ACCREDITATION CANADA

Driving Quality Health Services

Accreditation Report

Prepared for:

Mamawetan Churchill River Health Region

La Ronge, SK

On-site Survey Dates:

May 29, 2011 - June 3, 2011

June 22, 2011

Accredited by ISQua

Accreditation Report

About this Report

The results of this accreditation survey are documented in the attached report, which was prepared by Accreditation Canada at the request of Mamawetan Churchill River Health Region.

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

Confidentiality

This Report is confidential and is provided by Accreditation Canada to Mamawetan Churchill River Health Region only. Accreditation Canada does not release the Report to any other parties.

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

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About the Accreditation Report

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

Legend

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

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

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

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

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

Items marked with an arrow indicate a high risk criterion.

Accreditation Summary

Mamawetan Churchill River Health Region

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

On-site survey dates	May 29 to June 3, 2011
Report Issue Date:	June 22, 2011

Accreditation Decision	Accreditation with Condition (Report)

Locations

The following locations were visited during this survey visit:

1 Creighton Health Centre
2 La Ronge Health Centre
3 Pinehouse Health Centre
4 Sandy Bay Health Centre

Service areas

The following service areas were visited during this survey visit:

1 Addictions/Gambling
2 Community Health Services
3 Diagnostic Imaging
4 Emergency Department
5 Emergency Medical Services
6 Home Care
7 Long Term Care
8 Maternal/Perinatal
9 Medicine
10 Mental Health
11 Public Health
12 Sterilization and Reprocessing of Medical Equipment
13 Telehealth

Surveyor's Commentary

The following global comments regarding the survey visit are provided:

Overall strengths:

Strong Board and leadership team dedicated to fulfilling the mission, visions, values and strategic directions aligned with the Provincial Health Ministry. The organization is aware of this mandate and each operational unit/program has aligned their strategic directions with those of the organization and province.

Physician complement for both La Ronge and outlying areas is well -staffed and organized with physicians using the "hub and spoke approach" of physicians living and working in the hub and travelling on a rotational basis to the sites.

The Northern Health Indicators report 2011, led by the Medical Officer of Health is a model of health indicator reporting for population health for the three northern regions of Saskatchewan. It provides benchmarking not only to the north of the province but to the northern communities of Canada.

There is an effective communication plan, policies and procedures with an experienced Communications Director. The Board Chair and CEO are the official spokespersons.

There is sound financial status as evidenced by forecasting, budgeting, resource allocation and variance analysis following policies and procedures. The organization completed the 2010 fiscal year in a surplus position. This was partially achieved due to employee vacancies.

Quality improvement and risk management processes and plans are in place with supportive directors and infrastructure.

Facilities are generally in good repair and well maintained.

Community Partners including First Nations are collaborating on Emergency Preparedness.

The flat organizational structure is consistent with the size of the region.

There is a dedicated, caring, and creative staff.

The Population Health unit has become recognized as an influential and credible research group focusing on the impact of the determinants of health in rural and remote Canada.

Overall areas for improvement:

The organization is encouraged to develop a framework to guide financial decision making based on a set of consistent lenses such as ethics, economics, and evidence.

The organization needs to ensure that Human Resources implement screening and hiring- like processes for all volunteers that are similar to regular staff (e.g. criminal record checks).
Quality improvement reporting from the teams to the QI Department needs to move to process and outcome indicators from the current statistical reporting and results passed on the senior leadership and the Board for feedback.

Planning for Facilities improvement and capital construction needs to be placed in priority order across the region as it relates to needs, such as LTC beds in La Ronge, Elder homes in Sandy Bay, Emergency Department expansion, facility expansion at Pinehouse, and others.

Successes achieved by the leadership of the organization:

Recruitment and retention of physicians is NOT a current problem of the organization.

There is a steady CEO role for the past five years with consistency in many senior leadership roles.

Board chair appointed who had served a number of years on the Health Board.

Excellent understanding of the population needs will be enhanced with the imminent publication of the most recent Northern Indicators document.

Challenges facing the organization:

A clinical nursing leader is required to inform and implement best interdisciplinary practice across the organization.

Community partners voicing concern that the Health authority is not at their tables assisting with decision-making in the various community settings. The organization needs to appoint representatives to these meetings who are empowered with decision-making authority.

There is a major shortage of housing which is impacting mental health clients, staff who are locating to the region, LTC clients awaiting beds, and Elders in some communities seeking elder housing. Overcrowding leads to an increase in incidence of infectious diseases.

Communication:

Communication between Board and senior leadership is open and transparent. Board members appreciate the longevity of some senior staff and feel safe in their questions to and guidance from them.

Communication between different levels of management is open and respectful.

Communication between managers and front -line staff is open, respectful and engaging.

Relationship between the organization and community is currently somewhat disconnected from the community's perspective in that they have lost their usual connection to region through their committee relationships with the former Directors of Nursing and Primary Health Care.

Organization's Commentary

The organization has no comment at this time.

Leading Practices

Recognizing innovation and creativity in Canadian health care delivery

Leading practices are commendable or exemplary organizational practices that demonstrate high quality leadership and service delivery. Accreditation Canada considers these practices worthy of recognition as organizations strive for excellence in their specific field, or commendable for what they contribute to health care as a whole. They may have been identified as a leading practice in a particular geographic region, or for a particular service delivery area or health issue.

Leading Practices
- are creative and innovative
- demonstrate efficiency in practice
- are linked to Accreditation Canada standards
- are adaptable by other organizations

Mamawetan Churchill River Health Region is commended for the following:

Prenatal Care Flowsheets

Under the leadership of the Senior Medical Officer, primary care physicians at the Mamawetan Churchill River Health Region in Saskatchewan have developed a suite of tools for many clinical situations. Among them are excellent and comprehensive Perinatal Care Flowsheets for healthy and diabetic women. The flowsheets outline the best evidence based care from preconception to the postpartum period, and can be used to guide prenatal care. They are well accepted by mothers and physicians alike and are simple to implement. (Obstetrics/Perinatal Care Services)

Overview by Quality Dimension

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

Quality Dimension	Met	Unmet	N/A	Total
Population Focus (Working with communities to anticipate and meet needs)	100	6	3	109
Accessibility (Providing timely and equitable services)	86	1	7	94
Safety (Keeping people safe)	366	33	37	436
Worklife (Supporting wellness in the work environment)	140	7	2	149
Client-centred Services (Putting clients and families first)	143	9	8	160
Continuity of Services (Experiencing coordinated and seamless services)	56	3	2	61
Effectiveness (Doing the right thing to achieve the best possible results)	544	66	46	656
Efficiency (Making the best use of resources)	68	3	2	73
Total	**1503**	**128**	**107**	**1738**

Overview by Standard Section

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

Standard Section	Met	Unmet	N/A	Total
Sustainable Governance	89	0	2	91
Effective Organization	98	8	0	106
Infection Prevention and Control	96	1	6	103
Customized Managing Medications	41	8	2	51
Public Health Services	113	2	0	115
Community Health Services	65	3	0	68
Diagnostic Imaging Services	74	16	14	104
Emergency Department	83	21	17	121
Emergency Medical Services	134	6	20	160
Home Care Services	83	2	9	94
Long Term Care Services	100	16	5	121
Medicine Services	68	26	11	105
Mental Health Services	104	1	6	111
Obstetrics/Perinatal Care Services	94	15	10	119
Reprocessing and Sterilization of Reusable Medical Devices	95	0	4	99
Substance Abuse and Problem Gambling Services	100	2	1	103
Telehealth Services	66	1	0	67
Total	**1503**	**128**	**107**	**1738**

Overview by Required Organizational Practices (ROPs)

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

Criteria	Required Organizational Practices
Effective Organization 6.2	The organization develops and implements a client safety plan, and implements improvements to client safety as required.
Effective Organization 6.7	The organization carries out one client safety-related prospective analysis per year, and implements appropriate improvements.
Effective Organization 6.9	The organization's leaders provide the governing body with quarterly reports on client safety, and include recommendations arising out of adverse incident investigation and follow-up, and improvements made.
Effective Organization 8.5	The organization prevents workplace violence.
Infection Prevention and Control 6.5	The organization evaluates compliance with accepted hand hygiene practices.
Customized Managing Medications 1.8	The organization removes concentrated electrolytes (including, but not limited to, potassium chloride, potassium phosphate, sodium chloride >0.9%) from client service areas.
Customized Managing Medications 1.10	The organization has identified and implemented a list of abbreviations, symbols, and dose designations that are not to be used in the organization.
Diagnostic Imaging Services 14.6	The team informs and educates its clients and families in writing and verbally about the client and family's role in promoting safety.
Emergency Department 4.5	Staff and service providers receive ongoing, effective training on infusion pumps.
Emergency Department 10.4	The team uses at least two client identifiers before providing any services or procedures.
Emergency Department 11.8	The team transfers information effectively among service providers at transition points.
Long Term Care Services 8.4	The organization assesses each client's risk for developing a pressure ulcer and implements interventions to prevent pressure ulcer development.
Long Term Care Services 16.2	The team implements and evaluates a fall prevention strategy to minimize the impact of client falls.
Long Term Care Services 16.4	The team informs and educates its clients and families in writing and verbally about the client and family's role in promoting safety.
Long Term Care Services 16.5	The team implements verification processes and other checking systems for high-risk activities.
Medicine Services 7.4	The team identifies medical and surgical clients at risk of venous thromboembolism (DVT and PE) and provides appropriate thromboprophylaxis.
Medicine Services 15.2	The team implements and evaluates a falls prevention strategy to minimize the impact of client falls.
Medicine Services 15.4	The team informs and educates its clients and families in writing and verbally about the client and family's role in promoting safety.
Medicine Services 15.5	The team implements verification processes and other checking systems for high-risk activities.

Criteria	Required Organizational Practices
Substance Abuse and Problem Gambling Services 15.4	The team informs and educates its clients and families in writing and verbally about the client and family’s role in promoting safety.

Detailed Accreditation Results

System-Wide Processes and Infrastructure

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

Findings

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

Planning and Service Design

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

Surveyor Comments

Strengths
The Board and members of the senior leadership team are commended for the work done in the development and dissemination of the mission, vision and values. These have been reviewed on an annual basis usually on the Board Dialogue Day. Community stakeholders and staff and physicians have been involved in the process.
With regard to the strategic directions development process the strategic directions are received from the Ministry of Health for the province and it is each Health authority's responsibility to develop their own strategic directions aligned with the provincial set. This is accomplished by the Region assembling the provincial Accountability document, its budget, information about population health, and updated information from the 2004 Northern Indicators document. There is a draft document entitled Northern Saskatchewan Health Indicators Report 2011.The document provides an overview of community characteristics, the determinants of health and some indicators of health status and well-being of the people of Northern Saskatchewan in comparison with health regions across Northern Canada as well as the province.
The region develops indicators to measure the success of its processes and outcomes and these are presented to the Board on a Quarterly basis using a dashboard and balanced scorecard formats. The organization utilizes the services of a measurement committee to gather, collate, and report this information.

The organization is applauded for the excellent approaches to understanding the health needs of the community served. The draft indicator document for 2011 was made available to the surveyors and it will replace the 2004 document which had been updated as necessary by indicator or community needs. These are impressive documents developed for the three northern regions and reflect the significant needs for chronic disease improvements in diabetes, the large numbers of injuries to younger residents and the higher than expected suicide rate. The regions are then able to embark upon initiatives to deal with this information, and this is an effective use of information at the population level. The Medical Officer of Health has been instrumental in leading this charge and is joined in the effort by an excellent team including a nurse epidemiologist and administrative director for population health.

=a dcfhUbh`mh\YfY]g U gYbgY]b the community that this population health team is the "unbiased voice" and there is tremendous respect for the work accomplished. The team is also commended for analyzing information about environmental risks, exposures to pollutants, hazardous sites, local industry, and occupational conditions that may pose a risk as part of the community health assessment.

The team uses the opportunity to regularly assess the effectiveness of its communication strategy and uses this information to make improvements by presenting information at the community intersectorial meetings and obtaining feedback from the attendees. The Board also uses this approach to share information about its newly developed or revised strategic directions. The community Advisory Network in Pinehouse received the strategic directions for their feedback and there is a plan to have a Questions and Answers session in the community in the near future with Board members and stakeholders as well as members of the organization. This is encouraged and supported.
The organization is commended for its role as an advocate in healthy public policy in the community as there is evidence of a onetime influence on a report of the cost of northern food that impacted the social service allowance dollars per client in a positive way. The team has numerous examples of successful measurement results, such as tuberculosis, smoking, and needle exchange program, and the H1N1 situation was very well managed.

The team is applauded for its most recent publications and is often visited from other parts of Canada and world jurisdictions to view its work and accomplishments. It is proud of how it communicated with all levels of government, to staff, and to the communities when necessary during times of crises. Public health inspector rates reached high percentages in some sites in the region even though they needed to fly in on a seasonal basis.

The Health Region is pleased to note that physician recruitment is currently not a problem in the region. Physicians are provided to the region through Northern Medical Services. A hub and spoke model is used with all family physicians living and working in La Ronge with regular access to the communities in the region. This model addresses the concerns of days past when one physician would live in a small community with none or limited back-up often resulting in burnout and resignation. The medical complement is actually fully staffed as of the fall of 2011.The distributive model of education is well developed with five learners, a first year medical student, residents and eleven full time family physicians. Performance reviews are not completed on an annual basis for physicians but rather by the College of Physicians and Surgeons of Saskatchewan on a five year basis, including random requests to thirty of the physicians' patients for evaluation plus a one week onsite review of the practice by the college.

Areas for improvement
Planning for Facilities improvement and capital construction needs to have priority assignment in areas like Emergency Department and for additional LTC beds in La Ronge or Elders units in Sandy Bay for instance.

The team is encouraged to explore the concept of the operational plan and its benefit to the planning process even though this is not required by the province. There may be opportunity to have a clearer understanding of the flow of strategic directions with the organization’s operational plan rather than a composite of departments’ operational plans.

No Unmet Criteria for this Priority Process.

Resource Management

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

Surveyor Comments

The Board and leadership team are commended for the responsible resource allocation and operation within the allocated funds. The board receives appropriate and timely information from the organization in order to make sound financial decisions in keeping with its strategic directions. When faced with decisions the Board considers a number of factors most notably whether there is an impact to direct or indirect patient care. The Board considers risks to the organization in its decisions. Some identified risk areas include lengthy wait lists for LTC beds, or potential infections that can occur in situations of crowded Emergency Departments. With the risk of forest fires raging in the province and having just occurred with devastation in a neighbouring province, the Board members are concerned with the potential risk of loss of services in the event of another fire in the La Ronge area.

The CEO expresses risk in terms of this region being such a small region and not having its voice heard. There are many advocacy needs of the residents of the northern part of the province. In the La Ronge area there are 29 people awaiting long term care accommodations. A report was conducted with the rationale for these services and the Board members feel it is time to present the report and advocate for this cause. The Board and senior leadership is encouraged to address the situation in a timely manner as there are pockets of concern expressed in numerous parts of the region about this matter. It is becoming a more serious issue in light of the fact that housing itself is extremely limited in the area and for elders in the Sandy Bay area.

The organization gathers input from the community partners to assist the Board in its decision for funding allocations. An example is the partnership with the schools in its development of the forty developmental assets project. Also, there is a partnership with the Northern Healthy Communities Project which resulted in a business case being developed for the project entitled " Babies, Books and Bonding." This is effective use of resources.

The Quarterly report which is presented to the Board, is a three month composite of the managers monthly reports which contains a report on variances and a budget forecast. This information is used to determine the pressure areas and how they will be addressed. One area which presents pressure is the Dental Access Program which is very effective and is hoped to be continued but must have funding earmarked for it. On the other hand, some funding is removed from the budget allocation prior to the organization receiving it . This is done to accomplish a savings identified which is part of the provincial and regional strategic plan such as a reduction in overtime costs by a percentage. The Board is applauded for its efforts to fund new initiatives within its global funding package but is also applauded in recognizing when it cannot proceed without new funding.

The report of the auditor has been received and the recommendations are being addressed.

