ACCREDITATION
AGRÉMENT
CANADA
Qmentum

Accreditation Report

Southern Health-Santé Sud

Southport, MB

On-site survey dates: May 5, 2019 - May 10, 2019

Report issued: June 13, 2019

About the Accreditation Report

Southern Health-Santé Sud (referred to in this report as “the organization”) is participating in Accreditation Canada's Qmentum accreditation program. As part of this ongoing process of quality improvement, an on-site survey was conducted in May 2019. Information from the on-site survey as well as other data obtained from the organization were used to produce this Accreditation Report.

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

Confidentiality

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

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

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

A Message from Accreditation Canada

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

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

Your Program Manager or Client Services Coordinator is available if you have questions or need guidance.

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

We look forward to our continued partnership.

Sincerely,

Leslee Thompson
Chief Executive Officer

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Executive Summary

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

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

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

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

Accreditation Decision

Southern Health-Santé Sud's accreditation decision is:

Accredited (Report)

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

About the On-site Survey

- **On-site survey dates: May 5, 2019 to May 10, 2019**

- **Locations**

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

1. Altona Community Memorial Health Centre
2. Bethesda Regional Health Centre
3. Boundary Trails Health Centre
4. Boyne Valley Lodge Personal Care Home
5. Carman Memorial Hospital
6. Community Services/Services communautaires – Carman
7. Community Services/Services communautaires – Crystal City
8. Community Services/Services communautaires – Portage-la-Prairie
9. Community Services/Services communautaires – Steinbach
10. Crisis Stabilization Unit/Unité de stabilisation en cas de crise
11. Douglas Campbell Lodge
12. Eden Mental Health Centre
13. Emergency Medical Station - Carman
14. Emergency Medical Station - Southport
15. Emergency Medical Station - Steinbach
16. Heritage Life Personal Care Home
17. Hôpital Ste-Anne Hospital
18. Lions Prairie Manor
19. MacGregor Health Centre
20. Menno Home for the Aged
21. Mental Health/Santé mentale - Winkler (Pathways)
22. Midwifery - Steinbach
23. Morris General Hospital
24. Niverville Primary Health Care Centre

25. PCI Teen Clinic/Clinique pour adolescents
26. Pembina Manitou Health Centre
27. Portage District General Hospital
28. Prairie View Lodge
29. Primary Care Mobile Clinic
30. Red River Valley Lodge
31. Regional Office/Bureau régional - Southport
32. Rest Haven Nursing Home
33. Rock Lake Health District Hospital
34. Rock Lake Health District Personal Care Home
35. Salem Home Inc.
36. Tabor Home Inc.
37. Third Crossing Manor
38. Villa Youville
39. Vita & District Health Centre

- **Standards**

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

System-Wide Standards

1. Governance
2. Infection Prevention and Control Standards
3. Leadership
4. Medication Management Standards

Population-specific Standards

5. Population Health and Wellness

Service Excellence Standards

6. Ambulatory Care Services - Service Excellence Standards
7. Cancer Care - Service Excellence Standards
8. Community-Based Mental Health Services and Supports - Service Excellence Standards
9. Critical Care Services - Service Excellence Standards
10. Emergency Department - Service Excellence Standards

11. EMS and Interfacility Transport - Service Excellence Standards
12. Home Care Services - Service Excellence Standards
13. Inpatient Services - Service Excellence Standards
14. Long-Term Care Services - Service Excellence Standards
15. Mental Health Services - Service Excellence Standards
16. Obstetrics Services - Service Excellence Standards
17. Perioperative Services and Invasive Procedures - Service Excellence Standards
18. Primary Care Services - Service Excellence Standards
19. Public Health Services - Service Excellence Standards
20. Rehabilitation Services - Service Excellence Standards
21. Reprocessing of Reusable Medical Devices - Service Excellence Standards
22. Telehealth - Service Excellence Standards

- **Instruments**

  The organization administered:

  1. Governance Functioning Tool (2016)
  2. Client Experience Tool

Overview by Quality Dimensions

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

Quality Dimension	Met	Unmet	N/A	Total
 Population Focus (Work with my community to anticipate and meet our needs)	106	7	0	113
 Accessibility (Give me timely and equitable services)	135	14	2	151
 Safety (Keep me safe)	695	65	18	778
 Worklife (Take care of those who take care of me)	183	22	1	206
 Client-centred Services (Partner with me and my family in our care)	583	28	3	614
 Continuity (Coordinate my care across the continuum)	146	0	0	146
 Appropriateness (Do the right thing to achieve the best results)	998	111	25	1134
 Efficiency (Make the best use of resources)	84	1	1	86
Total	**2930**	**248**	**50**	**3228**

Overview by Standards

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

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

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

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

Standards Set	High Priority Criteria *			Other Criteria			Total Criteria (High Priority + Other)		
	Met	Unmet	N/A	Met	Unmet	N/A	Met	Unmet	N/A
	# (%)	# (%)	#	# (%)	# (%)	#	# (%)	# (%)	#
Governance	42 (93.3%)	3 (6.7%)	5	35 (97.2%)	1 (2.8%)	0	77 (95.1%)	4 (4.9%)	5
Leadership	50 (100.0%)	0 (0.0%)	0	92 (95.8%)	4 (4.2%)	0	142 (97.3%)	4 (2.7%)	0
Infection Prevention and Control Standards	38 (95.0%)	2 (5.0%)	0	29 (93.5%)	2 (6.5%)	0	67 (94.4%)	4 (5.6%)	0
Medication Management Standards	63 (80.8%)	15 (19.2%)	0	53 (86.9%)	8 (13.1%)	3	116 (83.5%)	23 (16.5%)	3
Population Health and Wellness	4 (100.0%)	0 (0.0%)	0	35 (100.0%)	0 (0.0%)	0	39 (100.0%)	0 (0.0%)	0
Ambulatory Care Services	44 (97.8%)	1 (2.2%)	2	78 (100.0%)	0 (0.0%)	0	122 (99.2%)	1 (0.8%)	2
Cancer Care	75 (96.2%)	3 (3.8%)	3	110 (97.3%)	3 (2.7%)	1	185 (96.9%)	6 (3.1%)	4
Community-Based Mental Health Services and Supports	44 (97.8%)	1 (2.2%)	0	89 (94.7%)	5 (5.3%)	0	133 (95.7%)	6 (4.3%)	0

Standards Set	High Priority Criteria *			Other Criteria			Total Criteria (High Priority + Other)		
	Met	Unmet	N/A	Met	Unmet	N/A	Met	Unmet	N/A
	# (%)	# (%)	#	# (%)	# (%)	#	# (%)	# (%)	#
Critical Care Services	55 (94.8%)	3 (5.2%)	2	97 (94.2%)	6 (5.8%)	2	152 (94.4%)	9 (5.6%)	4
Emergency Department	59 (81.9%)	13 (18.1%)	0	96 (89.7%)	11 (10.3%)	0	155 (86.6%)	24 (13.4%)	0
EMS and Interfacility Transport	97 (88.2%)	13 (11.8%)	4	99 (89.2%)	12 (10.8%)	9	196 (88.7%)	25 (11.3%)	13
Home Care Services	48 (100.0%)	0 (0.0%)	0	75 (100.0%)	0 (0.0%)	0	123 (100.0%)	0 (0.0%)	0
Inpatient Services	50 (84.7%)	9 (15.3%)	1	80 (95.2%)	4 (4.8%)	1	130 (90.9%)	13 (9.1%)	2
Long-Term Care Services	50 (90.9%)	5 (9.1%)	1	97 (98.0%)	2 (2.0%)	0	147 (95.5%)	7 (4.5%)	1
Mental Health Services	50 (100.0%)	0 (0.0%)	0	88 (95.7%)	4 (4.3%)	0	138 (97.2%)	4 (2.8%)	0
Obstetrics Services	63 (88.7%)	8 (11.3%)	2	78 (89.7%)	9 (10.3%)	1	141 (89.2%)	17 (10.8%)	3
Perioperative Services and Invasive Procedures	104 (91.2%)	10 (8.8%)	1	105 (97.2%)	3 (2.8%)	1	209 (94.1%)	13 (5.9%)	2
Primary Care Services	48 (81.4%)	11 (18.6%)	0	77 (85.6%)	13 (14.4%)	1	125 (83.9%)	24 (16.1%)	1
Public Health Services	40 (85.1%)	7 (14.9%)	0	60 (90.9%)	6 (9.1%)	3	100 (88.5%)	13 (11.5%)	3
Rehabilitation Services	45 (100.0%)	0 (0.0%)	0	78 (97.5%)	2 (2.5%)	0	123 (98.4%)	2 (1.6%)	0
Reprocessing of Reusable Medical Devices	79 (94.0%)	5 (6.0%)	4	31 (77.5%)	9 (22.5%)	0	110 (88.7%)	14 (11.3%)	4
Telehealth	39 (75.0%)	13 (25.0%)	0	80 (90.9%)	8 (9.1%)	1	119 (85.0%)	21 (15.0%)	1
Total	**1187 (90.7%)**	122 (9.3%)	25	1662 (93.7%)	112 (6.3%)	23	2849 (92.4%)	234 (7.6%)	48

* Does not includes ROP (Required Organizational Practices)

Overview by Required Organizational Practices

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

This table shows the ratings of the applicable ROPs.

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Safety Culture			
Accountability for Quality (Governance)	Met	4 of 4	2 of 2
Patient safety incident disclosure (Leadership)	Met	4 of 4	2 of 2
Patient safety incident management (Leadership)	Met	6 of 6	1 of 1
Patient safety quarterly reports (Leadership)	Met	1 of 1	2 of 2
Patient Safety Goal Area: Communication			
Client Identification (Ambulatory Care Services)	Met	1 of 1	0 of 0
Client Identification (Cancer Care)	Met	1 of 1	0 of 0
Client Identification (Critical Care Services)	Unmet	0 of 1	0 of 0
Client Identification (Emergency Department)	Met	1 of 1	0 of 0
Client Identification (EMS and Interfacility Transport)	Met	1 of 1	0 of 0

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Communication			
Client Identification (Home Care Services)	Met	1 of 1	0 of 0
Client Identification (Inpatient Services)	Unmet	0 of 1	0 of 0
Client Identification (Long-Term Care Services)	Met	1 of 1	0 of 0
Client Identification (Mental Health Services)	Unmet	0 of 1	0 of 0
Client Identification (Obstetrics Services)	Met	1 of 1	0 of 0
Client Identification (Perioperative Services and Invasive Procedures)	Met	1 of 1	0 of 0
Client Identification (Rehabilitation Services)	Met	1 of 1	0 of 0
Information transfer at care transitions (Ambulatory Care Services)	Met	4 of 4	1 of 1
Information transfer at care transitions (Cancer Care)	Met	4 of 4	1 of 1
Information transfer at care transitions (Community-Based Mental Health Services and Supports)	Met	4 of 4	1 of 1
Information transfer at care transitions (Critical Care Services)	Met	4 of 4	1 of 1
Information transfer at care transitions (Emergency Department)	Met	4 of 4	1 of 1

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Communication			
Information transfer at care transitions (EMS and Interfacility Transport)	Met	4 of 4	1 of 1
Information transfer at care transitions (Home Care Services)	Met	4 of 4	1 of 1
Information transfer at care transitions (Inpatient Services)	Met	4 of 4	1 of 1
Information transfer at care transitions (Long-Term Care Services)	Met	4 of 4	1 of 1
Information transfer at care transitions (Mental Health Services)	Met	4 of 4	1 of 1
Information transfer at care transitions (Obstetrics Services)	Met	4 of 4	1 of 1
Information transfer at care transitions (Perioperative Services and Invasive Procedures)	Met	4 of 4	1 of 1
Information transfer at care transitions (Rehabilitation Services)	Met	4 of 4	1 of 1
Medication reconciliation as a strategic priority (Leadership)	Met	3 of 3	2 of 2
Medication reconciliation at care transitions (Ambulatory Care Services)	Met	5 of 5	0 of 0
Medication reconciliation at care transitions (Cancer Care)	Met	5 of 5	0 of 0

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Communication			
Medication reconciliation at care transitions (Community-Based Mental Health Services and Supports)	Met	3 of 3	1 of 1
Medication reconciliation at care transitions (Critical Care Services)	Met	4 of 4	0 of 0
Medication reconciliation at care transitions (Emergency Department)	Met	1 of 1	0 of 0
Medication reconciliation at care transitions (Home Care Services)	Met	3 of 3	1 of 1
Medication reconciliation at care transitions (Inpatient Services)	Met	4 of 4	0 of 0
Medication reconciliation at care transitions (Long-Term Care Services)	Met	4 of 4	0 of 0
Medication reconciliation at care transitions (Mental Health Services)	Met	4 of 4	0 of 0
Medication reconciliation at care transitions (Obstetrics Services)	Unmet	3 of 4	0 of 0
Medication reconciliation at care transitions (Perioperative Services and Invasive Procedures)	Met	4 of 4	0 of 0

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Communication			
Medication reconciliation at care transitions (Rehabilitation Services)	Met	4 of 4	0 of 0
Safe Surgery Checklist (Obstetrics Services)	Met	3 of 3	2 of 2
Safe Surgery Checklist (Perioperative Services and Invasive Procedures)	Met	3 of 3	2 of 2
The “Do Not Use” list of abbreviations (Medication Management Standards)	Unmet	3 of 4	2 of 3
Patient Safety Goal Area: Medication Use			
Antimicrobial Stewardship (Medication Management Standards)	Met	4 of 4	1 of 1
Concentrated Electrolytes (Medication Management Standards)	Met	3 of 3	0 of 0
Heparin Safety (Medication Management Standards)	Unmet	2 of 4	0 of 0
High-Alert Medications (EMS and Interfacility Transport)	Met	5 of 5	3 of 3
High-Alert Medications (Medication Management Standards)	Unmet	5 of 5	2 of 3
Infusion Pumps Training (Ambulatory Care Services)	Met	4 of 4	2 of 2
Infusion Pumps Training (Cancer Care)	Met	4 of 4	2 of 2
Infusion Pumps Training (Critical Care Services)	Met	4 of 4	2 of 2

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Medication Use			
Infusion Pumps Training (Emergency Department)	Met	4 of 4	2 of 2
Infusion Pumps Training (EMS and Interfacility Transport)	Met	4 of 4	2 of 2
Infusion Pumps Training (Inpatient Services)	Met	4 of 4	2 of 2
Infusion Pumps Training (Obstetrics Services)	Met	4 of 4	2 of 2
Infusion Pumps Training (Perioperative Services and Invasive Procedures)	Met	4 of 4	2 of 2
Infusion Pumps Training (Rehabilitation Services)	Met	4 of 4	2 of 2
Narcotics Safety (EMS and Interfacility Transport)	Met	3 of 3	0 of 0
Narcotics Safety (Medication Management Standards)	Unmet	2 of 3	0 of 0
Patient Safety Goal Area: Worklife/Workforce			
Client Flow (Leadership)	Met	7 of 7	1 of 1
Patient safety plan (Leadership)	Met	2 of 2	2 of 2
Patient safety: education and training (Leadership)	Met	1 of 1	0 of 0
Preventive Maintenance Program (Leadership)	Met	3 of 3	1 of 1

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Worklife/Workforce			
Workplace Violence Prevention (Leadership)	Met	5 of 5	3 of 3
Patient Safety Goal Area: Infection Control			
Hand-Hygiene Compliance (EMS and Interfacility Transport)	Met	1 of 1	2 of 2
Hand-Hygiene Compliance (Infection Prevention and Control Standards)	Met	1 of 1	2 of 2
Hand-Hygiene Education and Training (EMS and Interfacility Transport)	Met	1 of 1	0 of 0
Hand-Hygiene Education and Training (Infection Prevention and Control Standards)	Met	1 of 1	0 of 0
Infection Rates (Infection Prevention and Control Standards)	Met	1 of 1	2 of 2
Reprocessing (EMS and Interfacility Transport)	Met	1 of 1	1 of 1
Patient Safety Goal Area: Risk Assessment			
Falls Prevention Strategy (Cancer Care)	Met	2 of 2	1 of 1
Falls Prevention Strategy (Critical Care Services)	Met	2 of 2	1 of 1
Falls Prevention Strategy (Inpatient Services)	Met	2 of 2	1 of 1
Falls Prevention Strategy (Long-Term Care Services)	Met	5 of 5	1 of 1

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Risk Assessment			
Falls Prevention Strategy (Mental Health Services)	Met	2 of 2	1 of 1
Falls Prevention Strategy (Obstetrics Services)	Met	2 of 2	1 of 1
Falls Prevention Strategy (Perioperative Services and Invasive Procedures)	Met	2 of 2	1 of 1
Falls Prevention Strategy (Rehabilitation Services)	Met	2 of 2	1 of 1
Home Safety Risk Assessment (Home Care Services)	Met	3 of 3	2 of 2
Pressure Ulcer Prevention (Critical Care Services)	Met	3 of 3	2 of 2
Pressure Ulcer Prevention (Inpatient Services)	Unmet	2 of 3	2 of 2
Pressure Ulcer Prevention (Long-Term Care Services)	Met	3 of 3	2 of 2
Pressure Ulcer Prevention (Perioperative Services and Invasive Procedures)	Unmet	2 of 3	2 of 2
Pressure Ulcer Prevention (Rehabilitation Services)	Met	3 of 3	2 of 2
Skin and Wound Care (Home Care Services)	Met	7 of 7	1 of 1
Suicide Prevention (Community-Based Mental Health Services and Supports)	Met	5 of 5	0 of 0

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Risk Assessment			
Suicide Prevention (Emergency Department)	Unmet	2 of 5	0 of 0
Suicide Prevention (Long-Term Care Services)	Unmet	0 of 5	0 of 0
Suicide Prevention (Mental Health Services)	Met	5 of 5	0 of 0
Venous Thromboembolism Prophylaxis (Cancer Care)	Met	3 of 3	2 of 2
Venous Thromboembolism Prophylaxis (Critical Care Services)	Met	3 of 3	2 of 2
Venous Thromboembolism Prophylaxis (Inpatient Services)	Unmet	2 of 3	1 of 2
Venous Thromboembolism Prophylaxis (Perioperative Services and Invasive Procedures)	Unmet	2 of 3	1 of 2

Summary of Surveyor Team Observations

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

The dedicated staff of Southern Health-Santé Sud and its affiliates are proud of the services they provide to their clients and communities. Services are focused on patients and clients. Staff are engaged and knowledgeable. The board's Compass provides a strong visual picture of Southern Health-Santé Sud's vision, mission, values, and strategic directions.

The staff and leadership of Southern Health-Santé Sud have experienced significant change over a relatively short period of time. The board and the leaders are encouraged to closely monitor the impact of the uncertainty about future changes. Human resources has identified tools and resources to help people manage the changes they are or will be experiencing. It is important to monitor the effectiveness of these measures and the actions being taken to support managers, leaders, staff, and the communities. Southern Health-Santé Sud is encouraged to draw on its success in managing change, such as the recent transfer of emergency medical services (EMS) to Shared Health. In addition, a number of leaders who are new to their roles will need support to help them and their teams succeed.

During the on-site survey, numerous occasions were observed where non-nursing tasks distracted from bedside care. For example, nursing time is spent cleaning beds. While this is a critical infection prevention and control (IPAC) activity, there may be others who could do it, thus releasing the nurse to provide care. Southern Health-Santé Sud is encouraged to consider how it might release health care professional time so they can focus on care.

A strategic approach to electronic record systems and documentation to support front-line care is needed. The organization is encouraged to explore potential opportunities in the existing systems. For example, it may be possible to autopopulate certain fields, such as the site where a client is receiving service. One form has 25 fields that the admitting person has to complete and many of these fields could be autopopulated.

Southern Health-Santé Sud is encouraged to draw on its successes and challenges to influence Shared Health to incorporate a client and family perspective.

Since the 2015 on-site survey, there has been significant improvement in a number of areas. Compliance with many Required Organizational Practices (ROPs) has improved, including prevention of skin breakdown and wounds, safe use of infusion pumps, and prevention of falls. Practices have been further standardized in the region. There is a strong preventive maintenance program. EMS was successfully transitioned from Southern Health-Santé Sud to Shared Health. Southern Health-Santé Sud has been recognized nationally for its approach and innovative practices to engage with Indigenous communities about health and access to health services. There is continued progress and improvement with regard to meeting the organization's mandate as a bilingual health organization to offer French language health services. There have been improvements in access to primary care and other health services, thus reducing wait times.

There are some ROPs where progress has not been made or has been made inconsistently. These include suicide prevention in some service areas and confirming the identity of the client before providing a service such as medication in other areas. Of particular concern is that some of the unmet ROPs were identified in the last two on-site surveys and the actions taken by Southern Health-Santé Sud to comply appear not to have been sustained.

There has been significant improvement in the areas of falls and pressure ulcers. Staff have a better understanding of the impact that a fall or a skin breakdown resulting in a skin ulcer can have on a client. Southern Health-Santé Sud has made a significant investment in lifts and related ergonomic equipment and this has benefited clients and staff, allowing for safe lifting and movement. The system to report adverse occurrences is used by health care staff and the board and leadership have successfully promoted a just culture. Examples were provided of prospective action being taken through a failure mode and effects analysis (FMEA) in some services to identify potential risks and remove or reduce them before an event or injury occurred. It is suggested that the FMEA approach be significantly increased, along with the associated process and structural supports and investments.

The organization has a strong commitment to emergency and disaster preparedness. This is an area that has benefited significantly from standardization across Southern Health-Santé Sud. The harm reduction activities that are being supported through public health in communities served by Southern Health-Santé Sud have been important preventive measures to reduce deaths and infections. The organization is encouraged to review how wait lists are managed to ensure that clients become a higher priority when their condition deteriorates.

The direct care and service provided by staff is very client and family oriented. Staff are open to learning from others, such as providing reminders to patients who are scheduled for surgery to reduce missed surgeries, assistance with transportation, and the use of navigators or advisors to improve access to services.

Some noteworthy Southern Health-Santé Sud services that can be seen as exemplars in client- and family-centred care include cancer services, select long-term care sites, community mental health, and home care. These services can be important internal resources to Southern Health-Santé Sud as it continues to pursue its commitment to client- and family-centred care. Its commitment to fulfilling its mandate as a bilingual health organization and offering French language services is another example.

Southern Health-Santé Sud is still in the early stages of incorporating client- and family-centred care in areas other than at the direct, individual service level. There is no meaningful direct participation or input with regard to committees or planning, with the exception of some specific issues such as critical incidents. The organization is encouraged to further formalize its commitment to incorporating client- and family-centred care into its operations. Accreditation Canada provides access to a number of resources to assist with this journey.

Southern Health-Santé Sud has developed a quality improvement framework and approach that is strongly linked to and supportive of the vision, mission, values, and strategic directions. Quality and risk management has been incorporated into the action plans of each service and support area. There is a commitment to

has been incorporated into the action plans of each service and support area. There is a commitment to providing quality improvement training and LEAN training and LEAN has been successfully applied. However, there is a lack of capacity, knowledge, and support at the unit or program levels, and limited awareness of the quality framework. Improvements are more informal. There is a need to make the connection between the quality management framework and what happens at the front-line service delivery level. Resources to support this connection are being rolled out, such as a video that shows how staff's day-to-day work is linked to and supports achievement of the strategic directions. Additional work is required to address the gaps at the front-line level.

Southern Health-Santé Sud has standardized its approach to risk management across the region. Since the last on-site survey, it has adopted the Healthcare Insurance Reciprocal of Canada (HIROC) framework and is using HIROC's electronic system. This allows for more efficient capture and recording of risks as well as comparison with other health care organizations across Canada. The information is incorporated into service planning and resource allocation decisions. Southern Health-Santé Sud has an effective system for incident reporting and review including regular reporting to the board. There is a culture of safety for clients, staff, and visitors, with an effective violence prevention program.

Significant areas of risk for Southern Health-Santé Sud are some physical structures that are no longer adequate due to aging infrastructure and changing requirements for safe client care.

Southern Health-Santé Sud's ethics framework is well developed and supported by a dedicated committee that includes representation from affiliates. In areas such as mental health, long-term care, EMS, emergency department (ED), and home care, staff have incorporated the framework into their day-to-day practice. However, there are other areas where staff do not understand how the framework could or should be applied.

The Ethics Committee is concerned over the future of the ethics framework under Shared Health.

The openness of Southern Health-Santé Sud and its affiliates at all levels (board, leadership, managers, front-line staff, support staff, physicians, and especially clients and families) during the on-site survey is appreciated.

