



ACCREDITATION CANADA



*Driving Quality Health Services*

# Accreditation Report

**Assiniboine Regional Health Authority**

Souris, MB

*On-site survey dates: November 27, 2011 - December 2, 2011*

*Report issued: December 21, 2011*



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

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## About the Accreditation Report

Assiniboine Regional Health Authority (referred to in this report as “the organization”) is participating in Accreditation Canada’s Qmentum accreditation program. As part of this ongoing process of quality improvement, an on-site survey was conducted in November 2011. Information from the on-site survey as well as other data obtained from the organization were used to produce this Accreditation Report.

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

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

## Confidentiality

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

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

*Accreditation Canada is a not-for-profit, independent organization that provides health services organizations with a rigorous and comprehensive accreditation process. We foster ongoing quality improvement based on evidence-based standards and external peer review. Accredited by the International Society for Quality in Health Care, Accreditation Canada has helped organizations strive for excellence for more than 50 years.*

## A Message from Accreditation Canada's President and CEO

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

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

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

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

We look forward to our continued partnership.

Sincerely,



Wendy Nicklin  
President and Chief Executive Officer

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## **Section 1      Executive Summary**

Accreditation Canada is an independent, not-for-profit organization that sets standards for quality and safety in health care and accredits health organizations in Canada and around the world. Organizations that are accredited by Accreditation Canada undergo a rigorous evaluation process. Following a comprehensive self-assessment, trained surveyors from accredited health organizations conduct an on-site survey to evaluate the organization's performance against Accreditation Canada's standards of excellence.

Assiniboine Regional Health Authority (referred to in this report as "the organization") is participating in Accreditation Canada's Qmentum accreditation program. This Accreditation Report shows the results to date and is provided to guide the organization as it continues to incorporate the principles of accreditation and quality improvement into its programs, policies, and practices.

Assiniboine Regional Health Authority is commended on its commitment to using accreditation to improve the quality and safety of the services it offers to its clients and its community.

### **1.1 Accreditation Decision**

Assiniboine Regional Health Authority has earned the following accreditation decision.

#### **ACCREDITATION DECISION**

**Accreditation with Condition (Report)**

## Section 1 Executive Summary

### 1.2 About the On-site Survey

- **On-site survey dates: November 27, 2011 to December 2, 2011**

- **Locations**

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

- 1 Carberry Health Centre
- 2 Deloraine Health Centre
- 3 Glenboro Health Centre
- 4 Hamiota Health Centre
- 5 Minnedosa Health Centre
- 6 Neepawa Health Centre
- 7 Russell Health Centre
- 8 Shoal Lake Regional Office
- 9 Souris Corporate Office
- 10 Souris Health Centre
- 11 Tiger Hills Health Centre (Treherne)
- 12 Tri-Lake Health Centre (Killarney)
- 13 Virden Health Centre
- 14 West-Man Nursing Home (Virden)

- **Standards**

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

***System-Wide Standards***

- 1 Sustainable Governance
- 2 Effective Organization

***Population-specific Standards***

- 3 Populations with Chronic Conditions

***Service Excellence Standards***

- 4 Managing Medications
- 5 Cancer Care and Oncology Services
- 6 Operating Rooms
- 7 Reprocessing and Sterilization of Reusable Medical Devices
- 8 Surgical Care Services

## Section 1      Executive Summary

- 9    Infection Prevention and Control
- 10   Home Care Services
- 11   Community Health Services
- 12   Long Term Care Services
- 13   Medicine Services
- 14   Obstetrics/Perinatal Care Services
- 15   Emergency Medical Services
- 16   Community-Based Mental Health Services and Supports Standards
- 17   Emergency Department

- **Performance Measures**

The organization submitted data related to the following performance measures.

***Instruments***









- 1    Governance Functioning Tool
- 2    Patient Safety Culture Tool
- 3    Worklife Pulse Tool

## Section 1 Executive Summary

### 1.3 Overview by Quality Dimensions

Accreditation Canada defines quality in health care using eight dimensions that represent key service elements.

Each criterion in the standards is associated with a quality dimension. This table lists the quality dimensions and shows how many of the criteria related to each dimension were rated as met, unmet, or not applicable during the on-site survey.

Quality Dimension	Met	Unmet	N/A	Total
 Population Focus (Working with communities to anticipate and meet needs)	96	4	0	100
 Accessibility (Providing timely and equitable services)	99	5	0	104
 Safety (Keeping people safe)	433	35	28	496
 Worklife (Supporting wellness in the work environment)	151	2	1	154
 Client-centred Services (Putting clients and families first)	166	3	5	174
 Continuity of Services (Experiencing coordinated and seamless services)	61	3	0	64
 Effectiveness (Doing the right thing to achieve the best possible results)	609	42	22	673
 Efficiency (Making the best use of resources)	55	1	3	59
<b>Total</b>	<b>1670</b>	<b>95</b>	<b>59</b>	<b>1824</b>

## Section 1 Executive Summary

### 1.4 Overview by Standards Sets

Qmentum standards of excellence identify policies and practices that contribute to high quality, safe, and effectively managed care. Each standard has associated criteria that contribute to achieving the standard as a whole.

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

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

Standards Set	High Priority Criteria			Other Criteria			Total Criteria (High Priority + Other)		
	Met	Unmet	N/A	Met	Unmet	N/A	Met	Unmet	N/A
	# (%)	# (%)	#	# (%)	# (%)	#	# (%)	# (%)	#
<b>System-Wide Standards</b>									
Sustainable Governance	23(100%)	0(0%)	0	65(96%)	3(4%)	0	88(97%)	3(3%)	0
Effective Organization	54(95%)	3(5%)	0	48(98%)	1(2%)	0	102(96%)	4(4%)	0
<b>Population-specific Standards</b>									
Populations with Chronic Conditions	3(100%)	0(0%)	1	26(76%)	8(24%)	1	29(78%)	8(22%)	2
<b>Service Excellence Standards</b>									
Infection Prevention and Control	43(81%)	10(19%)	4	38(88%)	5(12%)	3	81(84%)	15(16%)	7
Cancer Care and Oncology Services	37(100%)	0(0%)	0	74(100%)	0(0%)	1	111(100%)	0(0%)	1
Community Health Services	13(100%)	0(0%)	0	55(100%)	0(0%)	0	68(100%)	0(0%)	0

## Section 1 Executive Summary

Standards Set	High Priority Criteria			Other Criteria			Total Criteria (High Priority + Other)		
	Met	Unmet	N/A	Met	Unmet	N/A	Met	Unmet	N/A
	# (%)	# (%)	#	# (%)	# (%)	#	# (%)	# (%)	#
<b>Service Excellence Standards</b>									
Community-Based Mental Health Services and Supports Standards	23(100%)	0(0%)	0	112(100%)	0(0%)	0	135(100%)	0(0%)	0
Emergency Department	33(97%)	1(3%)	1	63(90%)	7(10%)	16	96(92%)	8(8%)	17
Emergency Medical Services	37(97%)	1(3%)	0	120(99%)	1(1%)	1	157(99%)	2(1%)	1
Home Care Services	44(94%)	3(6%)	1	51(98%)	1(2%)	2	95(96%)	4(4%)	3
Long Term Care Services	38(100%)	0(0%)	1	81(100%)	0(0%)	1	119(100%)	0(0%)	2
Managing Medications	74(95%)	4(5%)	5	50(96%)	2(4%)	0	124(95%)	6(5%)	5
Medicine Services	29(85%)	5(15%)	1	66(97%)	2(3%)	2	95(93%)	7(7%)	3
Obstetrics/Perinatal Care Services	44(94%)	3(6%)	4	67(97%)	2(3%)	1	111(96%)	5(4%)	5
Operating Rooms	63(93%)	5(7%)	4	28(97%)	1(3%)	1	91(94%)	6(6%)	5
Reprocessing and Sterilization of Reusable Medical Devices	30(83%)	6(17%)	4	44(77%)	13(23%)	2	74(80%)	19(20%)	6
Surgical Care Services	33(89%)	4(11%)	1	61(94%)	4(6%)	1	94(92%)	8(8%)	2
<b>Total</b>	<b>621(93%)</b>	<b>45(7%)</b>	<b>27</b>	<b>1049(95%)</b>	<b>50(5%)</b>	<b>32</b>	<b>1670(95%)</b>	<b>95(5%)</b>	<b>59</b>

**Section 1 Executive Summary**

**1.5 Overview by Required Organizational Practices**

In Qmentum, a Required Organizational Practice (ROP) is defined as an essential practice that an organization must have in place to enhance client safety and minimize risk. Each ROP has associated tests for compliance, and all of the tests for compliance must be met for the ROP as a whole to be rated as met.

This table shows how the applicable ROPs were rated during the on-site survey.

Required Organizational Practice	Rating
<b>Patient Safety Goal Area: Safety Culture</b>	
Adverse Events Disclosure	Met
Adverse Events Reporting	Met
Client Safety As A Strategic Priority	Met
Client Safety Quarterly Reports	Met
Client Safety Related Prospective Analysis	Met
<b>Patient Safety Goal Area: Communication</b>	
Client And Family Role In Safety	Unmet
Dangerous Abbreviations	Met
Information Transfer	Unmet
Medication Reconciliation As An Organizational Priority	Unmet
Medication Reconciliation At Admission	Met
Medication Reconciliation at Transfer or Discharge	Unmet
Surgical Checklist	Met
Two Client Identifiers	Unmet
Verification Processes For High-Risk Activities	Met

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Required Organizational Practice	Rating
<b>Patient Safety Goal Area: Medication Use</b>	
Concentrated Electrolytes	Met
Heparin Safety	Met
Infusion Pumps Training	Met
Medication Concentrations	Met
Narcotics Safety	Met
<b>Patient Safety Goal Area: Worklife/Workforce</b>	
Client Safety Plan	Met
Client Safety: Education And Training	Met
Client Safety: Roles And Responsibilities	Met
Preventive Maintenance Program	Unmet
Workplace Violence Prevention	Met
<b>Patient Safety Goal Area: Infection Control</b>	
Hand Hygiene Audit	Unmet
Hand Hygiene Education And Training	Met
Infection Control Guidelines	Met
Infection Rates	Unmet
Influenza Vaccine	Met
Pneumococcal Vaccine	Met
Sterilization Processes	Met
<b>Patient Safety Goal Area: Falls Prevention</b>	
Falls Prevention Strategy	Met

**Section 1      Executive Summary**

Required Organizational Practice	Rating
<b>Patient Safety Goal Area: Risk Assessment</b>	
Home Safety Risk Assessment	Met
Pressure Ulcer Prevention	Met
Suicide Prevention	Met
Venous Thromboembolism Prophylaxis	Unmet

## Section 1 Executive Summary

### 1.6 Summary of Surveyor Team Observations

During the on-site survey, the surveyor team made the following observations about the organization's overall strengths, opportunities for improvement, and challenges.

The Assiniboine Regional Health Authority (ARHA) provides a high quality of care and services to a population of 68,000, which covers a large geographic area and multiple sites. The population of the region is changing and has seen a decline in recent years, but more recently, it has seen a growth in immigration. This trend in itself has brought challenges that the system is addressing with identification of the need for translation services.

The organization lives its mission to: "share in enhanced well-being through the delivery of quality health services that are responsive to the needs of the population." This is evidenced in a number of initiatives including the ongoing assessment of community needs and identification of areas of focus to promote and maintain health and wellness. The ARHA is seen as a vital and respected member of the community and major employer. The staff are very passionate about their roles and proud of the work they do in providing high quality patient care and services. The health authority team has insight of what needs to be accomplished and has established plans to continue with their improvements.

The Board of Directors of the ARHA is appointed by the Ministry of Health for the Province of Manitoba. The Board comprises knowledgeable and dedicated community members. Ongoing education of the board members is evidenced in the support of attendance at conferences and regular board education sessions.

The Board of Directors has a clear understanding of their roles and responsibilities and the day to day operations that are entrusted to them and the chief executive officer (CEO) and executive management team. The Board has recently completed a Community Health Assessment (2009-2010) that included data collection, analysis and engagement of the community, partners and staff. The report has been used to determine the strengths and needs in the communities as well as to identify community wide priorities. This information was collected using a variety of methods such as focus groups, community interviews, surveys among others. The comprehensive content of this report is impressive. The report has outlined the changing population in the region and increasing diversity of the communities relative to immigration. This is the third such report for the Assiniboine Regional Health Authority.

The strategic plan emerging from this report reflects the findings that include addressing the changing population of the region and growth related to immigration. The plan reflects the need for interpreters for the immigrant population to ensure that the sharing of information with these clients is accurate. The achievement of the strategies is reviewed annually and submitted via the Board to the Ministry of Health. The review of the targets set for: "difficult to achieve" strategies on a more regular basis such as quarterly, would prove beneficial in changing actions that may be needed to remain on target.

Community and community partnerships are seen as a priority for the ARHA. Advisory councils are held on a regular basis to discuss specific issues and gather feedback. Community stakeholder meetings are held regularly and reflected in the minutes. Discussion with the community partners identifies a strong collaboration with the ARHA. The partners identified major issues to be addressed that included improving access to: therapies such as occupational, speech and physiotherapy; interpretation services for immigrants; transportation for clients in a large geographic area; and lack of available housing and homelessness. The group has an awareness of the issues the organization is dealing with in the area of recruitment and retention of both support and professional staff and the subsequent impact to the communities. Numerous strengths of the ARHA were identified and these included being approachable, accessible, cooperative and able to adopt innovative approaches to resolve issues.