The organization is encouraged to prepare the annual operating and capital budgets according to financial policies and procedures. This would ensure consistency among budgets year over year as well as providing a learning experience for those involved with the development and approval process. A further encouragement would be for the organization to utilize an evidence-based economical and ethical approach to decision making about both the operating and capital budget approval processes.

No Unmet Criteria for this Priority Process.

Human Capital

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

Surveyor Comments

The Board is appointed by the Ministry of Health and the eight members receive orientation and education to begin and or fulfil their roles and achieve the organization's strategic goals and objectives. There is a process to declare and resolve conflicts of interest and to regularly evaluate its performance and that of the CEO. The Board completed the Governance Functioning Tool for the second time in three years highlighting an area for improvement which included the need to conduct more benchmarking among similar organizations. The Board chair noted that the Board does receive benchmarking data among the different health authorities and is able to compare results of a number of areas including immunization rates. Similarly, the population health indicators project for the northern regions benchmarks with the northern parts of Canada, not only the northern parts of Saskatchewan.

The Board conducts performance reviews for the CEO and is embarking on a pay for performance process this year where performance is tied to successful achievement of the organizations goals and objectives. The Board also supports the ongoing professional development of the CEO.

The organization has successfully completed the Worklife Pulse tool for the second time in three years and with a focus on staff finding the hours of work long and physically challenging, the Wellness initiative was begun. This is an excellent approach to identified issues of worklife imbalance.
The organization has committed to a Healthy lifestyle approach to improving worklife balance. This process begins with a health risk assessment and consists of strategies to deal with high BP, cholesterol, diabetes checks, smoking cessation approaches, etc. This is an excellent recruitment and retention strategy. There is also a policy entitled Respect and Dignity which is a workplace violence policy in place for staff and service providers to confidentially report incidents of workplace violence.

New processes working more effectively for recruitment include advertising on the provincial websites, CanSask , Health Careers in Saskatchewan instead of spending thousands of dollars on print advertising which has not resulted in recruits in recent years. The team is commended for this positive change. Ongoing links to the Health Authority website is provided for job listings to Aboriginal agencies and organizations. This among other initiatives including the hiring of a coordinator has increased the percentage of jobs held by Aboriginals in the region from 15% to 30% of staff in the past few years. An ideal goal would be 70% based on the population of the region, but the team and coordinator are very positive about the success to date. This is excellent work. Congratulations!
Other positive approaches to recruitment and retention include a three year project assisting staff with career goals and a significant tuition and book support policy.

Staff in the region are provided with Aboriginal awareness training, and a new Representative Workforce policy and Representative Workforce statement on all job ads and application forms is applauded.

Health career promotion is commended as a way to encourage local high school students to consider healthcare training in their home region as appropriate. There are partnerships to promote practicums in entry level work placements, summer student placement, and job shadowing for high school students. Partnerships with the local college where a new nursing program will begin in the fall of 2011 has been exciting for the region as it begins thinking ahead to the future where local nurses are educated and then work in their home communities. This would lessen the burden of recruiting which often ends in short term employment with staff from away leaving the area soon after having been hired.

The ongoing HR programs are also commended for the consistency they bring to the organization, such as long term service recognition, return to work programs, workplace accommodation, and the implementation of an Human Resources Information System (HRIS) program.

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

Criteria	Location	Priority for Action
Effective Organization		
The organization prevents workplace violence.	8.5	↑
The organization's leaders review quarterly reports of incidents of workplace violence and use this information to improve safety, reduce incidents of violence, and make improvements to the workplace violence policy.	8.5.7	
The organization's leaders develop and regularly update position profiles for each position.	12.5	
The organization maintains a human resource record for each staff member, service provider, and volunteer.	12.12	

Integrated Quality Management

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

Surveyor Comments

The Board places a priority emphasis on Quality and reporting from the organization. The monthly Board meetings begin with an in camera session in order to hear of any critical incidents and how they are dealt with. Patient satisfaction reports, survey results and general morale are discussed, and any action plans for improvement are developed. The Board presents an open communication, blame-free approach to disclosure about client safety incidents, issues and potential problems.

The organization has a disclosure policy in place and there is clear evidence in patient records of disclosure conversations happening. This is particularly true in the context of critical incidents. There remains an opportunity to expand disclosure to "non-critical incidents". The Health Region should also be explicit, with respect to roles and responsibilities for disclosure in its expectations for contracted service providers - this is particularly important in their contract with La Ronge EMS - where Medical Oversight is provided by a Mamawetan Churchill River Health Region affiliated physician and care is routinely passed from EMS to the Region. The Region's policy is clear that disclosure should happen - but in some cases there is confusion as to who should be providing that disclosure to patients and/or families.

The organization self-identified that due to other priorities they had not been able to complete a prospective analysis this past year. On further investigation it is evident that the organization does participate in a number of prospective planning exercises (an example would be the decision to close part of the hospital during "non-business" hours) that do involve discussions about client-safety. With relatively little additional effort the organization could more formally address these client safety considerations (discussion of relevant and relative risk to patient safety associated with the different options being discussed and a decision and rationale on why a given option was chosen over another) and meet the intent of this ROP.

The organization does look at performance in managing contracts however it is unclear how the quality and safety of the care being provided impact the consideration of change requests within a contract and help inform the content of new contracts. For example - whose responsibility is it to ensure that the equipment being used by the contracted provider is appropriately maintained? How is budget to replace capital assets incorporated into contract negotiations?

There is clear evidence of leadership and physician involvement in Quality Improvement. This involvement, coupled with the direction articulated in the organization's quality management framework should position the Health Region to effectively monitor and manage the quality of the care it provides. It has self-identified the challenges in developing data related to patient outcomes and is hoping through its work on "Quality as a Business Strategy" will help address this issue.

With the increased focus on performance reporting there is an opportunity for the Quality Management team to utilize statistical process control charts to better represent the organization's data. Representing data in the manner makes it easier for operational managers to understand when an investigation or response may be required and when such a response would actually be a poor use of resources. The organization should continue to develop its data literacy for staff involved in data collection and analysis as well as those involved in consuming or using those data.

Quality improvement reporting from the teams to the QI Department needs to move to process and outcome indicators from the current statistical reporting and the results passed on to Senior leadership and the Board for feedback.

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

Criteria	Location	Priority for Action
Effective Organization		
The organization develops and implements a client safety plan, and implements improvements to client safety as required.	6.2	↑
There is a plan and process in place to address identified client safety issues.	6.2.2	

The organization carries out one client safety-related prospective analysis per year, and implements appropriate improvements.	6.7	↑
At least one prospective analysis has been completed within the past year.	6.7.1	
The organization's leaders provide the governing body with quarterly reports on client safety, and include recommendations arising out of adverse incident investigation and follow-up, and improvements made.	6.9	↑
The reports outline specific organizational activities and accomplishments in support of client safety goals and objectives.	6.9.2	
There is evidence of the governing body's involvement in supporting the activities and accomplishments, and acting on the recommendations in the quarterly reports.	6.9.3	

Principle Based Care and Decision Making

Identifying and decision making regarding ethical dilemmas and problems.

Surveyor Comments

The organization has established a framework for ensuring the mission, vision and values are used in their decision making.

An Ethics Committee has been established for a number of years with Terms of Reference. The committee is a committee of the Board with representation from the Board. The Board member attends meetings and provides updates to the Board on a regular basis. A separate group outside of the ethics committee review internal and external research proposals for ethical implications. The Population Health Unit Medical Health Officer and Nurse Epidemiologist review applications to determine if the proposals are for research or quality improvement. For research proposals, formal research ethics approval is required through one of the Canadian Universities. Recommendations are made which go to the Board and CEO who give final approval for research projects that will use health region staff time, facilities, records, or resources. Currently there are a number of research projects that involve this health region.

The Ethics Committee has staff participation from various communities across the region, including an elder representative. Initially their focus was committee member education, and they are now ready to focus on the education of front line staff with a goal to provide staff education around Ethics to 100% of their staff. Communication plans are being developed using newsletters for staff to increase the awareness around access to ethics committee resources. The Ethics Committee has developed a work plan for 2010- 2011. The work plan is supported by several working groups which focus on the development of an ethical framework, methods of consultation, incorporation of policy throughout the organization, and plans for education and communication which include education for the committee, staff and community.

Guidelines are currently being developed that outline the consultation service that will be available upon voluntary request, to physicians, care providers, patients/clients and families across the region. The committee has recently utilized their framework on a potential conflict of interest issue. The case will be used as a case study to assist with the education of staff across the region.

A challenge identified by the group related to their ability to maintain consistent committee representation as committee membership changes over time. Initially the committee met quarterly but has found it beneficial to meet monthly. Another challenge will be to roll out the education region wide.

No Unmet Criteria for this Priority Process.

Communication

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

Surveyor Comments

The organization maintains the Board’s records of activities and decisions as well as correspondence which are easily accessible and in keeping with legal requirements.
The Board holds two in camera sessions at the beginning and end of the Board meeting with Board members only. The Board works with the CEO to communicate with staff and other members of the organization .A Communications and Engagement plan has been established to meet a number of objectives notably:
1. to ensure the public is aware of how to access Health Region and Health Line service.
2. to ensure employees are informed of new initiatives and decisions that impact their work, and to promote the spirit of teamwork within the region.
3. to ensure the successful handling of special situations by establishing a well-developed communications component.
4. to ensure the public is able to access the decision-making process of the Health Region.

There is an experienced Communications Director who is responsible for a number of excellent initiatives around getting the message out to staff, health care providers and the public. One example is a poster called "How can we do better?" with an emphasis on Quality and contact numbers for the Quality coordinator. The poster is meant to reflect the emphasis on continually improving and promoting the Quality department.

The Board speaks with one voice and the CEO is the other spokesperson for the organization. If another employee provides information to the media as at an education session in the community, a media log is filled out advising the Communications Director about the information provided. This provides a record for future use if the Board or CEO is asked to follow up with additional information on the subject, and it is a good process.

The Board conducts a Dialogue Day annually and numerous stakeholders are invited including Lac La Ronge Indian Band, Northern Intertribal Health Authority, Prince Albert Grand Council, Peter Ballantyne Cree Nation, Education and awareness, HIV Aids groups and numerous others. This is an excellent opportunity for internal and external stakeholders to discuss the needs of the organization and understand the development of the strategic directions based on the province's strategic directions. This time together also allows the organizations involved to conduct at least informal evaluations of their relationships and is applauded. The Board Chair has indicated the Board's intention to conduct the meetings in the different parts of the region, holding information with the town's stakeholders ,a public meeting and the Board meeting.

The Board receives the Quarterly Dashboard Report with information on the programs volumes.

Security guards have been hired for the La Ronge facility. Training was obtained in Regina in self-defence and verbal judo. They patrol the site and grounds, are visible to staff coming and going, checking vehicles, fire extinguishers, etc. A plan to move to swipe cards for access to certain areas, such as drug cupboards and main doors is in the planning stages and is encouraged.

There is a Privacy Coordinator for the region for which all questions and concerns regarding confidentiality are directed to her. A privacy breach package has been received from the province and is utilized if a breach occurs.

There is a regional information service provided out of La Ronge with three employees. All inquiries to the help desk initially go to the help desk in Regina and if unable to be dealt with through an online process, one of the three employees in La Ronge follows through and resolves the problem. Trips are made to the other sites as necessary and preventative visits have begun. For example, Population Health is visited every Friday morning and one trip to both Sandy Bay and Pinehouse is planned every two months by the dedicated IT staff.

The community partners interviewed expressed concern with lack of representation on external committees of employees who have authority to make decisions or the expertise needed to make the decisions. They sense the Region is pulling back and this is affecting the partners' abilities to advance their work for clients in their opinion.

Beds and housing are considered by the community partners to be the biggest problem areas in the region. They cite limited palliative care beds and a 60 day wait time for respite and no opportunities for Mental health supportive living. The partners wonder how they are going to work toward resolving the problems without the right people at the table. When are staff who are enabled to make decisions going to be representing MCRHR again so they can get on with group decisions and plans on behalf of the community, they ask.? The organization is encouraged to work with the partners to ensure these concerns are addressed and MCRHR staff who are enabled to make decisions are deployed to these committees with the community partners.

No Unmet Criteria for this Priority Process.

Physical Environment

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

Surveyor Comments

The physical space at La Ronge Hospital is well maintained by plant and maintenance staff. Staff take pride in the facility and this is evident in the state of the building. Safety is a priority, for both patients and staff. There are comprehensive reports for fire inspection, drills, elevator inspection, generator batteries, oxygen usage, driver certification of hospital vehicles, and time allotted for staff to be certified or recertified in a number of patient /staff safety initiatives including, WHMIS.

The premises are clean and inviting as are the grounds.

At Pinehouse the site is well maintained and staff have spearheaded a community Green Team to minimize the impact on the environment.

Physical Environment: Creighton and Sandy Bay

Creighton Health Centre is a one story office building aged perhaps 20 years, which houses public health, oral health, home care and some other services including justice. The space is mainly offices with a few clinic rooms. It is well laid out, well lit and furnished, clean and in good condition. There are no concerns. The vaccine fridge has temperature regulation and is locked, and since the building has no backup generator, there is a call system in case of power failure. The facility has all the commonly used equipment for a paper based office; there are computers, but the health records are not electronic. There is a bank of cell phones for home care staff. There are paper message boards for each staff member in home care as the manager makes an effort not to call them at home.

Sandy Bay is an isolated community at the "end of the road". There is a paved runway with several flights weekly, and the community is situated on the shore of a large lake in a pristine and beautiful setting. The population is believed to be approximately 2200 and increasing. All roads are dirt roads. While the public buildings are in good shape, housing is poorly maintained and in short supply. There is one grocery store. The community is administered between municipality and a First Nation band. There is a municipal administration and a band administration (Peter Ballantyne Cree Nations).

The Sandy Bay Health Centre is a 30 year old one story building leased from the Ministry of Government Services. The Mental Health and Addictions services are provided in a trailer home adjacent to the Health Centre. The "trailer" is spacious and well-kept with comfortable meeting space, but was quite warm during the visit; portable air conditioners have been purchased and are about to be installed. Both buildings are handicapped accessible.

The Health Centre recently had a new roof and siding installed and many internal renovations have been done. Every corner of the space is utilized for clinical programs, including a resuscitation area, three clinic examining areas, several washrooms, one with a pass through hatch to the small laboratory, a handicapped accessible tub (for the use of Home Care clients), a locked medication room, maintenance space, a backup generator, and offices for staff, including four advanced practice nurses, an educator, and support staff. Furnishings are generally utilitarian but adequate. There is hand sanitizer everywhere and staff were observed to use it frequently. There is a good sized staff kitchen/lounge. Equipment was current and is regularly checked. There was a good inventory of commonly used supplies. The vaccine fridge is locked and temperature regulated. Health records are paper based but there are several computers for staff use. The nursing staff perform medication reconciliation. A clerical staff member distributes packaged prescription drugs which have been dispensed from a pharmacy in Flin Flon, MB

Areas for improvement

La Ronge: Spaces are fairly generous in which staff work with the exception of the Emergency Department which is in need of a redesign to accommodate the ambulance entry, new waiting area and most importantly a washroom for patients being treated in the treatment areas.

The LTC dining and open living area is a large area which was originally intended to be a dining area and was not being well utilized. An accordion door between the current dining room and kitchen is continually splashed with food and is difficult to keep clean. This is an infection control problem which the team is encouraged to resolve.

In Pinehouse space is limited for the outpatient services/clinics that are provided. Privacy is an issue for the staff due to lack of soundproofing between the rooms that are used for Mental Health and addictions counselling. Renovations have been recommended but not approved to date. Staff are aware of the need to include infection prevention prior to proceeding with any further renovations on site.

No Unmet Criteria for this Priority Process.

Emergency Preparedness

Dealing with emergencies and other aspects of public safety.

Surveyor Comments

The region is to be commended on their work in the area of Emergency Preparedness. They have just recently updated their regional emergency response plan and as well have a "tri-city" community plan in place with the community partners of Air Ronge, La Ronge and Lac La Ronge Indian Band.

As well, the Emergency Preparedness Coordinator has commenced work with community leaders in the outlying sites to assist in development of integrated community emergency response plans and the organization is encouraged to continue to work with the community leaders to ensure they are aware of and informed of their community leadership responsibilities in emergency preparedness. This will assist in establishing a clear chain of command when wide spread disasters occur.

