ACCREDITATION
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Qmentum

Accreditation Report

Saskatchewan Health Authority

Saskatoon, SK

On-site survey dates: November 24, 2019 - November 29, 2019

Report issued: December 21, 2019

About the Accreditation Report

Saskatchewan Health Authority (referred to in this report as “the organization”) is participating in Accreditation Canada's Qmentum accreditation program. As part of this ongoing process of quality improvement, an on-site survey was conducted in November 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

Table of Contents

Executive Summary 1

Accreditation Decision 1

About the On-site Survey 2

Overview by Quality Dimensions 5

Overview by Standards 6

Overview by Required Organizational Practices 8

Summary of Surveyor Team Observations 15

Detailed Required Organizational Practices Results 17

Detailed On-site Survey Results 19

Priority Process Results for System-wide Standards 20

Priority Process: Governance 20

Priority Process: Planning and Service Design 22

Priority Process: Resource Management 23

Priority Process: Human Capital 24

Priority Process: Integrated Quality Management 26

Priority Process: Principle-based Care and Decision Making 28

Priority Process: Communication 29

Priority Process: Physical Environment 30

Priority Process: Emergency Preparedness 32

Priority Process: People-Centred Care 33

Priority Process: Patient Flow 35

Priority Process: Medical Devices and Equipment 36

Service Excellence Standards Results 40

Standards Set: Ambulatory Care Services - Direct Service Provision 40

Standards Set: Critical Care Services - Direct Service Provision 44

Standards Set: Emergency Department - Direct Service Provision 47

Standards Set: Home Care Services - Direct Service Provision 51

Standards Set: Infection Prevention and Control Standards - Direct Service Provision 53

Standards Set: Inpatient Services - Direct Service Provision 55

Standards Set: Intellectual and Developmental Disabilities - Direct Service Provision 59

Standards Set: Long-Term Care Services - Direct Service Provision 64

Standards Set: Medication Management Standards - Direct Service Provision 66
Standards Set: Obstetrics Services - Direct Service Provision 72
Standards Set: Perioperative Services and Invasive Procedures - Direct Service Provision 77
Standards Set: Rehabilitation Services - Direct Service Provision 81
Instrument Results 86
Governance Functioning Tool (2016) 86
Client Experience Tool 89
Organization's Commentary 91
Appendix A - Qmentum 92
Appendix B - Priority Processes 93

Executive Summary

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

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

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

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

Accreditation Decision

Saskatchewan Health Authority's accreditation decision is:

Accredited (Report)

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

About the On-site Survey

- **On-site survey dates: November 24, 2019 to November 29, 2019**

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

- **Locations**

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

1. Alvin Buckwold Child Development Program (Kinsmen Children's Centre)
2. Battlefords Union Hospital
3. Central Parkland Lodge
4. Circle Drive Special Care Home
5. Cypress Regional Hospital
6. Dr. F. H. Wigmore Regional Hospital
7. Home Care Services
8. Humboldt District Health Complex
9. Jim Pattison Children's Hospital
10. Kindersley & District Health Centre
11. La Ronge Health Centre
12. Lloydminster Hospital
13. Meadow Lake Hospital
14. Melfort Hospital
15. Nipawin Hospital
16. Regina General Hospital
17. RGH - Ambulatory - Fetal Assessment Unit
18. RGH - Ambulatory - Pediatric Outpatient Unit
19. RGH - Ambulatory - Women's Health/Early Pregnancy Assessment Clinic
20. Royal University Hospital
21. Saskatoon City Hospital
22. Southeast Integrated Care Centre
23. St. Joseph's Hospital of Estevan
24. St. Paul's Hospital
25. Victoria Hospital

26. Warman Mennonite Special Care Home
27. Wascana Rehabilitation Centre
28. Westwinds Primary Health Centre
29. Yorkton Regional 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

Service Excellence Standards

5. Ambulatory Care Services - Service Excellence Standards
6. Critical Care Services - Service Excellence Standards
7. Emergency Department - Service Excellence Standards
8. Home Care Services - Service Excellence Standards
9. Inpatient Services - Service Excellence Standards
10. Intellectual and Developmental Disabilities - Service Excellence Standards
11. Long-Term Care Services - Service Excellence Standards
12. Obstetrics Services - Service Excellence Standards
13. Perioperative Services and Invasive Procedures - Service Excellence Standards
14. Rehabilitation Services - Service Excellence Standards
15. Reprocessing of Reusable Medical Devices - 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)	43	2	0	45
Accessibility (Give me timely and equitable services)	94	6	0	100
Safety (Keep me safe)	461	51	15	527
Worklife (Take care of those who take care of me)	122	19	1	142
Client-centred Services (Partner with me and my family in our care)	404	10	3	417
Continuity (Coordinate my care across the continuum)	85	1	0	86
Appropriateness (Do the right thing to achieve the best results)	775	41	16	832
Efficiency (Make the best use of resources)	45	3	4	52
Total	**2029**	**133**	**39**	**2201**

