ACCREDITATION CANADA



Driving Quality Health Services

Accreditation Report

Interlake-Eastern Regional Health Authority

Selkirk, MB

On-site survey dates: June 14, 2015 - June 19, 2015

Report issued: July 14, 2015

ACCREDITATION CANADA
AGRÉMENT CANADA

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

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About the Accreditation Report

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 2015. Information from the on-site survey as well as other data obtained from the organization were used to produce this Accreditation Report.

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

Confidentiality

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

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

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

A Message from Accreditation Canada's President and CEO

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

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

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

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

We look forward to our continued partnership.

Sincerely,

Wendy Nicklin
President and Chief Executive Officer

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Section 1 Executive Summary

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.

1.1 Accreditation Decision

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

Accredited (Report)

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

1.2 About the On-site Survey

- **On-site survey dates: June 14, 2015 to June 19, 2015**

- **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 Ashern Community Health Office
3 Beausejour Health Centre
4 Betel Home Foundation - Gimli
5 Betel Home Foundation - Selkirk
6 E. M. Crowe Memorial Hospital and Personal Care Home
7 East Gate Lodge
8 Fisher Personal Care Home and Community Health Office
9 Gimli Community Health Centre
10 HEW Building - Primary Health Clinic
11 Hodgson Area Renal Health Centre
12 Interlake-Eastern RHA Corporate Office
13 Kin Place Health Complex
14 Lakeshore General Hospital and Personal Care Home
15 Lundar EMS
16 Lundar Personal Care Home and Community Health Office
17 Pinawa Hospital and Primary Health Care Centre
18 Pine Falls Health Complex
19 Rosewood Lodge
20 Selkirk and District General Hospital
21 Selkirk Community Health Office
22 Selkirk Community Mental Health Office
23 Selkirk Crisis Unit
24 Stonewall and District Health Centre
25 Stony Plains Terrace
26 Teulon Health Centre

- **Standards**

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

  System-Wide Standards

  1 Leadership
  2 Governance
  3 Medication Management Standards
  4 Infection Prevention and Control Standards

  Population-specific Standards

  5 Public Health Services
  6 Population Health and Wellness

  Service Excellence Standards

  7 Reprocessing and Sterilization of Reusable Medical Devices
  8 Primary Care Services
  9 Home Care Services
  10 Medicine Services
  11 Emergency Medical Services
  12 Community-Based Mental Health Services and Supports Standards
  13 Ambulatory Systemic Cancer Therapy Services
  14 Obstetrics Services
  15 Perioperative Services and Invasive Procedures Standards
  16 Long-Term Care Services
  17 Emergency Department

- **Instruments**

  The organization administered:

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

1.3 Overview by Quality Dimensions

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

Quality Dimension	Met	Unmet	N/A	Total
 Population Focus (Work with my community to anticipate and meet our needs)	108	10	1	119
 Accessibility (Give me timely and equitable services)	84	6	2	92
 Safety (Keep me safe)	519	41	26	586
 Worklife (Take care of those who take care of me)	148	13	0	161
 Client-centred Services (Partner with me and my family in our care)	190	18	5	213
 Continuity of Services (Coordinate my care across the continuum)	77	7	1	85
 Appropriateness (Do the right thing to achieve the best results)	678	87	33	798
 Efficiency (Make the best use of resources)	53	7	1	61
Total	**1857**	**189**	**69**	**2115**

1.4 Overview by Standards

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

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

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

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

Standards Set	High Priority Criteria *			Other Criteria			Total Criteria (High Priority + Other)		
	Met	Unmet	N/A	Met	Unmet	N/A	Met	Unmet	N/A
	# (%)	# (%)	#	# (%)	# (%)	#	# (%)	# (%)	#
Governance	42 (100.0%)	0 (0.0%)	0	30 (96.8%)	1 (3.2%)	1	72 (98.6%)	1 (1.4%)	1
Leadership	39 (84.8%)	7 (15.2%)	0	78 (91.8%)	7 (8.2%)	0	117 (89.3%)	14 (10.7%)	0
Infection Prevention and Control Standards	38 (95.0%)	2 (5.0%)	1	31 (100.0%)	0 (0.0%)	0	69 (97.2%)	2 (2.8%)	1
Medication Management Standards	61 (83.6%)	12 (16.4%)	5	52 (85.2%)	9 (14.8%)	3	113 (84.3%)	21 (15.7%)	8
Population Health and Wellness	3 (100.0%)	0 (0.0%)	1	27 (93.1%)	2 (6.9%)	6	30 (93.8%)	2 (6.3%)	7
Public Health Services	45 (95.7%)	2 (4.3%)	0	62 (89.9%)	7 (10.1%)	0	107 (92.2%)	9 (7.8%)	0
Ambulatory Systemic Cancer Therapy Services	40 (85.1%)	7 (14.9%)	3	73 (76.8%)	22 (23.2%)	4	113 (79.6%)	29 (20.4%)	7
Community-Based Mental Health Services and Supports Standards	17 (77.3%)	5 (22.7%)	0	106 (93.8%)	7 (6.2%)	0	123 (91.1%)	12 (8.9%)	0

Standards Set	High Priority Criteria *			Other Criteria			Total Criteria (High Priority + Other)		
	Met	Unmet	N/A	Met	Unmet	N/A	Met	Unmet	N/A
	# (%)	# (%)	#	# (%)	# (%)	#	# (%)	# (%)	#
Emergency Department	41 (87.2%)	6 (12.8%)	0	67 (83.8%)	13 (16.3%)	0	108 (85.0%)	19 (15.0%)	0
Emergency Medical Services	36 (85.7%)	6 (14.3%)	7	86 (90.5%)	9 (9.5%)	16	122 (89.1%)	15 (10.9%)	23
Home Care Services	42 (97.7%)	1 (2.3%)	1	49 (92.5%)	4 (7.5%)	1	91 (94.8%)	5 (5.2%)	2
Long-Term Care Services	40 (100.0%)	0 (0.0%)	0	90 (95.7%)	4 (4.3%)	0	130 (97.0%)	4 (3.0%)	0
Medicine Services	28 (93.3%)	2 (6.7%)	1	70 (98.6%)	1 (1.4%)	0	98 (97.0%)	3 (3.0%)	1
Obstetrics Services	58 (100.0%)	0 (0.0%)	6	78 (98.7%)	1 (1.3%)	1	136 (99.3%)	1 (0.7%)	7
Perioperative Services and Invasive Procedures Standards	96 (100.0%)	0 (0.0%)	4	84 (95.5%)	4 (4.5%)	0	180 (97.8%)	4 (2.2%)	4
Primary Care Services	28 (75.7%)	9 (24.3%)	0	43 (62.3%)	26 (37.7%)	0	71 (67.0%)	35 (33.0%)	0
Reprocessing and Sterilization of Reusable Medical Devices	48 (98.0%)	1 (2.0%)	4	58 (96.7%)	2 (3.3%)	3	106 (97.2%)	3 (2.8%)	7
Total	**702 (92.1%)**	60 (7.9%)	33	1084 (90.1%)	119 (9.9%)	35	1786 (90.9%)	179 (9.1%)	68

* Does not includes ROP (Required Organizational Practices)

1.5 Overview by Required Organizational Practices

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

This table shows the ratings of the applicable ROPs.

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Safety Culture			
Accountability for Quality (Governance)	Met	4 of 4	2 of 2
Adverse Events Disclosure (Leadership)	Met	3 of 3	0 of 0
Adverse Events Reporting (Leadership)	Unmet	1 of 1	0 of 1
Client Safety Quarterly Reports (Leadership)	Met	1 of 1	2 of 2
Client Safety Related Prospective Analysis (Leadership)	Met	1 of 1	1 of 1
Patient Safety Goal Area: Communication			
Client And Family Role In Safety (Ambulatory Systemic Cancer Therapy Services)	Unmet	0 of 2	0 of 0
Client And Family Role In Safety (Community-Based Mental Health Services and Supports Standards)	Met	2 of 2	0 of 0
Client And Family Role In Safety (Home Care Services)	Met	2 of 2	0 of 0
Client And Family Role In Safety (Long-Term Care Services)	Met	2 of 2	0 of 0
Client And Family Role In Safety (Medicine Services)	Met	2 of 2	0 of 0

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Communication			
Client And Family Role In Safety (Obstetrics Services)	Met	2 of 2	0 of 0
Client And Family Role In Safety (Perioperative Services and Invasive Procedures Standards)	Met	2 of 2	0 of 0
Dangerous Abbreviations (Medication Management Standards)	Unmet	3 of 4	3 of 3
Information Transfer (Ambulatory Systemic Cancer Therapy Services)	Met	2 of 2	0 of 0
Information Transfer (Community-Based Mental Health Services and Supports Standards)	Met	2 of 2	0 of 0
Information Transfer (Emergency Department)	Met	2 of 2	0 of 0
Information Transfer (Emergency Medical Services)	Met	2 of 2	0 of 0
Information Transfer (Home Care Services)	Met	2 of 2	0 of 0
Information Transfer (Long-Term Care Services)	Met	2 of 2	0 of 0
Information Transfer (Medicine Services)	Met	2 of 2	0 of 0
Information Transfer (Obstetrics Services)	Met	2 of 2	0 of 0
Information Transfer (Perioperative Services and Invasive Procedures Standards)	Met	2 of 2	0 of 0
Medication reconciliation as a strategic priority (Leadership)	Met	4 of 4	2 of 2

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Communication			
Medication reconciliation at care transitions (Ambulatory Systemic Cancer Therapy Services)	Met	7 of 7	0 of 0
Medication reconciliation at care transitions (Community-Based Mental Health Services and Supports Standards)	Met	4 of 4	1 of 1
Medication reconciliation at care transitions (Emergency Department)	Met	5 of 5	0 of 0
Medication reconciliation at care transitions (Home Care Services)	Met	4 of 4	1 of 1
Medication reconciliation at care transitions (Long-Term Care Services)	Met	5 of 5	0 of 0
Medication reconciliation at care transitions (Medicine Services)	Met	5 of 5	0 of 0
Medication reconciliation at care transitions (Obstetrics Services)	Met	5 of 5	0 of 0
Medication reconciliation at care transitions (Perioperative Services and Invasive Procedures Standards)	Met	5 of 5	0 of 0
Safe Surgery Checklist (Obstetrics Services)	Met	3 of 3	2 of 2
Safe Surgery Checklist (Perioperative Services and Invasive Procedures Standards)	Unmet	2 of 3	2 of 2

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Communication			
Two Client Identifiers (Ambulatory Systemic Cancer Therapy Services)	Met	1 of 1	0 of 0
Two Client Identifiers (Emergency Department)	Met	1 of 1	0 of 0
Two Client Identifiers (Emergency Medical Services)	Met	1 of 1	0 of 0
Two Client Identifiers (Home Care Services)	Met	1 of 1	0 of 0
Two Client Identifiers (Long-Term Care Services)	Met	1 of 1	0 of 0
Two Client Identifiers (Medicine Services)	Met	1 of 1	0 of 0
Two Client Identifiers (Obstetrics Services)	Met	1 of 1	0 of 0
Two Client Identifiers (Perioperative Services and Invasive Procedures Standards)	Met	1 of 1	0 of 0
Patient Safety Goal Area: Medication Use			
Antimicrobial Stewardship (Medication Management Standards)	Met	4 of 4	1 of 1
Concentrated Electrolytes (Medication Management Standards)	Unmet	2 of 3	0 of 0
Heparin Safety (Medication Management Standards)	Unmet	3 of 4	0 of 0
High-Alert Medications (Emergency Medical Services)	Unmet	3 of 5	3 of 3
High-Alert Medications (Medication Management Standards)	Unmet	3 of 5	2 of 3

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Medication Use			
Infusion Pumps Training (Ambulatory Systemic Cancer Therapy Services)	Met	1 of 1	0 of 0
Infusion Pumps Training (Emergency Department)	Met	1 of 1	0 of 0
Infusion Pumps Training (Emergency Medical Services)	Met	1 of 1	0 of 0
Infusion Pumps Training (Medicine Services)	Met	1 of 1	0 of 0
Infusion Pumps Training (Obstetrics Services)	Met	1 of 1	0 of 0
Infusion Pumps Training (Perioperative Services and Invasive Procedures Standards)	Met	1 of 1	0 of 0
Narcotics Safety (Emergency Medical Services)	Met	3 of 3	0 of 0
Narcotics Safety (Medication Management Standards)	Met	3 of 3	0 of 0
Patient Safety Goal Area: Worklife/Workforce			
Client Flow (Leadership)	Met	7 of 7	1 of 1
Client Safety Plan (Leadership)	Met	2 of 2	2 of 2
Client Safety: Education And Training (Leadership)	Met	1 of 1	0 of 0
Preventive Maintenance Program (Leadership)	Met	3 of 3	1 of 1
Workplace Violence Prevention (Leadership)	Unmet	3 of 5	0 of 3

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Infection Control			
Hand-Hygiene Compliance (Emergency Medical Services)	Unmet	1 of 1	1 of 2
Hand-Hygiene Compliance (Infection Prevention and Control Standards)	Met	1 of 1	2 of 2
Hand-Hygiene Education and Training (Emergency Medical Services)	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
Pneumococcal Vaccine (Long-Term Care Services)	Met	2 of 2	0 of 0
Reprocessing (Emergency Medical Services)	Met	1 of 1	1 of 1
Patient Safety Goal Area: Falls Prevention			
Falls Prevention Strategy (Ambulatory Systemic Cancer Therapy Services)	Met	3 of 3	2 of 2
Falls Prevention Strategy (Emergency Department)	Met	3 of 3	2 of 2
Falls Prevention Strategy (Home Care Services)	Met	3 of 3	2 of 2
Falls Prevention Strategy (Long-Term Care Services)	Met	3 of 3	2 of 2
Falls Prevention Strategy (Medicine Services)	Met	3 of 3	2 of 2
Falls Prevention Strategy (Obstetrics Services)	Met	3 of 3	2 of 2

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Falls Prevention			
Falls Prevention Strategy (Perioperative Services and Invasive Procedures Standards)	Met	3 of 3	2 of 2
Patient Safety Goal Area: Risk Assessment			
Home Safety Risk Assessment (Home Care Services)	Met	3 of 3	2 of 2
Pressure Ulcer Prevention (Long-Term Care Services)	Met	3 of 3	2 of 2
Pressure Ulcer Prevention (Medicine Services)	Met	3 of 3	2 of 2
Pressure Ulcer Prevention (Perioperative Services and Invasive Procedures Standards)	Met	3 of 3	2 of 2
Skin and Wound Care (Home Care Services)	Met	7 of 7	1 of 1
Suicide Prevention (Community-Based Mental Health Services and Supports Standards)	Met	5 of 5	0 of 0
Venous Thromboembolism Prophylaxis (Medicine Services)	Met	3 of 3	2 of 2
Venous Thromboembolism Prophylaxis (Perioperative Services and Invasive Procedures Standards)	Met	3 of 3	2 of 2

1.6 Summary of Surveyor Team Observations

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

The organization, Interlake-Eastern Regional Health Authority (IERHA) is commended on preparing for and participating in the Qmentum survey program. The IERHA board is made up of fifteen members appointed by the Minister of Health. Members are representative of the communities across the region; a region which is geographically and culturally diverse. There is a clear and deliberate effort on the part of the board to be present in community forums. Because the organization has a mandate to undertake system transformation initiatives so that resources are used wisely, there is commitment to do what it takes to be clear about strategic and operational plans, and as one board member articulated: "to be fearless as a unit addressing care issues openly and above all being honest".

The board has made deliberate efforts to come together with the intention of building strategic and operational plans that are aligned with the Manitoba Ministry of Health's priorities and that are future oriented. There is a diversity of skills and knowledge amongst board members. The board has three members sitting on the ethics committee and one member that sits with a provincial research ethics group. This positions the board to develop its plans and engage in decision-making using an ethical lens.

Numerous community partners participated in focus groups during the survey. Municipal leaders, clients, non-government organizations, private providers, a federal hospital, and others all identified that while there are always opportunities for improvement, their experience has been that the IERHA's leaders are collaborative and open. They expressed clearly that there have been proactive efforts to reach out, and there have been significant improvements in communications since the formation of the IERHA. The regional health authority has established Local Health Involvement Groups (LHIG) and First Nation Collaboration Tables, along with other means of communication with the community.