Detailed Required Organizational Practices

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

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

Unmet Required Organizational Practice	Standards Set
Patient Safety Goal Area: Communication	
Client Identification Working in partnership with clients and families, at least two person-specific identifiers are used to confirm that clients receive the service or procedure intended for them.	· Inpatient Services 10.2 · Critical Care Services 9.4 · Mental Health Services 9.5
The Do Not Use list of abbreviations A list of abbreviations, symbols, and dose designations that are not to be used have been identified and implemented.	· Medication Management Standards 14.6
Medication reconciliation at care transitions Medication reconciliation is conducted in partnership with clients and families to communicate accurate and complete information about medications across care transitions.	· Obstetrics Services 8.5
Patient Safety Goal Area: Medication Use	
Heparin Safety The availability of heparin products is evaluated and limited to ensure that formats with the potential to cause patient safety incidents are not stocked in client service areas.	· Medication Management Standards 9.3
Narcotics Safety The availability of narcotic products is evaluated and limited to ensure that formats with the potential to cause patient safety incidents are not stocked in client service areas.	· Medication Management Standards 9.4
High-Alert Medications A documented and coordinated approach to safely manage high-alert medications is implemented.	· Medication Management Standards 2.5

Unmet Required Organizational Practice	Standards Set
Patient Safety Goal Area: Risk Assessment	
Pressure Ulcer Prevention Each client's risk for developing a pressure ulcer is assessed and interventions to prevent pressure ulcers are implemented.NOTE: This ROP does not apply for outpatient settings, including day surgery, given the lack of validated risk assessment tools for outpatient settings.	· Perioperative Services and Invasive Procedures 11.10 · Inpatient Services 9.9
Suicide Prevention Clients are assessed and monitored for risk of suicide.	· Emergency Department 10.7 · Long-Term Care Services 8.9
Venous Thromboembolism Prophylaxis Medical and surgical clients at risk of venous thromboembolism (deep vein thrombosis and pulmonary embolism) are identified and provided with appropriate thromboprophylaxis.NOTE: This ROP does not apply for pediatric hospitals; it only applies to clients 18 years of age or older. This ROP does not apply to day procedures or procedures with only an overnight stay.	· Perioperative Services and Invasive Procedures 11.12 · Inpatient Services 9.10

Detailed On-site Survey Results

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

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

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

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

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

See Appendix B for a list of priority processes.

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

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

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

Priority Process Results for System-wide Standards

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

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

Priority Process: Governance

Meeting the demands for excellence in governance practice.

Unmet Criteria		High Priority Criteria
Standards Set: Governance		
2.8	Each member of the governing body signs a statement acknowledging his or her role and responsibilities, including expectations of the position and legal duties.	!
2.11	The governing body's renewal cycle supports the addition of new members while maintaining a balance of experienced members to support the continuity of corporate memory and decision-making.	!
13.7	The governing body regularly reviews the contribution of individual members and provides feedback to them.	!

Surveyor comments on the priority process(es)

The Southern Health-Santé Sud board has a clear vision and mission that was developed collaboratively. The board's commitment to a positive environment for clients and staff is reflected in its practice of using a Sacred Moment as an opportunity for reflection at the start of all its meetings.

The Southern Health-Santé Sud regional board is appointed by the minister of health from individuals who apply for positions on the board. The board member application form, available on the website, outlines the expectations and responsibilities of board members. Interested individuals can reapply annually. Terms are for three years with an opportunity for reappointment. Transitions in membership are effectively managed.

The board identifies desired skill sets for new members and the chair provides these recommendations to the Minister of Health. The board chair is appointed by the minister. Board members actively seek out individuals who could contribute important perspectives to the board and its governance role and they encourage those individuals to apply. The board believes that Manitoba Health, Seniors and Active Living could improve its process for acknowledging applications of interest.

New board members receive a comprehensive orientation and are assigned a buddy. They also have access to courses offered through the Crown Secretariat to help them function effectively.

The board uses the Governance Functioning Tool to evaluate its performance and has identified a need to improve its processes to provide effective and meaningful feedback to individual board members.

The governance model is based on the Carver governance model. The board has established several committees, three of which function as committees of the whole.

Board Ends are healthy people and healthy environment; accessible health services; safe, people-centred, quality health care; and sustainable, accountable, and responsive health organization.

Southern Health-Santé Sud has made effective use of the community needs assessment to establish its priorities. The board receives updates from the regional medical officer of health on population health issues, with the most recent information focusing on health equity.

The board has a governance dashboard that is used to track organizational performance in relation to the board Ends and strategic directions. It provides a mechanism for the board to receive reports from the senior leadership team on Southern Health-Santé Sud's action plans in support of the strategic directions and the board's ends. The board receives updated reports on strategic, operational, and compliance risks that have been identified. Recently Southern Health-Santé Sud has adopted the Provincial Risk Management Framework and utilizes Healthcare Insurance Reciprocal of Canada's electronic system to capture the risk.

Client safety and quality is an identified priority for the board and there is a commitment to focusing a significant amount of time at each board meeting for purposeful discussion about it.

Southern Health-Santé Sud is committed to client and community engagement.

The Blurring the Lines project has helped develop a shared vision for improved health and health care experiences for First Nations people. The success of the initiative has seen it move from being a project to being incorporated into ongoing operations across the region, supported through its Indigenous-focused program. Discussions about expanding the initiative to include the Métis are underway. Southern Health-Santé Sud also has human resources initiatives to increase the number of Indigenous health care staff.

The board is committed to ensuring that Southern Health-Santé Sud fulfills its responsibilities as a bilingual health services organization, so clients can access French Language services if they choose. It has engaged effectively with French Language organizations at the local and provincial levels.

The board uses the Southern Health-Santé Sud ethics framework. The board works to "think strategically, lead ethically."

As part of the on-site survey and at the request of Southern Health-Santé Sud, a review of the nine affiliate and community-owned not for profit boards of directors was conducted at Eden Mental Health Centre, Heritage Life Personal Care Home, Menno Home for the Aged, Prairie View Lodge, Rest Haven Nursing Home, Rock Lake Health District Personal Care Home, Salem Home Inc., Tabor Home Inc., and Villa Youville. In general, all of the personal care homes' boards of directors provide good governance. Their practices follow policies and bylaws and the board members are passionate about ensuring high-quality, safe care for the residents and clients of Southern Health-Santé Sud.

The Eden Mental Health Care Centre is a faith-based organization that is governed by a very competent and passionate board. The board has a good relationship with the new CEO and program director. While very committed to those they serve, the board structure itself is large and complex, and the board may wish to re-visit this structure with a view to making the board smaller. As well, the board might consider instituting an annual peer board assessment as well as peer self-evaluations that could follow each meeting.

The Heritage Life Personal Care Home is a unique organization. It is a part of the community of Niverville, through a trust relationship, and the Niverville Heritage Holdings Inc. as the parent corporation. The board applied the Southern Health-Santé Sud ethics framework to a recent situation and each member of the board has a good working knowledge of the framework. When the board identified a gap as a result of its skills assessment, there was a positive response and new members were supported to join. There is a well-rounded, seven-person board with an external, arms-length Nomination Committee that appoints board members. The board has clear priorities for gender and age balance.

Priority Process: Planning and Service Design

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

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

Southern Health-Santé Sud's approach to planning and service design effectively links key components such as the community health needs assessment, identified organizational and strategic risks, and the mission, values, and strategic directions to set directions for organizational planning and service design. A missing component is a more formal approach to including the client and community perspective.

Southern Health-Santé Sud has effectively used its community health needs assessment from 2015 and a regional health equity assessment that the decision support team completed in 2018 in its strategic and action plans. Planning is underway for the 2019 community health needs assessment.

Under the "healthy people and healthy environment" board end, health equity and health promotion and community engagement and partnerships are identified as strategic directions. The decision support team has produced one-page overviews of the community health needs assessment and the population statistics, so they are accessible and can be shared widely.

Southern Health-Santé Sud uses the HIROC integrated risk management electronic platform to help compile risks. Nine risks have been identified: six operational, two strategic, and one financial. Observations during the on-site survey validated the operational risks and risk mitigation strategies have been identified. The leadership team reports regularly to the board on the risks.

Priority Process: Resource Management

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

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

Southern Health-Santé Sud's resource allocation process is linked to its strategic directions. Annual operational plans are developed based on a series of assumptions that in recent years have included no growth other than for uncontrolled external expenses such as Canada Pension Plan increases, inflation, and contractual commitments. This reflects the tension between the strategic direction of accessible health services and being a sustainable, accountable, and responsive health organization, and has created challenges for Southern Health-Santé Sud in addressing its operational risks and service needs.

There are established processes to identify and prioritize capital equipment requests.

Each Senior Leader is supported by a budget analyst and there is a commitment to have the budget analyst develop an understanding of the clinical operations being supported. There is limited ability for leaders to manage within their assigned budgets and areas of responsibility before requiring the support of other senior leaders for the shift.

There are no recommendations from the organization's auditor.

Priority Process: Human Capital

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

Unmet Criteria		High Priority Criteria
Standards Set: Leadership		
2.10	An immunization policy and associated procedures, which include recommending specific immunizations for team members, are developed.	
10.14	Human resource records are maintained for all team members.	

Surveyor comments on the priority process(es)

Southern Health-Santé Sud has a dedicated group of human resource professionals who are located across the region in a decentralized model of service delivery. Human resources is identified as a strategic risk for Southern Health-Santé Sud due to the large number of staff who are eligible or will become eligible for retirement in the next five years. The human resource plan and associated action plan identify a number of actions to which the organization has committed to address the risk.

An additional challenge facing the human resources team is the impact of Shared Health. Human resource leaders from Southern Health-Santé Sud have been seconded to provincial working groups to support the development of Shared Health and the work on provincial policies. This allows Southern Health-Santé Sud to share its successes from earlier integration activities as a region and promote a provincial standard, but this work has a significant impact on the availability of staff to undertake initiatives at the regional level. Of particular concern is the impact it may have on Southern Health-Santé Sud senior leadership's ability to support change management in the region. The perception of staff across the region is that senior leadership have not been visible recently.

Human resources staff play a key role in supporting and working with the senior and regional leadership teams to provide a safe and supportive environment that includes change management.

Many staff indicate that they have not had a performance appraisal or a performance conversation for a number of years. The organization is encouraged to monitor this to see if there is an improvement with the use of the performance conversation approach.

Southern Health-Santé Sud complies with the provincial Manitoba Health, Seniors and Active Living policy #HCS 215.5 on a violence prevention program for health care workers in Manitoba and the related operational procedures. Education and training is provided to staff.

and retention strategy. It has established a partnership with Red River College to offer a leadership development course for staff, to grow and develop future leaders. Individuals, whose professional development have a return in service agreement.

Southern Health-Santé Sud has an innovative approach to increasing the number of Indigenous health care workers. It is expanding a successful program that supported Indigenous high school students to consider a career in health care to create a program that is focused on young Indigenous adults.

A review of human resources records and discussions with human resources and IPAC leaders and the regional medical officer of health identify a significant client and staff risk that is not being addressed in either the human resources or the IPAC action plans. Southern Health-Santé Sud does not collect staff vaccination history, and it has discontinued any reference to vaccination on the checklist of documentation that staff need to provide. The importance of vaccination and that staff may wish to provide their vaccination history are mentioned briefly at the IPAC orientation. Not tracking staff and physician vaccination history is inconsistent with standards of practice in other health care organizations. It creates a significant risk of infection for clients from an unvaccinated health care worker and creates a risk for the health care worker who is exposed. There can be significant disruption to service and client safety when unvaccinated health care workers need to be excluded from work after exposure. Southern Health-Santé Sud is strongly encouraged to work with Shared Health and Manitoba Health, Seniors and Active Living to address this risk. There is also a disconnect between Southern Health-Santé Sud's practice and that of organizations that train health care workers and require them to be vaccinated to enter the program.

Two identified issues are workload for non-union administrative and management staff and compression of compensation.

Non-monetary strategies are used to support individuals who are moving to manager positions through a mentoring program.

Southern Health-Santé Sud continues to increase the number of health care workers who are able to offer French language services to clients who request such service.

Priority Process: Integrated Quality Management

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

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

Southern Health-Santé Sud's strong commitment to quality improvement and client safety extends from the board through to the senior leadership team in the development of team action plans. A corporate risk assessment informs the development of action plans using the HIROC tool. The action plans have measurable objectives and clearly identify accountable individuals. This provides Southern Health-Santé Sud with a strong framework on which to build its quality improvement activities. However, there is a gap between the overarching framework and action plans and the quality improvement activities that may be occurring at the front lines. While there is an awareness of the action plans, there is not always a clear link to the work that is occurring at the unit or service levels. Work at the unit levels seems to be more ad hoc or reactive and is usually not linked to indicator measurement. Southern Health-Santé Sud is encouraged to establish and strengthen the links between the quality improvement framework, the action plans, and the quality improvement activities at the unit levels. There is also a need to build capacity for quality improvement activities at the service levels.

Southern Health-Santé Sud has worked with HIROC to adopt its electronic tool to replace the manual development of the risk assessment. This includes migration of data to provide comparison data.

Southern Health-Santé Sud is providing LEAN Yellow Belt training to build staff/leaders knowledge and experience with leading small-scale quality improvment intiatives. A comprehensive FMEA guideline has been developed and utilized at some sites and led by the Quality, Patient Safety and Risk portfolio. Examples of FMEA undertaken include, but are not limited to, obstetrical triage and emergency department patient flow. It is suggested that the use of FMEA could be significantly increased, although additional resources would be required to support this wider use.

Priority Process: Principle-based Care and Decision Making

Identifying and making decisions about ethical dilemmas and problems.

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

A dedicated Ethics Committee provides guidance for the Southern Health-Santé Sud ethics framework. The ethics framework is used in front-line service delivery as well as in planning and resource allocation decisions.

While some staff have embraced the ethics framework in their day-to-day activities, others appear to have little awareness of the framework and its importance to their work and the clients. Southern Health-Santé Sud is encouraged to spread the learnings from sites and staff who are using the ethics framework in day-to-day care across the region. It might also share these successes with Shared Health to help inform the development of the current provincial ethics framework.

Priority Process: Communication

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

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

Southern Health-Santé Sud's communication plan is based on its core values of respect, compassion, integrity, and excellence and clearly identifies the purpose and objectives it intends to achieve in communicating the organization's vision, mission, and strategic directions. The emphasis is on how Southern Health-Santé Sud will communicate with its internal and external stakeholders rather than the message, emphasizing that "how you say it is more important than what you say."

The principles underlying the communications plan are:

• Communicating and engaging with integrity

• Communicating and engaging with compassion

• Communicating and engaging with excellence

• Communicating and engaging with respect

The plan describes the behaviours and actions that reflect and support these principles.

A straightforward and powerful approach that is used is the concept of the "family portrait." This clusters together five key visuals that communicate who Southern Health-Santé Sud is, including that it is a bilingual health organization.

Southern Health-Santé Sud uses a variety of methods to engage with internal and external stakeholders. It uses a collaborative approach to work and communicate with Shared Health and other health organizations, including affiliates.

Southern Health-Santé Sud is responsive to the news media, recognizing the important role it plays in supporting communications with stakeholders.

The small, dedicated communications team uses a capacity-building approach to work with the regional leadership team to effectively engage with internal and external stakeholders. This approach is aligned with a culture of shared responsibility and reinforces Southern Health-Santé Sud's local presence in communities.

The communications plan references the International Association for Public Participation. Southern Health-Santé Sud is encouraged to review models on the continuum of engagement with clients and families such as that of Carmen et al. (Health Affairs, 2013). A model that is more reflective of the health system might help Southern Health-Santé Sud strengthen its understanding of the differences among "in consultation with clients," "clients are involved," and "in partnership with clients."

Southern Health-Santé Sud has created several online, easily accessible resources to support staff in their work and promote its brand identity. Internal graphic design support is provided as well as web-based support.

Southern Health-Santé Sud does not have a social media presence. This is a conscious decision given that it does not have the dedicated resources that would be required to monitor and maintain an effective social media presence as a health organization. However, it creates a risk as it leaves the social media area open to others. Apparently, there are discussions with Shared Health about social media strategies. Social media will be an important tactic and tool to reach key audiences that primarily use mobile platforms for communication.

Southern Health-Santé Sud is committed to improving the ability of residents in the region to access health services in French if that is their preference. The organization has established a strong partnership with Table de concertation rurale du Sud to work collaboratively to improve the availability of French language services. Southern Health-Santé Sud has been recognized for its leading practices in recruiting and developing staff so they can offer French language services or facilitate access if they are unable to provide it themselves. Targets have been established to show progress in the number of staff who can provide bilingual services. The organization has participated in the development of a new Health Standards Organization standard called Access to Health and Social Services in Canada's Official Languages.

Priority Process: Physical Environment

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

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

Bethesda Regional Health Centre is going through a major renovation of its heating, ventilation, and air conditioning facilities as part of the project to replace the operating rooms. In addition, the generators are being replaced in an adjacent new structure. Deliberate redundancy is being built into the new structures to mitigate against system breakdown.

All of the criteria under physical environment related to EMS are met. There is solid leadership for EMS. Many things are provincially mandated. All of the paramedics have driver's abstracts on file and this information is updated annually. There is regular training on how to operate the ambulances. The fleet of vehicles is well maintained through a preventive maintenance program. Loading systems are powered so there is no manual lifting. Critical incidents are reported and reviewed with appropriate follow-up.

The vehicle equipment management agency looks after maintenance, repairs, and replacement for the EMS transport vehicle.

The Boundary Trails Health Centre building is spotless. One full-time equivalent housekeeping staff for perioperative services has been added to provide consistency. Hoarding is outsourced in the region and the company works closely with IPAC. The regional centres (Portage District General Hospital, Bethesda Regional Health Centre and Boundary Trails Health centre) have been recognized for their hookless curtain system that has improved privacy, infection prevention and control, and ergonomics for housekeeping staff. Twenty air exchanges per hour are consistently maintained. There are two electricity feeds into the building. There is a move to switch to all LED lighting.

The physical environment at Portage District General Hospital was not formally surveyed. However, the operating room was assessed and the state of that area is very problematic. It is too small and the layout makes appropriate patient and equipment flow impossible. The doors are unpainted wood and are chipped and poorly maintained and this is not acceptable.

Priority Process: Emergency Preparedness

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

Unmet Criteria	High Priority Criteria
Standards Set: Public Health Services	
13.3 There are clear activation criteria for initiating an emergency response.	!

Surveyor comments on the priority process(es)

Emergency preparedness is centrally planned and organized, and locally delivered. The regional disaster management officer has a wide network of local, regional, and provincial connections that enables the organization to have a robust emergency plan. Southern Health-Santé Sud is a part of the provincial disaster management network that meets quarterly. There was flood planning for spring 2019 and partnerships put in place to respond in a timely manner.

Southern Health-Santé Sud is encouraged to consider the role of emergency preparedness in the current unprecedented surge in syphilis cases. This requires a system-wide response that is larger than public health alone (e.g., a type of code orange). The 26 percent poverty rate and drug use in Portage la Prairie creates a high risk for further spread of infection, along with other co-infections such as HIV.

With the 2018 SLT mock exercise called Operation Turn Up the Heat, a video was produced that was adapted for use with the city EMO of Portage la Prairie. In terms of opportunities to apply knowledge, there have also been two code red/green incidents, one a stage 1 and the other a significant stage 2 event with a seven-day evacuation of Pembina Manitou Health Centre. The teams are commended for keeping residents and staff safe and for the good teamwork that took place, including with community partners. In Portage la Prairie the local fire chief, who is also the Director of Public Safety, has been engaged in several activities from planning to execution and evaluation.

There was a code red at Portage District General Hospital during the on-site survey and it was executed efficiently.

Southern Health-Santé Sud has a formal policy commitment to emergency and disaster management using the incident command system. Orientation and education are provided for staff and there are ongoing updates to the codes. Task sheets are clear and are being used, along with after-action reports. Each incident and mock exercise has led to learning and the team applies this to continuously improve.

Some memoranda of understanding need to be updated and/or prioritized for updates in the context of the provincial transformation. These include an October 2013 memorandum of understanding with Manitoba Family Services and Housing and a 2013 template for a memorandum of understanding with

communities or rural municipalities. The organization may wish to consider updating these in collaboration with Shared Health. The memorandum of understanding with communities and rural municipalities regarding emergency preparedness is in the proess of being updated.

There is a good working relationship with public health in the region and with the ministry for access to medical health officer and epidemiology expertise. There is a sound interface with infection control for its expertise. There are plans to update four codes in 2019/2020 and to continuously train, test, and improve existing ones.

Priority Process: People-Centred Care

Working with clients and their families to plan and provide care that is respectful, compassionate, culturally safe, and competent, and to see that this care is continuously improved upon.

Unmet Criteria		High Priority Criteria
Standards Set: Ambulatory Care Services		
1.1	Services are co-designed with clients and families, partners, and the community.	!
Standards Set: Cancer Care		
27.3	Measurable objectives with specific timeframes for completion are identified for quality improvement initiatives, with input from clients and families.	!
Standards Set: Community-Based Mental Health Services and Supports		
1.11	Barriers that may limit clients, families, service providers, and referring organizations from accessing services are identified and removed where possible, with input from clients and families.	
Standards Set: Critical Care Services		
3.3	A comprehensive orientation is provided to new team members and client and family representatives.	
3.13	Client and family representatives are regularly engaged to provide input and feedback on their roles and responsibilities, role design, processes, and role satisfaction, where applicable.	
Standards Set: Emergency Department		
1.8	Barriers that may limit clients, families, service providers, and referring organizations from accessing services are identified and removed where possible, with input from clients and families.	
2.5	Space is co-designed with clients and families to ensure safety and permit confidential and private interactions with clients and families.	
3.5	Barriers within the emergency department that impede clients, families, providers, and referring organizations from accessing services are identified and addressed, with input from clients and families.	
4.3	A comprehensive orientation is provided to new team members and client and family representatives.	

4.15	Client and family representatives are regularly engaged to provide input and feedback on their roles and responsibilities, role design, processes, and role satisfaction, where applicable.	
17.7	Patient safety incidents are analyzed to help prevent recurrence and make improvements, with input from clients and families.	!
18.3	Measurable objectives with specific timeframes for completion are identified for quality improvement initiatives, with input from clients and families.	!
Standards Set: EMS and Interfacility Transport		
26.8	Patient safety incidents are analyzed to help prevent recurrence and make improvements, with input from patients and families.	!
27.3	Measurable objectives with specific timeframes for completion are identified for quality improvement initiatives, with input from patients and families.	!
Standards Set: Governance		
2.3	The governing body includes clients as members, where possible.	
Standards Set: Inpatient Services		
3.3	A comprehensive orientation is provided to new team members and client and family representatives.	
3.12	Client and family representatives are regularly engaged to provide input and feedback on their roles and responsibilities, role design, processes, and role satisfaction, where applicable.	
Standards Set: Leadership		
3.6	There are regular dialogues between the organization's leaders and clients and families to solicit and use client and family perspectives and knowledge on opportunities for improvement.	
6.2	When developing the operational plans, input is sought from team members, clients and families, and other stakeholders, and the plans are communicated throughout the organization.	
Standards Set: Long-Term Care Services		
17.3	Measurable objectives with specific timeframes for completion are identified for quality improvement initiatives, with input from residents and families.	!

Standards Set: Mental Health Services		
1.10	Barriers that may limit clients, families, service providers, and referring organizations from accessing services are identified and removed where possible, with input from clients and families.	
Standards Set: Obstetrics Services		
1.1	Services are co-designed with clients and families, partners, and the community.	!
1.7	Barriers that may limit clients, families, service providers, and referring organizations from accessing services are identified and removed where possible, with input from clients and families.	
2.4	Space is co-designed with input from clients and families to ensure safety and permit confidential and private interactions with clients and families.	
3.3	A comprehensive orientation is provided to new team members and client and family representatives.	
3.13	Client and family representatives are regularly engaged to provide input and feedback on their roles and responsibilities, role design, processes, and role satisfaction, where applicable.	
17.9	Patient safety incidents are analyzed to help prevent recurrence and make improvements, with input from clients and families.	!
18.3	Measurable objectives with specific timeframes for completion are identified for quality improvement initiatives, with input from clients and families.	!
Standards Set: Perioperative Services and Invasive Procedures		
25.3	Measurable objectives with specific timeframes for completion are identified for quality improvement initiatives, with input from clients and families.	!
Standards Set: Primary Care Services		
2.5	Space is co-designed with clients and families to ensure safety and permit confidential and private interactions with clients and families.	
15.7	Patient safety incidents are analyzed to help prevent recurrence and make improvements, with input from clients and families.	!
16.3	Measurable objectives with specific timeframes for completion are identified for quality improvement initiatives, with input from clients and families.	!

Standards Set: Public Health Services		
16.3	Measurable objectives with specific timeframes for completion are identified for quality improvement initiatives, with input from clients and families.	!
Standards Set: Telehealth		
16.7	Patient safety incidents are analyzed to help prevent recurrence and make improvements, with input from clients and families.	!
17.3	Measurable objectives with specific timeframes for completion are identified for quality improvement initiatives, with input from clients and families.	!

