ACCREDITATION CANADA



Driving Quality Health Services

Accreditation Report

Prepared for:

Interlake Regional Health Authority

Stonewall, MB

On-site Survey Dates:

October 3, 2010 - October 8, 2010

October 26, 2010

ACCREDITATION CANADA
AGRÉMENT CANADA

Accredited by ISQua

Accreditation Report

About this Report

The results of this accreditation survey are documented in the attached report, which was prepared by Accreditation Canada at the request of Interlake Regional Health Authority.

This report is based on information obtained from the organization. Accreditation Canada relies on the accuracy of this information to conduct the survey and to prepare the report. The contents of this report is subject to review by Accreditation Canada. Any alteration of this report would compromise the integrity of the accreditation process and is strictly prohibited.

Confidentiality

This Report is confidential and is provided by Accreditation Canada to Interlake Regional Health Authority only. Accreditation Canada does not release the Report to any other parties.

In the interests of transparency, Accreditation Canada encourages the dissemination of the information in this Report to staff, board members, clients, the community, and other stakeholders.

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About the Accreditation Report

The accreditation report describes the findings of the organization's accreditation survey. It is Accreditation Canada's intention that the comments and identified areas for improvement in this report will support the organization to continue to improve quality of care and services it provides to its clients and community.

Legend

A number of symbols are used throughout the report. Please refer to the legend below for a description of these symbols.

Items marked with a GREEN flag reflect areas that have not been flagged for improvements. Evidence of action taken is not required for these areas.

Items marked with a YELLOW flag indicate areas where some improvement is required. The team is required to submit evidence of action taken for each item with a yellow flag.

Items marked with a RED flag indicate areas where substantial improvement is required. The team is required to submit evidence of action taken for each item with a red flag.

Leading Practices are noteworthy practices carried out by the organization and tied to the standards. Whereas strengths are recognized for what they contribute to the organization, leading practices are notable for what they could contribute to the field.

Items marked with an arrow indicate a high risk criterion.

Accreditation Summary

Interlake Regional Health Authority

This section of the report provides a summary of the survey visit and the status of the accreditation decision.

On-site survey dates	October 3 to 8, 2010
Report Issue Date:	October 26, 2010

Accreditation Decision	Accreditation with Condition (Report)

Locations

The following locations were visited during this survey visit:

1 Arborg and District Health Centre
2 E. M. Crowe Memorial Hospital and PCH
3 Gimli Community Health Centre
4 Lundar Personal Care Home and Community Health Office
5 Selkirk and District General Hospital
6 Stonewall and District Health Centre
7 Teulon Health Centre

Service areas

The following service areas were visited during this survey visit:

1 Emergency Department
2 Emergency Medical Services
3 Home Care
4 Long Term Care
5 Maternal/Perinatal
6 Medicine
7 Mental Health
8 Operating Room
9 Public Health
10 Sterilization and Reprocessing of Medical Equipment
11 Surgical Care

Surveyor's Commentary

The following global comments regarding the survey visit are provided:

Surveyor Comments

1. Strengths
Staff enthusiasm for projects such as electronic health care record was noted.
There is a recruitment of health care providers for hard to fill positions.
Staff show flexibility to embrace change and handle many roles.
Ethics process is developed and ready for implementation
Board senior management is committed to patient/client/staff safety and concerns.
Home care service has capacity for expansion.
Integrated chronic disease management and population health and wellness are strengths of this organization.

2. Improvements
Budget deficit is a risk.
Continue paying attention to patient/client safety such as patient safety rounds and near misses.
Data collection and analysis need to be improved to facilitate best practices.
Review the utilization of inpatient beds to improve patient flow from emergency departments.
Increase focus on retention of healthcare providers.

3. Leadership Successes
Major capital construction project at Selkirk General Hospital is in place.
H1N1 was successfully managed.
Expansion of working relationships with First Nations was effectively implemented for example the health promotion and disease prevention.
Recruitment including aboriginal human resources development officer has been successful.
Chronic disease prevention program is in place.
Radiology information system and PACS picture archival computerized system were implemented.
There are dedicated resources to patient safety.
Communicable disease management program is in place.

4. Communication
Accessibility of governance and leadership team is strength.
Staff see the example of senior leadership accessibility as a positive model.
Physicians are actively engaged in the care provider teams.
EMS with hospital, RCMP, and fire services are linked.

5. Community Relations
Organization has effective communication with community partners including school boards, municipalities, and band councils.
Senior leaders and managers have open door policy.
CEO visits and meets with municipal partners and community groups.

Other Information
While this region is close to Winnipeg, it serves a largely rural population.
This is a large geographical area to serve (equivalent of Montreal to Toronto).
There is a large influx of summer residents each year that increases service demands.

Organization's Commentary

The following comments were provided to Accreditation Canada post survey.

Programs and services across the region have had the opportunity to look at the most up to date national standards and rate themselves. We found we are meeting the standards in almost all areas. Of the areas where we need to improve, especially the high priority actions, we are well on our way to implementing the required practices as a lot of work has already been done. Our long term strategic and operational plan highlights quality, risk management, patient safety, and ethics as an integrated part of every program's activities and goals.

Overview by Quality Dimension

The following table provides an overview of the organization's results by quality dimension. The first column lists the quality dimensions used. The second, third and fourth columns indicate the number of criteria rated as met, unmet or not applicable. The final column lists the total number of criteria for each quality dimension.

Quality Dimension	Met	Unmet	N/A	Total
Population Focus (Working with communities to anticipate and meet needs)	124	2	0	126
Accessibility (Providing timely and equitable services)	98	3	2	103
Safety (Keeping people safe)	467	15	19	501
Worklife (Supporting wellness in the work environment)	151	1	0	152
Client-centred Services (Putting clients and families first)	149	1	2	152
Continuity of Services (Experiencing coordinated and seamless services)	57	1	0	58
Effectiveness (Doing the right thing to achieve the best possible results)	612	19	18	649
Efficiency (Making the best use of resources)	62	1	1	64
Total	**1720**	**43**	**42**	**1805**

Overview by Standard Section

The following table provides an overview of the organization by standard section. The first column lists the standard section used. The second, third and fourth columns indicate the number of criteria rated as met, unmet or not applicable. The final column lists the total number of criteria for that standard section.

Standard Section	Met	Unmet	N/A	Total
Sustainable Governance	87	2	2	91
Effective Organization	103	2	0	105
Infection Prevention and Control	97	2	4	103
Populations with Chronic Conditions	69	0	0	69
Mental Health Populations	69	0	0	69
Public Health Services	111	3	1	115
Emergency Department	97	10	0	107
Emergency Medical Services	143	1	16	160
Home Care Services	88	6	1	95
Long Term Care Services	118	3	0	121
Managing Medications	127	5	3	135
Medicine Services	101	2	1	104
Mental Health Services	103	6	2	111
Obstetrics/Perinatal Care Services	113	1	5	119
Operating Rooms	99	0	2	101
Reprocessing and Sterilization of Reusable Medical Devices	94	0	5	99
Surgical Care Services	101	0	0	101
Total	**1720**	**43**	**42**	**1805**

Overview by Required Organizational Practices (ROPs)

Based on the accreditation review, the table highlights each ROP that requires attention and its location in the standards.

Criteria	Required Organizational Practices
Effective Organization 6.6	The organization reconciles clients' medications at admission and discharge, transfer, or end of service.
Effective Organization 12.6	The organization clearly defines the roles, responsibilities, and accountabilities of leaders, staff, service providers, and volunteers for client care and safety.
Emergency Department 4.5	Staff and service providers receive ongoing, effective training on infusion pumps.
Home Care Services 8.8	The organization implements and evaluates a falls prevention strategy to minimize the impact of client falls.
Home Care Services 11.3	The organization transfers information effectively among providers at transition points.
Long Term Care Services 12.3	The team reconciles medications with the client at referral or transfer, and communicates information about the client's medication to the next provider of service at referral or transfer to another setting, service, service provider, or level of care within or outside the organization.
Long Term Care Services 16.2	The team implements and evaluates a fall prevention strategy to minimize the impact of client falls.
Managing Medications 3.6	The organization evaluates and limits the availability of narcotic (opioid) products and removes high-dose, high-potency formats from patient care areas.
Medicine Services 11.3	The team reconciles medications with the client at referral or transfer, and communicates information about the client's medications to the next provider of service at referral or transfer to another setting, service, service provider, or level of care within or outside the organization.
Medicine Services 15.2	The team implements and evaluates a falls prevention strategy to minimize the impact of client falls.
Mental Health Services 11.3	The team reconciles medications with the client at referral or transfer, and communicates information about the client's medications to the next provider of service at referral or transfer to another setting, service, service provider, or level of care within or outside the organization.
Mental Health Services 15.3	The team implements and evaluates a falls prevention strategy to minimize the impact of client falls.
Obstetrics/Perinatal Care Services 11.3	The team reconciles medications with the client at referral or transfer, and communicates information about the client's medications to the next provider of service at referral or transfer to another setting, service, service provider, or level of care within or outside the organization.

Detailed Accreditation Results

System-Wide Processes and Infrastructure

This part of the report speaks to the processes and infrastructure needed to support service delivery. In the regional context, this part of the report also highlights the consistency of the implementation and coordination of these processes across the entire system. Some specific areas that are evaluated include: integrated quality management, planning and service design, resource allocation, and communication across the organization.

Findings

Following the survey, once the organization has the opportunity to address the unresolved criteria and provide evidence of action taken, the results will be updated to show that they have been addressed.

Planning and Service Design

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

Surveyor Comments

Strengths

The organization benefits from a strong, committed Board and senior leadership team who have just completed a review of its mission, vision, values, and strategic directions. Numerous information sources were used to prepare for the review including a PEST (Political,Environment,Social,Technological) Scan which is a reality check, the organization's CHIRP (Coordinated Health Indicators Health Reporting process) reports, community needs assessment, Youth survey, and data from Manitoba Health.

The information from the 2010 community needs assessment is a thorough document although it does not include input from the First Nations population. The Youth survey does as it was completed in the schools.

The organization identifies areas of risk and include recruitment and retention of nursing staff in the northern areas of the region, the need to enhance the Aboriginal workforce which is estimated to be one in four employees in the future, and to monitor and actively sustain the physical structure of the Selkirk General hospital while at the same time building a new structure over the next three years. At the same time, the organization and planning portfolio is commended for the significant community-linked planning and preparation of the functional design of this new facility.

The Board ties its monthly agenda to the strategic directions and receives regular indicator reports. The update on the strategic directions is consistent, documented and available as is the annual operational planning information.

The Community partners interviewed are very impressed and supportive of the organization. They describe a respectful approach and an open door policy and believe the organization is making great strides in population health and wellness initiatives including resources for seniors, First Nations health and recreation, and risk factor surveillance for youth grades 6-12.

Issues of concern that needed to be addressed promptly included first responder requests in light of long ambulance waits to the First Nations communities. The partners are satisfied with the ongoing work in this area. The licensing of Personal Care Homes by the province and the involvement of Indian and Northern Affairs and the Interlake Regional health Authority is another example of how representatives from the First Nations community are experiencing trust and a people -oriented approach by the senior leaders and staff of the organization.

The Community Partners also described the organization's commitment to population health and wellness, nutrition, smoking cessation and healthy lifestyles including recreation and noted how well this is received in the community.

The organization and First Nations population have strong partnerships and the CEO meets regularly with leaders on health and community programs initiatives, two of which are the implementation of the Dialysis program at the Percy Moore Hospital and Mobile Screening for Diabetes.