The Region has established a variety of communication strategies that include print, radio, training sessions as well as yearly public service announcements specific to the risks and threats of an upcoming season. The Population Health Unit assists in the PSAs.

The regional emergency response plan is based on the uniform emergency code for 'Canadian Health Care Facilities and Agencies' and staff are educated to the codes and responses through practice of some of these as well as through the highly visible "Rapid Response Guide" posted throughout the facilities. This guide and the accompanying documents delineate roles and responsibilities for staff in a disaster or emergency situation.

There is regular annual testing of fire panels, sprinkler heads etc. and as well fire extinguishers are checked at least monthly as evidenced by the full documentation and records of these checks.

The Region leases the physical space (primarily from the Ministry of Government Services) at the outlying sites such as Pinehouse and Sandy Bay and Creighton and through the lease agreements these sites are required to be maintained for building public safety such as lighting, fire etc. However, when the Region utilizes alternate space for group training or public educational opportunities such as the Legion Hall etc. the Region relies that fire safety regulations have been met by the owner. The region is encouraged to verify this.

The Region does hold regular fire drills monthly. There are fire plans developed for each site. A major mock exercise was last held in 2008 and following the debriefing, plan revisions and changes were implemented. They did have a community evacuation due to forest fires approximately 3 years ago. A major mock exercise is planned for July 2011 and as well, there is a mock exercise and training plan that will implement drills and exercises every 30 days (as per a new provincial directive)

The Region has a robust Pandemic plan that was implemented during the 2009-10 H1N1 outbreak. Outbreaks and Pandemics plans are based on national guidelines and developed with assistance from the Population Health Unit.

There are ongoing practice drills for fire on a consistent basis; however, not all emergency codes are exercised regularly at this time such as the less frequently called codes, for example code purple or code black. There is a plan to commence this on a regular and routine schedule. Staff would benefit from additional learning through drills and exercising of even those codes that are used more frequently such as code blue.

The Region is to be commended for the First Responder training and network of providers they have established throughout the Region.

The Region has a well-developed Bio Hazard plan inclusive of training, transportation, resources and personal protective equipment. They have just recently invested in new fully lockable bio hazard cleaning carts for housekeeping. There are spill kits available throughout the facility for any blood and body fluid spills as well as eye wash stations, WHIMS information, and certification of trained staff.

Since the last accreditation, the region has established a senior administration on call roster for the region which is working well and has provided support to staff throughout the region including outlying sites. As well they have developed emergent evacuation bed roll bundles in conjunction with the laundry service in Prince Albert where 1000 such bundles are stored for use throughout the region and the North. As well the Region has adopted the Incident Command system for their Emergency Operations Centre which is working well.
The Region has active Occupational Health and Safety committees to ensure the OH&S standards are met.

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

Criteria	Location	Priority for Action
Effective Organization		
When the organization uses an office in a public building to provide services, the organization's leaders regularly verify fire safety precautions with the property manager, e.g. lighted exit signs, emergency lighting in stairwells, and regularly maintained fire extinguishers that are centrally located and well-marked.	11.7	↑
The organization's leaders regularly test the organization's disaster and emergency plans with drills and exercises.	11.8	↑
Emergency Department		
The team participates in regular practice drills of the emergency preparedness plan.	2.6	↑

Emergency Medical Services		
The team conducts regular disaster exercises at least once per year.	2.3	
Public Health Services		
The organization annually tests the plan using one or more simulations.	14.8	↑
The organization, with its partners, reviews and revises the plan at least every two years, and more often if necessary.	14.9	↑

Patient Flow

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

Surveyor Comments

There are sixteen adult acute care beds, fourteen long term care beds, four paediatric, three obstetrical, and four special care unit beds at La Ronge Hospital. The special care unit beds are designed to care for the short stay admissions including patients who require a longer period of observation and may be able to avoid admission.
Currently acute care capacity and emergency department wait to see a physician are not an issue. However, access to Long term care beds is cited as an issue with 29 patients waiting in for placement in the community. Waits for Primary Health appointments within the local Health Clinic are an issue. The Primary Health Clinic is moving into a new facility in the near future and will be implementing an integrated Collaborative Model of Care which will improve the access to Primary Care.

While transportation is still an issue in the North there have been significant improvements made. The staff speak positively about the intermediate airvac service that was instituted to assist response times providing a more timely service for the non-critical patient in the outlying communities.

The Emergency Department at La Ronge works closely with many community partners including RCMP, Victim Services, Home and Community Care and Youth Services for youth with substance use and abuse.

Another one of the successes is the travelling specialist program at the La Ronge site. Several specialists provide services on a rotational basis which increases access including: psychiatrist, ENT specialists, Paediatricians, Surgeons, Gynaecologists etc.

Patients have access to their health records and often the physician will assist the patient with the interpretation of the health record.

Access to diagnostic services was not a concern except for access to ultrasound. A new ultrasound machine has been purchased but staffing is only provided on a half time basis which is cited as an issue as currently approximately 50% of patients are transported to Prince Albert.

The physicians are also requesting access to Fetal Firbronectin and Lactate testing. The Picture Archiving Communication system (PACs) implementation went well and has made a positive impact around access to local services and the receipt of timely diagnostic results.

Some barriers to patient flow were identified including; emergency department staffing levels can be insufficient on occasion and there is a need to call in additional staff, sexual assault examinations require dedicated consistent staff, which takes staff away from the emergency department for significant periods of time, other issue is to access to mental health support after hours.

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

Criteria	Location	Priority for Action
Diagnostic Imaging Services		
The team tracks wait times and average response times to requests for diagnostic imaging services.	2.1	↑

Medical Devices and Equipment

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

Surveyor Comments

There are dedicated staff that are knowledgeable in their role of sterilization and reprocessing of medical devices and equipment. Planning for equipment needs and new procedures is completed by the site director associated with the service. La Ronge has one gastroscope, with guidelines developed around cleaning. This scope is only used for pre-booked Gastroscopies and is manually cleaned following each use.

Since the last Accreditation Canada visit they have completed some minor renovations to separate the decontamination room from the sterilization room. Staff working in Sterilization, have taken a Sterilization and Reprocessing course. New staff, who provide coverage on a casual or infrequent basis are required to minimally complete a short onsite training education. It is difficult to ensure staff covering during vacation or on weekends have completed a course in Sterilization and Reprocessing, but it is encouraged. Efforts have been made to provide a shorter onsite course, but the full certification would be preferred. Flash Sterilization does not occur on site. The majority of instruments are transferred to the Decontamination area from the inpatient areas in a closed container. The Central Supply and Reprocessing department at La Ronge is also responsible for cleaning instruments from other facilities. The instruments transferred in from the outlying areas are pre washed and transported in covered containers. Non reusable instruments are widely used in the smaller outlying facilities.

Policies have been established to ensure materials management staff, reprocessing staff, managers and infection control practitioners shall be aware of the usual lifespan of all reprocessing equipment. Canadian Standards Association reprocessing standards are used to determine the type and size of reprocessing equipment required based on the demands and type of equipment reprocessed. Preventative maintenance schedules are in place and recall procedures have been established.

The dental clinic has dedicated and knowledgeable staff. They have well established sterilization and reprocessing processes in the dental outpatient clinic at La Ronge and the dental clinics in the surrounding areas as well. Processes and quality improvement audits and activities are documented.

The cleaning of probes in the ultrasound department of diagnostic imaging is completed according to a set of guidelines. Cleaning solutions are dated and records are retained related to solution testing etc.

The organization appears to have a good process related to the selection of new and replacement of old equipment. They utilize a tool to assist with the prioritization process which includes the following criteria: impact on patient care, human resources, governance, infrastructure and financial resources. Preventative maintenance occurs on a regular basis and there is a process established for equipment that is malfunctioning.

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

Criteria	Location	Priority for Action
Emergency Medical Services		
The team documents and keeps current records of all preventative maintenance and cleaning for vehicles, medical equipment and communication equipment.	11.8	

Horizontal Integration of Care

Findings

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

Population Health and Wellness

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

Surveyor Comments

The Regional Public Health staff work in collaboration with the health staff in First Nation Communities. An increased level of integration and partnership occurred during the H1N1 outbreak as the two teams worked closely together to schedule clinics and immunize community members.

The Public health staff work closely with the Population Health Unit to identify areas of needed focus.

Public Health is to be commended on their multidisciplinary approach to pre-natal education classes. They provide a comprehensive program in a variety of formats (for example pre-natal days, variable timing of classes) with an extensive roster of program partners including dental health, nutritionist, mental health and addictions. A screening of pre-natal needs is completed and appropriate referrals made. Post natal partnership with Kids First provides home based programs for new parents to assist them in coping with their new role, assist in sustaining breastfeeding, and assistance to promote a healthy start for the newborn.

A number of programs utilize screening tools to assist in defining client and community needs as well as a harm reduction approach.

Public Health offers a full immunization program. Work and effort have been directed to ensuring cold chain vaccine security. Vaccine is stored in locked, temperature controlled fridges and with the exception of Creighton all sites have back up power, however in Creighton there is a call system in place in case of power failure. The Region may also wish to look at a back-up plan to re-locate the vaccines to an appropriate health facility in the neighbouring community of Flin Flon. Temperature controlled transport carriers have been implemented.

The Region has invested in an extensive sexual health program with the education sector. There is a full curriculum taught in the schools beginning in the early grades. Many successes are reported.
Many positive advances have been achieved by the Public Health Inspectors to ensure compliance with regulations, health protection laws and ordinances across the communities.

This region is one of three in Northern Saskatchewan who works closely with the Population Health Unit of Northern Saskatchewan. This unit provides a wealth of research, data and health status indicators.

The unit also participates with many other sectors and government agencies to conduct and review research, environmental impact assessments and human health risk assessments that involve northern communities and residents. The unit also provides opportunities for students at both the undergraduate and graduate levels in various disciplines including public health inspection, nursing, medicine, public health, health promotion and epidemiology. They have become a well-respected 'authority' and 'expert body' of influence and reference for Saskatchewan Health as well as other northern, rural and remote areas of Canada and internationally.

No Unmet Criteria for this Priority Process.

Direct Service Provision

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

Findings

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

Community Health Services

Clinical Leadership

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

Surveyor Comments

There is a complement of health professionals with this team that serves to enrich it and provide a health environment for collaborative efforts in programming. The team has a number of team members who are relatively new to their positions and who bring enthusiasm and energy to complement the solid foundational leadership already within the team. Since there are a number of new members on the team they are in the process of developing their goals and objectives around the strategic priorities of the region as well as the identified needs of the clientele. The health promotion team is working together to develop their action plan.

The team is appreciative of the grant dollars forwarded to them from the Region for health promotion work and program delivery.

The Health Promotion team has welcomed a colleague who is employed through a three year Health Canada Illicit Drug prevention project and who adds another dimension for the team.

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

Criteria	Location	Priority for Action
The team's goals and objectives for community health services are measurable and specific.	2.2	

Competency

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

Surveyor Comments

The team leader provides positive feedback for team members and demonstrates support and pride in their achievements. A formal review process is yet to be implemented.

Team members have opportunity for professional development.

This team is encouraged to complete the formal development of their team action plans and set their annual goals and targets including an evaluation process.

Staff are appreciative of and have access to leadership and mentorship training and professional development opportunities.

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

Criteria	Location	Priority for Action
The interdisciplinary team follows a formal process to regularly evaluate its functioning, identify priorities for action, and make improvements.	3.7	
Team leaders regularly evaluate and document each team member's performance in an objective, interactive, and positive way.	4.7	

Episode of Care

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

Surveyor Comments

Team members engage community stakeholders through a variety of methods including group work, engagement in the school classrooms, print and verbal materials, radio and television coverage. As well they work closely with providers of health and community services in the First Nation communities.

There is a sexual health program that is a school curriculum and taught by the teachers with support from the region's sexual health educator which is one example of partnerships that have been cultivated by the Health Region.

The team provides many community focused services such as cooking classes, youth programs and events that emphasize healthy living. The team works with the community to plan the content and timing of events and program delivery. For example the Diabetic Education Network (DEN) worked with the community to determine the location and time of classes as well as special speakers and content offered.

DEN classes have attracted community members beyond those who are diabetic and who are interested in learning about healthy diets and meal preparation. This is a commendable achievement! The DEN client who was interviewed by the surveyor reported finding the classes helpful and comprehensive and credited the classes for his broad knowledge of diabetes, kidney health, meal preparation and blood values and testing.

In Pinehouse where this survey visited, there are many positive accomplishments achieved through the teams' work with their community through the Interagency Council as well as a Health Advocate Group. The community of Sandy Bay has also implemented a Health Advocate Committee that one of the Board members indicated are in the process of jointly implementing strategies that will impact the health of the community members.

In Pinehouse the team's work with the community at every level is evident and vibrantly shines through in the program outcomes they have achieved. They have developed a true model of integrated health service delivery that addresses the full spectrum of the determinants of health and hence have a profound impact on the health status of the residents of Pinehouse, from the community Elder Care that is evident, the child care, the Home care, Mental health and youth programs at the school and community levels as well as care of the residents' physical needs.

Through their community and health team's integrated approach they address issues of addiction, employment, healthy lifestyle as well as other determinants of health. Further community achievements are yet in the planning such as a regulation size running track.

No Unmet Criteria for this Priority Process.

Decision Support

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

Surveyor Comments

The team uses the 40 Developmental Assets student profile to gather the information and evidence to direct programming and initiatives. Programs are then developed and tailored to address the areas of demonstrated need for each student group.

As well the team utilizes the health indicators reports and research from the Regional Population Health Unit.

No Unmet Criteria for this Priority Process.

Impact on Outcomes

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

Surveyor Comments

The team has access to a volume of community based research and are awaiting the updated Health indicator report which will be released in 2011. As well the Developmental Assets youth survey has been completed across the schools in the region which provides community based information for program development.

The team utilizes a harm reduction approach in many of their programs an example being the needle exchange program.

The team members are each able to relate cases where significant positive progress and outcomes have been achieved. Team members report that community members will approach them in the grocery store and elsewhere in the community demonstrating the level of trust the community members have in the professional staff and their expertise.

These team members are very interconnected with community partners and stakeholders. They are to be commended for their high level of integration which builds community capacity and promotes sustainability.

No Unmet Criteria for this Priority Process.

Customized Managing Medications

Medication Management

Interdisciplinary provision of medication to clients.

Surveyor Comments

The team is clear that physicians, nurses and the pharmacy technician are all responsible for ensuring that medications are safely administered. There is no pharmacist on staff.

On admission, home medications are retained in a sealed bag in the medication room till they are ready for discharge. If a medication is no longer appropriate it is disposed of as a biohazard. If clients are taking non formulary medications, either these meds are ordered from community pharmacies or equivalent hospital stock is used.

Medication rooms on acute and long term care and in the Emergency Department meet standards. Narcotics are kept in locked cupboards. Medication rooms are locked and are accessible only to staff. Medication order sheets and prescription pads (from the La Ronge Clinic) are available as stationery at the nursing stations.

Heparin concentrations are limited to a maximum of 10,000 units per ml. Enoxaparin is the most frequently used type of heparin. Opioid concentrations have been audited and standardized as much as possible; the maximum morphine concentration available is 15 mg/ml.

The organization has a policy on prohibited abbreviations, but it has not been audited.

There is no pharmacist on staff and none on call. The organization has outsourced pharmacy services to a community pharmacy in Prince Albert, which employs a pharmacy technician on site at La Ronge. Her work is supervised by the pharmacist in Prince Albert. Informal calls to community pharmacists occur out of hours. The CPS directory is in the medication room. The team has contracted with Vancouver Island Health Authority to receive and use its drug monographs. These are kept up to date with regular revisions from VIHA. Several Saskatchewan organizations use the VIHA monographs. Other information sources include eMedicine and Lexicomp. These are used principally by physicians.

Staff and physicians are aware of the process for reporting an adverse event associated with medication administration. A serious incident occurred months ago and the physician disclosed the error to the family. There is organizational support for review and mitigation of serious incidents and policy on disclosure.