Surveyor comments on the priority process(es)

People-centred care is a guiding principle that is evident in Southern Health-Santé Sud's organizational culture and practices. Providing people-centred care means working collaboratively with clients and families to provide care that is respectful, compassionate, culturally safe, and competent while being responsive to their needs, values, cultural backgrounds, and beliefs and preferences. Accordingly, there is deliberate focus on nurturing mutually beneficial partnerships among the organization's staff and the clients and families. Collaboration and engagement occur by developing care plans and through complaints, concerns, and safety incidents. These communication and relationship management channels provide the structure and process to solicit client and family input, perspective, and feedback to improve quality, safety, and the client and family care experience.

To that end, people-centred care is more than working in partnership with clients and families to develop appropriate solutions and ensuring that client values are reflected in clinical decisions that affect their care. It is a philosophy and an approach that fosters and guides all aspects of planning, delivering, and evaluating services and programs. It involves partnering with clients and families to review and improve services and programs. Co-design explicitly means involving clients and families in organizational design, service delivery development, and decision-making and evaluation processes.

For Southern Health-Santé Sud, the evolution and cultural adoption of people-centred care will require executive clarity, vision, leadership, and strategic change management. Adopting and sustaining people-centred care as "business as usual" will require a fundamental shift in thinking about how services are designed as well as roles – not only of the organization's staff, but of clients and families too – and the relationships among clients, families, and Southern Health-Santé Sud's leadership and teams. The executive leadership team is encouraged to consider piloting the integration of a client and/or family advisor as part of the Ethics and/or Quality Committee(s), using the organizational quality improvement framework and change management tools. Ideally, the test site for this pilot would be in a receptive community facility.

Priority Process: Patient Flow

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

Unmet Criteria	High Priority Criteria
Standards Set: Emergency Department	
3.12 Protocols are followed to manage clients when access to inpatient beds is blocked.	
Standards Set: Perioperative Services and Invasive Procedures	
9.9 Wait times for service are monitored and compared to identified targets (e.g., provincial wait-time targets).	

Surveyor comments on the priority process(es)

A Patient Flow Indicator Working Group was established in June 2015 after Southern Health-Santé Sud's last on-site survey. The group recognized early the importance of patient flow to enhance patient and client safety and minimize risk, as well as the benefits of taking a regional approach. The group has made progress in a number of ways to support flow throughout the region, including:

- Creating flow strategies for the three regional centres
- Implementing ED information systems in the three regional EDs and monitoring ED wait times
- Developing and implementing the interim placement policy
- Establishing nine key indicators with data from facility and unit levels in the form of the patient flow operational report
- Creating dashboards that are readily accessible and allow data to be reviewed and shared
- Engaging the Regional Medical Advisory Committees at all the regional centres
- Engaging physician leaders and managers
- Implementing regular bed huddles
- The Utilization Facilitator, formerly Discharge Coordinator position
- Implementing hospital-based home care case coordinators at the three regional hospitals

• Developing the hospital-to-home pilot at Bethesda Regional Health Centre

• Expanding committee membership to include home care, seniors, palliative care, and cancer care in March 2019

Ongoing challenges include:

• Patients awaiting placement in alternate levels of care

• Access to appropriate care services and settings for mental health clients

• Access to home care for rural areas. Currently there is a one-month waiting period for rural clients, largely due to shortage of home care aides. In addition, on First Nations, home care is only available Monday to Friday which prevents discharges on weekends or clients who require home care six or seven days a week.

• Appropriate transport of patients waiting in hospital for investigations or treatment in Winnipeg. Examples were provided of patients who, because of limited financial resources, could not afford to pay for private transfer even if it is subsidized at $25, so they were scheduled to go by ambulance. However, they could get bumped because of an emergency and miss their scheduled appointment.

• Appropriate housing options for homeless clients

It is suggested that patient flow and client care could be improved by bundling investigations for clients who have to travel some distance for services, to reduce the number of trips and time spent travelling.

Patient Flow Committee members are committed and passionate about their work. They are aware of their mandate and the importance of their work to support safe and quality client care. They are the little engine that can! They have access to decision support to ensure they have the necessary information to make decisions and monitor progress, and they know how to use the data that are generated.

The Patient Flow Committee is encouraged in its plans to include patient flow initiatives in the non-regional hospitals, long-term care, and other programs, and to spread its work and successes. It will be important for the committee to conduct periodic monitoring to ensure the gains have been sustained.

Bethesda Regional Health Centre uses whiteboards at the bedside. Whiteboards are standardized across Southern Health-Santé Sud and the organization is commended for implementing this strategy.

There are delays in moving admitted patients from the ED at the Bethesda Regional Health Centre, particularly during the evenings and nights, due to limited hospitalist coverage. Patients are held in the ED until the hospitalist arrives in the morning. This impacts ED operations and patient flow. It is suggested that the organization consider ways to streamline the admission process 24/7.

Portage District General Hospital has a well-established process of daily bed rounds and makes effective use of a continuously updated bed availability whiteboard in the ED. A quality improvement project in 2017 to improve patient flow resulted in changes such as the medical/paediatric patient unit pulling patients from the ED rather than the ED pushing them and standardizing the admission checklist for all calls from the ED. Having the unit provide updated bed availability information to populate the ED whiteboard eliminated the need to routinely call the utilization facilitator.

The team is encouraged to consider having EMS/interfacility transport (IFT) representation on the committee, as EMS/IFT is a key enabler and partner in patient flow. The team is also encouraged to formalize its structures and processes to facilitate meaningful input from clients and families and to consider having a client and family representative on the Patient Flow Committee, to support its mandate of “patient flow in Southern Health-Santé Sud as a people-centred, collaborative, standardized, and integrated approach.”

Priority Process: Medical Devices and Equipment

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

Unmet Criteria		High Priority Criteria
Standards Set: Perioperative Services and Invasive Procedures		
4.3	Surgical equipment or medical devices returned to the operating/procedure room following repair or replacement are clearly marked with the date of their return/arrival and a signed notice describing the maintenance or purchase.	!
Standards Set: Reprocessing of Reusable Medical Devices		
3.6	The MDR department has floors, walls, ceilings, fixtures, pipes, and work surfaces that are easy to clean, non-absorbent, and will not shed particles or fibres.	!
8.2	The reprocessing area's designated hand-washing sinks are equipped with faucets supplied with foot-, wrist-, or knee-operated handles, electric eye controls, automated soap dispenser and single-use towels.	
11.3	All flexible endoscopic reprocessing areas are equipped with separate clean and contaminated/dirty work areas as well as storage, dedicated plumbing and drains, and proper air ventilation.	
15.1	There is a quality improvement program for reprocessing services that integrates the principles of quality control, risk management, and ongoing improvements.	
15.2	Information and feedback is collected about the quality of services to guide quality improvement initiatives with input from stakeholders and team members.	
15.3	The information and feedback gathered is used to identify opportunities for quality improvement initiatives and set priorities with input from stakeholders.	
15.4	Measurable objectives with specific timeframes for completion are identified for quality improvement initiatives with input from stakeholders.	!
15.5	Indicator(s) that monitor progress for each quality improvement objective are identified, with input from stakeholders.	

15.6	Quality improvement activities are designed and tested to meet objectives.	!
15.7	New or existing indicator data are used to establish a baseline for each indicator.	
15.9	Indicator data is regularly analyzed to determine the effectiveness of the quality improvement activities.	!
15.10	Quality improvement activities that were shown to be effective in the testing phase are implemented broadly throughout the organization.	!
15.11	Information about quality improvement activities, results, and learnings is shared with stakeholders, teams, organization leaders, and other organizations, as appropriate.	
15.12	Quality improvement initiatives are regularly evaluated for feasibility, relevance, and usefulness, with input from stakeholders.	

Surveyor comments on the priority process(es)

Southern Health-Santé Sud manages medical devices and equipment well, from purchases to preventive maintenance to cleaning, disinfecting, and sterilizing as warranted. Policies, procedures, and processes are in place to ensure the safety of all who come into contact with these devices.

EMS ensures that its vehicles and equipment are well maintained, cleaned, disinfected, and stocked to provide services as needed.

Sharps are handled safely throughout the regional facilities. Sharps containers are suitably placed and removed when full.

Reprocessing area staff have the required training and education to ensure competency. Orientation is comprehensive and education is ongoing thereafter. Hand-hygiene education is included at orientation and audited regularly. Performance appraisals are conducted regularly. Staff are recognized for their service. Human resource needs in the department are regularly assessed and changes made as appropriate, with senior management approval. Staff in these areas show great teamwork and exceptional communication skills.

The medical device reprocessing departments are clean and well maintained; however, aging and cramped infrastructure in some areas is problematic. Much has been done to mitigate the risk of cross-contamination, but the environments are not ideal. A new space is planned for the medical device reprocessing department at Boundary Trails Health Centre which will make the layout much more efficient and safer. The Portage District General Hospital has significant deficits requiring remediation. Wood countertops are being gradually replaced by stainless steel which is excellent. Sinks in the reprocessing area are not hands-free which is standard practice. There is no dedicated plumbing or air ventilation in the endoscopic reprocessing area and the area gets extremely hot. Every effort has been made to

eliminate cross-contamination through closed containers in the area but having such a small area with clean and dirty items passing closely is an issue.

A regional, systematic quality improvement program is needed at all sites. Data for many indicators are being collected and quality initiatives are occurring at certain sites, but it would be advantageous to broaden the program. Initiatives that are trialed in one area can be spread to others when they are successful.

Southern Health-Santé Sud should be very proud of the work that is done by its reprocessing services teams as well as those who purchase and maintain medical equipment.

Priority Process Results for Population-specific Standards

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

Priority processes specific to population-specific standards are:

Population Health and Wellness

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

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

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

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

Although seniors are still identified provincially and in the region as a priority population, the population health and wellness focus for the on-site survey was populations with chronic conditions.

The public health–healthy living and primary health care teams are dynamic and work collaboratively with each other and with others to address the burden of chronic conditions by coordinating services, promoting health, and preventing disease. The organization is recognized for working with many partners including recreation, municipal leaders, church groups, community activists, and health advocacy groups. These groups speak highly of the staff and of the work being done. The organization is encouraged to leverage these strong connections to recruit clients and family members to become involved in planning and service design, quality improvement initiatives, and client safety activities.

The last community health assessment was completed in 2014 with the next release due in 2019. In the meantime, the organization continues to collect, analyze, and share significant population health data. It is recognized for mapping health status indicators with premature mortality rates to create a stark visual. This information could help prioritize its efforts and is a call to action that should be shared and discussed throughout the many programs and services offered by Southern Health-Santé-Sud.

There is growing awareness throughout the organization that the burden of chronic disease is increasingly influenced by inequity, rurality, social determinants of health, and racism.

The public health–healthy living team has identified three priorities: health equity and healthy public policy, workforce and infrastructure, and data for decision making. The team is encouraged to continue to review evidence-informed guidelines on a regular basis, with input from clients and families, and to share promising practices with others.

The team is responsible for administering two types of healthy living grants. Recipients speak highly of the process and the opportunities to access these funds. It is suggested that some or all of these funds be reallocated to address social determinants of health and create opportunities for communities to understand and address upstream issues.

The organization offers a chronic disease self-management program, Get Better Together, based on principles of adult learning, problem solving, and motivational communication. These are well attended.

With an increasingly young and more diverse population, Southern Health-Santé-Sud is encouraged to continue to promote cultural safety and other appropriate training. The public health–healthy living team is recognized for its Indigenous racial equity and anti-racism action plan (June 2018 to June 2019).

There are opportunities for program and service teams to plan and act together to better meet the needs of and improve outcomes for priority populations. Consistent internal and public messaging will be important for success.

The organization is commended for its attention to vulnerable groups and the passion shown by staff and leaders to address inequities.

Service Excellence Standards Results

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

Priority processes specific to service excellence standards are:

Clinical Leadership

- Providing leadership and direction to teams providing services.

Competency

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

Episode of Care

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

Decision Support

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

Impact on Outcomes

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

Medication Management

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

Organ and Tissue Donation

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

Infection Prevention and Control

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

Public Health

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

Standards Set: Ambulatory Care Services - Direct Service Provision

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

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

Two ambulatory centres were visited.

Portage District General Hospital in Portage la Prairie provides a nine-bed dialysis unit through a provincially funded and directed program. Two dialysis sessions are provided through twelve-hour shifts each day Monday to Friday.

Boundary Trails Health Centre in Winkler provides services to three orthopaedic surgeons for post-operative services (e.g., post-operative follow-up, suture removal, casts) with a weekly clinic day. General surgeons and gynaecologists are supported on the other two days for minor surgeries and colposcopy respectively.

The Portage unit is in the bottom floor of an older building. There is a negative pressure isolation room. There is adequate room for lifts and equipment. The nursing station is small, very busy, and used to manage medications. There is only one small window so it is very dark. Staff are diligent in their handling of medications and manage well with the limited desk space and inadequate lighting. If there are plans to renovate, the organization is encouraged to expand the space available for dialysis and ensure that the nursing station provides adequate space to manage medications safely and complete documentation and other nursing activities.

The physical space in Winkler is new, well laid out, and allows for good work flow. The waiting area shares space with diagnostic imaging without any problem. There is a plan for senior administration and some other services to move to an external site, giving ambulatory services more space.

There are very knowledgeable, engaged, caring, and client-focused teams at both sites. Leaders are well respected, enthusiastic, and constantly promote teamwork and quality improvement. There is ongoing evaluation and changes to support teamwork, but no formal evaluation. Generally, staff are happy with their work, but would like to see changes such as more electronic applications so they can reduce duplication, limit mistakes, and maximize client time.

Relationships with community services and groups support awareness of services, transition, and follow-up.

Communication in both service areas is extremely good (e.g., huddles, meetings, memos, ongoing feedback and support from leaders). However, staff generally would like more information from senior leaders. Staff feel strongly supported for their contributions at the unit level, but not as much at the organization level.

Priority Process: Competency

Staffing, equipment, back-up, and resources are appropriate for ambulatory services. Staff hiring and evaluations for Portage are done by the Provincial Nephrology Program Manager from Winnipeg. Consideration could be given to having the clinical resource nurse participate in these processes.

Evaluations are not up to date in Portage. The organization is encouraged to conduct regular evaluations to provide staff with opportunities to have a formal conversation about their strengths, areas for improvement, and professional development needs.

For dialysis in Portage, training is done for six weeks in Winnipeg with four weeks of supervised work on the unit. In Winkler, there are two licensed practical nurses; one is a certified orthopaedic technician and the second is in the process of finishing.

In both units there is access to wound management training that staff have used. There is access to a series of annual updates, many webinars, and reading information. Both teams are very proud of the services they provide as well as the education and training that is supported.

Priority Process: Episode of Care

Service delivery at Portage is supported by local physicians who make rounds and a physician assistant who visits daily. Externally, support is provided through rounds done weekly by phone with a nephrologist and a manager in Winnipeg. Social workers and Indigenous support workers provide what staff refer to as an “above and beyond” service.

In Winkler, the client remains in the office/treatment area and the physician and staff come to the room to provide service. This is commendable. For infection control purposes, the organization is encouraged to have staff perform treatments on a stand or table in the room rather than the desk.

Clients are very pleased with care and services they receive and they praise the staff. Clients are well informed about care and service, and they have some participation in planning and changes through such things such as complaint mechanisms and surveys. However, there is limited direct involvement in things such as needs assessments, planning, and design.

There are seven people on the wait list for dialysis in Portage. The ministry recently announced that another sitting will be funded and staff are looking forward to this. There are no wait lists for the Winkler unit but clinic numbers are growing quickly.

Winkler does not appear to have issues with no shows. In the Portage unit, there are no shows and sometimes clients shorten treatments, not always appropriately. Transportation issues are one reason for no-shows. Neither the no-shows nor the shortened treatments are tracked to determine the magnitude and causes. The organization is encouraged to track and analyze these data to identify opportunities to help clients access treatment.

Priority Process: Decision Support

There are great information-sharing tools and processes. The use of technology to support electronic communication for reports and clinical records is an area for improvement.

Priority Process: Impact on Outcomes

Data is collected for some indicators that are determined at senior levels (e.g. wait times, infections, falls), with some reports to unit leaders. However, these are frequently not especially useful as they are not broken down for the particular unit.

Quality improvement activities are happening informally at the unit levels, with leaders and staff seeking to improve client care, services, and their work place. There is a lot of enthusiasm for improvement and they would welcome assistance with more formalization, measurement, analysis, and interpretation so that they can proactively support constant improvement.

Standards Set: Cancer Care - Direct Service Provision

Unmet Criteria		High Priority Criteria
Priority Process: Clinical Leadership		
The organization has met all criteria for this priority process.		
Priority Process: Competency		
8.11	Team member performance is regularly evaluated and documented in an objective, interactive, and constructive way.	!
Priority Process: Episode of Care		
The organization has met all criteria for this priority process.		
Priority Process: Decision Support		
The organization has met all criteria for this priority process.		
Priority Process: Impact on Outcomes		
27.4	Indicator(s) that monitor progress for each quality improvement objective are identified, with input from clients and families.	
27.5	Quality improvement activities are designed and tested to meet objectives.	!
27.6	New or existing indicator data are used to establish a baseline for each indicator.	
27.7	There is a process to regularly collect indicator data and track progress.	
Priority Process: Medication Management		
The organization has met all criteria for this priority process.		

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

Treatment protocols are designed and planned at Cancer Care Manitoba (CCMB) in Winnipeg. In Southern Health-Santé Sud, chemotherapy treatment regimens are reviewed with CCMB and administered under the guidance of family practice oncologists according to well-established protocols. Most radiation treatments are administered in Winnipeg, with some patients from Portage la Prairie receiving radiation in Brandon. A nurse navigator is on staff to ensure patient care is coordinated effectively.

The physical space at Bethesda Regional Health Centre is new, bright, sunny, and very positive. This contrasts with the crowded, poorly organized space at Portage District General Hospital, which is clearly not adequate for the population it serves. Two new clinic offices are being constructed that should help make the area more functional.

The community cancer care team at Boundary Trails Health Centre is committed to safe, high-quality patient and family-centred care, as affirmed by patients and families who were interviewed. The team includes dedicated physicians and nurses as well as access to psychosocial oncology, pharmacy, rehabilitation, dietitian services, and spiritual care.

Patient and family engagement is formalized and coordinated through CCMB. The acute oncology patient satisfaction survey hosted by CCMB is used to obtain input and feedback from patients and families. Eight patient/family advisors from Southern Health-Santé Sud are involved in the CCMB patient network. All information and feedback that CCMB receives is shared with the Boundary Trails Health Centre community cancer care team for response or to make improvements.

Appropriate space for the provision of care is a challenge for the cancer care team at the health centre. There is a lack of privacy and appropriate space for isolation patients. With the increase in demand the team is struggling to provide care in the current space. Discussions about how to address the need for expansion are underway. The team is encouraged to develop local quality improvement activities such as selecting and monitoring unit-specific key performance indicators. The team benefits from having access to excellent outcome data through CCMB.

Priority Process: Competency

Staff are hired and trained according to policies and procedures developed by CCMB for the entire province. All staff undertake standardized training. There is very close coordination between the Winnipeg oncologists and the family practice oncologists who provide essential services that allow for treatment as close to home as possible.

Performance appraisals do not appear to be consistently completed.

Priority Process: Episode of Care

There is very close coordination of care with CCMB and oncology specialty services are readily available at all times. The organization uses only one type of standardized infusion pump throughout the province. Preparation of all systemic therapies is done according to standard protocol, although this process is being revamped for all facilities.

Specialized counselling services are provided in Winnipeg. Psychosocial and spiritual services are available locally.

Priority Process: Decision Support

Most patient information is stored in the province-wide patient record that is available to physicians and caregivers in every hospital and many offices. Southern Health-Santé Sud maintains some paper-based charts that contain printouts of treatment protocols and physician orders, but these are being phased out.

All treatments are planned in accordance with evidence-based guidelines and protocols.

Priority Process: Impact on Outcomes

Planning for procedures of care is done centrally by CCMB, which determines treatment protocols based on best available evidence. Southern Health-Santé Sud does not initiate research, but sometimes has patients who are enrolled in clinical trials. While the organization has engaged in quality improvement activities to address specific issues, there is no formal process to establish annual quality improvement objectives with set goals and targets.

Priority Process: Medication Management

Medication management protocols are established by CCMB and all staff are trained to follow these protocols. There are very robust systems to ensure compliance and to appropriately follow up on deviations or adverse outcomes.

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

Unmet Criteria		High Priority Criteria
Priority Process: Clinical Leadership		
The organization has met all criteria for this priority process.		
Priority Process: Competency		
5.4	Standardized communication tools are used to share information about a client's care within and between teams.	!
6.1	The workload of each team member is assigned and reviewed in a way that ensures client and team safety and well-being.	
Priority Process: Episode of Care		
7.1	There is a process to respond to requests for services in a timely way.	
7.2	Hours of operation are flexible and address the needs of the clients and families it serves.	
Priority Process: Decision Support		
The organization has met all criteria for this priority process.		
Priority Process: Impact on Outcomes		
17.10	Information about quality improvement activities, results, and learnings is shared with clients, families, teams, organization leaders, and other organizations, as appropriate.	

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

While there are good relationships with community partners, there are limited services available in many of the communities. Community mental health works in partnership with public health to deliver health promotion.

Resource nurses work in the EDs and provide mental health assessments for those who are in mental health distress. The hours that the nurses work are not consistent throughout the region; consideration could be given to making the hours of service of these practitioners the same.

Priority Process: Competency

Staff in all service areas are very committed to the people they serve. There is a focus on quality service.

There are many educational opportunities for managers and staff. Many of these opportunities are designed to increase the clinical skills of practitioners.

Priority Process: Episode of Care

The community mental health program offers an array of services across the life span at multiple sites.

Services are offered by interdisciplinary professionals and are of significant quality. There are good assessment processes and goal-oriented treatment is offered. Clients report significant satisfaction with services. There are no psychiatrists on the teams; adding them would be of significant benefit. Currently the psychiatrists act as consultants to the service.

Of significant concern is the demand for service in all areas. This has resulted in significant wait lists for services. Some clients report waiting up to six months. Of more concern is the lack of wait list management strategies. The organization is encouraged to develop such strategies, which could include intake and psycho-educational groups.

Priority Process: Decision Support

Records are both paper and electronic depending on the service. A project is underway in the adult team to develop an electronic chart.

Priority Process: Impact on Outcomes

The province's mental health program was reviewed approximately one year ago. The Virgo Report was the result and many practitioners believe it provides a good blueprint and pathway for future mental health services. The government of Manitoba recently announced a transformation initiative and the status of the Virgo Report within the larger transformation initiative is unknown. This is creating uncertainty in the entire mental health program.

The crisis stabilization unit provides a non-medical short stay to individuals in crisis. The organization is encouraged to review the use of this service, particularly in the context of the significant demand for other services in the program. The use of the mobile crisis teams could also be reviewed to determine if this is the best model for crisis response.

The program has a stakeholder advisory mechanism and this group is used regularly for consultation on current programs and future directions. Experience surveys are also conducted.

Standards Set: Critical Care Services - Direct Service Provision

Unmet Criteria		High Priority Criteria
Priority Process: Clinical Leadership		
The organization has met all criteria for this priority process.		
Priority Process: Competency		
The organization has met all criteria for this priority process.		
Priority Process: Episode of Care		
9.4	Working in partnership with clients and families, at least two person-specific identifiers are used to confirm that clients receive the service or procedure intended for them.	ROP
9.4.1	At least two person-specific identifiers are used to confirm that clients receive the service or procedure intended for them, in partnership with clients and families.	**MAJOR**
Priority Process: Decision Support		
The organization has met all criteria for this priority process.		
Priority Process: Impact on Outcomes		
17.2	The information and feedback gathered is used to identify opportunities for quality improvement initiatives and set priorities, with input from clients and families.	
17.4	Indicator(s) that monitor progress for each quality improvement objective are identified, with input from clients and families.	
17.5	Quality improvement activities are designed and tested to meet objectives.	!
17.8	Indicator data is regularly analyzed to determine the effectiveness of the quality improvement activities.	!
17.9	Quality improvement activities that were shown to be effective in the testing phase are implemented broadly throughout the organization.	!
17.10	Information about quality improvement activities, results, and learnings is shared with clients, families, teams, organization leaders, and other organizations, as appropriate.	

17.11	Quality improvement initiatives are regularly evaluated for feasibility, relevance, and usefulness, with input from clients and families.	

Priority Process: Organ and Tissue Donation

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

The critical care unit at Portage District General Hospital is an open room with four critical care beds and two spaces for observation patients. There is an isolation room adjacent to the other beds. The observation beds are used for postoperative patients who are not yet fully recovered when the post-anaesthetic unit closes, post-operative patients with sleep apnea, and other similar lower acuity patients who cannot be safely looked after on the inpatient units. The room is crowded and lacks privacy and confidentiality between patients as there are no walls. There is little room to store equipment. Beds are separated by bedside curtains and this does not meet current critical care space standards.

