced the challenge and opportunity to increase the number of procedures performed and has successfully met the increased demand within the current resources. With the increase in services, the team monitors storage and infrastructure challenges as the MDR department expands its program to support additional procedures.

The MDR team partnered with the Red River College MDR technology course and supported a practicum student. The team reports high satisfaction from this experience and hired the student following the practicum. Recruitment and retention efforts are underway. The MDR department held an open house as a recruitment strategy, which resulted in the hiring of new staff. Feedback forms were provided to participants of the open house, and the feedback demonstrates a positive experience and recruitment initiative for the MDR department.

A perioperative review was completed in 2021 by an external consulting firm, resulting in several recommendations. Interviews were conducted with perioperative staff and physicians, as well as stakeholders who interact with the perioperative program. MDR was included in the working groups when there were specific action items pertaining to that role and area. Working groups were formed, and many of the recommendations were implemented, including the hiring of a full-time MDR lead. This has helped ensure consistency of support for the team, management of inventory processes, and increased leadership.

A recent Safe Work Manitoba audit was conducted, and the MDR departments performed well. Challenges with temperature and humidity were identified, and these concerns are being assessed and monitored to make informed decisions regarding required infrastructure for air quality (like vapours, humidity, and temperature).

The Selkirk Regional Health Centre and the Beausejour Hospital have increased collaboration, including the implementation of joint meetings. The teams are encouraged to continue developing standardized operational procedures (SOPs) where applicable, as well as staff education and training programs. The inclusion of the materials management team is encouraged when relevant for the transportation of medical devices and equipment.

Medical equipment and devices are appropriately returned to the MDR for cleaning, disinfection, and sterilization. However, the team does not receive all equipment and devices that are supposed to be returned. Disposable devices are sometimes returned in place of the actual device. An education and training program is encouraged across the region, along with the formalization of a quality improvement initiative. Further review of safe disposal practices for contaminated devices and Infection Prevention and Control (IPAC) practices is recommended, particularly with regard to HCA practices. The formalization of quality improvement initiatives, including indicators and timelines, is encouraged. Testing initiatives through processes such as Plan-Do-Study-Act (PDSA) cycles are also encouraged.

Priority Process Results for Population-specific Standards

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

Priority processes specific to population-specific standards are:

Population Health and Wellness

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

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

Unmet Criteria	High Priority Criteria
Priority Process: Population Health and Wellness	
2.1 The organization sets measurable and specific goals and objectives for its services for its priority population(s).	
Surveyor comments on the priority process(es)	
Priority Process: Population Health and Wellness	

A highly dynamic, compassionate, and dedicated team met with surveyors to review IERHA's efforts in Population Health and Wellness.

Beginning with the Community Health Needs Assessment, there is a clear understanding of the priority needs of the population served. The team firmly believes in the principle of "meeting people where they are" and acknowledges that a one-size-fits-all approach is inadequate. In this regard, the team takes great care to ensure that the programs they offer and deliver align closely with the specific needs of the diverse populations they serve, including cultural considerations. A prime example of this is the Indigenous Doula Project.

There is a strong alignment with Manitoba Health, as the government sets the tone for key public health priorities throughout the province. However, IERHA retains autonomy to address the unique needs of their specific populations, which they do responsibly and proactively. IERHA also places significant emphasis on integrating Public Health Physicians, including having them as voting members of the Medical Advisory Committee. This inclusion approach strengthens relationships and, ultimately, the trust necessary for advancing population-level initiatives.

The surveyors also noted the commendable resource commitments made by IERHA. While it is acknowledged that some investments are driven at the provincial level, local commitments above and beyond provincial requirements have been made to enhance the health and wellness of the population in the Region.

Harm Reduction efforts were also recognized and appreciated, as was the Authority's understanding that not all programs receive support and that adopting a localized perspective is important when approaching initiatives.

One specific program shared with the surveyors was the Correctional Centre Outreach program, which aims to provide Sexually Transmitted and Blood-Borne Illness testing to all inmates at the Milner Ridge designing it around the needs and expectations of the inmates. The outstanding results of this program can largely be attributed to the philosophy of designing it around the needs and expectations of the inmates. Out of the 440 inmates, 338 agreed to testing, and the resulting positivity rates clearly highlight the importance of initiatives like this in public health. The team has developed plans to support inmates and has had a highly positive impact on reducing the spread of infections. Continuing this effort entails not only on-site testing and support at the Correctional Facility but also follow-up outreach once inmates are released, which remains a top priority.

Building relationships, trust, and partnerships are key to achieving truly effective population health, wellness, and public health outcomes. The IERHA Team is fully committed to establishing the necessary connections to ensure the development of appropriate programs and to facilitate their widespread implementation, reaching the greatest number of people possible. The IERHA is commended for prioritizing this approach and is encouraged to update its Community Health Needs Assessment regularly, while also allocating resources to support upstream health and wellness initiatives.

IERHA is highly praised for the strength of this program.

Service Excellence Standards Results

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

Priority processes specific to service excellence standards are:

Clinical Leadership

- Providing leadership and direction to teams providing services.

Competency

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

Episode of Care

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

Decision Support

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

Impact on Outcomes

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

Medication Management

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

Organ and Tissue Donation

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

Infection Prevention and Control

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

Public Health

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

Standards Set: Aboriginal Community Health and Wellness - Direct Service Provision

Unmet Criteria		High Priority Criteria
Priority Process: Clinical Leadership		
The organization has met all criteria for this priority process.		
Priority Process: Competency		
3.8	Education and training are provided on the organization's ethical decision-making framework.	
Priority Process: Episode of Care		
The organization has met all criteria for this priority process.		
Priority Process: Decision Support		
The organization has met all criteria for this priority process.		
Priority Process: Impact on Outcomes		
13.4	Indicator(s) that monitor progress for each quality improvement objective are identified, with input from clients and families.	
13.5	Quality improvement activities are designed and tested to meet objectives.	!
13.7	There is a process to regularly collect indicator data and track progress.	
13.8	Indicator data is regularly analyzed to determine the effectiveness of the quality improvement activities.	!
13.9	Quality improvement activities that were shown to be effective in the testing phase are implemented broadly throughout the organization.	!
13.10	Information about quality improvement activities, results, and learnings is shared with clients, families, teams, organization leaders, and other organizations, as appropriate.	
13.11	Quality improvement initiatives are regularly evaluated for feasibility, relevance, and usefulness, with input from clients and families.	

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

The community primary care centres in Ashern, Eriksdale, and St. Laurent (remotely) underwent a review to jointly cover the Priority Processes of Aboriginal Community Health and Wellness and the Aboriginal Integrated Primary Care service areas. These three primary care centres are situated in rural communities in the North Zone of the Interlakes Region, and represent the combined and integrated services provided to all clients, regardless of their identified racial status.

The programs are multidisciplinary, with medical services provided by physicians and Nurse Practitioners, Chronic Disease Nurse Specialists, Mental Health Counsellors, primary care RNs, and other allied providers, all of whom have access to further specialty care as needed, such as acute hospital care, psychiatry, Dialysis, physiotherapy, and others. These services are provided to remote First Nation and Metis communities in partnership with their community leadership and their federally funded First Nations and Inuit Health Branch (FNIHB) community health centres. Engaging the Public Health Agency of Canada and other federally governed FNIHB entities to commit to innovative change has proven to be a significant challenge. It is hoped that applying Jordan's Principle legislation may help overcome jurisdictional hurdles.

The "My Health" team at Ashern Lakeshore General Hospital and Personal Care Home has further developed the concept of integrated care and outreach programs with other services in Aboriginal communities.

Most of the services are provided through outreach visits to the clients in their communities. These visits to clients or to the clients' local health stations are essential since most clients have families to care for and lack the time and transportation to attend a healthcare visit. When available, telephone support is also provided, but there are gaps in cell service, and many clients do not own cell phones. The regional manager supports local team leads.

Staff members are clearly passionate about the programs and services they provide, and there is a strong sense of camaraderie and ownership of their responsibilities. They are willing to bend the rules to ensure that a particular client receives the care they deserve. They report an increase in trust between clients and health providers, as well as a gradual breakdown of suspicion and reluctance to accept care.

Exciting new partnerships are being developed or restored following COVID-19 shutdowns, with mixed funding sources. One of these partnerships is the Indigenous Doula Project, which will soon be implemented. It involves an Indigenous Doula who will visit pregnant and new mothers at their homes to provide culturally supportive local traditional knowledge and rituals, aiming to improve emotional and health outcomes for young families. Statistics have shown an increased incidence of preterm births and congenital syphilis in these vulnerable communities. One of the traditional teaching rituals being reintroduced is the strawberry heart berry ceremony, which played a central role in maintaining balance within oneself and close human relationships. The Knowledge Keeper Role nurtures others to follow in their footsteps and leads the way in restoring Indigenous traditions and values.

While the project is supported by IERHA, its leadership is centred within the Indigenous communities, following the principle of "nothing about us without us." The IERHA promotes these projects with the objective of aligning with the Truth and Reconciliation recommendations to encourage the breakdown of systemic racism in healthcare institutions.

The Knowledge Keeper role is rapidly developing in IERHA, with increasing opportunities to participate in traditional culturally significant rituals that help restore inner balance in people's lives. One popular restored activity is the Full Moon teachings, which involve ritual fire building during each of the 13 annual full moons. During these sessions, tobacco and yellow cloth are used, and individuals have the opportunity to release their pain into the fire, facilitating the healing process.

Priority Process: Competency

Primary care health services in Ashern are coordinated by the "My Health" team, which aims to consolidate all services and outreach through a unified patient access point. The team appears to have successfully addressed the challenge of collaborating with other jurisdictions and their health services—such as First Nations and Inuit Health Branch (FNIHB)—by maintaining effective communication and ensuring proper follow-up with the health staff from those centres, including the sharing of client health data. However, due to the use of different platforms, double charting is necessary.

Priority Process: Episode of Care

The "My Health" team, operating at Ashern Lakeshore General Hospital and Personal Care Home, is a collaborative program under joint IERHA and Indigenous partnership. The program has made notable advancements in service delivery. These include the provision of robot-mediated services in the communities through the support of University of Manitoba physiotherapy services, as well as the inclusion of a traditional healer and addictions support.

Through partnerships with numerous small Indigenous communities, the program has expanded its services to encompass specialized RN-led chronic illness care, follow-up medical care, Mental Health counselling, and additional support services such as rehab. These services now have regular appointment days within the communities and involve direct interaction with the health personnel at the community clinics. Plans are underway to introduce withdrawal services both in a hospital setting and through a mobile unit.

It is worth mentioning that the Pine Falls programs follow a similar collaborative approach. However, this accreditation survey only evaluated the Addictions care offered at that particular location. Moreover, the Pine Falls location houses the highly successful Giigewigamig Traditional Healing Centre, with an Indigenous Addiction Treatment Centre located nearby.

Priority Process: Decision Support

All the IERHA Aboriginal and primary clinics visited during the survey have access to the Accuro Electronic Medical record (EMR) platform. It is acknowledged that hospitalization data and services received in FNIHB health centres are not integrated into the network.

There is an opportunity to involve IT and EMR educators to assist and train staff members in maximizing the benefits of the software. For instance, they can help develop reminders for patients' future visits or flag referrals or tests that are pending completion.

The client e-chart is a particularly valuable document as it provides an up-to-date medication record, completed by both retail and hospital-based pharmacists, and lab and diagnostic test results, completed by the diagnostic services in the province. This record is accessible to any practitioner in any of the healthcare facilities.

There are opportunities to engage clients, families, and team members to provide feedback on the EMR and information system, as well as how to use them more efficiently.

Priority Process: Impact on Outcomes

The services provided through "My Health" teams and those involving outreach to smaller communities entail collaborative administrative arrangements with local community council leaders. The development of the "My Health" Team and the collaborative nature of the care serve as Quality Improvement strategies in themselves. The individual communities and the leadership of the "My Health" Team are encouraged to develop projects within their services that can enhance the quality and efficiency of the rendered services. Most importantly, they should establish measurable objectives (deliverables) with predetermined indicator data. For instance, the Cradle of Care project, which incorporates an Indigenous Doula, aims to reduce preterm births and the incidence of syphilis within this population. These statistics/indicators should be monitored as the project commences. Other statistics may include client satisfaction and safer deliveries, for example. Another local Quality Improvement example could involve creating two clinic rooms for the practitioner to work from: while the patient settles in one room and has their vitals measured, the practitioner attends to the client in the other room, switching between the two.

Standards Set: Aboriginal Integrated Primary Care - Direct Service Provision

Unmet Criteria		High Priority Criteria
Priority Process: Clinical Leadership		
The organization has met all criteria for this priority process.		
Priority Process: Competency		
The organization has met all criteria for this priority process.		
Priority Process: Episode of Care		
10.6	There is a system in place that provides team members reminders about clients needing follow-up services.	
10.11	A process to track clients through the referral process and consult with service providers is followed to monitor each client's progress.	
Priority Process: Decision Support		
The organization has met all criteria for this priority process.		
Priority Process: Impact on Outcomes		
17.4	Indicator(s) that monitor progress for each quality improvement objective are identified, with input from clients and families.	
17.5	Quality improvement activities are designed and tested to meet objectives.	!
17.6	New or existing indicator data are used to establish a baseline for each indicator.	
17.7	There is a process to regularly collect indicator data and track progress.	
17.8	Indicator data is regularly analyzed to determine the effectiveness of the quality improvement activities.	!
17.9	Quality improvement activities that were shown to be effective in the testing phase are implemented broadly throughout the organization.	!
17.10	Information about quality improvement activities, results, and learnings is shared with clients, families, teams, organization leaders, and other organizations, as appropriate.	

