Accreditation Report

Prairie Mountain Health

Souris, MB

On-site survey dates: June 12, 2016 - June 17, 2016

Report issued: July 7, 2016

About the Accreditation Report

Prairie Mountain Health (referred to in this report as “the organization”) is participating in Accreditation Canada's Qmentum accreditation program. As part of this ongoing process of quality improvement, an on-site survey was conducted in June 2016. Information from the on-site survey as well as other data obtained from the organization were used to produce this Accreditation Report.

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

Confidentiality

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

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

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

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A Message from Accreditation Canada

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

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

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

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

We look forward to our continued partnership.

Sincerely,

Leslee Thompson
Chief Executive Officer

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Executive Summary

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

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

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

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

Accreditation Decision

Prairie Mountain Health's accreditation decision is:

Accredited (Report)

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

About the On-site Survey

- **On-site survey dates: June 12, 2016 to June 17, 2016**

- **Locations**

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

1. Benito Health Centre
2. Birtle Health Centre
3. Boissevain Health Center
4. Brandon - Community Mental Health Office
5. Brandon - Public Health Office
6. Brandon - Regional Administration Office
7. Brandon - 7th Street Health Access Centre
8. Brandon - Child and Adolescent Treatment Centre
9. Brandon - Fairview Personal Care Home
10. Brandon - Home Care Office
11. Brandon - Midwifery Office
12. Brandon - Rideau Park Personal Care Home
13. Brandon - Westman Crisis Services
14. Brandon 7th Street Access Centre - Western Medical Clinic
15. Brandon Community Mental Health- PSR Psychosocial Rehabilitation
16. Brandon Regional Health Centre
17. Carberry Health Center
18. Carberry Personal Home
19. Dauphin Community Health Services Office
20. Dauphin Regional Health Centre
21. Deloraine Health Centre
22. Dinsdale Personal Care Home
23. Elkhorn - Elkwood Manor Personal Care Home
24. Erickson Health Centre
25. Gilbert Plains Health Centre
26. Grandview District Hospital
27. Hamiota Health Centre
28. Killarney - Tri-Lake Health Centre
29. McCreary/Alonsa Health Care Centre

30. Minnedosa Health Centre
31. Neepawa Health Center
32. Reston Health Centre
33. Rivers Health Centre
34. Roblin District Health Centre
35. Rossburn Health Centre
36. Russell Health Centre
37. Shoal Lake/Strathclair Health Centre
38. Souris Health Center
39. Ste. Rose - Dr. Gendreau Personal Care Home
40. Ste. Rose District Hospital
41. Swan River - Swan Valley Health Centre
42. Swan River - Swan Valley Lodge (PCH)
43. Swan River - Swan Valley Primary Care Centre
44. Virden - West-Man Nursing Home
45. Virden Health Centre
46. Wawanesa Health Centre
47. Winnipegosis and District Health Centre

- **Standards**

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

System-Wide Standards

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

Population-specific Standards

5. Population Health and Wellness

Service Excellence Standards

6. Ambulatory Systemic Cancer Therapy Services - Service Excellence Standards
7. Community-Based Mental Health Services and Supports - Service Excellence Standards
8. Critical Care - Service Excellence Standards
9. Emergency Department - Service Excellence Standards
10. Emergency Medical Services - Service Excellence Standards

11. Home Care Services - Service Excellence Standards
12. Hospice, Palliative, End-of-Life Services - Service Excellence Standards
13. Long-Term Care Services - Service Excellence Standards
14. Medicine Services - Service Excellence Standards
15. Mental Health Services - Service Excellence Standards
16. Obstetrics Services - Service Excellence Standards
17. Perioperative Services and Invasive Procedures - Service Excellence Standards
18. Primary Care Services - Service Excellence Standards
19. Public Health Services - Service Excellence Standards
20. Rehabilitation Services - Service Excellence Standards
21. Reprocessing and Sterilization of Reusable Medical Devices - Service Excellence Standards

- **Instruments**

The organization administered:

1. Governance Functioning Tool (2011 - 2015)
2. Canadian Patient Safety Culture Survey Tool
3. Worklife Pulse
4. Client Experience Tool

Overview by Quality Dimensions

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

Quality Dimension	Met	Unmet	N/A	Total
Population Focus (Work with my community to anticipate and meet our needs)	102	7	0	109
Accessibility (Give me timely and equitable services)	128	10	0	138
Safety (Keep me safe)	567	96	14	677
Worklife (Take care of those who take care of me)	162	17	0	179
Client-centred Services (Partner with me and my family in our care)	531	29	5	565
Continuity of Services (Coordinate my care across the continuum)	123	2	0	125
Appropriateness (Do the right thing to achieve the best results)	959	148	15	1122
Efficiency (Make the best use of resources)	52	6	0	58
Total	**2624**	**315**	**34**	**2973**

Overview by Standards

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

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

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

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

Standards Set	High Priority Criteria *			Other Criteria			Total Criteria (High Priority + Other)		
	Met	Unmet	N/A	Met	Unmet	N/A	Met	Unmet	N/A
	# (%)	# (%)	#	# (%)	# (%)	#	# (%)	# (%)	#
Governance	50 (100.0%)	0 (0.0%)	0	34 (94.4%)	2 (5.6%)	0	84 (97.7%)	2 (2.3%)	0
Leadership	43 (87.8%)	6 (12.2%)	0	91 (94.8%)	5 (5.2%)	0	134 (92.4%)	11 (7.6%)	0
Infection Prevention and Control Standards	37 (90.2%)	4 (9.8%)	0	27 (93.1%)	2 (6.9%)	2	64 (91.4%)	6 (8.6%)	2
Medication Management Standards	49 (70.0%)	21 (30.0%)	8	41 (73.2%)	15 (26.8%)	8	90 (71.4%)	36 (28.6%)	16
Population Health and Wellness	3 (75.0%)	1 (25.0%)	0	30 (85.7%)	5 (14.3%)	0	33 (84.6%)	6 (15.4%)	0
Ambulatory Systemic Cancer Therapy Services	66 (100.0%)	0 (0.0%)	0	91 (98.9%)	1 (1.1%)	0	157 (99.4%)	1 (0.6%)	0
Community-Based Mental Health Services and Supports	42 (95.5%)	2 (4.5%)	0	91 (96.8%)	3 (3.2%)	0	133 (96.4%)	5 (3.6%)	0

Standards Set	High Priority Criteria *			Other Criteria			Total Criteria (High Priority + Other)		
	Met	Unmet	N/A	Met	Unmet	N/A	Met	Unmet	N/A
	# (%)	# (%)	#	# (%)	# (%)	#	# (%)	# (%)	#
Critical Care	49 (98.0%)	1 (2.0%)	0	109 (95.6%)	5 (4.4%)	1	158 (96.3%)	6 (3.7%)	1
Emergency Department	56 (78.9%)	15 (21.1%)	0	88 (83.0%)	18 (17.0%)	1	144 (81.4%)	33 (18.6%)	1
Emergency Medical Services	47 (97.9%)	1 (2.1%)	1	102 (91.9%)	9 (8.1%)	0	149 (93.7%)	10 (6.3%)	1
Home Care Services	39 (79.6%)	10 (20.4%)	0	61 (83.6%)	12 (16.4%)	3	100 (82.0%)	22 (18.0%)	3
Hospice, Palliative, End-of-Life Services	41 (91.1%)	4 (8.9%)	0	101 (94.4%)	6 (5.6%)	1	142 (93.4%)	10 (6.6%)	1
Long-Term Care Services	51 (94.4%)	3 (5.6%)	0	98 (100.0%)	0 (0.0%)	1	149 (98.0%)	3 (2.0%)	1
Medicine Services	40 (88.9%)	5 (11.1%)	0	71 (92.2%)	6 (7.8%)	0	111 (91.0%)	11 (9.0%)	0
Mental Health Services	50 (100.0%)	0 (0.0%)	0	92 (100.0%)	0 (0.0%)	0	142 (100.0%)	0 (0.0%)	0
Obstetrics Services	65 (89.0%)	8 (11.0%)	0	74 (85.1%)	13 (14.9%)	1	139 (86.9%)	21 (13.1%)	1
Perioperative Services and Invasive Procedures	95 (82.6%)	20 (17.4%)	0	95 (87.2%)	14 (12.8%)	0	190 (84.8%)	34 (15.2%)	0
Primary Care Services	48 (82.8%)	10 (17.2%)	0	82 (91.1%)	8 (8.9%)	1	130 (87.8%)	18 (12.2%)	1
Public Health Services	43 (91.5%)	4 (8.5%)	0	57 (82.6%)	12 (17.4%)	0	100 (86.2%)	16 (13.8%)	0
Rehabilitation Services	45 (100.0%)	0 (0.0%)	0	79 (98.8%)	1 (1.3%)	0	124 (99.2%)	1 (0.8%)	0
Reprocessing and Sterilization of Reusable Medical Devices	44 (84.6%)	8 (15.4%)	1	48 (78.7%)	13 (21.3%)	2	92 (81.4%)	21 (18.6%)	3
Total	**1003 (89.1%)**	123 (10.9%)	10	1562 (91.2%)	150 (8.8%)	21	2565 (90.4%)	273 (9.6%)	31

* Does not includes ROP (Required Organizational Practices)

Overview by Required Organizational Practices

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

This table shows the ratings of the applicable ROPs.

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Safety Culture			
Accountability for quality (Governance)	Met	4 of 4	2 of 2
Patient safety incident disclosure (Leadership)	Met	4 of 4	2 of 2
Patient safety incident management (Leadership)	Met	6 of 6	1 of 1
Patient safety quarterly reports (Leadership)	Met	1 of 1	2 of 2
Patient safety-related prospective analysis (Leadership)	Met	1 of 1	1 of 1
Patient Safety Goal Area: Communication			
Client Identification (Ambulatory Systemic Cancer Therapy Services)	Met	1 of 1	0 of 0
Client Identification (Critical Care)	Met	1 of 1	0 of 0
Client Identification (Emergency Department)	Met	1 of 1	0 of 0
Client Identification (Emergency Medical Services)	Met	1 of 1	0 of 0

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Communication			
Client Identification (Home Care Services)	Unmet	0 of 1	0 of 0
Client Identification (Hospice, Palliative, End-of-Life Services)	Met	1 of 1	0 of 0
Client Identification (Long-Term Care Services)	Met	1 of 1	0 of 0
Client Identification (Medicine Services)	Met	1 of 1	0 of 0
Client Identification (Mental Health Services)	Met	1 of 1	0 of 0
Client Identification (Obstetrics Services)	Met	1 of 1	0 of 0
Client Identification (Perioperative Services and Invasive Procedures)	Met	1 of 1	0 of 0
Client Identification (Rehabilitation Services)	Met	1 of 1	0 of 0
Information transfer at care transitions (Ambulatory Systemic Cancer Therapy Services)	Met	4 of 4	1 of 1
Information transfer at care transitions (Community-Based Mental Health Services and Supports)	Unmet	4 of 4	0 of 1
Information transfer at care transitions (Critical Care)	Met	4 of 4	1 of 1
Information transfer at care transitions (Emergency Department)	Unmet	4 of 4	0 of 1

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Communication			
Information transfer at care transitions (Emergency Medical Services)	Unmet	2 of 4	0 of 1
Information transfer at care transitions (Home Care Services)	Unmet	1 of 4	0 of 1
Information transfer at care transitions (Hospice, Palliative, End-of-Life Services)	Unmet	3 of 4	1 of 1
Information transfer at care transitions (Long-Term Care Services)	Met	4 of 4	1 of 1
Information transfer at care transitions (Medicine Services)	Unmet	3 of 4	0 of 1
Information transfer at care transitions (Mental Health Services)	Met	4 of 4	1 of 1
Information transfer at care transitions (Obstetrics Services)	Unmet	4 of 4	0 of 1
Information transfer at care transitions (Perioperative Services and Invasive Procedures)	Unmet	1 of 4	0 of 1
Information transfer at care transitions (Rehabilitation Services)	Met	4 of 4	1 of 1
Medication reconciliation as a strategic priority (Leadership)	Unmet	4 of 4	1 of 2
Medication reconciliation at care transitions (Ambulatory Systemic Cancer Therapy Services)	Met	7 of 7	0 of 0

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Communication			
Medication reconciliation at care transitions (Community-Based Mental Health Services and Supports)	Unmet	0 of 4	0 of 1
Medication reconciliation at care transitions (Critical Care)	Met	5 of 5	0 of 0
Medication reconciliation at care transitions (Emergency Department)	Unmet	2 of 4	0 of 0
Medication reconciliation at care transitions (Home Care Services)	Unmet	4 of 4	0 of 1
Medication reconciliation at care transitions (Hospice, Palliative, End-of-Life Services)	Met	5 of 5	0 of 0
Medication reconciliation at care transitions (Long-Term Care Services)	Met	5 of 5	0 of 0
Medication reconciliation at care transitions (Medicine Services)	Unmet	4 of 5	0 of 0
Medication reconciliation at care transitions (Mental Health Services)	Met	5 of 5	0 of 0
Medication reconciliation at care transitions (Obstetrics Services)	Met	5 of 5	0 of 0

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Communication			
Medication reconciliation at care transitions (Perioperative Services and Invasive Procedures)	Unmet	4 of 8	0 of 0
Medication reconciliation at care transitions (Rehabilitation Services)	Met	5 of 5	0 of 0
Safe surgery checklist (Obstetrics Services)	Unmet	3 of 3	0 of 2
Safe surgery checklist (Perioperative Services and Invasive Procedures)	Unmet	2 of 3	0 of 2
The “Do Not Use” list of abbreviations (Medication Management Standards)	Unmet	3 of 4	3 of 3
Patient Safety Goal Area: Medication Use			
Antimicrobial stewardship (Medication Management Standards)	Unmet	3 of 4	0 of 1
Concentrated electrolytes (Medication Management Standards)	Unmet	2 of 3	0 of 0
Heparin safety (Medication Management Standards)	Met	4 of 4	0 of 0
High-alert medications (Emergency Medical Services)	Met	5 of 5	3 of 3
High-alert medications (Medication Management Standards)	Unmet	3 of 5	2 of 3
Infusion pump safety (Ambulatory Systemic Cancer Therapy Services)	Met	4 of 4	2 of 2

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Medication Use			
Infusion pump safety (Critical Care)	Met	4 of 4	2 of 2
Infusion pump safety (Emergency Department)	Met	4 of 4	2 of 2
Infusion pump safety (Home Care Services)	Unmet	4 of 4	0 of 2
Infusion pump safety (Hospice, Palliative, End-of-Life Services)	Met	4 of 4	2 of 2
Infusion pump safety (Medicine Services)	Met	4 of 4	2 of 2
Infusion pump safety (Obstetrics Services)	Unmet	2 of 4	1 of 2
Infusion pump safety (Perioperative Services and Invasive Procedures)	Met	4 of 4	2 of 2
Infusion pump safety (Rehabilitation Services)	Met	4 of 4	2 of 2
Narcotics safety (Emergency Medical Services)	Met	3 of 3	0 of 0
Narcotics safety (Medication Management Standards)	Unmet	1 of 3	0 of 0
Patient Safety Goal Area: Worklife/Workforce			
Client Flow (Leadership)	Unmet	5 of 7	1 of 1
Patient safety plan (Leadership)	Met	2 of 2	2 of 2

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Worklife/Workforce			
Patient safety: education and training (Leadership)	Met	1 of 1	0 of 0
Preventive maintenance program (Leadership)	Met	3 of 3	1 of 1
Workplace violence prevention (Leadership)	Met	5 of 5	3 of 3
Patient Safety Goal Area: Infection Control			
Hand-hygiene compliance (Emergency Medical Services)	Unmet	1 of 1	1 of 2
Hand-hygiene compliance (Infection Prevention and Control Standards)	Unmet	0 of 1	0 of 2
Hand-hygiene education and training (Emergency Medical Services)	Met	1 of 1	0 of 0
Hand-hygiene education and training (Infection Prevention and Control Standards)	Met	1 of 1	0 of 0
Infection rates (Infection Prevention and Control Standards)	Met	1 of 1	2 of 2
Pneumococcal vaccine (Long-Term Care Services)	Met	2 of 2	0 of 0
Reprocessing (Emergency Medical Services)	Met	1 of 1	1 of 1

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Risk Assessment			
Falls prevention (Ambulatory Systemic Cancer Therapy Services)	Unmet	3 of 3	0 of 2
Falls prevention (Critical Care)	Unmet	3 of 3	0 of 2
Falls prevention (Emergency Department)	Unmet	0 of 3	0 of 2
Falls prevention (Home Care Services)	Unmet	0 of 3	0 of 2
Falls prevention (Hospice, Palliative, End-of-Life Services)	Met	3 of 3	2 of 2
Falls prevention (Long-Term Care Services)	Met	3 of 3	2 of 2
Falls prevention (Medicine Services)	Unmet	3 of 3	0 of 2
Falls prevention (Mental Health Services)	Met	3 of 3	2 of 2
Falls prevention (Obstetrics Services)	Unmet	3 of 3	0 of 2
Falls prevention (Perioperative Services and Invasive Procedures)	Unmet	3 of 3	0 of 2
Falls prevention (Rehabilitation Services)	Met	3 of 3	2 of 2
Home safety risk assessment (Home Care Services)	Met	3 of 3	2 of 2

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Risk Assessment			
Pressure ulcer prevention (Critical Care)	Unmet	3 of 3	1 of 2
Pressure ulcer prevention (Hospice, Palliative, End-of-Life Services)	Met	3 of 3	2 of 2
Pressure ulcer prevention (Long-Term Care Services)	Met	3 of 3	2 of 2
Pressure ulcer prevention (Medicine Services)	Unmet	2 of 3	1 of 2
Pressure ulcer prevention (Perioperative Services and Invasive Procedures)	Unmet	1 of 3	1 of 2
Pressure ulcer prevention (Rehabilitation Services)	Met	3 of 3	2 of 2
Skin and wound care (Home Care Services)	Unmet	6 of 7	0 of 1
Suicide prevention (Community-Based Mental Health Services and Supports)	Met	5 of 5	0 of 0
Suicide prevention (Emergency Department)	Unmet	3 of 5	0 of 0
Suicide prevention (Long-Term Care Services)	Unmet	3 of 5	0 of 0
Suicide prevention (Mental Health Services)	Met	5 of 5	0 of 0
Venous thromboembolism prophylaxis (Critical Care)	Met	3 of 3	2 of 2

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Risk Assessment			
Venous thromboembolism prophylaxis (Medicine Services)	Met	3 of 3	2 of 2
Venous thromboembolism prophylaxis (Perioperative Services and Invasive Procedures)	Unmet	3 of 3	1 of 2

Summary of Surveyor Team Observations

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

Prairie Mountain Health Authority has been operational since 2012. The organization has a diverse and committed Board that is reflective of the demographics across the region. The Board has recently formulated its first strategic plan (2016 – 2021) since amalgamation. There are currently three Local Health Involvement Groups providing advice to the Board. Communication and consultation with the community partners has been a priority for the Senior Management Team and the Board. Although patient advisers, community partners, and affiliates all told the survey team that efforts to communicate broadly have been noticed and appreciated the desire to be involved earlier on in decision making processes was expressed.

It is noted that although the strategic plan contains a list of strategic priorities, there is no organization wide operational plan to identify the details of how these will be achieved. A robust Community Health Assessment was recently completed. This and other documents and information systems demonstrate that PMH has rich data sets from which it can draw information to establish outcome targets and measure its progress. The organization should harness this opportunity to support its quality improvement program and use its well-resourced communication capacity to demonstrate progress and accountability to stakeholders.

Although the organization has just begun to build its capacity to bring the voice of the client into its client and family centred care approaches, surveyors had the opportunity to hear from a large and diverse group of patient advisers, community partners, and clients who participated in tracer activities. People consistently praised the organization for their experiences at the point of care. They identified a desire for increased opportunity to bring the stories of their experience into the program development activities of the region, particularly in relation to continuity of care, cultural safety, and the care of people with mental health and addiction issues.

The organization in its current configuration is relatively new. As such, a significant amount of time has been spent taking the best from the pre-existing organizations to formulate the new corporate identity, policies, procedures, and programs. There are many revitalized or new initiatives that have not been rolled out or that are in their infancy. The work of implementing high priority programs, particularly those that contribute to a culture of safety need to be clearly identified as priorities and acted upon with some urgency. Particular priorities that stand out would be hand-hygiene, medication management, and falls assessment and prevention. Choosing the vital few must do/can't fail initiatives that are to be accomplished within a short time frame will not preclude the many things that require attention as daily work. Evaluation and full implementation of quality improvement initiatives need also to be a priority.

This is a large region with many sites and services. It was noted that everywhere surveyors visited, the sites were well maintained, uncluttered, and clean.

The Learning Management System stands out as an excellent program to engage staff, support performance review and planning, and build human resource capacity.

Positive feedback about regionalization was received from stakeholders.

The organization is encouraged to continue to aggressively implement a successful regional recruitment and retention strategy.

Detailed Required Organizational Practices

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

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

Unmet Required Organizational Practice	Standards Set
Patient Safety Goal Area: Communication	
Information transfer at care transitions Information relevant to the care of the client is communicated effectively during care transitions.	· Community-Based Mental Health Services and Supports 10.9 · Perioperative Services and Invasive Procedures 12.11 · Emergency Department 12.16 · Emergency Medical Services 18.1 · Home Care Services 9.10 · Medicine Services 9.11 · Hospice, Palliative, End-of-Life Services 9.11 · Obstetrics Services 9.16
Client Identification Working in partnership with clients and families, at least two person-specific identifiers are used to confirm that clients receive the service or procedure intended for them.	· Home Care Services 9.2
The Do Not Use list of abbreviations The organization has identified and implemented a list of abbreviations, symbols, and dose designations that are not to be used in the organization.	· Medication Management Standards 14.6

Unmet Required Organizational Practice	Standards Set
Medication reconciliation as a strategic priority There is a documented and coordinated approach to partner with clients and families to collect accurate and complete information about client medications and utilize this information during transitions of care.NOTE: Accreditation Canada will move towards full implementation of medication reconciliation in two phases.For on-site surveys between 2014 and 2017, medication reconciliation should be implemented in ONE service (or program) that uses a Qmentum standard containing the Medication Reconciliation at Care Transitions ROP. Medication reconciliation should be implemented as per the tests for compliance for each ROP.For on-site surveys in 2018 and beyond, medication reconciliation should be implemented in ALL services (or programs) that use Qmentum standards containing the Medication Reconciliation at Care Transitions ROP. Medication reconciliation should be implemented as per the tests for compliance for each ROP.	· Leadership 15.7
Safe surgery checklist A safe surgery checklist is used to confirm that safety steps are completed for a surgical procedure performed in the operating room.	· Obstetrics Services 10.6 · Perioperative Services and Invasive Procedures 14.3
Medication reconciliation at care transitions When medication management is a component of care (or deemed appropriate through clinician assessment), a Best Possible Medication History (BPMH) is generated in partnership with clients, families, or caregivers (as appropriate) and used to reconcile client medications.	· Emergency Department 10.5 · Perioperative Services and Invasive Procedures 11.6 · Perioperative Services and Invasive Procedures 11.7 · Medicine Services 8.5 · Home Care Services 8.6 · Community-Based Mental Health Services and Supports 9.5

Unmet Required Organizational Practice	Standards Set
Patient Safety Goal Area: Medication Use	
Concentrated electrolytes The organization evaluates and limits the availability of concentrated electrolytes to ensure that formats with the potential to cause harmful medication incidents are not stocked in client service areas.	· Medication Management Standards 12.9
Infusion pump safety A documented and coordinated approach for infusion pump safety that includes training, evaluation of competence, and a process to report problems with infusion pump use is implemented.	· Home Care Services 3.8 · Obstetrics Services 3.9
Narcotics safety The organization evaluates and limits the availability of narcotic (opioid) products to ensure that formats with the potential to cause harmful medication incidents are not stocked in client service areas.	· Medication Management Standards 9.4
Antimicrobial stewardship The organization has a program for antimicrobial stewardship to optimize antimicrobial use. NOTE: This ROP applies to organizations providing the following services: inpatient acute care, inpatient cancer, inpatient rehabilitation, and complex continuing care.	· Medication Management Standards 2.3
High-alert medications The organization implements a comprehensive strategy for the management of high-alert medications.	· Medication Management Standards 2.5
Patient Safety Goal Area: Worklife/Workforce	
Client Flow Client flow is improved throughout the organization and emergency department overcrowding is mitigated by working proactively with internal teams and teams from other sectors.NOTE: This ROP only applies to organizations with an emergency department that can admit clients.	· Leadership 13.4

Unmet Required Organizational Practice	Standards Set
Patient Safety Goal Area: Infection Control	
Hand-hygiene compliance The organization measures its compliance with accepted hand-hygiene practices.	· Infection Prevention and Control Standards 8.6 · Emergency Medical Services 8.7
Patient Safety Goal Area: Risk Assessment	
Falls prevention To minimize injury from falls, a documented and coordinated approach for falls prevention is implemented and evaluated.	· Emergency Department 10.6 · Perioperative Services and Invasive Procedures 11.11 · Ambulatory Systemic Cancer Therapy Services 11.6 · Medicine Services 8.6 · Obstetrics Services 8.6 · Critical Care 8.7 · Home Care Services 8.7
Pressure ulcer prevention Each client's risk for developing a pressure ulcer is assessed and interventions to prevent pressure ulcers are implemented. NOTE: This ROP does not apply for outpatient settings, including day surgery, given the lack of validated risk assessment tools for outpatient settings.	· Perioperative Services and Invasive Procedures 11.12 · Medicine Services 8.7 · Critical Care 8.8
Suicide prevention Clients are assessed and monitored for risk of suicide.	· Emergency Department 10.7 · Long-Term Care Services 8.8
Venous thromboembolism prophylaxis Medical and surgical clients at risk of venous thromboembolism (deep vein thrombosis and pulmonary embolism) are identified and provided with appropriate thromboprophylaxis.NOTE: This ROP does not apply for pediatric hospitals; it only applies to clients 18 years of age or older. This ROP does not apply to day procedures or procedures with only an overnight stay.	· Perioperative Services and Invasive Procedures 11.13

Unmet Required Organizational Practice	Standards Set
Skin and wound care An interprofessional and collaborative approach is used to assess clients who need skin and wound care and provide evidence-informed care that promotes healing and reduces morbidity and mortality.	· Home Care Services 8.8

Detailed On-site Survey Results

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

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

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

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

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

See Appendix B for a list of priority processes.

