ACCREDITATION AGRÉMENT CANADA

Accreditation Report

Qmentum Global™ for Canadian Accreditation Program

Prairie Mountain Health Sequence 2

Report Issued: September 16, 2026

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About Accreditation Canada

Accreditation Canada is a global, not-for-profit organization with a vision for safer care and a healthier world. Our people-centred programs and services have been setting the bar for quality across the health ecosystem for more than 60 years. We continue to grow in our reach and impact. Accreditation Canada empowers and enables organizations to meet national and global standards with innovative programs that are customized to local needs. Accreditation Canada's assessment programs and services support the delivery of safe, high-quality care in health systems, hospitals, laboratories and diagnostic centres, long-term care, rehabilitation centres, primary care, home, and community settings. Our specialized accreditation and certification programs support safe, high-quality care for specific populations, health conditions, and health professions.

About the Accreditation Report

The Organization identified in this Accreditation Report (the "**Organization**") has participated in Accreditation Canada's Qmentum Global™ for Canadian Accreditation program.

As part of this program, the Organization has partaken in continuous quality improvement activities and assessments, including an on-site survey from May 23, 2026 to May 29, 2026. This Accreditation Report reflects the Organization's information and data, and Accreditation Canada's assessments, as of those dates.

Information from the assessments, as well as other information and data obtained from the Organization, was used to produce this Report. Accreditation Canada relied on the accuracy and completeness of the information provided by the Organization to plan and conduct its on-site assessments and to produce this Report. It is the Organization's responsibility to promptly disclose any and all incidents to Accreditation Canada that could impact its accreditation decision for the Organization.

Program Overview

The Qmentum Global Program enables your organization to continuously improve quality of care through the sustainable delivery of high-quality care experiences and health outcomes. The program provides your organization with standards, survey instruments, assessment methods and an action planning feature that were designed to promote continuous learning and improvement, and a client support model for on-going support and advice from dedicated advisors.

Your organization participates in a four-year accreditation cycle that spreads accreditation activities over four years supporting the shift from a one-time assessment while helping your organization maintain its focus on planning, implementing, and assessing quality and improvements. It encourages your organization to adopt accreditation activities in everyday practices.

Each year of the accreditation cycle includes activities that your organization will complete. Accreditation Canada provides ongoing support to your organization throughout the accreditation cycle. When your organization completes year 4 of the accreditation cycle, Accreditation Canada's Accreditation Decision Committee determines your organization's accreditation status based on the program's accreditation decision guidelines. The assessment results and accreditation decision are documented in a final report stating the accreditation status of your organization. After an accreditation decision is made, your organization enters year 1 of a new cycle, building on the actions and learnings of past accreditation cycles, in keeping with quality improvement principles.

The assessment manual (Accreditation Canada Manual) which supports all assessment methods (self-assessment, attestation, and on-site assessment), is organized into applicable Standards and ROPs/RSPs. To promote alignment with the assessment manual (Accreditation Canada Manual), assessment results and surveyor findings are organized by Standard, within this report.

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Additional report contents include a comprehensive executive summary, the organization's accreditation decision, locations assessed during the on-site assessment, required organizational practices results, and conclusively, People-Centered Care and Quality Improvement Overviews.

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Executive Summary

About the Organization

Prairie Mountain Health (PMH) was established in 2012 following the amalgamation of 3 Regional Health Authorities (Assiniboine, Brandon, and Parkland).

Prairie Mountain Health facilities are located on Treaty 1, 2, and 4 Territories, the original lands of the Dakota, Anishinaabe, Cree, Oji-Cree, and the National Homeland of the Red River Métis.

PMH employs approximately 7500 staff who together provide a broad continuum of health programs and services. In Prairie Mountain Health region, there are twenty acute care (hospital) sites, forty-three long term care (personal care home) sites, and nine transitional care sites. Community health programs/allied health services are offered across the region, inclusive of rehabilitation and therapy services, cancer care, home care, palliative care, public health, primary health care, mental health & addiction services.

PMH partners with Shared Health for services such as emergency medical services, laboratory & diagnostics.

PMH spans an area of 67,000 square kilometers and is growing in population and diversity. The population of approximately 168,876 residents is inclusive of 58 towns/municipal councils (including the cities of Brandon and Dauphin), 14 First Nation communities, 15 Northern Affairs communities, and 38 Hutterite communities.

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Surveyor Overview of Team Observations

Prairie Mountain Health (PMH) was officially formed in June 2012 following the Manitoba government amalgamation of the former regional health authorities of Assiniboine, Brandon and Parkland. It is one of five regional health authorities in southwest Manitoba. PMH is an organization with a strong foundation of innovation, collaboration, and quality improvement, while also identifying strategic opportunities that warrant focused senior leadership attention regionally and provincially in the coming years. This survey sequence included an assessment of both urban and rural acute care facilities in PMH.

The provincial health authority, Shared Health Manitoba (Shared Health), oversees all Manitoba health authorities to plan and implement a coordinated, provincial approach to health services. The regional health authorities contribute to provincial efforts to improve access, quality and reliability of health services for all Manitobans. Shared Health's committee and network structures provide policies, practices, and committee structures that reflect oversight and alignment across the provincial, regional, and local levels. This multi-level leadership and governance structure supports consistency, accountability, and strategic coordination across the organization and reinforces PMH's commitment to high-quality care delivery.

All regional health authorities were included in this current accreditation survey sequence. PMH goals for accreditation were aligned with the approach to the assessment: engage and empower direct care teams, highlight delivery of quality health care and impacts of provincial shared initiatives implementation, and support and validate their work.

PMH demonstrates notable strengths in its ability to implement creative human resources strategies, support continuous learning through a Knowledge Exchange Program, and maintain accountability through annual formalized quality audits. The organization is commended for identifying and implementing several quality improvement initiatives that were based on the award-winning Wounds Canada wound care champion program, a revised surgical checklist that includes a new sign-in process that has been implemented provincially.

A particularly important strength of PMH is its commitment to partnership, inclusion, and patient-centred care. Collaboration with First Nations and Métis communities reflects a meaningful effort to build relationships that support culturally informed care and community responsiveness across the region. In addition, people-centred care is clearly embedded in organizational activities and strategies, ensuring that the voice of the patient informs decision-making and service delivery. This is further supported by an engaged and motivated senior leadership team and an organizational culture characterized by a practical, action-oriented mindset. For senior leaders, these attributes represent a solid strategic platform - a leadership environment that is values-driven, responsive to community needs, and supported by governance and oversight mechanisms that connect local operational realities with regional priorities and provincial direction.

At the same time, several opportunities point to areas where continued planning, prioritization, and system-level coordination will be essential. Addressing aging infrastructure remains critical to sustaining safe, efficient, and modern care environments. There is also a significant opportunity to advance a more comprehensive rural strategy for clinical services, infection prevention and control and human resources, particularly in the context of persistent staff and physician recruitment and retention challenges. Nursing leadership at both the provincial and regional levels is to be commended for the creativity and innovation demonstrated in implementing new initiatives, roles, and models of care to support recruitment and retention. Examples include the undergraduate nurse employee role, initiatives to support internationally educated nurses in becoming practice ready, international recruitment strategies, implementation of a travel nurse role negotiated in partnership with unions to reduce reliance on agency nurses, and support for licensed practical nurses to work to their full scope of practice. Provincial support has further strengthened these efforts through investments in clinical mentorship and required education days. These workforce pressures, coupled with change fatigue, nonetheless underscore the need for strong performance conversations, clear communication, and practical supports that enable teams to adapt while remaining engaged.

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The coexistence of hybrid documentation systems and the ongoing journey toward provincial and regional standardization present an important leadership challenge and opportunity to improve consistency, reduce variation, and strengthen integration across service areas and levels of the health system. Staff verbalized some frustrations with the long process involved in making changes to provincial policies in addition to some confusion about which policies they should be following. Focused attention on policy development, reviews, distribution and implementation processes would go a long way in supporting clinical teams.

Additional opportunities such as expanding involvement in organ and tissue donation, updating policies, and adopting a more strategic approach to resource distribution reinforce the need for a coordinated and forward-looking strategy. Overall, PMH appears well positioned to build on its considerable strengths while addressing the structural, workforce, and system-level challenges ahead. Its engaged leadership team, collaborative culture, and established oversight structure spanning provincial, regional, and local levels provide a strong foundation for advancing strategic priorities, strengthening service delivery, and supporting sustainable, equitable health outcomes for the populations and communities it serves.

Key Opportunities and Areas of Excellence

Areas of Excellence:

- Engaged and motivated staff and physicians
- Creative HR strategies
- Knowledge exchange boards
- Leading practice -- wound care program
- Integrated models of care
- Comprehensive education and training opportunities for staff
- Good relationships between hospitals and Emergency Response Services (ERS)
- Effective patient flow committee structure up to the provincial level
- Involvement/collaboration with First Nations and Métis communities
- People-centred care activities and strategies to integrate the voice of the patient in everything they do
- Just do it attitude
- Positive patient satisfaction
- Capital investments in redeveloped and redesign (Neepawa, Brandon)

Opportunities:

- Addressing aging infrastructure
- Develop a rural strategy for clinical services and human resources
- Address the potential for change fatigue
- Staff and Physician recruitment and retention
- Performance conversations
- Hybrid documentation systems
- Navigating the journey of Provincial and Regional standardization
- Organ and Tissue Donation involvement
- Policy updates and confusion about provincial vs regional
- Review distribution of resources

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People-Centred Care

PMH has demonstrated a strong and sustained organizational commitment to people centred care which was evident across the organization. Various sites visited during the survey actively seek to incorporate the voice of patients into the design, delivery and improvement of their health services. The establishment of provincial patient partner roles and network support have helped PMH to more readily include the voice of patients and families into quality improvement. Examples of this work include patient education pamphlet design, redevelopment projects (Brandon's new critical care and inpatient building, and program patient satisfaction surveys. There has also been involvement by regional patient partners.

PMH has demonstrated strong examples of collaboration between the organization, clients and communities in the co-design of services and physical spaces; in several instances patients and families were engaged from the earliest stages of projects, contributing to consultation processes and participating in project specific focus or work in groups with defined objectives and timelines.

PMH has implemented a variety of mechanisms to receive and act on feedback from patients demonstrating a clear commitment to listening and responding to the voices of those it serves. Patients/families are invited to become a patient partner when feedback surveys are completed and when the teams receive concerns about their care and service.

The delivery of patient care is respectful and collaborative. Shared decision making and care planning were notable.

PMH is encouraged to conduct an inventory of teaching and information pamphlets that are provided to patients and families. Most information is provided in English. Patient partners might assist the region to identify those that would be useful in other languages.