The organization has developed an ethics framework, have an Ethics Committee and have made arrangements for consultation with an ethicist from Winnipeg who has already provided education to managers in the organization and who will be available on an as-needed basis to support staff with ethical issues. The program which has not yet been implemented to staff is functional at the unit manager level and the organization is encouraged to proceed with this important link at the earliest time.

Areas for Improvement

An area for improvement includes a need for staff in the region to have a better understanding of how the federal funding for First Nations health is provided. There needs to be processes and approvals before a client can be referred and transferred to other programs in health care. The organization is encouraged to provide this education to staff to assist in a smoother transition of care for clients.

Another area for potential improvement is the school health program URIS (Unified Referral Intake Services). There are over 100 students in the system with diagnoses of Diabetes, Asthma, etc .Currently nurses are coming from Winnipeg to provide training for staff as necessary and there is a question as to whether this service could be provided closer to home.

The organization is encouraged to conduct a workforce assessment to determine the capacity of its workforce and volunteers to meet community health needs, and to subsequently develop a plan to action findings.

The table below indicates the specific criteria that require attention, based on the accreditation review.

Criteria	Location	Priority for Action
Public Health Services		
The organization conducts a workforce assessment at least every three years to determine the capacity of its workforce and volunteers to meet community health needs.	9.1	

The organization develops and implements a plan to address workforce gaps.	9.2
Team leaders regularly evaluate and document each team member's performance in an objective, interactive, and positive way.	9.6

Resource Management

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

Surveyor Comments

Strengths

The IRHA utilizes a comprehensive approach to resource planning, budgeting and resource allocation. In the budgeting process which operates at the manager level, there are training sessions for managers, a standard template is used, and the process is rolled up to the senior team. Three priority areas are always on the discussion agenda.

The Board has an effective Finance Committee which receives and approves financial reports on a regular basis. It also reviews capital expenditures. Separate financials for capital construction is provided. The Board ensures donation expenditure greater than $5,000 is approved at the Board level. The External Auditor's report has only one recommendation which includes segregation of duties for Accounts. In smaller organizations this is often not realistic and some discussion has occurred with the organization and the Auditor on this issue.

The preparation of the annual operating and capital budgets follows the organization's policies and procedures.

The Finance Senior leader also oversees Information Services and is able to attend provincial meetings with her counterparts in both areas, and this is effective.

Variance reporting based on expenses, utilization of staff and resources, and contingency issues has been discussed on an individual basis by the financial analyst in the past and while the concept is appropriate, the development of documented monthly variance reports may result in more consistency and as well be a teaching tool for new managers.

The IRHA is experiencing a deficit this year and one contributing factor is significant staffing pressures and a drive to maintain facilities for northern communities with support from the provincial level that services are maintained in the communities. The Board and senior leaders as a result are concerned with the next year's allocation of resources and how this will impact their strategic directions and operations. The Board and senior leaders are encouraged to continue their budget planning cycle and ongoing monitoring using the comprehensive approach they have in place while reviewing utilization of resources, risks and continuous improvement to patient safety.

Areas for improvement

While it is not documented as a process, the organization utilizes an allocation process which includes review through both an ethics and a risk lens. There is encouragement to document the process for consistency and as a method to ensure new senior leaders are informed.

No Unmet Criteria for this Priority Process.

Human Capital

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

Surveyor Comments

Strengths

The Board has policies and processes in place which deal with their roles and responsibilities, orientation, and ongoing education.

The Board completed the Governance Functioning tool and reviewed flags to develop action plans. One area noted is the Board's approval of process indicators and their desire to start to receive more outcome indicator reports from the organization. The organization is encouraged to continue the initiatives that are being developed in these areas. Work Life and working environment satisfaction are areas where indicators are strong and the Board would like to see more outcome measures reported.

There is a trusting relationship expressed between the Board and Senior leaders with an emphasis on openness and willingness to provide and explain appropriate information as requested. The organization is applauded for developing this culture which appears to transcend to staff from senior leaders who are of similar opinion.

The organization completed the Work Life Pulse Tool and is effectively responding to the flags through an Action Plan approach.

There are two significant education programs which have potential to enhance management in the future and they include a management development program and a leadership program aimed at succession planning. The team is encouraged to track the outcome of these interventions to determine the effectiveness and the quality of leadership which results.

Another significant addition to the Human Resources Team is the Aboriginal Human Resources Developmental Officer and Assistant. The mandate is the recruitment and retention of Aboriginal people as recognized by the Canadian Constitution. The percentage of Aboriginal people in the region is estimated to be 21% in the future, and this is an excellent way to assure culturally appropriate care is delivered if there is appropriate representation in the workforce.
The organization is applauded for its implementation of a Patient Safety and an Occupational Health and Safety position, HR Plan, Workplace Safety Health Plan and its Aboriginal Work Plan. As well there is a strong leader and HR officer and education team who provides effective and people-oriented service to the region.

Areas for improvement

With a current recruitment and retention concern and risk in the northern part of the region, the HR team is encouraged to follow through regularly on the retention strategies to ensure they are effective and work with local managers and senior leaders to manage any deficits in human resources in a timely and safe manner.

All staff, leaders, service providers and volunteers in the organization have a role and responsibility for client care and safety. There is a plan to update the position profiles as well as performance appraisals and other Human Resources handbooks and orientation material with clear documentation on these roles for client safety and this is required.

The governing body deals with conflict issues from time to time and works toward resolving these conflicts. Due to member turnover and new members joining the Board, it is encouraged that a documented process be implemented that addresses how to resolve conflicts. This document would guide members in the process, as well as evaluate the process of group decision-making.

The table below indicates the specific criteria that require attention, based on the accreditation review.

Criteria	Location	Priority for Action
Effective Organization		
The organization clearly defines the roles, responsibilities, and accountabilities of leaders, staff, service providers, and volunteers for client care and safety.	12.6	↑
Attention to client safety is demonstrated by defining roles and responsibilities for client safety in position profiles, performance appraisals, handbooks, orientation material, and by addressing client safety on regular basis in newsletters and client safety committee minutes.	12.6.2	
Sustainable Governance		
The governing body has a decision-making process that addresses how to resolve conflicts or disagreements, how to use group decision-making effectively, and how to analyze and learn from past decisions.	6.10	

Integrated Quality Management

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

Surveyor Comments

An organization wide commitment exists to integrated quality management. Resources have been made available, staffing is in place to support the initiative and significant evidence exists to show ongoing development and understanding by staff at all levels.

The governing board has endorsed a deficit budget and holds the hope that the government will approve the deficit (apparently many other regions are in similar circumstances) or the "run-rate" will actually result in a balanced budget. This is an area of significant risk to the organization which can lead to a structural deficit ballooning rapidly over a short period of time such as 2-3 years. Resolution of this risk should be addressed.

Process and outcome measures need to continue development. More outcome focused indicators are sought by the board. Generally across the system the organization would benefit by setting and monitoring more quantitative data.

The Patient Safety Culture Survey was last completed a year ago and a number of initiatives have been reviewed and set in motion, however, management must remain cognizant of the breadth of gaps reported. They need to maintain this as a critical strategic element of their operations as of paramount concern and continuous attention noting change on the "front lines" of operations of IRHA where success can only be measured by staff and clients/patients. The proposed additional part time staff for this purpose is noted as is the action plan recently updated.

The table below indicates the specific criteria that require attention, based on the accreditation review.

Criteria	Location	Priority for Action
Effective Organization		
The organization reconciles clients' medications at admission and discharge, transfer, or end of service.	6.6	↑
The plan includes locations and timelines for implementing medication reconciliation throughout the organization.	6.6.4	

Principle Based Care and Decision Making

Identifying and decision making regarding ethical dilemmas and problems.

Surveyor Comments

Strengths

The Board is in the process of reviewing and revising its values statements. The organization is encouraged to utilize the same process as in its previous presentation to the organization and community so there is widespread understanding and awareness of the values.

The Board is commended for the emphasis placed on its values and the importance of the values and ethics perspective which helps to guide decision making at both the senior and Board tables.

Areas for improvement

The IRHA has formed a regional Ethics Steering Committee with the objective of developing a regional ethics program and process. There has been an ethics policy developed as well as an ethical framework for decision-making. A consultant from Winnipeg has become involved and in addition to providing education sessions for managers, she will be available as necessary for consultation regarding ethical issues that require her assistance. At this time, the process has not been implemented region wide at the staff level. The organization is encouraged to act on this excellent initiative.

No Unmet Criteria for this Priority Process.

Communication

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

Surveyor Comments

A robust strategy exists across the whole scope of communications from the traditional component of public relations now under new leadership to health records, protection of privacy, access to information, staff education, and information technology.

The tight control of IT access to patient records on a need to know basis is carefully adapted to enable hand-held technologies used by some physicians. Current IT platforms are scheduled to be closely integrated with Manitoba Health over the next 3 years providing substantial new resources in terms of scope of management information.

IT continues to roll out services to Home Care providing the team with opportunities for new and timely information.

The table below indicates the specific criteria that require attention, based on the accreditation review.

Criteria	Location	Priority for Action
Sustainable Governance		
The governing body holds regular in-camera sessions without the presence of the CEO, senior managers, or clinical leaders.	9.5	

Physical Environment

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

Surveyor Comments

Sites are generally well maintained, and improvements are ongoing. Plans are in place for redevelopment of Selkirk site, where remediation of immediate issues has occurred. Organization is encouraged to ensure that sites, for example Teulon Health Centre and Arborg and District Health Centre, are clearly labelled to identify entrances, including but not limited to Emergency entrances. Site Managers, Maintenance and Infection Prevention and Control are encouraged to complete walk arounds on sites, to ensure convenient access to hand sanitizer on all sites, appropriate location of ice machines, (Teulon Health Centre), appropriate location of clean laundry storage, for example (Teulon Health Centre), marking of changes in elevation or low ceilings or pipes, (Teulon Health Centre), and reduction of unnecessary items (E. M. Crowe Memorial Hospital and PCH).

Organization established free standing sanitizer, mask, glove stations on sites in response to Pandemic (H1N1) 2009. Sites are encouraged to ensure stations remain in place, clearly labelled and fully stocked thereby encouraging continued respiratory etiquette.

Team is encouraged to review infection prevention and control requirements of patients receiving chemotherapy at Selkirk site.

No Unmet Criteria for this Priority Process.

Emergency Preparedness

Dealing with emergencies and other aspects of public safety.

Surveyor Comments

The organization is in the process of re-education of staff regarding Emergency and Disaster Planning. The team regularly conducts table top exercises, and has experience in responding to various issues, including multi-casualty, flood, and environmental spill situations. Communication has been established with municipal leaders; team recognizes the value and importance of ongoing contact to ensure communication continues to occur in a timely way.

A focus on fire safety is evident, drills are held regularly, and building systems have been installed to enable monitoring. Post Pandemic (H1N1) 2009 reviews continue, and changes to plan will be incorporated into overall plan. Organization utilized pharmacy contacts for distribution of information during pandemic. Organization recognizes importance of timely contact of staff through both on call and fan out mechanisms. Organization is encouraged to ensure that sites are aware of, and have documented, their alternative sources of potable water.

No Unmet Criteria for this Priority Process.

Patient Flow

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

Surveyor Comments

Clients served at the Interlake Regional Health Authority multiple sites of care know how to access services. At Teulon Health Centre, there is a clear indication on the street for the Emergency Department, but once on the parking lot, no indication shows which entrance gives access to ED; this could be a barrier preventing clients in critical situations not familiar with the site, to reach emergency services in timely manner.