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

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

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

Priority Process Results for System-wide Standards

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

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

Priority Process: Governance

Meeting the demands for excellence in governance practice.

Unmet Criteria		High Priority Criteria
Standards Set: Governance		
2.2	There are established mechanisms for the governing body to hear from and incorporate the voice and opinion of clients and families.	
2.3	The governing body includes clients as members, where possible.	

Surveyor comments on the priority process(es)

The Board is made up of members from across the region who have been appointed by the Minister after having expressed an interest in serving. An annual Board education schedule is developed based on needs / interests identify. Orientation is offered at the regional level, and there are opportunities for members to participate in provincial gatherings.

The Board recently participated in the preparation of a strategic plan for 2016-2021. Input and data support was provided by the senior management team and consultation with the Local Health Involvement Groups (LHIG). The Authority has a robust process to create a Community Health Assessment report every five years. The assessment involves extensive consultation with stakeholders across the region and population health data. The information contained in the report is helpful in identifying strategic directions that are responsive to population health and community priorities. Although targets for the Strategic Priorities have been identified, more clarity regarding reporting on progress toward achievement of those targets is recommended. Having said this, the Board is routinely provided with financial, safety, and risk data to keep members well informed and supported to fulfil their fiduciary duties. There is an opportunity to make better use of explicit metrics to monitor and report on outcomes.

The Board members do receive orientation from the management team and have access to educational opportunities through the authority and the government if they choose to participate. It was noted during the discussions about the Learning Management System (LMS) that there would be an excellent opportunity there to provide governance and governing for quality modules via the online system.

The affiliates who participated in the survey stated that they would value the opportunity to participate more fully in strategic planning. Due to their limited capacity as stand-alone operations they are seeking further integration that would provide them with access to resources such as the LMS, the incident management system, and communication support. They state that their service agreements should be reviewed and updated on a regular basis with the opportunity to negotiate access to regional supports that improve their capacity to provide clients with service equivalent to what is provided across the region.

Priority Process: Planning and Service Design

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

Unmet Criteria		High Priority Criteria
Standards Set: Leadership		
4.11	The organization's progress toward achieving the strategic goals and objectives is reported to internal and external stakeholders and the governing body where applicable.	
6.1	Annual operational plans are developed to support the achievement of the strategic plan, goals, and objectives, and to guide day-to-day operations.	!
6.6	Management systems and tools are used to monitor and report on the implementation of operational plans.	!

Surveyor comments on the priority process(es)

The organization has recently produced a community health assessment that provides comprehensive and current information about the health status of the population and the perceived needs, priorities, and expectations of communities. The surveyors received positive feedback from staff and clients throughout the organization about the work of the Health Authority to communicate and be responsive to health needs.

Community partners and LHIG members identify areas for improvement but consistently report that the leadership of Prairie Mountain Health (PMH) is engaged and interested in inter-agency initiatives and in partnerships that support a responsive coordinated continuum of care. The areas for improvement have to do with how information gets shared at transition points, hearing the voice of the customer as an opportunity even when concern is being expressed, resourcing workload surges, and visibly identifying staff by their profession.

The organization has done some good foundational work to build capacity for client and family centred care. The organization is encouraged to build on the good work already being done, to bring the voice of the patient into its planning and quality improvement work.

Significant work has been done to update policies, procedures, visual identity, and other communication materials. There is a strategic plan. PMH is encouraged to develop an organization level operational plan with measurable targets. There are robust systems in place from which data can be extracted to support progress reporting toward strategic and operational priorities. Good evidence was provided that six sigma initiatives result in excellent information about improvement activities that may be suitable for

spread across the organization. The organization has also been able to report its progress on provincial targets.

Feedback received throughout the region over the course of this week supports the statement that the organization is doing good work to engage stakeholders and bring about transformational change. It is remarkable that an organization that has undertaken such a significant merger is receiving consistently positive feedback about communication and continuity of care. Internal and external stakeholders report that the partnerships created in the building of Prairie Mountain Health have created expanded opportunities to share information, build best practices, and facilitate continuity of care.

Priority Process: Resource Management

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

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

Since the amalgamation of the three former health regions, Prairie Mountain Health has worked very hard to ensure that there are excellent and sound processes in place to ensure fiscal accountability and responsibility. The organization undertakes a principle based approach which includes the integration of long range planning with short term operating and capital budget needs and, at the same time, ensuring overall financial sustainability.

Finance works collaboratively together to support managers in understanding their financial reports. This collaboration has facilitated the opportunity for the Finance staff to develop an understanding and appreciation for the services being planned and delivered by the programs and to also support the team in their financial responsibilities. There is an expectation also that programs and services monitor and manage their budgets.

There is a culture of financial accountability. The organization has also developed and implemented rigorous processes to determine the allocation of resources. This includes the Capital Assessment Prioritization Process (CAPP) which categories the process into 5 categories; basic equipment, specialized equipment, safety and security, major capital, and room renovations (repurposing of space). For each category a prioritization process is undertaken. The process is very rigorous and transparent. The CAPP process ensures the prioritization of all equipment needs in the region.

The Information System Advisory Committee (ISAC) has also been established to prioritize the information system needs of the organization. Although there are significant information and communications technology (ICT) needs and inequities throughout the region, the team is supported in moving this agenda forward. The organization has allocated funding to implement the evergreen of computers. The organization is also mindful that when making decisions regarding resource allocations, the potential impact on other programs and services is considered. The Product Evaluation and Capital Equipment Committee (PEACE) is continually working at standardizing and prioritizing some types of equipment within the PMH. The organization is supported in their continuing efforts to standardize products across the PMH.

The organization has recently developed a draft Risk Management Plan. The organization is encouraged to finalize the Risk Management plan to ensure that the organization has a sound framework to assess and monitor risk within the organization. Overall, the members involved in Resource Management can be extremely proud of the many activities they have completed, or are in the process of implementing. With this level of success the team needs to ensure they can sustain the efforts.

Priority Process: Human Capital

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

Unmet Criteria		High Priority Criteria
Standards Set: Leadership		
2.14	Process and outcome measures related to worklife and the work environment are identified and monitored.	
10.13	An exit interview is offered to team members that leave the organization, and the information is used to improve performance, staffing, and retention.	

Surveyor comments on the priority process(es)

There is a dedicated and knowledgeable team leading and supporting the Human Resources functions within Prairie Mountain Health. The team oversees functions related to labor relations, compensation and benefits, recruitment and organizational development and staff wellness. It was also a pleasure to have representation present from Volunteer Services which contributes and supports the mission and vision of the organization.

PMH's vision of "Health and Wellness for All" is guiding the organization's goal of "Healthy employees making a contribution to the organization within a healthy workplace environment". The organization is investing significant effort and time in creating a healthy workplace for the staff, physicians and volunteers. They have taken the results of the Work life Pulse survey to guide the recommendations and action plans to support a healthy workplace culture for all staff. The organization is commended on including union and management staff on the Workplace Wellness Team. PMH has already implemented and evaluated several initiatives to support a safe work environment and a healthy workplace. Of note was the successful Employee Wellness Week and the implementation of the workplace violence prevention strategy. The Wellness Committee has developed a Workplace Wellness Framework which is guiding the committee's work and goals. The operational plan they have developed is comprehensive and will be an excellent roadmap to support PMH's workplace wellness.

The organization has recently piloted a new and simplified performance management system. It is important that the organization finalize the process as soon as possible so that the performance management system can move forward. It is also strongly recommended that the organization set clear targets, timelines and expectations related to performance review completion, and that they monitor and report progress.

The organization can be very proud of the investment and commitment they have made in education and training for staff in the areas of leadership development, management training, and the required organizational practices. The online education modules (SPOT) have been an excellent vehicle to

facilitate access to education and information for staff. There is no question that PMH believes in their people and are investing in their career development and professional education. They are providing ongoing educational opportunities to support the organization's quality and safety agenda.

The organization acknowledged that they continue to be extremely challenged with the recruitment and retention efforts for many disciplines including family physicians, and this challenge often makes the delivery of service very difficult, particularly in the rural areas. They continue to have a high utilization of agency nurses as well as high overtime rates. They are exploring innovative approaches to recruit and retain staff. Currently, exit interviews are not consistently taken. If this process is implemented it may provide some helpful learnings related to recruitment and retention strategies.

The organization does not have a detailed work force plan. To understand the current workforce, and to ensure a sustainable workforce for the future, it is suggested that the organization undertake a detailed analysis of the current workforce. This would involve analysis of criteria such as age, gender, position, geographical location and skill mix so that they can anticipate and plan for current and future workforce needs. The organization is also encouraged to continue with their succession planning activities throughout all levels within the organization in order to ensure a solid leadership foundation.

Throughout the survey there was a notable absence of formal physician leadership within several of the clinical programs. It is suggested that the organization consider formalizing roles for physician leaders in order to legitimize authority and responsibility.

With the 2012 amalgamation the organization has undergone significant change as it worked to establish new processes and structures coupled with the significant retention and recruitment challenges. It was noted throughout the survey that these many changes have resulted in stress and change fatigue for the organization's leaders and point of care providers. The organization is encouraged to monitor the number of initiatives that are happening at the same time. PMH would like to consider the opportunity of adopting a change management framework and supporting the Workplace Wellness agenda.

It is evident that the Human Resources portfolio will be guided by the organizations strategic plan. The HR operational plan is aligned with the challenges and priorities of the organization. The team is encouraged to establish and measure key performance indicators in order to monitor the health of the organization's people plan.

Priority Process: Integrated Quality Management

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

Unmet Criteria	High Priority Criteria
Standards Set: Leadership	
15.7 There is a documented and coordinated approach to partner with clients and families to collect accurate and complete information about client medications and utilize this information during transitions of care. NOTE: Accreditation Canada will move towards full implementation of medication reconciliation in two phases. For on-site surveys between 2014 and 2017, medication reconciliation should be implemented in ONE service (or program) that uses a Qmentum standard containing the Medication Reconciliation at Care Transitions ROP. Medication reconciliation should be implemented as per the tests for compliance for each ROP. For on-site surveys in 2018 and beyond, medication reconciliation should be implemented in ALL services (or programs) that use Qmentum standards containing the Medication Reconciliation at Care Transitions ROP. Medication reconciliation should be implemented as per the tests for compliance for each ROP.	ROP
15.7.6 Compliance with the medication reconciliation process is monitored and improvements are made when required.	MINOR
16.2 A defined process is followed to select and monitor system-level process and outcome measures to evaluate the organization's performance at a strategic level.	!
16.3 The organization's leaders require, monitor, and support service, unit, or program areas to monitor their own process and outcome measures that align with the broader organizational strategic goals and objectives.	!
16.9 Reports about the organization's performance and quality of services with are shared the team, clients, families, the community served, and other partners and stakeholders.	
16.10 The results of the organization's quality improvement activities are communicated broadly, as appropriate.	!

Surveyor comments on the priority process(es)

There are robust quality improvement, information management, and communication teams in the organization. The senior team and the Board are enthusiastic, engaged and interested in continuous quality improvement.

The strategic plan outlines the mission, vision, values and priorities of the Board. Communication tools are attractive, engaging, and informative. There is an impressive education and professional development system which includes curriculum.

The organization collects a wealth of data about the health status of the population and the utilization of services by staff and the public. A large group of client advisors, patients throughout the organization, and community partners all reported a high level of satisfaction with the services provided. Along with the positive feedback, many recommendations and suggestions for improvement were noted. All of these positives create the ideal conditions for a strong quality improvement program that is highly visible and demonstrates accountability for the way scarce resources are being utilized to get the best possible results. PMH is encouraged to use the available data to clearly articulate how quality improvement activities are targeted to achieve the organization's highest priorities.

Priority Process: Principle-based Care and Decision Making

Identifying and making decisions about ethical dilemmas and problems.

The organization has met all criteria for this priority process.
Surveyor comments on the priority process(es)

The ethics framework is specifically aligned with the value of "integrity" set by the Board. There are committees focused on the evaluation of research proposals, issues review and education. There is a relationship with the Manitoba Provincial Health Ethics Network (MBPHEN) when a broader range of expertise and experience is helpful or needed. An easy to understand video has been developed for orientation and instructional purposes. The topic of ethics is a standing item in the new employee orientation. Plans are underway to implement ethics review for new policy development.

When the episode of care tracers were undertaken in mental health the concern was raised that there is currently a procedure to identify a potentially violent patient whereby a purple dot is placed on the chart. There is a procedure that identifies how and when the dot would be removed; however, most communication with staff regarding this process is required. The implementation of this procedure could involve potential issues that need to be discussed by the ethics committee. The ethics committee may also facilitate any further discussion.

Priority Process: Communication

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

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

The organization has a diverse, engaged, and active group of fifteen people involved in its ethics committee, including senior management and the Board. The committee has developed a framework that is designed to support staff and managers to consider and resolve ethical issues. The focus is education and awareness.

The organization has recently completed a strategic planning process, producing a document reflective of its mission, vision, values, and strategic priorities. The plan is aligned with the priorities of the provincial health system.

The communication plan speaks to strategies that will engage internal and external stakeholders. The current health authority has made a concerted effort to take the best practices of the previous three health authorities and build on those to create an identity and a range of programs and services that reflect the diversity of people and geography covered by the new entity.

Based on evidence provided by the organization, and input received from a wide range of stakeholders; including patients, caregivers, staff, physicians and others, there is consensus that communication strategies have been effective in demonstrating to the communities that Prairie Mountain Health is making the effort to be transparent and accountable to the public.

The information received during the on-site survey indicates that for the four years since amalgamation, PMH has focused internal communications on engaging staff in choosing and creating tools that will support consistency of practice through standardization of policies and practices that support service delivery across the region. The concept of "equity" for Prairie Mountain Health residents is front and centre in the strategies guiding this work.

External communications have been focused on the creation of a visual identity for the new organization and the engagement of the population served. The CEO has made efforts to be visible at high priority public forums and has tasked the management team to develop operational plans that are aligned with the strategic plan. Development of the LHIGs, a variety of media tools, and efforts to advance client and family centred care initiatives are evident.

Priority Process: Physical Environment

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

Unmet Criteria		High Priority Criteria
Standards Set: Emergency Medical Services		
10.3	The team conducts and documents annual checks of the driving records of all persons who drive an EMS vehicle.	!
Standards Set: Leadership		
9.1	The physical space meets applicable laws, regulations, and codes.	!
9.2	There are mechanisms to gather input from clients and families in co-designing new space and determining optimal use of current space to best support comfort and recovery.	

Surveyor comments on the priority process(es)

Prairie Mountain Health is fortunate to have a dedicated and knowledgeable team to oversee the various components of the physical environment needs within the organization. There is representation from capital planning, infrastructure and maintenance, environmental services, biomedical engineering, and the executive sponsor.

The organization has excellent processes to ensure that the physical environments throughout Prairie Mountain Health are well maintained and safe. Even though some sites are very old, they are very clean and well maintained. All of the cleaning and laundry staff follow standard operating procedures. They have received the appropriate training to do their job.

Preventative maintenance programs are in place. They have a process to ensure that heating, ventilating, and air conditioning (HVAC) and medical gas systems are monitored and well maintained. The organization has also undertaken a process to prioritize major capital building projects. Working groups and steering committees have been established for all major capital building projects. It will be important to engage patients and families in current, and future, building and renovation projects.

The organization is encouraged to establish some key performance indicators related to each of the components within the physical environment so that they can monitor their progress and success. They can be very proud of their accomplishments to date.

Priority Process: Emergency Preparedness

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

Unmet Criteria		High Priority Criteria
Standards Set: Emergency Medical Services		
2.2	The team identifies its role and participates in local, regional, provincial and federal disaster plans, responses and exercises.	
Standards Set: Public Health Services		
13.7	The public health emergency response is tested as part of broader all-hazard disaster and emergency response plan drills.	

Surveyor comments on the priority process(es)

The organization is commended on the incredible efforts they have undertaken to develop and implement a sound Emergency and Disaster Preparedness program throughout the entire region. The emergency color codes are standardized across the region. All staff has color code cards and are aware of the location of their resource binders. Emergency Preparedness education is provided at orientation and then available through SPOT.

There is 24/7 access to on call support. The organization has also undertaken several table top exercises to prepare staff. They have also had real life situations with floods, severe weather and fires in facilities where they have had the opportunity to test the effectiveness of their plans. It is evident that staff is very well prepared. They know their roles and responsibilities. They are also in the process of activating a Mass Notification System across Prairie Mountain Health.

Dauphin has focused on Code Red (fire) as the foundation for its emergency preparedness education strategy. There have been a number of drills in Acute and Community, with clearly defined roles and responsibilities tested and "just in time" debriefings completed. Similarly, there has been education for Code Yellow, Code Blue, and Code Brown. The Dauphin team has not yet implemented table top exercises or formal education with respect to Code Orange or mass casualty events. The organization is encouraged to start this work once they have a sustainable plan in place for their code red education and training.

The city of Dauphin hosts a number of festivals that result in tremendous surges in volume for the emergency department as well as inpatient units. The leadership team has partnered with the organizers to try and ensure that there is adequate on site first aid support, but these efforts have been challenging. They are encouraged to continue to advocate for this support and to look at strategies to decrease the reliance on Dauphin Health Care Centre to provide low acuity care.

The EMS team is commended on the level of involvement in community events to raise awareness about EMS and out-of- hospital-care. Some examples of this engagement include the following:

•The program Hidden Hugs is based on a car seat emergency information kit that includes a clear stick on mounting envelope. This envelope is intended to be placed on a child's car seat so that parents or guardians can place children's pertinent information into it. This information includes name, date of birth, MB health number, Parent/Guardian names, emergency contacts, known medical conditions, medications, and allergies. The kit also includes a red identification sticker that is to be placed on a vehicle's rear driver's side window indicating to emergency care providers that there may be a child in the car during an incident.
•Establishment of the farm safety day and farm safety workshops.
•A teddy bear clinic that engages EMS staff in schools with young students and their teachers. This program focuses on face to face meet and greets with EMS, educating children on what basic assessments EMS completes during a call and the use of assessment questions that include medical conditions or injuries, medications and allergies. These youth also receive a certificate for participation.
•Good Sam's Campground CPR program that has involved as many as 40 campers staying at a local fair ground during each summer.
•Seniors' hypertension clinic where staff and seniors get to meet while evaluating blood pressure. This is a great practice and offers an opportunity for each group to get to know each other better.
•Life Jacket awareness and Bike helmet programs. Life Jackets and helmets are supplied free of charge to participants of these programs. Partners are the Canadian Red Cross, and MPI.
•Attendance at local ball tournaments and music festivals.

The planning and the detail that Prairie Mountain Health has undertaken to ensure that the organization is well prepared to respond to emergency situations are commendable. The organization is to be congratulated on the level of engagement of internal and external stakeholders and the investment in staff education and orientation, as well as checklists and quick reference tools, which will contribute to the ongoing success of the disaster and emergency preparedness program. It will be important that the organization ensures that staff remains current on the knowledge and response required when involved in disaster and emergency situations.

Priority Process: Patient Flow

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

Unmet Criteria		High Priority Criteria
Standards Set: Leadership		
13.4	Client flow is improved throughout the organization and emergency department overcrowding is mitigated by working proactively with internal teams and teams from other sectors. NOTE: This ROP only applies to organizations with an emergency department that can admit clients.	ROP
13.4.3	There is a documented and coordinated approach to improve client flow and address emergency department overcrowding.	MAJOR
13.4.6	Interventions to improve client flow that address identified barriers and variations in demand are implemented.	MAJOR

Surveyor comments on the priority process(es)

The organization has made a great start on managing patient flow throughout Prairie Mountain Health. The Emergency Departments are not overcrowded, or have patients waiting long hours for an inpatient bed. The medical and surgical units run at between 85-90% occupancy, and some of the rural sites run at about 50%. This allows for swift movement from the Emergency Department to an inpatient bed. Dauphin Regional Health Centre is slated for a renovation to their Emergency department, which will assist in the flow through this department.

The area where the organization has identified barriers to patient flow is in ensuring a timely transfer of those clients in hospital who require placement in a personal care home. Clients can wait up to a year or more for a bed in a personal care home.

The organization is encouraged to develop an overcapacity/surge protocol that encompasses the region as a whole.

The organization does move clients with their permission, from site to site in order to ensure there is flow in each of the facilities. The status of some smaller sites has been changed to transitional sites, which are a big help to the larger sites in ensuring that patient flow does occur. This process may not be sustainable with an aging population when all beds are filled. It is suggested that the organization look at the admission criteria and the average length of stay (ALOS) in the personal care homes and try to maximize staying at home.

The organization is encouraged to continue to review data related to waiting placement, access and barriers to primary care, access to home care and support, and also to review access to specialty services and rehabilitation to inform a regional approach to flow.

The organization is also encouraged to develop regular reports that provide the metrics and trending to ensure they are effecting a change in the right direction without impacting on other services.

Priority Process: Medical Devices and Equipment

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

Unmet Criteria		High Priority Criteria
Standards Set: Reprocessing and Sterilization of Reusable Medical Devices		
3.1	When planning and designing the layout of the medical device reprocessing department, the organization considers the volume and types of reprocessing and sterilization services, flow of devices and equipment, and traffic patterns.	
3.3	The medical device reprocessing department is designed to prevent cross-contamination of sterilized and contaminated devices or equipment, isolate incompatible activities, and clearly separate different work areas.	!
3.4	The medical device reprocessing department has a specific, closed area for decontamination that is separate from other reprocessing areas and the rest of the organization.	!
3.5	The organization regulates the air quality, ventilation, temperature, and relative humidity, and lighting in decontamination, reprocessing, and storage areas.	
3.6	The organization selects materials for the floors, walls, ceilings, fixtures, pipes, and work surfaces that limit contamination, promote ease of washing and decontamination, and will not shed particles or fibres.	
5.1	The medical device reprocessing department is equipped with hand hygiene facilities at entrances to and exits from the reprocessing areas, including personnel support areas.	
5.2	The medical device reprocessing department's hand hygiene facilities are equipped with faucets supplied with foot-, wrist-, or knee-operated handles, or electric eye controls.	!
10.2	The organization limits and monitors access to the storage area to appropriate team members.	
13.1	The team has a documented quality management system for its reprocessing and sterilization services that integrates principles of quality assurance, risk management, and continual improvement.	

13.3	The team collects information and feedback from clients, families, staff, service providers, organization leaders, and other organizations about the quality of its services to guide its quality improvement initiatives.	
13.4	The team uses the information and feedback it has gathered to identify opportunities for quality improvement initiatives.	
13.5	The team identifies measurable objectives for its quality improvement initiatives and specifies the timeframe in which they will be reached.	!
13.6	The team identifies the indicator(s) that will be used to monitor progress for each quality improvement objective.	
13.7	The team monitors compliance with policies and procedures, safe work practices, and OHS requirements in the reprocessing unit or area.	!
13.9	The team designs and tests quality improvement activities to meet its objectives.	!
13.10	The team collects new or uses existing data to establish a baseline for each indicator.	
13.11	The team follows a process to regularly collect indicator data to track its progress.	
13.12	The team regularly analyzes and evaluates its indicator data to determine the effectiveness of its quality improvement activities.	!
13.13	The team implements effective quality improvement activities broadly.	!
13.14	The team shares information about its quality improvement activities, results, and learnings with clients, families, staff, service providers, organization leaders, and other organizations, as appropriate.	
13.15	The team regularly reviews and evaluates its quality improvement initiatives for feasibility, relevance and usefulness.	

Surveyor comments on the priority process(es)

Since amalgamation in 2012, the Regional Manager of the Medical Device Reprocessing Centre (MDR) has provided oversight to all sites where reprocessing occurs. A review resulted in six of the twelve sites being decommissioned. It is important to continue to review the sites to ensure that the physical plant can meet the standards of reprocessing and sterilization, as there are some sites where the physical plant layout is not conducive to reprocessing. While some have implemented processes to ensure that the workflow is from dirty to clean with no cross over, others do not have proper hand washing sinks in the area or enough power to run a sterilizer. In some rural sites, MDR is not monitored for ventilation or air quality.

Ultra sound probes continue to be high level disinfected in rooms where the procedure takes place. This is being address through a provincial initiative collusive of all regional health authorities, diagnostics services of Manitoba and Manitoba Health.

A multidisciplinary committee includes representation from Infection Prevention, Capital Infrastructure, Human Resources, Education, Clinical Services Material Management and other key stakeholders. A Provincial Reprocessing Committee, which the Regional Manager of the team is a member, is currently reviewing key issues affecting reprocessing in the province. An Endoscopy and Surgical Committee each meet monthly. Manitoba Health supported infrastructure reviews at Brandon, Dauphin and Minnedosa. A tracking system has been approved and will be implemented at Brandon in the fall.

Policies and procedures are standardized and monitored. All new staff are required to complete the MDR course successfully within 18 months of hiring. New staff have competency audits completed before their trial period is completed and on an annual basis. One Source is used as a reference guide for staff.

It is encouraged that outcome measures and targets be established to address consistent safety issues such as single use and bioburden left on instruments. A focus for the program is to standardize transportation of equipment to and from rural sites and ensuring that single use items are not reprocessed unless risk issues are identified and mitigated. There may be an opportunity to review the use of disposables at some sites. Clean blueware is put in plastic to identify that it is clean. Consideration may be given to reducing the amount of plastic that is used.

The rural sites spoke positively about the networking opportunities that have been created. The Regional Manager appreciates the provincial link to other Manitoba Reprocessing Programs.

There is strict adherence to proper Personal Protective Equipment (PPE) in all areas.