## Section 1 Executive Summary

From the perspective of delivery of care and services, the patients and families appreciate the high quality that they receive. Patient safety is seen as a priority across the organization and many initiatives are in place. These include: the disaster management plan, Falls Prevention program and ongoing risk assessments. The e-learning program established to support the skill maintenance and professional development of staff is exceptional. The staff portal on line training (SPOT) learning program allows staff to register and complete mandatory courses and training on line. More than ninety percent (90%) of staff have registered to date.

The organization's ethics program has evolved significantly since 2008, with a collaborative relationship established with the Manitoba Provincial Health Ethics Network, formed in 2009. This network supports the ten (10) regions across the province in the teaching of clinical ethics. Some of these programs include: Ethics in Healthcare Management, Level 1 Introduction to Health Ethics, and Tools and Strategies to Address Ethics Issues.

Patient safety is a priority across the organization and many initiatives are in place such as the falls prevention program, completion of risk assessments and ongoing communications relating to keeping patients safe. The cleanliness of the facilities is noted and demonstrates the great work of the housekeeping team, facilities maintenance and infection prevention and control, especially for the "aging" facilities.

Client satisfaction is seen an important measure of the quality of care and services delivered by the ARHA. All programs and services are expected to establish processes to gather satisfaction information on a regular basis. The clients/patients responses to the assessment of "overall quality" ranged from good and excellent and were all rated higher than ninety percent (90%) satisfaction.

The ARHA has had numerous successes since the previous accreditation survey. Some of the initiatives include the establishment of a regional orientation program, e-learning program, and the successful Philippine recruitment mission. Numerous other examples of achievements are noted in body of this report.

Opportunities for improvement to be considered include ensuring that the mission, vision and values are posted in all public areas in the facilities. Although this document was observed in most areas, it does require a review for consistency across the region. Sustaining the momentum, new initiatives and ongoing evaluation of the outcomes of projects will be one of the challenges for the ARHA. The organization is encouraged to focus on "branding" the visual identity of the ARHA, specifically related to forms, health record documents and published materials.

A priority risk management issue is the sterilization and reprocessing practices across the region. These processes do not meet current standards relative to the physical structure and need review as soon as possible.

The primary human resources (HR) challenge for the ARHA is the recruitment of support and professional staff to support the delivery of care and services.

Overall, the organization has much to be proud of and there is strong evidence across the system of the dedication and multiple efforts that all employees and volunteers extend into their day to day work.

**Section 2 Detailed Required Organizational Practices Results**

This section gives more information about unmet ROPs. It shows the patient safety goal area into which the ROP falls, the requirements of the ROP, and the set of standards where it can be found.

The patient safety goal areas are safety culture, communication, medication use, worklife/workforce, infection control, and risk assessment.

Unmet Required Organizational Practice	Standards Set
<b>Patient Safety Goal Area: Communication</b>	
<p><b>Client And Family Role In Safety</b> The team informs and educates clients and families in writing and verbally about the client and family's role in promoting safety.</p>	<ul style="list-style-type: none"> <li>• Surgical Care Services 15.4 (*15.3)</li> <li>• Medicine Services 15.4</li> <li>• Obstetrics/Perinatal Care Services 16.4 (*16.3)</li> </ul>
<p><b>Information Transfer</b> The organization transfers information effectively among service providers at transition points.</p>	<ul style="list-style-type: none"> <li>• Home Care Services 11.3 (*11.4)</li> </ul>
<p><b>Medication Reconciliation at Transfer or Discharge</b> The team reconciles the client's medications with the involvement of the client, family or caregiver at transition points where medication orders are changed or rewritten (i.e. internal transfer, and/or discharge).</p>	<ul style="list-style-type: none"> <li>• Home Care Services 11.2 (*11.3)</li> <li>• Medicine Services 11.3</li> <li>• Obstetrics/Perinatal Care Services 11.3</li> <li>• Surgical Care Services 11.4</li> </ul>
<p><b>Two Client Identifiers</b> The team uses at least two client identifiers before providing any service or procedure.</p>	<ul style="list-style-type: none"> <li>• Emergency Department 10.4</li> </ul>
<p><b>Medication Reconciliation As An Organizational Priority</b> The organization reconciles clients' medications at admission, and transfer or discharge.</p>	<ul style="list-style-type: none"> <li>• Effective Organization 6.6</li> </ul>
<b>Patient Safety Goal Area: Worklife/Workforce</b>	
<p><b>Preventive Maintenance Program</b> The organization's leaders implement an effective preventive maintenance program for medical devices, medical equipment, and medical technology.</p>	<ul style="list-style-type: none"> <li>• Effective Organization 10.5</li> </ul>

**Section 2 Detailed Required Organizational Practices Results**

Unmet Required Organizational Practice	Standards Set
<b>Patient Safety Goal Area: Infection Control</b>	
<p><b>Infection Rates</b> The organization tracks infection rates; analyzes the information to identify clusters, outbreaks, and trends; and shares this information throughout the organization.</p>	<ul style="list-style-type: none"> <li>· Infection Prevention and Control 1.2</li> </ul>
<p><b>Hand Hygiene Audit</b> The organization evaluates its compliance with accepted hand-hygiene practices.</p>	<ul style="list-style-type: none"> <li>· Infection Prevention and Control 6.5</li> </ul>
<b>Patient Safety Goal Area: Risk Assessment</b>	
<p><b>Venous Thromboembolism Prophylaxis</b> The team identifies medical and surgical clients at risk of venous thromboembolism (deep vein thrombosis and pulmonary embolism) and provides appropriate thromboprophylaxis.</p>	<ul style="list-style-type: none"> <li>· Medicine Services 7.4</li> <li>· Surgical Care Services 7.7</li> </ul>

\* Note: Criterion number in brackets make reference to the criterion number in version 4 of the standard sets.

## Section 3 Detailed On-site Survey Results

This section shows detailed on-site results. When reviewing these results, it is important to review the service excellence and the system-wide results together, as they are complementary.

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

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

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

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

See Appendix B for a list of priority processes.

**Interpreting the tables:** The tables show all unmet criteria from each set of standards, identify high priority criteria, and list surveyor comments related to each priority process. High priority criteria are identified by the following symbols:



High priority criterion



Required Organizational Practice

### 3.1 Priority Process Results for System-wide Standards

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

Some priority processes in this section also apply to the service excellence standards. Where there are unmet criteria that also relate to services, those results should be shared with the relevant team.

## Section 3 Detailed On-site Survey Results

### 3.1.1 Priority Process: Planning and Service Design

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

Unmet Criteria	High Priority Criteria
<b>Standards Set: Sustainable Governance</b>	
12.3 The governing body completes an annual environmental scan to identify changes and new challenges, and adjusts its strategic plan, goals, or objectives accordingly.	

#### Surveyor comments on the priority process(es)

The community needs assessment completed is impressive. The ARHA uses a prioritization process using a quality framework that is used to set priorities for resource allocation across the region. There are three principal evaluation criteria used in the assessment namely, quality, accessibility and affordability. This framework assessment is applied annually to all facilities. Information is gathered on a routine basis from the community by way of regular interaction with the Assiniboine Health Advisory committee and discussions with community partners and individual communities.

Health promotion and prevention has been identified as a strategic priority of ARHA and it will prioritize resources and strategies to support and enhance health promotion and disease prevention management.

Although there are mission, vision and value statements noted in the strategic plan, the sharing of these value statements should be more consistent across the region. Posting of the mission, vision and values in all public areas, specifically in the lobby and board rooms of the various sites will ensure that the public and staff are reminded of the purpose and focus on the health authority as well as the values being used in providing care and making decisions. The mission, vision and values were formally reviewed and the values were adjusted in spring 2010.

The Board is encouraged to complete an environmental scan on an annual basis to ensure that the current plans or goals and objectives are accurately focused on the needs of the community. It was noted that a meeting is scheduled in January 2012 to complete this process and review the status of meeting targets set in the strategic directives.

The challenges the ARHA continues to address is the recruitment of support and professional staff to support the care delivery and services offered and the retention of medical staff. The organization has had to become innovative in ensuring the staff complement at the facilities can care for the level of care offered at these facilities. This has led to the development of some "transitional care" beds, whose patients have less complex care needs, as opposed to acute care and emergency services. Additionally, maintaining the current financial stability is an important issue.

## Section 3 Detailed On-site Survey Results

### 3.1.2 Priority Process: Resource Management

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

The organization has met all criteria for this priority process.

#### Surveyor comments on the priority process(es)

The Board has clearly defined policies, procedures and processes for the allocation of resources. The Board and the executive management committee have demonstrated strategic plan implementation across the system by making the plan operational, with operating and capital plan developments. There is involvement in the budgeting processes for both operating and capital at all levels of the organization. Front line staff are involved in the planning process by way of seeking their comments on the equipment needs for their areas. The budgeting process is a component of the strategic planning cycle.

The budgeting process is outlined in policy format and available as a flow chart.


Financial reports are reviewed by the finance committee on a monthly basis and reports are shared with the full board.

Audits of the financial processes at the ARHA are carried out on a regular basis. A Government Services Internal Audit was completed in August 2009 and all recommendations were followed up by the finance team. This was a comprehensive review of financial policies, procedures and processes. The results of the audit identified a high level of compliance to the criteria used in the assessment.

## Section 3 Detailed On-site Survey Results

### 3.1.3 Priority Process: Human Capital

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

Unmet Criteria	High Priority Criteria
<b>Standards Set: Effective Organization</b>	
8.9 The organization's leaders share the results of the Worklife Pulse Tool and use the results to make improvements.	
<b>Standards Set: Sustainable Governance</b>	
7.3 The governing body reviews the contribution of and provides feedback to individual members.	
8.3 Performance objectives for the CEO are set in partnership with the CEO and revised annually.	
<b>Surveyor comments on the priority process(es)</b>	

The Board members are appointed using a process defined by the regulations set out by the Regional Health Authority. There is an orientation program for board members. Review of the program identified a comprehensive education component for the new board member. Evaluation of the board consists of evaluation following each board meeting and annual evaluation of the committee as a whole. The Board is encouraged to adopt a process for individual member evaluation, provided in a one to one format with the Board chair. This should occur on an annual basis.

The CEO's performance is reviewed on an annual basis by the Board and executive management committee on an annual basis. The Board is encouraged to define specific annual performance objectives for the CEO and follow up on achievement at the time of the annual evaluation.

The Governance Functioning tool has been completed but analysis of the areas identified for improvement have not been addressed. The Board supported the need to focus on the areas for improvement by development of a work plan.

The ARHA is proactive in providing education and ensuring that personal safety of both staff and patient/client is managed in the most effective manner. A course is offered titled: "Prevention is 9/10ths of the Law", which is replacing non violent crisis intervention (NVCR) training. The objective of the training is to focus on prevention and resolution of potential problems prior to violent aggressive behavior.

Recruitment and retention of staff is a key focus of this organization for both support and professional staff. There is a nursing recruitment and retention continuing education fund committee. The committee's mandate is to establish priorities and implement recruitment and retention strategies that will enhance the nurses' role in the work environment. This committee assists in the allocation of funding for financial support of nurses for continuing education. It is noted that this is a joint collaboration between nursing and the union. Quarterly reports are submitted to the Provincial Nursing Resource Task Force.

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Staffing is an issue for the region owing to the nurse and support staff shortages in some areas. There is a focus on maintaining the census within staffing capabilities at these affected sites.


The Human Resource team is encouraged to share the Work Life survey results with staff and to identify strategies in a collaborative manner in order to move the ARHA forward in addressing the identified areas for improvement.

The completion of performance appraisals (PAs) continues to be an issue, with an eighteen (18%) completion rate. It is acknowledged this is an improvement from the past year, with an eight percent (8%) completion rate. The HR team is encouraged to continue efforts at improving this rate, as the performance evaluation process is a time of valuable interaction between management and staff.

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### 3.1.4 Priority Process: Integrated Quality Management

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

Unmet Criteria	High Priority Criteria
<b>Standards Set: Effective Organization</b>	
<p>6.6 The organization reconciles clients' medications at admission, and transfer or discharge.</p> <p>6.6.4 The plan includes locations and timelines for implementing medication reconciliation throughout the organization.</p>	
<b>Surveyor comments on the priority process(es)</b>	

The ARHA demonstrates a clear commitment to quality improvement (QI), with a comprehensive quality framework which it uses to guide organizational priorities. The quality framework was developed in 2008 and has been updated annually since that time.

It is also apparent that the leadership at all levels of the organization is committed to continuous learning and improvement. Two significant incidents over the past year namely, a flood and a violence event were responded to swiftly, appropriately and comprehensively. The organization has received many accolades from community and government partners for the response to the flood in the spring of 2011. Analysis of the critical event related to the violence incident involved departments and services across the region including staff, patients, and clients that were affected as well as community partners and government ministries and agencies. Recommendations and lessons learned from both of these events also had an impact on many service areas, both internal and external to ARHA and to the government. There is comprehensive, documented evidence that most recommendations stemming from these events have been implemented thoughtfully and respectfully, while the remainder are in the process of being implemented.