17.11 Quality improvement initiatives are regularly evaluated for feasibility, relevance, and usefulness, with input from clients and families.	

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

The primary care centres in Ashern, Eriksdale, and Saint Laurent (remotely) were collectively evaluated to encompass the Priority Processes of Aboriginal Community Health and Wellness and the Aboriginal Integrated Primary Care service areas.

As primary care clinics in rural communities within IERHA, the daily programming aligns with the schedules of the services offered, following the standard format of primary care clinics in the region. Additionally, there are designated days of the week or month for providing mobile services in remote communities or homes within the catchment area.

Priority Process: Competency

The human resource section at IERHA is responsible for maintaining staffing credentials and proficiency documents. Staff members are required to have insurance, which is covered by both the staff member and their registered licensing body. However, for staff members in non-registered fields such as Knowledge Keeper or Doula, insurance is provided by IERHA as part of their contract.

Staff members who were interviewed from the Ashern, Eriksdale, and Saint Laurent programs demonstrated a strong sense of pride in their work, appreciation for teamwork, and a shared sense of purpose fostered at these sites. These locations have a well-established organizational culture.

Priority Process: Episode of Care

The surveyor reviewed clinics located off reserve in the communities of Ashern, Eriksdale, and St. Laurent. Many clients served reside in smaller First Nation or Métis communities on and off reserves. Often, First Nation communities or FNIHB provide basic primary care health clinics, which serve as the primary facilities for these residents' care. The IERHA collaborates with partners to provide additional physician, addiction, chronic illness, and physiotherapy support through outreach visits and community clinics. There are ongoing partnerships being developed to support more traditional healing services and establish stronger liaisons with Knowledge Keepers and the Doula project.

//The patients interviewed, who visit these clinics, universally appreciate the services provided and feel they have good access to care. They feel safe and attended to, and those who identify as First Nation feel respected and receive equal care as non-indigenous individuals. Non-First Nation patients also feel safe and well cared for, receiving better, more comprehensive, and faster service compared to their family doctors in Winnipeg.

Access to tele-triage outside regular hours is not always possible when clients lack phones or live in areas without cell or internet coverage.

Providing care closer to home is an important service that IERHA is addressing. A regular blood collection service is now available at St. Laurent Health Clinic, which has been received positively by patients. Efforts have been made to improve the number of clients served and blood samples collected by streamlining the requisition process. If indicator data had been collected, it would have been an excellent quality improvement activity.

There is an opportunity to train staff members in using the Accuro EMR for logging requisitions and referrals, as well as highlighting overdue ones. Similarly, reminders for regular follow-up with patients for their chronic conditions can be created in the EMR.

Priority Process: Decision Support

The clinics utilize Accuro EMR for documenting patient encounters. Additionally, they possess access to the patient e-chart, which contains more extensive details regarding patient diagnostic results, medications, and certain discharge summaries and consultation letters. Collaborating with FNIHB for on-reserve documentation presents an opportunity to decrease the number of charts for a specific patient. It is beneficial that some of the Reserve Health centres already have access to Accuro.

Priority Process: Impact on Outcomes

The physicians, nurse practitioners, and other clinical providers, including chronic disease nurses and mental health providers, adhere to standard guidelines within their scope of practice. They engage in discussions with patient clients to ensure comprehension and promote improved compliance with management protocols.

Within each clinic, there are opportunities to develop quality improvement initiatives following the Plan-Do-Study-Act (PDSA) cycle. These initiatives should incorporate client and family advice, aiming to enhance the quality and efficiency of the services provided.

Standards Set: Aboriginal Substance Misuse Services - Direct Service Provision

Unmet Criteria			High Priority Criteria
Priority Process: Clinical Leadership			
The organization has met all criteria for this priority process.			
Priority Process: Competency			
3.7	Education and training are provided on the organization's ethical decision-making framework.		
3.11	Team member performance is regularly evaluated and documented in an objective, interactive, and constructive way.		!
Priority Process: Episode of Care			
9.9	Information relevant to the care of the client is communicated effectively during care transitions.		ROP
	9.9.1	The information that is required to be shared at care transitions is defined and standardized for care transitions where clients experience a change in team membership or location: admission, handover, transfer, and discharge.	**MAJOR**
	9.9.2	Documentation tools and communication strategies are used to standardize information transfer at care transitions.	**MAJOR**
	9.9.5	The effectiveness of communication is evaluated and improvements are made based on feedback received. Evaluation mechanisms may include: • Using an audit tool (direct observation or review of client records) to measure compliance with standardized processes and the quality of information transfer • Asking clients, families, and service providers if they received the information they needed • Evaluating safety incidents related to information transfer (e.g., from the patient safety incident management system).	**MINOR**
Priority Process: Decision Support			
The organization has met all criteria for this priority process.			
Priority Process: Impact on Outcomes			

16.2	The information and feedback gathered is used to identify opportunities for quality improvement initiatives and set priorities, with input from clients and families.	
16.4	Indicator(s) that monitor progress for each quality improvement objective are identified, with input from clients and families.	
16.5	Quality improvement activities are designed and tested to meet objectives.	!
16.6	New or existing indicator data are used to establish a baseline for each indicator.	
16.7	There is a process to regularly collect indicator data and track progress.	
16.8	Indicator data is regularly analyzed to determine the effectiveness of the quality improvement activities.	!
16.9	Quality improvement activities that were shown to be effective in the testing phase are implemented broadly throughout the organization.	!
16.10	Information about quality improvement activities, results, and learnings is shared with clients, families, teams, organization leaders, and other organizations, as appropriate.	
16.11	Quality improvement initiatives are regularly evaluated for feasibility, relevance, and usefulness, with input from clients and families.	

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

The Substance Misuse clinic at Pine Falls is a well-run and compact program situated within a beautiful, new (established seven years ago) Ambulatory Care Health Complex adjacent to the hospital in Pine Falls. It serves as a catchment area comprising several First Nation reserves, Metis communities, and general rural towns and communities. The health complex offers a variety of services, including cancer care and support services, primary care, chronic care, and the Substance Misuse clinic. The clinic serves a caseload of approximately 40–60 clients, which staff members believe represents less than 50% of the potential clients. There are excellent collaborations with other partners, including the nearby Mino treatment centre, which provides culturally appropriate seven-week programs, as well as harm reduction programs within the Reserves.

Barriers to client service include a lack of transportation to the clinic, limited-service options (a Rapid Access Addiction Medicine [RAAM] clinic offers more choices), the stigma associated with seeking help, and the fear of treatment failure stigma. Other barriers to the program include funding limitations and a lack of federal support for collaborative programming with the FNIHB Reserves within the catchment area, as well as significant staffing shortages.

The manager is developing program "ambassadors,' where successful clients become spokespersons for the program within their families or communities.

Priority Process: Competency

The service was originally developed seven years ago by one of the primary care doctors who recognized the need for Opioid Agonist Therapy (OAT) in the community. The service grew rapidly and now includes several doctors and a Nurse Practitioner (NP) who are fully trained in OAT and cater to the clientele. Access is open to all residents, and the protocols are followed for everyone. The team is close-knit and cohesive, maintaining strong ties with support programs in the surrounding communities. Innovative programming has been necessary to assist those who cannot regularly visit the clinic.

Staff members are well-acquainted with ethical dilemmas but are unfamiliar with the organization's ethical decision-making framework. There is an opportunity to develop a decision tree that aligns more closely with the cultural heritage of the First Nations people. Moving forward, it will be necessary to keep staff performance evaluations up to date and continue conducting regular crisis management and emergency response drills, at least annually.

Priority Process: Episode of Care

Medical charting at Pine Falls Health Complex is conducted using the Accuro EMR. The chart is shared among all providers, including the Substance Misuse team and the Primary Care team. The patient's medication list is maintained by all the prescribers and is reviewed prior to the onset of OAT. Additionally, there is a retail pharmacy located within the building.

The service collaborates with other programs that aim to promote education about the processes and underlying causes of addictions, substance misuse, and mental distress within Aboriginal communities (10.2). These programs also provide opportunities for healthy recreation and cultural activities to promote healing and a healthy lifestyle (10.4). However, many of these activities take place in Reserves that receive federal support (FNIHB), resulting in barriers to full participation in each other's programs. Some members of the discussion group noted that during the pandemic, there was a willingness to overcome these barriers in order to organize vaccine programs. Regrettably, these barriers seem to have resurfaced.

Transfers of care from the Substance Misuse team are infrequent. When they do occur, individualized information, including copies of medical records, is transferred along with a verbal report to the accepting provider. However, there is no structured review of the effectiveness of these transfers. This presents an opportunity for the entire Pine Falls Health Complex to develop or standardize existing provincial/health authority transfer communication forms.

Priority Process: Decision Support

The team utilizes the Accuro EMR, which is shared with other providers at the Health Complex.

Priority Process: Impact on Outcomes

Providers adhere to protocols for OAT treatments, while clients provide their consent to participate. Flexibility in dosage regimes is necessary due to the remoteness of certain communities and clients" lack of access to transportation to the health centre.

At present, there are no ongoing or scheduled quality improvement initiatives that utilize indicator data for outcome measurements. The program is understaffed and continuously adjusting to meet the demands, yet there is no monitoring of these changes through indicator data.

Standards Set: Ambulatory Care Services - Direct Service Provision

Unmet Criteria		High Priority Criteria
Priority Process: Clinical Leadership		
The organization has met all criteria for this priority process.		
Priority Process: Competency		
3.6	Education and training are provided on the organization's ethical decision-making framework.	
Priority Process: Episode of Care		
The organization has met all criteria for this priority process.		
Priority Process: Decision Support		
The organization has met all criteria for this priority process.		
Priority Process: Impact on Outcomes		
13.2	The procedure to select evidence-informed guidelines is reviewed, with input from clients and families, teams, and partners.	
13.3	There is a standardized process, developed with input from clients and families, to decide among conflicting evidence-informed guidelines.	!
13.4	Protocols and procedures for reducing unnecessary variation in service delivery are developed, with input from clients and families.	!
15.2	The information and feedback gathered is used to identify opportunities for quality improvement initiatives and set priorities, with input from clients and families.	
15.4	Indicator(s) that monitor progress for each quality improvement objective are identified, with input from clients and families.	
15.9	Quality improvement activities that were shown to be effective in the testing phase are implemented broadly throughout the organization.	!
15.10	Information about quality improvement activities, results, and learnings is shared with clients, families, teams, organization leaders, and other organizations, as appropriate.	
15.11	Quality improvement initiatives are regularly evaluated for feasibility, relevance, and usefulness, with input from clients and families.	

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

Dialysis

The IERHA operates six dialysis sites with a total capacity of approximately 128 runs per day. One of these sites, the Selkirk Regional Health Centre, has the capacity for 48 runs per day and offers service for six days a week, with three full shifts each day. Another site, the Berens River Renal Health Centre, has an operating capacity of four runs and is open on Mondays, Wednesdays, and Fridays. The capacity at Gimli Hospital fluctuates during the summer months when cottages are open. The renal programs provided by IERHA are part of the Manitoba Renal Program.

Outpatient Clinic

An outpatient clinic at the Selkirk site offers ambulatory services to patients who may require intravenous antibiotics, blood transfusions, paracentesis, or complex wound care, among other treatments. The clinic comprises four treatment rooms and a procedure room for minor procedures, three stretchers, and three lounge chairs. The clinic is supported by two Licensed Practical Nurses and a Health Care Aide. Additionally, a Clinical Nurse Specialist, who has successfully completed a level 2 wound care course, can provide wound care support. The clinic aims to provide essential care services while ensuring patients remain as outpatients.

The area is well-lit, clean, and spacious.

There are plans to open a pain clinic in September 2023 at the Selkirk site, and lead lining is currently being installed in the walls of a procedure room. It is estimated that approximately 2,000 patients will receive treatment in the first year of the pain service. The community welcomes this service, as it offers hope for reducing long wait times.

Priority Process: Competency

The nursing staff working in the dialysis unit have received hands-on training, education, and mentoring at a larger facility in Winnipeg. The healthcare aides are trained to perform various administrative tasks, in addition to gathering dialysis supplies and supporting the nursing staff.

The dialysis machines, protocols, and practices are standardized across all sites. Some dialysis staff may move from one site to another to provide coverage during vacations or leaves. While speaking with an agency nurse who works in multiple dialysis units at IERHA, she found the transition to be relatively easy and mentioned only a few minor differences in practices among the hospital dialysis sites.

This program is complemented by the support of spiritual care staff, and patients and their families have access to a beautiful spiritual room located near the dialysis unit.

The staff working in the ambulatory programs have received education on IV pumps.

The manager is new to her position and plans to complete performance appraisals in the upcoming months.