The organization continues to strive to improve their people-centred care practices, focusing on engaging with culturally diverse staff, clients and families to better understand their cultural needs related to health and wellness. Many clinical programs include Indigenous liaisons that support the team to better support this patient and family population. PMH is encouraged to continue efforts to recruit local patient partners to support health care organizations across the region.

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Accreditation Decision

Prairie Mountain Health's accreditation decision is:

Accredited

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

Locations Assessed during On-Site Assessment

The following locations were assessed during the organization's on-site assessment:

- PMH - Boissevain Health Center & Evergreen Personal Care Home
- PMH - Brandon Regional Health Centre
- PMH - Carberry Health Centre and Personal Care Home
- PMH - Dauphin Regional Health Centre
- PMH - Deloraine Health Centre & Personal Care Home
- PMH - Grandview District Hospital
- PMH - Minnedosa Health Centre
- PMH - Ste. Rose General Hospital

[1]Location sampling was applied to multi-site single-service and multi-location multi-service organizations.

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Required Organizational Practices

Required Organization Practices (ROP) and Required Safety Practices (RSP) are essential practices that an organization must have in place to enhance client safety and minimize risk. ROP/RSP contain multiple criteria, which are called Tests for Compliance (TFC).

Table 1: Summary of the Organization's ROPs/RSPs

ROP/RSP Name	Standard(s)	# TFC Rating Met	% TFC Met
Adhering to a Do-Not-Use List of Abbreviations, Symbols, and Dose Designations	Medication Management	3 / 5	60.0%
Antimicrobial Stewardship	Medication Management	5 / 5	100.0%
Cleaning and Low-Level Disinfecting Medical Equipment	Infection Prevention and Control	5 / 5	100.0%
Client Identification	Critical Care Services	1 / 1	100.0%
	Emergency Department	1 / 1	100.0%
	Inpatient Services	1 / 1	100.0%
	Obstetrics Services	1 / 1	100.0%
	Perioperative Services and Invasive Procedures	1 / 1	100.0%
Improving Hand Hygiene Practices	Infection Prevention and Control	5 / 5	100.0%
Infection Rates	Infection Prevention and Control	3 / 3	100.0%

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Table 1: Summary of the Organization's ROPs/RSPs

ROP/RSP Name	Standard(s)	# TFC Rating Met	% TFC Met
Information Transfer at Care Transitions	Critical Care Services	5 / 5	100.0%
	Emergency Department	5 / 5	100.0%
	Inpatient Services	3 / 5	60.0%
	Obstetrics Services	2 / 5	40.0%
	Perioperative Services and Invasive Procedures	4 / 5	80.0%
Infusion Pump Safety	Service Excellence	6 / 6	100.0%
	Service Excellence for Critical Care Services	6 / 6	100.0%
	Service Excellence for Emergency Department	5 / 5	100.0%
	Service Excellence for Obstetrics Services	6 / 6	100.0%
	Service Excellence for Perioperative Services and Invasive Procedures	6 / 6	100.0%
Limiting High-Concentration and High-Total-Dose Opioid Formulations	Medication Management	5 / 5	100.0%

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Table 1: Summary of the Organization's ROPs/RSPs

ROP/RSP Name	Standard(s)	# TFC Rating Met	% TFC Met
Maintaining an Accurate List of Medications during Care Transitions	Critical Care Services	5 / 5	100.0%
	Emergency Department	5 / 5	100.0%
	Inpatient Services	5 / 5	100.0%
	Obstetrics Services	5 / 5	100.0%
	Perioperative Services and Invasive Procedures	5 / 5	100.0%
Managing High-Alert Medications	Medication Management	4 / 5	80.0%
Optimizing Skin Integrity	Critical Care Services	6 / 6	100.0%
	Emergency Department	2 / 6	33.3%
	Inpatient Services	6 / 6	100.0%
	Obstetrics Services	2 / 6	33.3%
	Perioperative Services and Invasive Procedures	6 / 6	100.0%

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Table 1: Summary of the Organization's ROPs/RSPs

ROP/RSP Name	Standard(s)	# TFC Rating Met	% TFC Met
Preventing Falls and Reducing Injuries from Falls	Critical Care Services	7 / 7	100.0%
	Emergency Department	7 / 7	100.0%
	Inpatient Services	7 / 7	100.0%
	Obstetrics Services	6 / 7	85.7%
	Perioperative Services and Invasive Procedures	7 / 7	100.0%
Preventing Venous Thromboembolism	Critical Care Services	6 / 6	100.0%
	Emergency Department	6 / 6	100.0%
	Inpatient Services	6 / 6	100.0%
	Obstetrics Services	6 / 6	100.0%
	Perioperative Services and Invasive Procedures	6 / 6	100.0%
Reprocessing	Infection Prevention and Control	2 / 2	100.0%
Safe Surgery Checklist	Obstetrics Services	5 / 5	100.0%
	Perioperative Services and Invasive Procedures	5 / 5	100.0%

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Table 1: Summary of the Organization's ROPs/RSPs

ROP/RSP Name	Standard(s)	# TFC Rating Met	% TFC Met
Suicide Prevention Program	Service Excellence	3 / 5	60.0%
	Service Excellence for Critical Care Services	5 / 5	100.0%
	Service Excellence for Emergency Department	4 / 5	80.0%
	Service Excellence for Obstetrics Services	5 / 5	100.0%
	Service Excellence for Perioperative Services and Invasive Procedures	4 / 5	80.0%

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Assessment Results by Standard

The following section includes the outcomes from the attestation (if applicable) and on-site assessments, at the conclusion of the on-site assessment.

Core Standards

Qmentum Global™ for Canadian Accreditation has a set of core assessment standards that are foundational to the program and are required for the organization undergoing accreditation. The core assessment standards are critical given the foundational areas of high quality and safe care they cover.

The core standards are always part of the assessment, except in specific circumstances where they are not applicable.

Infection Prevention and Control

Standard Rating: 100.0% Met Criteria

0.0% of criteria were unmet. For further details please review the table at the end of this section.

Assessment Results

The Prairie Mountain Health (PMH) Infection Prevention and Control (IPC) team serves a large geographical area with sites that range from regional centres to small rural health centres and personal care homes. The teams working across all sites and the IPC teams are commended for their commitment to a safe and quality IPC program. However, there are notable gaps in the support provided to smaller rural sites for implementing the numerous new provincial initiatives. As highlighted by staff, leaders and Infection Control Practitioners, the current approach is not sustainable.

Infection Control Practitioners (ICPs) have assignments based on facility size, bed numbers and proximity to their “home” site. Since the previous survey cycle and the release of the Stevenson Review and Report, commissioned to review practices in long-term care (LTC) due to COVID-19 infections, Infection Control Associate (ICA) roles and positions (9) have been created and distributed across the region to support the LTC sites with oversight from the ICPs assigned to each.

Although the number of ICPs has increased since the previous survey cycle, so have the expectations on teams for monitoring (auditing) and actioning the results of audits. A new “auditing framework” (including site audits, clean and soiled utility room audits, hand hygiene audits, PPE audits, equipment cleaning audits) from Shared Health is expected to define both frequency and responsibility for who should be conducting audits. At the smaller rural sites, the consensus amongst staff and leaders is that the current approach to IPC monitoring/surveillance is not sustainable and was described as, “firefighting, not prevention”. Clinical resource nurses (CRNs) and other staff at rural sites to whom audit functions are currently delegated reported that, due to staffing shortages and the lack of dedicated time for IPC responsibilities, these duties are managed ad hoc (“off the side of their desks”). As a result, key responsibilities (primarily hand hygiene audits) are deprioritized and can easily fall off the radar.

ICPs dedicated to the smaller rural sites reported they feel stretched and conflicted, focusing on outbreak management and reporting rather than education and hands on support to their acute care site teams. The dual LTC/acute care role was also noted as creating a push/pull situation, as LTC needs (due to the higher number of outbreaks) take precedence.

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In Brandon, retired nurses have been hired to conduct audits, creating a clear sense that these activities are appropriately resourced and prioritized. However, there is also a need for dedicated resources to support follow-up on audit results and findings, including developing and testing improvement ideas and implementing changes once they are ready to spread. One person stated, “there is no drive after the data is collected”.

During the onsite survey, many of the deficiencies noted in the previous survey remained unaddressed. These included wooden surfaces (e.g., railings), non-medical grade furnishings in waiting areas and patient rooms, storage in hallways, patients separated by curtains in the Emergency Department, a lack of one-way flow in smaller medical device reprocessing departments (MDRDs), and pony walls that are not sealed to the ceiling in previously identified areas. The organization is encouraged to prioritize renovation projects to address these significant risks to patient care and infection prevention and control.

The organization is encouraged to address the challenge with meeting hand hygiene (HH) audit completion rates, there was consensus from team members, leaders and ICPs alike about the need for executing a plan to fund and hire a dedicated HH Coordinator position to oversee and streamline the auditing processes. Exploring technological means to release time to focus on IPC functions, such as installing automated bedpan washers would also have downstream impacts on both better and safer cleaning practices.

There are many committees that engage IPC team members, frontline and regional leaders across the organization, including representatives from occupational health and safety, the MDRD and, nursing in key IPC initiatives, policy and procedure development with a view to evidence-based, best practice and standardization where appropriate. Policies and procedures are being developed at the provincial level by Shared Health and where appropriate adapted and adopted to fit the regional or local context. Local teams noted that the volume and pace of changes to policies and protocols can be overwhelming, expressing a desire for a more streamlined and manageable approach.

Community partnerships with Public Health and others in the area of surveillance and reporting is strong. A grass roots committee within PMH (a subset of the Acute Care Education Committee) conducted a survey to explore how to better engage with acute care teams. Infectious diseases/conditions were listed, and respondents were asked to rate their confidence in managing them. They were also asked what makes IPC practices difficult to achieve. The results are being used to develop a plan that tailors both content and delivery of learning from the results of the survey.

Laundry, housekeeping, and food services staff encountered during tracers are well trained in IPC protocols and are proud to keep their site and kitchens clean and safe. Staff demonstrated strong knowledge of how to protect themselves and their patients and strong commitment to ensuring a clean and safe environment. A challenge for infection prevention and control is the aging infrastructure on many of the rural sites which results in limited storage resulting in hallway and room clutter.

In the clinical areas, triage and admissions processes were observed that included communicable disease screening and an MRSA positive patient who was managed according to protocols.

Table 2: Unmet Criteria for Infection Prevention and Control

There are no unmet criteria for this section.

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Medication Management

Standard Rating: 89.9% Met Criteria

10.1% of criteria were unmet. For further details please review the table at the end of this section.