The community health assessment was recently completed. The process involved a series of focus groups, surveys, interviews and review of population health data. This provides relatively up-to-date data that has been informative in the development of the organization's five-year strategic plan, which will be released once a communication plan has been developed.

There are high-level efforts in evidence to develop quality and risk management frameworks. However, these have not been disseminated widely in the organization. There is a need to work on strategies to engage staff members and clients in how quality improvement opportunities are identified and then carried out at the point of care. There are many improvements occurring, but clients may not be engaged and staff may not recognize these activities as deliberate efforts to improve the client experience. Quality is identified as a management responsibility. Quality improvement needs to be evidenced in the targets that are set for all programs and supported by metrics that can be monitored for progress.

The organization is largely paper-based in terms of how client progress is documented and monitored. Where there are electronic records, work needs to be done to ensure privacy, and to ensure that retrieval of information is intuitive to the end users, and that information is flagged when it is critical for diagnostic and follow-up purposes. This tool is currently being used in primary healthcare. Full utilization of the tool however is being compromised by challenges in how information is entered and retrieved by members of the multidisciplinary team. It is important to ensure full functionality is understood and supported at each of the sites where the electronic medical record (EMR) is scheduled to be rolled out.

During the on-site survey, staff members across the organization were consistently passionate about their work and their commitment to excellent patient care, especially at the local level. Work needs to be done on an ongoing basis to ensure engagement in activities that align with and support the strategic and operational plans of the IERHA. Numerous clients consistently expressed high-level satisfaction with the services they are receiving. Two clients expressed that their interactions with the chronic disease program were: “life changing”.

Section 2 Detailed Required Organizational Practices Results

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

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

Unmet Required Organizational Practice	Standards Set
Patient Safety Goal Area: Safety Culture	
Adverse Events Reporting The organization establishes a reporting system for adverse events, sentinel events, and near misses, including appropriate follow-up. The reporting system is in compliance with any applicable legislation, and within any protection afforded by legislation.	· Leadership 15.3
Patient Safety Goal Area: Communication	
Client And Family Role In Safety The team informs and educates clients and families in writing and verbally about the client and family's role in promoting safety.	· Ambulatory Systemic Cancer Therapy Services 21.5
Dangerous Abbreviations The organization has identified and implemented a list of abbreviations, symbols, and dose designations that are not to be used in the organization.	· Medication Management Standards 14.6
Safe Surgery Checklist The team uses a safe surgery checklist to confirm that the safety steps are completed for a surgical procedure.	· Perioperative Services and Invasive Procedures Standards 13.3
Patient Safety Goal Area: Medication Use	
Concentrated Electrolytes The organization evaluates and limits the availability of concentrated electrolytes to ensure that formats with the potential to cause harmful medication incidents are not stocked in client service areas.	· Medication Management Standards 12.9
Heparin Safety The organization evaluates and limits the availability of heparin products to ensure that formats with the potential to cause harmful medication incidents are not stocked in client service areas.	· Medication Management Standards 9.3

Unmet Required Organizational Practice	Standards Set
High-Alert Medications The organization implements a comprehensive strategy for the management of high-alert medications.	· Medication Management Standards 2.5 · Emergency Medical Services 12.10
Patient Safety Goal Area: Worklife/Workforce	
Workplace Violence Prevention The organization implements a comprehensive strategy to prevent workplace violence.	· Leadership 2.10
Patient Safety Goal Area: Infection Control	
Hand-Hygiene Compliance The organization measures its compliance with accepted hand-hygiene practices.	· Emergency Medical Services 8.7

Section 3 Detailed On-site Survey Results

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

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

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

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

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

See Appendix B for a list of priority processes.

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

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

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

3.1 Priority Process Results for System-wide Standards

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

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

3.1.1 Priority Process: Governance

Meeting the demands for excellence in governance practice.

Unmet Criteria	High Priority Criteria
Standards Set: Governance	
2.4 The governing body has written criteria and follows a defined process to recruit and select new members.	

Surveyor comments on the priority process(es)

The regional board of directors is made up of fifteen members appointed by the Minister of Health for the Province of Manitoba. The chair is selected by ministerial appointment. Appointments are staggered to allow for retention of corporate knowledge when turn-over occurs.

This is a board whose members are engaged in the major system transformation that the IERHA has embarked upon as a result of the amalgamation that occurred in May 2012.

The board is committed to developing the organization as a single entity, providing health services to a population that is geographically dispersed over a large area and culturally diverse. The board is also committed to the alignment of regional priorities with those of the province. To this end, the strategic plan and other guiding documents either come from work that the province has done for the Manitoba health system, or from the board and senior leaders that have taken the initiative to align regional priorities with the provincial system.

The facilitation of local groups has been established to ensure community input. Community input is obtained by involvement in board committees, board presence at community meetings, and collaboration with the chief executive officer (CEO) and the senior leadership team. The board makes every effort to ensure that policies and programs are built on information and input about community needs. There is also a current community health assessment that provides a mix of population health data and self-reported health status data and expectations.

The board has recently updated its strategic and operational plan for a second three-year term in the life of the organization. Board members are excited about the fact that this plan is moving the organization forward from the initial pre-occupation with amalgamation to a forward thinking plan about the future direction of the IERHA. The plan is so new that at the time of the survey it had not been disseminated. The regional health authority is taking a thoughtful approach to what the communication strategy needs to be so that the strategic plan resonates with internal and external stakeholders. The focus of the plan is to further the priorities of Manitoba's health system.

Board members and the chair have a process for self-evaluation, participate in the ethics committee to ensure that there is an ethical lens on decision-making, organize orientation and training to build the competencies of board members, and have recently updated position descriptions.

3.1.2 Priority Process: Planning and Service Design

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

Unmet Criteria		High Priority Criteria
Standards Set: Leadership		
4.6	The organization's strategic plan includes goals and objectives that have measurable outcomes that are consistent with the mission and values.	
4.10	The organization's leaders report on the organization's progress toward achieving the strategic goals and objectives to internal and external stakeholders and the governing body where applicable.	
Standards Set: Public Health Services		
3.4	The organization's goals and objectives for its public health services are measurable and specific.	

Surveyor comments on the priority process(es)

The IERHA has been in existence since May 2102. In its first three years, the organization has undertaken a major system transformation to bring two previously existing organizations together, to create a new identity and engage with a large and diverse community to establish priorities.

There is abundant evidence that the chief executive officer (CEO) and his team have established a variety of vehicles for communication with staff members, key partners, and the public. There are collaboration tables with First Nations, Local Health Involvement Groups (LHIGs), open board meetings, town halls, a current website, and other mechanisms for stakeholder consultation.

The province mandates that a Community Health Assessment be conducted every five years. The IERHA recently completed this process. The document was created under the direction of a senior leader and in consultation with an epidemiologist. Multiple stakeholders were consulted, focus groups were facilitated, population health data was reviewed, and a youth survey was completed. This document and the one that preceded it have been used to inform the organization's strategic and operational plans. The board and CEO are commended for the extensive efforts to promote consultation and transparency in the planning that has gone into the development of strategies and plans to move through all of the steps that have been undertaken and will continue to be taken to bring the new organization into the future.

There is evidence that the organization is taking initiatives to assess its risks and to respond to its constraints. There are significant challenges with alternate level of care (ALC) clients in acute care beds while awaiting placement. There are significant fiscal pressures that are driving a deficit budget, and there are change management issues as a result of amalgamation and merging of programs that previously belonged to two employers. Recruitment and retention of professional staff and physicians is an ongoing challenge. There are significant volume increases in programs designed to manage non-communicable disease. There have been many changes in the senior leadership team in the past years, with more anticipated. People are experiencing change fatigue. It is evident that leaders are aware of these challenges and are making deliberate efforts to mitigate risk and move forward.

During the on-site survey community partners spoke highly of the work that the organization (Authority) has been doing to engage non-government organizations and others in service delivery options. Several of the partners provided examples of historical challenges that they felt were largely left unaddressed prior to amalgamation. For the most part, they told the surveyor team that there is now a new transparency and willingness to build more productive and mutually beneficial relationships.

It is evident that the organization has concentrated its efforts to date on putting mechanisms in place to drive the organization forward. This is good work but it is taking place at as high level for the most part. For example, there has been work done to create a quality improvement framework, yet there is limited awareness of it at the staff level, and little evidence that staff members know how they should identify program-specific priorities with time-limited measurable outcomes attached to them. This is not to say that improvement work is lacking, but rather that it could be done in a more deliberate way that clearly communicates what is expected and how people will be held accountable for moving the organization's agenda forward.

3.1.3 Priority Process: Resource Management

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

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

The organization follows a well-established process for development of its annual operating budget, which is developed collaboratively with managers, directors and the senior team. Guidelines are provided and the budget is normally developed as a status quo budget. The budget process is informed by the previous year's actual results and multi-year health plan, which is refreshed annually.

The organization has a position management system which also informs the budget process. A process is in place to identify the top three to six priorities for additional budget consideration, which often involves increased staffing requirements related to service pressure points.

Ministry approval is required for all but routine capital projects and expenditures. The organization has been fairly successful in acquiring capital funding in both the major capital and safety and security capital funding areas. Managers receive variance reports in a timely way. Regular reports are provided to the board finance, capital planning and audit committee and to the full board. An external auditor conducts an annual review of internal controls and confirms that the Interlake-Eastern Regional Health Authority is providing appropriate systems and controls for financial and other resource management.

3.1.4 Priority Process: Human Capital

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

Unmet Criteria			High Priority Criteria
Standards Set: Leadership			
2.9	The organization's leaders monitor staff and service providers' fatigue and stress levels and work to reduce safety risks associated with fatigue and stress.		
2.10	The organization implements a comprehensive strategy to prevent workplace violence.		ROP
	2.10.4	The organization conducts risk assessments to ascertain the risk of workplace violence.	**MAJOR**
	2.10.5	There is a documented process in place for staff and service providers to confidentially report incidents of workplace violence.	**MINOR**
	2.10.6	There is a documented process in place for the organization's leaders to investigate and respond to incidents of workplace violence.	**MAJOR**
	2.10.7	The organization's leaders review quarterly reports of incidents of workplace violence and use this information to improve safety, reduce incidents of violence, and make improvements to the workplace violence prevention policy.	**MINOR**
	2.10.8	The organization provides information and training to staff on the prevention of workplace violence.	**MINOR**
10.6	The organization's leaders ensure that position profiles for each position are developed and updated regularly.		
10.10	The organization's leaders implement policies and procedures to monitor staff performance that align with the organization's mission, vision, and values.		!
10.12	The organization's leaders conduct exit interviews and use this information to improve performance, staffing, and retention.		

Surveyor comments on the priority process(es)

The IERHA has a strong corporate culture built on its core values. The organization has developed a comprehensive human resource (HR) plan for the region. The IERHA monitors a number of HR indicators and participates in benchmarking.

The organization has demonstrated a commitment to staff safety. This includes a mandatory annual safety refresher for all staff. The refresher includes updates on workplace hazardous management information system (WHIMS), hand hygiene, occurrence reporting, and infection control. A respectful workplace policy is

in place, and the provincial policy on violence prevention is planned to be rolled out during the next year. The new policy will require increased occurrence reporting because of the expanded definition of workplace violence. Workplace violence incidents are rare but if they occurred they would be immediately reported to the appropriate senior leader.

Staff members that were interviewed during the survey expressed high-level of satisfaction with their jobs and a sense of pride and loyalty to IERHA. Staff turnover is within a reasonable range, although competition with Winnipeg is challenging, particularly in the southern parts of the region because of the proximity of the city.

Staffing issues have resulted in mandated overtime occurring fairly routinely in the emergency services, which is affecting staff morale and fatigue.

The organization has developed a comprehensive orientation for new staff. There are good relationships with unions and low grievance rates. Workplace safety remains a challenge, particularly for staff members working in high-risk areas such as mental health and those that work alone in the community. In the absence of in-house security staff, the organization is encouraged to continue to explore creative ways to enhance staff safety.

There is a policy requiring formal performance reviews at least bi-annually however, not all areas are meeting this target. Human resources has reformatted the performance review documents and notification for review to facilitate improving the timeliness of performance reviews

3.1.5 Priority Process: Integrated Quality Management

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

Unmet Criteria		High Priority Criteria
Standards Set: Leadership		
12.4	The organization's leaders disseminate the risk management approach and contingency plans throughout the organization.	!
15.3	The organization establishes a reporting system for adverse events, sentinel events, and near misses, including appropriate follow-up. The reporting system is in compliance with any applicable legislation, and within any protection afforded by legislation.	ROP
15.3.2	Improvements are made following investigation and follow-up.	**MINOR**
16.3	The organization's leaders require, monitor, and support service, unit, or program areas to monitor their own process and outcome measures that align with the broader organizational strategic goals and objectives.	!
16.6	The organization's leaders verify that the quality improvement plans and related changes are implemented.	!
16.8	The organization's leaders communicate the results of quality improvement activities broadly, as appropriate.	!

Surveyor comments on the priority process(es)

Although there is good work being done to establish one quality improvement framework out of two that existed in the previous regional health authority structure, the team indicated that: "quality is still quite an abstract concept". Having said that, the organization has adopted a framework that is solid. It has not yet been disseminated throughout the organization.

A lot of decisions about what initiatives will be undertaken in the near and distant future are made by committee. Staff members perceive quality to be the work of management and many indicated they do not feel that their input to those kind of decisions would be welcome. This situation could be a significant disconnect as the organization moves forward with its strategies to eliminate waste in the system, and to standardize operations across the continuum. It is recommended that effort be put into engaging point-of-care staff members in the formulation of improvement strategies in order that staff may become focused on better client outcomes, and for the organization to have a good chance of getting traction where it counts.

The engagement of staff and patients in designing a quality improvement strategy is critical to its success. In the absence of a plan that contains clear targets with measurable and time-limited outcomes, people mention that: "there is a lot of deferring to the next quarter". Some staff members indicated that pilot initiatives and trials with planned roll-outs are not always the best way to achieve buy-in from staff across

the organization. Doing upfront work to involve people across the IERHA in the selection of indicators, establishing a mechanism to make them visible to all, and facilitating regular report-outs on progress using clear metrics might promote better uptake and engagement of front line staff.

In the three years since amalgamation, the quality team states that there has been a pre-occupation with objectives that have to do with updating and alignment of guiding instruments so that all components of the IERHA are working from the same set of operating principles and priorities. This is a logical phase in the transformative change that the province has undertaken. In fact, much of what the IERHA is doing to align its internal processes is driven by a mandate to adopt system-wide provincial priorities and goals.

The organization has identified desirable outputs for a lot of its programs but is not so clear about the metrics it would use to monitor its progress.

3.1.6 Priority Process: Principle-based Care and Decision Making

Identifying and decision making regarding ethical dilemmas and problems.

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

The ethics committee has been in place for about eighteen months. There is participation from the board, senior leadership, the physician community, long-term care, spiritual care and others. The committee has exercised its process with examples of issues brought forward from the point-of-care and found it to be a beneficial exercise. The committee meets quarterly.

There is a formal ethics framework in place and the committee exists to provide education and awareness around this, and to provide ethics consultation as required. The committee has put together a resource kit for employees and others that could benefit from the program. There is also a promotional poster and a power point presentation that can be used for education.

In terms of research there is a provincial process to review research requests, most of which would be students fulfilling there academic requirements. In these situations the committee also relies on the academic institutions to review proposals from an ethical point of view. The IERHA committee also has access to the Winnipeg Regional Health Authority's resources, which are tied to the academic institutions in Winnipeg.

3.1.7 Priority Process: Communication

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

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

The organization is reaching out to as many stakeholders as possible and engage the community. A significant portion of the chief executive officer's (CEO) time is spent engaging internal and external stakeholders. A number of different initiatives are underway including the local health involvement groups (LHIG), First Nations Tables, newsletters and Townhall meetings. There is significant effort spent engaging communities and determining the needs of the community and how the region can be responsive to those needs.

At the unit level, a variety of formal and informal mechanisms are used to communicate amongst staff. Mechanisms include communications books, bulletin boards, staff meetings and informal discussions. There are many excellent posters to inform about patient safety, including infection control and medication safety. There has been significant effort made for the protection of patient privacy including a quick reference guide that covers many situation that may arise. The guide provides excellent and easy to follow information.