Priority Process: Episode of Care

The Dialysis unit is spacious, well-organized, and each patient has a bed with privacy curtains. Television is provided at no cost to the patient.

Weekly telephone rounds are completed by the Dialysis Resource Nurse and the Renal team. It would benefit this unit to have telemedicine capabilities, enabling the provision of clinical health information and visual assessment of the patient from a distance. Once a year, the Renal team will visit the site. The Renal Team consists of a Social Worker, Nephrologist, Dietician, Pharmacist, and Nephrology Nurse. When speaking to patients in the Dialysis Unit, they expressed the desire for more contact with the Renal Team.

In the Dialysis Department, the Best Possible Medication History (BPMH) is currently completed by the referring hospital and reviewed with the client upon admission. The organization is encouraged to complete their own BPMH upon admission to the IERHA dialysis program and include input from the patient.

The Dialysis Program is encouraged to standardize the methods used for patient identification. Some staff use a photo of the patient located in the patient's file, while others use the name and birthday of the patient. Some patient files were missing phones, which can pose a risk, especially for patients with dementia.

When speaking to patients, they expressed extreme satisfaction and gratitude for the care they receive from the healthcare team. They feel comfortable and have their needs met. There is a request for designated parking for dialysis patients near the building, as well as consideration for reduced parking rates for patients who need to visit the hospital at least three times a week.

Priority Process: Decision Support

The patients' health records are hybrid charts, which are well-organized and include relevant documents like advanced directives, consents, histories, demographic information, and next of kin details. These charts are kept at the communication stations, and patients can access their health information through the Health Information Services Department. The organization's website offers information to the community regarding privacy and the patient advocate agreement processes.

The staff has received privacy education and is acquainted with the procedures for submitting an occurrence, conducting investigations, and disclosing information.

Family members are welcome on-site when accompanying dialysis patients.

Priority Process: Impact on Outcomes

As part of a quality improvement initiative, a Patient Experience Survey was conducted in February 2022. The results were analyzed and shared with the Dialysis team. Overall, the feedback was very positive. One key finding was that patients expressed a desire for improved communication and education throughout the entire continuum of care. This finding was reinforced during discussions with patients in the dialysis unit.

In the Ambulatory programs, quality boards are in place, and daily huddles are held. Staff members review the indicators. The organization encourages ongoing development of quality initiatives and key indicators that can be monitored by staff. There is an opportunity to enhance staff knowledge on quality assurance work and engage their support in advancing quality within the organization. By doing so, staff capacity for understanding and implementing quality and safety initiatives will have a positive impact on both quality and patient safety.

Falls and medication safety calendars are posted on the Visboards.

Standards Set: Cancer Care - Direct Service Provision

Unmet Criteria	High Priority Criteria
Priority Process: Clinical Leadership	
The organization has met all criteria for this priority process.	
Priority Process: Competency	
17.12 Access to spiritual space and care is provided to meet clients' needs.	
Priority Process: Episode of Care	
18.5 Environmental distractions are minimized for team members who are performing critical tasks requiring concentration.	
Priority Process: Decision Support	
The organization has met all criteria for this priority process.	
Priority Process: Impact on Outcomes	
27.12 Data about disease control and survival outcomes are collected.	
Priority Process: Medication Management	
The organization has met all criteria for this priority process.	

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

The chemotherapy satellites of the Interlake-Eastern Regional Health Authority (IERHA) collaborate with CancerCare Manitoba (CCM).

We conducted surveys at the two satellite sites in Gimli and Pinawa. At both locations, the clinical teams are dedicated and passionate about providing excellent care to their patients. Patients and their families expressed wholehearted praise and positive comments regarding the staff and the quality of care they receive.

One barrier that was identified is the vast geographic area and potential transportation issues. The cancer navigation services, along with their dedicated staff, work diligently to address this by arranging transportation to and from appointments, as well as repatriating patients to their home communities. Additionally, the nurse navigator team ensures optimal cancer management and provides support to patients and their families.

The Gimli site has long-standing issues related to space. Families who wish to accompany clients have nowhere to sit, exacerbating the cramped quarters. The limited space creates challenges in infection control, noise, falls, and confidentiality. Despite this issue being raised in previous surveys, it has not yet been resolved.

Priority Process: Competency

CancerCare Manitoba is responsible for overseeing and providing cancer care at multiple sites throughout the region. The sites included in this health authority are Selkirk, Gimli, and Pinawa.

CancerCare Manitoba handles a significant portion of the specialized training and certification. Local site-specific orientation is also provided. Care providers have access to various educational opportunities, including training on new medications and therapies. Meticulous adherence to guidelines and safety protocols is ensured.

Unfortunately, neither site currently offers a dedicated spiritual space. It may be beneficial to provide an area where families can wait during treatment or simply have a quiet space available.

Priority Process: Episode of Care

Patients and families expressed overall satisfaction with the care they received. Many local clients expressed gratitude for being able to receive their treatment locally. They felt they were provided with all the necessary information and were comfortable asking any additional questions. The Cancer Navigation Services were frequently mentioned, and there was a strong appreciation for the support and guidance provided by this program.

Employees undergo regular performance reviews, and their skills and competencies are maintained at both satellite sites. They receive recognition for their contributions in team huddles, meetings, and on a one-to-one basis with leadership.

The Gimli site has two older chairs that may pose a safety hazard. It is recommended that these chairs be replaced. The environment does not provide a distraction-free space for nurses to prepare for medication administration or a low-stimulation zone for patients.

Despite these sites being located in small rural communities where many patients are known to the staff, there was still a commitment to ensuring proper patient identification.

Priority Process: Decision Support

The Cancer Care program greatly benefits from the computerization of its information. There is a smooth flow of information regarding patients between CancerCare Manitoba and the satellite sites. Referrals can be promptly made, and patient information can be easily shared between the sites through this system.

Pharmacy support is provided by Selkirk and Winnipeg, and medications are transported between the sites using a courier service.

Priority Process: Impact on Outcomes

Audits and surveys are conducted by CancerCare Manitoba and the individual satellite centres. However, the data collected by these surveys is not shared with clients, families, and teams. The inclusion of a quality board in the Cancer Care area could provide these groups with accessible information.

A variety of indicators are being collected and discussed at the leadership level. This includes new patient referrals, outpatient treatment numbers, and nurse-patient ratios per year, which are compared to previous years' performance. This information is then used at the site levels to make improvements. For instance, notable increases in outpatient referrals have led to the need for higher staffing levels. However, most quality project initiatives are primarily driven by Cancer Care Manitoba, with limited input from site teams, patients, and families. The sites are encouraged to identify some quality projects at the site level and showcase them.

Priority Process: Medication Management

CancerCare Manitoba provides a comprehensive orientation program and ongoing teaching opportunities to enhance and maintain best practice guidelines and safety protocols for administering systemic chemotherapy.

Procedures are in place to accommodate patients and families who prefer to undergo certain chemotherapies at home. Detailed instruction packages have been prepared, covering safety measures such as the provision of take-home spill kits.

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

Unmet Criteria		High Priority Criteria
Priority Process: Clinical Leadership		
The organization has met all criteria for this priority process.		
Priority Process: Competency		
The organization has met all criteria for this priority process.		
Priority Process: Episode of Care		
The organization has met all criteria for this priority process.		
Priority Process: Decision Support		
The organization has met all criteria for this priority process.		
Priority Process: Impact on Outcomes		
17.5	Quality improvement activities are designed and tested to meet objectives.	!
17.6	New or existing indicator data are used to establish a baseline for each indicator.	
17.9	Quality improvement activities that were shown to be effective in the testing phase are implemented broadly throughout the organization.	!
17.10	Information about quality improvement activities, results, and learnings is shared with clients, families, teams, organization leaders, and other organizations, as appropriate.	
17.11	Quality improvement initiatives are regularly evaluated for feasibility, relevance, and usefulness, with input from clients and families.	
Surveyor comments on the priority process(es)		
Priority Process: Clinical Leadership		

Mental Health Services are planned at the regional and provincial levels. The ongoing task involves navigating provincial movements, initiatives, and programs. The organization places a strong emphasis on building relationships and engaging with provincial partners. The efficient management of patient flow is considered a crucial measure for the organization. Collaborations and partnerships with other organizations are established to provide support to clients and the community, with an ongoing focus on

raising awareness about mental health.

The services and supports provided adopt a client-centred and client-directed approach. Client goals and objectives are identified and expressed using the clients' own words. Whenever possible, services and supports are focused on recovery and are inclusive of the client's family and natural support systems. The organization actively participates in activities aimed at enhancing the community's ability to support clients and families seeking mental health services.

Priority Process: Competency

Staff and leaders in this organization are dedicated to providing excellent services and care. The staff receives training and ongoing educational opportunities. They feel supported in their continuous education and training efforts. Additionally, team member performance is regularly evaluated and documented in an objective and interactive manner. Recently, there has been a positive change in the format of the performance evaluation, as reported by the staff.

To ensure effective communication, standardized tools are used to share information about the clients' care among different teams. The staff expresses high satisfaction with the implementation of the EMR system. They are also hopeful that the EMR will be expanded to include other departments involved in the care continuum.

Priority Process: Episode of Care

Community Mental Health (CMH) provides individuals with the least restrictive, least resource-intensive, least expensive, and least intrusive intervention through a stepped care approach. There are five steps, ranging from the general population (step 1) to severe or complex needs (step 5). There are approximately eleven CMH programs, such as child and adolescent CMH, adult CMH, intensive care management, shared care, and mental health services for the elderly. Consulting psychology and psychiatry services are available. A committed and engaged CMH team supports individuals and the community.

Access to CMH occurs through central intake or direct referral to programs, such as Cognitive Behavioural Therapy with Mindfulness (CBTm) classes or shared care. Crisis services are supported through a 24-hour crisis line, a crisis stabilization unit, mental health liaison nurses, and mobile crisis services for both adult and youth populations. There are a number of partnerships in the community, including Selkirk Mental Health Centre, Harm Reduction Network, Suicide Prevention Committee, and Fetal Alcohol Spectrum Disorder (FASD) Coalition.

There has been a noted increase in the complexity of cases and an increase in wait time to access services and programs. It is recommended to continue exploring timely access to services. Recruitment and retention have been ongoing challenges. Access issues to CMH in remote and First Nations communities are ongoing challenges, including limitations to technology and connectivity in remote regions.

Clients and families are provided with their choice of location for support wherever possible, including a hybrid approach. Defined criteria are used to determine when to initiate services. In addition, there is a process to quickly schedule clients who require immediate services into the team's schedules. Each team member holds a weekly time slot in their schedule for immediate and high-risk referrals.

Clients report high satisfaction with the program. There is a high level of trust and confidence in the staff and clinicians. Staff are accessible and supportive. Clients and families are encouraged to be actively engaged in their care. The clients' wishes regarding family involvement in their care are respected and followed.

Standardized assessment tools—such as a suicide risk screener and depression rating scale—are used during the assessment process. Medication history is taken, and a list of medications is generated. It is recommended that the medication list be compared more thoroughly with medications in the client's home (when home visits occur) and that the client is encouraged to bring all medications (over-the-counter and vitamins) to the office appointment. This would generate a more comprehensive understanding of medications that are not currently captured in the EMR.

Priority Process: Decision Support

Technology and information systems have been developed and implemented in Community Mental Health with the EMR. This has assisted in maintaining accurate, up-to-date, and comprehensive records. A standardized set of health information is collected to ensure consistency and comparability of client records. Standardized assessments, such as suicide risk assessment, violence screeners, depression rating scale, and cognitive assessments (where applicable), are completed.

Clients can access their records upon request. They are provided with copies of their goals and objectives, including SMART (Specific, Measurable, Achievable, Relevant, and Time-Bound) goals where applicable. Information is documented in the client's record, which is securely stored in the EMR. Clients report feeling that their information is kept confidential and private.

There are proposed plans for the growth of mental health support, including the addition of approximately four mental health liaison nurses and increased resources for youth with complex neurological disorders. The approval of these proposals is yet to be determined. Integrated mental health team pilot projects present an opportunity for the development of quality improvement indicators, timelines, testing, evaluation, and the formalization of quality improvement processes.

Priority Process: Impact on Outcomes

There are guidelines and protocols in place to reduce unnecessary variation in service delivery, in accordance with Canadian and British spelling. A proactive approach is employed to identify risks to clients and team members. It might be beneficial to consider implementing "panic buttons" or other measures as staff members work with clients who exhibit violent or unpredictable behaviours (such as purple rings).

The CMH team has embraced a hybrid model of in-person and virtual services, based on input from individuals and clients. Additionally, the RAAM clinic has expanded its services, and there has been an enlargement of the EMR system. Staff and physicians express satisfaction with the EMR expansion, although there is a desire for its extension to other programs, such as home care and personal care homes.

Patient safety incidents are reported, and efforts are made to make improvements. The organization is encouraged to formalize the involvement of clients and families in the program, including participation in quality improvement initiatives. Furthermore, it is recommended to formalize the quality improvement initiatives themselves, including the testing and evaluation of these initiatives. Sharing the results of these initiatives with staff members throughout the organization is highly encouraged.