Priority Process Results for Population-specific Standards

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

Priority processes specific to population-specific standards are:

Population Health and Wellness

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

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

Unmet Criteria		High Priority Criteria
Priority Process: Population Health and Wellness		
2.1	The organization sets measurable and specific goals and objectives for its services for its priority population(s).	
5.5	The organization shares benchmark and best practice information with its partners and other organizations.	
6.5	The organization uses the information system to generate regular reports about performance and adherence to guidelines, and to improve services and processes.	
6.6	The organization monitors and validates the quality of data in the clinical information system.	
7.1	The organization identifies and monitors performance measures for its services for its priority population(s).	!
7.4	The organization compares its results with other similar interventions, programs, or organizations.	
Surveyor comments on the priority process(es)		
Priority Process: Population Health and Wellness		

The findings of the 2015 Community Needs Assessment have been widely shared both internally and externally. The significant health inequities that the Community Health Assessment identified have been shared. The communities and populations that are experiencing the greatest inequities have been engaged through an approach that is reflective of a true partnership to identify a potential intervention strategy based on promising practices from the literature or communities that are experiencing similar challenges.

There is a focused effort to identify and engage with key partners using a strategy that builds on existing community assets such as educational institutions and non-profit and voluntary organizations.

The organization is encouraged to continue to work with it partners to identify specific measurable goals and objectives with timelines. The ability to demonstrate that interventions are resulting in changes in the health inequities will be important for the ongoing commitment of the partners as well as to identify if there is a need to adjust the intervention strategy.

Standards Set: Public Health Services - Horizontal Integration of Care

Unmet Criteria	High Priority Criteria
Priority Process: Population Health and Wellness	
The organization has met all criteria for this priority process.	

Surveyor comments on the priority process(es)

Priority Process: Population Health and Wellness

The Public Health Units provide programming and services to the populations within and surrounding their communities. Public Health Nurses supported by Unit Clerks provide the following services: Well-Baby Clinics, Prenatal & Post-Partum Care, Immunizations, Communicable Disease Management, Surveillance, and Reproductive Health Services.

Travel Health services are available in Brandon on a cost recovery basis.

Programming is aligned with the Public Health prioritized strategies.

Service Excellence Standards Results

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

Priority processes specific to service excellence standards are:

Competency - Primary Care

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

Clinical Leadership

- Providing leadership and direction to teams providing services.

Competency

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

Episode of Care

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

Decision Support

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

Impact on Outcomes

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

Medication Management

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

Organ and Tissue Donation

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

Infection Prevention and Control

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

Public Health

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

Standards Set: Ambulatory Systemic Cancer Therapy Services - Direct Service Provision

Unmet Criteria			High Priority Criteria
Priority Process: Clinical Leadership			
The organization has met all criteria for this priority process.			
Priority Process: Competency			
The organization has met all criteria for this priority process.			
Priority Process: Episode of Care			
11.6	To minimize injury from falls, a documented and coordinated approach for falls prevention is implemented and evaluated.		
	11.6.4	The effectiveness of the approach is evaluated regularly.	**MINOR**
	11.6.5	Results from the evaluation are used to make improvements to the approach when needed.	**MINOR**
Priority Process: Decision Support			
The organization has met all criteria for this priority process.			
Priority Process: Impact on Outcomes			
The organization has met all criteria for this priority process.			
Priority Process: Medication Management			
3.2	Established guidelines are followed for safe handling of systemic cancer therapy medications.		
Surveyor comments on the priority process(es)			
Priority Process: Clinical Leadership			

The leaders and team members of Prairie Mountain Health are passionate about enhancing the quality of the ambulatory systemic cancer therapy services provided to clients and families. There are seven Community Cancer Program sites throughout Prairie Mountain Health. Leaders, team members, clients and families have all commented on the importance and value of providing quality cancer care “close to home.” A client also stated, “I am so grateful to have the facility here.” Clients and families are partners in the design of the Community Cancer program. This includes the development of made-in-Manitoba cancer resources such as My Cancer Passport.

There are strong interdisciplinary teams providing care for clients and their families. This network includes the leadership and support of Cancer Care Manitoba. Team members noted that they are supported by Prairie Mountain Health and the entire provincial network of cancer care programs. There are many strong partnerships established to meet the needs of clients and families. This has included initiatives such as volunteer programs, therapeutic gardens, and a patient support fund. Quality processes are embraced by the team members and leaders. They seek opportunities to improve services. Team members have described it as a "privilege" to work in cancer care. The caring and concern for clients and families was evident throughout the Community Cancer Program.

Prairie Mountain Health has encouraged the participation of clients and families in designing space to ensure a safe and therapeutic environment. This includes the design of therapeutic gardens and the Western Manitoba Cancer Care. The organization is encouraged to continue to involve clients and families in any re-design of space. The organization is encouraged to continue to support and encourage client and family engagement throughout the Community Cancer Program.

Priority Process: Competency

The commitment and passion of the leaders, team members and physicians to provide quality community cancer care to the clients and families was evident throughout the Community Cancer Program. The leaders, team members and physicians are ambassadors in providing quality cancer care to clients throughout Prairie Mountain Health. There is collaboration among the team with a strong interdisciplinary approach. The leaders and team members described strong professional networks across Prairie Mountain Health and Cancer Care Manitoba.

There are comprehensive orientation and training processes in place. Team members described the orientation program with four weeks of training in Winnipeg as being invaluable to them in providing quality systemic cancer therapy. They also noted that this helped build relationships and a community of people to call upon if there are questions or concerns. A team member stated, "I feel we work as one system." The team members noted that they felt supported with the education and training provided by the organization including conferences, rounds, on-line training, and staff meetings. Team member contributions are recognized. Team members commented that they felt safe at work and that they received education and training on occupational health and safety and workplace violence prevention.

Prairie Mountain Health is to be commended for the commitment to infusion pump training. There is a documented and coordinated approach to infusion pump training. Training on the safe use of infusion pumps is completed on an annual basis.

The organization is to be commended for the commitment to education and training. The organization is encouraged to continue to provide team members, leaders and physicians with opportunities for continued professional growth and development. Prairie Mountain Health is encouraged to continue with the commitment to occupational health and safety and workplace violence prevention for team members, leaders and physicians.

Priority Process: Episode of Care

The leaders and team members of the Community Cancer Program are a dynamic group of highly dedicated professionals with a commitment to improving care for clients and families. They strive to remove access barriers for clients and families. They are deeply committed to providing care for clients close to their home therefore, reducing the burden of illness and improving access. The clients and families spoke highly of the team members and their commitment to support them in their health care decisions and they felt their wishes were respected. The clients stated they were treated with dignity and respect. An environment was fostered that clients and families are partners with the health team and felt comfortable in asking questions.

The Community Cancer sites were welcoming, warm and provided a therapeutic environment for clients and families. This included warm blankets, refreshments, comfort pillows, and television at some sites. One client stated, “There is a lot of laughter that goes on here.” The clients and families are supported by a committed group of volunteers including someone to talk with, provide refreshments, and support. The volunteers noted that they were supported by the team members and leaders.

The leaders and team members are committed to ensuring the voice and participation of clients and families. This included the experience of clients in the development of resource material, design of physical space and development of therapeutic gardens. It was stated that the community is involved in the Community Cancer Program. A community member stated, “We work to improve services for the community.” The organization is encouraged to continue to engage clients and families in any re-design of space and development of the Community Cancer Programs.

The interdisciplinary Community Cancer Program team works collaboratively to meet the needs of clients and families. The team members participate in regular staff and interdisciplinary team meetings. The team members commented on the supportive work environment and the importance of team work.

The team members are committed to ensuring quality care transitions. They noted that they work in partnership with community partners and Cancer Care Manitoba in this regard. The Nurse Navigators provide a proactive approach to coordinating care for clients and families.

The Community Cancer Program is committed to minimizing injury from falls. A universal risk assessment process is used with documentation of the risk assessment on the Compass form. Clients who are identified at risk for falls then have an icon placed on the electronic health record. It is recommended that the Fall Prevention Program be reviewed with changes implemented as appropriate.

The organization is encouraged to continue to promote and support the experiences and involvement of clients and families into the Community Cancer Program.

Priority Process: Decision Support

The leaders and team members are committed to ensuring quality decision support for the Community Cancer Program. Information systems are in place and connect the seven Community Cancer Program sites. The Community Cancer Program both within Prairie Mountain Health and Cancer Care Manitoba are connected electronically. The support of Cancer Care Manitoba was acknowledged in achieving this connectivity. The leaders and team members have commented on the value of electronic health records in enhancing the safety and quality of care provided. The electronic health records have enabled team members within the Community Cancer Program to link with other care providers within the circle of care.

Team members are provided with education and training on the information systems. Team members and leaders are committed to protecting the privacy and confidentiality of client information with privacy audits conducted. Leaders and team members have received education and training on privacy and confidentiality. Clients are knowledgeable regarding the process to review their health records.

The organization is encouraged to continue to support the implementation of quality information systems including team member education and training.

Priority Process: Impact on Outcomes

The leaders and team members are acknowledged for their commitment to safety and quality improvement. An Action Plan 2017-2019 has been implemented with objectives identified and evaluated. Clients and families were involved in the development of the Action Plan. Quality improvement initiatives have been implemented and supported. Hand hygiene stations are available and team members were observed following hand hygiene protocols. Education has been provided to clients and families on hand hygiene. The clients and families are aware of the importance of hand hygiene and were observed practicing hand hygiene.

Education on patient safety is provided to clients and families with a patient safety check list completed and signed. The team members received training on patient safety. They are aware of the disclosure process to clients if an adverse health event occurs. The occurrence system is used by leaders and team members. The incidents are analyzed for trends and it is used as a teaching tool. The learnings are shared across Prairie Mountain Health and Cancer Care Manitoba.

The leaders and team members are encouraged to continue to involve clients and families in the design and evaluation of safety improvement strategies including falls prevention. The organization is encouraged to continue to analyze the indicator data to determine the effectiveness of the quality improvement initiatives.

Priority Process: Medication Management

The leaders and team members of Prairie Mountain Health are committed to the safe acquisition, storing, handling, preparing, administering, transporting, spills management, and waste disposal of systemic cancer therapies. Team members take great pride in ensuring that policies and procedures are followed in administering systemic cancer therapy.

Pharmacy services are consolidated at some Community Cancer Program sites. This includes the Russell Health Centre and the Deloraine Health Centre with systemic cancer therapy medications being prepared for these sites at the Brandon Regional Health Centre. Processes have been instituted to ensure the safe transporting and delivery of the systemic cancer therapy medications.

The team members have quality physical spaces to prepare and administer the systemic cancer therapy medications. The lighting is good with minimal distractions.

Team members have stated that they feel that occupation health and safety is important to Prairie Mountain Health and they feel safe at work. Established guidelines are developed for the safe handling of systemic cancer therapy medications. This includes the development and implementation of a new policy, “Safe handling of cytotoxic medications.” The new guidelines are supported by the leaders and team members. The team members administer systemic cancer therapy medication using gloves as their personal protective equipment. The new policy identifies the need for additional personal protective equipment including a gown and face shield. This equipment has been ordered but has not yet been obtained. The organization is very committed to implementing this process and it is anticipated that the personal protective equipment will be available for team members in July 2016. It is recommended that Prairie Mountain Health fully implement the new policy and evaluate the policy regularly.

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

Unmet Criteria		High Priority Criteria
Priority Process: Clinical Leadership		
The organization has met all criteria for this priority process.		
Priority Process: Competency		
5.5	The effectiveness of team collaboration and functioning is evaluated and opportunities for improvement are identified.	
Priority Process: Episode of Care		
9.5	When medication management is a component of care (or deemed appropriate through clinician assessment), a Best Possible Medication History (BPMH) is generated in partnership with clients, families, or caregivers (as appropriate) and used to reconcile client medications.	ROP
9.5.1	The types of clients who require medication reconciliation are identified and documented.	**MAJOR**
9.5.2	At the beginning of service, a Best Possible Medication History (BPMH) is generated and documented in partnership with the client, family, health care providers, and caregivers (as appropriate).	**MAJOR**
9.5.3	Medication discrepancies are resolved in partnership with clients and families OR communicated to the client's most responsible prescriber, and actions taken to resolve medication discrepancies are documented.	**MAJOR**
9.5.4	When medication discrepancies are resolved, the current medication list is updated and provided to the client or family (or primary care provider, as appropriate) along with clear information about the changes.	**MINOR**
9.5.5	Clients and families are educated on how to share the complete medication list when encountering health care providers within the client's circle of care.	**MAJOR**
10.9	Information relevant to the care of the client is communicated effectively during care transitions.	

10.9.5	The effectiveness of communication is evaluated and improvements are made based on feedback received. Evaluation mechanisms may include: • Using an audit tool (direct observation or review of client records) to measure compliance with standardized processes and the quality of information transfer • Asking clients, families, and service providers if they received the information they needed • Evaluating safety incidents related to information transfer (e.g., from the patient safety incident management system).	**MINOR**
12.7	The effectiveness of transitions is evaluated and the information is used to improve transition planning, with input from clients and families.	
Priority Process: Decision Support		
13.1	An accurate, up-to-date, and complete record is maintained for each client, in partnership with the client and family.	!
Priority Process: Impact on Outcomes		
16.7	Patient safety incidents are analyzed to help prevent recurrence and make improvements, with input from clients and families.	!
17.2	The information and feedback gathered is used to identify opportunities for quality improvement initiatives and set priorities, with input from clients and families.	

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

The staff are very dedicated and passionate about their work and go above and beyond to assist their clients. Staff are flexible and innovative in accessing services especially as some staff are in small towns with limited resources and services. Staff work very well in collaboration with clients and families and are well connected in the community and with other services.

Prairie Mountain Heatlh staff monitors the client’s needs, goals and resources to adjust planning.

The organization is encouraged to form stronger partnership with primary care because of overlap in population of interest and clients and the chronic disease needs.

Dedicated resources to review and support medication storage and management is encouraged.

Priority Process: Competency

The staff are very dedicated and passionate about their work and go above and beyond to assist their clients.

PROCURA is the new electronic health records (EHR) software rolled out recently and training has been provided. Assessment notes in PROCURA are the major means of communicating between workers and services. Telephone is used for urgent communication then conversations are noted in assessment notes.

Annual performance reviews are done. However, some staff members indicated that it had been two years since their last performance review. Staff members indicated that they do meet regularly with the manager to review case files. The managers are aware of each team members' case load.

Forms online (intranet) are available to fill out for incidents, near misses, errors, violence and grievances.

Nonviolent crisis intervention training courses are available to staff to prevent violence and enhance safety.

Staff expressed concern about the new Prairie Mountain Health Violence Policy and that for many of their clients that an incident when they were psychotic could result in them being labeled for life as a violence/safety risk when there is no concern while clients are taking their medications. The team wondered about a process to remove a person's violence flag on their record.

PROCURA has implemented the purple dot alert related to the Workplace Violence Prevention program. The organization is encouraged to communicate to staff how to deactivate the alert.

The organization is encouraged to evaluate and analyze their team’s functions.

Priority Process: Episode of Care

Client’s are provided with Prairie Mountain Health contact information for a complaint relate to services.

The client's health status is assessed and risk factors for chronic disease are identified, and support is offered but there is not a formal assessment or screening of their risk factors for chronic disease that would inform a treatment plan. There may be an opportunity for a pilot project with primary care to look at offering screening for chronic disease risk factors through their family physician or through nurse practitioners.

Standardized information, discharge summary, list of medication, follow up with their respective professionals are all documented and completed.

The effectiveness of care transition has not been systematically evaluated in most areas. The organization is encouraged to evaluated transition of care.

Priority Process: Decision Support

All staff regularly use the formal suicide assessment guide.

Some locations are using a paper chart but are moving to an electronic health record version (PROCURA) in the future.

There is no easy way to see in PROCURA if the suicide risk assessment has been done other than to go to that area of the chart and see if the form has been completed. In other words, it is not possible to tell if a staff member has assessed and determined a risk assessment, since it is not indicated in PROCURA. The organization is encouraged to find a way to include suicide risk assessment in PROCURA.

Priority Process: Impact on Outcomes

Safety is at the forefront of all discussions and interactions. Safety topics include medications, falls, drugs, alcohol, guns and home safety.

Safety incidents such as falls or medication errors are reported, recorded and the client/family are notified.

Incidents are analysed to mitigate and promote safety.

Two S.M.A.R.T. quality improving initiative have been done, the first one is a two person client identifier, especially involving new staff in the transfer of information at care transitions and the second one is creating different care plans after any change in health status such as cataract surgery or getting a hearing aid.

Standards Set: Critical Care - Direct Service Provision

Unmet Criteria		High Priority Criteria
Priority Process: Clinical Leadership		
1.5	Partnerships are formed and maintained with other services, programs, providers, and organizations to meet the needs of clients and the community.	
Priority Process: Competency		
	The organization has met all criteria for this priority process.	
Priority Process: Episode of Care		
8.7	To minimize injury from falls, a documented and coordinated approach for falls prevention is implemented and evaluated.	ROP
	8.7.4 The effectiveness of the approach is evaluated regularly.	**MINOR**
	8.7.5 Results from the evaluation are used to make improvements to the approach when needed.	**MINOR**
8.8	Each client's risk for developing a pressure ulcer is assessed and interventions to prevent pressure ulcers are implemented. NOTE: This ROP does not apply for outpatient settings, including day surgery, given the lack of validated risk assessment tools for outpatient settings.	ROP
	8.8.5 The effectiveness of pressure ulcer prevention is evaluated, and results are used to make improvements when needed.	**MINOR**
10.7	Where possible, the presence of the client's family members in the room is accommodated when performing emergency procedures.	
11.9	The effectiveness of transitions is evaluated and the information is used to improve transition planning, with input from clients and families.	
Priority Process: Decision Support		
	The organization has met all criteria for this priority process.	
Priority Process: Impact on Outcomes		
17.2	The information and feedback gathered is used to identify opportunities for quality improvement initiatives and set priorities, with input from clients and families.	

17.7	There is a process to regularly collect indicator data and track progress.	
17.8	Indicator data is regularly analyzed to determine the effectiveness of the quality improvement activities.	!

Priority Process: Organ and Tissue Donation

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

The critical care team at Brandon Regional Health Centre (BRHC) supports 9 ICU beds, plus 1 flex bed, and employees five RNs plus care aides. Staff retention is high, with a number of the team members having more than 10 years within the organization; however, recently the team has had to retain agency staff for one FTE (full-time equivalent) position. There are critical care leadership team meetings regularly scheduled that are interdisciplinary in nature and have a strong physician representation. This closed unit is staffed with six intensivists.

This interdisciplinary team is highly functioning and has a high degree of teamwork. Their partnership with the referring sites is positive. In particular, Souris indicates they rely on the availability of the intensivists to support the critically ill patients in their region.

The staff has access to educational opportunities through conferences and on-site training. This enables the team to seek evidence-based best practices. As an example, the team was mobilizing ICU patients well before it became the norm. This year, they have a new initiative for managing pain and delirium.

There are specific goals and objectives that have been outlined; however, they could be improved if specific targets are identified. Although the team inputs data, information is not provided to them on a regular basis to support their improvement objectives (e.g. readmission rates, length of stay, percentage of patients vented, and other outcomes).

The province has removed clinical guidelines to influence the mode of transport for critically ill patients, which presents issues for outcomes of patients.

Work has been done to improve turnaround time for dictated physician notes to be transcribed into the record and needs to be monitored. This could pose a risk for patients for the interim period if the record is incomplete.

Teamwork is clearly evident in the functioning of this team in caring for critically ill patients.

Priority Process: Competency

The critical care staff has access to educational opportunities to maintain their practices and to look for emerging practices. On-line education is available 24/7. There is evidence of annual infusion pump training.

Teamwork is strong within the interdisciplinary team. Pharmacy is on-site and contributes to the achievements of med rec in ICU. Spiritual care has a strong presence in the ICU and provides support to patients who are end-of-life, and even provides indigenous requirements. Physiotherapy has advanced mobilization for ventilated patients. The physician is a core member of the team and provides leadership. Nursing is well represented on the team with leadership to coordinate care among team members. Dietitians ensure patients continue to receive nutrition during these critical days.

Priority Process: Episode of Care

Since the last survey, criteria have been established for admission and discharge. Pediatric care is less frequent than noted in the previous survey and is normally a short-term period prior to transfer or stabilization.

Clinical care throughout the region benefits from the teamwork provided by the ICU team in Brandon. Patients at risk of readmission are identified by the physician, with the charge nurse providing follow-up checks for monitoring these patient's progress.

Medication reconciliation on admission and transfer occur in the ICU. The transfer/discharge medication reconciliation was implemented recently (within the month) and is supported by the on-site pharmacist. The team is encouraged to develop evaluation indicators to monitor its success.

This unit is progressive in its pursuit of evidence-based practices. It has been evolving its mobility practices for ventilated patients. This year it has implemented the assessment of delirium and measuring pain as a potential contributor to delirium (PAD). The team is evaluating the processes in this project.Ventilator Associated Pneumonia (VAP) and Central Line Infection (CLI) rates are low and stable. Safer Healthcare Now bundles were implemented years ago. Further support for assessing the prevalence of pressure ulcers is recommended.

Assessments and transition communication is well standardized. Referral sites, such as Souris, indicated how well their patients are supported by the intensivists from Brandon.

There is a need to develop a quality improvement partnership with the organ and transplant team in Winnipeg as a result of recent negative experiences related to both access and clinical assessments.

Priority Process: Decision Support

Overall, records are well maintained. The ICU record is manual. Dictated notes take up to three weeks to be transcribed, representing a risk, particularly for critically ill patients.

There are many data elements that are submitted (such as Apache scoring); however, there is no information or analysis provided to the team from this data. The unit could benefit from some evaluation metrics to be measured on a regular basis so that trends can be monitored and quality improvement plans can be developed. This could include basic information such as readmissions, ventilation hours, length of stay, deaths, transfers to begin informing practice with evidence.

Priority Process: Impact on Outcomes

This team is proactive in their pursuit of evidence-based practices. Opportunities remain to advance their critical thinking through the availability of critical care indicators that would inform their practice. Despite the lack of available information, this team supports their quality improvement initiatives with an evaluation of their process measures.

Priority Process: Organ and Tissue Donation

This site is supported virtually through the team in Winnipeg. The team is supportive of organ and tissue donation. Recent events indicate that the team could benefit from a quality improvement initiative with the provincial providers of organ and tissue donation.

Standards Set: Emergency Department - Direct Service Provision

Unmet Criteria		High Priority Criteria
Priority Process: Clinical Leadership		
1.4	Services are reviewed and monitored for appropriateness, with input from clients and families.	
2.6	Seclusion rooms and/or private and secure areas are available for clients.	!
Priority Process: Competency		
4.1	Required credentials, training, and education are defined for all team members with input from clients and families.	!
4.7	Education and training are provided on the organization's ethical decision-making framework.	
4.11	Education and support to work with clients with mental health and addictions are provided to team members.	
4.14	Team member performance is regularly evaluated and documented in an objective, interactive, and constructive way.	!
4.15	Client and family representatives are regularly engaged to provide input and feedback on their roles and responsibilities, role design, processes, and role satisfaction, where applicable.	
4.16	Team members are supported by team leaders to follow up on issues and opportunities for growth identified through performance evaluations.	!
5.6	The effectiveness of team collaboration and functioning is evaluated and opportunities for improvement are identified.	
6.8	Education and training are provided to team members on how to prevent and manage workplace violence, including abuse, aggression, threats, and assaults.	!
Priority Process: Episode of Care		
1.8	Barriers that may limit clients, families, service providers, and referring organizations from accessing services are identified and removed where possible, with input from clients and families.	
7.1	Entrance(s) to the emergency department are clearly marked and accessible.	!

8.2	The Pediatric-CTAS is used to conduct the triage assessment of pediatric clients.	
8.4	A triage assessment for each pediatric client is conducted within P-CTAS timelines, and in partnership with the client and family.	!
8.7	There is ongoing communication with clients who are waiting for services.	
8.8	Clients waiting in the emergency department are monitored for possible deterioration of condition and are reassessed as appropriate.	
10.2	The assessment process is designed with input from clients and families.	
10.5	In partnership with clients, families, or caregivers (as appropriate), medication reconciliation is initiated for clients with a decision to admit and a target group of clients without a decision to admit who are at risk for potential adverse drug events (organizational policy specifies when medication reconciliation is initiated for clients without a decision to admit).	ROP
10.5.2	The criteria for a target group of non-admitted clients who are eligible for medication reconciliation are identified and the rationale for choosing those criteria is documented.	**MAJOR**
10.5.4	For non-admitted clients in the target group, medication changes are communicated to the primary health care provider.	**MAJOR**
10.6	To minimize injury from falls, a documented and coordinated approach for falls prevention is implemented and evaluated.	ROP
10.6.1	A documented and coordinated approach to falls prevention is implemented.	**MAJOR**
10.6.2	The approach identifies the populations at risk for falls.	**MAJOR**
10.6.3	The approach addresses the specific needs of the populations at risk for falls.	**MAJOR**
10.6.4	The effectiveness of the approach is evaluated regularly.	**MINOR**
10.6.5	Results from the evaluation are used to make improvements to the approach when needed.	**MINOR**
10.7	Clients are assessed and monitored for risk of suicide.	ROP
10.7.2	The risk of suicide for each client is assessed at regular intervals or as needs change.	**MAJOR**
10.7.3	The immediate safety needs of clients identified as being at risk of suicide are addressed.	**MAJOR**

10.14	Priority access to consultation services is available 24 hours a day, 7 days a week.	!
12.3	Client privacy is respected during registration.	
12.8	Clients with known or suspected infectious diseases are identified, isolated, and managed.	!
12.16	Information relevant to the care of the client is communicated effectively during care transitions.	ROP
	12.16.5 The effectiveness of communication is evaluated and improvements are made based on feedback received. Evaluation mechanisms may include: • Using an audit tool (direct observation or review of client records) to measure compliance with standardized processes and the quality of information transfer • Asking clients, families, and service providers if they received the information they needed • Evaluating safety incidents related to information transfer (e.g., from the patient safety incident management system).	**MINOR**
13.8	The client's risk of readmission is assessed, where applicable, and appropriate follow-up is coordinated.	!
13.9	The effectiveness of transitions is evaluated and the information is used to improve transition planning, with input from clients and families.	
Priority Process: Decision Support		
10.12	Evidence-based protocols are used to select diagnostic imaging services for pediatric clients.	
Priority Process: Impact on Outcomes		
16.2	The procedure to select evidence-informed guidelines is reviewed, with input from clients and families, teams, and partners.	
16.3	There is a standardized process, developed with input from clients and families, to decide among conflicting evidence-informed guidelines.	!
16.5	Guidelines and protocols are regularly reviewed, with input from clients and families, to ensure they reflect current research and best practice information.	!
17.4	Safety improvement strategies are evaluated with input from clients and families.	!

