ACCREDITATION
AGRÉMENT
CANADA
Qmentum

Accreditation Report

Winnipeg Regional Health Authority

Winnipeg, MB

On-site survey dates: April 17, 2016 - April 22, 2016

Report issued: May 13, 2016

About the Accreditation Report

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

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

Confidentiality

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

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

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

A Message from Accreditation Canada

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

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

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

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

We look forward to our continued partnership.

Sincerely,

Leslee Thompson
Chief Executive Officer

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Executive Summary

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

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

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

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

Accreditation Decision

Winnipeg Regional Health Authority's accreditation decision is:

Accredited (Report)

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

About the On-site Survey

- **On-site survey dates: April 17, 2016 to April 22, 2016**

This on-site survey is part of a series of sequential surveys for this organization. Collectively, these are used to assess the full scope of the organization's services and programs.

- **Locations**

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

1. 1050 Leila
2. 2735 Pembina
3. 490 Hargrave
4. 496 Hargrave
5. 5 Donald Street
6. 755 Portage Avenue
7. 817 Bannatyne
8. Aboriginal Health - 323 Portage Ave
9. Access Downtown Centre
10. Access Norwest
11. Access River East Centre
12. Access Transcona Centre
13. Access Winnipeg West
14. Actionmarguerite Personal Care Home - Taché
15. Bethania Mennonite Personal Care Home
16. Birth Centre
17. Breast Health Centre
18. Calvary Place
19. Churchill Health Centre
20. Clinique Youville Clinic
21. Concordia Hospital
22. Concordia Place
23. Crisis Response Centre
24. Deer Lodge Centre
25. Donwood Manor Personal Care Home
26. Fred Douglas Lodge

27. Golden Door Geriatric Centre
28. Grace Hospital
29. Health Sciences Centre
30. Health Sciences Centre - Children's
31. Health Sciences Centre - Psychealth Centre
32. Health Sciences Centre - Women's Health
33. Hope Centre Health Care
34. Kildonan Medical Centre
35. Lions Personal Care Centre
36. Luther Home
37. MATC (120 Tecumseh)
38. Middlechurch Home of Winnipeg
39. Misericordia Health Centre
40. Mount Carmel Clinic
41. Pan Am Clinic
42. Quick Care Clinic - McGregor
43. River East Personal Care Centre
44. Riverview Health Centre
45. Seven Oaks General Hospital
46. Smile Plus Dental Program
47. Southeast Personal Care Home
48. St. Amant Centre (River Road Place)
49. St. Boniface Hospital
50. St. Joseph's Residence
51. St. Norbert Nursing Home
52. Tissue Bank Manitoba
53. Victoria General Hospital
54. West Park Manor Personal Care Home
55. WRHA Corporate Office - 650 Main St.

- **Standards**

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

System-Wide Standards

1. Governance
2. Leadership

3. Infection Prevention and Control Standards
4. Infection Prevention and Control Standards for Community-Based Organizations
5. Medication Management Standards
6. Medication Management Standards for Community-Based Organizations

Population-specific Standards

7. Population Health and Wellness

Service Excellence Standards

8. Acquired Brain Injury Services - Service Excellence Standards
9. Ambulatory Care Services - Service Excellence Standards
10. Ambulatory Systemic Cancer Therapy Services - Service Excellence Standards
11. Cancer Care and Oncology Services - Service Excellence Standards
12. Community-Based Mental Health Services and Supports - Service Excellence Standards
13. Critical Care - Service Excellence Standards
14. Developmental Disabilities - Service Excellence Standards
15. Diagnostic Imaging Services - Service Excellence Standards
16. Emergency Department - Service Excellence Standards
17. Emergency Medical Services - Service Excellence Standards
18. Home Care Services - Service Excellence Standards
19. Hospice, Palliative, End-of-Life Services - Service Excellence Standards
20. Long-Term Care Services - Service Excellence Standards
21. Medicine Services - Service Excellence Standards
22. Mental Health Services - Service Excellence Standards
23. Obstetrics Services - Service Excellence Standards
24. Organ Donation Standards for Living Donors - Service Excellence Standards
25. Organ and Tissue Donation Standards for Deceased Donors - Service Excellence Standards
26. Organ and Tissue Transplant Standards - Service Excellence Standards
27. Perioperative Services and Invasive Procedures - Service Excellence Standards
28. Primary Care Services - Service Excellence Standards
29. Public Health Services - Service Excellence Standards
30. Rehabilitation Services - Service Excellence Standards
31. Reprocessing and Sterilization of Reusable Medical Devices - Service Excellence Standards
32. Spinal Cord Injury Acute Services - Service Excellence Standards
33. Spinal Cord Injury Rehabilitation Services - Service Excellence Standards

- **Instruments**

  The organization administered:

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

Overview by Quality Dimensions

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

Quality Dimension	Met	Unmet	N/A	Total
Population Focus (Work with my community to anticipate and meet our needs)	127	10	0	137
Accessibility (Give me timely and equitable services)	191	10	3	204
Safety (Keep me safe)	908	95	51	1054
Worklife (Take care of those who take care of me)	249	20	1	270
Client-centred Services (Partner with me and my family in our care)	939	28	6	973
Continuity of Services (Coordinate my care across the continuum)	192	3	2	197
Appropriateness (Do the right thing to achieve the best results)	1618	108	59	1785
Efficiency (Make the best use of resources)	81	4	4	89
Total	**4305**	**278**	**126**	**4709**

Overview by Standards

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

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

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

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

Standards Set	High Priority Criteria *			Other Criteria			Total Criteria (High Priority + Other)		
	Met	Unmet	N/A	Met	Unmet	N/A	Met	Unmet	N/A
	# (%)	# (%)	#	# (%)	# (%)	#	# (%)	# (%)	#
Governance	45 (100.0%)	0 (0.0%)	5	34 (97.1%)	1 (2.9%)	1	79 (98.8%)	1 (1.3%)	6
Leadership	43 (87.8%)	6 (12.2%)	0	85 (88.5%)	11 (11.5%)	0	128 (88.3%)	17 (11.7%)	0
Infection Prevention and Control Standards	35 (85.4%)	6 (14.6%)	0	25 (83.3%)	5 (16.7%)	1	60 (84.5%)	11 (15.5%)	1
Infection Prevention and Control Standards for Community-Based Organizations	21 (84.0%)	4 (16.0%)	2	41 (89.1%)	5 (10.9%)	0	62 (87.3%)	9 (12.7%)	2
Medication Management Standards	64 (82.1%)	14 (17.9%)	0	57 (89.1%)	7 (10.9%)	0	121 (85.2%)	21 (14.8%)	0
Medication Management Standards for Community-Based Organizations	64 (97.0%)	2 (3.0%)	8	52 (98.1%)	1 (1.9%)	7	116 (97.5%)	3 (2.5%)	15

Standards Set	High Priority Criteria *			Other Criteria			Total Criteria (High Priority + Other)		
	Met	Unmet	N/A	Met	Unmet	N/A	Met	Unmet	N/A
	# (%)	# (%)	#	# (%)	# (%)	#	# (%)	# (%)	#
Population Health and Wellness	4 (100.0%)	0 (0.0%)	0	35 (100.0%)	0 (0.0%)	0	39 (100.0%)	0 (0.0%)	0
Acquired Brain Injury Services	43 (93.5%)	3 (6.5%)	0	85 (96.6%)	3 (3.4%)	0	128 (95.5%)	6 (4.5%)	0
Ambulatory Care Services	40 (88.9%)	5 (11.1%)	1	72 (92.3%)	6 (7.7%)	0	112 (91.1%)	11 (8.9%)	1
Ambulatory Systemic Cancer Therapy Services	63 (96.9%)	2 (3.1%)	1	90 (97.8%)	2 (2.2%)	0	153 (97.5%)	4 (2.5%)	1
Cancer Care and Oncology Services	45 (97.8%)	1 (2.2%)	0	83 (98.8%)	1 (1.2%)	0	128 (98.5%)	2 (1.5%)	0
Community-Based Mental Health Services and Supports	43 (97.7%)	1 (2.3%)	0	89 (94.7%)	5 (5.3%)	0	132 (95.7%)	6 (4.3%)	0
Critical Care	47 (94.0%)	3 (6.0%)	0	109 (95.6%)	5 (4.4%)	1	156 (95.1%)	8 (4.9%)	1
Developmental Disabilities	52 (98.1%)	1 (1.9%)	0	81 (100.0%)	0 (0.0%)	3	133 (99.3%)	1 (0.7%)	3
Diagnostic Imaging Services	32 (94.1%)	2 (5.9%)	33	37 (90.2%)	4 (9.8%)	28	69 (92.0%)	6 (8.0%)	61
Emergency Department	60 (84.5%)	11 (15.5%)	0	103 (96.3%)	4 (3.7%)	0	163 (91.6%)	15 (8.4%)	0
Emergency Medical Services	36 (85.7%)	6 (14.3%)	7	89 (91.8%)	8 (8.2%)	14	125 (89.9%)	14 (10.1%)	21
Home Care Services	46 (93.9%)	3 (6.1%)	0	74 (97.4%)	2 (2.6%)	0	120 (96.0%)	5 (4.0%)	0
Hospice, Palliative, End-of-Life Services	43 (95.6%)	2 (4.4%)	0	107 (99.1%)	1 (0.9%)	0	150 (98.0%)	3 (2.0%)	0
Long-Term Care Services	52 (96.3%)	2 (3.7%)	0	96 (97.0%)	3 (3.0%)	0	148 (96.7%)	5 (3.3%)	0
Medicine Services	44 (97.8%)	1 (2.2%)	0	75 (97.4%)	2 (2.6%)	0	119 (97.5%)	3 (2.5%)	0

Standards Set	High Priority Criteria *			Other Criteria			Total Criteria (High Priority + Other)		
	Met	Unmet	N/A	Met	Unmet	N/A	Met	Unmet	N/A
	# (%)	# (%)	#	# (%)	# (%)	#	# (%)	# (%)	#
Mental Health Services	50 (100.0%)	0 (0.0%)	0	89 (96.7%)	3 (3.3%)	0	139 (97.9%)	3 (2.1%)	0
Obstetrics Services	71 (100.0%)	0 (0.0%)	2	88 (100.0%)	0 (0.0%)	0	159 (100.0%)	0 (0.0%)	2
Organ and Tissue Donation Standards for Deceased Donors	53 (98.1%)	1 (1.9%)	0	85 (89.5%)	10 (10.5%)	1	138 (92.6%)	11 (7.4%)	1
Organ and Tissue Transplant Standards	87 (100.0%)	0 (0.0%)	0	114 (96.6%)	4 (3.4%)	0	201 (98.0%)	4 (2.0%)	0
Organ Donation Standards for Living Donors	61 (92.4%)	5 (7.6%)	0	107 (91.5%)	10 (8.5%)	0	168 (91.8%)	15 (8.2%)	0
Perioperative Services and Invasive Procedures	101 (87.8%)	14 (12.2%)	0	105 (96.3%)	4 (3.7%)	0	206 (92.0%)	18 (8.0%)	0
Primary Care Services	55 (94.8%)	3 (5.2%)	0	89 (97.8%)	2 (2.2%)	0	144 (96.6%)	5 (3.4%)	0
Public Health Services	40 (85.1%)	7 (14.9%)	0	65 (94.2%)	4 (5.8%)	0	105 (90.5%)	11 (9.5%)	0
Rehabilitation Services	40 (88.9%)	5 (11.1%)	0	76 (95.0%)	4 (5.0%)	0	116 (92.8%)	9 (7.2%)	0
Reprocessing and Sterilization of Reusable Medical Devices	44 (84.6%)	8 (15.4%)	1	50 (82.0%)	11 (18.0%)	2	94 (83.2%)	19 (16.8%)	3
Spinal Cord Injury Acute Services	50 (100.0%)	0 (0.0%)	0	92 (98.9%)	1 (1.1%)	0	142 (99.3%)	1 (0.7%)	0
Spinal Cord Injury Rehabilitation Services	47 (100.0%)	0 (0.0%)	0	87 (100.0%)	0 (0.0%)	0	134 (100.0%)	0 (0.0%)	0
Total	**1621 (93.2%)**	118 (6.8%)	60	2566 (95.2%)	129 (4.8%)	58	4187 (94.4%)	247 (5.6%)	118

* Does not includes ROP (Required Organizational Practices)

Overview by Required Organizational Practices

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

This table shows the ratings of the applicable ROPs.

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

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Communication			
Client Identification (Critical Care)	Met	1 of 1	0 of 0
Client Identification (Diagnostic Imaging Services)	Met	1 of 1	0 of 0
Client Identification (Emergency Department)	Unmet	0 of 1	0 of 0
Client Identification (Emergency Medical Services)	Met	1 of 1	0 of 0
Client Identification (Home Care Services)	Met	1 of 1	0 of 0
Client Identification (Hospice, Palliative, End-of-Life Services)	Met	1 of 1	0 of 0
Client Identification (Long-Term Care Services)	Met	1 of 1	0 of 0
Client Identification (Medicine Services)	Met	1 of 1	0 of 0
Client Identification (Mental Health Services)	Met	1 of 1	0 of 0
Client Identification (Obstetrics Services)	Met	1 of 1	0 of 0
Client Identification (Organ and Tissue Transplant Standards)	Met	1 of 1	0 of 0
Client Identification (Organ Donation Standards for Living Donors)	Met	1 of 1	0 of 0

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Communication			
Client Identification (Perioperative Services and Invasive Procedures)	Met	1 of 1	0 of 0
Client Identification (Rehabilitation Services)	Met	1 of 1	0 of 0
Client Identification (Spinal Cord Injury Acute Services)	Met	1 of 1	0 of 0
Client Identification (Spinal Cord Injury Rehabilitation Services)	Met	1 of 1	0 of 0
Information transfer at care transitions (Acquired Brain Injury Services)	Met	4 of 4	1 of 1
Information transfer at care transitions (Ambulatory Care Services)	Met	4 of 4	1 of 1
Information transfer at care transitions (Ambulatory Systemic Cancer Therapy Services)	Met	4 of 4	1 of 1
Information transfer at care transitions (Cancer Care and Oncology Services)	Met	4 of 4	1 of 1
Information transfer at care transitions (Community-Based Mental Health Services and Supports)	Unmet	3 of 4	0 of 1
Information transfer at care transitions (Critical Care)	Met	4 of 4	1 of 1
Information transfer at care transitions (Emergency Department)	Unmet	2 of 4	0 of 1
Information transfer at care transitions (Emergency Medical Services)	Unmet	2 of 4	0 of 1

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Communication			
Information transfer at care transitions (Home Care Services)	Met	4 of 4	1 of 1
Information transfer at care transitions (Hospice, Palliative, End-of-Life Services)	Met	4 of 4	1 of 1
Information transfer at care transitions (Long-Term Care Services)	Unmet	3 of 4	0 of 1
Information transfer at care transitions (Medicine Services)	Unmet	4 of 4	0 of 1
Information transfer at care transitions (Mental Health Services)	Unmet	3 of 4	0 of 1
Information transfer at care transitions (Obstetrics Services)	Met	4 of 4	1 of 1
Information transfer at care transitions (Organ and Tissue Transplant Standards)	Unmet	0 of 4	0 of 1
Information transfer at care transitions (Organ Donation Standards for Living Donors)	Met	4 of 4	1 of 1
Information transfer at care transitions (Perioperative Services and Invasive Procedures)	Unmet	3 of 4	1 of 1
Information transfer at care transitions (Rehabilitation Services)	Met	4 of 4	1 of 1
Information transfer at care transitions (Spinal Cord Injury Acute Services)	Met	4 of 4	1 of 1
Information transfer at care transitions (Spinal Cord Injury Rehabilitation Services)	Met	4 of 4	1 of 1

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Communication			
Medication reconciliation as a strategic priority (Leadership)	Met	4 of 4	2 of 2
Medication reconciliation at care transitions (Acquired Brain Injury Services)	Met	5 of 5	0 of 0
Medication reconciliation at care transitions (Ambulatory Care Services)	Met	7 of 7	0 of 0
Medication reconciliation at care transitions (Ambulatory Systemic Cancer Therapy Services)	Met	7 of 7	0 of 0
Medication reconciliation at care transitions (Cancer Care and Oncology Services)	Met	5 of 5	0 of 0
Medication reconciliation at care transitions (Community-Based Mental Health Services and Supports)	Met	4 of 4	1 of 1
Medication reconciliation at care transitions (Critical Care)	Met	5 of 5	0 of 0
Medication reconciliation at care transitions (Emergency Department)	Unmet	3 of 4	0 of 0
Medication reconciliation at care transitions (Home Care Services)	Met	4 of 4	1 of 1

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Communication			
Medication reconciliation at care transitions (Hospice, Palliative, End-of-Life Services)	Met	5 of 5	0 of 0
Medication reconciliation at care transitions (Long-Term Care Services)	Met	5 of 5	0 of 0
Medication reconciliation at care transitions (Medicine Services)	Met	5 of 5	0 of 0
Medication reconciliation at care transitions (Mental Health Services)	Met	5 of 5	0 of 0
Medication reconciliation at care transitions (Obstetrics Services)	Met	5 of 5	0 of 0
Medication reconciliation at care transitions (Perioperative Services and Invasive Procedures)	Met	5 of 5	0 of 0
Medication reconciliation at care transitions (Rehabilitation Services)	Met	5 of 5	0 of 0
Medication reconciliation at care transitions (Spinal Cord Injury Acute Services)	Met	5 of 5	0 of 0
Medication reconciliation at care transitions (Spinal Cord Injury Rehabilitation Services)	Met	5 of 5	0 of 0

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Communication			
Safe surgery checklist (Obstetrics Services)	Met	3 of 3	2 of 2
Safe surgery checklist (Organ and Tissue Transplant Standards)	Met	3 of 3	2 of 2
Safe surgery checklist (Organ Donation Standards for Living Donors)	Met	3 of 3	2 of 2
Safe surgery checklist (Perioperative Services and Invasive Procedures)	Met	3 of 3	2 of 2
The “Do Not Use” list of abbreviations (Medication Management Standards)	Unmet	4 of 4	1 of 3
The “Do Not Use” list of abbreviations (Medication Management Standards for Community-Based Organizations)	Unmet	4 of 4	2 of 3
Patient Safety Goal Area: Medication Use			
Antimicrobial stewardship (Medication Management Standards)	Unmet	0 of 4	0 of 1
Concentrated electrolytes (Medication Management Standards)	Unmet	1 of 3	0 of 0
Heparin safety (Medication Management Standards)	Unmet	3 of 4	0 of 0
High-alert medications (Emergency Medical Services)	Unmet	5 of 5	2 of 3
High-alert medications (Medication Management Standards)	Unmet	1 of 5	0 of 3

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Medication Use			
Infusion pump safety (Ambulatory Care Services)	Met	4 of 4	2 of 2
Infusion pump safety (Ambulatory Systemic Cancer Therapy Services)	Met	4 of 4	2 of 2
Infusion pump safety (Cancer Care and Oncology Services)	Met	4 of 4	2 of 2
Infusion pump safety (Critical Care)	Met	4 of 4	2 of 2
Infusion pump safety (Emergency Department)	Met	4 of 4	2 of 2
Infusion pump safety (Hospice, Palliative, End-of-Life Services)	Met	4 of 4	2 of 2
Infusion pump safety (Long-Term Care Services)	Met	4 of 4	2 of 2
Infusion pump safety (Medicine Services)	Met	4 of 4	2 of 2
Infusion pump safety (Obstetrics Services)	Met	4 of 4	2 of 2
Infusion pump safety (Organ and Tissue Transplant Standards)	Met	4 of 4	2 of 2
Infusion pump safety (Organ Donation Standards for Living Donors)	Met	4 of 4	2 of 2
Infusion pump safety (Perioperative Services and Invasive Procedures)	Met	4 of 4	2 of 2

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Medication Use			
Infusion pump safety (Rehabilitation Services)	Met	4 of 4	2 of 2
Infusion pump safety (Spinal Cord Injury Acute Services)	Met	4 of 4	2 of 2
Infusion pump safety (Spinal Cord Injury Rehabilitation Services)	Met	4 of 4	2 of 2
Narcotics safety (Emergency Medical Services)	Met	3 of 3	0 of 0
Narcotics safety (Medication Management Standards)	Met	3 of 3	0 of 0
Patient Safety Goal Area: Worklife/Workforce			
Client Flow (Leadership)	Unmet	4 of 7	1 of 1
Patient safety plan (Leadership)	Met	2 of 2	2 of 2
Patient safety: education and training (Leadership)	Met	1 of 1	0 of 0
Preventive maintenance program (Leadership)	Met	3 of 3	1 of 1
Workplace violence prevention (Leadership)	Unmet	4 of 5	2 of 3
Patient Safety Goal Area: Infection Control			
Hand-hygiene compliance (Emergency Medical Services)	Unmet	1 of 1	0 of 2

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Infection Control			
Hand-hygiene compliance (Infection Prevention and Control Standards)	Met	1 of 1	2 of 2
Hand-hygiene compliance (Infection Prevention and Control Standards for Community-Based Organizations)	Unmet	0 of 1	0 of 2
Hand-hygiene education and training (Emergency Medical Services)	Met	1 of 1	0 of 0
Hand-hygiene education and training (Infection Prevention and Control Standards)	Met	1 of 1	0 of 0
Hand-hygiene education and training (Infection Prevention and Control Standards for Community-Based Organizations)	Met	1 of 1	0 of 0
Infection rates (Infection Prevention and Control Standards)	Unmet	1 of 1	1 of 2
Infection rates (Infection Prevention and Control Standards for Community-Based Organizations)	Met	1 of 1	2 of 2
Pneumococcal vaccine (Long-Term Care Services)	Met	2 of 2	0 of 0
Reprocessing (Emergency Medical Services)	Met	1 of 1	1 of 1

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Infection Control			
Reprocessing (Infection Prevention and Control Standards for Community-Based Organizations)	Met	1 of 1	1 of 1
Patient Safety Goal Area: Risk Assessment			
Falls prevention (Acquired Brain Injury Services)	Met	3 of 3	2 of 2
Falls prevention (Ambulatory Care Services)	Unmet	2 of 3	0 of 2
Falls prevention (Ambulatory Systemic Cancer Therapy Services)	Met	3 of 3	2 of 2
Falls prevention (Cancer Care and Oncology Services)	Met	3 of 3	2 of 2
Falls prevention (Critical Care)	Unmet	0 of 3	0 of 2
Falls prevention (Diagnostic Imaging Services)	Met	3 of 3	2 of 2
Falls prevention (Emergency Department)	Unmet	3 of 3	0 of 2
Falls prevention (Home Care Services)	Met	3 of 3	2 of 2
Falls prevention (Hospice, Palliative, End-of-Life Services)	Met	3 of 3	2 of 2
Falls prevention (Long-Term Care Services)	Met	3 of 3	2 of 2

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Risk Assessment			
Falls prevention (Medicine Services)	Unmet	3 of 3	0 of 2
Falls prevention (Mental Health Services)	Met	3 of 3	2 of 2
Falls prevention (Obstetrics Services)	Met	3 of 3	2 of 2
Falls prevention (Organ and Tissue Transplant Standards)	Unmet	0 of 3	0 of 2
Falls prevention (Organ Donation Standards for Living Donors)	Met	3 of 3	2 of 2
Falls prevention (Perioperative Services and Invasive Procedures)	Unmet	2 of 3	0 of 2
Falls prevention (Rehabilitation Services)	Met	3 of 3	2 of 2
Falls prevention (Spinal Cord Injury Acute Services)	Met	3 of 3	2 of 2
Falls prevention (Spinal Cord Injury Rehabilitation Services)	Met	3 of 3	2 of 2
Home safety risk assessment (Home Care Services)	Met	3 of 3	2 of 2
Pressure ulcer prevention (Cancer Care and Oncology Services)	Met	3 of 3	2 of 2
Pressure ulcer prevention (Critical Care)	Met	3 of 3	2 of 2

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

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Risk Assessment			
Venous thromboembolism prophylaxis (Cancer Care and Oncology Services)	Met	3 of 3	2 of 2
Venous thromboembolism prophylaxis (Critical Care)	Met	3 of 3	2 of 2
Venous thromboembolism prophylaxis (Medicine Services)	Met	3 of 3	2 of 2
Venous thromboembolism prophylaxis (Organ and Tissue Transplant Standards)	Met	3 of 3	2 of 2
Venous thromboembolism prophylaxis (Organ Donation Standards for Living Donors)	Met	3 of 3	2 of 2
Venous thromboembolism prophylaxis (Perioperative Services and Invasive Procedures)	Met	3 of 3	2 of 2
Venous thromboembolism prophylaxis (Spinal Cord Injury Acute Services)	Met	3 of 3	2 of 2
Venous thromboembolism prophylaxis (Spinal Cord Injury Rehabilitation Services)	Met	3 of 3	2 of 2

Summary of Surveyor Team Observations

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

Governance

The Winnipeg Regional Health Authority (WRHA) board is engaged and supportive of the organization's leadership and direction. Roles are defined by three bylaws approved by the Ministry. The board governs with regular meetings in addition to six board committees which have clear terms of reference and report to the full board regularly. Board members are appointed by the Ministry for three-year terms; the WRHA Board is diverse in skill set and experience. Conflicts of interest are declared at the beginning of each meeting.

An orientation is provided to new board members, consisting of reading material, courses, and one-on-one sessions with the CEO, depending on the needs of the individual directors. After each meeting and annually, a board self-assessment is completed to evaluate each board member's effectiveness related to having enough time to speak, having sufficient reading material, preparedness, and board chair facilitation. Adjustments are implemented if needed.

Decisions are made with extensive deliberation and discussion until consensus is reached or when board members are ready to vote. If more information or a deep dive is required, this will be arranged and further discussion will occur as necessary.

CEO selection is mandated to a search committee of the board. For their recent decision, a national firm was recruited to assist the board and feedback related to leadership criteria was sought from staff, physicians, and community partners. Objectives and expectations for the CEO are set by the board and annual evaluations are completed. Every two years a 360 feedback approach is used as well.

The client- and family-centred presence is incorporated into deliberations through patient stories that are brought to the board via the Quality/Patient Safety and Innovation Committee. This was evidenced via a review of board minutes as well as through discussions at the board interview.

Board members are knowledgeable about their role in governance as opposed to management, and clearly understand the difference. They take their role seriously and are engaged at all meetings. All members present participated in the discussions. Board members are passionate and patient focused in their deliberations and respectful of each other. They have established appropriate partnerships with municipalities, justice systems, housing, and other social programs and other regions to facilitate collaboration and optimize their ability to work together on common issues.

Quality is a regular agenda item and key performance indicators are brought to the board regularly for review.

Leadership

The new WRHA CEO has been in place for six months. There are 28,000 staff operating in over 200 sites in 12 community areas, and a $2.6B operating budget. In addition, there are a number of operating sites and programs with various contractual service agreements.

The leadership structure is a matrix model with operational and program accountability within the region and sometimes within the province. Programs are responsible for strategic planning, quality, and program priorities, with sites having budget and operational responsibilities. Previously the board established a Leadership Council and a Leadership Operations Committee. Now there are three “tables” with the executive who meet weekly, a Senior Operations Leadership Council (consisting of CEOs and COOs of all of the hospitals) that meets monthly, and a Regional Program Council that includes all leaders. The intent is for the executive to focus on strategic issues, with the programs focusing on specific operational matters.

The community of Churchill has been integrated with the WRHA since 2012 but due to rotating COOs and the lack of consistency in a solid management team, the organization is now just implementing a sustainable plan to effectively integrate Churchill within the WRHA. It is well underway but not yet complete (e.g., the map for the WRHA does not yet include Churchill and some of the branding, such as the sign outside the centre, says Churchill Health Authority rather than WRHA Churchill). The team is aware and plans are underway to close the gap.

There are 36 regional programs. Collaborative service delivery is provided with other organizations including Diagnostic Services Manitoba, CancerCare Manitoba, and Addictions Foundation Manitoba. A community model is entrenched with teams that are co-located, focusing on the integration of services across the continuum of care.

A new strategic plan was implemented effective April 1, 2016. The plan was developed with extensive engagement with clients, staff, and the public throughout the region. Six strategic directions were established. The priority WRHA population to be addressed is individuals living at the social and economic margins, especially those at risk for homelessness.

A formal region-wide approach to change management was not evident during interactions with the organization. This would be an excellent opportunity to develop a consistent evidence-based model for change management, to spread and sustain transformational change specifically related to patient flow innovation.

Community and community partnerships

The organization has maintained and strengthened previous partnerships as it has gone through organizational changes in recent years. WRHA has an excellent relationship and partnership with the University of Manitoba on matters related to collaboration on innovation, knowledge translation, and research on health-related quality improvement topics.

Some community partners have established excellent joint working relationships with specific WRHA staff, but the general consensus is that if that particular staff were to leave or move to another position, their replacement would find it challenging to navigate through the complex organizational matrix.

The organization has fostered and maintained Family Advisory Councils and Local Health Involvement Groups since the last accreditation on-site survey. These groups are valued and their input has been consistently sought for strategic planning and policy reviews. The patient stories to the board and other opportunities to share information are welcomed and sought by the organization to continue to strengthen their community relationships. In conversations with the public and community groups, there was a consistent message that the WRHA's priority focus on patient flow must be sustained, but also that the organization might consider other areas including staff attitude in client/patient interactions, communication, and "warm handoffs."

More than 20 CEOs, executive directors, directors of care, chief nursing officers, and leaders of the patient care homes (PCH), long-term care (LTC) homes, and other affiliated sites were present and engaged in the accreditation process.

The relationship between the WRHA and the affiliates is formalized through service agreements. Some agreements have lapsed, some will be rolled over for another five years, and some are being renegotiated. The relationships between individual affiliate sites works well when it is a person-to-person relationship focused on dialogue and problem-solving related to common operational concerns. The affiliates as a group would like to have a greater presence in strategic planning on a regular basis, as they have a common concern related to optimizing safe patient care.

Because the patient care homes and long-term care homes have a different philosophy of how care is delivered (i.e., the site is a home for the resident, they feel the organization treats them as if they are an extension of the acute care system), there is currently friction in the relationship, especially related to patient flow. There is an opportunity to take a more strategic approach and effect transformational change in patient flow by considering it as a system across the entire continuum of care, including the LTC and PHC systems. The affiliate sites feel that they have something to offer related to improvements but that they haven’t been asked to participate as part of the solution.

There have been starts and stops to some opportunities to work together. For instance, the Long-Term Care Committee, the Budget Task Force, and human resource planning meetings were started but no follow-up meetings occurred. The affiliates were encouraged to reach out to the organization again and initiate engagement in areas where there is common ground such as patient safety.

Integrated quality management

Each site and program is responsible for implementing and monitoring quality at their respective sites and services. There is also a board Quality/Patient Safety and Innovation Committee and the organization is in the planning stages of initiating an overall Quality Council. There was little evidence of coordination among the committees that monitor quality and the organization is encouraged to continue with its plan to develop a Quality Council to monitor the region-wide patient safety plan.

Performance indicators

Improving patient flow has been a priority since 2012. Various approaches such as LEAN, re-engineering, and process improvements have been adopted and two regional forums where staff and partner feedback was sought have occurred. Targets still have not been met and the WRHA has refocused the strategy as a flow improvement initiative, with targeted areas for improvement. Two technology systems have or will be implemented in the near future, including Oculys software and a Medworxx update.

The WRHA is encouraged to intensify its focus on managing resources by creating an accountable financial management culture and a transparent resource allocation process, seeking public feedback on funding priorities, linking population health and other utilization data, and implementing business technology solutions.

The board is encouraged to continue its focus on improving engagement using through strategies such as action planning by all managers, implementing performance conversations, establishing a leadership development program using a LEADS framework, implementing a talent pool planning process, initiating a physician engagement survey, and improving the hiring process.

Delivery of care and services

The Aboriginal program is a separate program that exists across the entire province. To ensure timely, high-quality service, it is suggested the self-referral/self-identification on admission initiative be reviewed so the program can be flagged and be proactive in assisting with the care of these clients. And, considering that at least 40 percent of the delivery of WRHA services involves the Aboriginal population, it is suggested a policy be implemented which would consider a review box for the program, to ensure cultural consideration has been included. Now that Metis citizens have status, this population also requires consideration.