Standards Set: Emergency Department - Direct Service Provision

Unmet Criteria			High Priority Criteria
Priority Process: Clinical Leadership			
1.3	Specific goals and objectives regarding wait times, length of stay (LOS) in the emergency department, client diversion to other facilities, and number of clients who leave without being seen are established, with input from clients and families.		
2.9	The effectiveness of resources, space, and staffing is evaluated with input from clients and families, the team, and stakeholders.		
Priority Process: Competency			
The organization has met all criteria for this priority process.			
Priority Process: Episode of Care			
10.2	The assessment process is designed with input from clients and families.		
12.6	Working in partnership with clients and families, at least two person-specific identifiers are used to confirm that clients receive the service or procedure intended for them.		ROP
	12.6.1	At least two person-specific identifiers are used to confirm that clients receive the service or procedure intended for them, in partnership with clients and families.	**MAJOR**
Priority Process: Decision Support			
The organization has met all criteria for this priority process.			
Priority Process: Impact on Outcomes			
16.2	The procedure to select evidence-informed guidelines is reviewed, with input from clients and families, teams, and partners.		
16.3	There is a standardized process, developed with input from clients and families, to decide among conflicting evidence-informed guidelines.		!
16.4	Protocols and procedures for reducing unnecessary variation in service delivery are developed, with input from clients and families.		!
18.2	The information and feedback gathered is used to identify opportunities for quality improvement initiatives and set priorities, with input from clients and families.		

18.4	Indicator(s) that monitor progress for each quality improvement objective are identified, with input from clients and families.	
18.7	Quality improvement activities are designed and tested to meet objectives.	!
18.10	Indicator data is regularly analyzed to determine the effectiveness of the quality improvement activities.	!
18.11	Quality improvement activities that were shown to be effective in the testing phase are implemented broadly throughout the organization.	!
18.12	Information about quality improvement activities, results, and learnings is shared with clients, families, teams, organization leaders, and other organizations, as appropriate.	
18.13	Quality improvement initiatives are regularly evaluated for feasibility, relevance, and usefulness, with input from clients and families.	

Priority Process: Organ and Tissue Donation

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

The Emergency Departments (ED) are well supported by enthusiastic and dedicated leaders who possess a genuine understanding of the day-to-day work involved in running an ED. The ED staff members feel supported and listened to by management when they raise concerns, issues, or provide positive feedback regarding patient care. IERHA should encourage the implementation of processes to mentor and coach new ED leaders. One possible opportunity is to include a regular item on their monthly agenda for discussing leadership approaches, including performance management and quality improvement.

The space is designed to be universally accessible for staff, clients, and family members. It features wide hallways with ample lighting, ensuring a clutter-free environment.

The EDs should continue to explore opportunities to incorporate feedback and input from clients and families in various areas, including service design, physical space, and care and safety.

Priority Process: Competency

The EDs perform an outstanding job in providing training and education to staff, including the necessary support for agency personnel. This encompasses both orientation and ongoing education and training. The ED nursing teams are dedicated to delivering safe, competent, and compassionate care to clients, utilizing their Learning Management System (LMS), and conducting face-to-face seminars.

A comprehensive training program is in place for smart pumps, including processes to facilitate the introduction of the new smart pump (B Braun).
Processes are reviewed and updated to ensure the safe use of both existing and new equipment, devices, and supplies.

Staff members reported receiving annual performance appraisals that identify their strengths, areas for improvement, and an action plan. Staff members acknowledged receiving recognition through various means, such as thank-you notes, emails, and celebrations.

The EDs employ a collaborative approach that involves clients and their families.

Robust protocols are in place to support training and education concerning workplace violence.

The EDs are encouraged to collaborate with the sites in establishing spiritual spaces for their clients and families.

Priority Process: Episode of Care

The EDs are well supported by enthusiastic and dedicated leaders who possess a genuine understanding of the day-to-day work involved in running an ED. IERHA is encouraged to establish processes for mentoring and coaching a number of new ED leaders.

The EDs have a collaborative, interprofessional team that is committed to person-centred care. Their caring and compassionate approaches were evident during each and every ED visit. The physicians and nurses collaborate seamlessly, ensuring smooth handovers at each stage of the care journey in the ED. Well-established transition processes exist between staff, including EMS and the ED. The transfer of accountability between the ED and inpatient services is effectively managed. The EDs have sound processes and strategies in place to handle both anticipated volume increases (e.g., summer surges) and unexpected surges (e.g., diversions from unexpectedly closed EDs). The EDs maintain clutter-free high-traffic areas.

The EDs need to collaborate with staff to ensure consistent use of two-person identifiers for all clinical client interactions (e.g., triage, assessment, and treatment).

Redesigns are required in the registration and triage areas to optimize client and staff safety, privacy, and confidentiality. The current physical structure of the EDs hinders monitoring of clients' stability in the waiting rooms. Staff currently conduct hourly checks, but more frequent monitoring is usually carried out to ensure clients' safety (e.g., monitoring for changes in conditions) at all times.

The triage area at Beausejour places staff in an unsafe situation as there is no alternative exit route. While a panic button has been added, it would be beneficial to redesign the space.

The registration area at Stonewall and District Health Center poses a safety risk for staff. There is no barrier to prevent agitated clients or families from approaching, creating an unsafe situation for staff members. Installing plexiglass across the counter-opening is recommended to provide staff protection.

Priority Process: Decision Support

The ED possesses a comprehensive documentation system that captures information from registration to discharge. Clear triage documentation tools are in place, providing guidance on prioritizing clients based on Canadian Triage and Acuity Scale (CTAS). Robust handoff processes are implemented, encompassing written and verbal communication between EMS and ED, as well as during the transition from ED to inpatient bed or external transfer. The transfer of accountability is thoroughly documented through bedside handover and signatures involving clients and family members.

Effective processes are in place to facilitate the coordination of information.

The EDs adhere to legislated record-keeping practices for the storage, retention, and destruction of client medical records.

The organization needs to continue its shift toward an electronic medical record that can integrate numerous processes in the ED, such as triage, assessment/treatment, and transfers.

Priority Process: Impact on Outcomes

The EDs do an excellent job of sharing performance metrics related to patient safety, such as falls, medication management, and hand hygiene. They also share information pertaining to results captured from the Canadian In-Patient Experience Surveys. The EDs are encouraged to re-engineer how the performance metrics are communicated on the Visboard so that team members can understand the relevance of the information within their work area. For example, the one pager that shares the hand hygiene metrics does not include the organization target or the target the ED has set for themselves.

There was a lack of evidence that the metrics are being used to generate quality improvement initiatives. It is encouraged to educate frontline staff to become champions in quality improvement. Small teams coming together for one cause have shown that changes are easily achieved (for example, staff input into the design and implementation of the bedside whiteboards).

Priority Process: Organ and Tissue Donation

IERHA has well-developed organ and tissue donation policies and protocols in partnership with Winnipeg Health Sciences Centre. The staff have a good understanding of the timeframes for calling once a death occurs in the rural ED sites. Registration staff and nursing have a “Death Package” that helps rural staff with the process. Organ and tissue procurement are not carried out in the rural ED sites; however, early awareness to identify potential donors facilitates the timely donation process.

The EDs are encouraged to place posters in the treatment rooms at each site, communicating the organ and tissue donation processes.

Standards Set: EMS and Interfacility Transport - Direct Service Provision

	Unmet Criteria	High Priority Criteria
Priority Process: Clinical Leadership		
1.4	Transport planning is undertaken with input from patients, families, and partners.	
3.3	Awareness is raised about the organization's role in the community through team participation in community and outreach events.	
27.5	The results of ongoing retrospective case reviews are used to improve care.	!
Priority Process: Competency		
5.8	Education and training are provided on the organization's ethical decision-making framework.	
5.20	Team member performance is regularly evaluated and documented in an objective, interactive, and constructive way.	!
5.21	Patient and family representatives are regularly engaged to provide input and feedback on their roles and responsibilities, role design, processes, and role satisfaction, where applicable.	
5.22	Team members are supported by team leaders to follow up on issues and opportunities for growth identified through performance evaluations.	!
6.7	The effectiveness of team collaboration and functioning is evaluated and opportunities for improvement are identified.	
7.2	Training for stress recognition and management is provided to team members.	
7.9	Education and training are provided on how to identify, reduce, and manage risks to patient and team safety.	!
Priority Process: Episode of Care		
16.2	The ethical decision-making framework is used when deciding whether to decline or accept a mission.	!
19.11	Ethics-related issues are proactively identified, managed, and addressed.	!
20.16	There is a standardized process to manage situations where patients refuse services.	!

Priority Process: Decision Support		
	The organization has met all criteria for this priority process.	
Priority Process: Impact on Outcomes		
25.2	The procedure to select evidence-informed guidelines is reviewed, with input from patients and families, teams, and partners.	
25.3	There is a standardized process, developed with input from patients and families, to decide among conflicting evidence-informed guidelines.	!
25.4	Protocols and procedures for reducing unnecessary variation in service delivery are developed, with input from patients and families.	!
25.5	Guidelines and protocols are regularly reviewed, with input from patients and families.	!
26.1	A proactive, predictive approach is used to identify risks to patient and team safety, with input from patients and families.	!
26.3	Strategies are developed and implemented to address identified safety risks, with input from patients and families.	!
26.5	Safety improvement strategies are evaluated with input from patients and families.	!
27.1	Information and feedback is collected about the quality of services to guide quality improvement initiatives, with input from patients and families, team members, and partners.	
27.2	The information and feedback gathered is used to identify opportunities for quality improvement initiatives and set priorities, with input from patients and families.	
27.4	Indicator(s) that monitor progress for each quality improvement objective are identified, with input from patients and families.	
27.6	Quality improvement activities are designed and tested to meet objectives.	!
27.7	New or existing indicator data are used to establish a baseline for each indicator.	
27.8	There is a process to regularly collect indicator data and track progress.	
27.9	Indicator data is regularly analyzed to determine the effectiveness of the quality improvement activities.	!

27.10	Quality improvement activities that were shown to be effective in the testing phase are implemented broadly throughout the organization.	!
27.11	Information about quality improvement activities, results, and learnings is shared with patients, families, teams, organization leaders, and other organizations, as appropriate.	
27.12	Quality improvement initiatives are regularly evaluated for feasibility, relevance, and usefulness, with input from patients and families.	
Priority Process: Medication Management		
13.10	A documented and coordinated approach to safely manage high-alert medications is implemented.	ROP
13.10.1	There is a policy for the management of high-alert medications.	**MAJOR**
13.10.2	The policy names the role or position of individual(s) responsible for implementing and monitoring the policy.	**MINOR**
13.10.4	The policy includes procedures for storing, prescribing, preparing, administering, dispensing, and documenting each identified high-alert medication.	**MAJOR**
13.10.5	Concentrations and volume options for high-alert medications are limited and standardized.	**MAJOR**
13.10.6	Client service areas are regularly audited for high-alert medications.	**MINOR**
13.10.7	The policy is updated on an ongoing basis.	**MINOR**
13.10.8	Information and ongoing training is provided to team members on the management of high-alert medications.	**MAJOR**
Priority Process: Infection Prevention and Control		
8.1	An individual or group is designated to lead and coordinate the IPC program.	
8.7	Compliance with accepted hand-hygiene practices is measured.	ROP

8.7.1	Compliance with accepted hand-hygiene practices is measured using direct observation (audit). For organizations that provide services in clients' homes, a combination of two or more alternative methods may be used, for example: • Team members recording their own compliance with accepted hand-hygiene practices (self-audit). • Measuring product use. • Questions on client satisfaction surveys that ask about team members' hand-hygiene compliance. • Measuring the quality of hand-hygiene techniques (e.g., through the use of ultraviolet gels or lotions).	**MAJOR**
8.7.2	Hand-hygiene compliance results are shared with team members and volunteers.	**MINOR**
8.7.3	Hand-hygiene compliance results are used to make improvements to hand-hygiene practices.	**MINOR**
9.2	Policies, procedures, and legal requirements are followed when handling bio-hazardous materials.	

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

Emergency Medical Services (EMS) falls under the Shared Services portfolio, and efforts are currently underway to construct and facilitate a provincial EMS service delivery model. As part of this process, surveys were conducted with the local EMS leadership team and six sites within the area served by the Interlake-Eastern Regional Health Authority. Discussions also took place with the communication/dispatch centre for rural Manitoba, which is situated in Brandon. The response and deployment plan, known as the System Status Management (SSM) plan, is well-defined. This plan relies on geo-posting to ensure adequate coverage of a large rural area with a limited fleet and several small hospitals that may or may not be operational at any given time due to challenges related to physician, nurse, and other staff availability. The plan identifies castle sites, which are priority locations with in-service ambulances, and strategically positions geo-posted vehicles to cover areas beyond the castle sites. Mechanisms are in place to regularly review the SSM plan and make additional determinations regarding inter-facility transfers, particularly when critical staff shortages or other factors causing service disruptions are involved.

A Medical Oversight Team (MOT) has been established as part of the provincial service. The leadership team describes the MOT's role in a manner that aligns with the standards and provides support to the service providers in the communities visited during the survey. The teams have acknowledged the value of additional support for services such as palliative care, stroke, and cardiac care. These supports are appreciated, routinely utilized, and play a significant role in ensuring safety and quality assurance.

There is no evidence of a formalized approach to engaging clients and their families beyond discussions that occur during episodes of care or opportunities to provide feedback through surveys.