18.3	Measurable objectives with specific timeframes for completion are identified for quality improvement initiatives, with input from clients and families.	!
18.4	Indicator(s) that monitor progress for each quality improvement objective are identified, with input from clients and families.	
18.6	Data on wait times for services, the length of stay in the emergency department, and the number of clients who leave without being seen is tracked and benchmarked.	
18.10	Indicator data is regularly analyzed to determine the effectiveness of the quality improvement activities.	!
Priority Process: Organ and Tissue Donation		
11.2	There is a policy on neurological determination of death (NDD).	
11.5	Training and education on organ and tissue donation and the role of the organization and the emergency department is provided to the team.	

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

The surveyor team visited ten emergency departments in the following locations: Brandon, Dauphin, Hamiota, St. Rose, Russell, Killarney, Carberry, Minnedosa, Deloraine, and Neepawa. Brandon Regional Health Centre in Brandon is the largest site and sees approximately 28, 000 visits per year, with many of the smaller sites seeing 10,000 visits or less per year.

The regional emergency department leadership team has been meeting for approximately two years. Through these regional meetings, they have worked to prioritize initiatives and identify opportunities for improvement. There is an opportunity to standardize meeting agendas and to work together as a team to determine which metrics the regional program wishes to monitor. These metrics should be used to determine priorities and inform service delivery.

Monitoring wait times and access data for Brandon Regional Health Centre with the emergency department information system is relatively straightforward; however, the remainder of the emergency departments are reliant on manual chart reviews or data collection processes. This is resource intensive and limits the number of indicators that can be realistically monitored for quality improvement purposes. There is an opportunity to improve the spread of electronic documentation tools and overall support for obtaining data.

The organization continues to establish its formal processes for engaging clients and families in service design. Formal processes for engaging clients and families in service delivery, resource, capital, and quality improvement planning is less consistently in place across the emergency departments. In addition,

there is limited data available regarding the services offered and this data is not reviewed in a formal way. The regional leadership team recognizes the value of more formally incorporating these strategies into their standard work and this is an opportunity for focus in the future. There are a few quality improvement initiatives and a large emergency department redevelopment project that have worked to include the community, patients, and families. These have the potential to serve as a model for the organization as it moves forward with its efforts to embed client and family engagement across the organization. The organization may want to consider conducting regular focus groups or emergency specific surveys.

Not all sites have access to seclusion or safe rooms. The organization is encouraged to look at short and long-term options for these particular emergency departments. Across the sites visited, there is evidence that emergency preparedness plans are in place. Some sites report completing annual fire drill training, but this is inconsistent. The organization is encouraged to develop formal tabletop exercises to practice responding to mass casualty events.

Priority Process: Competency

The front line staff appears to be highly engaged in the services they provide and are proud of the care they deliver. They describe having strong orientation programs, good access to ongoing education, and opportunities for professional development. Staff feel mentored and supported through their orientation, but there may be an opportunity to formalize a mentorship program within the organization. Retention came up as a recurrent theme and there is some reliance on agency nurses to augment health authority staffing.

Many of the staff express a desire for education and training related to the assessment and care of individuals with mental health and addictions issues. There appears to be some good community mental health resources in place that the acute emergency staff can access; however, given the prevalence and seriousness of these issues in the community it is strongly recommended that the organization place some emphasis on developing and delivering education that is tailored to the emergency department setting.

Team members are aware of the diverse cultural backgrounds of the clients they serve. While there was no evidence of formal training, the education is available through the organization, it is not mandatory but is encouraged. The organization has developed an ethical decision making framework; however, education on how to use this resource has not yet rolled out to the front line staff within the organization. The organization does have a plan to move this forward, and this will be very helpful to staff.

The organization has a well-developed process for infusion pump training through their online SPOT education. The course can be audited by staff who work in areas where they have frequent exposure to pumps (like ED) with an exam still being required for re-certification. The managers receive certificates and can download a list of employees who are certified.

The workplace violence initiatives are at various stages of development. Online training is available, however, the processes for identifying clients who have a risk of violent or aggressive behavior were not consistently observed in the emergency departments. Continuing to roll this out, particularly in a high-risk area such as the emergency department, should be a priority for the organization. A number of the rural emergency departments have staff who are working alone, particularly on the night shift. The organization is encouraged to review its safety strategy for these staff to ensure that there are personal and site duress alarms or communication processes with a coordinated response, should a staff member require assistance.

There is no formal way to evaluate team functioning at this time. Some programs described using their staff meetings for this purpose, but this was not consistently observed. The majority of staff recognition happens peer to peer in an informal way. There is an opportunity to develop a formal recognition program that meets the needs of the programs and staff.

Priority Process: Episode of Care

The emergency departments use standardized assessment tools; although, they are not yet standardized across the region. Some sites are working with two versions of a document: the new PMH tool and the legacy organization tool. The departments should be supported to fully implement the new regional tools. Adult Canadian Triage and Acuity Scale (CTAS) guidelines are used and training is available through SPOT; although, there were occasions when nurses who have not been trained in CTAS might be triaging patients. There is an opportunity to increase focus on pediatric CTAS as a standard in triage documentation and assessment protocols. It would be beneficial to standardize the education and experience required to triage in the emergency department.

The organization has made an incredible effort to reduce wait times for patients who access the emergency department and to ensure that regular monitoring and re-assessment strategies are in place for those patients who wait for service. This work is admirable. However, at Dauphine Health Centre the clients waiting are monitored via remote TV, and reassessments are not completed. It will be helpful with the redevelopment to include a well designed triage and waiting area with a designated triage RN.

The clients interviewed felt extremely comfortable to ask for assistance and knew how to reach the staff and, in the majority of cases, which particular staff to speak with. Most clients felt they could ask anyone. However, some of the emergency departments have poor sight lines to the waiting rooms. In most cases they have made an effort to improve visibility, however, there are no standardized intervals and documentation of reassessment.

The majority of the assessment processes have existed for some time and were not developed with input from clients and families. As the region moves forward with standardizing care, there will be an opportunity to involve clients and families in these processes, and the organization is encouraged to do so.

In reviewing the compliance with the Required Organizational Practices (ROPs), there is an opportunity

for continued improvement. Medication reconciliation is not consistently in place, in particular for non-admitted high-risk patient populations. The organization has a plan for an universal approach to falls risk, however, currently legacy falls policies and processes remain. There is no standardized process followed in an emergency department for identification of high-risk populations or implementation of associated care plans. Most locations were aware of clients who expressed suicidal ideation and implement increased monitoring for those clients as well as access resources to support assessment and care planning. There is an opportunity to standardize assessment of suicide risk and formalize the associated approaches to care and management of clients in the emergency department.

Documentation at care transitions for inter-facility and intra-facility transfers is standardized. There is an opportunity to evaluate the effectiveness of these communication tools. Documentation provided to the primary care providers or teams for clients who are discharged is less consistent. There is access to the emergency department record for those general physicians (GPs) who are on the regional system which is a very efficient and comprehensive way to share information; however, this is not the case for all GPs and primary or home care teams. There are still some documents in place from the previous health authorities, prior to regionalization. The organization should continue to review and update these documents ensuring that they are aligned with best practice standards across the organization.

The organization is to be commended for the work it has done to minimize or eliminate offload delays. The EMS arrivals observed were efficient and effective, with patients primarily brought directly in to a treatment space and a verbal handover of care conducted between EMS and the primary nurse.

The frontline staff is aware of the processes for reporting safety incidents, close calls and critical incidents. There is a formal debriefing process for critical incidents and learnings are shared. There is no regular reporting for safety event trends, limiting the use of the system to drive quality improvement.

Dauphin emergency department is in the RFP stages for a redevelopment, which is desperately needed. At this time they are extremely constrained in terms of their physical layout and design. Entrances are not clearly marked and isolation within the emergency department at Dauphin is not currently possible given their physical space. However, it is anticipated that this will be resolved with the new development.

Priority Process: Decision Support

Only one site is on the Emergency Department Information System. The organization should ensure that this technology is spread across the region. There is good evidence that standardized policies, protocols and assessments are implemented within the emergency department setting. Some of the documentation is not regional (PMH) and reflects legacy organizations.

Client records are handled appropriately and follow legislative guidelines. Documentation practices are consistently strong. Clients and families are engaged in the process to obtain medical history, history of presenting complaint, medication information and other details related to the assessment process.

There is no evidence of a formal process to evaluate the effectiveness of transitions. There is some evidence of informal processes. There is an opportunity to focus on clients who have a high rate of re-visits as a starting point to understand the risks and implement strategies to mitigate those risks.

There is no formal risk for readmission tool in use at this time. The teams reported that there are known clients who are frequent visitors and there may be an opportunity to develop a process for shared care planning between the community providers, primary care, EMS and the emergency department in order to more effectively manage the care of this clients.

Priority Process: Impact on Outcomes

Quality improvement initiatives have largely been driven by recommendations from the Brian Sinclair Inquest, focusing on wait time improvement strategies. There is a regional pre-alert process and pre-notification process for EMS to call the emergency departments when they are ten minutes out. This call is documented and there is some evidence of an auditing process. Similarly, there is an initiative underway with the community GP's to have them call and notify when a patient is being sent in and what is the presenting complaint. There has been some auditing of this process.

There is some great work being done within the region to improve access to care for stroke patients. The EMS staff are well aware of the FAST protocol and the destination protocols related to stroke. Telehealth connectivity where purposes of acute stroke consultation has been completed in the two designated hyper acute stroke centres such as Brandon and Dauphin.

Overall there is limited evidence that evaluation metrics and outcomes are defined, measured, reported or evaluated. The sites have limited access to data and support to create the framework for measurement and monitoring of quality improvement initiatives. There are some excellent quality improvement initiatives underway, and this work should continue to be encouraged. The organization is strongly encouraged to support sites in the quality improvement work by providing assistance to increase the use of data and to provide the tools to share this data with front line staff.

Guidelines are reviewed and protocols are being updated, however there are still a number of legacy documents across the organization. There is an opportunity to involve client engagement facilitators as the protocols are being updated.

There is evidence of informal feedback and complaints being used to drive service improvements. There is an opportunity to further engage patients and families in formally obtaining feedback, whether through surveys or regular focus groups or post discharge follow up phone calls.

All of the emergency departments visited engage informally with clients and families, demonstrate respectful relationships and interactions throughout the assessment and care delivery processes. Clients expressed appreciation for the presence of emergency department services. There is public opposition to the idea of downsizing access to services even where visit volumes are extremely low and staffing is a significant challenge. Some of the smaller rural sites have been forced to implement closures due to limited staffing. As the organization moves forward with service reviews and program changes, it is

strongly encouraged to have a high degree of community involvement in creating new service delivery models. It will also be important to involve neighbouring emergency departments and EMS in these reviews and planning sessions. The organization should use quality indicators to drive this process.

Priority Process: Organ and Tissue Donation

There is limited applicability of this priority process to the emergency departments within PMH. The majority of sites are too far from Winnipeg to make organ donation a practical option. Brandon had good processes in place for eye tissue donation. Sites were aware of the provincial program, but due to the limited ability to arrange timely transport for potential donors the organization and sites have understandably not made this a priority area of focus.

Standards Set: Emergency Medical Services - Direct Service Provision

Unmet Criteria	High Priority Criteria
Priority Process: Clinical Leadership	
3.1 The team has a communications policy for sharing information and raising awareness about emergency medical services.	
3.4 The team meets cultural and language diversity within the community it serves.	
Priority Process: Competency	
7.1 The team leaders regularly evaluate the effectiveness of staff scheduling and make improvements.	
Priority Process: Episode of Care	
17.4 When using chemical or physical restraints to manage a violent patient, the EMS team follows medical policies or restraint protocols that are appropriate to the patient.	
18.1 Information relevant to the care of the client is communicated effectively during care transitions.	ROP
18.1.1 The information that is required to be shared at care transitions is defined and standardized for care transitions where clients experience a change in team membership or location: admission, handover, transfer, and discharge.	**MAJOR**
18.1.2 Documentation tools and communication strategies are used to standardize information transfer at care transitions.	**MAJOR**
18.1.5 The effectiveness of communication is evaluated and improvements are made based on feedback received. Evaluation mechanisms may include: • Using an audit tool (direct observation or review of client records) to measure compliance with standardized processes and the quality of information transfer • Asking clients, families, and service providers if they received the information they needed • Evaluating safety incidents related to information transfer (e.g., from the patient safety incident management system).	**MINOR**
Priority Process: Decision Support	

The organization has met all criteria for this priority process.

Priority Process: Impact on Outcomes	
22.2 The team uses the information and feedback it has gathered to identify opportunities for quality improvement initiatives.	
22.7 The team follows a process to regularly collect indicator data to track its progress.	

Priority Process: Medication Management

The organization has met all criteria for this priority process.

Priority Process: Infection Prevention and Control	
8.7 The organization measures its compliance with accepted hand-hygiene practices.	ROP
8.7.3 The organization uses the results of measuring hand-hygiene compliance to make improvements to its hand-hygiene practices.	**MINOR**
9.2 The team properly uses personal precautions and personal protective equipment.	
9.4 The team regularly receives immunizations against diseases as appropriate.	

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

The organization has strong clinical leadership in emergency medical services (EMS). Also there are passionate and supportive Medical Director of EMS in this organization and is highly dedicated to teams, education, and patient outcomes. It is recommended that the organization consider backup support for the one EMS Medical Director.

Pockets of EMS teams are producing some brilliant leading practice programs to their communities but the teams are not being recognized or shared broadly throughout the Prairie Mountain Health.

Priority Process: Competency

EMS operation staff are well supported by Prairie Mountain Health, including for new hires. Good process and practice is evident during staff orientation, education, collection of education practitioner success, completion and competency.

Priority Process: Episode of Care

A very strong 911 and emergency services Medical Transportation Coordination Centre (MTCC) dispatching service is found in this region. Operations staff feels very well supported by the dispatch team. Those seeking care receive prompt service by care providers and the anatomy of the call starts with the MTCC. Patients are in efficient, safety minded, highly educated, and practiced caring hands in this region. An area for improvement suggested is communication at care transitions.

Priority Process: Decision Support

Leaders in Prairie Mountain Health are quick to respond to the needs of operations staff when staff has an opportunity to share issues and ideas. One challenge is offering a process for information and communications that engage operations staff in the sharing of efficient and easy communication.

Priority Process: Impact on Outcomes

Another strong area for Prairie Mountain Health is that the MTCC dispatch center collects data related to performance measures and it is apparent that the organization is using some of this data to improve.

Priority Process: Medication Management

Prairie Mountain Health EMS does a good job along with its pharmacy partners to ensure a safe, simple and auditable tracking system for controlled drugs used by EMS.

Priority Process: Infection Prevention and Control

There are clear best practices for infection prevention and control in the EMS. Good education from EMS clinical educators is provided to front line staff.

An area and opportunity for improvement would be to evaluate and audit these best practices across Prairie Mountain Health sites.

Hand hygiene education is available through online learning modules. Alcohol based cleanser is readily available in the vehicles.

The Prairie Mountain Health Infection Prevention and Control Committee are working on plans to implement a hand hygiene audit but to date has not implemented an EMS initiative.

Safety glasses are not used consistently in practice. The use of safety glasses is loosely guided by call acuity and individual preference. During conversation with staff it was stated that the use of safety glasses was not used consistently and it was also noted during actual witnessed events or calls the same is true. Gloves are used consistently and are culturally accepted. Prairie Mountain Health does have a good process and guidance for the use of personal protective equipment (PPE) in EMS for specific communicable and infectious disease.

Standards Set: Home Care Services - Direct Service Provision

Unmet Criteria		High Priority Criteria
Priority Process: Clinical Leadership		
The organization has met all criteria for this priority process.		
Priority Process: Competency		
3.8	A documented and coordinated approach for infusion pump safety that includes training, evaluation of competence, and a process to report problems with infusion pump use is implemented.	ROP
3.8.5	The effectiveness of the approach is evaluated. Evaluation mechanisms may include: • Investigating patient safety incidents related to infusion pump use • Reviewing data from smart pumps • Monitoring evaluations of competence • Seeking feedback from clients, families, and team members.	**MINOR**
3.8.6	When evaluations of infusion pump safety indicate improvements are needed, training is improved or adjustments are made to infusion pumps.	**MINOR**
3.10	Team member performance is regularly evaluated and documented in an objective, interactive, and constructive way.	!
3.12	Team members are supported by team leaders to follow up on issues and opportunities for growth identified through performance evaluations.	!
4.5	Standardized communication tools are used to share information about a client's care within and between teams.	!
4.6	The effectiveness of team collaboration and functioning is evaluated and opportunities for improvement are identified.	
5.1	The workload of each team member is assigned and reviewed in a way that ensures client and team safety and well-being.	
Priority Process: Episode of Care		
7.12	Ethics-related issues are proactively identified, managed, and addressed.	!
8.5	Standardized clinical measures are used to evaluate the client's pain in partnership with the client and family.	

8.6	When medication management is a component of care (or deemed appropriate through clinician assessment), a Best Possible Medication History (BPMH) is generated in partnership with clients, families, or caregivers (as appropriate) and used to reconcile client medications.	ROP
8.6.4	When medication discrepancies are resolved, the current medication list is updated and provided to the client or family (or primary care provider, as appropriate) along with clear information about the changes.	**MINOR**
8.7	To minimize injury from falls, a documented and coordinated approach for falls prevention is implemented and evaluated.	ROP
8.7.1	A documented and coordinated approach to falls prevention is implemented.	**MAJOR**
8.7.2	The approach identifies the populations at risk for falls.	**MAJOR**
8.7.3	The approach addresses the specific needs of the populations at risk for falls.	**MAJOR**
8.7.4	The effectiveness of the approach is evaluated regularly.	**MINOR**
8.7.5	Results from the evaluation are used to make improvements to the approach when needed.	**MINOR**
8.8	An interprofessional and collaborative approach is used to assess clients who need skin and wound care and provide evidence-informed care that promotes healing and reduces morbidity and mortality.	ROP
8.8.7	There is a process to share information between providers, especially at care transitions, about the client's skin and wound care.	**MAJOR**
8.8.8	The effectiveness of the skin and wound care program is monitored by measuring care processes (e.g., accurate diagnosis, appropriate treatment, etc.) and outcomes (e.g., healing time, pain, etc.) and this information is used to make improvements.	**MINOR**
9.2	Working in partnership with clients and families, at least two person-specific identifiers are used to confirm that clients receive the service or procedure intended for them.	ROP
9.2.1	At least two person-specific identifiers are used to confirm that clients receive the service or procedure intended for them, in partnership with clients and families.	**MAJOR**
9.6	Client progress toward achieving goals and expected results is monitored in partnership with the client, and the information is used to adjust the care plan as necessary.	

9.10	Information relevant to the care of the client is communicated effectively during care transitions.	ROP
	9.10.1 The information that is required to be shared at care transitions is defined and standardized for care transitions where clients experience a change in team membership or location: admission, handover, transfer, and discharge.	**MAJOR**
	9.10.2 Documentation tools and communication strategies are used to standardize information transfer at care transitions.	**MAJOR**
	9.10.4 Information shared at care transitions is documented.	**MAJOR**
	9.10.5 The effectiveness of communication is evaluated and improvements are made based on feedback received. Evaluation mechanisms may include: • Using an audit tool (direct observation or review of client records) to measure compliance with standardized processes and the quality of information transfer • Asking clients, families, and service providers if they received the information they needed • Evaluating safety incidents related to information transfer (e.g., from the patient safety incident management system).	**MINOR**
10.7	The effectiveness of transitions is evaluated and the information is used to improve transition planning, with input from clients and families.	
Priority Process: Decision Support		
11.2	A standardized set of health information is collected to ensure client records are consistent and comparable.	
11.5	Information is documented in the client's record in partnership with the client and family.	
11.8	There is a process to monitor and evaluate record-keeping practices, designed with input from clients and families, and the information is used to make improvements.	!
Priority Process: Impact on Outcomes		
13.1	There is a standardized procedure to select evidence-informed guidelines that are appropriate for the services offered.	!
13.2	The procedure to select evidence-informed guidelines is reviewed, with input from clients and families, teams, and partners.	
13.3	There is a standardized process, developed with input from clients and families, to decide among conflicting evidence-informed guidelines.	!

13.4	Protocols and procedures for reducing unnecessary variation in service delivery are developed, with input from clients and families.	!
15.4	Indicator(s) that monitor progress for each quality improvement objective are identified, with input from clients and families.	
15.5	Quality improvement activities are designed and tested to meet objectives.	!
15.6	New or existing indicator data are used to establish a baseline for each indicator.	
15.8	Indicator data is regularly analyzed to determine the effectiveness of the quality improvement activities.	!
15.10	Information about quality improvement activities, results, and learnings is shared with clients, families, teams, organization leaders, and other organizations, as appropriate.	
15.11	Quality improvement initiatives are regularly evaluated for feasibility, relevance, and usefulness, with input from clients and families.	

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

The services provided in the Home Care Program are meeting the needs of the clients in the community. Strong partnerships exist in each community which enables referrals to other agencies when the program cannot meet a particular client need.

There is evidence that services are reviewed and monitored for appropriateness. This process may benefit from staff having standardized criteria or a decision making framework. Establishing, collecting and monitoring key performance indicators related to service appropriateness could also ensure all clients are receiving an appropriate level of service and that all resources are fully utilized.

The program is encouraged to partner with clients/families and staff as partners in setting the goals and objectives for Home Care at PMH.

Priority Process: Competency

Clients express deep appreciation for the staff that provide their services. They feel they are listened to and that staff are professional, competent and respectful of their needs and wishes. The program is to be commended for conducting such an extensive consultation with clients to gain feedback about the programs and services provided.

The Home Care Program is encouraged to ensure they are celebrating accomplishments and recognizing staff contributions frequently. Staff express feeling overwhelmed with the amount of change that the

organization is going through. Engaging staff in the change efforts and identifying what success looks like can provide opportunities for staff to feel as though they are connected to and accountable for the success of the organization.

Education related to the ethical decision-making framework has been delivered to staff and that has influenced awareness. Giving staff opportunities to practice applying the framework to experiences relevant in Home Care may help staff gain the confidence needed to bring ethical issues forward.

In Home Care there are often cases when the same client is receiving nursing and support services. A client's experience and their health outcomes can be positively influenced when team members have effective mechanisms by which to share information with each other and the client. Clients expect that team members from the same organization work together and that information about them travels quickly. The program is encouraged to ensure that the flow of information is efficient and that steps in that process and the mechanisms that support it are evaluated to ensure that they add value to the client.

Priority Process: Episode of Care

A significant achievement of the Home Care Program at PMH rests in the response time to service. Case Coordinators are very responsive to requests for services and the entire team prioritizes getting services in place for clients quickly.

When it comes to determining eligibility for service, the Home Care Program could benefit from a standardized criteria and process to ensure all relevant questions are asked and that decisions of eligibility or ineligibility are consistent. Doing so may decrease potential inequities across the region.

When asked, most clients are familiar with and are often in contact with their Case Coordinator throughout their service period. Most have been provided with information about their rights and responsibilities. Examples were provided from clients where they felt very comfortable calling the Case Coordinator if there was anything they were concerned about.

The Home Care Program is encouraged to consistently engage with clients in setting the goals and expected results of the care that is being provided. Establishing goals in partnership with clients and then monitoring progress towards those goals will ensure that the care being provided is appropriate and based on a shared understanding of the client's needs.

Most home care clients visited were at risk of falling. The program is encouraged to prioritize the implementation of the falls prevention program in partnership with clients and staff. The program is also encouraged to select 1-2 key performance indicators to monitor related to falls so that teams and clients can observe the impact of their efforts and make improvements if necessary.

Priority Process: Decision Support

As in other care settings, the client record plays a critical role in Home Care. There is good evidence to suggest that the client record at the sites is complete and that it contains appropriate documentation of but not limited to history, decisions, assessment, service delivery activities and observations. All of this information is essential to decisions that must be made related to client care. There is an opportunity for the Home Care Program to review how the client record is organized and assembled to ensure that the information contained in that record can be easily retrieved and referenced.

The organization is also encouraged to evaluate the effectiveness of having parts of the client record in multiple areas. Decision making and communication may be better enabled if the complete client record was easily accessible to the client and all relevant members of a client's care team.

Priority Process: Impact on Outcomes

The organization is to be congratulated for putting such a significant effort into gathering input from their home care clients. This information has prompted the creation of several action plans and activities.

It is evident that the Home Care Program has started to engage in an effort to improve the quality of their services. The program is encouraged to work with clients and staff to select key indicators that would bring focus to improvement efforts. The selection of these indicators could then form the basis for a scorecard that could be used to display performance over time and communicate the level of progress to staff and clients.

All sites are encouraged to ensure that patient safety incidents are analyzed, trended and discussed with client care teams. This process would create the space for staff to bring their expertise on how to reduce patient safety incidents to the table.

Standards Set: Hospice, Palliative, End-of-Life Services - Direct Service Provision

Unmet Criteria		High Priority Criteria
Priority Process: Clinical Leadership		
2.4	There are policies and resources in place to support the volunteer component of hospice palliative and end-of-life services.	
2.5	There is a designated person to oversee and lead hospice palliative and end-of-life volunteer services.	
Priority Process: Competency		
3.14	Team member performance is regularly evaluated and documented in an objective, interactive, and constructive way.	!
4.4	Standardized communication tools are used to share information about a client's care within and between teams.	!
5.4	Team members, informal caregivers, and volunteers are assisted to cope with the dying or grieving experience and the cumulative deaths of clients.	
Priority Process: Episode of Care		
6.7	In cases where access to hospice, palliative, and end-of-life services are coordinated through a single point of entry, there is a process to link with this point of entry in order to respond appropriately for requests for service.	
9.1	The client's individualized care plan is followed when services are provided.	
9.11	Information relevant to the care of the client is communicated effectively during care transitions.	ROP
9.11.1	The information that is required to be shared at care transitions is defined and standardized for care transitions where clients experience a change in team membership or location: admission, handover, transfer, and discharge.	**MAJOR**
Priority Process: Decision Support		
	The organization has met all criteria for this priority process.	
Priority Process: Impact on Outcomes		

16.3	Measurable objectives with specific timeframes for completion are identified for quality improvement initiatives, with input from clients and families.	!
16.4	Indicator(s) that monitor progress for each quality improvement objective are identified, with input from clients and families.	
16.5	Quality improvement activities are designed and tested to meet objectives.	!