Another noted strength is the quality sharing day where staff were supported to inform their peers and the Board of their CQI initiatives. While this was done as a part of the preparation for this survey, it would be worth considering making it an annual event. The Releasing Time to Care project received an achievement award for its work from the Board of Directors and it is anticipated that this project will spread across the ARHA.

There are a number of very important improvement initiatives underway in the organization. It is always a challenge to determine the highest priority and to balance the need to implement priorities with sound change management practices to ensure that improvements implemented are sustained. It is suggested that strategy to: "hold the gains" be employed as part of a complete plan do study act (PDSA) cycle for all initiatives.

It was noted that while CQI audits were completed on topics such as hand hygiene and provided to managers and unit coordinators, there was no clearly articulated expectation of follow up activities to address improvements that were required. In conjunction with the proceeding recommendation, roles, responsibilities and processes related to actions required post CQI audit need to be developed and implemented.

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Further, a link of the current, very progressive CQI activities to longer term organizational outcome measures would assist ARHA with determining if the initiatives are making a difference and are achieving their desired outcomes.

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### 3.1.5 Priority Process: Principle-based Care and Decision Making

Identifying and making decisions about ethical dilemmas and problems

The organization has met all criteria for this priority process.

#### Surveyor comments on the priority process(es)

The Board has endorsed the ethics framework that is used at the ARHA. The organization partners with the Brandon Regional Health Authority's ethics committee to avoid the duplication of another committee.

A significant achievement has been the collaborative network established between the Assiniboine Regional Health Services and the recently formed Manitoba Provincial Health Ethics Network (2009). These relationships have seen the development and implementation of processes and procedures to access ethics education for all levels of the organization. There is cross region awareness at the front line level of the ethics framework and knowledge of accessing the service as required.

Although there is no active participation in research, there is a policy in place for reference and direction if required.

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### 3.1.6 Priority Process: Communication

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

The organization has met all criteria for this priority process.

#### Surveyor comments on the priority process(es)

The organization has a well developed communication plan, and recognizes that communication is a strategic enabler. The communication plan addresses the requirements of a geographically distributed health region, with seven (7) First Nations communities, and staff at twenty (20) acute care, twenty eight (28) long term care (LTC) centres, and twenty five (25) Emergency Medical Services (EMS) stations as well as a numerous community locations. This region is a designated bilingual region for French language services. Barriers to communication with external audiences are defined and include: French language; languages other than English; the geography, First Nations jurisdiction and corporate Identity. Process solutions have been identified and outcomes are tracked.

Defined barriers to internal communication have been identified and strategies to support communication include: the intranet and web page; laboratory 'truck' distribution of hard copy information; email with distribution lists; electronic bulletin boards; e-learning web site and clinical best practice resources.

Information technology supports communication in the areas of: education, primary care records and access to policies and procedures. Telehealth is available at eleven (7) sites and utilizes Blackberry devices for the Regional Leadership team, facilitating timely communication. ARHA also provides cell phones to staff that are defined as having a travel component to their role. Internal communication has standardized headings and one example is the: "For Your Information" template.

The ARHA has an identified strategic priority directed at communication and engagement, specifically number five (#5) that states ARHA will develop and enhance public and client engagement processes for regional priority areas. Activities intended to support achievement of the strategic priority include: expanding the list of direct invites to key community stakeholder meetings and monitoring of attendance; increased advertising of the annual general meeting (AGM); change of format for the AGM to engage attendees on specific issues; monitoring and evaluation of the Assiniboine Health Advisory committee meetings, and seeking of targeted client input to review of existing and planning for new programs and services.

The region has a mechanism to prioritize requests, renew and refresh equipment, monitor usage and plan for increased access in areas which include: admission, discharge and transfer systems and electronic medical records, which will support chronic disease management evaluation and documentation of outcomes. Initiatives are planned and include implementation of Share Point, improved data quality, profiling of occupations and programs and services, additional provincially led implementations and local priority projects.

The ARHA is encouraged to establish visual identity guidelines that are available for use by those that are developing health record documents, publishing material or preparing documents and also, to ensure that information is dated thereby supporting use of the most current material.

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### 3.1.7 Priority Process: Physical Environment

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

The organization has met all criteria for this priority process.

#### Surveyor comments on the priority process(es)

It was noted that transfers between the northern area such as Russell and Saskatoon experience an approximate twenty (20) minute period; when contact cannot be made by fleetnet radio, cell phone can still be used for contact. (11.7)

Overall, the facilities visited despite their various ages, were clean and cosmetically well maintained. As detailed by the Assiniboine leadership team, the aging infrastructure is a challenge and there are more capital projects than dollars available to maintain the facilities. The facilities try to be proactive in identifying their respective needs for repairs and maintenance.

Storage is a challenge for some of the sites and there appears to be a significant amount of 'over stocking' of many items. There may be an opportunity to reduce inventory of stores, as the organization moves across the facilities with the Releasing Time to Care and the teams clearly define what they need to provide services.

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### 3.1.8 Priority Process: Emergency Preparedness

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

The organization has met all criteria for this priority process.

#### Surveyor comments on the priority process(es)

The Regional Emergency Preparedness program reflects committed senior leadership and dedicated management and front line staff.

The Emergency Response Management system has been submitted as a Leading Practice, which is deserved from this surveyor's experience during this survey.

It is commendable to observe the degree of success attained by this level of team commitment, promoting patient safety and emergency management.

It is recommended that efforts continue to reinforce the importance of this subject area with staff to continue to support and promote their participation and commitment.

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### 3.1.9 Priority Process: Patient Flow

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

The organization has met all criteria for this priority process.


#### Surveyor comments on the priority process(es)

Region wide patient flow is not seen as a regular or significant problem in this setting and when it does occur, procedures in place are felt to be adequate in dealing with this situation. Patient flow can become an issue during transfers to Winnipeg such as the rural Assiniboine patients being delayed due to prioritizing but this is dealt with at a provincial level.

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### 3.1.10 Priority Process: Medical Devices and Equipment

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

Unmet Criteria	High Priority Criteria
<b>Standards Set: Effective Organization</b>	
10.3 The organization's leaders have a formal and open process for selecting and buying medical devices and equipment, and for selecting suppliers.	
10.5 The organization's leaders implement an effective preventive maintenance program for medical devices, medical equipment, and medical technology. 10.5.2 There are documented preventive maintenance reports. 10.5.3 The organization's leaders have a process to evaluate the effectiveness of the preventive maintenance program.	
<b>Standards Set: Infection Prevention and Control</b>	
12.6 For each disinfectant, the organization follows manufacturers' recommendations for use, contact time, shelf life, storage, appropriate dilution, and required PPE.	!
12.9 The organization appropriately contains and transports contaminated items to the reprocessing unit or area.	!
12.18 The organization has a quality control program for the cleaning, disinfection and sterilization of reusable medical devices.	!
<b>Standards Set: Operating Rooms</b>	
12.4 For each disinfectant, the team follows manufacturers' recommendations for use, contact time, shelf life, storage, appropriate dilution, and required PPE.	!
12.5 The operating room team appropriately contains and transports contaminated items to the reprocessing unit or area.	!
13.1 The team has a preventive maintenance program for all surgical equipment and medical devices.	!
<b>Standards Set: Reprocessing and Sterilization of Reusable Medical Devices</b>	
1.1 The organization collects information at least annually about service volumes and patterns of medical device use.	

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1.2	The organization reviews its operational plan and the information it collects about service volumes and equipment use to decide which reprocessing and sterilization services are offered within the organization.	
1.5	The designated person reports directly to the organization's senior management or the executive office.	
2.5	The organization conducts baseline and annual competency evaluations of staff members involved in reprocessing and sterilization.	
3.1	When planning and designing the layout of the medical device reprocessing department, the organization considers the volume and types of reprocessing and sterilization services, flow of devices and equipment, and traffic patterns.	
3.3	The medical device reprocessing department is designed to prevent cross-contamination of sterilized and contaminated devices or equipment, isolate incompatible activities, and clearly separate different work areas.	!
3.4	The medical device reprocessing department has a specific, closed area for decontamination that is separate from other reprocessing areas and the rest of the organization.	!
3.5	The organization regulates the air quality, ventilation, temperature, and relative humidity, and lighting in decontamination, reprocessing, and storage areas.	
3.6	The organization selects materials for the floors, walls, ceilings, fixtures, pipes, and work surfaces that limit contamination, promote ease of washing and decontamination, and will not shed particles or fibres.	
4.2	When establishing or updating the team's infection prevention and control policies, the team works closely with the organization's IPAC staff, team, or committee.	
5.1	The medical device reprocessing department is equipped with hand hygiene facilities at entrances to and exits from the reprocessing areas, including personnel support areas.	
5.2	The medical device reprocessing department's hand hygiene facilities are equipped with faucets supplied with foot-, wrist-, or knee-operated handles, or electric eye controls.	!
5.7	The team follows a detailed dress code while in the clean reprocessing area that addresses clothing, hair, jewelry, artificial fingernails of any form, and covered footwear.	!
5.8	The team wears the appropriate and properly maintained personal protective equipment (PPE) in the decontamination area.	!
5.9	The team regularly conducts workplace assessments of its medical device reprocessing department for ergonomics and occupational health and safety (OHS).	

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7.2	The organization has a documented preventive maintenance and cleaning program for its decontamination and sterilization equipment.	
8.8	For each detergent, solution and disinfectant, the team follows manufacturers' recommendations for use, contact time, shelf life, storage, appropriate dilution, testing for appropriate concentration and effectiveness, and required PPE.	!
10.5	Trained team members follow established procedures for handling and distributing sterile devices.	
12.2	As part of the quality management system, the team engages in an annual review of reprocessing and sterilization activities, with formal reports provided to the organization's senior management.	

Surveyor comments on the priority process(es)

The AHRA is encouraged to standardize the preventive maintenance (PM) program across all sites, detailing the schedule, the information that is to be collected and audit of the equipment to determine trends. This will help ensure not only consistency but will also identify potential areas of risk. The current system is 'home grown' at each of the sites and some are totally manual, and other sites have developed their own system of documentation, utilizing simple computer tools.

It was also observed at one of the sites that the maintenance staff were unable to complete their PM duties due to the demands placed on them for non maintenance duties such as the delivery and pick up between sites. The organization is encouraged to review job functions and assist with the prioritization of duties.

In the sterilization and reprocessing departments visited, all the staff were appropriately trained. The staff were receptive to suggestions and motivated to make the necessary improvements to their practice. Each of the staff in these departments would however, benefit from an annual competency review as many of them work alone and there are limited opportunities to review their own work flow and processes with a trained individual.

Infection prevention and control (IPAC) has limited involvement in the sterilization and reprocessing areas. The surgical program would benefit from an increased involvement particularly in the handling of methicillin resistant staphylococcus aureus (MRSA), vancomycin resistant enterococci (VRE) and related infection control issues. A needs assessment would provide direction for both the surgical and reprocessing teams.

From the tracers conducted at Neepawa, Hamiota and Virden sites, most of the cleaning and decontamination complied with standards.

The most challenging area for the physical infrastructure of the three sterilization and reprocessing and endoscopy areas visited is the way these are currently configured, as they do not meet the accreditation standards. The following deficiencies were found in all of the departments. There is no physical separation (a wall) between the clean and dirty areas, as required by Canadian Standards Association (CSA) standards. A separate hand washing sink is not available and/or wall mounted alcohol dispensers. There was no ability to determine the air quality specifically, the required ten (10) air changes per hour. Although the sites are able to monitor the humidity and temperature of the sterilization and processing departments, they have little or no ability to adjust these if required to do so. The counter tops are primarily of laminate and this would be

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considered a porous material which is against best practice. Inappropriate work flow, with lack of separate doors for clean and dirty items, configuration of the department which involves the clean and dirty areas mixing, and which was particularly noted in the endoscopy areas.

Other issues identified during the tracers were related to the storage of items not appropriate in the reprocessing areas, such as corrugated cardboard and general supplies, including in the endoscopy area.

In addition, the movement of sterile goods between sites is not monitored to ensure integrity of the sterilized products in terms of temperature consistency. Currently, the sterile packages are transported in the cab compartment of a maintenance truck. It is suggested that teaching and a method of maintaining the temperature be implemented for the drivers.

Many of the issues identified during this accreditation survey for the Sterilization and Reprocessing areas were identified in the recently conducted in depth quality assurance project: "Review of Decontamination Practices by Linda Kingsbury in September 2011". The ARHA is encouraged to utilize this report and the accreditation report to address the issues identified.

## Section 3 Detailed On-site Survey Results

### 3.2 Priority Process Results for Population-specific Standards

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

Priority processes specific to population-specific standards are:

#### Chronic Disease Management

- Integrating and coordinating services across the continuum of care for populations with chronic conditions

### Section 3 Detailed On-site Survey Results

#### 3.2.1 Standards Set: Populations with Chronic Conditions

Unmet Criteria	High Priority Criteria
<b>Priority Process: Chronic Disease Management</b>	
2.6 The organization provides staff and service providers, including primary care providers, with access to specialist expertise to manage chronic conditions.	
2.7 Specialists provide leadership and consultation to improve services to populations with chronic conditions.	
6.3 The organization uses the clinical information system to establish service priorities by classifying clients according to condition and other factors such as co-morbid conditions.	
6.5 The organization uses the information system to generate regular reports about performance and adherence to guidelines, and to improve services and processes.	
6.6 The organization monitors and validates the quality of data in the clinical information system.	
7.4 The organization compares its results with other similar interventions, programs, or organizations.	
7.5 The organization uses the information it collects about the quality of its services to identify successes and opportunities for improvement, and makes improvements in a timely way.	
7.6 The organization shares information about its successes and opportunities for improvement, improvements made, and what it is planning for the future with staff, service providers, clients and families.	