Priority Process: Competency

Staff consistently describe training as “hit and miss,” particularly when in-person training is required. In certain instances, the deficiencies are attributed to the pandemic response, while in other cases, they are attributed to things slipping through the cracks during the transition from the Health Authority to the Shared Services organization. Many educational modules are available in the LMS, but staff members are not accessing education and professional development unless it is mandatory and followed up by management.

It is recommended that a review of mandatory education requirements be conducted, along with an evaluation of the approach to performance review and planning. This review could focus on identifying existing barriers, developing strategies to improve uptake, and establishing connections between education and priorities for quality improvement.

Priority Process: Episode of Care

There is a dedicated Communication and Dispatch Centre for rural EMS located in Brandon, Manitoba. The centre is operated in-house by Shared Services. The tracers conducted during this on-site survey provided consistent evidence and feedback from staff, indicating that processes are standardized, reliable, and sensitive to rural operations.

A standardized patient record is in place, reflecting the steps in an episode of care and proving useful for the point of transition during patient handoff.

A well-defined deployment plan, known as System Status Management, is implemented. The plan incorporates geo-posting methodology to optimize available staffing and emergency department capacity in the geographic area.

The organization is experiencing considerable stress due to the transition to a provincial body and the challenges associated with recruitment and retention. This stress has resulted in a sense of disengagement from the strategic and operational priorities of the organization at the point of care. During numerous site visits, interviews, and tours conducted for this survey, staff consistently demonstrated good practice. However, they attributed the quality of care to their professional training and accountability, rather than tangible support from the organization.

Although there were few concerns regarding the quality of care, it is evident that there are risks associated with the lack of engagement with systemic priorities. These priorities include ethical decision-making, incident reporting, occupational health and safety, infection prevention and control, client and family-centred care, cultural safety and competence for Indigenous Health, and structured Quality Improvement.

It is recommended that the organization consider communication strategies and activities aimed at improving engagement and involving staff in decision-making processes. This approach should aim to mitigate the perception that all decisions are made from the top down. One possible solution is to make a more concerted effort to employ Quality Improvement activities and tools specifically designed to ensure staff participation in the selection and monitoring of key performance indicators. This can be achieved through huddles, quality boards, facilitated quality improvement initiatives, and other similar measures.

Priority Process: Decision Support

The primary health record in accordance with Canadian/British spelling is the Patient Care Report (PCR). This is a paper-based multi-copy form utilized to record interventions starting from the call initiation by the Communications/Dispatch Centre up to the handover. Documentation takes place in real time or immediately after an intervention, depending on whether the paramedic can write while delivering care.

The PCR is a standardized document that has been in use since approximately 1996. While there is feedback from staff suggesting that certain aspects of the form are obsolete or poorly designed, there is a consensus that it contains the essential sections for documenting patient registration, clinical notes, and billing information.

Privacy and confidentiality are prioritized in consultations with patients, family members, and in terms of records storage. The PCR serves as the written process for sharing information during handoff at the point of transition. Some concerns have been addressed regarding the level of engagement by receiving facilities during this transition.

All units have access to standardized online care maps, policies, and procedures that support clinical practice.

Priority Process: Impact on Outcomes

At the site and zone levels, there is a sense that not much rigour is applied to collecting, analyzing, sharing, and evaluating indicator data. A more in-depth discussion about performance indicators, such as response times and time spent waiting in emergency departments, indicates awareness that such data is available. However, there has been very little engagement regarding results and evidence-based decision-making since the transition to Shared Services was initiated.

There is evidence that documentation, protocols, and practices are quite standardized. This puts the organization in a good position to select and establish key performance indicators that align with strategic and operational plans, making them meaningful and visible. It is recommended that a concerted effort be made to ensure selected key performance indicators are highly visible to staff through regular reporting intervals. This way, discussions about targeted quality improvement initiatives and the role of staff and leaders in achieving operational and strategic outcomes can occur at the point of care.

Priority Process: Medication Management

There are a limited number of medications stocked in the EMS stations and ambulances. Policies and procedures are in place to secure and reconcile narcotics at the beginning and end of each shift.

Storage and inventory management for medications other than narcotics show inconsistent approaches. Generally, these medications are not kept in locked storage. For instance, high alert medications are not consistently separated and visibly identified as such.

An initiative is currently underway to install secure storage in every ambulance.

It is recommended to undertake a review of medication management practices with the aim of improving storage and inventory procedures for all medications. Staff would benefit from access to pharmacist consultation and support for this purpose.

Priority Process: Infection Prevention and Control

There are policies and procedures in place to support Infection Prevention and Control (IPAC) practices. However, in the field, staff and local leaders have expressed that there is minimal presence of IPAC practitioners and a low profile for IPAC. Educational materials, including hand hygiene promotional materials, are not prominently displayed at the sites. Staff members describe the IPAC program as largely unsupported, with individuals having to rely on their own professional training to understand expectations and practise accordingly. While there are awareness and standard practices regarding the sanitization of ambulances between episodes of care, it is recommended that a more proactive and visible approach to IPAC be adopted.

Standards Set: Home Care Services - Direct Service Provision

Unmet Criteria		High Priority Criteria
Priority Process: Clinical Leadership		
The organization has met all criteria for this priority process.		
Priority Process: Competency		
3.1	Required training and education are defined for all team members with input from clients and families.	!
3.10	Team member performance is regularly evaluated and documented in an objective, interactive, and constructive way.	!
3.12	Team members are supported by team leaders to follow up on issues and opportunities for growth identified through performance evaluations.	!
Priority Process: Episode of Care		
The organization has met all criteria for this priority process.		
Priority Process: Decision Support		
The organization has met all criteria for this priority process.		
Priority Process: Impact on Outcomes		
15.6	New or existing indicator data are used to establish a baseline for each indicator.	
15.8	Indicator data is regularly analyzed to determine the effectiveness of the quality improvement activities.	!
15.9	Quality improvement activities that were shown to be effective in the testing phase are implemented broadly throughout the organization.	!
15.10	Information about quality improvement activities, results, and learnings is shared with clients, families, teams, organization leaders, and other organizations, as appropriate.	
15.11	Quality improvement initiatives are regularly evaluated for feasibility, relevance, and usefulness, with input from clients and families.	

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

Home Care Services, as evidenced by site-specific reviews of Kin Place Health Complex and Lundar Personal Care Home and Community Health Office, meet all the referenced criteria. The services provided are vibrant, enthusiastic, and committed to the principle of enabling individuals to live independently in their own homes. The primary goal is to maximize functionality. Episodes of care tracers consistently demonstrate the dedication of the care providers and the positive feedback from patients/clients and their families regarding Home Care Services. As part of the tracer, two home visits were conducted, both of which provided clear evidence of the service's positive impact. The home care staff, including the professional team, are highly regarded and valued.

Priority Process: Competency

A well-educated and trained staff requires constant attention.

Priority Process: Episode of Care

Two home visits formed the foundation for validating this highly effective program. The Home Care Program distinguishes itself by providing a wide range of services and comprehensive psychological and social support.

Priority Process: Decision Support

The standard for home care records in Canada and Britain is an electronic Home Care Record. It offers high functionality, and there are opportunities for vendor feedback to improve it according to clinicians' directions.

Priority Process: Impact on Outcomes

Quality improvement activities can generally be enhanced, which can be particularly challenging when staff are fully engrossed in the imperative to provide service.

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

Unmet Criteria		High Priority Criteria
Priority Process: Infection Prevention and Control		
2.7	Input is gathered from the IPC, and the OHS teams to maintain optimal environmental conditions within the organization.	
2.10	Applicable standards for food safety are followed to prevent food-borne illnesses.	!
7.7	Safety engineered devices for sharps are used.	!
8.4	Team members, and volunteers have access to dedicated hand-washing sinks.	
9.5	Compliance with policies and procedures for cleaning and disinfecting the physical environment is regularly evaluated, with input from clients and families, and improvements are made as needed.	
14.3	Input is gathered from team members, volunteers, and clients and families on components of the IPC program.	
Surveyor comments on the priority process(es)		
Priority Process: Infection Prevention and Control		

They have a strong IPAC leadership team that includes the director and coordinators who maintain an active and regular presence at each of the IERHA sites. The IPAC coordinators conduct regular rounds with team members, which involve HandyAudits at each site and providing input and feedback to enhance performance.

The IPAC team played a crucial role in managing COVID-19, gaining valuable insights that led to revised and updated IPAC processes and protocols.

IPAC effectively posts performance metrics related to key indicators, such as hospital-acquired infections and hand hygiene. They are encouraged to utilize these metrics in developing and implementing quality improvement initiatives that push performance toward the identified IPAC targets.

IPAC policies and procedures have been updated, and revisions have been communicated to team members. One suggestion is to integrate client and family input on IPAC protocols regularly. For instance, conducting spot checks with clients and families to gauge their awareness of hand hygiene practices and employing informative posters. Additionally, the Visboard could be reshaped to make the information relevant not only to team members but also to clients and families.

The organization has integrated an interprofessional team approach that outlines the roles and responsibilities for cleaning the physical environment, including devices and equipment. The introduction of colour-coded buckets for clean and dirty materials demonstrates a commitment to efficiency in cleaning equipment, devices, and surfaces. These buckets serve as a proactive strategy, with IPAC cloths prepared in the appropriate cleaning solution, following a standardized approach throughout the organization.

The IPAC team collaborates with several key stakeholders, such as Shared Health Manitoba and Public Health, to address potential and emerging outbreaks. The organization receives surveillance reports focusing on key areas, including recommendations and action plans.

The direction provided by Shared Health regarding IPAC definitions and data collection has been instrumental in supporting benchmarking with similar organizations.

The organization must reinforce the importance of adhering to IPAC policies and guidelines with the staff —such as refraining from bringing food and drinks into clean rooms, removing corkboards, and taking down posted papers exceeding thirty days.

It would be beneficial to assess the effectiveness of HandyAudits six months after implementation to identify further opportunities for improving the auditing experience for team members.

Standards Set: Inpatient Services - Direct Service Provision

Unmet Criteria		High Priority Criteria
Priority Process: Clinical Leadership		
1.3	Services are co-designed to meet the needs of an aging population, where applicable.	
Priority Process: Competency		
	The organization has met all criteria for this priority process.	
Priority Process: Episode of Care		
8.12	Ethics-related issues are proactively identified, managed, and addressed.	!
9.10	Medical and surgical clients at risk of venous thromboembolism (deep vein thrombosis and pulmonary embolism) are identified and provided with appropriate thromboprophylaxis. NOTE: This ROP does not apply for pediatric hospitals; it only applies to clients 18 years of age or older. This ROP does not apply to day procedures or procedures with only an overnight stay.	ROP
9.10.2	Clients at risk for VTE are identified and provided with appropriate, evidence-informed VTE prophylaxis.	**MAJOR**
9.14	Diagnostic and laboratory testing and expert consultation are available in a timely way to support a comprehensive assessment.	
Priority Process: Decision Support		
	The organization has met all criteria for this priority process.	
Priority Process: Impact on Outcomes		
14.2	The procedure to select evidence-informed guidelines is reviewed, with input from clients and families, teams, and partners.	
14.3	There is a standardized process, developed with input from clients and families, to decide among conflicting evidence-informed guidelines.	!
14.4	Protocols and procedures for reducing unnecessary variation in service delivery are developed, with input from clients and families.	!

16.2	The information and feedback gathered is used to identify opportunities for quality improvement initiatives and set priorities, with input from clients and families.	
16.4	Indicator(s) that monitor progress for each quality improvement objective are identified, with input from clients and families.	
16.10	Quality improvement activities that were shown to be effective in the testing phase are implemented broadly throughout the organization.	!
16.11	Information about quality improvement activities, results, and learnings is shared with clients, families, teams, organization leaders, and other organizations, as appropriate.	
16.12	Quality improvement initiatives are regularly evaluated for feasibility, relevance, and usefulness, with input from clients and families.	

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

In 2014, new construction took place at the Selkirk Regional Health Centre, increasing its bed count from 53 to 65. Currently, another redevelopment project is underway in 2023, which will add a total of 30 beds. These additional beds will comprise a combination of medical and surgical beds. Construction is also underway at the Ashern Hospital, where a total of 26 beds will be added.

The acute inpatient program faces several identified problems, including insufficient acute care beds, limited standard operating procedures and policies, and a shortage of human resources, including nurses, physicians, and allied health professionals. This program is led by a director and manager. The surveyors observed that registered nurses, licensed practical nurses, healthcare aides, and allied healthcare professionals provide direct care at each of the hospital sites visited.

Priority Process: Competency

Newly hired staff undergo classroom orientation and receive support from a mentor during their initial clinical shifts. Managers conduct performance appraisals at the six-month mark. However, due to the pandemic, performance conversations and appraisals have declined in some clinical areas. Managers are urged to reinstate these processes.

Educators—totalling four in IERHA—provide support to novice nurses and agency staff within the clinical programs. Education sessions for rural sites are primarily conducted virtually. Two Clinical Practice and Process Improvement Facilitators are responsible for reviewing and revising policies, as well as monitoring and developing nursing practices. Many of the policies at IERHA are outdated and require review and revision. All policies should be dated and signed by the most responsible person, with identified sources of information. Hard copies of policies are available at Communication Stations in various IERHA clinical areas, but they are outdated versions. The organization is encouraged to eliminate hard copy sources and ensure the intranet policy source is kept up to date.