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	50 (100.0%)	0 (0.0%)	0	36 (100.0%)	0 (0.0%)	0	86 (100.0%)	0 (0.0%)	0
Leadership	48 (100.0%)	0 (0.0%)	2	95 (99.0%)	1 (1.0%)	0	143 (99.3%)	1 (0.7%)	2
Infection Prevention and Control Standards	38 (95.0%)	2 (5.0%)	0	26 (89.7%)	3 (10.3%)	2	64 (92.8%)	5 (7.2%)	2
Medication Management Standards	62 (84.9%)	11 (15.1%)	5	54 (85.7%)	9 (14.3%)	1	116 (85.3%)	20 (14.7%)	6
Ambulatory Care Services	36 (76.6%)	11 (23.4%)	0	67 (85.9%)	11 (14.1%)	0	103 (82.4%)	22 (17.6%)	0
Critical Care Services	58 (98.3%)	1 (1.7%)	1	93 (100.0%)	0 (0.0%)	12	151 (99.3%)	1 (0.7%)	13
Emergency Department	70 (97.2%)	2 (2.8%)	0	105 (98.1%)	2 (1.9%)	0	175 (97.8%)	4 (2.2%)	0
Home Care Services	45 (95.7%)	2 (4.3%)	2	71 (94.7%)	4 (5.3%)	1	116 (95.1%)	6 (4.9%)	3

Standards Set	High Priority Criteria *			Other Criteria			Total Criteria (High Priority + Other)		
	Met	Unmet	N/A	Met	Unmet	N/A	Met	Unmet	N/A
	# (%)	# (%)	#	# (%)	# (%)	#	# (%)	# (%)	#
Inpatient Services	51 (87.9%)	7 (12.1%)	2	76 (90.5%)	8 (9.5%)	1	127 (89.4%)	15 (10.6%)	3
Intellectual and Developmental Disabilities	54 (100.0%)	0 (0.0%)	0	93 (100.0%)	0 (0.0%)	0	147 (100.0%)	0 (0.0%)	0
Long-Term Care Services	53 (94.6%)	3 (5.4%)	0	93 (95.9%)	4 (4.1%)	2	146 (95.4%)	7 (4.6%)	2
Obstetrics Services	60 (84.5%)	11 (15.5%)	2	85 (96.6%)	3 (3.4%)	0	145 (91.2%)	14 (8.8%)	2
Perioperative Services and Invasive Procedures	106 (92.2%)	9 (7.8%)	0	108 (99.1%)	1 (0.9%)	0	214 (95.5%)	10 (4.5%)	0
Rehabilitation Services	45 (100.0%)	0 (0.0%)	0	80 (100.0%)	0 (0.0%)	0	125 (100.0%)	0 (0.0%)	0
Reprocessing of Reusable Medical Devices	75 (85.2%)	13 (14.8%)	0	38 (95.0%)	2 (5.0%)	0	113 (88.3%)	15 (11.7%)	0
Total	**851 (92.2%)**	72 (7.8%)	14	1120 (95.9%)	48 (4.1%)	19	1971 (94.3%)	120 (5.7%)	33

* 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 (Critical Care Services)	Unmet	0 of 1	0 of 0
Client Identification (Emergency Department)	Unmet	0 of 1	0 of 0
Client Identification (Home Care Services)	Met	1 of 1	0 of 0
Client Identification (Inpatient Services)	Unmet	0 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 (Long-Term Care Services)	Met	1 of 1	0 of 0
Client Identification (Obstetrics Services)	Unmet	0 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 (Critical Care Services)	Met	4 of 4	1 of 1
Information transfer at care transitions (Emergency Department)	Met	4 of 4	1 of 1
Information transfer at care transitions (Home Care Services)	Unmet	3 of 4	1 of 1
Information transfer at care transitions (Inpatient Services)	Met	4 of 4	1 of 1
Information transfer at care transitions (Intellectual and Developmental Disabilities)	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 (Obstetrics Services)	Unmet	0 of 4	0 of 1

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Communication			
Information transfer at care transitions (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 (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 (Obstetrics Services)	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 (Perioperative Services and Invasive Procedures)	Unmet	3 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	0 of 3
Patient Safety Goal Area: Medication Use			
Antimicrobial Stewardship (Medication Management Standards)	Unmet	0 of 4	0 of 1
Concentrated Electrolytes (Medication Management Standards)	Unmet	2 of 3	0 of 0
Heparin Safety (Medication Management Standards)	Unmet	3 of 4	0 of 0
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 (Critical Care Services)	Met	4 of 4	2 of 2
Infusion Pumps Training (Emergency Department)	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 (Home Care Services)	Met	4 of 4	2 of 2
Infusion Pumps Training (Inpatient Services)	Met	4 of 4	2 of 2
Infusion Pumps Training (Long-Term Care 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
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
Workplace Violence Prevention (Leadership)	Met	5 of 5	3 of 3