There is capacity to have one ventilated patient at a time. The unit is staffed with one or two nurses, with the potential to draw on another observation nurse when needed. There are times when there is only one nurse in the unit but there is support from the ED when this happens.

Staff identify a gap in respiratory therapy coverage, a gap in after-hours health care aide coverage for non-nursing duties, and a need for additional social work support especially during off-hours and weekends. There is one social worker who works Monday to Friday and supports the whole hospital.

Priority Process: Competency

The critical care unit is a closed unit supported by the ED physicians and anaesthesiologists at Portage District General Hospital. The critical care staff team is an all registered nurse team and staff are cross-trained to both critical care and the ED. New staff receive a three-month orientation to the ED at Winnipeg Health Sciences Centre. This has a didactic and practical component, with the practical component being spent at Portage District General Hospital. In addition, all staff are requited to maintain their advanced life support certification as well as their trauma nursing core course.

Only two of about 40 nurses have specialized critical care training even through the level of acuity and complexity of some of the patients is similar to larger units elsewhere in Manitoba. The leadership team is encouraged to explore opportunities to develop a larger cohort of critical care trained nurses, recognizing that while some skills are similar in the ED, there are skills that are unique to each area. Having critical care expert nurses will help support novice nurses to provide safe care while they gain confidence and comfort in the intensive care environment. This is particularly important when acuity is high and they are caring for ventilated patients, as respiratory therapy coverage is only available Monday to Friday. The remainder of the time, nurses and physicians support ventilated patients and make ventilator adjustments without the benefit of a respiratory therapist's expertise.

A regional ED/critical care educator is available but may only spend one day a week at the site given their other responsibilities. When the educator is on-site staff value this support and expertise. There is also an on-site generalist educator.

Priority Process: Episode of Care

There is a visible family presence in the critical care unit despite the overcrowding and limited space for additional seating. More importantly, family presence is encouraged, and family remain at the bedside during daily care team rounds.

Although there is no specific person identified as an ethicist or ethics expert, staff have been oriented to the use of the ethics framework and use it when ethical dilemmas arise. The leadership team is encouraged to explore ways to provide enhanced ethics support for the difficult dilemmas that are particular to the intensive care unit. This could include developing a process so staff could access ethics support from Winnipeg Health Sciences Centre.

Following the death of a patient or a traumatic resuscitation, staff debrief with their manager and the involved physicians. They support each other and if required also have access to the employee assistance program.

Priority Process: Decision Support

Daily rounds at the bedside include family members.

The patient chart is exclusively paper based and there is extensive repetition from one form to another. An electronic system would reduce the documentation burden on physicians and nurses and increase time available at the bedside.

Priority Process: Impact on Outcomes

Patient safety incidents are reviewed at monthly staff meetings with a view to learning from these incidents and preventing recurrences. All stage 4 skin ulcers are reviewed by the skin and wound team that is made up of clinical resource nurses and the educator.

All falls are reviewed by the director. Twice a year there is an occurrence analysis to look for trends and systemic issues.

Priority Process: Organ and Tissue Donation

The recently developed death policy helps staff identify imminent death and guides them as to the process to follow for potential organ donors. All deaths are reported to Tissue Bank Manitoba (TBM) for feasibility of retrieval and staff at the tissue bank approach the patient's family.

When asked, staff could only recall an eye donation and some tissue donation in the past few years.

Standards Set: Emergency Department - Direct Service Provision

Unmet Criteria			High Priority Criteria
Priority Process: Clinical Leadership			
2.6	Seclusion rooms and/or private and secure areas are available for clients.		!
Priority Process: Competency			
4.14	Team member performance is regularly evaluated and documented in an objective, interactive, and constructive way.		!
Priority Process: Episode of Care			
10.7	Clients are assessed and monitored for risk of suicide.		ROP
	10.7.1	Clients at risk of suicide are identified.	**MAJOR**
	10.7.2	The risk of suicide for each client is assessed at regular intervals or as needs change.	**MAJOR**
	10.7.5	Implementation of the treatment and monitoring strategies is documented in the client record.	**MAJOR**
10.13	Urgent medications and pharmacy staff can be accessed 24 hours a day, 7 days a week.		!
12.3	Client privacy is respected during registration.		
Priority Process: Decision Support			
The organization has met all criteria for this priority process.			
Priority Process: Impact on Outcomes			
16.2	The procedure to select evidence-informed guidelines is reviewed, with input from clients and families, teams, and partners.		
16.3	There is a standardized process, developed with input from clients and families, to decide among conflicting evidence-informed guidelines.		!
16.4	Protocols and procedures for reducing unnecessary variation in service delivery are developed, with input from clients and families.		!
16.5	Guidelines and protocols are regularly reviewed, with input from clients and families.		!
16.6	There is a policy on ethical research practices that outlines when to seek approval, developed with input from clients and families.		!

17.1	A proactive, predictive approach is used to identify risks to client and team safety, with input from clients and families.	!
17.2	Strategies are developed and implemented to address identified safety risks, with input from clients and families.	!
17.3	Verification processes are used to mitigate high-risk activities, with input from clients and families.	!
17.4	Safety improvement strategies are evaluated with input from clients and families.	!
18.2	The information and feedback gathered is used to identify opportunities for quality improvement initiatives and set priorities, with input from clients and families.	
18.4	Indicator(s) that monitor progress for each quality improvement objective are identified, with input from clients and families.	
18.13	Quality improvement initiatives are regularly evaluated for feasibility, relevance, and usefulness, with input from clients and families.	

Priority Process: Organ and Tissue Donation

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

The emergency program is part of the critical care and medicine team. The emergency teams across Southern Health-Santé Sud are engaged, caring, and patient focused. Leadership is enthusiastic, knowledgeable, well respected, and always looking to do better. Staff feel supported by the leaders and take great pride in providing person-centred care.

The team has developed goals and objectives, including priorities, and these are identified in the team action plans. Where appropriate, the team works collaboratively with critical care to harmonize, revise, or develop policies, procedures, and guidelines. It has targets related to wait times, left without being seen, and length of stay.

Team members are active participants in the Patient Flow Committee. The team is encouraged to develop and implement formal processes to solicit meaningful input and feedback from patients and families.

Priority Process: Competency

All staff receive a comprehensive orientation prior to working in the ED. Clinical resource nurses and nurse educators provide education and support to the staff. Since the same staff work in ED and critical care, the

team has standardized equipment and education. Staff have received training in cardiac defibrillation and infusion pumps.

Formal and informal strategies are used to recognize staff.

As per the organization's policy, performance appraisals need to be regularly conducted. There is also variability across the EDs in terms of staff knowledge of Southern Health-Santé Sud's ethics framework.

Priority Process: Episode of Care

There are excellent processes in place to complete and document a triage assessment for all patients. Timely reassessments are completed. Staff use the Canadian Triage and Acuity Scale (CTAS) and receive regular education regarding using CTAS during the triage process. CTAS is well documented in the patient record.

The team has implemented the recommendations from the Brian Sinclair inquiry. Patients and families who were interviewed appreciate the excellent care they receive and have high praise for the team. The team is encouraged to develop and implement formal processes to solicit meaningful input and feedback from patients and families.

Medication reconciliation and a falls prevention strategy have been implemented. The team has developed policies and processes for a suicide prevention strategy but needs to follow through with full implementation at all regional and non-regional EDs.

The team has timely access to diagnostic and laboratory services. There is variable access to 24/7 pharmacy services, including clinical consultation, particularly at Bethesda Regional Health Centre.

There are processes that include standardized documentation tools to effectively communicate during care transitions.

Indigenous Support Workers are available at Portage District General Hospital. As well, the program has participated in the Indigenous Health High School Internship Program.

The organization is encouraged to review its consent processes to ensure policy is followed. For example, a paracentesis was done at Portage District General Hospital with only verbal consent being obtained.

Priority Process: Decision Support

The emergency team ensures that a comprehensive health record is established for all patients. Staff maintain privacy and confidentiality.

The registration and triage areas at Bethesda Regional Health Centre are open to the waiting room and do not provide adequate privacy.

Priority Process: Impact on Outcomes

Up-to-date, evidence-based guidelines for adult and paediatric patients are readily available to staff. Guidelines are regularly reviewed. Key performance indicators are monitored and reported.

Quality improvement activities are occurring at the local level (e.g., a LEAN project to help with supplies storage, triage, and work flow). There is much enthusiasm for quality improvement and local teams would welcome formalization and measurement. The team is encouraged to develop and monitor outcome indicators, and to develop and implement formal processes to solicit meaningful input and feedback from patients and families.

Priority Process: Organ and Tissue Donation

Organ and tissue donation is managed by TBM. Southern Health-Santé Sud informs TBM when there is a death and then awaits direction from them. Staff are aware of the process and follow TBM policies and procedures.

The team might consider including the TBM processes as part of the patient/family orientation and involving families who have experienced the TBM processes in developing appropriate messaging. The team might also consider encouraging TBM to provide public education on its processes to improve clarity about the role and functions of TBM and the local health team.

Standards Set: EMS and Interfacility Transport - Direct Service Provision

Unmet Criteria		High Priority Criteria
Priority Process: Clinical Leadership		
1.4	Transport planning is undertaken with input from patients, families, and partners.	
3.4	Injury prevention and health promotion sessions are provided to the public and partner organizations by the team.	
7.5	Work and job design, roles and responsibilities, and assignments are determined with input from team members, and from patients and families where appropriate.	
Priority Process: Competency		
5.20	Team member performance is regularly evaluated and documented in an objective, interactive, and constructive way.	!
5.21	Patient and family representatives are regularly engaged to provide input and feedback on their roles and responsibilities, role design, processes, and role satisfaction, where applicable.	
Priority Process: Episode of Care		
21.6	When transporting a patient with a known or suspected communicable disease, appropriate precautions are used by the team and other passengers in the patient compartment.	!
Priority Process: Decision Support		
23.9	There is a process to monitor and evaluate record-keeping practices, designed with input from patients and families, and the information is used to make improvements.	!
24.2	Policies on the use of electronic communications and technologies are developed and followed, with input from patients and families.	
Priority Process: Impact on Outcomes		
25.2	The procedure to select evidence-informed guidelines is reviewed, with input from patients and families, teams, and partners.	
25.3	There is a standardized process, developed with input from patients and families, to decide among conflicting evidence-informed guidelines.	!

25.4	Protocols and procedures for reducing unnecessary variation in service delivery are developed, with input from patients and families.	!
25.5	Guidelines and protocols are regularly reviewed, with input from patients and families.	!
25.6	There is a policy on ethical research practices that outlines when to seek approval, developed with input from patients and families.	!
26.1	A proactive, predictive approach is used to identify risks to patient and team safety, with input from patients and families.	!
26.3	Strategies are developed and implemented to address identified safety risks, with input from patients and families.	!
26.4	Verification processes are used to mitigate high-risk activities, with input from patients and families.	!
26.5	Safety improvement strategies are evaluated with input from patients and families.	!
27.2	The information and feedback gathered is used to identify opportunities for quality improvement initiatives and set priorities, with input from patients and families.	
27.4	Indicator(s) that monitor progress for each quality improvement objective are identified, with input from patients and families.	
27.12	Quality improvement initiatives are regularly evaluated for feasibility, relevance, and usefulness, with input from patients and families.	
Priority Process: Medication Management		

The organization has met all criteria for this priority process.

Priority Process: Infection Prevention and Control		
9.3	Personal precautions and personal protective equipment are used.	
9.7	Team members receive regular immunizations against diseases as appropriate.	
9.8	There is a process to follow when team members are not immunized.	
Surveyor comments on the priority process(es)		
Priority Process: Clinical Leadership		

Southern Health-Santé Sud's EMS/IFT program was transitioned to Shared Health in April 2019. Team action plans were developed under South Health-Santé Sud and are still relevant. The program is

commended for planning and implementing a smooth transition with little to no disruption to staff or operations.

The team is committed to providing high quality and sustainable EMS/IFT service. The team works collaboratively and in partnership with agencies such as police, fire, and local municipalities and communities. The team will also be involved in injury prevention and health promotion activities.

Case reviews are regularly conducted. The program is commended for the Raystarr Indigenous paramedic program to support recruitment of Indigenous paramedics.

Coordination of IFT can be a challenge while meeting the demand for EMS response. Shared Health will be developing separate streams for EMS and IFT. In the meantime, collaboration, communication, and active involvement in the Southern Health-Santé Sud Patient Flow Committee is encouraged.

Priority Process: Competency

There is a commitment to ongoing education and training. Clinical managers use a variety of strategies to support learning and development. YouTube videos that have been created in-house are only accessible to staff and online modules are used for training and education. Staff complete attestations as they finish training and educational materials.

The program is encouraged to complete staff performance appraisals as per organizational policy, and to develop formal structures and processes to facilitate meaningful input and engagement with patients and families.

Priority Process: Episode of Care

The dispatch/communication centre is provided by an external provider. The EMS/IFT program has excellent relations with the provider and follows up on feedback or concerns that impact operations.

During IFT transfers there is excellent documentation and communication between EMS/IFT and the sending and receiving sites. Translation services are available and used when required.

Current evidence-based clinical practice guidelines and protocols are available. All patients and families are provided with the information and process to provide their feedback and opinions about their EMS experience.

Two person-specific identifiers are used for IFT. Medication verification processes and independent double checks are in place for high-alert and high-risk medications. Refusal of service is clearly documented on the patient record.

The team has ready access to medical oversight and excellent processes are in place for information at

point-of-care transition. Audits show 98 to 100 percent which is commendable. The program is congratulated on being the first provincial rural program to implement ST-elevation myocardial infarction (STEMI).

Priority Process: Decision Support

The EMS/IFT program has sound processes to secure patient records. There are lock boxes in all stations and records are only accessed by a limited number of individuals.

There is a record of all calls and the EMS quality officer reviews almost all calls for quality purposes and shares this information as part of the quality improvement process.

Priority Process: Impact on Outcomes

Key performance and outcome indicators are monitored and improvements are made accordingly.

There is ongoing auditing of calls and results are shared and reviewed with staff.

The program is commended for the investment and support it provides for staff wellness. It has implemented a staff wellness peer support team and uses the Road to Mental Wellness education. The program may wish to consider offering an awareness program for the spouses and partners of EMS/IFT staff to help them develop an appreciation and understanding of the stress and mental health challenges facing paramedic staff.

Priority Process: Medication Management

Fentanyl is the only narcotic available in EMS vehicles and regular audits are conducted to ensure compliance with EMS/IFT policy and procedure. All staff receive appropriate training.

Priority Process: Infection Prevention and Control

The EMS/IFT team has support from IPAC at Southern Health-Santé Sud.

The team follows the IPAC policies, procedures, and guidelines. Although hand-hygiene audits are conducted, compliance remains low in the EMS/IFT program. It is suggested that the program conduct regular hand-hygiene self-audits. This may help to continuously raise awareness about the importance of hand hygiene, create some “healthy competition” between stations, and improve compliance that can then be validated through the official hand-hygiene auditing process.

Personal protective equipment is available to all staff, and they are well-versed in donning and doffing. N-95 mask fit testing is not being completed as per Southern Health-Santé Sud guidelines and policy. It is suggested that EMS/IFT ensure that all staff are up to date on their N-95 mask fit testing.

Southern Health-Santé Sud requires all new hires to be up to date on their immunizations, and staff are

responsible for keeping their immunizations up to date. Southern Health-Santé Sud does not require staff immunizations to be current. It is suggested that EMS/IFT encourage staff to keep their immunizations up to date.

There are excellent processes, protocols, and auditing functions to ensure all vehicles and medical equipment are regularly cleaned and disinfected. A luminometer is occasionally used to determine the cleanliness of the vehicles and the results are shared with staff. A YouTube video was also created to share the findings.

Standards Set: Home Care Services - Direct Service Provision

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

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

It is noted with approval that the leadership group has identified specific functions for the home care team. Leadership is encouraged to consider adding a specific statement about client-centred care.

Primary functions of the home care team include facilitating client flow (e.g., supporting clients in the community to avoid unnecessary hospitalization, supporting timely discharges from hospital, reducing the rate of readmissions, placing clients requiring another level of care appropriately) and supportive and restorative delivery of health services to clients in their homes.

There are eighteen community offices in the region, including two clinics, to provide access to services. The home care team has established relationships with the region's care and service teams and with external agencies in the community.

Leadership monitors and assesses several metrics on an ongoing basis to ensure high-quality services continue to be provided. Leadership has identified four team priorities for the home care team: delivery of safe, evidence-based client services; improving work flow and timely access to services; aligning capacity to service demand; and standardizing home care policies, guidelines, assessments, and documentation records where appropriate.

Leadership continues to be challenged with increasingly complex service delivery needs, maintaining staff well-being, maintaining consistency in service delivery across the region, and maintaining staff levels as the workforce ages. Leadership has found it necessary to contract with staffing services to supplement shortages at several branches.

Priority Process: Competency

All members of the client service team have the necessary training and skills to provide high-quality services. There is active continuing education and professional development for staff. Standardized communication tools are used to facilitate effective communication in a very decentralized service environment. Clients and families are very appreciative of the staff who provide care and services.

Congratulations are extended to the four staff members who completed the University of Toronto international interdisciplinary wound care course. Two more are currently enrolled.

Priority Process: Episode of Care

The provision of safe, high-quality services in the face of increasing demand is noted with approval. Service evaluation is done on an ongoing basis. Potential and existing safety concerns are reviewed and effectively addressed.

The provincial auditor general recently made recommendations related to tracking and reporting client complaints.

Priority Process: Decision Support

Updating IT technology to better support communication and evaluation of service delivery is ongoing.

Client files are well maintained, securely stored, and standardized across the region.

Priority Process: Impact on Outcomes

The team is experiencing several improvement activities that are being effectively facilitated and evaluated. It is encouraged in its efforts to conduct more formal quality improvement activities where they are deemed necessary to spread and sustain improvement. The team is commended for its identification, implementation, and referencing of best practices into its service delivery.

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

Unmet Criteria		High Priority Criteria
Priority Process: Infection Prevention and Control		
5.2	Team members, clients and families, and volunteers are engaged when developing the multi-faceted approach for IPC.	
7.4	There are work restrictions that are in line with OHS guidelines for team members, and volunteers with transmissible infections.	!
9.5	Compliance with policies and procedures for cleaning and disinfecting the physical environment is regularly evaluated, with input from clients and families, and improvements are made as needed.	
14.1	There is a quality improvement plan for the IPC program.	!
Surveyor comments on the priority process(es)		
Priority Process: Infection Prevention and Control		

Southern Health-Santé Sud has a strong IPAC program that is led by a passionate, informed group of individuals who represent internal and external partners.

The region has initiated some early practices to heighten the movement toward people-centred care with regard to IPAC. Two examples are asking for public input on an information sheet for urinary tract infections and adding specific questions to a hospital satisfaction survey. The region is encouraged to continue to look for meaningful ways to include patients, clients, residents, and families in its decision-making processes.

The IPAC program has worked diligently to standardize equipment, policies, and procedures throughout the region in all facilities and departments. Communication among all sites, departments, and programs is essential.

There is extensive education on IPAC policies and procedures, including hand hygiene, at orientation. Follow-up sessions on hand hygiene may not be as well attended. Hand-hygiene audits with results that are below targets may indicate that education needs to be made a priority and, possibly, mandatory.

It would be helpful to provide written information for patients and families about hand hygiene and the spread of infection that they could keep for reference after admission.

The region excels at collecting data on several IPAC indicators, including health care–associated infections,

influenza, and hand-hygiene and environmental audits. Using this information to create a quality improvement program would improve auditing for compliance with all IPAC policies and procedures. Formal, consistent audits and evaluations that are standardized across the region could be used to inform the quality improvement program and identify improvement initiatives.

There is a staff immunization policy and staff are encouraged to be immunized annually and report their immunization status to their supervisors. Given that reporting whether staff have been immunized for the flu is not mandatory, work restrictions to help prevent the spread of disease are not possible. This can be problematic during a large outbreak when containment is hampered.

Southern Health-Santé Sud provides patients, clients, families, and staff with a safe environment based on policies and procedures that it has put in place. All sites appeared clean and well maintained, and statistics show a low rate of infection among those using the region's services.

Standards Set: Inpatient Services - Direct Service Provision

Unmet Criteria		High Priority Criteria
Priority Process: Clinical Leadership		
The organization has met all criteria for this priority process.		
Priority Process: Competency		
3.11	Team member performance is regularly evaluated and documented in an objective, interactive, and constructive way.	!
3.13	Team members are supported by team leaders to follow up on issues and opportunities for growth identified through performance evaluations.	!
4.5	Education and training on when clients need to be accompanied when receiving service in another service or location is provided to the team.	!
Priority Process: Episode of Care		
8.9	The client's informed consent is obtained and documented before providing services.	!
8.10	When clients are incapable of giving informed consent, consent is obtained from a substitute decision maker.	!
9.9	Each client's risk for developing a pressure ulcer is assessed and interventions to prevent pressure ulcers are implemented. NOTE: This ROP does not apply for outpatient settings, including day surgery, given the lack of validated risk assessment tools for outpatient settings.	ROP
9.9.1	An initial pressure ulcer risk assessment is conducted for clients upon admission, using a validated, standardized risk assessment tool.	**MAJOR**
9.10	Medical and surgical clients at risk of venous thromboembolism (deep vein thrombosis and pulmonary embolism) are identified and provided with appropriate thromboprophylaxis. NOTE: This ROP does not apply for pediatric hospitals; it only applies to clients 18 years of age or older. This ROP does not apply to day procedures or procedures with only an overnight stay.	ROP

9.10.2	Clients at risk for VTE are identified and provided with appropriate, evidence-informed VTE prophylaxis.	**MAJOR**
9.10.3	Measures for appropriate VTE prophylaxis are established, the implementation of appropriate VTE prophylaxis is audited, and this information is used to make improvements to services.	**MINOR**
10.2	Working in partnership with clients and families, at least two person-specific identifiers are used to confirm that clients receive the service or procedure intended for them.	ROP
10.2.1	At least two person-specific identifiers are used to confirm that clients receive the service or procedure intended for them, in partnership with clients and families.	**MAJOR**
11.8	The client's risk of readmission is assessed, where applicable, and appropriate follow-up is coordinated.	!
11.9	The effectiveness of transitions is evaluated and the information is used to improve transition planning, with input from clients and families.	
Priority Process: Decision Support		
12.8	There is a process to monitor and evaluate record-keeping practices, designed with input from clients and families, and the information is used to make improvements.	!
Priority Process: Impact on Outcomes		
14.2	The procedure to select evidence-informed guidelines is reviewed, with input from clients and families, teams, and partners.	
14.3	There is a standardized process, developed with input from clients and families, to decide among conflicting evidence-informed guidelines.	!
14.5	Guidelines and protocols are regularly reviewed, with input from clients and families.	!
Surveyor comments on the priority process(es)		
Priority Process: Clinical Leadership		

There are some wonderful examples of collaboration between the foundation and leadership on the various inpatient units within the region, as they actively work together to obtain much-needed equipment and education for staff.

Leaders at several sites identify that they would like to be able to provide addiction training for staff. While some surgical programs have established report cards and other such structures, these could easily be applied to the other inpatient programs in the region. At some facilities, the medical and surgical

wards collaborate seamlessly to share staff and determine how to cohort specific client populations such as oncology and paediatrics. At others, teams could collaborate more closely and share resources such as staff when one area needs additional staff while another has a lower patient volume.

Priority Process: Competency

While training and education for care of paediatric patients is available, is not mandatory at all sites. The organization could benefit from making this more accessible to staff who work with this patient population.

Staff at all sites are not consistently provided with education and training on accompanying patients to another service location.

The organization could benefit from promoting and enhancing respectful interprofessional communication to better contribute to a respectful workplace.

Priority Process: Episode of Care

Throughout the region, patients and families are very complimentary about the care provided, particularly from nursing staff. An identified area for improvement is to streamline and standardize the admission assessment for patients, particularly those with a mental health history, in terms of their ability to provide consent and next steps.

Patients and families have not had input into the design of the assessment process. The organization is encouraged to more thoroughly evaluate the effectiveness of information that is shared. Some staff feel that the information pathway is sometimes incomplete when they receive patients from other facilities. The organization is also encouraged to incorporate the patient and family perspective into evaluating this aspect of care.

Consent for treatment was not obtained for admission to one of the inpatient units. There is also no process to consistently assess a patient's risk for re-admission. The organization is encouraged to do this, and to include admissions to surrounding hospitals to effectively reduce its re-admission rate.

Priority Process: Decision Support

While some aspects of the record keeping process are audited, such as compliance with medication reconciliation, these are not designed with input from patients and families. Inpatient units are all equipped with whiteboards, some of which are very well used by patients, families, and staff. Patients and families appreciate the whiteboards that are well populated.

Some areas are limited in terms of accessibility to clinical computers and would benefit from additional workstations to accommodate the care team. Staff have difficulty accessing certain records, such as echocardiogram results that can only be viewed by cardiologists until the results are faxed to the requesting unit.