Assessment Results

Prairie Mountain Health (PMH oversees medication management through its organizational structure and several regional multidisciplinary committees.

The Transformation of Healthcare in Manitoba and the Clinical and Preventative Services Plan (CPSP) have increased provincial initiatives related to medication management. Given that medication management is a high-risk area, stronger provincial coordination is a positive direction. It will support greater standardization across the province, reduce variation in practice, improve patient safety, and help bring care closer to home outside tertiary centres. At the same time, change fatigue and burnout require focused attention. Staff and leaders were observed to be already managing heavy workloads, vacancies, and ongoing operational pressures, and these realities may affect the pace and sustainability of further change.

Medication management was assessed at five sites:

Dauphin Regional Health Centre

The Dauphin Regional Health Centre Pharmacy Department provides distribution and clinical services to rural sites such as Grandview Health Centre and Ste. Rose General Hospital. Chemotherapy services are provided for Dauphin RHC and Swan River Health Centre. Pharmacy services are also provided to rural Emergency Response Services (ERS) in the geographic area.

The Department is original to the facility and is unlikely to meet National Association of Pharmacy Regulatory Authorities (NAPRA) standards in its current form, including the original hood setup. Anaesthetic gases in the main pharmacy are stored on a bottom shelf to reduce risk; however, they are not kept in a dedicated area with continuous air exchange. Additional environmental concerns were noted, including air conditioning that blows directly into the pharmacy and is covered for staff comfort, and a fire alarm that is also covered because staff find it too loud. Overall, the department should be prioritized for refurbishment to better support current service delivery.

Computerized provider order entry appears to be in place only in Brandon, while standardized order sets are used by diagnosis and department. PMH is expected to shift to a provincial formulary on June 1. The pharmacy lead in Dauphin is also the PMH infusion pump librarian, and weekly PMH calls are held to discuss and manage medication back orders. Space remains limited, with additional storage required in another room down the hall, and the team also identified challenges related to agency nurse education. Medication transport practices also warrant review. Medications are transported in the clean linen truck, and narcotics and chemotherapy agents are included in a locked, tracked plastic bin along with other medications. Outdated medications are often returned via ERS.

Site storage arrangements vary. There is a well-appointed medication room with a Pyxis shared by the Emergency Department (ED) and Special Care Unit (SCU), and the surgery unit also has a Pyxis used as the night cupboard. In contrast, the obstetrics unit does not have a true medication room; instead, medications are stored in a locking medication cart at the nursing station, open to the unit.

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The main pharmacy door remains partially open during business hours, with the bottom half locked and the top half open. Staff indicated they cannot manage with the door fully closed. The pharmacy is also located near the cafeteria, resulting in considerable foot traffic and limited discretion around the pharmacy space.

Grandview Health Centre

At Grandview Health Centre, there is no onsite pharmacy presence. Medication orders are received at Dauphin Regional Health Centre, and medications are shipped once daily, Monday to Friday, in a secure tackle box. On arrival, they are stocked in labelled bins in a locked medication room. The site is in queue for a Pyxis machine, although no implementation date has been confirmed. The site appears to be doing a strong job of complying with the required organizational practices (ROPs). There is no site-based Antimicrobial Stewardship Committee; stewardship activities are led regionally by the Dauphin pharmacy team. Other audits, measurements, and action plans align with those from Dauphin, reflecting Grandview's role as a satellite medication management site.

In the Emergency Department (ED), medications are stored openly in treatment areas. Locking cabinetry is planned, but the implementation date is unconfirmed. In the interim, mitigation strategies should be implemented to ensure medications are not accessible to the public. Because Grandview Health Centre does not have a pharmacy, the nursing unit medication room is accessible around the clock and a night cupboard is not warranted. Injectable medications are administered immediately after preparation and are therefore not labelled.

Carberry Health Centre

At Carberry Health Centre, the pharmacist support is based in Neepawa and attends the weekly Tuesday interdisciplinary team meeting in person. A pharmacy technician visits the site twice weekly to restock supplies and audit for expired medications. Any medications needed outside of these visits are sent via the lab truck and arrive the next morning in tied, but not locked, bins. An on-call pharmacist is available 24/7 from Brandon.

The medication storage room has keypad access. Narcotics are kept in a safe, with additional narcotic stock stored in a locked box inside the safe. High-alert medications are labelled on the shelf, on the package, and on the medication itself. The room is clean and well organized. The room is shared by the ED and acute inpatient unit.

Do-Not-Use Abbreviation lists are posted in the medication room, and the supporting pharmacist conducts regular chart audits. A recent audit shared during the tracer confirmed that prohibited abbreviations continue to be used. While some follow-up with individual prescribers is done, it is inconsistent, and incident reports are not always entered into the reporting system. The organization is encouraged to support staff to complete incident reports whenever prohibited abbreviations are used. Pharmacists may benefit from coaching on how to have respectful patient safety conversations with physicians about abbreviation use, along with a clear expectation and an escalation pathway if improvement does not occur over time.

The pharmacist reports that best efforts are made to review medication orders in advance of the first dose; however, this occasionally occurs after the first dose.

The antimicrobial stewardship program (ASP) is Regional. The Pharmacist at this site monitors antibiotic usage. The ASP pharmacist based in Brandon and a microbiologist co-chair the ASP Committee and have provided guidance to the pharmacists to implement changes/innovations at the local site that resulted in changes to antibiotic protocols/initiation of antibiotic treatment based on the urinary tract infection (UTI) initiative.

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Ste Rose General Hospital

At Ste. Rose General Hospital (SRH), pharmacy support has been provided by Dauphin for just over one year and is currently limited to virtual and telephone support; historically, the site was supported by a local pharmacy.

The PMH medication committee organizational chart is outdated and should be revised to show where SRH fits within PMH. A pharmacy technician visits weekly to restock and place orders, and a process is in place when current stock runs out. The medication storage room is large, organized, secure, and used for restocking and after-hours admissions. Stock is primarily single-dose, although some high-alert labels are missing, and narcotic stock is limited. Implementation of a Medication Delivery System (MDS) has not planned for several years. There is an opportunity to improve the current dispensing process, as night stock is single-dose but routine dispensing remains multi-dose without a clearly articulated rationale, resulting in avoidable medication waste.

Although pharmacist support is available 24/7 by phone, the site would benefit from more visible pharmacist involvement in day-to-day care and medication management oversight. The pharmacist is encouraged to attend weekly integrated case conferences and discharge planning virtually, as this would strengthen relationships with staff and enhance support for an already robust, inclusive care process.

Boissevain Health Centre

The pharmacist is on site one day per week. Given the limited on-site presence, there is an opportunity to optimize scope by involving a pharmacy technician in routine inventory management, restocking, and expiry-date checks.

The pharmacist aims to review medication orders before the first dose whenever possible. When that is not feasible, the review is completed after the first dose.

Prohibited Do-Not-Use Abbreviations were observed on Best Possible Medication History (BPMH) records, medication administration records (MARs), and medication orders. The posted Do-Not-Use Abbreviations (DNUA) list in the medication preparation area should be updated to the current version and maintained under version control. The current poster is dated 2008.

A formal quality improvement process is recommended to strengthen adherence to the DNUA policy. While a policy exists, inconsistent compliance across clinical areas indicates the need for a more structured and accountable approach to implementation and monitoring. To improve oversight, consider reporting unit-level audit results through existing quality and safety structures, including the Knowledge Exchange Boards and the regional committee responsible for medication management.

The policy for telephone and verbal orders requires strengthening. There was no evidence that verbal orders or telephone orders were being co-signed. Consider reporting unit-level audit results through existing quality and safety structures, including the Knowledge Exchange Boards, and escalate to the regional committee responsible for medication management as required.

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Table 3: Unmet Criteria for Medication Management

Criteria Number	Criteria Text	Criteria Type
1.2.3	Adhering to a Do-Not-Use List of Abbreviations, Symbols, and Dose Designations 1.2.3.2 The organizational leaders ensure clinical teams follow the organization's procedure to adhere to the do-not-use list of abbreviations, symbols, and dose designations in all medication-related communication. 1.2.3.3 The organizational leaders ensure the use of misinterpreted abbreviations, symbols, and dose designations that could have harmed or did harm a client are reported as medication safety incidents.	ROP
1.2.4	Managing High-Alert Medications 1.2.4.2 The organizational leaders ensure clinical teams follow the organization's procedure to safely manage high-alert medications.	ROP
1.3.2	Pharmacists collaborate with clients and interprofessional clinical teams to provide care using evidence-informed care activities associated with improved client and system outcomes.	HIGH
5.1.1	Access to medication storage areas is limited to authorized team members.	HIGH
5.2.4	Anesthetic gases and volatile liquid anesthetic agents are stored in an area with adequate ventilation, as per the manufacturer's instructions.	HIGH
7.1.1	The pharmacist reviews each medication order prior to the first dose being administered.	HIGH
7.2.2	Appropriate ventilation, temperature, and lighting are maintained in the medication preparation areas.	HIGH
8.1.3	Unit dose oral medications are kept in manufacturer or pharmacy packaging until they are administered.	HIGH

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Criteria Number	Criteria Text	Criteria Type
9.1.2	Medications are dispensed in unit dose packaging and exclusions (e.g., liquids, topical preparations, antacids, otic/ophthalmics, multi-dose vials) are specified in organizational policy.	HIGH
10.3.6	When using medications intended for the topical use in surgical procedures, such as concentrated epinephrine, it is not drawn up into a parenteral syringe but placed in a labelled bowl within the sterile field.	HIGH
10.3.7	When using any medication intended for injection, it is drawn into the syringe from the original vial and labelled immediately prior to use.	HIGH

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Service Excellence

Standard Rating: 94.1% Met Criteria

5.9% of criteria were unmet. For further details please review the table at the end of this section.

Assessment Results

This Service Excellence standard was assessed at rural sites in Prairie Mountain Health (PMH) including Boissevain Health Centre, Carberry Health Centre, Deloraine Health Centre, Grandview Health Centre, Minnedosa Health Centre, and St. Rose General Hospital. Committed and resilient leadership teams were evident at these rural sites, even amid turnover and wide spans of control that limit onsite managerial presence. Despite these pressures, staff consistently report feeling supported, and care across all sites is described as kind, compassionate, and trusted.

Quality improvement culture is strengthening, with Knowledge Exchange Boards emerging as a promising mechanism for spreading best practices, engaging frontline teams, and making performance data visible. Variation in implementation remains, but where boards are active, they reinforce accountability and continuous improvement. Knowledge Exchange Boards further support risk management visibility and project tracking.