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Infection Control			
Hand-Hygiene Compliance (Infection Prevention and Control Standards)	Met	1 of 1	2 of 2
Hand-Hygiene 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
Patient Safety Goal Area: Risk Assessment			
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
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

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Risk Assessment			
Pressure Ulcer Prevention (Inpatient Services)	Met	3 of 3	2 of 2
Pressure Ulcer Prevention (Long-Term Care Services)	Met	3 of 3	2 of 2
Pressure Ulcer Prevention (Perioperative Services and Invasive Procedures)	Met	3 of 3	2 of 2
Skin and Wound Care (Home Care Services)	Met	7 of 7	1 of 1
Suicide Prevention (Emergency Department)	Met	5 of 5	0 of 0
Suicide Prevention (Long-Term Care Services)	Met	5 of 5	0 of 0
Venous Thromboembolism Prophylaxis (Perioperative Services and Invasive Procedures)	Met	3 of 3	2 of 2

Summary of Surveyor Team Observations

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

The Saskatchewan Health Authority (SHA) was established in December 2017 with the amalgamation of the twelve former health regions. The ten-member Board of Directors were appointed by the Ministry of Health for three-year terms. Although this is a new Board, the majority of the Directors have extensive governance experience in healthcare and beyond and have impressively led the transition to the new structure. There is comprehensive governance knowledge and skills within the Board related to quality, safety, and ethical decision making.

A comprehensive Strategic Planning Process was undertaken resulting in the Strategic Plan focus for 2019-2020 and beyond. Engagement of the public, patients, families, and First Nations and Metis partners contributed to its all inclusiveness.

Appropriate emphasis has been placed on Connected Care and services for the Saskatchewan population. This was executed through effective teamwork across the continuum of care and services and ensuring improved access to Mental Health and Addictions Services, as an example. Secondly, there is a strategic imperative to ensure safe high-quality care as the new structure takes root and flourishes. There has been significant investment in leadership focused on improving the system-wide culture to ensure quality and patient safety, harnessed to explicit efforts to ensure both appropriateness and cultural sensitivity in decision-making. As well, there has been development of effective teams at all levels of the system through the roll out of the SHA Management System. To date, this has only infiltrated the most senior of teams and departments as the middle management level of the structure is to be confirmed by March 2020. Thus, it is in its infancy in reaching the front lines, although tracers conducted in Saskatoon hospitals validated it is beginning to do so.

Thoughtful attention has been given to the development of an Accreditation Model for the new organization, developed with broad input from community and patient family advisors, accreditation leads, and representatives from First Nations and Metis partners in care. This has resulted in a deliberate and planned approach to accreditation over a four-year cycle, using a 'Medicine Wheel". The model depicts the goals and rationale for moving in a sequential process, while simultaneously bridging parts of the provincial system to ensure accreditation progress and improvement gains were not lost through the transition period.

This first provincial survey is focused on both bridging for the previous Saskatoon Health Region and an initial review of Maternal and Children's Provincial Programs across the continuum of care. Furthermore, core standards related to Leadership, Governance, Infection Prevention and Control, and Medication Management were assessed. The Board and the Executive Leadership Team are applauded for their courage in engaging in this process so early in their tenure. It speaks highly to their commitment to learning and to the accreditation process and value.

The work of high-level transition resulted in the "Building the Foundation for Transformation and System

Sustainability Framework". This has provided a solid grounding foundation to portray the current and future state and understanding what it will take to create a sustainable system, and why. Impressively many teams referred to its use and value as an underpinning of their day to day work.

The transition has been labour intensive in terms of setting the organization on a deliberate path following the best pre-established Lean quality foundations already built in, however, there is now a need to focus on getting the middle management level established by March 2020 as planned to better engage staff, teams, and partners at the point of care level.

The SHA has inherited more than 80 back office and legacy systems from the previous former regions which has resulted in enormous obstacles for data collection, collation and analysis, as well as fiscal oversight. AIMS will be in place by June 2020 which will strengthen integrated financial and human resource processes and key performance indicators.

It was determined that a significant barrier to achievement of strategic goals overall is the lack of an integrated Clinical Information System. This has been addressed in the report as an imperative need in moving forward.

People-centred care principles, values, and ways of working permeate the organization, and there is an overwhelming validation that engagement accountability is well entrenched in practice. It will be important to broaden the inclusion of younger voices and perspectives and those of new immigrants to the province in the future.