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

The team, whose current mandate is mostly an expert counsel role, partners with other programs such as home care as well as other hospital units to ensure a roll-out of the palliative-end of life approach to services provided.

Volunteers in the palliative program in the community are recruited and managed by partnering community organizations. The organization is in the process of recruiting a part-time resource to coordinate the activities of these partner organizations. The organization is encouraged to pursue this position in order to provide training and guidance to these organizations as well as to ensure a consistent quality and appropriateness in the volunteers actions.

The organization is reviewing its structure of coordinators and clinical resource nurses in order to be able to provide more equitable and more consistent service throughout the region. This process is being done with input from existing team members as well as feedback from patients.

Priority Process: Competency

The team provides education and training on the organization's care delivery model in palliative care. In addition to the dedicated unit at the Brandon Regional Health Centre, palliative care beds are spread throughout the region, making it difficult to ensure a standardize approach. The imminent restructuring of the coordination and clinical resource nurse roles will contribute to this standardization.

A harmonization of the medical vision to palliative care would also be advisable. Feedback from patients at the Brandon Regional Health Centre indicate that conflicting information and medical treatment plan could occur when the treating physician is rotated.

Team members indicate that performance conversations are in the beginning phases to be implemented.

Client and their families are an integral part of palliative treatments.

A very informal support is given to team members usually by the supervisor. The team is encouraged to develop formal and permanent support systems to assist staff, volunteers and others cope with the emotional nature of their work.

Priority Process: Episode of Care

Access to the palliative team's services have recently been widened. The team no longer includes a prognosis in its acceptance criteria.

Services in Brandon, as well as new referrals to the palliative care program are coordinated through a single point of entry. However, in other parts of the Region, it is possible for patients to be admitted to reserved palliative care beds directly, without the knowledge of the program team.

Informed consent, for home care patients, is obtained verbally.

The team indicates that there have not been research activities in this program in recent years.

It would be advisable to ensure the continuity and consistency of care plans among team members, including medical staff.

Clients and families are encouraged, to the extent to which they desire, to be involved in their treatments. Feedback from clients indicate satisfaction in the process, and that team members respect their wishes for the level of service required.

Priority Process: Decision Support

Record keeping systems vary within the region. The team is encouraged to develop a standardized communication tool in order to ensure the transfer of a standardized minimum set of data, between, for example the palliative care team and the home care team and between the palliative team and other palliative care beds in the region.

Priority Process: Impact on Outcomes

The team is encouraged to seek opportunities for networking with other organizations in order to be able to share learnings, benchmark and ensure that they are current on latest evidence-based practices.

Incident reporting is done through the PMH system, and data from patient experience surveys is used to guide planning and improvement.

The team is encouraged to set program objectives as well as indicators to measure progress toward these objectives in order to guide in its activities.

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

Unmet Criteria		High Priority Criteria
Priority Process: Infection Prevention and Control		
7.2	The organization has or follows an immunization policy to screen and offer vaccinations to staff and service providers.	!
7.5	The organization follows its policies, procedures, and legal requirements when handling bio-hazardous materials.	!
7.7	The organization uses safety engineered devices for sharps.	!
8.3	The organization's staff, service providers, and volunteers have access to alcohol-based hand rubs at the point of care.	!
8.4	The organization's staff, service providers, and volunteers have access to dedicated hand-washing sinks.	
8.6	The organization measures its compliance with accepted hand-hygiene practices.	ROP
8.6.1	The organization measures its compliance with accepted hand-hygiene practices using direct observation methods (e.g., audit). For organizations that provide services in clients' homes, a combination (two or more) of alternative methods may be used.	**MAJOR**
8.6.2	The organization shares the results of measuring hand-hygiene compliance with staff, service providers, and volunteers.	**MINOR**
8.6.3	The organization uses the results of measuring hand-hygiene compliance to make improvements to its hand-hygiene practices.	**MINOR**
14.5	The organization shares evaluation results with staff, service providers, volunteers, clients, and families.	

Surveyor comments on the priority process(es)

Priority Process: Infection Prevention and Control

The Infection Prevention & Control (ICP) team consists of nine Full-time equivalent (FTE) regional infection control practitioners supported by a dedicated administrative support. There has been a modest improvement in FTEs since the last survey. The interdisciplinary team meets regularly with

established terms of reference. Partnerships are apparent with Public Health, Environmental Services and Occupational Health and Safety. The Medical Officer of Health participates in the meetings, in addition to diverse members from Prairie Mountain Health (PMH). This team attends the provincial infection prevention and control (ICP) meetings, where evidence-based practice and service decisions are driven.

The IPC team has had many successes since the last survey. Since the last survey, orientation and training of staff are incorporated and provided consistently. Since September, regional orientation has standardized the training for new staff. A personal protective equipment (PPE) lanyard tag was created. New policies have been established which include routine practices, single use device, surveillance, and surgical site infection (SSI) among others.

Releasing Time to Care (RTC) has been observed to reduce clutter in units, organize and improve efficiency and safety for staff. This has been a positive engagement process with excellent results in the units which are engaged in this. It is hoped that this initiative spread throughout the region. There is a notable difference between units when RTC has not been adopted.

Manitoba recently stopped isolating and screening for Vancomycin-resistant Enterococci (VRE), which was a provincial decision. This is evidence of the teams having regular review of evidence-based practices.

In 2014/15, PMH encountered 40-50 outbreaks regionally. In response to this, the IPC developed a new protocol for ensuring notification of outbreaks in a timely manner. This includes ensuring ICPs are copied on microbiology results. Further, staff are to send written notification of patient's results when positive, to the ICP. This is evidence of a quality improvement initiative in response to the increase in the number of outbreaks seen in that year. In 2015/16, the number of outbreaks has been reduced to 10-15.

It is noted that the hand hygiene policy has been improved, although implementation of the policy is not consistently seen throughout the region. Although a baseline audit was completed in December, 2015, there have been no further hand hygiene audits completed. The organization should focus on measuring hand hygiene rates more frequently than annually. Visibility of unit results should be more readily available for staff. Higher engagement is required to ensure optimal hand hygiene rates are achieved. Improvements in the locations of alcohol-based hand rubs would likely result if staff had more frequent audits. Currently, there are many sites where there are no alcohol-based hand rubs available at point of care or in each patient room.

There are limited hand-washing sinks in the older units. Further, in many locations, spray wands have yet to be capped off, despite a recommendation from the previous survey. In Killarney, the main clean supply must be separated from the traffic of the garbage containers going through the room.

The Environmental Services team has robust policies and procedures for cleaning of multiple areas. Staff performance against the policies are audited regularly. There is on-line PIDAC training (6 modules) which the staff must attend. The team provide "SAY it" (someone appreciates you)cards to acknowledge good

performance. Recently, managers have acknowledged staff with excellent attendance records. There is evidence of consistent cleaning practices throughout the region. The team should be commended for this improvement.

Laundry is done internally. Concern has been raised about the need to replace the washers and dryers that support all laundry done at BRHC.

Incineration of biohazards are done on-site.

The kitchen standards are audited regularly by the public health inspector with positive results.

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

Unmet Criteria		High Priority Criteria
Priority Process: Clinical Leadership		
The organization has met all criteria for this priority process.		
Priority Process: Competency		
3.15	Team member performance is regularly evaluated and documented in an objective, interactive, and constructive way.	!
Priority Process: Episode of Care		
8.8	Clients are assessed and monitored for risk of suicide.	ROP
	8.8.1 Clients at risk of suicide are identified.	MAJOR
	8.8.2 The risk of suicide for each client is assessed at regular intervals or as needs change.	MAJOR
Priority Process: Decision Support		
The organization has met all criteria for this priority process.		
Priority Process: Impact on Outcomes		
17.8	Indicator data is regularly analyzed to determine the effectiveness of the quality improvement activities.	!
17.9	Quality improvement activities that were shown to be effective in the testing phase are implemented broadly throughout the organization.	!

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

There were 14 sites visited. There are variation in the age, design and size of facilities across the region. All homes visited were well maintained, secure, clean and provided a home like environment. Residents are encouraged to personalize their space. Input is sought from residents and families on the design of space and need to change space to accommodate resident's needs. Opportunities for input is provided through resident/family councils at the sites and through satisfaction surveys.

Facilities have been upgraded to address changing needs such as secure units for wandering residents and installation of ceiling lifts for transferring safely.

The long term care leadership team have been focusing on reviewing and standardizing policies and procedures across PMH. Although there are many PMH policies in place there is significant work to be done. The team is encouraged to complete standardization in a timely manner and develop a communications plan to ensure staff are engaged and aware.

Feedback from residents, families and the community is used to improve the environment. Partnerships are developed at the local level. Community group initiatives such as secure gardens and palliative care rooms have been developed with community support. In Fairview the foundation supported a guest room that is available to residents families at a nominal cost to use when their family member is visiting.

The team uses information from a variety of areas such local data on wait times and type of service. A significant gap was identified regarding the need for services for clients with aggressive and challenging behaviours. The team is encouraged to explore and advocate for opportunities to address the need for this service.

Information is provided to residents and families in the form of a Personal Care Home (PCH) booklet, through email, letters and one on one meetings and resident/family council. Residents council participates very actively in the planning of most activities, from outings, to menu choices, and to building changes and improvements.

A comprehensive resident information package is available.

For safety, all doors are locked at night. All residents are evaluated for fall and pressure ulcer risk upon admission.

Suicide risk assessment is being rolled out and not yet in application.

Priority Process: Competency

The team roles and responsibilities were defined, and work assignments were done according the mix of the team, considering the scope of practice of each member. Although there were some variation in the makeup of the teams across the sites resources were matched to meet the clients' needs.

The teams at the sites visited demonstrated a collaborative approach in planning and delivering care in order to attain the objectives set out in the treatment plans. Team members were very complimentary of each other and identified the value of working together.

Residents and family members met with during the site visit indicated that they were involved in decisions about their care and their input was considered in how care was provided.

Staff receive training through the SPOT system. Education was provided on many areas such as safe resident handling, restraints, abuse, etc. Staff across sites consistently indicated they were supported to do training both through e-learning and to attend sessions at their sites and the region.

Training is provided to staff on managing resident aggression.
Risk management of residents identified to have potential for violence was consistent across sites though using a purple flag symbol which was placed on the file and outside the resident room so staff and visitors were alerted before approaching them. Staff with PIECES training are available to deal with aggressive behaviors.

The staff were aware of the ethical framework and identified how they used it to discuss issues identified. Most issues were resolved within the team however, they were aware they had access to a regional resource if needed.

Performance reviews were not completed consistently across the sites. "Performance conversations" is a new approach to provide staff with feedback, and it sets to be rolled out across all the sites. However, thus far only a handful of employees have had their conversation. The team is encouraged to move this performance review initiative forward and track the effectiveness of it.

Residents and families receive information through a variety of means such as email, letters, notices and resident and family councils. All sites had resident/family councils that were used to share information and get feedback and input on changes from residents and families. There were examples of changes that were made as a result of input from residents/family councils such as space improvements and menu changes and improvements to meal temperatures.

Priority Process: Episode of Care

A comprehensive resident assessment is completed on admission which includes a falls risk assessment, pressure ulcer risk and medication reconciliation. Sites are engaged in the pre-admission process. The team completes a comprehensive assessment within 24-48 hours of admission and a care conference is held within the first 8 weeks of admission.

There is a standardized process involving the interdisciplinary team reviewing residents care plans and a quarterly medication review is completed with the physician and pharmacist. An annual care conference is held with the resident and family.

The team identified that there are challenges with meeting the needs of clients with aggressive/challenging behaviors. The team reviews these cases and makes recommendations for alternative services. This has been identified as a gap in service by the leadership team. A proposal is being developed to identify options to create capacity to address this gap.

Staff and management appear to be very transparent in providing clinical as well as administrative information to residents and seek input from them. Residents were engaged in decisions about their care and families were informed when conditions changed. The Resident Bill of Rights was posted in a visible area at all sites.

There is no signed informed consent in files. According to PMH policy, written informed consent is not required for long term care services.

The staff were observed to treat residents in a respectful and caring manner. Feedback from the residents and families during the tracers was positive and they were aware of how to get issues/concerns addressed.

There were no research activities ongoing in long term care. The team is encouraged to participate in research opportunities to have a positive impact on the resident.

There were a number of indicators being tracked across site including falls, restraints, aggressive incidents, medication reviews etc. This data is collected and analyzed quarterly. There was not widespread awareness of the data at the site level and not all sites are currently tracking the same information. The team is encouraged to identify key indicators and track across long term care and share results at site level inform areas for improvement.

A suicide risk assessment is currently not being completed on residents. The PMH suicide risk strategy is being rolled out. A suicide assessment guide has been developed for long term care and is currently in draft. This team is encouraged to implement this tool and evaluate it. While suicide risk is not systematically addressed, when clients are identified to be at risk interventions are put in place and staff consulted to develop a plan to reduce risks. The team is encouraged to implement the suicide assessment tool in a timely manner. A psycho-geriatric nurse is present one day a week to address the needs of the residents at most sites.

Oral hygiene of residents is facilitated by assisting with accessing dental professionals. However, there is no systematic oral hygiene program.

The team regularly reassesses the possibility to apply the minimum restraint. Medications, including anti-psychotic medications are reviewed at all resident's quarterly care plan review. This is done individually for residents and has been tracked for several PCH's in the region for comparison and to reduce use. The team is encouraged to share this data and use it to identify areas for improvement.

Residents participate very actively in choice of food and meals and this is discussed at resident and family council meetings. Menus were adapted with input from residents.

There were several quality improvement initiatives identified by the team. A Falls reduction initiative was implemented as the Carberry site with a target to reduce falls by 20%. Initiatives to reduce falls were implemented and resulted in a reduction of 17%. The team is encouraged to share the results across sites to increase spread of implementation.

Similar tools are used across sites for resident assessment however some tools vary as the former organizations tools are still in use. There is an ongoing initiative to standardize assessment tools across all sites.

The team were engaged in providing palliative care across all sites and areas had been developed to provide space for families to stay on site when their loved ones were end of life.

There were active recreation programs in LTC and residents were consulted regarding what type of activities they were interested. Families and residents indicated they were pleased with the services provide. Volunteers were engaged in assisting to enhance programs were possible.

Dining experience was highlighted as an area that had been reviewed and a change in practice had been implemented where residents went to the dining room for all meals. Residents that are unwell or prefer not to go to the dining room are accommodated where possible.

Priority Process: Decision Support

The team identified the need for technology to improve the collection and analysis of data to plan and improve care delivery.

Documentation, except for incident reporting, is all paper-based. The electronic point click care is used at the affiliate Dinsdale Personal Care Home. The incident report information is collected and some reports provided back to the site. The team is encouraged to use the data to identify area for improvement and benchmark it across the sites.

The records are kept in good order and up to date. There are different documents in use from former organizations and PMH are currently reviewing a charting system. A list of standard chart content is inserted in the beginning of each resident file. The team is encouraged to move forward with adopting a standardized documentation system.

Residents interviewed during the tracer indicated they were involved in their care plan and had input at their care conference. Residents were aware that they could access their chart.

Staff were aware of the privacy policy and took measures to protect resident information. Several initiatives such as using symbols to identify residents with aggression and potential choking were implemented.

There is ethics framework and process to identify issue that require ethical consideration. There is an ethics team that is consulted and several examples of consultation to resolve issues were identified.

Priority Process: Impact on Outcomes

A safety handbook is provided to residents and families and discussions with them around safety practices.

Incidents are disclosed to the residents and family and appropriate follow up initiated. Satisfaction surveys are completed annually and reviewed to determine areas for improvement. The results are share

with the sites to identify areas for improvement. Resident and family council is used as an avenue to get ongoing feedback.

With the previous incident report system, the organization generated audit data for baseline and indicator of progress, as well as aggregate data information to guide quality improvement activities. The new roll out of the PMH risk management system has started to develop indicator reports; however, this has not been shared widely at the site level.

The site engages in elements of quality improvement which would be enhanced by a more robust process of objective setting and rapid cycle testing.

Standards Set: Medication Management Standards - Direct Service Provision

Unmet Criteria		High Priority Criteria
Priority Process: Medication Management		
2.3	The organization has a program for antimicrobial stewardship to optimize antimicrobial use. NOTE: This ROP applies to organizations providing the following services: inpatient acute care, inpatient cancer, inpatient rehabilitation, and complex continuing care.	ROP
2.3.2	The program includes lines of accountability for implementation.	**MAJOR**
2.3.5	The organization establishes mechanisms to evaluate the program on an ongoing basis, and shares results with stakeholders in the organization.	**MINOR**
2.4	The interdisciplinary committee establishes procedures for each step of the medication management process.	!
2.5	The organization implements a comprehensive strategy for the management of high-alert medications.	ROP
2.5.2	The policy names the individual(s) responsible for implementing and monitoring the policy.	**MINOR**
2.5.5	The organization limits and standardizes concentrations and volume options available for high-alert medications.	**MAJOR**
2.5.8	The organization provides information and ongoing training to staff on the management of high-alert medications.	**MAJOR**
2.8	The interdisciplinary committee standardizes critical information found in medication orders, medication labels, and medication administration records.	
2.15	The interdisciplinary committee develops a process to determine which medications can be stored in client service areas.	
2.16	The interdisciplinary committee monitors compliance with each step of the medication management process.	
4.2	If required, the organization provides training on a new medication before it is used.	!

9.4	The organization evaluates and limits the availability of narcotic (opioid) products to ensure that formats with the potential to cause harmful medication incidents are not stocked in client service areas.	ROP
9.4.2	The organization avoids stocking the following narcotic (opioid) products in client service areas: • Fentanyl: ampoules or vials with total dose greater than 100 mcg per container • HYDROmorphone: ampoules or vials with total dose greater than 2 mg • Morphine: ampoules or vials with total dose greater than 15 mg in adult care areas and 2 mg in paediatric care areas.	**MAJOR**
9.4.3	When it is necessary for narcotic (opioid) products to be available in selected client service areas, the organization's interdisciplinary committee for medication management reviews and approves the rationale for availability and safeguards put in place to minimize the risk of error.	**MAJOR**
11.1	The organization sets soft and hard dose limits for high-alert medications in the smart infusion pumps.	!
11.2	The organization has a policy for when and how to override smart infusion pump alerts.	!
11.3	The organization has a process to regularly update the medication information stored in the smart infusion pumps.	!
11.4	The organization regularly tests the limits set for soft and hard doses to make sure they are working in the smart infusion pump.	!
11.5	The organization regularly reviews the limits set for soft and hard doses and makes changes as required.	
12.1	The organization limits access to medication storage areas to authorized staff and service providers.	!
12.3	The organization maintains appropriate conditions in the medication storage areas to protect the stability of medications.	
12.6	The organization separates look-alike, sound-alike medications; different concentrations of the same medication; and high-alert medications in the pharmacy and client service areas.	!
12.8	The organization minimizes the use of multi-dose vials in client service areas.	!

12.9	The organization evaluates and limits the availability of concentrated electrolytes to ensure that formats with the potential to cause harmful medication incidents are not stocked in client service areas.	ROP
	12.9.3 When it is necessary for concentrated electrolytes to be available in selected client service areas, the organization's interdisciplinary committee for medication management reviews and approves the rationale for availability and safeguards put in place to minimize the risk of error.	**MAJOR**
12.10	The organization regularly inspects its medication storage areas and makes improvements if needed.	
13.3	The organization stores chemotherapy medications in a separate negative pressure room with adequate ventilation segregated from other supplies.	!
13.4	The organization stores anaesthetic gases and volatile liquid anesthetic agents in an area with adequate ventilation as per the manufacturer's instructions.	!
14.6	The organization has identified and implemented a list of abbreviations, symbols, and dose designations that are not to be used in the organization.	ROP
	14.6.2 The organization implements the Do Not Use List and applies this to all medication-related documentation when hand written or entered as free text into a computer.	**MAJOR**
14.7	The organization has a policy for responding to telephone and verbal orders for medications.	!
14.9	The organization regularly audits a sample of medication orders to verify compliance with existing criteria and makes improvements as needed.	!
15.1	The pharmacist reviews prescription and medication orders within the organization prior to administration of the first dose.	!
16.3	The organization has a separate negative pressure area with a 100 percent externally-vented biohazard hood for preparing chemotherapy medications.	!
16.4	The organization has a separate area with a certified laminar air flow hood for preparing sterile products and intravenous admixtures.	!
17.1	The organization labels all medication packages/units in a standardized manner.	!
18.2	The pharmacy team dispenses medications in unit dose packaging.	!

18.3	The pharmacy team dispenses emergency, urgent, and routine medications within the timelines set by the organization.	
19.1	When the pharmacy is closed, the organization provides designated staff and service providers with controlled access to a night cabinet or automated dispensing cabinets for a limited selection of urgently required medications.	
21.1	Service providers provide clients and families with information on their medications prior to the initial dose, and when the dose is adjusted, and document this information.	!
23.3	Service providers seek an independent double check before administering high-alert medications at the point of care.	!
25.2	The interdisciplinary committee reviews medication errors and near misses to identify and address areas for improvement.	!
25.3	The interdisciplinary committee determines which staff and service providers to involve in the review of medication errors and near misses.	
25.4	The interdisciplinary committee provides staff and service providers with regular feedback about medication errors and near misses, and risk reduction strategies that are being implemented.	
26.1	The organization informs staff and service providers on the value of reporting adverse drug reactions to Health Canada specifically unexpected or serious reactions to recently marketed medications, and their role in reporting this information.	
26.2	The organization provides staff and service providers with information on how to detect and report adverse drug reactions to Health Canada Vigilance Program.	
27.2	Where medication management processes are contracted to external providers, the organization establishes and maintains a contract with each provider that requires consistent levels of quality and adherence to accepted standards of practice.	
27.3	Where medication management processes are contracted to external providers, the organization regularly monitors the quality of services provided.	
27.4	The interdisciplinary committee regularly completes a comprehensive evaluation of its medication management system.	

Surveyor comments on the priority process(es)

Priority Process: Medication Management

The Prairie Mountain Health has a dedicated pharmacy staff and strong leadership that have enabled implementation of numerous improvements since regionalization. The standardization to one pharmacy computer system was a significant undertaking that set the groundwork for a number of additional improvements including the ability to receive and enter orders at any site for another site. Additional functionality is expected to be incorporated to include alerts for drug interactions and dose range checking.

Formation of the interdisciplinary Pharmacy and Therapeutics Committee and the Medication Systems Safety Committee (MSSC) has proved foundational for making improvements to the medication system. A significant success was the implementation of one regional formulary as it is one of those key initiatives to standardizing and reducing variation across the system. As the Directors of Pharmacy across the province meet regularly, leveraging some of the work of other health authorities on formulary management and utilization might be considered.

The implementation of the Antimicrobial Stewardship Program is to be commended and the ongoing work of this team will be important to ensure the appropriate and cost effective use of antimicrobials. Accountability for implementation and measuring the success of the program overall should be clearly delineated.

Work has started on initiating a Nursing Pharmacy Committee to address standardization of medication policies and processes for the entire system. This work is encouraged to be moved forward and can be prioritized according to risk for approval and implementation. The trends from incident occurrences involving medications can be used to help with this.

A number of regionalized medication policies and procedures have been approved and implemented since the amalgamation. These have addressed certain standards that were not met in the previous surveys. Policies such as regional on-call provision, medication order writing standards, and formulary decision making are relatively new and regionalized. Other policy areas such as controlled substance management, standardized labelling, high alert medications and verbal/telephone orders are drafted or approved but not implemented. The MSSC has recognized the need for comprehensive procedures for the entire medication management process. A formal Medication Management Action Plan has been created and many of the actions have been completed or are in progress. Continued work on this plan is imperative to ensure the safety of the medication system.

Infusion pumps have been standardized for the Region but not all sites that use the pumps have drug libraries, or the software to set dose limits and alerts. The updates for those libraries that do exist are done manually for each pump; however, there is the potential to do this wirelessly for all pumps. The organization is encouraged to start this process.

Work on limiting the availability of concentrated electrolytes and high dose narcotics has been initiated.

Audits have been completed and initiatives to provide alternate sources are in progress. The audits indicated specific units that still had electrolytes and high dose narcotics stocked in patient care areas and these were observed at the sites during the survey. The high alert policy has been approved but not yet implemented so there is inconsistency in the health authority in how these medications are handled. Implementation should be a high priority over the next few months.

A regional list of dangerous abbreviations has been implemented and a number of educational campaigns completed on individual problematic abbreviations with improved compliance. One audit has been completed in March 2016 and initiatives to improve compliance overall will be forwarded for consideration to the Medication System Safety Committee.

Drug Distribution Systems – The systems are more advanced at some sites like Brandon Hospital with automated dispensing cabinets and all oral unit dosed products. At other sites such as Minnedosa Health Centre, Swan Valley Health Centre and the Dauphin Regional Health Centre there is almost total reliance on a traditional/wardstock system using multiple day supplies of medications. With the purchase of a high volume automated unit dose packaging machine in Brandon there is potential for supplying patient specific strips for those sites that do not have automated dispensing cabinets, offering a safer system than currently exists. In some sites such as Dauphin Health Centre the medication carts are old, not locked or secured.

Sterile Compounding is variable across the region, with the most advanced being Brandon Regional Health Centre of the sites visited. There are minimal IV admixtures being prepared by pharmacy placing a heavy reliance on nursing to prepare their IV medications. At the Dauphin Regional Health Centre, the pharmacy space is extremely small not allowing for adequate and efficient workflow. The sterile compounding room does not meet USP 797 standards and requires additional space as well. The Swan Valley Health Centre Pharmacy has a sterile compounding space that has potential to meet the standards but is not used as does not have staff to compound chemotherapy products and relies on the Dauphin Regional Health Centre.