Priority Process: Impact on Outcomes

The region is responsive to requests and complaints from patients and families and does not shy away from involving them in the improvement process when they raise a concern. The process to proactively integrate patient and family input and participation has not yet been firmly established in the quality measurement and improvement forums across the region.

Given the challenges of recruiting professional staff and the ideas for innovation from local leaders, the organization, particularly human resources, would benefit from championing novel approaches to building this capacity, as has been suggested between local colleges and the inpatient units.

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

Unmet Criteria			High Priority Criteria
Priority Process: Clinical Leadership			
5.2	Work and job design, roles and responsibilities, and assignments are determined with input from team members, and from residents and families where appropriate.		
Priority Process: Competency			
3.15	Team member performance is regularly evaluated and documented in an objective, interactive, and constructive way.		!
Priority Process: Episode of Care			
8.9	Clients are assessed and monitored for risk of suicide.		ROP
	8.9.1	Clients at risk of suicide are identified.	**MAJOR**
	8.9.2	The risk of suicide for each client is assessed at regular intervals or as needs change.	**MAJOR**
	8.9.3	The immediate safety needs of clients identified as being at risk of suicide are addressed.	**MAJOR**
	8.9.4	Treatment and monitoring strategies are identified for clients assessed as being at risk of suicide.	**MAJOR**
	8.9.5	Implementation of the treatment and monitoring strategies is documented in the client record.	**MAJOR**
9.7	A procedure is followed to appropriately implement restraints, monitor a resident in restraint, and document the use in the resident's record.		!
Priority Process: Decision Support			
The organization has met all criteria for this priority process.			
Priority Process: Impact on Outcomes			
15.2	The procedure to select evidence-informed guidelines is reviewed, with input from residents and families, teams, and partners.		
15.3	There is a standardized process, developed with input from residents and families, to decide among conflicting evidence-informed guidelines.		!
15.4	Protocols and procedures for reducing unnecessary variation in service delivery are developed, with input from residents and families.		!

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

There are 22 personal care homes in the region. Fifteen are owned by Southern Health-Santé Sud and there are seven affiliates for a total of 1,229 beds. The homes range in size from 18 beds to 145 beds and they are located in urban and rural areas across southern Manitoba. More than 300 residents are waiting for a bed in one of the personal care homes.

Since the last on-site survey, the homes have worked very hard to standardize processes, policies, and forms. The team is encouraged to continue with this standardization.

The teams have many partners such as public health, municipalities, churches, schools, daycares, and community groups. Residents and family members describe feeling like partners in their care. There are many volunteers who help the residents live with dignity and have meaning in their lives.

The preparation work that is completed in advance of moving into a personal care home contributes to a smoother transition and this is appreciated by the residents and their families. It is a stressful time for families and the up-front preparation work helps them know what to expect.

The homes conduct resident satisfaction surveys bi-annually and the results are relatively positive. The last one was done in 2018. Seven questions are new and now form a baseline. The homes have improved the overall response rate as well as results for some of the indicators (e.g., pain). The next survey should help demonstrate if the quality work that is being done to improve activities is having an impact. Some homes have instituted baking days and a men's shed, and have added cupboards with items such as books with large text, needlepoint, and knitting.

The next step for the team is to find other ways to incorporate the voices of the families and residents in areas such as reviewing guidelines, role descriptions, and participating in hiring practices.

Priority Process: Competency

Across the personal care homes there is ongoing training and education to ensure staff are up to date. The organization has invested in DementiAbility training and is seeing positive outcomes as a result. Staff report that they are looking at responsive behaviours with a new lens and changing how they work with residents with responsive behaviours as a result. Staff report reduced injuries to other residents and themselves, reduced use of medications for responsive behaviours, and a reduction in the use of restraints. The teams are commended for these results.

The teams use the ethics framework to help resolve ethical dilemmas and to problem solve other issues. The framework has been used for such things as allowing residents to use the kitchen after hours to medical assistance in dying.

Infusion pumps are not currently being used in any of the homes that were surveyed. However, several of the homes have education packages ready and could do just-in-time training if a resident were to require an infusion pump.

The teams are highly collaborative and staff work to their full scope. They report that they have the tools to do their job and many receive support from foundations, auxiliaries, and community groups to help with education funding.

An area that the organization is encouraged to improve is providing formal feedback on performance, as the rates vary across the homes. It is important that staff receive ongoing formal and informal feedback. While informal feedback appears to occur regularly, the teams need to work on providing formal feedback as per organizational policy.

Priority Process: Episode of Care

The homes use a number of standardized tools to document assessments. Each resident has a comprehensive medication review by an interdisciplinary team every three months. Formal care plans are completed quarterly in partnership with the resident, and family if they wish, along with an annual review of care and goals for care. The annual review is conducted in partnership with the residents and their families.

Southern Health-Santé Sud is implementing a suicide prevention program. Training packages have been prepared and implementation will begin in the very near future. When someone is identified as being depressed and potentially suicidal, there is enhanced monitoring and interventions. However, the actual risk assessment is not used for every resident. Salem Home is the only site doing routine screening and monitoring with a tool that is included in the electronic medical record.

The homes have improved their efforts to reduce pressure injuries. All residents are screened with the Braden tool at admission, quarterly, and after any change in their condition. Staff report fewer pressure injuries and that they are not as severe. An intervention that has been implemented is ensuring adequate hydration and this has helped reduce the number of urinary tract infections.

All departments in the homes work hard to ensure a resident have a good experience. Nutrition staff have added Susie Q carts in some of the homes. There are fewer complaints about food and overall satisfaction with the dining experience has improved.

Recreational activities are another area of focus. DementiAbility training has provided ideas and tools to enhance recreation and it will be interesting to see the impact. Several residents and families note that they would appreciate more outings for residents who are more mobile.

The homes have adopted a least restraint policy and approach and this is done well at most sites. The next step is to ensure proper documentation is completed. The homes have also adopted a falls strategy and, while the number of falls has not dropped dramatically, the severity of injury has.

The use of two person-specific identifiers appears to be done well and consistently. Families describe being involved in their loved one's care and feeling like they are one of the team. A collaborative team effort was observed at all sites visited.

Medication reconciliation is not consistently done well during transfer out of the homes. While the homes transfer the most recent medication administration record, this may not include standing orders or the list of previous medications. A more formal evaluation of the documentation at transitions may be beneficial.

The homes have very respectful practices and processes when there is a death of one of the residents. Quilts and special blankets are used as well as an honour guard for the resident as they leave the home. Families appreciate this very much.

Priority Process: Decision Support

Most homes use paper records except for Salem Home that uses an electronic record with computerized provider order entry. The records are comprehensive with good flow of information. Standardized assessment tools to document pain assessments, risk of falls, wound assessments, and mobility status are used and documented.

When residents need to be transferred, records are sent with them, including advance care directives or living wills. It might be useful to conduct a more formal evaluation of the transfer processes. Indicators that it is working well include a lack of complaints and a lack of calls seeking additional information.

Family members who were spoken with did not report any privacy breaches and feel the homes do a good job of protecting the resident and family's privacy.

Priority Process: Impact on Outcomes

Long-term care staff have a good culture of identifying and reporting safety incidents, along with mitigation strategies. Incidents are reviewed and actioned, and learnings shared. Incidents are also reported to the board on a quarterly basis. Disclosure is done with families and this is documented in the resident's record.

The teams monitor several indicators, such as number of falls, pressure injuries, and medication occurrences. Lessons learned are used to make quality improvements. Indicator data are reported to the organization's leadership team as well as the boards of directors.

The homes are encouraged to increase the involvement of residents and families in reviewing guidelines, job descriptions, and policies and protocols, and perhaps having them participate in hiring practices. One site has residents and/or family members participate in leadership interviews.

Standards Set: Medication Management Standards - Direct Service Provision

Unmet Criteria		High Priority Criteria
Priority Process: Medication Management		
2.5	A documented and coordinated approach to safely manage high-alert medications is implemented. 2.5.6 Client service areas are regularly audited for high-alert medications.	ROP **MINOR**
2.16	The interdisciplinary committee monitors compliance with each step of the medication management process.	
5.1	Information about medication allergies and previous adverse drug reactions is recorded in the client's medication profile, in partnership with the client and family.	!
5.2	Teams have timely access to the client's medication profile and essential client information.	
6.5	Teams can access an on-site or on-call pharmacist at all times to answer questions about medications or medication management.	!
7.2	A policy on when and how to override CPOE alerts is developed and implemented.	!
8.1	There is a process for determining the type and level of alerts required by the pharmacy computer system including, at minimum: alerts for medication interactions, drug allergies, and minimum and maximum doses for high-alert medications.	!
8.2	A policy on when and how to override alerts by the pharmacy computer system is developed and implemented.	!
8.4	The pharmacy computer system is regularly tested to make sure the alerts are working.	!
8.5	Alert fatigue is managed by regularly evaluating the type of alerts required by the pharmacy computer system based on best practice information and with input from teams.	
9.3	The availability of heparin products is evaluated and limited to ensure that formats with the potential to cause patient safety incidents are not stocked in client service areas.	ROP

	9.3.1 An audit of unfractionated and low molecular weight heparin products in client service areas is completed at least annually.	**MAJOR**
	9.3.2 High dose unfractionated heparin (50,000 units total per container) is not stocked in client service areas.	**MAJOR**
9.4	The availability of narcotic products is evaluated and limited to ensure that formats with the potential to cause patient safety incidents are not stocked in client service areas.	ROP
	9.4.1 An audit of the following narcotic products in client service areas is completed at least annually: • Fentanyl: ampoules or vials with total dose greater than 100 mcg per container • HYDROmorphone: ampoules or vials with total dose greater than 2 mg • Morphine: ampoules or vials with total dose greater than 15 mg in adult care areas and 2 mg in paediatric care areas.	**MAJOR**
11.2	A policy that specifies when and how to override smart infusion pump alerts is developed and implemented.	!
12.8	The use of multi-dose vials is minimized in client service areas.	!
13.3	Chemotherapy medications are stored in a separate negative pressure room with adequate ventilation, and are segregated from other supplies.	!
13.4	Anesthetic gases and volatile liquid anesthetic agents are stored in an area with adequate ventilation, as per the manufacturer's instructions.	!
14.6	A list of abbreviations, symbols, and dose designations that are not to be used have been identified and implemented.	ROP
	14.6.3 Preprinted forms related to medication use do not include any abbreviations, symbols, and dose designations identified on the Do Not Use List.	**MAJOR**
	14.6.7 Compliance with the Do Not Use List is audited and process changes are implemented based on identified issues.	**MINOR**
15.1	The pharmacist reviews all prescription and medication orders within the organization prior to administration of the first dose.	!
16.3	There is a separate negative pressure area with a 100 percent externally vented biohazard hood for preparing chemotherapy medications.	!
17.4	Unit dose oral medications are kept in manufacturer or pharmacy packaging until they are administered.	!

18.2	Medications are dispensed in unit dose packaging.	!
18.3	Emergency, urgent, and routine medications are dispensed within the timelines set by the organization.	
21.2	Information on how to prevent patient safety incidents involving medications is discussed with the client and family.	!
27.1	Resources needed to support quality improvement activities for medication management are provided.	
27.2	When medication management processes are contracted to external providers, a contract is established and maintained with each provider that requires consistent levels of quality and adherence to accepted standards of practice.	
27.3	When medication management processes are contracted to external providers, the quality of services provided is regularly monitored.	
27.4	The interdisciplinary committee regularly and comprehensively evaluates its medication management system.	

Surveyor comments on the priority process(es)

Priority Process: Medication Management

Southern Health-Santé Sud has a regional Pharmacy and Therapeutics Committee that oversees medication management in the organization. There has been a standardized regional formulary and regional IV manual in place for several years and it is continually maintained.

The antimicrobial stewardship program is a part of the regional Pharmacy and Therapeutics Committee and also receives support from the provincial antimicrobial stewardship program. Medication policies and procedures are approved through the committee and implemented locally.

Progress has been made in meeting several ROPs, such as antimicrobial stewardship and Do Not Use abbreviations. Audits have been completed at most sites and the additional auditing information will help with ongoing quality improvement initiatives to enhance compliance with and encourage ongoing work on these two initiatives.

ROP requirements for high-alert medications, concentrated electrolytes, heparin, and narcotics are in place but are only audited every two years. It is suggested that this be increased to annually, as high-dose heparin was noted as wardstock in two locations.

Considerable effort has been made to standardize medication reconciliation across the region. It is completed very well in most areas, although a few still need attention, particularly on transfer and discharge.

There are challenges in implementing medication initiatives due to various pharmacy information systems being in place. Updates to each system will be needed and there may be system constraints such as how alerts are added and managed. Pharmacy information system capabilities are limited and thus inefficient. For instances, staff have to manually enter admission, discharge, and transfer information, and no electronic medication profile can be shared with other health care providers as there are no interfaces. The systems are also limited in addressing capabilities such as minimum and maximum dose alerts and this increases the risk to patients. The lack of computer-generated medication administration records is inherently error prone.

Staffing levels do not allow for seven-day, evening, or on-call service. There is no dedicated time for pharmacists to provide clinical services and many pharmacists provide service at more than one site, making it difficult to provide consistent clinical services. The lack of a dedicated medication safety resource makes it challenging to implement quality improvement initiatives in this area.

Several contracts for pharmacy services do not include specifications on the quality of services or types of standards that must be met, or how and when they are to be met. The organization is encouraged to revise the contracts to include these details.

The medication distribution system has not changed over the years. It is still a traditional medication distribution and wardstock system and this is not considered best or safe practice. Most Canadian health regions have some form of unit dose medication distribution supported by automated technology (e.g., barcoded medication administration) as this is a more efficient and safer system. It also allows the organization to be prepared for electronic health recording and a closed loop medication system, and makes it easier to meet specific standards.

As the National Association of Pharmacy Regulatory Authorities has new standards that must be met for compounding sterile non-hazardous, sterile hazardous, and non-sterile compounds, the pharmacy will require significant upgrades in sterile compounding facilities and staffing prior to 2021 in order to meet the new standards. This will need to be a priority for the organization.

Most of the above-noted improvements were suggested in the previous two on-site surveys that were undertaken in 2012 and 2015. The organization is encouraged to make these a priority.

Standards Set: Mental Health Services - Direct Service Provision

Unmet Criteria	High Priority Criteria
Priority Process: Clinical Leadership	
The organization has met all criteria for this priority process.	
Priority Process: Competency	
The organization has met all criteria for this priority process.	
Priority Process: Episode of Care	
6.2 There is a process to review and respond to the needs of clients in emergency or crisis situations who are waiting for services.	
6.3 There is a process to respond to requests for services in a timely way.	
6.6 When the team is unable to meet the needs of a potential client, access to other services is facilitated.	
9.5 Working in partnership with clients and families, at least two person-specific identifiers are used to confirm that clients receive the service or procedure intended for them. 9.5.1 At least two person-specific identifiers are used to confirm that clients receive the service or procedure intended for them, in partnership with clients and families.	ROP **MAJOR**
Priority Process: Decision Support	
The organization has met all criteria for this priority process.	
Priority Process: Impact on Outcomes	
The organization has met all criteria for this priority process.	

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

The leadership team at the Eden Mental Health Centre is new due to significant recent turnover. The new CEO and the new program director appear to work well with the board and there is evidence that many quality improvements are underway.

The composition and size of the Eden board is very complex and large. The board is encouraged to consider whether alternative structures are possible.

Up until a few months ago the police in Winkler used to respond to situations where patients became aggressive. This service has been withdrawn and Eden has been advocating for a replacement security service. While there has been discussion with Southern Health-Santé Sud and the government as to who is responsible for paying for this service, it has yet to be resolved. In the interim the psychiatrists at Eden who are concerned for the welfare of the nursing staff are refusing to admit patients who have a history of aggression. This has resulted in vacancy rates at a time when the demand for service is high. As a result, residents of Southern Health-Santé Sud who require mental health service but who have a history of aggression are having to go farther from home to receive services or, in some cases, receive inappropriate services.

Priority Process: Competency

The atmosphere on the unit is very positive. Team members appear to work well together and there is a strong patient focus.

Many staff have worked at Eden for over 20 years.

Priority Process: Episode of Care

Eden is a 25-bed psychiatric hospital in Winkler, established in 1967 by the Mennonite Church. It is an affiliate of Southern Health-Santé Sud.

The service provides inpatient mental health services to residents of Southern Health-Santé Sud. Admission is by psychiatrist and services include assessment and treatment delivered by an interdisciplinary team. Computed tomography is also offered. The average length of stay is 15 days.

Although there are coordinating mechanisms between the institution and the community, the path from the community to the institution and then the return to community is not always smooth.

Patients speak highly of the services they receive at Eden. They state that the nursing staff are very responsive to their needs and that they see their psychiatrists regularly. There is a robust recreation program on the unit and many therapeutic groups are also held. The environment is dated but is very clean and tidy. Patients report that the food is good.

Priority Process: Decision Support

Charts are paper.

Priority Process: Impact on Outcomes

Eden Mental Health Centre is awaiting further clarity on its role as the health system transformation unfolds in the province. While it is unusual for a psychiatric hospital to be run by an affiliate, the main issue is not the governance but the services offered. The Mennonite Church is commended for having the foresight over 50 years ago to develop this hospital.

Eden is very integrated into the Winkler community and this has contributed in no small measure in destigmatizing mental illness in this area of Southern Manitoba.

Standards Set: Obstetrics Services - Direct Service Provision

Unmet Criteria		High Priority Criteria
Priority Process: Clinical Leadership		
The organization has met all criteria for this priority process.		
Priority Process: Competency		
3.12	Team member performance is regularly evaluated and documented in an objective, interactive, and constructive way.	!
3.14	Team members are supported by team leaders to follow up on issues and opportunities for growth identified through performance evaluations.	!
5.3	Team members are recognized for their contributions.	
Priority Process: Episode of Care		
8.5	Medication reconciliation is conducted in partnership with clients and families to communicate accurate and complete information about medications across care transitions.	ROP
8.5.1	Upon or prior to admission, a Best Possible Medication History (BPMH) is generated and documented in partnership with clients, families, caregivers, and others, as appropriate.	**MAJOR**
Priority Process: Decision Support		
The organization has met all criteria for this priority process.		
Priority Process: Impact on Outcomes		
18.4	Indicator(s) that monitor progress for each quality improvement objective are identified, with input from clients and families.	
18.5	Quality improvement activities are designed and tested to meet objectives.	!
18.6	New or existing indicator data are used to establish a baseline for each indicator.	
18.8	Indicator data is regularly analyzed to determine the effectiveness of the quality improvement activities.	!
18.9	Quality improvement activities that were shown to be effective in the testing phase are implemented broadly throughout the organization.	!

18.10	Information about quality improvement activities, results, and learnings is shared with clients, families, teams, organization leaders, and other organizations, as appropriate.	
18.11	Quality improvement initiatives are regularly evaluated for feasibility, relevance, and usefulness, with input from clients and families.	

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

Obstetric births are available at five Southern Health-Santé Sud sites. With the exception of the largest site at Boundary Trails Health Centre, three others have a combination of midwives and/or family physicians who are present at the birth and general surgeons who provide caesarean sections. Boundary Trails has two obstetricians and a neonatologist, and an additional obstetrician has been recruited for fall 2019.

All sites have a relationship with the tertiary centres in Winnipeg for higher risk mothers and babies, and two sites have the ability to do telehealth for complex newborn resuscitation. This demonstrates their willingness to work as a system or province and recognize each other's unique pressures.

The hospitals vary in size. At four of the five sites there are likely sufficient births (150, 300, 450, and 1,000) for nurses to maintain competence. The smallest site, Notre Dame, does only 12 to 14 births a year. This is insufficient to provide opportunities for nurses to maintain their competence. In addition, there is no ability to conduct caesarean sections or address a deteriorating mother in the postpartum period without at least a 45-minute delay and a transfer to another site. There may be a political reason to keep births in this small community but is a significant risk to Southern Health-Santé Sud. The team is encouraged to review its appropriateness as a birth site and ensure appropriate risk mitigation strategies are in place.

The Regional Obstetrics Group is a large interprofessional committee that meets monthly. The group might consider including increasing their involvment of Public Health, which would be accomplished through the Regional Perinatal Team.

Committee members have worked very diligently to build standard policies and consistency in practice across the sites. The team is encouraged to continue this work as there are still many inconsistencies. For example, some of the smaller sites have infant security systems and yet the largest site, with the most births and least secure unit layout, does not. This poses a risk of infant abduction as there are many non-obstetric staff, families, and visitors on a busy surgical unit and it is challenging to control the traffic of people. Another example is the use of Nitronox (Entonox). In the obstetric unit at Boundary Trails nitrous oxide is delivered via an appropriate machine and with an attachment to scavenge exhaled gases. In the three other obstetric sites that were visited, nitrous oxide is also used but not appropriately scavenged and as such poses an unacceptable risk of occupational exposure to health care staff.

Priority Process: Competency

Staff at all sites that were visited are cross-trained to several areas as obstetric volumes in the region are unpredictable and insufficient to maintain dedicated staffing. The regional clinical educator assists with cross-training. More OB has helped increase staff comfort with perinatal care and More OB drills help ensure they can practice their skills. Boundary Trails has been recognized by the Society of Obstetricians and Gynaecologists of Canada for its work on delivering twins safely.

With work already underway to standardize practices and policies, perinatal onboarding or orientation is also standardized and centrally delivered. There are also opportunities for learning through regional education days for staff, with midwives and perinatal public health nurses covering topics such as breastfeeding, risk assessment, and fetal monitoring. This is critical to the obstetrics program as it is challenged to recruit nursing staff.

Staff who were interviewed indicate they would like to receive more performance feedback. Many report they have not had a performance review or performance conversation in many years, or ever. They also would like feedback after an incident review and to have their contributions acknowledged more frequently. Leadership is encouraged to take action as dissatisfaction about these issues as well as the many non-nursing tasks that nurses must do at all sites except Boundary Trails may result in higher staff turnover and further compound recruitment challenges.

Priority Process: Episode of Care

The obstetrics team has a lot of which to be proud. The team is commended for standardizing and implementing patient-centred birth plans initiated by the patient and filed on the chart so staff are aware of birthing wishes. This truly reflects the partnership with patients and gives them a voice in their care.

The team is very proud of its designation as a Baby Friendly organization. The Baby Friendly Health Initiative is a joint UNICEF and the World Health Organization project that aims to give every baby the best start in life by creating health care environments where breastfeeding is the norm and practices known to promote the health and well-being of all women and babies are followed. Baby Friendly accreditation is a quality assurance measure that demonstrates a facility's commitment to offering the highest standard of maternity care.

Skin-to-skin kangaroo care is practiced consistently at all sites. No formula samples are provided and breastfeeding rates on discharge are excellent.

The are several areas that need attention. Medication reconciliation in obstetrics is an expectation but does not occur. Staff were not observed to use two patient-specific identifiers and patients indicate that their bracelet is checked less than 50 percent of the time when they receive medication or when their baby is removed from their room and then returned to them. Without this check and balance there is a high potential for an error to occur.

There is a willingness to incorporate patient input into program planning and quality improvement. The team is encouraged to do site visits or to talk to other organizations that are further along in this journey. It is suggested that the regional Perinatal Obstetrics Committee might be a place to start, after appropriate selection, orientation, and mentoring of a patient/family representative.

The most significant risk that needs to be urgently addressed is the transfer of patients requiring emergency caesarean section from Bethesda Regional Health Centre to Ste. Anne Hospital. The operating rooms at Bethesda are closed for renovation and elective surgical activity has been relocated to Ste. Anne. However, this means that when a labouring mother requires an emergency caesarean section, she is transferred by ambulance to another site at a time when she and the fetus are most vulnerable. It does not meet the standards of care set out by the Society of Obstetricians and Gynaecologists for timeliness of emergency caesareans.

Priority Process: Decision Support

There are various numbers of verbal and phone orders that are not signed off during the patient's stay in hospital and remain unsigned even when the chart is filed in health records. This poses a medical/legal risk to physicians and nurses. The organization is encouraged to improve compliance with signing off physician orders.

Paper-based documentation with significant numbers of duplicate entries mean that staff, in particular nurses, spend a significant amount of nursing time filling in forms and documenting patient demographics and other similar information on each and every form.

Patient progress notes are interdisciplinary. This provides one place for all providers to enter information and to be able to review significant changes.

The team is encouraged to enhance its use of data to drive improvement and illustrate the results of its improvement efforts. For example, with regard to indicators that are not at regional targets or provincial or national benchmarks, the team could consider which quality initiatives it will undertake to achieve these and how it will share the data with staff to engage them in solutions. Likewise, the team could consider how gaps in documentation are being addressed. This approach, along with some basic quality improvement methodology training such as plan-do-study-act will help the team develop a robust quality improvement plan with opportunities for staff-led quality improvement.