Detailed Required Organizational Practices

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

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

Unmet Required Organizational Practice	Standards Set
Patient Safety Goal Area: Safety Culture	
Patient safety incident disclosure A documented and coordinated approach to disclosing patient safety incidents to clients and families, that promotes communication and a supportive response, is implemented.	· Leadership 15.6
Patient Safety Goal Area: Communication	
Information transfer at care transitions Information relevant to the care of the resident is communicated effectively during care transitions.	· Community-Based Mental Health Services and Supports 10.9 · Perioperative Services and Invasive Procedures 12.11 · Emergency Department 12.16 · Organ and Tissue Transplant Standards 16.3 · Emergency Medical Services 18.1 · Medicine Services 9.11 · Mental Health Services 9.18 · Long-Term Care Services 9.19
Client Identification Working in partnership with clients and families, at least two person-specific identifiers are used to confirm that clients receive the service or procedure intended for them.	· Emergency Department 12.6
The Do Not Use list of abbreviations The organization has identified and implemented a list of abbreviations, symbols, and dose designations that are not to be used in the organization.	· Medication Management Standards for Community-Based Organizations 1.5 · Medication Management Standards 14.6

Unmet Required Organizational Practice	Standards Set
Medication reconciliation at care transitions In partnership with clients, families, or caregivers (as appropriate), medication reconciliation is initiated for clients with a decision to admit and a target group of clients without a decision to admit who are at risk for potential adverse drug events (organizational policy specifies when medication reconciliation is initiated for clients without a decision to admit).	· Emergency Department 10.5
Patient Safety Goal Area: Medication Use	
Concentrated electrolytes The organization evaluates and limits the availability of concentrated electrolytes to ensure that formats with the potential to cause harmful medication incidents are not stocked in client service areas.	· Medication Management Standards 12.9
Heparin safety The organization evaluates and limits the availability of heparin products to ensure that formats with the potential to cause harmful medication incidents are not stocked in client service areas.	· Medication Management Standards 9.3
Antimicrobial stewardship The organization has a program for antimicrobial stewardship to optimize antimicrobial use. NOTE: This ROP applies to organizations providing the following services: inpatient acute care, inpatient cancer, inpatient rehabilitation, and complex continuing care.	· Medication Management Standards 2.3
High-alert medications The organization implements a comprehensive strategy for the management of high-alert medications.	· Medication Management Standards 2.5 · Emergency Medical Services 12.10
Patient Safety Goal Area: Worklife/Workforce	
Workplace violence prevention A documented and coordinated approach to prevent workplace violence is implemented.	· Leadership 2.12

Unmet Required Organizational Practice	Standards Set
Client Flow Client flow is improved throughout the organization and emergency department overcrowding is mitigated by working proactively with internal teams and teams from other sectors.NOTE: This ROP only applies to organizations with an emergency department that can admit clients.	· Leadership 13.4
Patient Safety Goal Area: Infection Control	
Infection rates The organization tracks health care-associated infections, analyzes the information to identify outbreaks and trends, and shares this information throughout the organization.NOTE: This ROP only applies to locations that have beds and provide nursing care.	· Infection Prevention and Control Standards 12.2
Hand-hygiene compliance The organization measures its compliance with accepted hand-hygiene practices.	· Infection Prevention and Control Standards for Community-Based Organizations 8.4 · Emergency Medical Services 8.7
Patient Safety Goal Area: Risk Assessment	
Falls prevention To minimize injury from falls, a documented and coordinated approach for falls prevention is implemented and evaluated.	· Emergency Department 10.6 · Perioperative Services and Invasive Procedures 11.11 · Organ and Tissue Transplant Standards 12.2 · Ambulatory Care Services 8.6 · Medicine Services 8.6 · Critical Care 8.7
Pressure ulcer prevention Each client's risk for developing a pressure ulcer is assessed and interventions to prevent pressure ulcers are implemented. NOTE: This ROP does not apply for outpatient settings, including day surgery, given the lack of validated risk assessment tools for outpatient settings.	· Medicine Services 8.7

Unmet Required Organizational Practice	Standards Set
Suicide prevention Clients are assessed and monitored for risk of suicide.	· Long-Term Care Services 8.8

Detailed On-site Survey Results

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

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

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

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

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

See Appendix B for a list of priority processes.

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

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

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

Priority Process Results for System-wide Standards

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

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

Priority Process: Governance

Meeting the demands for excellence in governance practice.

Unmet Criteria		High Priority Criteria
Standards Set: Governance		
11.4	The communication plan includes strategies to communicate key messages to clients and families, team members, stakeholders, and the community.	

Surveyor comments on the priority process(es)

The board is engaged and supportive of the organization's leadership and direction. Roles are defined by three bylaws approved by the Ministry. The board governs with regular meetings and different board committees: Quality/Patient Safety and Innovation, First Nations, Metis, and Inuit Health, Resources, and Audit. The committees have clear terms of reference and report to the full board regularly. Board members are appointed by the Ministry for three-year terms; the WRHA Board is diverse in skill set and experience. Conflicts of interest are declared at the beginning of each meeting.

The orientation for new board members includes reading material, courses, or one-on-one sessions with the CEO to meet the directors' needs. After each meeting and annually a self-assessment is completed to evaluate their own effectiveness related to having enough time to speak, enough reading material, preparedness, and board chair facilitation. Adjustments are made if needed.

Decisions are made with extensive deliberation and discussion until consensus is reached or they are ready to vote. If further information is required they arrange for a deep dive to be held and discuss again as needed.

The selection of the CEO is mandated to a board search committee. For their recent decision, a national firm was recruited to assist them and feedback on leadership criteria was sought from staff, physicians, and community partners. Objectives and expectations for the CEO are set by the board and annual evaluations are completed. Every two years a 360 approach is used as well.

The client- and family-centred presence is heard and included in deliberations through patient stories brought to the board by the Quality/Patient Safety and Innovation Committee. This was evidenced through the review of board minutes and discussions at the board interview.

The board is knowledgeable about its role in governance as opposed to management, and the difference is clearly understood. They take their role seriously and are engaged in the meetings. All members present participated in the discussions. They are passionate and patient focused and their deliberations are respectful of each other. They have established appropriate partnerships with municipalities, justice systems, housing, and other social programs and other regions to collaborate and work together on common issues.

Quality is a regular agenda item and key performance indicators are brought to the board regularly.

Priority Process: Planning and Service Design

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

Unmet Criteria		High Priority Criteria
Standards Set: Leadership		
1.3	Client- and family-centred care is identified as a guiding principle for the organization.	!
6.5	Formal strategies or processes are used to manage change.	

Surveyor comments on the priority process(es)

Previously, the leadership team identified and discussed both strategic and tactical issues and met weekly. This included the director of quality and planning. The new CEO recognized the need for a more strategic approach. Rather than operational committees, an executive steering group was formed to address the strategic needs of the organization. There are legislated requirements for a regular cycle of strategic planning and the organization now needs to focus on how to deliver the plan. It has recognized the need to look beyond sites and programs to engage staff, communities, and the public in the process.

Staff, local health involvement groups, and advisory councils were surveyed when the values, mission, and vision were reviewed. During this process a Declaration of Patient Values, written by patients for patients, was created and will be used by the organization. It is available on the website. The organization is commended on this work done by patient groups.

Consistent themes of needing more work on equity as heard from the board were followed up by stakeholder discussions with advisory councils.

Eighty sites and programs were asked to submit operational plans to accomplish the tactical activities to meet the strategic direction. The expectation was that sites and programs would work together to accomplish common outcomes. However, although sites and programs were encouraged and/or expected to work together to draft the operational plans, there was little evidence this occurred. For example, some acute care sites that have alternative level of care patients in acute care beds are not aware of what the community has in their plans to work toward the patient flow issues. Operational plans have been recently submitted and will be reviewed by the various levels of senior leadership teams for an overall plan for the organization.

The organization is encouraged to critically reflect on its measurement process and the key performance indicators that have been chosen, to monitor progress and ensure they are directly related to the desired strategic outcomes. It is important to be cautious about staff balancing their valuable time between daily

activities and conducting audits for the purpose of monitoring or working on change management to impact desired change.

With regard to the patient flow strategic direction, the organization is encouraged to find appropriate opportunities to work together among the many components of the health system along the continuum of care, such as acute care, community care, home care, and primary care, to ensure all are working toward the common goal, as this is a system issue. The Emergency Department (ED) is a symptom of the problem and perhaps a holistic approach might be required.

The organization is in the beginning stages of developing operational plans and measurable outcomes. In the few plans reviewed by surveyors, there are many process indicators with a start made on some high-level outcome measures. The organization is encouraged to move toward developing more outcome measures and to ensure, when process measures are used, that staff have a clear understanding of how they directly impact the strategic direction.

Priority Process: Resource Management

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

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

The leadership and commitment of the finance team to make a difference is laudable. They want to work toward a culture of being business partners. The operational plans of the region are being developed as a new strategy this year and this needs to be put in place in all areas and cascaded to the point of care to deliver results and realign resources. The finance team has done this work and is asking for a 0.5 percent reduction across the board from all areas to enhance financial stewardship. The region is in a significant deficit position and expects to double its current deficit in future years if the financial sustainability plan is not approved. The planning parameters that are bestowed on the region make it very challenging to achieve system efficiency while maintaining service levels and improving quality.

There has been some integration of financial systems, including moving to a standardized financial platform, over the past three years. The organization is encouraged to look at other opportunities to align and integrate regional structures and processes to achieve regional outcomes and comparative analysis. For example, there is more than one capital management team for major capital and this could be combined to enhance expertise and communication and decrease duplication and cost.

The finance and change management teams are working together to determine current and future needs. This work needs to continue from a value-add perspective. Kanban has taken place in some areas and the two-bin radio-frequency identification (RFID) system has started in some areas and needs to be applied in high-cost areas to enhance further savings. They are using visible pricing to enhance awareness at the point of care, which is a good visual. Continue to explore shared services opportunities including supply chain to enhance cost savings.

The capital management plan is submitted annually. The top ten priorities have been identified. There is an infrastructure risk throughout the region that the region is mitigating to the best of its ability. That said, there are opportunities to move to master assessment planning that aligns with program delivery. The region is aware of and is working on this, which is commendable. Comparability would enhance planning and the region is working on this as well, which is excellent. There is a significant projected need for long-term care beds over the next twenty years which will need to be addressed from a flow perspective and additional beds.

Master planning has helped identify opportunities for space and alignment of services. Continue to look at opportunities to synergize efficiencies throughout the region, similar to what was done with the cardiac program.

The organization is encouraged to put its "small house model" forward as a leading practice. This model is based on evidence-based design and interconnected pods. It been presented internationally and offers huge cost savings.

Priority Process: Human Capital

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

Unmet Criteria			High Priority Criteria
Standards Set: Leadership			
2.12	A documented and coordinated approach to prevent workplace violence is implemented.		ROP
	2.12.4	Risk assessments are conducted to ascertain the risk of workplace violence.	**MAJOR**
	2.12.8	Information and training is provided to team members on the prevention of workplace violence.	**MINOR**
10.5	There is a talent management plan that includes strategies for developing leadership capacity and capabilities within the organization.		
10.7	Position profiles are developed for each position and are updated regularly.		
10.8	Roles and responsibilities for patient safety are defined in writing.		!
10.10	Reporting relationships and leaders' span of control is regularly evaluated.		

Surveyor comments on the priority process(es)

The team has made progress since the last on-site survey, including the implementation of the SAP program which has helped them analyze the workforce and predict needs at a local and a regional level. They have started to roll out their performance conversations in a few pilot sites. The Health Sciences Centre (HSC) Winnipeg has rolled this out to its entire organization and is documenting what is important to people from a development perspective.

Cultural diversity and sensitivity is supported in the organization and this is appreciated by the staff. The organization did the AON Hewitt employee survey and asked for action plans from each site. These are being worked on. It would help this team greatly to have a single staff scheduling system and an enterprise risk management system; they are working on this. There are many unions and collective agreements in the organization and it would be beneficial to have a redesign of this challenge to assist with managing the work flow. Many staff members voiced concern about wage freezes that have been implemented for out of scope as well as the ability to recruit and retain people.

There have been many initiatives in many areas of the organization to increase staff engagement and enhance patient experience. These need to be shared regionally to enhance good practices throughout

the health authority. Also, continuing to look at shared services opportunities will enhance the workforce management systems.

Priority Process: Integrated Quality Management

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

Unmet Criteria			High Priority Criteria
Standards Set: Leadership			
12.5	The effectiveness of the integrated risk management approach is regularly evaluated and improvements are made as necessary.		
15.6	A documented and coordinated approach to disclosing patient safety incidents to clients and families, that promotes communication and a supportive response, is implemented.		ROP
	15.6.3	Those responsible for guiding and supporting the disclosure process are provided with training on disclosure.	**MAJOR**
	15.6.4	Communication occurs throughout the disclosure process with clients, families, and team members involved in the patient safety incident. Communication is documented and based on their individual needs.	**MAJOR**
	15.6.6	Feedback is sought from clients, families, and team members about their experience with disclosure and this information is used to make improvements, when needed, to the disclosure process.	**MINOR**
16.4	The organization has uploaded a client experience survey report for applicable services. Please refer to the current client experience requirement documentation in the client portal for more information.		!
16.5	Action has been taken on the client experience results.		!

Surveyor comments on the priority process(es)

There is a corporate quality and patient safety team as well as quality consultant resources at the program level to assist the programs to improve services and patient safety.

Staff feel supported in some areas to pursue quality initiatives.

The organization is pursuing LEAN Six Sigma training for all levels of management, to enhance the skill sets with a set of tools to foster change in the organization. This is in its beginning stages.

There is a complex strategic quality improvement initiative on patient flow which is led by a senior executive. The community, partners, and staff are aware that this issue is a strategic priority for the

organization and are available and willing to assist in any way possible. The organization is encouraged to reach out to all partners, public, and innovators to work on this together.

The feedback from community partners, patients, and public is that although a feedback loop exists, it is not timely and could be improved.

Priority Process: Principle-based Care and Decision Making

Identifying and making decisions about ethical dilemmas and problems.

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

The ethics framework was developed by ethics services and has been rolled out to be used by every program.

The framework is on the website and education is offered with tools and guidelines. An ethics public engagement group was also formed to focus on getting more intensive input.

There are approximately 40 ethics committees in the region and there is representation on the regional ethics committee. Not all sites, including affiliate sites, use the ethics framework. There is an opportunity to review the current structure to better meet the needs of direct care providers and clients.

There is a decision-making tool available that clients and families can use to work through ethical dilemmas, but not all staff are aware of it or how to access it.

Priority Process: Communication

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

Unmet Criteria	High Priority Criteria
Standards Set: Leadership	
7.5 There is an organization communication plan that addresses disseminating information to and receiving information from internal and external stakeholders.	

Surveyor comments on the priority process(es)

In late 2015 at the annual board retreat, one of the priorities and next steps was to develop a communication strategy for the region. A Request for Proposal was issued and the successful company will begin in 2016. The deliverables will be planned through a multilevel, focused review and assessment of WRHA's community engagement and communication capacity, and a vision, recommendations for change, and an implementation plan.

The information management systems are at different levels of electronic chart integration. The clinical information system is governed at the provincial level for all health regions.

There are clear processes to manage access to clinical and administrative information. However, patients find the process frustrating in that access to the complete continuum of care is not available through one access point.

Priority Process: Physical Environment

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

Unmet Criteria		High Priority Criteria
Standards Set: Emergency Medical Services		
10.2	The team's vehicle operators participate in regular training on how to drive and operate EMS vehicles.	!
Standards Set: Leadership		
9.1	The physical space meets applicable laws, regulations, and codes.	!
9.2	There are mechanisms to gather input from clients and families in co-designing new space and determining optimal use of current space to best support comfort and recovery.	
9.3	Client and team health and safety are protected at all times and particularly during periods of construction or renovation.	
Standards Set: Perioperative Services and Invasive Procedures		
3.1	The physical layout of the operating and/or procedure room(s) and equipment are designed to consider client flow, traffic patterns, the types of procedures performed, ergonomics, and equipment movement logistics.	
3.2	The area where invasive procedures are performed has three levels of increasingly restricted access: unrestricted areas, semi-restricted areas, and restricted areas.	!
3.3	Heating, ventilation, temperature, and humidity in the area where surgical and invasive procedures are performed are monitored and maintained according to applicable standards, legislation, and regulations.	
3.6	Airflow and quality in the area(s) where surgical and invasive procedures are performed are monitored and maintained according to standards applicable for the type of procedures performed.	!
3.9	The operating/procedure room has a restricted-access area for the sterile storage of supplies.	!

Surveyor comments on the priority process(es)

There are areas where clean and dirty equipment and material are in the same space. For example, in some sites, equipment was cleaned in the dirty utility room and stored in the same room until it was needed. The organization is strongly encouraged to review this practise.

There is old infrastructure throughout the region and the organization is doing its best to mitigate the effects. A master capital plan has been established and priorities identified. Priorities for the organization have been identified in the master capital plan. Staff are working hard to maintain the infrastructure but it does pose potential risks that the organization is aware of.

There is carpet on the walls and the floors at Victoria General and this is a potential infection risk that needs to be addressed.

Staff and patients were involved in the planning the new Women's Centre and they used an integrated design process that included the neighbours, which is laudable.

A standardized process to install hand-washing stations needs to be explored regionally.

HSC is using many opportunities to enhance the patient experience that could be shared regionally including amenities for the people they serve, the welcome desk, the digital signage program, a transitional unit, round the clock access to food, a staff wellness centre, and a relaxation room, to name a few.

Priority Process: Emergency Preparedness

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

Unmet Criteria		High Priority Criteria
Standards Set: Emergency Medical Services		
9.6	The organization trains team members on how to safely handle, store, use, and dispose of hazardous materials.	
Standards Set: Leadership		
14.9	A business continuity plan is developed and implemented in order to continue critical operations during and following a disaster or emergency.	
14.10	The business continuity plan addresses back-up systems for essential utilities and systems during and following emergency situations.	!
Standards Set: Public Health Services		
13.5	There is capacity to enhance surveillance during an emergency.	!

Surveyor comments on the priority process(es)

Site teams have had many opportunities to test their plans including power outages, evacuation of the children's hospital, a formaldehyde spill, a boil water advisory, and flooding, to name a few examples. The responsiveness and partnerships with the internal teams and police, fire, and EMS has been excellent and the plans have been executed well. Communications has been on top of these incidents and effective communication occurred through Twitter, text, media, and other modes to get the message out to internal and external stakeholders.

There is an opportunity for the WRHA to look at the structure of the committees and develop a regional integrated structure that enables further collaboration and coordination, shares best practices across the region, and decreases rework. Debriefings are done and opportunities for improvement are shared, although not always consistently, with partners including affiliates and non-devolved entities. Sharing this information consistently would enhance learning for all.

The communication newsletter that HSC puts out on contingency planning is a great way to raise awareness and could be shared region wide. There is an opportunity to look at updating regional plan to enhance coordination and standardization across the region, including surveillance. EMS screening is an excellent example of planning upstream and the team is encouraged to look at this model across the continuum. It is important to ensure material data sheets are updated in a timely manner and reflect what is being used.

Cluttered hallways were noted in many of the facilities. This could pose a potential risk during evacuation which needs to be addressed in patient and resident care areas.

There is great mobilization, planning, and partnerships to assist refugee populations in the communities. The organization is encouraged to ensure business continuity plans are revised and in place for all areas in the region.

Priority Process: Patient Flow

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

Unmet Criteria		High Priority Criteria
Standards Set: Emergency Department		
3.1	Client flow throughout the organization is addressed and managed in collaboration with organizational leaders, and with input from clients and families.	!
3.2	A proactive approach is taken to prevent and manage overcrowding in the emergency department, in collaboration with organizational leaders, and with input from clients and families.	!
3.3	Timely access for clients is coordinated with other services and teams within the organization.	!
3.5	Barriers within the emergency department that impede clients, families, providers, and referring organizations from accessing services are identified and addressed, with input from clients and families.	
3.11	Protocols to move clients elsewhere within the organization during times of overcrowding are followed by the team.	!
Standards Set: Leadership		
13.2	Information about barriers to client flow is used to develop a strategy to build the organization's capacity to meet the demand for service and improve client flow throughout the organization.	
13.3	The organization's leaders collaborate with other service providers and partners to improve and optimize client flow.	
13.4	Client flow is improved throughout the organization and emergency department overcrowding is mitigated by working proactively with internal teams and teams from other sectors. NOTE: This ROP only applies to organizations with an emergency department that can admit clients.	ROP
13.4.1	The organization's leaders, including physicians, are held accountable for working proactively to improve client flow and mitigate emergency department overcrowding.	**MAJOR**

13.4.4	The approach specifies the role of teams within the hospital and other sectors of the health system to improve client flow.	**MAJOR**
13.4.6	Interventions to improve client flow that address identified barriers and variations in demand are implemented.	**MAJOR**

Surveyor comments on the priority process(es)

Over the past years and even during the week of the on-site survey, there have been public outcries about sentinel events that has made patient flow and access one of the highest visible priorities and risks within the WRHA.

The region has worked tirelessly to identify mitigation strategies to deal with overcrowding and has invested in resources in the EDs to address patient flow and the lack of access to beds. However, within the region it was evident that access and flow issues were focused primarily on the EDs and acute care. This lack of integration along the health care continuum continued to not have the outcomes needed to truly affect access and flow and regain public confidence in timely access to care. Although strides and gains and pockets of excellence have been made at different sites, a formal regional approach that supports clear engagement and collaboration has not yet been implemented among primary care, pre-hospital, acute, community, and long-term care. This is evident not only in the health care sector but also with the minimal engagement at the client and family level.

A committed organizational accountability for flow at the executive level was noted at each site and region wide. However, there is no evidence to support that this mandate is fully embraced and that all health care leaders, including physicians, are held accountable throughout the continuum of care. Although it appears at the regional and site level that a proactive approach in the ED is taken to manage overcrowding, through the demonstration of many initiatives such as bed and safety huddles, leadership walks, and flow meetings, this work is primarily reactive and deals with real time situations of overcrowding and lack of access to beds. While there is consistent monitoring of trends, the strategies that are needed to support access and flow need to shift from a reactive nature to an inclusive proactive nature. This can only be accomplished working in inclusive accountable partnership with all care teams and along the continuum of care.

Timely access to care is still an issue at the site and region level for all levels of care in the ED. Full access depends on the level of acuity with priority for CTAS 1/2/3 clients; however, noted delays for lower level of care patients have a significant impact on overall access and flow in the department. Examples include a lack of inpatient and critical care beds, a lack of fast track ambulatory programs that support urgent referrals, and limitations in access to diagnostic imaging. This is most evident in access to CT with contrast and ultrasound procedures for some sites, and hard negotiations with on call radiologists are needed to determine priority. This occurs daily at some sites, with the work being deferred until the day shift as it was deemed not necessary by the on call radiologist. This puts continued stress on the department and further contributes to unnecessary waits for confirmation of diagnosis.

Each ED visited has made access and flow the top priority and is commended on their major contributions. However, even with all of this hard-focused LEAN work on flow processes in the ED, there continue to be apparent barriers in accessing timely services. Flow should not be viewed as solely the responsibility of the ED but rather the responsibility of the entire health care system. Using LEAN methodology, the teams have created unique strategies to deal with the barriers faced daily at their sites. Some ED physicians noted that they felt keeping the patients longer in the ED and resolving their issues there would have a positive effect on flow. By admitting them they in turn block an acute care bed for a longer length of stay due to the unwillingness of some physicians to discharge their inpatients. These perceptions need to be validated at the site level, so site-wide physician accountability can be addressed.

Within the region there are many data sources that can be used to support access and flow not only at the site level, but also at the provincial system level. Once completed, the data warehouse project will have the ability to merge data from all databases. Although currently not linked, the data is available to the region to create a bigger picture of the access system along the continuum of care. Data is collected on health determinants at pre-hospital, acute site, and community levels. This data is essential in supporting the continued growth and maturation of the regional flow program.

Current real time data sources in acute care that support the goal of right care, right place, and right time include ED Bedboard and ED Information System (EDIS) which are currently at all sites, Oculys, and Medworxx (in varying stages of rollout at the site level). The ED dashboard guides clients to make informed choices about timely access; however, it has not yet been proven to have a major impact on services. The Bedboard is available to the public online and also as an app. Bedboard stats clearly demonstrate that clients are accessing this data regularly and possibly using it to determine which ED they will go to, although no formal evaluation of the data has been done to prove this theory. There also still seem to be gaps in community understanding of services available in all jurisdictions and some clients interviewed did not understand the differences between urgent care, access, and emergency.

Comprehensive discharge planning is occurring at all sites, some with community and long-term care involvement. However, without formal integration with primary care, community, and long-term care, there will continue to be global barriers to discharging patients home or to another level of care in the community.

Priority Process: Medical Devices and Equipment

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

Unmet Criteria		High Priority Criteria
Standards Set: Diagnostic Imaging Services		
8.1	The individual responsible for the overall coordination of reprocessing and sterilization activities within the organization reviews and approves the team's set up and policies and procedures for cleaning and reprocessing.	
8.6	All diagnostic imaging reprocessing areas are physically separate from client service areas.	!
8.7	All diagnostic imaging reprocessing areas are equipped with separate clean and decontamination work areas as well as separate clean storage, dedicated plumbing and drains, and proper air ventilation and humidity levels.	!
8.10	The team stores clean diagnostic devices and equipment according to manufacturer's instructions and separate from soiled equipment and waste.	
8.11	The team has a process to track all reprocessed diagnostic devices and equipment so they can be identified in the event of a breakdown or failure in the reprocessing system.	
8.12	The individual responsible for the overall coordination of reprocessing and sterilization activities within the organization oversees the team's compliance with the organization's policies and procedures on cleaning and reprocessing.	
Standards Set: Infection Prevention and Control Standards for Community-Based Organizations		
10.1	The organization ensures that all staff involved in cleaning, disinfecting, and sterilizing reusable medical devices are trained to do so. This happens at orientation and whenever there is a change in the cleaning, disinfection, and sterilization processes.	
10.2	The organization verifies the competencies of staff involved in cleaning, disinfecting, and sterilizing reusable medical devices, as well as their knowledge of related policies and procedures.	

10.5	For each contaminated device and piece of equipment, a trained staff person uses a recognized classification system to determine what level of disinfection or sterilization is required.	!
10.7	When an organization cleans, disinfects, and/or sterilizes devices and equipment in-house, there are designated and appropriate area(s) where these activities are done.	!
10.8	The organization appropriately contains and transports items to the appropriate area for sterilization.	!
10.9	The organization selects disinfectants based on manufacturers' recommendations; the compatibility with the devices being disinfected; the compatibility with other agents used in disinfection or sterilization; the intended use of the devices being disinfected; and client/resident, staff, and environmental safety.	
Standards Set: Perioperative Services and Invasive Procedures		
4.4	For each contaminated device and piece of equipment, a trained team member uses a recognized classification system to determine the level of reprocessing required.	!
4.5	If disinfection is required, the organization's and manufacturer's detailed procedures for cleaning and disinfecting the reusable device or equipment are followed by a trained and competent team member.	!
4.9	Contaminated items are transported separately from clean or sterilized items, and away from client service and high-traffic areas.	!
4.14	The education, certification, and competency of team members involved in reprocessing in the operating/procedure room are verified.	!
Standards Set: Reprocessing and Sterilization of Reusable Medical Devices		
1.1	The organization collects information at least annually about service volumes and patterns of medical device use.	
1.2	The organization reviews its operational plan and the information it collects about service volumes and equipment use to decide which reprocessing and sterilization services are offered within the organization.	
1.4	The organization designates a trained and competent individual with the accountability for coordinating all reprocessing and sterilization activities across the organization, including those performed outside the medical device reprocessing department.	

1.6	The organization has the right number and mix of staff to carry out its reprocessing and sterilization activities.	
2.4	Supervisors and staff members involved in reprocessing have completed a recognized course in reprocessing and sterilization.	
2.5	The organization conducts baseline and annual competency evaluations of staff members involved in reprocessing and sterilization.	
2.7	The organization documents and retains records of education, training, and competency assessments.	
3.2	The organization limits access to the medical device reprocessing department to appropriate team members, and posts clear signage limiting access to all entry points.	!
3.3	The medical device reprocessing department is designed to prevent cross-contamination of sterilized and contaminated devices or equipment, isolate incompatible activities, and clearly separate different work areas.	!
3.4	The medical device reprocessing department has a specific, closed area for decontamination that is separate from other reprocessing areas and the rest of the organization.	!
3.6	The organization selects materials for the floors, walls, ceilings, fixtures, pipes, and work surfaces that limit contamination, promote ease of washing and decontamination, and will not shed particles or fibres.	
4.10	The team tracks changes to policies, SOPs, standards of practice, and manufacturers' instructions using a document control procedure.	
5.1	The medical device reprocessing department is equipped with hand hygiene facilities at entrances to and exits from the reprocessing areas, including personnel support areas.	
5.2	The medical device reprocessing department's hand hygiene facilities are equipped with faucets supplied with foot-, wrist-, or knee-operated handles, or electric eye controls.	!
11.2	All endoscopic reprocessing areas are physically separate from client care areas.	!
11.3	All endoscopic reprocessing areas are equipped with separate cleaning and decontamination work areas as well as storage, dedicated plumbing and drains, and proper air ventilation.	!

11.10	The record of endoscopic device reprocessing includes the identification number and the type of endoscope, the identification number of the automated endoscope reprocessor (if applicable), the date and time of the clinical procedure, the name or unique identifier of the client, the results of the individual inspection and leak test, and the name of the person reprocessing the endoscope.	
13.7	The team monitors compliance with policies and procedures, safe work practices, and OHS requirements in the reprocessing unit or area.	!
13.16	The team verifies and documents the quality of reprocessing services provided in other areas, or by contracted services or subsidiaries.	!

Surveyor comments on the priority process(es)

All team members were found to be energetically engaged in the accreditation process, clearly committed to the quality journey, and very proud of their programs and services. The clinical engineering team maintains medical devices and equipment in the organization and has an electronic preventive maintenance system that facilitates the preventive maintenance work. The organization has a good process to address demand maintenance requests as they are identified and the team responds to these in a timely fashion. The system also allows the organization to determine when equipment should be replaced based on its life cycle and repair history. Any equipment that is not maintained by the clinical engineering team is on a service contract.

The medical device reprocessing department (MDRD) is organized under the surgical services program at each of the sites, with regional program leadership. Throughout the WRHA, staff were found to be extremely dedicated and committed to performing quality work. WRHA could have a more integrated and comprehensive approach to coordinating medical device reprocessing by reassessing oversight of the service. There is no single, trained individual accountable for the coordination of reprocessing across the region. While the regional director of the MDRD is very skilled and competent, this position does not have responsibility for direct operations at any site or accountability for reprocessing that occurs outside of MDRD. The accountability for reprocessing of medical devices in areas outside of MDRD rests with the department performing the reprocessing (e.g. urology, maternal/fetal, ultrasound, etc.). This has led to suboptimal practices in some departments, with reprocessing occurring in patient care areas, inconsistencies in staff education and qualification, and varying reprocessing practices. WRHA is encouraged to create an organization-wide reprocessing committee with a single leader accountable for better coordinating services across the region and ensuring consistent reprocessing practice.

All MDRD departments across the region have a policy and procedure manual and standard operating procedures (SOPs). All staff are aware of the need to use personal protective equipment (PPE) and do so appropriately. While staff are aware of the need to use PPE, it was observed that on some units (e.g. endoscopy, where there is no physical separation between dirty and clean), staff would move from the decontamination area to the clean area without changing/removing their PPE. It would be advisable for the organization to ensure staff are aware of the cross-contamination risk and remind them of the need to remove PPE that was worn during decontamination.

Staff are also aware of the hand-hygiene policies and procedures and articulated their importance. While there are policies and procedures for MDRD, some do not appear to have been regularly reviewed and may be outdated. The SOPs at each site appear to be developed individually and do not appear to have been standardized across the region. There may be opportunities for the WRHA to disseminate the great work that is being done at some sites to other sites in the region and reduce the duplication of effort. This will ensure greater standardization and provide consistent practice across the WRHA.

The reprocessing and sterilization practices in the medical device reprocessing departments that were observed were generally within the documented quality standards. There is no reprocessing of single-use devices. Sites reported that flash sterilization is only used in emergency situations. The reprocessing of medical devices and equipment outside of the MDRD varied and the organization is encouraged to undertake a review of all reprocessing within the organization to ensure these processes meet documented quality standards.

The Health Sciences Centre has implemented an instrument tracking system that provides many benefits. These include the ability to trace instrument life cycle information, track individual instruments through the reprocessing and sterilization cycle, and tie the instrumentation to an individual patient procedure. This system has not been deployed at any other site within the WRHA. It may be beneficial for WRHA to assess whether the additional deployment of this system could provide further benefit.