The survey team was honoured to be invited to the traditional territory of the Treaty 6 and Metis homeland and respect the commitment of the Saskatchewan Health Authority to Truth and Reconciliation in all they do.

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	
Information transfer at care transitions Information relevant to the care of the client is communicated effectively during care transitions.	· Home Care Services 9.10 · Obstetrics Services 9.16
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 · Emergency Department 12.6 · Obstetrics Services 9.2 · Critical Care Services 9.4
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 Inpatient care only: Medication reconciliation is conducted in partnership with clients and families to communicate accurate and complete information about medications across care transitions.	· Perioperative Services and Invasive Procedures 11.6
Patient Safety Goal Area: Medication Use	
Concentrated Electrolytes The availability of concentrated electrolytes 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 12.9

Unmet Required Organizational Practice	Standards Set
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
Antimicrobial Stewardship There is an antimicrobial stewardship program to optimize antimicrobial use. NOTE: This ROP applies to organizations providing the following services: inpatient acute care, inpatient cancer, inpatient rehabilitation, and complex continuing care.	· Medication Management Standards 2.3
High-Alert Medications A documented and coordinated approach to safely manage high-alert medications is implemented.	· Medication Management Standards 2.5

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.

The organization has met all criteria for this priority process.
Surveyor comments on the priority process(es)

Nine of the ten Board members participated in dialogue with surveyors. The Board is an impressive mix of individuals highly skilled in governance. The Board Charter is both comprehensive and is explicitly aligned with the Qmentum governance standard. Board meeting agendas are appropriately constituted, and meetings always begin with a meaningful patient story and reflection on the ethical checklist which aligns with the Ethics Framework for the Saskatchewan Health Authority (SHA). The Board validated that this practice grounds their work and allows them to conduct their business in a person-centred way and serves as a reminder as to why they are meeting. Board minutes reflect that quality and safety are consistent standing agenda items.

A Patient Family Advisor sits on the Quality and Safety Committee of the Board. The Board is commended for this inclusion of a patient family lens and for a voice in governance. The majority of the oversight functions of the Board are effectively addressed through the established Board Committees, with accountability reports and issues requiring full Board input pushed up to the Board as a whole. By-laws are clear and adhered to as validated by a review of minutes and audit reports.

The Board was able to speak to their governance development needs based on their use of their own Governance Functioning Survey Results. One recent example of development built into the September 2019 Board Retreat included a presentation from and dialogue with, Dr. Ross Baker, who focused on patient safety and implications for effective Boards.

Boundary spanning external to the organization is broad. The Board Chair and CEO have regular meetings with the Ministry of Health and other targeted stakeholders to garner the necessary shared understandings and supports for intentional full implementation of the Strategic Plan. This approach is important to achieve a single and sustainable integrated system of health services for the people of Saskatchewan, as close to home as possible.

The provincial investment in Lean methodology in previous years provided a legacy of quality science

knowledge and tools for capacity-building prior to the amalgamation. This is viewed as a strength by the Board and validated by surveyors. The people within the provincial system, from the Ministry of Health to those at points of care and service delivery, clearly share a common quality and safety language, and common knowledge and tools to facilitate both monitoring, accountability, and achievement of strategic imperatives. In doing so, there is also clear recognition of the imperative need to invest in an integrated Clinical Information System for the province to allow real time collection, collation, and use of clinical, financial, and statistical measures of outcomes and variations. The Board was able to speak comprehensively to the issues and risks associated with the inheritance of more than 80 disparate legacy electronic platforms, that are not linked, for which AIMS, which will be introduced in spring 2020, will assist with financial and human resource components.

The SHA Board is commended on its governance success through the amalgamation, while overseeing safe quality care, and commissioning the new Jim Pattison Children's Hospital. This requires execution of a complex set of governance skills. The people of Saskatchewan should be proud of the Board’s service on their behalf.

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)

Planning and service design is comprehensively done with good alignment between community and population health needs, strategic pillars and directions, and operational plans. Accountability oversight processes are strong and there is robust use of quality, safety, and risk mitigation methodology, knowledge, skills, and tools. This foundation was validated as a grounding strength of the planning and oversight processes that will measure progress on long-term goal attainment. The Framework "Building the Foundation for Transformation and Sustainability" is comprehensive and used as a touch stone by all Leadership in every undertaking they take. Impressive analysis of the current state of the system has informed purposeful and deliberate actions to get to a preferred, sustainable system. The resource team, Board, Provincial Ethics Committee, and formal Patient Family Advisors engaged with the surveyors and could readily speak to the various ways their cross-functional work aligned with the Framework. There is now a need to engage more directly with front line teams and community partners who support people in service delivery to better understand the Framework and it's meaning, so as to fully engage them in Network development. Staff at all locations of the organization and community partners are wanting and ready to engage in the work ahead. This is a "just in time" opportunity.