Evidence informed decision-making is well established, and safety events are systematically analyzed, though teams would benefit from clearer communication of resulting improvements. A coordinated infusion pump safety program is in place, and suicide risk assessment training is progressing toward broader implementation. Wi-Fi infrastructure gaps in rural sites continue to delay drug library updates, an issue that was previously identified and still unresolved. Barriers to access and technology gaps have been identified, and preparation for the Electronic Health Record rollout is underway.

Protocols for screening for suicide risk are not currently in place across all sites. Training has recently been introduced, and the staff are to commence training in the near future. The screening policy and tool for suicide prevention are in place, but they are not used consistently.

Staffing shortages remain a significant operational challenge. Reliance on agency and travel nurses continues, though efforts to stabilize the workforce such as the undergraduate nurse employee role, internationally educated nursing (IEN) readiness initiatives, international recruitment, travel nurse models, and optimizing licensed practical nurse (LPN) scope are showing positive impact. Rural staff often work across both emergency and inpatient settings, supported by structured orientation and ongoing performance discussions.

PMH continues to advance system level quality, safety, and accessibility. Strategic goals are in place across programs, though some sites require support to define local goals and objectives there is an opportunity for cross site mentorship. Several sites (Boissevain and Deloraine) are encouraged to develop goals and objectives specific to their Emergency Departments.

Patient and family feedback is gathered by teams through a variety of mechanisms at the regional and hub sites but is lacking in the rural sites. The structures and processes for engaging the patient, family and community in the planning of or evaluation of services may be strengthened by leveraging the great sense of ownership that community members feel with their local hospitals. Developing site-based quality councils with community representation could be a valuable approach.

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Table 4: Unmet Criteria for Service Excellence

Criteria Number	Criteria Text	Criteria Type
1.1.3	The team develops its service-specific goals and objectives.	NORMAL
1.2.7	The team works with the organization to create a universally accessible service environment.	NORMAL
2.3.2	The team leadership engages with team members to determine work and job design, roles and responsibilities, and assignments.	NORMAL
4.2.2	Suicide Prevention Program 4.2.2.2 The team leadership ensures the team receives appropriate training and education to deliver safe suicide prevention services. 4.2.2.3 The team leadership ensures the team conducts standardized routine screening for suicide risk, using evidence-informed tools provided by the organizational leaders.	ROP

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Service Specific Assessment Standards

The Qmentum Global™ for Canadian Accreditation program has a set of service specific assessment standards that are included in the accreditation program based on the services delivered by different organizations. Service standards are critical to the management and delivery of high-quality and safe care in specific service areas.

Critical Care Services

Standard Rating: 100.0% Met Criteria

0.0% of criteria were unmet. For further details please review the table at the end of this section.

Assessment Results

The Brandon Regional Health Centre (BRHC) Critical Care Unit (ICU) is the only adult unit of its kind in Prairie Mountain Health (PMH) and supports other service delivery organizations within Manitoba and occasionally eastern Saskatchewan. Critically ill patients who require more complex treatment modalities are usually transferred to a tertiary care unit in Winnipeg.

The overall number of patients admitted to the unit is steadily increasing year over year. The ICU is also mandated to accept pediatric patients provided certain conditions are met and discussed with the team (18 years with BMI or body weight similar to an adult). Admissions are received from the Emergency Department (ED), rural hospitals and inpatient transfers -- approximately 360 annually. The average length of stay is 4.6 days. The team is an active member of the Shared Health Adult Critical Care Network (together with St Boniface Hospital, Health Science Centre, and Grace Hospital in Winnipeg). Work has focused on developing provincial standards, assessment tools, and practices that are based on best practices. The teams have been working diligently over the last couple years to streamline these processes.

The BRHC hemodialysis unit staff provide support to the unit, but when urgent dialysis is required (during the night), the patient would be offered Continuous Renal Replacement Therapy (CRRT). Staff can receive additional training in order to provide this care.

The Rapid Response Team is a critical care nurse-led team and together with a respiratory therapist, responds to calls on units throughout the hospital to address urgent clinical situations. The team conducts follow-up visits to the patient following the initial visit to evaluate outcomes. Additionally, team members are part of the code blue team. To support medical units with the General Centre of BRHC who are wired for telemetry monitoring, the staff in the critical care unit are responsible for monitoring the cardiac tracings for telemetry outside of the ICU. When changes are noted to a patient’s cardiac rhythm, the nurse will call the unit to check on the patient or run to the unit themselves. These activities add to the workload of the clinical staff. Once the team moves from the General Centre, into the new Cardiac Care unit, inpatient unit staff will be responsible for their own monitoring and are in the process of receiving cardiac rhythm interpretation education.

The passionate and highly engaged interprofessional critical care team includes all expected roles but is supported by an Indigenous Health Advocate and Mental Health practitioners when required. The leadership team (manager, clinical resource nurse, educators) is very visible and supportive. Learners from a variety of professions are eager to spend their clinical placements with this highly qualified team. This closed-Intensivist led program provides care to 10 beds (capacity is 11 but one is closed due to

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staffing) in an open model for patients requiring intensive medical and surgical care. Referrals are made through a collaborative approach with the Intensivists. The medical team is augmented by a group of house EMO - emergency medical officers (fully licensed ED physicians). The critical care team is excited to be moving into a brand-new state-of-the-art critical care unit in the next few months. The current infection control, privacy, space, and storage issues will soon be resolved with this move. The new unit will have a capacity of 16 beds, but 10 will be staffed when the unit opens with gradually introducing more beds into the complement when staffing can be hired. It will offer large, private rooms with state-of-the-art amenity ties to enable a more patient and family-focused critical care experience. There will be significant planning involved when furniture, equipment, and supplies must be moved into the space.

Patient flow through the department has been challenging at times. There is good collaboration with the utilization team. Given the rural nature of this region, the availability of patient transport can cause delays and backlogs.

Patient care is based on evidence-informed practices that are guided by provincial and regional quality improvement teams and networks. The team has implemented appropriate care bundles to reduce the incidence of sepsis related to central lines, catheters, and ventilators. Routine practices to assess and manage delirium, pain, sedation, hypoglycemia and hyperglycemia are in place. Patients are positioned to reduce the incidence of pressure injuries. Patient rounding (Intensivist driven) results in the development of daily goals of care and this is the plan that is communicated with the team for the day.

The team is commended for continuing to implement the requirements of the Accreditation Canada Required Organizational Practices. The electronic patient record (EPR) has not been specifically designed for critical care services, and the team has managed to keep their paper flow sheet. Staff report they have no issues knowing where to document the various components of patient care.

Medication reconciliation is performed by the pharmacist and intensivist. However, it was reported that when patients are transferred out of the unit to other inpatient units, critical care orders on the medication reconciliation form are deleted and the receiving unit starts from scratch. It is highly recommended that this practice should be reevaluated through a patient safety lens given that medication reconciliation was developed to ensure current required medications are reviewed and continued or deleted as appropriate -- but not from scratch.

The team developed an end-of-life program to demonstrate compassion and respect for the patient who has passed. A non-flame candle is placed beside the patient’s bed, and a heart is placed in a glass and given to the family.

The team reported they would like to be involved in research but are currently not able to conduct research because they do not have resources to support these activities. When there is an opportunity for funding, this team would appreciate the opportunity to participate in research.

Table 5: Unmet Criteria for Critical Care Services

There are no unmet criteria for this section.

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Service Excellence for Critical Care Services

Standard Rating: 100.0% Met Criteria

0.0% of criteria were unmet. For further details please review the table at the end of this section.

Assessment Results

The critical care team won a Canadian Association of Critical Care Nurses Spotlight Challenge award for promoting the important role of the critical care nurse. One of the nurses who made the submission attended the ceremony and received the award. Congratulations!

The team experienced certain safety incidents related to the pumps used hospital wide. An investigation was conducted following safety incidents, and the team chose a different pump to be used when certain high alert medications must be administered. As a result, the staff label not only on the various IV infusions but also the specific pumps that are put into use to be extra vigilant.

The team is involved in several quality improvement activities. This information is not posted yet on the Knowledge Exchange board—the manager is waiting for the new unit to open; however, discussions do occur with the team in the nursing station.

Significant staff education is available to enhance their critical care knowledge. The full-time 4-month orientation program (Provincial Critical Care Orientation Program) includes theory and clinical practicum. This is an excellent opportunity for nurses to transition into a specialty nursing role. Two wound care champions are members of this team and provide education and support for managing complex wounds.

Staff are involved in regular performance review discussions and take the opportunity to highlight their personal professional goals that include education requests.

People-centred care is flourishing in this unit. Family members reported gratitude for being included in the daily bedside rounding activities and appreciate the information and teaching that is provided at every interaction. The new unit was co-designed with the help of a patient partner and a former patient. A new ICU patient and family information booklet was also informed by patients and family members identifying questions that they have had when they were in the unit. Patient experience surveys report high satisfaction outcomes and the staff and leadership are very responsive to feedback. While family members are encouraged to go home to sleep, family members can stay overnight according to their wishes.

Table 6: Unmet Criteria for Service Excellence for Critical Care Services

There are no unmet criteria for this section.

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Emergency Department

Standard Rating: 93.9% Met Criteria

6.1% of criteria were unmet. For further details please review the table at the end of this section.

Assessment Results

Emergency services are provided in 19 communities across Prairie Mountain Health (PMH), servicing larger catchment areas throughout the region. Seven Emergency Departments (EDs) were visited during the survey:

- Brandon Regional Health Centre
- Dauphin Regional Health Centre
- Boissevain Health Centre
- Deloraine Health Centre
- Carberry Health Centre
- Grandview Health Centre
- Ste. Rose General Hospital

Brandon is the largest ED program within PMH, with more than 27,000 visits annually. Dauphin provides over 10,000 visits annually, while the remaining sites each experience fewer than 10,000 visits per year. The EDs continue to experience increasing patient volumes and acuity, particularly at the regional and hub sites, due in part to rural ED closures.

Human resourcing remains a significant challenge across PMH EDs. Vacancy rates approach 50% at some sites, creating a high reliance on agency and travel staff, many of whom have contributed to the teams for several years.

The organization is encouraged to strengthen the integration of Shared Health and PMH Human Resources supports to assist managers with recruitment and hiring efforts.

As identified in previous surveys, some smaller sites continue to face challenges maintaining patient privacy during the triage process. Registration areas remain open at many sites. Staff report that, when privacy is required, efforts are made to move patients directly into the department or into nearby rooms for triage. The organization is encouraged to consider white noise technology to further support patient privacy.