The organization has created 'staffnet' for use region-wide to both inform and include staff members in activities of the region. The addition of off-site access facilitates a greater sense of community for staff. Facebook and Twitter accounts are active in an effort to reach out across the region using social media.

Communication, both internally and externally, will continue to be a priority, as the organization is well aware. Communities and staff members across the new region are looking for opportunities to see themselves reflected in the vision, mission and values of the IERHA.

3.1.8 Priority Process: Physical Environment

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

Unmet Criteria	High Priority Criteria
Standards Set: Emergency Medical Services	
10.2 The team's vehicle operators participate in regular training on how to drive and operate EMS vehicles.	!

Surveyor comments on the priority process(es)

The IERHA physical environment benefits from a leadership group that is committed and has been present pre- and post-amalgamation.

Reports on preventive maintenance (PM) for both biomedical and maintenance were available for review, and there is evidence that communication processes are in place to ensure action is reported and taken (closing the loop) with any areas that need attention. The next step needed is evaluation of the PM and maintenance process by stakeholders. There are some gaps identified at individual sites and it would be good for leaders to collect and work toward improvement.

Processes are in place for equipment acquisition at all levels, with executive leaders involved in prioritization. As the Interlake-Eastern Regional Health Authority matures, it is recommended that key processes in this area become standardized. At the time of the survey for example, there are some sites still using paper systems and some using electronic work order systems. As the process for input of information improves, so will the data, which will help the organization as it works toward improvements or needs with the province.

It was also noted during the survey, that there is a positive working relationship between finance, materials management, maintenance leads, and the director.

3.1.9 Priority Process: Emergency Preparedness

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

Unmet Criteria		High Priority Criteria
Standards Set: Emergency Medical Services		
2.2	The team identifies its role and participates in local, regional, provincial and federal disaster plans, responses and exercises.	
3.2	The team participates in community events to raise awareness about EMS and out-of- hospital-care.	
9.1	The organization trains team members on how to minimize exposure and risk to themselves and patients using an all hazards approach.	
9.7	The team follows a standardized process when responding to hazardous materials incidents.	!
Standards Set: Leadership		
14.3	The organization's leaders align the organization's all-hazard disaster and emergency response plan with those of partner organizations and local, regional, and provincial governments.	!
14.4	The organization's leaders provide access to education to support the all-hazard disaster and emergency response plan.	
14.9	The organization's leaders develop and implement a business continuity plan to continue critical operations during and following a disaster or emergency.	
14.10	The business continuity plan addresses back-up systems for essential utilities and systems during and following emergency situations.	!

Surveyor comments on the priority process(es)

The IERHA has adopted an incident management system and an all-hazards approach. The emergency disaster plan has integrated the plans of the former health regions into a new region-wide plan that is being implemented across the region. The plan is based on a common set of codes that all new staff members are educated on as part of their orientation. There is a detailed implementation schedule for introduction of the plan across the region.

There is a quick reference flow sheet available at all the sites, which is usually at the nursing station along with the disaster kit.

There is varying levels of understanding of the incident management system (IMS) across the organization and this was noted at all levels, including senior leadership and at individual sites. The IERHA is encouraged to look at establishing a minimal level of training in and incident command system (ICS) or IMS, or for anyone that may be asked to assume a significant role during an incident.

The IERHA by way of emergency disaster management has begun to participate in table-top exercises with key community partners such as municipalities. The organization's participation has indicated that there is a need for improved understanding of IERHA response capability, and how organizations may be able to mutually support one another. One example is the new Healing Centre being built in Pine Falls which will have significant redundant systems that other facilities in the community may not have.

The IERHA regularly practices its code green (evacuations) and code red (fire). Encouragement is offered to practice other codes as well. An example of codes that staff members were unaware of during tracers is code brown where cancer care clinic staff indicated that they would clean up a spill themselves without calling a code or contacting environmental staff. Likewise, in discussion with Public Health staff, and with the exception of another pandemic event, staff indicated they would not normally implement the IMS for a mass vaccination clinic that would stress public health resources. There is a number of potential situations where proactive use of emergency disaster management and the IMS approach could effectively use other available resources of IERHA to support the response of a particular program/service area.

There is a process for evaluation of exercises and debriefing of events where the information is used to improve response.

The decontamination of patients and clients appears to be a gap across the region. Emergency disaster management staff members are encouraged to work with Emergency Medical Services (EMS), emergency departments (EDs) and facilities to identify potential options to address this need.

3.1.10 Priority Process: Patient Flow

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

Unmet Criteria		High Priority Criteria
Standards Set: Emergency Medical Services		
19.5	The team meets applicable legislation for protecting the privacy, security, and confidentiality of patient information.	!
Standards Set: Perioperative Services and Invasive Procedures Standards		
6.7	The team regularly monitors and updates wait lists and keeps clients informed as to the anticipated date of their scheduled procedure.	
6.9	The team regularly monitors wait times for service and compares them to identified targets (e.g. provincial wait-time targets).	

Surveyor comments on the priority process(es)

The organization is working hard to address the various barriers impeding patient flow in the services. The organization is currently feeling the strain from: bed shortages, staff shortages, aging infrastructure, and almost double the population beginning at the May long weekend until September. Strategic measures include: provincially mandated Community Health Assessments every five years, focus groups - local health involvement groups (LHIG) in all regions (some offered in both English and French), as well as new initiatives to come such as patient advisory groups.

Other measures being undertaken include the development of a minor treatment clinic staffed by a nurse practitioner (NP) and licensed practical nurses (LPNs) at the Selkirk and District General Hospital site to address the Canadian Triage Acuity Scale (CTAS) scores of 4 and 5 presenting to the emergency department (ED). The Selkirk and Gimli site triage and registration desks are proactive in handing out business cards entitled: "Family Doctor Finder - Connecting me to my primary care". These cards have a toll free number, or online registration regarding physician attachment. There is the emergency department information system (EDIS) implementation in the Selkirk and District General Hospital ED to manage and monitor patient presentations and wait times. There are discharge planning processes such as “Home Sweet Home”, which is a Lean project in Stonewall to be rolled out region wide to other sites. There is data collection of ambulance diversions to determine impact on sites across the region. The IERHA has hired a director of patient experience to coordinate "regional" bed utilization and improve patient flow across the region. There has been hiring of after-hours nursing supervisors to facilitate transfers, and perform bed utilization during evenings and weekends, as well as provide support for nursing staff. Recently established ED Nursing Protocols are on the verge of being implemented to allow nurses to work to full scope of practice in the absence of an on-site physician thus, helping to reduce EMS transfers to other sites for care.

Another initiative is the development of policies and procedural documents such as the GA-10-80 Personal Care Home (PCH) Bed Management policy. This policy outlines the process for ensuring an admission to a PCH bed is done on a rotational basis, in a fair, equitable, and timely manner as possible, occurring equally from the hospital, the community and the PCH Regional transfer list. The organization is using interim bed

placements, but not without push back and complaints from the public. Many of these patients have spent years in their own community fundraising the required 10% portion for the development of PCHs only to be denied access when they need it. Patients in hospital refusing to accept interim placement options are then required to pay a non-insured per diem rate of $200.00 in lieu of the authorized charge. Nursing staff members are frustrated with the fall out of family upset being added to their patient care and rarely see anyone attempting to enact the fee.

The provincial government has requested the region to develop a: "Ten Year PCH plan" in order to alleviate some of the pressures on the regional system.

An admissions committee exists and meets to review the waiting lists. A draft interdisciplinary patient discharge document is currently being piloted with the intention of having it be the first sheet in a patient's chart for all to see. Its purpose is to streamline the interdisciplinary recommendations and actions to expedite the discharge process. At the time of the survey this document remains in draft form. The patient admission assessment combines all information regarding ambulation, mental status, care needs, equipment and other things into one place. This allows the inter-professional health care team to develop a comprehensive and evidence-informed individualized care plan based on clinical best practice.

It is understood that "capping" of panelled patients per facility to approximately half of a facility's capacity does not include the number of patients "awaiting panel" (AP), which can take a very long time according to staff. Most facilities appear to be up by at least two or three patients higher than cap, based on the additional AP patients.

3.1.11 Priority Process: Medical Devices and Equipment

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

Unmet Criteria		High Priority Criteria
Standards Set: Emergency Medical Services		
11.4	The team's cleaning and disinfection procedures outline the cleaning schedule, the choice of cleaners or disinfectants and their proper dilution and effective contact time, and protocols to wash cleaning equipment.	
12.5	The team regularly checks back-up vehicles to make sure they always have a full set of medical equipment, communication equipment, and medications.	
Standards Set: Reprocessing and Sterilization of Reusable Medical Devices		
5.2	The medical device reprocessing department's hand hygiene facilities are equipped with faucets supplied with foot-, wrist-, or knee-operated handles, or electric eye controls.	!
13.1	The team has a documented quality management system for its reprocessing and sterilization services that integrates principles of quality assurance, risk management, and continual improvement.	
13.15	The team regularly reviews and evaluates its quality improvement initiatives for feasibility, relevance and usefulness.	

Surveyor comments on the priority process(es)

The pride and commitment of the teams working in medical devices and equipment are evidenced in all aspects of their work. The surveyor observed processes and witnessed interactions that demonstrated co-operation and inquiry to ensure best results. In the operating room (OR) and medical devices reprocessing (MDR), the team spoke freely of the benefits of good communication between these department teams, as this is key to their role and they spoke of how it has improved.

For MDR, the ongoing education and all-site meetings, which include infection prevention and control (IPAC), are commended as this can be challenging in a largely dispersed health authority.

There is also interest in standardizing equipment purchasing; for example, scope processors. This would be valuable as it would benefit functioning, capacity and contract requirements at sites.

Paper work remains blended and as the organization works toward standardized IERHA forms and processes.Standardization will reinforce safety, requirements, and common understanding.

3.2 Priority Process Results for Population-specific Standards

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

Priority processes specific to population-specific standards are:

Population Health and Wellness

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

3.2.1 Standards Set: Population Health and Wellness

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).	
6.1	The organization maintains a clinical information system and longitudinal client records.	
Surveyor comments on the priority process(es)		
Priority Process: Population Health and Wellness		

The team uses the Community Health Assessment, completed every 5 years, and the results of the 2012 Youth Survey for planning health promotion and chronic disease activities. Both these resources provide rich and comprehensive information.

Clients that were contacted about the services they receive from chronic disease team reported that this service has been "life changing". They report they are able to manage their condition(s) with confidence and have achieved very positive results. The clients report their input is valued and they feel part of a team. The staff work with them to set small, realistic and achievable goals. They believe the staff to be quite competent. The community partners are quite engaged and there has been some very good collaborations. There are numerous health promotion and wellness programs that are offered as a result of the partnering of health promotion, sport and recreation, and the schools. The challenge going forward is to begin to evaluate these programs to see if they are achieving the desired results.

The team has goals and objectives, but they need to be able to measure these results and this is challenging given the current format of the goals and objectives. The team is going to look at how they can refine these goals/objectives to be able to measure their results.

The team is reaching out to vulnerable populations in very creative and innovative ways. An example is the Mobile Wellness Van that goes into remote communities. The team is working with communities in creative and innovative ways as well. A good example is the Community Gardens at the Museum.

A big challenge for these teams is around having an information system; currently most of the information is paper-based and it is labour-intensive to obtain any statistics.

The team is working on a framework for managing chronic disease referred to as the “wellness-chronic disease framework”. This will provide them with the direction they need moving forward.

A final challenge for the team is to ensure the community at large knows about their services. The team does work very hard in this area with classes and programs being advertised on the website, or through notices in the paper, as examples. The clients interviewed found out about these services serendipitously and are of the opinion that the organization "needs to get the word out".

3.2.2 Standards Set: Public Health Services

Unmet Criteria		High Priority Criteria
Priority Process: Population Health and Wellness		
9.7	The organization regularly evaluates its health promotion activities and makes improvements.	
10.9	The organization regularly evaluates its disease prevention activities and makes improvements.	
12.6	The organization reports non-compliance with public health laws and practices to the appropriate bodies and disseminates the information to the public, where appropriate.	!
16.1	The team collects information and feedback from clients, families, staff, service providers, organization leaders, and other organizations about the quality of its services to guide its quality improvement initiatives.	
16.2	The team uses the information and feedback it has gathered to identify opportunities for quality improvement initiatives.	
16.9	The team implements effective quality improvement activities broadly.	!
16.10	The team shares information about its quality improvement activities, results, and learnings with clients, families, staff, service providers, organization leaders, and other organizations, as appropriate.	
16.11	The team regularly reviews and evaluates its quality improvement initiatives for feasibility, relevance and usefulness.	
Surveyor comments on the priority process(es)		
Priority Process: Population Health and Wellness		

Public Health Services provides a wide range of services that are targeted at the needs of the population that they serve. As part of the integration process, they are working to standardize both the range of services (Teen clinics, Travel Clinic Services) that are available across the region as well as the practices within specific services. They have a number of effective partnerships and collaborations that they utilize in responding to their clients' needs. Some of the programs and services have a deliberate focus on equity as part of the program design (Families First & Harm Reduction) while others are more universal.

The development of the Teen Clinic in Pine Falls is an excellent example of collaboration with the community, the local School Board, and other IERHA services such as Mental Health, Primary Care along with local physicians. As a result of a cluster of 5 teen pregnancies in one year within a relatively small high school population, the Parent Advisory Council raised questions about the services available to students. A coalition was formed and other teen clinics in the region visited. The School Board and IERHA agreed to collaborate in establishing a clinic. The school board made space available and covered the cost of renovation while IERHA will provide the staffing.

Another example of responding to the communities needs is the development of a Harm Reduction program in Selkirk in response to an increase in hepatitis C infections being reported to Communicable Disease who in following-up the cases, identified that there was a vulnerable high-risk population that was increasing in size from people relocating to Selkirk that did not have access to harm reduction services. A broad group was engaged to ensure that there was understanding and awareness of the underlying issue and need, and of the proposed response. This included Selkirk city council, RCMP, and other community agencies. There was broad based public support for the establishment of the program which reflected a change from the past, and there is now interest from other communities in the region in harm reduction services also being made available in their communities.

Families First is an example of an evidence based early childhood development and parenting program with ongoing evaluation. It is a targeted program with good outcome measures that are tracked and reported. Clients spoke highly of the services provided and how they have fundamentally changed their life and their children's lives.

Public Health Services has a limited number of quality improvement measures that they are tracking and reporting on. A number of potential opportunities for quality improvement activities exist that could address potential client safety risks as well as making more effective use of staff time. For example, during a childhood vaccination tracer, the Public Health Nurse had to initially go into the Manitoba Immunization System to confirm the specific vaccination that a child was missing, even though the parent had received a letter from Manitoba Health indicating such; and the nurse had to schedule the child's appointment directly herself. After the child arrived, she had to do the greeting and weighing, obtain informed consent and administer the vaccine. She then had to enter the information on the vaccination, client consent and the client contact three separate times: once into Panorama, then in the EMR in two separate areas - the immunization fields and then the Public Health clinical note area. Of concern is the immunization field in the EMR which is known to be only a partial record, yet it is being made available to physicians and Nurse Practioners (NPs) for decision making when Public Health knows that it is unreliable. Other concerns with how the EMR is being implemented were observed during other tracers and are discussed under Primary Care. The way that the post partum discharge record is scanned and entered in as a document is another example where how to best represent or record this information in the EMR should be reviewed.

For existing quality improvement measures, the team is encouraged to further develop them. For example for influenza vaccination, they may wish to establish specific targets with accompanying strategies to increase immunization in the 65 plus, 0 to 2 years old, and adults with chronic diseases. There may be opportunities to partner with physicians, primary care and NPs for the chronic disease population.

The appropriate measures to monitor and assure vaccine cold chain were observed in Pine Falls and Selkirk. The vaccine fridge in Pine Falls is not on a back-up power plug and is only locally alarmed. As a result, it is recommended that Public Health work with Emergency Disaster Management and maintenance to include in the loss of power response plan for the Pine Falls site that maintenance will monitor the vaccine fridge alarm and advise Public Health so appropriate steps could be taken to relocate the vaccines to an acceptable monitored fridge in the facility or transported to another location.