Impressive patient, family, and community input to transition, strategy, operations, in-focused quality improvement planning, testing, and implementation, as a few examples, was validated. Broad input from children and families was sought and effectively applied in the design and customization of the new Jim Pattison Children's Hospital. The challenge ahead is viewed as the engagement of new partners and patient perspectives as each Network is co-designed, as the community’s needs and resource capacity will be so varied. There is validation and acknowledgement that SHA is well positioned to do this extremely well.

Priority Process: Resource Management

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

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

The Resource Management Team is an enthusiastic and skilled mix of individuals who very openly shared the value they experienced in working in cross-functional ways to prepare for transition and day one operational support for the amalgamation of the twelve former health regions to one provincial health authority.

The ability to produce an accurate year end audit after one year of operation as an amalgamated system with more than 80 legacy and back end systems is impressive and applauded.

The team has invested significant human resources in the development, testing, and refinement of AIMS for financial, supply chain, and human resource information management. It is intended to be fully operational by summer 2020 and will require a labour intensive running of two systems to achieve implementation. Attention to long term resource requisites at the sites and to support the 38 Health Networks will be top of mind considerations for this team in informing operational plans provincially.

Priority Process: Human Capital

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

Unmet Criteria	High Priority Criteria
Standards Set: Leadership	
2.13 A process is developed for team members to confidentially bring forward complaints, concerns, and grievances.	

Surveyor comments on the priority process(es)

The Human Resources (HR) Portfolio in the SHA has developed a Human Resources Plan and a Target Operating Model to provide direction over the next three to five years. This is supported by a HR Business Partner Team, Staff Services (Staff Services Inquiry Centre and Delivery Services) and Communities of Expertise (Workforce Planning and Employment Strategies, Organizational Development and Employee Wellness, Employee and Labour Relations, and HR Systems and Analytics). This Model was put in place after an extensive review of the former health regions and looking at the best practices and variances across the regions. As the team begins to implement the model, there is recognition that more staff will be required, especially Business Partners. The implementation of the Business Partner role has freed up to two hours per day of Manager time that was previously spent on HR issues. A key to the success of this model will be the implementation of AIMS in the spring of 2020 where the 82 non-integrated systems will become one. This platform will provide accurate, up to date data and will enable the organization to forecast HR needs provincially.

Physician recruitment and HR planning, while not part of the HR portfolio, has a plan to address significant recruitment needs. Return of Service Agreements are in place for some physicians and for staff where tuition, bursaries, or relocation expenses have been awarded. There is an onboarding process for all staff, including physicians. Many of the modules can be accessed through the e-learning program. Not all staff have an organization email address, and this will need to be in place with the upcoming implementation of AIMS.

There are numerous approaches to wellness in place in the previous health regions. Work to consolidate processes and policies is in the planning stages. The cross-functional teams that will be employed in the Health Networks are a priority focus for the guidance and support from the HR team. Workforce planning will be key to the success of these teams.

There is a standard process for Performance Reviews for out of scope staff following the LEADS Framework. In scope reviews are moving towards a coaching conversation approach and currently there is no standard process in place. The organization is encouraged to develop a process that is shared broadly with all in scope staff. Work has begun to standardize job descriptions and updates have been made as for hiring managers (next level out of scope) into the SHA will begin in spring 2020. First Nations and Metis

Knowledge Keepers and Patient Family Advisors are invited to participate on many interview panels. Due to capacity issues, this may not take place at the future hiring of managers Employee files were standardized, as outlined in the previous regions, and will become SHA files once AIMS is in place.

The HR plan is updated quarterly. The team described the many opportunities for updates and sharing of information such as the SLT Huddles, the Director Huddles, an HR Blog, and Webex. The HR team was passionate about the work that they do. Members spoke of the strong teamwork to move the organization to becoming an Employer of Choice.

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)

Integrated quality management is a strength of the Saskatchewan Health Authority (SHA). Impressive cross-functional ways of working are in place and more are being tested. The SHA Management System roll-out is strengthening the approaches and effectiveness of integrated quality management. Continued attention to inclusion of those selected for positions in the next management level in the system is encouraged.

There was a provincial investment in Lean methodology by the province prior to the amalgamation of the twelve former health regions to the Saskatchewan Health Authority, which, is a strength for the system at its inception. Participation in national Learning Collaboratives extends to the Board as well.

The SHA Management System is developing manager and team relationships that are collaborative in identifying and resolving safety issues, pertinent to the work that each team is responsible for. Amazing quality improvements have already been realized in such areas as Retail Food Services with reductions in staff injuries, improvements in equipment loads, and standardization, as a few examples. Teams celebrate their success and staff are now naming the safety issues and offering ideas. As a result of safety huddles, communication between staff and with managers has improved and there is an evident sense that all are sharing leadership for safe team functioning.