Priority Process: Impact on Outcomes

The obstetrics team, in partnerships with the Quality, Patient Safety & Risk team, is congratulated for the FMEA analysis conducted prior to implementing obstetrical triage greater than 24 weeks gestation. This is now working very well at several sites, in response to issues with potential delay in assessment when triage for expectant mothers is done in the ED.

The use of nitrous oxide (Nitronox) without adequate air testing or scavenging systems to eliminate exhaled gases increases the risk of occupational exposure for health care workers. This can result in

decreased mental performance, audiovisual ability, and manual dexterity and presents potential reproductive effects with chronic exposure. It is strongly suggested that the organization discontinue its use until air quality can be ensured through adequate ventilation and an appropriate scavenging device.

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

Unmet Criteria		High Priority Criteria
Priority Process: Clinical Leadership		
The organization has met all criteria for this priority process.		
Priority Process: Competency		
6.6	Education and training are provided on the organization's ethical decision-making framework.	
6.11	Team member performance is regularly evaluated and documented in an objective, interactive, and constructive way.	!
6.13	Team members are supported by team leaders to follow up on issues and opportunities for growth identified through performance evaluations.	!
Priority Process: Episode of Care		
11.10	Each client's risk for developing a pressure ulcer is assessed and interventions to prevent pressure ulcers are implemented. NOTE: This ROP does not apply to outpatient settings, including day surgery, given the lack of validated risk assessment tools for outpatient settings.	ROP
11.10.1	An initial pressure ulcer risk assessment is conducted for clients upon admission, using a validated, standardized risk assessment tool.	**MAJOR**
11.12	Medical and surgical clients at risk of venous thromboembolism (deep vein thrombosis and pulmonary embolism) are identified and provided with appropriate thromboprophylaxis. NOTE: This ROP does not apply for pediatric hospitals; it only applies to clients 18 years of age or older. This ROP does not apply to day procedures or procedures with only an overnight stay.	ROP
11.12.2	Clients at risk for VTE are identified and provided with appropriate, evidence-informed VTE prophylaxis.	**MAJOR**

11.12.3	Measures for appropriate VTE prophylaxis are established, the implementation of appropriate VTE prophylaxis is audited, and this information is used to make improvements to services.	**MINOR**
Priority Process: Decision Support		
21.8	There is a process to monitor and evaluate record-keeping practices, designed with input from clients and families, and the information is used to make improvements.	!
Priority Process: Impact on Outcomes		
23.1	There is a standardized procedure to select evidence-informed guidelines that are appropriate for the services offered.	!
23.2	The procedure to select evidence-informed guidelines is reviewed, with input from clients and families, teams, and partners.	
23.3	There is a standardized process, developed with input from clients and families, to decide among conflicting evidence-informed guidelines.	!
23.4	Protocols and procedures for reducing unnecessary variation in service delivery are developed, with input from clients and families.	!
23.5	Guidelines and protocols are regularly reviewed, with input from clients and families.	!
24.4	Safety improvement strategies are evaluated with input from clients and families.	!
Priority Process: Medication Management		

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

The perioperative program obtains information from the public for service design through regular group discussions carried out by the region. Services are reviewed and adjusted based on the needs of the community.

An appropriate mix of personnel is available to provide care for patients.

All anaesthetic services in the region are provided by general practice anaesthetists, including one with special expertise in the treatment of paediatric patients.

There is no operating room manager at Portage District General Hospital and attempts to recruit one have so far been unsuccessful.

Priority Process: Competency

The program employs appropriately qualified staff in all areas and makes ongoing training readily available. Online resources for occupational health and safety and workplace violence are available.

Priority Process: Episode of Care

At the time of the on-site survey, no surgery was occurring at Bethesda Regional Health Centre due to construction. There was very little surgery being done at Portage District General Hospital due to cancellations, and there was no surgery at Boundary Trails Health Centre due to continuing medical education sessions.

Operating room staff call patients who have been booked for surgery to ensure that the preoperative questionnaire is completed. The questionnaire is very detailed and asks all relevant questions. Patients are called several times in the two weeks prior to surgery to ensure they are aware of the surgical date and to answer questions. If needed, volunteers are available to drive the patient to the hospital. Pre-anaesthetic visits are completed and the patients have detailed preoperative instructions. After surgery, all patients are contacted to monitor recovery.

The physical plant of the operating room suite at Portage District General Hospital is not appropriate for surgery. The area is much too small to accommodate the needs of the community, and it is crowded with equipment. Proper flow of sterile materials is impossible. Dirty and clean operating room trays travel the same path and this is not acceptable. The doors are wood and they are unpainted and chipped extensively. Proper infection control is not possible. If surgery is to continue at Portage District General Hospital, the organization is strongly encouraged to make renovating the operating room a high priority.

Priority Process: Decision Support

Medical charting is a combination of electronic and paper systems. There is a highly functional SIMS system for surgical slating, although it has some challenges, particularly with regard to booking future cases.

Priority Process: Impact on Outcomes

There is a strong emphasis in Manitoba on standardizing care. Groups of clinicians from many disciplines work to create guidelines to be used throughout the province. Choosing Wisely is used extensively. However, the process to choose which guidelines to use and how to assess guidelines developed by others is not clear.

Patient and family input into the guideline development process seems to be minimal.

There does not appear to be a standardized process to evaluate the effectiveness of the guidelines or to re-evaluate the guidelines on a regular and defined basis.

Priority Process: Medication Management

All medication management processes in the surgical areas are appropriate.

Narcotics are locked up and accounted for. All anaesthetic cart medications are standardized.

Standards Set: Primary Care Services - Direct Service Provision

Unmet Criteria		High Priority Criteria
Priority Process: Clinical Leadership		
1.3	Service-specific goals and objectives are developed, with input from clients and families.	
1.4	Services are reviewed and monitored for appropriateness, with input from clients and families.	
2.3	An appropriate mix of skill level and experience within the team is determined, with input from clients and families.	
2.6	The effectiveness of resources, space, and staffing is evaluated with input from clients and families, the team, and stakeholders.	
2.8	A universally-accessible environment is created with input from clients and families.	
5.2	Work and job design, roles and responsibilities, and assignments are determined with input from team members, and from clients and families where appropriate.	
Priority Process: Competency		
The organization has met all criteria for this priority process.		
Priority Process: Episode of Care		
8.16	A process to investigate and respond to claims that clients' rights have been violated is developed and implemented with input from clients and families.	!
9.2	The assessment process is designed with input from clients and families.	
Priority Process: Decision Support		
12.8	There is a process to monitor and evaluate record-keeping practices, designed with input from clients and families, and the information is used to make improvements.	!
13.2	Policies on the use of electronic communications and technologies are developed and followed, with input from clients and families.	

Priority Process: Impact on Outcomes		
14.2	The procedure to select evidence-informed guidelines is reviewed, with input from clients and families, teams, and partners.	
14.3	There is a standardized process, developed with input from clients and families, to decide among conflicting evidence-informed guidelines.	!
14.4	Protocols and procedures for reducing unnecessary variation in service delivery are developed, with input from clients and families.	!
14.5	Guidelines and protocols are regularly reviewed, with input from clients and families.	!
15.1	A proactive, predictive approach is used to identify risks to client and team safety, with input from clients and families.	!
15.2	Strategies are developed and implemented to address identified safety risks, with input from clients and families.	!
15.3	Verification processes are used to mitigate high-risk activities, with input from clients and families.	!
15.4	Safety improvement strategies are evaluated with input from clients and families.	!
16.2	The information and feedback gathered is used to identify opportunities for quality improvement initiatives and set priorities, with input from clients and families.	
16.4	Indicator(s) that monitor progress for each quality improvement objective are identified, with input from clients and families.	
16.11	Quality improvement initiatives are regularly evaluated for feasibility, relevance, and usefulness, with input from clients and families.	

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

There is evidence of a high degree of alignment between the primary health care clinical leadership activities and the needs of the communities.

Primary health care has identified five priority areas: improving access; standardizing assessments, documentation, care planning, and processes; enhancing communication at transition points; proactively identifying and mitigating risk; and strengthening human resources.

The clinical team regularly updates client information in the electronic medical record. It is commended for regularly reviewing the program and services and making changes when opportunity and resources allow, such as adding a kinesiologist to the chronic disease self-management program. The team is

encouraged to formally coordinate this process and ensure client and family input is incorporated into the reviews.

The program is well connected with many community health programs, primary care practitioners, specialist services, and community agencies. There appear to be sound relationships and good will among the partners to work together to meet client and community needs. The organization is encouraged to formalize some of its most promising relationships with community partners, especially with regard to identified priority populations such as youth.

The clinical and support staff mix is appropriate for the clientele served. Clients are pleased with the amount of time providers are able to spend with them. The organization is commended for a model that allows and encourages this level of service.

The team reviews guidelines for clinical care and proactive agencies such as CCMB promote evidence-informed best practices. It is suggested the organization create a primary health care clinical practice lead role to ensure the best evidence is used to inform current practice, increase efficiencies, reduce unnecessary testing, and ensure good stewardship of public funds.

Priority Process: Competency

The organization is recognized for its primary health care interdisciplinary teams that plan, work, and learn together. Each member of the team works to their full scope of practice and shares care when appropriate. Position profiles reflect the role, responsibilities, and requirements for the position. Recent performance reviews have been completed for many primary health care staff using the recently introduced performance conversation tool. Leadership is encouraged to continue these efforts.

The team is encouraged to find creative ways to ensure there is input from clients and families with regard to staff training and education, roles, responsibilities, and assignments.

Staff members are deeply committed to and proud of their work. They describe reaching out to individuals and groups to improve access to services and strengthen primary care pathways. They are recognized by partners and clients for engaging the community and helping clients navigate a complex health system. The team meets regularly to plan, collaborate on clients, and participate in training.

Team members are knowledgeable and passionate and practice within a client-centred approach when working with individual clients and families.

It is suggested that all primary health care staff complete motivational interview training.

Priority Process: Episode of Care

The team is acknowledged for the variety of services offered in the program area. The team is encouraged to plan together and with partners to improve care and communication as clients move back and forth

between primary and secondary care.

Access to primary health care services varies throughout Southern Health-Santé Sud, dependent on variables such as the type of service request, staff availability, burden of community illness, time of day, and the limitations of clients and families. The team tracks these variations and is commended for creating same day/next day access at many sites. Some of its quality improvement initiatives are designed to address variability in access.

The team is recognized for the Mobile Clinic-Clinique Mobile, a state-of-the-art bus designed to be fully functional as a primary care clinic bringing services to some of the region's most rural and under-served communities. The Mobile Clinic team offers a full range of primary health care services and staff document client encounters in an integrated electronic medical record. The registered nurse on the bus works at the top of the registered nurse scope.

Although primary health care settings do not usually offer dedicated spiritual space, the team is encouraged to ensure people of any or no faith feel welcome in their environments.

While the reception areas are comfortable and clean, in some locations it is difficult to maintain privacy and confidentiality during conversations with the front office reception staff. Although space is limited the organization is encouraged to be inventive with regard to increasing the level of privacy and confidentiality.

Clients who were interviewed are very satisfied with the care they receive, including assessment and examination, test results, screening, and plans for follow-up. All of them are aware of their right to make a complaint and, although they have none, they are confident that any issues would be dealt with quickly. Several clients did not know how they would go about filing a complaint. The organization is encouraged to ensure this information is posted in all locations.

Team members understand the processes to deal with ethical issues and complaints. The team at Pembina Manitou Health Centre is commended for using the ethics decision-making framework and worksheet to address an ethical issue involving youth. Southern Health-Santé Sud is encouraged to look for opportunities to put the needs of the client first to decrease unintended impacts on clients caused by siloed programs.

There are complete medical and social assessments in the electronic medical record and paper charts, including up-to-date medication profiles, social history, screening, laboratory and diagnostic reports, referrals, and discharge summaries. Results from diagnostic tests are received in a reasonable time with notification of critical values by phone. The clinical team members are strong advocates for self-care and self-management.

Several nurse practitioners spend part of their time working in teen health clinics in schools. The organization is encouraged to expand this service to the most vulnerable youth and ensure it is a youth-centred model.

Primary health care dietitians in the regions have created many valuable community linkages and work to address issues such as food security (e.g., the intergenerational gardening program), marketing of food, food and body image in children, and aging and food.

Open Health Niverville houses fee-for-service primary care physicians and Southern Health-Santé Sud staff. The primary health care nurse offers advanced wound care services. The team is recognized for its collaborative relationship and collegiality and there is high job satisfaction.

The dynamic interdisciplinary team works with others to improve timely access to community-based services and remove the barriers facing clients whenever possible. Clients and families trust the team members and know they are available to help coordinate care when needed. Clients report feeling welcome and truly appreciate how their individual care needs are met.

Priority Process: Decision Support

Primary health care team members have access to and use information, research, and evidence-informed best practices to make the best possible clinical decisions for clients. This information helps inform and guide assessment and care planning.

Providers may use one of several electronic medical records or paper. All client records that were reviewed were accurate and up-to-date, with documented assessments, screening, treatment, consultation, and referral notes for services provided.

The organization is encouraged to optimize the use of electronic medical records where possible, ensure timely recording of client information, and maintain record integrity. Confidentiality is maintained and data are backed up for clinical providers with access to an electronic medical record.

The team has several years of client information in its electronic medical records. It is encouraged to analyze clinical data to look for gaps and areas of clinical strength, and make time to reflect on current research and best practice information.

Priority Process: Impact on Outcomes

Team members are recognized for their commitment to identifying and managing risk and keeping clients and families safe. The importance placed on client and staff safety is evident throughout the program.

As more programs and services are offered outside Southern Health-Santé Sud facilities, the organization is encouraged to update and revise its remote location assessment process and plan to enhance safety for off-site staff.

The team is recognized for its performance measures and advanced access measurements such as third-next available appointment. It is encouraged to consider both process and clinical indicators.

Clients and community partners are very satisfied with the quality of the primary health care services that the team provides. The team makes adjustments as needed to improve access and service delivery.

Standards Set: Public Health Services - Direct Service Provision

Unmet Criteria		High Priority Criteria
Priority Process: Clinical Leadership		
5.1	Work and job design, roles and responsibilities, and assignments are determined with input from team members, and from clients and families where appropriate.	
Priority Process: Competency		
4.2	Required training and education are defined for all team members with input from clients and families.	!
4.3	Team member performance is regularly evaluated and documented in an objective, interactive, and constructive way.	!
Priority Process: Impact on Outcomes		
16.5	Quality improvement activities are designed and tested to meet objectives.	!
16.9	Quality improvement activities that were shown to be effective in the testing phase are implemented broadly throughout the organization.	!
Priority Process: Public Health		
3.1	The community is involved and engaged in the design of its public health services.	
3.12	Utilization reviews are regularly completed to ensure resources have been used appropriately.	
7.6	The effectiveness of communication strategies is evaluated and improvements are made as a result.	
8.3	Health impact assessments for proposed public policies, programs, and projects are conducted in collaboration with partners and with input from the community.	
11.4	The vaccine cold chain is monitored and maintained according to provincial/territorial legislation.	!
15.4	The organization works with research partners across sectors and at all levels to advance public health research.	

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

There is strong clinical leadership for the public health team, and the leaders are experienced public and population health practitioners. There is work to be done to consistently include clients and families and to develop a framework to support this inclusion. On an individual client basis, there is a strong connection.

The team is commended for its Indigenous racial equity and anti-racism action plan for 2018–2019.

Priority Process: Competency

The leadership team is committed to health equity and has made strides in educating the teams and others in the organization. It is significant that Southern Health-Santé Sud's Compass has identified health equity as an important strategic direction. Truth and reconciliation calls to action have been integrated into the Sacred Moments.

While there is a single medical health officer for Southern Health-Santé Sud it is strategic that this position reports on a dotted line to the CEO and has an influence at the strategic level of the organization with specialized knowledge in preventive medicine and public and population health. The position reports to and has good access to the ministry, and it is perceived to be a good resource.

Priority Process: Impact on Outcomes

The public health team monitors many indicators and routinely uses the data to inform programming. However, a robust quality improvement plan that includes program evaluation is not available, primarily due to operational workload and limited access to decision support and analytics. Seeking partnerships and working through the health transformation with Shared Health may help the team develop a quality improvement plan.

Priority Process: Public Health

The on-site survey focused on four service delivery sites: the Portage Collegiate Institute teen clinic, the pre- and postnatal program at the Vita & District Health Centre, perinatal services in at the Bethesda Regional Health Centre, and the reproductive sexual health and harm reduction services at Portage District General Hospital.

Teens self-refer to the Portage Collegiate Institute clinic and receive team-based care in a warm, safe, and confidential manner.

The Vita community, which includes an Amish group of families, receives opportunistic immunizations, such as requesting the measles vaccine when measles cases were confirmed. This opens the door to having a dialogue to determine what could be provided to support these families and respect their way of life. The team appears to have a good relationship with clients and the community and this could be used

as an opportunity for greater engagement.

Public health has developed a community breastfeeding plan that is consistent with the breastfeeding plan initiated in the hospital and supports the Southern Health-Santé Sud Baby Friendly certification and designation from the World Health Organization.

All new mothers are offered a home visit by a public health nurse and new parents have access to well-baby clinics. This is particularly important for families who may not have access to primary care or who may be reluctant to access physician care. Mothers who have been identified by hospital staff or through the initial contact by a public health nurse as having support needs or more significant risk factors are eligible for home visits by paraprofessionals for an extended period of time, with regular supervision by a public health nurse.

The public health team has several challenges. The team does an excellent job of prioritizing its work based on health equity, population health parameters, and working to meet provincial standards. Many families and new parents are immigrants or from cultural or marginalized groups and it can be time-consuming and difficult to help them access, in a timely manner, resources related to determinants of health. There is a significant need to help them navigate provincial programs. In addition, not all health care providers fully understand the role of public health nurses which goes far beyond being an extension of primary care.

There is regular surveillance for communicable diseases and good protocols and processes to determine when an outbreak is declared and actions to take at each stage. There is good communication provincially with the medical health officer and the coordinators.

Clients express very positive and positive comments about the experience and service they receive.

The team identifies its immediate strategic priorities as strengthening connections with municipal government and First Nations communities.

The team identifies its immediate operational priorities as addressing the surge in syphilis cases and deploying the data loggers to maintain the safety of the vaccine supply and reduce waste due to cold chain breaks.

Standards Set: Rehabilitation Services - Direct Service Provision

Unmet Criteria	High Priority Criteria
Priority Process: Clinical Leadership	
The organization has met all criteria for this priority process.	
Priority Process: Competency	
The organization has met all criteria for this priority process.	
Priority Process: Episode of Care	
The organization has met all criteria for this priority process.	
Priority Process: Decision Support	
The organization has met all criteria for this priority process.	
Priority Process: Impact on Outcomes	
15.4 Indicator(s) that monitor progress for each quality improvement objective are identified, with input from clients and families.	
15.7 There is a process to regularly collect indicator data and track progress.	

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

The team's leadership effectively manages resources and evaluates the services provided on an ongoing basis.

Priority Process: Competency

Staff education is a key component to help maintain competency.

The team makes ready use of the various communication tools to share information within the team and with clients and families.

Priority Process: Episode of Care

The team establishes effective care and service relationships with clients and families. It is suggested that a formal mechanism to obtain client feedback be developed and implemented.

Care plans appear to be well documented and up to date. They are an integral part of the team's communication with each other and the clients.

Priority Process: Decision Support

There are established policies and procedures to maintain and store client health records, and privacy of client information is maintained according to policy and provincial legislation.

Priority Process: Impact on Outcomes

Rehabilitation services is a regional program offering its services out of three locations in the region. A traditional scope of rehabilitation is offered that consists of audiology, occupational therapy, physiotherapy, speech-language pathology, and fetal alcohol spectrum disorder coordination. The services are provided across the continuum of care and include children and youth as well as adults.

There are approximately 78 full-time equivalent staff.

Services are provided to facilities and clients in the region and external stakeholders including Family Services, the Ministry of Education, First Nations communities, and Child and Family Services. Services are provided to inpatients with designated rehabilitation beds as well as other clinical programs in the facilities. Outpatient services are also provided in the communities.

The recent implementation of an electronic workload measurement system has improved data collection, although further work in this area is needed.

The rehabilitation program continues to standardize services where appropriate. Providing timely access to existing services is challenged by staff vacancies and increased demand for service. This places further demands on the space needed for providing these services.

Standards Set: Telehealth - Direct Service Provision

Unmet Criteria		High Priority Criteria
Priority Process: Clinical Leadership		
1.4	Service-specific goals and objectives are developed, with input from clients and families.	
2.3	An appropriate mix of skill level and experience within the team is determined, with input from clients and families.	
Priority Process: Competency		
4.1	Required training and education are defined for all team members with input from clients and families.	!
Priority Process: Episode of Care		
9.13	A process to investigate and respond to claims that clients' rights have been violated is developed and implemented with input from clients and families.	!
10.2	The assessment process is designed with input from clients and families.	
Priority Process: Decision Support		
13.9	There is a process to monitor and evaluate record-keeping practices, designed with input from clients and families, and the information is used to make improvements.	!
14.2	Policies on the use of electronic communications and technologies are developed and followed, with input from clients and families.	
Priority Process: Impact on Outcomes		
15.2	The procedure to select evidence-informed guidelines is reviewed, with input from clients and families, teams, and partners.	
15.3	There is a standardized process, developed with input from clients and families, to decide among conflicting evidence-informed guidelines.	!
15.4	Protocols and procedures for reducing unnecessary variation in service delivery are developed, with input from clients and families.	!
15.5	Guidelines and protocols are regularly reviewed, with input from clients and families.	!

15.6	There is a policy on ethical research practices that outlines when to seek approval, developed with input from clients and families.	!
16.1	A proactive, predictive approach is used to identify risks to client and team safety, with input from clients and families.	!
16.2	Strategies are developed and implemented to address identified safety risks, with input from clients and families.	!
16.3	Verification processes are used to mitigate high-risk activities, with input from clients and families.	!
16.4	Safety improvement strategies are evaluated with input from clients and families.	!
17.2	The information and feedback gathered is used to identify opportunities for quality improvement initiatives and set priorities, with input from clients and families.	
17.4	Indicator(s) that monitor progress for each quality improvement objective are identified, with input from clients and families.	
17.11	Quality improvement initiatives are regularly evaluated for feasibility, relevance, and usefulness, with input from clients and families.	

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

The regional Telehealth Committee is accountable for coordinating the planning and delivery of telehealth services in Southern Health-Santé Sud. The members are eager to ensure a sustainable and quality program.

Committee members collaborate with health care providers and health programs to identify and explore possibilities to expand the program. This is especially important given the access issues that remote or vulnerable residents face.

The telehealth support team includes Southern Health-Santé Sud staff as well as representation from eHealth Solutions and MBTelehealth. This partnership fosters coordination, provides expertise and administrative support, and is the link to the provincial telehealth program.

The committee is commended for identifying quality improvement and compliance as two of its priorities. It is encouraged to find novel ways to involve clients and families proactively in these activities. Perhaps starting with an issue in which clients are interested, such as client and team safety, would be a place to start.

The Southern Health-Santé Sud telehealth policies were last reviewed and updated in 2018.

Telehealth equipment is securely stored, well maintained, and replaced as per MBTelehealth aging-out specifications.

Priority Process: Competency

MBTelehealth provides training and materials to ensure the safe use of equipment, peripheral devices, and supplies required to support the telehealth program. The eHealth Solutions facilitator is responsible for supporting and training staff at the sites.

The service desk and trained super users provide immediate assistance to staff or users who are experiencing technical issues.

Besides the clinical application, telehealth services are used extensively in Southern Health-Santé Sud for staff education, regional meetings, and grand rounds.

Staff are committed to ensuring privacy and confidentiality during telehealth sessions.

Staff report that they have had recent performance conversations.

Priority Process: Episode of Care

Teleheath services has continued to expand across the organization, resulting in more clinical access for clients and more professional development opportunities for staff.

A recent addition is the introduction of a telestroke program that has been welcomed by emergency physicians in the community. Future expansion and further demand may create telehealth staffing pressures. The organization is encouraged to explore alternative booking and set-up options, especially for non-client telehealth events.

Staff are welcoming and encourage questions. Clients and families appreciate that their need for timely assessment is being met. Care is taken to ensure clients understand what will happen during the telehealth event.

Two identifiers are used and assessment tools are standardized.

A collaborative approach to service delivery keeps the client and their family front and centre.

Infection control policies with regard to telehealth equipment and settings are met.

Appropriate follow-up services for clients are coordinated, in collaboration with other providers and teams.

Team members understand the process to address ethical issues and complaints.

Priority Process: Decision Support

There is an excellent working relationship between MBTelehealth and Southern Health-Santé Sud staff with regard to ensuring the technology and systems required for a robust, secure, and confidential platform are in place.