Rural sites may benefit from enhanced “on-call” or backup resources to support situations where medical and nursing staff are required to transport patients to higher levels of care. The current process can create delays and may place patients, staff, and sites at increased risk.

Required ED training for nurses currently includes:

- Advanced Cardiovascular Life Support (ACLS)
- Pediatric Advanced Life Support (PALS)
- Trauma Nursing Core Course (TNCC)
- Canadian Triage and Acuity Scale (CTAS) training

PMH is encouraged to consider implementing the Neonatal Resuscitation Program (NRP) in rural EDs where no other credentialed NRP staff are available to support the care of infants presenting to the department.

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Addictions and Mental Health training is provided to ED teams; however, staff reported that education is limited. The organization is encouraged to explore Nonviolent Crisis Intervention (NVCI) training for ED teams, particularly in rural areas where support resources may be limited. The organization is also encouraged to continue promoting awareness of the provincial “Giga Mino Ganawenimaag Anishinaabeg / We Will Take Good Care of People” training initiative, as many teams were unaware that it was available.

To enhance security, the installation of “amnesty lockers” located at the entrances of some emergency departments has been completed. They allow patients and visitors to safely and anonymously check prohibited personal items such as sharp objects or weapons before entering, without the threat of confiscation or judgment. This initiative is to be commended and recommended to be spread to additional sites.

Wayfinding within several rural hospitals was identified as unclear. PMH is encouraged to review ED signage, potentially in partnership with patient advisors, and revise signage based on feedback received. As noted during the previous ED assessment, many rural sites continue to lack appropriate seclusion rooms and/or private, secure areas for patients. The organization is encouraged to engage patients and families in co-designing future spaces and improvements.

The Dauphin ED was observed to be newer, spacious, and well lit. The rural ED spaces, although older, were found to be well maintained, clean, bright, and equipped with equipment in good repair.

Patients spoke of being well cared for, safe and respected by their ED teams. The teams were observed checking two patient identifiers appropriately to support safety.

The team has a falls prevention program and staff members receive training in this regard. There were some inconsistencies noted in the application of the policy and when the initial screening occurs – the universal screening practices in place assume that everyone is at risk for falls in the hospital. However, staff stated that they don’t always conduct an assessment to identify patients who are at a higher risk of falls and so no additional measures are put in place other than informing patient and support person to ring for the nurse if ambulation is required. The team is encouraged to ensure staff identify criteria for their patients that indicate when patients are at higher risk for falls during their time in the ED.

There is currently no formal skin integrity screening tool in use within the EDs. Standardized skin assessment risk screening is in various stages of implementation, and the organization has a rollout plan for a newly developed tool.

Brandon Regional Health Centre has outgrown its current footprint, and teams expressed optimism regarding upcoming renovation plans, beginning with the triage area. The recently opened Minor Injury and Illness Clinic (MIIC) has helped improve patient flow through the ED and address gaps in community primary care access. Patients presenting at triage with lower-acuity concerns are offered referral to the clinic. The organization is commended for the success of this initiative and encouraged to explore opportunities to expand this model to additional EDs that may benefit from similar approaches.

PMH teams are commended for their leadership in quality and safety initiatives. Public-facing knowledge exchange boards at several sites display quality improvement projects, including goals, objectives, indicators, timelines, targets, and Key Performance Indicators (KPIs). These boards are referenced during team huddles at some sites, and this practice is highly commendable.

The organization is encouraged to:

- Continue engaging patient partners at the onset of quality improvement initiatives
- Ensure patients and families receive the same information as staff regarding project goals and structures
- Expand co-design methodologies into rural programs, where this approach is currently limited
- Scale and spread successful quality improvement practices across the region

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Table 7: Unmet Criteria for Emergency Department

Criteria Number	Criteria Text	Criteria Type
2.2.1	Entrance(s) to the emergency department are clearly marked and accessible.	HIGH
2.4.8	Seclusion rooms and/or private and secure areas are available for clients.	HIGH
2.5.6	Optimizing Skin Integrity 2.5.6.1 The team follows the organization's procedure to conduct screening for risk of impaired skin integrity. 2.5.6.2 The team follows the organization's procedure to ensure a comprehensive assessment is conducted for a client who screens positive for risk of impaired skin integrity. 2.5.6.5 The team participates in continuous learning activities about the program to optimize skin integrity. 2.5.6.6 The team participates in activities to improve the program to optimize skin integrity as part of the organization's integrated quality improvement plan.	ROP
2.7.3	Client privacy is respected during registration.	NORMAL
2.7.13	Access to spiritual space and care is provided to meet clients' needs.	NORMAL

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Service Excellence for Emergency Department

Standard Rating: 97.6% Met Criteria

2.4% of criteria were unmet. For further details please review the table at the end of this section.

Assessment Results

This standard was assessed at Brandon Regional Health Centre and Dauphin Regional Health Centre. The provincial Emergency Department (ED) nursing orientation program (hosted by the Provincial Health Care Retention & Recruitment department), with some education days occurring at BRHC, currently offered for new hires in Brandon, is robust and staff indicate they feel well supported. Infusion pump training is provided, documented, tracked, and evaluated. Many sites have new and temporary staff, and all confirmed they received the required education and training during orientation. Educators tracked all training required and had plans in place to offer additional education and skills to ensure staff maintain the required competencies. Staff mention the challenges of completing their ongoing education SPOT e-learning modules while on shift due to the consistent workload. The organization is encouraged to consider staffing up on some shifts to allow the teams to take turns completing their modules.

Staff members at the point of care were not all aware of the ethics framework but could locate it when asked.

The organization has transitioned to the RL Solutions incident reporting system. Staff described a strong, non-punitive reporting culture focused on quality improvement. Reports are completed promptly, and managers receive electronic copy to support timely follow-up. Staff also indicated they are becoming increasingly comfortable using the new system. The organization is encouraged to make fuller use of the system's trending and theming functions so that data can be analyzed and applied in a timely manner to support quality improvement and positively impact patient outcomes. Critical incidents are addressed promptly.

Palliative and end of life training is provided as part of the Provincial Emergency Nursing Orientation, however, those staff hired prior to the rollout of this orientation model have not been provided with this training. The organization is encouraged to consider bridge training to support these legacy employees.

Staff indicate that the hybrid documentation between EDIS and paper in Dauphin creates potential gaps in the appropriate space to document; the organization is encouraged to clarify expectations for the teams in order to establish a single source of truth for suicide risk screening in the Emergency Department. A suicide prevention screening policy and screening tool are in place; however, they are not used consistently across all sites, and universal screening has not yet been adopted across the Prairie Mountain Health (PMH) EDs assessed. Staff indicated that limited privacy within triage areas creates challenges when asking the proposed screening questions. In response, some teams have adopted simplified initial screening questions, such as: "Do you have any concerns about your mental health?" Patients who screen positive are then provided with a more comprehensive assessment.

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Table 8: Unmet Criteria for Service Excellence for Emergency Department

Criteria Number	Criteria Text	Criteria Type
2.1.9	The team leadership ensures that staff are provided with education and training on identifying and addressing palliative and end-of-life care needs.	HIGH
4.2.2	Suicide Prevention Program 4.2.2.3 The team leadership ensures the team conducts standardized routine screening for suicide risk, using evidence-informed tools provided by the organizational leaders.	ROP

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Inpatient Services

Standard Rating: 97.0% Met Criteria

3.0% of criteria were unmet. For further details please review the table at the end of this section.

Assessment Results

Prairie Mountain Health (PMH) operates 18 acute care sites, with 795 acute beds. These sites include 15 small to medium sized facilities with between 9-25 inpatient beds each. For this survey, inpatient services were assessed at the following sites: Boissevain Health Centre, Carberry Health Centre, Deloraine Health Centre, Grandview Health Centre, Minnedosa Health Centre, St. Rose General Hospital.

In addition to these facilities, there are 10 transitional care sites with 116 transitional care beds, 57 psychiatry beds, 48 in-house addiction treatment beds, 43 long-term care sites with 2001 long-term care beds and 28 Shared Health Emergency Response Service (ERS) stations, all which support and optimize capacity within the acute care inpatient units. However, Alternate Level of Care (ALC) remains a significant challenge across all sites, with low acuity patients occupying acute care beds while awaiting placement in a more appropriate alternate setting. ALC numbers at Minnedosa range from 2 to 8 patients in acute care beds as patients are transferred from Brandon following daily discussions at PMH Daily Flow Call. Leadership noted that a Shared Health provincial table has been established to include bed mapping and address this issue from a broader system perspective. Compounding the issue, inpatients beds have been closed at some sites for reasons cited such as staffing challenges or budgetary constraints. For example, Carberry operating 8 of 10, Minnedosa operating 18 beds of 27, Grandview operating 10 of 16, Deloraine operating at 11 from 14.

Ste. Rose is a small rural religious affiliate hospital that serves a large geographic area with significant Indigenous and older adult populations. Complex chronic conditions, as well as mental health and addiction concerns, are common in this area. Many patients at Ste. Rose are ALC or subacute, unless they are awaiting transfer for a higher level of care or diagnostic procedures, such as a mental health bed or pacemaker insertion. Staffing is increased as needed based on patient acuity. Ste. Rose has also made bed reductions.

It was noted across all inpatient sites that staff and physicians are passionate about delivering safe, timely, high-quality evidence informed care, as close to home as possible. There is a strong culture of collaboration and teamwork, despite the challenges of limited resources. Patients were complementary about the care and the staff and physicians; they felt they were treated with compassion and respect. Everyone was able to identify to whom they would raise concerns and complaints.

Staff and physicians reported that the Virtual Emergency Care & Transfer Resource Service (VECTRS) program for higher-level care does not always reflect the clinical judgment of rural teams and can contribute to delays in decision-making. They were also unaware of a clear escalation pathway when disagreements arise about a patient's care needs and transfer barriers are present. Although the program is seen as valuable in principle, the organization is encouraged to implement an evaluation process that gathers feedback from rural physicians and operational teams to identify improvements that could strengthen the program and enhance patient safety and experience.

At some sites, staff and physicians were unaware of the ethical decision-making framework, though they could find it on the intranet when prompted. Staff and physicians noted that they discuss issues causing moral distress with one another and access organizational supports, such as palliative care and social work, and others through PMH and Shared Health as needed.

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Although PMH has interpretation services available, Grandview and other sites indicated that the service is not reliably available in a timely manner and so they often utilize translation apps or rely on community members.