When patients require chemotherapy, they are generally started on their course of treatment at the tertiary care centre. They purchase their medications from one of the two local pharmacies and IV medications are administered on the acute care unit on an ambulatory basis. The team does not feel confident about this process.

The charts of several older patients reviewed revealed that they were taking many medications. Patients report receiving some written information at the start of treatment. Staff and physicians report providing informal verbal education but there is no standardized educational program. Patients receive their regular oral medications in blister packs. They are often unaware of the reasons they are taking the medications. One patient reported regular review of his medications in his home community. Patients do not administer their own medications while hospitalized.

The team uses the provincial drug management system to print a medication profile for clients who present for admission. This document does not include doses; these are inserted by the physician, who also decides whether the medication is continued or discontinued. New medications may be added. The physician signs off on this document, which is set up as an order sheet. However, the practice is to rewrite all the medications on a green order sheet in the chart. This provides another opportunity for a transcription error.

Allergies are well documented in the provincial pharmacy system. The physicians can access this at their clinic and in the hospital. When a patient has a medication allergy, a coloured sticker is placed on his or her chart. Two identifiers, usually the wristband and a verbal verification, are used when administering medications. Room numbers are not used as sole identifiers. In the medication room, medication drawers are labelled with the name and room number of the individual patient.

The team identified several concerns. First, there is a Pharmacy and Therapeutics Committee (which does not include a pharmacist) but it has not held a meeting for over a year. The absence of a pharmacist makes the team very reliant on external information to support policy making. Protocols are adapted from several organizations across the province and across the country. Sets of standing orders are in place, e.g. for heparin administration and insulin administration. However, they do not show the accountability, the date of approval or the date of review. Hence, there is a danger that out dated or inappropriate protocols could be used.

Second, the team is concerned about the absence of CPOE (Computer Physician Order Entry). It can be very beneficial in reducing medication errors when properly implemented, but it does not replace basic safeguards and indeed may introduce many new ways to make an error.

Third, the team is caring for a large number of patients on the methadone withdrawal program. There are currently 23 people on the waiting list. Local pharmacies cannot cope with these numbers and the team feels they need some inpatient resources for these patients. Of note, the policy is that pregnant women on the methadone program deliver at a tertiary care centre.

Fourth, the team needs better systems in place to administer chemotherapy. There are no certified chemotherapy nurses.

The team would really benefit from having enhanced pharmacy services.

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

Criteria	Location	Priority for Action
The organization removes concentrated electrolytes (including, but not limited to, potassium chloride, potassium phosphate, sodium chloride >0.9%) from client service areas.	1.8	↑
There are no concentrated electrolytes stored in client service areas.	1.8.1	
The organization has identified and implemented a list of abbreviations, symbols, and dose designations that are not to be used in the organization.	1.10	↑
The organization educates staff about the list at orientation and when changes are made to the list.	1.10.5	
The organization updates the list and implements necessary changes to the organization's processes.	1.10.6	

The organization audits compliance with the Do Not Use List and implements process changes based on identified issues.	1.10.7	
Team members document in the client record verbal or written information about medication that is provided to the client.	3.5	↑
The organization has a quality control program for managing medications.	9.1	
The organization selects and monitors process and outcome performance indicators for managing medications.	9.2	
The organization regularly monitors adherence to its policies and procedures for medications.	9.3	
The organization monitors medication use with an ongoing medication utilization review.	9.4	
Based on the data collected and analyzed, the organization identifies and addresses areas for improvement.	9.5	

Diagnostic Imaging Services

Impact on Outcomes

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

Surveyor Comments

The team's work is very focused; only plain X-ray and ultrasound are performed. There is no radiologist in the health region, so interpretation of these studies is by radiologists in Saskatoon or Prince Albert Health Region. There are no audits of the impact of the services.

No Unmet Criteria for this Priority Process.

Diagnostic Services - Diagnostic Imaging

Availability of diagnostic imaging to provide health care practitioners with information about the presence, severity, and causes of health problems, and the procedures and processes used by these services.

Surveyor Comments

The Diagnostic Imaging team has a very focused mandate, to deliver timely service in plain X-ray and ultrasound. The equipment in use is up to date and well maintained, as is the physical plant. A portable X-ray machine is also available. A quality control program is carried out, addressing mainly the image quality and radiation dosing. Records are assiduously maintained.

The technology staff are CLXTs (Combined Lab and X-ray Technicians) and they maintain a high level of competency. They are on call every fourth or fifth night and are required to work through the next day. This is often challenging as their nights on call tend to be very busy. Approximately twenty X-rays per weekday or 5000 per year are done. Access to X-rays is very prompt.

There is only one ultrasound technician, who is also the manager. She does approximately 1000 ultrasound examinations per annum. The demand is significantly more. It has been impossible to recruit additional ultrasound technicians. Currently, only 40% of the ultrasound examinations requested can be accommodated. Many patients are referred to other centres for ultrasound.

Since there is no radiologist within the health region, the recent advent of PACS has been a godsend. This has decreased the time from imaging to reporting from five days to less than 24 hours.

No nuclear medicine or MRI is carried out, and the only piece of equipment that is used inside the body is an endovaginal probe. This is disinfected in the clinical area by the ultrasound technologist, who is also the manager. Patient specific records of the disinfection are not available.

There is a radiology safety program which is well documented. There is no utilization review.

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

Criteria	Location	Priority for Action
The team regularly surveys referring medical professionals about their needs related to diagnostic imaging services.	1.2	
The team's service providers meet at least quarterly to discuss trends in service demand, and changes its services accordingly.	1.3	
The medical director is an imaging specialist credentialed by the appropriate professional college or association.	3.2	↑
The team identifies and verifies the education and competency of staff involved in reprocessing of diagnostic imaging equipment and devices.	7.4	
All DI reprocessing areas are physically separate from client care areas.	7.5	↑
For each contaminated DI device and piece of equipment, a trained staff person uses a recognized classification system to determine the type of reprocessing that is required, i.e. sterilization, or high- or low-level disinfection.	7.7	↑

Before storage, a qualified staff member rinses each DI device or piece of equipment using sterile water or water filtered using a submicron filter.	7.12	↑
The record of reprocessing includes the identification number and type of device or piece of equipment, the identification of the automated device reprocessor if applicable, date and time of the clinical procedure, the name or unique identifier of the client, and the name of the person responsible for reprocessing.	7.15	
The team follows a specific procedure for persons assisting during imaging examinations.	10.5	
The team documents the communication of results to referring medical professionals.	11.4	
The team informs and educates its clients and families in writing and verbally about the client and family's role in promoting safety.	14.6	↑
Written and verbal information is provided to clients and families about their role in promoting safety.	14.6.1	
Staff uses written and verbal approaches to inform and educate clients about their role in promoting safety.	14.6.2	
Clients indicate that they have received written and verbal communication about their role in promoting safety.	14.6.3	
The team involves clients, families, and other organizations when evaluating its diagnostic imaging services.	16.2	↑
The team collects, analyzes, and interprets data on the appropriateness of examinations, the accuracy of the interpretations, and the incidence of complications and adverse events.	16.3	↑
The team monitors service outcomes.	16.4	↑
The team uses a utilization management or review process to monitor diagnostic imaging services.	16.5	

Emergency Department

Clinical Leadership

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

Surveyor Comments

At the Pinehouse Health Centre, the staff work closely with the community and are very familiar with the clients they serve. Many of the services in the health centre are focused on the needs of the community and individual clients. There is an inter- agency committee within the community who partner on many initiatives to promote a healthier community. The staff are wanting to move forward with a Patient and Family Centered Model of Care, but in many ways they demonstrate this in their day to day interactions with their clients.

The staff at Pinehouse are required at times to provide pre hospital care and transport clients to the facility for Emergency Care. They transport patients in a horizontal transport vehicle. The vehicle is older and is somewhat unreliable. While staff value their ability to provide this service they are concerned about the reliability of this vehicle and potential risk if it breaks down while on transport to or from a home in the community, or airport. The community should be commended for the dedication and innovation but are urged to consider upgrading the vehicle when possible.

At the La Ronge site the physical space is limited and is lacking a washroom in the direct patient care area. Team members were able to identify patients at risk of infection and what personal protective equipment would be required. Patients are registered upon arrival and Triage occurs following registration, usually at the same time as the secondary nursing assessment. Due to volume and staffing level the staff believe this is the safest and most efficient process. Staff and physicians indicate that they have access to the equipment needed and have input into the equipment required.

Regionally, minimal information is collected around emergency department patients. At La Ronge there were 11,000 patient visits during the last fiscal year and it is estimated that approximately 80% of the patients are a lower acuity level 4 or 5. CTAS is not completed on a consistent basis and staff do not seem to recognize the importance of collecting and reporting information around the Canadian Triage Acuity Scale (CTAS) .

Staff are encouraged to use CTAS on a consistent basis as it has been adopted across the country in emergencies departments of various sizes. In addition to using CTAS, the organization is encouraged to consider how to provide this information back to the providers, to ensure information is available around wait times for care are it is monitored on a ongoing basis.

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

Criteria	Location	Priority for Action
The team works together to develop goals and objectives.	2.1	
The team has the workspace needed to deliver effective services in the Emergency Department.	2.8	

Competency

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

Surveyor Comments

At La Ronge, nurses receive an orientation upon hire. The nursing staff have access to educational opportunities including ACLS, ATLS and PALs etc. to support competency development and sustain skills and abilities. There are 2 RNs and 2 LPNs who cover both the ED and the medical unit. Staff are a close knit team who adjust their assignments to assist in either the ED or Medicine Unit as required.

Performance reviews provided at Pinehouse provide an opportunity for staff to identify their level of competency and educational opportunities to support their learning. The staff utilize the Clinical Practice Guidelines for Nurses in Primary Care (2004) by the First Nations and Inuit Health. They manage patients independently after completing the Medical Transfer of Function. As required the Physicians at La Ronge provide medical oversight for the nursing staff at Pinehouse. The staff are very complimentary around the provision of medical oversight obtained from La Ronge.

Staff indicate they have received some training related to IV pumps on hire or when new pumps are purchased, but the training is not documented as required. The region is encouraged to continue to provide the ongoing training on IV pumps and to develop a mechanism to track the IV pump training.

The majority of staff have not received a performance appraisal in the last few years.

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

Criteria	Location	Priority for Action
Staff and service providers receive ongoing, effective training on infusion pumps.	4.5	↑
There is documented evidence of ongoing, effective training on infusion pumps.	4.5.1	
Team leaders regularly evaluate and document each team member's performance in an objective, interactive, and positive way.	4.12	

Episode of Care

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

Surveyor Comments

At PInehouse the staff provide after hours call for emergencies with medical oversight provided by the physicians at La Ronge if required. At times staff are required to provide pre-hospital assessment and transport to the hospital.

Data related to ED wait times and length of stay is not collected routinely. The Canadian Triage and Acuity Scale (CTAS) is not used on a consistent basis. There is no policy or process established to ensure that the patients CTAS scores are re-assessed while they are waiting for care. Staff state that rarely patients wait beyond the CTAS wait time guidelines, and are proud of the prompt service they are able to provide on most days to their Emergency Patients.

Ambulance delays are infrequent and not tracked. Care is transferred verbally between the EMS staff and the ED staff.

Medication Reconciliation is completed on admission and on transfer. This is a newer process and the staff are to be complemented for their efforts in this area, and encouraged to continue to ensure compliance to this requirement. Nurses document the transfer of care on the medical units but ED documentation upon transfer of care is absent

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

Criteria	Location	Priority for Action
The team sets, tracks, and benchmarks data related to waiting times for services and information, and the length of stay (LOS) in the Emergency Department.	6.11	
The team uses the Canadian Triage and Acuity Score (CTAS) to conduct the triage assessment.	7.1	
The team conducts a triage assessment for each client within CTAS timelines.	7.2	
The team has a policy and process to ensure that client CTAS scores are re-assessed.	7.8	
The team records the CTAS and re-assessments in the client record.	7.9	
The team transfers information effectively among service providers at transition points.	11.8	↑
There is documented evidence that timely transfer of information occurs.	11.8.3	

Decision Support

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

Surveyor Comments

At La Ronge, access to emergency care is good with 24/7 physician coverage. Physician coverage is provided by a pool of physicians and the service is continuous, without gaps. Two physicians are on call at all times, with the second physician able to provide back up as required. CTAS levels and wait times are not currently tracked or used across sites for comparisons. Ambulance off load delays or ED wait times are not cited as an issue within the health authority.

The team at La Ronge is not currently using a wide variety of evidence based guidelines or protocols and are encouraged to implement more as capacity permits. They have indicated they are in process of going to the Pharmacy and Therapeutics Committee with a Sepsis Protocol for implementation in the near future. Nursing documentation will be revised going forward prior to electronic charting. Nursing staff are encouraged to review other documentation forms and processes to ensure their documentation includes the required elements, as per ED nursing documentation standards.

The staff at Pinehouse provide documented case histories when patients are transferred to a higher level of care. Nursing charting is completed in an inconsistent format at Pinehouse. There may be an opportunity to standardize the documentation form with clear guidelines around what should be charted where. On an INR (International Normalized Ratio) record there was no mention of the drug administered. The dosage and time when the drug was administered was signed off but the name of the drug was not mentioned. When patients are transferred to a higher level of care, there is a significant delay in Pinehouse receiving a summary related to the recent hospitalization.

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

Criteria	Location	Priority for Action
The organization has a process to select evidence-based guidelines for Emergency Department services.	14.1	
The team reviews its guidelines to make sure they are up-to-date and reflect current research and best practice information.	14.2	
The team's guideline review process includes seeking input from staff and service providers about the applicability of the guidelines and their ease of use.	14.3	

Impact on Outcomes

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

Surveyor Comments

All staff are trained to manage violent and aggressive behaviour, which is a mandatory staff education requirement. While the team acknowledges issues around safety and risk are discussed at monthly staff meetings, they are not discussed on a regular basis in a safety briefing on the unit. Patient satisfaction has been surveyed in the past, but the response rate was very low so the team is now considering alternate ways to obtain the patient perspective around the quality of services. Patients interviewed at the time of this survey stated the care they received was excellent.

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

Criteria	Location	Priority for Action
The team uses at least two client identifiers before providing any services or procedures.	10.4	↑
The team uses at least two client identifiers before providing any service or procedure.	10.4.1	
The team shares benchmark and best practice information with its partners and other organizations.	14.5	
Staff and service providers participate in regular safety briefings to share information about potential safety problems, reduce the risk of error, and improve the quality of service.	15.3	↑
The team identifies and monitors process and outcome measures for its Emergency Department services.	16.1	↑
The team monitors clients' perspectives on the quality of Emergency Department services.	16.2	
The team compares its results with other similar interventions, programs, or organizations.	16.3	↑
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.	16.4	↑

Organ and Tissue Donation

Donation services provided from identification of a potential donor to donor management and organ recovery.

Surveyor Comments

Critical Care is not provided at La Ronge. All potential organ donors would be stabilized and transferred out to a higher level of care. Family members may be approached around their wishes related to organ donation and consultation would occur with a tertiary care facility following. Recently a staff education session was held at La Ronge pertaining to organ donation.

No Unmet Criteria for this Priority Process.

Emergency Medical Services

Clinical Leadership

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

Surveyor Comments

The organization has made some recent efforts to increase staff involvement in organizational decision making and policy formulation - this was commented on by staff and has led to increased staff engagement. The organization's communication policy covers some practical suggestions to increase internal communication and it is complemented by a suite of community relations policies that when fully implemented should help the organization better involve the local community in organizational decision making.

The partnership between Mamawetan Churchill Regional Health Authority and La Ronge EMS has resulted in increased training opportunities for EMS personnel - examples include EMS attendance at safe handling (patient movement and lifting) training and N95 fit testing.

Online Medical Consultation is available via patch to the local hospitals however the staff do identify challenges in reaching the La Ronge Medical Centre Emergency Department - in particular when La Ronge EMS is transporting a patient into the La Ronge Medical Centre they often lose cellular reception - they are able to maintain communication to other facilities and to Dispatch via radio - however the EMT's report that the staff at the emergency department (ED) do not routinely carry or utilize their radios. This leaves the crew unable to communicate with the La Ronge Medical Centre ED for long stretches of time.

