

WRHA Annual Report

2016-17



September 29, 2017



Winnipeg Regional
Health Authority
Caring for Health

Office régional de la
santé de Winnipeg
À l'écoute de notre santé

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Who is the WRHA?

The Winnipeg Regional Health Authority (WRHA) co-ordinates and delivers health services and promotes well-being within the Winnipeg and Churchill geographical areas. The WRHA is home to Manitoba's two tertiary hospitals: Health Sciences Centre Winnipeg (HSC), the largest teaching hospital and provincial trauma centre, and St. Boniface General Hospital (SBGH), a Catholic teaching hospital housing a spectrum of services, including the Cardiac Sciences Program.

The WRHA's role is defined largely under the Regional Health Authorities Act. In carrying out its responsibilities in the administration and co-ordination of health-care services, it directly manages or contracts with others to provide a wide range of health-care services. The WRHA collaborates with community, government and other health partners to protect and enhance the health and well-being of our community. It also relies on a dedicated team of health-care professionals and support staff to achieve its mission.

The WRHA is governed by a community board of directors appointed by the Minister of Health. Its integrated leadership model includes the Executive Council, the Senior Operations Leadership Council (SOLC) and the Clinical Program Council (CPC).

The WRHA maintains an accredited status, meaning it has succeeded in meeting the fundamental requirements of Accreditation Canada's Qmentum accreditation program.

Our Region

The WRHA serves residents of the city of Winnipeg, as well as the northern community of Churchill and the rural municipalities of East and West St. Paul, representing a total population of more than 700,000. The WRHA also provides health-care support and specialty referral services to nearly half a million Manitobans who live beyond these boundaries, as well as residents of northwestern Ontario and Nunavut, who often require the services and expertise available within the WRHA.

Our People and Facilities

Among the largest employers in Manitoba, the WRHA employs more than 28,000 people. With an annual operating budget of nearly \$2.6 billion, the WRHA is the largest health authority in the province, and operates or funds over 200 health service facilities and programs.

Health Service Facilities Operating Within the WRHA Include:

TWO TERTIARY HOSPITALS

Health Sciences Centre Winnipeg
St. Boniface General Hospital

FOUR COMMUNITY HOSPITALS

Concordia Hospital
Grace Hospital (Winnipeg West Integrated Health and Social Services)
Seven Oaks General Hospital
Victoria General Hospital (South Winnipeg Integrated Health and Social Services)

FIVE HEALTH CENTRES

Churchill – J.A. Hildes Northern Medical Unit
Deer Lodge Centre
Misericordia Health Centre
Riverview Health Centre
St. Amant

PERSONAL CARE HOMES

38 personal care homes
10 supportive housing providers

COMMUNITY-BASED HEALTH

13 community health agencies
Rehabilitation Centre for Children
Manitoba Adolescent Treatment Centre
Pan Am Clinic
70 grant-funded community agencies
Six QuickCare clinics

ACCESS CENTRES

Community-Based Health and Social Services (WRHA and Department of Families Community-Based Services). All paired community areas have at least one Access Centre where health and social services staff are co-located.

Saint Boniface / St. Vital
Downtown / Point Douglas
St. James / Assiniboine (Winnipeg West Integrated Health and Social Services)
Fort Garry / River Heights (South Winnipeg Integrated Health and Social Services)
River East / Transcona
Seven Oaks / Inkster

KEY PARTNERS AND HEALTH RELATIONSHIPS

Government of Manitoba

Department of Families (including Social Services, Child Protection, Housing and Income Assistance – Winnipeg Integrated Services)
Manitoba Health, Seniors and Active Living

Educational Institutions

University of Manitoba
Université de Saint-Boniface
Red River College

Municipal Government

City of Winnipeg (including the Winnipeg Fire and Paramedic Service, Winnipeg Police Service)
Town of Churchill

Community Partners

End Homelessness Winnipeg
United Way of Winnipeg
Santé en Français
Downtown Winnipeg BIZ
Winnipeg Chamber of Commerce
Manitoba Council of Health Care Unions (MCHCU)

Health Partners

CancerCare Manitoba
Diagnostic Services of Manitoba
Manitoba eHealth
Northern Regional Health Authority
Prairie Mountain Health
Southern Regional Health Authority
Interlake-Eastern Regional Health Authority

Indigenous Organizations

Assembly of Manitoba Chiefs
Southern Chiefs' Organization
Manitoba Keewatinook Ininiw Okimowin (MKO)
Manitoba Metis Federation

Community Health Agencies

The WRHA funded 13 community health agencies a total of \$51.5 million in the 2016-17 fiscal year. The services of these community health agencies are focused on the delivery of primary care. Mental health services are typically embedded in the primary care services. Specialty services provided include pre and post-natal care, HIV treatment, crisis intervention, occupational therapy, rehabilitation services, diabetes education and sexuality education.

Grant-Funded Agencies

The WRHA funded 80 additional agencies a total of \$46.6 million* in the 2016-17 fiscal year. These agencies deliver services in the following program areas: cardiac rehabilitation, community development, home care, housing support services, mental health, primary care, disabilities services, senior centres and other support services to seniors.

WINNIPEG REGIONAL HEALTH AUTHORITY

650 Main Street

Winnipeg, MB

R3B 1E2

Phone: (204) 926-7000

Fax: (204) 926-7007

www.wrha.mb.ca

*This number was corrected on August 15, 2018. The number previously read \$14.6 million, which was incorrect.

Health Services Message from the interim President and CEO

In 2016-17, the WRHA took the initial steps on a journey that will see the most significant change to regional health-care delivery in a generation. As interim President and CEO, it's my pleasure to report on our progress and to share our plans for the first phase of changes that will come into effect this fall.

For too long, Winnipeg has lagged behind the national average on a number of key measures, most notably wait times for emergency services and lengths of stay in hospital. Those challenges affect the entire continuum of care, diminishing our ability to serve our community and threatening the sustainability of our system. The changes we are undertaking are necessary, and long overdue.

And so, in line with recommendations in reports by Dr. David Peachey and the consulting firm KPMG, we have engaged clinical experts across the system in designing a framework for health-care delivery that better serves our patients, streamlining processes and removing roadblocks to quality care.

These changes were announced by my predecessor, Milton Sussman, in April of 2017. On behalf of our entire organization, I want to extend our sincere thanks to Milton for his wisdom and direction in setting our course and, in particular, for his dedication to both patients and staff across the region.

I want to thank our Board of Directors, as well, for their unwavering support and guidance in our efforts to enhance and sustain quality health care in Manitoba. All of this change brings with it a considerable amount of disruption. It's stressful and it's hard. But our staff and physicians remain focused on providing the best care possible, contributing to discussions and challenging the status quo. I want to acknowledge and thank them – all 28,000 – for their dedication and professionalism throughout this process.

Since taking on my role in June 2017, I have had the opportunity to meet staff across the region, to hear their feedback and their ideas for improvement. Change of this magnitude does not happen without a sense of shared purpose and commitment to those we serve. I'm intensely proud of our people, their conviction and their willingness to participate fully in meaningful, transformative change – for ourselves and generations to come.

Sincerely,

Réal Cloutier

Interim President and CEO, WRHA

Message du PDG par intérim sur les services de santé

En 2016-2017, l'ORSW a pris les premiers pas sur un parcours de changements parmi les plus significatifs dans la prestation de soins de santé régionale depuis une génération. À titre de président-directeur général par intérim, j'ai le plaisir de vous faire un rapport sur notre progrès et de partager nos plans pour la première étape de changements qui entreront en vigueur à l'automne.

Depuis trop d'années Winnipeg prend du retard sur un certain nombre de mesures clés, en comparaison de la moyenne du reste du pays, notamment sur les délais d'attente pour les services d'urgence et la durée des séjours à l'hôpital. Ces défis affectent tout le continuum de soins et, par ce fait, diminue notre capacité de servir la communauté et menace la pérennité de notre système. Les changements que nous mettons en œuvre sont nécessaires et souhaitables depuis longtemps.

Par conséquent, conformément aux recommandations énoncées dans les rapports du Dr David Peachey et de la firme d'experts-conseils KPMG, nous avons engagé des experts cliniques dans tout le système pour concevoir un cadre de prestation de soins de santé qui sert mieux nos patients, pour simplifier les processus et supprimer les obstacles aux soins de qualité.

Ces changements ont été annoncés par mon prédécesseur, Milton Sussman, en avril 2017. Au nom de tout l'organisme, je le remercie sincèrement pour sa sagesse et sa direction qui ont tracé la voie à suivre et, tout particulièrement, pour son dévouement envers les patients et le personnel partout dans la région.

Je remercie aussi le conseil d'administration pour son appui indéfectible et ses conseils qui ont renforcé nos efforts visant à améliorer et faire durer la qualité des soins de santé au Manitoba. Tous ces changements entraînent beaucoup de perturbations. C'est stressant et difficile. Par contre, les membres du personnel et les médecins s'efforcent toujours de fournir les meilleurs soins possibles, de participer aux discussions et de défier le statu quo. Je les remercie, tous et chacun – ils sont au nombre de 28 000 – de leur dévouement et leur professionnalisme au cours du processus.

Depuis que j'ai entrepris ce rôle en juin 2017, j'ai eu l'occasion de rencontrer les membres du personnel dans toute la région, d'écouter leurs commentaires et leurs idées pour l'amélioration. Les changements de cette ampleur ne peuvent pas être mis en œuvre sans un sens de finalité commune et d'engagement envers ceux et celles que nous servons. Je suis très fier des membres de notre personnel, de leur conviction et leur volonté de participer pleinement aux changements significatifs et transformateurs – pour nous-mêmes et les générations à venir.

Je vous prie d'agrérer mes sincères sentiments.

Réal Cloutier

Président-directeur général de l'ORSW par intérim

Message from the Board Chair

In my first annual report message as Chair of the Board of Directors, I'm pleased to report on what has been a year of profound change for the WRHA. Reaching both deeply into and broadly across the region's programs and services, the Healing our Health System plan introduced in April 2017 aims squarely at addressing fundamental challenges that have impeded quality and timeliness of care for too long, to the frustration of our patients and staff alike.

The region has consistently fallen below national averages in a number of critical measures of care – including wait times – and our Board is committed to continuous improvement and innovative solutions that result in improved access, better care and efficient and effective use of resources.

Despite the disruption that is a natural and expected part of transformation, staff and physicians across the WRHA are rising to the challenge, propelled by their dedication to patients and their families. Their commitment is commendable and inspiring, and I thank them – all 28,000 – on behalf of the Board, for their professionalism.

The Board is confident that as the Healing our Health System plan is implemented over the next two years, the WRHA will emerge more focused, accountable and structured to deliver the right care, at the right time and in the right place. It is a needed framework for health-care delivery that deploys resources, both human and financial, in a manner that provides better patient care while preserving the system that delivers it. Our community deserves nothing less.

I wish to thank the Board members who retired from service this year:

Bob Brennan (Chair)	Jean Friesen
Myrle Ballard	Robert Freedman
Maj. Joanne Biggs	Doris Koop
Elaine Bishop	Connie Krahenbil
Sheila Carter	Dr. Pravinsagar Mehta
Jeff Cook	David Rondeau
Jennifer Faulder	Rob Santos
Verna Flett	Bruce Thompson

Their vision, hard work and commitment are greatly appreciated.

In addition, I would like to acknowledge current Board members:

Derek Johannson (Vice-Chair)	Maj. Catherine Harris
Dr. Alaa Awadalla	Kiran Kumedan
Bill Baines	Donald Lepp
Jan Byrd	Bruce Matlashewski
Dawn Daudrich	Dr. Judith Scanlan

Victor Giesbrecht
Raquel Godin
Stuart Greenfield

Gord Steeves
Shannon Stefanson

I speak for all of us when I say it's an honour and a privilege to serve in this capacity.

In closing, I would like to thank former WRHA president and CEO Milton Sussman, who retired from the WRHA this summer, for his direction in launching the Healing our Health System plan. I would also like to extend my appreciation to interim President and CEO Réal Cloutier and his team for leading the plan's effective implementation as we transform our health region, improving the quality of care and service during a time of great change.

Sincerely,

Karen Dunlop
Board Chair, WRHA

Message de la présidente du conseil d'administration

Dans mon premier message du rapport annuel à titre de présidente du conseil d'administration, j'ai le plaisir de vous faire un rapport sur cette dernière année de grands changements au sein de l'ORSW. Touchant au plus profond et largement aux programmes et services de la région, le plan *Guérir notre système de santé*, présenté en avril 2017, vise directement à aborder les défis fondamentaux à relever qui ont entravé la qualité et les délais de soins depuis trop longtemps, causant la frustration chez nos patients et notre personnel.

La région se situe constamment sous la moyenne nationale dans un certain nombre de mesures de soins critiques, notamment les délais d'attente. Notre conseil d'administration s'est engagé à proposer des améliorations continues et des solutions novatrices qui mèneront vers un meilleur accès, de meilleurs soins et une utilisation efficace des ressources.

Malgré les perturbations normales et attendues qui découlent de la transformation, les membres du personnel et les médecins de l'ORSW relèvent le défi, poussés par leur dévouement envers les patients et leurs familles. Leur engagement est louable et inspirant, et, au nom du conseil d'administration, je les remercie, tous et chacun – ils sont au nombre de 28 000 – de leur professionnalisme.

Le conseil d'administration est convaincu qu'au fur et à mesure que le plan *Guérir notre système de santé* sera mis en œuvre au cours des deux prochaines années, l'ORSW en sortira plus centré, responsable et structuré afin de prodiguer les soins voulus, au moment voulu, à l'endroit voulu. Ce cadre est nécessaire pour la prestation de soins de santé qui déploie les ressources humaines et financières de manière à offrir de meilleurs soins aux patients tout en préservant le système qui les prodigue. Notre communauté le mérite bien.

Je tiens à remercier les membres du conseil d'administration qui ont pris leur retraite cette année :

Bob Brennan (président)
Myrle Ballard
Maj. Joanne Biggs
Elaine Bishop
Sheila Carter
Jeff Cook
Jennifer Faulder
Verna Flett

Jean Friesen
Robert Freedman
Doris Koop
Connie Krahnenbil
D' Pravinsagar Mehta
David Rondeau
Rob Santos
Bruce Thompson

Leur vision, leur travail acharné et leur engagement ont été très appréciés.

De plus, je tiens à reconnaître les membres du conseil d'administration actuel :

Derek Johannson (vice-prés.)	Maj. Catherine Harris
D'r Alaa Awadalla	Kiran Kumedian
Bill Baines	Donald Lepp
Jan Byrd	Bruce Matlashewski
Dawn Daudrich	D'r Judith Scanlan
Victor Giesbrecht	Gord Steeves
Raquel Godin	Shannon Stefanson
Stuart Greenfield	

Au nom de tout le CA, c'est pour nous un honneur et un privilège de vous servir dans ce rôle.

Pour conclure, je tiens à remercier l'ancien président-directeur général de l'ORSW, Milton Sussman, qui a pris sa retraite l'été dernier, et qui nous a tracé la voie à suivre dans le lancement du plan *Guérir notre système de santé*. J'aimerais aussi remercier le président-directeur général par intérim, Réal Cloutier, et son équipe d'avoir mené la mise en œuvre efficace du plan alors que nous transformons notre région sanitaire, améliorons la qualité des soins et des services pendant cette période de grands changements.

Je vous prie d'agréer mes sincères sentiments.

Karen Dunlop

Présidente de l'ORSW

Letter of Transmittal and Accountability

It is my pleasure to present the annual report of the WRHA for the fiscal year ended March 31, 2017.

This annual report was prepared under the board's direction, in accordance with the Regional Health Authorities Act and directions provided by the Minister of Health, Seniors and Active Living. All material, including economic and fiscal implications known as of July 31, 2017, has been considered in preparing the annual report. The board has approved this report.