There is good collaboration between sites to accommodate situations of overcrowding emergency services by admitting patients from other sectors when needed and beds are not available at the site of origin. The EMS complies with provincial legislation and protocols and is committed to the centralized provincial dispatch centre. The patient flow in surgery at Selkirk is well managed and a standardized follow up procedure is in place.

The table below indicates the specific criteria that require attention, based on the accreditation review.

Criteria	Location	Priority for Action
Emergency Department		
The team identifies barriers that prevent clients, families, providers, and referring organizations from accessing services in the Emergency Department.	1.5	

Medical Devices and Equipment

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

Surveyor Comments

The Regional Interlake Health Authority leaders have a well structured team to manage medical devices and equipment acquisition, maintenance, and replacement. The organization has a solid infection prevention procedure.

The leaders of the organization are involved with the EMS of the region and care about the quality and safety for the clients and the staff. Every employee in the Reprocessing and Sterilization service is certified and complies with strict protocols. There is no flash sterilization device in Selkirk and District Hospital. The Selkirk and District Hospital does not contract any sterilization service to external providers.

No Unmet Criteria for this Priority Process.

Horizontal Integration of Care

Findings

Following the survey, once the organization has the opportunity to address the unresolved criteria and provide evidence of action taken, the results will be updated to show that they have been addressed.

Chronic Disease Management

Integration of services to meet the needs of populations across the continuum of care.

Surveyor Comments

Chronic Disease Management

The strategy to incorporate Chronic Disease Management (CDM) program with Wellness including Seniors Care under the banner of "Get Better Together" has shown positive results and leadership in this area across Manitoba and beyond. The core team is high energy, committed, and progressive. Data is collected and is being used to develop strategy going forward. Future success will be dependent on continued executive championship, retention of the strong team members, successful expansion of physician engagement along with multi-disciplinary team members, the community engagement ranging from the local volunteer to corporate and municipal sponsorship, and participation.

Aggressive and broad based longitudinal data is essential to ensure measures that support value for money are evident. Research of external websites and the literature is noted as is the intention to incorporate the learning from these studies. The team is encouraged to publish their model with lessons learned and directions for future consideration.

Mental Health Population

The Mental Health team has a clear understanding of their demographic and high risk populations. Resources are directed accordingly and new positions developed to suit needs.

Interdisciplinary approach is evident with strong communication and information transfer between team members in a timely fashion. Confidentiality is protected throughout the care plans. Ongoing team training, information updates and educational sessions are accessed. Even proctors who may initially have been consumers of the mental health services are trained in crisis intervention.

Access to service is facilitated at intake in a central approach for children, adolescents and adults. Flexibility is apparent in the decentralization of intake for the elderly who are less mobile for services. A mobile crisis unit is utilized to optimize access as well. Access to inpatient bed admission is limited-see Mental Health Services.

Valuable attention is paid to health promotion and prevention strategies and community partners are well linked and accessed both by the team and by the clients on a regular basis. In particular the team and partners should be congratulated for impressive efforts related to housing and support. "Working on wellness" and Interlake Mental Health Support Centre are two great examples. The support centre does double duty as a means for client consumers to take part in their own rehabilitation and wellness as integral members of the centre.

Programs are compared with other similar endeavours country wide where work is presented at national meetings. It is likely that this group may be seen as a leader in this field. Data collection is largely through Manitoba Health but fed back to this group who responds to population mental health needs in a dynamic and competent way.

No Unmet Criteria for this Priority Process.

Population Health and Wellness

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

Surveyor Comments

Organization has conducted a broad community needs assessment and has conducted the youth health assessment survey for second time, and has identified modest improvements in youth health. Provincial survey of youth has been model after the work in the organization.

Organization is working with community to increase access to health care provider education, and has partnered with educational institutions for program delivery.

The team, in conjunction with partners, has implemented programs to reduce farm related injuries, starting with the youth and building future awareness. The team analyses immunization data, and determines strategies or mechanisms to improve rates.

The team plans to continue to utilize web based material to convey timely information to communities, but recognizes alternate forms, including radio are important mediums. Food and water safety inspections are the responsibility of the ministry, members of the organization work closely with ministry staff. Public Health and Infection Prevention and Control have access to lab services in Winnipeg. Human resources have been added for communicable disease services.

The team is encouraged to continue working on the action plan, ensuring that updates to the plan describe progress and are readily available.

The team is encouraged to formally link and engage with IP and C structures and committees.

No Unmet Criteria for this Priority Process.

Direct Service Provision

This part of the report provides information on the delivery of high quality, safe services. Some specific areas that are evaluated include: the episode of care, medication management, infection control, and medical devices and equipment.

Findings

Following the survey, once the organization has the opportunity to address the unresolved criteria and provide evidence of action taken, the results will be updated to show that they have been addressed.

Emergency Department

Clinical Leadership

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

Surveyor Comments

The Interlake Regional Health Authority emergency departments offer good quality clinical emergency services in all sites surveyed but rarely use data driven management tools to improve performance and ultimately quality of care (for example waiting time, Length of stay (LOS), etc). They all wish for more nurses to handle the workload.

The nurse manager of the emergency in Selkirk has only been in charge for two months but he demonstrates a dynamic attitude and competency. The team's goals and objectives in this emergency service still need to be improved according to wait times and time to admission. The workspace in this hospital is too small and bulky to deliver effective services. The triage of incoming ambulatory and ambulance patients is done in the same area as the waiting room and not in a separate area, thus compromising confidentiality.

The team supports students but there are no volunteers on the team. This hospital is supposed to be replaced by a new and more adequate building in the next three years.
The emergency department in Teulon Health Centre does not have any signage identifying emergency entrance. The actual location of the waiting room does not permit nursing staff to easily see the patients while treating patients already inside the emergency department. This situation puts waiting patients in a more vulnerable situation particularly at night when staff is reduced at minimum. The number of physicians is not sufficient to cover this emergency department (ED) 24/7. Standing orders and protocols have been developed and approved by the medical regional board to help nurses when no doctor is available, and emergency medical services (EMS) is advised to bypass the facility during these periods. This ED is also used as an ambulatory care unit.

The emergency department in Gimli is particularly well equipped with two stretchers in the resuscitation area, a Bear Hugger device, two Level one line warmers and a Browselow paediatric kit. This ED is also used as an ambulatory care unit. It has a waiting room near the entrance not easily visible by the nurses when they are occupied with patients in the ED.

The table below indicates the specific criteria that require attention, based on the accreditation review.

Criteria	Location	Priority for Action
The team's goals and objectives are linked to benchmarking of bed availability in the Emergency Department, time to admission, client diversion to other facilities, and wait times.	2.2	
The team has the workspace needed to deliver effective services in the Emergency Department.	2.8	

Competency

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

Surveyor Comments

Competency to ensure quality of care is adequate in all the EDs surveyed. Otherwise, the training on infusion pumps is offered once to new team members but not on a regular basis thereafter in Selkirk hospital as it is annually in Teulon and Gimli.

The table below indicates the specific criteria that require attention, based on the accreditation review.

Criteria	Location	Priority for Action
Staff and service providers receive ongoing, effective training on infusion pumps.	4.5	↑
There is documented evidence of ongoing, effective training on infusion pumps.	4.5.1	

Episode of Care

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

Surveyor Comments

In the EDs surveyed, offload response times and waiting times for services are not strictly monitored on a permanent basis. Despite the fact that the transfer of mental health cases from the Selkirk emergency department to the provincial mental health facility are often difficult and impose some retention problems in the ED, other cases are transferred in a timely manner with appropriate information.

The table below indicates the specific criteria that require attention, based on the accreditation review.

Criteria	Location	Priority for Action
The team measures ambulance offload response times, and sets and achieves target times for clients brought to the Emergency Department by EMS.	6.7	
The team monitors ambulance offload response times and uses this information to improve its services.	6.8	
The team sets, tracks, and benchmarks data related to waiting times for services and information, and the length of stay (LOS) in the Emergency Department.	6.11	

Decision Support

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

Surveyor Comments

The EDs surveyed have ready access to a Picture Archiving & Communication System (PACS) and the Selkirk emergency team is planning to implement the ETIS information system in the near future.

No Unmet Criteria for this Priority Process.

Impact on Outcomes

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

Surveyor Comments

All teams in sites surveyed share evaluation results with staff but not with clients and families.

The teams need to share benchmark and best practice information with their partners and other organizations and compare their results with other similar programs or organizations.

The emergency departments of the Interlake Regional Health Authority should use more data driven tools to facilitate quality improvement and patient safety.

The table below indicates the specific criteria that require attention, based on the accreditation review.

Criteria	Location	Priority for Action
The team shares benchmark and best practice information with its partners and other organizations.	14.5	

The team compares its results with other similar interventions, programs, or organizations.	16.3	↑
The team shares evaluation results with staff, clients, and families.	16.5	

Emergency Medical Services

Clinical Leadership

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

Surveyor Comments

The team is beginning to receive area specific data from the provincially centralized communication centre. They are encouraged to pursue data analysis and set benchmarks to track response rates and service details to support accountability and continuous improvement.

The team is looking at locations for deploying vehicles and shift assignments to align resources with demands. The team is regularly involved with other districts to help and receive assistance based on service needs. The team also works with first responders at fire stations to promote prompt response and support continuing education to enhance quality of care.

The medical oversight team is set by provincial guidelines and the local medical director is a member of the provincial committee as a rural representative.

No Unmet Criteria for this Priority Process.

Competency

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

Surveyor Comments

A working group has developed resources for well being and work life of staff and are now moving forward on a new staff orientation for emergency medical services (EMS) and specific orientation to EMS stations. There is an action plan with timelines in place.

There is an extensive up to date EMS training and education plan. There is work underway to proactively develop individualized educational plans to enhance communication and help staff meet the required education credits to maintain competency and licensure requirements.

There are numerous student placements at various levels that are made possible through effective coordination, scheduling, and staff mentorship and support.

There is a formal critical incidence stress debriefing available. It is well publicized and participation is encouraged.

Staff are very motivated and committed to education and quality.

No Unmet Criteria for this Priority Process.

Episode of Care

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

Surveyor Comments

The communication center is not part of the services provided by the region. It is a provincially centralized 911 service. Therefore rating items related solely to the communication center have been marked as not assessed.

Vehicle maintenance is formalized and up to date with four new vehicles ordered. One sharps container was tucked under a bar rather than secured during a tour but all other containers were appropriately secured.

A centralized provincial 911 has been in place for approximately two years and staff have adapted to this change. One consideration that might be investigated is related to the geographic layout at Selkirk where the pre alerts result in teams arriving very quickly and sometimes in advance of the communication centre obtaining data which leads to the centre requesting the crew to go to staging until there is sufficient information or support so that teams are not sent into high risk environments. However, crews are already at the scene are visible. This situation should be monitored and examples shared with central dispatch to see if processes need to be refined to protect crews.

Pain is assessed using a ten point visual analog scale and charted in the open text area of the chart which is a provincial form. Consideration might be given to including pain assessment as a box item on the main page as the fifth vital sign.

The crew uses a red,orange, green code rather than Canadian Triage and Acuity Scale (CTAS) in keeping with provincial practice.

The EMS educator is planning to link with the Safe Medication Committee to obtain ongoing information about high risk/high alert medications that may be used by paramedics.

Patients are charged for ambulance transfers so crews are adept at dealing with clients who decline services.

Inter Facility transfer is now funded by the province and this change has led to significant increases in inter facility transfers. Staff are measuring volumes and responding appropriately. There are plans under discussion for provincial transfer services to reduce ambulance demands.

Patients and family requiring emergency services are very satisfied and commented on the caring and supportive nature of the staff.