At this stage of transition to the almost two year old Saskatchewan Health Authority, from the amalgamation of the twelve former health regions, there has been little focus on or ability to scale up for spread of quality improvements; although, there are pockets of examples where this has already occurred. The plans to address shortfalls in processes related to important safety practices in, medication management, medication reconciliation, patient handovers, discharge transitions, and standardized infection prevention and control practices, as examples, are very much encouraged as the next steps. This will ensure improvement gains that have already been realized are not lost and future risks are mitigated. Leaders are expert in improvement science application, and it is the core of people-centred care closest to home values and strategic directions. There are well over 2000 physicians and staff who are expertly trained in quality improvement and working in cross-functional ways and within Physician/Administrative Dyads who are well-positioned to lead and support these ongoing efforts.

There is intentional leadership focus and support for reducing variation. In less than two years of operation as a single provincial Health Authority, much has been accomplished in the standardization of processes and decision support tools. In doing so, many processes and tools that existed in the previous twelve former health regions at the time of amalgamation remain in place until thoughtfully replaced with

streamlined provincial processes, decision support tools, and Clinical Practice Guidelines. Two examples are, the commissioning and opening of the new and first pediatric hospital in the province and the establishment of a contract with the MoreOB Program. Policies and procedures are being systematically gathered, inventoried, and streamlined as replacements are developed and deployed. It is recognized that this takes time, and there is encouragement to continue to focus on prioritizing those processes that have the biggest impacts on mitigating risk, using the risk matrices that have already been developed, and which have shaped such things as the provincial medication management operational plan.

Having said that, the imperative need and benefits of moving to have an integrated Clinical Information System was validated. Consolidation of clinical systems across the continuum of care (primary health care, acute care, continuing care) is a critical foundational element to achieving the SHA's strategic goals of "Connected Care, Safe and High-Quality Health Care, and System Wide Coordination and Alignment of Services".

Seamless system/patient flow requires an understanding of patients' needs in order to ensure they are receiving care by the most appropriate team in the most appropriate location. A critical requirement is access to real time clinical data.

Standardization of clinical practice and workflow supported by enabling technology, is a key component of improving the quality and safety of patient care.

In addition, managing system capacity requires unencumbered real time access to clinical data and will also be a requisite for successful implementation of new Health Networks. Care teams within Networks will need to collaborate confidently using standardized clinical care processes, workflows, and sharing of clinical care information between geographic areas. Consolidation of clinical systems unleashes the power of clinical analytics tools and allows for real time management of system performance and care delivery. It will strengthen system performance accountability measurement, risk identification, mitigation capability, and enable case costing. In order to achieve this, the SHA will also need an appropriate mechanism to hold their IT service provider accountable to deliver and meet their needs.

Priority Process: Principle-based Care and Decision Making

Identifying and making decisions about ethical dilemmas and problems.

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

The new Provincial Ethics Committee established in the spring of 2019 is a strength and has resulted in the Board approved Ethics Framework for the Saskatchewan Health Authority. Research ethics is undertaken by a separate Ethics Review Board with the universities as partners.

Impressive support has already been provided to local ethics committees as some of the committees lost their footing with the amalgamation with staff movement. It is impressive that this has been able to be achieved in six short months. The establishment of Ethics Rounds and Community of Practice is applauded.

The tracer of a comprehensive long term care (LTC) ethical issue in safe care was reviewed and was validated as offering broad suggestions that satisfied the needs of the referring team and the individual.

There was robust discussion of what ethical situations are likely to be encountered as the system transformation is completed, as Health Networks are introduced, and as the changing needs of people served are addressed. As a result, there is encouragement for the Provincial Ethics Committee to take proactive leadership in making themselves more visible in their engagement with the system, and by profiling their availability for input during key policy discussions and the development of cross-functional teams, as the system requires.

The Provincial Ethics Committee was validated as a highly insightful and collaborative team with rich expertise to offer the Saskatchewan Health Authority. Impressively, the team is proud of its accomplishments thus far and were able to flag the ethics consultation trends they are now able to track. In doing so, it will be important to provide feedback to the Board and to teams in the system to help further embed ethics considerations into care, when questions may arise. The team discussed an array of options including case studies, stories, and decision trees, as a few examples.

Priority Process: Communication

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

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

The Communication Team provided an overview of their targeted communication audiences and stakeholders. Examples of privacy breach situations were reviewed as a tracer and effective quality improvements were put in place to mitigate future breach of privacy risks.

There was robust discussion of the changing demands being placed on the team which is distributed throughout the province. Some of the pressures relate directly to the impacts of amalgamation and taking a "one system" approach; others are seen to be the result of the Engagement Strategy itself which is broad and comprehensive. The strategy is purposefully explicit in its design to include patients and families, staff and physicians, affiliates and partners, the Ministry of Health, existing and new Networks at the community and primary care levels, as well as partnerships with Affiliate Organizations, Foundations, and First Nation and Metis groups, as a few examples.