The physical environment of the medical device reprocessing departments/areas varies by site. Some sites have opportunities for improvement that could enhance the quality of the service. Some of these opportunities will require capital investment while others may simply require adjustments to workflow. The faucets in some sites are not equipped with hands-free handles or controls. The MDRD team indicated that faucets have been ordered and were awaiting installation. The organization is encouraged to expedite the installation of the faucets and sinks in those areas that do not meet this standard.

Some sites lack physical separation between decontamination and clean areas. Some of these require minor modifications to ensure cross contamination from outside areas does not occur, while others appear to require more substantive renovations. The organization is encouraged to address physical plant issues as soon as possible and as they arise. In some sites, contaminated instruments were being transported in public elevators or elevators that also transported sterile devices. It is recommended that the organization investigate opportunities to create dedicated routes, that do not use public elevators, for the separate delivery of soiled and sterile items.

Priority Process Results for Population-specific Standards

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

Priority processes specific to population-specific standards are:

Population Health and Wellness

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

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

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

Surveyor comments on the priority process(es)
Priority Process: Population Health and Wellness

The WRHA's most recent Community Health Assessment report was released in 2015. Following a review of this report, the region identified its priority population as individuals living on the social and economic margins, especially those at risk for homelessness.

In the newly released 2016–2021 strategic plan, equitable care for all now forms part of the WRHA vision and has been added as a value, applying to all programs, sites, and community services in the region.

The dedicated and committed staff are congratulated on the work that has been done to date in positioning the region to move forward with this strategic direction. Committees such as the Health for All Executive Leadership Team, the Health for All Coordinating Committee, and the Health Outreach and Community Support Community Coordinating Network, to name a few, have clearly defined mandates with respect to reducing barriers and increasing equity in health services delivery.

Initiatives such as building capacity by educating staff on the importance of their role in reducing inequities specific to their program areas, increasing educational opportunities for working with culturally diverse populations, focusing on enhancing existing regional partnerships such as End Homelessness Manitoba and the Winnipeg Poverty Reduction Council, and establishing new partnerships including with government departments (e.g., justice, social services, health) have been undertaken. There is also an increased focus on the need for an organization-wide integrated service delivery model.

The energized population health and wellness team has identified several challenges on the journey to increase equity in health services for the WRHA population. These include limited resources, a lack of affordable housing, influencing public policy for improvements in health inequities, cultural diversity, sustainability, public support, and readiness for change.

There is evidence the team is monitoring performance measures for its priority population. An opportunity exists for the team to further refine these measures to ensure the data collected includes system indicators as well as process and outcome indicators.

There is evidence the region is an active participant in health promotion and disease prevention in the community. Educational sessions, including self-management education for chronic diseases, the Towards Flourishing program to reduce the stigma of mental illness, and various public health information sessions are held via a variety of public venues.

Standards Set: Public Health Services - Horizontal Integration of Care

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

Surveyor comments on the priority process(es)
Priority Process: Population Health and Wellness
The focus on health equity and the team's written plans are sound. There is evidence that their strategies and activities are addressing physical and social environmental factors. Strong and diverse intersectoral partnerships are in place.

Service Excellence Standards Results

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

Priority processes specific to service excellence standards are:

Competency - Primary Care

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

Living Organ Donation

- Living organ donation services provided by supporting potential living donors in making informed decisions, to donor suitability testing, and carrying out living organ donation procedures.

Organ and Tissue Transplant

- Providing organ and/or tissue transplant service from initial assessment to follow-up.

Infection Prevention and Control for Community-Based Organizations

- Infection Prevention and Control for Community-Based Organizations

Medication Management for Community-Based Organizations

- Medication Management for Community-Based Organizations

Clinical Leadership

- Providing leadership and direction to teams providing services.

Competency

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

Episode of Care

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

Decision Support

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

Impact on Outcomes

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

Medication Management

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

Organ and Tissue Donation

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

Infection Prevention and Control

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

Diagnostic Services: Imaging

- Ensuring the availability of diagnostic imaging services to assist medical professionals in diagnosing and monitoring health conditions

Blood Services

- Handling blood and blood components safely, including donor selection, blood collection, and transfusions

Public Health

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

Standards Set: Acquired Brain Injury Services - Direct Service Provision

Unmet Criteria		High Priority Criteria
Priority Process: Clinical Leadership		
1.3	Service-specific goals and objectives are developed, with input from clients and families.	
1.7	Working collaboratively with partners, service needs of clients moving from youth to adult services are identified and access to those services is facilitated.	
Priority Process: Competency		
The organization has met all criteria for this priority process.		
Priority Process: Episode of Care		
The organization has met all criteria for this priority process.		

Priority Process: Decision Support	
The organization has met all criteria for this priority process.	
Priority Process: Impact on Outcomes	
13.3 There is a standardized process, developed with input from clients and families, to decide among conflicting evidence-informed guidelines.	!
15.7 There is a process to regularly collect indicator data and track progress.	
15.8 Indicator data is regularly analyzed to determine the effectiveness of the quality improvement activities.	!
15.9 Quality improvement activities that were shown to be effective in the testing phase are implemented broadly throughout the organization.	!
Surveyor comments on the priority process(es)	
Priority Process: Clinical Leadership	

The acquired brain injury (ABI) unit in Riverview Health Centre is a well run, high-functioning unit. Client feedback is sought and changes made to space and set up when appropriate. An example is the realignment of existing space to create a more private family room, based on client and family input.

While this team is high functioning and understands the program goals, there is no formalized operational plan for the service that links to the broader organizational strategic plan. Clear goals in alignment with the organizational strategic plan and measurable outcomes would help focus the team and make best use of resources.

There is a strong interdisciplinary team that includes staff from the facility as well as integrated rehabilitation/allied professionals who are regional staff. Additional program staff from home care and external agencies as needed participate actively in patient rounds and discharge planning.

The interdisciplinary team is well represented by numerous rehabilitation professionals (occupational therapy, physical therapy, speech language pathology, nursing and physician support, pharmacy, dietetics, social work, and management) to provide team dialogue, discussion, and planning. Team members are comfortable with one another, know their roles, and work together in a strong collaborative way to facilitate client-centred care.

External agency partners (e.g., Manitoba Brain Injury Association, income support) are also involved as needed. Additional strong partnerships exist in the community to support clients on discharge.

Throughout their rehabilitation journey, appropriate information is shared with clients and families about services available during inpatient recovery and discharge planning and options for families to consider in preparation for discharge. This is discussed regularly with clients and families as well as more formally at family meetings.

Staff members stated that they receive regular performance reviews and allied professional staff receive joint reviews from the unit manager and their allied health manager.

Priority Process: Competency

The interdisciplinary ABI team is led by a strong and collaborative physician, enhancing the work of this high-functioning team. Respect for expertise and skills among team members is evident, as is close collaboration. All staff have appropriate skill sets and qualifications to support this population.

Clients and their families are aware of their key lead and the team members on their care team. They feel comfortable bringing concerns or queries forward. As stays are often lengthy in this unit, patients and families have developed strong connections with staff and for the most part feel comfortable communicating and planning together.

To enhance skills, there are internal staff development opportunities via the intranet and website and external workshops and conferences.

While staff felt they manage ethical discussions as a team, they had little awareness and knowledge of the ethical framework at the organizational level.

The organization offers training on violence prevention in the workplace as part of the comprehensive orientation. A policy is in place to identify reporting processes.

There is a comfortable spiritual space at Riverview that provides regular services and could be realigned to provide support and space for alternate cultural events.

Since the last on-site survey this team has embarked on a team functioning evaluation process and used the results to further build team strength. In addition, several front-line staff were trained in the collaborative care model. The organization is encouraged to provide this training across the organization as amalgamation continues.

Priority Process: Episode of Care

The interdisciplinary team is a highly motivated, client-focused group of professional staff. Respect and recognition of each other's roles and skill sets are obvious among team members, who work together to maximize functional gains for their clients.

The unit is well designed with private rooms for clients, rooms for family and patient interactions, and adequate clinic space. A whiteboard for client therapy times is posted to ensure timely attendance. The hallway and public spaces are clean and clutter free.

During observation on the unit and in therapy it was evident staff and clients maintain a close working relationship with a strong focus on client goal achievement. The clients interviewed spoke highly of the staff and the services provided by the team. Each team member completes a comprehensive assessment for every client which is shared during team discussions, and decisions are documented.

The clients spoken with were aware of their rights and knew who to contact if they had concerns about their care. Client rights and responsibilities were posted in the facility.

A best possible medication history (BPMH) is gathered at admission and shared with required services at transition and discharge points. This is well documented in the charts, using a standard form.

While the BPMH is present and there is evidence of transition out of the unit, there is no consistent receipt of medication reconciliation information being received from sending facilities inside the WRHA and from other regions. The organization is encouraged to explore supports for transferring programs to facilitate receipt of medication information.

The team collaborates with clients and their families to develop goals and objectives. The goals are identified as integrated goal lists at the front of the charts. This ensures they are clearly visible and at the top of everyone's mind.

The team has developed a transition document to ensure pertinent information is provided at transition points and at discharge. It includes summary information from all programs.

The care for ABI clients is excellent at Riverview but coordination across the organization and other facilities is a challenge. Home care is very supportive along the discharge planning path but the ABI program is challenged in discharging their clients due to limited resources in the community. Access to and the availability of outpatient treatment, housing, and vocational training are a few of the community gaps that hinder discharge.

There continues to exist a two-tier system in that clients who have been involved in a motor vehicle accident have access to third-party funding for private care providers after discharge, but other ABI clients are unable to access the same level of post-discharge care and outpatient services. Although this is a challenging provincial dialogue, the WRHA is encouraged to continue to work at developing a consistent model of care that covers the full continuum of services for this complex client population.

Priority Process: Decision Support

Technology is utilized for ABI with the development of a centralized wait list that assists the unit in the admission process.

Charts reviewed were complete and accurate. Charts were well organized and standardized assessment tools and testing protocols were used by the interdisciplinary team and provided consistent information collection. The functional independence measure (FIM) was used by all disciplines to create a

comprehensive picture of clients' functioning and improvement. The charts contained team and client-specific goals that had been jointly developed, with action plans.

The ABI unit has well done integrated progress notes on the main chart; however, a secondary charting process continues for specific disciplines. This practice has the potential to cause errors and conflicting information. It also impacts staff work time as they have to complete two charting systems. The organization is encouraged to review this practice and explore charting processes to eliminate the duplication. This documentation risk will be minimized once EMR is in place but encouragement is given to find a more timely solution.

There are policies to support disclosure and staff can readily speak to the process and indicate they are comfortable speaking to families in the event of an incident.

Priority Process: Impact on Outcomes

The ABI unit has a highly skilled team with an understanding and awareness of current best practices and guidelines in this field. Continued growth and awareness of evidence-based guidelines is encouraged to ensure a high quality of care, as are opportunities for staff development, including collaborative care model refreshers.

Increasing their knowledge of the most current guidelines may assist the team members to develop a formal review process when assessing the most appropriate evidence-based guidelines. This process is not currently in place.

Safety issues and conversations are key and readily visible throughout the unit. Formal falls risk assessments are done and charted at admission and at regular intervals to ensure client safety. Equipment is in place to assist with falls risk on the unit and in the rehabilitation delivery areas. Documentation and client and family education regarding falls is posted at multiple locations and safety on this unit appears to be embedded in their culture.

Incidents are reported on the computer through the RL6 process throughout the facility. Results are shared appropriately with managers and staff and improvements are identified. Trending of falls will provide additional information and opportunities for improvement. Disclosure is also done as per policy in the event of a client fall.

Indicator development is in the early stages with some collection of data having been completed. Ongoing collection with analysis would highlight improvements and required corrections. Benchmarking and use of comparative targets would further demonstrate positive gains.

The organization is encouraged to share the results of quality improvement indicator tracking and trending and consider displaying them on a quality board or similar communication vehicle so this knowledge can be used in other areas of the organization.

Standards Set: Ambulatory Care Services - Direct Service Provision

Unmet Criteria			High Priority Criteria
Priority Process: Clinical Leadership			
2.7	A universally-accessible environment is created with input from clients and families.		
Priority Process: Competency			
3.3	A comprehensive orientation is provided to new team members and client and family representatives.		
3.4	Education and training are provided to team members on how to work respectfully and effectively with clients and families with diverse cultural backgrounds, religious beliefs, and care needs.		
3.6	Education and training are provided on the organization's ethical decision-making framework.		
5.5	Education and training on occupational health and safety regulations and organizational policies on workplace safety are provided to team members.		!
5.7	Education and training are provided to team members on how to prevent and manage workplace violence, including abuse, aggression, threats, and assaults.		!
Priority Process: Episode of Care			
7.14	Clients and families are provided with information about how to file a complaint or report violations of their rights.		!
8.2	The assessment process is designed with input from clients and families.		
8.6	To minimize injury from falls, a documented and coordinated approach for falls prevention is implemented and evaluated.		ROP
	8.6.1	A documented and coordinated approach to falls prevention is implemented.	**MAJOR**
	8.6.4	The effectiveness of the approach is evaluated regularly.	**MINOR**
	8.6.5	Results from the evaluation are used to make improvements to the approach when needed.	**MINOR**
Priority Process: Decision Support			

11.8	There is a process to monitor and evaluate record-keeping practices, designed with input from clients and families, and the information is used to make improvements.	!
Priority Process: Impact on Outcomes		
15.8	Indicator data is regularly analyzed to determine the effectiveness of the quality improvement activities.	!
15.11	Quality improvement initiatives are regularly evaluated for feasibility, relevance, and usefulness, with input from clients and families.	

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

Including patients on the Patient Advisory Councils and Local Health Involvement Groups is commended. In each of the areas, a strong culture of continuous quality improvement supported both at the local and program level was evident. However, there was less understanding as to how all of the program-specific quality councils aligned with the organizational quality.

The on-site survey included clinics in oral health, bariatrics, health psychology, rehabilitation geriatrics, the Manitoba renal program, genetics, child health, sleep, cardiac science, surgery outpatient, and breast health. Clinics were easy to recognize with welcoming images and appropriately located directional signs.

Staff interviewed in all of the programs are extremely engaged. They commented on strong clinical leadership and demonstrated an interdisciplinary team model dedicated to meeting the needs of the patient populations in the various programs. This was reflected in the client satisfaction surveys in addition to in-person feedback.

Staff members all stated that they received their annual performance appraisals.

Priority Process: Competency

The WHRA is to be commended on the wide array of courses available to support staff in orientation and training. The use of technology to deliver many of the modalities makes it easier for staff to access and provides real time learning when required. The use of infusion pumps was sporadic among the programs surveyed but where applicable the teams implemented the appropriate protocols.

All areas demonstrated a strong team approach to client-centred care. Teams consist of both regulated professionals and non-regulated staff. In all areas staff members have the necessary credentials to perform their roles and a review of human resource files demonstrated that the annual performance appraisal process was being followed. In each of the areas an orientation was provided to new staff, students, and volunteers; however, this was inconsistent for physicians. Some programs could benefit from a standardized orientation process focused on organization policies and workplace safety.

There was no formal cultural competency training for Aboriginal (First Nations, Inuit, and Metis) clients. The organization might want to consider competency training related to other groups as well.

Priority Process: Episode of Care

The ambulatory programs surveyed provide a wide range of services to a very diverse population. Each program had evidence of great strengths and also opportunities for improvement. There is a strong focus on providing client-centred care and providing clients and families with information that is pertinent to their specific needs. All programs demonstrated flexibility within their processes to accommodate client requests, where possible, and to coordinate schedules across services to facilitate access. This was validated through all of the client interviews.

Each program has developed an approach to medication reconciliation specific to their area, but consistency across programs was apparent. There was a strong understanding of not only the process but also of the client safety benefits related to medication reconciliation. As identified by the quality roadmaps, many of the programs have just started implementing their falls assessment tools. The organization is encouraged to continue its focus on this safety initiative.

Observation of the genetics program brought attention to not only a strong team and a well-oiled clinic, but also to the standard use of patient care plans.

All areas demonstrated consistency in information shared during transition points, and clients were provided with information at end of service to support their specific care needs. Information is provided to clients and their families in easy-to-understand language and, if required, interpretive services are readily available. However, few programs evaluated the effectiveness of the information provided. The organization may want to implement a process to obtain this feedback.

Priority Process: Decision Support

Among all programs surveyed, a process exists to ensure client information is complete and maintained in a secure environment. The use of research varies across the programs and in certain areas a dedicated approach to research and development to support improvements to care and care environments is evident. In all instances where research is undertaken, there is appropriate research and ethics oversight.

The areas surveyed demonstrated a wide range of information management and clinical systems. In all instances the systems met their unique needs but there exists an opportunity for WRHA to implement a consistent information management system for ambulatory care settings.

Priority Process: Impact on Outcomes

All programs demonstrated a procedure to select evidence-informed guidelines for the services being offered. Programs demonstrated evidence of reducing variation and improving clinical standardization in addition to related processes and forms. There is effective collaboration with other services and programs to provide comprehensive services for clients and ensure a smooth transition between services.

All programs had specific goals with clear targets related to access and quality which was evident with the quality roadmaps. In many areas, quality improvement boards displayed these measures and were placed in areas open to the public. A few programs are challenged from a space and capacity perspective that may impact their ability to continue to deliver services in a timely manner.

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

Unmet Criteria		High Priority Criteria
Priority Process: Clinical Leadership		
The organization has met all criteria for this priority process.		
Priority Process: Competency		
6.4	Education and training are provided to team members on how to work respectfully and effectively with clients and families with diverse cultural backgrounds, religious beliefs, and care needs.	
6.14	Team member performance is regularly evaluated and documented in an objective, interactive, and constructive way.	!
Priority Process: Episode of Care		
The organization has met all criteria for this priority process.		
Priority Process: Decision Support		
The organization has met all criteria for this priority process.		
Priority Process: Impact on Outcomes		
18.3	There is a standardized process, developed with input from clients and families, to decide among conflicting evidence-informed guidelines.	!
Priority Process: Medication Management		
4.5	Environmental distractions for team members who are ordering, verifying, checking, preparing, dispensing, and administering systemic cancer therapies are identified, addressed, and limited.	
Surveyor comments on the priority process(es)		
Priority Process: Clinical Leadership		

Some services are co-designed with families. For example, discharging home to primary care has a patient advisory component and input from patients and providers is considered for improvements.

Several sites had patient input into their physical design. For example, many of the renovations to Seven Oaks General Hospital and a patient waiting room at Concordia Hospital were designed with input from patients and community members. Many of the chemotherapy chairs are in areas that do not allow for

private conversations; however, clients and families did not take issue with this. The programs may want to consider offering an alternative room, or making clients aware of the option, should they need a space for private treatment or discussion.

It was observed that the leadership was committed and engaged in providing excellent service in addition to improving it. Leaders were passionate about their work which it turn led staff to be passionate about the care they provide. All teams were observed to be cohesive and take pride in their work. Clients and families often remarked that they felt the teams were high functioning and the care they received was outstanding.

Many partnerships exist, the most significant being with CancerCare Manitoba (CCMB). Many patients are seen in the innovative Hub program and linked to service for certain disease sites within 60 days. In additional to clinical work, CCMB offers many psychosocial programs and supports for patients at various points along the cancer continuum.

Priority Process: Competency

Provider credentials and qualifications are regularly verified. Competencies (for example, infusion pump training) were also thoroughly verified.

An opportunity for improvement might be to include mandatory cultural competency training, particularly around First Nations, Inuit, and Metis patients in addition to other marginalized populations (for example, newcomers, lesbian, gay, bisexual and transgender patients) who often face significant barriers to care. It was noted that at several sites visited, this was not occurring despite a strong Aboriginal health program. Certainly this type of training needs to be balanced with other training priorities.

The orientation processes were clearly outlined and followed by new hires. Staff are encouraged to further certify themselves with programs such as ONDEC (Oncology Nursing Distance Education Course) and those from the Canadian Nurses Association (CNA). One site had all registered nurses certified with ONDEC and should be commended for this. The leaders for the oncology programs at WRHA have a vision to have all nurses ONDEC and CNA certified.

The organization has also taken steps to hire a nurse educator in oncology and this further demonstrates the commitment to safety and quality improvement, as much of this position's focus has been around medication reconciliation, infusion pumps, and other Required Organizational Practices. The nurse educator has brought consistency to training in quality and safety at a regional level and allowed for improvements in training (for example, infusion pump education).

Also impressive was the spiritual support program at Concordia that sends condolences and offers support to families after the death of a patient.

All sites visited had high levels of staff engagement and plans to continually improve in this domain. For example, the Grace oncology program scored 77 percent on their AON survey.

Priority Process: Episode of Care

Patients report a high degree of satisfaction with the care they receive. They feel empowered to speak up if they have an issue or complaint; however, none felt they had any to offer when asked during the on-site survey.

Patients felt their wishes for involvement in terms of knowing about their illness and care were respected and those who wanted full information had this request fulfilled. They had a good sense of planning for transitions and discharge and continue to be involved in the evaluation of transitions, along with the receiving primary care providers. Also impressive was an oncologist's discharge summary inviting a primary care provider to connect with her in the future if there were any further questions about survivorship care and/or recurrence.

It was evident that barriers to care were removed for patients. The organization promotes a CancerCare Manitoba urgent care line when direct care from an organization is not available, and online resources in multiple languages and in audio format are available for patients to learn about treatment and side effects. Other barriers that were removed include linking patients to primary care if they don't have a provider (through the WRHA or Hub), reserving parking for oncology patients receiving therapy, and providing drop-in/same-day appointments for patients at the Hub who face difficulties keeping appointments (many of whom may be struggling with substance use, mental health issues, and/or homelessness).

There appears to be good access to both psychosocial and palliative care. Not only are nurses educated about these areas and lend support, but specialized care was reported to be very accessible.

On numerous occasions, patients reported excellent access to written, electronic, and in-person learning to manage their cancer, psychosocial needs, and systemic treatment side effects.

Priority Process: Decision Support

Sites administering systemic chemotherapy use the ARIA system in combination with paper charts. Progress notes and medications can be found on the ARIA system and are easy to access. The organization is commended for its work in incorporating medication reconciliation and survivorship care plans into ARIA, and is encourged to strive toward a paperless system.

The COMPASS (Comprehensive Problem and Symptom Screening) tool is used at regular intervals. This allows providers to monitor symptoms, risk of falls, medication changes, smoking, and psychosocial care. It is impressive that interventions for certain symptom scores and for smoking status are recorded. Even more impressive is that education needs of patients are elucidated and specific programming geared to need (e.g., a fatigue workshop for clients) is created.

The organization is encouraged to continue this evidence-based work and use the data to further inform improvement strategies. Also, since many of the systemic chemotherapy programs are looking for either organizational or philanthropic support for tablets and wifi, an electronic version of the tool could be created to lessen the burden of data input.

Priority Process: Impact on Outcomes

There are standardized procedures to select evidence-informed guidelines at CancerCare Manitoba. Patients and families are not involved in all guideline selection; however, they are very involved with the In Sixty initiative. In this initiative pathways are developed with timelines and reviewed with patient input and further evaluated by a patient participation advisory group.

It is clear that safety incidents are reported and used to make improvements. Patients are informed of any risk or potential risk to their health.

Leadership uses indicator data to monitor their quality improvement efforts. For example, they are monitoring transitions back to family practices as well as the number of medication reconciliations that occur. A major quality initiative is the In Sixty program described above, that outlines timeframes from initial presentation to care for patients. It has been successful and is being used for other disease sites.

The oncology program director completes an annual operating plan that includes improvement plans and strategy and client and public engagement.

All sites visited had a strong improvement culture. Of particular note is the Grace Hospital that had leadership visits for improvement and several quality improvement initiatives informed by patient surveys.

Priority Process: Medication Management

WRHA has a comprehensive orientation that includes many aspects of medication management. Spill kits were observed on all sites. No abbreviations or dashes were seen on chemotherapy labelling or prescriptions. All sites were using ARIA for computerized physician order entry (CPOE). A pharmacist was on-site at the Grace and Concordia sites who works directly with the prescribing physician and oncology nurses. Documentation appeared to be appropriate for the planned care and any changes to care.

The environments where nurses complete double checks of systemic agents were open and in two cases the double check took place in the treatment room. This creates a higher potential for distraction and the organization is encouraged to address it. Staff at Seven Oaks, which has an alcove-type area for checking, also endorsed the potential for distraction.

Standards Set: Cancer Care and Oncology Services - Direct Service Provision

Unmet Criteria	High Priority Criteria
Priority Process: Clinical Leadership	
The organization has met all criteria for this priority process.	
Priority Process: Competency	
3.4 Education and training are provided to team members on how to work respectfully and effectively with clients and families with diverse cultural backgrounds, religious beliefs, and care needs.	
Priority Process: Episode of Care	
The organization has met all criteria for this priority process.	
Priority Process: Decision Support	
The organization has met all criteria for this priority process.	
Priority Process: Impact on Outcomes	
13.3 There is a standardized process, developed with input from clients and families, to decide among conflicting evidence-informed guidelines.	!
Surveyor comments on the priority process(es)	
Priority Process: Clinical Leadership	

There is strong clinical leadership on this team. Physicians and staff are very engaged, collaborative, and collegial. Of note, the team worked with clients and families on improvements to parts of the ward, and clients and families raised funds to purchase new furniture and redesign a common/quiet room for the ward. The leaders of this service either work closely or have dual roles with CancerCare Manitoba or other provincial agencies and have been synergistic for planning and caring for patients.

A long-standing physician has and continues to be central to the activities of the ward and was involved in planning its infection prevention and control infrastructure. His planning and expertise has led to low rates of fungal (and likely other) infections in clients with compromised immune systems.

Despite not having a nurse educator, there were several opportunities for staff education on this service. However, a desire to have a dedicated clinical nurse educator was raised by the team. There are clinical research nurses and clinical nurse specialists who often fill this gap.

The team also identified a desire for a dedicated general oncology ward/service as many oncology patients are on medicine or elsewhere in the hospital or care system. They believe this would improve the care of these patients by clustering an area of expertise. If this is being considered a needs assessment would be a good place to start.

Of note, a clinical nurse educator position was created for the region following the last accreditation cycle, and this has led to many improvements and well-articulated and extensive orientation.

Staff are educated about the use of infusion pumps and have received feedback on performance and an opportunity to discuss their professional goals. Of note, an engagement survey is used for this and other teams and leaders are charged with making improvements in this area.

Priority Process: Competency

Credentials, qualifications, and competencies are documented and are current. Staff report a solid orientation to the service and to the skills and knowledge needed to provide care. There is good evidence of ongoing education and training.

All staff interviewed report that performance appraisals and discussions about professional goals take place. Staff report formal and informal recognition for their work. The service and organization are commended for this.

Team functioning is evaluated using a validated engagement tool from AON with high levels of active engagement on this unit. Staff reported satisfaction working on this team. Clients felt the care they receive on this service was superior because staff were happy and this directly translated to excellent care.

There was no evidence of cultural competency training (e.g., for First Nations, Inuit, or Metis), and care for other marginalized groups such as newcomers to Canada or lesbian, gay, bisexual, and transgender clients also may be enhanced with further training. However, it is noted that this team makes the patient the centre of care and any issues related to a lack of formal cultural competency training are likely minimal, if that.

Priority Process: Episode of Care

It is clear this clinical team removes barriers to care. For example, several clients faced severe mental health and substance use disorders that made care challenging. The team worked on strategies to care for these individuals and other marginalized clients to help them achieve their goals. Otherwise, they would not have any options for care. Furthermore, access and client empowerment is improved by having information about cancer care in multiple languages and in audio format on the CancerCare Manitoba website. The team even creates DVDs for clients who may not have access to the resources on their website (e.g., those without internet access in the north) and mails them to remote parts of the province.

There is a comprehensive intake process that includes several instances to educate clients and orient them to the ward. A client remarked, “It is not home, but the staff make it like home.” Clients consistently described excellent communication from staff, continually checking in about understanding and needs. It is evident in the charts and from discussion with clients that informed consent is obtained before care or procedures are undertaken.

The clients' physical and psychosocial health is assessed at intake. Clients report a good understanding of the goals of care. A falls strategy is fully implemented and it was observed that the team was making a change to the use of benzodiazepines after several falls were reported.

Transition planning occurs through a day/night treatment unit that bridges the gap between inpatient and outpatient care. This transition approach was evaluated and published in the Canadian Oncology Nursing Journal. Clients feel they have a clear understanding of their illness and when a transition may occur. They also describe having confidence that if their clinical status changes the team has other evidence-informed and patient-centred approaches to care.

Priority Process: Decision Support

Paper charts and medication administration records (MARs) are still being used on this program. They are complete, comprehensive, and current. Moving to an electronic medical record (EMR) would help with ease of communication and decision support (e.g., computerized physician order entry and remote access for on call providers). The organization is encouraged to consider using ARIA, as this would align with other oncology services.

It is clear that clients are informed about how their personal health information is collected. They are also aware that they may access it and how staff are to appropriately use this information. Clients are peripherally involved in some of the use of their personal information, for example, that complaints or feedback often shape improvements or strategy. The organization is encouraged to formally and proactively engage patients in planning and implementing changes to how personal health information is collected, stored, accessed, and used.

Priority Process: Impact on Outcomes

Evidence-informed guidelines are selected through processes either at CancerCare Manitoba or the organization itself. The In Sixty program includes clients and families in the selection of various care pathways.

This service uses the RL6 occurrence reporting system. If an occurrence is submitted, the manager is emailed and a review occurs. Near-miss occurrences at this organization are often under reported and the service and/or the organization is encouraged to look at strategies to improve this stream of information about safety.

The inpatient oncology team has published on a day/night transitional program and has also had success with a mucositis quality improvement strategy that was incorporated into regular clinical practice for the team. There has been some early interim success in terms of education about mucositis and the evaluation is ongoing. If the initiative is successful, the team is encouraged to further share their learnings.

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

Unmet Criteria			High Priority Criteria
Priority Process: Clinical Leadership			
3.4	Space is co-designed with input from clients and families to ensure safety and permit confidential and private interactions with clients and families.		
Priority Process: Competency			
4.6	Education and training are provided on the organization's ethical decision-making framework.		
5.3	Position profiles with defined roles, responsibilities, and scope of employment or practice exist for all positions.		
Priority Process: Episode of Care			
10.9	Information relevant to the care of the client is communicated effectively during care transitions.		ROP
	10.9.1	The information that is required to be shared at care transitions is defined and standardized for care transitions where clients experience a change in team membership or location: admission, handover, transfer, and discharge.	**MAJOR**
	10.9.5	The effectiveness of communication is evaluated and improvements are made based on feedback received. Evaluation mechanisms may include: • Using an audit tool (direct observation or review of client records) to measure compliance with standardized processes and the quality of information transfer • Asking clients, families, and service providers if they received the information they needed • Evaluating safety incidents related to information transfer (e.g., from the patient safety incident management system).	**MINOR**
12.7	The effectiveness of transitions is evaluated and the information is used to improve transition planning, with input from clients and families.		
Priority Process: Decision Support			
13.1	An accurate, up-to-date, and complete record is maintained for each client, in partnership with the client and family.		!

Priority Process: Impact on Outcomes	
17.4 Indicator(s) that monitor progress for each quality improvement objective are identified, with input from clients and families.	

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

The teams at the community-based mental health services sites visited are passionate about their services and there is evidence of a commitment to client-centred care and service delivery. The team is encouraged to further explore opportunities for family involvement and input into service structure and design in some program areas. It is recognized that this is happening in many areas while in some areas families have demonstrated a lack of commitment to become involved at this level. Team members are acknowledged for their continued efforts in these areas.

The teams have a clear understanding of the population they serve and use a collaborative approach to service delivery that is beneficial to all of the clients in their diverse programs.

The transition from the Manitoba Adolescent Treatment Centre (MATC) to the Intensive Community Re-integration Service (ICRS) approximately 2.5 years ago has resulted in increased space for client, family, and staff interaction in a private environment.

A strategy is in place to reduce the stigma of mental illness through a variety of public forums.

Priority Process: Competency

There is a qualified team of service providers with appropriate skill sets to meet the high standards of service delivery set by this program area.

A collaborative team approach is evident across all programs within this service. Strong, passionate leadership focused on client needs and services is clearly noted. The cross-disciplinary teams use a recovery model approach in working with clients to assist them to achieve their full potential.

Client rights are respected, including the right to refuse treatment when appropriate. Some program areas where the mental health court is involved have boundaries outside the program's scope.

WRHA sees itself as a teaching organization and as such students are welcomed. Student placements frequently come from the University of Manitoba health care curriculum.

Opportunity exists for staff to have ongoing annual training in key competency areas, such as suicide assessment and workplace violence prevention.

Staff note that professional development opportunities are available and encouraged.