Respectfully submitted,

Karen Dunlop

Board Chair, WRHA

Past and Current Board Members

Past members:

Bob Brennan (Chair)	Jean Friesen
Myrle Ballard	Robert Freedman
Maj. Joanne Biggs	Doris Koop
Elaine Bishop	Connie Krahnenbil
Sheila Carter	Dr. Pravinsagar Mehta
Jeff Cook	David Rondeau
Jennifer Faulder	Rob Santos
Verna Flett	Bruce Thompson

Current members:



Karen Dunlop (Chair)

Karen has been a Registered Nurse (RN) for more than 30 years. In her career, Karen has practised nursing in a variety of roles including Critical Care Nurse, Registrar of the Manitoba Association of Registered Nurses, Consultant, Regional Director of the WRHA Emergency Program, President of the College of Registered Nurses of Manitoba, Board member of the Canadian Nurses Association and President of the Canadian Nurses Protective Society. Karen is a founding member of the Association of Registered Nurses of Manitoba and is the former interim Executive Director.



Derek Johannson (Vice-Chair)

Derek has a rich history of community involvement on a number of local and international Boards including the Winnipeg Chamber of Commerce, True North Sports & Entertainment Inc., Young Presidents' Organization International and Health Sciences Centre Foundation.

In addition to his role with the WRHA board, he also finds time to sit on the Boards of Online Business System, and the advisory boards for the Institute of Corporate Directors Manitoba and Buhler Furniture.



Dr. Alaa Awadalla

Dr. Awadalla graduated from medical school in Egypt in 1984 but his penchant for learning saw him repeat his residency, by choice, a second time in England. Dr. Awadalla worked in the U.K. and in Newfoundland before landing in Winnipeg.

Dr. Awadalla is committed to improving the patient experience and working to provide minimally invasive procedures for clients across the province. The President of the Medical Presidents Board of Manitoba, Dr. Awadalla is an ex-officio member of the WRHA board providing insight and reporting from the physician community.



Bill Baines

Bill brings over 36 years of business experience to the WRHA. Bill is currently active with the Boards of the Winnipeg Football Club (Blue Bombers), Exchange Income Corporation, the Institute of Corporate Directors – Manitoba Chapter Executive and the Manitoba Museum Foundation Board of Governors.

Bill is the President and CEO of AML Wireless Networks Inc. and is the former President of OMT Technologies Inc., Intertain Media Inc. and President and COO of Manitoba Telecom Services (MTS).



Jan Byrd

A senior leader in the public sector, Jan Byrd is passionate about creating safer systems in health care and on post-secondary campuses. Jan Byrd was an early adopter and champion of the patient safety movement in Canada, having worked at the Manitoba Institute for Patient Safety (MIPS), and then for several years at SBGH as the Manager of Patient Safety, Quality and Patient Relations. Jan is currently Patient Safety Improvement Lead at the Canadian Patient Safety Institute (CPSI), where she supports a national Consortium and its Integrated Patient Safety Action Plan, and leads the Surgical Care Safety portfolio.



Dawn Daudrich

Business manager and owner, Dawn Daudrich, divides her time between her Churchill-based Lazy Bear Expeditions eco-tourism office, work on a number of different boards across the province and her family. An active volunteer both within Churchill and in Winnipeg, Dawn is committed to improving business opportunities for Manitobans. Her eco-tourism company operates both out of Churchill and Winnipeg with over 50 employees and she sits on the Chamber for Manitoba, Winnipeg and Churchill.



Victor Giesbrecht

Victor is president and co-founder of Trikor Builders, helping hundreds of Winnipeg families find their ideal home. Actively involved in the community, he is also a member of the Board of Directors for the Winnipeg Housing Rehabilitation Corporation, and has volunteered with the Manitoba Home Builders' Association in a number of committees for years.



Raquel Godin

After contracting bacterial meningitis in 2001, Raquel underwent extensive treatment including the amputation of both legs below the knees and a number of fingers. Her rehabilitation included being fit with prosthetic legs. Raquel continues her volunteer work with other amputees at the HSC's Rehabilitation Day Program.



Stuart Greenfield

Board President for his own local business development company, SMG Development, Stuart has years of experience working with Winnipeg's business community. Stuart is the past Chair for Seven Oaks General Hospital (SOGH) Board of Directors and has gained an appreciation for the work of multi-cultural organizations through his involvement with the Manitoba Intercultural Council and Folklorama.



Maj. Catherine Harris

Catherine is a Salvation Army officer, teaching in Toronto, St. John's and Winnipeg at Booth University College and the College for Officer Training.

Born in Ontario and having lived in a number of cities across the country, Catherine has become a strong advocate for the City of Winnipeg and the Province of Manitoba. Catherine hopes to make a meaningful contribution as a Board member of the WRHA, working towards the holistic health of Manitobans.



Kiran Kumedan

With 14 years' experience in business operations, Kiran applies her skills as a business consultant and process engineer with Online Business Solutions/Wawanese Insurance in Winnipeg. She has worked with both federal government and health-care organizations. A visible minority herself, Kiran seeks to represent Manitoba's immigrant population and visible minorities on the WRHA Board of directors and is dedicated to achieving sustainability in the health-care system for future generations.



Donald Lepp

Donald is a senior manager with Canada Post and a certified professional in human resources. Donald is a patient advocate and has experience as a patient caregiver. Both his wife and son have complex cardiac conditions. Donald has a rich volunteer history with organizations such as Stollery Children's Hospital (Edmonton), SOGH, the College of Registered Nurses of Manitoba and the WRHA.



Bryce Matlashewski

An investment advisor with over a decade of experience in wealth management, Bryce is keen to share his financial expertise with the WRHA board. Raised in a business-minded family, Bryce's upbringing exposed him to a number of family businesses which complement his degree in economics from the University of Manitoba. His background in business also makes him a great fit as the voice of the *Business Report* live on air with CJOB.

Bryce divides his time between work, his family and the Community Leaders Board of the United Way.



Dr. Judith Scanlan

An Associate Professor in nursing at the University of Manitoba, Judith's leadership expertise is in nursing education and administration.

Judith brings experiences in education, research and leadership, including former Associate Dean, Graduate Programs in Nursing, board governance in acute care and community health-care organizations and Director of international development projects. Judith is passionate about ensuring that all people receive equitable and quality care.



Gord Steeves

Gord Steeves is a partner at the law firm of AVS LAW LLP, with a focus on real estate and general litigation.

As a council member for the City of Winnipeg, Gord served as acting-Deputy Mayor for many years, and sat on the Executive Policy Committee. His primary role was as chairperson of the Protection and Community Services Committee, which stewarded the ongoing operations of the Winnipeg Police Service, the Winnipeg Fire Paramedic Service and the Community Services Department of the City of Winnipeg.



Shannon Stefanson

Shannon is an advocate for quality improvement and patient safety. She spent the first 18 years of her nursing career performing a variety of different roles in a hospital setting. Shannon currently teaches at The College of Nursing, Rady Faculty of Health Sciences, University of Manitoba. In addition to her commitment to providing patients a voice, Shannon provides the Board insight into community health, adult education and nursing research.

STRATEGIC PLAN

VISION



Healthy People



Vibrant Communities



Equitable Care for All

MISSION

To co-ordinate and deliver **QUALITY, caring services** that promote **HEALTH & well-being.**

VALUES



DIGNITY - as a reflection of the self-worth of every person



CARE - as an unwavering expectation of every person



RESPECT - as a measure of the importance of every person

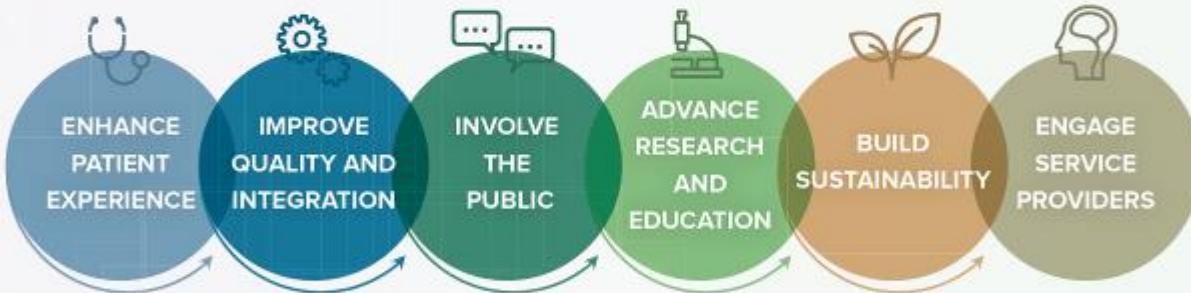


EQUITY - promote conditions in which every person can achieve their full health potential



ACCOUNTABILITY - as being held responsible for the decisions we make

STRATEGIC DIRECTION



OPERATIONAL STRATEGIES



PLAN STRATÉGIQUE

VISION



Des gens en santé



Des communautés dynamiques



Des soins équitables pour tous

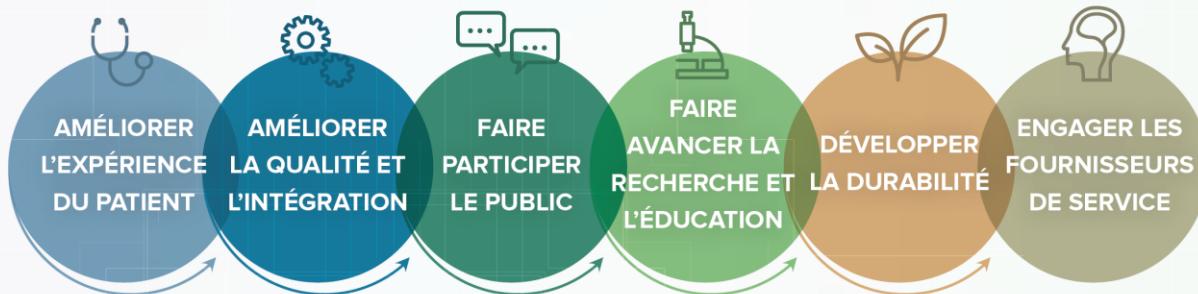
MISSION

Coordonner et offrir des services de soins de qualité qui favorisent la santé et le bien-être.

VALEURS

**DIGNITÉ**- Le Reflet de l'estime de Soi de Chaque Personne**SOINS**- Une Attente Inébranlable de Chaque Personne**RESPECT**- La Mesure de l'importance de Chaque Personne**ÉQUITÉ**- Favoriser les Conditions dans Lesquelles Chaque Personne Puisse Réaliser son Plein Potentiel de Santé**RESPONSABILITÉ**- Prendre la Responsabilité des Décisions que l'on Prend

ORIENTATION STRATÉGIQUE



STRATÉGIES OPÉRATIONNELLES



17

Public Compensation Disclosure

In compliance with *The Public Sector Compensation Disclosure Act of Manitoba*, interested parties may obtain copies of the WRHA public sector compensation disclosure by contacting:

Winnipeg Regional Health Authority Chief Privacy Officer
Winnipeg Regional Health Authority
650 Main Street
Winnipeg, MB, R3B 1E2
Phone: (204) 926-7049
Fax: (204) 926-7007

This report, which has been prepared for this purpose and audited by an external auditor, contains the amount of compensation it pays or provides in the corresponding calendar year for each of its officers and employees whose compensation is \$50,000 or more.

The report only includes the compensation paid to individuals employed by the facilities and services directly owned and operated by the region including HSC, Grace Hospital, Victoria General Hospital (VGH), Deer Lodge Centre (DLC), Pan Am Clinic, Manitoba eHealth, Community Areas Services, Churchill Health Centre and River Park Gardens.

SBGH, Riverview Health Centre (RHC), Misericordia Health Centre (MHC), SOGH, Concordia Hospital (Concordia) and personal care homes other than River Park Gardens and the Middlechurch Home of Winnipeg (Middlechurch) are separate legal entities. As such, they generate and make available their own disclosure reports.

The Public Interest Disclosure (Whistleblower Protection) Act Annual Report

July 6, 2017

The Public Interest Disclosure (Whistleblower Protection) Act

The Public Interest Disclosure (Whistleblower Protection) Act (“Act”) came into effect in April 2007. This law gives employees a clear process for disclosing concerns about significant and serious matters (wrongdoing) in the Manitoba public service, and strengthens protection from reprisal. The Act builds on protections already in place under other statutes, as well as collective bargaining rights, policies, practices and processes in the Manitoba public service.

Wrongdoing under the Act may be: contravention of federal or provincial legislation; an act or omission that endangers public safety, public health or the environment; gross mismanagement; or knowingly directing or counselling a person to commit a wrongdoing. The Act is not intended to deal with routine operational or administrative matters.

A disclosure made by an employee in good faith, in accordance with the Act, and with a reasonable belief that wrongdoing has been or is about to be committed is considered to be a disclosure under the Act, whether or not the subject matter constitutes wrongdoing. All disclosures receive careful and thorough review to determine if action is required under the Act, and must be reported in a department’s annual report in accordance with Section 18 of the Act.

The following is a summary of disclosures received by WRHA for fiscal year 2016-17:

Information Required Annually (by Section 18 of the Act)	Fiscal Year 2016-17
The number of disclosures received, and the number acted on and not acted on. <i>Paragraph 18(2)(a)</i>	<ul style="list-style-type: none">• Four disclosures were received by the Designated Officer of the WRHA.<ul style="list-style-type: none">○ Two disclosures were reviewed and assessed, and were determined to not fall within the responsibilities of the Designated Officer of the WRHA. These disclosures were forwarded to the Designated Officer of SBGH

	<ul style="list-style-type: none"> ○ Two disclosures were reviewed and assessed, and were determined not to fall within the criteria under the Act. As such, those did not require further investigation by the Designated Officer of the WRHA.
The number of investigations commenced as a result of a disclosure. <i>Paragraph 18(2)(b)</i>	<ul style="list-style-type: none"> • NIL
In the case of an investigation that results in a finding of wrongdoing, a description of the wrongdoing and any recommendations or corrective actions taken in relation to the wrongdoing, or the reasons why no corrective action was taken. <i>Paragraph 18(2)(c)</i>	<ul style="list-style-type: none"> • NIL

Our Stories



Healing our Health System

RIGHT CARE. RIGHT TIME. RIGHT PLACE.

The time for change – Improving patient care and the system that delivers it

At the WRHA, providing the best patient care possible is at the heart of all we do. Our staff and physicians come to work intent on doing exactly that – but our system, the framework within which our staff and physicians work, has itself failed to deliver. The evidence is in unacceptably long wait times and lengths of stay in hospital, key measures of service delivery that, in Winnipeg, have lagged behind national averages for years...

[Click to read the full story...](#)

The time for change – Improving patient care and the system that delivers it

At the WRHA, providing the best patient care possible is at the heart of all we do. Our staff and physicians come to work intent on doing exactly that – but our system, the framework within which our staff and physicians work, has itself failed to deliver. The evidence is in unacceptably long wait times and lengths of stay in hospital, key measures of service delivery that, in Winnipeg, have lagged behind national averages for years.

"We know that fundamental and comprehensive change is needed in order to address our challenges," says Réal Cloutier, WRHA interim President and CEO. "That kind of change, while necessary, creates a lot of disruption. We can't shy away from that, though. These challenges erode the quality of care we provide, with very real clinical implications."

To address the challenges our region introduced Healing our Health System in spring of 2017, a sweeping plan aimed at consolidating services, matching patient populations to appropriate staffing and building system sustainability.

"It's about providing the right care at the right time and in the right place," says Lori Lamont, WRHA Vice-President, acting Chief Operating Officer, Vice-President for Nursing and Allied Healthcare Professionals. "Our staff and physicians need a system they can work with, not around."

The clinical consolidation aspect of Healing our Health System groups patients with like needs at specific sites with the staff and diagnostic resources needed to deliver the right care. “Larger urban centres like Vancouver and Calgary have fewer emergency departments than Winnipeg yet our wait times are longer. Our specialty staff and diagnostic resources are spread too thinly across too many sites. Clearly more is not always better,” adds Lamont.