Standards Set: Medicine Services - Direct Service Provision

Unmet Criteria	High Priority Criteria
Priority Process: Clinical Leadership	
1.3 Service-specific goals and objectives are developed, with input from clients and families.	
Priority Process: Competency	
3.11 Team member performance is regularly evaluated and documented in an objective, interactive, and constructive way.	!
3.12 Client and family representatives are regularly engaged to provide input and feedback on their roles and responsibilities, role design, processes, and role satisfaction, where applicable.	
3.13 Team members are supported by team leaders to follow up on issues and opportunities for growth identified through performance evaluations.	!
4.5 The effectiveness of team collaboration and functioning is evaluated and opportunities for improvement are identified.	
Priority Process: Episode of Care	
1.7 Barriers that may limit clients, families, service providers, and referring organizations from accessing services are identified and removed where possible, with input from clients and families.	
8.5 A Best Possible Medication History (BPMH) is generated in partnership with clients, families, or caregivers (as appropriate) and used to reconcile client medications at care transitions.	ROP
8.5.4 The prescriber uses the Best Possible Medication History (BPMH) and the current medication orders to generate transfer or discharge medication orders.	**MAJOR**
8.6 To minimize injury from falls, a documented and coordinated approach for falls prevention is implemented and evaluated.	ROP
8.6.4 The effectiveness of the approach is evaluated regularly.	**MINOR**
8.6.5 Results from the evaluation are used to make improvements to the approach when needed.	**MINOR**

8.7	Each client's risk for developing a pressure ulcer is assessed and interventions to prevent pressure ulcers are implemented. NOTE: This ROP does not apply for outpatient settings, including day surgery, given the lack of validated risk assessment tools for outpatient settings.	ROP
8.7.2	The risk of developing pressure ulcers is assessed for each client at regular intervals and when there is a significant change in the client's status.	**MAJOR**
8.7.5	The effectiveness of pressure ulcer prevention is evaluated, and results are used to make improvements when needed.	**MINOR**
9.11	Information relevant to the care of the client is communicated effectively during care transitions.	ROP
9.11.4	Information shared at care transitions is documented.	**MAJOR**
9.11.5	The effectiveness of communication is evaluated and improvements are made based on feedback received. Evaluation mechanisms may include: • Using an audit tool (direct observation or review of client records) to measure compliance with standardized processes and the quality of information transfer • Asking clients, families, and service providers if they received the information they needed • Evaluating safety incidents related to information transfer (e.g., from the patient safety incident management system).	**MINOR**
10.8	The effectiveness of transitions is evaluated and the information is used to improve transition planning, with input from clients and families.	
Priority Process: Decision Support		
12.2	Policies on the use of electronic communications and technologies are developed and followed, with input from clients and families.	
Priority Process: Impact on Outcomes		
14.4	Safety improvement strategies are evaluated with input from clients and families.	!
15.5	Quality improvement activities are designed and tested to meet objectives.	!
15.9	Quality improvement activities that were shown to be effective in the testing phase are implemented broadly throughout the organization.	!

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

Medicine services are provided across the region in 20 acute-care facilities. The majority of medicine services are provided by family physicians and nursing staff in rural hospitals. However, the Brandon Health Centre also utilizes hospitalists to care for patients without a family physician and the Dauphin Regional health Centre utilizes a “Physician of the day model” to care for patients without a family physician.

The region has a mixture of facilities and units offering medicine services in buildings of varying age and design. There are renovation plans for the medicine unit at the Brandon hospital. While there has been input from staff and practitioners, there has not been a formal process to engage clients and families in the design of space and provision of medicine services at the Brandon hospital or consistently in other sites.

The region has implemented initiatives to improve the delivery of care to medical patients through the implementation of the "releasing time to care" of nursing service delivery. This has been met with varied success in different facilities.

An ongoing organizational challenge is the recruitment and retention of sufficient positions to provide sustainable medicine services across all of the facilities. This challenge was articulated on a variety of occasions by physicians and nursing staff over the course of the survey.

There are no consistent unit or facility specific goals and objectives for medicine services across the region. Individual facilities offer medicine services as part of the spectrum of care available to community members. However, there are no specific goals and objectives to guide the organization and delivery of medicine services at the unit, facility, or regional levels.

Priority Process: Competency

The delivery of medicine services within the regional health authority involves practitioners from a number of professional backgrounds. It also includes family physicians, internal medicine specialists, and dedicated hospitalists. The staff are all appropriately credentialed, privileged and have documentation of appropriate training and professional certification designation. While feedback from individual clients and their families is obtained on a regular basis, there is no mechanism across the region to engage clients and family representatives to provide input and feedback on the roles and responsibilities and role design of the clinical practitioners providing medicine services.

Currently, there is no formal palliative care program available to medicine patients within the region. However, staff has access to palliative care resources to meet the needs of their palliative and end-of-life patients.

Although there is a process for staff performance reviews, that includes a preliminary performance discussion and leading to formal performance review, this is being implemented inconsistently across the region. Numerous staff report that they have never had a performance review or have not had one in a number of years. The organization is encouraged to implement a consistent system of regular performance evaluations and performance reviews of staff. This is critical, not only for ensuring ongoing quality of care but for maintaining staff morale and engagement.

While there is no formal, region-wide mechanism for evaluation of team functioning, each site surveyed has implemented some form of team huddles or safety briefing or some other mechanism by which team members communicate around their functioning. These are used as an informal mechanism for identifying opportunities for improvements in team functioning.

Priority Process: Episode of Care

Medicine services are delivered in a variety of settings in facilities across the region. There are dedicated medicine wards within the acute care hospitals in Brandon, and often medicine services are offered on general inpatient wards in the rural hospitals across the region. A variety of specialized and general duties of clinical staff are involved in the delivery of medicine services. In addition, certain medical services are provided by a blend of family physicians, internal medicine specialists, and hospitalists. Overall, the staff reports that they have access to decision-support tools that allow them to provide high-quality medical for patients presenting with a wide range of medical conditions. They are also well trained and have access to training courses and up-to-date information.

The Patient Safety Handbook (Acute Care) is reviewed and provided to all admitted patients. All patients sign the patient safety information sheet to confirm their understanding of their requirements as patients.

The organization has implemented a number of strategies to maintain patient safety, such as the use of routine screening tools for risk of development of pressure ulcers, the risk of falls, and risk of thromboembolism. These strategies, however, have not been uniformly and consistently implemented across the region. Audits have been done of compliance and targeted units have been identified for follow-up and improvement initiatives. The organization is encouraged to ensure full implementation of the strategies.

The organization's medication reconciliation process involves medication on admission through the generation of a "best possible medical history" and medication reconciliation discharge through the use of a standardized discharge form. This form, however, has not been fully implemented at all facilities and there are some locations where medications are not reconciled on discharge through a formal medication reconciliation process. The organization is encouraged to complete implementation of its medication reconciliation process at all points of transfer of care (admission, transfer, and discharge) in all sites.

All falls occurring within the organization's facilities are registered as incidents in the incident risk system. However, there is no information available on a routine basis to monitor fall rates at a number of facilities

and units, nor is there a mechanism to indicate whether or not the fall prevention strategies employed at the sites are effective.

Recent audit results show that some sites are consistently using the Braden scale for initial assessment of clients' risk of developing pressure ulcers on admission, but no subsequent use of the Braden scale for periodic reassessment of their risk of developing pressure ulcers.

Overall, audit information for a number of initiatives is not consistently available to clinical staff at the local unit level and this lack of information stands in the way of local identification of quality improvement opportunities. The organization is encouraged to routinely evaluate the effectiveness of patient safety and risk mitigation strategies and to ensure that these evaluation results are available to staff at the local unit level. In addition, the organization needs to develop mechanisms for patient and family input to the evaluation of the strategies and the identification of appropriate quality improvement initiatives.

The organization is encouraged to work with its front line and clinical staff to provide information to patients and their families on how they can self-manage chronic conditions (e.g. diabetes, congestive heart failure, Chronic Obstructive Pulmonary Disease). This education can have profound impacts for patients living with chronic conditions. Clinical staff are receptive and enthusiastic about working with their patients to assist them to self-manage their chronic conditions and would welcome organizational support.

Priority Process: Decision Support

Staff across the health authority have access to a comprehensive range of decision-support tools to assist them in the delivery of medicine services. These include protocol driven, evidence-informed clinical guidelines and accompanying clinical order sets, as well as access to external clinical resources such as "Up to Date" to assist them in decision-making.

While there is a process for developing clinical guidelines, and for choosing between competing guidelines, across the region, staff at the unit level are not necessarily aware of the process for guideline development and do not feel that they have input into these. The organization is encouraged to ensure that its process for guideline development is inclusive and, specifically, includes input from patients and families.

The organization has implemented some elements of an electronic patient record, but the clinical modules are not yet implemented. As a result, staff on the medical units utilize a combination of paper charts and electronic records and there are a number of "workarounds" that staff has developed to combine these two systems. Each of these represents an opportunity for error and creates a risk in information transfer. The organization is encouraged to develop a comprehensive information technology / information management strategy and to implement an electronic patient clinical record as soon as is feasible. As part of this implementation, a comprehensive strategy to address the use of electronic communication, such as text messages, email, and photographic input into the patient record

should be developed and implemented across the region to ensure the security of patient-specific data transmission.

Priority Process: Impact on Outcomes

There are a number of excellent quality improvement initiatives underway throughout the organization. Quality teams have been formed to focus work in targeted areas aligned with accreditation standards. These teams form the basis through which quality improvement outcomes and evaluation results are shared across the organization.

The organization is encouraged to focus on the development of cultural quality improvement that permeates down to the unit level. There are excellent examples of this within the organization. The medicine unit at the Dauphin Regional Centre has recently filled the position of two clinical resource nurses who have developed a comprehensive action plan for quality improvement for their unit. This action plan incorporates a schedule of audits, evaluations, and identify quality improvement opportunities. This type of local quality production planning should be encouraged and systematized across the region.

Standards Set: Mental Health Services - Direct Service Provision

Unmet Criteria	High Priority Criteria
Priority Process: Clinical Leadership	
The organization has met all criteria for this priority process.	
Priority Process: Competency	
The organization has met all criteria for this priority process.	
Priority Process: Episode of Care	
The organization has met all criteria for this priority process.	
Priority Process: Decision Support	
The organization has met all criteria for this priority process.	
Priority Process: Impact on Outcomes	
The organization has met all criteria for this priority process.	

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

There is a long waiting list for some clients who require long term rehabilitation. Some locations have 93 percent, and 80 percent occupancy, and the waitlist is manageable.

Some locations include single rooms with attached toilet, and sinks. The washrooms and shower doors are stable, and designed to discourage barricading. Men and women are housed in different areas. The washrooms are closely supervised.

Crisis stabilization unit beds are well managed, however, outpatient access to services has a waitlist which is being actively analysed to find newer or creative solutions.

Priority Process: Competency

Credentials, training, and qualifications were confirmed in human resource files.

Mental Health services have minimal equipment, devices or supplies for service delivery.

No patients requiring infusion pumps are serviced at the Brandon Regional Health Centre. Even though there are two rooms with oxygen and suction hookups.

At Brandon-Child and Adolescent Treatment Centre no clients are accepted either who need infusion pumps.

At all sites yearly performance appraisals are done, and documented.

At some locations face to face transfer of info occurs at each shift change in a standard Situation, Background, Assessment, Recognition (SBAR) format.

Internal referral forms, and discharge information sheets are used.

A patient glance board is used in some locations which contains most details particularly relevant to discharge planning.

SAY it (someone appreciates you) is a recognition tool for staff performance, and annual meetings are done to recognize overall contributions.

Nonviolence Crisis Intervention courses, and in-services are regularly provided.

Spiritual care is an integral part of the care, and treatment. Smudging is offered weekly.

Seven Sacred Teaching of the Indigenous Culture is openly promoted in a large poster format.

Priority Process: Episode of Care

Emergency Departments (ED) are open for mental health services, and crisis staff are also available. Some crisis workers are also available on-call to come in, if deemed necessary by the nurse in the ED.

Family Physicians are providing very good physical health care for all mental health clients within 24 hours of admission.

A psychologist regularly carries out psychometric assessments.

Suicide risk assessment are carried out during admission, and at regular intervals or as needs change and before, and after leave of absence (LOA) from the unit.

Seclusions, and restraints forms are part of the accepted package for in-patient care.

Evaluations of the effectiveness of communication during care transitions is not completed or uniformed across all services.

Clients who were admitted for a suicide attempt are followed up every day for seven days post discharge.

Priority Process: Decision Support

The organization has purchased an electronic health record system (PROCURA) which the organization has done the training and rolled out.

Client files are stored electronically after discharge, and records in paper files are safely secured.

Priority Process: Impact on Outcomes

Regional research activities are ongoing, however, no specific research is currently underway in Brandon Adult or Children's units.

All safety incident reporting is online since last 1.5 years.

Most recent safety incident was a nose bleed in the gym and the family was notified and adequate treatment was provided.

An assault on a nurse by a client leads to a review and improvements for all staff and clients.

Wait list management for crisis stabilization unit was looked at, and analysed. Changes were made by increasing the capacity for comprehensive intake assessments.

Quality improvement (QI) objectives were developed in conjunction with primary care providers.

Advanced access has its own data collection.

Plan, Do, Study, Act (PDSA) cycles for efficient processes are measured to watch for improvement following changes. If shown to be effective, these are shared with advanced access team.

QI activities, results, and learnings are published in the annual report.

Standards Set: Obstetrics Services - Direct Service Provision

Unmet Criteria		High Priority Criteria
Priority Process: Clinical Leadership		
1.3	Service-specific goals and objectives are developed, with input from clients and families.	
2.3	An appropriate mix of skill level and experience within the team is determined, with input from clients and families.	
2.4	Space is co-designed with input from clients and families to ensure safety and permit confidential and private interactions with clients and families.	
Priority Process: Competency		
3.9	A documented and coordinated approach for infusion pump safety that includes training, evaluation of competence, and a process to report problems with infusion pump use is implemented.	ROP
3.9.2	Initial and re-training on the safe use of infusion pumps is provided to team members: • Who are new to the organization or temporary staff new to the service area • Who are returning after an extended leave • When a new type of infusion pump is introduced or when existing infusion pumps are upgraded • When evaluation of competence indicates that re-training is needed When infusion pumps are used very infrequently, just-in-time training is provided.	**MAJOR**
3.9.4	The competence of team members to use infusion pumps safely is evaluated and documented at least every two years. When infusion pumps are used very infrequently, a just-in-time evaluation of competence is performed.	**MAJOR**
3.9.5	The effectiveness of the approach is evaluated. Evaluation mechanisms may include: • Investigating patient safety incidents related to infusion pump use • Reviewing data from smart pumps • Monitoring evaluations of competence • Seeking feedback from clients, families, and team members.	**MINOR**

3.12	Team member performance is regularly evaluated and documented in an objective, interactive, and constructive way.	!
3.13	Client and family representatives are regularly engaged to provide input and feedback on their roles and responsibilities, role design, processes, and role satisfaction, where applicable.	
3.14	Team members are supported by team leaders to follow up on issues and opportunities for growth identified through performance evaluations.	!
Priority Process: Episode of Care		
8.2	The assessment process is designed with input from clients and families.	
8.6	To minimize injury from falls, a documented and coordinated approach for falls prevention is implemented and evaluated.	ROP
	8.6.4 The effectiveness of the approach is evaluated regularly.	**MINOR**
	8.6.5 Results from the evaluation are used to make improvements to the approach when needed.	**MINOR**
9.16	Information relevant to the care of the client is communicated effectively during care transitions.	ROP
	9.16.5 The effectiveness of communication is evaluated and improvements are made based on feedback received. Evaluation mechanisms may include: • Using an audit tool (direct observation or review of client records) to measure compliance with standardized processes and the quality of information transfer • Asking clients, families, and service providers if they received the information they needed • Evaluating safety incidents related to information transfer (e.g., from the patient safety incident management system).	**MINOR**
10.6	A safe surgery checklist is used to confirm that safety steps are completed for a surgical procedure performed in the operating room.	ROP
	10.6.4 The use of the checklist is evaluated and results are shared with the team.	**MINOR**
	10.6.5 Results of the evaluation are used to improve the implementation and expand the use of the checklist.	**MINOR**
13.8	The effectiveness of transitions is evaluated and the information is used to improve transition planning, with input from clients and families.	

Priority Process: Decision Support		
15.2	Policies on the use of electronic communications and technologies are developed and followed, with input from clients and families.	
Priority Process: Impact on Outcomes		
16.2	The procedure to select evidence-informed guidelines is reviewed, with input from clients and families, teams, and partners.	
16.4	Protocols and procedures for reducing unnecessary variation in service delivery are developed, with input from clients and families.	!
17.4	Safety improvement strategies are evaluated with input from clients and families.	!
18.3	Measurable objectives with specific timeframes for completion are identified for quality improvement initiatives, with input from clients and families.	!
18.4	Indicator(s) that monitor progress for each quality improvement objective are identified, with input from clients and families.	
18.5	Quality improvement activities are designed and tested to meet objectives.	!
18.6	New or existing indicator data are used to establish a baseline for each indicator.	
18.7	There is a process to regularly collect indicator data and track progress.	
18.8	Indicator data is regularly analyzed to determine the effectiveness of the quality improvement activities.	!
18.9	Quality improvement activities that were shown to be effective in the testing phase are implemented broadly throughout the organization.	!
18.10	Information about quality improvement activities, results, and learnings is shared with clients, families, teams, organization leaders, and other organizations, as appropriate.	
18.11	Quality improvement initiatives are regularly evaluated for feasibility, relevance, and usefulness, with input from clients and families.	

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

Prairie Mountain Health (PMH) offers acute mother and child (obstetrical) services at three of its regional sites: Brandon Regional Health Centre (BRHC), Dauphin Regional Health Centre (DRHC), and Neepawa

Health Centre (NHC). Planning is underway to re-establish low-risk obstetrical services in Swan River. All three sites were visited and their services reviewed during the 2016 accreditation survey. In addition, the Midwifery Services Office in Brandon was included in the survey process. Client satisfaction with this service is high with Client Experience Scores in regards to overall quality of care ranging from 97% to 100% across the three sites.

There are 28 obstetrical beds in the region and 26 bassinettes, with one level 2 nursery located in Brandon. There were, on average, 1,934 births in the region annually over the past four years with the highest volume being in Brandon (1,522). The midwives deliver approximately 200 babies each year. The overall C-section rate is approximately 30%.

Care is provided by an interdisciplinary team with the team composition and skill-mix varying site to site. Brandon is the only community that is served by registered midwives. The skill set of the nurses at NHC is noteworthy as these individuals are trained at a high level with multiple certifications to enable them to provide a full spectrum of services at the hospital including maternal and infant care. Public Health is a key partner with the acute Mother & Child Service and offers post-partum follow-up and Well Baby Care to all the clients who deliver at PMH.

The Mother & Child Services fall within the acute care portfolio at PMH. The Regional Quality team has cross-site representation comprised of Directors, Managers, Resource Nurses, Educators, physicians and midwives as well as representation from Public Health. There is a formal leadership role within the obstetrical unit in Brandon Health Centre and informal medical leadership in Neepawa Health Centre and Dauphin Health Centre.

The leadership team is encouraged to establish strategic goals and objectives with client input to guide service delivery aligned with the organization’s strategic plan and designed to meet the needs of the population served. These goals should provide focus and direction, and assist in advancing the quality of care and improved health outcomes for this population. The new Accreditation Canada standards include a focus on client- and family-centred care. Again, aligned with the corporate strategy, the program is encouraged to formally engage with their clients and families to solicit input on the design of and planning for services offered.

The Maternal Child Unit at BRHC is well designed, functional, bright and uncluttered. Space is conducive to maintaining privacy and confidentiality in care delivery. The Maternal Child Unit at NHC is quite old and a capital plan has been submitted to replace the facility. The leadership has oversight for the program’s resource requirements and follows the organizational process to identify needs and request for resources to the administrative team.

Priority Process: Competency

The Mother & Child Service is supported by a well-rounded interdisciplinary team comprised of dedicated obstetricians, pediatricians, general practitioners, anesthetists, midwives, registered nurses, licensed practical nurses, health care aides, and unit clerks. In addition, support is offered by numerous allied

health professionals including pharmacists, social workers, physiotherapists, and spiritual care practitioners. The licensing for professional staff and assessment of credentials is done centrally at PMH. It was observed that the team composition varies from site to site and the program is encouraged to look at standardization aligned with the patient care needs. Recruitment and retention is a concern for this service. At DRHC, there is a 33% vacancy rate for nursing with a heavy reliance on agency nurses.

There is a well-developed orientation program for clinical staff and multiple modules for learning and professional development on the e-learning system "SPOT". Mandatory professional certifications to ensure safe clinical practice have been identified for the program and resources are available to support programs such as NRP (Neonatal Resuscitation Program) and AWONN (Association of Women's Health, Obstetrics and Neonatal Nurses).

As a rural site within PMH, Neepawa is a 38-bed hospital offering a wide range of clinical services with obstetrics being one focus. One of the challenges is ensuring staff is trained and competent to work in all clinical areas. There is a detailed orientation for registered nurses and licensed practical nurses in obstetrics with graduated exposure and accountability for the full spectrum of maternal child care. Additional clinical exposure is provided on an as-needed basis at BRHC. Historically, the clinical resources nurse was able to pull records on staff training from their legacy e-learning system; however, this is no longer available. As PMH standardizes its e-learning system, this capability will be available again in the future. Currently, manual records need to be kept on completion of all the mandatory clinical and corporate education for staff.

Recent changes have been implemented to the management of IV pump infusions. When fully implemented, these changes should address the gap that currently exists which precludes managers from knowing which nurses require the bi-annual re-certification.

Within the Mother & Child Service at PMH, performance reviews are not being conducted consistently, with the exception of the Midwifery Service where there is 100% completion. The new process to ensure feedback to staff on their performance is currently being rolled out across PMH.

Priority Process: Episode of Care

The program staff is to be commended for the phenomenal amount of work they have done over the past couple of years to review and revise policies and procedures to create standardized quality care across the region. The new policies are evidence-based and aligned with the SOGC (Society of Obstetricians & Gynecologist of Canada) and CPS (Canadian Pediatric Society) clinical guidelines. The goal of standardizing care across all three sites and reducing variability in care delivery will enhance the quality of care. These policies and procedures provide direction and guidance to the episode of care. The Midwifery Service has set a goal to revise its policies and procedures related to clinical guidelines to ensure greater consistency in practice. Until such time, as all the policies and procedures are reviewed and revised, the legacy policies at each site will be in effect.

Operational processes are in place to guide and prioritize access to care. If required care is not available at one site, patients are transferred to an appropriate higher level of care. Tertiary level support is available at Winnipeg Health Sciences as well as through telehealth connections with this organization. PMH covers a large geographical area and people living in remote rural communities have increased challenges with access to care. One barrier that was identified within the Mother & Child service was within the Midwifery service. Due to appropriate patient safety requirements, home deliveries cannot be performed outside of a 20 minute travel radius to BRHC, thus resulting in barriers to this service for some clients. Another barrier identified in this survey was reduced access to C-sections in Neepawa when anesthesia support was not available due to manpower shortages.

The program does a good job at engaging patients in their care planning. Prenatal care is well documented and some clients are involved in developing birthing plans. The Patient Safety Handbook for Acute Care is given to every admitted patient and signed off by both the patient and the care provider. Patient education is provided to patients for the self-management of their health upon discharge and the health of their babies. There is an opportunity to further partner with clients and families to involve them more in the planning and delivery of care within the program. The program is encouraged to standardize the consent process across all three sites as there is variability in terms of which procedures require consent. The new PMH policy (June 2016) will help to guide this standardization process.

The program staff complete Best Possible Medication Histories (BPMH) upon admission as well as upon discharge. The current process does not include sending a copy of the reconciled discharge medication list to the primary care clinician or to the pharmacy. Furthermore, there does not appear to be an evaluation of the current BPMH process to guide ongoing quality improvement.

The program staff follows the falls prevention protocol and all charts reviewed were observed to have a completed falls assessment done. The organization has recently reviewed the falls prevention program and will be moving towards a universal approach to falls prevention.

Fetal health assessments are conducted at all sites and staff are trained at interpreting and monitoring the strips. There is a process in place to escalate concerns to a midwife or obstetrician as required. Fetal monitoring strips become a permanent part of the infant’s chart.

Protocols are in place to guide oxytocin and prostaglandin inductions of labour. C-sections are performed in the operating room suites. As per the perioperative standards, safety measures are followed including the implementation of the surgical safety checklists, sponge and needle counts and anesthesia monitoring.

At BRHC, there is a process in place to manage the handling, storage, labeling and disposal of breast milk. The fridge is in a secure location accessible by nursing staff. The staff encourages skin-to- skin contact between mom and baby in the first hour after delivery and there are posters throughout the unit promoting this practice. There is a new feeding policy for infants and PHM supports a baby friendly environment as per the World Health Organization guidelines.

The organization has recently rolled out an audit tool that will be used until August 2016 to audit compliance with the surgical safety checklist protocol. The service is encouraged to share the results of these audits with their staff to solicit input for any related quality improvement initiatives.

Priority Process: Decision Support

There is a paper health record for both inpatient and outpatient clients at PMH. Charting is comprehensive and standardized assessment tools are used consistently throughout the Mother and Child Service. Throughout the survey, at all sites, there was consistent evidence of efforts to protect client information and preserve patient confidentiality.

Priority Process: Impact on Outcomes

Clinical care within the Mother and Child Service at PMH is aligned with the clinical guidelines from the Society of Obstetricians and Gynecologist of Canada, the Canadian Pediatric Society, the College of Midwifery of Manitoba and the Association of Women's Health, Obstetrics and Neonatal Nursing. The work undertaken to standardize care across the region will further enhance a quality of care by reducing variability in practice. As per the accreditation standards, the program needs to determine a way to engage the clients and families and seek their input in the planning and delivery of care.