No Unmet Criteria for this Priority Process.

Decision Support

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

Surveyor Comments

The team is encouraged to work with Emergency Department staff to implement STEMI protocol which would also further develop the synergy of combined EMS and Emergency Department staff.

There may also be opportunities to use tools such as SBAR (situation, background, assessment and recommendation) based on work from the Institute for Healthcare Improvement to enhance communication and decision making.

No Unmet Criteria for this Priority Process.

Impact on Outcomes

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

Surveyor Comments

Occurrence reports are completed. There may be potential to increase near misses and programs such as a "good catch" approach with limited documentation. This approach might be considered to facilitate this important source for quality improvement.

Staff address any complaints they receive. The last patient survey was three years ago so more frequent input would be helpful to provide up to date opinions from the communities they serve. There are many methods to obtain this and survey is only one way to do it. Staff are encouraged to consider how best to get feedback and input for quality improvement.

The table below indicates the specific criteria that require attention, based on the accreditation review.

Criteria	Location	Priority for Action
The team monitors stakeholder, patient and family perspectives on the quality of its services.	21.4	

Infection Prevention and Control

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

Surveyor Comments

Equipment and supplies are readily available to promptly clean and prepare vehicles and staff. Staff keep the vehicles clean and well stocked.

No Unmet Criteria for this Priority Process.

Home Care Services

Clinical Leadership

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

Surveyor Comments

The team needs to develop goals and objectives that are measurable and specific.

The table below indicates the specific criteria that require attention, based on the accreditation review.

Criteria	Location	Priority for Action
The organization's goals and objectives are measurable and specific.	2.3	

Competency

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

Surveyor Comments

Home Care Aides are hired without having been credentialed. Scope of work is limited and pay scale is lower than the standard for Home Care Aides. Training is on the job and clients are matched to the skill level available from the staff member. Encouragement to become credentialed is given but access to courses is restricted due to distance and to time offerings of the certified program (Home Care Standards, criteria 4.2 and 4.9)

The table below indicates the specific criteria that require attention, based on the accreditation review.

Criteria	Location	Priority for Action
Each staff member has the necessary credentials or license from the appropriate professional college or association.	4.2	↑
The organization regularly evaluates and documents each staff member's performance in an objective, interactive, and positive way.	4.10	

Episode of Care

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

Surveyor Comments

Now under new leadership the program is well organized and supports 1700+ clients of which 220+ are tracked for eventual placement in nursing home care. It is estimated that 120+ clients are being managed with non-surgical wounds. Additional training for wound care is underway and clearly of concern.

The issue of casual status of the home care aides (HCA) is being addressed at the negotiating table provincially, and management is optimistic this will assist in stabilizing this workforce.

All staff are to be given annual reviews and management is encouraged to audit this and ensure that staff are appropriately engaged and participate in their annual reviews. Training and orientation of staff appears to ensure safety for both clients and staff.

The Home Care management team is part of the larger portfolio of Long Term Care, Seniors Support Services (appropriately linked with the Chronic Disease Management team) -an appropriate alignment which should enable broader strategies to emerge concurrently with the generation of longitudinal data, currently in the process of evaluation.

The aging population represents a significant opportunity for IRHA to resource this team and continue to reduce costly hospitalization of seniors with multiple morbidities that may be effectively managed outside the acute care hospital and/ or allow the current acute beds in some locations to be restructured/classified to more appropriate care levels.

Medication reconciliation has been made a major area of focus. On chart review all charts were complete with medication records in place- management is committed to a continuous focus on this area and understand that work is still required to meet a high standard of care.

The table below indicates the specific criteria that require attention, based on the accreditation review.

Criteria	Location	Priority for Action
Medication reconciliation at the beginning of service.	6.8	
The organization does not have any unaddressed priority for action flags based on their medication reconciliation at the beginning of service indicator results.	6.8.2	
The organization implements and evaluates a falls prevention strategy to minimize the impact of client falls.	8.8	↑
The organization uses the evaluation information to make improvements to its falls prevention strategy.	8.8.5	
The organization transfers information effectively among providers at transition points.	11.3	↑
There is documented evidence that timely transfer of information occurs.	11.3.3	

Decision Support

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

Surveyor Comments

Computerized technology has only recently started to roll out in this area of IRHA.

No Unmet Criteria for this Priority Process.

Impact on Outcomes

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

Surveyor Comments

Clients are well oriented along with families and essentially contract for home care services under specified conditions. Intake Assessments are thorough and comprehensive enabling excellent care plans to be developed.

No Unmet Criteria for this Priority Process.

Infection Prevention and Control

Infection Prevention and Control

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

Surveyor Comments

The organization is encouraged to review locations of ice machines, to ensure that locations and practices for obtaining ice reflect best practice.

The organization is encouraged to review number of hand sanitizer stations, to ensure sanitizer is readily available in close proximity to resident/patient rooms and care areas to encourage hand hygiene. Infection Prevention and Control staff participated in medical device reprocessing training and certification. The team is encouraged to continue working with Ministry of Health (MOH), ministries, and other regions on standardization of definitions and analysis.

The team is encouraged to work with support services to ensure that the required checks of materials used for cleaning and disinfecting occur and are recorded.

All medical device reprocessing staff have participated in education and certification.

The table below indicates the specific criteria that require attention, based on the accreditation review.

Criteria	Location	Priority for Action
The organization regularly monitors the quality of its cleaning and disinfection of the physical environment, and uses the information to make changes to policies and procedures.	10.6	
The organization verifies the concentration of its disinfectants daily using appropriate test strips, and disposes of disinfectants that are more than two weeks old, even if the concentration is verified.	12.7	

Long Term Care Services

Clinical Leadership

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

Surveyor Comments

The team has a good understanding of community requirements, and utilizes geographical community service area responsibilities to develop increased awareness.

Work closely with community to plan services that are responsive to needs, including education programs for local residents who in turn are prospective staff of the region.

Investment in sites is evident, ceiling lift initiatives, bed replacement and tub replacement initiatives have occurred and are planned for the future.

No Unmet Criteria for this Priority Process.

Competency

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

Surveyor Comments

Team members communicate via email, case review updates are documented and shared. Additional computer access will support exploration of practice information on sites.

The team is encouraged to develop mechanisms to regularly review performance.

The table below indicates the specific criteria that require attention, based on the accreditation review.

Criteria	Location	Priority for Action
Team leaders regularly evaluate and document each team member's performance in an objective, interactive, and positive way.	4.11	

Episode of Care

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

Surveyor Comments

Medication reconciliation at time of admission has been established, medication reconciliation at time of transfer or referral has not yet been established.

The team is encouraged to ensure that if tub temperature mechanisms are questionable, or have failed, that processes are in place to perform daily, recorded checks to ensure water temperatures are appropriate.

The table below indicates the specific criteria that require attention, based on the accreditation review.

Criteria	Location	Priority for Action
The team reconciles medications with the client at referral or transfer, and communicates information about the client's medication to the next provider of service at referral or transfer to another setting, service, service provider, or level of care within or outside the organization.	12.3	↑
There is a demonstrated, formal process to reconcile client medications at referral or transfer.	12.3.1	
The process includes generating a comprehensive list of all medications the client has been taking prior to referral or transfer.	12.3.2	
The process includes a timely comparison of the prior-to-referral or transfer medication list with the list of new medications ordered at referral or transfer.	12.3.3	
The process requires documentation that the two lists have been compared; differences have been identified, discussed, and resolved; and appropriate modifications to the new medications have been made.	12.3.4	
The processes makes it clear that medication reconciliation is a shared responsibility involving the client, nursing staff, medical staff, and pharmacists, as appropriate.	12.3.5	
The organization has a documented plan to implement throughout the organization, and before the next accreditation survey, a medication reconciliation process at referral and transfer.	12.3.6	

Decision Support

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

Surveyor Comments

Resident health records reflect process of care and responsibilities of providers.

No Unmet Criteria for this Priority Process.

Impact on Outcomes

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

Surveyor Comments

The team is encouraged to implement a consistent regional fall prevention strategy across all sites.

The table below indicates the specific criteria that require attention, based on the accreditation review.

Criteria	Location	Priority for Action
The team implements and evaluates a fall prevention strategy to minimize the impact of client falls.	16.2	↑
The team has implemented a falls prevention strategy.	16.2.1	
The strategy identifies the populations at risk for falls.	16.2.2	
The strategy addresses the specific needs of the populations at risk for falls.	16.2.3	
The team evaluates the falls prevention strategy on an ongoing basis to identify trends, causes and degree of injury.	16.2.4	
The team uses the evaluation information to make improvements to its falls prevention strategy.	16.2.5	

Managing Medications

Medication Management

Interdisciplinary provision of medication to clients.

Surveyor Comments

The Medication Safety committee is a subcommittee of the Pharmacy and Therapeutics Committee and includes comprehensive representation from sites and professions. The group is moving ahead with the Institute for Safe Medication Practices (ISMP) and Accreditation Canada initiatives as well as internal audits, process reviews, and policy development.

The organization should continue their efforts to manage high alert medications including their audit/action processes.

Pharmacist access is creatively addressed by staffing across sites to maximize coverage. After hour access to pharmacists is limited and the region is encouraged to explore options to provide access. Consideration might be given to phone access that might incorporate other regions or programs to minimize workload and resource requirements.

The Medication Safety Committee or other designated group is encouraged to address the patient controlled analgesia so that nurses are not mixing medication "cocktails."

There is a three year process underway to critically evaluate the formulary and the work to date is commended.

The organization has identified the need to address management of pharmaceutical samples and should follow through on this initiative.

There is clear recognition that the ultimate goal should be up to date medication profiles for all patients accessible by providers in pharmacy and the clinical areas. A plan with timelines should be developed for availability of up to date profiles in keeping with the standards and to support medication reconciliation.

The location of allergy information should be standardized across sites and a system that limits duplicating information is encouraged such as a one page sheet that all practitioners would use and update as information and clinical course necessitate.

There are no investigational drugs used in the region.

There are plans developed and executed for medication shortages as they arise. There is also a substitution list available for some common medications to support formulary consistency. Given the frequency of medication supply chain issues, there is an opportunity to formalize these responses and manage the risk by developing a policy and procedure that covers anticipated and actually shortages/supply disruptions.

There is some capacity to use TALL man lettering; the pharmacy staff are encouraged to pursue this option for medications with similar names.

The medication cart in Obstetrics in Selkirk was unlocked in a relatively open nursing station and has ward stock in the bottom drawers. Consideration should be given to the potential risk of visiting children (and others) having access.

Medication storage in pharmacy is well organized and staff are very resourceful in limited space with special note made of the constraints in Selkirk.

Unit dose is not generally available in acute care. Blister packages are available in the long term care. There is a long term plan to move to unit dose using Pixus. The district is encouraged to develop shorter term strategies to phase in unit dose.

Cytotoxic agents are processed in appropriate settings and staff handling the products used WHMIS (Workplace Hazardous Materials Information System) and medication safety practices. The coordination between Winnipeg and the chemo day unit and pharmacy department at Selkirk are patient and safety centred while working in physically constrained spaces.

Anasesthetic gases are stored in a segregated area with adequate ventilation. Two cylinders were found unsecured standing upright on the floor. There needs to be adequate space for all full units to be stored (shelving provided looked quite full so there may be a need to increase the cubby holes to hold the complete complement of full cylinders or assign some space from the storage section for empty cylinders).

If there was a vaccine recall, using the public health reports they could easily go back to the shipping receipts to look for the lot number, and they could identify if any of the lot number was administered and who received it by using the information on the consent forms.