Cloutier agrees. System transformation means focusing squarely on the value our health system delivers to patients every day, and asking the right questions instead of adhering to the status quo. “Are we convinced that every step in a patient’s journey system adds value? Are we always looking at more efficient ways to deliver service without compromising safety? What would we ourselves expect, if we were in need of care? Our community deserves nothing less.”

What lies ahead:

Initial [Healing our Health System](#) changes to clinical services at Winnipeg hospitals

Phase 1 – Begins Oct. 3, 2017

- VGH’s emergency department converts to an urgent care centre;
- MHC’s urgent care centre begins conversion to intravenous therapy clinic;
- River Ridge II opens to individuals in process of or awaiting long-term care placement ([transitional care](#));
- [Priority Home](#), the WRHA’s enhanced home care service, begins.

Phase 2 – Begins early 2018

- New emergency department at Grace Hospital opens;
- SOGH emergency department converts to urgent care centre;
- Concordia emergency department closes.

Nos témoignages



Guérir notre système de santé

SOINS VOULUS. MOMENT VOULU. ENDRIOT VOULU.

L'heure est au changement : Améliorer les soins aux patients et le système qui les prodigue

Les meilleurs soins possibles aux patients sont au cœur de tout ce que fait l'ORSW. Le personnel et les médecins travaillent justement avec cette intention en tête, par contre, notre système, le cadre même dans lequel le personnel et les médecins travaillent, n'arrive pas à répondre aux besoins. La preuve se trouve dans les délais d'attente et les séjours à l'hôpital beaucoup trop longs, et les mesures clés en matière de prestation de services qui, à Winnipeg, prennent du retard sur les moyennes du pays depuis nombre d'années.

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« Nous comprenons qu'afin de relever nos défis, cela prend un changement fondamental et global », explique Réal Cloutier, le président-directeur général par intérim de l'ORSW. « Ce genre de changement, bien que nécessaire, provoque beaucoup de perturbations. Mais nous ne devons pas les ignorer. Ces défis grugent la qualité des soins fournis et entraîne de véritables répercussions cliniques. »

Afin de répondre aux défis, notre région a présenté *Guérir notre système de santé* au printemps de 2017, un plan vaste qui vise à consolider les services, à jumeler les populations de patients au personnel approprié et à bâtir un système durable.

« Il s'agit de prodiguer les soins voulus, au moment voulu, à l'endroit voulu », dit Lori Lamont, la vice-présidente de l'ORSW, chef des opérations par intérim, vice-présidente des infirmières et infirmiers et des professionnels paramédicaux. « Le personnel et les médecins ont besoin d'un système avec lequel ils peuvent travailler au lieu d'être obligés de le contourner. »

La consolidation clinique du plan *Guérir notre système de santé* regroupe les patients qui ont des besoins semblables dans des établissements spécifiques pourvus de personnel et de ressources diagnostiques requis pour prodiguer les soins voulus. « Les grands centres urbains tels que Vancouver et Calgary ont moins de services d'urgence que Winnipeg et pourtant nos délais d'attente sont plus longs. Le personnel spécialisé et les ressources diagnostiques sont mal répartis parmi trop d'établissements. De toute évidence, plus n'est pas toujours mieux », ajoute M^{me} Lamont.

M. Cloutier abonde dans le même sens. La transformation du système veut dire que l'on se concentre résolument sur la valeur qu'offre le système de santé aux patients chaque jour, et que l'on pose les bonnes questions au lieu d'accepter le statu quo. « Sommes-nous convaincus que chaque étape du cheminement du patient ajoute de la valeur? Cherchons-nous toujours des moyens plus efficaces de prodiguer le service sans compromettre la sécurité du patient? À quoi nous attendrions-nous si nous-mêmes avions besoin de soins? Notre communauté le mérite bien. »

Ce qui nous attend :

Les premiers changements aux services cliniques dans les hôpitaux de Winnipeg dans le cadre de Guérir notre système de santé

Étape 1 – À compter du 3 oct. 2017

- La conversion du service d'urgence de l'Hôpital Victoria en centre de soins d'urgence mineure;
- Le début de la conversion du centre de soins d'urgence mineure du Centre de santé Misericordia en clinique de thérapie intraveineuse;
- L'ouverture de River Ridge II pour les personnes qui attendent un placement dans un établissement de soins de longue durée ([soins transitoires](#));
- Le début de [Votre chez-vous – Notre priorité](#), le service de soins à domicile approfondis de l'ORSW.

Étape 2 – Au début de 2018

- L'ouverture du nouveau service d'urgence à l'Hôpital Grace;
- La conversion du service d'urgence de l'Hôpital Seven Oaks en centre de soins d'urgence mineure;
- La fermeture du service d'urgence de l'Hôpital Concordia.

Our Stories



HSC heliport helps speed patients to life-saving care

In January, Kelby Sprung, a 14-year-old hockey player from Manitou, suffered a compound fracture of his leg after crashing into the boards with an opposing player. Kelby was initially brought to the Carman Hospital by ground ambulance, where it was quickly determined that he needed specialized care. He was then flown by STARS air ambulance to the heliport at HSC, where the team at HSC Children's Hospital repaired his leg...

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As Kelby's mother, Jenn, explains, "He was lacking a pulse in his foot, and they needed to get that circulation back because they were saying that the limb was compromised. His transport from the hockey arena to Carman Hospital was very traumatic for him because he was in so much pain. He felt every little bump on those winter roads, so he was very happy to have the helicopter drop him off in Winnipeg with as little disruption as possible to his injury site. And to be moved right into the operating room on arrival was amazing for him."

Kelby's air ambulance flight was one of approximately 300 that have occurred since the provincial government joined the WRHA and STARS air ambulance in January 2016 to introduce plans for Winnipeg's first downtown heliport, located at HSC.

The heliport, which officially became operational in November 2016, significantly improves access to care for critically ill and injured patients being airlifted to HSC. The heliport routinely saves up to 30 minutes transport time for critically ill and injured patients, while reducing the risks involved with transferring patients in and out of ground ambulances.

HSC is the first health facility in Manitoba to have a heliport. The heliport sits on the roof of the new, 91,000-square-foot Diagnostic Centre of Excellence (DCE), located between pediatric inpatient units of HSC Children's Hospital and the Ann Thomas Building, which houses critical care services including intensive care units, operating theatres and emergency departments. The 60-by-60-foot rooftop-landing pad meets an H1 Heliport Standard and accommodates twin-engine helicopters.

In May of 2017, the heliport expanded its capacity by accepting incoming air ambulance transfers from Ornge Air Ambulance services from Ontario. Ornge co-ordinates all aspects of Ontario's air ambulance system.

Nos témoignages

L'héliport du Centre des sciences de la santé (HSC) permet de transporter rapidement les patients vers les soins qui peuvent sauver la vie

Au mois de janvier, Kelby Sprung, un joueur de hockey de 14 ans de Manitou, a subi une fracture ouverte à la jambe après s'être écrasé contre la bande avec un joueur adverse. Kelby a d'abord été amené à l'Hôpital Carman par ambulance terrestre où on a vite compris qu'il avait besoin de soins spécialisés. On l'a ensuite transporté par ambulance aérienne STARS à l'héliport du HSC où l'équipe de l'Hôpital pour enfants HSC a soigné sa jambe.

Cliquez ici...



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Selon la mère de Kelby, Jenn : « Il n'avait aucun pouls dans son pied et ils devaient raviver la circulation puisque sa jambe était endommagée. Le transport de l'aréna de hockey vers l'Hôpital Carman était traumatisant pour lui parce qu'il souffrait beaucoup. Il sentait chaque petit choc sur les routes d'hiver, alors il était content que l'hélicoptère l'ait déposé à Winnipeg sans trop affecter sa blessure. Et il était étonné d'être transporté directement au bloc opératoire à son arrivée. »

Le transport par ambulance aérienne de Kelby était parmi environ 300 qui ont eu lieu depuis que le gouvernement provincial s'est joint à l'ORSW et au service d'ambulance aérienne STARS en janvier 2016 pour présenter des plans pour le premier héliport au centre-ville de Winnipeg, au Centre des sciences de la santé (HSC).

L'héliport, qui a officiellement commencé ses activités en novembre 2016, améliore sensiblement l'accès aux soins pour les patients gravement malades et blessés que l'on transporte par ambulance aérienne au HSC. L'héliport permet de gagner jusqu'à 30 minutes en temps de transport pour les patients gravement malades et blessés tout en diminuant les risques liés au transfert des patients à l'intérieur et à l'extérieur des ambulances terrestres.

Le HSC est le premier établissement de santé au Manitoba à s'être doté d'un héliport. L'héliport est installé sur le toit du nouveau centre de diagnostic, Diagnostic Centre of Excellence (DCE), de 91 000 pieds carrés (8 454 mètres carrés), situé entre les unités pédiatriques de patients hospitalisés de l'Hôpital pour enfants et l'édifice Ann Thomas, qui comprend les services de soins critiques, notamment les unités de soins intensifs, des blocs opératoires et les services d'urgence. La plateforme d'atterrissement de 60 x 60 pieds (18 x 18 mètres) sur le toit répond aux normes de l'héliport H1 et peut recevoir les hélicoptères biturbines.

En mai 2017, l'héliport a augmenté sa capacité : il accepte désormais les transferts d'ambulance aérienne entrants des services d'ambulance aérienne Ornge de l'Ontario. Ornge coordonne tous les aspects du système d'ambulance aérienne de l'Ontario.

Our Stories



Making a Commitment to Improve Family Presence

The WRHA signed the Better Together pledge on April 5, 2016. Better Together focuses on encouraging the inclusion of patients and family members as partners in care.

"I think family presence is so important because, honestly, if your family member is sick and unable to think straight, you can be that conduit. You can interpret the information, make sure the medications are right and notice things right away that maybe a nurse might not notice at first, because that nurse doesn't know the patient like you do." - Dee Dee Budgell.

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Making a Commitment to Improve Family Presence

One year ago, Dee Dee Budgell picked up her ringing phone at 2 a.m. to hear a nurse say, "You need to come here. Harry's not doing well."

"Oh, my God. You get that call and your heart is racing. I've been told all along that my husband won't survive this," Dee Dee explains. "So of course you get in the car and you try to settle yourself down. Then I get into the parking lot, I go to the front door of the hospital and it's locked and I think, 'Are you kidding me?' My daughter and I run to the emergency entrance and the security guard stops me. I thought, 'I can't deal with this.' I needed to get upstairs and I couldn't even barely breathe."

Her daughter, Kati Budgell, stayed behind to talk to the security guard while Dee Dee rushed to her husband's bed. After Dee Dee reunited with her husband, Harry Budgell, she took a moment to let the medical staff know that the front door was locked overnight. The staff had never considered this.

When Harry was 64, he suffered a massive stroke after having a triple by-pass heart valve replacement. RHC said that he would never walk or talk again and gave him a year to live. That was 11 years ago, and he walked out of the facility.

He did lose his speech though. Harry has aphasia.

"People who have aphasia won't be saying things that make any sense. Their family members will."

Harry's lack of speech can be dangerous since he cannot communicate his pain well. Years after his original stroke, Harry fell while at home. He was taken to a hospital where they treated his congestive heart failure and within hours Harry was breathing normally again and would be discharged in a few days.

But Dee Dee interpreted his hand gestures and insisted on getting an X-ray of his hip. The medical staff assured her that there was no need for an X-ray, but when the results arrived they learned that Harry had broken his hip and needed a hip replacement.

Dee Dee is one of the volunteers on the WRHA's Patient and Family Advisory Council. During her time on the council, she has shared these stories and others similar to it where she has faced roadblocks as a family member and advocate.

The council evaluates these shortcomings in acute care, community health services and personal care homes and advises the WRHA on where to implement changes. In the past, they have been involved in many projects, from the emergency department wait times webpage, to participating in a Dignity in Care video, to providing input on the Clinical Practice Guidelines for Pain Assessment and Management.

Later this year, the council looks forward to working on a comprehensive implementation and education plan for the Family Presence Policies that are being developed.

The WRHA signed the Better Together pledge on April 5, 2016. Better Together focuses on encouraging the inclusion of patients and family members as partners in care. The WRHA's new policies will allow designated family members and caretakers to regularly access patients in the hospital 24-7 instead of just during visiting hours, and enable them to more fully participate in the patient's care and feel welcome to be present during physician rounds.

"I think family presence is so important because, honestly, if your family member is sick and unable to think straight, you can be that conduit. You can interpret the information, make sure the medications are right and notice things right away that maybe a nurse might not notice at first, because that nurse doesn't know the patient like you do."

Family presence isn't a new concept, but it is evolving as we learn just how much it can benefit patients. If you are interested in becoming a volunteer for the Patient and Family Advisory Council, visit <http://www.wrha.mb.ca/about/engagement/pfac/index.php> for more information. Volunteers can participate in person or electronically.

For more information about the Better Together pledge, visit www.cfhi-fcass.ca/WhatWeDo/better-together/pledge.

Nos témoignages



S'engager à améliorer la présence de la famille

Le 5 avril 2016, l'ORSW a signé la promesse Meilleurs ensemble. La campagne Meilleurs ensemble vise à encourager l'inclusion des patients et des membres de la famille en tant que partenaires dans les soins.

« La présence de la famille est très importante parce que, franchement, si un membre de votre famille est malade et ne peut pas penser clairement, vous pouvez servir d'intermédiaire. Vous pouvez interpréter l'information, vérifier que le patient a les bons médicaments et remarquer tout de suite des choses que l'infirmière n'aura pas vu nécessairement au départ puisqu'elle ne connaît pas le patient autant que vous. »

- Dee Dee Budgell.

[Cliquez ici...](#)

S'engager à améliorer la présence de la famille

Il y a un an, une infirmière appelait Dee Dee Budgell à 2 h 00 pour lui dire de venir, Harry n'allait pas bien.

« Oh mon Dieu, un tel appel fait sauter le cœur. On m'a dit depuis le début que mon mari ne survivrait pas, explique Dee Dee. Alors naturellement, je monte dans la voiture et j'essaie de me calmer. En arrivant à l'hôpital, je stationne la voiture et je découvre que la porte principale de l'hôpital est verrouillée. Ce n'est pas possible, je me dis. Ma fille et moi courons à l'entrée du service d'urgence et le gardien de sécurité nous arrête. Je n'en pouvais plus, je devais monter à l'étage mais je pouvais à peine respirer. »

Sa fille, Kati Budgell, est restée en arrière pour parler au gardien de sécurité pendant que Dee Dee s'est précipitée au chevet de son mari. Une fois près de son mari, Harry Budgell, elle a pris le temps d'informer le personnel médical que la porte principale était verrouillée pendant la nuit. Le personnel n'y avait pas pensé.

À l'âge de 64 ans, Harry a souffert d'un AVC après avoir subi le remplacement d'une valvule de son triple pontage coronarien. Le personnel du Centre de santé Riverview lui a dit qu'il ne marcherait ni ne parlerait plus jamais et qu'il lui restait un an pour vivre. C'était il y a 11 ans et il est sorti de l'établissement en marchant.

Par contre, il a perdu l'usage de la parole. Harry souffre d'aphasie.

« Les personnes qui souffrent d'aphasie disent des choses qui n'ont pas beaucoup de sens. Par conséquent, les membres de la famille parleront à leur place. »

Sa perte de l'usage de la parole peut mettre Harry en danger s'il ne peut pas bien communiquer la gravité de sa douleur. Plusieurs années après le premier AVC, Harry a fait une chute à la maison. On l'a transporté à l'hôpital pour traiter son insuffisance cardiaque congestive et, quelques heures plus tard, Harry recommençait à respirer normalement et quittait l'hôpital quelques jours plus tard.

Toutefois, Dee Dee, interprétant ses gestes manuels, insistait pour obtenir une radiographie de sa hanche. Le personnel médical lui disait que la radiographie n'était pas nécessaire, mais les résultats ont révélé que Harry avait en effet une hanche cassée et que celle-ci devait être remplacée.