Depending on the service provided, a set of standardized health information is collected. The team uses information, research, and best practices to make the best possible decisions for the program.

Policies are in place with regard to secure collection, documentation, access to, and use of client information.

The organization is recognized for its ongoing audits of compliance with documentation processes.

Priority Process: Impact on Outcomes

Team members are recognized for their commitment to identifying and managing risk in the program. It is suggested that they work with MBTelehealth to regularly review guidelines and protocols to ensure they are evidence informed.

The team is encouraged to find novel ways to obtain regular and meaningful input from clients and families in all aspects of their work.

The team is commended for its plan to expand its client surveys. Supplemental questions or focused interviews could be added periodically to better understand issues such as language preference for the many newcomers in the region, possible increased use of the telephone interpreter program, and questions to help quantify the cost savings to the client (for a clinical event) or staff member (for a meeting or education session).

Instrument Results

As part of Qmentum, organizations administer instruments. Qmentum includes three instruments (or questionnaires) that measure governance functioning, patient safety culture, and quality of worklife. They are completed by a representative sample of clients, staff, senior leaders, board members, and other stakeholders.

Governance Functioning Tool (2016) - Eden Mental Health Centre

The Governance Functioning Tool enables members of the governing body to assess board structures and processes, provide their perceptions and opinions, and identify priorities for action. It does this by asking questions about:

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

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

- **Data collection period: September 5, 2017 to November 10, 2017**
- **Number of responses: 6**

Governance Functioning Tool Results - Eden Mental Health Centre

	% Strongly Disagree / Disagree	% Neutral	% Agree / Strongly Agree	%Agree * Canadian Average
	Organization	Organization	Organization	
1. We regularly review and ensure compliance with applicable laws, legislation, and regulations.	17	33	50	94
2. Governance policies and procedures that define our role and responsibilities are well documented and consistently followed.	0	0	100	95
3. Subcommittees need better defined roles and responsibilities.	60	0	40	70
4. As a governing body, we do not become directly involved in management issues.	33	0	67	85
5. Disagreements are viewed as a search for solutions rather than a “win/lose”.	0	0	100	95

	% Strongly Disagree / Disagree	% Neutral	% Agree / Strongly Agree	%Agree * Canadian Average
	Organization	Organization	Organization	
6. Our meetings are held frequently enough to make sure we are able to make timely decisions.	0	0	100	96
7. Individual members understand and carry out their legal duties, roles, and responsibilities, including subcommittee work (as applicable).	0	0	100	96
8. Members come to meetings prepared to engage in meaningful discussion and thoughtful decision making.	0	0	100	94
9. Our governance processes need to better ensure that everyone participates in decision making.	33	33	33	59
10. The composition of our governing body contributes to strong governance and leadership performance.	0	17	83	95
11. Individual members ask for and listen to one another's ideas and input.	0	17	83	97
12. Our ongoing education and professional development is encouraged.	0	0	100	86
13. Working relationships among individual members are positive.	0	0	100	98
14. We have a process to set bylaws and corporate policies.	0	17	83	95
15. Our bylaws and corporate policies cover confidentiality and conflict of interest.	0	0	100	98
16. We benchmark our performance against other similar organizations and/or national standards.	17	17	67	77
17. Contributions of individual members are reviewed regularly.	0	33	67	71
18. As a team, we regularly review how we function together and how our governance processes could be improved.	0	17	83	84
19. There is a process for improving individual effectiveness when non-performance is an issue.	17	50	33	60
20. As a governing body, we regularly identify areas for improvement and engage in our own quality improvement activities.	0	17	83	84

	% Strongly Disagree / Disagree	% Neutral	% Agree / Strongly Agree	%Agree * Canadian Average
	Organization	Organization	Organization	
21. As individual members, we need better feedback about our contribution to the governing body.	50	17	33	44
22. We receive ongoing education on how to interpret information on quality and patient safety performance.	20	0	80	81
23. As a governing body, we oversee the development of the organization's strategic plan.	0	0	100	97
24. As a governing body, we hear stories about clients who experienced harm during care.	17	0	83	86
25. The performance measures we track as a governing body give us a good understanding of organizational performance.	0	17	83	91
26. We actively recruit, recommend, and/or select new members based on needs for particular skills, background, and experience.	20	20	60	86
27. We lack explicit criteria to recruit and select new members.	20	20	60	77
28. Our renewal cycle is appropriately managed to ensure the continuity of the governing body.	0	0	100	89
29. The composition of our governing body allows us to meet stakeholder and community needs.	0	0	100	94
30. Clear, written policies define term lengths and limits for individual members, as well as compensation.	0	0	100	93
31. We review our own structure, including size and subcommittee structure.	0	17	83	87
32. We have a process to elect or appoint our chair.	0	0	100	86

*Canadian average: Percentage of Accreditation Canada client organizations that completed the instrument from July to December, 2017 and agreed with the instrument items.

Overall, what is your assessment of the governing body's impact over the past 12 months, in terms of driving improvements to:	% Poor / Fair	% Good	% Very Good / Excellent	%Agree * Canadian Average
	Organization	Organization	Organization	
33. Patient safety	0	17	83	80
34. Quality of care	0	17	83	81

*Canadian average: Percentage of Accreditation Canada client organizations that completed the instrument from July to December, 2017 and agreed with the instrument items.

Governance Functioning Tool (2016) - Southern Health-Santé Sud

The Governance Functioning Tool enables members of the governing body to assess board structures and processes, provide their perceptions and opinions, and identify priorities for action. It does this by asking questions about:

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

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

- **Data collection period: September 6, 2017 to December 20, 2017**
- **Number of responses: 11**

Governance Functioning Tool Results - Southern Health-Santé Sud

	% Strongly Disagree / Disagree	% Neutral	% Agree / Strongly Agree	%Agree * Canadian Average
	Organization	Organization	Organization	
1. We regularly review and ensure compliance with applicable laws, legislation, and regulations.	0	0	100	94
2. Governance policies and procedures that define our role and responsibilities are well documented and consistently followed.	0	0	100	95
3. Subcommittees need better defined roles and responsibilities.	82	0	18	70
4. As a governing body, we do not become directly involved in management issues.	9	0	91	85
5. Disagreements are viewed as a search for solutions rather than a “win/lose”.	0	0	100	95
6. Our meetings are held frequently enough to make sure we are able to make timely decisions.	0	0	100	96
7. Individual members understand and carry out their legal duties, roles, and responsibilities, including subcommittee work (as applicable).	0	0	100	96
8. Members come to meetings prepared to engage in meaningful discussion and thoughtful decision making.	0	0	100	94

	% Strongly Disagree / Disagree	% Neutral	% Agree / Strongly Agree	%Agree * Canadian Average
	Organization	Organization	Organization	
9. Our governance processes need to better ensure that everyone participates in decision making.	82	0	18	59
10. The composition of our governing body contributes to strong governance and leadership performance.	0	0	100	95
11. Individual members ask for and listen to one another's ideas and input.	0	0	100	97
12. Our ongoing education and professional development is encouraged.	0	9	91	86
13. Working relationships among individual members are positive.	0	0	100	98
14. We have a process to set bylaws and corporate policies.	0	0	100	95
15. Our bylaws and corporate policies cover confidentiality and conflict of interest.	0	0	100	98
16. We benchmark our performance against other similar organizations and/or national standards.	0	9	91	77
17. Contributions of individual members are reviewed regularly.	9	0	91	71
18. As a team, we regularly review how we function together and how our governance processes could be improved.	0	0	100	84
19. There is a process for improving individual effectiveness when non-performance is an issue.	9	9	82	60
20. As a governing body, we regularly identify areas for improvement and engage in our own quality improvement activities.	0	0	100	84
21. As individual members, we need better feedback about our contribution to the governing body.	64	0	36	44
22. We receive ongoing education on how to interpret information on quality and patient safety performance.	0	0	100	81
23. As a governing body, we oversee the development of the organization's strategic plan.	0	0	100	97
24. As a governing body, we hear stories about clients who experienced harm during care.	0	0	100	86

	% Strongly Disagree / Disagree	% Neutral	% Agree / Strongly Agree	%Agree * Canadian Average
	Organization	Organization	Organization	
25. The performance measures we track as a governing body give us a good understanding of organizational performance.	0	0	100	91
26. We actively recruit, recommend, and/or select new members based on needs for particular skills, background, and experience.	0	0	100	86
27. We lack explicit criteria to recruit and select new members.	82	0	18	77
28. Our renewal cycle is appropriately managed to ensure the continuity of the governing body.	0	0	100	89
29. The composition of our governing body allows us to meet stakeholder and community needs.	0	0	100	94
30. Clear, written policies define term lengths and limits for individual members, as well as compensation.	0	0	100	93
31. We review our own structure, including size and subcommittee structure.	9	0	91	87
32. We have a process to elect or appoint our chair.	11	0	89	86

*Canadian average: Percentage of Accreditation Canada client organizations that completed the instrument from July to December, 2017 and agreed with the instrument items.

Overall, what is your assessment of the governing body's impact over the past 12 months, in terms of driving improvements to:	% Poor / Fair	% Good	% Very Good / Excellent	%Agree * Canadian Average
	Organization	Organization	Organization	
33. Patient safety	0	0	100	80
34. Quality of care	0	0	100	81

*Canadian average: Percentage of Accreditation Canada client organizations that completed the instrument from July to December, 2017 and agreed with the instrument items.

Governance Functioning Tool (2016) - Salem Home

The Governance Functioning Tool enables members of the governing body to assess board structures and processes, provide their perceptions and opinions, and identify priorities for action. It does this by asking questions about:

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

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

- **Data collection period: September 6, 2017 to January 25, 2018**
- **Number of responses: 15**

Governance Functioning Tool Results - Salem Home

	% Strongly Disagree / Disagree	% Neutral	% Agree / Strongly Agree	%Agree * Canadian Average
	Organization	Organization	Organization	
1. We regularly review and ensure compliance with applicable laws, legislation, and regulations.	0	0	100	94
2. Governance policies and procedures that define our role and responsibilities are well documented and consistently followed.	0	0	100	95
3. Subcommittees need better defined roles and responsibilities.	100	0	0	70
4. As a governing body, we do not become directly involved in management issues.	0	0	100	85
5. Disagreements are viewed as a search for solutions rather than a “win/lose”.	0	0	100	95
6. Our meetings are held frequently enough to make sure we are able to make timely decisions.	0	0	100	96
7. Individual members understand and carry out their legal duties, roles, and responsibilities, including subcommittee work (as applicable).	0	0	100	96
8. Members come to meetings prepared to engage in meaningful discussion and thoughtful decision making.	0	0	100	94

	% Strongly Disagree / Disagree	% Neutral	% Agree / Strongly Agree	%Agree * Canadian Average
	Organization	Organization	Organization	
9. Our governance processes need to better ensure that everyone participates in decision making.	100	0	0	59
10. The composition of our governing body contributes to strong governance and leadership performance.	0	0	100	95
11. Individual members ask for and listen to one another's ideas and input.	0	0	100	97
12. Our ongoing education and professional development is encouraged.	0	0	100	86
13. Working relationships among individual members are positive.	0	0	100	98
14. We have a process to set bylaws and corporate policies.	0	0	100	95
15. Our bylaws and corporate policies cover confidentiality and conflict of interest.	0	0	100	98
16. We benchmark our performance against other similar organizations and/or national standards.	0	0	100	77
17. Contributions of individual members are reviewed regularly.	0	93	7	71
18. As a team, we regularly review how we function together and how our governance processes could be improved.	0	0	100	84
19. There is a process for improving individual effectiveness when non-performance is an issue.	0	7	93	60
20. As a governing body, we regularly identify areas for improvement and engage in our own quality improvement activities.	7	0	93	84
21. As individual members, we need better feedback about our contribution to the governing body.	93	0	7	44
22. We receive ongoing education on how to interpret information on quality and patient safety performance.	0	0	100	81
23. As a governing body, we oversee the development of the organization's strategic plan.	0	0	100	97
24. As a governing body, we hear stories about clients who experienced harm during care.	0	0	100	86

	% Strongly Disagree / Disagree	% Neutral	% Agree / Strongly Agree	%Agree * Canadian Average
	Organization	Organization	Organization	
25. The performance measures we track as a governing body give us a good understanding of organizational performance.	0	0	100	91
26. We actively recruit, recommend, and/or select new members based on needs for particular skills, background, and experience.	0	100	0	86
27. We lack explicit criteria to recruit and select new members.	100	0	0	77
28. Our renewal cycle is appropriately managed to ensure the continuity of the governing body.	0	0	100	89
29. The composition of our governing body allows us to meet stakeholder and community needs.	0	0	100	94
30. Clear, written policies define term lengths and limits for individual members, as well as compensation.	0	0	100	93
31. We review our own structure, including size and subcommittee structure.	0	0	100	87
32. We have a process to elect or appoint our chair.	0	0	100	86

*Canadian average: Percentage of Accreditation Canada client organizations that completed the instrument from July to December, 2017 and agreed with the instrument items.

Overall, what is your assessment of the governing body's impact over the past 12 months, in terms of driving improvements to:	% Poor / Fair	% Good	% Very Good / Excellent	%Agree * Canadian Average
	Organization	Organization	Organization	
33. Patient safety	0	0	100	80
34. Quality of care	0	7	93	81

*Canadian average: Percentage of Accreditation Canada client organizations that completed the instrument from July to December, 2017 and agreed with the instrument items.

Governance Functioning Tool (2016) - Tabor Home

The Governance Functioning Tool enables members of the governing body to assess board structures and processes, provide their perceptions and opinions, and identify priorities for action. It does this by asking questions about:

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

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

- **Data collection period: September 6, 2017 to January 26, 2018**
- **Number of responses: 10**

Governance Functioning Tool Results - Tabor Home

	% Strongly Disagree / Disagree	% Neutral	% Agree / Strongly Agree	%Agree * Canadian Average
	Organization	Organization	Organization	
1. We regularly review and ensure compliance with applicable laws, legislation, and regulations.	0	0	100	94
2. Governance policies and procedures that define our role and responsibilities are well documented and consistently followed.	0	0	100	95
3. Subcommittees need better defined roles and responsibilities.	100	0	0	70
4. As a governing body, we do not become directly involved in management issues.	0	0	100	85
5. Disagreements are viewed as a search for solutions rather than a “win/lose”.	0	0	100	95
6. Our meetings are held frequently enough to make sure we are able to make timely decisions.	0	0	100	96
7. Individual members understand and carry out their legal duties, roles, and responsibilities, including subcommittee work (as applicable).	0	0	100	96
8. Members come to meetings prepared to engage in meaningful discussion and thoughtful decision making.	0	0	100	94

	% Strongly Disagree / Disagree	% Neutral	% Agree / Strongly Agree	%Agree * Canadian Average
	Organization	Organization	Organization	
9. Our governance processes need to better ensure that everyone participates in decision making.	100	0	0	59
10. The composition of our governing body contributes to strong governance and leadership performance.	0	0	100	95
11. Individual members ask for and listen to one another's ideas and input.	0	0	100	97
12. Our ongoing education and professional development is encouraged.	0	0	100	86
13. Working relationships among individual members are positive.	0	0	100	98
14. We have a process to set bylaws and corporate policies.	0	0	100	95
15. Our bylaws and corporate policies cover confidentiality and conflict of interest.	0	0	100	98
16. We benchmark our performance against other similar organizations and/or national standards.	0	0	100	77
17. Contributions of individual members are reviewed regularly.	0	0	100	71
18. As a team, we regularly review how we function together and how our governance processes could be improved.	0	0	100	84
19. There is a process for improving individual effectiveness when non-performance is an issue.	0	0	100	60
20. As a governing body, we regularly identify areas for improvement and engage in our own quality improvement activities.	0	0	100	84
21. As individual members, we need better feedback about our contribution to the governing body.	100	0	0	44
22. We receive ongoing education on how to interpret information on quality and patient safety performance.	0	0	100	81
23. As a governing body, we oversee the development of the organization's strategic plan.	0	0	100	97
24. As a governing body, we hear stories about clients who experienced harm during care.	0	0	100	86

	% Strongly Disagree / Disagree	% Neutral	% Agree / Strongly Agree	%Agree * Canadian Average
	Organization	Organization	Organization	
25. The performance measures we track as a governing body give us a good understanding of organizational performance.	0	0	100	91
26. We actively recruit, recommend, and/or select new members based on needs for particular skills, background, and experience.	0	0	100	86
27. We lack explicit criteria to recruit and select new members.	100	0	0	77
28. Our renewal cycle is appropriately managed to ensure the continuity of the governing body.	0	0	100	89
29. The composition of our governing body allows us to meet stakeholder and community needs.	0	0	100	94
30. Clear, written policies define term lengths and limits for individual members, as well as compensation.	0	0	100	93
31. We review our own structure, including size and subcommittee structure.	0	0	100	87
32. We have a process to elect or appoint our chair.	0	0	100	86

*Canadian average: Percentage of Accreditation Canada client organizations that completed the instrument from July to December, 2017 and agreed with the instrument items.

Overall, what is your assessment of the governing body's impact over the past 12 months, in terms of driving improvements to:	% Poor / Fair	% Good	% Very Good / Excellent	%Agree * Canadian Average
	Organization	Organization	Organization	
33. Patient safety	0	0	100	80
34. Quality of care	0	0	100	81

*Canadian average: Percentage of Accreditation Canada client organizations that completed the instrument from July to December, 2017 and agreed with the instrument items.

Governance Functioning Tool (2016) - Rest Haven Personal Care Home

The Governance Functioning Tool enables members of the governing body to assess board structures and processes, provide their perceptions and opinions, and identify priorities for action. It does this by asking questions about:

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

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

- **Data collection period: September 6, 2017 to February 21, 2018**
- **Number of responses: 9**

Governance Functioning Tool Results - Rest Haven Personal Care Home

	% Strongly Disagree / Disagree	% Neutral	% Agree / Strongly Agree	%Agree * Canadian Average
	Organization	Organization	Organization	
1. We regularly review and ensure compliance with applicable laws, legislation, and regulations.	0	0	100	94
2. Governance policies and procedures that define our role and responsibilities are well documented and consistently followed.	0	0	100	95
3. Subcommittees need better defined roles and responsibilities.	100	0	0	70
4. As a governing body, we do not become directly involved in management issues.	0	0	100	85
5. Disagreements are viewed as a search for solutions rather than a “win/lose”.	0	0	100	95
6. Our meetings are held frequently enough to make sure we are able to make timely decisions.	0	0	100	96
7. Individual members understand and carry out their legal duties, roles, and responsibilities, including subcommittee work (as applicable).	0	0	100	96
8. Members come to meetings prepared to engage in meaningful discussion and thoughtful decision making.	0	0	100	94

	% Strongly Disagree / Disagree	% Neutral	% Agree / Strongly Agree	%Agree * Canadian Average
	Organization	Organization	Organization	
9. Our governance processes need to better ensure that everyone participates in decision making.	100	0	0	59
10. The composition of our governing body contributes to strong governance and leadership performance.	0	0	100	95
11. Individual members ask for and listen to one another's ideas and input.	0	0	100	97
12. Our ongoing education and professional development is encouraged.	0	0	100	86
13. Working relationships among individual members are positive.	0	0	100	98
14. We have a process to set bylaws and corporate policies.	0	0	100	95
15. Our bylaws and corporate policies cover confidentiality and conflict of interest.	0	0	100	98
16. We benchmark our performance against other similar organizations and/or national standards.	0	0	100	77
17. Contributions of individual members are reviewed regularly.	0	0	100	71
18. As a team, we regularly review how we function together and how our governance processes could be improved.	0	0	100	84
19. There is a process for improving individual effectiveness when non-performance is an issue.	0	0	100	60
20. As a governing body, we regularly identify areas for improvement and engage in our own quality improvement activities.	0	0	100	84
21. As individual members, we need better feedback about our contribution to the governing body.	100	0	0	44
22. We receive ongoing education on how to interpret information on quality and patient safety performance.	0	0	100	81
23. As a governing body, we oversee the development of the organization's strategic plan.	0	0	100	97
24. As a governing body, we hear stories about clients who experienced harm during care.	0	0	100	86

	% Strongly Disagree / Disagree	% Neutral	% Agree / Strongly Agree	%Agree * Canadian Average
	Organization	Organization	Organization	
25. The performance measures we track as a governing body give us a good understanding of organizational performance.	0	0	100	91
26. We actively recruit, recommend, and/or select new members based on needs for particular skills, background, and experience.	0	0	100	86
27. We lack explicit criteria to recruit and select new members.	100	0	0	77
28. Our renewal cycle is appropriately managed to ensure the continuity of the governing body.	0	0	100	89
29. The composition of our governing body allows us to meet stakeholder and community needs.	0	0	100	94
30. Clear, written policies define term lengths and limits for individual members, as well as compensation.	0	0	100	93
31. We review our own structure, including size and subcommittee structure.	0	0	100	87
32. We have a process to elect or appoint our chair.	0	0	100	86

*Canadian average: Percentage of Accreditation Canada client organizations that completed the instrument from July to December, 2017 and agreed with the instrument items.

Overall, what is your assessment of the governing body's impact over the past 12 months, in terms of driving improvements to:	% Poor / Fair	% Good	% Very Good / Excellent	%Agree * Canadian Average
	Organization	Organization	Organization	
33. Patient safety	0	0	100	80
34. Quality of care	0	0	100	81

*Canadian average: Percentage of Accreditation Canada client organizations that completed the instrument from July to December, 2017 and agreed with the instrument items.

Governance Functioning Tool (2016) - Prairie View Lodge

The Governance Functioning Tool enables members of the governing body to assess board structures and processes, provide their perceptions and opinions, and identify priorities for action. It does this by asking questions about:

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

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

- **Data collection period: September 6, 2017 to March 2, 2018**
- **Number of responses: 7**

Governance Functioning Tool Results - Prairie View Lodge

	% Strongly Disagree / Disagree	% Neutral	% Agree / Strongly Agree	%Agree * Canadian Average
	Organization	Organization	Organization	
1. We regularly review and ensure compliance with applicable laws, legislation, and regulations.	0	0	100	94
2. Governance policies and procedures that define our role and responsibilities are well documented and consistently followed.	0	0	100	95
3. Subcommittees need better defined roles and responsibilities.	86	14	0	70
4. As a governing body, we do not become directly involved in management issues.	14	0	86	85
5. Disagreements are viewed as a search for solutions rather than a “win/lose”.	0	0	100	95
6. Our meetings are held frequently enough to make sure we are able to make timely decisions.	0	0	100	96
7. Individual members understand and carry out their legal duties, roles, and responsibilities, including subcommittee work (as applicable).	0	0	100	96
8. Members come to meetings prepared to engage in meaningful discussion and thoughtful decision making.	0	0	100	94

	% Strongly Disagree / Disagree	% Neutral	% Agree / Strongly Agree	%Agree * Canadian Average
	Organization	Organization	Organization	
9. Our governance processes need to better ensure that everyone participates in decision making.	86	0	14	59
10. The composition of our governing body contributes to strong governance and leadership performance.	0	14	86	95
11. Individual members ask for and listen to one another's ideas and input.	0	0	100	97
12. Our ongoing education and professional development is encouraged.	0	0	100	86
13. Working relationships among individual members are positive.	0	0	100	98
14. We have a process to set bylaws and corporate policies.	0	0	100	95
15. Our bylaws and corporate policies cover confidentiality and conflict of interest.	0	0	100	98
16. We benchmark our performance against other similar organizations and/or national standards.	0	14	86	77
17. Contributions of individual members are reviewed regularly.	57	29	14	71
18. As a team, we regularly review how we function together and how our governance processes could be improved.	0	0	100	84
19. There is a process for improving individual effectiveness when non-performance is an issue.	0	0	100	60
20. As a governing body, we regularly identify areas for improvement and engage in our own quality improvement activities.	0	14	86	84
21. As individual members, we need better feedback about our contribution to the governing body.	86	14	0	44
22. We receive ongoing education on how to interpret information on quality and patient safety performance.	0	0	100	81
23. As a governing body, we oversee the development of the organization's strategic plan.	0	0	100	97
24. As a governing body, we hear stories about clients who experienced harm during care.	0	29	71	86

	% Strongly Disagree / Disagree	% Neutral	% Agree / Strongly Agree	%Agree * Canadian Average
	Organization	Organization	Organization	
25. The performance measures we track as a governing body give us a good understanding of organizational performance.	0	0	100	91
26. We actively recruit, recommend, and/or select new members based on needs for particular skills, background, and experience.	14	29	57	86
27. We lack explicit criteria to recruit and select new members.	71	14	14	77
28. Our renewal cycle is appropriately managed to ensure the continuity of the governing body.	0	0	100	89
29. The composition of our governing body allows us to meet stakeholder and community needs.	0	0	100	94
30. Clear, written policies define term lengths and limits for individual members, as well as compensation.	0	0	100	93
31. We review our own structure, including size and subcommittee structure.	0	0	100	87
32. We have a process to elect or appoint our chair.	0	0	100	86

*Canadian average: Percentage of Accreditation Canada client organizations that completed the instrument from July to December, 2017 and agreed with the instrument items.