There may be opportunities to critically evaluate practice such as objective indications for outpatient IV antibiotic therapy including initiation and then duration beyond 48 or 72 hours.

The Insulin sliding scale on the peel and stick paper at Stonewall Health Centre is an excellent example of evidence based, standardized practice that has been implemented in a way to make it easy for prescribers and transcribers and reduce potential for error. There is an opportunity to roll this out throughout the district. Discussions about an insulin resistant scale are clinically challenging and staff are recognized for taking on this ambitious topic.

The Medication Safety Committee is encouraged to pursue strategies such as safety huddles to encourage the safety culture and report near misses for quality improvement opportunities.

The table below indicates the specific criteria that require attention, based on the accreditation review.

Criteria	Location	Priority for Action
The organization has access to a pharmacist on a 24-hour basis to answer questions about medications or medication management.	1.6	↑
The organization evaluates and limits the availability of narcotic (opioid) products and removes high-dose, high-potency formats from patient care areas.	3.6	↑
The organization standardizes and limits the number of parenteral narcotic (opioid) concentrations available.	3.6.3	
Medications are stored in secure areas accessible only by authorized staff.	6.3	↑
Medications for client service areas are stored in labelled, unit dose packaging.	7.4	↑
The pharmacy dispenses medications in unit dose packaging.	13.3	↑

Medicine Services

Clinical Leadership

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

Surveyor Comments

Surveyors focused on medical patients in Gimli, Stonewall, Eriksdale as well as contacts through other tracer processes including medication management and infection control in various sites.

Data collection is limited so trending and benchmarking are not consistently done. The introduction of a new Admissions, Discharge, Transfer (ADT) system should provide data that can be used to describe, predict and help control resource demands to evolving needs. Clearly the increasing demands of patients awaiting long term care placement is a priority for the organization.

Patient mix is demanding given the acute, chronic and palliative needs that are being addressed. Consideration may be given to identifying patients with very complex social needs to provide some consultation services to locations such as social work consultation in Gimli.

No Unmet Criteria for this Priority Process.

Competency

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

Surveyor Comments

The region has developed an acute care orientation for new nursing staff and also offers a variety of education tailored to fit the clinical needs of the patients in various facilities such as emergency skills day, advanced cardiac life support, electrocardiogram (ECG) rhythm interpretation, and emergency maternity management. Staff recognize and are appreciative of the ongoing education.

Medical staff have regular opportunities for education with Continuing medical education (CME) credits.

Staffing is well managed and schedules are developed to support patient care and quality of work life.

Regular rounds with staff were identified in several sites and physicians are included in the rounds or make additional rounds with charge nurses to support interdisciplinary practice. The inclusion of pharmacists, social work and other services are encouraged based on patient needs. Patient and family conferences are well utilized by the multidisciplinary teams.

No Unmet Criteria for this Priority Process.

Episode of Care

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

Surveyor Comments

Standardized processes are underway for disease management such as acute coronary syndrome and strokes. Site specific work has been done for others such as alcohol withdrawal that will benefit from review and region wide implementation.

The palliative care services are well organized and clearly valued by patients and families and staff.

On occasion, admitted patients wait for inpatient beds in observation/overflow areas that have less privacy and access to amenities. The staff work diligently to find alternatives in a timely manner but ideally admission should be a direct timely process.

Patients and families are very positive about their experiences. They find staff are very responsive, safe, conscious, and focus on what is important to them for example pain management.

Pain assessment is done using the ten point scale and may be documented in the interdisciplinary notes. A procedure or algorithm might be considered to build in ongoing assessment and interventions to manage trends in pain and promote communication among team members.

There is evidence of staff "going the extra mile" to help patients, for example bringing diet specific cookbooks from home to help patients adapt to changes with new diagnoses.

The table below indicates the specific criteria that require attention, based on the accreditation review.

Criteria	Location	Priority for Action
The team reconciles medications with the client at referral or transfer, and communicates information about the client's medications to the next provider of service at referral or transfer to another setting, service, service provider, or level of care within or outside the organization.	11.3	↑
There is a demonstrated, formal process to reconcile client medications at referral or transfer.	11.3.1	
The process includes generating a comprehensive list of all medications the client has been taking prior to referral or transfer.	11.3.2	
The process includes a timely comparison of the prior-to-referral or prior-to-transfer medication list with the list of new medications ordered at referral or transfer.	11.3.3	
The process requires documentation that the two lists have been compared; differences have been identified, discussed, and resolved; and appropriate modifications to the new medications have been made.	11.3.4	
The organization has a documented plan to implement throughout the organization, and before the next accreditation survey, a medication reconciliation process at referral and transfer.	11.3.6	

Decision Support

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

Surveyor Comments

Allergy tracking is done in several locations on the chart, and any process with numerous steps is more vulnerable to errors. Consideration might be given to an allergy sheet that all practitioners would use to consolidate information now found in several locations.

Periodic audits are encouraged to review utilization and results of initiatives such as the skin protocol. The new fall prevention program has just been rolled out and the team is encouraged to implement and evaluate this initiative.

Medical staff keep up to date with new protocols for example pain management.

The implementation of the acute coronary syndrome protocol has been noted throughout the region and staff are encouraged to continue implementation of this and future evidence based practices such as segment elevation myocardial infarction (STEMI).

Excerpts of journal articles were noted on charts to give information to practitioners.

Occurrence reports are filed, but staff do not know what trends exist in the reports. Near misses are seldom included in these reports so other strategies to identify them might be considered such as good catch program. Safety huddles are also valuable to communicate changes in practice, identify near misses, and act a vehicle for education and quality improvement.

No Unmet Criteria for this Priority Process.

Impact on Outcomes

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

Surveyor Comments

There is some evidence of best practice information being shared particularly between sites in the region and with Winnipeg.

The falls prevention strategy has just been introduced within the last month so evaluation and improvements will come in the future.

Staff notices and bulletin boards provide some information. Sign in sheets or initialling, or electronic posting with tracking might be to ensure people are receiving the information.

There is a relative paucity of data. Most comparisons are experiential and while valuable they alone are not sufficient to direct future patient care. The increasing inclusion of best practice guidelines and evidence based practice will provide helpful information to optimize patient care.

Patients and families are surveyed and there are comment cards available throughout the facilities.

The rapport between patients, families, and staff is very positive and supports quality care.

The table below indicates the specific criteria that require attention, based on the accreditation review.

Criteria	Location	Priority for Action
The team implements and evaluates a falls prevention strategy to minimize the impact of client falls.	15.2	↑
The team evaluates the falls prevention strategy on an ongoing basis to identify trends, causes, and degree of injury.	15.2.4	
The team uses the evaluation information to make improvements to its falls prevention strategy.	15.2.5	

Mental Health Services

Clinical Leadership

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

Surveyor Comments

The team is commended for the amount of information obtained and collated in order to develop a plan for the delivery on Mental Health services in the region. The team is now encouraged to develop goals and objectives for the program which are measurable and specific. As well the team collects a large amount of statistics about volumes and service areas. The movement toward process and outcome indicators is encouraged to enhance the level of information more directly related with safe client care. The 8 bed Crisis Centre which is an excellent addition to the Mental Health Program could form the basis for outcome measures which would assist the team in determining whether there may be changes that could be effected that would provide more effective care.

The use of the Crisis Centre which was started in the 1980s as an alternative to the need for a client hospital bed has accomplished the objective for approximately 90% of clients according to the staff. The clients interviewed were grateful for this aspect of mental health care in the region. It is considered to be a "Safe House" for them and while the average length of stay is 7.5 days, many benefit from a few days in this environment to help them back into the community. The staff of the Crisis Centre works effectively as a team and is respectful of the clients. Congratulations on this excellent program area.

The table below indicates the specific criteria that require attention, based on the accreditation review.

Criteria	Location	Priority for Action
The team works together to develop goals and objectives.	2.1	
The team's goals and objectives for its mental health services are measurable and specific.	2.2	

Competency

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

Surveyor Comments

The team providing Mental Health services to the region is well orientated, educated and presents a passion about their roles and responsibilities which is reflected in the positive comments heard by clients.

Team leaders are strongly encouraged to conduct reviews of each members's performance and provide this in documented form on a regular basis.

The table below indicates the specific criteria that require attention, based on the accreditation review.

Criteria	Location	Priority for Action
Team leaders regularly evaluate and document each team member's performance in an objective, interactive, and positive way.	4.10	

Episode of Care

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

Surveyor Comments

The team uses a central intake process for children and youth, adults, and the elderly. Referrals come from a variety of places including doctor's offices, schools, and homes. Waiting times to be initially contacted by an intake mental health worker is within the standard as is the time to first visit for both children and adults. The team responsible for the elderly is applauded for reviewing the wait list in a team setting and discussing the referrals to ensure clients are appropriately called and brought into the system.

The team is commended for its initiatives in achieving medication reconciliation at admission as well as at transfer and discharge. The process for transfer and discharge reconciliation will be finalized once the organizational plan has been implemented across the region.

The team assesses and monitors all clients for risk of suicide on admission and at regular intervals. As well all Mental Health staff are trained in the ASSIST process which recognizes emergency help to provide if a client is attempting suicide.

The clients interviewed were very pleased with their care and the relationship with their Community Mental Health worker was paramount. They expressed trust and being in control of their own condition. As well they were appreciative of being able to make their own choices and had confidence the workers would support them. One client who had experienced a number of Community Health workers as a result of job changes, sickness, etc, noted that she functioned with these worker changes by separating the parts of her condition that she had dealt with and "put behind her" so she would not have to start over with the whole story each time.

The team works with the clients to assist them to develop their own objectives and life plans. A number were reviewed on the client files although they do not necessarily start on admission. The plans were consistent with the client ability to function in the community.

There is a very effective Proctor process in place and this consists of many former clients who are discharged from the system and others who spend a few hours a day helping clients shop, attend appointments, visiting family members in other parts of the region. This is a paid position and the proctors provide a tremendous support to clients and the community mental health workers who would not be able to transport the clients as necessary.

The IRHA community health assessment indicated that 41-53% (depending on the type of service) of respondents indicated they were "somewhat likely" to "very likely" to use telehealth mental health services. This may open an option to care and the team is encouraged to pursue this opinion.

The team needs to continually monitor wait times for the elderly to ensure the clients are being assessed in a timely manner.

The Mental Health Crisis Centre with 8 beds has been an effective source of admission from the Emergency Department, the community, or mental health community worker for approximately 90% of mental health clients who require admission to a nursing care area. The other 10% of clients who require admission do not always have such an easy process of admission. The client is often required to go to Winnipeg for a Psychiatric assessment without any guarantee of a bed in that region. In fact the client may have to be admitted to a provincial psychiatric bed miles and hours away from home. There is a provincial Mental Health Hospital in Selkirk next door to the Selkirk Hospital where the Emergency Department process begins but there are very often no beds available. This has caused significant frustration to the Emergency Department physicians as well as other staff, clients, and their families. The team is strongly encouraged to work with a provincial work group tasked with this issue to come up with a solution which will provide a more effective method by which clients can receive emergency mental health care which requires an admission.

Although current consents used are completed appropriately for clients there are a large number of consents in place. The team is encouraged to consolidate theses consents to one if possible for standardization and safety purposes.

The table below indicates the specific criteria that require attention, based on the accreditation review.