**Surveyor comments on the priority process(es)**

**Priority Process: Chronic Disease Management**

The Region has an EMR system that is available to physicians. Physicians can refer and will identify patients to the Chronic Disease Management team, so that person specific information will be available to the team in the future. The organization is encouraged to identify additional indicators for chronic disease management, and to incorporate condition and person specific indicators into the client health record to support capture of outcomes, client goals and objectives and client goal attainment.

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### 3.3 Service Excellence Standards Results

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

Priority processes specific to service excellence standards are:

#### Clinical Leadership

- Providing leadership and direction to teams providing services

#### Competency

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

#### Episode of Care

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

#### Decision Support

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

#### Impact on Outcomes

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

#### Medication Management

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

#### Organ Donation

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

#### Infection Prevention and Control

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

#### Surgical Procedures

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

**Section 3 Detailed On-site Survey Results**

**3.3.1 Standards Set: Cancer Care and Oncology Services**

Unmet Criteria	High Priority Criteria
<b>Priority Process: Clinical Leadership</b>	
The organization has met all criteria for this priority process.	
<b>Priority Process: Competency</b>	
The organization has met all criteria for this priority process.	
<b>Priority Process: Episode of Care</b>	
The organization has met all criteria for this priority process.	
<b>Priority Process: Decision Support</b>	
The organization has met all criteria for this priority process.	
<b>Priority Process: Impact on Outcomes</b>	
The organization has met all criteria for this priority process.	
<b>Surveyor comments on the priority process(es)</b>	
<b>Priority Process: Clinical Leadership</b>	
The regional oncology network quarterly meeting allows staff input to design. The annual provincial conference adds strong cohesiveness.	
<b>Priority Process: Competency</b>	
<p>CancerCare Manitoba (CCMB) appears to have limited information technology (IT) support.</p> <p>Staff are monitored to ensure they meet CCMB requirements of fifty (50) chemotherapy administrations per year for competency and further education is provided if the standard is not met.</p> <p>Staff work to rotate their shifts in clinic, which enables them to know all the patients and consequently, to provide safe care and clinic coverage for all patients.</p>	
<b>Priority Process: Episode of Care</b>	
The volunteer coordinator provides support groups and a network of volunteers to assist patients and families with palliative care. An opportunity to build a patient care library in the rural communities exists not only for cancer information but for other chronic diseases. Partnership with non government organization (NGOs)	

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might enable a community resource base for information generally available to the public. The patient/public care library could be positioned in the community library versus the hospital.

ARHA may want to consider looking into a fifteen (15) day target breast cancer program from positive screen to diagnostic to pathology and surgery for the region, to address the challenge in this rural region of travel time for repeated work ups for cancer diagnosis and staging, resulting in protracted period of time between the different stages experienced by some patients.

### Priority Process: Decision Support

Information technology (IT) support from the ARHA is excellent for internal region interface. Electronic charting audits are only available from CCMB and options to enable local CQI reviews should be explored.

The current charting of electronic records is supported by paper charting at the local level and options for better electronic integration should be explored.

### Priority Process: Impact on Outcomes

The commitment of physicians and staff to the standards of care defined by CCMB is exemplary. Patients are very well supported and grateful for the ease of access, the care and compassion of their clinicians. The ARHA has a strong model in place providing essential services across their broad rural region.

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**3.3.2 Standards Set: Community Health Services**

Unmet Criteria	High Priority Criteria
<b>Priority Process: Clinical Leadership</b>	
The organization has met all criteria for this priority process.	
<b>Priority Process: Competency</b>	
The organization has met all criteria for this priority process.	
<b>Priority Process: Episode of Care</b>	
The organization has met all criteria for this priority process.	
<b>Priority Process: Decision Support</b>	
The organization has met all criteria for this priority process.	
<b>Priority Process: Impact on Outcomes</b>	
The organization has met all criteria for this priority process.	
<b>Surveyor comments on the priority process(es)</b>	
<b>Priority Process: Clinical Leadership</b>	
<p>The Public Health (PH) program recently carried out a planning session during which it reviewed the relevant information from the comprehensive Community Health Assessment. A Logic Model is being used to develop operational plans for each program within the portfolio and to ensure that these are aligned with the new ARHA Strategic Priorities. The goals, activities and expected outcomes will provide the needed framework for regularly reviewing and evaluating the work being done. This model will serve the team well moving forward and the team is encouraged to ensure a regular review process.</p> <p>A significant strength of this team is the development and maintenance of partnerships in the various small communities in which team members' work. They have well developed relationships and work effectively with the schools in the communities, social service agencies and other ARHA program and Brandon Regional Health Authority programs. Strides have also been made in engaging members of the First Nations communities in the region, as well as a number of the Hutterite colonies.</p> <p>The program welcomes students for clinical placements. These have included medical and nursing students. Team members report that they feel supported by the organization to carry out their roles.</p>	

## Section 3 Detailed On-site Survey Results

Teams report having the equipment needed to carry out their roles. Vaccine refrigerators are monitored daily and at some sites during the weekend. The team needs to ensure that refrigerators at all sites are monitored seven days a week.

### Priority Process: Competency

The PH team is made up of a number of disciplines including public health nurse, social worker, psychologist, and home visitors.

Team members are supported in skill development and all have access to the staff portal to on line training (SPOT). Modules specific to public health include immunization and breast feeding. Staff also have access to programs required by the region. The system tracks all education completed and provides the staff member with a certificate of completion. Friendly reminders are sent when staff have not completed the required modules.

Team members are working over a large geographic area and in many instances, are the only PH staff providing service to more than one small town. They maintain communication by telephone and e mail and staff meetings are held.

There is a formal regional orientation program and specific orientation to the work area. Performance reviews are carried out on a regular basis.

Work load is monitored and volume data have been utilized successfully to achieve an additional position.

There are a number of recognition programs in place including long service awards, ARHA Spirit week, and a program of tagging colleagues to recognize good work.

### Priority Process: Episode of Care

Public health (PH) services are provided across the region in many sites and include office based, community based and home based services. Most services are able to meet referral time standards and staff use priority service guidelines when work loads surge in any given area. There is however, insufficient occupational therapy (OT), physiotherapy (PT) and speech and language therapy (SPL) services in the region, which means that clients can have significant waits for these services. Telehealth has been suggested to assist with the SPL service and the team is encouraged to pursue this option.

Geography is the biggest barrier to service and the team members work diligently to make the services available across the region. The influx of immigrants in some areas of the region has created some language issues and the team is encouraged to provide some basic service information and health teaching material in languages other than English.

Records reviewed were up to date and well recorded. Staff are cognizant of confidentiality and secure records when travelling.

The team works well together and has established relationships with community organizations and other parts of the AHRA programs such as mental health.

The team is heavily involved in health promotion activities in the various communities across the region. Examples of this include providing Reproductive Health and Sexually Transmitted Diseases programs to grade nine students and Healthy Baby programs. Human papilloma virus (HPV) vaccination is offered to female

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students via the school system. Parenting programs have been offered in some of the Hutterite colonies on request.

Staff frequently discuss ethics issues and are aware of the availability of ethics consultation.

Complaints are handled with openness and sensitivity. The team uses information from this process to make appropriate changes to programming, such as changes to the prenatal class content.

### Priority Process: Decision Support

The team is conscientious about ensuring their programs are based on the best evidence available. Team members research guidelines from other areas and from the research literature. An example is the current review of the Post Partum program. The review group has looked at a number of models including the World Health Organization, the United Kingdom models and also models from other Canadian provinces.

A process is in place to trial the new program and then to have it reviewed by the Public Health Practice Council. Once implemented, the program will be shared with other regions as appropriate. Guidelines relative to immunization schedules are regularly reviewed. A provincial review of the Reproductive Health program has been recently done, and education about the new guidelines is planned before its implementation. The revised guidelines provide clarity around eligibility and supply of reproductive materials.

The team is engaged in research activities and one example is a recent proposal that was accepted by the REB of the University of Manitoba. This project will add a mental health promotion strategy to the Manitoba Family First program.

The team recognized deficiencies in the data relative to the Post Partum program. With assistance from information management it has developed a new data base and will roll it out across the program in January, 2012. The new system will provide quarterly reports that can be used for work load management, volumes in the program and types of interventions being used with clients.

### Priority Process: Impact on Outcomes

Program components are reviewed on a regular basis. Volume data are used to demonstrate need in various programs and the team takes part in the ARHA's budget process. The team has had some success in adding EFTs and is hoping to be able to offer some services seven days per week in the future, as this is an identified access need.

A number of the programs have used satisfaction surveys to gather feedback from clients. The Healthy Baby program undertook a review of the prenatal classes, which are offered across the region. Participant and staff feedback was sought and provided the basis for a number of recommendations for change in the program. The team is aware of the limited data available via the consumer satisfaction survey process and is attempting to supplement this with a percentage of telephone surveys.

Staff are very conscious of safety issues for both clients and work colleagues. There are risk management guidelines for working alone either in a home or office setting. Risk assessments are carried out before home visiting commences and a risk plan is initiated when needed. Staff are supported in their decisions not to complete a home visit if they feel there is an unsafe environment for any reason. Emergency kits and First Aid kits are provided for all vehicles. There are regular staff meetings and sharing of information.

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There is a region wide process for reporting adverse events, sentinel events and near misses. The information from these is collated and reports are sent to managers. Events that occur in the service are discussed at the PH Nurses Practice Council. The team is encouraged to ensure that reports are available to all staff.

The program monitors a number of measures, including immunization rates, breast feeding rates, and distribution of prenatal packages. Most indicators are process indicators and the team is encouraged to consider more clinical outcome measures.

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**3.3.3 Standards Set: Community-Based Mental Health Services and Supports Standards**

Unmet Criteria	High Priority Criteria
<b>Priority Process: Clinical Leadership</b>	
The organization has met all criteria for this priority process.	
<b>Priority Process: Competency</b>	
The organization has met all criteria for this priority process.	
<b>Priority Process: Episode of Care</b>	
The organization has met all criteria for this priority process.	
<b>Priority Process: Decision Support</b>	
The organization has met all criteria for this priority process.	
<b>Priority Process: Impact on Outcomes</b>	
The organization has met all criteria for this priority process.	
<b>Surveyor comments on the priority process(es)</b>	
<b>Priority Process: Clinical Leadership</b>	
<p>The team has used the Community Health Assessment in the planning process and identified team priorities based on the strategic priorities of the organization. Goals, actions, targets and indicators have been identified. The use of the Logic Model has been discussed by the team and the team is encouraged to pursue this direction.</p> <p>The team is commended for the recovery focus. Individual client goals are established and family involvement is encouraged.</p> <p>The team serves both a large geographic area, with much cultural diversity including a number of First Nations communities and Hutterite colonies. The welcoming strategy employed by staff has served them very well in developing and maintaining relationships with these diverse communities. Work with the First Nations health staff has developed into a very collaborative relationship. The team has been invited to provide health promotion programs for a number of Hutterite colonies and provides direct care to members. Cultural training has been available for staff.</p> <p>There has been an increase in immigration to some of the communities and this has created issues with language translation. Some interpreter services are available. Client information materials are primarily in</p>	

## Section 3 Detailed On-site Survey Results

English. The ARHA is encouraged to make some of the basic client information material available in languages that are represented in the communities.

The manager and team are well aware of the volumes of service and surge times during the year. Staff adjustments are made when possible to balance work loads during high volume episodes. Justification for more staff is presented during the organization's budgeting process. A central intake process has recently been implemented in the Adult program to assist with clinician workload management. There is intent to implement this for the Child and Youth program as well.

The team focuses significantly on mental health awareness in efforts to reduce the stigma associated with mental illness. Programs are provided in schools and in the community.

### Priority Process: Competency

The program team is multidisciplinary and all professional staff meet the credentialing requirements yearly. This is tracked by the manager.

Students from a number of disciplines seek clinical experiences with the program, including nursing and psychiatric nursing programs.

A comprehensive orientation process is in place and includes general orientation and specific program orientation components. Staff indicate that they felt well prepared for their roles following the orientation phase and have ongoing access to other staff for mentoring purposes.

The organization is commended on introducing the SPOT on line training, which has been well received by staff. Numerous self learning modules are available for both general information and also programs specific to teams. For example, all mental health staff are required to complete the Co Occurring Disorders Initiative (CODI) modules. Completion of programs is tracked in the system. Staff education is a high priority for this organization.

Performance reviews are carried out as per the organization policy and includes a process to determine educational needs.

Because of the wide geographic area in this region with many small towns, staff are most often working alone in a community and travelling significant distances between areas. The program is aware of the safety issues associated with this and has numerous strategies in place to mitigate the risks to staff. These include: using 'working alone plans' in which staff identify where they will be and an expected return time. Road safety kits and first aid kits are supplied for staff vehicles. Cell phones are provided to many staff. The organization is encouraged to increase the use of cell phones, as resources and reception permit. Staff that work in offices are able to have a second person during an interview if there is a potential for inappropriate behaviour by a client. All staff are trained in crisis intervention. Staff are aware of the work refusal policy.