Dee Dee siège bénévolement au Conseil consultatif des patients et des familles de l'ORSW. Pendant son mandat dans le conseil, elle a communiqué ces témoignages et d'autres situations semblables lors desquelles elle faisait face à des obstacles en tant que membre de la famille et porte-parole.

Le conseil évalue les lacunes dans les soins actifs, les services de santé communautaire et les foyers de soins personnels, et recommande à l'ORSW les changements à apporter. Dans le passé, le conseil s'est engagé dans plusieurs projets, de la page Web des délais d'attente des services d'urgence, à la contribution de rétroaction sur les Lignes directrices cliniques pour l'évaluation et la gestion de la douleur, en passant par une vidéo sur les soins dans la dignité.

Plus tard dans l'année, le conseil aura le plaisir de travailler sur une mise en œuvre et un plan d'éducation complets des Politiques sur la présence de la famille, actuellement en stade d'élaboration.

Le 5 avril 2016, l'ORSW a signé la promesse *Meilleurs ensemble*. La campagne *Meilleurs ensemble* vise à encourager l'inclusion des patients et des membres de la famille en tant que partenaires dans les soins. Les nouvelles politiques de l'ORSW permettront aux membres de la famille et aux fournisseurs de soins désignés d'avoir régulièrement accès aux patients hospitalisés 24 heures sur 24, 7 jours sur 7 au lieu de les voir seulement pendant les heures de visite, et de participer pleinement aux soins du patient et d'être les bienvenus pendant les visites du médecin.

« La présence de la famille est très importante parce que, franchement, si un membre de votre famille est malade et ne peut pas penser clairement, vous pouvez servir d'intermédiaire. Vous pouvez interpréter l'information, vérifier que le patient a les bons médicaments et remarquer tout de suite des choses que l'infirmière n'aura pas vu nécessairement au départ puisqu'elle ne connaît pas le patient autant que vous. »

La présence de la famille n'est pas un nouveau concept, mais l'idée évolue à mesure que nous comprenons à quel point cette présence peut aider le patient. Si vous aimeriez devenir bénévole au Conseil consultatif des patients et familles, visitez <http://www.wrha.mb.ca/about/engagement/pfac/index-f.php> pour obtenir plus d'information. Les bénévoles peuvent participer en personne ou par voie électronique.

Pour obtenir plus d'information sur la promesse *Meilleurs ensemble*, visitez
<http://www.fcass-cfhi.ca/WhatWeDo/better-together/pledge>.

Staff Stories



Kim Baessler, OTReg (MB)

WRHA Program Consultant Home Care Equipment, Supplies & Wheelchairs

"Through collaboration with other departments, I was able to implement new clinical and monitoring processes for the rental of therapeutic sleep surfaces (specialized mattresses) for home care clients resulting in cost savings exceeding \$952,000 over about a two-year period."

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Through collaboration with other departments, I was able to implement new clinical and monitoring processes for the rental of therapeutic sleep surfaces (specialized mattresses) for home care clients resulting in cost savings exceeding \$952,000 over about a two-year period.

In health care, we use specialty air or gel mattresses to prevent pressure injuries. Sometimes clients need them only for a short term after a surgery or injury, and we would arrange for a daily rental from a vendor, but we had no formal process for a clinical reassessment so the mattress would end up staying in the client's home for years.

Now clients get reassessed every six months to see if they still need the specialty mattress, and we also started utilizing a rent-to-own program with the vendor that we didn't know was available.

Other savings were realized by developing a process to recycle overhead lift slings.

Home care provides slings for transferring clients with an overhead lifting system in their home. When the lifting system was no longer needed and removed from the client's home, we used to throw the slings out for hygienic reasons. Unlike slings used in hospitals that are laundered with the rest of the hospital linens, our slings in home care weren't laundered because our vendor for overhead lifts doesn't provide laundering. The slings are about \$300 each.

So in April 2016 I developed a process. I arrange for the overhead lift slings to go to the WRHA laundry facility on Inkster, and when they've been laundered, they are inspected, repackaged and then used again. We estimate the initiative saves about \$10,000 annually.

There are two slings in each household and I actually find a lot of clients, after they've had a laundered one, say, "Can I have another recycled sling? They're softer." When the sling comes out of the package, they're all stiff and uncomfortable. It's like breaking in blue jeans.

I was new to this role three years ago. I'm an occupational therapist in a role looking at equipment and supplies for home care and trying to apply clinical best practice. In the past, we didn't always translate clinical evidence to equipment provision such as determining which client would benefit from a hospital bed, special mattress or other equipment. The decision-making was usually left up to each individual health-care professional without a lot of resources. Now we are looking at evidence and applying it to the equipment we order and provide to patients to ensure that we are providing the best clinical care possible and at the same time being fiscally responsible.

Témoignages du personnel



Kim Baessler, ergothérapeute agréée (MB)

Consultante de programme de l'ORSW en équipement des soins à domicile, fournitures et fauteuils roulants

Grâce à la collaboration avec d'autres services, j'ai pu mettre en œuvre de nouveaux processus cliniques et de suivi pour la location de surfaces thérapeutiques pour le sommeil (matelas spécialisés) destinées aux clients des soins à domicile, ce qui a permis une économie de plus de 952 000 \$ sur deux ans.

[Cliquez ici...](#)

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Dans le domaine des soins de santé, nous utilisons les matelas à air ou au gel spécialisés afin de prévenir les blessures dues à la pression. Parfois, les clients en ont besoin pour une courte période après une chirurgie ou une blessure, et nous aurions organisé une location quotidienne d'un vendeur, mais nous n'avions pas de processus officiel pour la réévaluation clinique; par conséquent, le matelas pouvait rester chez le client pendant des années.

Désormais, les clients reçoivent une réévaluation à tous les six mois s'ils ont toujours besoin du matelas spécialisé; de plus, nous avons commencé à profiter d'un programme *louer avec option d'acheter*, dont nous ne connaissons pas l'existence au départ, auprès du vendeur.

Nous avons réalisé d'autres économies au moyen de l'élaboration d'un processus de recyclage des toiles de lève-personne plafonniers.

Le programme des soins à domicile fournit les toiles de lève-personne pour transférer un client à l'aide d'un système de lève-personne plafonnier à domicile. Quand le système de lève-personne n'était plus nécessaire et qu'on l'avait retiré du domicile du client, on jetait la toile pour des raisons hygiéniques. Au contraire des toiles de lève-personne que l'on utilise dans les hôpitaux et que l'on lave avec les autres linges de l'hôpital, les toiles de lève-personne destinées aux soins à domicile ne se faisaient pas laver parce que notre vendeur de lève-personne plafonniers ne fournit pas le service de blanchissage. Les toiles de lève-personne coûtent environ 300 \$ chacune.

Par conséquent, en avril 2016, j'ai élaboré un processus. J'ai pris des dispositions pour que les toiles de lève-personne soient lavées à la buanderie de l'ORSW, boulevard Inkster, et après qu'elles soient lavées, elles sont inspectées, réemballées et réutilisées. Nous estimons que l'initiative économise environ 10 000 \$ par an.

Il y a deux toiles par domicile et bon nombre de clients demandent, après avoir utilisé une toile lavée, des toiles recyclées car elles sont plus douces. Quand on sort une nouvelle toile de l'emballage, elle est raide et inconfortable, comme une nouvelle paire de jeans.

Il y a trois ans, ce rôle était nouveau pour moi. Je suis ergothérapeute et j'étudie l'équipement et les fournitures pour les soins à domicile en essayant d'appliquer les meilleures pratiques cliniques. Dans le passé, les preuves cliniques ne se traduisaient pas toujours en fourniture d'équipement pour, par exemple, déterminer quel client bénéficierait d'un lit d'hôpital, d'un matelas spécialisé ou d'une autre pièce d'équipement. La prise de décision était habituellement laissée à chaque professionnel de la santé, sans recours à beaucoup de ressources. Aujourd'hui, nous voyons les preuves et nous les appliquons à l'équipement que nous commandons et fournissons aux patients afin de nous assurer de fournir les meilleurs soins cliniques possibles tout en étant responsables sur le plan financier.

Jessica Slater

Clerk Typist V, Health Information Services, SBGH

"With the support of my transformation coach and co-workers, I was able to reduce training time in my area from 12 weeks to three weeks or less, which played a significant role in reducing our overall training costs by over 75 per cent."

"We as a region are truly working on functional solutions that are sustainable and patient-focused."

[Click to read the full story...](#)



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With the support of my transformation coach and co-workers, I was able to reduce training time in my area from 12 weeks to three weeks or less, which played a significant role in reducing our overall training costs by over 75 per cent.

I am a late reports clerk, and our responsibility is to put the reports that come down to health information services (HIS) into each patient's corresponding chart. Our standard is 3.5 inches of paper per day, per person.

My area was frequently backlogged (taking longer than two weeks to process), which caused pain for patients, HIS staff and primary care providers because they did not have the most updated information in the patients' charts when they needed it.

When the region announced that each area would need to work within their budget allocation, we were no longer allowed to use overtime as our "Band-Aid" to fix backlog; we had to find a real solution to this problem otherwise reports would pile up even more.

In a February 2017 sample, reports were coming in at approximately 200 inches per month, but we were only able to process about one third of that amount within that time.

We needed to hire new staff to take on this work, but it took 12 weeks to train a person to become a late reports clerk and training time cost \$12,000.

After I had discussions with my team, supervisor and coach, we decided training time needed to be reduced. We accomplished this by creating deliberate training objectives, and updating our system of filing reports for the first time in 20 years. Now our tabs have been updated to represent current reports and we file our reports by date where the most current results are always on top.

We reached our goal of reducing training time from 12 weeks to three weeks or less. In one case, we were able to train a person in four days. We reduced training costs from \$12,000 to \$3,000 or less. We increased the speed that records were being processed, due to our newer, simpler system of filing. Some late reports clerks are now filing closer to four or 4.5 inches a day per person instead of 3.5 inches.

Today we are no longer backlogged in this area and are processing reports well within two weeks of arriving to HIS.

Everyone has the power to make a positive impact within their department if they commit to it, no matter your position within the hospital. You will always have pushback from some individuals when introducing change. This is simply part of the process. Do not let that discourage you from making a change. We as a region are truly working on functional solutions that are sustainable and patient-focused.

Jessica Slater

Commis-dactylo V, service de renseignements médicaux, HSB

Grâce au soutien de mon mentor en transformation et mes collègues, j'ai pu réduire le temps de formation dans mon secteur de 12 semaines à 3 ou moins, ce qui a permis de sensiblement réduire le coût global de formation de plus de 75 %.

En tant que région, nous cherchons de véritables solutions fonctionnelles qui assurent la pérennité et qui sont axées sur le patient.

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Je suis commis aux dossiers médicaux et ma responsabilité consiste à ranger les rapports qui viennent du service de renseignements médicaux (SRM) dans le dossier correspondant de chaque patient. La norme est 3,5 pouces (9 cm) de papier par jour, par personne.

Le retard était fréquent dans mon secteur (plus de deux semaines à traiter les renseignements), ce qui était difficile pour les patients, le personnel du SRM et les fournisseurs de soins primaires parce qu'ils n'avaient pas les derniers renseignements dans les dossiers des patients au moment voulu.

Lorsque la région a annoncé que chaque secteur devait travailler dans les paramètres de son allocation budgétaire, nous ne pouvions plus recourir aux heures supplémentaires en tant que solution de secours pour résoudre le retard; il fallait trouver une vraie solution au problème afin d'éviter que les rapports s'accumulent davantage.

Dans un échantillon de février 2017, les rapports entraient à environ 200 pouces (508 cm) par mois, mais nous ne pouvions en traiter qu'environ le tiers dans ce délai.

Nous devions embaucher d'autres personnes pour effectuer le travail, mais la formation pour devenir commis aux dossiers médicaux durait 12 semaines et coûtait 12 000 \$.

Après des discussions avec mon équipe, mon superviseur et mon mentor, nous avons compris qu'il fallait diminuer la durée de la formation. Nous y sommes arrivés en créant des objectifs de formation voulus et en mettant à jour notre système de classement des rapports pour la première fois depuis 20 ans. Désormais les onglets sont à jour afin de représenter les rapports actuels et nous classons les rapports par date, les résultats les plus actuels étant toujours sur le haut.

Nous avons réussi à réduire la durée de la formation de 12 semaines à 3 ou moins. Dans un cas, nous avons réussi à former une personne en 4 jours. Nous avons diminué le coût de formation de 12 000 \$ à 3 000 \$ ou moins. Grâce à notre nouveau système de classement simplifié, nous avons pu accélérer le traitement des dossiers. Certains commis aux dossiers médicaux classent à l'heure actuelle plus près de 4 ou 4,5 pouces (10 ou 11 cm) par jour par personne au lieu de 3,5 pouces (9 cm).

Aujourd'hui, il n'y a plus de retard dans ce secteur et nous traitons les rapports dans un délai de deux semaines après leur arrivée au SRM.

Chacun de nous peut avoir un effet positif dans son service s'il le veut vraiment, quel que soit notre poste à l'hôpital. Il y a toujours des gens qui résistent au changement. Cela fait partie du processus, par contre, ne vous découragez pas face au besoin de changement. En tant que région, nous cherchons de véritables solutions fonctionnelles qui assurent la pérennité et qui sont axées sur le patient.



Leslie Dryburgh

Clinical Nurse Specialist for Geriatrics and Advance Wound Care, Grace Hospital

"I'm a nurse, I'm an old nurse. I was taught by the nuns at SBGH and it really is all about the patient. I have a lot of pride in my job, I have a lot of pride that I'm able to give people the care that they deserve and they expect when they come into a hospital because they have so many other crisis's in their life, the last thing they need to worry about is somebody leaving a soaker pad under them and getting a pressure ulcer."

[Click to read the full story...](#)

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Clinical Nurse Specialist for Geriatrics and Advance Wound Care, Grace Hospital

The soaker pad removal was a regional project. Historically, soaker pads were thought to keep patient's skin dry by absorbing moisture from incontinence, post-surgical discharge and weeping skin. Research shows no benefit of soaker pads related to improving patient care. The problem with soaker pads is their inability to properly pull fluid away from the skin, thereby leaving skin sitting in fluid and causing skin breakdown.

They were put on every bed.

Sometimes you have to ask the question, "Why are you doing that? What's the purpose?" and "Is it beneficial to patient care?"

We audited the units to see why and how many were used. The number of soaker pads used but not required was staggering.

After removing the soaker pads we brought in absorbent disposable sheets that wick moisture away from the skin, thus preventing skin breakdown. And now units are only putting them under the patients that need them. The sheets cost about \$1.50 each. Soaker pads cost us about \$3 each after we account for laundering and transporting to laundry services and back.

Another instance where we made improvements was after the revised constant care guidelines came out January 2016. We educated staff, showed the statistics and our philosophy became "constant care is the last resort, not the first option." It could be only used for a specific behavior, and once the specific behaviour was gone, so was constant care.

For a bit of background, instead of restraints we use constant care to ensure the patient isn't pulling out lines (for example, removing epidural), which can be very dangerous.

The key piece for this project was education and auditing. So we decreased the time of constant care and we audited every instance of constant care, every morning, seven days a week.

If you look at our stats, they went down so low to the point at regional meetings for Chief Nursing Officers, they wouldn't even put us on the graph showing costs for constant care. One month, we were under \$2,000.

I'm a nurse, I'm an old nurse. I was taught by the nuns at SBGH and it really is all about the patient. I have a lot of pride in my job, I have a lot of pride that I'm able to give people the care that they deserve and they expect when they come into a hospital because they have so many other crisis's in their life, the last thing they need to worry about is somebody leaving a soaker pad under them and getting a pressure ulcer.



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Infirmière clinicienne spécialisée en gériatrie et soins des plaies avancés, Hôpital Grace

Je suis infirmière, une vieille infirmière. Les religieuses m'ont enseigné à l'Hôpital Saint-Boniface et l'éducation était focalisée sur le patient. Je tire une grande fierté de mon travail, je suis très fière de pouvoir donner aux gens les soins qu'ils méritent et auxquels ils s'attendent pendant leur séjour à l'hôpital; ils vivent déjà assez de crises, sans avoir à s'inquiéter qu'un protège-drap sera laissé sous leur corps qui pourrait causer une plaie de pression.