Staff utilize an electronic procedural manual called Elsevier for support and guidance.

Staff members were unfamiliar with the ethics framework.

Priority Process: Episode of Care

As part of its recruitment strategies, the organization is collaborating with the Provincial Float Pool to access nurses with the required skill sets to work at IERHA. IERHA is currently in the early stages of considering the establishment of a Regional Float Pool. The organization is making efforts to provide accommodations for agency staff and is currently renting a duplex house. Additionally, there is a mentoring program in place to support new and novice staff. IERHA is commended for its innovative recruitment and retention strategies.

New processes for Transfer of Accountability (TOA) have been introduced over the past two months. Nurses now complete the transfer of accountability and include the patient in the handover of information if he or she desires. Nurses are signing to acknowledge that the information has been given and received. It is recommended that an evaluation of the TOA process be conducted at the three-month mark using an audit tool. The audit should include input from both nurses and patients. The organization is commended for this quality improvement initiative, particularly for involving patients in the exchange of information process. The completion of whiteboards at the bedside is also acknowledged, and staff members are commended for their work. In some areas, input from patients and staff should be obtained to consider including more information on the whiteboards.

A standardized care approach is followed for inpatients at IERHA. Admission processes, including fall and pressure sore assessments, have been well executed. However, the organization might consider conducting more frequent skin and Braden scale assessments, currently performed weekly, and increasing the frequency when there is a change in skin integrity.

During discussions with patients and family members, the surveyors received positive comments. Patients expressed gratitude for their community hospitals and the ability to receive care closer to home.

All patients had Venous Thromboembolism (VTE) orders on their charts; however, only about 40% of them had any information written on the orders. The reasons for the lack of indication were not specified.

Patient identification practices varied across the hospital sites, indicating the need for ongoing education and auditing to address non-compliance. “Do Not Use” abbreviations were found in patients’ health records, specifically on physician orders and medication forms.

Bed flow issues are a daily occurrence at IERHA. Daily huddles and bed management meetings involve all team members, including Long-Term Care, Mental Health, and Home Care, who collaborate to ensure focused and informative. It was observed that there is an increasing need for Alternative Level of Care following the pandemic. Care options are available for patients who require bariatric support and equipment.

The organization provides an "Inpatient Guide" book accessible on its website. It contains information such as parking details, what to bring to the hospital, visiting hours, and privacy policies, among others. Additionally, the organization's website includes a "Well Wishes" form. If a loved one wishes to send a get-well message to an inpatient, they can fill out the form, and it will be delivered to the patient during daytime hours from Monday to Friday. Patients may also provide feedback on their care through a "Compliments and Concerns" form, which is available on the organization's website or through a toll-free number provided. These forms are received by the Patient Relations Office, and timely follow-up occurs.

The staff at IERHA are commended and congratulated for the excellent care and support they provide to patients and their families.

Priority Process: Decision Support

The patients' health records consist of hybrid charts that are well-organized and include relevant documents, such as advanced directives, consents, histories, demographic information, and details of next of kin. The clerical staff at IERHA demonstrate excellent skills in organizing these charts.

Patients have the option to access their health information through the Health Information Services Department. The organization's website offers information to the community regarding privacy regulations, and the processes involved in patient advocate agreements.

Priority Process: Impact on Outcomes

IERHA utilizes a paper-based incident reporting system. Managers have the responsibility to review and gather data for the purpose of analyzing and identifying trends in occurrences. The Visboards prominently display calendars for falls and medication safety, which are discussed during huddles. A disclosure policy is in place, ensuring that the most responsible person communicates with patients and their families.

The organization strongly encourages continuous quality improvement and emphasizes the inclusion of staff, patients, and families throughout the entire process. It is an opportunity to enhance staff's understanding of quality assurance efforts and actively involve them in advancing quality within the organization.

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

Unmet Criteria			High Priority Criteria
Priority Process: Clinical Leadership			
The organization has met all criteria for this priority process.			
Priority Process: Competency			
The organization has met all criteria for this priority process.			
Priority Process: Episode of Care			
8.5	Medication reconciliation is conducted in partnership with the resident, family, or caregiver to communicate accurate and complete information about medications across care transitions.		ROP
	8.5.1	Upon or prior to admission, a Best Possible Medication History (BPMH) is generated and documented in partnership with the resident, family, health care providers, or caregivers (as appropriate).	**MAJOR**
	8.5.2	The BPMH is used to generate admission medication orders or the BPMH is compared with current medication orders and any medication discrepancies are identified, resolved, and documented.	**MAJOR**
9.8	A process to monitor the use of restraints is established by the team, and this information is used to make improvements.		!
9.19	Information relevant to the care of the resident is communicated effectively during care transitions.		ROP
	9.19.4	Information shared at care transitions is documented.	**MAJOR**
Priority Process: Decision Support			
13.3	Policies and procedures to securely collect, document, access, and use resident information are followed.		!
13.6	Policies and procedures for securely storing, retaining, and destroying resident records are followed.		!

Priority Process: Impact on Outcomes		
17.9	Quality improvement activities that were shown to be effective in the testing phase are implemented broadly throughout the organization.	!
17.11	Quality improvement initiatives are regularly evaluated for feasibility, relevance, and usefulness, with input from residents and families.	

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

Leadership and management at all sites demonstrate a strong presence in their leadership style, role modelling a caring and passionate approach to caring for all residents. There is evidence of collaboration, partnerships, and excellent teamwork at all levels to ensure that the delivery of care and range of services meet the residents' and their families' needs. Communication from the executive level to the site level and staff at the ground level is particularly effective. Teams have implemented the lessons learned during the pandemic regarding the value of regular huddles at all levels, recognizing how valuable this is for disseminating information and sharing ideas.

However, there are still opportunities for improvement in engaging with residents and families in designing spaces, delivering care, and providing a range of services. While resident councils are established and operational at the sites, family engagement is still lacking. It may be beneficial to inform families that they are once again welcome to attend these meetings and encourage their participation. The organization is encouraged to increase resident and family partnerships with greater focus and formality.

Priority Process: Competency

The long-term care teams and the leaders who support them have demonstrated commendable resilience, rooted in care and compassion for their residents. They have remained steadfast during a challenging period in healthcare delivery, relying on one another as a cohesive team.

Like all facilities, staffing requirements present an issue, and the rural geography exacerbates recruitment and retention challenges. Dependence on contract staff hinders the delivery of consistent care. Further consideration should be given to implementing a standardized orientation for agency staff.

The health authority and the province deserve recognition for their creative efforts in seeking additional staff for long-term care homes. The introduction of unregulated care aides swiftly filled positions and positively impacted staffing levels. However, this achievement was not without challenges. While training and education for nurses and care aides are well-defined, the training and education for unregulated care aides vary across different sites. Developing a consistent orientation package that is utilized at all sites could help mitigate these variations.

Leaders regularly conduct performance reviews that encompass discussions on career planning and educational opportunities. Although there is a template available for these reviews, managers often adopt a less formal approach. They take a positive stance, reserving negative feedback for separate meetings.

here are opportunities for improved verification and documentation of credentials, competencies, and qualifications. Locating and organizing this information can be challenging. Some education is completed through the Learning Management System, while other records are stored in spreadsheets or on paper.

Priority Process: Episode of Care

Despite encountering some staffing challenges and navigating through the pandemic, residents and families have expressed overall satisfaction with the care provided. They hold the staff and site leadership in high regard. However, there is still room for improvement, particularly in terms of further engagement and enhancing communication and information exchange with residents and families.

The IERHA has developed a Resident Welcome Book that offers a comprehensive and thorough information package to residents and families entering care. While this book is well-crafted, sites could enhance it by incorporating site-specific references and information.
Although residents and families were content with the care received, there were some additional concerns raised. These concerns included long wait times and the need to accept the first available bed, often resulting in admission outside their community.

Medication Reconciliation was identified as an organizational process requiring improvement. A list of medications is generated by the pharmacy or physician, but it is not reviewed with the resident or their family. No inquiries are made regarding non-prescription medications, and there is no established process for identifying and resolving discrepancies.

There are three affiliates: two Betel sites and Tudor. These sites consistently deliver the same level of care and services. Notably, attention is given to quality initiatives. Self-audits have been designed, and several leading indicators are meticulously tracked. The data is thoroughly analyzed, and a detailed plan is implemented to address any identified issues. The site administrator deserves commendation for their dedicated efforts in driving these initiatives forward.

Priority Process: Decision Support

A dedicated team of long-term care providers focuses on the delivery of consistent and quality care. They have a good understanding of the ethical framework and how to seek support on ethical issues. Ethical topics are regularly discussed during team huddles and meetings. Currently, all documentation is paper based. The organization is encouraged to explore electronic record-keeping options to enhance efficiency, streamline accessibility, and facilitate information sharing.

Priority Process: Impact on Outcomes

Quality teams have been established and hold regular meetings. There is effective communication with other health authorities and provincial initiatives. The inclusion of Infection Prevention and Control specific to Long-Term Care has added an additional layer of quality initiatives.

Prominent quality boards are displayed in easily observable areas. These boards include summaries of Quality Indicators in the Long-Term Care (LTC) program for Personal Care Homes (PCH). At the director level, data is mined and effectively utilized to evaluate services and policies, leading to improvements. However, at the site level, managers are not always aware of the indicators being monitored or how this information can be utilized to enact tangible changes on the ground. Staff, residents, and families can view some of these statistics on the boards, but they did not report having any input into the selection of qualitative initiatives or how these results affected their care. Therefore, it is recommended to involve site administrators, staff, families, and residents in providing more input and feedback.

Standards Set: Medication Management (For Surveys in 2021) - Direct Service Provision

Unmet Criteria			High Priority Criteria
Priority Process: Medication Management			
2.1	The interdisciplinary committee ensures there is a process to update medication management policies and procedures based on revisions to applicable laws, regulations, and standards of practice.		
2.4	The interdisciplinary committee establishes procedures for each step of the medication management process.		!
2.5	A documented and coordinated approach to safely manage high-alert medications is implemented.		ROP
	2.5.6	Client service areas are regularly audited for high-alert medications.	**MINOR**
	2.5.7	The policy is updated on an ongoing basis.	**MINOR**
	2.5.8	Information and ongoing training is provided to team members on the management of high-alert medications	**MAJOR**
7.3	Teams have access to an on-call pharmacist and prescriber to answer questions about medications or medication management.		!
13.1	Access to medication storage areas is limited to authorized team members.		!
13.2	Medication storage areas are clean and organized.		!
13.6	Medication storage areas meet legislated requirements and regulations for controlled substances.		!
13.7	Separate storage in client service areas and in the pharmacy is used for look-alike medications, sound-alike medications, different concentrations of the same medication, and high-alert medications.		!
13.8	Pending removal, expired, discontinued, recalled, damaged, or contaminated medications are stored separately in the medication storage areas from medications that are in use.		!
15.6	A list of abbreviations, symbols, and dose designations that are not to be used have been identified and implemented.		ROP

	15.6.2	The organization's 'Do Not Use' List is implemented and applies to all medication-related documentation when hand written or entered as free text into a computer.	**MAJOR**
	15.6.7	Compliance with the organization's 'Do Not Use' List is audited and process changes are implemented based on identified issues.	**MINOR**
16.1		The pharmacist reviews each medication order prior to the first dose being administered	!
21.1		Medications are delivered securely from the pharmacy to client service areas.	!

Surveyor comments on the priority process(es)

Priority Process: Medication Management

The IERHA has nine pharmacists who provide coverage to the ten acute sites. Pharmacy coverage varies from site to site. In total, there are twenty staff members working in the pharmacy department, including pharmacy technicians and pharmacy assistants. During the summer, students also work in the department. The pharmacists have noted that there don't appear to be any recruitment issues for pharmacy staff at IERHA. Long-term care facilities tender contracts for pharmacy support. The pharmacies are open during the day, and Selkirk is the only pharmacy open seven days a week. After the pharmacies close at 5 p.m., there is no pharmacist support; however, the staff have their phone numbers and can be contacted in case of urgent needs. The pharmacists and pharmacy technicians are dedicated to providing clinical services and supporting the staff.

The lack of pharmacy availability after hours means that staff have no choice but to administer the first dose of medication without verification from the pharmacy department, which poses a risk to patient safety. The nurses prepare intravenous medications, except for chemotherapy. Handwritten and telephone medication orders are written by nurses. This pharmacy service model carries a high risk to patient safety.

There are Administration Dispensing Cabinets (ADC) only at the Selkirk site, which have an override capability during evening and night shifts. Reconciliation is performed by the pharmacy on the following working day. The practice of ward stock is provided at the other hospital sites that do not have ADCs. The province is working toward implementing automated dispensing cabinets, and the IERHA pharmacist fully supports this initiative.

The central pharmacy department at the Selkirk site meets practice standards for handling hazardous drugs and is the only pharmacy in IERHA that mixes cancer medications. The organization is commended for introducing this approach. A courier is used to transport medications from the Selkirk Hospital to the other sites. However, the courier staff have not received training for handling chemotherapy medications, and a spill kit is not included in the transport process. The organization is encouraged to review this process. A chain of signatures is obtained during the transportation of medications.