The organization has a number of recognition programs during the year, including long service awards and a week of staff recognition called, Spirit week. A process of being able to "tag" a colleague or team that has demonstrated exceptional work is a well received strategy.

### Priority Process: Episode of Care

## Section 3 Detailed On-site Survey Results

The program advocates a recovery model. A service plan is developed with every client, establishes the client's goals and actions to obtaining them. The plan is reviewed on a regular basis. Family involvement is encouraged but privacy is also respected if this is the wish of the client. Suicide risk is assessed initially and at intervals as needed. When suicide is a potential issue, a crisis plan is created and the client is encouraged to share this with someone they trust to assist them when in need. For clients that have persistent suicide ideation, a caution sheet is placed on the record and an alert is communicated to the Mobile Crisis team. Hospital care is available at the Brandon Centre for Adult Psychiatry. All clients are made aware of services available on a 24/7 basis such as the Mobile Crisis service, Child and Adolescent after hours number and Health Links. Confidentiality is respected by all staff and a process is in place to handle any potential breach. As available, clients are referred to community support groups such as the Anxiety Disorders support group or the Mood Disorders support group. As clients near transition to other services or discharge from the service, a Wellness Recovery Action plan is developed and shared with individuals selected by the client. Clients are made aware that they can contact the service at any time following discharge.

On intake, client medications are recorded and this is checked at each subsequent visit. The staff use this information for education purposes. They are not involved in accepting medication orders, transcribing or administering medications.

Staff discuss ethics issues as a team and are aware of the Ethics committee and have accessed this process successfully. There is a process in place for clients to bring forward a complaint. Staff are made aware of the types of complaints and use this information to improve their practice.

There is a lot of written information available for clients, almost exclusively in English. The region is experiencing an influx of immigrants including Ukrainian and Korean, and is encouraged to make some of the basic client information available in languages other than English and to increase the availability of interpreter services as this may be a barrier to accessing mental health care when needed.

The Mental Health team works closely with other regional services such as Public Health and numerous community organizations across the region. The team has developed positive relationships with the First Nations communities and with the Hutterite colonies in the region. Representatives from the First Nations sit on a number of committees. A health promotion program called "Live Forward", developed by members of the First Nations is being presented to Aboriginal youth. Team members are connected to the schools in their areas and receive referrals from Guidance Counsellors.

Wait times for service are within the program standards, with clients discharged from the Brandon in patient unit seen within five days. There is good communication with the in patient services for both adults and children and youth.

Team members follow up with high risk clients that do not attend appointments and do so via telephone, checking with next of kin and can engage police, if required.

The Mental Health team has limited responsibility for medication administration. During assessment, a medication history is taken and staff use this to ensure education about the medications being taken. They recheck medications at every visit. Although in minimal numbers, they do administer injectable psychotropic medication and have developed a process for reconciling any changes in the medication following a transition in care. The Community Mental Health nurse assumes the role of consulting with the family physician, psychiatrist or pharmacist as required.

As medication reconciliation develops across the region, the team is encouraged to introduce the same forms for medication reconciliation as is used in other areas.

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### Priority Process: Decision Support

Given the nature of the geography and work being done, it is necessary for client records to be transported in provider cars. Locked cases are available for transporting files and it is policy to leave files locked in the trunk during transport.

The team members are cognizant of ensuring that their practices are supported by evidence. Examples include the use of a recovery model, programs such as ASIST, Safe Talk, and Non Violent Crisis Intervention. Before implementing a new strategy or program, research in the area is reviewed and best practices are sought from other areas. This is evident in the approaches to suicide prevention education and the modules associated with the Co-occurring Disorders Initiative (CODI).

The team has been engaged in research and has recently been approved as a participant in the program: "Towards Flourishing: Mental Health Promotion for Families". This is an addition to the Families First program that is managed by Public Health and will represent another collaborative activity. Research is approved by the REB at the University of Manitoba.

### Priority Process: Impact on Outcomes

Staff use numerous strategies to ensure their safety when working alone in the community or in their offices. Co occurring diseases has been a recent focus and staff are required to complete a series of learning modules relative to this initiative. Team support is obvious in the community offices.

A Falls prevention strategy is in place and specific assessment is completed as appropriate. Records are flagged with a leaf when a client has a risk for falls.

The team has focused heavily on suicide and self harming behaviour. Awareness programs have been carried out in schools, in community settings and are the focus of regular health promotion activities. Display boards are utilized for public education on a regular monthly basis. These are placed in each site and changed monthly. Examples of topics include: eating disorders and body image, depression and caregiver burden and senior/elderly abuse. The 'Coffee on Us' health promotion program has been recognized as a Leading Practise.

The team monitors a number of indicators including compliance with initial assessment standards, numbers of community participants in suicide prevention programs, and timely response times for trauma responses. Consumer satisfaction surveys are carried out regularly and these can be benchmarked provincially. The team is encouraged to include more clinical outcome measures in their quality plan.

Section 3 Detailed On-site Survey Results

3.3.4 Standards Set: Emergency Department

Unmet Criteria	High Priority Criteria
<b>Priority Process: Clinical Leadership</b>	
2.8 The team has the workspace needed to deliver effective services in the Emergency Department.	
<b>Priority Process: Competency</b>	
4.12 Team leaders regularly evaluate and document each team member's performance in an objective, interactive, and positive way.	
<b>Priority Process: Episode of Care</b>	
6.11 The team sets, tracks, and benchmarks data related to waiting times for services and information, and the length of stay (LOS) in the Emergency Department.	
<b>Priority Process: Decision Support</b>	
The organization has met all criteria for this priority process.	
<b>Priority Process: Impact on Outcomes</b>	
10.4 The team uses at least two client identifiers before providing any service or procedure.	ROP
10.4.1 The team uses at least two client identifiers before providing any service or procedure.	
16.2 The team monitors clients' perspectives on the quality of Emergency Department services.	
16.3 The team compares its results with other similar interventions, programs, or organizations.	
16.4 The team uses the information it collects about the quality of its services to identify successes and opportunities for improvement, and makes improvements in a timely way.	
16.5 The team shares evaluation results with staff, clients, and families.	
<b>Priority Process: Organ Donation</b>	
The organization has met all criteria for this priority process.	
Surveyor comments on the priority process(es)	

## Section 3 Detailed On-site Survey Results

### Priority Process: Clinical Leadership

Virden site: The physical space limitations were felt to contribute to patient wait times during busy times. (2.8)

Deloraine site: Wait times were felt to be adequate at this location.

It was noted in several locations that EMS must transport patients by various hospital patient care areas, including the Cancer Care outpatient clinic. The ARHA is encouraged to examine the communicable disease risk associated with these existing practices to ensure minimizing the potential impact of this problem.

### Priority Process: Competency

Beyond the daily work interactions, benefit may be derived from promoting opportunities to meet as a team. Performance appraisals (PAs) should be examined to ensure frequency requirements.

### Priority Process: Episode of Care

The team should examine current recording practices for wait times to ascertain if opportunities exist to gain further valuable information such as overall length of stay (LOS), time to laboratory and time to diagnostic imaging.

### Priority Process: Decision Support

Currently, all medical records are paper driven including laboratory results and imaging. Patient registration is the sole function currently automated for nursing staff. Staff believe discussions have been taking place for several years regarding improvements in computer based technology. Advancements such as for the EMR and diagnostics are currently under way.

### Priority Process: Impact on Outcomes

Please refer to the Emergency Medical Services (EMS) report section for a recommendation to consider combining a satisfaction questionnaire covering both Emergency Department and EMS, and have the survey available in EDs and distributed to patients and/or families visiting the Emergency Department.

### Priority Process: Organ Donation

The nature of this rural setting and distance to services capable of determining NND are such that organ or tissue donation is felt to be unfeasible.

**Section 3 Detailed On-site Survey Results**

**3.3.5 Standards Set: Emergency Medical Services**

Unmet Criteria	High Priority Criteria
<b>Priority Process: Clinical Leadership</b>	
4.1 The medical oversight team is led by one or more licensed physicians that have completed an orientation or training program on how to provide EMS medical oversight.	<b>!</b>
<b>Priority Process: Competency</b>	
5.10 The organization regularly evaluates and documents each team member's performance in an objective, interactive, and positive way.	
<b>Priority Process: Episode of Care</b>	
The organization has met all criteria for this priority process.	
<b>Priority Process: Decision Support</b>	
The organization has met all criteria for this priority process.	
<b>Priority Process: Impact on Outcomes</b>	
The organization has met all criteria for this priority process.	
<b>Priority Process: Infection Prevention and Control</b>	
The organization has met all criteria for this priority process.	
<b>Surveyor comments on the priority process(es)</b>	
<b>Priority Process: Clinical Leadership</b>	
<p>One of the most critical challenges faced by regional pre hospital care is the current reliance on call paramedics. This has wide spread implications for providing the best, safest and most appropriate patient care.</p> <p>Regional and other stakeholders are encouraged to support and assist Emergency Medical Services (EMS) leadership as they continue to develop innovative solutions to this broad and significant issue.</p> <p>The EMS uses a variety of information sources to plan for adjustments in scope of services, including the Community Assessment and PCR data. One example is locating paramedics within the Riding Mountain National Park area during the busy summer months.</p> <p>ARHA currently has a Medical Director with significant relevant experience, but more formal training is still required related to medical oversight for EMS</p>	

## Section 3 Detailed On-site Survey Results

### Priority Process: Competency

The reliance on call paramedics is discussed elsewhere in this section insofar as the far reaching implications that may impact patient care. The ARHA recognizes this issue and is encouraged to continue addressing this in a timely manner. Ongoing efforts are directed at maximizing the matching of paramedic qualifications to individual patient needs. (5.1)

The EMS has a dedicated e learning web site to support maintenance and enhancement of skills. (5.7)

### Priority Process: Episode of Care

A review of existing orientation and ongoing training materials is recommended. Materials need to include guidance on sensitizing/training paramedics to an all hazards approach to scene assessment. (15.2)  
Strong collaboration exists between EMS and allied health providers.

Information was provided on an existing partnership between BC Ambulance Service and MedicAlert Canada offering free bracelets or 'necklettes' identifying patients' "No CPR" wishes. This is to be forwarded to the medical director. This initiative attempts to obviate the problem of paper advance directives becoming misplaced or lost in the patient's home. If desired, MedicAlert also offers secure computer based storage of patient clinical information, which may be accessed by paramedics 24/7. (16.14)

### Priority Process: Decision Support

Medical protocols are researched and maintained provincially. If not already initiated, EMS leadership may wish to inquire about an existing research partnership that includes BC, Alberta and Nova Scotia whose primary goal is to research responsibilities and provide effective knowledge sharing. Medical protocols are within the mandate of the province and are available to paramedics in paper form as well as web based. (20.2)

### Priority Process: Impact on Outcomes

Client satisfaction is measured every two years and results are appropriately reflected in action plans. The Provider Advisory Council and Assiniboine Health Advisory Council also provide valuable input. (22.4)




It is recommended the organization consider a satisfaction tool that combines both emergency services that is, EMS and Emergency Department, to obtain feedback on client experiences. Perhaps it could be handed out in the Emergency Department itself. The existing required frequency of satisfaction tools is such that patients may have poor recollection of service/care events.

### Priority Process: Infection Prevention and Control

There are procedures for conducting vehicle inspection and forms are used for this purpose. However, inspections should be audited on a regular basis by supervisory staff to ensure completion and resolution of noted deficiencies. More broadly, the review of other forms suggests that an overall form review may be of benefit. Ultimately, it must be assured that resolution of deficiencies is recorded, and to accomplish this, it might require form simplification. It may be an opportunity for modifications as well.

Section 3 Detailed On-site Survey Results

3.3.6 Standards Set: Home Care Services

Unmet Criteria	High Priority Criteria
<b>Priority Process: Clinical Leadership</b>	
The organization has met all criteria for this priority process.	
<b>Priority Process: Competency</b>	
The organization has met all criteria for this priority process.	
<b>Priority Process: Episode of Care</b>	
10.6 The organization responds to requests for medication information after hours.	
11.1 The organization works collaboratively with other services and organizations to support the development of a comprehensive follow-up plan at the end of service or following a transition.	
11.2 (*11.3) The team reconciles medications with the client at referral or transfer, and communicates information about the client's medications to the next provider of service at referral or transfer to another setting, service, service provider, or level of care within or outside the organization. 11.2.1 (*11.3.1) There is a demonstrated, formal process to reconcile client medications at referral or transfer. 11.2.3 (*11.3.3) The process includes a timely comparison of the prior-to-referral or prior-to-transfer medication list with the list of new medications ordered at referral or transfer. 11.2.4 (*11.3.4) The process requires documentation that the two lists have been compared; differences have been identified, discussed, and resolved; and appropriate modifications to the new medications have been made. 11.2.5 (*11.3.5) The process makes it clear that medication reconciliation is a shared responsibility involving the client, nursing staff, medical staff and pharmacists, as appropriate.	
11.3 (*11.4) The organization transfers information effectively among service providers at transition points. 11.3.1 (*11.4.1) The organization has established mechanisms for timely and accurate transfer of information at transition points. 11.3.2 (*11.4.2) The organization uses the established mechanisms to transfer information.	
<b>Priority Process: Decision Support</b>	

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The organization has met all criteria for this priority process.

### Priority Process: Impact on Outcomes

The organization has met all criteria for this priority process.