Priority Process: Episode of Care

The community-based mental health services team is knowledgeable and committed to excellence in mental health care. They provide comprehensive services to a culturally diverse population and support clients through initial intake, assessment, and transition and discharge.

Although the various program teams identify themselves as part of the WRHA, there is still a sense of a need for further integration between some in-patient hospital-based services and some community-based mental health services. An organization-wide integrated service delivery model such as the evidence-informed, integrated, population-based, shared model of care currently being evaluated at ACCESS Winnipeg West is producing positive results, including improved access to services and improved navigation for clients and families within the organization. Plans to expand this model across the region as resources become available are positively noted.

The Mental Health Crisis Response Centre that opened in June 2013 is a welcome addition to the WRHA. This centre was developed with extensive stakeholder input. A comprehensive formative evaluation has been completed by the team and reflects feedback from clients and accompaniers, staff, and psychiatrists. This has yielded positive results.

The organization's suicide risk assessment tool is not used consistently across all community-based mental health services. However, clients are evaluated for high-risk behaviours and individual personal care plans identify safety measures on admission and at regular intervals during active admission. The formal, standardized organizational suicide risk assessment tool was introduced to all community-based mental health services in March 2016 and is used to assess new admissions and current clients that have been there for a while.

The team is encouraged to evaluate the effectiveness of its client information transfer and client follow-up services. Currently no formalized processes or mechanisms exist.

Priority Process: Decision Support

Community-based mental health services use both an EMR and a paper-based client record. In some program areas both records are used for each client while some are completely EMR or completely paper based. Team members note that this creates some inefficiency across the programs as service providers share information about a mutual client.

Privacy and confidentiality are protected. Access to client records is limited according to the needs of each of the disciplines.

Priority Process: Impact on Outcomes

There is opportunity for further development of data collection, analysis, and trending as a quality improvement initiative.

The Intensive Re-Integration Community Services (ICRS) program has been in place for approximately 2.5 years. A formal evaluation of this program has not yet been completed. The team is working toward developing indicators that will be used to assist in identifying and implementing quality improvement initiatives.

Standards Set: Critical Care - Direct Service Provision

Unmet Criteria		High Priority Criteria
Priority Process: Clinical Leadership		
1.3	Service-specific goals and objectives are developed, with input from clients and families.	
2.3	The required level of staffing is determined and maintained to provide consistent quality of service at all hours of the day and on all days of the week.	
2.5	Space is co-designed with input from clients and families to ensure safety and permit confidential and private interactions with clients and families.	
Priority Process: Competency		
5.7	Education and training are provided to team members on how to prevent and manage workplace violence, including abuse, aggression, threats, and assaults.	!
5.8	The organization's policy on reporting workplace violence is followed by team members.	!
Priority Process: Episode of Care		
6.1	Standardized criteria are used to determine whether potential clients require critical care services.	
7.12	Ethics-related issues are proactively identified, managed, and addressed.	!
8.2	The assessment process is designed with input from clients and families.	
8.7	To minimize injury from falls, a documented and coordinated approach for falls prevention is implemented and evaluated.	ROP
8.7.1	A documented and coordinated approach to falls prevention is implemented.	**MAJOR**
8.7.2	The approach identifies the populations at risk for falls.	**MAJOR**
8.7.3	The approach addresses the specific needs of the populations at risk for falls.	**MAJOR**
8.7.4	The effectiveness of the approach is evaluated regularly.	**MINOR**
8.7.5	Results from the evaluation are used to make improvements to the approach when needed.	**MINOR**

Priority Process: Decision Support

The organization has met all criteria for this priority process.

Priority Process: Impact on Outcomes

The organization has met all criteria for this priority process.

Priority Process: Organ and Tissue Donation

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

The critical care program is a respected and busy program that has a catchment area ranging from all across Manitoba, northwestern Ontario, Nunavut, and portions of southeastern Saskatchewan. While the program runs as a provincial program it does not have the funding that goes with a provincial program. The critical care programs appear to draw approximately 40 percent of their patients from outside Winnipeg. Having it designated as a provincial program may assist in providing some preventive, upstream care in the areas from which it draws its patients.

The critical care program is very responsive to the patients who require its services. The organization is encouraged to link all of the critical care programs under the critical care umbrella, such as the cardiac sciences surgical intensive care unit.

There is good evidence of strong partnerships between the medical leadership and the managerial leadership, which has translated into high-functioning teams.

Priority Process: Competency

The inability to effectively recruit nursing staff has led to bed closures in more than one critical care unit. Recruitment strategies such as setting up different technological machinery in the atrium and enticing nurses from other areas into the critical care educational programs has led to almost fully staffed units. One of the managers has taken to recruiting outside the city to attract nurses to critical care areas.

Filling managerial level positions is also problematic which has led to a concerted effort in career laddering and succession planning.

There is an obvious collegial atmosphere in the critical care unit, with all professions working closely together in a trusting manner. This leads to open, honest conversation and a true learning environment.

Staff have access to education and are encouraged to present at symposiums and conferences due to their expertise. A group of nurses at the Victoria General has won awards in Manitoba for developing

Cherry Blossoms, a visual aid that provides staff and providers with a cue that there is a patient in the room who is actively dying and to please respect their privacy and be respectful of noise when working in the area. The same staff developed a comfort basket, with tissues, water, and small snacks for families that were reluctant to leave the bedside when their loved one was close to death. These innovations are being rolled out to other critical care units in the region.

Priority Process: Episode of Care

Families are encouraged to take part in the provision of care as much as they feel comfortable. Staff will show them how to do certain procedures, such as oral suctioning, to allow them to be involved in caregiving. This is a great example of how the region shows that patients and families come first.

The critical care team's handover procedures at shift change, intake, and discharge, with all team members present and participating, going through the plans and goals of care and involving family and patient if able, should be considered the gold standard. There is ample opportunity for all members to ask questions and receive pertinent information for the next stage in the patient's care.

The team at St. Boniface is commended for their acclaimed work on managing delirium, as well for the innovative work they are doing to develop an advanced life support program for patients following cardiac surgery.

Priority Process: Decision Support

The WRHA is commended on starting the journey of implementing a single electronic patient health record across the region. The critical care program would benefit from having ready access to patient records as both the physicians and the patients move from site to site.

Priority Process: Impact on Outcomes

There are opportunities even within sites for managers and directors to do operational planning together that will benefit all services. The ability to extend surgical OR hours to decrease overtime for staff and ensure surgical procedures will then be able to be completed within the OR times and not run into up to three hours of overtime daily. This puts a financial burden on two programs.

Some unit leaders expressed a desire to have unit-specific goals and objectives with meaningful indicators that staff could feel they had an opportunity to be part of. One leader expressed a wish for monthly management meetings that just dealt with unit-specific issues and opportunities for improvement.

The team is encouraged to develop unit-specific indicators that can tied to program goals and ultimately to the WRHA strategic goals. Plan-do-study-act (PDSA) cycles are encouraged and the data needs to be analyzed to ensure desired outcomes are being achieved.

The team is also encouraged to look for ways to bring families and patients into planning and evaluating services at a program level. Satisfaction surveys are one way to get feedback on services, but interactive

dialogue when planning and evaluating services is recommended. There is great work with patients on advisory teams and on the outcome improvement team, where they have the ability to review outcomes and provide input into improvement strategies and program goals.

Priority Process: Organ and Tissue Donation

The team is encouraged to persist in identifying both organ and tissue donors. There is a good process developed that identifies potential organ donors, and the team is well prepared to maintain the donor.

Standards Set: Developmental Disabilities - Direct Service Provision

Unmet Criteria	High Priority Criteria
Priority Process: Clinical Leadership	
The organization has met all criteria for this priority process.	
Priority Process: Competency	
The organization has met all criteria for this priority process.	
Priority Process: Episode of Care	
The organization has met all criteria for this priority process.	
Priority Process: Decision Support	
The organization has met all criteria for this priority process.	
Priority Process: Impact on Outcomes	
14.3 There is a standardized process, developed with input from clients and families, to decide among conflicting evidence-informed guidelines.	!

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

St. Amant is a high functioning institution with a compelling mission and values, as evidenced in its reputation for quality care delivery. The leadership team is committed to ensuring staff feel well supported and safe. Volunteers are used extensively and their long-standing contributions are well respected and recognized by the organization. Student nurses and licensed practical nurses regularly participate in clinical placements. There are potential opportunities for the organization to consider expanding additional placements for other students in the coming years.

There is great team spirit across the facility. Staff members are engaged, compassionate, and knowledgeable in care delivery. A tuition assistance program to encourage staff to continue their education is in place and used consistently. The St. Amant programs are well integrated within the community and staff collaborate extensively with other external stakeholders in health, housing, education, and social and human services. Several staff members will soon be moving to the new Specialized Services for Children and Youth (SSCY) Centre, a novel partnership to support children with disabilities and their families.

A quality improvement roadmap has been implemented at St. Amant and initiatives are evident, although there are potential opportunities to create a more visible quality agenda. Families and staff indicate that

care continuity during transitions can be challenging, particularly when St. Amant residents are transferred to an acute care hospital ED and must remain on a stretcher before being admitted as an inpatient.

Medication management processes and practices are appropriate.

Interdisciplinary team members are engaged and knowledgeable and committed to best practices. Spiritual care services are available for residents, families, and staff, with formalized religious services occurring regularly in the facility chapel.

Family comments were exemplary regarding the care provided. A family council is well established with approximately 40 active members. Overall, St. Amant is a tremendous facility, with staff providing quality resident care.

Priority Process: Competency

St. Amant serves children and adults with developmental and physical disabilities with dignity and respect, making every effort eliminate to barriers to inclusion. The leadership and staff are invested in the lives of the individuals receiving services and are committed to helping residents achieve their desired outcomes. The staff have been particularly supportive on behalf of their residents in promoting Disability Matters: Vote 2016, a non-partisan public advocacy and awareness campaign.

There is an extensive orientation program for all staff working at the centre. Staff at St. Amant are afforded sufficient education and training to optimize care to residents. Input is received from all team members for the assessment and ongoing care of the residents. Staff spoke positively about their experience at St. Amant. Person-centred care is very much a priority for all employees.

Employees have access to regular staff educational opportunities including webinars, in-services, and self-taught modules to ensure skills are current. Education is offered on any new equipment or new skills or techniques such as new dressings. Reviews are done to ensure staff are confident in performing skills.

There is a process to assess and deliver safe lifting and handling for residents. The falls prevention program is well understood by staff. There is also ongoing education related to skin care and management of violence in the workplace. The policy on the reporting of incidents and accidents is closely followed. Reports are available and demonstrate changes and trends.

A multidisciplinary approach is in place at St. Amant and there are regular meetings to discuss care and services. Discussions on best approaches to use with individual residents are conducted on an ongoing basis. Care conferences are held for all residents on a yearly basis, with active participation by all staff involved in the care of the particular resident, including the family and when possible the resident. Physicians do not typically attend the conference, but are aware of the meetings and visit the residents on a regular basis. Dental services are available on site; there is a strong focus on optimization of oral health.

Every year several activities are planned to recognize the important contributions of staff and volunteers. Barbecues, holiday celebrations, recognition for long service in the facility, and regular volunteer appreciation events are some of the ways the organization makes a visible effort to say thank you.

Priority Process: Episode of Care

St. Amant has identified multiple strategies to improve resident care processes. The team is modifying the physical space to improve quality and safety, enhance resident experience, and ensure care is provided in a more contemporary home-style manner. Management monitors staffing needs and looks for solutions to ensure adequate coverage while allowing residents to see familiar and consistent professionals during their care journey. A massage therapist on contract with St. Amant provides fee-for-service interventions to residents and has developed a coaching program for St. Amant staff on mindfulness.

There is a well-documented process to administer medications, using matching photo identification on the dosette package and on the wheelchairs to ensure medication is administered to the right resident. Consents were evident on resident charts and residents and families were able to communicate their involvement. Advance care directives were documented using a standard form.

Standardized policies and procedures have been developed and are implemented across the site. Assessment tools have been developed according to best practices and are used to assist teams in conducting thorough, pertinent assessments.

There is a good regional approach to service coordination and regular meetings occur between St. Amant staff and community providers. Skin care is excellent, with few pressure ulcers across the organization. Staff take pride in ensuring residents are clean and well groomed. Residents are bathed daily. The organization uses shower stretchers for bathing and has purchased century tubs for all floors to allow residents to soak in the water during bath time.

Residents are given the opportunity to travel into the community and participate in local events as health, behaviour, and staffing allows.

There are waiting lists for admission to the facility. St. Amant is limited by its physical layout and by its staffing levels in the number of residents it can accommodate who are ambulatory with concomitant severe behavioural disorders.

Hospitalization admission rates are monitored and adjustments in care occur to avoid hospital admission. St. Amant staff are concerned about the frailty and vulnerability of their residents in the bigger acute care system and have witnessed adverse events (e.g., pressure ulcers, skin breakdown) when residents must be admitted to hospital.

Priority Process: Decision Support

Staff receive training on the use of software and specific standardized clinical equipment and protocols. The teams use a number of evidence-based guidelines, which is commendable.

Sharing information is a priority of the team. All nursing stations have computer access for staff. An up-to-date electronic record is maintained for every resident admitted to the facility. There are also hard copy paper files. Staff have easy access to the paper medical record which is appropriately stored to assure confidentiality. Staff are able to take individual charts and document, or take notes and enter these onto the appropriate electronic/paper chart on their return.

There is good flow of information between providers and across facilities and programs. St. Amant leadership has identified a specific budget for staff development and training and makes best use of these resources by prioritizing staff education needs. At times, education is brought in house as a more cost effective process. Webinars and self-learning modules are also used to provide staff with information regarding best practices, education, and research.

Consent is discussed and documented as verbal consent on the resident's chart. Telehealth is being used more routinely across the organization. The organization is encouraged to look for additional ways to engage families living at a distance (e.g., tele-visitation, FaceTime, Skype, etc.)

Priority Process: Impact on Outcomes

There are limited resources for this specialized population, resulting in longer than optimal wait lists for some services and supports. The St. Amant leadership team does discuss resource requirements and reviews and revises priorities as required to meet as many needs as possible.

There is written documentation regarding safety initiatives in the region and these are available to residents, families, and staff.

Outcome measurement across all service sectors will be helpful as St. Amant moves to expand and enhance its services. As the evaluation of all services at St. Amant becomes a more formal process, this information should help focus the organization to continue with its strong commitment to quality improvement.

The organization is encouraged to formalize its quality training for front-line staff and showcase more broadly its excellent quality initiatives and results.

Standards Set: Diagnostic Imaging Services - Direct Service Provision

Unmet Criteria	High Priority Criteria
Priority Process: Competency	
The organization has met all criteria for this priority process.	
Priority Process: Diagnostic Services: Imaging	
The organization has met all criteria for this priority process.	

Surveyor comments on the priority process(es)

Priority Process: Competency

Space dedicated to the Maternal Fetal Assessment Unit (MFAU) is well laid out and ensures privacy for the patients.

Priority Process: Diagnostic Services: Imaging

Observation of the Maternal Fetal Assessment Unit (MFAU) focused on the flow of patients, the quality of service and care provided by the health care providers, and the environment of the unit.

The team members are very responsive to the needs of the community and make every effort to accommodate more urgent demands. The nurses who administer the probe are highly experienced and well qualified.

The one concern noted is with regard to the space used for reprocessing the probes. This is done in a patient care room and can happen when a patient is in the room. This was discussed with the leadership of the unit and they are encouraged to advocate for a more appropriate set up and space for probe reprocessing when they move to the new site in the next year or so.

Standards Set: Emergency Department - Direct Service Provision

Unmet Criteria			High Priority Criteria
Priority Process: Clinical Leadership			
2.6	Seclusion rooms and/or private and secure areas are available for clients.		!
Priority Process: Competency			
The organization has met all criteria for this priority process.			
Priority Process: Episode of Care			
8.2	The Pediatric-CTAS is used to conduct the triage assessment of pediatric clients.		
8.4	A triage assessment for each pediatric client is conducted within P-CTAS timelines, and in partnership with the client and family.		!
10.5	In partnership with clients, families, or caregivers (as appropriate), medication reconciliation is initiated for clients with a decision to admit and a target group of clients without a decision to admit who are at risk for potential adverse drug events (organizational policy specifies when medication reconciliation is initiated for clients without a decision to admit).		ROP
	10.5.1	Medication reconciliation is initiated for all clients with a decision to admit. A Best Possible Medication History (BPMH) is generated, in partnership with clients, families, or caregivers, and documented. The medication reconciliation process may begin in the emergency department and be completed in the receiving inpatient unit.	**MAJOR**
10.6	To minimize injury from falls, a documented and coordinated approach for falls prevention is implemented and evaluated.		ROP
	10.6.4	The effectiveness of the approach is evaluated regularly.	**MINOR**
	10.6.5	Results from the evaluation are used to make improvements to the approach when needed.	**MINOR**
10.11	Priority access to diagnostic services and laboratory testing and results is available 24 hours a day, 7 days a week.		!
10.14	Priority access to consultation services is available 24 hours a day, 7 days a week.		!

12.6	Working in partnership with clients and families, at least two person-specific identifiers are used to confirm that clients receive the service or procedure intended for them.	ROP
12.6.1	At least two person-specific identifiers are used to confirm that clients receive the service or procedure intended for them, in partnership with clients and families.	**MAJOR**
12.16	Information relevant to the care of the client is communicated effectively during care transitions.	ROP
12.16.2	Documentation tools and communication strategies are used to standardize information transfer at care transitions.	**MAJOR**
12.16.4	Information shared at care transitions is documented.	**MAJOR**
12.16.5	The effectiveness of communication is evaluated and improvements are made based on feedback received. Evaluation mechanisms may include: • Using an audit tool (direct observation or review of client records) to measure compliance with standardized processes and the quality of information transfer • Asking clients, families, and service providers if they received the information they needed • Evaluating safety incidents related to information transfer (e.g., from the patient safety incident management system).	**MINOR**
13.9	The effectiveness of transitions is evaluated and the information is used to improve transition planning, with input from clients and families.	
Priority Process: Decision Support		
	The organization has met all criteria for this priority process.	
Priority Process: Impact on Outcomes		
16.3	There is a standardized process, developed with input from clients and families, to decide among conflicting evidence-informed guidelines.	!
16.4	Protocols and procedures for reducing unnecessary variation in service delivery are developed, with input from clients and families.	!
16.5	Guidelines and protocols are regularly reviewed, with input from clients and families, to ensure they reflect current research and best practice information.	!
18.13	Quality improvement initiatives are regularly evaluated for feasibility, relevance, and usefulness, with input from clients and families.	

Priority Process: Organ and Tissue Donation

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

The ED leadership is well defined in the region. There are three regional program leads with clearly defined roles that support the program, and clinical leadership at each site that reports to the CEO of the region.

Following two major incidents and public inquiries involving the EDs, they continue to be under public and media scrutiny while implementing numerous region-wide recommendations to support access to safe, timely care. One of the biggest gaps noted in the region is the lack of a coordinated approach to care along the health care continuum. This is demonstrated by the lack of formal partnerships among acute care, primary care, and the community. Although partnerships and relationships differ among the sites, there continue to be clear gaps in the relationships that need to be formalized and improved to provide for and meet the full needs of patients and families in the region. Some sites, like Concordia Hospital, Grace Hospital, and Victoria General Hospital have stronger relationships with community, primary care, and long-term care, and this has a more positive impact for their patients and families in the ED.

Emergency services in the region continue to strive to work in partnership with the patients and families. In the last quarter, regional patient experience survey results note improvements in all dimensions, reflecting an overall improvement in the quality of care and physical comfort provided. Enhancing overall patient experience continues to be a high priority for the region.

Staff at each ED surveyed stated that they felt supported and had clear lines of communication in an open venue with their clinical leadership teams regarding the provision of safe emergency care. At sites that have implemented the new performance conversation, tremendous positive results have been noted. Although overall staff engagement survey results were low and had seen some slight improvements in the region with regard to the EDs, all staff interviewed expressed positive reasons why they love working in their respective ED. No negative comments were made to the surveyor teams. All of the ED teams were undergoing pilot projects to look at creating greater access, flow, and departmental efficiencies, and all staff felt supported and were encouraged to work on quality projects using LEAN methodology.

There has been a significant increase in mental health referrals for the pediatric population, primarily related to residents from northern Aboriginal communities where the number of suicides has escalated. Numbers presenting to ED continue to increase (7 to 12 per day). The introduction of psychiatric emergency nurses has been positively received; however, a dedicated space that is quiet and removed from the fast-paced bustle of the ED is required for these patients. Recently, the HSC Children's Hospital

hired a child life specialist and clinical staff. Although these roles are new the impression is that the positions are making a difference with improved care. A formal evaluation of the roles from a needs/cost/benefit perspective will be done.

Many of the EDs that are new or have undergone physical upgrades to support safe and confidential care were developed with feedback from and in partnership with patients and families. Spaces such as the waiting rooms are now open with viable sight lines, and are staffed with either aides or volunteers.

Priority Process: Competency

The EDs have standardized defined credentials and training for all roles. For the professional roles such as nursing, allied, and medical, it is mandatory that all staff are licensed by a regulatory body. All staff members have an HR file with up-to-date information on their education and training. As emergency is a specialty area for both pediatric and adult, there is a comprehensive regional plan for education and training for nursing. This is mandatory for all nursing roles and takes a tiered approach to training, starting with the fundamentals of emergency care for the less acute population and increasing to higher acuity in the triage area. Each tiered level builds on levels of knowledge and understanding and is followed by hours of experience. This is a unique way to approach specialty training in the ED. It allows staff to build confidence and skills in a safe environment before being placed in higher acuity areas. Training includes dealing with mental health, pediatrics, palliative, and organ donation care.

It was noted through discussions with ED staff that this training is mandatory even for experienced new hires with specialty training. To deal with the redundancy in training, the regional emergency program is creating a challenge process to assess for competency and skill set. This will help expedite new hires with experience to placement in the department and should help with staffing issues.

All staff members new to the department not only receive specialty training, but also unit-specific training and organizational training in areas such as equipment, medical devices, and supplies. All staff are oriented to occupational health and safety, quality, documentation standards, and the organization's risk management process and ethics framework. Training is modified based on each role and includes all disciplines, inclusive of support services and volunteers. As there is an increased risk for violence in the EDs, a focus and training on workplace violence and reporting is also done as a high priority.

There is a clear, documented, and coordinated approach within the EDs regionally to look at training, evaluation, and competence with Infusion pump safety. Each site uses only one type of infusion pump (either one or three channels). All staff interviewed felt safe and competent in the use of infusion pumps.

As teaching and education are a mandate and focus in the region, each department has educators who support the staff. The majority of tertiary and community EDs also support formal universities by taking placements for nursing, medical, and allied health students. This also aids in the recruitment of new staff to their areas. The EDs are commended on their commitment and access to ongoing education and training.

Priority Process: Episode of Care

All EDs are well set up with equipment and processes to provide access to care with the highest level of standards regardless of infrastructure limitations in some of the departments. Each department took pride in their work. They made efforts to overcome the challenges of ED overcrowding and felt ownership and accountability to maintain access and flow at all times. Each of the EDs should be applauded on the work they have done regionally and at the site level to address the issues and recommendations from previous accreditation surveys and public inquiries. Although there continues to be a serious problem and public scrutiny with ED overcrowding, the EDs are leaders in the organization in the area of access and flow. Each site has leaders in the area and staff work hard to provide care under major system constraints.

All departments are clearly marked, making it easy for families and EMS to pick up and drop off patients. As a result of patient and family complaints during the winter, recent renovations to the Health Sciences Centre ED created a covered walkway to the entrance to provide a dry, warm entry into the department. Each department triage area is laid out differently but aims to support timely access for quick evaluation of patients for triage coding using CTAS and PCTAS standards. Although the waiting room is not the optimal place for patients to wait, lower level acuity patients may have long waits depending on congestion.

While in the waiting room, patients are mandated by the region to be monitored, reassessed, and formally documented on by staff, security and volunteers. There are audited targets of two to four hour assessments depending on CTAS classification, and every four hours for minor treatment area patients. This policy is strictly enforced following the Sinclair inquiry. The waiting room staff also provide support, communication, and care if appropriate to the patients while they wait. In patient and family interviews the waiting room staff were viewed positively by the community as a forward step in providing access to safe care.

Overcrowded waiting room and lack of sight lines from the triage desk to the waiting room were noted at the Health Sciences Centre Children's Hospital. There is concern that during busy periods patients and families may bypass the triage desk and go directly to the waiting room, and then experience an adverse event with no one from the ED staff noticing until it is too late. Although security staff are situated in the triage area and waiting room, it was noted by staff that if security is called away it leaves the waiting room unmonitored, which is not compliant with the new mandated policy. All physicians and staff interviewed expressed some concern about patient and staff safety related to this serious issue.

All patients are required to sign informed consent which is documented and witnessed and kept in the health care record. If the patient is incapable of giving informed consent a substitute decision maker is required. As the community that the WRHA serves is very diverse there is access to translation and interpretation services for over 40 languages to assist in providing safe care. All patients and families are informed during admission and provided information about their rights and responsibilities. They are also given information on how to file complaints or report issues.

The region as a whole is commended on putting patient-centred care and quality first and foremost within the vision and values. Although affiliate site's vision and values differ slightly depending on the organization and board, there continue to be close alignment with the overarching regional vision and values. This was clearly evidenced at all sites and each took immense pride in demonstrating respect and compassion for their patients and their distinctive cultural values while providing inclusive, integrated, holistic care.

Access and flow are key strategic priorities in the organization, with an emphasis on ED processes of care. Numerous ED flow targets have been set and are monitored daily, including ED wait times, EMS offload delays, and ED length of stay. Access and flow and achieving benchmarks continue to be major challenges due to downstream flow issues, lack of integration in community and long-term care, and gaps in access to primary care. There are significant off-load delays noted throughout the region and each site has created mitigation strategies to try to deal with this issue. It is noted, however, that EMS offload times are reported to be exemplary in the HSC pediatric ED.

There was significant improvement within the EDs since the last accreditation survey with regard to the uptake of medication reconciliation in the department. The ED programs are congratulated on their hard work on this Required Organizational Practice.

The new regional falls protocol was very recently implemented so is only in the infancy stages of differing levels of implementation and evaluation throughout the region. The region is using the "falling man" symbol and it was noted during the on-site survey to be in active use. Most EDs are compliant with education on the new process; however, formal evaluations to determine the effectiveness of the falls initiative in the ED are not fully implemented.

Suicide risk is a high priority in the ED and assessment is a mandatory part of the triage assessment. All the EDs met the criteria and are congratulated on their high compliance rates.

There are varying levels of access to diagnostic imaging (DI) and laboratory testing in the region. Both the tertiary centres (Health Sciences Centre and St. Boniface Hospital) have on call access after hours for CT and ultrasound services. St. Boniface and Concordia staff noted that negotiations were required at times with on call DI staff to convince them to come in after hours. This was not an issue for statutory holiday calls; however, staff felt that needs to be reviewed.

Priority Process: Decision Support

Within the EDs, there are multiple information systems that support the delivery of care to each of the EDs.

Although each site has differing levels of implementation of technology, there is a clear goal and timelines to address and standardize all information systems in the region. All departments currently use EDIS as well as the bedboards to track real time patient activity in the department. The regional

electronic ED dashboard reflects real time ED wait times at all sites and is currently available online and as an app. The latest regional data show the dashboard is receiving thousands of hits per month. In conversations with patients and families it is felt that the dashboard is used frequently to determine which site they will visit for their emergency care needs. In many of the sites the dashboard is up in the waiting room and visible to everyone.

The formal expansion of ClinDoc and Oculys is expected to roll out to all sites over the next year. The regional administrative director supports the site and regional program with up-to-date data and routine data analysis. Although there is no standardized documentation in the region, all sites have a combination of paper and electronic charting that supports care. All sites with EMRs have proper downtime procedures, which were visible and easy to access in the department. There are standardized policies on emergency room documentation and procedures including frequency of documentation and assessments which were met in the charts that were reviewed during the site visit.

There were no problems noted with the collection of standardized health information and all patient records reviewed were complete and up to date. All team members fully utilize all sources of information to support and drive quality patient care. This includes evidence-based best practice protocols and guidelines for the provision of emergency care, including pediatrics.

Formal processes are in place for patients to access their health records if requested. There was a culture of openness, transparency, and compassion in all patient/staff interactions witnessed during the ED on-site surveys. Many departments have formal interdisciplinary rounds at the bedsides of the patients, demonstrating an inclusive, family-centred care approach. This supports the patients and allows them to be included in their own health care and decision making when appropriate.

There is a strong culture of privacy at WRHA that meets provincial standards and is designed to protect patients. All staff attend education sessions on privacy and information regulation during orientation. Although the physical layout of each ED is different and not all triage areas were initially designed to today's standards, measures are taken by all staff to maintain confidentiality and privacy for patients in the area. St. Boniface Hospital and Concordia Hospital are bringing forward to leadership plans for triage and departmental renovations. The design process for the renovations included input from patients, families, and key stakeholders.

Priority Process: Impact on Outcomes

Within the WRHA there are standardized procedures to select evidence-informed guidelines for the provision of emergency care for adult and pediatric populations.

Partnerships with patients and families within a fully integrated care model that also encompasses reviewing and providing input into policy, procedures, and guidelines is still lacking. However, the family-centred care model exists within the region and it is anticipated this work will start once the system evolves and matures.

WRHA is an integrated teaching organization with robust research in all areas of the ED. All ethical research standards are met within the EDs. There is an inherent risk aversion culture in most of the sites in the region. This not only promotes some of the highest standards of emergency care, it is often perceived at the sites that patients cannot be discharged back to the community until they are better than baseline. This philosophy of providing the best care was demonstrated in all the EDs equally, with the ED teams taking pride in always promoting safe discharge.

Al EDs visited had resources to provide not only emergency care to mitigate risk, but also downstream allied rehabilitation care to ensure all discharges were safe. It is noted that this is not the norm in EDs across the country. The teams took immense pride in their added resources and feel it has huge impacts on their low national readmission rates. There was an increasing culture of adverse event reporting noted in the ED and each site demonstrated a clear, accountable, and timely process in the review of patient safety incidents. It is important to note that all EDs had open and highly visible quality boards showing their performance and outcome measures. Each site was proud to showcase the efforts of their quality initiatives through multiple dissemination strategies such as email, newsletters, websites, and in the local papers.

Many projects have been put on hold in the region. Sites are encouraged to review all quality improvement initiatives within the numerous regional councils and committees to come to consensus on priorities in the region. It was also noted that there were many successful quality initiatives in the EDs and program leaders are encouraged to promote open sharing of these successes across the region. Sites could leverage each other's successfully proven and effective quality initiatives to move their respective departments forward. Although the work may be derived from another site, each site can use its culture and traditions to individualize the initiative while maintaining the core goals and objectives to achieve the same intended outcomes. The regional emergency program is encouraged to continue with its quality improvement roadmap with clear and measurable criteria that are linked to the regional and site strategic priorities.

Priority Process: Organ and Tissue Donation

Transplant Manitoba is a well-established, province-wide program that supports and coordinates all organ and tissue donation within the WRHA. There are well-established province-wide protocols and policies on organ and tissue donation that help identify not only the donor but all processes along the transplant continuum of care.

Within the bundle of policies there are clear guidelines on neurological determination of death (NDD), as well as established referral points that assist health care professionals to identify potential organ donors. Although transplants are only performed at the Health Sciences Centre, each of the EDs visited during the on-site survey stated the staff were well supported by Transplant Manitoba not only for procurement but also for ongoing training and education to support their teams, patients, and families.

Transplant Manitoba posters were noted in all EDs and staff interviewed stated it was a seamless process from notification of the team to procurement when applicable. They also stated they were supported by the teams and a culture of respect and collegiality was noted when working with the teams.

Standards Set: Emergency Medical Services - Direct Service Provision

Unmet Criteria			High Priority Criteria
Priority Process: Clinical Leadership			
4.5	The medical oversight team makes sure the results of ongoing retrospective case reviews are applied to the organization.		!
Priority Process: Competency			
The organization has met all criteria for this priority process.			
Priority Process: Episode of Care			
16.15	The EMS team obtains and documents the patient's informed consent for high-risk treatment.		
18.1	Information relevant to the care of the client is communicated effectively during care transitions.		ROP
	18.1.1	The information that is required to be shared at care transitions is defined and standardized for care transitions where clients experience a change in team membership or location: admission, handover, transfer, and discharge.	**MAJOR**
	18.1.2	Documentation tools and communication strategies are used to standardize information transfer at care transitions.	**MAJOR**
	18.1.5	The effectiveness of communication is evaluated and improvements are made based on feedback received. Evaluation mechanisms may include: • Using an audit tool (direct observation or review of client records) to measure compliance with standardized processes and the quality of information transfer • Asking clients, families, and service providers if they received the information they needed • Evaluating safety incidents related to information transfer (e.g., from the patient safety incident management system).	**MINOR**
Priority Process: Decision Support			
The organization has met all criteria for this priority process.			
Priority Process: Impact on Outcomes			
22.2	The team uses the information and feedback it has gathered to identify opportunities for quality improvement initiatives.		