Obstetrics is considered a high-risk clinical area. There are good protocols in place to manage clinical care and reduce risk. Ongoing formal evaluation of practices is important to ensure the effectiveness of clinical practices. Consideration may be given to implementing the MORE- OB (Managing Obstetrical Risk Efficiently) program to further enhance teamwork and manage risk in this patient population particularly in the smaller sites with fewer births. The Acute Care Patient Safety Handbook is used at all sites and engages the clients and their families with respect to their role in ensuring safe clinical care.

The current Accreditation Canada standards emphasize the importance of using robust performance indicators to monitor quality improvement. Establishing measurable time-bound objectives with input from clients and families and monitoring progress is an expectation. In alignment with the organization's direction, it is recommended that the Mother and Child Service select key performance indicators and put a process in place to monitor quality improvement outcomes. In addition, there should be a process in place to ensure successful pilot projects or initiatives are implemented more broadly across the service as appropriate.

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

Unmet Criteria		High Priority Criteria
Priority Process: Clinical Leadership		
1.1	Services are co-designed with clients and families, partners, and the community.	!
1.3	Service-specific goals and objectives are developed, with input from clients and families.	
1.4	Services are reviewed and monitored for appropriateness, with input from clients and families.	
2.4	Space is co-designed with input from clients and families to ensure safety and permit confidential and private interactions with clients and families.	
2.7	A universally-accessible environment is created with input from clients and families.	
Priority Process: Competency		
6.1	Required credentials, training, and education are defined for all team members with input from clients and families.	!
6.12	Client and family representatives are regularly engaged to provide input and feedback on their roles and responsibilities, role design, processes, and role satisfaction, where applicable.	
7.4	Standardized communication tools are used to share information about a client's care within and between teams.	!
8.5	Education and training on occupational health and safety regulations and organizational policies on workplace safety are provided to team members.	!
Priority Process: Episode of Care		
11.2	The assessment process is designed with input from clients and families.	
11.6	INPATIENT CARE ONLY: A Best Possible Medication History (BPMH) is generated in partnership with clients, families, or caregivers (as appropriate) and used to reconcile client medications at care transitions.	ROP

	11.6.5 The client, community-based health care provider, and community pharmacy (as appropriate) are provided with a complete list of medications the client should be taking following discharge.	**MAJOR**
11.7	OUTPATIENT CARE ONLY: In partnership with clients, families, or caregivers, medication reconciliation is initiated for a target group of outpatients who may be at risk for potential adverse drug events (organizational policy specifies when medication reconciliation is initiated for outpatients).	ROP
	11.7.1 The criteria for a target group of outpatients who are eligible for medication reconciliation are identified and the rationale for choosing those criteria is documented.	**MAJOR**
	11.7.2 For outpatients in the target group, a BPMH is generated in partnership with clients, families, or caregivers, and documented.	**MAJOR**
	11.7.3 For outpatients in the target group, the current medication list is updated to reflect changes made to medications, and the changes are communicated to the client, family, and next care provider.	**MAJOR**
11.11	To minimize injury from falls, a documented and coordinated approach for falls prevention is implemented and evaluated.	ROP
	11.11.4 The effectiveness of the approach is evaluated regularly.	**MINOR**
	11.11.5 Results from the evaluation are used to make improvements to the approach when needed.	**MINOR**
11.12	Each client's risk for developing a pressure ulcer is assessed and interventions to prevent pressure ulcers are implemented. NOTE: This ROP does not apply for outpatient settings, including day surgery, given the lack of validated risk assessment tools for outpatient settings.	ROP
	11.12.1 An initial pressure ulcer risk assessment is conducted for clients upon admission, using a validated, standardized risk assessment tool.	**MAJOR**
	11.12.2 The risk of developing pressure ulcers is assessed for each client at regular intervals and when there is a significant change in the client's status.	**MAJOR**
	11.12.5 The effectiveness of pressure ulcer prevention is evaluated, and results are used to make improvements when needed.	**MINOR**

11.13	Medical and surgical clients at risk of venous thromboembolism (deep vein thrombosis and pulmonary embolism) are identified and provided with appropriate thromboprophylaxis. NOTE: This ROP does not apply for pediatric hospitals; it only applies to clients 18 years of age or older. This ROP does not apply to day procedures or procedures with only an overnight stay.	ROP
11.13.3	Measures for appropriate VTE prophylaxis are established, the implementation of appropriate VTE prophylaxis is audited, and this information is used to make improvements to services.	**MINOR**
12.5	Treatment protocols are consistently followed to provide the same standard of care in all settings to all clients.	!
12.11	Information relevant to the care of the client is communicated effectively during care transitions.	ROP
12.11.1	The information that is required to be shared at care transitions is defined and standardized for care transitions where clients experience a change in team membership or location: admission, handover, transfer, and discharge.	**MAJOR**
12.11.2	Documentation tools and communication strategies are used to standardize information transfer at care transitions.	**MAJOR**
12.11.4	Information shared at care transitions is documented.	**MAJOR**
12.11.5	The effectiveness of communication is evaluated and improvements are made based on feedback received. Evaluation mechanisms may include: • Using an audit tool (direct observation or review of client records) to measure compliance with standardized processes and the quality of information transfer • Asking clients, families, and service providers if they received the information they needed • Evaluating safety incidents related to information transfer (e.g., from the patient safety incident management system).	**MINOR**
14.3	A safe surgery checklist is used to confirm that safety steps are completed for a surgical procedure performed in the operating room.	ROP
14.3.1	The team has agreed on a three-phase safe surgery checklist to be used for surgical procedures performed in the operating room.	**MAJOR**

14.3.4	The use of the checklist is evaluated and results are shared with the team.	**MINOR**
14.3.5	Results of the evaluation are used to improve the implementation and expand the use of the checklist.	**MINOR**
14.4	Procedure-specific care maps or guidelines are used to guide the client through preparation for and recovery from the procedure.	
16.5	The client is monitored during and immediately following the administration of anesthesia, according to the organization's procedures.	!
20.16	There is a process to follow up with discharged day surgery clients.	
20.17	The effectiveness of transitions is evaluated and the information is used to improve transition planning, with input from clients and families.	
Priority Process: Decision Support		
	The organization has met all criteria for this priority process.	
Priority Process: Impact on Outcomes		
23.1	There is a standardized procedure to select evidence-informed guidelines that are appropriate for the services offered.	!
23.2	The procedure to select evidence-informed guidelines is reviewed, with input from clients and families, teams, and partners.	
23.3	There is a standardized process, developed with input from clients and families, to decide among conflicting evidence-informed guidelines.	!
23.4	Protocols and procedures for reducing unnecessary variation in service delivery are developed, with input from clients and families.	!
23.5	Guidelines and protocols are regularly reviewed, with input from clients and families, to ensure they reflect current research and best practice information.	!
23.6	There is a policy on ethical research practices that outlines when to seek approval, developed with input from clients and families.	!
24.1	A proactive, predictive approach is used to identify risks to client and team safety, with input from clients and families.	!
24.2	Strategies are developed and implemented to address identified safety risks, with input from clients and families.	!
24.4	Safety improvement strategies are evaluated with input from clients and families.	!

24.7	Patient safety incidents are analyzed to help prevent recurrence and make improvements, with input from clients and families.	!
25.3	Measurable objectives with specific timeframes for completion are identified for quality improvement initiatives, with input from clients and families.	!
25.4	Indicator(s) that monitor progress for each quality improvement objective are identified, with input from clients and families.	
25.5	Quality improvement activities are designed and tested to meet objectives.	!
25.6	New or existing indicator data are used to establish a baseline for each indicator.	
25.7	There is a process to regularly collect indicator data and track progress.	
25.8	Indicator data is regularly analyzed to determine the effectiveness of the quality improvement activities.	!
25.9	Quality improvement activities that were shown to be effective in the testing phase are implemented broadly throughout the organization.	!
25.11	Quality improvement initiatives are regularly evaluated for feasibility, relevance, and usefulness, with input from clients and families.	
Priority Process: Medication Management		
5.2	Medications in the surgical area are stored in a locked area or similarly secured, as per the organization's policies regarding medication storage.	!

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

The service uses the Community Health Assessment completed in 2015. Also, Manitoba Health has contracted a consultant to review the surgical services within Manitoba. While there has been a Community Health Assessment completed, the organization is encouraged to engage with clients and families regarding the designing of the space, monitoring the appropriateness of the services, and to develop goals and objectives for the service. Having the patient voice present during planning and service design can assure that future plans will meet the needs of the future patients. Currently, space is challenging for staff and clients in maneuvering. There are no automatic door openers or even holdbacks for the doors.

Resource gaps are noted throughout the region, such as human resource shortages for both physicians and nurses. These resource issues may lead to a destabilization of the perioperative program if not addressed.

Priority Process: Competency

The organization is commended for their hard work in standardizing the perioperative nursing educational program for the region. Education, orientation, and training have allowed staff to seamlessly move between two smaller sites, thus assuring both sites have the ability to maintain their surgical programs. This pragmatic approach is to be applauded. It would be beneficial to the organization to encourage the smaller sites to access the Regional Clinical Educator to maintain standards and best practice that align with the larger surgical sites. Access to the Regional Clinical Educator would ensure that similar practice is followed from preoperative to intraoperative, to post-operative recovery and through to discharge.

The organization is encouraged to formalize processes to engage clients and families to provide input and feedback on team members roles and responsibilities and role design.

Priority Process: Episode of Care

Prairie Mountain Health provides a range of surgical services for children and adults living within the various communities. The two larger sites, Brandon and Dauphin, provide more specialized services, while the smaller sites provide a much needed range of services to the clients in their communities. Some of the sites do have fragile services and are dependent on only one general practitioner surgeon. Endoscopy services are provided at a variety of sites; however, the wait list remains high at the larger centres.

Through the continuum of care for the surgical patient (from the pre-assessment clinic, to pre-operative, to the operating suite, to then recovery and onto admission to the inpatient unit) there is a focus on patient safety. Patients and their families are engaged in discussions related to the plan of care and their role in safety. The surgical safety checklist was done at all sites; however, the organization is encouraged to actively use the newly implemented audit tool to identify any areas for ongoing improvement in the surgical safety checklist procedure at their sites.

On the inpatient unit, the nurses use multiple standardized assessment tools to conduct their assessments on newly admitted patients. While the Braden tool is currently only used on non-mobile patients to assess and monitor skin integrity, this tool should be used with all patients. While some areas have a standardized reporting tool for capturing patient status information at transition points to enhance the quality of care, others do not. The organization is encouraged to look at best practices within their region, and provide all surgical sites with the same tool.

There is inconsistent practice in the final components of medication reconciliation, with ensuring the pharmacy and prescriber have a current version of the discharge medication list. The discharge medication form is a duplicate form. One copy goes to the patient and one copy remains on the file. Information is not relayed to the family physician nor to the community pharmacy. Additionally, the organization has not identified a population for outpatient medication reconciliation.

The VTE protocol has been incorporated into the standing orders as of January 2016. There is no evidence that an evaluation has been undertaken since the implementation of the new protocol. At Dauphin Regional Health Centre (DRHC), the surgeons are still using the legacy standing orders and have not yet implemented the 2016 version.

It was observed that clinical guidelines and care maps are not being used in the surgical program at DRHC.

The organization is encouraged to review post-operative care standards to determine the most appropriate time to keep a patient post-operatively, after both a general anesthetic and a conscious sedation protocol, plus review the time after a narcotic has been given to discharge the patient from post-anesthesia.

Priority Process: Decision Support

There are different chart forms used throughout the region, the organization is encouraged to standardize this as much as possible. The perioperative records should be standard across the region as there should be no variance in practice.

There is a policy on communication that includes the use of computers and emails but lacks specificity to personal phones and texting. The organization is encouraged to update the policy to ensure all methods of communication are addressed.

Priority Process: Impact on Outcomes

The organization is encouraged to develop a process to engage with clients and families to assist with providing input for reviewing policies, service changes and quality improvement (QI) activities. Using the data that is available to the organization can assist in determining where the opportunities exist for quality improvement projects. Additionally, gathering input from clients and families will also assist in validating the feasibility of the QI initiatives. Using the Plan-Do-Study-Act (PDSA) methodology and Lean management techniques will parse out the projects into manageable segments.

Priority Process: Medication Management

Some of the smaller rural sites do not have restricted access to the operating rooms and the doors are unsecured. This allows access to some of the medications in the perioperative suite. The narcotics are secured and locked, but a number of other medications are easy to access. The organization is encouraged to look at restricting access to the perioperative areas.

Standards Set: Primary Care Services - Direct Service Provision

Unmet Criteria		High Priority Criteria
Priority Process: Competency - Primary Care		
The organization has met all criteria for this priority process.		
Priority Process: Clinical Leadership		
1.4	Services are reviewed and monitored for appropriateness, with input from clients and families.	
Priority Process: Competency		
3.1	Required credentials, training, and education are defined for all team members with input from clients and families.	!
3.11	Client and family representatives are regularly engaged to provide input and feedback on their roles and responsibilities, role design, processes, and role satisfaction, where applicable.	
4.5	Standardized communication tools are used to share information about a client's care within and between teams.	!
4.6	The effectiveness of team collaboration and functioning is evaluated and opportunities for improvement are identified.	
10.6	Access to spiritual space and care is provided to meet clients' needs.	
Priority Process: Episode of Care		
6.7	Written policies and procedures to screen all clients at the point of contact, and to identify clients with immediate or urgent needs, are followed.	!
11.13	The effectiveness of transitions is evaluated and the information is used to improve transition planning, with input from clients and families.	
Priority Process: Decision Support		
12.8	There is a process to monitor and evaluate record-keeping practices, designed with input from clients and families, and the information is used to make improvements.	!
13.2	Policies on the use of electronic communications and technologies are developed and followed, with input from clients and families.	
Priority Process: Impact on Outcomes		

14.1	There is a standardized procedure to select evidence-informed guidelines that are appropriate for the services offered.	!
14.2	The procedure to select evidence-informed guidelines is reviewed, with input from clients and families, teams, and partners.	
14.3	There is a standardized process, developed with input from clients and families, to decide among conflicting evidence-informed guidelines.	!
14.4	Protocols and procedures for reducing unnecessary variation in service delivery are developed, with input from clients and families.	!
14.5	Guidelines and protocols are regularly reviewed, with input from clients and families, to ensure they reflect current research and best practice information.	!
15.4	Safety improvement strategies are evaluated with input from clients and families.	!
16.9	Quality improvement activities that were shown to be effective in the testing phase are implemented broadly throughout the organization.	!
16.11	Quality improvement initiatives are regularly evaluated for feasibility, relevance, and usefulness, with input from clients and families.	

Surveyor comments on the priority process(es)

Priority Process: Competency - Primary Care

The primary care clinics, both those operated directly by Prairie Mountain Regional Health Authority, and the Western Medical Clinic operated by a private consortium of family physicians in partnership with the Health Authority, employ and provide practice space to a wide variety of practitioners. These include Nurse Practitioners, Nurses, Licensed Practical Nurses, Mental Health Counselors, Primary Care Outreach Workers, and others. These practitioners are deployed in a model care that utilizes them to the full scope of their professional training and licensing.

Priority Process: Clinical Leadership

The Primary Care Program encompasses a wide range of professional practices. It directly employs nurse practitioners and deploys mental health outreach workers and other professionals. The program involves family physicians, both as a co-located integrated practice (Swan Valley Primary Care Centre) and as a partnership practice through the My Health Program (Western Medical Clinic).

Staff are deployed in a strategic manner to meet the needs of the specific populations being served. There are specific settings and models of care delivery, designed to meet the needs of target populations such as the 7th Street Access Centre and the Western Medical Clinic in Brandon. Staff are also deployed in a non-traditional method such as the mobile primary care clinic serving a number of First Nations communities within the region.

The degree of collaboration between practitioners and the degree of integration of practices varies. There is an apparent strategic effort by the region to integrate through engagement and in some instances to encourage co-location of family physicians with other primary care providers. However, a degree of parallel service delivery between family physicians and organization employed primary care practitioners continues to exist.

Primary care staff employed by the organization have roles allowing them to work to the full scope of their professional training and experience.

Priority Process: Competency

The staff of the Primary Care Program include practitioners from a variety of professional backgrounds with complementary and sometimes overlapping scope of practice. Staff are deployed strategically, in order that they may work to the full scope of their professional training.

Staff have access to ongoing training opportunities and feedback on their performance, however a consistent and comprehensive program of performance evaluation is not yet in place.

Staff have access to training and education on meeting the health care needs of the distinct populations within the organization catchment area. Specifically, there is a focus on training staff to work with First Nations clients and communities. There are outreach programs with staff training to meet the needs of disadvantaged populations within the region.

Priority Process: Episode of Care

The Primary Care Program has implemented a number of strategies to improve access to primary care and to ensure access to the right practitioner at the right time. These strategies include the deployment of a number of practitioners of varying professional backgrounds: nurse practitioners, mental health counselors, dietitians, pharmacists, and others. The Primary Care Program has employed strategies to engage with, and in some instances integrate with family physician practices. Examples of the latter include the Swan Valley Primary Care Centre operated by the organization and the Western Medical Clinic as a partner clinic through the My Health Program.

There is a focus on access with consistent tracking of "third next available appointment" as the primary indicator. However, threshold targets for achievement of specific quality parameters (24 to 72 hour availability of the third next available appointment, for example) have not been consistently set and monitored throughout the organization. Staff and patients report improvements in access; however, this is not universal. For instance, in the integrated Swan Valley Primary Care Clinic, while patients report an increasing wait time for access to their family physician, it is recognized that the clinic is not functioning to full provider capacity and an improvement initiative related to patient “no shows” is being explored. The Western Medical Clinic, by contrast, has successfully attached an additional 1800 new patients to

family physicians which is close to reaching the target of 2000 new patients. It is not clear, however, whether all of these patients were previously without a family physician or whether some have transferred from other family positions in Brandon, due to the perceived desirability of the new Western Medical Clinic.

The mobile medical clinic operated by MPH as part of a province wide initiative employs a non-traditional approach to providing access to primary care for residents of First Nations communities. This approach is well received by the community served. The organization is encouraged to explore opportunities to further integrate the mobile medical clinic with existing primary care services, including family physician practices in the region to avoid potential duplication of primary care services for specific clients.

The My Health program, which the organization manages as part of the provincial initiative, has effectively expanded services available to patients and clients of the Western Medical Clinic. Patients and staff report satisfaction with this increased range of available services and with the degree of integration. Clients have access to practitioners other than their family physician in the same location and with convenient access. Physicians have access to other allied support staff, such as mental health counselors on an urgent basis, through an integrated electronic patient record. There is effective sharing of client specific information and a team approach to the delivery of client specific services.

The organization is encouraged to explore further integration between the Western Medical Clinic, its practitioners and services offered, and the 7th Street Access Centre. This would enable better integration of the nurse practitioners practice with the practices of the family physicians participating in the My Health Program. Such integration would help to ensure sustainability of the Primary Care Program in the event that the provincial My Help Program winds down and the specific funding and explicit deliverables are no longer available from the Ministry of Health.

Priority Process: Decision Support

The Primary Care Program has access to an excellent electronic medical record (Acuro) which is used consistently across the region by staff and by family physicians working in collaboration with the primary care program. This creates a comprehensive, consistent client record. At the present time, not all instances of client records are integrated, but the organization is moving forward strategically to create integrated common client files. This has occurred in at least one instance in the Swan Valley Primary Care Clinic. Within the Western Medical Clinic in Brandon, there is an integrated client file that is used by physicians and other primary care health practitioners employed by the organization and deployed to the clinic.

In creating a co-located practice at the Swan Valley Primary Care Clinic, the organization has created a set of implicit assumptions around the ownership, custodianship, maintenance, and ongoing access to client specific records. It is recommended that the organization and family physicians review their agreements for ongoing record maintenance and custodianship and embed this in their collaboration agreement.

Priority Process: Impact on Outcomes

The Primary Care Program is in the process of designing and implementing a number of primary care initiatives. These include the expansion of the types of primary care services offered and the range of primary care practitioners available to clients and new models such as the collaboration between existing primary care practitioners (family physician) and the organization employed primary care practitioners.

In implementing these programs, there are a number of early indicators that are being tracked. The most consistent indicator is one of access, the "third next available appointment". However, to date, there has been no consistent evaluation of the effectiveness of these initiatives, or tracking and trending of the indicator data that it can be used by both managers and practitioners for quality improvement in service delivery.

Currently, the Primary Care Program does not have a formal mechanism for engaging clients and families in the design, implementation, review and evaluation, and improvement of services. This represents a challenge not only in obtaining regular feedback from clients and families, but also to formally integrate it into the Primary Care Program's decision process.

Initiatives currently being implemented by the Primary Care Program vary in different communities and in serving different populations. The organization has collected comprehensive information regarding the populations it serves. To date, however, these initiatives continue to be viewed as "one off" initiatives, and there is no consistent strategy to spread these initiatives to other communities or to scale them up within communities. Individual initiatives include plans to increase the population served, but the sustainability will be reliant on ongoing provincial support and funding.

Standards Set: Public Health Services - Direct Service Provision

Unmet Criteria		High Priority Criteria
Priority Process: Clinical Leadership		
The organization has met all criteria for this priority process.		
Priority Process: Competency		
4.3	Team member performance is regularly evaluated and documented in an objective, interactive, and constructive way.	!
Priority Process: Impact on Outcomes		
16.3	Measurable objectives with specific timeframes for completion are identified for quality improvement initiatives, with input from clients and families.	!
16.4	Indicator(s) that monitor progress for each quality improvement objective are identified, with input from clients and families.	
16.6	New or existing indicator data are used to establish a baseline for each indicator.	
16.7	There is a process to regularly collect indicator data and track progress.	
16.8	Indicator data is regularly analyzed to determine the effectiveness of the quality improvement activities.	!
16.9	Quality improvement activities that were shown to be effective in the testing phase are implemented broadly throughout the organization.	!
16.11	Quality improvement initiatives are regularly evaluated for feasibility, relevance, and usefulness, with input from clients and families.	
Priority Process: Public Health		
3.4	Goals and objectives for public health services are measurable and specific.	
3.5	The resources needed to achieve public health goals and objectives are identified.	
3.12	Utilization reviews are regularly completed to ensure resources have been used appropriately.	

8.3	Health impact assessments for proposed public policies, programs, and projects are conducted in collaboration with partners and with input from the community.	
9.7	Health promotion activities are regularly evaluated and improvements are made as a result.	
10.9	Disease prevention activities are regularly evaluated and improvements are made as a result.	
14.5	The data system, i.e., hardware and software, is evaluated annually and upgrades to improve the access, quality and use of health data are planned and implemented.	

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

The Community Health Assessment and Provincial Program Standards provide clear direction for many of the Public Health programs and services. There is still significant work in PMH to standardize policies and procedures from the former health regions. It is recognized that one of the factors is work that is occurring provincially on key performance indicators. PMH is encouraged given its Community Health Assessment to proceed with developing goals and objectives and key performance indicators. PMH could feed these measures into the provincial process.

One example of the variation in policies in the region is the approach to the management of blood and body fluid exposures. It will be important for the new policy being developed/ introduced to reflect the provincial program direction responding to blood and body fluid exposures (BBFE). Staff identified potential inequities in access to medication for some clients unable to afford the high cost of HIV post-exposure prophylaxis (PEP) meds. If the provincial policy does not cover the high cost of HIV post exposure medications, the region is encouraged to look at other options.

Staff appreciate the access to specialized resource experts in areas such as communicable disease and immunization and to the Medical Officer of Health. Concern was expressed over the current number of vacancies for Medical Officers of Health. It will be important for Manitoba Health to recruit to the MOH vacancies as well as succession planning and redundancy for other key specialized areas of expertise.

Priority Process: Competency

There is a multi-disciplinary team that provides Public Health services with a range of background and education ranging from high school to post graduate. There is a strong commitment to continuing development and education that staff expressed appreciation for. There is recognition of the importance of specialized education events or conferences for the ongoing development of staff, and this is supported.

Staff in specialized areas such as sexually transmitted disease, travel health, diabetes education in the former Brandon Health Authority had delegated authority to allow them to operate to their full scope of practice and meet client needs. PMH is encouraged to look at expanding this model of delegated authority to other areas of the region to enhance access and range of services for clients. This will require engagement with physicians.

A number of staff identified that they have not had a recent formal performance appraisal although some indicated they had informal discussions. A formal process for performance appraisal is encouraged.

Priority Process: Impact on Outcomes

Even with the current challenges with the multiple electronic information systems being used in Public Health (Panorama, Procura, Occura, Excel) plus the paper based records, a substantial amount of data is being collected and reported. While examples were provided of how this information (client satisfaction surveys) is being used to improve programs and services, there are opportunities to use it even more for quality improvement.

The team is encouraged to develop specific goals, objectives and key performance indicators for programs and services starting with the data that is currently being collected.

The team is encouraged to incorporate as part of its quality improvement work, a specific plan to spread the findings across all public health programs in the region. Currently while information about pilot projects is shared, there was no evidence that the findings from pilots were implemented more widely.

Priority Process: Public Health

Public Health Services were surveyed in the communities of Brandon, Neepawa Virden and Dauphin. Similar Public Health programming was available at all sites with additional supports for Health Promotion services located in Brandon. Dauphin and Virden Public Health offices are servicing the other areas of PMH. Coordinator positions for the Families First are located in Virden, Dauphin and Brandon Public Health offices.

The Public Health Units provide programming and services to the populations within and surrounding their communities. Public Health Nurses supported by Unit Clerks provide the following services: Well-Baby Clinics, Prenatal & Post-Partum Care, Immunizations, Communicable Disease Management, Surveillance, and Reproductive Health Services. Travel Health services are available in Brandon on a cost recovery basis. Programming is aligned with the Public Health prioritized strategies. While there is not a Health Promotions Coordinator on site in all communities, the local staff in all communities have access to support from Primary Care and Health Promotion Team based on identified needs. Examples of recently conducted health promotional programs are the “Healthy Together Now” program and “Creating Change in Our Relationship with Food” workshop.