### Surveyor comments on the priority process(es)

#### Priority Process: Clinical Leadership

Leadership is aware, and in concert with Manitoba Health, is preparing for the trend for continued demand/growth of services. One strategy to meet this demand is to move staff to positions of greater employment security by creating equivalent full time (EFT) positions now underway.

The roll out of Procura will significantly enhance management information for decision making, despite the technological change meeting and some staff concerns. The leadership is working to provide the resources to enhance staff change management needs and will build in additional time in training.

#### Priority Process: Competency

With the expected growth of services and the move to EFT, a plan to progressively enable staff (attendants) to be fully certified should be considered.

#### Priority Process: Episode of Care

Medication reconciliation at transfer to and from hospital while in care is not completed and should be addressed.

The transfer of information appears limited by work schedules. Home care is not a 24/7 service consequently, gaps in information will occur particularly on transfer from hospital to home.

Use of the EMS staff in the provision of home safety assessments is a positive activity. It appears it could be organized more thoroughly and systematically across the region and pilots to bring this into effect are underway.

The need for access to emotional support and particularly for mental health issues while available, it is not always accessible due to limited staff resources.

#### Priority Process: Decision Support







Please refer to earlier report sections for comments on Home Care services.

#### Priority Process: Impact on Outcomes

The organization has some outcome measures that are monitored relative to goals and objectives and is working to establish more. (15.1)

## Section 3 Detailed On-site Survey Results

### 3.3.7 Standards Set: Infection Prevention and Control

Unmet Criteria	High Priority Criteria
<b>Priority Process: Infection Prevention and Control</b>	
<p>1.2 The organization tracks infection rates; analyzes the information to identify clusters, outbreaks, and trends; and shares this information throughout the organization.</p> <p>1.2.3 Staff and service providers are aware of the infection rates and recommendations from outbreak reviews.</p>	
<p>1.7 The organization collects information about its infection prevention and control activities and uses it to plan, implement, and evaluate those activities.</p>	
<p>5.1 The organization develops an IPAC education program that is tailored to the organization, its services, and client populations.</p>	
<p>5.7 The organization monitors compliance with its infection prevention and control policies and procedures.</p>	
<p>6.4 The organization's staff, service providers and volunteers have access to alcohol-based hand rubs at the point-of-care and service delivery.</p>	
<p>6.5 The organization evaluates its compliance with accepted hand-hygiene practices.</p> <p>6.5.2 The organization shares results from the audits with staff, service providers, and volunteers.</p> <p>6.5.3 The organization uses the results of the audits to make improvements to its hand hygiene practices.</p>	
<p>7.1 The organization provides clients and families with information and education about preventing infections in a format that is easy to understand.</p>	
<p>7.2 The information and education provided to clients and families about IPAC covers hand hygiene and respiratory etiquette, e.g. coughing and sneezing.</p>	
<p>7.3 Information provided to clients and families is documented in the client record.</p>	
<p>7.5 Staff, service providers, and volunteers encourage clients, families, and visitors to follow effective hand hygiene behaviour.</p>	
<p>12.11 When transporting contaminated equipment and devices, the organization complies with applicable regulations, controls the environmental conditions, and uses clean and appropriate bins, boxes, bags, and transport vehicles.</p>	

Section 3 Detailed On-site Survey Results

13.4 All endoscope reprocessing areas are equipped with separate clean and decontamination work areas as well as storage, dedicated plumbing and drains, and proper air ventilation.



Surveyor comments on the priority process(es)

Priority Process: Infection Prevention and Control

There has been a great deal of work in the region with respect to hand hygiene and overall infection prevention and control (IPAC). There is evidence of hand washing audits being carried out. The IPAC annual report for 2010/11 indicates that eleven out of twenty five (11/25) sites participated in the audit in whole or in part. The ARHA is encouraged to continue the spread of and compliance with utilizing the audit tool and improving accountability to improve results. The staff in the sites where the audit was conducted are unaware of their results.

The organization may also want to consider reviewing the tool to use and identifying a simpler tool, as well as determining the appropriate number of observations to ensure validity. The organization may consider focusing on observations rather than a staff member or volunteer verbalizing how to appropriately utilize the hand sanitizer or soap and water.

There is good evidence of monitoring hospital acquired infection rates over several years. This material is reported as overall trends and there is also site specific information available. There is inconsistent use of this information to either evaluate practice or improve the rates at some of the sites observed.

There has been a focused effort by the IPAC educators for dealing with the causes of the infections such as urinary tract infections (UTIs), education and protocols to reduce the incidence, particularly in nursing homes. However, the staff are unaware of the results of the infection rates as they apply to their sites.

Overall, there appears to be a lack of accountability with respect to IPAC activities.

**Section 3 Detailed On-site Survey Results**

**3.3.8 Standards Set: Long Term Care Services**

Unmet Criteria	High Priority Criteria
<b>Priority Process: Clinical Leadership</b>	
The organization has met all criteria for this priority process.	
<b>Priority Process: Competency</b>	
The organization has met all criteria for this priority process.	
<b>Priority Process: Episode of Care</b>	
The organization has met all criteria for this priority process.	
<b>Priority Process: Decision Support</b>	
The organization has met all criteria for this priority process.	
<b>Priority Process: Impact on Outcomes</b>	
The organization has met all criteria for this priority process.	
<b>Surveyor comments on the priority process(es)</b>	
<b>Priority Process: Clinical Leadership</b>	
<p>The team is in the process of reviewing the requirements for seniors, an external consultant has been engaged, and a report on required services and service distribution will be ready in spring 2012.</p> <p>The team works closely with Home Care (HC) and physicians to arrive at a 'needs based' approach to admission. Services vary across location, in response to resident requirements. The team identifies specific goals and goals are reviewed at specified intervals, and are updated quarterly. Annual care conferences, which also include family involvement, occur annually or as needed.</p> <p>Volunteers are involved, and undergo appropriate security screening. Care providers work to full scope of practice.</p> <p>Pneumococcal vaccine status of residents is known, vaccine is offered to those not yet vaccinated. Residents are afforded the right to choose.</p>	
<b>Priority Process: Competency</b>	
The organization employs an interdisciplinary approach. Occupational therapy (OT), physiotherapy (PT), dietitian, recreation and rehabilitation aides are members of the team.	

## Section 3 Detailed On-site Survey Results

Teams have determined the need for additional capacity at some sites. Mental health consultants are available to participate in assessment and care planning. Education is provided on safe lift and transfer, supporting the fall risk assessment and resident mobility assessment. Teams have received education on managing difficult behaviours, and have information posted to remind staff of appropriate management strategies.

The team is encouraged to ensure care plans utilized by all members of the care team, including health care aides, are current and reflective of the resident's current status thereby enabling safe resident care.

### Priority Process: Episode of Care

The team utilizes check lists to ensure that all aspects of the admission process are addressed. The team is encouraged to review the check lists to determine if standardized lists are of value, particularly for staff filling new roles. Assessment standardization has occurred, and when further in depth assessment is required, the physical intellectual emotional capabilities environment social self (PIECES) tool is utilized.

Family members participate in the admission process and are invited to the subsequent care conferences, and participation by conference call is facilitated as required.

Admission is determined by need. Wait listed individuals are reviewed prior to admission of new residents to ensure that those most at risk have access to facility services.

The team is encouraged to review documents used for medication reconciliation and verify they are consistently completed and accurately reflect the processes that are facilitated by the document, including timely contact with the pharmacy service provider.

Access to electronic communication tools, including Skype is occurring across sites.

### Priority Process: Decision Support

Release of information, including photographs, is addressed prior to use of the memory boxes. The team is utilizing e-learning material and has been introduced to the systems that are also accessible from home. The team uses best practice evidence for assessment and intervention. The team uses information systems for e mail and e learning.

### Priority Process: Impact on Outcomes

The team completes a fall risk assessment and updates the assessment on a regular basis. A least restraint policy has been implemented, and while incident of falls has increased, fractures have been reduced. Family members are notified of adverse events, including falls.

Resident satisfaction surveys are conducted regularly. Team members are encouraged to review region wide, the fall and infection rate information to ensure strategies for improvement are identified.

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3.3.9 Standards Set: Managing Medications

Unmet Criteria	High Priority Criteria
<b>Priority Process: Medication Management</b>	
1.6 The organization has access to a pharmacist on a 24-hour basis to answer questions about medications or medication management.	!
4.2 The organization uses alerts to inform staff and service providers about problematic labelling, packaging, and nomenclature.	!
10.4 In organizations without CPOE systems, prescribing medical professionals use standard, preprinted forms to order medications.	
17.1 The organization has explicit selection criteria for establishing which clients are permitted to self-administer medications.	
19.1 The organization has and follows a proactive risk assessment process to evaluate the risk potential for new medication delivery devices.	!
20.3 The organization uses alarms on client monitoring systems to alert staff and service providers immediately to potential adverse drug events.	!

Surveyor comments on the priority process(es)

Priority Process: Medication Management

The Pharmacy 'centricity' system is currently being implemented with the pilot site being Neepawa Health Centre. This is anticipated to bring significant improvement to the ordering, delivery and safety of medications for clients. There is an e-learning program (SPOT), and online sessions (Up to Date, Mosby skills) available to staff.

There is identified need to standardize/formalize the process for contact of pharmacy personnel or support after hours and during weekends.

Space for the pharmacy needs to be increased. Security for the pharmacy requires review. The pharmacy for Russell Health Centre is located in the basement and the corridor for the loading dock is next to the pharmacy. The door to the pharmacy is open understandably, because it gets warm in the pharmacy, but access could easily be gained to the pharmacy from that corridor. It may be wise to review the security for both Neepawa and Russell pharmacy areas.

There is use of the Do Not Use Abbreviations list. Although the organization has implemented and is auditing there is still insufficient compliance with this list. Additional and more intensive education and training of the physician community is recommended.

Communication of new processes and policies to the staff needs to improve.

Section 3 Detailed On-site Survey Results

3.3.10 Standards Set: Medicine Services

Unmet Criteria	High Priority Criteria
<p><b>Priority Process: Clinical Leadership</b></p>	
<p>The organization has met all criteria for this priority process.</p>	
<p><b>Priority Process: Competency</b></p>	
<p>3.7 The interdisciplinary team follows a formal process to regularly evaluate its functioning, identify priorities for action, and make improvements.</p>	
<p><b>Priority Process: Episode of Care</b></p>	
<p>7.4 The team identifies medical and surgical clients at risk of venous thromboembolism (deep vein thrombosis and pulmonary embolism) and provides appropriate thromboprophylaxis.</p> <p>7.4.1 The organization has a written thromboprophylaxis policy or guideline.</p> <p>7.4.2 The team identifies clients at risk for venous thromboembolism (VTE), [(deep vein thrombosis (DVT) and pulmonary embolism (PE)] and provides appropriate evidence-based, VTE prophylaxis.</p> <p>7.4.3 The team establishes measures for appropriate thromboprophylaxis, audits implementation of appropriate thromboprophylaxis, and uses this information to make improvements to their services.</p> <p>7.4.4 The team identifies major orthopaedic surgery clients (hip and knee replacements, hip fracture surgery) who require post-discharge prophylaxis and has a mechanism in place to provide appropriate post-discharge prophylaxis to such clients.</p> <p>7.4.5 The team provides information to health professionals and clients about the risks of VTE and how to prevent it.</p>	<p>ROP</p>
<p>11.3 The team reconciles the client's medications with the involvement of the client, family or caregiver at transition points where medication orders are changed or rewritten (i.e. internal transfer, and/or discharge).</p> <p>11.3.1 There is a demonstrated, formal process to reconcile client medications at transition points where medication orders are changed or rewritten (i.e. internal transfer, and/or discharge).</p> <p>11.3.3 The team documents that the BPMH, the active medication orders, and the transfer or discharge medication orders have been reconciled; and appropriate modifications to medications have been made where necessary.</p>	<p>ROP</p>

**Section 3 Detailed On-site Survey Results**

11.3.4	Depending on the transition point, an up-to-date medication list is retained in the client record (internal transfer), OR, the team generates a Best Possible Medication Discharge Plan (BPMDP) that is communicated to the client, community-based physician or service provider, and community pharmacy, as appropriate (discharge).	
11.3.5	The process is a shared responsibility involving the client or family, and one or more health care practitioner(s), such as nursing staff, medical staff, and pharmacy staff, as appropriate.	
11.6	Following transition or end of service, the team contacts clients, families, or referral organizations to evaluate the effectiveness of the transition, and uses this information to improve its transition and end of service planning.	
<b>Priority Process: Decision Support</b>		
14.2	The team reviews its guidelines to make sure they are up-to-date and reflect current research and best practice information.	!
<b>Priority Process: Impact on Outcomes</b>		
15.3	Staff and service providers participate in regular safety briefings to share information about potential safety problems, reduce the risk of error, and improve the quality of service.	!
15.4	The team informs and educates clients and families in writing and verbally about the client and family's role in promoting safety.	ROP
15.4.1	The team develops written and verbal information for clients and families about their role in promoting safety.	
15.4.2	The team provides written and verbal information to clients and families about their role in promoting safety.	
<b>Surveyor comments on the priority process(es)</b>		
<b>Priority Process: Clinical Leadership</b>		
The team is congratulated on its Releasing Time to Care initiative, and also for its work with the diabetes and heart programs.		
<b>Priority Process: Competency</b>		
The team is complimented on its electronic learning program. It is a wonderful example of how knowledge transfer can be facilitated in places with resource and geography constraints.		
There is adequate space at Minnedosa site. There are significant space challenges at Neepawa site. However, there is a plan to introduce a tele monitoring system.		