Many of the hospital spaces are older but are well maintained, clean, and bright. Equipment is in good repair. For the most part, staff reported that they have the equipment needed to do their work and understand the process to follow if an issue arises. At most of these sites, wooden and fabric furnishings were observed within the inpatient units, including wooden chairs with fabric seats in the hallways and patient rooms. Patient beds with wooden headboards and footboards were also noted, although most other beds have been replaced with medical -grade beds. Leadership is encouraged to consider a replacement plan for all remaining wooden and fabric covered furnishings with IPAC- approved materials such as medical grade vinyl to support infection and prevention practices. The Ste. Rose site is aging and requires significant investment.

PMH has implemented an electronic patient record (EPR) with computerized provider order entry (CPOE) in Brandon. The remainder of the region is expected to follow a transition plan. The amount of paper for the front-line staff and physicians is overwhelming for staff to keep organized, especially as more documents and screening tools and other paperwork are added. Hybrid record systems that combine electronic and paper documentation are known to create operational, clinical, and patient safety risks. While recognizing the complexity of regional implementation and the operational pressures involved, it is recommended that PMH prioritize the transition to a fully integrated electronic record system as expeditiously as planned.

The PMH accreditation team supports clinical programs by preparing Quality Chart Audit Reports for Required Organizational Practices (ROPs) that fall below the 80% compliance target. The team also assists programs in developing site specific Quality Improvement Plans to address identified gaps. To better support continuous quality improvement and achieve meaningful impact, it is encouraged that these audits be conducted more frequently with improvement opportunities implemented more rapidly to facilitate improvement on identified gaps.

There is an opportunity to strengthen information flow within care teams. The verbal handover report tool is helpful but inconsistently used and not regularly documented. Enhancing expectations and standardization would improve continuity and safety. The implementation of audits or evaluation of effectiveness of communication at care transitions is also encouraged.

At several sites (Boissevain and Deloraine) access to a spiritual space is not available. The organization is encouraged to review supporting patient and family needs.

Table 9: Unmet Criteria for Inpatient Services

Criteria Number	Criteria Text	Criteria Type
3.4.14	Access to spiritual space and care is provided to meet clients' needs.	NORMAL

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Criteria Number	Criteria Text	Criteria Type
3.4.18	Information Transfer at Care Transitions 3.4.18.4 Information shared at care transitions is documented. 3.4.18.5 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	ROP

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Obstetrics Services

Standard Rating: 93.2% Met Criteria

6.8% of criteria were unmet. For further details please review the table at the end of this section.

Assessment Results

The Prairie Mountain Health (PMH) Obstetrics Program demonstrates a strong regional commitment to safe, respectful, and responsive maternal-newborn care across a broad and diverse population in both urban and rural settings. The program serves patients with differing social, economic, and cultural needs and has worked to align patients with the right level of service through clearer regional and provincial guidance for levels of care, transfers, and higher-acuity referral pathways.

This standard was assessed at Brandon Regional Health Centre (BRHC) and Dauphin Regional Health Centre (DRHC). BRHC is the regional obstetrical hub, with 23 beds and approximately 1,500 annual births, continuous hospital-based obstetrical care, access to cesarean section capability, and support from obstetricians, general practitioners, anaesthetists, midwives, nurses, and allied health partners are significant strengths. Patients under 34 weeks gestation are transferred to tertiary sites in Winnipeg. The program also plays a key role in supporting non-birthing hospital Emergency Departments through regular in-person simulation and virtual education, reinforcing a standardized and regionally connected approach to care. DRHC provides an important rural service with 3 beds and approximately 410 annual births.

Publicly available community and Public Health services, including prenatal education, postpartum follow-up, child health services, Healthy Baby programming, and breastfeeding support, contribute to continuity beyond the inpatient stay.

Patients are presenting with increased acuity thereby creating ongoing challenges for the Maternal-Child team. The PMH region is experiencing the highest rate of HIV in the province in addition to high rates of syphilis and lower levels of patients with prenatal care. This results in Neonatal Intensive Care Unit (NICU) overcrowding that is a growing concern as BRHC is the only site in the region caring for critically ill neonates. While NICU was not assessed this visit, it was noted that the unit is operating above their budget in order to manage the increase in neonate admissions. A proposed NICU expansion is therefore an important strategic priority, particularly given the current open-concept space and lack of negative pressure rooms in the context of provincial infectious disease risks such as measles.

The PMH Maternal Child Working Group provides leadership to the obstetrics programs and meets ten times per year. Provincial standardization activities are in their early stages. This work is strongly supported by dedicated clinical educators and local teams who provide ongoing education, simulation, and skill development across the region. Recent education days in May 2026 involving more than 60 staff are a notable example of the program's commitment to high-quality, standardized emergency obstetrical and neonatal care regardless of location. These educational efforts, together with shared practice guidelines, equipment models, and access to consultation, strengthen confidence and consistency across sites.

There are also ongoing infrastructure concerns that continue to affect care environments at DRHC. Cesarean sections are performed in an operating room located three floors away from the obstetrical unit, creating significant challenges in meeting knife-to-skin targets for urgent procedures. The unit also competes with other services for a single on-call anaesthesia provider, which can delay epidural access and affect patient experience. Similar issues exist in BRHC, where cesarean sections are also performed in the main operating room despite the presence of an unused theatre space within the labour and delivery unit that has never opened because of staffing limitations. Leadership may wish to review the ongoing processes associated with maintaining that unused space.

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More broadly, older physical environments at some rural sites may not fully support current best practice expectations while teams have adapted to local realities with commitment and resourcefulness. Older physical spaces may not always reflect current expectations for privacy, infection prevention, family-centred care, or efficient patient flow. Where birthing areas are limited in size or configuration, pressure on beds and rooms can create avoidable operational risk and reduce the overall comfort and dignity of care experience for mothers, newborns, and families. Over time, capital planning, renovation, and space redesign will remain important considerations if the organization wishes to modernize the full regional obstetrical pathway and better align physical environments with contemporary standards.

Skin-to-skin practices are encouraged immediately following birth, including after cesarean sections in the OR, illustrating the teams' impressive focus on evidence-informed maternal-newborn care. At the same time, recent service disruptions and temporary changes to midwifery birth coverage highlight the importance of workforce stability in a regional system where even small staffing changes can have immediate operational impacts.

The maternal-child team at BRHC documents in the electronic patient record in addition to using some paper forms. The team is still trying to adapt some of the standardized electronic assessment tools to meet the needs of their obstetric patients. Pain assessment prompts are not in alignment with how they assess labouring mothers who experience pain. They are working together to determine how to comply with documentation standards with these tools.

The BRHC team is encouraged to standardize their clinical approach to screening for skin integrity and falls risks on admission and when the patient's clinical status changes (such as following epidural insertion and removal) and then identifying appropriate interventions then subsequent documentation of this information.

There are opportunities to strengthen consistency in safety practices and quality monitoring across sites. Variations remain in how shift report is structured and documented, particularly between BRHC and DRHC, and the development of clear criteria for information exchange would improve reliability and audit value. Annual chart audits are completed, but more frequent review of Required Organizational Practices, including falls prevention, skin integrity, transfer of information, VTE prophylaxis, and medication reconciliation, would better support timely improvement. Documentation of patient-specific assessments and interventions also requires further attention. For example, falls prevention interventions are not always clearly documented when risk status changes, such as following epidural removal, and skin integrity assessments are encouraged to be completed consistently and recorded even when risk is perceived to be low. The teams have shown responsiveness to safety incidents, and there would be value in sharing improvement work more broadly at regional and provincial levels.

Overall, the PMH Obstetrics Program has a solid foundation and many important strengths, including committed teams, strong regional collaboration, outstanding educational and training opportunities, patient- and family-centred care, and a clear commitment to evidence-informed practice.

The program has also demonstrated an ability to respond to feedback, support staff development, and adapt practical solutions across a geographically dispersed system. The greatest opportunities for continued improvement are likely to be in workforce stabilization, infrastructure renewal, optimization of documentation systems, and more structured quality improvement that is closely connected to front-line teams and the communities they serve.

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Table 10: Unmet Criteria for Obstetrics Services

Criteria Number	Criteria Text	Criteria Type
1.3.5	Preventing Falls and Reducing Injuries from Falls 1.3.5.4 The team implements interventions to prevent falls and reduce injuries from falls as part of the client's individualized care plan.	ROP
1.3.6	Optimizing Skin Integrity 1.3.6.1 The team follows the organization's procedure to conduct screening for risk of impaired skin integrity. 1.3.6.2 The team follows the organization's procedure to ensure a comprehensive assessment is conducted for a client who screens positive for risk of impaired skin integrity. 1.3.6.3 The team implements interventions to optimize skin integrity as part of the client's individualized care plan. 1.3.6.6 The team participates in activities to improve the program to optimize skin integrity as part of the organization's integrated quality improvement plan.	ROP

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Criteria Number	Criteria Text	Criteria Type
1.4.16	Information Transfer at Care Transitions 1.4.16.1 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. 1.4.16.4 Information shared at care transitions is documented. 1.4.16.5 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)	ROP

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Service Excellence for Obstetrics Services

Standard Rating: 96.5% Met Criteria

3.5% of criteria were unmet. For further details please review the table at the end of this section.

Assessment Results

A culture of quality improvement moderately developed within the program, with meaningful opportunities to strengthen measurement and visibility of performance across sites. Identifying and routinely monitoring clinical process and outcome indicators at both local and regional levels aligned with provincial expectations would support more focused quality improvement. Making these indicators visible to staff, patients, and families through existing knowledge exchange structures could encourage shared learning, stimulate discussion, and strengthen accountability for improvement priorities. Staff welcome opportunities to enhance the quality of their care processes.

The program demonstrates a strong commitment to people-centred care. Patients and families report high satisfaction with their care experiences, and patient partners are actively engaged through the Regional Quality Team, contributing to policy development, planning, and improvement activities. The regional program also shows a strong sense of responsibility for accepting and managing patients whose needs exceed what can be supported locally. This is an important strength in a geographically dispersed region.

Collaboration with Public Health, lactation supports, Indigenous health resources, students, community nurses, and family support contributes to a more inclusive and holistic care experience. Staff understand admission and transfer criteria and appropriately transfer patients to tertiary centres in Winnipeg when higher levels of care are required. However, capacity and patient flow remain ongoing concerns. Increasing acuity, urgent presentations, transfer demands, variable local volumes, and rising psychosocial complexity place strain on teams, reinforcing the need for coordinated pathways and service planning that reflect the population’s actual needs.

Quality care and clinical standardization are supported using order sets, common assessment tools, and access to online protocols and evidence-informed guidance. Documentation processes, however, still rely on a mix of electronic and paper-based systems in some settings. DRHC continues to use paper assessment forms, while BRHC uses a hybrid approach in which many core records are electronic, but some practices documented on paper remain less standardized. Staff report ongoing challenges with some electronic documentation tools, including assessment fields that do not always reflect obstetrical care needs, resulting in workarounds and narrative charting. Continued optimization of the electronic patient record, stronger interoperability, and ongoing clinical informatics support will be important to reduce duplication, improve communication, and strengthen continuity of care across the region.