Criteria	Location	Priority for Action
The team reconciles medications with the client at referral or transfer, and communicates information about the client's medications to the next provider of service at referral or transfer to another setting, service, service provider, or level of care within or outside the organization.	11.3	↑
The organization has a documented plan to implement throughout the organization, and before the next accreditation survey, a medication reconciliation process at referral and transfer.	11.3.6	

Decision Support

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

Surveyor Comments

The team is applauded for the preciseness in addressing staff education needs associated with client safety. Modules have been developed in areas which did not have them and some are under review for revision. These include: Medication and IV Therapy, at-risk behaviour, discharge, alarms, client safety, and security issues such as client smoking.

A flowchart for accessing phone contacts has been developed based on need and this appears to be an effective tool to assist with decision-making with whom to call and the phone number.

A recent restructuring to one program manager and two clinical team supervisors is in place and appears to be meeting the needs of staff.

No Unmet Criteria for this Priority Process.

Impact on Outcomes

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

Surveyor Comments

The falls prevention strategy is planned for implementation this month across the region. The team is applauded for the work done in setting up task forces and conducting an assessment of the environment resulting in the addition of a call bell in one room. The policy and tool are in the readiness stage for staff education. For the Mental Health Program a screening checklist on the intake form is completed and in place.

The team is encouraged to implement the Falls strategy once the organization-wide program is in place and proceed with the evaluation to identify trends, causes and degree of injury, as well to make improvements to the falls strategy based on the evaluation.

The team is encouraged to develop both process and outcome indicators to measure the success of its initiatives, treatments, and service provision.

The table below indicates the specific criteria that require attention, based on the accreditation review.

Criteria	Location	Priority for Action
The team implements and evaluates a falls prevention strategy to minimize the impact of client falls.	15.3	↑
The team has implemented a falls prevention strategy.	15.3.1	
The team evaluates the falls prevention strategy on an ongoing basis to identify trends, causes, and degree of injury.	15.3.4	
The team uses the evaluation information to make improvements to its falls prevention strategy.	15.3.5	
The team identifies and monitors process and outcome measures for its mental health services.	16.1	↑

Obstetrics/Perinatal Care Services

Clinical Leadership

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

Surveyor Comments

Key collaborators are public health and Winnipeg obstetrical services.

The Obstetrical Review Committee has been established since the last accreditation and is developing policies and procedures and identifying trends and changes for quality improvement. They are encouraged to focus on "smart" indicators (statistical, measurable, accurate, realistic and timely).

Caesarean sections are done in the adjacent operating suite so flash sterilization and recall for sterilization is not applicable for this team.

The team relies on maintenance staff for equipment inventory, preventative maintenance, and repairs.

No Unmet Criteria for this Priority Process.

Competency

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

Surveyor Comments

There is a process underway to identify information and team training for obstetrical emergencies that will include a workshop and a multi area mock emergency training exercise. This direction is commended.

No Unmet Criteria for this Priority Process.

Episode of Care

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

Surveyor Comments

The team is very responsive to provide for unplanned delivery for women who plan to deliver in Winnipeg but can't make it that far.

The team is encouraged to consider pain as the fifth vital sign and develop standardized assessment and documentation. The team should continue to explore future opportunities, perhaps in conjunction with new construction, to consider how to provide patient access to safe epidural pain control as part of a comprehensive service.

Partners should be considered as part of a baby safety strategy and babies should only be given to individuals with the required identification.

Ultrasound availability is available for selected times with limited night and Sunday coverage.

Team goals include a client survey after discharge and they are encouraged to pursue this planned action.

The team may wish to consider developing a written birth plan process for clients to develop prior to delivery that can be used to help guide their care. This would be part of a broader approach to family centred care.

Patients and partners were very appreciative of the care they described as" really great...so helpful....caring and patient".

The table below indicates the specific criteria that require attention, based on the accreditation review.

Criteria	Location	Priority for Action
The team reconciles medications with the client at referral or transfer, and communicates information about the client's medications to the next provider of service at referral or transfer to another setting, service, service provider, or level of care within or outside the organization.	11.3	
There is a demonstrated, formal process to reconcile client medications at referral or transfer.	11.3.1	
The process includes generating a single documented, comprehensive list all medications the client has been taking prior to referral or transfer.	11.3.2	
The process includes a timely comparison of the prior-to-referral or transfer medication list with the list of new medications ordered at referral or transfer.	11.3.3	
The process requires documentation that differences between the two lists have been identified, discussed, and resolved, and that appropriate modifications to the new medications have been made.	11.3.4	

Decision Support

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

Surveyor Comments

The team is encouraged to track and benchmark indicators including breastfeeding rates and possibly consider tracking with public health to look at rates three months after delivery.

Their work underway to measure post partum referral time to client contact by public health is an important consideration in effective coordination of care.

The team may consider exploring opportunities for education with other providers for example Winnipeg to reduce duplication of efforts and enhance relations with transfer hospitals.

The team should pursue the prophylactic antibiotics preoperatively for caesarean sections.

No Unmet Criteria for this Priority Process.

Impact on Outcomes

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

Surveyor Comments

The team is encouraged to pursue benchmarking and best practice with other provider organizations and professional bodies.

The Selkirk site staff have just received the information about their falls program and the obstetrical team will critically appraise the program for implementation in their patient population.

No Unmet Criteria for this Priority Process.

Surgical Procedures

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

Surveyor Comments

The Selkirk and District Hospital is equipped to perform general surgery, particularly endoscopic procedures, c-sections, plastic, and laser surgery but not trauma surgery, orthopaedic surgery nor other specialized surgical procedures.

The OR team has developed expertise and credentials for laser surgery. The surgical team documents the preoperative pause confirming the client's identity and nature, site and side of the procedure. There is no flash sterilization unit in the operating suite and all surgical instruments are disinfected in the central reprocessing sterilization unit of the hospital. The surgical site infection rate (SSI) is 0% over the last six months. Services will be expanding to two operating suites per day soon in October.

No Unmet Criteria for this Priority Process.

Performance Measure Results

The following section provides an overview of the performance measures collected for the entire organization. These measures consist of both instrument and indicator results, which are valuable components of evaluation and quality improvement.

Instrument Results

The instruments are questionnaires completed by a representative sample of clients, staff, leadership and/or other key stakeholders that provide important insight into critical aspects of the organization's services. The following tables summarize the organization's results and highlight each item that requires attention. Results are presented in three main areas: governance functioning, patient safety culture and worklife.

Governance Functioning Tool

The Governance Functioning Tool is intended for members of the governing body to assess their own structures and processes and identify areas for improvement. The results reflect the perceptions and opinions of the governing body regarding the status of its internal structures and processes.

Summary of Results

	Governance Structures and Processes	% Agree	% Neutral	% Disagree	Priority for Action
		Organization	Organization	Organization	
1	We actively recruit, recommend and/or select new members based on needs for particular skills, background, and experience.	80	0	20	
2	We have explicit criteria to recruit and select new members.	50	0	50	✕
3	Our renewal cycle is appropriately managed to ensure continuity on the governing body.	100	0	0	
4	The composition of our governing body allows us to meet stakeholder and community needs.	100	0	0	
5	Clear written policies define term lengths and limits for individual members, as well as compensation.	100	0	0	
6	We regularly review, understand, and ensure compliance with applicable laws, legislation and regulations.	100	0	0	
7	Governance policies and procedures that define our role and responsibilities are well-documented and consistently followed.	100	0	0	
8	We review our own structure, including size and sub-committee structure.	100	0	0	
9	We have sub-committees that have clearly-defined roles and responsibilities.	92	0	8	
10	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.	92	0	8	
11	We each receive orientation that helps us to understand the organization and its issues, and supports high-quality decision-making.	100	0	0	

12	Disagreements are viewed as a search for solutions rather than a “win/lose”.	100	0	0	
13	Our meetings are held frequently enough to make sure we are able to make timely decisions.	100	0	0	
14	Individual members understand and carry out their legal duties, roles and responsibilities, including sub-committee work (as applicable).	100	0	0	
15	Members come to meetings prepared to engage in meaningful discussion and thoughtful decision-making.	100	0	0	
16	Our governance processes make sure that everyone participates in decision-making.	92	0	8	
17	Individual members are actively involved in policy-making and strategic planning.	100	0	0	
18	The composition of our governing body contributes to high governance and leadership performance.	100	0	0	
19	Our governing body’s dynamics enable group dialogue and discussion. Individual members ask for and listen to one another’s ideas and input.	92	0	8	
20	Our ongoing education and professional development is encouraged.	91	0	9	
21	Working relationships among individual members and committees are positive.	100	0	0	
22	We have a process to set bylaws and corporate policies.	100	0	0	
23	Our bylaws and corporate policies cover confidentiality and conflict of interest.	100	0	0	
24	We formally evaluate our own performance on a regular basis.	100	0	0	
25	We benchmark our performance against other similar organizations and/or national standards.	58	0	42	⚠
26	Contributions of individual members are reviewed regularly.	55	0	45	⚠
27	As a team, we regularly review how we function together and how our governance processes could be improved.	75	0	25	
28	There is a process for improving individual effectiveness when non-performance is an issue.	60	0	40	⚠

29	We regularly identify areas for improvement and engage in our own quality improvement activities.	83	0	17	
30	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.	100	0	0	
31	As individual members, we receive adequate feedback about our contribution to the governing body.	55	0	45	
32	We have a process to elect or appoint our chair.	40	0	60	
33	Our chair has clear roles and responsibilities and runs the governing body effectively.	100	0	0	

Patient Safety Culture Survey

The patient safety culture survey results provide valuable insight into staff perceptions of patient safety, as well as an indication of areas of strength, areas of improvement, and a mechanism to monitor changes within the organization.

Summary of Results

Number of survey respondents = 323 respondents

A. Patient Safety: Activities to avoid, prevent, or correct adverse outcomes which may result from the delivery of health care	% Disagree	% Neutral	% Agree	Priority for Action
	Organization	Organization	Organization	
1 Patient safety decisions are made at the proper level by the most qualified people	8	16	75	
2 Good communication flow exists up the chain of command regarding patient safety issues	17	17	67	⚠
3 Reporting a patient safety problem will result in negative repercussions for the person reporting it	75	14	11	
4 Senior management has a clear picture of the risk associated with patient care	16	24	61	⚠
5 My unit takes the time to identify and assess risks to patients	6	14	81	
6 My unit does a good job managing risks to ensure patient safety	5	11	84	
7 Senior management provides a climate that promotes patient safety	7	16	77	
8 Asking for help is a sign of incompetence	91	4	5	
9 If I make a mistake that has significant consequences and nobody notices, I do not tell anyone about it	95	3	2	
10 I am sure that if I report an incident to our reporting system, it will not be used against me	21	14	65	⚠
11 I am less effective at work when I am fatigued	6	9	85	
12 Senior management considers patient safety when program changes are discussed	8	24	68	⚠
13 Personal problems can adversely affect my performance	18	12	70	⚠
14 I will suffer negative consequences if I report a patient safety problem	84	8	8	

15	If I report a patient safety incident, I know that management will act on it	11	22	67	⚠
16	I am rewarded for taking quick action to identify a serious mistake	25	38	36	✖
17	Loss of experienced personnel has negatively affected my ability to provide high quality patient care	34	33	33	✖
18	I have enough time to complete patient care tasks safely	25	26	49	✖
19	I am not sure about the value of completing incident reports	58	20	22	⚠
20	In the last year, I have witnessed a co-worker do something that appeared to me to be unsafe for the patient in order to save time	44	16	41	✖
21	I am provided with adequate resources (personnel, budget, and equipment) to provide safe patient care	28	19	53	⚠
22	I have made significant errors in my work that I attribute to my own fatigue	80	12	8	
23	I believe that health care error constitutes a real and significant risk to the patients that we treat	11	18	71	⚠
24	I believe health care errors often go unreported	22	25	53	✖
25	My organization effectively balances the need for patient safety and the need for productivity	10	29	61	⚠
26	I work in an environment where patient safety is a high priority	8	12	80	
27	Staff are given feedback about changes put into place based on incident reports	32	29	39	✖
28	Individuals involved in patient safety incidents have a quick and easy way to report what happened	16	23	61	⚠
29	My supervisor/manager says a good word when he/she sees a job done according to established patient safety procedures	17	24	60	⚠
30	My supervisor/manager seriously considers staff suggestions for improving patient safety	13	16	72	⚠
31	Whenever pressure builds up, my supervisor/manager wants us to work faster, even if it means taking shortcuts	81	12	7	
32	My supervisor/manager overlooks patient safety problems that happen over and over	84	10	6	