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Leslie Dryburgh

Infirmière clinicienne spécialisée en gériatrie et soins des plaies avancés, Hôpital Grace

L'élimination des protège-draps était un projet régional. Dans le passé, on croyait que le protège-drap aidait à maintenir la peau du patient sèche en absorbant l'humidité causée par l'incontinence, les pertes après la chirurgie et la peau qui suinte. Les études démontrent que le protège-drap n'améliore en rien les soins aux patients. Par ailleurs, le protège-drap n'éloigne pas le liquide de la peau et, par conséquent, la peau reste dans le liquide, provoquant des lésions cutanées.

Chaque lit était recouvert d'un protège-drap.

Il faut parfois demander pourquoi on fait cela, quel en est le but? Cela améliore-t-il les soins au patient?

Nous avons contrôlé les unités pour savoir combien de protège-draps on utilisait et pourquoi. Le nombre de protège-draps utilisés inutilement était stupéfiant.

Une fois les protège-draps éliminés, nous avons choisi des draps absorbants jetables qui chassent l'humidité, prévenant ainsi les lésions cutanées. Et désormais, les unités placent les protège-draps seulement sous les patients qui en ont besoin. Les draps jetables coûtent environ 1,50 \$ chacun. Les protège-draps coûtent environ 3 \$ chacun, après les coûts de blanchissage et de transport vers et en provenance de la buanderie.

Nous avons aussi apporté des améliorations après la parution des lignes directrices révisées sur les soins assidus en janvier 2016. Nous avons éduqué le personnel, montré les statistiques et notre nouvelle philosophie est devenue : « Les soins assidus sont le dernier recours, pas la première option. » Les soins assidus servaient dans le cas d'un comportement spécifique, mais une fois le comportement spécifique résolu, on ne donnait plus les soins assidus.

Un peu de contexte : au lieu de matériel de contention, nous utilisons les soins assidus pour assurer que le patient ne retire pas ses lignes (p. ex., une péridurale), ce qui peut être très dangereux.

La pièce clé du projet était l'éducation et la vérification. Par conséquent, nous avons diminué le temps des soins assidus et vérifié chaque cas de soins assidus, chaque matin, sept jours sur sept.

Si vous consultiez nos statistiques, vous verriez qu'elles ont diminué à un tel point qu'aux réunions régionales des directrices du personnel infirmier, elles ne figuraient même pas sur le graphique des coûts des soins assidus. Une fois, nos coûts étaient moins de 2 000 \$ pour le mois.

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Enterprise risk management

The WRHA uses an enterprise risk management (ERM) process to identify, monitor and manage risks that may impact the achievement of its strategic directions.

New this year:

- The ERM process continued to be rolled out throughout the WRHA;
- Priority risks were folded into the WRHA's annual operating plan.

Current ERM priority areas for the WRHA include:

- Improvement of patient flow;
- Replacement and maintenance of infrastructure and equipment;
- Managing within existing funding allocation and advocating for reasonable funding increases;
- Replacement and maintenance of aging or obsolete information technology;
- Management and implementation of new initiatives;
- Full implementation and improvement of the shared services model;
- Revision of current organizational structure to be both appropriate and effective;
- Accountability for performance of individual sites and programs;
- Timely, evidence-based, quality decision-making;
- Increased/improved business continuity planning;
- Response to health care needs of specific and changing demographic groups;
- Equitable provision of health-care services;
- Privacy of personal health information.

Risk mitigation plans are currently being developed for these areas to guide risk management activities.

Critical Incident Process

A key component of the WRHA's quality improvement efforts is the critical incident review process.

The critical incident process is continually evolving to better meet the needs of our patients and families and ensure that we continually strive to improve care. As a region, we have committed to completing critical incident reviews within 88 business days from the day the incident is reported. In the event that 88-day timeline cannot be met, the region has committed to follow up directly with the family to explain the delay and provide an update on the progress of the review.

The region is also working to improve communication strategies to facilitate conversations with patients and families in order to provide them the information they need while maintaining the confidentiality of the review.

Additionally, the region is in the process of launching a review of the way it carries out critical incident reviews, including how it reports and investigates an event and the communication of progress and findings with family members.

What constitutes a critical incident, as well as many aspects of the process, is legally defined by The Regional Health Authorities Act which defines a critical incident as an incident which:

- is serious and undesired, such as death, disability, injury or harm, unplanned admission to hospital or unusual extension of a hospital stay, and;
- does not result from the individual's underlying health condition or from a risk inherent in providing health services.

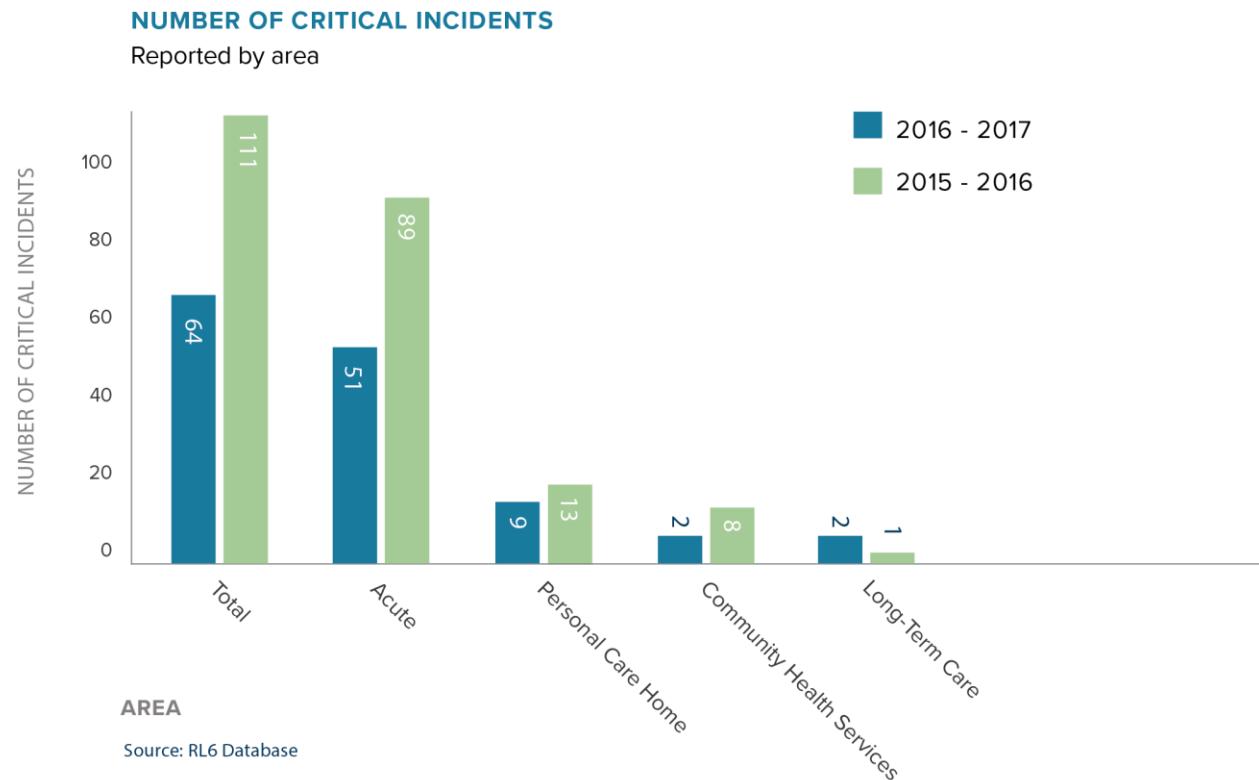
Some examples of a critical incident might include:

- receiving the wrong medicine or wrong dose of a medicine that results in serious harm to the patient, resident or client, or;
- "breakdowns" in communication during transitions of care that result in serious harm to the individual.

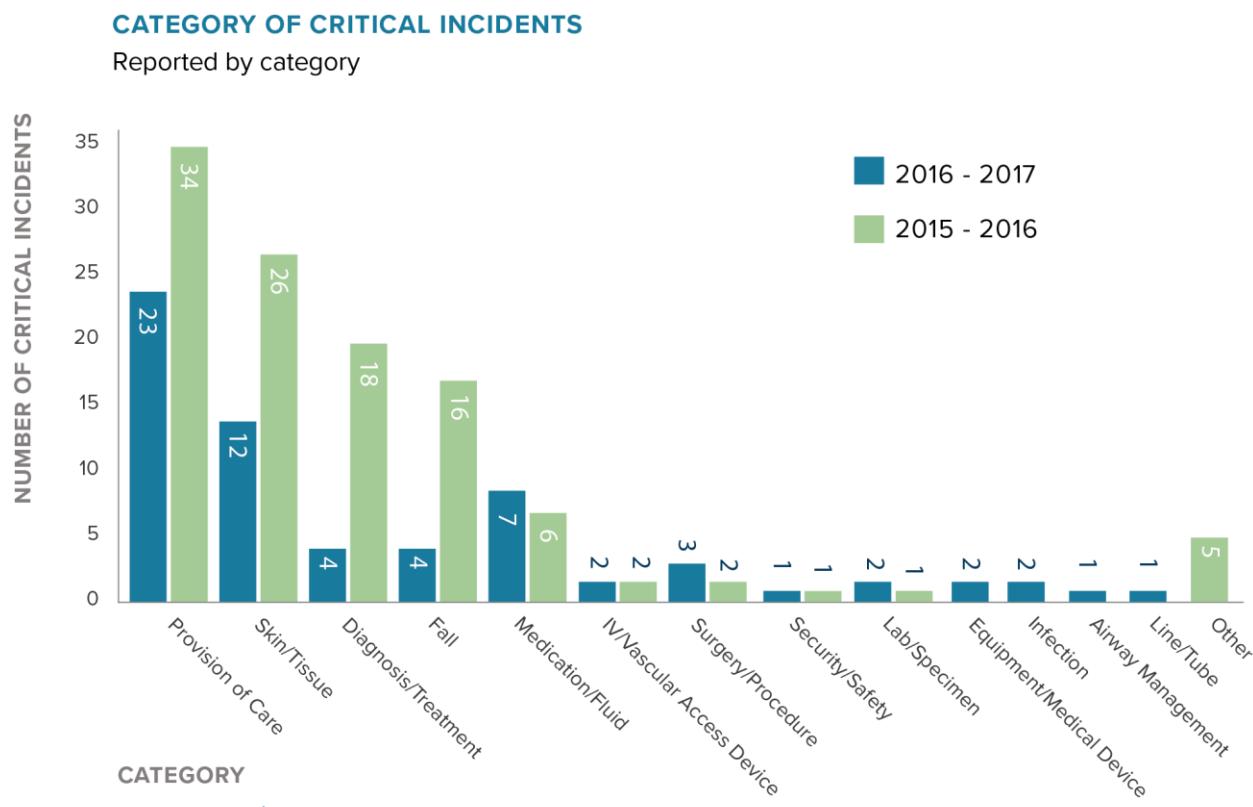
The WRHA is committed to creating conditions that encourage disclosure of critical incidents, and it recognizes the need to also be open with patients and their families when a medical error occurs, sharing with them the findings from the investigation, including the facts about what happened.

This helps promote an organizational culture of trust and transparency, where those reporting critical incidents can do so without fear of reprisal, and where the overall focus is on safety and improvement.

The chart below highlights the number of critical incidents across the region reported in the fiscal years 2016-17 and 2015-16.



The chart below highlights the number of critical incidents in the region reported with an event date in the fiscal years of 2016-17 and 2015-16.



Source: RL6 Database

Client Relations

At the individual level of engagement, the WRHA's Client Relations service provides an accessible way for the public to share any concerns or compliments with the region regarding their personal experiences receiving care within the region, or the care received by a family member or friend. It is a key way in which the region listens and responds to the public. Every week, the Client Relations line averages between 75 and 100 calls.

Feedback received through Client Relations is kept confidential, and is used together with other data to improve patient care and health services across the region.

Client Relations can be reached at:

WINNIPEG REGIONAL HEALTH AUTHORITY CLIENT RELATIONS

Phone: (204) 926-7825

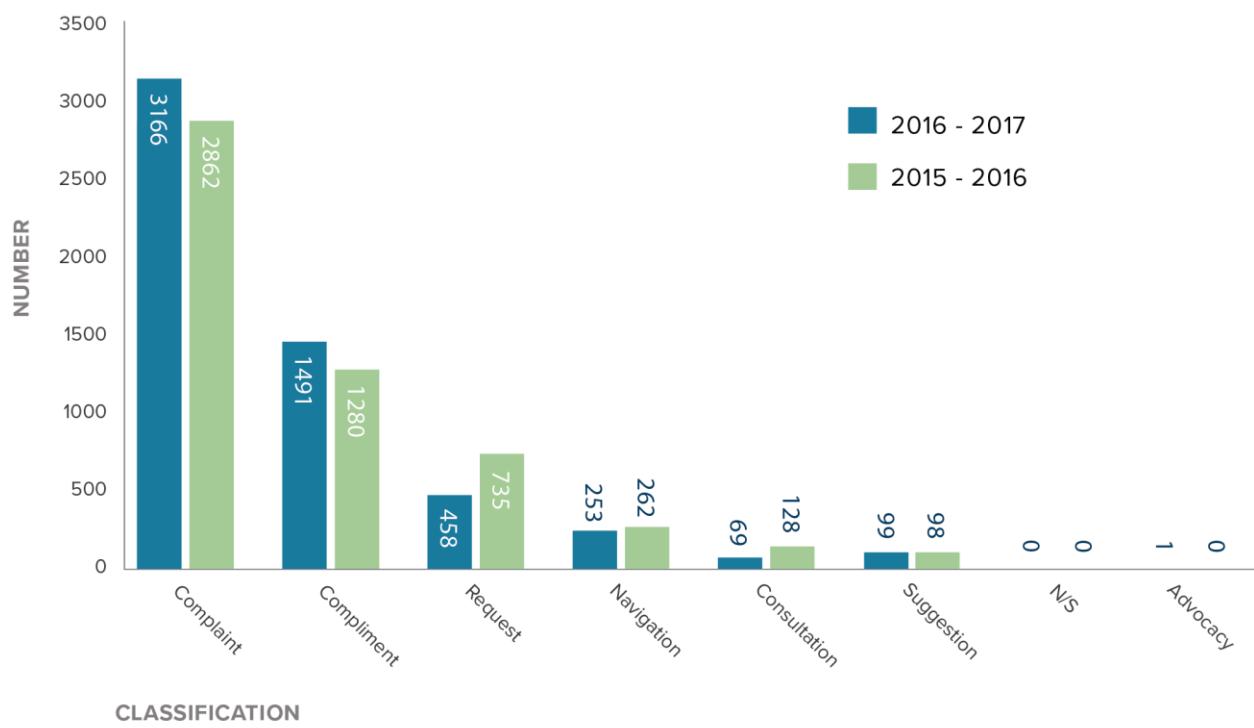
Fax: (204) 940-1974

E-mail: clientrelations@wrha.mb.ca

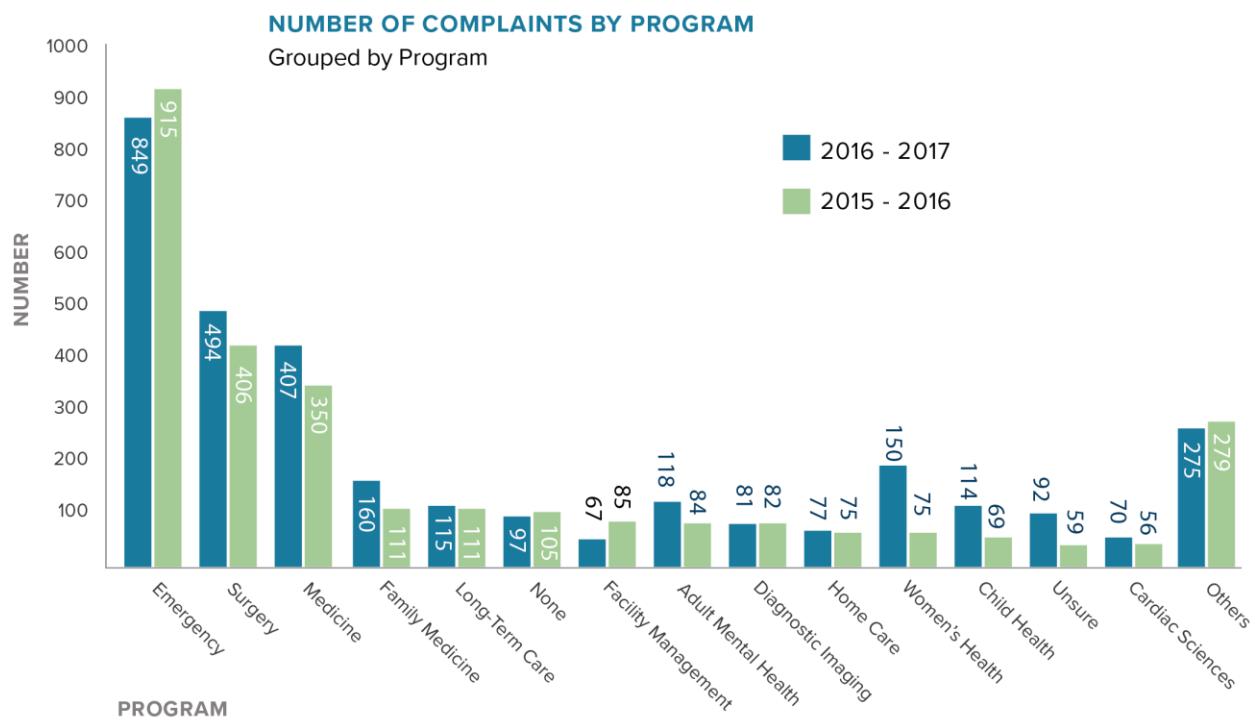
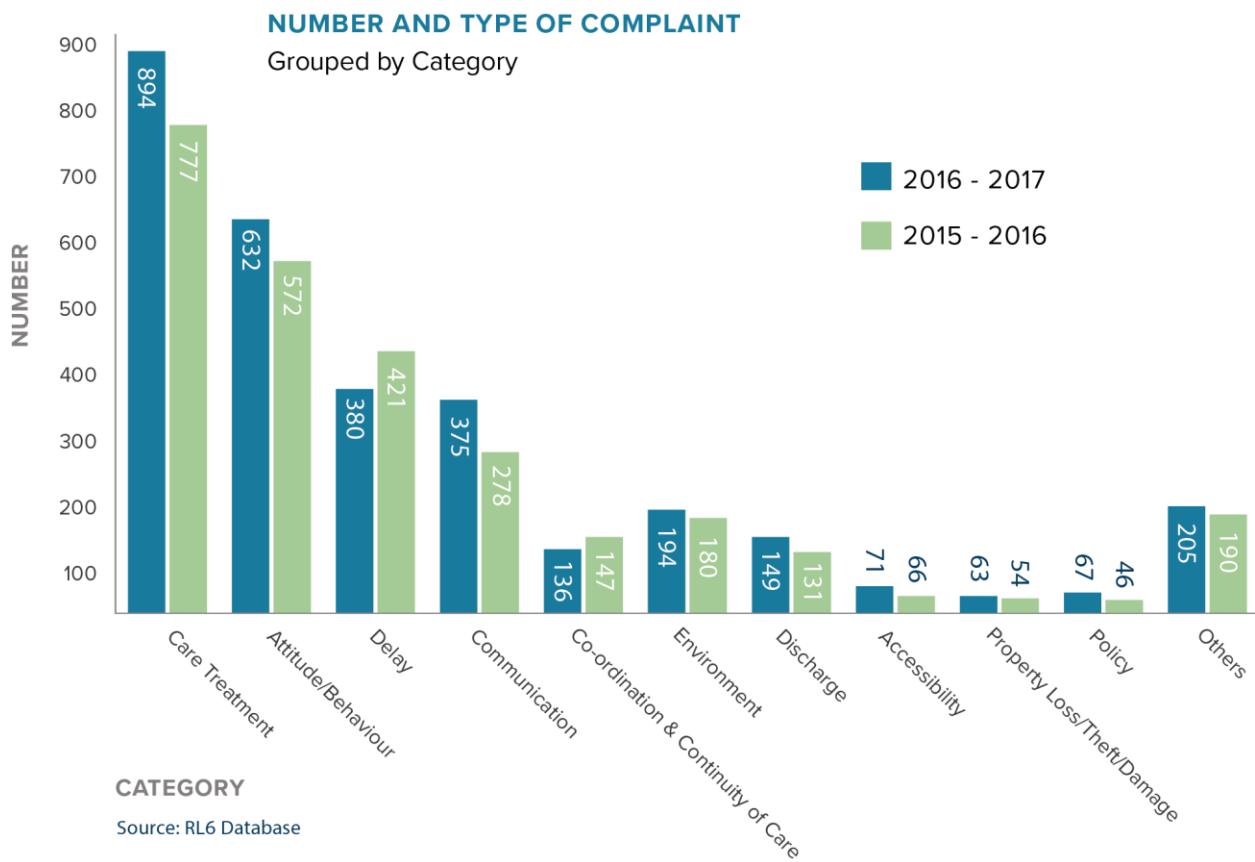
Monday – Friday from 8:30 a.m. – 4:30 p.m.

NUMBER AND CLASSIFICATION OF CALLS TO CLIENT RELATIONS

Grouped by Classification



Source: RL6 Database



Statistics

URGENT CARE VISITS

	2016 - 17	2015 - 16	2014 - 15
MHC Urgent Care	38,614	39,027	39,979
Pan Am Minor Injury Clinic	57,832	60,160	60,746
Total	99,446	99,187	100,725

Source: SAP

Retroactive changes have been made to Pan Am for prior years to include all visit types.

HOME CARE CLIENTS¹ RECEIVING SERVICES

2016 - 17	2015 - 16	2014 - 15
14,751	14,254	14,037

Source: Compiled from Community Office Statistics by the Home Care Program

1) Excludes clients under assessment but not yet receiving services: 2016/17 = 325 clients; 2015/16 = 345 clients; 2014/15 = 277 clients.

TOTAL BIRTHS AND DELIVERIES

Births ¹	2016 - 17	2015 - 16	2014 - 15
Births (including stillbirths)	11,478	11,475	11,234
Home Birth Midwife	26	34	35
Birth Centre	204	163	152
Total Births	11,708	11,672	11,421

Source: WRHA DAD DSS

1) Births represent the number of babies born. Stillbirths are included. Babies born before arrival to hospital are excluded. The newborn abstract is used for the calculation.

Deliveries¹	2016 - 17	2015 - 16	2014 - 15
Deliveries by physician	11,047	10,956	10,833
Deliveries by midwife	174	206	155
Total deliveries	11,221	11,162	10,988

Source: DAD DSS

1) Deliveries represent the number vaginal and cesarean section births. The mother's abstract is used.

MAIN OPERATING ROOM (OR) SURGICAL CASES¹

Inpatient	2016 - 17	2015 - 16	2014 - 15
WRHA Acute Sites	23,669	22,949	23,599
MHC	407	463	498
Pan Am Clinic	-	-	-
Total	24,076	23,412	24,097

Day Surgery	2016 - 17	2015 - 16	2014 - 15
WRHA Acute Sites	23,341	23,407	23,196
MHC	11,466	11,480	11,497
Pan Am Clinic	3,793	3,734	3,818
Total	38,600	38,621	38,511

Total	2016 - 17	2015 - 16	2014 - 15
WRHA Acute Sites	47,010	46,356	46,795
MHC	11,873	11,943	11,995
Pan Am Clinic	3,793	3,734	3,818
Total	62,676	62,033	62,608

Source: WRHA DAD

1) Represents inpatient cases that had at least one surgery in a site's main operating room (OR). For some cases, more than one surgical procedure or main OR trip may have been done during an episode and/or admission; however, only one surgical case is counted per admission for this analysis.

PROCEDURE VOLUMES (RELATED TO WAIT TIME TRACKING)

Inpatient and Day Surgeries	2016 - 17	2015 - 16	2014 - 15
All (Therapeutic interventions on the heart and related structures, excluding CABG)	2,682	2,539	2,068
CABG (Coronary Artery Bypass Graft)	588	628	598
Joint Surgery:			
Primary Hip Replacements	1,506	1,497	1,526
Primary Knee Replacements	1,714	1,656	1,627
Cataract - Adults	9,119	9,224	9,213
Pediatric Dental (includes Churchill)	1,605	1,873	2,051

Source: WRHA DAD DSS. Pediatric dental statistics for previous years have been updated to include Churchill Health Centre.

GAMMA KNIFE PROCEDURES

2016 - 17 ¹	2015 - 16 ¹	2014 - 15 ¹
507	551	459

Source: SAP

1) Includes cases where the patient is booked and prepared in the gamma knife frame, goes through the MRI exam, but the gamma knife procedure is abandoned due to the size of the tumor.

WRHA SERVICES PROVIDED THROUGH THE PROVINCIAL HEALTH CONTACT CENTRE (PHCC)

Inpatient	2016 - 17	2015 - 16	2014 - 15
Health Links - Info Santé - Client calls answered Live ¹	95,969	100,277	108,997
Health Links - Info Santé - Outbound Calls ²	980	1,054	1,205
Left But Not Seen - Follow-up Contacts	4,566	6,427	7,495
After Hours Central Intake Program - Client calls answered Live	160,237	153,749	153,488
After Hours Central Intake Program - Outbound Calls	209,412	195,480	176,988
TeleCARE Manitoba - Client calls answered Live	610	527	632
TeleCARE Manitoba - Outbound Calls ³	9,362	8,179	9,045
Dial a Dietitian - Client calls answered Live ⁴	1,357	1,367	1,342
Dial a Dietitian - Outbound Calls	800	799	666
Triple P Positive Parenting Program - Client calls answered Live ⁵	565	550	677
Triple P Positive Parenting Program - Outbound Calls ⁶	1,195	1,125	1,234

1) The number of calls where a client spoke with a health-care professional.

2) Total number of followup contacts to clients already in contact with Health Links - Info Santé staff (i.e. those contacts serviced in line 1).

3) The number of calls where a client spoke with a health-care professional.

4) Total number of followup contacts to clients already in contact with TeleCARE TÉLÉSOINS Manitoba Nurse (i.e. those contacts serviced in the above line).

5) The number of calls where a client spoke with a registered dietitian.

6) Total number of followup contacts to clients already in contact with registered dietitian staff (i.e. those contacts serviced in the above line).

TOTAL NUMBER OF RESIDENTS IN PERSONAL CARE HOMES (PCH)

	2016 - 17	2015 - 16	2014 - 15
Winnipeg PCH in RHC and DLC ¹	463	463	431
Winnipeg Non-Proprietary PCH	2,992	2,965	2,951
Winnipeg Proprietary PCH	2,030	2,025	2,032
Rural Proprietary PCH ²	366	366	367
Total	5,851	5,819	5,781

Source: WRHA Long-Term Care Program

1) Assumes 100 per cent bed occupancy of PCH beds at RHC and DLC.

2) Includes proprietary PCHs that are located outside the Winnipeg geographic region but which Manitoba Health funds through the WRHA Long-Term Care Program. Includes Central Park Lodge - Valley View, Extendicare - Hillcrest Place and Extendicare - Red River Place.

DIAGNOSTIC IMAGING

2016-17	WRHA Acute Sites	MHC	Pan Am Clinic	Other ¹	Total
CT Scans	123,568	7,329	-	-	130,897
Ultrasounds	120,610	8,830	-	-	129,440
X-Rays	298,701	19,490	-	3,546	321,737
Mammograms ²	4,678	-	-	-	4,678
Nuclear Medicine	22,981	-	-	-	22,981
PET	1,992	-	-	-	1,992
MRI	53,384	-	9,278	-	71,940
Bone Density	7,656	-	-	-	7,656
Angiography	6,051	-	-	-	6,051
Cardiac Angiography	13,295	-	-	-	13,295
Total Diagnostic Imaging Procedures	652,916	35,649	9,278	3,546	701,389

2015-16	WRHA Acute Sites	MHC	Pan Am Clinic	Other ¹	Total
CT Scans	114,725	6,567	-	-	121,292
Ultrasounds	109,750	8,259	-	-	118,009
X-Rays	291,070	19,919	-	3,277	314,266
Mammograms	3,147	-	-	-	3,147
Nuclear Medicine	21,699	-	-	-	21,699
PET	1,836	-	-	-	1,836
MRI	49,835	-	9,369	-	59,204
Bone Density	6,883	-	-	-	6,883
Angiography	5,274	-	-	-	5,274
Cardiac Angiography	13,281	-	-	-	13,281
Total Diagnostic Imaging Procedures	617,500	34,745	9,369	3,277	664,891

2014-15	WRHA Acute Sites	MHC	Pan Am Clinic	Other ¹	Total
CT Scans	109,050	6,711	-	-	115,761
Ultrasounds	103,669	8,731	-	-	112,400
X-Rays	285,001	18,857	-	3,326	307,184
Mammograms	2,440	-	-	-	2,440
Nuclear Medicine	21,317	-	-	-	21,317
PET	1,741	-	-	-	1,741
MRI	49,553	-	9,187	-	58,740
Bone Density	6,436	-	-	-	6,436
Angiography	5,363	-	-	-	5,363
Cardiac Angiography	12,710	-	-	-	12,710
Total Diagnostic Imaging Procedures	597,280	34,299	9,187	3,326	644,092

Source: WRHA Diagnostic Imaging Program

1) Other includes RHC and DLC.

2) Includes HSC and Breast Health Centre.