Staff were aware of the recent Community Health Assessment conducted for Prairie Mountain Health (PMH) and had the opportunity through the regional Public Health Nurses meeting and through the

Health Promotions & Primary Health Team meetings to have input on setting program priorities based on the needs identified in the Population Health Assessment. Services have responded to the increased number of new immigrants with different language and culture that have been seen in many communities. These new populations bring new challenges and needs such as the increased prevalence of latent TB and chronic Hepatitis B. This is creating pressures on existing resources and in some communities contributing to further increases in the gaps that exist in health equity.

Public Health, based on the Community Health Assessment, is focusing on improving health equity. After a respectful community engagement process discussing the results from the needs assessment the Health Promotions team is working with a Metis community in the North to implement a Food Basket program. The evaluation of this initiative will look at the reach of the program and number of clients served.

The immunization program is well established and is incorporated into the Well-Baby Clinic visits. Information related to immunization status is entered into the “Panorama” software system. The Public Health Nurses make visits to the schools to implement targeted immunization programs for specific age groups. The quality assurance for the cold-chain oversight of vaccines is well established in all sites visited.

The surveillance program for communicable diseases is supported through the larger Public Health system within PMH. Patients are identified through laboratory testing and cases are assigned to the Unit. The Public Health Nurses follow up with all cases, identifying contacts and taking appropriate actions as per the Manitoba Centre for Communicable Diseases clinical guidelines. While they enter data into the system, there is not a consistent process to generate reports to trend and monitor reports reflecting activity within their community. There is a system for schools to identify greater than 10% absenteeism but it is not a practice to routinely collect naso-pharyngeal swabs to confirm the etiology of the outbreak.

For the majority of programs, the primary source of performance measurements are client satisfaction surveys. Results of the surveys are acted on although some front line staff indicated they did not always find out what the results were. These surveys are sent to administration and currently there is not a process in place to receive feedback on the results. It is encouraged that the management team report the findings back to the local sites to help guide quality improvement initiatives. Examples were given of how changes to the influenza and prenatal education programs were made based on the client feedback.

Chart management on site is designed to secure patient confidentiality and all files are secured behind a double lock system, for example file and door, to mitigate risk.

Education has been provided to the staff on the new PMH Ethics Framework. It is an ongoing practice within Public Health Nursing to have Ethics as a standing item on their regional monthly meetings creating an opportunity for discussion related to ethical dilemmas within their practice.

In Virden Health Centre, difficulties in access to speech language pathology were identified with the wait time over one year during a recent maternity leave that resulted in clients having to be referred to private practice speech language pathologists in Saskatchewan. Clients had to pay for the service.

Standards Set: Rehabilitation Services - Direct Service Provision

Unmet Criteria		High Priority Criteria
Priority Process: Clinical Leadership		
The organization has met all criteria for this priority process.		
Priority Process: Competency		
The organization has met all criteria for this priority process.		
Priority Process: Episode of Care		
7.11	Clients and families are provided with opportunities to be engaged in research activities that may be appropriate to their care.	
Priority Process: Decision Support		
The organization has met all criteria for this priority process.		
Priority Process: Impact on Outcomes		
The organization has met all criteria for this priority process.		

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

There is an interdisciplinary quality improvement (QI) team with representation from the therapy program, nursing, rehabilitation units, and management. The team meets quarterly to review services, and to develop a plan to provide services, and address gaps and identify ways to address them.

The rehabilitation therapy team provides services across the community, for acute, and long term care settings. There are challenges identified with recruitment, and there are vacancies across physical therapist (PT) and occupational therapist (OT) and audiology. The interdisciplinary team work within the resources to meet the needs of the clients. Clients are prioritized based on urgency. The gaps in positions due to vacancies, are communicated to leadership, and efforts are ongoing to recruit.

The rehabilitation program partners with various committees within Prairie Mountain Health such as stroke, falls prevention, and wound care. There are multiple external partners, and links such as the Provincial Universal Newborn Hearing Screening, Provincial Therapy Counterparts, and Family Services Manitoba. These partnerships provide opportunities to implement initiatives to meet specific needs. The team has partnered with Family Services School Divisions and the Rehabilitation Centre for Children to provide PT, OT, speech language pathologists (SLP) and audiology services to children.

The team has achieved much success since regionalization, and through their model of shared staffing have been better able to meet the demands across the region. The team is commended for its collaborative approach within the organization, and their contributions to initiatives with other teams such as stroke.

Clients are provided with information on services available in rehabilitation, and a patient/family information booklet is provided. Staff provide information to clients/families about their therapy on an ongoing basis.

Feedback from clients is obtained on an ongoing basis during therapy, and annually through satisfaction surveys. The results of the survey showed that clients were very satisfied with the information provided to them, and their service. Families, and clients indicated they received adequate information about their therapy.

Priority Process: Competency

The team works collaboratively to meet client's needs. Members of the team are engaged in treatment as the clients need indicate.

Communication between the team is through standardized assessment, treatment tools, and multidisciplinary progress notes. Rehabilitation white boards in clients rooms are used to share information detailing patient's mobility status with team members and families.

Workload is reviewed daily in consultation with the care coordinator and prioritized based on criteria and urgency. Members of the therapy team work across acute, long term care and community and at times there are many demands.

Staff were aware of the organization's new initiatives, and policies. Staff were familiar with the new ethical decision-making framework, work-place violence prevention, infusion pumps, risk management and incident reporting procedures.

Staff are provided opportunities to participate in education, and training. Allied Health professionals were able to access financial support up to $350.00 annually, and leave is supported for staff to attend when possible.

There were many on-site training opportunities through e-learning, and on new initiatives, and equipment. The team are involved in providing education to nursing staff in oral care, pressure ulcer prevention, and orthopedic protocols. Speech language pathologists have received training in swallowing assessment, and they are providing training to nurses which will enable this to be completed across the region.

Staff indicated that they receive feedback on their performance from their manager on an ongoing basis, and several indicated they had a performance review within the past year.

Clients, and families are involved in the elaboration of their treatment plans. Rehabilitation staff work on goals with the clients/families, to provide feedback, and encouragement to help clients achieve their goals. They provide realistic, and honest feedback to clients on progress.

Priority Process: Episode of Care

The team assess clients on the waitlist for admission to the rehabilitation units. There are criteria in place to determine eligibility, and priority. The team reviews demand, and responds to needs where possible. For example, when a client has been identified to need therapy, and a bed is not available the therapist may provide therapy on the acute unit on an interim basis. Also a review of demand showed a long wait for stroke rehabilitation in the region, and a sub-optimal occupation rate for the beds at the Rivers location. Therefore, the team decided to expand its admission criteria to allow stroke patients when necessary.

To be eligible for admission, the client communicates their wishes to have rehabilitation, to be cognitively well, physically able to participate in rehabilitation, and medically stable, among other criteria. Clients and families participate actively in treatment planning as well as discharge planning.

Limited access to services across the region, particularly in the rural areas was identified as a gap. The team is encouraged to proceed with focused recruitment strategies to fill vacant therapist positions. The training of nursing staff, and aides to assist with the delivery of services is encouraged.

Clients are referred to Winnipeg for services that are not available in the region.

Informed consent is verbally obtained, and written in admission assessment. Physiotherapists are encouraged to review their consent process to ensure that it meets the requirements of their licensing body.

Staff are aware of new ethics framework, and have used it to address ethical issues.

Clients interviewed during the tracer indicated they were provided with information about their treatment, how to access equipment, and services. Information regarding complaints is provided in the Patient Safety Handbook.

The admission process to rehabilitation services is comprehensive, includes a fall risk assessment, and the Braeden wound assessment. A best possible medication history is prepared sourcing the pharmacy network, information from the clients and family or the referring facility, and validated by the teams' physician.

The client is involved in setting their therapy goals, and targets for progress are established with the clients. A discharge plan is initiated with client, and families input. Families are encouraged to participate in the therapy sessions when possible. Families interviewed, indicated they felt welcomed, and supported to participate.

An Advanced Care Directive is completed with each client upon admission, and updated if the clients condition changes.

Clients are provided information on transfer or discharge. Incidents are reported when identified. The satisfaction survey completed asks if clients were satisfied with the information they received on transfer or discharge. The organization is encourgare to improve the transfer or discharge information process for clients.

The team is involved in assessing clients that have been referred that are palliative, end of life in the facility, or in the home. The team assess using tools for pain, ymptom management, psycho-social needs, and mobility. The team are involved with clients that may need therapy to facilitate them returning home.

The Activities of Daily Living room on the rehabilitation unit is used to assess clients to determine their readiness to return home, and facilitate their transition.

Priority Process: Decision Support

Health records are paper-based. A "Basic Chart Order" list is placed at the beginning of each client record to ensure standardization. The records were in good order and comprehensive.

The flow of information across the team was good, and facilitated the care in a timely, and efficient manner.

A procedure for clients to access their own files is clearly identified in the Patient Safety Handbook provided to clients upon admission.

The team is encouraged to use technology such as videoconferencing to enhance access to therapists where possible.

Priority Process: Impact on Outcomes

There is awareness among the team of risks, tools to assess, and mitigate risks. Assessments for fall risks, and pressure ulcer risk are integrated into the assessment of all clients.

Staff use the incident report to report an error or accident such as falls and medication errors. The incident is investigated, the manager reviews, and analyses reports. These reports are reviewed with the clinical leadership team. The team is encouraged to use these reports to identify areas for improvement, and share the results with the front line staff.

The evaluation of the Functional Independence Program which involves OT/PT case managing clients in their home with a Rehabilitation Aide providing intense rehabilitation for a period of eight (8) weeks has shown positive impacts. This includes reducing Emergency Department usage, and falls for participating clients. Further evaluation is ongoing, and will be used to provide evidence to continue the program, and expand it to other areas in the region to reduce hospital admissions, and enable clients to stay home longer. Measurement of pre-service falls, and emergency room usage as well as qualitative analysis of premature admission to Prairie Mountain Health will be used to provide evidence for the program.

Instrument Results

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

Governance Functioning Tool (2011 - 2015)

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

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

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

- **Data collection period: January 20, 2015 to February 27, 2015**
- **Number of responses: 7**

Governance Functioning Tool Results

	% Disagree	% Neutral	% Agree	%Agree * Canadian Average
	Organization	Organization	Organization	
1 We regularly review, understand, and ensure compliance with applicable laws, legislation and regulations.	0	14	86	93
2 Governance policies and procedures that define our role and responsibilities are well-documented and consistently followed.	0	14	86	96
3 We have sub-committees that have clearly-defined roles and responsibilities.	0	0	100	97
4 Our roles and responsibilities are clearly identified and distinguished from those delegated to the CEO and/or senior management. We do not become overly involved in management issues.	0	0	100	94

		% Disagree	% Neutral	% Agree	%Agree * Canadian Average
		Organization	Organization	Organization	
5	We each receive orientation that helps us to understand the organization and its issues, and supports high-quality decisionmaking.	0	0	100	93
6	Disagreements are viewed as a search for solutions rather than a “win/lose”.	0	0	100	95
7	Our meetings are held frequently enough to make sure we are able to make timely decisions.	14	0	86	97
8	Individual members understand and carry out their legal duties, roles and responsibilities, including sub-committee work (as applicable).	0	0	100	97
9	Members come to meetings prepared to engage in meaningful discussion and thoughtful decision-making.	0	14	86	94
10	Our governance processes make sure that everyone participates in decision-making.	0	14	86	95
11	Individual members are actively involved in policy-making and strategic planning.	0	14	86	90
12	The composition of our governing body contributes to high governance and leadership performance.	0	0	100	93
13	Our governing body’s dynamics enable group dialogue and discussion. Individual members ask for and listen to one another’s ideas and input.	0	0	100	96
14	Our ongoing education and professional development is encouraged.	0	14	86	90
15	Working relationships among individual members and committees are positive.	0	0	100	97
16	We have a process to set bylaws and corporate policies.	0	0	100	96
17	Our bylaws and corporate policies cover confidentiality and conflict of interest.	0	0	100	98
18	We formally evaluate our own performance on a regular basis.	14	0	86	83
19	We benchmark our performance against other similar organizations and/or national standards.	29	43	29	71

		% Disagree	% Neutral	% Agree	%Agree * Canadian Average
		Organization	Organization	Organization	
20	Contributions of individual members are reviewed regularly.	29	29	43	66
21	As a team, we regularly review how we function together and how our governance processes could be improved.	0	29	71	79
22	There is a process for improving individual effectiveness when non-performance is an issue.	14	29	57	62
23	We regularly identify areas for improvement and engage in our own quality improvement activities.	0	29	71	79
24	As a governing body, we annually release a formal statement of our achievements that is shared with the organization's staff as well as external partners and the community.	0	29	71	81
25	As individual members, we receive adequate feedback about our contribution to the governing body.	14	43	43	69
26	Our chair has clear roles and responsibilities and runs the governing body effectively.	0	0	100	96
27	We receive ongoing education on how to interpret information on quality and patient safety performance.	0	0	100	90
28	As a governing body, we oversee the development of the organization's strategic plan.	0	0	100	96
29	As a governing body, we hear stories about clients that experienced harm during care.	0	0	100	88
30	The performance measures we track as a governing body give us a good understanding of organizational performance.	0	14	86	95
31	We actively recruit, recommend and/or select new members based on needs for particular skills, background, and experience.	25	25	50	91
32	We have explicit criteria to recruit and select new members.	0	100	0	87
33	Our renewal cycle is appropriately managed to ensure continuity on the governing body.	0	0	100	94

		% Disagree	% Neutral	% Agree	%Agree * Canadian Average
		Organization	Organization	Organization	
34	The composition of our governing body allows us to meet stakeholder and community needs.	0	0	100	93
35	Clear written policies define term lengths and limits for individual members, as well as compensation.	0	0	100	95
36	We review our own structure, including size and subcommittee structure.	0	25	75	91
37	We have a process to elect or appoint our chair.	33	33	33	93

*Canadian average: Percentage of Accreditation Canada client organizations that completed the instrument from January to June, 2015 and agreed with the instrument items.

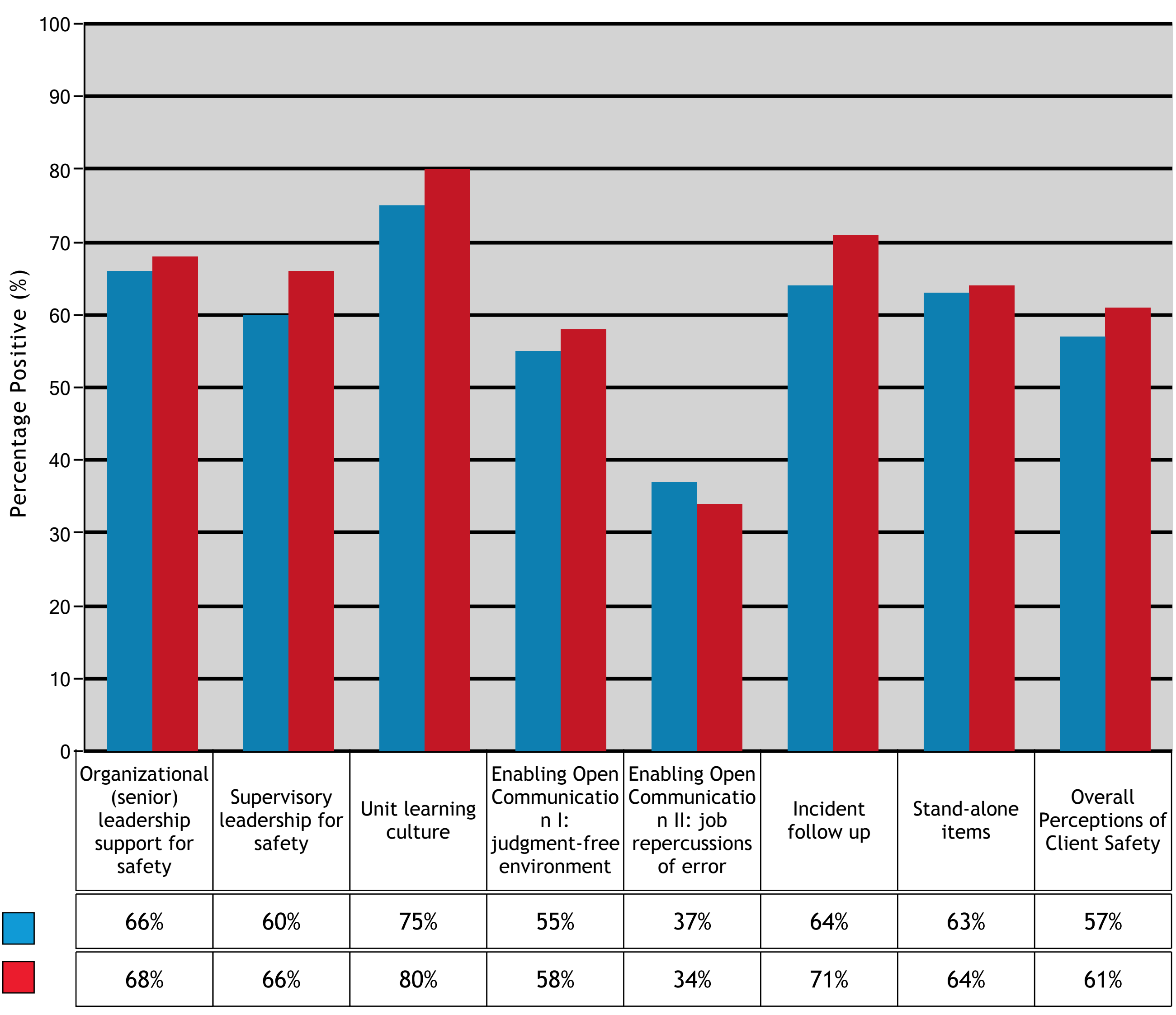
Canadian Patient Safety Culture Survey Tool

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

Results from the Patient Safety Culture Tool allow the organization to identify strengths and areas for improvement in a number of areas related to patient safety and worklife. Accreditation Canada provided the organization with detailed results from its Patient Safety Culture Tool prior to the on-site survey through the client organization portal. The organization then had the opportunity to address areas for improvement. During the on-site survey, surveyors reviewed progress made in those areas.

- **Data collection period: September 1, 2015 to October 9, 2015**
- **Minimum responses rate (based on the number of eligible employees): 359**
- **Number of responses: 361**

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



	Organizational (senior) leadership support for safety	Supervisory leadership for safety	Unit learning culture	Enabling Open Communication I: judgment-free environment	Enabling Open Communication II: job repercussions of error	Incident follow up	Stand-alone items	Overall Perceptions of Client Safety
Prairie Mountain Health	66%	60%	75%	55%	37%	64%	63%	57%
* Canadian Average	68%	66%	80%	58%	34%	71%	64%	61%

Legend

Prairie Mountain Health

* Canadian Average

*Canadian average: Percentage of Accreditation Canada client organizations that completed the instrument from July to December, 2015 and agreed with the instrument items.

Worklife Pulse

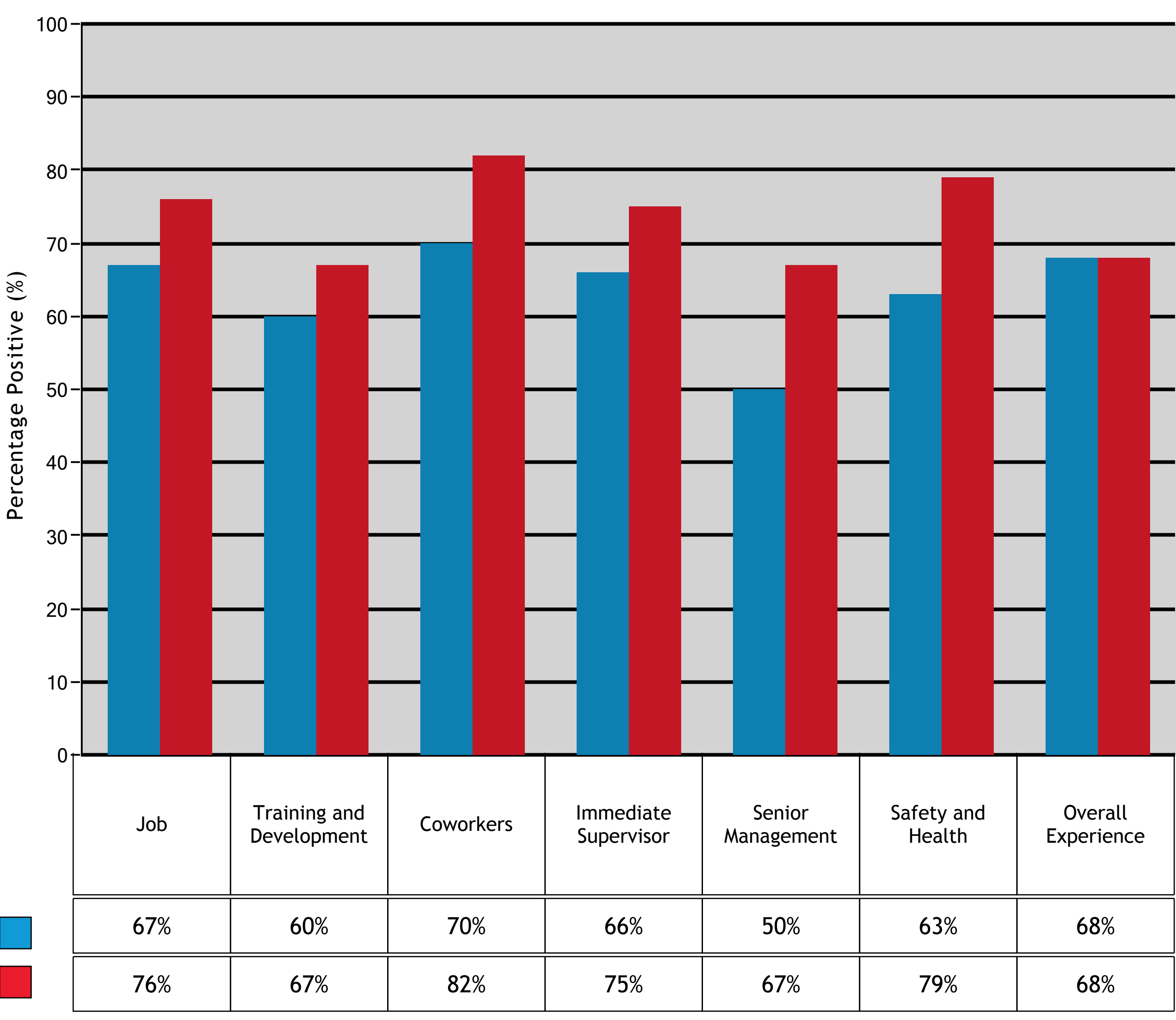
Accreditation Canada helps organizations create high quality workplaces that support workforce wellbeing and performance. This is why Accreditation Canada provides organizations with the Worklife Pulse Tool, an evidence-informed questionnaire that takes a snapshot of the quality of worklife.

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

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

- **Data collection period: November 24, 2014 to February 15, 2015**
- **Minimum responses rate (based on the number of eligible employees): 363**
- **Number of responses: 839**

Worklife Pulse: Results of Work Environment



	Job	Training and Development	Coworkers	Immediate Supervisor	Senior Management	Safety and Health	Overall Experience
Prairie Mountain Health	67%	60%	70%	66%	50%	63%	68%
* Canadian Average	76%	67%	82%	75%	67%	79%	68%

Legend

Prairie Mountain Health

* Canadian Average

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

Client Experience Tool

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

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

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

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

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

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

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

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

Organization's Commentary

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

Prairie Mountain Health has completed an initial review of the June 12-17, 2016 draft Accreditation Canada on-site results report and finds the results to be generally consistent with current organizational successes and challenges.
The organization is proud to be able to report to the population served that 89.5% of Accreditation Canada national standards of care have been met as assessed by an independent team of surveyors from across Canada. The organization continually strives to improve and this is evident through the findings within this report.
The organization does have teams/committees established working towards the implementation of remaining unmet standards and the sustainability of standards achieved. The final Accreditation Canada on-site report will be utilized to help strengthen ongoing efforts in achieving the Prairie Mountain Health vision and in validating the mission and values:
VISION: Health And Wellness For All
MISSION: Together, we promote and improve the health of people in our region through the delivery of innovative and client-centered health care.
VALUES: Integrity, Accountability, Equity, Respect, Responsiveness, Engagement
Prairie Mountain Health believes in continuous improvement as a means of achieving the provision of quality care and services. Quality is comprised of care that is safe, accessible, appropriate, effective, efficient, and coordinated. In addition, wellness is supported in the work environment which positively influences care that is client-centered and population focused. Our partnership with Accreditation Canada is a valuable mechanism to incorporate continuous improvement into the organizational structure and operations.

Appendix A - Qmentum

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

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

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

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

Action Planning

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

Evidence Review and Ongoing Improvement

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

Appendix B - Priority Processes

Priority processes associated with system-wide standards

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

Priority processes associated with population-specific standards

Priority Process	Description
Chronic Disease Management	Integrating and coordinating services across the continuum of care for populations with chronic conditions

Priority Process	Description
Population Health and Wellness	Promoting and protecting the health of the populations and communities served through leadership, partnership, and innovation.

Priority processes associated with service excellence standards

Priority Process	Description
Blood Services	Handling blood and blood components safely, including donor selection, blood collection, and transfusions
Clinical Leadership	Providing leadership and direction to teams providing services.
Competency	Developing a skilled, knowledgeable, interdisciplinary team that can manage and deliver effective programs and services.
Decision Support	Maintaining efficient, secure information systems to support effective service delivery.
Diagnostic Services: Imaging	Ensuring the availability of diagnostic imaging services to assist medical professionals in diagnosing and monitoring health conditions
Diagnostic Services: Laboratory	Ensuring the availability of laboratory services to assist medical professionals in diagnosing and monitoring health conditions
Episode of Care	Partnering with clients and families to provide client-centred services throughout the health care encounter.
Impact on Outcomes	Using evidence and quality improvement measures to evaluate and improve safety and quality of services.
Infection Prevention and Control	Implementing measures to prevent and reduce the acquisition and transmission of infection among staff, service providers, clients, and families
Living Organ Donation	Living organ donation services provided by supporting potential living donors in making informed decisions, to donor suitability testing, and carrying out living organ donation procedures.
Medication Management	Using interdisciplinary teams to manage the provision of medication to clients

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