## Section 3 Detailed On-site Survey Results

### Priority Process: Episode of Care

Releasing Time to Care is an excellent initiative that has improved teamwork, improved morale and put the joy back in nursing

Use of the whiteboards where the nurse as well as the client can put their goals for the day is a good thing

A policy on deep vein thrombosis (DVT) prophylaxis has been developed and is anticipated to be soon approved through the Medical Advisory Committee (MAC).

### Priority Process: Decision Support




It is suggested that inclusion of the medical staff and nursing staff in selection of evidence based guidelines can be enhanced.

### Priority Process: Impact on Outcomes

As already mentioned in the LTC services report section, the Falls strategy is resulting in a reduction in number of falls. Another noted strength is the Releasing Time to Care initiative.

Section 3 Detailed On-site Survey Results

3.3.11 Standards Set: Obstetrics/Perinatal Care Services

Unmet Criteria	High Priority Criteria
<b>Priority Process: Clinical Leadership</b>	
The organization has met all criteria for this priority process.	
<b>Priority Process: Competency</b>	
The organization has met all criteria for this priority process.	
<b>Priority Process: Episode of Care</b>	
6.7 The team follows defined criteria to gather information from other service providers when deciding whether to offer services to a client or family.	
7.8 Prior to delivery, the team evaluates and identifies strategies to manage the client's delivery pain.	
11.3 The team reconciles the client's medications with the involvement of the client, family or caregiver at transition points where medication orders are changed or rewritten (i.e. internal transfer, and/or discharge). 11.3.3 The team documents that the BPMH, the active medication orders, and the transfer or discharge medication orders have been reconciled; and appropriate modifications to medications have been made where necessary.	
<b>Priority Process: Decision Support</b>	
13.5 The team shares client information and coordinates its flow among service providers, other teams, and other organizations, as required.	
<b>Priority Process: Impact on Outcomes</b>	
16.4 (*16.3) The team informs and educates clients and families in writing and verbally about the client and family's role in promoting safety. 16.4.2 (*16.3.2) The team provides written and verbal information to clients and families about their role in promoting safety.	
<b>Surveyor comments on the priority process(es)</b>	
<b>Priority Process: Clinical Leadership</b>	
The team actively tracks population information and numbers and locations of deliveries and uses this information in service planning. The program closely aligns its priorities with the organization's strategic priority of safe yet accessible services. Service improvements are made in close collaboration with the regional PH services and the obstetrical programs of neighbouring regions.	

## Section 3 Detailed On-site Survey Results

A well established and active quality improvement team is in place but would benefit from enhanced physician participation.

The obstetrics/perinatal care team has benefited from its opportunity to pilot the Releasing Time to Care program, which has afforded staff greater opportunity to make changes in their work flow and environment and as a result, has enhanced efficiency.

### Priority Process: Competency

Evaluation of team functioning is incorporated into the Releasing Time to Care program.

The team has invested much effort into enhancing the rigour and standardization of unit specific orientation. Progress has also been made in providing enhanced obstetrics/perinatal care training to staff. This is being accomplished via formal courses, informal in services and exposure to higher risk obstetrical services in Brandon. Particular note is made of the training being provided to staff at non obstetrical facilities in the region to better prepare them for unplanned deliveries that present via their emergency departments. Given the relatively low numbers of deliveries and the impracticality of dedicating staff solely to the obstetrical service, the team is strongly encouraged to continue to pursue opportunities to enhance staff training and competence in managing obstetrical risk. Courses offered include Acute Care of At-Risk Newborns (ACoRN), Advanced Labour and Risk Management (ALARM), and comprehensive risk management programs of the Society of Obstetricians and Gynecologists, such as managing obstetrical risk effectively (More Ob) program.

### Priority Process: Episode of Care

Although it was a shared view among staff that any high risk birth would not be managed in the region, there was no evidence of a consistent process to determine whether or not the delivery was appropriate to be performed in the region. Physicians performing deliveries individually decide whether or not to deliver in the region or refer out. There are no standardized criteria requiring referral to Brandon for higher risk births or standardized processes to determine whether or not appropriate anesthesia or surgical back up would be available at any given time prior to making service eligibility decisions.

Access to Cesarean section and epidural services is dependent on the availability of the sole anesthetist and elective services are not available during the weekend.

Women in the region generally develop a birth plan in conjunction with their pre natal primary care provider. This plan would include preferences for analgesia, labour and delivery options and breast feeding intentions. This information is not fully communicated in the antenatal information sheet that is forwarded to the hospital in anticipation of the delivery. At this time, the admission process does not routinely cover these items and there is no mechanism in place to ensure that the birth plan is available to the hospital staff in a timely way. The team is encouraged to look at processes to address this communication gap.

The admission form used by the team to collect client information prior to delivery is outdated and does not cover all key information required to manage the perinatal care in accordance with current best practices. The team is encouraged therefore, to evaluate and update the form.

The team is recognized for the work done, along with public health (PH) in ensuring that patient education products in support of perinatal care are available, comprehensive, user friendly and consistent between

## Section 3 Detailed On-site Survey Results

providers. Clients interviewed made note of the usefulness of the package and voiced their appreciation for the responsiveness of the teaching and care provided by both hospital and PH staff.

There is an organization wide policy for medication reconciliation on discharge/transition and the policy requires that the discharge medication orders be compared to the admission BPMH and the current MAR and any discrepancies resolved with the physician prior to generating a discharge/transition medication list. The current policy does not however, require that this reconciliation be documented nor do the supporting forms feature a specific space to record that this was done. As a result, there is no mechanism by which the reconciliation can be confirmed via an audit. The organization is encouraged to review the current policy and amend it as necessary.

### Priority Process: Decision Support

The team is encouraged to develop mechanisms to improve both the flow of birth plan information from the primary care provider to the hospital and in hospital care information back to the primary care provider after the delivery is completed and the patient is discharged home.

### Priority Process: Impact on Outcomes

The team receives regular feedback on incidents reported and overall incident report trends. This is tracked by the team, along with a number of other indicators and there is evidence that this information is used to improve services.

Although the staff were of the belief that pamphlets had been developed, no written hand outs for patients concerning their role in safety could be located. The team is encouraged to re establish the practice of providing this information to patients and consider including verbal review of the information at admission.


Section 3 Detailed On-site Survey Results

3.3.12 Priority Process: Surgical Procedures

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

Unmet Criteria	High Priority Criteria
<b>Standards Set: Operating Rooms</b>	
1.8 The interdisciplinary team follows a formal process to regularly evaluate its functioning, identify priorities for action, and make improvements.	
3.6 The team posts, follows, and documents a regular and comprehensive cleaning schedule for the operating room and supporting areas.	!
6.5 Qualified team members administer preoperative antibiotics within the appropriate timeframe.	!
<b>Standards Set: Surgical Care Services</b>	
1.2 The team uses the information it collects about clients and the community to define the scope of its services and set priorities when multiple service needs are identified.	
2.2 The team's goals and objectives for its surgical care services are measurable and specific.	
3.7 The interdisciplinary team follows a formal process to regularly evaluate its functioning, identify priorities for action, and make improvements.	
7.7 The team identifies medical and surgical clients at risk of venous thromboembolism (deep vein thrombosis and pulmonary embolism) and provides appropriate thromboprophylaxis. <ul style="list-style-type: none"> <li>7.7.1 The organization has a written thromboprophylaxis policy or guideline.</li> <li>7.7.3 The team establishes measures for appropriate thromboprophylaxis, audits implementation of appropriate thromboprophylaxis, and uses this information to make improvements to their services.</li> <li>7.7.5 The team provides information to health professionals and clients about the risks of VTE and how to prevent it.</li> </ul>	ROP
8.2 The team verifies that the client and family understand the service information provided.	!
11.4 The team reconciles the client's medications with the involvement of the client, family or caregiver at transition points where medication orders are changed or rewritten (i.e. internal transfer, and/or discharge).	ROP

Section 3 Detailed On-site Survey Results

11.4.3	The team documents that the BPMH, the active medication orders, and the transfer or discharge medication orders have been reconciled; and appropriate modifications to medications have been made where necessary.	
11.6	Following transition or end of service, the team contacts clients, families, or referral organizations or teams to evaluate the effectiveness of the transition, and uses this information to improve its transition and end of service planning.	
15.4(*15.3)	The team informs and educates clients and families in writing and verbally about the client and family's role in promoting safety.	
15.4.2(*15.3.2)	The team provides written and verbal information to clients and families about their role in promoting safety.	

Surveyor comments on the priority process(es)

The operating room (OR) teams at all three sites where surgery is performed are small and have stable staffing, with clear understanding of roles. To date, teams have not undertaken activities specifically designed to develop enhanced team functioning or formally measure team performance and are encouraged to do so, particularly with the introduction of new staff members or new processes. For the surgical care unit staff, there was no evidence that the teams undertook formal evaluation of team functioning with the exception of teams participating in the Releasing Time to Care (RTC) initiative. Compliance with this standard should improve with the planned roll out of RTC across the region.

The team has invested much effort into enhancing the rigour and standardization of unit specific orientation. In addition, progress has been made in upgrading qualifications for OR staff and ensuring that all have recognized training specific to OR.

Although the organization is still transitioning toward a single model of infusion pump, staff are trained on all applicable models and the training is diligently documented via the SPOT program.

At all three sites performing surgery, prophylactic antibiotics appeared to be ordered in accordance with accepted guidelines and there was no evidence that they were being used beyond the recommended duration. Success in consistently administering the medication within the appropriate time frame however, across all sites has yet to occur, and teams are actively working on process changes to improve their performance in this regard.

Although there is evidence that a safe surgery check list was used for every surgical patient, adherence to all elements of the organization's check list as per policy, and full participation in the "time out" is variable. This was particularly true for cases not requiring general anaesthetic. Encouragement is given to explore developing or adopting abbreviated safe surgery check lists, tailored to high volume, low acuity procedures such as cataract surgery or endoscopy, as a means of enhancing full team compliance.

The surgical program, in conjunction with quality and risk management (QI/RM) has articulated two goals specifically related to incident reporting, which is the only indicator specific to the program that is tracked on a regular basis. The surgical service has not yet articulated comprehensive program goals and objectives and the existing goals are not linked to the Community Health Assessment data. Current quality improvement initiatives are largely focused on putting processes in place to improve compliance with Accreditation Canada standards.

## Section 3 Detailed On-site Survey Results

Additional goals and objectives for pre and post surgical care originate from the organization's Releasing Time to Care pilot but do not apply to the Surgical services as a whole. As the Surgical program continues to mature, the teams are encouraged to review and improve the process by which they establish and track goals and objectives.

Encouragement is offered to continue to further develop a panel of performance indicators and performance targets.

Commendation is given for collaborations with neighbouring health authorities to rationalize surgical resources.

Given the wide variety of patients that staff must care for on the multi service units and the success of the SPOT continuing professional education system, the organization is encouraged to continue to develop a more extensive menu of modules to assist in keeping specialized surgical care skills and knowledge up to date.

Standing orders, protocols and standardized care plans are in use and encouragement is given to continue expanding the number and scope of the care maps.

Mechanical measures are employed to prevent VTE and there is a protocol for the administration of low molecular weight heparin when ordered. There is however, no organization wide policy on VTE prophylaxis that includes the full breadth of clinical recommendations, including indications for chemo prophylaxis, or formal audit of their use.

The teams provide extensive post operative care information to patients both verbally and as written instructions, but do not consistently verify that patients have understood the information. Encouragement is offered to take the time to verify understanding of critical information in populations vulnerable to hearing loss, confusion, or language difficulties in particular.

Throughout the surgical service, team members were extremely diligent with regard to patient and procedure identification and ensuring that consents were in place prior to surgery.

There is an organization wide policy for medication reconciliation on discharge and transition, which requires that the discharge medication orders be compared to the admission BPMH and the current MAR. This involves resolving any discrepancies with the physician prior to generating a discharge/transition medication list. The current policy does not require that this reconciliation be documented nor do the supporting forms feature a specific space to record that this was done. As a result, there is no mechanism by which the reconciliation can be confirmed by an audit. The organization is encouraged to review the current policy/process and amend as necessary.

Encouragement is offered to provide clients with information regarding their role in patient safety on a consistent basis.

## **Section 4 Performance Measures Results**

Under Qmentum, client organizations collect performance measure data using instruments.

- **Instruments (or tools)** are surveys related to areas such as governance, patient safety culture, and quality of worklife. They are completed by a representative sample of clients, staff, senior leaders, board members, and other stakeholders.

The information in this section shows some of the performance measure results at the organizational level.