3.3 Service Excellence Standards Results

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

Priority processes specific to service excellence standards are:

Clinical Leadership - Primary Care

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

Competency - Primary Care

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

Decision Support - Primary Care

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

Episode of Care - Ambulatory Systemic Cancer Therapy

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

Impact on Outcomes - Primary Care

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

Primary Care Clinical Encounter

- Providing primary care in the clinical setting, including making primary care services accessible, completing the encounter, and coordinating services

Clinical Leadership

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

Competency

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

Episode of Care

- Providing clients with coordinated services from their first encounter with a health care provider through their last contact related to their health issue

Decision Support

- Using information, research, data, and technology to support management and clinical decision making

Impact on Outcomes

- Identifying and monitoring process and outcome measures to evaluate and improve service quality and client outcomes

Medication Management

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

Organ and Tissue Donation

- Providing organ donation services for deceased donors and their families, including identifying potential donors, approaching families, and recovering organs

Infection Prevention and Control

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

Surgical Procedures

- Delivering safe surgical care, including preoperative preparation, operating room procedures, postoperative recovery, and discharge

3.3.1 Standards Set: Ambulatory Systemic Cancer Therapy Services

Unmet Criteria		High Priority Criteria
Priority Process: Episode of Care - Ambulatory Systemic Cancer Therapy		
8.3	Current and potential clients and their families are provided access to essential services 24 hours a day, seven days a week.	
9.2	The team works with the client and family to identify, monitor, and re-evaluate service goals and expected results.	
9.3	In collaboration with the client, the team develops and documents an integrated and comprehensive care plan.	
15.3	The team conducts independent double checks on infusion pumps prior to administration.	!
Priority Process: Clinical Leadership		
1.2	The team uses the information it collects about clients and the community to define the scope of its services and to set priorities when multiple service needs are identified.	
2.1	Team members work together to develop goals and objectives that are measurable and specific to the delivery of ambulatory systemic cancer therapy services.	
2.4	The team has access to the supplies and equipment needed to deliver ambulatory systemic cancer therapy services.	
2.5	The team has sufficient space to accommodate its clients and to provide safe and effective services.	

2.6	The team has sufficient staff to accommodate clients and meet workload demands.	
4.1	The team's schedule is designed to meet client needs and provide safe ambulatory systemic cancer therapy services.	
4.4	Team members have input on work and job design, including the definition of roles, responsibilities, and case assignments, where appropriate.	
4.5	Team leaders regularly evaluate the effectiveness of staffing and use the information to make improvements.	
4.6	The team has specific measures in place to avoid excessive consecutive hours of work and fatigue.	
Priority Process: Competency		
3.4	The team develops standardized processes and procedures to improve teamwork and minimize duplication.	
3.5	Sufficient workspace is available to support team functioning and interaction.	
Priority Process: Decision Support		
18.1	The team maintains one accurate and up-to-date record for each client.	!
Priority Process: Impact on Outcomes		
21.4	The team and service providers participate in regular safety briefings to share information about potential safety problems, reduce the risk of error, and improve the quality of service.	!
21.5	The team informs and educates clients and families in writing and verbally about the client and family's role in promoting safety.	ROP
21.5.1	The team develops written and verbal information for clients and families about their role in promoting safety.	**MAJOR**
21.5.2	The team provides written and verbal information to clients and families about their role in promoting safety.	**MAJOR**
22.2	The team uses the information and feedback it has gathered to identify opportunities for quality improvement initiatives.	
22.3	The team identifies measurable objectives for its quality improvement initiatives and specifies the timeframe in which they will be reached.	!
22.4	The team identifies the indicator(s) that will be used to monitor progress for each quality improvement objective.	
22.5	The team designs and tests quality improvement activities to meet its objectives.	!

22.6	The team collects new or uses existing data to establish a baseline for each indicator.	
22.7	The team follows a process to regularly collect indicator data to track its progress.	
22.8	The team regularly analyzes and evaluates its indicator data to determine the effectiveness of its quality improvement activities.	!
22.9	The team implements effective quality improvement activities broadly.	!
22.10	The team shares information about its quality improvement activities, results, and learnings with clients, families, staff, service providers, organization leaders, and other organizations, as appropriate.	
22.11	The team regularly reviews and evaluates its quality improvement initiatives for feasibility, relevance and usefulness.	
Priority Process: Medication Management		
10.4	The team follows organizational guidelines for spills of systemic cancer therapy medications.	
11.5	The organization identifies, addresses, and limits environmental distractions for team members who are ordering, verifying, checking, preparing, dispensing, and administering systemic cancer therapies.	

Surveyor comments on the priority process(es)

Priority Process: Episode of Care - Ambulatory Systemic Cancer Therapy

During the survey, the clients spoke highly of the care that they receive in the Ambulatory Cancer Care clinics. While they greatly appreciate the services and care that they receive from CancerCare Manitoba in Winnipeg, the ability to access services locally was described as: "so great to be here instead of Winnipeg". A client described the program as "awesome".

Priority Process: Clinical Leadership

CancerCare Manitoba provides overall direction to Ambulatory Systemic Cancer Therapy services. There is strong support from CancerCare Manitoba to the clinic staff members, and the clinics rely on CancerCare Manitoba for providing them with reports on the clients for whom they are providing service. At this time, the information that they receive is limited.

The program is encouraged to work with CancerCare Manitoba to identify the types of reports that may be available from existing data being collected to assist with service planning and quality improvement activities; for example, to determine what portion of residents living in the catchment areas of the clinics is accessing their services through the clinics.

The current space for the Selkirk clinic does not allow for appropriate infection control measures to be effectively implemented; this is of concern for this vulnerable population. It is recommended that the clinic work with infection prevention and control (IPAC) to look at how the clinic can best manage patients with

vancomycin resistant enterococci (VRE) and methicillin resistant staphylococcus aureus (MRSA). It is important that the clinic location in the new hospital facility allow for adequate physical separation of the patient chairs.

The staffing model differs according to the clinics. The model with nursing as well as clerical and social work support appears to make more effective use of the care team members' scope of practice to support clients and to deliver services. The organization is encouraged to review staffing models to determine if nurses only and no clerical support is the most appropriate staffing model where it is occurring.

Priority Process: Competency

A clear focus on responding to client needs was noted during the visit. Staff members indicated that they receive training and are supported with access to ongoing education and certification. Updates to clinical practices and changes to individual treatments are communicated in a clear and timely manner.

The workspace in the Selkirk clinic does not support safe practice. The nursing work area is crowded, requiring 'ballet' movements as one charts or responds to the telephone, while the other organizes medication for administration. The clinic in Pinawa provides good space for patient chairs and while the workspace is still limited, it is much more functional.

Priority Process: Decision Support

The team maintains a duplicate paper record as well as the electronic record in the AREA system. Limited reporting is being provided to the clinics from the information that is being collected and analysed from AREA. The team is encouraged to discuss with CancerCare Manitoba what reports might potentially be generated that would assist with clinic planning and operations.

Priority Process: Impact on Outcomes

In conversation with patients, they were not able to recall discussions about the patient's role in patient safety. They were also not able to describe who they would contact to discuss a concern with their care and treatment other than their physician or nurse. There were business cards available at the Pinawa reception area with information about the contact information for the patient representative.

Clients spoke highly of the Cancer Care Navigator although it was not clear if they fully understood the navigator's role. Clients described the navigator's role as keeping track of the client's care, monitoring that treatments are on time and that nothing is being missed.

It was not clear if clients felt empowered to be able to question if they were receiving the right medications and dosages. They were involved in confirming the medications being provided but this would not catch if a prescribed medication was missed and not given.

The team is encouraged to look at strategies for creating greater awareness of the client role in patient safety.

Priority Process: Medication Management

In case of a spill of systemic cancer therapy medication, the spill kits are readily available; however, clinic staff members indicated that they would clean up the spill themselves without calling a code brown. Clinic staff felt they had the training, and not necessarily the environmental cleaning staff.

It is recommended that clinic staff work with environmental cleaning staff on the protocol in the event of a spill. Further, it is recommended that a code brown be called as assistance may be required in being able to contain the spill and prevent others being exposed, particularly if there are ongoing patient care requirements at the same time.

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

Unmet Criteria		High Priority Criteria
Priority Process: Clinical Leadership		
2.4	The organization's goals and objectives are specific and measurable.	
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		
17.2	The team has procedures in place for reporting safety risks and trending and analyzing this information to improve safety.	
17.5	Staff and service providers participate in regular safety briefings to share information about potential safety problems, reduce the risk of error, and improve the quality of service.	!
19.2	The team uses the information and feedback it has gathered to identify opportunities for quality improvement initiatives.	
19.3	The team identifies measurable objectives for its quality improvement initiatives and specifies the timeframe in which they will be reached.	!
19.4	The team identifies the indicator(s) that will be used to monitor progress for each quality improvement objective.	
19.5	The team designs and tests quality improvement activities to meet its objectives.	!
19.6	The team collects new or uses existing data to establish a baseline for each indicator.	
19.7	The team follows a process to regularly collect indicator data to track its progress.	
19.8	The team regularly analyzes and evaluates its indicator data to determine the effectiveness of its quality improvement activities.	!

19.9	The team implements effective quality improvement activities broadly.	!
19.10	The team shares information about its quality improvement activities, results, and learnings with individuals, families, staff, service providers, organization leaders, and other organizations, as appropriate.	

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

It is clearly evident that the leadership and the planning committees have done good work to identify the framework with which all mental health services should work.

Implementation of the recovery model is in evidence across the organization. Staff members, clients and the documentation demonstrate consistent practice in terms of engagement and contracting for safe solution-focused care. Staff members consistently demonstrated passion for their work, client focused orientation, and an interest in continuous improvement.

There is still a fair bit of discussion happening about a "disconnect" between the work of management and the work of the front line. It appears that this disconnect is more perception than reality in the sense that there is a lot of consistency in the way care is delivered and in the implementation of new practices across the region.

The chief executive officer (CEO) and others in leadership positions do identify multiple strategies to improve communication and engagement. These strategies need to include ongoing efforts to bring point-of-care staff members together to formulate operational plans to which everyone can agree will improve the service. Operational plans need to contain measurable outcomes with strategies to hold owners accountable to demonstrate progress or present corrective actions within specified time frames.

Priority Process: Competency

Staff members are qualified to participate in various components of the multidisciplinary team, and they welcome continuing education programs that contribute to their job competencies and their professional development. There is evidence that when a new program is initiated by the province or the health authority, educational support is provided. There are multiple examples, but one example in particular is the implementation of a dialectical behaviour therapy program, which clinical staff feel will really add value by building client capacity for self-care. In addition, staff provided really positive comments about opportunities to build capacity to implement Lean methodologies to make improvements.

Generally, staff members commented that they feel like they work for a caring organization. People are recognized for their work and years of service, and there is access to an employee assistance program (EAP). There is evidence that work is being done to develop the culture of safety around staff safety, although many staff in mental health services indicated that they did not feel that there was much risk associated with their work. This could be an indicator for which more works needs to be done around safety in the workplace, especially for working alone, or doing home visits. The working alone policy and procedure was identified as something new and it has not yet rolled out to all areas.

The leadership team and staff members all indicated a willingness to participate in new initiatives that would potentially result in better outcomes for clients, but there is a pervasive impression that current workload is a barrier to change or innovation.

Priority Process: Episode of Care

Management has set priorities for community mental health programs across the region, specifically improving access for Aboriginal and Francophone people.

The team has established a variety of tables for consultation. Community partners confirmed that this work is welcomed by the communities and is adding value. In fact, it was mentioned several times that improvement in opportunities for community consultation is significant and much better since the establishment of the IERHA.

The crisis stabilization unit, adult mental health, intensive case management, intake, the proctor program, services to the elderly and child an adolescent mental health all have consistent practices in terms of the experience of the client when accessing and utilizing programs from intake to discharge.

Medication reconciliation, suicide risk assessment, recovery planning and progress notes are done in a consistent manner. It is noteworthy that the leadership team speaks about its intent to discourage dependency, promote a strengths-based approach, and contracts with clients for specified treatment goals. This model of interaction with clients was evident. Although there are new forms and procedures being implemented under the IERHA banner, there is no resistance to these attempts to standardize recording and communication methods.

Clients expressed satisfaction with the services and awareness of their treatment goals. It is evident that discharge planning begins on admission and that conscious efforts have been made to strengthen the continuum of care between services. Good linkages exist between programs in the hospital emergency department, mobile crisis intervention, and each of the specialized streams. Each of these programs identified that it is a priority to prevent admissions to over-burdened emergency and acute care services where possible.

Priority Process: Impact on Outcomes

Evidence on how the organization selects and engages staff and others - such as clients and care givers - in improvement initiatives is lacking. Quality improvement work begins at a high level in the IERHA, and needs to filter down to the point of care and become an iterative and collaborative process.

At this stage there is a quality framework but it is not in evidence in the clinical areas. This is not to say that quality improvement is not happening. In the mental health programs, staff members were able to identify many examples of work that has been undertaken to improve and standardize processes and care delivery mechanisms. There is also evidence of family and community partner engagement. The staff identify these initiatives as things that have been done to prepare for accreditation, directions from management, work that is being done as a result of amalgamation, pilot projects, or just good clinical practice.

There is also significant indication that work is underway to take the best practices from the pre-existing regional health authorities and incorporate them into the new organization. There is ground-breaking work being done in several areas. The co-location of mental health services with the rest of the primary care team in Beausejour and the multidisciplinary use of the electronic medical record is impressive, although staff indicate there is a lot of work still required to move from co-location to integration.

It is recommended that the organization advance the work that has been done to establish a quality improvement framework. This can be done by developing an implementation plan that aims to engage staff at all levels of the organization in the selection of a manageable set of targets with measurable outcomes. A process is also required whereby the people delivering the programs and owning accountability for performance review can report on progress at regular intervals. A communication strategy would support the sharing and celebration of success over time.

3.3.3 Standards Set: Emergency Department

Unmet Criteria		High Priority Criteria
Priority Process: Clinical Leadership		
1.3	The team uses the information it collects about clients and the community to define the scope of its services and set priorities when multiple service needs are identified.	
2.2	The team has the workspace it needs to deliver effective services in the emergency department.	
2.3	The team has access to seclusion rooms and/or private and secure areas for clients.	!
6.3	The team has a process for identifying and reducing risks to team members while delivering emergency department services.	!
Priority Process: Competency		
5.13	Team leaders regularly evaluate and document each team member's performance in an objective, interactive, and constructive way.	
Priority Process: Episode of Care		
5.4	New team members are trained on the safe use, storage, and operation of equipment, devices, and supplies used in delivering emergency department services, as well as preventive maintenance and what to do in case of breakdown.	!
7.1	The organization ensures that the entrance(s) to the emergency department are clearly marked and accessible.	!
11.1	The team works to ensure that client privacy is respected during registration.	
Priority Process: Decision Support		
11.7	The team uses evidence-based care protocols when providing emergency department services to clients.	!
13.1	The team maintains an accurate and up-to-date record for each client.	
13.2	The team meets applicable legislation for protecting the privacy and confidentiality of client information.	!
Priority Process: Impact on Outcomes		

The organization has met all criteria for this priority process.

Priority Process: Organization and Tissue Donation		
10.1	The organization has established protocols and policies on organ and tissue donation.	
10.2	The organization has a policy on neurological determination of death (NDD).	
10.3	The organization has a policy to transfer potential organ donors to another level of care once they have been identified.	
10.4	The organization has established clinical referral triggers to identify potential organ and tissue donors.	
10.5	The team receives training and education on organ and tissue donation and the role of the organization and the Emergency Department.	
10.6	The team receives training and education on how to support and provide information to families of potential organ and tissue donors.	
10.7	The team notifies the OPO or tissue centre in a timely manner when death is imminent or established for potential donors.	
10.8	The team records all aspects of the donation process, including the family's decision about organ and tissue donation, in the client record.	

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

Extensive community health assessments as mandated by the province are performed every five years to give an overall view of the region's and communities' health status. Nurse managers receive the monthly statistical information per fiscal year for their units, which includes admissions, discharges, deaths, separations and occupancy rates. Selkirk and District General Hospital has the only emergency department (ED) working with the Emergency Department Information System (EDIS), which can be viewed by the Manitoba Ministry of Health with regards to requesting "diversion".