WRHA HOSPITAL STATISTICS

TOTAL WRHA

Key Statistic:	2016 - 17	2015 - 16	2014 - 15
Number of Beds ¹	3,192	3,188	3,205
Average Occupancy ²	92.5%	90.0%	90.5%
Emergency Department Visits ³	291,277	279,915	277,385
Emergency Department Visits Admitted (with % in brackets) ³	34,068 (11.70%)	32,853 (11.74%)	28,444 (12.66%)
Left Without Being Seen (with % in brackets) ³	19,898 (6.83%)	20,906 (7.47%)	20,139 (8.97%)
Total Number of Inpatient Discharges ^{4, 9}	84,387	82,797	82,111
Average LOS ^{4, 9}	8.64	8.45	8.71
Total Number of Day Surgery Cases ^{4, 9}	65,060	63,198	61,017
Percentage of Alternate Level of Care (ALC) Days ^{4, 9}	12.80%	10.27%	11.33%
ALOS: ELOS Ratio ⁴	1.14	1.14	1.16
Hospital Standardized Mortality Ratio ⁵	114	116	115
Hospital Readmission Rate Within 30 Days of Discharge ⁷	7.2%	7.1%	6.6%
Clostridium Difficile Rate (per 10,000 pt days) ⁸	2.87	3.96	2.87
MRSA Rate (per 10,000 pt days) ⁸	5.77	5.61	5.29

Health Sciences Centre Winnipeg

Key Statistic:	2016 - 17	2015 - 16	2014 - 15
Number of Beds ¹	777	775	771
Average Occupancy ²	90.5%	88.5%	87.4%
Emergency Department Visits ³	114,923	110,524	108,259
Emergency Department Visits Admitted (with % in brackets) ³	13,282 (11.56%)	12,762 (11.55%)	12,868 (11.89%)
Left Without Being Seen (with % in brackets) ³	7,313 (6.36%)	7,020 (6.35%)	7,021 (6.49%)
Total Number of Inpatient Discharges ^{4, 9}	34,162	33,544	33,427
Average LOS ^{4, 9}	7.60	7.59	7.55
Total Number of Day Surgery Cases ^{4, 9}	21,498	19,980	18,463
Percentage of Alternate Level of Care (ALC) Days ^{4, 9}	7.15%	5.31%	4.90%
ALOS: ELOS Ratio ⁴	1.12	1.10	1.12
Hospital Standardized Mortality Ratio ⁵	119	112	122
Hospital Readmission Rate Within 30 Days of Discharge ⁷	7.4%	7.2%	7.0%
Clostridium Difficile Rate (per 10,000 pt days) ⁸	3.00	5.28	3.48
MRSA Rate (per 10,000 pt days) ⁸	12.52	11.78	10.72

St. Boniface General Hospital

Key Statistic:	2016 - 17	2015 - 16	2014 - 15
Number of Beds ¹	493	477	472
Average Occupancy ²	94.3%	93.4%	92.9%
Emergency Department Visits ³	42,239	40,156	39,061
Emergency Department Visits Admitted (with % in brackets) ³	6,748 (15.98%)	6,592 (16.42%)	6,334 (16.22%)
Left Without Being Seen (with % in brackets) ³	3,549 (6.03%)	3,351 (8.34%)	3,582 (9.17%)
Total Number of Inpatient Discharges ^{4, 9}	26,218	25,913	25,719
Average LOS ^{4, 9}	6.42	5.94	6.19
Total Number of Day Surgery Cases ^{4, 9}	14,773	14,771	14,621
Percentage of Alternate Level of Care (ALC) Days ^{4, 9}	8.97%	6.84%	7.61%
ALOS: ELOS Ratio ⁴	1.05	1.05	1.07
Hospital Standardized Mortality Ratio ⁵	116	102	105
Hospital Readmission Rate Within 30 Days of Discharge ⁷	6.7%	6.7%	6.0%
Clostridium Difficile Rate (per 10,000 pt days) ⁸	3.34	4.98	4.13
MRSA Rate (per 10,000 pt days) ⁸	3.12	4.13	3.36

Concordia Hospital

Key Statistic:	2016 - 17	2015 - 16	2014 - 15
Number of Beds ¹	185	185	185
Average Occupancy ²	98.6%	96.6%	94.5%
Emergency Department Visits ³	30,515	29,608	31,805
Emergency Department Visits Admitted (with % in brackets) ³	3,568 (11.69%)	3,420 (11.55%)	3,499 (11.00%)
Left Without Being Seen (with % in brackets) ³	2,834 (9.29%)	3,311 (11.18%)	3,931 (12.36%)
Total Number of Inpatient Discharges ^{4, 9}	6,205	5,867	5,934
Average LOS ^{4, 9}	10.99	11.30	11.01
Total Number of Day Surgery Cases ^{4, 9}	4,539	4,351	4,238
Percentage of Alternate Level of Care (ALC) Days ^{4, 9}	18.05%	17.71%	19.61%
ALOS: ELOS Ratio ⁴	1.16	1.14	1.11
Hospital Standardized Mortality Ratio ⁵	97	109	105
Hospital Readmission Rate Within 30 Days of Discharge ⁷	8.3%	8.3%	7.2%
Clostridium Difficile Rate (per 10,000 pt days) ⁸	3.45	3.20	3.29
MRSA Rate (per 10,000 pt days) ⁸	4.20	3.66	4.54

Victoria General Hospital

Key Statistic:	2016 - 17	2015 - 16	2014 - 15
Number of Beds ¹	195	193	193
Average Occupancy ²	98.7%	93.9%	97.5%
Emergency Department Visits ³	32,056	31,079	31,736
Emergency Department Visits Admitted (with % in brackets) ³	3,144 (9.81%)	2,889 (9.30%)	2,819 (8.88%)
Left Without Being Seen (with % in brackets) ³	2,324 (7.25%)	2,639 (8.49%)	2,548 (8.03%)
Total Number of Inpatient Discharges ^{4, 9}	5,408	5,196	5,090
Average LOS ^{4, 9}	13.21	12.48	14.05
Total Number of Day Surgery Cases ^{4, 9}	10,772	10,473	10,035
Percentage of Alternate Level of Care (ALC) Days ^{4, 9}	20.44%	18.48%	25.41%
ALOS: ELOS Ratio ⁴	1.21	1.23	1.23
Hospital Standardized Mortality Ratio ⁵	132	158	141
Hospital Readmission Rate Within 30 Days of Discharge ⁷	6.7%	6.8%	6.6%
Clostridium Difficile Rate (per 10,000 pt days) ⁸	1.85	3.02	1.75
MRSA Rate (per 10,000 pt days) ⁸	2.71	2.57	2.04

Grace Hospital

Key Statistic:	2016 - 17	2015 - 16	2014 - 15
Number of Beds ¹	235	251	257
Average Occupancy ²	85.8%	81.5%	89.6%
Emergency Department Visits ³	30,072	27,237	25,372
Emergency Department Visits Admitted (with % in brackets) ³	3,381 (11.24%)	3,422 (12.56%)	3,334 (13.14%)
Left Without Being Seen (with % in brackets) ³	1,859 (6.18%)	1,414 (5.19%)	1,728 (6.81%)
Total Number of Inpatient Discharges ^{4, 9}	6,536	6,610	6,437
Average LOS ^{4, 9}	11.37	11.65	13.25
Total Number of Day Surgery Cases ^{4, 9}	7,185	7,187	7,372
Percentage of Alternate Level of Care (ALC) Days ^{4, 9}	17.04%	13.81%	15.10%
ALOS: ELOS Ratio ⁴	1.25	1.28	1.33
Hospital Standardized Mortality Ratio ⁵	128	141	113
Hospital Readmission Rate Within 30 Days of Discharge ⁷	6.2%	6.8%	5.9%
Clostridium Difficile Rate (per 10,000 pt days) ⁸	5.30	6.41	3.78
MRSA Rate (per 10,000 pt days) ⁸	3.80	2.40	3.07

Seven Oaks General Hospital

Key Statistic:	2016 - 17	2015 - 16	2014 - 15
Number of Beds ¹	308	308	308
Average Occupancy ²	97.0%	93.5%	93.5%
Emergency Department Visits ³	41,472	41,311	41,152
Emergency Department Visits Admitted (with % in brackets) ³	3,945 (9.51%)	3,768 (9.12%)	3,531 (8.58%)
Left Without Being Seen (with % in brackets) ³	3,019 (7.28%)	3,171 (7.68%)	3,132 (7.61%)
Total Number of Inpatient Discharges ^{4, 9}	5,721	5,535	5,376
Average LOS ^{4, 9}	15.08	14.88	14.86
Total Number of Day Surgery Cases ^{4, 9}	6,070	5,997	5,846
Percentage of Alternate Level of Care (ALC) Days ^{4, 9}	23.17%	16.37%	15.66%
ALOS: ELOS Ratio ⁴	1.20	1.22	1.27
Hospital Standardized Mortality Ratio ⁵	90	94	111
Hospital Readmission Rate Within 30 Days of Discharge ⁷	8.1%	8.0%	6.5%
Clostridium Difficile Rate (per 10,000 pt days) ⁸	2.84	2.35	2.19
MRSA Rate (per 10,000 pt days) ⁸	4.31	4.23	4.28

Churchill Health Centre

Key Statistic:	2016 - 17	2015 - 16	2014 - 15
Number of Beds ¹	27	27	28
Average Occupancy ⁶	36.1%	38.0%	36.5%
Emergency Department Visits ⁶	957 ⁽⁶⁾	1,165 ⁽⁶⁾	1,253 ⁽⁶⁾
Emergency Department Visits Admitted (with % in brackets) ⁶	56 (5.85%) ⁽⁴⁾	52 (4.46%) ⁽⁴⁾	75 (5.98%) ⁽⁴⁾
Left Without Being Seen (with % in brackets) ⁶	n/a	n/a	41 (3.27%) ⁽⁶⁾
Total Number of Inpatient Discharges ^{4, 9}	137	132	128.00
Average LOS ^{4, 9}	5.99	4.67	7.13
Total Number of Day Surgery Cases ^{4, 9}	223	439	442
Percentage of Alternate Level of Care (ALC) Days ^{4, 9}	0%	0%	0.00%
ALOS: ELOS Ratio ⁴	1.05	1.04	0.83
Hospital Standardized Mortality Ratio ⁵	51‡	43	0‡
Hospital Readmission Rate Within 30 Days of Discharge ⁷	10.0%	16.5%	10.3%
Clostridium Difficile Rate (per 10,000 pt days) ⁶	n/a	n/a	n/a
MRSA Rate (per 10,000 pt days) ⁶	n/a	n/a	n/a

1) Source: WRHA Annual Bed Map reported to Manitoba Health, Seniors and Active Living as of April 1 of the applicable fiscal year. WRHA figures include all hospitals as well as DLC, RHC, MHC and MATC. Excludes Bassinets.

2) Source: SAP. Occupancy rates: Excludes newborn days, bassinets and community hospice days and beds. All three fiscal years have been updated with data from SAP.

Churchill occupancy: Nursing unit inpatient days were used as well as the assumption that the seven long-term care Beds were at 100-per cent occupancy.

3) Source: EDIS. HSC includes both Adult and Children's Emergency visits.

4) Source: DAD DSS.

5) Source: CIHI Your Health System: Insight Tool, reflecting crude (unadjusted) rates. FY 14/15 has been updated to show complete year data. HSC data excludes Children's.

6) Source: Churchill Health Centre statistics.

7) Source: CIHI Your Health System: Insight Tool. All years have been updated to reflect crude (unadjusted) rates.

- 8) Rates provided by WRHA Regional Infection Control. Includes RHC and DLC in the WRHA total as they are included in WRHA acute care surveillance.
- 9) Includes all facility types (hospice, forensic psychiatry, pediatrics). Excludes rehab.
‡ Volume is too low to report.

French Language Services

Bilingual employees of the region provide service and support to patients, residents and their families across the region every day. The principles of active offer are respected to ensure service in French is evident and accessible. From essential patient information and educational materials, consent forms, websites and advertising to signage, donor recognition and way-finding, reflecting both official languages is essential to our region's culture and character.

Identification of French-speaking clients:

Language identification and/or preference are assured either at centralized intake, according to the program, or at direct intake at designated sites and programs. There are some known gaps in the identification of francophone clients in regional centralized services. Some are currently being worked on. Others will be reviewed in conjunction with the changes that will occur due to the region's Clinical Service Plan.

If the client presents at a designated site, they will receive service in French by a designated bilingual employee. At non-designated sites, where possible, a bilingual employee will assist. Otherwise the client can be provided with interpretation services through the region's Language Interpreter program, if required.

Identification of French-speaking employees:

Some positions within the region, including those in ACCESS Centres, community offices, regional programs such as home care, long-term care, primary care and palliative care and funded agencies are designated bilingual. Individuals in these positions wear a "Hello Bonjour" identification badge, and provide service to patients, residents and families in both official languages. Other bilingual staff members are encouraged to self-identify and use French as a personal choice if they feel capable and comfortable doing so.

Recruitment results:

Fifty-one designated bilingual positions were posted in corporate and community offices in 2015-16 – 43 permanent and eight term. Forty-one were filled with bilingual incumbents. No positions required a condition of employment. Seven of the 51 positions were filled by anglophone incumbents. Six positions required multiple postings and four term positions were unfilled. The following positions could not be filled:

- Nurse – Health Links – Info Santé;
- Health-care aide;
- Two team managers;
- Resource co-ordinator;

- Case co-ordinator;
- Public health clerk.

All linguistic testing – speaking, listening, reading and writing is done internally, and French Language Services (FLS) also occasionally provides services to other agencies.

Translation:

- All new patient and public information is regularly translated as per policy (education materials; pre- and post-op surgical information; surveys; and pamphlets, brochures, advertising and videos);
- 236 documents were translated in 2015-16 equaling 143,724 words. Since 2003, 1.9 million words have been translated, representing almost 3,000 documents;
- The majority of essential information on the main Internet site pages is bilingual; however, secondary and drill-down information is not always bilingual due to its detailed or specific nature. Translation of non-essential web materials has been put on hold until the launch of a redeveloped WRHA website;
- Individual program-specific websites (with much less content) are developed entirely French;
- FLS is promoting that the new WRHA website be developed in simple English so that the French translation of the content may follow suit.

Training:

- Two evening programs = 86 staff trained;
- Four daytime programs = 27 staff trained;
 - Themed workshop – Health-care equity;
 - Themed workshop – Mental health;
 - Cultural diversity workshop;
 - Clinical interviews workshop.

A grand total of 113 employees are formally trained across the region.

- FLS also has a comprehensive resource centre, which also includes access to the two top individual learning systems. Thirteen employees are actively pursuing language training via these programs. In addition, the FLS intranet site has links to eight credible online programs for employees of all levels to access.

Policy Implementation Highlights:

In year four of the FLS five-year strategic plan, the following activities were undertaken:

- Accès-ACCESS Saint-Boniface opened spring 2017. Centre de santé re-located to Goulet site and expanded its services;

- Project underway to improve the identification of francophone seniors at initial point of access to long-term care system;
- FLS Facebook page was developed to ensure greater sharing of WRHA and FLS activities to the francophone community and provide opportunities for dialogue. This page replaces the quarterly print newsletter, *La Voix*;
- A client satisfaction tool was developed to receive continual feedback from the public regarding the offer of service in French in our designated bilingual programs and site, and the patient experience when presenting at non-designated sites. A French print version was distributed via *La Liberté*; and the English and French online versions were promoted by various methods including social media. The tools allow FLS to identify trends of concern and to develop more immediate solutions. Data from the tool will be used to aid in the development of the 2018-21 FLS three-year plan;
- A number of employees working in highly specialized positions in non-designated sites were identified to undergo an extensive language-tutoring program. These positions include: speech language pathologist, rehab physiotherapist, occupational therapist, acquired brain injury nurse and client relations. They were also provided profession-specific lexicons developed by FLS;
- A project to enhance after-hours home care service to francophone clients was developed with the Provincial Health Contact Centre and remains ongoing;
- FLS celebrated its 15th anniversary in 2016 with a variety of activities and promotions including the launch of the Champion Award, which will be awarded every two years;
- Extensive French content was provided to support the WRHA component of the new 211 Manitoba program, a searchable online database of government, health and social services that are available across the province;
- Compliance to our new translation policy which implements user fees in a variety of situations was audited.

Collaboration:

WRHA FLS regularly collaborates with the following groups and entities:

Université de Saint-Boniface, Santé en français, Consortium national de formation en français, Centre de santé and other RHAs in the areas of program development and evaluation, employee training, translation, research, committee and project work.

Services en langue française

Chaque jour, les employés bilingues de la région fournissent des services et du soutien aux patients, aux résidents et à leurs familles dans toute la région. Les principes de l'offre active sont respectés afin d'assurer un service en français évident et accessible. Des renseignements médicaux essentiels et matériel d'éducation, des formulaires de consentement, sites Web et de la publicité aux enseignes, de la reconnaissance des donateurs à l'aiguillage, il est essentiel à la culture et au caractère de notre région de refléter les deux langues officielles.

Identification des clients de langue française :

L'identification et/ou la préférence de langue sont toutes les deux assurées soit à l'accueil centralisé, selon le programme, soit à l'accueil direct dans les établissements et programmes désignés. Il existe des lacunes en rapport avec l'identification des clients francophones dans les services régionaux centralisés. Nous travaillons pour en résoudre quelques-unes. D'autres lacunes seront révisées en conjonction avec les changements qui auront lieu en raison du Plan de services cliniques de la région.

Lorsqu'un client se présente dans un établissement désigné, il sera servi en français par un employé bilingue. Dans un établissement non désigné, un employé bilingue, le cas échéant, aidera. Autrement, le client pourra obtenir le service d'interprétation au moyen du programme de services d'interprétation de la région, s'il y a lieu.