22.3	The team identifies measurable objectives for its quality improvement initiatives and specifies the timeframe in which they will be reached.	!
22.4	The team identifies the indicator(s) that will be used to monitor progress for each quality improvement objective.	
22.5	The team designs and tests quality improvement activities to meet its objectives.	!
22.6	The team collects new or uses existing data to establish a baseline for each indicator.	
22.7	The team follows a process to regularly collect indicator data to track its progress.	
22.8	The team regularly analyzes and evaluates its indicator data to determine the effectiveness of its quality improvement activities.	!
22.9	The team implements effective quality improvement activities broadly.	!
22.10	The team shares information about its quality improvement activities, results, and learnings with patients, families, staff, service providers, organization leaders, and other organizations, as appropriate.	
22.11	The team regularly reviews and evaluates its quality improvement initiatives for feasibility, relevance and usefulness.	
Priority Process: Medication Management		
12.10	The organization implements a comprehensive strategy for the management of high-alert medications.	ROP
12.10.6	The organization regularly audits client service areas for high-alert medications.	**MINOR**
Priority Process: Infection Prevention and Control		
8.7	The organization measures its compliance with accepted hand-hygiene practices.	ROP
8.7.2	The organization shares the results of measuring hand-hygiene compliance with staff, service providers, and volunteers.	**MINOR**
8.7.3	The organization uses the results of measuring hand-hygiene compliance to make improvements to its hand-hygiene practices.	**MINOR**
Surveyor comments on the priority process(es)		

Priority Process: Clinical Leadership

The programs reviewed clearly have strong medical leadership and support and are highly thought of by the organization.

Of particular note, the organization has exceptional relationships with contracted partners. While complicated in relational structure the system works and the partnerships are strong. The WRHA works hard to establish and foster relations with contractors, acting like a partnership rather than just a contract to be fulfilled.

Priority Process: Competency

The clinical competency of the practitioners in these programs is well examined and validated. In particular, the transfer team program is an excellent model that other jurisdictions may wish to emulate. The level of critical care provided in transit between facilities is excellent. The use of advanced practice respiratory therapists is a novel initiative that is not common in other jurisdictions.

Priority Process: Episode of Care

It is obvious the care teams are very engaged in the services they provide and take personal accountability for their practice. The critical care framework for interfacility transfer (IFT) in Winnipeg is innovative and appears to be extremely effective.

One opportunity for the organization involves enhancing the standardization of information transfer at transitions of care. A formal and recognized process helps mitigate issues around knowledge degradation when transitions occur.

A second area to consider is formalizing the documentation of consent by individuals when an intervention occurs outside of the admission process, specifically with regard to high-risk interventions.

Priority Process: Decision Support

The guidelines and clinical support for front-line practitioners are very good. Those who were interviewed commented on how well they are supported.

As can be expected, there was some comment on resource allocations, especially with regard to the IFT program. There continues to be some negative view on emergency resources to address IFT issues and who feel the programs should not overlap.

Priority Process: Impact on Outcomes

There is an opportunity for the organization to formalize and add rigour to the quality improvement projects that are being applied at the local level. There was evidence of several small incremental projects that were being done but for the most part they lacked process and rigour.

Of note was the excellent community integration being done in Churchill by the EMS team. They have embarked on many excellent initiatives, such as the non-emergency home visit program. This partners EMS with home care to manage patients in the community. The next step for this initiative would be quantitative and qualitative evaluation to demonstrate results. There are plans to do so but they have not yet been formalized.

Priority Process: Medication Management

Medication management was typically well controlled within the organization. The one opportunity for improvement identified was regarding the audit and assessment of high-alert medications.

Priority Process: Infection Prevention and Control

Infection prevention and control (IPC) philosophies are well recognized in the organization. The biggest opportunities for WRHA in this regard would be to enhance the hand-hygiene program to include increased surveillance and the development of initiatives to improve compliance.

Standards Set: Home Care Services - Direct Service Provision

Unmet Criteria		High Priority Criteria
Priority Process: Clinical Leadership		
The organization has met all criteria for this priority process.		
Priority Process: Competency		
3.10	Team member performance is regularly evaluated and documented in an objective, interactive, and constructive way.	!
Priority Process: Episode of Care		
9.9	Support for the family, team members, and other clients is provided throughout and following the death of a client.	
Priority Process: Decision Support		
11.8	There is a process to monitor and evaluate record-keeping practices, designed with input from clients and families, and the information is used to make improvements.	!
Priority Process: Impact on Outcomes		
15.8	Indicator data is regularly analyzed to determine the effectiveness of the quality improvement activities.	!
15.10	Information about quality improvement activities, results, and learnings is shared with clients, families, teams, organization leaders, and other organizations, as appropriate.	
Priority Process: Medication Management		
The organization has met all criteria for this priority process.		

Surveyor comments on the priority process(es)
Priority Process: Clinical Leadership
Since the last on-site survey, the home care program has begun to offer case coordination seven days per week and the high percentage of casual staff have been converted to permanent staff (equivalent full time optimization). This has resulted in the program being very responsive to hospital holds and urgent community needs, sometimes taking clients within hours of the request for service, which is to be commended. While not without its growing pains, this has resulted in higher satisfaction with the direct service staff in that they now have permanent employment, and clients are noticing a difference. The whole process has also resulted in less unassigned time, less agency use, a decrease in overtime, and more continuity in care for clients.

The program offers a wide basket of services (e.g., caregiver support, nursing, home support) to a diverse population of people with varying needs, some of whom are quite vulnerable).

It was very evident during home visits that some of the clients/families would not be able to keep the clients in their home without the excellent care being provided by the home care staff.

The home care staff work quite closely with their hospitals and the case coordinators working at the hospitals. There is a great deal of back and forth between the sites and the hospitals. Community Therapy Services is one the main partners, providing occupational, physio, and speech language therapy to home care clients. It is contracted by the WRHA.

The focus on client safety is evident at all sites visited. There is a quality board at the Pembina site and staff conduct their huddles there. Clients and families report feeling like partners in their care.

Priority Process: Competency

Numerous staff were approached about their orientation, including direct service staff (DSS), case coordinators, resource coordinators, scheduling staff, and administrative staff, and almost unanimously they reported their orientation met their needs. The orientation consisted of classroom time, shadowing/buddying opportunities, and in some cases more classroom time.

Staff recognition can be a challenge. However, team managers have been working to ensure staff feel valued and recognized for their hard work. The use of STAR cards, emails, telephone calls, and verbal in-person recognition are used. In some instances team managers provide treats or meals out of their own pockets. The staff did comment on this recognition and express their appreciation.

The recording of appropriate credentials is an HR role and team managers are confident this is complete.

Twice yearly the direct service staff are brought in for refresher training. Training on new equipment is done at the point of care and just in time. Attendance at training is recorded.

Priority Process: Episode of Care

Clients and families visited are for the most part very satisfied with their care. The only concerns raised related to direct service staff having to rush with care sometimes due to heavy workload. The direct service staff confirmed this can happen. Some clients may be lonely and consequently quite talkative when staff are there. Sometimes unexpected issues arise (e.g., low blood sugar) and as the time is so compressed this can impact the rest of the day.

Wound care is well done. The Braden Scale is used and staff have developed expertise around wound care. Physicians seek advice from the nurses who have additional training and education in wound care.

On a home visit the documentation was reviewed and the evolution of the wounds and the healing process was documented very clearly. The wounds were measured and the presence of exudate and the client's response was documented. The client had a drawing of where his wound was and was quite involved in his care.

Death of clients was discussed with staff. Several reported that they can develop strong relationships with clients and it can be quite traumatic to be the one who discovers a client is deceased. Some staff attend funerals to gain closure; however, the team needs to ensure that there is recognition that staff may be struggling.

The organization is to be commended on the work they are doing to meet the Required Organizational Practice on client identifiers, as this was an issue at the last on-site survey.

Priority Process: Decision Support

Client records are quite extensive with good communication tools. There is, however, a great deal of paper printed and/or faxed (sometimes multiple times) which could be a risk for the organization.

The program uses several electronic tools and works very hard to ensure the charts are complete.

There is a policy on privacy of personal information based on the Personal Health Information Act (PHIA), which is adhered to. All staff receive training on this policy during orientation and on a regular basis thereafter.

Priority Process: Impact on Outcomes

Since the last on-site survey, the RL6 solution has been implemented to document incidents and near misses. The team appears to have a fairly good culture of reporting incidents and near misses. Incidents are dealt with on an individual basis. Disclosure happens with clients and families. The next step for the team is to start compiling these reports on a monthly to quarterly basis, analyzing them, and sharing them with staff and clients.

The teams do not conduct formal safety huddles and they are encouraged to find ways to do this, perhaps by telephone or email, consider those working in the field.

A quality improvement roadmap has been developed for April 1, 2016 to March 31, 2017. It outlines performance measures and anticipated outcomes, and is quite comprehensive with good rationale for the issues identified. This needs to be shared and vetted with staff, clients, and families to help ensure these are the issues that most need to be addressed. In speaking to numerous staff throughout the on-site survey, many were not clear on the top quality issues being addressed in the coming year.

Priority Process: Medication Management

Many home care clients come from the hospital and medication reconciliation is completed on discharge. The case coordinator completes a best possible medication history on intake.

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

Unmet Criteria	High Priority Criteria
Priority Process: Clinical Leadership	
1.1 Services are co-designed with clients and families, partners, and the community.	!
Priority Process: Competency	
The organization has met all criteria for this priority process.	
Priority Process: Episode of Care	
7.17 Clients and families are provided with information about their rights and responsibilities.	!
10.2 When dealing with children and youth, space and opportunity for play and recreation are provided.	
Priority Process: Decision Support	
The organization has met all criteria for this priority process.	
Priority Process: Impact on Outcomes	
The organization has met all criteria for this priority process.	

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

Patient feedback is obtained a number of ways, including unsolicited feedback, hospital client councils where present, and public forums. A formal mechanism to collaborate with patients, families, community, or partners on the design of future services was not observed during the site visits. The organization is encouraged to develop a robust mechanism to intentionally seek input in the planning and design of services and space, and the identification of resources to meet patient care needs.

The organization is encouraged to resume client and family surveys and create a client and family advisory council for the program. This would allow the program to have intentional interaction with their primary stakeholders regarding the planning and evaluation of services, space, equipment and staffing resources.

Services are monitored at a program level with a number of indicators and initiatives being monitored.

There was evidence that information is shared to the sites. Several sites posted information for staff to access. Some sites did not provide access to patients due to the desire to create a homelike atmosphere. The organization needs to balance environment with transparency and inclusion of those served.

Information has been developed for families at the Grace and St. Boniface sites. A standardized client and family handbook has been drafted and will be ready in the near future. This handbook was developed with the assistance of and input from six families that have received services from the program.

The skill mix across the program is appropriate to meet the needs of the population served. Each site has limitations and is challenged to meet demand at times. Some sites are limited by their infrastructure and some by the supports available in their location.

There are policies to support volunteer participation across the program. All sites have volunteers registered with either an internal volunteer service or Palliative Manitoba. There are designated leaders for volunteer services at all sites. Not all sites have volunteers performing visitation for clients, and use Palliative Manitoba's expertise for that purpose.

Space in all locations was designed to be client and family centred, and privacy and safety were considered. All rooms were private with the exception of one semi-private room at St. Boniface that is less than ideal for this patient population.

Space, equipment availability, and staffing resources in all locations were correlated to the identified needs of the patient population requiring the service. The program is monitoring a number of indicators to determine the effectiveness of the program. Staff report having an opportunity to provide input and believe their feedback is used; however, there was no evidence observed during the site visit of the involvement of clients, families, or other stakeholders.

Priority Process: Competency

The program has defined the team composition required to meet the identified needs of the client population served. Unsolicited input from clients and families, team feedback, and evaluation of day-to-day operational issues are gathered to assess the quality of the program.

Families are encouraged to participate in all aspects of their care. Staff often referred to them as the one "in charge." Clients and families reported that they are encouraged to ask questions and verbalize their needs when they felt changes were required. Clients said they felt respectfully included and listened to, and they felt very much a part of the team. Many verbalized that they were "driving the bus" with a co-pilot. They believed their wishes were respected and felt they were encouraged to participate in any way they could.

Staff reported having strong teams to work with. They indicated that teams supported each other and felt comfortable challenging each other, and that there was an openness to deal with issues in a respectful way. Most indicated they had received a recent performance evaluation, with the exception of the

community team. This staff group reported having had valuable dialogue but did not know if that was considered their appraisal. Staff at the Grace site indicated they enjoyed the performance conversation process as it gave them an opportunity to discuss their goals and the goals of the department in a meaningful way.

Several tools are in place to assist with communication between teams, including the "I pass the baton" process used to improve communication at transitions during transfer. This tool has demonstrated significant improvement in accurate passing of information and smoother transitions with an increase in units being prepared for the patient at the time of arrival and having the necessary supplies and drugs to care for patients. The organization is encouraged to consider using this tool elsewhere to improve communication at transition points.

Team members indicated that there were a variety of ways they were recognized at the unit, site, and organizational level. Some examples included having recognition purposefully planned in communication tools, thank you cards, long-service awards, follow up by program staff for difficult cases, and regular communication with acknowledgement from the WRHA CEO.

Priority Process: Episode of Care

The program has identified a number of barriers, including volume demands, an increase in referrals outside their mandate, and limitations of some inpatient locations due to limited support, space, and resources. While space may be a barrier for the program, it is very patient centred and provides a homelike experience for clients and their families.

The program has a standardized method of contact for consultation and referral. This has improved its ability to manage demand. Staff stated there are challenges with requests for service that are not their core business. Concerns were voiced, particularly in the ED, regarding access to consultation. Units reported an improvement in the identification of who would be admitted; however, there continue to be long delays for the client to arrive on the unit, negatively impacting patient flow. The program is encouraged to remain focused on their primary function and revise their program criteria if demands make this necessary.

The program has standardized the intake process with standardized intake forms. This has improved the quality of information and the process for determining the most appropriate individual with the most immediate needs for admission into the community program and/or an inpatient bed.

During the on-site survey clients in the community, the inpatient palliative care units, and the hospice consistently voiced their significant satisfaction with the care relationship they have with the program, units, and teams. They shared personal stories and articulated in meaningful ways how much they appreciate the care and support they are given. Statements made by clients include "satisfaction does not begin to describe my experience," "dignity is part of the fabric of this facility," "it feels like they have time for everybody, whenever I need it, when I know they don't," and "there is an openness to hear how I think things are really going."

During interviews with clients, at every location they said they were encouraged to determine what care they wanted and to participate as much as they could or wanted to.

Staff in all locations verbalized knowing how to access ethics support. Many indicated they had accessed ethics support in the past. At the St. Boniface site they have created a monthly recurring session called Compass Rounds where ethics program staff are available for staff from the unit to seek advice on ethical challenges. This has increased confidence and reduced the need for committee consultations. The organization is encouraged to consider expanding this approach.

Clients and families indicated being oriented to the units on admission to the service. They were made aware of how to provide feedback if they did not feel their needs were being met. Some facilities have an established patient bill of rights. The organization is encouraged to develop a standardized patient bill of rights for use across all programs and sites.

A best possible medication history was available on each record in all sites, while a current medication list was evident on a chart in the community setting. Staff were able to describe the process for admission and transitions in care. There was evidence on the chart that the process was in place at care transitions across the organization.

All clients have initial falls assessments with risks and plans as appropriate identified on their chart and in their rooms. This patient demographic is at risk of falls as their diseases progress. The program is focused on trying to predict when falls risks are increased and educate clients and families about the disease process and the increased risk of falls. Patients said that staff have spoken to them about the need to be safe.

The program uses the Edmonton Symptom Assessment System (ESAS). If they can, patients independently complete the tool. The program is auditing compliance as completion levels were found to be low.

The program has implemented a tool called "I pass the baton" to improve information sharing and accuracy at transition points. There has been a demonstrated improvement with accuracy after the pilot with full roll out now across all sites.

The program provides care for both the adult and youth population. Volumes of youth clients are low, and many choose care at home. Space designated for youth was not evident.

Priority Process: Decision Support

With the introduction of electronic charting at the St. Boniface site, planned implementation in the community this summer, and the continuation of paper charting in other areas, there is some significant risk in ensuring information is always easily accessible to all members of the team, and that all team members are aware of what is charted where.

The program has standardized assessment tools as well as tools for communication at transition points, which will decrease the impact until the move to complete electronic charting across the organization.

Priority Process: Impact on Outcomes

There is a programmatic approach to the development of guidelines and protocols. All sites are participating in and welcoming of standardization. The organization is encouraged to consider creating a formalized mechanism to engage clients and teams, such as a program-wide quality team.

There is a standardized process for reporting incidents such as near misses, errors, or sentinel events. Staff report the system is easy to use and adjusting to it has been easy. There is an inconsistent approach to how broadly sites have trained and given access to staff to enter reports. At some sites only the registered nurses can enter reports, at other sites any staff member can do this. The organization is encouraged to take a consistent and more inclusive approach to this matter.

Staff reported variation in what happens when an incident is entered. Information is provided to some staff at the end of the investigation. The organization is encouraged to establish a consistent way of communicating the outcome of incidents so staff can learn, participate, and prevent recurrence.

The program has identified a number of priority quality initiatives, including improving the use of ESAS, documenting outcomes of pain management, infusion pump education, and the “I pass the baton” tool. There are also some initiatives close to the implementation stage, including a sedation protocol, venous thromboembolism prophylaxis, and the client and family handbook. Each initiative has a post-implementation audit planned to evaluate effectiveness.

The program has focused on a number of indicators such as wound prevalence in the community, including Braden Scale assessment compliance, falls and their contributing factors, and the patient safety and culture survey results. They have initiated corrective action initiatives as needed.

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

Unmet Criteria		High Priority Criteria
Priority Process: Infection Prevention and Control		
4.7	The organization monitors compliance with IPC policies and procedures and makes improvements to the policies and procedures based on the results.	
4.8	The organization regularly updates IPC policies and procedures based on changes to the applicable regulations, evidence, and best practices.	!
5.3	The organization's multi-faceted approach to IPC includes an education program tailored to its IPC priorities, services, and client populations.	!
5.5	The organization requires staff, service providers, and volunteers to attend the IPC education program at orientation and on a regular basis, based on their IPC roles and responsibilities.	!
5.6	The organization regularly evaluates the effectiveness of the multi-faceted approach for promoting IPC and makes improvements as needed.	
6.1	The organization provides clients, families, and visitors with information about routine practices and additional precautions as appropriate, and in a format that is easy to understand.	!
6.3	The organization screens clients to determine whether additional precautions are required based on the risk of infection.	!
8.4	The organization's staff, service providers, and volunteers have access to dedicated hand-washing sinks.	
9.1	The organization categorizes the areas in the physical environment based on the risk of infection to determine the necessary frequency of cleaning, the level of disinfection, and the number of environmental services staff required.	!
12.2	The organization tracks health care-associated infections, analyzes the information to identify outbreaks and trends, and shares this information throughout the organization. NOTE: This ROP only applies to locations that have beds and provide nursing care.	ROP

12.2.3	The organization shares 1) information about relevant health care-associated infections and 2) recommendations from outbreak reviews with staff, service providers, senior leadership, and the governing body.	**MINOR**
14.3	The organization seeks input from staff, services providers, volunteers, and clients and families on components of the IPC program.	
14.5	The organization shares evaluation results with staff, service providers, volunteers, clients, and families.	

Surveyor comments on the priority process(es)

Priority Process: Infection Prevention and Control

The infection prevention and control (IPC) team is an interdisciplinary, collaborative team with a strong commitment to quality and patient safety. It is led by a dedicated program director with strong medical support. The infection control practitioners work throughout the WRHA at the hospitals and long-term care and affiliate facilities across the region. The team provides IPC information for staff and volunteers at initial orientation. Ongoing education is limited to in-services that they are able to provide on a unit-by-unit basis.

Policies and procedures related to IPC are located on the intranet; however, many of the policies have not been updated in the past five years. The organization is encouraged to ensure all policies and procedures are routinely updated to incorporate best practices. Also, IPC staff noted that printed IPC manuals are sometimes located on the units. This practice could result in outdated policies and procedures being used by front-line staff. It is advisable that access to the policies and procedures be limited to a single source such as the intranet.

The distribution of IPC information to patients and families is inconsistent throughout the organization and appears to be limited predominantly to patients with nosocomial infections such as methicillin-resistant Staphylococcus aureus (MRSA), etc. Consequently, information provided to patients and families about IPC and their role in safety varies significantly by site and unit.

There are good processes for managing outbreaks and attempting to identify the root cause of the outbreak. Infection rates are reported on the website. However, staff on the inpatient units were unaware of information about relevant health care-associated infections, where to access this information, or any recommendations from outbreak reviews. It is advisable that the organization publish this information on staff quality improvement boards for broader dissemination.

The physical environment in some sites presents challenges from an infection prevention and control perspective. Some patient and resident rooms do not have sinks or alcohol-based hand sanitizer units. In those circumstances, staff carry personal hand sanitizer units which they report as presenting a challenge at times. Consequently, hand-hygiene compliance is quite variable depending on the unit and the site. Some staff also referenced challenges in the availability of wall-mounted alcohol-based hand rubs at the

point of care. In addition, the availability of alcohol-based hand rubs in entrances and public spaces was quite limited. Reasons provided for the limited availability of the hand rub included vandalism and theft, as well as concerns expressed by the fire marshal regarding the volume of alcohol-based hand sanitizer in a given area. Opportunities may exist to enhance hand hygiene among staff, patients, families, volunteers, etc. through further dialogue with the fire marshal, a reassessment of the availability of alcohol-based hand rub, and assessing opportunities to better secure wall-mounted dispensing units.

While staff had good awareness of the importance of hand hygiene, the collection and dissemination of hand-hygiene results varied greatly. On some inpatient wards, rates were published at the entry to the unit, while others were not available. In long-term care, hand-hygiene rates were not available as the team has just started regular audits. The organization is encouraged to continue with its hand-hygiene promotion and monitoring strategies.

Due to challenges with space, some inpatient units were quite cluttered with equipment and medical devices in the corridors and hallways. Staff could not confirm whether the equipment located in the corridors was clean or dirty. In some sites, equipment was cleaned in the dirty utility room and stored in the same room until it was needed. At Victoria General Hospital, many of the inpatient units and corridors have carpeted walls, which presents an infection risk. The leadership team indicated that plans have been developed to remove the carpet and replace it with appropriate wall coverings. The organization is encouraged to implement these plans as soon as possible.

The IPC team has strong relationships with organizational stakeholders such as facility maintenance, the medical device reprocessing department, and the clinical units. This has led to enhanced infection prevention and control associated with clinical care areas, new facilities projects, and medical devices. The IPC team reported some challenges with the lack of awareness of facilities renovations projects that were underway within the organization, although this was site specific and not common. The organization is encouraged to continue the good work that is underway and ensure all facilities projects and equipment acquisition is undertaken with proper infection prevention and control consultation and oversight in the case of facility renovations.

The IPC team is encouraged to work closely with the medical device reprocessing department to ensure appropriate infection prevention and control practices are being conducted across the organization. Reprocessing practices for medical devices are very inconsistent across WRHA and represent an infection prevention and control risk. For example, a variety of practices for the reprocessing of ultrasound probes and endoscopes were observed throughout the region. In all sites, the cleaning of the ultrasound probes occurred in the diagnostic procedure room where the test was being performed. The organization is encouraged to undertake a thorough review of all areas outside the medical device reprocessing department to ensure reprocessing practices meet IPC standards.

Standards Set: Infection Prevention and Control Standards for Community-Based Organizations - Direct Service Provision

Unmet Criteria			High Priority Criteria
Priority Process: Infection Prevention and Control for Community-Based Organizations			
4.6	The organization monitors compliance with its infection prevention and control policies and procedures and makes improvements to the policies and procedures based on the results. of its monitoring activities.		
6.2	The organization provides clients/residents, families, and visitors with information on how to access hand hygiene resources and personal protective equipment based on risk of infection.		!
8.4	The organization measures its compliance with accepted hand-hygiene practices.		ROP
	8.4.1	The organization measures its compliance with accepted hand hygiene practices using direct observation methods (i.e., audit). For organizations that provide services in client homes, a combination (two or more) of alternative methods may be used.	**MAJOR**
	8.4.2	The organization shares the results of measuring hand hygiene compliance with staff, service providers, and volunteers.	**MINOR**
	8.4.3	The organization uses the results of measuring hand hygiene compliance to make improvements to its hand hygiene practices.	**MINOR**
13.5	The organization shares these evaluation results with staff, service providers, volunteers, clients/residents, and families.		
Surveyor comments on the priority process(es)			
Priority Process: Infection Prevention and Control for Community-Based Organizations			

The commitment of the organization toward infection prevention and control was evident at all sites.

Training is being provided regularly and is part of the orientation process. Risk assessments and interventions to mitigate risk are in place. Hand hygiene and the use of personal protective equipment are common practice. Hand hygiene is performed at most of the sites with the exception of Portage Avenue and ACCESS River East. Different degrees of compliance with hand hygiene was found, with remarkable successful results at ACCESS NorWest.

There is just one person designed by the organization for infection prevention and control for 30 primary care sites and this same person is responsible for other sites in the community. This might affect the capacity of the organization to respond to specific issues and slow the process of reporting back to the sites on indicators such as hand-hygiene compliance. Availability of hand sanitizer to clients is a challenge at ACCESS Downtown. This merits further and prompt evaluation.

A document written by the community infection control professional on "Home Visit Bag Survey Results and Recommendations" in 2015 made recommendations to prevent the spread of microorganisms via the home visit bags. Home care is not conducting hand-hygiene audits with any consistency and the organization is encouraged to do so.

The physical environment of the sites surveyed was clean and well organized. Quality standards are included in the contract when cleaning and disinfecting services are contracted out. The organization is encouraged to monitor compliance with these standards in a regular and methodical fashion instead of relying on self-monitoring by the contractors, whose results aren't shared with the sites.

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

Unmet Criteria			High Priority Criteria
Priority Process: Clinical Leadership			
2.8	A universally-accessible environment is created with input from residents and families.		
Priority Process: Competency			
3.15	Team member performance is regularly evaluated and documented in an objective, interactive, and constructive way.		!
3.17	Team members are supported by team leaders to follow up on issues and opportunities for growth identified through performance evaluations.		!
Priority Process: Episode of Care			
8.8	Clients are assessed and monitored for risk of suicide.		ROP
	8.8.1	Clients at risk of suicide are identified.	**MAJOR**
	8.8.2	The risk of suicide for each client is assessed at regular intervals or as needs change.	**MAJOR**
9.19	Information relevant to the care of the resident is communicated effectively during care transitions.		ROP
	9.19.4	Information shared at care transitions is documented.	**MAJOR**
	9.19.5	The effectiveness of communication is evaluated and improvements are made based on feedback received. Evaluation mechanisms may include: • Using an audit tool (direct observation or review of resident records) to measure compliance with standardized processes and the quality of information transfer • Asking residents, families, and service providers if they received the information they needed • Evaluating safety incidents related to information transfer (e.g., from the patient safety incident management system).	**MINOR**
10.1	Residents and families are provided with an environment that is flexible and meets their needs.		

12.7 The effectiveness of transitions is evaluated and the information is used to improve transition planning, with input from residents and families.

Priority Process: Decision Support

The organization has met all criteria for this priority process.

Priority Process: Impact on Outcomes

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

Although most personal care homes do not yet co-design services with community partners, families, and residents, all sites use input and feedback from a wide variety of sources, such as community members, agencies, residents, and families, to shape services and environments.

Affiliate organizations have developed their own strategic plans, goals, and objectives that are felt to be well aligned with WRHA's strategic plan and goals. WRHA sites develop goals and objectives in an operational plan that is connected to the WRHA plan. Additionally, affiliates are able to align with regional policies and procedures and develop their own to meet local needs and differences.

Although it is not possible for community partners, families, and residents to provide direct input on the specific staff mix and staff experience, they consistently provide comments in surveys and council meetings on gaps and the need for additional skills (e.g., dementia care and creating a pleasant dining experience).

Some facilities or parts of facilities are older and present accessibility and other challenges. Luther Home has some bathrooms that are not wheelchair accessible. Team members, volunteers, and community supporters make special efforts to create safe, homelike environments.

Feedback from surveys, resident council meetings, and individual discussions with residents and families is used to improve space, menus, and care. The top concern raised was the need for more front-line staff to meet the increasing health and social needs of residents.

Enhancing staff resources to meet the increasingly complex needs of long-term care residents has been identified as a need. Strategies to advocate with the Ministry on their guidelines are being developed.

Priority Process: Competency

Staff report being encouraged to participate in a broad range of educational programs to increase their skills and abilities and for their own professional development. The annual education fairs are appreciated.

Palliative and end-of-life care education is led regionally and implemented at the site level. Most staff and physicians are skilled in having conversations about advance care planning and goals of care. Staff who were interviewed are looking forward to additional opportunities for education.

While it is not possible for residents and families to provide input on credentials, feedback from surveys is considered when determining the need for and content of some non-mandatory education programs.

The long-term care team and sites are commended on the comprehensive dementia care program that is being implemented. A key feature is the ongoing roll-out of P.I.E.C.E.S. (Physical, Intellectual, Emotional, Capabilities, Environment, Social) education to all sites for managing responsive behaviours, in partnership with the Alzheimer Society of Manitoba. Educational approaches have been tailored for different groups such as nurses, support staff, managers, and families. In some sites, interdisciplinary huddles are held to problem solve behavioural issues. All staff who were interviewed felt the program has improved their understanding and skills when interacting with residents with responsive behaviours. The family education component is now underway and is being well received. Evaluation results are used to design follow-up sessions.

In parallel with P.I.E.C.E.S., an education program, algorithm, and clinical guideline for reducing the unnecessary use of antipsychotics is being implemented with a target 25 percent reduction at each site. Many sites have reached their target with rates as low as 3 percent. WRHA will shared P.I.E.C.E.S with other jurisdictions in Canada.

The provincial Violence Prevention Program has been fully implemented in some personal care homes and partly implemented in others. Other non-violence intervention programs are covering the gap. The P.I.E.C.E.S. education program also helps ensure staff have the necessary knowledge and skills to manage potential violence from residents with dementia or mental health diagnoses.

Spiritual care space and programs are provided in all personal care homes. Enhanced programming is provided by the faith-based affiliates through donations and is much appreciated by residents and families.

Some staff were unsure whether they had learned about the organization's ethical framework but all were able to describe ethical dilemmas and indicate how to address them. Faith-based affiliate organizations have adapted the regional ethics framework to meet the organization’s mission and values.

To address client-centred care at the regional level, the LTC Advisory Council was created in 2014 to provide WRHA with advice on the planning, delivery, and improvement of long-term care services. The council is composed of representatives of residents and families from personal care homes and is ultimately accountable to the CEO. To date the council has provided feedback on several new initiatives and members were invited to participate in the consultations for the strategic plan. Members have identified areas for further involvement. It is suggested that members also be involved in creating and implementing a process to evaluate satisfaction with their roles.

At the site level, resident and/or family councils provide valuable input on issues relevant to their site. Many councils have been involved in quality improvement, facility design, dining experience improvements, and reviewing the facility's bill of rights, among other topics.

Regular performance appraisals are not consistently provided at all sites. This may lead to less opportunities for professional and personal development conversations between staff and management.

Priority Process: Episode of Care

Few barriers to accessing services were identified. Some older facilities have two- and four-bed rooms which may be a barrier to accessing preferred accommodation. Although not all facilities offer special needs units, the number of beds are being increased to improve access to residents who need them.

A flow initiative has been initiated to decrease the time an available personal care home (PCH) bed is vacant and to accommodate urgent admissions from the community. The access team has developed new processes including navigators to balance accommodating family and resident preferences with timely access to the right services. Personal care home processes have been revised to contribute to the improvements. The access centre and PCH admission coordinators collaborate to plan for transitions to sites that were not the resident's first choice.

All residents and families who were interviewed report that they feel respected and offered many compliments to team members. Their primary concern was that staffing levels be reviewed. Families and residents are comfortable reporting concerns to a key caregiver or manager.