The ED at the Gimli Community Health Centre has had to work hard in collaboration with leadership and education to attain creative, safe solutions surrounding its limited ED physician coverage. Monthly ED visits increase from 600 to more than 900 in the summer months according to the monthly statistical information sheets, with vacationers descending upon the district. The nurse-managed ED guidelines instruct how to officially activate "diversion" due to physician vacancy. Nurses consult the covering site physicians by telephone for additional direction regarding Canadian Triage Acuity Scale (CTAS) 1, 2, 3, patients. The CTAS 4 and 5 clients are discharged with either instructions or a request to see a physician the following day. The IERHA experiences a lot of emergency medical services (EMS) diversions, based mainly on staff shortages and/or lack of in-patient beds to decongest the ED.

This organization's EDs take patient feedback and concerns seriously and will attempt to make necessary changes. For example, a glass partition now replaces a former complete wall at the triage desk in Selkirk and District General Hospital to improve the safety and visibility of the patients in the waiting room chairs. Some facilities recognize the changes that need to be made, but lack access to the funding in order to enact the best practice and privacy containment. Stonewall and District General Hospital ED has issues with managing

privacy during the triage process and in some cases, for dealing with resuscitation and trauma patients arriving when the waiting room and other beds are full. The other patients can not only hear everything, but may witness disturbing sights such as amputation trauma and highly charged situations.

Recently, a patient presented to the ED of the Selkirk and District General Hospital and required a bariatric bed. Because the facility did not have bariatric beds or stretchers, a rental bariatric bed was supplied for the site during this patient's stay. With obesity listed as a major community health problem across the region, as well as the drive to reduce musculoskeletal related injuries for the staff, the organization may consider developing a bariatric protocol. The protocol would include extraction or non-extraction, call 911 from personal vehicles, as well as a request for the purchase of their own equipment. When the new hospital facility in Selkirk opens late next year, a bariatric treatment private room is on the blue prints, complete with bariatric furniture and equipment.

The current Selkirk and District General Hospital ED has access to a private room which is mostly utilized by grieving families; however, this room also doubles as a quasi-seclusion room for violent, aggressive, drunk, or psychotic patients brought in usually by the RCMP. The room is housing several chairs, a flat screen television that is not mounted, as well as some clinical equipment such as IV poles, all of which can be used as weapons. Most of the time the RCMP will stay with the patient however, due to a zero restraint policy, four-point restraints are never utilized. This has resulted in several injuries to staff and RCMP, and equipment being destroyed. The new Selkirk ED does include plans for an actual seclusion room complete with monitoring cameras for observation. In the meantime, it is strongly recommended that the team try to find somewhere else to house the IV poles, chairs and other items when utilizing the room for violent patients. Security is available in the evening and night shift at this hospital.

At many of the rural sites there is no security presence, and the nurses rely solely on the RCMP to respond or to stay with patients. Incidents with in-patients becoming violent and aggressive do happen. One rural ED setting has had a number of incidents reported via their incidence system where staff have been verbally abused and/or physically threatened. Leadership has been approached with regards to obtaining security staff, which has been declined. Staff members report RCMP response time can be up to two hours away owing to distance or attending incidents elsewhere. These incidents are becoming more frequent according to staff. These incidents are becoming more frequent according to staff. These incidents are becoming more frequent according to staff. These incidents are becoming more frequent according to staff. Statistical reports outlining the frequency of threats or violence occurring could be reviewed; however, staff and local managers state they do not see any reports of these types of incidents, only medication errors. Additionally, the RCMP is said to be frustrated with their length of stay in the EDs with patients. Not every ED locks down at night and therefore, anyone can walk in, when two to four staff members might be present administering care alone, with narcotics on site.

Student placements from the Red River College, the University of Manitoba Nursing, and Licensed Practical Nurse (LPN) to Nursing program are all taking place both in the city and rural settings. Funding is available from various sources for education, conferences and even potentially, for upgrading from registered nurse to nurse practitioner as a physician shortage solution in some cases.

Priority Process: Competency

Patients are either transported, or referred to nearby specialized facilities offering rehab, stroke and/or taken by ambulance to specialty centres for impending procedures such as angios or urgent diagnostics such as computerized tomography and magnetic resonance imaging.

Staff education is perceived by staff as one thing the IERHA does well, not just offering courses but paying the staff to attend. Although not all of the ED nurses are emergency registered nurse certified via formal education, they all receive advanced cardiac life support (ACLS), Canadian Triage Acuity Scale (CTAS) training, and annual intensive required emergency education days (REED), which all occur on site. In some cases pediatric advanced life support (PALS), trauma nursing critical care (TNCC) or the ED/ICU specialty education is funded however, a lot of staff have also taken courses on their own initiative without funding. One rural site is working towards a four-year plan whereby LPN's would also attain ACLS status and complete some components of the REED days to better assist the ED nurses during resuscitation when there is no doctor present.

Regional orientation covers many aspects of the IERHA, from payroll to spiritual care. According to staff, there is a limited focus on the importance of discharge planning from the moment the patient walks through the doors, and there is only 45 minutes slated to cover infection prevention and control. Most on-site orientations to the organization's EDs are flexible, based on the nurses' prior competency level, rural experience and comfort working independently, and is completed with a flexible number of buddy shifts until the new nurse is comfortable in the role.

Each ED is actively participating in once or twice daily information huddles. This is where information is shared by the nurse manager or clinical nurse (CRN) with the staff present that day.

Increasing the frequency of and having regular performance reviews are becoming a priority for many of the acute care sites. Some nurses stated they had not received a review in five years, others felt that they had been told they were "doing ok" and that "no news was good news". Performance reviews are delayed for various reasons such as waiting for the new form to be rolled out by HR, returning from a leave, lack of private space to perform them, and other competing priorities. Leadership staff are well aware of the need to improve in this area and are doing everything they can to promote annual review of staff.

Some sites have gone above and beyond to bring in extra staff to cope with the heavy acute, chronic and long-term care (LTC) patient loads. Unfortunately, another method being used routinely to deal with staff shortages, high volume and acuity is mandatory overtime. The organization utilizes mandatory overtime frequently in their critical care locations such as the EDs. This practice is damaging morale, leading to increased burnout, increased sick calls and potentially, setting up the organization and the individual nurse for serious mistakes being made on the basis of fatigue.

Compassionate, competent, dedicated, engaged patient care delivery was noted not just to the patients, but to the family members and the auxiliary workers. During patient interviews, patients provided comments such as "they saved my life, I wouldn't be here without those nurses and doctors" and "the nurses are so diligent about hand washing and being immuno-compromised, I could get an infection and die if they weren't".

Priority Process: Episode of Care

Staff members are knowledgeable with regards to the safe use, storage and operation of equipment, devices and supplies that are used in delivering emergency services. However, at times, staff members are unsure or are having difficulties dealing with breakdowns; obtaining replacements; or getting the right person involved with the specific equipment. A lack of an ED-specific contract with the supplier for preventive maintenance was noted to be a large part of the problem; had such been in place, the problem would have been addressed immediately.

The ED staff members are all adept at their assessments. Canadian Triage Acuity Scale scores appeared to match the presenting complaints when the patient charts were reviewed. Two sheets are available to document triage assessments, adult and pediatric. Assessment times were complete for nursing, less so for physicians. Timely general and focused assessments are performed well and documented by both longhand and a checklist. Medication reconciliation is performed consistently and noted to occur for clientele that are not admitted but require a review with a physician.

With regards to overall hospital signage, signage to the hospital could be improved. There was usually only one "H" sign close to the hospital entrance. With long highways surrounding most of the rural sites, extra signs further away would be of assistance to out-of-town visitors and non-locals accessing ED services.

Priority Process: Decision Support

The Nurses Board, Regional Director, and clinical educators recently collaborated to develop and implement the advanced nursing protocols primarily for use in the nurse-managed emergency departments.

As per the Manitoba Personal Health Information Act "WHEREAS health information is personal and sensitive and its confidentiality must be protected so that individuals are not afraid to seek health care or to disclose sensitive information to health professionals", however areas of concern were witnessed in the Selkirk and District General Hospital ED, and were mainly due to the lack of physical space. The department and staff at this time are in the midst of undergoing a Lean review in the hopes of improving patient flow and optimizing their existing space over the next year, while waiting to access their new department. Care for protecting health information should also be an outcome of the review.

It is recommended that the organization review its practice related to initial registration sheets at triage in the registration areas, its use of ED's whiteboard, and the location of the computer screen for possible breach of confidentiality by leaving the information exposed for others to see.

When sharing is required, staff members are quick to provide education, information, discharge instruction sheets and supportive comments.

Priority Process: Impact on Outcomes

The ED teams are regularly meeting with clinical nurse leaders and managers for daily safety and information huddles. There is a high level of engagement and participation noted.

There are many different quality projects occurring across the region and in the acute centres. One important quality project taking place is a Lean assessment of theSelkirk and District General Hospital ED with regards to patient flow and best use of space. This will certainly help the department and staff to make the best of their last year in that facility. With only one year to go it would be easy to just withhold further assessments on the premise of moving. The organization is commended for moving forward with this important assessment.

Staff members interviewed feel strongly about self-reporting and in some cases, there is concern with regards to a shame and blame atmosphere prevailing, and that the littlest thing could result in being written up. A new educational in-service is just about to be held outlining what actually constitutes a critical incident report, and when it is appropriate to report.

At each of the ED site visits, falls prevention is alive and well with regards to the use of equipment such as bed, chair alarms, walkers, safety slippers, and decrease of certain medications. In some facilities there is the sense on the part of staff that the number of falls are 'climbing' due to the increasing number of long-term care patients with no change in staffing levels to accommodate their needs and frequent monitoring.

Priority Process: Organ and Tissue Donation

Organ tissue donation is not a frequent occurence in IERHA. The Gift of Life operates under the umbrella of the Winnipeg Regional Health Authority. Binders with the existing protocols and guidelines were available at some sites, although staff members could not always remember where these were kept. Many staff members thought they could trouble-shoot directly with the Health Sciences Centre in Winnipeg when needed.

During survey visits, all three sites had difficulty speaking to the existing policies for organ and tissue donation. A new policy (#AC1 GN09) is for roll-out which will help to serve as education and a refresher for most of the staff members involved with the process. The new policy clearly covers all the required assessments.

Increased collaboration with the Manitoba organ and transplant team could also be beneficial to explore options such as a mini in-services for staff members, 24/7 stickers for telephones, guest appearances at regional orientation or a Powerpoint presentation for the regional orientation, and information for viewing on the new staff intranet; different options in order to increase staff awareness and knowledge of the process.

3.3.4 Standards Set: Emergency Medical Services

Unmet Criteria			High Priority Criteria
Priority Process: Clinical Leadership			
The organization has met all criteria for this priority process.			
Priority Process: Competency			
5.3	The organization's orientation process includes a formal mentoring program.		
6.2	The team regularly communicates to coordinate services, roles, and responsibilities.		!
Priority Process: Episode of Care			
17.2	The EMS team secures and positions the patient in a way that prevents the risk of injury during transport.		!
Priority Process: Decision Support			
20.5	The team communicates the evidence-based guidelines, research, and best practice information to patients, families, and the public receiving services.		
Priority Process: Impact on Outcomes			
22.10	The team shares information about its quality improvement activities, results, and learnings with patients, families, staff, service providers, organization leaders, and other organizations, as appropriate.		
Priority Process: Medication Management			
12.10	The organization implements a comprehensive strategy for the management of high-alert medications.		ROP
	12.10.1	The organization has a policy for the management of high-alert medications.	**MAJOR**
	12.10.8	The organization provides information and ongoing training to staff on the management of high-alert medications.	**MAJOR**
Priority Process: Infection Prevention and Control			
8.7	The organization measures its compliance with accepted hand-hygiene practices.		ROP
	8.7.2	The organization shares the results of measuring hand-hygiene compliance with staff, service providers, and volunteers.	**MINOR**
9.4	The team regularly receives immunizations against diseases as appropriate.		

11.3 The team regularly cleans all EMS vehicles and medical equipment.	!

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

The province manages the medical protocols however, local protocols have been developed specific to the IERHA rural areas, and one example is the stroke bypass protocol. These protocols have a direct impact on patient care in rural communities and fall in line with the organization's mission and values. Further expanding local protocols to benefit the rural population is suggested moving forward.

The medical oversight for the organization is highly regarded by the front-line staff. The paramedics have timely access to the medical support and feel supported with challenging patients or transport logistics.

The organization is encouraged to continue to work with the provincially centralized communication centre to analyze call times and area coverage. This data will continue to assist IERHA to plan for the increase in call volume and summer population spikes. Additionally, this will support the Emergency Medical Service (EMS) leadership in looking at locations for deploying vehicles and shift assignments to align resources with fluctuating demands.

Priority Process: Competency

The organization has focused on training for their paramedics, which has allowed for more than 50 new intermediate care paramedics (ICP) to be trained in the region. This has benefited the communities by increasing the level of care to more patients outside of the hospital setting. Paramedics have been pleased with the focus on the training and allowed new opportunities to expand their scope of practice for pain control and complex patients.

With the new supervisor team, the paramedics have timely access to management support including critical incidence stress debriefing. Paramedics are encouraged to access support as required and the organization has widely communicated the availability of the supervisors.

A formal mentoring process is established for all new employees joining the IEHA. An EMS orientation has been created however, it appears to be inconsistently applied to all areas. Specifically, an EMS orientation to station, equipment, infection-prevention-control and the area geography is suggested.

Priority Process: Episode of Care

The ambulance dispatch centre is managed by the Manitoba Transportation Coordination Centre (MTCC) in the city of Brandon. As such, the communication centre is not part of the services provided by the IERHA. The paramedics acknowledged that they have a good working relationship with MTCC. The organization is encouraged to continue the collegial working relationship and to continue to build the teamwork between the two operations.

The ambulances are well-maintained and are equipped with the proper equipment to the paramedics license level. Equipment was in good working order however, shoulder straps were inconsistently applied on the main cots. Additionally, paramedics refrained from utilizing the shoulder straps even when they were supplied on the cot. It is suggested the organization renew the safety focus of properly restraining patients while being transported in the ambulance.

The paramedics use a red, orange, green code rather than the Canadian Triage and Acuity Scale (CTAS) consistent with provincial practice. All hospitals in the region use the same scale and it is an accepted triage evaluation.

Paramedics demonstrated compassion and dedication to their patients. Their focus on patient care was consistent in areas seen in the survey. Patients are satisfied with the service from the paramedics and feel safe when in their care.

Priority Process: Decision Support

EMS protocols are managed by the Province of Manitoba and are widely available on their website. Ambulances have printed copies of the treatment guidelines available to the paramedics, and some paramedics use their own personal smart-phones to access the guidelines while at the patient-side. The organization should consider providing mobile devices on ambulances so that up-to-date treatment guidelines can be available to the paramedics when required.

As identified in previous surveys, the organization is encouraged to work with the emergency department to implement STEMI protocols for EMS. Additionally, the organization is encouraged to communicate evidence-based guidelines, research, and best practice information to patients, families and the public receiving services. This can further promote the profession of EMS to the general public and create a better synergy with the emergency department staff.

Priority Process: Impact on Outcomes

Most staff members are aware of the reporting process for near misses and reporting errors. Documentation on occurrence reports is completed and investigated by the management team and medical director. Some staff however, are not confident that the reporting process will be under the lens of quality improvement. The organization is encouraged to further communicate this process, so that the staff has confidence in the reporting of errors or near misses.

The organization is also encouraged to, when appropriate, share information about quality improvement activities, results and learning with patients, families, partner health agencies, and hospital staff.

Priority Process: Medication Management

Medications are well-controlled by the organization. Only the paramedics that are licensed to administer narcotics had access to the controlled drugs. The narcotics are always carried on the paramedics' belts and the extra stock is double-locked in the ambulance station. There are established protocols for signing out the narcotics, and for reporting any breakage, disposal and miss-counts.

The organization has a policy for high-alert medications; however, it appears to be unchanged since 2006. The policy is for the entire health authority of which the EMS falls under. The organization is encouraged to review the policy and include EMS if required. At all the sites surveyed, none of the high-alert medications were flagged at the station storage room, within the ambulances, or the medical bags.

Priority Process: Infection Prevention and Control

The staff members are diligent in ensuring equipment is cleaned after every patient contact. Appropriate cleaning of medical equipment and the ambulance after the treatment and transport of any infectious patient is performed prior to returning it into service.

The EMS staff members do regularly deep-clean the vehicles, but this occurs on an ad hoc basis or as required after an infectious patient. The organization is encouraged to create a deep-clean schedule so that ambulances are regularly cleaned and tracked on a proactive basis. This includes the back-up units.