La Ronge EMS does participate in the health region's reporting process - however there remains concern among EMS personnel that the inevitable outcome of reporting an error is discipline and/or possible reporting to and investigation by the College.

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

Criteria	Location	Priority for Action
The team establishes partnerships with other health and public safety agencies to participate in region-wide quality improvement reviews and initiatives.	2.7	
The medical oversight team includes physicians, paramedics, nurses, clinical educators, and clinical performance managers.	4.2	↑
The team has a policy and a process to address continuous physician responsibility and availability during all phases of the patient’s care in the field and during transport.	4.8	

Competency

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

Surveyor Comments

The organization's adaptation of the Northern Employment Opportunities Program for their own purposes in order to increase the number of northern staff in the organization has resulted in improved staff retention.

The personnel files are maintained and current for each staff member. Evidence based performance reviews are conducted on each employee with a focus on learning as evidenced by the provider specific Patient Care Record audit results.

The organization's new hire process is consistently applied - it includes both academic and experiential learning. A particular strength is the Northern Road Policy by which a new employee partners with a senior crew member to experience both care provision and driving while transporting on northern roads. Following five patient transports in the back of the ambulance on a northern road (while being driven by a senior staff member) the new staff member then meets with management to discuss driving. This policy demonstrates the organization's commitment to patient and staff safety as well as the organizational approach to learning.

Although the organization does support education and training within the EMS provider's role there is limited if any support offered for PCPs to advance their skill sets to potentially be hired into ICP roles. This makes it difficult for staff to advance their career while remaining employed with La Ronge EMS.

The creation of the Quality Assurance Coordinator role and the related committees for workplace health and safety and staff relations have resulted in better evaluation of polices, procedures and performance. Staff report greater stability with respect to clinical and business processes as a result.

No Unmet Criteria for this Priority Process.

Episode of Care

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

Surveyor Comments

The EMS crew reports that there is constant communication between the EMS crew and the Communication Centre and identifies a positive working relationship with the local fire departments - this partnership extends to assistance in dealing with hazardous materials and ensuring scene safety. The EMS crew reports that Fire often takes the lead role in any MCI.

There has been ongoing discussion between the organization and the province with respect to the level of service provided by La Ronge EMS - at present the decision taken is to NOT elevate the care level of this service to the Paramedic level. This limits the type of care that EMS can provide. Given recent call volume increases (a reported 45% increase in calls over the last 5 years) an audit to determine the frequency and/or number of calls that may have benefited from a paramedic response (to determine whether the community is receiving the appropriate level of support) may help inform future negotiations with the Province.

Although the crew reports using appropriate PPE when notified that the patient had a known or suspected communicable disease they also reported that more typically they are "going in blind". In addition the ambulance that was toured was not equipped with N95 masks.

There appeared to be good tracking of medications and supplies and a process in place to identify expired products - however while touring the EMS base it was noted that there were expired glucometer test reagents as well as test strips that had been opened without the date of opening being recorded. The QA check on the glucometers was clearly routinely completed on this equipment.

No Unmet Criteria for this Priority Process.

Decision Support

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

Surveyor Comments

EMS providers were well versed in the clinical protocols - a copy was available on each vehicle and provider compliance with these protocols formed part of the quality assurance review process.

No Unmet Criteria for this Priority Process.

Impact on Outcomes

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

Surveyor Comments

The organization uses available information to identify potential improvements to the service model - however their ability to implement is limited when that implementation requires additional resources.

The EMS provider reported that they are currently in the process of renegotiating the contract with the Health Region. Management and staff identified challenges with continuing to operate their service due to aging equipment and vehicles coupled with an increased call volume without a corresponding increase in resource allocation. As an example the EMS provider is funded to operate three ambulances, but routinely needs to put a fourth vehicle into operation. This need has increased lately as a result of increased hospital times when they transport patients to Saskatoon. A policy to notify Saskatoon ED staff earlier in the transport was adopted last week following discussions with the ED around this ongoing issue.

Fatigue management remains a concern of both staff and management - in particular the long shifts required by staff when they transport to Saskatoon by ground coupled with the need to return the vehicle to service in La Ronge causes some concerns. A typical round trip to Saskatoon can take up to 15 hours (a trip reviewed during the survey took 14 hours and 22 minutes) and may come at any point during the EMS personnel's tour of duty. The organization has tried to implement some fatigue management techniques including switching out drivers on the transport - however this becomes difficult given different qualifications of the EMS personnel (i.e. depending on the care being delivered it may not be appropriate for the higher trained individual to take on driving responsibilities).

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

Criteria	Location	Priority for Action
The team follows the organization’s policy and process to disclose adverse events to patients and families.	21.3	↑

Infection Prevention and Control

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

Surveyor Comments

All infection prevention and control criteria are met. The team is applauded.

No Unmet Criteria for this Priority Process.

Home Care Services

Clinical Leadership

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

Surveyor Comments

The Home Care Program has a set of measurable goals and objectives which have been developed with the staff. These are posted within the Home Care office at La Ronge and reviewed regularly. Pinehouse has set measurable goals to have 100% of their home care client assessments completed, as well as 100% of the homes safety checked and TLR processes in place.

The Home Care program in the region offers home care across the continuum and staff follow their clients from the community and into hospital and palliative care providing the 'constant' care giver for their clients. Clients report tremendous support and caring from the Home Care program with no concerns regarding timeliness or access to services. Clients find cost for home services reasonable and affordable. An Adult Day Program (respite) is offered in La Ronge and in Pinehouse they have plans to expand to provide an Adult Day Program and enhance their day respite program when resources are available to do so.

The Home Care Program has just implemented Procura software. This will assist to reduce duplication.

Home Care work is provided primarily by trained Home Health Aides, however the health team is to be complimented as the Home Care program feel they have very timely access to all other team members for their clients such as Mental Health, Nursing and Physicians.

Although there is a printed handout for clients and families, the staff find verbal communication in various languages is most effective. Cree is especially appreciated in Pinehouse. They have on occasion utilized pictorial communication as well.

The Home Care Staff work closely with housing authorities to ensure needed home safety improvements are completed. For examples Pinehouse works with Beaver River Housing when any deficiencies are found in the home Safety Check. Should there be an item that Beaver River Housing is unable to supply or repair, the Home Care staff in Pinehouse have access to a Health Centre Maintenance resource. As well the Home Care Program will connect with family members to assist addressing the deficiencies when needed.

No Unmet Criteria for this Priority Process.

Competency

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

Surveyor Comments

There is an orientation package for new staff which consists of printed program specific materials but as well orientation is provided through the buddy system as well as direct observation.

A recent example of staff education and ongoing training is the implementation of the Procura program. Staff have been trained on site through didactic and hands on training.

The Program does provide performance reviews but they have not been able to complete formal reviews annually as per policy requirement. There is a great deal of informal performance review occurring through regular meetings with staff. As well, staff report that they feel valued and respected through the ongoing feedback and recognition provided as group acknowledgement of achievements and successes. For example two Health Centre staff from Pinehouse have recently been away to participate in a marathon in Rome. The pride of the health staff in these individual's achievement is obvious through conversation. Staff are proud of the work they do and relationships they have with their clients. They have built strong trust relationships with clients which is highly appreciated by the clients.

There is a comprehensive client home risk assessment for falls prevention, a sharps disposal program, electrical plug in checks, smoke detector checks, safe seating, presence and storage of consumables, lighting, home clutter, use of oxygen to name some of the components.

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

Criteria	Location	Priority for Action
The organization regularly evaluates and documents each staff member's performance in an objective, interactive, and positive way.	4.10	

Episode of Care

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

Surveyor Comments

There is a cohesive team in each site within the region who are proud of their achievements in the Home Care program.

In Pinehouse, the Health Staff meet as a full group at minimum once per week. This is very beneficial to the individual team members and to the group as a whole in building, sustaining a healthy team balance.

Many comments were made by different Home Care team members across the region regarding how closely and collaboratively they are able to work across disciplines. Home Care works in a health promotion/ illness prevention and harm reduction model as much as within a service delivery model. They recognize the need to ensure health is maintained so that seniors are able to remain in the community and in their own homes since there are few other options for seniors care within the communities (there is only one long term care facility which is filled to capacity with a long wait list and that is in located in La Ronge). Not all seniors would find re-locating out of their own community to move to LTC desirable even if space was available.

Although the Home Care staff are not responsible for the administration of medications the Home Care nurses do perform medication reconciliation for each client on entry to the program at the site where it is required. If any discrepancies or concerns arise, the physician and/or pharmacist is contacted. Other sites have access to nursing but the program is staffed with Home Health Aides and do not have responsibility for medications. In these sites, medication reconciliation is performed by the Health Unit nursing staff when clients seek their services.

The Home Care staff developed a pain management measurement tool for their program. They are proud of this tool and it works well for them within the program. It is a tool specific to Home Care.

In Pinehouse, although the Home Care staff are not responsible for medications and pain management, they will advise the client to seek medical or nursing assistance for pain management if they observe the client seems to be in more discomfort.

Staff have found written communication less valuable than verbal education for clients and family members in some situations but staff are very in tune with their communities and clients. Staff modify their communication strategies to fit their target populations.

Staff are aware of the reporting and processes regarding sentinel events and near misses. Pinehouse staff related a near miss involving a client and staff injury on ice at a community business when on an outing. The program manager has written a letter to various businesses in town to point out the safety risks at their business and the measures required to mitigate these risks for clients and staff.

The Home Care charts each contain a large coloured photo of the client that is taken to the home with each visit, and as well as a second identifier the staff use the medial number, treaty number, house name and/or by directly addressing the client by name.

Home Care staff in La Ronge reconcile medications upon admission to the program and again following a physician visit or ER visit. Staff do not administer medications and medications are blister packaged.

For Pinehouse clients, medications are blister packed by a pharmacist in Prince Albert and delivered to the Health Centre where the clients pick them up or the Home Care staff deliver them to the client home. The staff do not administer or manage the medications.

Although a variety of patient satisfaction surveys have been tried in the Region with limited success, the Home Care staff do gather verbal client feedback regarding the service. Client visits made by the surveyor in two locations indicated high degree of satisfaction with the Home Care services and staff.

The Home Care staff work with any transferring facility or program to smooth the transition back to the community.

No Unmet Criteria for this Priority Process.

Decision Support

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

Surveyor Comments

The Home Care program is very creative in their use and assignment of resources. They provide support upstream when needed for vulnerable community members, in the emergency department and as well through to palliative care.

No Unmet Criteria for this Priority Process.

Impact on Outcomes

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

Surveyor Comments

The Home Care team have a clearly defined set of goals and objectives which are posted within the department. This program has a relatively new manager who has achieved a number of accomplishments. The charting system has been revamped. It is well organized. There has been implementation of the Procura system and the implement ion of MDS is in the near future. A client pain management scale has been developed for Home Care Clients. An infection control program is in place along with beginning policies and procedures for the program. She has plans for further policy development. Medication reconciliation and two identifiers has been implemented as well as home safety checks.

The Home Care Program does have some statistical indicators that they report quarterly. They are encouraged to develop and monitor process and outcome measures for this service for further program evaluation.

The Home Care Regional Manager involves the La Ronge staff in any program evaluation and the results and is encouraged to formally share these results with staff across all sites.

The program has defined the statistics to be monitored and these are reported quarterly.

This program uses not only a home based delivery model but also works upstream with clients intervening where necessary at the community and ER junctures. As well they follow their clients while in hospital or palliative care and the home care staff are often the only 'constant' for the clients. This is highly appreciated by the clients.

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

Criteria	Location	Priority for Action
The organization identifies and monitors process and outcome measures for its services.	15.1	

Infection Prevention and Control

Infection Prevention and Control

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

Surveyor Comments

A Mamawetan Churchill River Health Region Health Infection Prevention and Control Plan has been developed. There is a Northern Infection Control Committee in place which includes senior representation from the three Northern Health Authorities in the area. The committee meets quarterly and on an ad hoc basis as required. In addition, there is a Regional Infection Control Committee which includes representation from all sites across Mamewetan Churchill River Health Region. This group has a mandate to provide coordination, direction and recommendations. A Regional Infection Control Coordinator has been hired and significant progress has been made by the Infection Control Team and strong leadership is very evident.

An Infection Control for Health Care providers - Self Study Manual has been developed. Certificates are awarded to staff upon completion of this voluntary program.

A hand washing policy is in place and efforts have been made to enhance the awareness. For example newsletters have been developed by Infection Prevention and Control to reinforce the importance of hand washing and bulletins have been used to increase the awareness around the need to cover your cough and the need to keep common areas clean. Efforts are in place across the region to ensure attention is given to hand washing. Some audits have been completed but there is further opportunity in this area to increase the awareness and compliance related to hand washing, to complete further audits and report compliance to the Board.

Staff are aware of the process to identify and report an outbreak. The incidence of infections such as Nosocomial VRE, MRSA and C Difficile has not been a concern within the facility at La Ronge or across the region. Community acquired MRSA has been an issue but the numbers are trending downward now. It is estimated that there has been a 50% decrease in the number of cases within the past two years. They describe a rigorous program targeting students in the local schools to increase the awareness around the importance of proper hand washing and other strategies.

Following an outbreak a debriefing is held which includes all of the stakeholders to discuss lessons learned. An outbreak notification and summary report has been developed by the Ministry of Health and is used by the Mamewetan Health Region. Policies and procedures at the provincial and regional level are available at the sites regarding the management of respiratory and gastrointestinal outbreaks. Staff working at Pinehouse were aware of the procedures for the management of patient who present with suspected infections and the personal protective equipment required.

Infection control is not a concern at Creighton in the public health building. As everywhere else, there is frequent use of hand sanitizers. No acute care is delivered.

The entrance hall of the Sandy Bay Health Centre has prominent signs urging people to use hand sanitizers and to wear a mask if they have a cough. The site, while old, is clean, including a small emergency unit and three examination rooms. There are facilities for washing stained linen and for disposal of biohazards and sharps. Equipment is mostly disposable and disinfection procedures are followed for any that is not.

There is a policy in place across the region related to influenza vaccinations and staff are strongly encouraged to obtain vaccinations.

While hospital based infections have not been an issue at La Ronge, it was identified that the team relies on staff to alert them to outbreaks. Some staff were not able to describe how they would respond to or identify the Personal Protective Equipment required to use before entering a room. When asked about their orientation they were unsure if PPE was included in the orientation but they were able to obtain the Infection Manual quickly. The onsite Infection Prevention Coordinator is accessible and a very knowledgeable resource that staff and managers can call on anytime. Microbiology laboratory specimens are plated and sent to the provincial lab in Regina, which takes a minimum of two days to reach Regina and further time to be process with reports being faxed back or phoned back to the Medical Health Officer working or on call.

It is noted that with the Infection Control Coordinator in place, there is an increasingly awareness of the need to involve Infection Control guidelines when considering renovations. While there is more awareness of the need, there is further opportunity to ensure it occurs when any renovations are considered.

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

Criteria	Location	Priority for Action
The organization evaluates compliance with accepted hand hygiene practices.	6.5	↑
The organization audits its compliance with hand hygiene practices.	6.5.1	
The organization uses the results of the audits to make improvements to its hand hygiene practices.	6.5.3	

Long Term Care Services

Clinical Leadership

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

Surveyor Comments

The facility is bright, cheerful and clean and is well supplied with lifts, tubs and other equipment required to care for clients. The long term care team has achieved 100% compliance with annual pneumococcal and influenza vaccination.

The team is short staffed. There is a long wait list for care. The organization may need to reallocate staffing and space to address this need.

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

Criteria	Location	Priority for Action
The team works together to develop goals and objectives.	2.1	

Competency

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

Surveyor Comments

Staff are all well aware of their scope of practice and work within it.

Performance assessments are informal. The team and the organization have evaluated the need for additional staff but have not been able to recruit.