A regional panel re-design initiative has improved the time required to assess and place individuals eligible for long-term care. The organization is encouraged to continue to work with personal care home sites to reduce unnecessary delays while accommodating the needs and preferences of individuals and families.

The region is commended for piloting and implementing a program to improve its overall rate of new pressure ulcers. Staff reported their appreciation for the expert resources, tools, and education that have assisted this improvement effort. Similarly, the falls prevention program has been effectively revised and improved.

The falls prevention program has been implemented consistently throughout long-term care with successful outcomes. Falls risk is assessed within the first day of admission and interventions put in place. Falls huddles are used to prevent further occurrences.

Although the process for investigating violations of resident rights is not developed with input from residents and families, most resident and family councils receive general information on the site bill of rights and how issues are being addressed (e.g., the right to privacy).

Personal care homes are committed to ongoing review of antipsychotic medications and have developed creative person-centred alternatives to medication use. Overall, WRHA personal care homes have made significant reductions in antipsychotic use over the last year. There are ongoing efforts to carefully review all medications for newly admitted residents and to prevent the need for new orders. Chemical and physical restraints are reviewed carefully by interdisciplinary teams, in collaboration with families and according to the regional policy.

Access to the on-site dental service provided to residents by the University of Manitoba is appreciated by residents, families, and teams.

All personal care homes are commended on the full implementation and regular review of goals of care. Decisions on whether to transfer to hospital are discussed in advance and regularly reviewed. This approach helps avoid unnecessary hospital admissions at end of life. Physicians or nurse practitioners at each site are readily available to assess whether other urgent admissions are necessary.

Although residents and families are not involved in the development of policies, the residents and families affected are educated on the procedure. In the homes visited, the only point-of-care testing used is blood glucose testing.

An initiative to assess and monitor residents at risk for suicide is being developed but has not yet been implemented. A Suicide Prevention Working Group has been established and has begun to identify best practices from which a regional guideline, algorithm, and toolkit will be developed. In the meantime, most teams are monitoring the worsening of depression as measured quarterly for each resident as well as any suicidal vocalization and are developing care plans for these individuals to mitigate risk.

Priority Process: Decision Support

Although residents and families do not yet provide input on the use of electronic or other communications in personal care homes at the site level, regional policies are in place. There is the potential to involve the LTC Advisory Council.

All sites generate goal-oriented care plans from the quarterly Resident Assessment Instrument Minimum Data Set (RAI MDS). In some sites the care plans are not used effectively on a regular basis due to their length. Teams are encouraged to find ways to make the care plans more effective such as implementing the full EMR. In addition, it is suggested that the MDS outcome scales be used to monitor resident changes at the individual and unit levels and to share changes at family conferences.

Priority Process: Impact on Outcomes

Although families and partners do not provide input directly in the development of evidence-informed guidelines or policies, feedback from surveys, meetings, and family councils may be used. Some front-line staff report having had the opportunity to provide input. A representative of each personal care home at the leadership or educator level is involved and brings information back to staff for comment.

The LTC Advisory Council is reviewing the results of surveys and quality initiatives at the regional level. Many resident and family councils are also involved at the site level.

Quality outcomes are shared with various groups depending on the focus. Some sites have not yet implemented quality boards and are encouraged to do so, to more fully engage team members and others. National presentations have been made on the reduction of antipsychotics in the early adopter sites.

Quality improvement activities are evaluated during strategic planning and annual priority setting at the regional level and at affiliate sites that also have their own strategic plans.

The LTC Risk Management and Safety Committee used an enterprise risk management approach to prioritize the top five risks. There has also been support for LEAN green belt projects such as urine trouble, optimization of chronic obstructive pulmonary disease (COPD) treatment, and urgent placements from community. Failure modes and effects analysis (FMEA) methods have also been used.

Most sites have developed quality boards and huddles to engage and educate staff.

Standards Set: Medication Management Standards - Direct Service Provision

Unmet Criteria			High Priority Criteria
Priority Process: Medication Management			
2.3	The organization has a program for antimicrobial stewardship to optimize antimicrobial use. NOTE: This ROP applies to organizations providing the following services: inpatient acute care, inpatient cancer, inpatient rehabilitation, and complex continuing care.		ROP
	2.3.1	The organization implements an antimicrobial stewardship program.	**MAJOR**
	2.3.2	The program includes lines of accountability for implementation.	**MAJOR**
	2.3.3	The program is inter-disciplinary involving pharmacists, infectious diseases physicians, infection control specialists, physicians, microbiology staff, nursing staff, hospital administrators, and information system specialists, as available and appropriate.	**MAJOR**
	2.3.4	The program includes interventions to optimize antimicrobial use that may include audit and feedback, a formulary of targeted antimicrobials and approved indications, staff training, antimicrobial order sets, guidelines and clinical pathways for antimicrobial utilization, strategies for streamlining or de-escalation of therapy, dose optimization, and parenteral to oral conversion of antimicrobials (where appropriate).	**MAJOR**
	2.3.5	The organization establishes mechanisms to evaluate the program on an ongoing basis, and shares results with stakeholders in the organization.	**MINOR**
2.5	The organization implements a comprehensive strategy for the management of high-alert medications.		ROP
	2.5.1	The organization has a policy for the management of high-alert medications.	**MAJOR**
	2.5.2	The policy names the individual(s) responsible for implementing and monitoring the policy.	**MINOR**

	2.5.3	The policy includes a list of high-alert medications identified by the organization.	**MAJOR**
	2.5.4	The policy includes procedures for storage, prescribing, preparation, administration, dispensing, and documentation for each high-alert medication, as appropriate.	**MAJOR**
	2.5.6	The organization regularly audits client service areas for high-alert medications.	**MINOR**
	2.5.7	The organization establishes a mechanism to update the policy on an ongoing basis.	**MINOR**
	2.5.8	The organization provides information and ongoing training to staff on the management of high-alert medications.	**MAJOR**
2.7	The interdisciplinary committee provides standard order sets for medications.		
2.10	The interdisciplinary committee develops a process for using sample medications.		
5.1	The organization has a process to maintain information on medication allergies and previous adverse drug reactions in the client's medication profile.		!
7.2	The organization has a policy for when and how to override CPOE alerts.		!
7.4	The organization regularly tests the CPOE to make sure that the alerts built into the system are working.		!
7.5	The organization manages alert fatigue by regularly evaluating the type of alerts required by the CPOE based on best practice information and input from staff and service providers.		
8.2	The organization has a policy for when and how to override alerts by the pharmacy computer system.		!
8.4	The organization regularly tests the pharmacy computer system to make sure that the built in alerts are working.		!
8.5	The organization manages alert fatigue by regularly evaluating the type of alerts required by the pharmacy computer system based on best practice information and input from staff and service providers.		
9.3	The organization evaluates and limits the availability of heparin products to ensure that formats with the potential to cause harmful medication incidents are not stocked in client service areas.		ROP
	9.3.1	The organization completes an audit of unfractionated and low molecular weight heparin products in client service areas at least annually.	**MAJOR**

11.2	The organization has a policy for when and how to override smart infusion pump alerts.	!
11.5	The organization regularly reviews the limits set for soft and hard doses and makes changes as required.	
12.1	The organization limits access to medication storage areas to authorized staff and service providers.	!
12.8	The organization minimizes the use of multi-dose vials in client service areas.	!
12.9	The organization evaluates and limits the availability of concentrated electrolytes to ensure that formats with the potential to cause harmful medication incidents are not stocked in client service areas.	ROP
12.9.1	The organization completes an audit of the following concentrated electrolytes in client service areas at least annually: • Calcium (all salts): concentrations greater than or equal to 10% • Magnesium sulfate: concentrations greater than 20% • Potassium (all salts): concentrations greater than or equal to 2 mmol/mL (2 mEq/mL) • Sodium acetate and sodium phosphate: concentrations greater than or equal to 4 mmol/mL • Sodium chloride: concentrations greater than 0.9%.	**MAJOR**
12.9.2	The organization avoids stocking the following concentrated electrolytes in client service areas: • Calcium (all salts): concentrations greater than or equal to 10% • Magnesium sulfate: concentrations greater than 20% • Potassium (all salts): concentrations greater than or equal to 2 mmol/mL (2 mEq/mL) • Sodium acetate and sodium phosphate: concentrations greater than or equal to 4 mmol/mL • Sodium chloride: concentrations greater than 0.9%.	**MAJOR**
13.3	The organization stores chemotherapy medications in a separate negative pressure room with adequate ventilation segregated from other supplies.	!

13.4	The organization stores anaesthetic gases and volatile liquid anesthetic agents in an area with adequate ventilation as per the manufacturer's instructions.	!
14.5	The organization helps provide minimal distractions, interruptions and noise for prescribing, writing and verifying medication orders either manually or electronically.	
14.6	The organization has identified and implemented a list of abbreviations, symbols, and dose designations that are not to be used in the organization.	ROP
14.6.5	The organization educates staff about the Do Not Use List at orientation and when changes are made to the list.	**MINOR**
14.6.7	The organization audits compliance with the Do Not Use List and implements process changes based on identified issues.	**MINOR**
15.1	The pharmacist reviews prescription and medication orders within the organization prior to administration of the first dose.	!
16.4	The organization has a separate area with a certified laminar air flow hood for preparing sterile products and intravenous admixtures.	!
18.2	The pharmacy team dispenses medications in unit dose packaging.	!
23.3	Service providers seek an independent double check before administering high-alert medications at the point of care.	!
26.1	The organization informs staff and service providers on the value of reporting adverse drug reactions to Health Canada specifically unexpected or serious reactions to recently marketed medications, and their role in reporting this information.	

Surveyor comments on the priority process(es)

Priority Process: Medication Management

The WRHA pharmacy staff lead and inspire excellent pharmacy practice that is integral to patient- and family-centred care. The pharmacy team is congratulated for receiving a national Safe Medication Practices Award from the Canadian Society of Hospital Pharmacists in February 2016, after implementing a standardized program to train and validate staff who do aseptic compounding. The team is also commended for the successful implementation of CPOE at St. Boniface Hospital.

While significant standardization has been achieved across multiple sites, numerous opportunities for improvement exist. Integration of the two pharmacy computer systems is integral to improving system safety, with the spread of CPOE and enhancement to built-in alerts for drug allergies plus minimum and maximum doses for high-alert medications.

The organization is encouraged to begin planning improvements to smart pump technology in order to efficiently update the parenteral drug formulary, ease management of dose alerts, and facilitate monitoring of pump key stroke data, to optimize the safe delivery of IV therapy.

Many of the pharmacy sterile preparation areas do not meet National Association of Pharmacy Regulatory Authorities standards for air handling. A number of the laminar flow hoods are approaching the end of service. The chemotherapy cabinet in the pharmacy admixture room at St. Boniface Hospital is not in use because it could not be certified, meaning staff must leave the pharmacy to prepare chemotherapy.

The risk of diversion of addictive medications (e.g., midazolam, propofol) in the operating room environment is high. Missing vials of these drugs would not be readily detected given the large quantities that were observed in unlocked shelves and bins. The organization is encouraged to resolve this by adopting a pharmacy-controlled anesthesia tray exchange system. Anesthesiologists are encouraged to place their controlled substances in a room safe when they exit the OR theatres at the end of each case, but this is not audited. Also, the diversion of excess controlled substances from the OR theatre would not be easily detected because a second person does not witness the wasting by anesthesiologists at the end of the day.

Pharmacy satellites and lockable rooms provide optimal storage of ward stock medications. The team is commended for developing a WRHA standard for medication rooms and have converted to this new standard at some clinical units at Seven Oaks Hospital.

A number of vulnerabilities were observed with medication distribution to other clinical areas. The doors to some medication rooms were propped open. Unauthorized staff could readily access medications in unlocked drawers, cupboards, and fridges in critical care areas such as emergency, intensive care, and post-anesthesia care.

Audits of error-prone abbreviations were recently completed. The organization is encouraged to develop and implement a more structured process, involving the medical leadership, to change the behaviour of prescribers who continue to use dangerous abbreviations.

Though an orientation program is in place for staff and residents, the organization is encouraged to formalize a new physician orientation program to ensure all medical staff are educated about their roles and responsibilities for medication management before beginning work in any WRHA facility. The plan should allow the organization to record and track the medical staff who successfully complete the orientation.

Standards Set: Medication Management Standards for Community-Based Organizations - Direct Service Provision

Unmet Criteria			High Priority Criteria
Priority Process: Medication Management for Community-Based Organizations			
1.5	The organization has identified and implemented a list of abbreviations, symbols, and dose designations that are not to be used in the organization.		ROP
	1.5.7	The organization audits compliance with the Do Not Use List and implements process changes based on identified issues.	**MINOR**
3.1	The organization limits access to medication storage areas to authorized staff and service providers.		!
14.2	Information on the client's/resident's medication allergies and previous adverse drug reactions are recorded in the client/resident record.		!
23.2	The organization regularly carries out focused audits of its medication management system.		
Surveyor comments on the priority process(es)			
Priority Process: Medication Management for Community-Based Organizations			

A variety of sites and services (home care, primary care, and an adult medical clinic) were assessed as part of the on-site survey.

Medication management at Mount Carmel is quite strong. They have an on-site pharmacist and the ability to use CPOE; however, there is still some duplication for staff as they must print off the orders in the short term.

Medication errors and near misses are entered into the RL6 system. The culture of reporting, particularly in home care, appears to be good and team managers are confident that reporting is fairly strong. Medication errors are addressed immediately. The next step is to trend these, share the results at staff meetings and with clients/families, and set targets for the next quarter.

The list of Do Not Use abbreviations needs to be more visible, particularly in areas where prescribing takes place (Pembina Adult Medical Clinic). Audits need to be conducted and reported with targets set.

Recording of allergies was inconsistent at two home care sites. The program is encouraged to contact the vendor of the electronic system to see if allergies can be coded in red.

The case coordinators and resource coordinators are available to the health care aides if there are medication issues and to support them in following safe medication practices.

Standards Set: Medicine Services - Direct Service Provision

Unmet Criteria			High Priority Criteria
Priority Process: Clinical Leadership			
2.4	Space is co-designed with input from clients and families to ensure safety and permit confidential and private interactions with clients and families.		
Priority Process: Competency			
3.11	Team member performance is regularly evaluated and documented in an objective, interactive, and constructive way.		!
Priority Process: Episode of Care			
8.6	To minimize injury from falls, a documented and coordinated approach for falls prevention is implemented and evaluated.		ROP
	8.6.4	The effectiveness of the approach is evaluated regularly.	**MINOR**
	8.6.5	Results from the evaluation are used to make improvements to the approach when needed.	**MINOR**
8.7	Each client's risk for developing a pressure ulcer is assessed and interventions to prevent pressure ulcers are implemented. NOTE: This ROP does not apply for outpatient settings, including day surgery, given the lack of validated risk assessment tools for outpatient settings.		ROP
	8.7.5	The effectiveness of pressure ulcer prevention is evaluated, and results are used to make improvements when needed.	**MINOR**
9.11	Information relevant to the care of the client is communicated effectively during care transitions.		ROP
	9.11.5	The effectiveness of communication is evaluated and improvements are made based on feedback received. Evaluation mechanisms may include: • Using an audit tool (direct observation or review of client records) to measure compliance with standardized processes and the quality of information transfer • Asking clients, families, and service providers if they received the information they needed • Evaluating safety incidents related to information transfer (e.g., from the patient safety incident management system).	**MINOR**

10.8	The effectiveness of transitions is evaluated and the information is used to improve transition planning, with input from clients and families.	

Priority Process: Decision Support

The organization has met all criteria for this priority process.

Priority Process: Impact on Outcomes

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

WRHA has developed regional strategic directions and operational strategies. Medicine services at each site share the regional strategic plan and deliver services focused on aligning with flow, managing resources, and improving engagement. WRHA has found new doctors for 45,000 people and is working toward creating a primary health system to support patients discharged from hospital services.

Patients are referred to the medicine program at each site primarily from the EDs. The flow of patients and the flow of accurate information from ED to medicine is paramount. Each site is working on strategies to improve flow. Medicine is addressing flow through the Overstay project.

Access and flow are strategic objectives. It is important to showcase to the public the work being done. For instance, Concordia publishes articles in the monthly Herald community newspaper.

WRHA does not want to lose sight of their strategies in order to offer the resources and support that are required to achieve their objectives. Despite increases in volume, the medicine program has seen a 21 percent reduction in length of stay. There is a young management team that will take on large projects and corporate strategies, so it is important each site supports their staff with appropriate knowledge and skills in order to carry out both the regional strategies and site-specific initiatives.

Priority Process: Competency

Medicine services were observed at the Health Sciences Centre Winnipeg, Victoria General Hospital, St. Boniface Hospital, and Concordia Hospital.

There is evidence of a highly engaged, passionate, patient- and family-focused interdisciplinary team of medical staff, clinical staff, and leaders who provide care to patients admitted to each site.

During interviews with staff they expressed their loyalty to their sites and this is evident from the long years of service for many professionals and support staff. Ward assistants, nursing, and physiotherapy expressed that loyalty and culture is part of the foundation. The medical staff seemed to rotate often at Health Sciences and St. Boniface; however, this appears to have little impact on the services offered.

Concordia Hospital has a model where physicians in family medicine support both the hospital and primary care. This model appreciates the challenges inside the hospital and in the community. The team at Concordia Hospital is very well coordinated which helps with integration.

Priority Process: Episode of Care

Medication reconciliation was observed at each site. A detailed best possible medication history was collected and a computer-generated discharge prescription was printed. A focus on falls prevention was evident at each site, with notification alerts on patient doors, patient care boards, and in the patient chart. Although it is assumed that all patients are at risk of falls and patients at risk of falls are stationed close to the nursing desk (St. Boniface), a visual management tool would enhance the program for patients who are ambulatory or going for tests outside the medical unit. Kudos to the rehabilitation unit at St. Boniface as they were recognized for their tremendous work with falls prevention.

Two pieces of identification were used for each patient encounter. Feedback from family and patients confirmed this practice and the practice of routine hand hygiene. Patients are offered alcohol rub and encouraged to wash their hands when required.

Care plans were also evident in medicine with the regional use of an acute myocardial infarction care map. The care map package is accompanied by a patient/family care guide. Staff are well trained and if training is required it is evident at sites like the Health Sciences Centre that management will offer the necessary education to meet the needs of the staff. This allows the centre to recruit and fill vacancies. Policy guidelines exist and venous thromboembolism prophylaxis is done at all sites. There is documentation and evidence that patients at risk for pressure ulcers are assessed and action is taken, such as using specialized mattresses, to reduce the risk of pressure ulcers.

Aging infrastructure is a risk. Except at St. Boniface, hallways are cluttered. This creates a risk of infection as well as falls. There is limited space to store equipment. Dirty equipment at some sites (Health Sciences Centre) is cleaned in the same room where clean equipment is stored. Concordia Hospital is addressing the issue of aging infrastructure with a capital renewal plan to upgrade patient and public washrooms as well as new doors to the operating suite. The challenge for the medicine program will be continuing the current trajectory and sustaining the good work that is being developed.

Priority Process: Decision Support

The various sites blend EMR and paper records with a hybrid system where both systems are used. This can pose risks but is also the reality of moving toward a fully electronic medical record. The flow of client information is present although there are times when information is not fully received. Charts are organized and standardized, and information within a site is shared in the progress notes. Policy and procedures are accessible.

During a family interview, the family expressed concerns about information sharing during a transfer of care between the Health Sciences Centre and St. Boniface. The family addressed the concerns with management.

Interactions during the site visits included nursing, students, physicians, residents, physiotherapists, occupational therapists, and support staff. There is a culture of interdisciplinary collaboration. This was very evident at Concordia Hospital. Regular meetings take place between divisions and there is focused collaboration aimed at managing flow. LEAN tools and methodology are being adopted at each site. St. Boniface is further along on the LEAN journey. Victoria General will benefit from advancing with LEAN to problem solve and continue with continuous process improvements.

Victoria General has adopted a strong patient advocacy committee and patients are involved in decision making. A LEAN process led to the creation of an ADT (admission, discharge, transfer) nurse position at St. Boniface and as flow strategies continue to mature it appears this position will have benefits in flowing patients from the ED to medicine services.

Priority Process: Impact on Outcomes

Quality initiatives are evident at each site. The organization is enhancing the patient experience by improving flow and integrating quality related to hand hygiene, performance management, and risk of falls. Recognition for staff and leadership continues to improve visibility.

The region is also faced with the challenge of delivering care to a geographically dispersed population. Patients are happy with the service they receive. Involving patients and patient advocacy committees helps integrate the voice of the patient into the decisions being made. Management at all sites appears engaged and motivated. This has an effect on staff and it was great to see management speaking with staff by their first name.

Staff members were open in discussions with management and staff, displaying at each site dedication and commitment. It was often mentioned that they enjoyed working together as a team. It will be important to maintain this level of staff engagement. The medicine program is working on many initiatives which include Overstay, LEAN strategies, ensuring medication reconciliation is completed, ensuring effective and timely transfer of information among service providers, hand-hygiene compliance, and improving access to medicine services. Meeting targets is a challenge and sustaining the gains will be a future challenge.

Standards Set: Mental Health Services - Direct Service Provision

Unmet Criteria			High Priority Criteria
Priority Process: Clinical Leadership			
The organization has met all criteria for this priority process.			
Priority Process: Competency			
The organization has met all criteria for this priority process.			
Priority Process: Episode of Care			
2.7	The physical environment is safe, comfortable, and promotes client recovery.		
9.18	Information relevant to the care of the client is communicated effectively during care transitions.		ROP
	9.18.1	The information that is required to be shared at care transitions is defined and standardized for care transitions where clients experience a change in team membership or location: admission, handover, transfer, and discharge.	**MAJOR**
	9.18.5	The effectiveness of communication is evaluated and improvements are made based on feedback received. Evaluation mechanisms may include: • Using an audit tool (direct observation or review of client records) to measure compliance with standardized processes and the quality of information transfer • Asking clients, families, and service providers if they received the information they needed • Evaluating safety incidents related to information transfer (e.g., from the patient safety incident management system).	**MINOR**
10.9	The effectiveness of transitions is evaluated and the information is used to improve transition planning, with input from clients and families.		
Priority Process: Decision Support			
11.2	A standardized set of health information is collected to ensure client records are consistent and comparable.		
Priority Process: Impact on Outcomes			
The organization has met all criteria for this priority process.			

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

The adult mental health program provides a range of mental health services in community settings, six hospitals, and an urgent care site. A variety of services are also offered by private and not-for-profit agencies, of which 14 are funded through WRHA. These include psychotherapy, counselling, Aboriginal services, and others. Outpatient services consist of general psychiatry, geriatric psychiatry, mood disorders, anxiety disorders, eating disorders, forensics, schizophrenia treatment, and education and community liaison.

The mental health service areas have been part of an overall mental health program planning strategic plan (Regional Mental Health Program 10 Year Strategic Plan: 2016-2026). Extensive stakeholder input was sought from all program areas and included individuals and families with lived experience to guide the further development of mental health services. An opportunity identified is the need to strengthen the involvement of community partners and funded agencies as the actions and service enhancements identified in the plan are operationalized. Specific service goals exist for the mental health program, sites, and service areas. Within the current matrix model of management, opportunity also exists to ensure alignment and clarity in establishing priorities and measurable outcomes.

The program has had an advisory council since 2005. Membership consists of those who have lived mental health experience and/or are family members of individuals with lived experience. The council has provided input on a number of issues, including the development of the Crisis Response Centre, staffing, and a LEAN project to review and revise the assessment process. Strategic priorities have been identified focusing on prevention and promotion services, improvements with quality and integration, and improved patient experience, among others. Some service areas are commencing with advisory groups, and the identified opportunity to strengthen family involvement is strongly encouraged.

Several good partnerships with community providers exist at site and service levels. Significant opportunity to expand collaboration and partnerships at the regional level is evident.

Priority Process: Competency

There is strong interdisciplinary team representation with timely access to psychiatrists, nurses, social workers, occupational therapists, recreation therapists, support workers, clinical specialists, physician assistants, case managers, psychologists, and other services including family assessment and therapy.

Results from the most recent staff engagement survey show a decrease in staff engagement. Several good initiatives are in place to address the decrease in staff engagement such as professional development, leadership education and development, attributed mostly to the management staff and the complexities identified with working with a site-based and regional-based matrix model of reporting and also additional drivers are identified at the staff level facilitating the program.

Hospital staff all take the required Foundations of Mental Health workshop facilitated by mental health educators from the five acute care sites. The WRHA mental health program has recently approved the recovery-oriented practice framework with key staff competencies. WRHA is encouraged in its efforts to apply this with practice and identified this as a priority.

The program has adopted an excellent trauma-informed, client-centred care approach by implementing the six core strategies of the enhancing seclusion and restraint-free mental health services program. The teams are highly commended on their approach to education and implementation of the six core strategies that have resulted in a significant reduction of the use of seclusion and restraints.

Priority Process: Episode of Care

Mental health services are very client focused. The teams are encouraged in their efforts to adopt more family-oriented practices with service delivery.

The program is commended on recent revisions to address access and patient flow as a priority, implementing a quality initiative to decrease the length of stay and improve access from the EDs and inpatient units. Several core activities are in place at a regional level, and the service teams are engaged in this process.

An excellent array of resources exist to respond to emergency or crisis situations, including emergency, intensive care and reassessment units, and inpatient and outpatient programs including access to the regional service of the Crisis Response Centre.

Site visits on the inpatient units reflect a strong focus on safety and security for clients and staff. Examples include personal safety plans, staffing levels, the presence of and access to security services at each site, and the use of duress alarms.

Environmental facility safety concerns in the inpatient areas at some sites are evident. Implementing a comprehensive environmental review and risk mitigation strategy are identified as priorities for the organization to address. The region also has the tremendous benefit of having established a new safe, secure, client-centred mental health inpatient unit at the Grace Hospital.

Several key quality initiatives are underway (e.g., suicide assessment and documentation) and the program is encouraged to develop processes and mechanisms to ensure consistent application.

A Psychealth Advisory Council was operating with the site-based mental health services to provide client perspective and feedback. The team is encouraged in its interest to re-establish this committee in fall 2016 and to consider mechanisms for including families in the process.

Given the comorbidity of the client population in mental health services, opportunity exists for regional mental health services to address education and professional development of staff as it pertains to concurrent capability.

The transfer of client information at transition points is inconsistent between sites and services. This is identified as part of the quality improvement roadmap as a priority for the program to implement.

Priority Process: Decision Support

Service areas are challenged in maintaining and coordinating paper copy health record information, supplemented with electronic health record information. Opportunity exists to standardize the information being collected and to ensure individualized care plans are consistently developed and documented for each client.

Priority Process: Impact on Outcomes

The program and teams are commended on their efforts to address quality improvement as reflected in the work completed and in progress with the mental health program quality improvement roadmap. Several key priorities have been established with defined activities, performance measures, and targets. Based on results received, a new quality initiative to meaningfully engage families in clinical services, program planning, and evaluation was added to the roadmap. Other quality initiatives include a LEAN project to reduce wait times for psychiatric assessment, evaluation of transition at end of service, evaluation of clinical outcomes, suicide risk assessment, and information transfer.

The teams are also incorporating outcome indicators identified by the Mental Health Advisory Council, such as a focus on the individual experience of recovery-oriented practices.

Good processes are in place with the work of the Regional Mental Health Quality Improvement Committee to ensure processes are in place to continuously improve quality and safety of services

The service monitors several utilization indicators including length of stay and client flow.

Feedback was collected in April 2016 to assess client experience service satisfaction and suggested improvements for care. Several services, such as the eating disorders program, are incorporating evaluation focused on client outcome measurement. Opportunity exists to continue to enhance the use of performance measurement to assess additional client outcomes across all service areas.

Standards Set: Obstetrics Services - Direct Service Provision

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

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

Obstetrics program team members at all sites are very focused on the needs of the clients and the families. They are responsive to their demands and wishes and work in a collaborative manner to meet as many of their needs as possible.

An expansion of the midwifery program would go a long way toward addressing the many needs of the Winnipeg community.

Priority Process: Competency

The teams are populated with highly competent and dedicated health professionals, as well as support and management staff. There is evidence of a culture of continuous learning and support is provided by the organization.

Priority Process: Episode of Care

There is a good working relationship between the different sites and many of the health care professionals (i.e., midwives, obstetricians, family physicians) work at more than one site. The mission of the obstetrical team is to reach as many women as possible to deliver good prenatal and post-partum

care. Many of their clients are high risk because of the determinants of health and therefore require encouragement, education, and support to access health care.

The teams at the Health Sciences Centre Winnipeg and St. Boniface are highly experienced and motivated to provide client-centred and professional care. The midwives, located at different sites, are very dedicated, committed, and professional. They are strong advocates for the women and babies of this region, in particular for the women who are at risk due to poverty, education, language, addiction, or violence. At this time, the team of midwives can meet only 50 percent of the demand for their services.

Evidence-based practices are the norm in this program but the leaders and educators need to continue to educate the health professionals on practices that are more cultural or force of habit, such as safe sleep practices or exclusive breastfeeding.

An excellent initiative of this team is the Partners in Inner-city Integrated Prenatal Care (PIIPC) which has a goal of reaching women who do not traditionally access prenatal care. These are women who suffer from addiction, who are homeless, or who are victims of violence. One year post trial, they are showing good results in reaching more women, increasing the knowledge levels of these women, and preventing hospital admissions. It should also be noted that with the participation of Child and Family Services and with the support provided to these women, they are reducing the number of apprehensions. It is only with close collaboration with the different players in health, social, or protection services that more women will be able to keep their babies in a safe and healthy environment.

Priority Process: Decision Support

The women's health team members at all the sites are very client centred in their decisions, approach, and interactions with their patients. They are committed to the patient population they serve and demonstrate a high level of innovation.

Priority Process: Impact on Outcomes

Protocols and procedures are developed using the most recent and valid evidence, and excellence in care is promoted. There is also a sense that even though there is a standard of care that is the guiding principle, how it is applied may vary among the women because of their own special needs. The goal is mother and child safety, optimal health, and keeping the child and mother together as much as possible.

Standards Set: Organ and Tissue Donation Standards for Deceased Donors - Direct Service Provision

Unmet Criteria		High Priority Criteria
Priority Process: Clinical Leadership		
1.3	Organ and tissue donation is part of the organization's strategic priorities.	
1.8	Goals should include identifying and referring every potential donor.	
1.10	Donor services are coordinated across the continuum with organ procurement organizations (OPOs), tissue banks, and transplant centres.	
2.1	A donation committee that is responsible for monitoring and improving the quality of the donation program is established with input from clients and families.	
2.2	Donation data is regularly reviewed by the donation committee and this information is reported to the organization's senior leadership with recommended strategies for improvement.	
Priority Process: Competency		
5.11	Education and training are provided on the organization's ethical decision-making framework.	
5.16	Client and family representatives are regularly engaged to provide input and feedback on their roles and responsibilities, role design, processes, and role satisfaction, where applicable.	
6.5	The effectiveness of team collaboration and functioning is evaluated and opportunities for improvement are identified.	
Priority Process: Episode of Care		
1.14	Barriers that may limit clients, families, service providers, and referring organizations from accessing services are identified and removed where possible, with input from clients and families.	
Priority Process: Decision Support		
The organization has met all criteria for this priority process.		
Priority Process: Impact on Outcomes		

19.9	Quality improvement activities that were shown to be effective in the testing phase are implemented broadly throughout the organization.	!
19.10	Information about quality improvement activities, results, and learnings is shared with clients, families, teams, organization leaders, and other organizations, as appropriate.	

Priority Process: Organ and Tissue Donation

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

All three human tissue gift programs recognized by the Manitoba Human Tissue Gift Act need to jointly develop a common purpose, vision, and guiding principles, as they have a provincial mandate to offer donation services to all Manitobans.

The WRHA donation program must become comprehensive in nature. Presently there is no single executive sponsorship from the WRHA to oversee the comprehensive donation program. There are different reporting structures for each donation program. Transplant Manitoba, living and deceased organ donation falls under the medicine program and reports to the WRHA vice president of nursing, Tissue Bank Manitoba reports to the chief operating officer of the Pan Am site, and the Misericordia Eye Bank reports to the Misericordia site director.

The organization does not have a donation committee with a clear mandate from the WRHA.

There are dedicated resources for quality assurance activities in all donation programs, including roles and responsibilities, maintaining updated SOPs, and promoting quality improvement initiatives in their distinctive programs. A more collaborative approach between these dedicated resources would add value to the organization in spreading best practices and lessons learned between donation programs, and ensuring a common approach to quality assurance and quality improvement initiatives.