33	On this unit, when an incident occurs, we think about it carefully	8	20	72	⚠
34	On this unit, when people make mistakes, they ask others about how they could have prevented it	16	27	57	⚠
35	On this unit, after an incident has occurred, we think about how it came about and how to prevent the same mistake in the future	8	18	74	⚠
36	On this unit, when an incident occurs, we analyze it thoroughly	15	28	57	⚠
37	On this unit, it is difficult to discuss errors	62	23	15	⚠
38	On this unit, after an incident has occurred, we think long and hard about how to correct it	11	30	59	⚠
	B. These questions are about your perceptions of overall patient safety	**% Good/ Excellent**	**% Acceptable**	**% Poor/ Failing**	**Priority for Action**
		Organization	Organization	Organization	
39	Please give your unit an overall grade on patient safety	67	30	2	⚠
40	Please give the organization an overall grade on patient safety	59	36	5	⚠
	C. These questions are about what happens after a Major Event	**% Disagree**	**% Neutral**	**% Agree**	**Priority for Action**
		Organization	Organization	Organization	
41	Individuals involved in major events contribute to the understanding and analysis of the event and the generation of possible solutions	6	27	68	⚠
42	A formal process for disclosure of major events to patients/families is followed and this process includes support mechanisms for patients, family, and care/service providers	8	33	59	⚠
43	Discussion around major events focuses mainly on system-related issues, rather than focusing on the individual(s) most responsible for the event	16	36	48	✖
44	The patient and family are invited to be directly involved in the entire process of understanding: what happened following a major event and generating solutions for reducing re-occurrence of similar events	11	34	55	⚠

45	Things that are learned from major events are communicated to staff on our unit using more than one method (e.g. communication book, in-services, unit rounds, emails) and / or at several times so all staff hear about it	15	22	63	
46	Changes are made to reduce re-occurrence of major events	7	21	72	

Worklife Pulse

The concept of 'quality of worklife' is central to Accreditation Canada's accreditation program. The Pulse Survey enables health service organizations to monitor key worklife areas. The survey takes the 'pulse' of quality of worklife, providing a quick and high level snapshot of key work environment factors, individual outcomes, and organizational outcomes. Organizations can then use the findings to identify strengths and gaps in their work environments, 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.

Summary of Results

Number of survey respondents = 387 respondents

	How would you rate your work environment	% Disagree	% Neutral	% Agree	Priority for Action
		Organization	Organization	Organization	
1	I am satisfied with communications in this organization.	24	25	51	▲
2	I am satisfied with communications in my work area.	18	20	62	▲
3	I am satisfied with my supervisor.	10	16	74	▲
4	I am satisfied with the amount of control I have over my job activities.	10	17	73	▲
5	I am clear about what is expected of me to do my job.	5	11	85	
6	I am satisfied with my involvement in decision making processes in this organization.	18	25	57	▲
7	I have enough time to do my job adequately.	33	18	49	✕
8	I feel that I can trust this organization.	14	27	59	▲
9	This organization supports my learning and development.	10	24	66	▲
10	My work environment is safe.	9	14	77	
11	My job allows me to balance my work and family/personal life.	17	19	64	▲

Individual Outcomes	% Not Stressful	% A bit Stressful	% Quite or Extremely Stressful	Priority for Action
	Organization	Organization	Organization	
12 In the past 12 months, would you say that most days at work were…	19	49	33	✕
	% Very Good/ Excellent	% Good	% Fair/ Poor	Priority for Action
	Organization	Organization	Organization	
13 In general, would you say your health is…	53	39	8	△
14 In general, would you say your mental health is…	56	35	9	△
15 In general, would you say your physical health is…	50	40	10	△
	% Very Satisfied	% Somewhat Satisfied	% Not Satisfied	Priority for Action
	Organization	Organization	Organization	
16 How satisfied are you with your job?	91	7	2	
	% < 10	% 10 - 15	% > 15	Priority for Action
	Organization	Organization	Organization	
17 In the past 12 months, how many days were you away from work because of your own illness or injury? (counting each full or partial day as 1 day)	85	6	9	
18 During the past 12 months, how many days did you work despite an illness or injury because you felt you had to (counting each full or partial day as 1 day)?	86	7	7	
	% Never/ Rarely	% Sometimes	% Often/ Always	Priority for Action
	Organization	Organization	Organization	
19 How often do you feel you can do your best quality work in your job?	3	18	79	

	% Disagree	% Neutral	% Agree	Priority for Action
	Organization	Organization	Organization	
20 Overall, I am satisfied with this organization.	9	26	65	⚠
21 Working conditions in my area contribute to patient safety.	6	24	70	⚠

Indicator Results

Indicators collect data related to important aspects of patient safety and quality care. The tables in this section show the indicator data that has been submitted by the organization.

Medication Reconciliation at Admission

Transition points in the care continuum are particularly prone to risk, and the communication of medication information has been identified as a priority area for improving the safety of healthcare service delivery. This performance measure will provide a practical guide for organizations as medication reconciliation is conducted more widely throughout the organization.

Medication Reconciliation at Admission

Flag	Location	Team Name (standard section)	Dates (dd/mm/yyyy)	% Formal medication reconciliation at admission
RED	Arborg and District Health Centre	Acute Care Med (Medicine Services)	01/04/2010 30/06/2010	30
GREEN	Arborg and District Health Centre	Ext Care Long Term Care (Long Term Care Services)	01/04/2010 30/06/2010	100
RED	E. M. Crowe Memorial Hospital and PCH	Acute Care Med (Medicine Services)	01/04/2010 30/06/2010	44
RED	E. M. Crowe Memorial Hospital and PCH	Ext Care Home Care (Home Care)	01/04/2010 30/06/2010	40
GREEN	Fisher PCH and Community Health Office	Ext Care Home Care (Home Care)	01/04/2010 30/06/2010	100
RED	Fisher PCH and Community Health Office	Ext Care Long Term Care (Long Term Care Services)	01/04/2010 30/06/2010	0
YELLOW	Gimli Community Health Centre	Acute Care Med (Medicine Services)	01/04/2010 30/06/2010	81
RED	Gimli Community Health Centre	Ext Care Home Care (Home Care)	01/04/2010 30/06/2010	0
RED	Lakeshore General Hospital and PCH	Acute Care Med (Medicine Services)	01/04/2010 30/06/2010	26
GREEN	Lundar Personal Care Home and Community Health Office	Ext Care Long Term Care (Long Term Care Services)	01/04/2010 30/06/2010	100

Medication Reconciliation at Admission				
Flag	Location	Team Name (standard section)	Dates (dd/mm/yyyy)	% Formal medication reconciliation at admission
GREEN	Rosewood Lodge	Ext Care Long Term Care (Long Term Care Services)	01/04/2010 30/06/2010	100
YELLOW	Selkirk and District General Hospital	Acute Care Med (Medicine Services)	01/04/2010 30/06/2010	76
RED	Selkirk and District General Hospital	Acute Care Obst (Obstetrics/Perinatal Care Services)	01/04/2010 30/06/2010	47
RED	Selkirk and District General Hospital	Acute Care Surg (Surgical Care Services)	01/04/2010 30/06/2010	62
YELLOW	Selkirk Community Health Office	Ext Care Home Care (Home Care)	01/04/2010 30/06/2010	82
GREEN	Stonewall and District Health Centre	Acute Care Med (Medicine Services)	01/04/2010 30/06/2010	95
YELLOW	Stonewall and District Health Centre	Ext Care Home Care (Home Care)	01/04/2010 30/06/2010	80
RED	Teulon Health Centre	Acute Care Med (Medicine Services)	01/04/2010 30/06/2010	58
GREEN	Teulon Health Centre	Ext Care Long Term Care (Long Term Care Services)	01/04/2010 30/06/2010	100

Threshold for Flags
RED: < 75/100
YELLOW: >= 75/100 AND < 90/100
GREEN: >= 90/100

Surgical Site Infection

Post-surgical infection rate is a key outcome measure that reflects process interventions.

The thresholds for this performance indicator are currently in development. Performance ratings will be provided when the thresholds are finalized.

Surgical Site Infection: Post-Surgical Infection - Colorectal Surgery				
Flag	Location	Team Name (standard section)	Dates (dd/mm/yyyy)	% post-surgical infections
	Selkirk and District General Hospital	Infection Prev (Infection Prevention and Control)	01/01/2010 31/03/2010	0
	Selkirk and District General Hospital	Infection Prev (Infection Prevention and Control)	01/04/2010 30/06/2010	0

The thresholds for this performance indicator are currently in development. Performance ratings will be provided when the thresholds are finalized.

Surgical Site Infection: Post-Surgical Infection - Hysterectomy				
Flag	Location	Team Name (standard section)	Dates (dd/mm/yyyy)	% post-surgical infections
	Selkirk and District General Hospital	Infection Prev (Infection Prevention and Control)	01/01/2010 31/03/2010	0

The thresholds for this performance indicator are currently in development. Performance ratings will be provided when the thresholds are finalized.

Surgical Site Infection: Post-Surgical Infection - C-Section				
Flag	Location	Team Name (standard section)	Dates (dd/mm/yyyy)	% post-surgical infections
	Selkirk and District General Hospital	Infection Prev (Infection Prevention and Control)	01/01/2010 31/03/2010	0
	Selkirk and District General Hospital	Infection Prev (Infection Prevention and Control)	01/04/2010 30/06/2010	0

Surgical Site Infection

Timeliness of administering antibiotic prophylaxis is a universal process measure applicable to many surgical procedures and with widely recognized benefits in reducing post-surgical infections in selected high risk procedures.

Surgical Site Infection: Prophylactic Antibiotics - Colorectal Surgery				
Flag	Location	Team Name (standard section)	Dates (dd/mm/yyyy)	% timely administrations of antibiotics
RED	Selkirk and District General Hospital	Infection Prev (Infection Prevention and Control)	01/01/2010 31/03/2010	40
RED	Selkirk and District General Hospital	Infection Prev (Infection Prevention and Control)	01/04/2010 30/06/2010	21

Threshold for Flags
RED: < 80/100
YELLOW: >= 80/100 AND < 90/100
GREEN: >= 90/100

Surgical Site Infection: Prophylactic Antibiotics - Hysterectomy				
Flag	Location	Team Name (standard section)	Dates (dd/mm/yyyy)	% timely administrations of antibiotics
RED	Selkirk and District General Hospital	Infection Prev (Infection Prevention and Control)	01/01/2010 31/03/2010	0

Threshold for Flags
RED: < 80/100
YELLOW: >= 80/100 AND < 90/100
GREEN: >= 90/100

Health Care Associated Infection Rates

Health care associated C. difficile and MRSA infections represent a significant risk to the individuals receiving care and are a substantial resource burden to organizations and the health care system. Measuring infection control performance measures has the additional benefit of informing and shaping the staff's view of safety. Evidence suggests that as staff become more aware of infection control rates and the evidence related to infection control there is a change in behaviour to reduce the perceived risk.