A focus on back-up units is recommended for the organization. These units can be shared between several stations and may not be deep-cleaned for several weeks. During the on-site visit one back-up unit was witnessed to have holes in the vinyl seats, which would prevent proper disinfection. Given that these are still operational units the same infection prevention and control procedures need to be uniformly applied.

The EMS staff members are trained in proper hand-hygiene procedures and understand the rationale of the process. Audits have been done however, results of these audits have yet to be made available to staff. The organization is encouraged to continue to audit hand-hygiene compliance and make the results available to staff.

3.3.5 Standards Set: Home Care Services

Unmet Criteria		High Priority Criteria
Priority Process: Clinical Leadership		
The organization has met all criteria for this priority process.		
Priority Process: Competency		
3.2	Staff and service providers have job descriptions that define their roles, responsibilities, and scope of practice.	
4.2	Each staff member has the necessary credentials or license from the appropriate professional college or association.	!
Priority Process: Episode of Care		
9.8	Staff members document all services received by the client in the client record.	
12.1	The organization maintains an accurate and up-to-date record for each client.	
Priority Process: Decision Support		
The organization has met all criteria for this priority process.		
Priority Process: Impact on Outcomes		
3.7	The organization follows a formal process to regularly evaluate the functioning of the team annually, identify priorities for action, and make improvements.	

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

At several of the sites, the Home Care team is co-located with other services and this enhances collaboration. For example, in Beausejour the team is co-located with the primary care centre and thus has access to a physician/nurse practitioner if the team wants to have an order changed or a quick consult about a client.

The Home Care team is highly collaborative and there is evidence of collaboration with retail pharmacies, EMS, Public Health Nursing, acute care, South Interlake Seniors Resource Council Inc., and the Canadian Cancer Society as examples.

The goals and objectives are not well understood or communicated and the team needs to understand the role it plays in meeting these goals and objectives. The teams needs to do this better.

There are welcome packages provided to every potential Home Care client. The packages contain written information about medication safety, emergency response information kit (E.R.I.K)., falls prevention, the Adult Day Program, medication supervision services, Health Information Access and Privacy and other documents. The packages are comprehensive and indeed welcoming!

The team is committed to the safety of their clients and staff.

Priority Process: Competency

The orientation and ongoing training is perceived by staff to be good and thorough. There is evidence of ongoing training that is appropriate to the work. The job descriptions however are old, one dates 2001 and the title has changed at least twice. These need to be updated to reflect the new organization and roles and responsibilities.

There is a shortage of credentialed Health Care Aides (HCAs). In Manitoba, there are no requirements for Home Care Attendants to be certified as Health Care Aids, however for un-credentialed Home Care Attendants the organization increased the amount of orientation and job shadowing opportunities provided. The organization reports that after the un-credentialed Health Care Attendants completes 1,000 hours of work, he/she may be able to take the exam and if successful, becomes credentialed. The organization should strongly encourage this practice if possible. The organization does work with the local college programs, and is encourage to work hard for their staff members to be credentialed.

Delegated functions have been a challenging issue for the organization. The College of Nurses of Manitoba requires that for every HCA to perform a delegated task such as administer eye drops, the HCA must be trained by a nurse in the presence of the client and/or family, and the client/family must consent to the HCA performing the delegated task. This situation has made it challenging in terms of scheduling HCAs and also, has added to the work of the nurses; however, the organization has made this work.

Priority Process: Episode of Care

Most home care supports are able to deliver 24-hour service and this is appreciated by clients. Collectively, the programs see approximately 2500-3000 clients per month across the region. The clients visited during the survey reported being completely satisfied with the service they are receiving. They report being treated with respect and dignity and that the staff are obviously concerned about their safety and well-being.

Staff members report being happy with their work and they work as a team. It is clear to staff members about whom to contact for support if required.

Medication reconciliation is done quite well for the most part; it is completed on admission to the service, any time the client has been transferred to another service such as acute care, and when medications are changed, added or deleted. It is also completed every six months while a client is receiving the home care service.

The falls strategy has been rolled out recently so there are no metrics to report yet, with the first quarter ending on June 30. The target is to have quarterly reporting. The team has rolled out the falls required organizational practice which is a longer assessment than the former; however, staff report they believe it is a better and more comprehensive tool. There are a number of staff members that are engaged in wound care and this is a noted strength for the organization.

There is a good culture of reporting for adverse events and near misses; the team needs to close the loop and ensure there is feedback to any staff involved. There is a good process for transfer of information, mainly to acute and long-term care. The trends noted by the staff members are that the clients are older and have more co-morbidities, and this trend is expected to continue.

Priority Process: Decision Support

The client records are paper based. Nursing care is well-documented however, there is no record of services provided by HCAs regarding bathing and mobilizing except for a communication record at the supportive housing unit. The organization may wish to consider using a flow sheet to document this care. Medication supervision is a well-documented and delegated task.

The organization needs to move forward with electronic documentation. The intake process involves the nurse coordinator doing the intake assessment in the home on paper, and then going back to the office and entering the information into the Procura system.

The care plans are done well on all clients and provided to the HCAs. The HCAs follow the care plans to provide the services. The HCAs do not go to the office every day so if a change is made to the care plan, the coordinator must telephone the HCA to let them know about the change.

Priority Process: Impact on Outcomes

There is a good culture of reporting of adverse events, including medication. The HCAs will contact the leaders if they visit a client and note the medication has not been taken, or if they find pills on the floor or any concerning situation.

The team has 20 plus indicators however, the staff members are not able to articulate what these are necessarily. The team needs to better communicate these indicators to staff.

The team needs to formalize the evaluation of its team functioning.

3.3.6 Standards Set: Infection Prevention and Control Standards

Unmet Criteria		High Priority Criteria
Priority Process: Infection Prevention and Control		
4.4	The organization has policies and procedures for loaned, shared, consigned, and leased medical devices.	!
8.3	The organization's staff, service providers, and volunteers have access to alcohol-based hand rubs at the point of care.	!
Surveyor comments on the priority process(es)		
Priority Process: Infection Prevention and Control		

The IERHA infection prevention and control (IPAC) program is robust and well on the way to being fully amalgamated as a region-wide program. The team is engaged with acute care, home care, long-term care (LTC), physician groups, occupational health and safety (OHS), facilities/services and most recently, EMS.

The IPAC team members are a passionate, well-liked group, with two fully certified coordinators and two enrolled for this fall. Not only do the coordinators certify in IPAC, but food service safety as well. The team is proactive when it comes to evidence-based practice reviews and incorporating leading best practices into the IERHA policies and procedures. There is collaboration with Ontario, Public Health Canada, provincial and national leads, Centre for Disease Control, and the Medical Officer for the Public Health Office of Manitoba that also serves the team as a supportive link for any provincial initiatives.

The IPAC team has various facilities and portfolios assigned to each coordinator, and IPAC champions have either volunteered or been selected to assist at each of the sites. The champions are provided with a small amount of time for their commitment and additional education.

Facilities and support service staff are all well-versed in their roles, as well as the required equipment, cleaners, protocols and importance of minimizing healthcare associated infections due to construction, renovation and/or preventive maintenance. A construction tool kit has been developed, complete with a checklist based on Canadian Standards Association (CSA) standards, for use in the region's facilities.

The housekeeping staff members are knowledgeable and extremely hard working in each of the sites surveyed. When asked for their perception of hand-hygiene performed by the healthcare providers while touring, the housekeeping staff also proved to be excellent sources of "under-cover" hand-hygiene auditors. The IPAC team is responsive to housekeeping feedback when it came to the way the environmental (EVD) education sessions were presented to them, allowing more time to practice with the personal protective equipment (PPE) and for questions and answers.

The regional IPAC team idemonstrates obvious passion for what it does on the basis of patient safety, combined with the team's commitment to working both for, and with, the staff to provide the best, safest, cleanest care possible. Since the amalgamation, the past two years have been spent developing regional policies, combining the best ways of doing things from both regions into one, and gathering data to assess the "new" situation. The team is just heading into the phase of 'digging deep' to see where the team can really begin to improve and diversify.

The team was quick to identify from the hand-hygiene initial audit as a region that the "before" moment of handwashing required improvements and this became the focus for follow-up education sessions. Input from the home care nurses self-hand hygiene audit was given for IPAC consideration. For instance, supplying paper towels instead of having to use a client's personal towel was put forward for consideration. The IPAC team is proud of the region's healthcare providers' daily commitment to infection prevention and control. The team was so impressed by the RN's and physician that correctly identified and isolated Manitoba's first case of the measles on a weekend.

One of the most positive influences to date has been the provision of the three-hour mandatory Ebola protection in-services. The preparation really enlightened staff and increased awareness about the sequencing of PPE donning and doffing, vigilant handwashing and the general importance of ongoing infection prevention and control. Hopefully, the additional IPAC measures will continue to be implemented for any patient presenting with a severe acute respiratory infection (SARI) that had travelled to the Middle East, South Korea or China within the past 14 days, or has been in contact with someone testing positive for Middle East respiratory syndrome coronavirus (MERS-CoV), which is the latest virus to be on the Canadian radar.

Quality improvements in IPAC are numerous, such as hand hygiene audits and reporting, outbreak containment and IPAC surveillance statistics, development of the outbreak tool kit for ease of implementing in a timely manner post outbreak debriefing sessions for staff, increased staff vaccination rates from approximately 33% to 38%, risk assessment guidelines for staff when removing patients from additional precautions, phone-script for notifying families to ensure consistency in the messages being communicated by different sites, and replacement of "string" call bells at one site. Plus, there is now a regional IPAC member on the provincial purchasing committee to provide input to equipment and medical device purchases such as glucometers. There is also capability for the team to manually enter the ARO alert on the admission, discharge, transfer (ADT) system with automatic screening/swabbing reminders.

An opportunity for improvement in the area of IPAC includes increased promotion by those at the leadership level to always have Microsan pumps at their desk, if not attached to the wall. As per the video released by the IPAC team "Follow the Leader" point-of-care hand sanitizer pumps and/or wall mounts are at different stages across the region. It is most notably absent in certain ED resuscitation and trauma rooms. It is suggested for the organization to have a pump become part of the mandatory crash cart check to ensure at least one is in the room, especially if there does not appear to be a dedicated sink.

It is recommended that the IPAC team have a larger role in regional and/or new site furniture purchases to ensure cloth-covered chairs are worked out of the system and replaced with 'wipeable' surface chairs whenever possible. The chairs, stretchers in EMS and acute care that have any surface damage to the exteriors need to be replaced, as well as include a continuous assessment during the site risk assessments.

IPAC plays such a significant role in safe quality health care today and as such, requires 'prime morning time', as well as the potential for more time than just 45 minutes during orientation sessions.

3.3.7 Standards Set: Long-Term Care Services

Unmet Criteria		High Priority Criteria
Priority Process: Clinical Leadership		
The organization has met all criteria for this priority process.		
Priority Process: Competency		
The organization has met all criteria for this priority process.		
Priority Process: Episode of Care		
11.1	The organization has policies and procedures for POCT.	
11.2	The organization appoints a health care professional who is responsible for overseeing the delivery of POCT and maintaining quality.	
11.3	The organization provides orientation and training for all health care professionals delivering POCT on the POCT policies and procedures.	
Priority Process: Decision Support		
The organization has met all criteria for this priority process.		
Priority Process: Impact on Outcomes		
20.10	The team shares information about its quality improvement activities, results, and learnings with residents, families, staff, service providers, organization leaders, and other organizations, as appropriate.	
Surveyor comments on the priority process(es)		
Priority Process: Clinical Leadership		

The organization has a current Community Needs Assessment and is aware of the challenges facing an ageing population with increased chronic conditions and the challenges of living in a large rural geographic area. The Personal Care Homes (PCH) visited during the survey had a wide variation in design and infrastructure however, all are 30 years of age and over, and one has celebrated its 100th anniversary.

The general knowledge about panelling and the wait-list process is impressive when speaking with family and community representatives. The care provided in every facility was characterized by knowledgeable and caring staff that truly had the best interest of residents and families at heart. The increased future demand on this sector can be overwhelming however, encouragement is offered to continue with existing and new initiatives.

The PCH sector has accepted the challenge of 'regionalization' and has made a good start on standardization of assessment tools and integrating this into service delivery and practice. This takes time to achieve and the

measures and monitoring in place will inform continued progress. The emphasis on quality and safety was evident at each of the sites surveyed.

In addition to the above, clinical leaders have supported other initiatives such as falls prevention, harm reduction with the least restraint initiative and continuing education program for existing staff, clinical leaders are also preparing to review the orientation for new staff. These initiatives support quality resident care and the results of these activities have been noted by residents and family members during the course of this survey. Medication reconciliation has been a significant undertaking and is a noted strength across sites. Regional leadership and continued efforts in documenting follow-up when incidents occur are key to demonstrating successful outcomes in this sector.

Priority Process: Competency

The PCH sector is supported by the PCH Program Management in identifying, adopting and assessing best practices and clinical guidelines. The nurse managers at each of the homes provide the link between the PCH Leadership Team and the home staff. At least one PCH has a resource nurse to assist with adoption of new practices and pilot projects. Staff member are currently dealing with a lot of change in the documentation and assessment practices. Provision of change management education to assist with individual understanding of organizational change and coping strategies may prove useful.

Performance appraisals are done yearly, or every second year depending on the sites. New employee orientation is to be reviewed. As the process for new staff evolves, on-boarding may be an option to consider. The PCH training for experienced nursing staff is timely and appropriate to the population served. The willingness to include staff from other programs in orientation/education is noted with approval.

Priority Process: Episode of Care

The standardization of the integrated assessment tool, care plan and inclusion of health aides in documenting on the resident record are progressive steps. In time, these will contribute to increased efficiency and improved communication. Effective teamwork and communication were noted during the survey, especially with Home Care and the Adult Day program. Access to a pharmacist and a pharmacy assistant is a strength for the program. In keeping with this, the extent to which medication reconciliation has been integrated into practice is noted with approval.

Residents and family members spoke positively about the caring approach of staff members and the extent to which they will go to ensure their well-being and comfort. Staff members were described variously as approachable, considerate, professional, knowledgeable, respectful and having a sense of humour.

Priority Process: Decision Support

The PCH sector has been supported by the Regional Office in policy and procedure development, standardization of the integrated care plan, and other improvement initiatives, such as infection control and emergency planning. This support has also been welcomed. The Regional Office receives the performance data collected at each home and compiles the results. This has led to increased sharing and benchmarking of results. Greater emphasis on communicating the results to increase knowledge transfer and reach more homes is suggested. Increased computerization and maintaining current websites would be beneficial.

Priority Process: Impact on Outcomes

The PCH program has many performance indicators and in one instance, the 30 indicators have been placed in a bi-monthly reporting schedule to ensure they are all discussed and understood as much as possible. Also, the establishment of 'champions' in some areas has kept quality audits in view and helped keep momentum.

Staff members are knowledgeable about reporting adverse events and near misses, and do so in a timely manner. Increased focus on documentation of follow-up is recommended. The production of reports and graphs by the Quality Improvement Team and Occupational Safety and Health Program is beneficial and has increased benchmarking and communication with more homes than previously.

3.3.8 Standards Set: Medication Management Standards

Unmet Criteria			High Priority Criteria
Priority Process: Medication Management			
2.5	The organization implements a comprehensive strategy for the management of high-alert medications.		ROP
	2.5.4	The policy includes procedures for storage, prescribing, preparation, administration, dispensing, and documentation for each high-alert medication, as appropriate.	**MAJOR**
	2.5.5	The organization limits and standardizes concentrations and volume options available for high-alert medications.	**MAJOR**
	2.5.6	The organization regularly audits client service areas for high-alert medications.	**MINOR**
2.10	The interdisciplinary committee develops a process for using sample medications.		
2.11	The interdisciplinary committee develops a process for using investigational and study medications that is in line with Health Canada regulations.		
2.15	The interdisciplinary committee develops a process to determine which medications can be stored in client service areas.		
3.2	The interdisciplinary committee develops a process to assess, approve, and purchase in a timely manner medications that are not on the formulary when they are therapeutically necessary.		
5.2	The organization provides staff and service providers with timely access to the client's medication profile and essential client information.		
6.5	The organization has access to a pharmacist on a 24-hour basis, 7 days a week either on-site or on-call to answer questions about medications or medication management.		!
8.1	The organization has a process for determining the type and level of alerts required by the pharmacy computer system which include, at minimum, alerts for medication interactions, drug allergies, and minimum and maximum doses for high-alert medications.		!
8.2	The organization has a policy for when and how to override alerts by the pharmacy computer system.		!
8.4	The organization regularly tests the pharmacy computer system to make sure that the built in alerts are working.		!
8.5	The organization manages alert fatigue by regularly evaluating the type of alerts required by the pharmacy computer system based on best practice information and input from staff and service providers.		