The donor after cardiac death (DCD) program has recently been developed and implemented. No potential DCD donors had been identified as of the date of the on-site survey.

All three donation programs presently offer services solely in the WRHA area. An implementation plan is underway to offer tissue donation services to the Interlake-Eastern Regional Health Authority in the next few months.

Priority Process: Competency

The transplant program teams are highly competent, proficient, and knowledgeable, and demonstrate excellent communication skills when interacting with patients and families involved in the organ donation

process. All team members have a keen interest in quality improvement science and see the value this adds to improve their services.

The teams are encouraged to continue their efforts to promote and work as a collaborative, be it within a team or among teams, especially for common guiding principles such as ethics, safety, patient-centred care, and quality improvement including patient-centred outcome measures.

It was stated that professional development and maintenance of competency is often done on personal time with little financial support from the organization.

Priority Process: Episode of Care

The donation program is a provincial mandate. The Gift of Life program is intended for all Manitobans; however, the program is mainly available to those living in the region of Winnipeg. This information is not available on the website nor is it disclosed in a transparent fashion to the public.

Priority Process: Decision Support

With the introduction of electronic charting in some areas of the organization and the continuation of paper charting in others, there is some significant risk in ensuring information is always easily accessible to all members of the team, and that all team members are aware of what is charted where.

The majority of the documentation is still on paper. The teams are encouraged to ensure some type of standardization where possible with forms, etc. to facilitate the eventual move toward complete electronic charting.

Priority Process: Impact on Outcomes

There is some good work being done by all three donor programs on quality assurance and quality improvement initiatives. They all have identified successes (with data) and areas of opportunity that have been translated into annual quality improvement plans. The quality improvement plans do not necessarily have clear timeframes, nor are targets necessarily well defined. The teams are encouraged to share, discuss, and learn from each other's quality improvement activities.

Tissue Bank Manitoba is accredited by the American Association of Tissue Banks. They have also received a number of recognition awards from the same organization for the quality of their services. In its internal quality management program, the corrective and preventative actions (CAPA) program is used. A number of its outcome indicators are well above North American averages.

Priority Process: Organ and Tissue Donation

The organ and tissue donation process for all three programs respects all elements required by the federal government for cell, tissue, and organ (CTO) establishments.

In addition Tissue Bank Manitoba is accredited by the American Association of Tissue Banks, and the Misericordia Eye Bank achieved a three-year accreditation with the Eye Bank Association of America in May 2014.

All teams have SOPs that are regularly updated and followed by team members using standardized forms to ensure proper documentation.

Standards Set: Organ and Tissue Transplant Standards - Direct Service Provision

Unmet Criteria			High Priority Criteria
Priority Process: Organ and Tissue Transplant			
The organization has met all criteria for this priority process.			
Priority Process: Clinical Leadership			
2.8	Space is co-designed with input from clients and families to ensure safety and permit confidential and private interactions with clients and families.		
2.11	The appropriate space and team members are available to manage recipients post-transplant.		
2.13	A universally-accessible environment is created with input from clients and families.		
Priority Process: Competency			
4.9	Education and training are provided on the organization's ethical decision-making framework.		
Priority Process: Episode of Care			
12.2	To minimize injury from falls, a documented and coordinated approach for falls prevention is implemented and evaluated.		ROP
	12.2.1	A documented and coordinated approach to falls prevention is implemented.	**MAJOR**
	12.2.2	The approach identifies the populations at risk for falls.	**MAJOR**
	12.2.3	The approach addresses the specific needs of the populations at risk for falls.	**MAJOR**
	12.2.4	The effectiveness of the approach is evaluated regularly.	**MINOR**
	12.2.5	Results from the evaluation are used to make improvements to the approach when needed.	**MINOR**
16.3	Information relevant to the care of the client is communicated effectively during care transitions.		ROP
	16.3.1	The information that is required to be shared at care transitions is defined and standardized for care transitions where clients experience a change in team membership or location: admission, handover, transfer, and discharge.	**MAJOR**

16.3.2	Documentation tools and communication strategies are used to standardize information transfer at care transitions.	**MAJOR**
16.3.3	During care transitions, clients and families are given information that they need to make decisions and support their own care.	**MAJOR**
16.3.4	Information shared at care transitions is documented.	**MAJOR**
16.3.5	The effectiveness of communication is evaluated and improvements are made based on feedback received. Evaluation mechanisms may include: • Using an audit tool (direct observation or review of client records) to measure compliance with standardized processes and the quality of information transfer • Asking clients, families, and service providers if they received the information they needed • Evaluating safety incidents related to information transfer (e.g., from the patient safety incident management system).	**MINOR**

Priority Process: Decision Support

The organization has met all criteria for this priority process.

Priority Process: Impact on Outcomes

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

Priority Process: Organ and Tissue Transplant

The kidney transplant programs participate in the national registry.

The programs offer services according to best practice guidelines. Policies and SOPs have been updated accordingly when needed.

Priority Process: Clinical Leadership

The pediatric and adult kidney transplant programs continue to improve the care delivery model. It is evidence based and respects provincial and federal regulations. Both programs are actively engaged in activities related to the Canadian Transplant Registry and have updated their program policies. Both programs work in close collaboration with the Manitoba Renal Program and have done excellent work to improve transitions for pediatric patients moving into the adult program. The program is comprehensive from referral to post-transplant care.

As identified in the previous on-site survey, the environment remains a challenge for team members to provide care in an environment that is universally accessible, ensures dignity and confidentiality, and ensures best practices regarding infection prevention.

The team is encouraged to promote best practices regarding patient-centred care in all their activities, including defining the care delivery models, the objectives (which are in line with the WRHA Patient First vision), the patient experience, and information/educaton/decision aid tools that promote shared decision-making practices.

The lung transplant program is now a joint program with the Edmonton transplant team. Work is being done to ensure pre-transplant workup, rehabilitation best practices, and seamless care transition.

Priority Process: Competency

The transplant program teams are highly competent, proficient, and knowledgeable, and demonstrate excellent communication skills when interacting with patients and families involved in the organ donation process. All team members have a keen interest in quality improvement science and see the value this adds to improve their services.

The teams are encouraged to continue their efforts to promote and work as a collaborative, be it within a team or among teams, especially for common guiding principles such as ethics, safety, patient-centred care, and quality improvement including patient-centred outcome measures.

Education on ethical decision making and the ethical framework was identified as a gap.

Priority Process: Episode of Care

The episode of care is generally well orchestrated. However, there is little use of validated screening tools in the ambulatory care setting for falls prevention, skin integrity, suicide risk, and depression. There is also improvement to be made regarding information transfer at care transitions.

The teams are encouraged to continue their efforts to introduce the patient- and family-centred care approach. Although the team is doing an excellent job on this regard, the approach is in its infancy.

Priority Process: Decision Support

The ambulatory care activities have transitioned to an electronic medical record (ACCURO).

A number of patient encounters in other clinical settings and sites are still documented on paper-based charts, including inpatient activities. Numerous forms, checklists, and other decision tools remain paper based. As mentioned in the previous on-site survey, there are a lot of back and forths. These are risks associated with clinical documentation practices. The teams are encouraged to introduce procedures to mitigate these risks and be proactive as they move along the journey toward complete electronic charting.

Priority Process: Impact on Outcomes

There is evidence that all transplant programs have quality improvement plans in place.

The teams are encouraged to identify and introduce patient-centred outcome indicators. Resources to support this work are available from a number of organizations, including the Patient-Centered Outcomes Research Institute and the International Consortium for Health Outcomes Measurement.

The pediatric kidney transplant program, through a Children's Hospital Foundation grant, has done exceptional work to improve the education program and material to meet appropriate developmental stages of patients and families. It would be beneficial to measure the impact of these initiatives on clinical outcomes.

Standards Set: Organ Donation Standards for Living Donors - Direct Service Provision

Unmet Criteria		High Priority Criteria
Priority Process: Living Organ Donation		
10.3	There is a process to identify and address ethical issues related to living donation.	!
11.2	A formal medical record is opened for the potential living donor when the medical assessment begins.	
Priority Process: Clinical Leadership		
1.6	There is an ethical framework or guidelines that are upheld throughout the living donation process.	
2.5	Space is co-designed with input from clients and families to ensure safety and permit confidential and private interactions with clients and families.	
2.8	A universally-accessible environment is created with input from clients and families.	
3.5	The SOPs are reviewed and evaluated annually, and based on the results, the SOPs, training activities, or monitoring processes are changed as necessary. CSA Reference: Z900.1-03, 6.4.	
6.2	Work and job design, roles and responsibilities, and assignments are determined with input from team members, and from clients and families where appropriate.	
Priority Process: Competency		
4.12	Education and training are provided on the organization's ethical decision-making framework.	
4.21	Ongoing professional development, education, and training opportunities are available to each team member.	
5.3	Position profiles with defined roles, responsibilities, and scope of employment or practice exist for all positions.	
Priority Process: Episode of Care		

The organization has met all criteria for this priority process.

Priority Process: Decision Support		
18.6	Policies and procedures to securely collect, document, access, and use client information are followed.	!
18.9	Policies and procedures for securely storing, retaining, and destroying client records are followed.	!
18.12	There is a process to monitor and evaluate record-keeping practices, designed with input from clients and families, and the information is used to make improvements.	!
Priority Process: Impact on Outcomes		
22.9	Quality improvement activities that were shown to be effective in the testing phase are implemented broadly throughout the organization.	!
22.10	Information about quality improvement activities, results, and learnings is shared with clients, families, teams, organization leaders, and other organizations, as appropriate.	
Priority Process: Blood Services		

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

Priority Process: Living Organ Donation

The living organ donation program had a successful Health Canada audit in 2014. The audit identified minor discrepancies that were rapidly corrected in the following months.

There are regular SOP meetings with the team to review the processes and ensure appropriate forms and tools are available to all team members, to make the process as consistent and standardized as possible.

Priority Process: Clinical Leadership

There is strong clinical leadership for the living donor program (kidney). They are actively involved in academic programs, clinical research, and national committees. The team has participated in the kidney paired donation living donation guidelines among other significant contributions.

The team is encouraged to use the WRHA ethical framework and bring to it specificities appropriate to the team's mandate and individual roles and responsibilities. During the on-site survey, a few ethical issues were identified such as dual roles (live organ donation program and call coverage for deceased organ donation), common working and care environments for the living donor program, deceased donor program, the transplant program, and confidentiality issues during patient encounters due to limited space.

The last accreditation survey identified issues with the care environment and the workspace for the teams. These issues related to confidentiality during patient encounters, an inability to abide by best practices regarding infection prevention, and inappropriate storage of medication charts. The environment is not universally accessible. Plans have been developed but there is no timeframe for next steps.

Priority Process: Competency

The transplant program teams are highly competent, proficient, and knowledgeable, and demonstrate excellent communication skills when interacting with patients and families involved in the organ donation process. All team members have a keen interest in quality improvement science and see the value this adds to improve their services.

The teams are encouraged to continue their efforts to promote and work as a collaborative, be it within a team or among teams, especially for common guiding principles such as ethics, safety, patient-centred care, and quality improvement including patient-centred outcome measures.

It was stated that professional development and maintenance of competency is often done on personal time with little financial support from the organization.

Priority Process: Episode of Care

All team members strive to provide the most positive experience for people going through the living donor care process. The team's professionalism is highly appreciated by those receiving the services as well as their families.

A number of LEAN initiatives have been done to improve care. These include improving ongoing communications, providing information and education throughout the living donation process, and efforts to decrease the timeframe for the living donor assessment process.

The team is encouraged to continue its efforts to actively engage patients by getting their input in the planning and adjustments made in the delivery model, ensuring shared decision-making approaches are used by all team members, and updating living donor decision aid tools (booklets, internet site, etc.) on a regular basis with input from potential living donors and those who have lived it.

Priority Process: Decision Support

Chart documentation for the living donor program is presently all paper based. Parallel charting is being used and it is not clear at what point the local chart becomes a recognized WRHA medical record.

Charts are kept in the clinic, many of them in the clerk and coordinator's offices, and are easily accessible as they are not in locked cabinets. There are also medical records that are locked in files in the clinic corridor due to lack of space. Older charts that are not active are sent to Iron Mountain.

The team, with support from health information experts, is encouraged to review the medical records procedures to ensure they respect legislation and WRHA policies and procedures.

Priority Process: Impact on Outcomes

The living donor program has a quality improvement roadmap (2015-2016) that involves updating and improving patient education material and a number of LEAN projects to improve the assessment process for living donation to make it more efficient. There is no formal approach that ensures active participation of patients in these initiatives, to find out the expectations of potential donors.

Most of the documentation is done in English. The team is encouraged to ensure information and education takes into account health literacy and health equity principles.

Priority Process: Blood Services

Evidence reviewed during the on-site survey indicate the criteria are met.

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

Unmet Criteria		High Priority Criteria
Priority Process: Clinical Leadership		
The organization has met all criteria for this priority process.		
Priority Process: Competency		
6.11	Team member performance is regularly evaluated and documented in an objective, interactive, and constructive way.	!
7.4	Standardized communication tools are used to share information about a client's care within and between teams.	!
Priority Process: Episode of Care		
11.11	To minimize injury from falls, a documented and coordinated approach for falls prevention is implemented and evaluated.	ROP
11.11.1	A documented and coordinated approach to falls prevention is implemented.	**MAJOR**
11.11.4	The effectiveness of the approach is evaluated regularly.	**MINOR**
11.11.5	Results from the evaluation are used to make improvements to the approach when needed.	**MINOR**
12.11	Information relevant to the care of the client is communicated effectively during care transitions.	ROP
12.11.1	The information that is required to be shared at care transitions is defined and standardized for care transitions where clients experience a change in team membership or location: admission, handover, transfer, and discharge.	**MAJOR**
14.4	Procedure-specific care maps or guidelines are used to guide the client through preparation for and recovery from the procedure.	
17.5	Airborne, droplet, and contact precautions are used as appropriate to reduce the risk of infection to clients and team members.	!
18.4	A smoke evacuation system is used when any energy source that produces plume (e.g. electrosurgical unit) is operated.	!
Priority Process: Decision Support		

21.8	There is a process to monitor and evaluate record-keeping practices, designed with input from clients and families, and the information is used to make improvements.	!
Priority Process: Impact on Outcomes		
23.5	Guidelines and protocols are regularly reviewed, with input from clients and families, to ensure they reflect current research and best practice information.	!
Priority Process: Medication Management		
5.1	The surgical area's supply of medications is appropriate to the procedures performed and the patient population served.	
5.2	Medications in the surgical area are stored in a locked area or similarly secured, as per the organization's policies regarding medication storage.	!

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

Services are co-designed in a co-led matrix model. The surgical director works collaboratively with department heads in both surgery and anesthesia, with executive vice president oversight.

Integrated planning is done regionally through a site model (anesthesia, surgery, and surgical directors) which integrates into the regional team. Once a year the team meets to set an operational plan and review progress on assigned objectives. A quality roadmap is noted with specific objectives and accountabilities assigned. The next phase will be to align program goals with the strategic plan of the organization.

Multiple committees support the work of the division. There is evidence of a strong collaboration between anesthesia and surgery with these processes. Work ahead may be to assess whether there are redundancies among committees, streamline committee workload, and move toward matrix model participation in regional initiatives.

The program seeks feedback from patients and families on a regular basis and there is a patient representative on the program Quality Council. Patient and family input was sought for the layout of the new Women’s Health facility.

The patient voice has been included in grand rounds and this has yielded findings for the perioperative team to consider in future care planning. The example cited was improvements to venous thromboembolism care for surgical patients that were made after case presentations and the patient voice were heard.

The patient voice strengthens program responsiveness. One example given is attention to the impact of surgical cancellations on patients and their families. To date the program has developed a surgical cancellation policy and monitors reasons for surgical cancellations.

There is both an electronic and manual charting system. This has been identified by the team as a service gap, with inherent handover issues. The electronic charting used by cardiac services at St. Boniface is impressive. All other surgical sites depend on a manual charting system. The service has conducted a survey to see what methods of verbal and written handover processes are used. Standardization of regional handover is pending.

End-of-life patient information was noted on surgical services at the Grace Hospital. Investigative cardiac services at St. Boniface noted that end-of-life discussions occur in the pacemaker clinic and staff and physicians see linkages with palliative care.

Through patient and family interviews at all surgical sites, all reported feeling included in care decisions. Surgical team members at all sites were praised for their attention to patient needs. Their commitment to the patient voice is exemplary.

Job design descriptions are both manual and electronic and can be changed as position roles change, with staff inclusion.

Priority Process: Competency

Credentials are verified and staff are required to take regular training. Documentation is available to all surgical managers with the assistance of the educator. Perioperative staff must pass certification standards. Some staff are certified, some have explored it, and some have expressed an interest. Critical care certification is required in the cardiac investigation unit. Staff can seek organization assistance for ongoing education through bursaries.

There is a standard orientation for the organization, and additional orientation support for surgical services, with the time varying among sites from three to six weeks. New perioperative staff have access to an internal program that supports them in gaining certification. Surgical units may give additional weeks of mentoring. The clinical resource nurse assists with new hire orientation. All units have orientation checklists, although they are not standardized across the program. An innovative approach is used at Grace Hospital, where a nurse is assigned to help the with the on-boarding of new surgical staff. Adding a research lens to this approach would validate the proposed benefit, which is staff retention.

Care delivery models vary across sites. All managers were able to show the approach used for assignments and the back-up plan for staff shortages or workload acuity. At the Health Sciences Centre Winnipeg, perioperative staff explained how their emergency plan worked this year when they moved cardiac services from St Boniface to Health Sciences. Surge capacity was gained within two hours.

The program aligns with the organization ethical framework. Staff and physicians are able to access this support through a process outlined in organization policy. Case reviews at St. Boniface showed evidence of ethical decision making in accordance with the framework.

Technology training is done and documented by educators, as is infusion pump training. Staff moving among sites note that pumps are not standardized. In the area of technology, on call physicians note that phone communication is creating challenges and may be a risk due to dropped calls.

Performance conversations are an initiative of the people services portfolio, and staff are looking forward to strategy implementation. Not all staff report having had regular performance evaluations. Some units have had regular informal feedback, others have had written feedback. This is an opportunity for improvement for the service that would align with organizational strategic initiatives.

HSC managers recognize the need for managerial succession planning. Although no formal program exists at present, managers are aware of the need to mentor those with an interest in surgical services management.

All perioperative teams visited exhibited collaboration to address patient care needs. The organization has worked hard to address surgical checklist recommendations. Audit data and reports are available quarterly, with nineteen data sets being are trended each quarter. Progress is apparent in the data reviewed year over year.

Allied health are collaborative partners. Physician assistants, clinical pharmacists, physiotherapists, and occupational therapists are assigned at varying levels to surgical units. Seamless communication occurred in the interest of best patient care.

In January 2015, standard communication tools were reviewed using Survey Monkey, and 97 responses were received. Method of communication (verbal and or written), person leading handover communication, and service area (pre-admission clinic, post-anesthesia care unit, surgical day centre, operating room, surgical inpatient unit, outpatient clinic) were noted. The survey reviewed the method of physician handover; most reported this to occur at shift change and at the bedside. The majority of areas in the service noted the SBAR (situation, background, assessment, recommendation) tool being used most commonly at transition points. Over 77 percent noted that both written and verbal communication were used at transition points. According to survey respondents, the patient and/or family was involved in care transitions 80 percent of the time, while 60 percent of respondents noted that care was safe, effective, and efficient during transition.
Guidelines for safe patient handovers and transfer of accountability were drafted in April 2015 and revised in April 2016. The management team provided examples of safe patient handover audits at St. Boniface and Seven Oaks.

Opportunities for improvement across the perioperative program would be for a standard transition point tool across all sites, with a standard audit tool (such as the one in place) monitored across all sites on a regular basis. Compliance among sites could be considered a key performance indicator.

Communication methods are not standardized among units. Bullet rounds varied in approach. A quality improvement initiative on cardiac services at St. Boniface started in fall 2015 and is ongoing. The pilot target date will defer to at least June 2016. Findings from the PDSA initiative will be reviewed before leveraging to other units.

Staff note informal recognition processes on the units.

Staff are aware of the violence prevention policy and ability to protect themselves and their patients.

St. Boniface and Misericordia noted the importance of spiritual care in their patient care plans.

Priority Process: Episode of Care

In Child and Women's Health there is evidence of a very collaborative relationship among the different sub-specialties. The approach with patients and families is respectful and non-judgemental. There is an open door policy for visitors. There is evidence of informed consent for invasive procedures but consent is implied for standard care.

The Women's Health program implemented an excellent initiative for the transfer of information at transition points, with a written document that is completed in the presence of the sending nurse and the receiving nurse, and both nurses must sign the document. This ensures there are no gaps in the information and provides an opportunity for the nurses to ask questions and expand on a particular issue.

Barriers are removed for patients and families in cardiac services. Patient advocacy was observed.

Wait list data for the service is trended monthly. Initiatives include a movement to centres of surgical excellence. Timely access to care is implicated by flow and this is identified as a core strategic goal.

Discharge pamphlets are seen in all surgical services areas, and a spreadsheet plan is available in cardiac services. In cardiac inpatient services at St. Boniface, an automated prompt is used for discharge follow up on patients. Any issues are followed up by the cardiac clinic.

Informed consent was noted on all reviewed charts. There is an organizational policy to guide consent when there is not capacity and no substitute decision maker.

The majority of the time pain, falls, pressure ulcer, and venous thromboembolism assessment tools were found on charts, although exceptions were noted. The falls prevention program is implemented throughout the program, with the exception of the Concordia site. Assessment tools are found on charts. Anaesthesia ASA criterion was noted on charts reviewed. Pre-admission surgery forms and processes were noted at all sites. Diagnostic and laboratory services had protocols to deliver diagnostic results on time and as required.

St. Boniface biomedical services was observed. They maintain an inventory of all medical assets and have scheduled required preventive maintenance. Original equipment manufacturers attend to perioperative

equipment as required. Room temperature and humidity was noted as a monitored issue in summer months at the Grace and Misericordia sites. No temperature control trending for sites was available during this on-site survey. Smoke evacuation policy is a gap. Technology improvements were noted with on call phones by some physicians.

Surgical site infection monitoring is ongoing. There is dialogue between the infection prevention and control team and the perioperative leadership team. Improvements will be expected in the area of improving antibiotic prophylaxis rates. Care pathways at the Misericordia site visit show prophylactic drops are used.

The Research Ethics Board process is available to staff and physicians on the intranet site. Research activities are noted at the St. Boniface site, where 90 trials are in progress. The research team is committed to growing the research process and innovative strategies are being explored. At the Misericordia site an exciting study in the area of history and physical requirements for ophthalmology patients is being explored by anesthesia. Phase one results will decrease lab utilization and decrease general practitioner workload, if adopted.

Rights and responsibilities are shared with patients on admission to the perioperative service. The surgical team is working with the wound care team to improve the policy (dated December 2011) on patient positioning for surgical procedures.

The surgical count policy was developed in May 2008 and revised in February 2012. It is currently being revised. Surgical count audits have been reviewed since 2014 across all nine program areas (St. Boniface, Pan Am, Grace, Seven Oaks, Victoria General, Health Sciences Centre Winnipeg, Concordia, Misericordia, Women's and Child Health). Progress is noted across the program areas from 2014/15 to the current fiscal year.

Starting in January 2016 Med Reconciliation in Perioperative Services and Invasive Procedures Standards is divided into two MedRec ROPs 1) for inpatient care (11.6) and 2) for outpatient care (11.7). The intent of the ROP is unchanged but requirements for outpatients have been adjusted to facilitate implementation. Due to the complexity of the on-site survey, timing of the release of these adjustments, and incomplete understanding of requirements the ROP outpatient care (11.7) is rated N/A for Perioperative and Invasive Procedures Services Standards during the 2016 accreditation survey. The ROP outpatient care (11.7) will be applicable for the next accreditation cycle.

The importance of the surgical checklist is noted with aggressive, regular interval auditing through the past two fiscal years. The most recent audit in February 2016 noted improvements, with most sites achieving 90 to 100 percent compliance to policy.

Standard operating procedures were cited for neurology, general surgery, orthopedics, and ophthalmology. Care plans were in kardex format on most units, and electronic was available in cardiac services. Patients were observed to participate in care decisions (e.g., discharge times).

Quality roadmaps for the program are focused, with objectives and accountability assigned. Next steps will be to align with the strategic plan and trend data for improvement.

A shower curtain process was noted for isolation patients in step down neurology (HSC) and the cardiac investigation unit (St. Boniface). Review of infection prevention and control standards is encouraged.

Seven Oaks and Pan Am do not have air exchange processes that meet environmental conditions.

Priority Process: Decision Support

Information system teaching requirements are assigned to the clinical educators for nursing and allied health on the units, as appropriate. In the perioperative area training on new equipment is arranged through the management team.

Accurate patient records and charts were observed. Chart format varies across sites. Staff are able to explain the process for chart transfer.

The organization has a policy on the use of patient information.

Training and education on privacy legislation is part of general orientation. There is a policy on disclosure with time limits.

On call physicians commented on an issue with phones and dropped calls. Leadership is aware and addressing this issue, due to the risk potential (HSC).

Priority Process: Impact on Outcomes

There is evidence of numerous order sets that are evidence-based and harmonized between different care providers. Continued work in the areas of policy standardization across the program and a systematic process for program policy review is encouraged.

Physicians and staff express an interest in research. The project at Misericordia may help change preparation standards for low-risk surgical patients.

The hip and knee institute at Concordia supports orthopedic research innovation. It is hoped the application of the research will decrease revisions and have a positive impact on orthopedic wait lists and patient outcomes.

Critical incidents have helped improve care (e.g., application of the venous thromboembolism protocol). Continuing to share incident recommendations across programs will help improve outcomes for patients.

Priority Process: Medication Management

There is a locked system in each operating suite for the use of the anesthetists.

All areas visited were aware of medication reconciliation and were able to provide information as required by standards. Double checks are done on high-alert medications. Some anaesthesia medications were unattended in theatres during cases (Concordia), and disposal of medications at end of slate (St. Boniface) did not meet standard.

Perioperative management considers staff training for emergent situations in their orientation. Anaesthesia carts are standardized at each site, and checked on a regular basis. There is a strong relationship with pharmacy staff at all sites in maintaining best medication practice.

Standards Set: Primary Care Services - Direct Service Provision

Unmet Criteria		High Priority Criteria
Priority Process: Competency - Primary Care		
The organization has met all criteria for this priority process.		
Priority Process: Clinical Leadership		
2.4	The funding or payment models used create incentives to deliver the best possible primary care services.	
Priority Process: Competency		
The organization has met all criteria for this priority process.		
Priority Process: Episode of Care		
6.11	Clients' ability to access services is tracked and the information used to make improvements to services.	
8.14	Clients and families are provided with information about their rights and responsibilities.	!
8.15	Clients and families are provided with information about how to file a complaint or report violations of their rights.	!
9.5	When prescribing any medication, the team reconciles the client's list of medications.	!
Priority Process: Decision Support		
The organization has met all criteria for this priority process.		
Priority Process: Impact on Outcomes		
The organization has met all criteria for this priority process.		

Surveyor comments on the priority process(es)

Priority Process: Competency - Primary Care

The collaborative approach in evidence at all sites, especially at the ACCESS Centres and the QuickCare Clinics, allows staff to work to their full scope of their practice, thus contributing to the system's efficiency.

Priority Process: Clinical Leadership

Clients' perspectives are taken into consideration for service design and improvement. There is a remarkable partnership with other services and programs. This is especially visible at the ACCESS Centres where, in addition, there is a great synergy of skill levels thanks to the multidisciplinary teams who go through a consistent orientation process.

Priority Process: Competency

Team members go through a comprehensive and consistent orientation program that they consider provides them with the knowledge they need to properly operate within the organization's care model. There are regular performance appraisals which are seen by staff as a constructive process and as an opportunity to foster professional development. The use of a standard electronic medical record allows for an easy sharing of information related to client care.

Priority Process: Episode of Care

Most sites have interventions or projects to remove barriers using methods such as advanced access and LEAN project management. Access improvements include reducing wait times for spirometry, a remarkable increase of patient intake at ACCESS Transcona, advanced access at Kildonan Medical Centre, the LEAN project for speech therapy at ACCESS Downtown, and the prenatal and mobile kidney projects at ACCESS NorWest. Teams interviewed identified the Family Doctor Finder tool as a key contributor to better access.

Almost all sites were able to provide same day access using different approaches, such as the Provider of the Day at ACCESS NorWest. The collaborative approach makes it easier for professionals to provide access to services which they cannot deliver and to better deal with clients with multiple comorbidities.

All of the interviewed clients expressed feeling respected, engaged, and empowered in their care and well informed of their progress. None of them were aware of the process to file a complaint, although protocols are easily accessible and those addressing the most common conditions are monitored for compliance. A holistic approach is used with each client to identify and address psychosocial needs. The QuickCare Clinic model allows for easy access to after-hours care with the advantage of linking clients with their family doctor. None of the clients interviewed knew about the QuickCare Clinics.

None of the clients interviewed were aware of their rights or their responsibilities.

Outreach care is provided to clients, which is remarkably facilitated by the ACCESS Centres. Clients are empowered to self-manage conditions by receiving education with strategies such as Hans Kai at ACCESS NorWest.

Staff identified follow up after discharge from hospital as a challenge because receipt of timely discharge notes varies from one hospital to the other.

The organization is encouraged to implement a formal and ideally standard medication reconciliation process for primary care sites.

Priority Process: Decision Support

It was evident that the organization uses several sources of information to identify and manage clients with immediate or urgent needs. The use of the same EMR at all the visited sites promotes safety, continuity of care, and a collaborative approach. The information documented in the EMR is easily accessible by providers and clients.

The EMR system is getting slow and this was identified as an inconvenience by staff who were interviewed.

Priority Process: Impact on Outcomes

The teams have access to guidelines that promote consistency of care.

A risk approach is used to manage safety risks. Staff were knowledgeable about the incident reporting process, which is followed by analysis. The primary care indicators in the primary care quarterly report are used by most of the sites to identify opportunities for improvement. This could be improved at ACCESS Downtown.

It is suggested that the organization put in place the necessary mechanisms to ensure key performance measures reach front-line staff regularly and in an easy-to-understand format.

Standards Set: Public Health Services - Direct Service Provision

Unmet Criteria		High Priority Criteria
Priority Process: Clinical Leadership		
5.4	Space is co-designed with input from clients and families to ensure safety and permit confidential and private interactions with clients and families.	
Priority Process: Competency		
4.5	Ongoing education on public health laws and regulations, and their relationship to public health practice is provided to the team.	
Priority Process: Episode of Care		
The organization has met all criteria for this priority process.		
Priority Process: Decision Support		
The organization has met all criteria for this priority process.		
Priority Process: Impact on Outcomes		
16.9	Quality improvement activities that were shown to be effective in the testing phase are implemented broadly throughout the organization.	!
Priority Process: Public Health		
3.8	Public health services are designed to address risks that impact health in the physical and built environments identified in the population health assessment, with input from the community.	
6.3	A population health improvement plan is jointly developed and implemented with partners, stakeholders, and the community.	!
6.4	There is a documented strategy to engage partners in implementing the population health improvement plan.	!
7.6	The effectiveness of communication strategies is evaluated and improvements are made as a result.	
8.1	The organization, in partnership with relevant organizations, and with input from the community, participates in the development of public policies with population health implications.	!
8.2	Current public policies with population health implications are analyzed and policy gaps are identified.	!

8.3	Health impact assessments for proposed public policies, programs, and projects are conducted in collaboration with partners and with input from the community.	
12.1	There is participation in the development of public health laws, regulations, and ordinances that influence population health.	!

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

Staff are recruited to meet client needs and the work design is flexible, so staff are able to work independently.

Over time, as client needs have changed, there have been adaptations to the workforce. While clear position accountabilities exist, they are strategic by capitalizing on the skills and training of a diverse workforce. There are no silos of work ownership as they are all focused on the clients served, who are defined broadly.

Priority Process: Competency

All teams encountered demonstrated professionalism, team work, and respect for each other. Everyone was focused on the client and an attitude of "servant leadership" came up in a number of conversations.

The Aboriginal Health Program has a strong cultural identity and a systems approach to their work.

There are diverse skills, competencies, and talents within all teams and programs surveyed.

Priority Process: Impact on Outcomes

Within population and public health, the singular conceptual framework is a unifying approach, with each program area having tailored plans and a logic framework. These cascading plans are a strength.