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

Criteria	Location	Priority for Action
The interdisciplinary team follows a formal process to regularly evaluate its functioning, identify priorities for action, and make improvements.	3.7	
Team leaders regularly evaluate and document each team member's performance in an objective, interactive, and positive way.	4.11	
Team leaders regularly evaluate the effectiveness of staffing and use the information to make improvements.	5.3	

Episode of Care

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

Surveyor Comments

The long term care unit can accommodate up to 16 residents and the current census is 14. Two beds are kept for respite. The facility is clean, bright and comfortable, with country style furniture and many pieces of artwork. Clients' rooms are spacious, with large external windows and well equipped and supplied. For example, there are grab poles close to the bed and toilet and the outside door is on a piano hinge, enabling double duty as the bathroom door. Clients are encouraged to bring their personal belongings. All clients have a bulletin board. The team prefers to use photographs rather than armbands for identification and most clients have their photos posted outside their doors.

There is a long waiting list for long term care placement. Currently, there are 29 clients on the waiting list. The infrastructure planning report of 2010 suggests that a total of 46 beds will be required in the next decade to accommodate community need. When a space opens up (usually because a client passes away), the staff usually have two weeks' notice of the next admission and are provided with all the relevant information. The room is redecorated for the incoming client. There is a detailed assessment on admission and the level of care and TLR (transfer, lift and repositioning) is determined. There is also a BPMH.

H\Y W`]Ybhg fidfc[fYgg ]g a cb]hcfYX XU]`m UbX reviewed on weekly rounds with the physicians. Clients' medications are kept in the medication room unless a family specifies otherwise. When identifying clients, the staff use their name and photograph. Armbands are not used in order to help clients feel at home. However, wander management devices are used for vulnerable clients. This is important because the courtyard adjacent to the unit is unlocked as required by the fire code. Residents do not have any outings beyond this courtyard unless taken by their families. Staff suggest that regular outings (e.g. to the lake) would have a positive effect on the residents' quality of life.

There is a day program that includes cooking, painting, bingo and indoor gardening. Most clients speak Cree as a first language. Several staff also speak Cree. Approximately half of the clients have advanced care directives and these are quite clear in their intent. They are flagged on the outside of the client chart. Not all staff are aware of the advanced care directive. Families are welcome at any time and their contact numbers are kept on the first page of the client chart. They are notifed of any significant developments. When a client passes away, the family is encouraged to visit and grieve and have a spiritual adviser conduct a service in the client's room. Time is allowed for the family to take home the client's belongings. Clients and families are happy with the care provided.

Over the past three years, the use of restraints has been eliminated. Procedures for bathing, transferring and dressing clients are well documented and staff are qualified to perform them. Some of these procedures require two staff members. At night, only one staff member is present in the unit; this can be problematic if a problem arises. Staff report that their colleagues in acute care are accountable for responding to an emergency, but that this does not always happen. The organization needs to develop a clear process to reduce this risk.

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

Criteria	Location	Priority for Action
The team uses standardized clinical measures to evaluate the client’s pain.	7.7	
The team works with the client and family to identify service goals and expected results.	8.1	
The organization assesses each client’s risk for developing a pressure ulcer and implements interventions to prevent pressure ulcer development.	8.4	↑
The organization monitors its success in preventing the development of pressure ulcers and makes improvements to its prevention strategies and processes.	8.4.5	

Decision Support

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

Surveyor Comments

Client records are comprehensive and up to date. They reflect a multidisciplinary team approach to holistic care, including medication reconciliation and a falls prevention strategy. The team has easy access to the information required.

Not all staff are aware of the advance directives on client charts.

No Unmet Criteria for this Priority Process.

Impact on Outcomes

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

Surveyor Comments

The team has implemented an excellent falls prevention strategy and has eliminated the use of restraints. Pressure ulcers are prevented almost entirely.

There is no monitoring of process and outcome indicators.

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

Criteria	Location	Priority for Action
The team shares benchmark and best practice information with its partners and other organizations.	15.5	
The team implements and evaluates a fall prevention strategy to minimize the impact of client falls.	16.2	↑
The team evaluates the falls prevention strategy on an ongoing basis to identify trends, causes and degree of injury.	16.2.4	
The team uses the evaluation information to make improvements to its falls prevention strategy.	16.2.5	
The team informs and educates its clients and families in writing and verbally about the client and family's role in promoting safety.	16.4	↑
Written and verbal information is provided to clients and families about their role in promoting safety.	16.4.1	
Staff are aware of the verbal and written approaches used by the organization to inform and educate clients about their role in client safety.	16.4.2	
Clients consistently indicate that they have received both written and verbal communication about their role in client safety.	16.4.3	

The team implements verification processes and other checking systems for high-risk activities.	16.5	↑
The team evaluates the verification processes and uses information to make improvements.	16.5.3	
The team identifies and monitors process and outcome measures for its long term care services.	17.1	↑
The team monitors clients' perspectives on the quality of its long term care services.	17.2	
The team compares its results with other similar interventions, programs, or organizations.	17.3	↑
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.	17.4	↑
The team shares evaluation results with staff, clients, and families.	17.5	

Medicine Services

Clinical Leadership

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

Surveyor Comments

The team members have some flexibility to develop their interests and financial support is readily provided for educational opportunities particularly within, but not limited to the Province.

Clinical leadership is strong among the physicians and they are engaged and committed. Physicians are employees of Northern Medical Services.

Clinical leadership and a focused approach to planning and improving services within the Health Region are required to introduce a focus on planning, efficiencies and improvement.

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

Criteria	Location	Priority for Action
The team works together to develop goals and objectives.	2.1	

The team's goals and objectives for its medicine services are measurable and specific.	2.2	
The organization provides support to the team to deliver quality medicine services.	2.5	

Competency

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

Surveyor Comments

This is a friendly, informal organization.

There is no evidence that formal practices are in place to evaluate and develop staff.

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

Criteria	Location	Priority for Action
The interdisciplinary team follows a formal process to regularly evaluate its functioning, identify priorities for action, and make improvements.	3.7	
The team monitors and meets each team member's ongoing education, training, and development needs.	4.7	
Team leaders regularly evaluate and document each team member's performance in an objective, interactive, and positive way.	4.8	
The organization has defined criteria that are used to assign team members to clients and other responsibilities in a fair and equitable manner.	5.1	
Team leaders regularly evaluate the effectiveness of staffing and use the information to make improvements.	5.3	

Episode of Care

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

Surveyor Comments

The team is clearly very caring and respectful of patients and their families. The population served has many population health and educational challenges, as well as geographic barriers to UWWYgg hc gYfj]WY"

The team does its best to assist people to overcome these barriers, without the expertise of a social worker. Some protocols are in use but there is opportunity to implement additional evidence based protocols. There is little impetus to reduce length of stay, which is acknowledged to be "long" because full occupancy is rare and because many patients have chronic problems which are expected to deteriorate at home, requiring readmission. Facing many barriers to cure, the team focuses on compassionate care rather than on care plans.

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

Criteria	Location	Priority for Action
The team develops standardized processes and procedures to improve teamwork and minimize duplication.	3.4	
The team identifies medical and surgical clients at risk of venous thromboembolism (DVT and PE) and provides appropriate thromboprophylaxis.	7.4	↑
The organization has an organization-wide, written thromboprophylaxis policy or guideline.	7.4.1	
The team identifies clients at risk for venous thromboembolism (DVT and PE) and provides appropriate evidence-based, VTE prophylaxis.	7.4.2	
The team establishes measures for appropriate thromboprophylaxis use, audits the implementation of appropriate thromboprophylaxis, and uses this information to make improvements to their services.	7.4.3	
The team identifies major orthopedic 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.	7.4.4	
The team provides information to health professionals and clients about the risks of VTE and its prevention.	7.4.5	
The team uses standardized clinical measures to evaluate the client’s pain.	7.8	
The team educates clients and families about their rights, and investigates and resolves any claims that these rights have been violated.	8.7	↑
The team follows the organization’s process to identify, address, and record all ethics-related issues.	8.8	↑
The team works with the client and family to identify service goals and expected results.	9.1	

The team develops an integrated and comprehensive service plan for each client.	9.2	
The team works with the client's other service providers to develop a comprehensive and integrated follow-up plan.	11.5	

Decision Support

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

Surveyor Comments

There is an opportunity to formalize and increase the introduction of evidence based guidelines and to audit their impact on the quality of care.

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

Criteria	Location	Priority for Action
The team reviews its guidelines to make sure they are up-to-date and reflect current research and best practice information.	14.2	

Impact on Outcomes

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

Surveyor Comments

There is no systematic approach to examining patient outcomes within the team. At an organizational level, the population health unit, shared between three northern Health Authorities, does an excellent job of describing the demographics and health status. However, the medicine team does not have the information it requires to determine whether the services it is delivering are making a difference to individual patients' lives.

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

Criteria	Location	Priority for Action
The team shares benchmark and best practice information with its partners and other organizations.	14.5	
The team implements and evaluates a falls prevention strategy to minimize the impact of client falls.	15.2	↑

The team evaluates the falls prevention strategy on an ongoing basis to identify trends, causes, and degree of injury.	15.2.4	
The team uses the evaluation information to make improvements to its falls prevention strategy.	15.2.5	
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.	15.3	↑
The team informs and educates its clients and families in writing and verbally about the client and family's role in promoting safety.	15.4	↑
Written and verbal information is provided to clients and families about their role in promoting safety.	15.4.1	
Staff uses written and verbal approaches to inform and educate clients about their role in promoting safety.	15.4.2	
Clients indicate that they have received written and verbal communication about their role in promoting safety.	15.4.3	
The team implements verification processes and other checking systems for high-risk activities.	15.5	↑
The team identifies high-risk activities.	15.5.1	
The team develops and implements verification processes for high-risk activities.	15.5.2	
The team evaluates the verification processes and uses information to make improvements.	15.5.3	
The team identifies and monitors process and outcome measures for its medicine services.	16.1	↑
The team monitors clients' perspectives on the quality of its medicine services.	16.2	
The team compares its results with other similar interventions, programs, or organizations.	16.3	↑
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.	16.4	↑

Mental Health Services

Clinical Leadership

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

Surveyor Comments

This cohesive, interdisciplinary team enjoys its work and works well together to support the mental health clients of the region. Information about its clients and community comes from the historical aspect of the clinic as well as from population data compiled for the Northern indicators document, led by the Chief Medical Officer. Recent information focuses on the rise of suicides in the region in the population and an assessment is done on all clients to determine potential for suicide at first time of meeting and during subsequent visits as needed.

The teams scope of service is well aligned with the organizations strategic directions and a workplan is evidenced based on:
1) Health of the individual
2)Health of the population
3)Providers
4)Sustainability
5) Supporting processes

It contains the teams goals, activities and tasks as well as the target groups and partnerships required to fulfil the tasks. Partnerships are extremely important to the team and help to provide assistance to the clients when in their communities and between the times of clinic visits with providers.

Statistics from the Mental Health Program are provided to the Senior leadership and Board on a quarterly basis and include the numbers of active clients ,registrations for children, youth and adults and service events such as intake, therapy case management and consultations.

The team feels well supported by the organization and is pleased to deliver care to clients in a safe and attractive space. Students enjoy their experience in the program and staff are eager to share their expertise with the students. Staff in Sandy Bay reported that involvement with MCRRHA-which began 5 years ago has been positive and supportive.

Mental Health and Addictions (Sandy Bay)
Sandy Bay is a deeply troubled community. There is a high incidence of Fetal Alcohol Spectrum Disorders (FASD) spanning at least two generations, and domestic violence, alcoholism and schizophrenia are all common. The incidence of suicide is high and three years ago there was a cluster of suicides followed by copycat suicide attempts among adolescents. Many families are unable to provide basic care for their children even when they are in crisis.

Referrals may come from clients themselves, from health services, from family members and often from the police or correctional services. Most referrals are mandated and clients are not very receptive to care. There is essentially no waiting time for services and team members make themselves available out of hours. No clients were available for interview during the visit. Seven charts (3 mental health and 4 addictions services) were reviewed. The documentation was excellent and thorough, and the assessments, follow up and correspondence, whether structured as in addictions services or narrative in mental health, were very clear.

Data are collected monthly on volumes of service, but there is no systematic data collection on process or outcome. They have learnt to celebrate small successes. One area for improvement that they identified is the need for updated educational materials, e.g. videos, for client education.

While there is regular reporting of statistics to the leadership and Board,the team is encouraged to develop outcome indicators focussed on the priority areas of service to clients to ensure clients are receiving the care they need.Trending and review of the information could then be used to determine any changes in programming as needed.

No Unmet Criteria for this Priority Process.

Competency

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

Surveyor Comments

The members of this eager interdisciplinary team have definite roles, responsibilities and scope of practice which are known to all team members. The intake team meets weekly to discuss the plan of service for the clients and if there is going to be a change in the regular service provider this is discussed at these meetings. Team building education sessions and experiential sessions are held regularly. A psychiatrist attends the clinic once a month from Saskatoon and this is a positive experience for staff also.

The team has incorporated the Outcome Rating Scale (ORS) into its daily work and each client completes a four part assessment of their personal well being, family and close relationships, work, school, friendships and overall sense of well being at the beginning of each session. This is very effective for the providers and clients alike as it points to the specific areas of need and gives the provider a place to start with the client at that particular visit. The team is commended for seeking out the authors of this scale and bringing them to La Ronge to get this computerized program initiated and implemented.

In addition to the pre-assessment by the client, the client is also asked to complete a short rating of the session after completion with the therapist under the headings of time spent, goals and topics, approach or methods used and overall rating of the session.This provides the therapist with immediate feedback and also an opportunity to alter the approach or even seek the assistance of another provider as necessary. Trending over time of both these rating scales is discussed with the client who is able to see their progress online in graph form. The team is commended for this initiative which is practice -based evidence care and is leading edge.

The therapists themselves complete a Therapist Development Rating Scale which assesses competence with current caseload, feeling challenged and engaged,worklife balance and overall feelings about their work.This contributes to the overall assessment and evaluation of the providers and the supervisor is able to provide real time support to the individual members of the team and the team as a whole. This whole process provides feedback to everyone involved in the clients care. Congratulations!

The team leaders are encouraged to document on each staff members file areas of strengths and opportunities for improvement or advancement.Staff themselves advise that they get ongoing feedback from their supervisor but it is important to have this information contained on their HR files.

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

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

Episode of Care

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

Surveyor Comments

The team prides itself in removing barriers that prevent clients, families, service providers and referring organizations from accessing services.As soon as a referral comes in, the client is contacted immediately if necessary or within 48 hours for an initial discussion. Clients are usually seen for assessment within the week and this is applauded. In Pinehouse, Sandy Bay and Creighton, staff may respond to requests made by other services after hours, but they are not required to do so. In La Ronge, after hours emergencies are referred to our Emergency Department.

There is a comprehensive assessment process for risk of suicide in clients and this is followed diligently.

The team is commended for the initiatives it takes in determining the best way to support their clients. Providers talk about researching the ways that might be helpful to provide therapy for clients and innovative Art therapy has been introduced with very successful results for clients.

The team faxes referral forms among Mental health units and receives information from the inpatient unit in Prince Albert as necessary all helping to understand the treatment provided to the clients.

Telehealth is used as well as extensive referrals between mental health and Addictions. Overall, care and service delivery to clients is excellent and this is confirmed by interview with a client who has been accessing services for a period of time.

No Unmet Criteria for this Priority Process.

Decision Support

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

Surveyor Comments

The client records are well documented and maintained, cared for in a confidential way and stored in a new filing system cabinet which is easily accessible to providers and meeting all applicable legislation.

The team is well versed in information technology and uses it in a practical way to enhance care and service to their clients with specific note of the ORS system used.

The team researches evidence-based guidelines and uses appropriately and prides itself in the use of practice-based evidence as a result of the information developed and used regularly from the ORS system. Congratulations!

No Unmet Criteria for this Priority Process.

Impact on Outcomes

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

Surveyor Comments

The team is cognizant of risks to staff while providing services and takes precautions not to have staff meeting alone over the lunch hour or late afternoon alone in the department.

The team uses the two client identifier system consistently and often adds a third as a result of a number of clients with the same name.

The team is commended for the implementation and evaluation of its falls prevention strategy. Falls in this program are generally low risk and would be seen mainly in the elderly population.If they occur in the home a referral is usually made to Home Care for a falls risk assessment. There are grab bars in all the washrooms used by the clients at the clinic and this is effective.

Staff provide ongoing information to each other about potential safety problems in order to reduce the risk to clients and staff alike.