9.3	The organization evaluates and limits the availability of heparin products to ensure that formats with the potential to cause harmful medication incidents are not stocked in client service areas.	ROP
9.3.3	The organization is taking steps to limit the availability of the following heparin products in client service areas: • Low molecular weight heparin: use of multi-dose vials is limited to critical care areas for treatment doses • Unfractionated heparin (high dose): greater than or equal to 10,000 units total per container (e.g. 10,000 units/1 mL; 10,000 units/10 mL; 30,000 units/30 mL) is provided on a client-specific basis when required • Unfractionated heparin for intravenous use: E.g. 25,000 units/500 mL; 20,000 units/500 mL is provided on a client-specific basis when required.	**MAJOR**
11.4	The organization regularly tests the limits set for soft and hard doses to make sure they are working in the smart infusion pump.	!
11.5	The organization regularly reviews the limits set for soft and hard doses and makes changes as required.	
12.6	The organization separates look-alike, sound-alike medications; different concentrations of the same medication; and high-alert medications in the pharmacy and client service areas.	!
12.9	The organization evaluates and limits the availability of concentrated electrolytes to ensure that formats with the potential to cause harmful medication incidents are not stocked in client service areas.	ROP
12.9.2	The organization avoids stocking the following concentrated electrolytes in client service areas: • Calcium (all salts): concentrations greater than or equal to 10% • Magnesium sulfate: concentrations greater than 20% • Potassium (all salts): concentrations greater than or equal to 2 mmol/mL (2 mEq/mL) • Sodium acetate and sodium phosphate: concentrations greater than or equal to 4 mmol/mL • Sodium chloride: concentrations greater than 0.9%.	**MAJOR**
13.3	The organization stores chemotherapy medications in a separate negative pressure room with adequate ventilation segregated from other supplies.	!
14.6	The organization has identified and implemented a list of abbreviations, symbols, and dose designations that are not to be used in the organization.	ROP
14.6.2	The organization implements the Do Not Use List and applies this to all medication-related documentation when hand written or entered as free text into a computer.	**MAJOR**
14.9	The organization regularly audits a sample of medication orders to verify compliance with existing criteria and makes improvements as needed.	!

15.1	The pharmacist reviews prescription and medication orders within the organization prior to administration of the first dose.	!
16.3	The organization has a separate negative pressure area with a 100 percent externally-vented biohazard hood for preparing chemotherapy medications.	!
16.4	The organization has a separate area with a certified laminar air flow hood for preparing sterile products and intravenous admixtures.	!
18.2	The pharmacy team dispenses medications in unit dose packaging.	!
18.3	The pharmacy team dispenses emergency, urgent, and routine medications within the timelines set by the organization.	
19.1	When the pharmacy is closed, the organization provides designated staff and service providers with controlled access to a night cabinet or automated dispensing cabinets for a limited selection of urgently required medications.	

Surveyor comments on the priority process(es)

Priority Process: Medication Management

It is evident that a lot of work has been carried out in medication management since regional amalgamation. The medication safety committee and pharmacy and therapeutics (P&T) committee have created policies and procedures for antibiotic stewardship, medication reconciliation, high-alert medications and dangerous abbreviations.

Medication reconciliation on admission and transfer is well-established and in place across the IERHA. Everyone is engaged in the work of medication reconciliation, including physicians. The antimicrobial stewardship program is underway at the Selkirk and District General Hospital (SDGH) site and needs successes to help the spread to other sites. Unit staff are engaged in following high-alert medication policy and procedure. Storage and stocking challenges exist in many location with respect to high-alert medications and to ameliorate risk there are error-reduction measures in place, including independent double checks, visual verification and smart pump libraries.

The IERHA is primarily using a traditional medication distribution system. This, combined with limited availability of pharmacy staff in small hospital locations, creates potential medication safe-use situations. Work has commenced to move towards a unit dose medication system which will position the organization to leverage additional technology such as automated dispensing cabinets and barcode medication identification.

The pharmacy information system is controlled provincially and while this allows for standardized information it limits the flexibility to adapt to unique needs at each of the sites. Continuing to enhance the leveraging of technology will optimize abilities of limited pharmacy staff to provide service across the region and to also provide further enhancements to existing programs to ameliorate risk from high-alert medications.

The use of high-potency narcotic storage boxes which are segregated from other narcotics is a solution that facilitates meeting the needs of patients for timely access to pain relief while reducing the risk of inappropriate or accidental medication selection.

The IERHA has dedicated staff members at all points in the medication management system and the organization is serious about the safe and appropriate use of medications. They appear engaged in many of recent changes and are interested in making improvements to the quality and safety of system. Many pharmacy staff make themselves available after hours when needed to ensure patient needs are being met.

3.3.9 Standards Set: Medicine Services

Unmet Criteria		High Priority Criteria
Priority Process: Clinical Leadership		
The organization has met all criteria for this priority process.		
Priority Process: Competency		
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		
16.5	The team designs and tests quality improvement activities to meet its objectives.	!
16.8	The team regularly analyzes and evaluates its indicator data to determine the effectiveness of its quality improvement activities.	!
16.11	The team regularly reviews and evaluates its quality improvement initiatives for feasibility, relevance and usefulness.	
Surveyor comments on the priority process(es)		
Priority Process: Clinical Leadership		

Medical services are provided at a number of sites in the IERHA. The major referral centre in the Regional Health Authority is the Selkirk and District General Hospital which provides services for all types of medical condition and acts as the referral site to which other facilities may send patients. The Selkirk site has 17 acute beds and 4 "overflow" beds in the emergency department. In addition, there are four high-acuity beds which can manage most medical patients not requiring ventilation.

Between the other sites there is a total of 150 beds, and these sites manage patients of lower acuity plus provide palliative care, rehabilitation services, diagnostics and laboratory, physiotherapy and occupational therapy. There appears to be good collaboration between these sites.

Renal dialysis services are provided in six sites across the IERHA. The Hodgson site is housed within the federal hospital on that site but managed by IERHA. The patients are referred by the Manitoba Renal Program which has assessed the patients as suitable for dialysis in a rural area.

During the survey the dialysis patients indicated a high degree of satisfaction with the care they received from the staff of the renal program.

Priority Process: Competency

The medicine program provides access to good training courses for staff. Staff orientation includes a regional orientation, an acute care orientation and a specific medicine orientation. Performance reviews are in the process of being done and will likely be completed by the end of this calendar year.

Priority Process: Episode of Care

The medicine service is challenged by shortages of patient care staff, including both Registered nurse (RN) and Licensed practical nurse (LPN). The workload is sometimes quite heavy and overtime is common. Staffing in the renal program however, is full.

Consultation in ethics-related issues is available and has been used. An internist is intermittently available to provide consultations on the unit. Physicians are generally well-integrated into the team but shortages of physicians and recruiting challenges occur.

Patient satisfaction appears to be high, and the consensus after talking with a number of very satisfied patients, several of whom had been admitted several times, seems to reflect quality of nursing care.

There are inadequate medicine beds and this is because of the high numbers of alternate level of care (ALC) patients awaiting placement. This results in the emergency department overflows and occasional off-service patients in surgery beds. The organization makes a real effort to preserve beds for incoming elective surgical patients and attempts to preserve these surgical beds 48 hours before patient surgery.

There is a high degree of satisfaction with diagnostic imaging and laboratory availability. Pharmacy contributes to the team's activities by providing teaching to patients and their families.

There does not appear to be a formal quality improvement program in place.

Priority Process: Decision Support

The medical chart is paper based which limits ease of auditing chart information. Computerized prescriber order entry (CPOE) is not available. Evidence-based guidelines are available for only a few conditions and work to increase these guidelines and audit compliance with them would be a useful way of improving consistency of care across medicine services.

Priority Process: Impact on Outcomes

The medicine service follows the organization's falls prevention protocol and the ulcer prevention protocol. Audits of the results of these protocols should be gathered and shared on a regular basis with program staff.

Formal safety briefings are not held, but patient and staff safety is an agenda item at all staff meetings and safety is always addressed at change of shift.

Full disclosure of adverse events is always provided to patients and families, usually by a nurse and a physician.

There are opportunities to expand hemodialysis services at both the Hodgson and Pinawa sites. Both sites currently operate three days per week. There are 12 patients on the Hodgson wait-list and six patients on the Pinawa wait-list. All these patients could be accommodated if these two sites expanded to six days per week.

3.3.10 Standards Set: Obstetrics Services

Unmet Criteria	High Priority Criteria
Priority Process: Clinical Leadership	
The organization has met all criteria for this priority process.	
Priority Process: Competency	
The organization has met all criteria for this priority process.	
Priority Process: Episode of Care	
12.5 Following transition or end of service, the team contacts clients, families, or referral organizations to evaluate the effectiveness of the transition, and uses this information to improve its transition and end-of-service planning.	
Priority Process: Decision Support	
The organization has met all criteria for this priority process.	
Priority Process: Impact on Outcomes	
The organization has met all criteria for this priority process.	

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

Obstetrical care delivered by the IERHA is provided only at the Selkirk and District General Hospital site. There are 300 deliveries performed per year of which 35% are by cesarean section. Approximately half of these sections are elective repeat sections. The program provides care to low risk obstetrical patients only. This percentage of sections seems excessive in a low risk population. This is recognized by the management team and an external review of this issue is currently being performed.

Priority Process: Competency

The obstetrics team members are a cohesive group with good morale. However, there are inter-professional conflicts that are under investigation and need to be resolved. In the meantime, some nurses are planning to leave despite enjoying their work and their team mates. It is vital to this program that the behaviour issues identified by the team be resolved.

There is a high degree of patient satisfaction with the care provided by the team.

Priority Process: Episode of Care

The team provides good obstetrics care to the relatively small population of pregnant patients, and is capable of handling obstetrical emergencies in a rapid and efficient way. Blood is available in the hospital.

Patient satisfaction appears to be high. Although breastfeeding rates are excellent while in the unit it would be interesting to see how successful the program is in encouraging mothers to continue breastfeeding after discharge.

Priority Process: Decision Support

The obstetrics team takes advantage of educational opportunities in both Selkirk and in Winnipeg. Participation in educational programs is recognized by the manager and is included in the employees' personal file. Performance reviews are done annually.

Clinical practice guidelines comply with the Society of Obstetricians and Gynecologists of Canada (SOGC) guidelines.

Priority Process: Impact on Outcomes

The obstetrics team provides quality care despite a relatively low birth rate at the hospital. It is noted that 1400 pregnant women from this health authority region choose to go to Winnipeg for their obstetrical care. The organization should look for opportunities to encourage low-risk pregnant women to consider coming to Selkirk, rather than travelling to Winnipeg. The satisfaction of current patients suggest that many of those going to Winnipeg would be happy with this decision.

The organization must continue to seek new staff members and physicians if the obstetrics program is to survive. Another family doctor/obstetrician is urgently needed.

3.3.11 Standards Set: Primary Care Services

Unmet Criteria		High Priority Criteria
Priority Process: Clinical Leadership - Primary Care		
1.2	The clinic uses the information it collects to define the scope of its services.	
2.5	The clinic follows a set process to transfer and refer clients, their families, information and records to and from other primary, secondary, acute and specialized health services.	
3.1	The clinic has the appropriate number and mix of physicians, other service providers, and staff needed to meet the needs of clients and families.	
3.3	The clinic's workspace supports interdisciplinary team functioning, interaction, and the timely delivery of primary care services.	
Priority Process: Competency - Primary Care		
4.2	The team works together to develop measurable goals and objectives and plan the team approach to service delivery.	
4.3	The clinic provides education and training to its staff on how to work together across disciplines.	
4.4	Each team member works to their full scope of practice.	
4.5	The clinic develops standardized processes and procedures to improve teamwork and minimize duplication.	
4.7	The team follows a formal process to regularly evaluate its functioning, identifies priorities for action, and makes improvements.	
Priority Process: Primary Care Clinical Encounter		
6.1	During regular hours, the clinic provides same-day access to primary care services for clients and their families, as required.	!
7.9	The team tracks the completion of diagnostic tests and informs the client and family about how they will follow up on both abnormal and normal results.	
7.11	The team shares the results of the assessment with the client and their family in a timely, accurate, and easy-to-understand way.	
8.2	The clinic follows a health risk assessment process to identify clients at risk for preventable health conditions.	!
8.3	The clinic screens clients at risk for preventable health conditions and provides timely follow up on the results.	!

8.4	The clinic plans screening exams and informs all clients of the examination date.	
9.1	The clinic maintains a shared roster or registry of clients and families who access the team's primary care services.	
9.5	A designated person or navigator is responsible for managing and coordinating the care and follow-up for each client.	
9.6	The designated person is clearly identified in the client's record and is known to all team members as well as the client and family.	
9.8	The team has access to tools that provide them with reminders about clients needing follow-up services.	!
9.9	The team has a process or system in place for managing and coordinating care for clients with complex health needs or multiple co-morbidities.	!
9.16	The clinic educates clients about their role in self-care and self-management of their health and helps them access services or health information that support self-management.	!
9.17	The clinic monitors and records whether clients and families achieve their goals and expected results, and updates the care plan, as needed.	
10.5	The clinic has a mechanism to follow clients through the referral and consults with service providers to follow client progress over time.	
10.6	Following discharge from hospital or consultation services, the clinic provides follow-up visits.	
Priority Process: Decision Support - Primary Care		
13.1	When delivering care, the clinic consistently selects and follows established evidence-based guidelines, policies, and protocols.	
13.2	The team follows a process to monitor the consistent use of guidelines in the delivery of primary care services.	
13.3	The clinic regularly reviews the selected evidence-based guidelines and its policies and protocols to make sure they are up to date and reflect current research and best practice information.	
13.4	The clinic collects and uses other research and best practice information to improve its services.	
13.5	The clinic communicates the use of evidence-based guidelines, research, and best practice information to its clients.	
Priority Process: Impact on Outcomes - Primary Care		
15.2	The team uses the information and feedback it has gathered to identify opportunities for quality improvement initiatives.	

15.3	The team identifies measurable objectives for its quality improvement initiatives and specifies the timeframe in which they will be reached.	!
15.5	The team designs and tests quality improvement activities to meet its objectives.	!
15.6	The team collects new or uses existing data to establish a baseline for each indicator.	
15.8	The team regularly analyzes and evaluates its indicator data to determine the effectiveness of its quality improvement activities.	!
15.11	The team regularly reviews and evaluates its quality improvement initiatives for feasibility, relevance and usefulness.	

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership - Primary Care

The IERHA identified that it is early in the implementation of its Primary Care strategy. Successful implementation of the Primary Care strategy has the potential to result in significant improvements in health care services and the health status of the population.

Priority Process: Competency - Primary Care

There is an opportunity to do work around process mapping as well as work to clarify functional responsibility that would improve use of existing resources. For example, in Pine Falls vaccination is currently delivered by the physicians, nurse practitioner or public health nurse. There is an opportunity to define who would be the most appropriate provider, likely the public health nurse, and then set up the scheduling process so that when clients call in for vaccination they are scheduled with the public health (PH) nurse.

Priority Process: Decision Support - Primary Care

The primary care team at Pine Falls is using the electronic medical record (EMR) to share information between providers about the client. Some potential concerns as to how the EMR is being implemented were identified. Lab results generated by the lab in Pine Falls were not entered into the laboratory section for review by the physician but instead, were scanned in as a clinical document for the patient record. The physician receives them as a clinical document for review and then they are recorded in the EMR as a clinical document. There does not appear to be a broadly-known process for describing/titling documents that are scanned in to allow for fast searching. Over time this need to open multiple different documents could make use of the EMR extremely cumbersome.

Further discussion is recommended on how the EMR can be implemented in a manner that supports and streamlines business processes, rather than changing business processes to support the EMR.

The team is encouraged to look at the use of clinical pathways in the provision of services and in particular, the use of established guidelines for screening and management of chronic diseases.