Staff have access to certification courses and ongoing professional development. Clinical educators offer training sessions that include simulation exercises. Education is provided not only to the Obstetrics teams but also to sites that provide emergency births in non-delivery settings, ensuring comprehensive maternal-newborn training.

Translation services are limited, leaving staff to rely on personal devices or incomplete workarounds to support communication with families. Discharge teaching materials remain predominantly in English, highlighting a further opportunity to improve accessibility and equity of care.

Performance reviews have not been consistently conducted with staff members. It is important for leaders to have conversations with staff about their performance and to identify goals and objectives for professional development. Leaders reported that planning these meetings with staff is underway.

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During chart reviews at BRHC, standardized assessment forms were available in the electronic patient record but were not completed. Staff stated these forms are not appropriate for their patient population. For example, the standardized fields in the electronic record do not allow them to adequately present their pain assessment findings. Many staff describe patient pain in a narrative form. The team is encouraged to work with clinical informatics to document assessments for obstetrics patients in a more standardized way.

The teams have been responsive to improving processes and practices related to safety incidents and suggest that sharing these improvements provincially and learning from others would be a welcome opportunity.

Table 11: Unmet Criteria for Service Excellence for Obstetrics Services

Criteria Number	Criteria Text	Criteria Type
2.1.10	The team leadership regularly evaluates and documents each staff member's performance in an objective, interactive, and constructive way.	HIGH
2.1.12	The team leadership supports staff to follow up on issues and opportunities for growth identified through performance evaluations.	HIGH
3.1.2	The team collects and documents a standardized set of health information to ensure client records are consistent and comparable.	NORMAL

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Perioperative Services and Invasive Procedures

Standard Rating: 97.8% Met Criteria

2.2% of criteria were unmet. For further details please review the table at the end of this section.

Assessment Results

This standard was assessed at three Prairie Mountain Health (PMH) sites: Brandon Regional Health Centre, Dauphin Regional Health Centre and Minnedosa Health Centre, covering Operating Rooms (OR), post anesthesia recovery units, surgical day care and inpatient units.

Decisions about operating room time are made through the Provincial Surgical Waitlist Information Management (SWIM), a cloud-based platform that went live in PMH in November 2024. SWIM was implemented to simplify pre-surgical workflows and communications, optimize surgical booking processes and improve the program's data quality and waitlist monitoring and management. The new booking process has been effective and was cited as lowering wait times, as presurgical lab work must be in place before scheduling occurs.

There are strong practices in place around perioperative program medication administration, including processes around medication reconciliation. Medication reconciliation is initiated on admission that starts with the best possible medication history. Procedures are followed to ensure correct medications are prescribed pre-procedure. Case carts are picked prior to the cases, and the pick lists are updated as needed. Post-care follow-up is offered by the admitting surgeon, and the clients are prepared for the follow-up care needed well in advance of the surgery; patients receive brochures and written documentation of post-surgical instructions and follow-up appointments.

Day surgical patients arrive on the day of surgery for nursing assessment and screening. Examples were shared during the tracer of situations where the screening determines a patient's surgery must be rescheduled. Staff were observed to consistently use two client identifiers to confirm identity. Screening for risks (allergies, falls) was observed in practice and in clinical documentation to be complete. Interpreters are available if required and there were some instances in which a tablet or Google translate (cell phone based) was used for translation.

The team is commended for implementing the new sign-in process (precursor to the Surgical Safety Checklist/surgical pause process) which was implemented at BRHC and spread to other sites and is led by the anesthetist.

Recruitment into nursing and anesthesiology vacancies continues to be a challenge for the program. The program has successfully recruited a urologist in the last year and is actively recruiting other specialists to meet population needs across the region and the province. Senior program leaders noted that they are "running almost as many slates as possible" within the operating room (OR) suite allotment in the region and available staffing.

The provincial approach to capital equipment planning implemented in the last two years was cited as a more objective process with a scoring algorithm that considers age, repairs and repair costs, end of life status, with rural programs seeing more success in meeting their needs. The leadership team is looking forward to provincial standardization of surgical equipment and "buyer power" for negotiating price and vendor maintenance contracts. A standardized equipment program based on depreciation that "holds" funds according to predicted lifespan would be welcomed by the regional program. The policy under development by the Medical Device Reprocessing (MDR) team to permit regionalization of instrument cleaning if/when necessary (equipment downtime/repair), addressing logistics, transportation, and

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responsibilities is much needed. Funding for a regional equipment coordinator for the peri-op program would be a big asset, especially due to the geography and regional differences in services across the rural areas of PMH.

The program is expanding pre-hab to include both virtual and in-person options to improve surgical outcomes and address wait times prior to surgery. Patients report greater satisfaction with the in-person program, as do therapy staff, however, due to geographical spread of the region the virtual delivery is an important option.

Minnedosa Health Centre operates two operating rooms with general, regional, spinal, epidural and local anesthesia provided by three GP anesthetists for arthroscopy, minor orthopedic procedures, ophthalmology/cataracts and general procedures. Patients spoke highly of the service and feel supported and listened to with their concerns. The surgical program operates primarily as a day surgery program with no pre-op clinic. The nurses conduct pre-operative activities including checking booking packages and need for special equipment.

Nursing staffing, shared at this site with Neepawa, is a challenge and results in cancelation of slates. When full staffing is available, the surgical suite runs in Minnedosa on Tuesdays and Fridays, 0700 to 1515, corresponding to the hours of the onsite MDR department; at Neepawa on Mondays, Wednesdays and Thursdays. In addition, nursing staff are on call to the Neepawa Maternity program (no obstetrics at Minnedosa). When nursing staff are not available, maternity patients needing c-sections are diverted to BRHC. There is strong, engaged and experienced leadership across both sites and the clinical nurse educator is a valued asset.

The three-part surgical safety checklist (before anesthesia, time-out before incision and sign-out before transfer from the OR suite to the post-anesthesia recovery room) was used as well as two client identifiers verified to support safety.

Information transfer is conducted verbally, however, there is no formal template.

The team was not aware of the organizational ethical decision-making framework; however, ethical issues are discussed and the team rallies to make “real time” decisions with the shared expertise in the room. Documentation in the patient record was complete. The team is anticipating the introduction of the electronic patient record (EPR) in the fall.

BRHC operates the largest perioperative program in the PMH region, including an active Pre-Operative Assessment Clinic with 6 Operating Rooms (capacity is 7). Anesthetists and GP anesthetists offer general, regional, sedation, spinal and peripheral nerve blocks. Surgical services include orthopedics, spine, general surgery, obstetrics and gynecology, ophthalmology, ear nose and throat (ENT), dental, urology, pacemaker insertion. At this site, surgeons work in collaboration with physician assistants. The team also provides administration of Ketamine and ECT. There is 24- hour coverage supported by a 24/7 in-house MDR Department. At this site, three procedure rooms are dedicated to endoscopy procedures. Procedural sedation is provided by nursing.

After hours coverage is available by the OR nursing team. Documentation on this site is mainly electronic, however, there are some paper flowsheets (PACU) and transfer documents. The electronic patient record supports effective communication and patient flow across the various components of the patient’s perioperative journey, although patient flow is impacted when there are no inpatient beds in which to transfer patients. The PACU nurses have access to patient information (cardiac monitoring as an example) to identify if their OR case is close to completion and the team can then be ready to receive the patient.

The team is proud of implementing Bear Hugger Blankets for normotherming. Staff members

heard about this program at a conference and brought it back to the hospital as a best practice. The patient or support person is invited to mark the surgical side with a special single use marker. This is an

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effective patient and family centred care safety initiative. For eye procedures, dots are placed on the operative site with different colours representing right or left.

Patient education related to skin integrity begins in the Preoperative assessment clinic. Patients are educated to monitor their heels for redness or skin issues because changes can occur post operatively. The team is committed to providing evidence-based quality care. Nursing staff can recite ORNAC standards and are proud of the care they provide. Bariatric stretchers and OR tables are available when needed and hover mats inflate to allow a safer transfer for bariatric patients.

The aging infrastructure of the BRHC Department creates challenges with storage and space constraints. Wait times continue to be very long and exceed provincial targets particularly for orthopedics.

At DRHC, there are three physical ORs on site with two in operation due to funding constraints. The peri-op service is well resourced with RNs, LPNs, health care aides and a recently added role of OR aide. They also have a clinical resource nurse and four general surgeons in the community as well as an OBGYN and several GP surgeons. Dentists also utilize the OR several times per year. Wait times for these services are well managed with surgeons' offices entering wait time information directly into the provincial SWIM – Surgical Waitlist Management System. Scheduled surgery is performed Monday to Friday with on call for urgent/emergent cases after hours and on weekends.

The team is to be commended for their recently standardized anaesthesia carts. Additionally, they recycle cardboard and plastic.

The department has a flash sterilizer that is used very infrequently – the last time was in 2024. The organization is encouraged to explore decommissioning this underutilized unit that requires daily checks and ongoing training to create additional storage capacity in the department. There are stained porous ceiling tiles in the department, including the sterile storage area.

Staff indicate that medications are not routinely labelled on the sterile field if only one medication is in place. The organization is encouraged to label all medications, regardless of the number. Additionally, the anaesthetists pre-draw medications into syringes that are labelled with the drug, however, the strength or the date drawn is not noted. Although staff note that they do permit some jewelry to remain in place during surgical procedures (staff indicated the practice is to tape the jewelry and document that it is in place), the organization is encouraged to implement a waiver document indicating that education of risks has been provided, and the patient accepts the risks.

The surgical inpatient unit operates 14 of the 20 beds due to staffing constraints. Flow barriers include patients that stay beyond the 10-day LOS target for the unit due to ongoing post-operative issues. As a result, the unit frequently operates overcapacity. A lighting refurbishment project beginning in June will reduce slates on this site during the refit.

Post surgical follow up calls are not in place across any of the sites visited. The program team shared that funding has been secured for a coordinator to implement the American College of Surgeons National Surgical Quality Improvement Program (NSQIP), a risk-adjusted registry of surgical cases that captures pre- and post-operative risk factors and 30-day post op outcomes across a range of surgical specialties, providing benchmarking data to drive surgical quality improvement (QI) through standardized and risk-adjusted outcome metrics. The program is also encouraged to consider adding patient reported outcome measures (PROMs), generic and/or condition/procedure specific, and to liaise with the Canadian Institute of Health Information (CIHI) about their standardized surgical PROMs program that provides Canadian benchmarking data about patient experiences and outcomes at 30, 90, one-year post-surgery.