### **4.1 Instruments**

#### **4.1.1 Governance Functioning Tool**

The Governance Functioning Tool enables members of the governing body to assess board structures and processes, provide their perceptions and opinions, and identify priorities for action. The four aspects of the governing body that it is designed to measure are:

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

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

**Data collection period: April 1, 2011 to September 2, 2011**

**Number of respondents: 10**

#### **Governance Functioning Tool: Results by Aspect of Governing Body**

Governance Structures and Processes	% Agree	% Neutral	% Disagree	%Agree * Canadian Average
	Organization	Organization	Organization	
1 We actively recruit, recommend and/or select new members based on needs for particular skills, background, and experience.	50	0	50	94
2 We have explicit criteria to recruit and select new members.	33	0	67	86
3 Our renewal cycle is appropriately managed to ensure continuity on the governing body.	100	0	0	93

## Section 4 Performance Measures Results

Governance Structures and Processes	% Agree	% Neutral	% Disagree	% Agree * Canadian Average
	Organization	Organization	Organization	
4 The composition of our governing body allows us to meet stakeholder and community needs.	88	0	13	96
5 Clear written policies define term lengths and limits for individual members, as well as compensation.	100	0	0	96
6 We regularly review, understand, and ensure compliance with applicable laws, legislation and regulations.	100	0	0	93
7 Governance policies and procedures that define our role and responsibilities are well-documented and consistently followed.	100	0	0	96
8 We review our own structure, including size and sub-committee structure.	100	0	0	94
9 We have sub-committees that have clearly-defined roles and responsibilities.	100	0	0	97
10 Our roles and responsibilities are clearly identified and distinguished from those delegated to the CEO and/or senior management. We do not become overly involved in management issues.	100	0	0	96
11 We each receive orientation that helps us to understand the organization and its issues, and supports high-quality decision-making.	100	0	0	93
12 Disagreements are viewed as a search for solutions rather than a “win/lose”.	100	0	0	95
13 Our meetings are held frequently enough to make sure we are able to make timely decisions.	100	0	0	98
14 Individual members understand and carry out their legal duties, roles and responsibilities, including sub-committee work (as applicable).	90	0	10	97
15 Members come to meetings prepared to engage in meaningful discussion and thoughtful decision-making.	90	0	10	95

## Section 4 Performance Measures Results

Governance Structures and Processes	% Agree	% Neutral	% Disagree	%Agree * Canadian Average
	Organization	Organization	Organization	
16 Our governance processes make sure that everyone participates in decision-making.	100	0	0	95
17 Individual members are actively involved in policy-making and strategic planning.	90	0	10	93
18 The composition of our governing body contributes to high governance and leadership performance.	100	0	0	94
19 Our governing body's dynamics enable group dialogue and discussion. Individual members ask for and listen to one another's ideas and input.	100	0	0	95
20 Our ongoing education and professional development is encouraged.	90	0	10	91
21 Working relationships among individual members and committees are positive.	100	0	0	97
22 We have a process to set bylaws and corporate policies.	100	0	0	97
23 Our bylaws and corporate policies cover confidentiality and conflict of interest.	100	0	0	98
24 We formally evaluate our own performance on a regular basis.	100	0	0	83
25 We benchmark our performance against other similar organizations and/or national standards.	80	0	20	75
26 Contributions of individual members are reviewed regularly.	70	0	30	72
27 As a team, we regularly review how we function together and how our governance processes could be improved.	100	0	0	83
28 There is a process for improving individual effectiveness when non-performance is an issue.	70	0	30	66
29 We regularly identify areas for improvement and engage in our own quality improvement activities.	70	0	30	84

**Section 4 Performance Measures Results**

Governance Structures and Processes	% Agree	% Neutral	% Disagree	%Agree * Canadian Average
	Organization	Organization	Organization	
30 As a governing body, we annually release a formal statement of our achievements that is shared with the organization’s staff as well as external partners and the community.	90	0	10	88
31 As individual members, we receive adequate feedback about our contribution to the governing body.	56	0	44	73
32 We have a process to elect or appoint our chair.	63	0	38	96
33 Our chair has clear roles and responsibilities and runs the governing body effectively.	100	0	0	97

\*Canadian average: Percentage of Accreditation Canada client organizations surveyed from January to June, 2011 that agreed with the instrument item.

## Section 4 Performance Measures Results

### 4.1.2 Patient Safety Culture Tool

The Patient Safety Culture Tool provides insight into staff perceptions of patient safety, allowing the organization to identify successes and challenges in a number of areas related to patient safety and worklife.

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

**Data collection period: June 7, 2010 to November 3, 2010**

**Minimum response rate (based on the number of employees): 317**

**Number of respondents: 570**

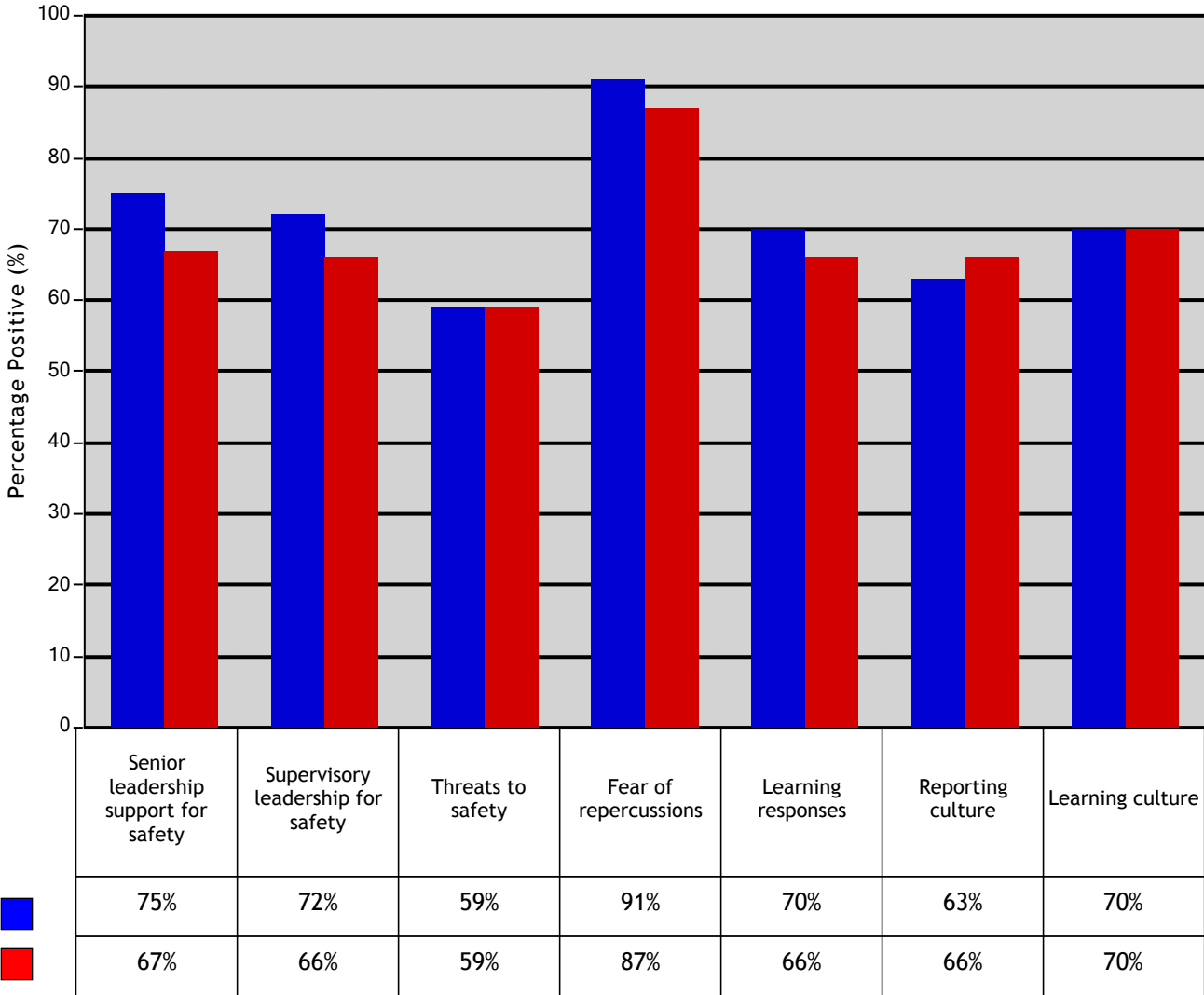
**Minimum response rate MET**

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Section 4 Performance Measures Results

Patient Safety Culture: Results by Patient Safety Culture Dimension

Patient Safety Culture Tool Results



**Legend**  
 ■ Assiniboine Regional Health Authority  
 ■ \* Canadian Average

\*Canadian average: Percentage of Accreditation Canada client organizations surveyed from July to December, 2010 that agreed with the instrument item.

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## Section 4 Performance Measures Results

### 4.1.3 Worklife Pulse Tool

The Worklife Pulse Tool enables organizations to take the “pulse” of the quality of worklife by monitoring staff perceptions of various aspects of worklife, such as on-the-job communication, staff health and well-being, and job satisfaction. It collects information related to 11 aspects of the work environment that are known to contribute to individual quality of worklife and organizational performance.

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

**Data collection period: October 13, 2010 to January 21, 2011**

**Minimum response rate (based on the number of employees): 322**

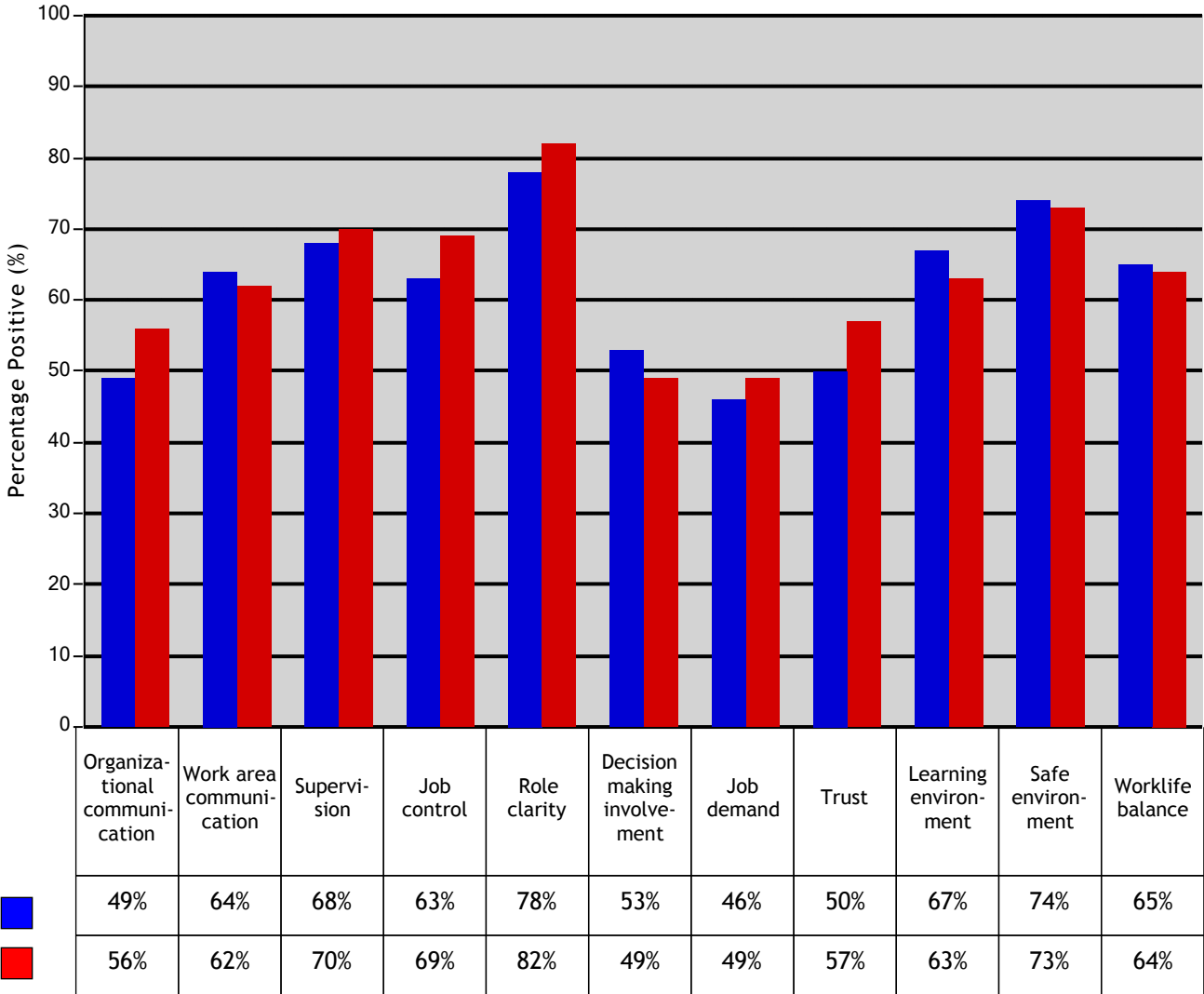
**Number of respondents: 547**

**Minimum response rate MET**

Section 4 Performance Measures Results

Worklife Pulse Tool: Results of Work Environment

Worklife Pulse Tool Results



**Legend**  
■ Assiniboine Regional Health Authority  
■ \* Canadian Average

\*Canadian average: Percentage of Accreditation Canada client organizations surveyed from January to June, 2011 that agreed with the instrument item.

## Appendix A Qmentum

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

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

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

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

### Action Planning

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

### Progress Review and Ongoing Improvement

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

## Appendix B Priority Processes

### Priority processes associated with system-wide standards

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

### Priority processes associated with population-specific standards

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

### Priority processes associated with service excellence standards

**Appendix B Priority Processes**

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

**Appendix B      Priority Processes**

Priority Process	Description
Blood Services	Handling blood and blood components safely, including donor selection, blood collection, and transfusions