The pharmacy staff stay connected and informed with regional and provincial planning initiatives and attend necessary meetings. IERHA has a multidisciplinary Pharmacy and Therapeutics Committee.

The committee is responsible for the formulary, including additions and removal of medications. A representative from the Medication Safety Committee sits on the committee and reports on incidents and complaints. Many of the policies are outdated and have not been reviewed or revised since 2019, including the high-alert medication policy. The Pharmacy and Therapeutics Committee is encouraged to develop a strategy for policy review. Policies should be signed by the Most Responsible Person, dated, and include or update the sources. Although some order sets are in place, there has been poor uptake, and physicians continue to write out orders. IERHA does not have Computerized Physician Order Entry, and efforts should be made to adopt this technology.

Incident reports are currently completed using a paper system. The paper copy of the incident is sent to the most responsible leader, who reviews and investigates it. There are concerns from a pharmacy perspective that not all medication-related incidents will be brought to the attention of the pharmacy department, and the follow-up process may not be timely. It is recommended that the pharmacy department be involved in all medication incidents to ensure inclusiveness and timeliness. The organization is encouraged to consider implementing an electronic risk management system.

“Do Not Use” (DNU) abbreviations were observed on some medication and physician order sheets in patient health records. Summer students are responsible for auditing charts. IERHA is encouraged to strategize and conduct monthly audits for DNU abbreviations. The results from the audits should be shared with the Pharmacy, Therapeutics Committee, and the Medical Advisory Council, providing an opportunity for re-education of identified physicians or nurse practitioners who continue to use DNU abbreviations.

The pharmacy department is encouraged to review the process of delivering medications to the inpatient unit. Currently, an open container is used, and only one pharmacy technician transports the medications, including narcotics, to the clinical areas.

There are practice issues at several hospital sites, and it is recommended that policies, processes, and protocols be established to ensure a standardized and safe approach to stocking and storing medications. Surveyors have noted several concerns, including propped open doors to medication rooms, keys left in narcotic drawers, storage of hydromorphone and morphine side by side (look-alike sound alike), lifting high-alert labels on containers and bottles, storage of high-alert medications on open shelves in a treatment room in the Emergency Department accessible to clients/visitors, and outdated Compendium of Pharmaceutical and Specialties (CPS) books and compatibility charts in the medication rooms. Discarded and outdated medications were found in open containers in the medication rooms. There were narcotic sheets that did not have double signage. The organization is encouraged to address these identified concerns as soon as possible and involve managers and frontline staff in the process.

Standards Set: Obstetrics Services - Direct Service Provision

Unmet Criteria		High Priority Criteria
Priority Process: Clinical Leadership		
The organization has met all criteria for this priority process.		
Priority Process: Competency		
The organization has met all criteria for this priority process.		
Priority Process: Episode of Care		
The organization has met all criteria for this priority process.		
Priority Process: Decision Support		
The organization has met all criteria for this priority process.		
Priority Process: Impact on Outcomes		
17.4	Safety improvement strategies are evaluated with input from clients and families.	!
18.4	Indicator(s) that monitor progress for each quality improvement objective are identified, with input from clients and families.	
18.5	Quality improvement activities are designed and tested to meet objectives.	!
18.6	New or existing indicator data are used to establish a baseline for each indicator.	
18.11	Quality improvement initiatives are regularly evaluated for feasibility, relevance, and usefulness, with input from clients and families.	
Surveyor comments on the priority process(es)		
Priority Process: Clinical Leadership		

The Obstetrics unit was established in 2017. The unit is clean, spacious, and well-designed to accommodate new mothers, infants, and families. The rooms are private, quiet, and provide ample space for the mother's partner to be present.

Although the service numbers had been declining, they have been on the rise again over the past two years. This significant increase can be attributed to the implementation of a robust epidural program.

Parents choose this facility because of its spacious and inviting environment, as well as the high-quality care they receive.

Priority Process: Competency

Both the nurse manager and the nurse educator are new in their roles, and they bring a strong sense of eagerness and a willingness to improve and change practices.

Education and training are top priorities, and staff appreciates the availability of educational opportunities. The smaller staff size in the Obstetrics Unit contributes to a sense of camaraderie and teamwork. The staff considers this teamwork to be the best they have experienced. Mandatory education—on privacy, violence prevention, working with diverse cultures, and managing client risks—is conducted regularly.

Priority Process: Episode of Care

The obstetrics team accepts and delivers low-risk pregnancies. They work closely with their counterparts in the city when either the mother or the infant requires more advanced care than Selkirk can safely provide.

They are well-equipped to resuscitate both the mother and the infant and provide necessary care until they can be transferred to a higher level of care.

The Unit has experienced occasional diversions due to being over capacity or when a physician is unavailable, such as during a transfer with an unstable mother or infant.

The team is dedicated to providing quality patient care for both the mother and the infant, and they offer emotional support when tragic events occur, such as the loss of a fetus or newborn.

Priority Process: Decision Support

Health information standards are strictly followed, and a standardized set of health information is collected from each client. However, electronic systems are fragmented, leading to a hybrid system of paper and electronic information, lacking comprehensive data.

Priority Process: Impact on Outcomes

Care maps and guidelines are utilized to guide the care of mothers and newborns. These are primarily developed at larger centres in Winnipeg or at a provincial level and are customized to fit the smaller regional centre. The organization is encouraged to regularly review and update its policies and procedures to align with current standards.

Audits are conducted and made available for public and staff viewing. Leadership has recognized the need to generate more quality projects from these audits and move forward with implementation and evaluation.

Incorporating formalized input from patients and their families into both quality improvement projects and service design would greatly enhance the value of the service. The organization must build the capacity to involve clients and families in the development of quality improvement projects.

There is no evidence of the evolution of quality improvement activities to include the design and testing of objectives and indicators. The involvement of clients and families in evaluating quality initiatives should be developed.

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

Unmet Criteria		High Priority Criteria
Priority Process: Clinical Leadership		
The organization has met all criteria for this priority process.		
Priority Process: Competency		
6.11	Team member performance is regularly evaluated and documented in an objective, interactive, and constructive way.	!
6.13	Team members are supported by team leaders to follow up on issues and opportunities for growth identified through performance evaluations.	!
Priority Process: Episode of Care		
10.7	Information is provided to clients about how to protect themselves against infection both before and following the procedure.	
10.15	Clients and families are provided with information about their rights and responsibilities.	!
10.16	Clients and families are provided with information about how to file a complaint or report violations of their rights.	!
Priority Process: Decision Support		
The organization has met all criteria for this priority process.		
Priority Process: Impact on Outcomes		
23.5	Guidelines and protocols are regularly reviewed, with input from clients and families.	!
24.4	Safety improvement strategies are evaluated with input from clients and families.	!
25.2	The information and feedback gathered is used to identify opportunities for quality improvement initiatives and set priorities, with input from clients and families.	
25.4	Indicator(s) that monitor progress for each quality improvement objective are identified, with input from clients and families.	
25.5	Quality improvement activities are designed and tested to meet objectives.	!

25.8	Indicator data is regularly analyzed to determine the effectiveness of the quality improvement activities.	!
25.9	Quality improvement activities that were shown to be effective in the testing phase are implemented broadly throughout the organization.	!
25.10	Information about quality improvement activities, results, and learnings is shared with clients, families, teams, organization leaders, and other organizations, as appropriate.	
25.11	Quality improvement initiatives are regularly evaluated for feasibility, relevance, and usefulness, with input from clients and families.	
Priority Process: Medication Management		
15.5	An independent double-check is conducted before administering high-alert medications on the sterile field.	!

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

The perioperative services in Selkirk boast a young, energetic, forward-thinking management team.

The perioperative program underwent a significant review in 2021, which resulted in several recommendations. Many of these recommendations have been implemented, such as the establishment of a clinical resource nurse in the Day Surgery/Post Anesthetic Care Unit and the addition of an on-call nurse in the Post Anesthetic Care Unit. The inclusion of an additional on-call nurse has enabled the Operating Staff to focus solely on the Operating Room, while the extra staff has covered the recovery of postoperative patients. This has increased staff satisfaction and reduced costs for the service. Furthermore, the collaboration with Shared Health Manitoba to introduce an operating room assistant program has also enhanced staff satisfaction.

Priority Process: Competency

Education and training are specific to the area, with some cross-training provided in Selkirk. Staff members are comfortable with the amount and type of education provided, as well as the duration of orientation to the actual units. Mandatory courses are available online, and staff can access additional education as needed.

The teams function at a high level and genuinely enjoy their work.

Priority Process: Episode of Care

The program in Selkirk has expanded its capacity for endoscopy, facilitating a significant increase in the number of endoscopies performed. Moreover, physicians from other regions, such as Winnipeg, can now access the service, reducing the overall waitlist for scopes in the province.

In Beausejour, the endoscopy service is efficiently operated four days a week with a single provider. Although the service runs smoothly, it relies on a single provider.

Currently, wait times for surgeries and endoscopies are unknown due to the absence of a centralized intake system in the Interlake-Eastern Regional Health Authority. However, efforts are underway to develop such a system, and it is strongly encouraged to proceed with this project. Each surgeon maintains their own waitlist and determines the urgency for scheduling scopes.

Booking and scheduling in Beausejour is a joint effort between the booking clerk and the physician's office clerk. Given the busy nature of the endoscopy program, the part-time clerk faces challenges completing the work within the allocated time, often resulting in overtime.

The physical layout of the Surgical Services area in Selkirk is excellent, ensuring smooth patient flow and providing excellent privacy. The area is equipped with security measures and card access restrictions for sterile areas. The purpose-built endoscopy area, endoscopy clean area, and scope cleaning areas are innovative and among the first in North America. In Beausejour, the endoscopy unit is small, but privacy is maintained to the best of the nurses' abilities using low voices and curtains. There is only one door for patients to enter and exit the endoscopy unit.

Priority Process: Decision Support

Health information standards are adhered to and a standardized set of health information is collected from each client. Electronic systems are scattered and do not provide a complete set of information leading to a hybrid system of paper and electronic information.

Priority Process: Impact on Outcomes

Quality improvement projects are not readily apparent to front-line staff. It is encouraged for the organization to develop the capacity within smaller sites to identify and implement quality projects. Ensuring client and family involvement is essential and could lead to further identification of quality projects.

Priority Process: Medication Management

Selkirk has an excellent medication management process in place. The anesthetist signs out medications from the Pyxis system and documents their use on each patient as well as on a separate document. Any unused medications are returned to the Pharmacy for double-checking.

Standards Set: Primary Care Services - Direct Service Provision

Unmet Criteria		High Priority Criteria
Priority Process: Clinical Leadership		
The organization has met all criteria for this priority process.		
Priority Process: Competency		
The organization has met all criteria for this priority process.		
Priority Process: Episode of Care		
11.13	The effectiveness of transitions is evaluated and the information is used to improve transition planning, with input from clients and families.	
Priority Process: Decision Support		
The organization has met all criteria for this priority process.		
Priority Process: Impact on Outcomes		
16.4	Indicator(s) that monitor progress for each quality improvement objective are identified, with input from clients and families.	
16.5	Quality improvement activities are designed and tested to meet objectives.	!
16.6	New or existing indicator data are used to establish a baseline for each indicator.	
16.7	There is a process to regularly collect indicator data and track progress.	
16.8	Indicator data is regularly analyzed to determine the effectiveness of the quality improvement activities.	!
16.9	Quality improvement activities that were shown to be effective in the testing phase are implemented broadly throughout the organization.	!
16.10	Information about quality improvement activities, results, and learnings is shared with clients, families, teams, organization leaders, and other organizations, as appropriate.	
16.11	Quality improvement initiatives are regularly evaluated for feasibility, relevance, and usefulness, with input from clients and families.	

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

A pervasive challenge for health service systems and health authorities is achieving a return on investment in primary healthcare/family practice services.

Primary care in Canada has received little to no investment. Since the introduction of Medicare, effective primary care has relied on a business model that utilizes fee-for-service income to fund and support the necessary infrastructure for clinical practice and team development.

Today, graduating family physicians show little interest in this business model and prefer turnkey operations. It is recommended to consider developing and investing in Primary Care with the same level of commitment as recruiting physicians to be hospitalists. Such investment would be in the best interest of the Health Authority. The level of investment that Health Authorities are willing to make in primary healthcare infrastructure (premises and professional staff) will not only determine the future of primary care but also impact key components of effective health services, such as the Quality Improvement Agenda.

Priority Process: Competency

For practitioners/practices “affiliated” with the Health Authority, the organization is well-structured. The College of Physicians and Surgeons of Manitoba handles the licensing to practise in Manitoba, while hospital and facility privileges fall under the purview of the Health Authority. Accountabilities are linked to these relationships.