The team is rightfully proud to acknowledge that the communication foundations established within the twelve former health regions were valued and honored in the transition process, which allowed effective communication to continue as the whole system approach continued to mature.

It was validated that technological solutions will be required to sustain more complex and effective system communication processes in a seamless integrated system, where patients and families are anticipated to speak in terms of being associated with "my health network". In doing so, the team understands that their support to the various customers they serve internally and externally, as well as at the individual patient level, requires real time access to a variety of communication data.

At this time, the eHealth IT support resource base is situated as a separate corporate entity within the Ministry of Health. There is encouragement for ongoing Executive Leadership discussion with the Board and the Ministry to ensure effective alignment of the essential eHealth contractual obligations required at the system operational level. The Strategic Plan is a one system plan shared by the people of the province, the Ministry of Health, the Health Council, and all stakeholders and partners. It is hoped that an integrated solution linked to a Clinical Information System for sustainability can be found in the coming years, to put Saskatchewan on the national and international map in this regard.

Having said that, strategic attention to communication roles and functions, as well as skill mix is anticipated to be required to support the 38 Networks in new and creative ways. This may be a strategic area for attention as business planning unfolds. As the Model of Care changes for existing and emerging programs, it will be imperative to monitor and address the changing needs for a variety of communication solutions for patients, families, and communities to effectively self-manage.

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)

The Saskatoon City Hospital is bright and clean. Signage is good and hallways are wide, accessible, and not crowded. Back-up systems are checked on a regular basis and monitored closely by Facilities Maintenance. Service contracts are in place as required. Fire drills and codes are tested on a regular basis. The facility may want to consider having fire drills on the evening or night shifts.

While many facilities are older, there is a strong commitment to safety. Infection control is consulted for all construction or renovations.

The Nipawin Hospital is an older building (built in 1950). The labour and delivery rooms are spacious but the pre- and post-rooms are cramped, with bathrooms and showers across the hall. Access to hot water in many of the rooms in a certain area of the unit is sporadic. Oxygen tanks stored on the Inpatient Unit were not secured properly and the organization is encouraged to address this issue.

There is strong leadership and team members supporting the physical plant at the Royal University Hospital. The team members are supported in ensuing a safe and proactive environment. There is a strong commitment to safety. Infection control permits are received prior to construction or renovations.

St. Paul’s Hospital is an acute care hospital with facility infrastructure of varying age and challenges. The Facilities Management Team has a robust electronic preventative management planning and tracking process. The team engages in safety rounds weekly and infection prevention and control representation is present at these meetings. There is a strong collaborative relation between the maintenance and ICP teams. The staff have safety training and all safety incidents are reviewed with their team. They have an asbestos management plan with yearly inspections of all areas containing asbestos. The physical design of the Operating Room and Medical Device Reprocessing Department (MDRD) do not allow for complete separation for increasing levels of infection control, with the area for surgical attire requirements being identified by a line on the floor. MDRD infrastructure contains wood products and the organization is encouraged to look at how this issue can be addressed.

The new Jim Pattison Children’s Hospital was opened September 29, 2019. The facility design is strongly influenced by patients and families. The facility is bright, warm, and has extensive use of colours. Stakeholder engagement was significant throughout the building process. IPC principles were embedded into all the areas. Care models changed and the staff had many opportunities to practice future events (day in the life) prior to the move. Staff safety and patient safety were strong considerations in all aspects of the building. Some rooms in the Emergency Department designated for children with mental health needs are being improved to address safety concerns. The facility has a computerized maintenance

program. Redundancies have been built into the system for electrical and water. Wayfinding and signage are being sorted out as staff and families become familiar with the building. The organization is fortunate to have such a wonderful facility to look after the needs of the mothers, children, and families of Saskatchewan.

Priority Process: Emergency Preparedness

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

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

Existing documentation and processes in the form of Emergency Plans from the former health regions are used to guide emergency management planning and management of incidents. Consolidation and harmonization of the processes is on the agenda but has yet to be actioned. The first initiative is to update and standardize codes across the SHA. Code Silver will be introduced to all staff through an e-learning module. Other codes will be reviewed as the organization moves to standardize the number of codes.

The organization has had multiple experiences with incidents and disasters in the past two years. The Humboldt bus tragedy tested the system in April 2016. Staff who participated felt well prepared and supported through this challenging time. As well, the organization has experienced two evacuations from Long Term Care facilities due to a nearby grassland wild fire in the area and flooding and power failure in another area. Furthermore, a tornado also hit part of the province. All incidents were debriefed, and lessons learned were shared.

Processes are in place to manage outbreaks. Service disruption plans exist but are not consolidated into an overall business continuity plan. The organization is encouraged to pull this information into one provincial document.