Moving Forward Together: Aboriginal Health Programs Strategy 2011-2016 has been a solid foundation for the past few years. The Truth and Reconciliation Commission of Canada (TRC) provides a strong platform to guide regional planning, drive quality improvement, and partner to meet the needs of Aboriginal populations. This team is using many strategies and tactics to have the TRC recommendations addressed.

Priority Process: Public Health

These teams are highly competent and passionate about their work. They keep the client, who is broadly defined, at the centre of their focus, and have good team work and a strong focus on health equity which poses them to be leaders in Canada.

They have strong and vibrant partnerships, including intersectoral partnerships. The ACCESS Centres are a fine model of service delivery and are becoming mature in terms of their policy development opportunities.

The Surveillance Winnipeg Initiative tool with a common operating picture (COP) is a leading edge tool not only for routine public health surveillance, but also for its innovative application to emergency and disaster preparedness.

Standards Set: Rehabilitation Services - Direct Service Provision

Unmet Criteria		High Priority Criteria
Priority Process: Clinical Leadership		
2.7	A universally-accessible environment is created with input from clients and families.	
Priority Process: Competency		
3.11	Team member performance is regularly evaluated and documented in an objective, interactive, and constructive way.	!
4.5	The effectiveness of team collaboration and functioning is evaluated and opportunities for improvement are identified.	
Priority Process: Episode of Care		
7.12	Ethics-related issues are proactively identified, managed, and addressed.	!
10.8	The effectiveness of transitions is evaluated and the information is used to improve transition planning, with input from clients and families.	
Priority Process: Decision Support		
The organization has met all criteria for this priority process.		
Priority Process: Impact on Outcomes		
13.3	There is a standardized process, developed with input from clients and families, to decide among conflicting evidence-informed guidelines.	!
15.7	There is a process to regularly collect indicator data and track progress.	
15.8	Indicator data is regularly analyzed to determine the effectiveness of the quality improvement activities.	!
15.9	Quality improvement activities that were shown to be effective in the testing phase are implemented broadly throughout the organization.	!
Surveyor comments on the priority process(es)		
Priority Process: Clinical Leadership		

Rehabilitation and geriatrics were assessed at four locations. Each offered specific services based on populations in the unit. Where possible space is designed to best meet the needs of each population; however, some units have four-bed units with cramped space and no dining facilities, hindering the recovery of activities of daily living for these patients. The organization is encouraged to explore other options for this patient population for improved rehabilitation opportunities.

These units provide care for patients with significant mobility issues and equipment needs. At some of the locations the hallway space is cluttered and has the potential to cause navigation challenges for patients and staff. Reviewing existing storage space may free up additional space for equipment and supplies that are currently housed in the hallway.

There are several good LEAN projects across the organization that focus on storage and organization. The organization is encouraged to share these practices across all sites and in particular those with extensive equipment, supply, and mobility needs such as rehabilitation and geriatrics.

The rehabilitation and geriatric teams meet as a regional program with overarching goals and objectives. While some areas visited have operational plans with measurable goals and outcomes, alignment with this plan this is not consistent. Program areas are encouraged to develop and implement unit-specific goals and objectives to align with broader WRHA planning.

The units have job profiles that outline job duties. A review of all profiles is encouraged to update job duties with input from staff where possible. A job profile review is being undertaken with input from affected staff at HSC Fifth floor rehabilitation. This review of the unit will clarify expectations and accountabilities and enhance staff understanding. It is an example of a good practice for staff involvement that could be shared across the organization.

Priority Process: Competency

Staff at each facility have the skill set and expertise to provide quality care to their patient population. Credentials are verified where indicated.

Staff indicate they can access staff development funds and have access to in-house and external conferences and workshops. Conference information can then be shared through a variety of internal options such as lunch and learns or mini-workshops to further spread that knowledge.

Each facility has an individual approach to infusion pump training as well as ongoing training schedules and educational material. The organization is encouraged to take a more coordinated approach so the educational material and approach is consistent in similar programs. While some units have developed their own educational material others rely on information provided by the pump provider. Sharing would help create consistent knowledge across sites.

Staffing is organized within each unit to provide the most appropriate care and can be realigned by the manager, within the existing budget, based on needs.

Performance reviews have been conducted recently in most areas. The organization is encouraged to roll out the conversational style of performance review to better engage staff in this process.

The teams in each unit work effectively as a team and strive to provide collaborative care. The organization is encouraged to evaluate team functioning in all areas to enhance coordination, and to provide training at all sites on the collaborative model of care that exists in some locations and units. Train the trainer opportunities have been provided so this should be accessed relatively easily.

Priority Process: Episode of Care

Care and support within the rehabilitation and geriatric program is provided by strong, client-focused interdisciplinary teams across the program. This is evident in the provision of care and the respect and trust between clients and providers.

The organization has the benefit of a central wait list management process. This ensures clients are placed in the most appropriate location for their needs. Admission criteria are completed for most programs and provide standardized tools and more accurate placement and admission.

Teams at all facilities work collaboratively between disciplines, with the client as the focus. Rounds in each program are an effective way of ensuring communication, joint problem solving, and treatment planning among the team. Respect for each discipline's expertise and insight was obvious at the rounds attended.

Clients are placed according to admission criteria but are transferred to more appropriate facilities and programs if needs change or cannot be met.

Standardized tools are used across programs including falls assessment, risk ratings, Braden pressure ulcer risk assessment, and other standardized tools and processes.

Clients and their families expressed appreciation in being involved in goal setting, planning, and discharge discussions. Several indicated it allowed them to feel more in charge of their care. They seemed aware of who was the most responsible person for their care, and they also stated they felt comfortable seeking out information from anyone.

There would be value in these teams continuing to work on improvement initiatives that bring the multidisciplinary team together, perhaps with client representatives, to identify initiatives to improve communication about priorities and expectations of assessment and treatment in these service areas. The use of LEAN methodologies that exist in many locations could be shared to ensure spread of this work.

While there is individual review when discharges fail, transitions are not effective, or rapid re-admissions occur, this is not evaluated on a regular and consistent basis. The organization is encouraged to develop a consistent and more comprehensive evaluation process around transitions and transfers, to identify opportunities for smoother and more effective transitions and discharges.

Priority Process: Decision Support

Client charts across all locations in this area are well organized and complete. While the charts are still paper based in many areas there is good evidence of information sharing between programs and across facilities. Many examples of transfer documents were observed.

In some locations chart audits were completed as part of a quality program and results posted on a quality board. This sharing of results provides increased staff awareness and additional education, and allows patients and families to understand the staff's focus on quality. The organization is encouraged to implement this quality practice across sites and programs, with like programs sharing and comparing results.

Standardized tools and processes for assessment are used across the sites, providing consistent assessment and understanding. The functional independence measure (FIM) is used across the program, providing consistent assessment information for other providers. Integrated process notes in these areas provide staff with a full picture of client needs.

There is a policy around incident reporting and disclosure where indicated. Staff can easily speak to the process and are comfortable with reporting.

Priority Process: Impact on Outcomes

Rehabilitation and geriatric programs used evidence-based guidelines where appropriate. The regional committee provides dialogue and support to enhance the use of care pathways and guidelines. There are examples of best practice initiatives in place across the sites. The team is encouraged to develop a more formal process to review and select the most appropriate guidelines when conflicting options exist.

Safety issues and awareness are a priority across the sites. This is evidenced by posters, staff and patient information on safety, and regular staff discussions. Information about falls is visible in all areas including patient-specific information in patient rooms. The chart audit review showed falls assessment, risk ratings, and pressure scales all completed and regularly reviewed in a timely way to ensure client safety.

The incident reporting process is well understood and recorded using the RL6 program for collection, tracking, and trending. The organization is encouraged to make this available to all programs across the sites.

Rehabilitation-specific strategic plans with measurable outcomes are developed and are in alignment with the broader high-level strategies of the organization. All programs are encouraged to move this to the next step and develop individual operational plans that align with these broader program strategies, using consistent indicators where appropriate.

Indicator development and monitoring has begun in many areas. The organization is encouraged to support similar programs to use consistent indicators and share information and learning across sites.

This will ensure the spread of quality improvements and limit duplication of effort. Further work is needed to analyze the effectiveness of data at all sites.

Standards Set: Spinal Cord Injury Acute Services - Direct Service Provision

Unmet Criteria	High Priority Criteria
Priority Process: Clinical Leadership	
2.7 The effectiveness of resources, space, and staffing is evaluated with input from patients and families, the team, and stakeholders.	
Priority Process: Competency	
The organization has met all criteria for this priority process.	
Priority Process: Episode of Care	
The organization has met all criteria for this priority process.	
Priority Process: Decision Support	
The organization has met all criteria for this priority process.	
Priority Process: Impact on Outcomes	
The organization has met all criteria for this priority process.	

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

HSC is the designated provincial trauma centre for Manitoba and northwestern Ontario. It provides specialized orthopedic and neurological surgical trauma care for patients with spinal cord injury (SCI). The trauma and acute care surgery ward and the step-down unit on GD3 were observed.

The unit's leaders indicated that patients treated on the unit are 16+ years of age. Children and youth with spinal cord related conditions are treated at the provincial children's hospital. A comprehensive discharge checklist has been developed with team input. There is a good relationship with the HSC rehabilitation centre that includes a patient flow transition role to facilitate early and efficient transition of patients requiring long-term rehabilitation services.

The clinical and administrative leadership of the SCI program presented as a strong, committed team. Leaders and clinicians actively advocate for the needs of this complex patient population.

The strategic priorities of the HSC have been aligned to operational goals for the surgical trauma units. Measurement of indicators against targets has not yet begun.

Priority Process: Competency

There is a strong interdisciplinary team in place on this unit. Every staff member encountered demonstrated commitment and passion for their work with spinal cord injury patients. A matrix reporting relationship exists for clinical staff who report to both program and allied discipline leadership.

Clinicians interviewed reported that they have participated in performance coaching conversations.

Priority Process: Episode of Care

There is a strong interdisciplinary focus on the care of patients with SCI. The team uses many avenues to ensure good communication and integrated care planning, including huddles (which can be called by any member of the team), daily rounds, and Bullet Rounds, which are led by the clinical resource nurse, occur daily, and are based on a collaborative care model. The goal of Bullet Rounds is to ensure the team is doing what is needed for each patient every day. The daily discussion focuses on the patient's reason for admission, anticipated discharge date, and what needs to be done and by whom to achieve the anticipated discharge date. All primary care provider stakeholders attend Bullet Rounds.

Plans are underway to use data from Medworxx, which will be updated every 24 hours at minimum by the RN/CRN prior to the daily Bullet Rounds; this information will be used to frame Bullet Rounds discussions, document action items from Bullet Rounds, communicate between disciplines, identify barriers to discharge, and flag complex discharges for weekly complex discharge rounds. It is anticipated that Medworxx will flag alternate level of care patients for potential transfer to non-acute beds, and other delays in discharge.

Bedside communication boards, implemented as a LEAN project, are used effectively as a communication tool between members of the team, as well as from patients and families to the interdisciplinary team. The boards are a good example of patient/family and team partnership, as they were customized to meet the specialized needs of the patients on the unit. Boards include the key discharge planning components of anticipated discharge date and location. It is expected this information will be used as an opportunity for staff to have discharge conversations with patients and families. As a part of the patient's orientation to a unit on admission, the admitting nurse ensures the purpose of the board is communicated to the patient/family. Each shift, the bedside RN is expected to ensure the information is up to date and accurate and that patients add their own questions to the board for discussion during Bullet Rounds.

Hand-hygiene audits are conducted using the HandyAudit tool that is tablet based. Audit results are prominently posted on the unit. The team indicated that hand-hygiene compliance, especially when hands are visibly soiled, is significantly compromised by only having two sinks on the unit. When hand-hygiene audit results were discussed with the team, the team validated that the lack of sinks compromised the effectiveness of space and staffing resources.

The focus of the entire team on pressure sore prevention and their skill and attention in managing wounds and wound care is commendable. The review of patient medical records showed the Braden

scale being used consistently to conduct an initial pressure ulcer risk assessment on admission to the unit. Daily flow sheets showed vigilance related to daily reassessment of each patient at shift change and during care routines.

Admission assessments are thorough and all patient charts reviewed had a safety and falls risk assessment screening completed. Pain and symptom assessment and attention to pressure sore development were also during the health record review. Falls risk stickers were noted at the bedside and in the health records. Care plans and goals were found to be individualized according to each patient's unique needs and personal goals.

Occupancy on the unit ranges from 94 to 102 percent. Vacancy rates for nursing staff are low and staffing on the unit has been stable. The team lamented the loss of standing physiotherapy orders for SCI patients that provided early intervention and supported nursing and patients.

The team is commended for its progress in formalizing and standardizing the approach to medication reconciliation. Medication reconciliation was evident on admission, transfer, and discharge in the charts reviewed. Staff commented that this may not be always consistent, but progress is being made. The team is encouraged to audit for continued compliance.

The use of two client identifiers was consistently noted.

Critical information about patients is effectively transferred at transition points (transfer between units, at shift change, and when a patient leaves a unit for a procedure). A checklist ensures the exchange of information is documented.

The unit staff are commended for their focus on infection prevention and control. Housekeeping, nursing, allied health, and the patients interviewed all understood the important role they play in keeping patients safe by preventing the spread of infection. Hand-hygiene audit results were prominently posted on the unit. Personal protective equipment is placed outside the room of patients on isolation precautions.

A patient and family member interviewed during the on-site survey acknowledged experiencing high-quality care on this unit. The unit is commended for its focus on a person-centred model of care. In both cases, the patient and/or family member reported being active participants, as much as they wished, in the care provided, and being able to contribute to care planning and goal setting.

Non-violent crisis intervention training has not yet been started with the team.

Priority Process: Decision Support

The care of SCI patients is highly specialized. Sharing of evidence based guidelines occurs, and staff are aware of the value this brings to their work.

A joint initiative between the SCI team and home care is noteworthy. Recognizing the barrier to discharge of patients with spinal braces, the team developed education materials for home care nurses on how to manage the SCI patient and the brace (how the brace is to be worn and cleaned) and orthotists provided training for the home care staff. Formal indicators of success were not defined; however, success was measured by the anecdotal feedback received from the home care coordinator and home care staff.

Priority Process: Impact on Outcomes

The team is commended for the development of an alcohol withdrawal protocol that was an initiative identified by the interdisciplinary team as needed to enhance care for patients on the surgical trauma units. The team conducted a review of the literature, learned from national best practices, and worked collaboratively to develop a protocol that would engage the interdisciplinary team in managing alcohol withdrawal. The team is encouraged to finalize the development of this initiative and develop measurable indicators to evaluate the impact of the initiative on patient outcomes.

Standards Set: Spinal Cord Injury Rehabilitation Services - Direct Service Provision

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

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

The HSC rehabilitation centre provides tertiary level interdisciplinary rehabilitation services for medically stable patients over the age of 16 with sub-acute spinal cord injury. Patients come from Manitoba and northwestern Ontario and are served by 13 dedicated Spinal Cord Injury Rehabilitation (SCI) beds on the 31-bed unit. All patients admitted to the program must be medically stable and able to participate in and benefit from an active rehabilitation therapy program for at least two hours per day. Ventilated patients are not eligible for admission.

The objective of the program is to optimize function in those with paraplegia or quadriplegia from a spinal cord lesion.

There is a strong interdisciplinary team on this unit, committed to meeting the needs of their patients and families. Team members interviewed expressed a passion for their work and for being a part of the HSC. There was clear evidence of collaborative practice and a desire to evaluate and improve the effectiveness of interventions. The interdisciplinary team functions within a program management model.

Priority Process: Competency

There is a strong interdisciplinary team on this unit. The team presented as capable and passionate about their work with the complex SCI patient population they serve. A matrix reporting relationship exists for clinical staff who report to both program and allied discipline leadership. There is strong support to the clinical team from residents, a clinical assistant, and the physicians who work with the team. Patient flow from the acute SCI unit to the rehabilitation unit is supported by a daily review of the bed map and patient status for discharge/transfer.

All staff interviewed reported they have participated in a performance conversation. Vacancy and overtime rates of nursing staff on the unit have been high (20 percent) for the past year, and active recruitment efforts are underway to fill vacant positions.

Priority Process: Episode of Care

There are clear admission guidelines for SCI rehabilitation beds and a pre-transfer checklist. A patient spoken with during the on-site survey reported having received information in writing and verbally about safety awareness.

Point-of-care improvement initiatives focused on collaborative goal setting in the program include:
Bedside nurses now attending rounds to report on their patients
Weekly summaries being completed prior to rounds (in preparation for rounds)
Collaboration on setting team goals and action plans
A teamwork poster clarifying the roles of team members ("Now that I'm in spinal cord rehab on RR5, who do I ask about my..?")
Each patient is assigned an attending nurse who participates in rounds
An SCI care pathway

Hand hygiene and infection rates were posted on the unit. Patient safety incidents are reported manually. Reporting of near misses seems to have increased over time.

Patients at risk are identified with Falls Risk stickers at the bedside and on their medical record. Falls prevention precautions are implemented and included on the transfer checklist and daily shift report.

The risk of pressure ulcers is a priority for the SCI patient population. Initial pressure ulcer risk assessment is conducted on admission using the Braden Scale assessment tool, and then weekly. Individualized care plans are developed based on the Braden scores and daily shift change visual inspections.

A best possible medication history (BPMH) is completed on all admitted patients using the admission medication reconciliation form. At discharge, a list of all medications to be taken by the patient are noted on the discharge medication reconciliation form. Reconciliation is done against the admission BPMH and the MAR. Two identifiers were routinely used to identify patients receiving medications. The Pyxis MedStation System is in place on the unit to dispense medications.

The physical space available to deliver spinal cord injury rehabilitation services is antiquated. For example, patients stay in four-bed rooms with no bathroom facilities. Male and female patients use separate communal male and female bathrooms with toilets and shower stalls that provide no privacy. Staff reported that these bathrooms were renovated in the last year. However, staff were not consulted and, as such, the design of the bathrooms does not meet the needs of the patients on the unit, nor does it provide efficient workflow for care staff. In addition, there is no emergency call bell system in the bathroom, which poses a safety risk to patients and staff.

There is no dining room on the unit; patients eat from trays delivered to their rooms. This practice is not consistent with the goals of a rehabilitation program. Staff noted that a large room on the unit could be used as a dining room but it is used to store equipment.

The inpatient rehabilitation unit is on the fifth floor. A therapeutic pool and a well-equipped physiotherapy gym and occupational therapy treatment space is available for treatment sessions for the SCI patient population on the first floor.

When asked to rate the quality of the care received on the unit on a scale of 1 to 5 (where 5 is excellent), the patient rated his care as a perfect 5.

Priority Process: Decision Support

There are formal processes for accepting referrals and admitting patients. Criteria are in place to determine who is appropriate for admission and the urgency and priority for the required admission. Admission assessments are thorough, and all new patients have a safety and falls risk assessment screening completed. The assessment is enhanced over time as the new patient settles into a routine and a more complete picture of strengths and limitations becomes known.

There is a very good consolidated, interdisciplinary assessment and goal setting framework in the clinical documentation.

Priority Process: Impact on Outcomes

The SCI unit participates in the National Rehabilitation Data Set Recording Project through the Canadian Institute for Health Information. Some benchmarking with similar rehabilitation centres is possible and is pursued as appropriate. The team is encouraged to use this information and pursue opportunities to share best practices with peer facilities.

Root cause analysis appears to be carried out at the incident level. Little interpretation of the data over time was noted.

Instrument Results

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

Governance Functioning Tool (2011 - 2015)

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

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

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

- **Data collection period: May 24, 2015 to June 30, 2015**
- **Number of responses: 3**

Governance Functioning Tool Results

		% Disagree	% Neutral	% Agree	%Agree * Canadian Average
		Organization	Organization	Organization	
1	We regularly review, understand, and ensure compliance with applicable laws, legislation and regulations.	50	50	0	94
2	Governance policies and procedures that define our role and responsibilities are well-documented and consistently followed.	50	0	50	95
3	We have sub-committees that have clearly-defined roles and responsibilities.	0	0	100	94
4	Our roles and responsibilities are clearly identified and distinguished from those delegated to the CEO and/or senior management. We do not become overly involved in management issues.	50	0	50	94

	% Disagree	% Neutral	% Agree	%Agree * Canadian Average
	Organization	Organization	Organization	
5 We each receive orientation that helps us to understand the organization and its issues, and supports high-quality decisionmaking.	50	0	50	92
6 Disagreements are viewed as a search for solutions rather than a “win/lose”.	0	50	50	93
7 Our meetings are held frequently enough to make sure we are able to make timely decisions.	0	0	100	96
8 Individual members understand and carry out their legal duties, roles and responsibilities, including sub-committee work (as applicable).	50	0	50	94
9 Members come to meetings prepared to engage in meaningful discussion and thoughtful decision-making.	50	0	50	94
10 Our governance processes make sure that everyone participates in decision-making.	50	0	50	95
11 Individual members are actively involved in policy-making and strategic planning.	50	0	50	89
12 The composition of our governing body contributes to high governance and leadership performance.	50	0	50	92
13 Our governing body’s dynamics enable group dialogue and discussion. Individual members ask for and listen to one another’s ideas and input.	50	0	50	95
14 Our ongoing education and professional development is encouraged.	0	0	100	90
15 Working relationships among individual members and committees are positive.	0	0	100	97
16 We have a process to set bylaws and corporate policies.	0	0	100	95
17 Our bylaws and corporate policies cover confidentiality and conflict of interest.	0	0	100	98
18 We formally evaluate our own performance on a regular basis.	50	0	50	81
19 We benchmark our performance against other similar organizations and/or national standards.	100	0	0	69

	% Disagree	% Neutral	% Agree	%Agree * Canadian Average
	Organization	Organization	Organization	
20 Contributions of individual members are reviewed regularly.	50	50	0	69
21 As a team, we regularly review how we function together and how our governance processes could be improved.	50	0	50	81
22 There is a process for improving individual effectiveness when non-performance is an issue.	50	50	0	63
23 We regularly identify areas for improvement and engage in our own quality improvement activities.	50	0	50	83
24 As a governing body, we annually release a formal statement of our achievements that is shared with the organization's staff as well as external partners and the community.	0	50	50	82
25 As individual members, we receive adequate feedback about our contribution to the governing body.	100	0	0	69
26 Our chair has clear roles and responsibilities and runs the governing body effectively.	0	0	100	95
27 We receive ongoing education on how to interpret information on quality and patient safety performance.	0	0	100	88
28 As a governing body, we oversee the development of the organization's strategic plan.	0	0	100	94
29 As a governing body, we hear stories about clients that experienced harm during care.	0	0	100	87
30 The performance measures we track as a governing body give us a good understanding of organizational performance.	50	0	50	92
31 We actively recruit, recommend and/or select new members based on needs for particular skills, background, and experience.	0	0	0	90
32 We have explicit criteria to recruit and select new members.	0	0	0	83
33 Our renewal cycle is appropriately managed to ensure continuity on the governing body.	100	0	0	90

	% Disagree	% Neutral	% Agree	%Agree * Canadian Average
	Organization	Organization	Organization	
34 The composition of our governing body allows us to meet stakeholder and community needs.	50	0	50	92
35 Clear written policies define term lengths and limits for individual members, as well as compensation.	0	0	100	95
36 We review our own structure, including size and subcommittee structure.	0	50	50	91
37 We have a process to elect or appoint our chair.	0	100	0	91

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

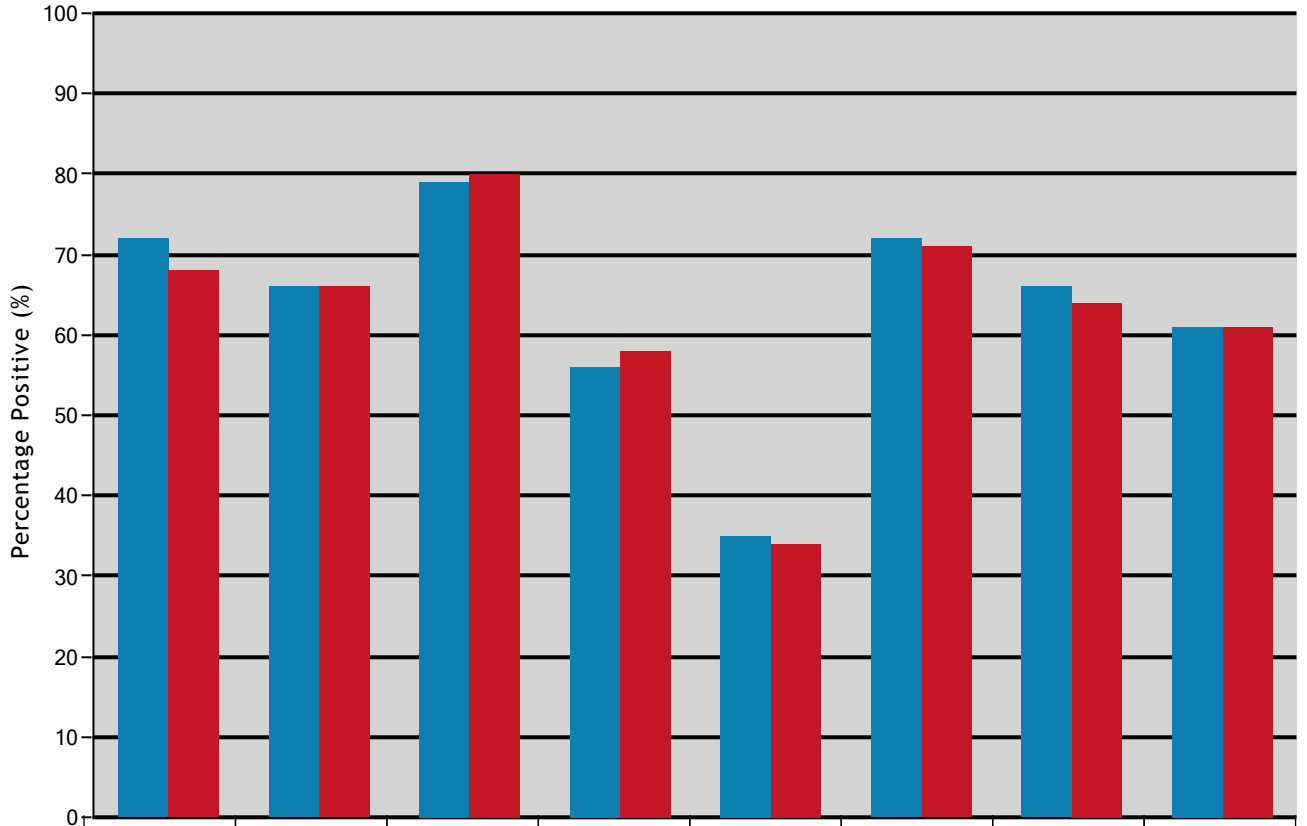
Canadian Patient Safety Culture Survey Tool

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

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

- **Data collection period: May 5, 2015 to October 31, 2015**
- **Minimum responses rate (based on the number of eligible employees): 378**
- **Number of responses: 1360**

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



	Organizational (senior) leadership support for safety	Supervisory leadership for safety	Unit learning culture	Enabling Open Communication I: judgment-free environment	Enabling Open Communication II: job repercussions of error	Incident follow up	Stand-alone items	Overall Perceptions of Client Safety
	72%	66%	79%	56%	35%	72%	66%	61%
	68%	66%	80%	58%	34%	71%	64%	61%

Legend

Winnipeg Regional Health Authority

* Canadian Average

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

Canadian Patient Safety Culture Survey Tool: Community Based Version

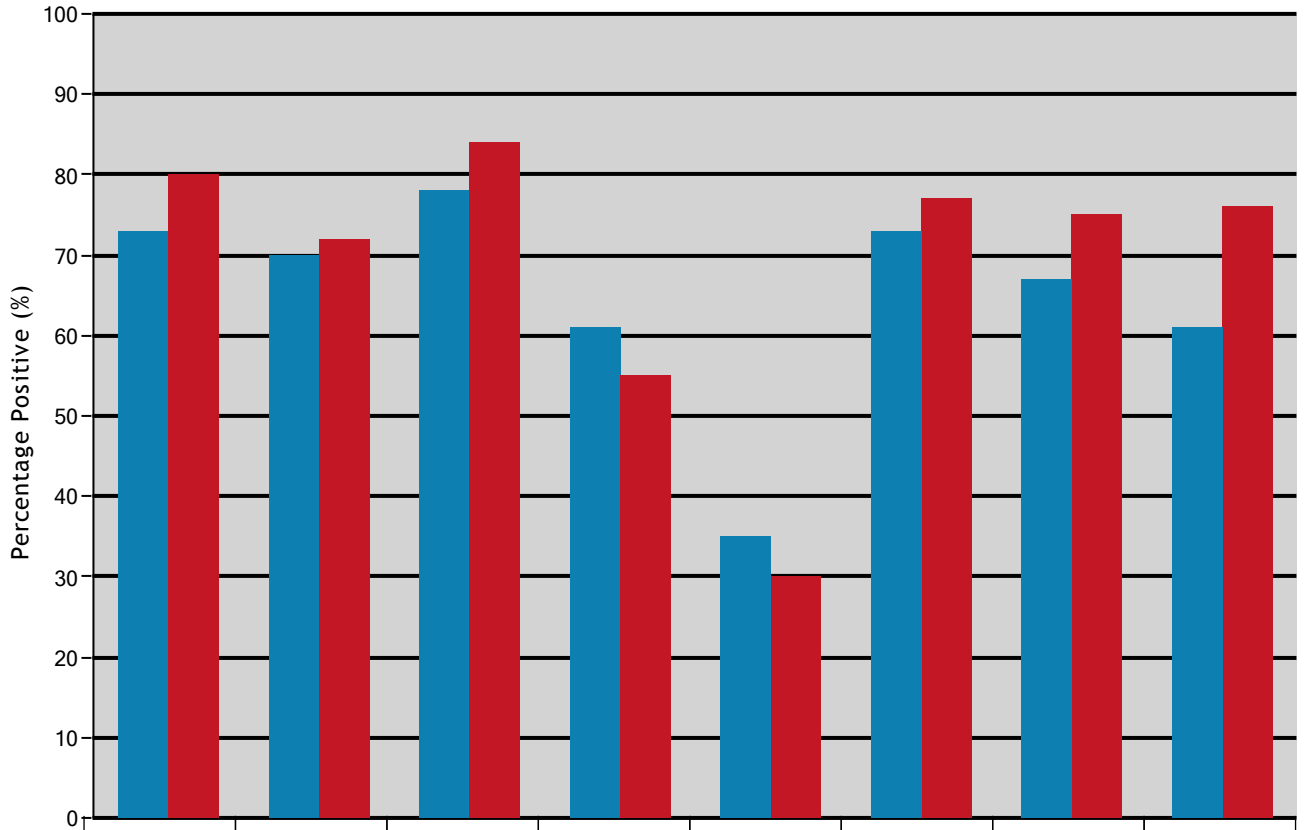
Organizational culture is widely recognized as a significant driver in changing behavior and expectations in order to increase safety within organizations. A key step in this process is the ability to measure the presence and degree of safety culture. This is why Accreditation Canada provides organizations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

Results from the Patient Safety Culture Tool allow the organization to identify strengths and areas for improvement in a number of areas related to patient safety and worklife.

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

- **Data collection period: May 20, 2015 to October 31, 2015**
- **Minimum responses rate (based on the number of eligible employees): 378**
- **Number of responses: 384**

Canadian Patient Safety Culture Survey Tool: Community Based Version: Results by Patient Safety Culture Dimension



	Organizational (senior) leadership support for safety	Supervisory leadership for safety	Learning culture	Enabling Open Communi-cation I: judgment-free environment	Enabling Open Communi-cation II: job repercussions of error	Incident follow up	Stand-alone items	Overall Perceptions of Client Safety
	73%	70%	78%	61%	35%	73%	67%	61%
	80%	72%	84%	55%	30%	77%	75%	76%

Legend

Winnipeg Regional Health Authority

* Canadian Average

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

Worklife Pulse

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

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

The organization used an approved substitute tool for measuring quality of Worklife. The organization has provided Accreditation Canada with results from its substitute tool and had the opportunity to identify strengths and address areas for improvement. During the on-site survey, surveyors reviewed actions the organization has taken.

Client Experience Tool

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

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

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

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

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

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

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

Client Experience program requirements have been met for the following services:

- Acute (including Emergency)
- Long Term Care
- Mental Health
- Primary Care

Client Experience survey for Home Care Services needs to be administered.

Appendix A - Qmentum

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

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

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

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

Action Planning

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

Evidence Review and Ongoing Improvement

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

Appendix B - Priority Processes

Priority processes associated with system-wide standards

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

Priority processes associated with population-specific standards

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

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

Priority processes associated with service excellence standards

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

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