Health Care-Associated MRSA & C. difficile - C. difficile

Flag	Location	Team Name (standard section)	Dates (dd/mm/yyyy)	# cases of infection / 10,000 patient days
GREEN	Arborg and District Health Centre	Infection Prev (Infection Prevention and Control)	01/01/2010 31/03/2010	0
GREEN	Arborg and District Health Centre	Infection Prev (Infection Prevention and Control)	01/04/2010 30/06/2010	2.4
GREEN	E. M. Crowe Memorial Hospital and PCH	Infection Prev (Infection Prevention and Control)	01/01/2010 31/03/2010	0
GREEN	E. M. Crowe Memorial Hospital and PCH	Infection Prev (Infection Prevention and Control)	01/04/2010 30/06/2010	0
GREEN	Fisher PCH and Community Health Office	Infection Prev (Infection Prevention and Control)	01/01/2010 31/03/2010	0
GREEN	Fisher PCH and Community Health Office	Infection Prev (Infection Prevention and Control)	01/04/2010 30/06/2010	0
GREEN	Gimli Community Health Centre	Infection Prev (Infection Prevention and Control)	01/01/2010 31/03/2010	0
GREEN	Gimli Community Health Centre	Infection Prev (Infection Prevention and Control)	01/04/2010 30/06/2010	0
GREEN	Lakeshore General Hospital and PCH	Infection Prev (Infection Prevention and Control)	01/01/2010 31/03/2010	0
GREEN	Lakeshore General Hospital and PCH	Infection Prev (Infection Prevention and Control)	01/04/2010 30/06/2010	0
GREEN	Lundar Personal Care Home and Community Health Office	Infection Prev (Infection Prevention and Control)	01/01/2010 31/03/2010	0

Health Care-Associated MRSA & C. difficile - C. difficile				
Flag	Location	Team Name (standard section)	Dates (dd/mm/yyyy)	# cases of infection / 10,000 patient days
GREEN	Lundar Personal Care Home and Community Health Office	Infection Prev (Infection Prevention and Control)	01/04/2010 30/06/2010	0
GREEN	Rosewood Lodge	Infection Prev (Infection Prevention and Control)	01/01/2010 31/03/2010	0
GREEN	Rosewood Lodge	Infection Prev (Infection Prevention and Control)	01/04/2010 30/06/2010	0
GREEN	Selkirk and District General Hospital	Infection Prev (Infection Prevention and Control)	01/01/2010 31/03/2010	4.6
GREEN	Selkirk and District General Hospital	Infection Prev (Infection Prevention and Control)	01/04/2010 30/06/2010	4.8
GREEN	Stonewall and District Health Centre	Infection Prev (Infection Prevention and Control)	01/01/2010 31/03/2010	0
GREEN	Stonewall and District Health Centre	Infection Prev (Infection Prevention and Control)	01/04/2010 30/06/2010	0
GREEN	Teulon Health Centre	Infection Prev (Infection Prevention and Control)	01/01/2010 31/03/2010	0
GREEN	Teulon Health Centre	Infection Prev (Infection Prevention and Control)	01/04/2010 30/06/2010	0

Threshold for Flags
RED: > 80/10,000
YELLOW: <= 80/10,000 AND > 60/10,000
GREEN: <= 60/10,000

Health Care-Associated MRSA & C. difficile - MRSA				
Flag	Location	Team Name (standard section)	Dates (dd/mm/yyyy)	# cases of infection + colonization / 10,000 patient days
GREEN	Arborg and District Health Centre	Infection Prev (Infection Prevention and Control)	01/01/2010 31/03/2010	0

Health Care-Associated MRSA & C. difficile - MRSA				
Flag	Location	Team Name (standard section)	Dates (dd/mm/yyyy)	# cases of infection + colonization / 10,000 patient days
GREEN	Arborg and District Health Centre	Infection Prev (Infection Prevention and Control)	01/04/2010 30/06/2010	0
GREEN	E. M. Crowe Memorial Hospital and PCH	Infection Prev (Infection Prevention and Control)	01/01/2010 31/03/2010	0
GREEN	E. M. Crowe Memorial Hospital and PCH	Infection Prev (Infection Prevention and Control)	01/04/2010 30/06/2010	0
GREEN	Fisher PCH and Community Health Office	Infection Prev (Infection Prevention and Control)	01/01/2010 31/03/2010	0
GREEN	Fisher PCH and Community Health Office	Infection Prev (Infection Prevention and Control)	01/04/2010 30/06/2010	0
GREEN	Gimli Community Health Centre	Infection Prev (Infection Prevention and Control)	01/01/2010 31/03/2010	0
GREEN	Gimli Community Health Centre	Infection Prev (Infection Prevention and Control)	01/04/2010 30/06/2010	0
GREEN	Lakeshore General Hospital and PCH	Infection Prev (Infection Prevention and Control)	01/01/2010 31/03/2010	0
GREEN	Lakeshore General Hospital and PCH	Infection Prev (Infection Prevention and Control)	01/04/2010 30/06/2010	0
GREEN	Lundar Personal Care Home and Community Health Office	Infection Prev (Infection Prevention and Control)	01/01/2010 31/03/2010	0
GREEN	Lundar Personal Care Home and Community Health Office	Infection Prev (Infection Prevention and Control)	01/04/2010 30/06/2010	0
GREEN	Rosewood Lodge	Infection Prev (Infection Prevention and Control)	01/01/2010 31/03/2010	0
GREEN	Rosewood Lodge	Infection Prev (Infection Prevention and Control)	01/04/2010 30/06/2010	0
GREEN	Selkirk and District General Hospital	Infection Prev (Infection Prevention and Control)	01/01/2010 31/03/2010	2.3

Health Care-Associated MRSA & C. difficile - MRSA				
Flag	Location	Team Name (standard section)	Dates (dd/mm/yyyy)	# cases of infection + colonization / 10,000 patient days
GREEN	Selkirk and District General Hospital	Infection Prev (Infection Prevention and Control)	01/04/2010 30/06/2010	2.4
GREEN	Stonewall and District Health Centre	Infection Prev (Infection Prevention and Control)	01/01/2010 31/03/2010	0
GREEN	Stonewall and District Health Centre	Infection Prev (Infection Prevention and Control)	01/04/2010 30/06/2010	0
GREEN	Teulon Health Centre	Infection Prev (Infection Prevention and Control)	01/01/2010 31/03/2010	0
GREEN	Teulon Health Centre	Infection Prev (Infection Prevention and Control)	01/04/2010 30/06/2010	0

Threshold for Flags
RED: > 80/10,000
YELLOW: <= 80/10,000 AND > 60/10,000
GREEN: <= 60/10,000

Next Steps

Congratulations! You have just completed your Qmentum on-site survey visit. Please note the following check list items that you need to attend to in the coming days and months.

- ☐ We ask that you review this report within the next five days for errors in titles of names of services. This will help ensure the report and our records are accurate. Once you have reviewed, please send your requested changes to your Accreditation Specialist.

- ☐ In 10 business days, a letter outlining your accreditation decision and requirements will be e-mailed to your Chief Executive Officer. If revisions to the report were required, a copy of a revised report will be sent along with that letter.

- ☐ You are required to submit your quarterly reports on indicators on May 31st, every year. If you have any questions regarding this submission, please contact your Accreditation Specialist.

Appendix A – Accreditation Decision Guidelines

Quality improvement continues to be a key principle of Accreditation Canada's Qmentum program. Accreditation Canada's standards assess the quality of services provided by an organization and are constructed around eight dimensions of quality:

1. Population focus
2. Accessibility
3. Safety
4. Worklife
5. Client-centred services
6. Continuity of services
7. Effectiveness
8. Efficiency

Each standard criterion is related to a quality dimension. Organizations participating in Accreditation Canada's Qmentum program are eligible for the recognition awards: Accreditation; Accreditation with Condition (Report and/or Focused Visit) and Non-accreditation.

Under the Qmentum accreditation program, Accreditation Canada High Priority Criteria and Required Organization Practices (ROPs) are the two main factors that are considered in determining the appropriate recognition award.

Accreditation Canada High Priority Criteria

Accreditation Canada identifies high priority criteria by their alignment with several key areas:

- Quality Improvement
- Safety
- Risk
- Ethics

Required Organization Practices (ROPs)

A Required Organizational Practice is defined as an essential practice that organizations must have in place to enhance patient/client safety and minimize risk. It is a specific requirement for healthcare organizations in the accreditation program.

Based on the above, the three accreditation decisions for 2010 Qmentum surveys are:

Option 1: Accreditation
An organization is eligible for full accreditation (with a resurvey in three years) if all of the following criteria are met:

(a) 90% or more of high priority criteria met per standard section, AND
(b) Compliance with all of the Required Organizational Practices, AND
(c) Compliance with collection of all the performance measures,

If the organization is a CSSS, participating in the Joint Program with Conseil québecois d'agrément (CQA) and Accreditation Canada, the following additional criteria are required, which are specific CQA indicators relating to customer service and worklife:

(d) Compliance with ≥66.6% of Client Satisfaction Indicators AND
(e) Compliance with ≥66.6% of Employees Mobilization Indicators

Option 2: Accreditation with Condition: Report and/or Focused Visit
An organization will receive Accreditation with Condition: Report and/or Focused Visit if any of following criteria is met:

(a) More than 10% and less than 30% of high priority criteria unmet in any standard section,
OR
(b) Non-compliance with any one of the Required Organizational Practices
OR
(c) Non-compliance with the collection of any one of the performance measures

If the organization is a CSSS, participating in the Joint Program with CQA and Accreditation Canada, the following addition criteria apply:

(d) Compliance with less than 66.6% of Client Satisfaction Indicators,
OR
(e) Compliance with less than 66.6% of Employees Mobilization Indicators

The condition, i.e. submission of a report or focused visit; and timeframe, i.e. 6 months or 12 months; is based upon the nature of the recommendations. If the organization is a CSSS, and their compliance with the Client Satisfaction Indicators OR Employees Mobilization Indicators is less than 66.6%, they must conduct the survey(s) again within 18 months following the onsite visit as a condition of accreditation.

Organizations are required to submit follow-up reports as a condition of maintaining accreditation status. If a satisfactory report is not submitted within the required timeline, Accreditation Canada may grant a one-time extension of 6 months, based on surveyor input, proof of progress, and a plan to meet the conditions. Failure to comply with these requirements within the maximum allotted time extension will result in removal of accreditation status, at the discretion of Accreditation Canada.

For organizations that fail to complete a satisfactory focused visit within the required timeline, Accreditation Canada may grant a one-time extension of 6 months, based on surveyor input, proof of progress and a plan to meet the conditions. Failure to comply with these requirements within the maximum allotted time extension will result in removal of accreditation status, at the discretion of Accreditation Canada.

Option 3: Non-accreditation
An organization will NOT be accredited if the following conditions exist:

(a) One or more ROPs not in place
AND
(b) 30% or more high priority criteria unmet in one or more standards sections
AND
(c) 20% or more criteria unmet overall for all standards applied to the organization

Should an organization wish to have their non-accreditation status reviewed within 6 months post survey, they are required to complete a focused visit within 5 months. Organizations that fail to complete a satisfactory focused visit within the required timeframe will maintain a non-accreditation status.

If the organization is a CSSS, and their compliance with the Client Satisfaction Indicators OR Employees Mobilization Indicators is less than 66.6%, they must conduct the survey(s) again within 18 months following the onsite visit as a condition of accreditation.