The team is diligent about the verification program for high risk activities and cites the example of a potent medication which requires monitoring of lab results on an ongoing basis while the client is taking the drug. This process in conjunction with the medication reconciliation program on admission are regarded as positive safety checks for improved client care and safety.

The team is encouraged to be in contact with a staff member whose last meeting of the day with a client is offsite.

The service provider works with the client to inform and educate the client about their role in promoting safety. This information is included in the consent for service which the client signs and receives a copy. The organization has developed a brochure entitled Health Care Safety: Our Priority; Your role which outlines many ways clients can be safe and it is encouraged that clients also receive this document and have it reviewed with the client on intake.

No Unmet Criteria for this Priority Process.

Obstetrics/Perinatal Care Services

Clinical Leadership

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

Surveyor Comments

The annual number of deliveries in the region is approximately 300. In former years, there were up to 150 deliveries annually at La Ronge; however, this has greatly declined in the past few years and in fiscal year 2010-2011 there were only 49 deliveries. The reasons for this decline may include patient and physician preference as well as more stringent risk management guidelines from the Society of Obstetricians and Gynaecologists of Canada (SOGC). Expectant mothers living in more remote communities are required to relocate to their delivery site a few weeks before term, and some prefer to relocate to larger centres, while others present late in labour. Selection on the basis of risk now excludes any significant prenatal problems including hypertension, and primigravidas are not delivered at La Ronge. With a decreasing number of deliveries comes the risk of losing competency.

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

Criteria	Location	Priority for Action
The team works together to develop team goals and objectives.	2.1	
The team's goals and objectives for its obstetrics/perinatal care services are measurable and specific.	2.2	
The team has access to the resources and infrastructure needed to clean and reprocess obstetric/perinatal devices within the service area.	2.6	

Competency

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

Surveyor Comments

Nurses and family practitioners are involved in perinatal care. There are no midwives. There is support for breastfeeding from Kids First North. Physicians have adopted the ALARM (Advances in Labour and Risk Management) course. Team members are encouraged to take Neonatal Resuscitation Program (NRP) courses and some nursing staff have taken STABLE (Temperature-Airway-Blood Pressure-Labs-Emotional Support) . There are two NRP instructors. There is no educator assigned to the team and no formal documentation of maintenance of competence. Simulations are not done. The team would like increased access to NRP and STABLE courses. ACoRN courses would also be helpful for the team.

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

Criteria	Location	Priority for Action
The interdisciplinary team follows a formal process to regularly evaluate its functioning, identify priorities for action, and make improvements.	3.7	

Criteria	Location	Priority for Action
Team leaders regularly evaluate and document each team member’s performance in an objective, interactive, and positive way.	4.10	
The organization has defined criteria that are used to assign team members to clients and other responsibilities in a fair and equitable manner.	5.1	
Team leaders regularly evaluate the effectiveness of staffing and use the information to make improvements.	5.3	

Episode of Care

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

Surveyor Comments

The physicians have developed excellent Prenatal Care Flowsheets for routine and diabetic pregnancies. Based on current evidence and guidelines, these flowsheets identify the tasks that are required during preconception and at successive gestational ages, and serve as a very useful reminder. The team also uses standard forms for obstetric assessment and admission.

Surgical and anesthesiology services are not available in the health region. If necessary, the team will augment a vaginal delivery using vacuum or forceps. However, neither Cesarian Section nor epidural analgesia are available to patients. Patients report being made aware of this when deciding where to receive care. Pain control in labour requires either opioids or nitrous oxide.

The LDR (Labour and Delivery) suites (two rooms) are pleasant, spacious and well equipped. On inspection, the neonatal resuscitation equipment was connected to 100% oxygen. Room air is also available and the blender in sites doing elective deliveries under 32 weeks (2006 NRP guidelines pp 8-5); however, a blender (as recommended in the 2006 edition of NRP guidelines) is not available. This decision was made following consultation with a neonatologist in Saskatoon. Consideration was given to the low frequency of deliveries. Some equipment may not be necessary. For example, size 2.0 ETTs are stocked. This size is not recommended for even the tiniest premature infants and it is difficult to imagine why it would be used in a centre delivering only term infants.

There is good support for breastfeeding and the staff believe that 80% of mothers are breastfeeding exclusively on discharge. Length of stay for a normal delivery is "as long as they want to" (in reality, 2-3 days).

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

Criteria	Location	Priority for Action
The team follows the organization’s process to identify, resolve, and record all ethics-related issues.	8.10	

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.	11.5	

Decision Support

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

Surveyor Comments

The physician primary care provider group has developed a clear Prenatal Care Flowsheet for normal pregnancies and for diabetic pregnancies. These documents are based on current guidelines and serve as an excellent reminder for healthcare providers.

No Unmet Criteria for this Priority Process.

Impact on Outcomes

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

Surveyor Comments

The team has endorsed the use of ALARM to reduce obstetric risk and NRP to reduce neonatal risk. There is no formal evaluation of outcomes. There is limited awareness of some relevant strategies to reduce risk, e.g. controlled neonatal hypothermia for moderate birth asphyxia.

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

Criteria	Location	Priority for Action
The team shares benchmark and best practice information with its partners and other organizations.	15.5	
Staff and service providers participate in regular safety briefings to share information about potential safety problems, reduce the risk of error, and improve the quality of service.	16.3	
The team identifies and monitors process and outcome measures for its obstetrics/perinatal care services.	17.1	
The team monitors clients and families' perspectives the quality of its obstetrics/perinatal care services.	17.2	
The team compares its results with other similar interventions, programs, or organizations.	17.3	

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.	17.4	

Substance Abuse and Problem Gambling Services

Clinical Leadership

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

Surveyor Comments

This team is cohesive and works well together. The clients interviewed appreciate the respect shown to them by their care providers and counsellors and say that they always feel listened to and in control of how their own treatment plan is evolving. This is in keeping with the move from a counsellor driven approach to a client centered approach which is now the norm on these sites at Mamawetan Churchill River Regional Health Authority (MCRRHA). This approach and philosophy is commended and better signals to the providers when the clients are treatment ready.

The team understands the population it is serving by reviewing population health reports, long service history of client care in the region, its close ties with the bands and provincial data on Hepatitis C and HIV Aids . The Aboriginal population is well -served by Aboriginal addictions counsellors whose numbers in the program are representative of the population served. There are satellite Addiction counsellors in Pinehouse and Sandy Bay as well as in the local Youth Addictions Services centre. Mental Health and Addiction counsellors work closely together in both programs often having the same population.

The team has developed goals and objectives based on the organizations strategic directions and is heavily focussed on the People First direction which has given further emphasis to the choice theory approach of service delivery. Creating greater community awareness of alcohol,drug and gambling problems and use go hand in hand with the team's objective of promoting greater community ownership and action towards reducing these problems,intervening and assisting addicted individuals to change their behaviour and achieve an abstinent healthy lifestyle.

The team supports student placement and have a number of opportunities to provide experiences for students,also in the hopes of further recruitment to the team itself. These experiences for students are appreciated and applauded.

No Unmet Criteria for this Priority Process.

Competency

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

Surveyor Comments

The team meets in adequate space to deliver the three aspects of its program; the Detox unit ,the outpatient program which provides counselling services and the day treatment program and intensive recovery program. Streamlining of the programs are ongoing and the team is supported in this evaluative process by the formalized approach whereby the client directs care based on the assessment completed at the beginning of each session with a counsellor.

5h h\Y end of the session, the client completes an assessment of the approach used and the success of the session with the counsellor. This is a very effective approach and used also in the Mental Health program. The clients interviewed enjoy watching their progress in graph form on the computer and in a few instances confirmed their progress when they were worried that progress was slow. This process confirms or suggests a change in the approach and possibly counsellor if indicated.

Certainly, the languages are a challenge as the intake forms are printed in English and need to be translated with the clients by the counsellors into the appropriate dialects but this is accomplished by a flexible staff.

The majority of clients in keeping with the population are Aboriginals coming from smaller communities and the programs are ever evolving in design to meet their needs. A number of the transition program (replacing the Day program) clients meet in group sessions.

The team is commended for its ongoing education and the use of information it receives to make improvements in the programs. The team works with partners in the community such as the RCMP, youth probation, schools, high school. A referral from RCMP whereby youth who have been ticketed for driving while drinking can become involved in a low intensity program with the youth counsellor in lieu of a fine. Often the ticket can be withdrawn also. There is some success with this program to date and this is applauded.

Each team member assures the necessary credentials are in place for the appropriate professional college or association. Health Sciences Association of Saskatchewan (HSAS) identified job descriptions as being education based. Some staff due to long term service can be grandfathered. Many education sessions take place in Saskatoon through the Saskatoon Health Region.

Problem gambling training outside the province is not recognized by the province and the specific education associated with this program must be obtained within the province.

Workplace violence reporting processes are in place and while individual resolution is followed up the process can take months.

Team members are assigned to clients using a balanced approach and taking into consideration needs based on gender or expertise in certain areas.Youth counselling has its own program and the team member has extensive experience.

The team treated itself to a Healing Day last year and this is represented as fair and objective way to recognize team members for their contributions. The usual length of service awards are part of the organization's recognition program.

The team works well together and individual members have opportunities for education and conferences to advance their service delivery. There is not a formal evaluation of the team's functioning as an interdisciplinary team that is conducted and this is encouraged in order to determine improvements in the interdisciplinary work of the team.

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

Criteria	Location	Priority for Action
The interdisciplinary team follows a formal process to regularly evaluate its functioning, identify priorities for action, and make improvements.	3.7	

Episode of Care

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

Surveyor Comments

The clients interviewed all reported positive experiences with the program. The clients have struggled over the years but all had been clean of alcohol and drugs for different amounts of time. They were very complementary of the counsellors and detox program.One client attributed his progress to a combination of psychiatric care in Prince Albert, followed by counselling in both mental health and Addictions citing the excellent work of the two counsellors and medication which he is gradually increasing. This client lived in a very small community about 11/2 hours away from La Ronge.

The three clients all spoke to to the fact that they were not forced to tell their whole story all at once but were given the opportunity to do so little by little. They noted this was very important in their healing process and allowed them to feel better about themselves as they went along.

The team has made tremendous efforts in developing partnerships including training for allied partners such as members attending one day with NNADAP (National Native Alcohol and Drug Abuse Program) workers,with Justice every six weeks, schools, youth probation, satellite office in one school for students with behavourial problems 2-3 times per week and attendance at court twice weekly . One counsellor provides native study education at the high school.

Patient and family first project emphasizes the voice of the customer. Satisfaction with counselling is understood as two case conferences run each week and staff is updated from the two groups on the satisfaction of the clients. In the Detox area staff provide three reports a day on progress and feedback from the clients. The common theme in the Detox program is that clients are not treatment -ready in Detox. They are more in transition and this has allowed the program to change its 60 hour day treatment program to a transition program rather than one which is counsellor -driven. It is more logical and makes sense to the clients. There are request from students in the education programs to attend this detox program and subsequently experience this transition mode of treatment.

The evaluation of the day treatment program is commendable and the rapid turnaround of the new transition program as a 25 hour per week program is applauded. Clients may enter the program at any point in the program to access the 10 program modules. Continuous intake and the format may increase the number of clients who are able to access the program and successfully complete it is very positive.

Outpatient counselling sessions are also able to adapt to the need for clients to enrol in the Safe Driving program which includes Saskatchewan Government Insurance (SGI) screening and clinical services for those referred by SGI.

One counsellor has provided over 70 hours in the past year of Native Traditional practices to those who sought healing through the sweat lodge ceremony,smudging and other traditional native practices. This work is encouraged and applauded.

The Detox program serves the north for alcohol or drugs. When a call is received for referral, the forms are faxed out along with the information package. The waiting list is about one week in duration but can be less. Those withdrawing from drugs go directly to the Emergency Department for 24 hours, receive a prescription for their medication and are then transferred to the Detox unit. The client medications are kept in their own separate basket and the client self administers in the presence of a worker. If the client is to receive Methadone, this is obtained from the Acute care unit as prescribed by the certified physician. The methadone is kept in a locked box at the Nurses station in Acute care.

The physician in charge of the program is interested in improving the program and together with his colleagues are providing excellent care and service in conjunction with the team.The trouble with this program is the same one being faced right across the country and that is more clients on the waiting list than can be serviced by the program, notably pharmacists to dispense the drug and observe consumption, whether the client is receiving counselling or not. In this region there are 40 clients in the program and 20 more on the waiting list not receiving Methadone.

The Detox attendants have been trained to assess the clients state of anxiety and other measures of alcohol withdrawal based on the Clinical Institutional Withdrawal scale (CIWA) rating scale. If the numerical score reaches 10 the physicians order for Valium on a prn basis is provided by the client coming to the office and self administering the medication under the auspices of the detox worker. There have not been any medication errors in the five years that the supervisor has been in this program. This program should be reviewed at regular intervals to determine if this is the best process to go forward with or if there may be alternatives which could be explored. At present, there does not appear to be a risk to either client or staff using this well monitored and strict approach to providing medications to clients in the absence of a nurse to administer the medications.

No Unmet Criteria for this Priority Process.

Decision Support

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

Surveyor Comments

The team is commended for the excellent documentation on the client files. The opportunity along with Mental Health to update the master client lists as well as changing the filing system to a more efficient numerical system replacing the alphabetical system is applauded. As well, the new filing system is more ergonomical for staff and user -friendly.

The team is encouraged to seek further opportunities to explore evidenced- based care and practice literature and incorporate this information into staff sessions.

No Unmet Criteria for this Priority Process.

Impact on Outcomes

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

Surveyor Comments

The team has a number of statistics which it submits to the Quality Department and is incorporated into the quality dashboard for reporting to the Board. The program client satisfaction graphs are well done and reflect the morning meditation sessions, group therapy, addiction education discussions and individual counselling sessions all with high levels of satisfaction. The evaluative process which altered the detox program from a 60 hour outpatient program to a transition program was consistent with the Patient First approach and indicated a high level of listening and hearing and then changing and putting new measures in place to further evaluate. This is the essence of measuring, evaluating, altering and restudying. The team is congratulated on this major initiative.

There is an excellent document provided by the Health Region entitled Health Care Safety: our priority; your role which should be provided to all clients on intake and reviewed with the client to ensure understanding. While the staff is effective in discussing safety issues with the client, this is additional information which may result in reduced potential for infection and help to encourage assertiveness in the client ensuring safety in the ways they may not normally believe is their right, such as not being afraid to ask staff to wash their hands. It is a further way to empower clients in their own safety. Clients interviewed did not have recollection of being provided written material about their safety.

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

Criteria	Location	Priority for Action
The team informs and educates its clients and families in writing and verbally about the client and family's role in promoting safety.	15.4	↑
Written and verbal information is provided to clients and families about their role in promoting safety.	15.4.1	
Clients indicate that they have received written and verbal communication about their role in promoting safety.	15.4.3	

Telehealth Services

Clinical Leadership

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

Surveyor Comments

The Telehealth Service based in La Ronge commenced in 1998. Newer technology was acquired in 2007 and more recently high definition equipment has been purchased. A provincial committee is in place that provides linkages and partnerships with other Telehealth providers. Policies and procedures are in place to govern the delivery of services. A Saskatchewan Telehealth Manual is available for users at the site. The Telehealth Clinic provides services for clinical visit, educational sessions and administrative meetings. The majority of clinical visits originate from the specialists at the larger centres and provide consultations to patients in MCRRHA. Telehealth Video Conferencing is available in all of the health care facilities within MCRRHA. Some areas have portable units that.could be connected anywhere in a facility.

The service provides scheduled clinics which include a number of services including: Child Psychiatry, Pediatric Surgery, Pediatric Rheumatology, Rehab Medicine, Stoma and Wound Therapy, Plastic Surgery, Memory Clinic, General Surgery, Genetics, Adult Psychology and Mental Health Consultants. One of the challenges related to patient visits is the booking of the equipment. The room is booked through the Regional Telehealth Coordinator and facilitated by the different departments within the facility and physician's office. A process is in place to send out reminders and alert staff around the pre- work required for the visit, but sometimes there are "no shows" and this is very inconvenient and a challenge for the busy specialist providing this service.

No Unmet Criteria for this Priority Process.