Overall, what is your assessment of the governing body's impact over the past 12 months, in terms of driving improvements to:	% Poor / Fair	% Good	% Very Good / Excellent	%Agree * Canadian Average
	Organization	Organization	Organization	
33. Patient safety	0	29	71	80
34. Quality of care	0	14	86	81

*Canadian average: Percentage of Accreditation Canada client organizations that completed the instrument from July to December, 2017 and agreed with the instrument items.

Governance Functioning Tool (2016) - Rock Lake District Hospital and Personal Care Home

The Governance Functioning Tool enables members of the governing body to assess board structures and processes, provide their perceptions and opinions, and identify priorities for action. It does this by asking questions about:

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

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

- **Data collection period: September 6, 2017 to March 2, 2018**
- **Number of responses: 8**

Governance Functioning Tool Results - Rock Lake District Hospital and Personal Care Home

	% Strongly Disagree / Disagree	% Neutral	% Agree / Strongly Agree	%Agree * Canadian Average
	Organization	Organization	Organization	
1. We regularly review and ensure compliance with applicable laws, legislation, and regulations.	0	13	88	94
2. Governance policies and procedures that define our role and responsibilities are well documented and consistently followed.	0	0	100	95
3. Subcommittees need better defined roles and responsibilities.	88	13	0	70
4. As a governing body, we do not become directly involved in management issues.	13	0	88	85
5. Disagreements are viewed as a search for solutions rather than a “win/lose”.	0	13	88	95
6. Our meetings are held frequently enough to make sure we are able to make timely decisions.	13	0	88	96
7. Individual members understand and carry out their legal duties, roles, and responsibilities, including subcommittee work (as applicable).	0	13	88	96
8. Members come to meetings prepared to engage in meaningful discussion and thoughtful decision making.	0	13	88	94

	% Strongly Disagree / Disagree	% Neutral	% Agree / Strongly Agree	%Agree * Canadian Average
	Organization	Organization	Organization	
9. Our governance processes need to better ensure that everyone participates in decision making.	63	0	38	59
10. The composition of our governing body contributes to strong governance and leadership performance.	0	13	88	95
11. Individual members ask for and listen to one another's ideas and input.	13	0	88	97
12. Our ongoing education and professional development is encouraged.	0	0	100	86
13. Working relationships among individual members are positive.	0	0	100	98
14. We have a process to set bylaws and corporate policies.	0	0	100	95
15. Our bylaws and corporate policies cover confidentiality and conflict of interest.	0	0	100	98
16. We benchmark our performance against other similar organizations and/or national standards.	13	13	75	77
17. Contributions of individual members are reviewed regularly.	50	13	38	71
18. As a team, we regularly review how we function together and how our governance processes could be improved.	13	0	88	84
19. There is a process for improving individual effectiveness when non-performance is an issue.	13	13	75	60
20. As a governing body, we regularly identify areas for improvement and engage in our own quality improvement activities.	13	0	88	84
21. As individual members, we need better feedback about our contribution to the governing body.	63	13	25	44
22. We receive ongoing education on how to interpret information on quality and patient safety performance.	0	13	88	81
23. As a governing body, we oversee the development of the organization's strategic plan.	0	0	100	97
24. As a governing body, we hear stories about clients who experienced harm during care.	25	0	75	86

	% Strongly Disagree / Disagree	% Neutral	% Agree / Strongly Agree	%Agree * Canadian Average
	Organization	Organization	Organization	
25. The performance measures we track as a governing body give us a good understanding of organizational performance.	0	13	88	91
26. We actively recruit, recommend, and/or select new members based on needs for particular skills, background, and experience.	13	38	50	86
27. We lack explicit criteria to recruit and select new members.	50	13	38	77
28. Our renewal cycle is appropriately managed to ensure the continuity of the governing body.	0	0	100	89
29. The composition of our governing body allows us to meet stakeholder and community needs.	0	0	100	94
30. Clear, written policies define term lengths and limits for individual members, as well as compensation.	0	0	100	93
31. We review our own structure, including size and subcommittee structure.	0	0	100	87
32. We have a process to elect or appoint our chair.	0	0	100	86

*Canadian average: Percentage of Accreditation Canada client organizations that completed the instrument from July to December, 2017 and agreed with the instrument items.

Overall, what is your assessment of the governing body's impact over the past 12 months, in terms of driving improvements to:	% Poor / Fair	% Good	% Very Good / Excellent	%Agree * Canadian Average
	Organization	Organization	Organization	
33. Patient safety	0	25	75	80
34. Quality of care	0	25	75	81

*Canadian average: Percentage of Accreditation Canada client organizations that completed the instrument from July to December, 2017 and agreed with the instrument items.

Governance Functioning Tool (2016) - Heritage Life Personal Care Home

The Governance Functioning Tool enables members of the governing body to assess board structures and processes, provide their perceptions and opinions, and identify priorities for action. It does this by asking questions about:

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

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

- **Data collection period: September 6, 2017 to March 22, 2018**
- **Number of responses: 1**

Governance Functioning Tool Results - Heritage Life Personal Care Home

	% Strongly Disagree / Disagree	% Neutral	% Agree / Strongly Agree	%Agree * Canadian Average
	Organization	Organization	Organization	
1. We regularly review and ensure compliance with applicable laws, legislation, and regulations.	0	0	100	94
2. Governance policies and procedures that define our role and responsibilities are well documented and consistently followed.	0	0	100	95
3. Subcommittees need better defined roles and responsibilities.	100	0	0	70
4. As a governing body, we do not become directly involved in management issues.	0	100	0	85
5. Disagreements are viewed as a search for solutions rather than a “win/lose”.	0	0	100	95
6. Our meetings are held frequently enough to make sure we are able to make timely decisions.	0	0	100	96
7. Individual members understand and carry out their legal duties, roles, and responsibilities, including subcommittee work (as applicable).	0	0	100	96
8. Members come to meetings prepared to engage in meaningful discussion and thoughtful decision making.	0	0	100	94

	% Strongly Disagree / Disagree	% Neutral	% Agree / Strongly Agree	%Agree * Canadian Average
	Organization	Organization	Organization	
9. Our governance processes need to better ensure that everyone participates in decision making.	100	0	0	59
10. The composition of our governing body contributes to strong governance and leadership performance.	0	0	100	95
11. Individual members ask for and listen to one another's ideas and input.	0	0	100	97
12. Our ongoing education and professional development is encouraged.	0	0	100	86
13. Working relationships among individual members are positive.	0	0	100	98
14. We have a process to set bylaws and corporate policies.	0	0	100	95
15. Our bylaws and corporate policies cover confidentiality and conflict of interest.	0	0	100	98
16. We benchmark our performance against other similar organizations and/or national standards.	0	100	0	77
17. Contributions of individual members are reviewed regularly.	0	0	100	71
18. As a team, we regularly review how we function together and how our governance processes could be improved.	0	0	100	84
19. There is a process for improving individual effectiveness when non-performance is an issue.	100	0	0	60
20. As a governing body, we regularly identify areas for improvement and engage in our own quality improvement activities.	0	0	100	84
21. As individual members, we need better feedback about our contribution to the governing body.	0	100	0	44
22. We receive ongoing education on how to interpret information on quality and patient safety performance.	0	0	100	81
23. As a governing body, we oversee the development of the organization's strategic plan.	0	0	100	97
24. As a governing body, we hear stories about clients who experienced harm during care.	0	0	100	86

	% Strongly Disagree / Disagree	% Neutral	% Agree / Strongly Agree	%Agree * Canadian Average
	Organization	Organization	Organization	
25. The performance measures we track as a governing body give us a good understanding of organizational performance.	0	0	100	91
26. We actively recruit, recommend, and/or select new members based on needs for particular skills, background, and experience.	0	0	100	86
27. We lack explicit criteria to recruit and select new members.	100	0	0	77
28. Our renewal cycle is appropriately managed to ensure the continuity of the governing body.	0	0	100	89
29. The composition of our governing body allows us to meet stakeholder and community needs.	0	0	100	94
30. Clear, written policies define term lengths and limits for individual members, as well as compensation.	0	0	100	93
31. We review our own structure, including size and subcommittee structure.	0	0	100	87
32. We have a process to elect or appoint our chair.	0	0	100	86

*Canadian average: Percentage of Accreditation Canada client organizations that completed the instrument from July to December, 2017 and agreed with the instrument items.

Overall, what is your assessment of the governing body's impact over the past 12 months, in terms of driving improvements to:	% Poor / Fair	% Good	% Very Good / Excellent	%Agree * Canadian Average
	Organization	Organization	Organization	
33. Patient safety	0	0	100	80
34. Quality of care	0	0	100	81

*Canadian average: Percentage of Accreditation Canada client organizations that completed the instrument from July to December, 2017 and agreed with the instrument items.

Governance Functioning Tool (2016) - Menno Home for the Aged

The Governance Functioning Tool enables members of the governing body to assess board structures and processes, provide their perceptions and opinions, and identify priorities for action. It does this by asking questions about:

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

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

- **Data collection period: September 6, 2017 to March 28, 2018**
- **Number of responses: 6**

Governance Functioning Tool Results - Menno Home for the Aged

	% Strongly Disagree / Disagree	% Neutral	% Agree / Strongly Agree	%Agree * Canadian Average
	Organization	Organization	Organization	
1. We regularly review and ensure compliance with applicable laws, legislation, and regulations.	0	0	100	94
2. Governance policies and procedures that define our role and responsibilities are well documented and consistently followed.	0	0	100	95
3. Subcommittees need better defined roles and responsibilities.	33	50	17	70
4. As a governing body, we do not become directly involved in management issues.	0	0	100	85
5. Disagreements are viewed as a search for solutions rather than a “win/lose”.	0	0	100	95
6. Our meetings are held frequently enough to make sure we are able to make timely decisions.	0	0	100	96
7. Individual members understand and carry out their legal duties, roles, and responsibilities, including subcommittee work (as applicable).	0	0	100	96
8. Members come to meetings prepared to engage in meaningful discussion and thoughtful decision making.	0	0	100	94

	% Strongly Disagree / Disagree	% Neutral	% Agree / Strongly Agree	%Agree * Canadian Average
	Organization	Organization	Organization	
9. Our governance processes need to better ensure that everyone participates in decision making.	17	50	33	59
10. The composition of our governing body contributes to strong governance and leadership performance.	0	0	100	95
11. Individual members ask for and listen to one another's ideas and input.	0	0	100	97
12. Our ongoing education and professional development is encouraged.	0	0	100	86
13. Working relationships among individual members are positive.	0	0	100	98
14. We have a process to set bylaws and corporate policies.	0	0	100	95
15. Our bylaws and corporate policies cover confidentiality and conflict of interest.	0	0	100	98
16. We benchmark our performance against other similar organizations and/or national standards.	0	17	83	77
17. Contributions of individual members are reviewed regularly.	0	83	17	71
18. As a team, we regularly review how we function together and how our governance processes could be improved.	0	0	100	84
19. There is a process for improving individual effectiveness when non-performance is an issue.	0	50	50	60
20. As a governing body, we regularly identify areas for improvement and engage in our own quality improvement activities.	0	0	100	84
21. As individual members, we need better feedback about our contribution to the governing body.	50	0	50	44
22. We receive ongoing education on how to interpret information on quality and patient safety performance.	0	0	100	81
23. As a governing body, we oversee the development of the organization's strategic plan.	0	0	100	97
24. As a governing body, we hear stories about clients who experienced harm during care.	17	0	83	86

	% Strongly Disagree / Disagree	% Neutral	% Agree / Strongly Agree	%Agree * Canadian Average
	Organization	Organization	Organization	
25. The performance measures we track as a governing body give us a good understanding of organizational performance.	0	0	100	91
26. We actively recruit, recommend, and/or select new members based on needs for particular skills, background, and experience.	50	0	50	86
27. We lack explicit criteria to recruit and select new members.	17	83	0	77
28. Our renewal cycle is appropriately managed to ensure the continuity of the governing body.	0	17	83	89
29. The composition of our governing body allows us to meet stakeholder and community needs.	0	0	100	94
30. Clear, written policies define term lengths and limits for individual members, as well as compensation.	0	0	100	93
31. We review our own structure, including size and subcommittee structure.	0	17	83	87
32. We have a process to elect or appoint our chair.	0	0	100	86

*Canadian average: Percentage of Accreditation Canada client organizations that completed the instrument from July to December, 2017 and agreed with the instrument items.

Overall, what is your assessment of the governing body's impact over the past 12 months, in terms of driving improvements to:	% Poor / Fair	% Good	% Very Good / Excellent	%Agree * Canadian Average
	Organization	Organization	Organization	
33. Patient safety	0	0	100	80
34. Quality of care	0	0	100	81

*Canadian average: Percentage of Accreditation Canada client organizations that completed the instrument from July to December, 2017 and agreed with the instrument items.

Governance Functioning Tool (2016) - Villa Youville

The Governance Functioning Tool enables members of the governing body to assess board structures and processes, provide their perceptions and opinions, and identify priorities for action. It does this by asking questions about:

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

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

- **Data collection period: September 6, 2017 to March 31, 2018**
- **Number of responses: 8**

Governance Functioning Tool Results - Villa Youville

	% Strongly Disagree / Disagree	% Neutral	% Agree / Strongly Agree	%Agree * Canadian Average
	Organization	Organization	Organization	
1. We regularly review and ensure compliance with applicable laws, legislation, and regulations.	0	13	88	94
2. Governance policies and procedures that define our role and responsibilities are well documented and consistently followed.	0	0	100	95
3. Subcommittees need better defined roles and responsibilities.	88	0	13	70
4. As a governing body, we do not become directly involved in management issues.	25	0	75	85
5. Disagreements are viewed as a search for solutions rather than a “win/lose”.	0	0	100	95
6. Our meetings are held frequently enough to make sure we are able to make timely decisions.	0	0	100	96
7. Individual members understand and carry out their legal duties, roles, and responsibilities, including subcommittee work (as applicable).	0	0	100	96
8. Members come to meetings prepared to engage in meaningful discussion and thoughtful decision making.	0	0	100	94

	% Strongly Disagree / Disagree	% Neutral	% Agree / Strongly Agree	%Agree * Canadian Average
	Organization	Organization	Organization	
9. Our governance processes need to better ensure that everyone participates in decision making.	63	0	38	59
10. The composition of our governing body contributes to strong governance and leadership performance.	0	0	100	95
11. Individual members ask for and listen to one another's ideas and input.	0	0	100	97
12. Our ongoing education and professional development is encouraged.	0	38	63	86
13. Working relationships among individual members are positive.	0	0	100	98
14. We have a process to set bylaws and corporate policies.	0	0	100	95
15. Our bylaws and corporate policies cover confidentiality and conflict of interest.	0	0	100	98
16. We benchmark our performance against other similar organizations and/or national standards.	29	29	43	77
17. Contributions of individual members are reviewed regularly.	14	0	86	71
18. As a team, we regularly review how we function together and how our governance processes could be improved.	0	13	88	84
19. There is a process for improving individual effectiveness when non-performance is an issue.	14	43	43	60
20. As a governing body, we regularly identify areas for improvement and engage in our own quality improvement activities.	0	25	75	84
21. As individual members, we need better feedback about our contribution to the governing body.	63	25	13	44
22. We receive ongoing education on how to interpret information on quality and patient safety performance.	13	0	88	81
23. As a governing body, we oversee the development of the organization's strategic plan.	0	0	100	97
24. As a governing body, we hear stories about clients who experienced harm during care.	0	50	50	86

	% Strongly Disagree / Disagree	% Neutral	% Agree / Strongly Agree	%Agree * Canadian Average
	Organization	Organization	Organization	
25. The performance measures we track as a governing body give us a good understanding of organizational performance.	0	13	88	91
26. We actively recruit, recommend, and/or select new members based on needs for particular skills, background, and experience.	0	0	100	86
27. We lack explicit criteria to recruit and select new members.	75	0	25	77
28. Our renewal cycle is appropriately managed to ensure the continuity of the governing body.	0	0	100	89
29. The composition of our governing body allows us to meet stakeholder and community needs.	0	0	100	94
30. Clear, written policies define term lengths and limits for individual members, as well as compensation.	0	0	100	93
31. We review our own structure, including size and subcommittee structure.	0	13	88	87
32. We have a process to elect or appoint our chair.	0	0	100	86

*Canadian average: Percentage of Accreditation Canada client organizations that completed the instrument from July to December, 2017 and agreed with the instrument items.

Overall, what is your assessment of the governing body's impact over the past 12 months, in terms of driving improvements to:	% Poor / Fair	% Good	% Very Good / Excellent	%Agree * Canadian Average
	Organization	Organization	Organization	
33. Patient safety	0	13	88	80
34. Quality of care	0	13	88	81

*Canadian average: Percentage of Accreditation Canada client organizations that completed the instrument from July to December, 2017 and agreed with the instrument items.

Worklife Pulse

Accreditation Canada helps organizations create high quality workplaces that support workforce wellbeing and performance. This is why Accreditation Canada provides organizations with the Worklife Pulse Tool, an evidence-informed questionnaire that takes a snapshot of the quality of worklife.

Organizations can use results from the Worklife Pulse Tool to identify strengths and gaps in the quality of worklife, engage stakeholders in discussions of opportunities for improvement, plan interventions to improve the quality of worklife and develop a clearer understanding of how quality of worklife influences the organization's capacity to meet its strategic goals. By taking action to improve the determinants of worklife measured in the Worklife Pulse tool, organizations can improve outcomes.

The organization used an approved substitute tool for measuring the quality of worklife Pulse. An action plan was submitted to Accreditation Canada.

Client Experience Tool

Measuring client experience in a consistent, formal way provides organizations with information they can use to enhance client-centred services, increase client engagement, and inform quality improvement initiatives.

Prior to the on-site survey, the organization conducted a client experience survey that addressed the following dimensions:

Respecting client values, expressed needs and preferences,including respecting client rights, cultural values, and preferences; ensuring informed consent and shared decision-making; and encouraging active participation in care planning and service delivery.

Sharing information, communication, and education,including providing the information that people want, ensuring open and transparent communication, and educating clients and their families about the health issues.

Coordinating and integrating services across boundaries,including accessing services, providing continuous service across the continuum, and preparing clients for discharge or transition.

Enhancing quality of life in the care environment and in activities of daily living,including providing physical comfort, pain management, and emotional and spiritual support and counselling.

The organization then had the chance to address opportunities for improvement and discuss related initiatives with surveyors during the on-site survey.

Client Experience Program Requirement	
Conducted a client experience survey using a survey tool and approach that meets accreditation program requirements	Met
Provided a client experience survey report(s) to Accreditation Canada	Met

Organization's Commentary

After the on-site survey, the organization was invited provide comments to be included in this report about its experience with Qmentum and the accreditation process.

Southern Health-Santé Sud (SH-SS) in partnership with the affiliate and community-owned not for profit organization participated in the on-site accreditation visit in the spring of 2019 as part of the four -year accreditation cycle.

SH-SS and affiliate/community-owned not for profit organizations are committed to providing quality, people-centered care with a focus on continuous improvement, patient safety and risk management. Our organizations strive to provide care in a manner that is consistent with our mission, vision and values. This report highlights our organizational strengths and also identifies areas for further growth and development so 'together we can lead the way for a healthier tomorrow'.

Appendix A - Qmentum

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

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

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

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

Action Planning

Following the on-site survey, the organization uses the information in its Accreditation Report and Quality Performance Roadmap to develop action plans to address areas identified as needing improvement.

Appendix B - Priority Processes

Priority processes associated with system-wide standards

Priority Process	Description
People-Centred Care	Working with clients and their families to plan and provide care that is respectful, compassionate, culturally safe, and competent, and to see that this care is continuously improved upon.

Appendix C - Linguistic Access: Pilot Survey Results

March 23, 2016

Introduction

Hôpital Ste-Anne Hospital participated in a voluntary pilot survey of Accreditation Canada`s new Linguistic Access Self-Assessment tools that aim to help organizations assess their ability to provide health services to linguistic minorities. Hôpital Ste-Anne Hospital was assessed against the Governance, Leadership and Service-level self-assessment tools during a half day pilot survey using the tracer methodology.

Overall Impressions

Hôpital Ste-Anne Hospital demonstrated excellence in the provision of linguistically accessible services. Hôpital Ste-Anne Hospital benefits from a dedicated leadership team that is committed to supporting their team in providing high quality French Language Services (FLS). Staff members demonstrated engagement in the process and were well prepared to receive the survey team. In fact, one member participated in the half day survey over teleconference during their vacation. All Ste-Anne participants were welcoming and willing to answer questions, or provide input. Hôpital Ste-Anne Hospital has worked with the Southern Health – Santé Sud region and partners to develop and implement a comprehensive FLS plan.

Survey Process

At the beginning of the visit, the organization provided an overview of the Southern Health - Santé Sud region, the population it serves, and the implementation of their FLS. This was helpful to provide context, and set the stage for FLS at their site. All materials and documents relevant to FLS were presented in a comprehensive binder, which facilitated the rating of criteria. A group discussion was held with the Leadership team, relevant FLS personnel, and a member of the governing body, to explain FLS within the region and how it is operationalized at the hospital site. This forum was used to evaluate the Leadership self-assessment tool.

Following the group discussion, a tour of the organization was provided to conduct the tracer, and evaluate the service-level assessment tool. For this part of the survey, a physician joined the conversation and provided further information on the provision of FLS. The survey team had the opportunity of speaking with several staff members, viewing client records, and speaking with 2-3 clients about their experiences of receiving FLS at Hôpital Ste-Anne Hospital.

Once the group discussion and tracer were conducted, the group reconvened to speak with a member of the governing body and rate the Governance-level assessment tool. A debrief session was provided by the surveyor to summarize strengths and areas of improvement.

Survey Results – Strengths

Hôpital Ste-Anne Hospital achieved the majority of the elements of the Language Access Tools. Out of a total of 49 criteria, 46 were rated as “met” and 3 were rated as “in progress”. At the governance level, Hôpital Ste-Anne Hospital has a well-established FLS plan (2013 – 2016), implemented at the regional

level (Southern Health – Santé Sud). The FLS plan is broadly communicated at the regional level, and there is an identified director responsible for the plan and its' implementation. The FLS plan is endorsed by the governing body, and includes input from the Francophone community. In addition, Southern Health - Santé Sud has developed solid partnerships with Santé en français.

At the leadership level, the FLS plan and relevant policies and procedures have been thoroughly implemented, and leaders demonstrated awareness of relevant legislation. Data that pertains to the Francophone population are collected, such as the languages spoken by clients and their preferred official language, as well as data pertaining to the health of Francophones. In addition, human resource data related to bilingual positions are gathered and regularly reported/available through dashboards, including the movement of bilingual personnel throughout the region. Resources pertaining to FLS are allocated adequately. It was evident during the survey that the leaders of the organization promote a culture of language accessibility by supporting staff in language training, and through the communication of the FLS plan and FLS policies and procedures. Finally, Hôpital Ste-Anne Hospital is applauded for including communication in incident reporting and the complaints procedure.

At the service level, team members were aware of relevant FLS policies and procedures, the FLS plan, and language assistance services to facilitate communication with clients. Team members were using a client-centred approach to service delivery by providing services in the client's preferred language and including them in service design.

Survey Results – Areas for Improvement

The three criteria rated as "in progress" pertained to: criterion 25 (Leadership level), which relates to identifying indicators to measure progress towards making health services linguistically accessible; criterion 9 (Service level), which pertains to documenting language preference and proficiency in each client record; and criterion 13 (Service level), which relates to the availability of French consent forms and other vital documents for clients and their families. Regarding criterion 25 (Leadership level), it was noted that the indicators that have been chosen are in the process of being implemented. Regarding criterion 9 (Service level), although the identification of language preference is standard as per ADT EPR Registration Tab Sequence, under demographics, the surveyor did not see this information in the client record during the tracer. Finally, regarding criterion 13 (Service level), it was indicated that this work is in progress due to the merger of the two regions.

Hôpital Ste-Anne Hospital improvement activities pertain mainly to the operationalization of FLS policies and procedures at the service level. This would include ensuring the consistency of active offers (hello, bonjour) by staff, and ensuring that all client records contain language preference data. In addition to language data, the surveyor discussed implementing a method to clearly identify the records of clients who speak French only (e.g., applying a green sticker on the front of those records). It is recognized that the provision of FLS services is a complex process that requires support from multiple levels (macro, meso and micro), and that, despite having the necessary infrastructure to support FLS, ensuring the consistent operationalization of established FLS structures and processes is a challenge that all health care settings face. Accreditation Canada congratulates Hôpital Ste-Anne Hospital for their tremendous efforts in the provision of linguistically accessible health services. Accreditation Canada is grateful for the opportunity of piloting these new tools in the Hôpital Ste-Anne Hospital setting.