Identification des employés de langue française :

Certains postes au sein de la région, y compris ceux dans les Centres d'accès, les bureaux communautaires, les programmes régionaux tels que les soins à domicile, les soins de longue durée, les soins primaires et les soins palliatifs, et dans les organismes subventionnés, sont désignés bilingues. Les personnes dans ces fonctions portent un insigne d'identification *Hello Bonjour* et fournissent le service aux patients, aux résidents et à leurs familles dans les deux langues officielles. Nous encourageons d'autres membres du personnel bilingues à s'identifier et à choisir le français s'ils s'en sentent capables et à l'aise.

Résultats du recrutement :

Cinquante et un postes désignés bilingues ont été affichés dans les bureaux administratifs et communautaires en 2015-2016 – 43 postes permanents et 8 postes de durée déterminée. Quarante et un des postes étaient pourvus par des titulaires bilingues. Aucun poste n'exigeait une condition d'emploi. Sept sur 51 des postes étaient pourvus par des titulaires anglophones. Six des postes ont dû être affichés plusieurs fois et quatre des postes de durée déterminée sont demeurés vacants. Les postes suivants n'ont pas été pourvus :

- Infirmière ou infirmier – Health Links – Info Santé;
- Aide en soins de santé;
- Deux gestionnaires d'équipe;
- Coordonnateur ou coordonnatrice des ressources;
- Coordonnateur ou coordonnatrice de cas;
- Commis à la santé publique.

Tous les examens linguistiques – parler, écouter, lire et écrire – sont effectués à l'interne et les Services en langue française fournissent aussi à l'occasion des services à d'autres organismes.

Traduction :

- Tous les nouveaux renseignements publics et destinés aux patients sont traduits assidument conformément à la politique (documentation éducative; information avant et après la chirurgie; sondages; brochures, dépliants, publicités et vidéos);
- 236 documents ont été traduits en 2015-2016 dont le compte de mot s'élevait à 143 724. Depuis 2003, 1,9 million de mots ont été traduits, ce qui représente presque 3 000 documents;
- La majorité des renseignements essentiels sur les pages principales du site Web sont bilingues; toutefois, les renseignements secondaires et plus détaillés ne sont pas toujours traduits en raison de leur caractère détaillé ou spécifique. La traduction de documents Web non essentiels a été suspendue jusqu'au lancement du nouveau site Web de l'ORSW;
- Les sites Web spécifiques aux programmes individuels (qui ont beaucoup moins de contenu) sont élaborés entièrement en français;
- Les SLF proposent que le nouveau site Web de l'ORSW soit élaboré dans un anglais facile afin que la traduction soit faite dans un français tout aussi facile.

Formation :

- Deux programmes en soirée = 86 membres du personnel en formation;
- Quatre programmes de jour = 27 membres du personnel en formation;
 - Atelier thématique – L'équité en matière de soins de santé;
 - Atelier thématique – La santé mentale;
 - Atelier sur la diversité culturelle;
 - Atelier sur les entrevues cliniques.

Un total de 113 membres du personnel ont fait une formation officielle dans la région.

- Les SLF ont aussi un centre de ressources complet qui comprend l'accès aux deux meilleurs systèmes d'apprentissage individuels. Treize employés poursuivent activement une formation linguistique par l'entremise de ces programmes. En outre, le site intranet des SLF offre des liens vers huit excellents programmes en ligne destinés aux employés de tous les niveaux.

Points saillants de la mise en œuvre des politiques :

Dans la quatrième année du plan stratégique quinquennal des SLF, les activités suivantes ont été réalisées :

- Accès-ACCESS Saint-Boniface a ouvert ses portes au printemps 2017. Le Centre de santé a déménagé à l'établissement rue Goulet et a élargi ses services;
- Un projet est en cours pour améliorer l'identification des personnes âgées francophones au premier point d'accès au système des soins de longue durée;
- La page Facebook des SLF a été élaborée afin d'assurer une meilleure transmission des activités à la communauté francophone et de fournir des occasions de dialogue. Cette page remplace le bulletin trimestriel imprimé, *La Voix*;
- Un outil pour mesurer la satisfaction des clients a été élaboré pour obtenir une rétroaction continue du public à l'égard de l'offre de services en français dans nos programmes et établissements désignés bilingues, ainsi que l'expérience des patients qui se présentent dans un établissement non désigné. Une version imprimée en français a été distribuée par l'entremise de *La Liberté*; et on a fait la promotion des versions en ligne en anglais et en français à l'aide de diverses méthodes, y compris les médias sociaux. Les outils permettent aux SLF d'identifier les tendances de préoccupation et d'élaborer des solutions plus immédiates. Les données des outils seront utilisées pour aider à élaborer le plan triennal des SLF 2018-2021;
- Un certain nombre d'employés qui travaillent dans des postes hautement spécialisés dans les établissements non désignés ont été identifiés pour entreprendre un programme de tutorat linguistique. Ces employés incluent : orthophoniste, physiothérapeute en réadaptation, ergothérapeute, infirmière en traumatisme cérébral acquis et relations avec la clientèle. Ces personnes ont aussi reçu des lexiques spécifiques à leur profession, élaborés par les SLF;

- Un projet continu pour améliorer les services de soins à domicile après les heures normales aux clients francophones a été élaboré en collaboration avec le Centre provincial de communication en matière de santé;
- Les SLF ont fêté leur 15^e anniversaire en 2016 au moyen de diverses activités et promotions, notamment le lancement du Prix du champion qui sera décerné à tous les deux ans;
- Un contenu plus élaboré a été fourni pour appuyer l'élément de l'ORSW du nouveau programme 211 du Manitoba, une base de données interrogable en ligne des services gouvernementaux, sociaux et de santé, disponibles partout dans la province;
- La conformité à notre nouvelle politique de traduction qui met en œuvre des frais d'utilisateur dans diverses situations a été vérifiée.

Collaboration :

Les SLF de l'ORSW collaborent régulièrement avec les groupes et organismes suivants :

Université de Saint-Boniface, Santé en français, Consortium national de formation en français, Centre de santé et d'autres ORS, dans les domaines de l'élaboration et l'évaluation des programmes, de la formation des employés, de la traduction, de la recherche, et du travail de comités et de projets.

Financials

Report of the independent auditors on the summarized consolidated financial statements.

To the directors of the WRHA,

The accompanying summarized consolidated financial statements, which comprise the summarized consolidated statement of operations and summarized consolidated statement of financial position, are derived from the audited consolidated financial statements of the WRHA for the year ended March 31, 2017. We expressed an unmodified audit opinion on those financial statements in our report dated June 27, 2017.

The summarized consolidated financial statements do not contain all the disclosures required by Canadian public sector accounting standards. Reading the summarized consolidated financial statements, therefore, is not a substitute for reading the audited consolidated financial statements of the WRHA.

Management's responsibility for the consolidated financial statements

Management is responsible for the preparation of the summarized consolidated financial statements.

Auditor's responsibility

Our responsibility is to express an opinion on the summarized consolidated financial statements based on our procedures, which were conducted in accordance with Canadian Auditing Standards (CAS) 810, "Engagements to Report on Summary Financial Statements".

Opinion

In our opinion, the summarized consolidated financial statements derived from the audited consolidated financial statements of the WRHA for the year ended March 31, 2017 are a fair summary of those consolidated financial statements.

Winnipeg, Canada
June 27, 2017

Ernst & Young LLP

Chartered Professional Accountants

Summarized Consolidated Statement of Financial Position

As at March 31 (in thousands of dollars)

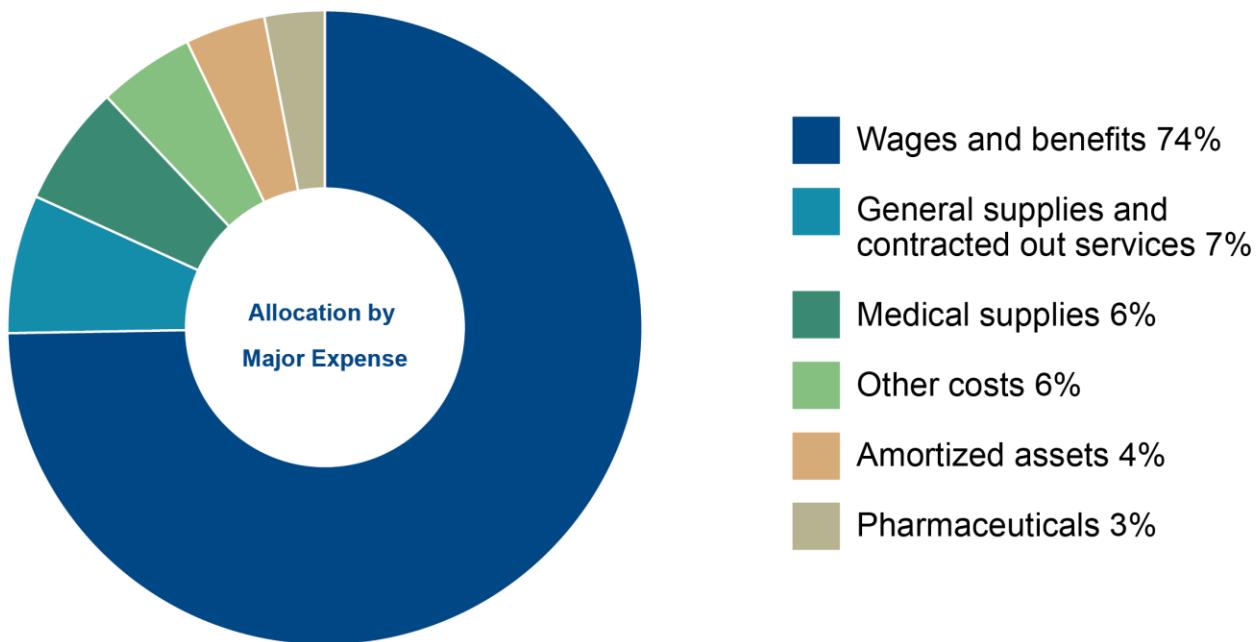
	2017	2016
ASSETS		
CURRENT		
Cash and cash equivalents	\$ 64,960	\$ 65,383
Accounts receivable	154,002	228,764
Inventory	48,549	46,509
Prepaid expenses	18,199	18,740
Investments	12,791	4,760
Employee benefits recoverable from Manitoba Health, Healthy Living and Seniors	78,957	78,957
	377,458	443,113
CAPITAL ASSETS, NET	1,788,342	1,764,454
OTHER ASSETS		
Employee future benefits recoverable from Manitoba Health, Healthy Living and Seniors	82,499	82,499
Investments	21,122	29,515
	\$ 2,269,421	\$ 2,319,581
LIABILITIES AND NET ASSETS		
CURRENT		
Bank indebtedness	\$ 119,426	\$ 127,213
Accounts payable and accrued liabilities	231,060	255,211
Deferred contributions, future expenses	41,375	56,955
Employee benefits payable	128,593	121,299
Current portion of long-term debt	31,836	33,976
	552,290	594,654
NON-CURRENT		
Long-term debt	29,259	31,542
Employee future benefits payable	220,761	225,533
Deferred contributions, capital	1,492,856	1,466,811
	1,742,876	1,723,886
NET ASSETS	(21,234)	7,319
ACCUMULATED REMEASUREMENT LOSSES	(4,511)	(6,278)
	\$ 2,269,421	\$ 2,319,581

Summarized Consolidated Statement of Operations

For the year ended March 31 (in thousands of dollars)

	2017	2016
REVENUE		
Manitoba Health, Healthy Living and Seniors operating income	\$2,791,575	\$2,722,389
Separately funded primary health programs	5,751	5,583
Patient and resident income	43,005	41,920
Recoveries from external sources	50,053	53,141
Investment income	200	2,374
Other revenue	8,453	6,807
Amortization of deferred contributions, capital	102,256	84,605
Recognition of deferred contributions, future expenses	26,156	18,917
	3,027,499	2,935,736
EXPENSES		
Direct operations	2,539,815	2,446,576
Interest	956	1,256
Amortization of capital assets	108,720	93,253
	2,649,491	2,541,085
FACILITY FUNDING		
Long-term care facility funding	310,698	310,835
Community health agency funding	51,513	47,769
Adult day care facility funding	3,013	2,954
Long-term care community therapy services	1,258	806
GRANT FUNDING		
Grants to facilities and agencies	46,598	41,745
	3,062,571	2,945,194
OPERATING DEFICIT	(35,072)	(9,458)
NON-INSURED SERVICES		
Non-insured services income	67,181	66,442
Non-insured services expenses	60,671	59,815
NON-INSURED SERVICES SURPLUS	6,510	6,627
DEFICIT FOR THE YEAR	\$ (28,562)	\$ (2,831)

Budget Allocation by Sector and Major Expense



Administrative Cost Report

The Canadian Institute of Health Information (CIHI) defines a standard set of guidelines for the classification and coding of financial and statistical information for use by all Canadian health service organizations. The WRHA adheres to these coding guidelines.

The most current definition of administrative costs determined by CIHI includes: general administration (including acute/long-term care/community administration, patient relations, community needs assessment, risk management, quality assurance and executive costs), finance, human resources, labour relations, nurse/physician recruitment and retention and communications.

The administrative cost percentage indicator (administrative costs as a percentage of total operating costs) adheres to CIHI definitions.

At the request of Manitoba Health, the presentation of administrative costs has been modified to include new categorizations in order to increase transparency in financial reporting. These categories and their inclusions are as follows:

Corporate

Includes: general administration, acute care/long-term care/community services administration, executive office, board of trustees, planning and development, community health assessment, risk management, internal audit, finance and accounting, communications, telecommunications and mail service.

Recruitment and Human Resources

Includes: personnel records, recruitment and retention (general, physicians, staff and nurses), labour relations, employee compensation and benefits management, employee health and assistance programs, occupational health and safety and provincial labour relations secretariat.

Patient Care-Related

Includes: utilization management, cancer standards and guidelines, patient relations, infection control, quality assurance (medical, nursing and other) and accreditation.

Administrative Costs and Percentages for the WRHA

(including hospitals, non-proprietary personal care homes and community health agencies)

For the year ended March 31, 2017 (in thousands of dollars)

	2017					
	Acute Care Facilities and Corporate Office		Personal Care Homes and Community Health Agencies		Total	
	\$	%	\$	%	\$	%
Corporate	\$66,128	2.39%	\$14,154	5.27%	\$80,282	2.64%
Recruitment and Human Resources	28,622	1.03%	2,250	0.84%	30,872	1.02%
Patient Care	18,042	0.65%	1	0.00%	18,043	0.60%
TOTAL	\$112,792	4.07%	\$16,405	6.11%	\$129,197	4.26%

	2016					
	Acute Care Facilities and Corporate Office		Personal Care Homes and Community Health Agencies		Total	
	\$	%	\$	%	\$	%
	(Restated)			(Restated)		
Corporate	\$62,296	2.27%	\$13,502	5.13%	\$75,798	2.52%
Recruitment and Human Resources	28,157	1.02%	2,271	0.87%	30,428	1.01%
Patient Care	18,185	0.66%	1	0.00%	18,186	0.60%
TOTAL	\$108,638	3.95%	\$15,774	6.00%	\$124,075	4.13%

The 2017 figures presented are based on preliminary data available at time of publication.

Restatements were made to the 2016 figures to reflect the final data that was submitted after the publication date.

Manitoba eHealth Operating Results
For the year ended March 31, 2017 (in thousands of dollars)

	2017	2016
REVENUE		
Manitoba Health operating income	\$ 84,043	\$ 81,297
Recoveries	13,041	11,191
	97,084	92,488
EXPENSES		
Salaries, wages and employee benefits	52,407	48,903
Data communications	2,239	2,053
License fees	8,110	7,349
Hardware and software maintenance	21,580	20,426
Buildings and ground expense	3,509	3,480
Miscellaneous and other	9,098	8,476
TOTAL EXPENSES	96,943	90,687
OPERATING SURPLUS	141	1,801
Manitoba Health operating income reduction	(141)	(1,801)
SURPLUS FOR THE YEAR	\$-	\$-

The above results are exclusive of items such as employee future benefits and the revenue and expenses related to capital assets, as these items are recorded outside of Manitoba eHealth operations.