Competency

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

Surveyor Comments

The Telehealth Coordinator has a job description with roles and responsibilities specified. The Coordinators ensures the program is current and keeps up to date with the provincial partners, recognizes need for additional knowledge and training as required and ensures policy and procedures are current.

The provincial network provides an opportunity for the various programs to share best practices, policy and procedure, standardize where possible and address issues.

No Unmet Criteria for this Priority Process.

Episode of Care

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

Surveyor Comments

Staff are orientated around the use of the equipment when delivering Telehealth services. The coordinator controls the access to equipment, devices and services. The Coordinator helps to remove any barriers around the provision of the service and assist to ensure patient appointments are made as streamlined as possible.

When scheduling a patient appointment the Coordinator identifies the patient needs and ensures the appropriate level of staffing is in place to facilitate the consultation. The procedures and various options for care are explained to the patients prior to the Telehealth encounter.

The team provides the patient with information around the services. There is a process in place to ensure those with more urgent needs are prioritized accordingly.

From a physician's (specialist) point of view, there have been barriers identified around the scheduling of appointments, specifically the "no shows". The physicians from the larger sites i.e. Saskatoon would prefer to have access to the Telehealth equipment in their office or at their desk, so the schedule doesn't disrupt their workday as significantly. Physician Examination cameras are not available to assist with consultation. Specialists in Saskatoon have indicated that exam cameras would be beneficial, providing a close up view of a body part. The Telehealth program within MCRRHA is encouraged to work with their partners to reduce the barriers to scheduling. The smaller sites are encouraged to seek out further opportunities to utilize the equipment to enhance access to care and ensure the service is used to capacity.

No Unmet Criteria for this Priority Process.

Decision Support

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

Surveyor Comments

Patient confidentiality is respected during the Telehealth encounter. In many cases the Coordinator will set the patient up, ensure they are comfortable with the process and then leave them for the duration of the appointment. Information or data obtained during the patient visit is locked up or filed with the patient record.

No Unmet Criteria for this Priority Process.

Impact on Outcomes

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

Surveyor Comments

Information related to the number of Telehealth visits, number of staff who attend educational sessions and the number of administrative meetings is collected and reported to the senior leaders. In addition, the dollars saved through avoiding travel is calculated. Patient follow up or patient satisfaction is evaluated for some patient groups.ie the Memory Clinic. The staff are very proud of the fact that the service they are providing eliminates the need for patients to travel long distances for this care. Patients interviewed are extremely appreciative and complementary of the service.

One of the challenges is the under usage of the service. The staff recognize the need to promote and market the service to maximize the benefits.

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

Criteria	Location	Priority for Action
The team shares evaluation results with staff, clients, and families.	13.4	

Performance Measure Results

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

Instrument Results

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

Governance Functioning Tool

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

Summary of Results

Governance Structures and Processes	% Agree	% Neutral	% Disagree	Priority for Action
	Organization	Organization	Organization	
1 We actively recruit, recommend and/or select new members based on needs for particular skills, background, and experience.	100	0	0	✖
2 We have explicit criteria to recruit and select new members.	50	0	50	✖
3 Our renewal cycle is appropriately managed to ensure continuity on the governing body.	0	0	100	✖
4 The composition of our governing body allows us to meet stakeholder and community needs.	100	0	0	
5 Clear written policies define term lengths and limits for individual members, as well as compensation.	100	0	0	
6 We regularly review, understand, and ensure compliance with applicable laws, legislation and regulations.	100	0	0	
7 Governance policies and procedures that define our role and responsibilities are well-documented and consistently followed.	100	0	0	

	Governance Structures and Processes	% Agree	% Neutral	% Disagree	Priority for Action
		Organization	Organization	Organization	
8	We review our own structure, including size and sub-committee structure.	67	0	33	
9	We have sub-committees that have clearly-defined roles and responsibilities.	75	0	25	
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	
11	We each receive orientation that helps us to understand the organization and its issues, and supports high-quality decision-making.	100	0	0	
12	Disagreements are viewed as a search for solutions rather than a “win/lose”.	100	0	0	
13	Our meetings are held frequently enough to make sure we are able to make timely decisions.	100	0	0	
14	Individual members understand and carry out their legal duties, roles and responsibilities, including sub-committee work (as applicable).	100	0	0	
15	Members come to meetings prepared to engage in meaningful discussion and thoughtful decision-making.	100	0	0	
16	Our governance processes make sure that everyone participates in decision-making.	100	0	0	
17	Individual members are actively involved in policy-making and strategic planning.	100	0	0	
18	The composition of our governing body contributes to high governance and leadership performance.	100	0	0	
19	Our governing body’s dynamics enable group dialogue and discussion. Individual members ask for and listen to one another’s ideas and input.	100	0	0	
20	Our ongoing education and professional development is encouraged.	100	0	0	
21	Working relationships among individual members and committees are positive.	100	0	0	
22	We have a process to set bylaws and corporate policies.	100	0	0	

	Governance Structures and Processes	% Agree	% Neutral	% Disagree	Priority for Action
		Organization	Organization	Organization	
23	Our bylaws and corporate policies cover confidentiality and conflict of interest.	100	0	0	
24	We formally evaluate our own performance on a regular basis.	100	0	0	
25	We benchmark our performance against other similar organizations and/or national standards.	25	0	75	△
26	Contributions of individual members are reviewed regularly.	75	0	25	△
27	As a team, we regularly review how we function together and how our governance processes could be improved.	75	0	25	
28	There is a process for improving individual effectiveness when non-performance is an issue.	75	0	25	
29	We regularly identify areas for improvement and engage in our own quality improvement activities.	100	0	0	
30	As a governing body, we annually release a formal statement of our achievements that is shared with the organization's staff as well as external partners and the community.	100	0	0	
31	As individual members, we receive adequate feedback about our contribution to the governing body.	100	0	0	△
32	We have a process to elect or appoint our chair.	0	0	100	×
33	Our chair has clear roles and responsibilities and runs the governing body effectively.	100	0	0	

Patient Safety Culture Survey

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

Summary of Results

Number of survey respondents = 122 respondents

	A. Patient Safety: Activities to avoid, prevent, or correct adverse outcomes which may result from the delivery of health care	% Disagree	% Neutral	% Agree	Priority for Action
		Organization	Organization	Organization	
1	Patient safety decisions are made at the proper level by the most qualified people	11	15	74	△
2	Good communication flow exists up the chain of command regarding patient safety issues	17	18	66	△
3	Reporting a patient safety problem will result in negative repercussions for the person reporting it	70	18	13	△
4	Senior management has a clear picture of the risk associated with patient care	11	21	68	△
5	My unit takes the time to identify and assess risks to patients	7	12	81	
6	My unit does a good job managing risks to ensure patient safety	5	8	87	
7	Senior management provides a climate that promotes patient safety	10	14	76	
8	Asking for help is a sign of incompetence	84	7	9	
9	If I make a mistake that has significant consequences and nobody notices, I do not tell anyone about it	90	4	6	
10	I am sure that if I report an incident to our reporting system, it will not be used against me	14	14	72	△
11	I am less effective at work when I am fatigued	4	12	83	
12	Senior management considers patient safety when program changes are discussed	13	19	68	△
13	Personal problems can adversely affect my performance	9	20	70	△
14	I will suffer negative consequences if I report a patient safety problem	82	13	5	

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	A. Patient Safety: Activities to avoid, prevent, or correct adverse outcomes which may result from the delivery of health care	% Disagree	% Neutral	% Agree	Priority for Action
		Organization	Organization	Organization	
15	If I report a patient safety incident, I know that management will act on it	8	18	74	⚠
16	I am rewarded for taking quick action to identify a serious mistake	18	47	36	✖
17	Loss of experienced personnel has negatively affected my ability to provide high quality patient care	40	33	27	✖
18	I have enough time to complete patient care tasks safely	17	18	65	⚠
19	I am not sure about the value of completing incident reports	63	16	21	⚠
20	In the last year, I have witnessed a co-worker do something that appeared to me to be unsafe for the patient in order to save time	60	12	27	⚠
21	I am provided with adequate resources (personnel, budget, and equipment) to provide safe patient care	12	23	65	⚠
22	I have made significant errors in my work that I attribute to my own fatigue	73	13	14	⚠
23	I believe that health care error constitutes a real and significant risk to the patients that we treat	10	21	69	⚠
24	I believe health care errors often go unreported	20	22	58	✖
25	My organization effectively balances the need for patient safety and the need for productivity	9	20	70	⚠
26	I work in an environment where patient safety is a high priority	7	14	79	
27	Staff are given feedback about changes put into place based on incident reports	18	26	55	⚠
28	Individuals involved in patient safety incidents have a quick and easy way to report what happened	9	20	70	⚠
29	My supervisor/manager says a good word when he/she sees a job done according to established patient safety procedures	12	18	70	⚠
30	My supervisor/manager seriously considers staff suggestions for improving patient safety	12	12	76	

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A. Patient Safety: Activities to avoid, prevent, or correct adverse outcomes which may result from the delivery of health care	% Disagree	% Neutral	% Agree	Priority for Action
	Organization	Organization	Organization	
31 Whenever pressure builds up, my supervisor/manager wants us to work faster, even if it means taking shortcuts	81	10	9	
32 My supervisor/manager overlooks patient safety problems that happen over and over	72	9	19	⚠
33 On this unit, when an incident occurs, we think about it carefully	5	16	78	
34 On this unit, when people make mistakes, they ask others about how they could have prevented it	10	22	68	⚠
35 On this unit, after an incident has occurred, we think about how it came about and how to prevent the same mistake in the future	4	13	83	
36 On this unit, when an incident occurs, we analyze it thoroughly	13	23	64	⚠
37 On this unit, it is difficult to discuss errors	67	18	15	⚠
38 On this unit, after an incident has occurred, we think long and hard about how to correct it	9	26	65	⚠

B. These questions are about your perceptions of overall patient safety	% Good/ Excellent	% Acceptable	% Poor/ Failing	Priority for Action
	Organization	Organization	Organization	
39 Please give your unit an overall grade on patient safety	74	20	6	⚠
40 Please give the organization an overall grade on patient safety	60	35	6	⚠

C. These questions are about what happens after a Major Event	% Disagree	% Neutral	% Agree	Priority for Action
	Organization	Organization	Organization	
41 Individuals involved in major events contribute to the understanding and analysis of the event and the generation of possible solutions	8	22	71	⚠
42 A formal process for disclosure of major events to patients/families is followed and this process includes support mechanisms for patients, family, and care/service providers	7	24	69	⚠

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C. These questions are about what happens after a Major Event	% Disagree	% Neutral	% Agree	Priority for Action
	Organization	Organization	Organization	
43 Discussion around major events focuses mainly on system-related issues, rather than focusing on the individual(s) most responsible for the event	16	34	50	✖
44 The patient and family are invited to be directly involved in the entire process of understanding: what happened following a major event and generating solutions for reducing re-occurrence of similar events	11	34	55	⚠
45 Things that are learned from major events are communicated to staff on our unit using more than one method (e.g. communication book, in-services, unit rounds, emails) and / or at several times so all staff hear about it	14	24	62	⚠
46 Changes are made to reduce re-occurrence of major events	9	14	78	

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Worklife Pulse

The concept of 'quality of worklife' is central to Accreditation Canada's accreditation program. The Pulse Survey enables health service organizations to monitor key worklife areas. The survey takes the 'pulse' of quality of worklife, providing a quick and high level snapshot of key work environment factors, individual outcomes, and organizational outcomes. Organizations can then use the findings to identify strengths and gaps in their work environments, engage stakeholders in discussions of opportunities for improvement, plan interventions to improve the quality of worklife, and develop a clearer understanding of how quality of worklife influences the organization's capacity to meet its strategic goals.

Summary of Results

Number of survey respondents = 161 respondents

	How would you rate your work environment	% Disagree	% Neutral	% Agree	Priority for Action
		Organization	Organization	Organization	
1	I am satisfied with communications in this organization.	27	22	51	⚠
2	I am satisfied with communications in my work area.	17	14	68	⚠
3	I am satisfied with my supervisor.	14	11	76	
4	I am satisfied with the amount of control I have over my job activities.	11	12	77	
5	I am clear about what is expected of me to do my job.	9	12	80	
6	I am satisfied with my involvement in decision making processes in this organization.	20	22	58	⚠
7	I have enough time to do my job adequately.	19	22	59	⚠
8	I feel that I can trust this organization.	15	19	66	⚠
9	This organization supports my learning and development.	12	12	75	
10	My work environment is safe.	12	9	79	
11	My job allows me to balance my work and family/personal life.	9	14	76	

Individual Outcomes	% Not Stressful	% A bit Stressful	% Quite or Extremely Stressful	Priority for Action
	Organization	Organization	Organization	
12 In the past 12 months, would you say that most days at work were...	26	51	23	✕
	% Very Good/ Excellent	% Good	% Fair/ Poor	Priority for Action
	Organization	Organization	Organization	
13 In general, would you say your health is...	45	42	13	✕
14 In general, would you say your mental health is...	56	36	8	△
15 In general, would you say your physical health is...	37	47	16	✕
	% Very Satisfied	% Somewhat Satisfied	% Not Satisfied	Priority for Action
	Organization	Organization	Organization	
16 How satisfied are you with your job?	92	5	3	
	% < 10	% 10 - 15	% > 15	Priority for Action
	Organization	Organization	Organization	
17 In the past 12 months, how many days were you away from work because of your own illness or injury? (counting each full or partial day as 1 day)	75	13	12	△
18 During the past 12 months, how many days did you work despite an illness or injury because you felt you had to (counting each full or partial day as 1 day)?	81	11	7	
	% Never/ Rarely	% Sometimes	% Often/ Always	Priority for Action
	Organization	Organization	Organization	
19 How often do you feel you can do your best quality work in your job?	1	19	80	

		% Disagree	% Neutral	% Agree	Priority for Action
		Organization	Organization	Organization	
20	Overall, I am satisfied with this organization.	14	13	73	△
21	Working conditions in my area contribute to patient safety.	9	22	70	△

Appendix A – Accreditation Decision Guidelines

The key factor that Accreditation Canada uses to determine an accreditation decision is the degree to which client organizations comply with high-priority criteria and Required Organizational Practices (ROPs). *High-priority criteria* are criteria related to safety, ethics, risk, and quality improvement; *ROPs* are practices that must be in place to enhance client safety and minimize risk.

There are three possible accreditation decisions under Qmentum.

Accreditation	Accreditation with Condition (Report, Focused Visit, or both)	Non-accreditation
Issued when the client organization has:	*Issued when the client organization has:*	*Issued when the client organization has:*
Met 90 to 100% of high-priority criteria in each applicable set of standards AND	Met 71 to 89% of high-priority criteria in each applicable set of standards OR	Met 70% or less of high-priority criteria in one or more sets of applicable standards AND
Complied with all applicable ROPs AND	Failed to comply with one or more applicable ROPs OR	Failed to comply with one or more applicable ROPs AND
Submitted all required performance measure data	Failed to submit required performance measure data	Met 80% or less of the total criteria in all applicable sets of standards
*CSSS only: obtained 66.6% or more on all CQA indicator questionnaires	*CSSS only: obtained less than 66.6% on any CQA indicator questionnaire	*CSSS only: obtained less than 66.6% on any CQA indicator questionnaire

***CSSS (Centre de santé et de services sociaux)** clients in the joint Accreditation Canada/Conseil québécois d'agrément (CQA) program must also administer CQA's Client Satisfaction indicator questionnaire and the Employee Mobilization indicator questionnaire.

NOTES

Accreditation with Condition means the organization must meet conditions specified by Accreditation Canada to maintain its accredited status. The nature of the unmet criteria and ROPs determines the timelines for compliance (six or twelve months) and whether the organization must submit a report, undergo a focused visit, or both. If the conditions are not met within the timelines, Accreditation Canada may grant an extension of six months, based on surveyor input, proof of progress, and a plan to meet the criteria.

Failure to comply within the allotted time may result in accreditation being revoked, at the discretion of Accreditation Canada.

Non-accreditation: A non-accreditation organization may have its status reviewed six months after the on-site survey if it completes a focused visit within five months. The organization maintains its non-accredited status if the focused visit results are unsatisfactory.