Priority Process: Episode of Care

Two primary healthcare practices, the Kin Place Health Complex and Selkirk Quick Care Clinic, were sampled for Episodes of Care. The Kin Place Health Complex is a well-established comprehensive and conventional primary healthcare practice with an extensive interdisciplinary team co-located within the facility. It offers a full range of primary healthcare services. The Selkirk Quick Care Clinic, established 12 years ago to address episodic care needs in the community, has predominantly been supported by Nurse Practitioners. All appointments are booked on the same day until capacity is reached. Due to the high volume of patients now being seen, the clinic needs to address logistical support, including their phone system. Spots are reserved each day to accommodate referrals from the Selkirk Regional Health Centre’s Emergency Department. Follow-up appointments are scheduled for patients who have previously presented at the clinic. Both clinics provide on-site testing, enabling faster turnaround times, such as urinalysis. Patients highly appreciate both clinics. One minor facility requirement is the need for a fire plan from the building owner, which does not impact day-to-day operations but should be addressed. The other practice requires repairs to its wheelchair ramp.

In the future, a Primary Care Clinic with a mix of nurse practitioners, family physicians, and other health professionals, capable of addressing both Urgent Care and Primary Health Care needs, may be necessary.

Priority Process: Decision Support

Accuro is the dominant primary care Electronic Medical Record (EMR) system within the Interlake-Eastern Regional Health Authority. It is highly functional and user-friendly for primary care. Interoperability is crucial for success. Alternatively, practitioners may be forced to use hospital-oriented systems that are often not tailored to the needs of primary care practices.

Priority Process: Impact on Outcomes

One major challenge in all non-hospital-based health systems is the extent to which primary healthcare practices (family practices) embrace quality assessment and improvement. This challenge is particularly prominent for health authorities with limited investments in these practices. While goodwill and encouragement play a role, they can only achieve so much. Without adequate investment, accountability and expectations cannot be fully met.

Standards Set: Public Health Services - Direct Service Provision

Unmet Criteria		High Priority Criteria
Priority Process: Clinical Leadership		
The organization has met all criteria for this priority process.		
Priority Process: Competency		
The organization has met all criteria for this priority process.		
Priority Process: Impact on Outcomes		
16.2	The information and feedback gathered is used to identify opportunities for quality improvement initiatives and set priorities, with input from clients and families.	
16.4	Indicator(s) that monitor progress for each quality improvement objective are identified, with input from clients and families.	
16.5	Quality improvement activities are designed and tested to meet objectives.	!
16.6	New or existing indicator data are used to establish a baseline for each indicator.	
16.8	Indicator data is regularly analyzed to determine the effectiveness of the quality improvement activities.	!
16.9	Quality improvement activities that were shown to be effective in the testing phase are implemented broadly throughout the organization.	!
16.10	Information about quality improvement activities, results, and learnings is shared with clients, families, teams, organization leaders, and other organizations, as appropriate.	
16.11	Quality improvement initiatives are regularly evaluated for feasibility, relevance, and usefulness, with input from clients and families.	
Priority Process: Public Health		
The organization has met all criteria for this priority process.		

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

Public Health Services are well-organized and coordinated, despite the challenges of integrating a Regional Health Authority, Shared Health, and the Public Health Agency of Canada.

Leadership and frontline practitioners have a clear understanding of their roles and responsibilities. The focus of the two separate Public Health Tracer sessions was on immunization, the Families First program, and the Healthy Baby Program.

A dedicated group of frontline health professionals, managers, and coordinators form the foundation of these three programs. The Families First and Healthy Babies Programs expressed concerns about demonstrating their effectiveness, despite the existence of publications supporting Manitoba's initiative. It is important for us to be reminded of our effectiveness. Several research articles were reviewed (Brownell et al., 2011; Chartier et al., 2017; Chartier et al., 2017). Like several others, there are numerous opportunities to formalize the quality improvement initiatives in both clinical content and professional activities.

Priority Process: Competency

All competency priority processes have been met.

Priority Process: Impact on Outcomes

Quality assessment of services goes beyond collecting and documenting the required data that is expected. This excellent and robust service has the potential to be more involved in quality improvement. Coaching and leadership are critical to success.

Priority Process: Public Health

Processes for population health are rigorously followed and well-documented.

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

Unmet Criteria		High Priority Criteria
Priority Process: Clinical Leadership		
The organization has met all criteria for this priority process.		
Priority Process: Competency		
9.7	Access to spiritual space and care is provided to meet clients' needs.	
Priority Process: Episode of Care		
The organization has met all criteria for this priority process.		
Priority Process: Decision Support		
The organization has met all criteria for this priority process.		
Priority Process: Impact on Outcomes		
15.5	Quality improvement activities are designed and tested to meet objectives.	!
15.6	New or existing indicator data are used to establish a baseline for each indicator.	

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

The Selkirk Rapid Access to Addictions Medicine (RAAM) clinic, which opened in 2018, is the second one in Manitoba after the Winnipeg Clinic. It is co-located with a small primary care clinic and a cancer care support clinic. The clinic is modelled after the successful RAAM clinics introduced in Ontario. There are good integration and collaboration with other mental health and addictions programs, such as acute care, mobile crisis teams, withdrawal care, and social support services. While there is always room for improvement, the Selkirk RAAM Clinic has recently expanded to include three client care workers (two RNs and one social worker), a half-day prescriber (MD or NP), and their manager. The primary care team occasionally provides support.

Priority Process: Competency

Staff members feel appropriately trained for the services they provide. They have undergone a comprehensive orientation with opportunities to work closely with other providers. Many training modules are available online through the LMS system.

Several staff members have prior experience working at crisis centres or emergency departments, providing them with a good perspective on the interconnected services. They have formed a cohesive team that supports one another and addresses problems together. Frequent team-building huddles are held. No formal performance evaluations have been conducted, but none of the staff members have been in their positions for longer than nine months.

There is no designated space for spiritual or meditation purposes.

Priority Process: Episode of Care

Currently, the team relies on implied consent when clients attend the RAAM clinic. Even for recurring injections, there is no signed consent for treatment. Plans are underway to introduce a signed "understanding of roles" form at the initiation of care.

While there are no current research opportunities, the University of Manitoba may establish a new research program to evaluate the outcomes of clients who could not be accommodated at this clinic. Once a client is admitted to the program, they often rely on the service to help navigate the healthcare system, as they often lack adequate housing or other social determinants of health. Discharge from the program is infrequent.

Priority Process: Decision Support

The team utilizes the Accuro EMR system. They also have access to the patient's e-chart, which includes laboratory and diagnostic records. However, they do not have access to hospitalization records. There is an opportunity for Manitoba to consolidate patient information into a single record.

Priority Process: Impact on Outcomes

The Selkirk RAAM Clinic adheres to regularly reviewed policies and standards, discussed at hub meetings with all the RAAM clinics. These meetings serve as a platform to develop new procedures and quality improvement strategies. As the Selkirk Clinic has only received funding for expansion in the past nine months, it is still too early to assess the impact on serving a larger clientele. Statistics are kept on client numbers, gender identification, return rates, and other demographic data.

The prescribing guidelines and dosages for Opioid Agonist Treatment (OAT) are coordinated among the RAAM clinics.

Instrument Results

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

Governance Functioning Tool (2016)

The Governance Functioning Tool enables members of the governing body to assess board structures and processes, provide their perceptions and opinions, and identify priorities for action. It does this by asking questions about:

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

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

- **Data collection period: March 2, 2023 to March 3, 2023**
- **Number of responses: 1**

Governance Functioning Tool Results

	% Strongly Disagree / Disagree	% Neutral	% Agree / Strongly Agree	%Agree * Canadian Average
	Organization	Organization	Organization	
1. We regularly review and ensure compliance with applicable laws, legislation, and regulations.	0	0	100	94
2. Governance policies and procedures that define our role and responsibilities are well documented and consistently followed.	0	0	100	94
3. Subcommittees need better defined roles and responsibilities.	100	0	0	70
4. As a governing body, we do not become directly involved in management issues.	0	0	100	88
5. Disagreements are viewed as a search for solutions rather than a “win/lose”.	0	0	100	93

	% Strongly Disagree / Disagree	% Neutral	% Agree / Strongly Agree	%Agree * Canadian Average
	Organization	Organization	Organization	
6. Our meetings are held frequently enough to make sure we are able to make timely decisions.	0	0	100	97
7. Individual members understand and carry out their legal duties, roles, and responsibilities, including subcommittee work (as applicable).	0	0	100	95
8. Members come to meetings prepared to engage in meaningful discussion and thoughtful decision making.	0	0	100	95
9. Our governance processes need to better ensure that everyone participates in decision making.	100	0	0	66
10. The composition of our governing body contributes to strong governance and leadership performance.	0	0	100	94
11. Individual members ask for and listen to one another's ideas and input.	0	0	100	96
12. Our ongoing education and professional development is encouraged.	0	0	100	85
13. Working relationships among individual members are positive.	0	0	100	96
14. We have a process to set bylaws and corporate policies.	0	0	0	95
15. Our bylaws and corporate policies cover confidentiality and conflict of interest.	0	0	0	98
16. We benchmark our performance against other similar organizations and/or national standards.	0	0	100	77
17. Contributions of individual members are reviewed regularly.	0	0	100	68
18. As a team, we regularly review how we function together and how our governance processes could be improved.	0	0	100	82
19. There is a process for improving individual effectiveness when non-performance is an issue.	0	0	100	62

	% Strongly Disagree / Disagree	% Neutral	% Agree / Strongly Agree	%Agree * Canadian Average
	Organization	Organization	Organization	
20. As a governing body, we regularly identify areas for improvement and engage in our own quality improvement activities.	0	0	100	85
21. As individual members, we need better feedback about our contribution to the governing body.	100	0	0	44
22. We receive ongoing education on how to interpret information on quality and patient safety performance.	0	0	100	78
23. As a governing body, we oversee the development of the organization's strategic plan.	0	0	100	96
24. As a governing body, we hear stories about clients who experienced harm during care.	0	0	100	78
25. The performance measures we track as a governing body give us a good understanding of organizational performance.	0	0	100	90
26. We actively recruit, recommend, and/or select new members based on needs for particular skills, background, and experience.	0	0	100	92
27. We lack explicit criteria to recruit and select new members.	100	0	0	80
28. Our renewal cycle is appropriately managed to ensure the continuity of the governing body.	0	0	100	91
29. The composition of our governing body allows us to meet stakeholder and community needs.	0	0	100	92
30. Clear, written policies define term lengths and limits for individual members, as well as compensation.	0	0	100	95
31. We review our own structure, including size and subcommittee structure.	0	0	100	92
32. We have a process to elect or appoint our chair.	0	0	100	93

Overall, what is your assessment of the governing body's impact over the past 12 months, in terms of driving improvements to:	% Poor / Fair	% Good	% Very Good / Excellent	%Agree * Canadian Average
	Organization	Organization	Organization	
33. Patient safety	0	0	100	81
34. Quality of care	0	0	100	82

*Canadian average: Percentage of Accreditation Canada client organizations that completed the instrument from January to June, 2023 and agreed with the instrument items.

Client Experience Tool

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

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

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

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

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

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

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

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

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 20 business days.

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

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

Action Planning

Following the on-site survey, the organization uses the information in its Accreditation Report and Quality Performance Roadmap to develop action plans to address areas identified as needing improvement.

Appendix B - Priority Processes

Priority processes associated with system-wide standards

Priority Process	Description
Communication	Communicating effectively at all levels of the organization and with external stakeholders.
Emergency Preparedness	Planning for and managing emergencies, disasters, or other aspects of public safety.
Governance	Meeting the demands for excellence in governance practice.
Human Capital	Developing the human resource capacity to deliver safe, high quality services.
Integrated Quality Management	Using a proactive, systematic, and ongoing process to manage and integrate quality and achieve organizational goals and objectives.
Medical Devices and Equipment	Obtaining and maintaining machinery and technologies used to diagnose and treat health problems.
Patient Flow	Assessing the smooth and timely movement of clients and families through service settings.
Physical Environment	Providing appropriate and safe structures and facilities to achieve the organization's mission, vision, and goals.
Planning and Service Design	Developing and implementing infrastructure, programs, and services to meet the needs of the populations and communities served.
Principle-based Care and Decision Making	Identifying and 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	Maintaining efficient, secure information systems to support effective service delivery.
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	Partnering with clients and families to provide client-centred services throughout the health care encounter.
Impact on Outcomes	Using evidence and quality improvement measures to evaluate and improve safety and quality of services.
Infection Prevention and Control	Implementing measures to prevent and reduce the acquisition and transmission of infection among staff, service providers, clients, and families

Priority Process	Description
Living Organ Donation	Living organ donation services provided by supporting potential living donors in making informed decisions, to donor suitability testing, and carrying out living organ donation procedures.
Medication Management	Using interdisciplinary teams to manage the provision of medication to clients
Organ and Tissue Donation	Providing organ and/or tissue donation services, from identifying and managing potential donors to recovery.
Organ and Tissue Transplant	Providing organ and/or tissue transplant service from initial assessment to follow-up.
Point-of-care Testing Services	Using non-laboratory tests delivered at the point of care to determine the presence of health problems
Primary Care Clinical Encounter	Providing primary care in the clinical setting, including making primary care services accessible, completing the encounter, and coordinating services
Public Health	Maintaining and improving the health of the population by supporting and implementing policies and practices to prevent disease, and to assess, protect, and promote health.
Surgical Procedures	Delivering safe surgical care, including preoperative preparation, operating room procedures, postoperative recovery, and discharge