Priority Process: Impact on Outcomes - Primary Care

The Primary Care strategy has a defined vision of: "delivering seamless and coordinated health care services based on the health needs of the population being served. Accessible services will be provided by the most appropriate health care provider at the right time and right place". Three priorities have been identified and are: increased access; strengthened primary care teams and integration of mental health capacity. While the strategy discusses the next steps, the actual measures and timelines that will be used to assess progress to the top three priorities has not been identified.

The IERHA is urged to define how it will measure and track its progress concerning the top three priorities. Establishment of the appropriate measures to use and report could represent an opportunity to engage with key groups such as physicians. Physicians are essential to achieving the top three priorities. While the vision is inspiring, there is a need to establish specific measures to be able to track progress and assess whether the existing operational plans are effective. There may be benefit to establishing and tracking some input and output measures such as the proportion of key groups or individuals met with, or number of affiliation or collaboration agreements reached.

Priority Process: Primary Care Clinical Encounter

The team is encouraged to select a particular chronic disease condition that would lend itself to preventive screening and/or intensive management. For example, in view that the demand for dialysis currently exceeds capacity at Pine Falls, the clinic may wish to screen its current patient population to identify those clients at high risk of progressing to dialysis to implement treatment strategies that would delay progression of their renal disease.

3.3.12 Priority Process: Surgical Procedures

Delivering safe surgical care, including preoperative preparation, operating room procedures, postoperative recovery, and discharge

Unmet Criteria		High Priority Criteria
Standards Set: Perioperative Services and Invasive Procedures Standards		
5.5	The team has a fair and objective process to recognize team members for their contributions.	
13.3	The team uses a safe surgery checklist to confirm that the safety steps are completed for a surgical procedure.	ROP
13.3.1	The team has agreed on a three-phase checklist to be used in the operating room.	**MAJOR**
24.8	The team follows a process to follow up with discharged day surgery clients.	

Surveyor comments on the priority process(es)

The surgical program provides general surgery, obstetrics and gynecology, urology, endoscopy and once monthly, plastics surgery services. All nursing staff members are 'peri-op' certified and laser trained. All forms of surgical anesthesia are available.

Mock fire drills, code blues drills and emergency cesarean section drills are held frequently. Once annually, the operating room (OR) closes for a day so that staff may participate in mandatory skill competency exercise. The staff display their competency in a number of skill exercises that reflect all aspects of OR and post-anesthetic (PACU) care. This is a truly innovative process and the nurse manager and educator is congratulated for their commitment to assuring the best possible care for the patients.

There is a full team meeting every two months, attended by OR staff, PACU staff, surgeons and anesthetists. Policy modifications, introduction of organizational processes and planning for the future are all accomplished at this meeting. The PACU, OR and medical devices reprocessing (MDR) staff members were recently recommended for regional recognition for their quality work and received the recognition. There are regular chart audits performed.

Section 4 Instrument Results

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

4.1 Governance Functioning Tool

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

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

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

- **Data collection period: June 17, 2014 to July 16, 2014**
- **Number of responses: 12**

Governance Functioning Tool Results

		% Disagree	% Neutral	% Agree	%Agree * Canadian Average
		Organization	Organization	Organization	
1	We regularly review, understand, and ensure compliance with applicable laws, legislation and regulations.	0	10	90	93
1	We regularly review, understand, and ensure compliance with applicable laws, legislation and regulations.	0	8	92	93
2	Governance policies and procedures that define our role and responsibilities are well-documented and consistently followed.	0	0	100	95
2	Governance policies and procedures that define our role and responsibilities are well-documented and consistently followed.	0	17	83	95
3	We have sub-committees that have clearly-defined roles and responsibilities.	0	0	100	97

		% Disagree	% Neutral	% Agree	%Agree * Canadian Average
		Organization	Organization	Organization	
3	We have sub-committees that have clearly-defined roles and responsibilities.	0	0	100	97
4	Our roles and responsibilities are clearly identified and distinguished from those delegated to the CEO and/or senior management. We do not become overly involved in management issues.	0	0	100	95
4	Our roles and responsibilities are clearly identified and distinguished from those delegated to the CEO and/or senior management. We do not become overly involved in management issues.	0	0	100	95
5	We each receive orientation that helps us to understand the organization and its issues, and supports high-quality decisionmaking.	0	0	100	92
5	We each receive orientation that helps us to understand the organization and its issues, and supports high-quality decisionmaking.	0	10	90	92
6	Disagreements are viewed as a search for solutions rather than a “win/lose”.	0	0	100	95
6	Disagreements are viewed as a search for solutions rather than a “win/lose”.	0	8	92	95
7	Our meetings are held frequently enough to make sure we are able to make timely decisions.	0	0	100	98
7	Our meetings are held frequently enough to make sure we are able to make timely decisions.	0	0	100	98
8	Individual members understand and carry out their legal duties, roles and responsibilities, including sub-committee work (as applicable).	0	0	100	96
8	Individual members understand and carry out their legal duties, roles and responsibilities, including sub-committee work (as applicable).	0	10	90	96
9	Members come to meetings prepared to engage in meaningful discussion and thoughtful decision-making.	0	10	90	94

		% Disagree	% Neutral	% Agree	%Agree * Canadian Average
		Organization	Organization	Organization	
9	Members come to meetings prepared to engage in meaningful discussion and thoughtful decision-making.	0	8	92	94
10	Our governance processes make sure that everyone participates in decision-making.	0	10	90	94
10	Our governance processes make sure that everyone participates in decision-making.	8	0	92	94
11	Individual members are actively involved in policy-making and strategic planning.	0	8	92	89
11	Individual members are actively involved in policy-making and strategic planning.	0	20	80	89
12	The composition of our governing body contributes to high governance and leadership performance.	0	0	100	93
12	The composition of our governing body contributes to high governance and leadership performance.	0	10	90	93
13	Our governing body's dynamics enable group dialogue and discussion. Individual members ask for and listen to one another's ideas and input.	0	0	100	96
13	Our governing body's dynamics enable group dialogue and discussion. Individual members ask for and listen to one another's ideas and input.	0	0	100	96
14	Our ongoing education and professional development is encouraged.	0	0	100	88
14	Our ongoing education and professional development is encouraged.	0	0	100	88
15	Working relationships among individual members and committees are positive.	0	0	100	97
15	Working relationships among individual members and committees are positive.	0	0	100	97
16	We have a process to set bylaws and corporate policies.	0	0	100	95
16	We have a process to set bylaws and corporate policies.	0	0	100	95

		% Disagree	% Neutral	% Agree	%Agree * Canadian Average
		Organization	Organization	Organization	
17	Our bylaws and corporate policies cover confidentiality and conflict of interest.	0	0	100	97
17	Our bylaws and corporate policies cover confidentiality and conflict of interest.	0	0	100	97
18	We formally evaluate our own performance on a regular basis.	0	0	100	82
18	We formally evaluate our own performance on a regular basis.	0	20	80	82
19	We benchmark our performance against other similar organizations and/or national standards.	0	50	50	72
19	We benchmark our performance against other similar organizations and/or national standards.	0	70	30	72
20	Contributions of individual members are reviewed regularly.	0	30	70	64
20	Contributions of individual members are reviewed regularly.	0	50	50	64
21	As a team, we regularly review how we function together and how our governance processes could be improved.	0	22	78	81
21	As a team, we regularly review how we function together and how our governance processes could be improved.	0	33	67	81
22	There is a process for improving individual effectiveness when non-performance is an issue.	0	60	40	64
22	There is a process for improving individual effectiveness when non-performance is an issue.	8	50	42	64
23	We regularly identify areas for improvement and engage in our own quality improvement activities.	0	11	89	80
23	We regularly identify areas for improvement and engage in our own quality improvement activities.	0	25	75	80
24	As a governing body, we annually release a formal statement of our achievements that is shared with the organization’s staff as well as external partners and the community.	0	0	100	84

		% Disagree	% Neutral	% Agree	%Agree * Canadian Average
		Organization	Organization	Organization	
24	As a governing body, we annually release a formal statement of our achievements that is shared with the organization's staff as well as external partners and the community.	8	25	67	84
25	As individual members, we receive adequate feedback about our contribution to the governing body.	0	17	83	69
25	As individual members, we receive adequate feedback about our contribution to the governing body.	0	56	44	69
26	Our chair has clear roles and responsibilities and runs the governing body effectively.	0	0	100	96
26	Our chair has clear roles and responsibilities and runs the governing body effectively.	0	0	100	96
27	We receive ongoing education on how to interpret information on quality and patient safety performance.	0	8	92	84
27	We receive ongoing education on how to interpret information on quality and patient safety performance.	0	22	78	84
28	As a governing body, we oversee the development of the organization's strategic plan.	0	0	100	95
28	As a governing body, we oversee the development of the organization's strategic plan.	0	0	100	95
29	As a governing body, we hear stories about clients that experienced harm during care.	0	0	100	85
29	As a governing body, we hear stories about clients that experienced harm during care.	0	8	92	85
30	The performance measures we track as a governing body give us a good understanding of organizational performance.	0	13	88	92
30	The performance measures we track as a governing body give us a good understanding of organizational performance.	0	8	92	92

	% Disagree	% Neutral	% Agree	%Agree * Canadian Average
	Organization	Organization	Organization	
31 We actively recruit, recommend and/or select new members based on needs for particular skills, background, and experience.	0	8	92	87
31 We actively recruit, recommend and/or select new members based on needs for particular skills, background, and experience.	20	20	60	87
32 We have explicit criteria to recruit and select new members.	0	42	58	84
32 We have explicit criteria to recruit and select new members.	25	50	25	84
33 Our renewal cycle is appropriately managed to ensure continuity on the governing body.	0	13	88	90
33 Our renewal cycle is appropriately managed to ensure continuity on the governing body.	8	8	83	90
34 The composition of our governing body allows us to meet stakeholder and community needs.	0	11	89	94
34 The composition of our governing body allows us to meet stakeholder and community needs.	0	8	92	94
35 Clear written policies define term lengths and limits for individual members, as well as compensation.	0	0	100	94
35 Clear written policies define term lengths and limits for individual members, as well as compensation.	0	8	92	94
36 We review our own structure, including size and subcommittee structure.	0	0	100	89
36 We review our own structure, including size and subcommittee structure.	0	8	92	89
37 We have a process to elect or appoint our chair.	0	0	100	95
37 We have a process to elect or appoint our chair.	33	33	33	95

*Canadian average: Percentage of Accreditation Canada client organizations that completed the instrument from July to December, 2014 and agreed with the instrument items.

4.2 Canadian Patient Safety Culture Survey Tool

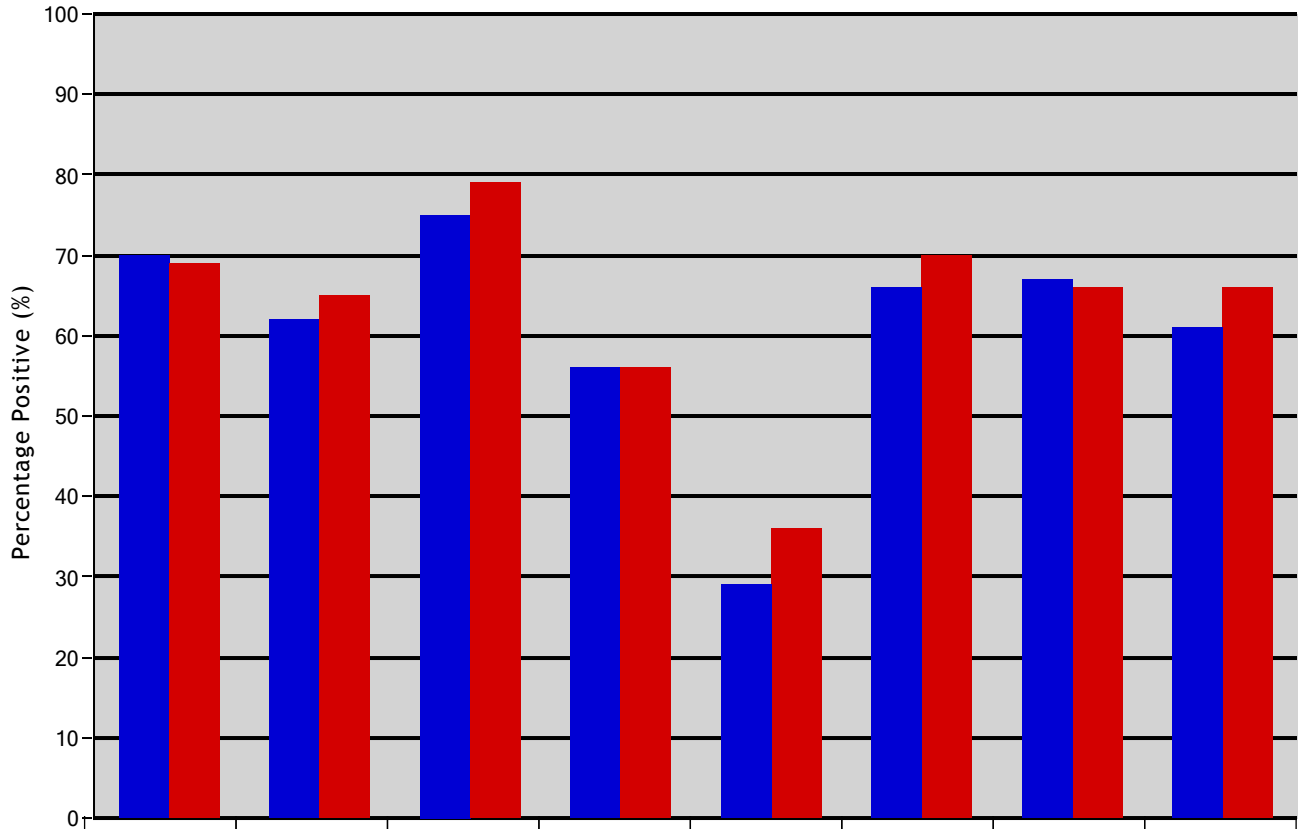
Organizational culture is widely recognized as a significant driver in changing behavior and expectations in order to increase safety within organizations. A key step in this process is the ability to measure the presence and degree of safety culture. This is why Accreditation Canada provides organizations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

Results from the Patient Safety Culture Tool allow the organization to identify strengths and areas for improvement in a number of areas related to patient safety and worklife.

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

- **Data collection period: March 28, 2014 to June 2, 2014**
- **Minimum responses rate (based on the number of eligible employees): 324**
- **Number of responses: 613**

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



	Organizational (senior) leadership support for safety	Supervisory leadership for safety	Unit learning culture	Enabling Open Communication I: judgment-free environment	Enabling Open Communication II: job repercussions of error	Incident follow up	Stand-alone items	Overall Perceptions of Client Safety
	70%	62%	75%	56%	29%	66%	67%	61%
	69%	65%	79%	56%	36%	70%	66%	66%

Legend

Interlake-Eastern Regional Health Authority

* Canadian Average

*Canadian average: Percentage of Accreditation Canada client organizations that completed the instrument from January to June, 2014 and agreed with the instrument items.

4.3 Worklife Pulse

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

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

The organization used an approved substitute tool for measuring the quality of worklife but did not provide Accreditation Canada with results.

4.4 Client Experience Tool

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

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

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

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

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

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

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

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

Section 5 Organization's Commentary

After the on-site survey, the organization was invited provide comments to be included in this report about its experience with Qmentum and the accreditation process.

This is the Interlake-Eastern RHA's first Accreditation as an amalgamated region and we have benefited from the peer review of our various programs and services. Many of the improvement opportunities outlined in the report are already in progress and we are eager to continue on our quality improvement journey as we strive to provide excellent client service.

Appendix A Qmentum

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

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

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

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

Action Planning

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

Evidence Review and Ongoing Improvement

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

Appendix B Priority Processes

Priority processes associated with system-wide standards

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

Priority processes associated with population-specific standards

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

Priority processes associated with service excellence standards

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

Priority Process	Description
Primary Care Clinical Encounter	Providing primary care in the clinical setting, including making primary care services accessible, completing the encounter, and coordinating services
Public Health	Maintaining and improving the health of the population by supporting and implementing policies and practices to prevent disease, and assess, protect, and promote health.
Surgical Procedures	Delivering safe surgical care, including preoperative preparation, operating room procedures, postoperative recovery, and discharge