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Table 12: Unmet Criteria for Perioperative Services and Invasive Procedures

Criteria Number	Criteria Text	Criteria Type
2.4.11	Information Transfer at Care Transitions 2.4.11.2 Documentation tools and communication strategies are used to standardize information transfer at care transitions.	ROP
2.6.5	All of the client's jewelry, body piercings, contact lenses, prostheses, dentures, and eyeglasses are removed prior to surgery.	HIGH
2.7.3	Every medication and solution on the sterile field is labeled.	HIGH
2.12.16	There is a process to follow up with discharged day surgery clients.	NORMAL

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Service Excellence for Perioperative Services and Invasive Procedures

Standard Rating: 98.8% Met Criteria

1.2% of criteria were unmet. For further details please review the table at the end of this section.

Assessment Results

All teams demonstrated a collaborative, interdisciplinary approach to care and care planning. Education is available to surgical nursing staff beginning with a comprehensive orientation. The five health centres that provide perioperative services have access to nurse educators, albeit this is a limited resource.

End of life training is offered to new hires and others can access the training via the SPOT learning platform.

Across all sites visited during this survey, the teams were very focused on evidence to develop and support new projects. There are strong processes in place around quality improvement initiatives. The program team is proud that the Provincial Surgery Safety Checklist being rolled out this spring is based largely on the process and forms developed in the PMH region.

The program provides patients with a questionnaire at discharge that includes a postage paid envelope and results inform quality improvement (QI) initiatives. Patient satisfaction across the program is very positive, and patients reported being treated with dignity and respect, that they felt confidence in their care team, surgeon, anesthetists and nurses and that the reputation of their facility in the community was positive. The program provided an example of an incident that involved the development of a trauma informed care plan based on action taken to engage a patient in addressing concerns.

Routine screening for suicide risk was not evident in the peri-op program at the Dauphin and Minnedosa sites. Both nursing staff and leaders indicated that this is not mandated due to privacy constraints in the pre- and post-op “lounge”. While privacy related to space constraints may be an issue, the organization is encouraged to determine if other options to address this safety risk can be adopted in the program.

Table 13: Unmet Criteria for Service Excellence for Perioperative Services and Invasive Procedures

Criteria Number	Criteria Text	Criteria Type
4.2.2	Suicide Prevention Program 4.2.2.3 The team leadership ensures the team conducts standardized routine screening for suicide risk, using evidence-informed tools provided by the organizational leaders.	ROP

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Reprocessing of Reusable Medical Devices

Standard Rating: 96.8% Met Criteria

3.2% of criteria were unmet. For further details please review the table at the end of this section.

Assessment Results

Prairie Mountain Health (PMH) operates Medical Device Reprocessing (MDR) services in five sites with the goal of ensuring both efficient and safe cleaning, disinfection and sterilization of the instruments required to provide care in 43 smaller, rural communities. This standard was assessed at Brandon Regional Health Centre (BRHC) Dauphine Regional Health Centre (DRHC) and Minnedosa Health Centre.

All sites follow standard operating procedures to enable the sharing of staff and equipment as needed. This approach reflects the diverse range of surgical cases across the region and supports ongoing adaptation to meet the needs of a growing population, including an aging demographic and a rising number of patients presenting with substance use issues. The availability of specialty surgeons, highly trained surgical nursing staff and specialized equipment requires the MDR program to continually adapt to ensure their teams have the knowledge skills and resources to maintain their current operations, while planning for the immediate and longer-term future needs of the region and the province.

Across all three MDR sites visited, the staff demonstrated commitment to ensuring they keep their patients safe. They understand the important role they play in patient safety. One staff member stated, “You have to think about everything you touch like it’s for your own Dad”. Recruitment and staffing challenges have necessitated hiring of incumbents who have not completed formal MDR training, however, all are required to complete a recognized MDR course within 15 months of onboarding and at a provincial level there is work in progress towards provincially mandating all MDR staff to have Canadian Standards Association (CSA) or Healthcare Sterile Processing Association certification. One member of the Minnedosa MDR has completed US certification and the team noted that the ability to connect with a broader community of practice that allows for sharing of best practices and new learning has prompted great discussion (and debate) within the team.

Across the region the MDR program reprocesses flexible gastrointestinal endoscopes (including Gastroscopes, Colonoscopes, Endoscopic Retrograde Cholangiopancreatographies) and specialty flexible endoscopes (Bronchoscopes, Intubation Scopes, Cystoscopes and Video Rhinoscopes) for various programs and sites. Volumes continue to grow, and the program accommodates process improvement initiatives aiming to increase efficiency, often workflow related, while maintaining adherence to standards.

Workflow, physical space and aging equipment, identified as problematic in the previous survey, continue to be problematic. The teams working in the MDRs at DRHC and Minnedosa Health Centre make efforts to optimize the existing space and mitigate risks, however, both MDRs are small and the MDR in Dauphin does not support one-way flow of medical devices. Case carts are utilized to transport clean and dirty instruments over the same pathway and elevator. Both have porous ceiling tiles, the DRHC MDR has cracked flooring and chipped wall board and the cupboards in the MDR at Minnedosa have delaminated, likely due to overspray of water from the sink or due to moisture from cleaning agents used to wipe down the area. The “pony wall” identified during the last survey in Minnedosa as not reaching the ceiling (a gap between the top of the wall and the ceiling) does not provide a full separation between the clean and dirty zones and hand hygiene sinks are not equipped with sensors (manual faucets). The organization is encouraged to prioritize a renovation of these departments given the goals of the surgical department to increase services and volumes. It is recommended that PMH consider immediate updates, such as the

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application of nonporous wallboard, replacing the ceiling tiles with cleanable ceiling tiles and installing a plexiglass or other material to bridge the gap from the top of the pony wall to the ceiling. In DRHC one of the two washers was not operating during the site visit; the sole cart washer was also out of commission. The sterilizer in Minnedosa is frequently in need of repair. There are hydraulic lift workstations in DRHC providing a safe ergonomic setting for the team and the new health centre in Neepawa will have a state of the art 3-zone MDR on completion and redundant equipment, such as the sterilizer, will be deployed to other sites (or retained as back up).

The MDR at DRHC utilizes reusable linens and there is a small linen room with a wooden light table that does not comply with infection control standards. A consideration for the organization is transitioning to single use wraps which would permit the removal of a wall to create a better flow through the department. Several detergents and enzymatics in Dauphin were observed to be unlabeled or unmarked upon opening. There is a relatively new endoscopy reprocessing area that meets all standards on this site.

The MDR at BRHC operates 24/7, providing support to operating room (OR), endoscopy, emergency obstetrics and other ambulatory services, in addition to supporting many rural sites. There is good separation in the department between clean and dirty with one way movement in the department. There are dedicated elevators to and from the OR. A feasibility study has been conducted and submitted to create a three-zone environmental separation in the MDR. The team is hoping that this request will be approved that would add a separation between the clean assembly area and sterile storage based on the best practice standards. The cabinets in the endoscopy storage room would benefit from having a hepa filter; it was also noted that the cabinets have no drying capability.

All sites visited have a strong quality program with quality improvement (QI) initiatives in place. Audits are performed and when issues are identified, projects to improve are developed. Incident reports are completed when instruments are missing or inaccurately placed on OR carts/packs. These incidents are tracked and discussed with staff. Knowledge Exchange (KE) boards are posted and generate discussions with staff. Development of the KE boards was seen as a team building exercise with the outcome that the team felt heard, were able to put their ideas in writing, then reviewed together as a team to discuss actioning those that were either “quick fixes” or would have the greatest impact and were feasible (e.g., moving items to first not last). The team at BRHC conducted a QI project related to isolation carts (since they were responsible for checking and restocking them throughout the organization). They revised the contents of the carts in consultation with infection prevention and control (IPC), and the nursing staff became responsible for restocking the carts with housekeeping cleaning them. This resulted in a saving of $1K monthly.

A new regional policy is in development that includes a new section on linen inspection that now shows shared responsibility with MDR and laundry services. An active physical demand analysis study was performed in 2021 to identify the risks, ergonomics issues, physical move analysis, and risk of musculoskeletal injuries for each workstation in the department in BRHC. As a result, the leaders ensure there is equitable distribution of staff at these stations for specific hours of work.

The regional team works collaboratively to plan for future needs and address current challenges, such as unplanned downtime and redundancy plans are in place. The new Neepawa MDR is expected to take on a greater share of reprocessing for the region. Plans are underway to modernize equipment in BRHC and DRHC, and proposals are in development for Swan River and Minnedosa. Storage capacity will need to be considered as the population and number of procedures increase; the team cited that addictions issues are adding to the complexity of both activity and volumes.

Preventative maintenance tracking is well done, and good relationships have been forged with vendors for repairs, as well as with PMH clinical engineering. Instrument tracking using the Alex Gold system helps to track and associate the various case carts and instruments with the respective patient; unfortunately, the company will no longer support the system at the end of December, so the team is searching for a new program to replace it.

An occupational health and safety representative remarked that “MDR is my gold star, great at hazard

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assessments to maintain safety". The Regional Case Facilitator noted that they are proud of the relationship between the OR teams and the MDR teams. There is a constant focus is on safety, always prepared for OR slates and ensuring all processes are working well.

The regional MDR program is represented on several provincial committees that attempt to prioritize the needs across the province, recognizing that each region has very different challenges and often different equipment and instrument needs, including supply chain disruptions and seasonal variation. The team noted provincial economies of scale are being leveraged as they work with Shared Health to develop a provincial master list of both supplies and capital equipment. The approach is to develop overall policy, then adapt to reflect regional needs.

Table 14: Unmet Criteria for Reprocessing of Reusable Medical Devices

Criteria Number	Criteria Text	Criteria Type
1.3.1	The layout of the Medical Device Reprocessing (MDR) department is designed based on service volumes, range of reprocessing services, and one way flow of medical devices.	NORMAL
1.3.2	The Medical Device Reprocessing (MDR) department is designed to prevent cross-contamination of medical devices, isolate incompatible activities, and clearly separate work areas.	HIGH
1.3.6	The Medical Device Reprocessing (MDR) department has floors, walls, ceilings, fixtures, pipes, and work surfaces that are easy to clean, non-absorbent, and will not shed particles or fibres.	HIGH
3.2.2	The reprocessing area's designated hand-washing sinks are equipped with faucets supplied with foot-, wrist-, or knee-operated handles, electric eye controls, automated soap dispenser and single-use towels.	NORMAL

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