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: Home Care Services		
3.3	A comprehensive orientation is provided to new team members and client and family representatives.	
3.11	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.	
14.11	Patient safety incidents are analyzed to help prevent recurrence and make improvements, with input from clients and families.	!
Standards Set: Long-Term Care Services		
1.1	Services are co-designed with residents and families, partners, and the community.	!
1.7	Barriers that may limit residents, families, service providers, and referring organizations from accessing services are identified and removed where possible, with input from residents and families.	
3.3	A comprehensive orientation is provided to new team members and resident and family representatives.	

Surveyor comments on the priority process(es)

The Saskatchewan Health Authority (SHA) is to be commended on the substantial amount of effort they have put on developing their people-centred care competency across the province in the past two years. The commitment to their number one value of patient and family-centred care is obvious from the CEO to the Board of Directors, senior leaders, to front line staff, and patient and family advisors.

The SHA has made a significant investment of human and financial resources into a dedicated and strategic Patient and Client Experience portfolio, including a large network of patient and family advisors. Taking the time to thoughtfully co-design their people-centred care strategy with patient and family advisors from across the province was a major effort and will serve the organization well in fostering

engagement capable environments.

The organization is fortunate to have 600 patient and family advisors who are passionate and eager to work together in partnership. The SHA can build upon the success of the past to increase patient and family advisor capacity across the province. The recent evaluation of the patient and family advisor experience illustrates the areas where things are going well and where some attention is required to make certain the feedback from advisors is making a difference. It is important to ensure diversity in advisors to reflect the diversity of the people of Saskatchewan. A special acknowledgment is given to the Patient and Family Leadership Council for incorporating First Nations' and Metis' world views.

Patients and families played a major role in the design of the new Jim Pattison Children's Hospital. The SHA embarked on an experience-based co-design project in the Children's Programs at Wascana Rehabilitation Centre, the Alvin Buckwold Child Development Program, and Victoria Hospital's Pediatric Inpatient Unit and may wish to consider how that engagement approach can be conducted in other program and service areas. Youth in northern Saskatchewan came together after a community crisis to form a youth council.

Health care providers are demonstrating caring, compassionate, and people-centred care every day. Patients and families are being involved as partners in their own care.

The Saskatchewan Health Authority is on a journey which can be summed up by the following comments heard this week. "Health care is a team sport", "There's no situation we can't take something good from", and "Anything great is worth the wait".

Priority Process: Patient Flow

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

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

The Saskatchewan Health Authority has a robust program to manage patient flow in the emergency departments. There is a daily check in at every level, in the individual emergency departments, and on other units. A Command Center reviews the day's situation and any needs for potential trading between areas.

The Command Center is supported by the information technology (IT) department and has developed multiple initiatives to reduce overcrowding in the emergency departments and other areas. These initiatives are divided into immediate and long term with the longer-term initiatives involving partnerships with other areas and potential program redesign. These initiatives are reviewed daily.

Despite this, overcrowding in the Emergency Department and within inpatient units is a chronic problem which peaks mid-week each week and is often a risky situation. The three prime drivers for this appear to be high and increasing patient demand and acuity, including delays along the care pathway for consultation or investigation, and including a lack of ability to transfer stable but high care needs individuals to an institution or home which can provide the required level of care. Each of these areas are being addressed with one of the utilization initiatives mentioned above.

The organization has put in place all the process mechanisms and indicators, is monitoring progress and is aware that this potentially risky situation exists; but the longer-term strategies will take a while to be implemented and impact the overcrowding issues.

The surgical program has centralized wait lists and has a system for reassigning cases, block booking times, and managing emergency cases that is working well. Indicators are used to prioritize the various parts of the system to ensure fairness and equity of access.

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		
4.7	For each disinfectant, manufacturers' recommendations for use, contact time, shelf life, storage, appropriate dilution, and any required PPE are followed.	!
4.8	Contaminated items are appropriately contained and transported to the reprocessing unit or area.	!
4.9	Contaminated items are transported separately from clean or sterilized items, and away from client service and high-traffic areas.	!
4.10	When transporting contaminated equipment and devices, applicable regulations are followed; environmental conditions are controlled; and clean and appropriate bins, boxes, bags, and transport vehicles are used.	!
4.11	Immediate-use (or “flash”) sterilization is used in the operating/procedure room only in an emergency, and never for complete sets or implantable devices.	!
4.13	Clean and sterile surgical equipment, medical devices, and supplies are stored separately from soiled equipment and waste, and according to manufacturers' instructions.	!
Standards Set: Reprocessing of Reusable Medical Devices		
3.2	The MDR department is designed to prevent cross-contamination of medical devices, isolate incompatible activities, and clearly separate work areas.	!
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.	!
5.11	Team member performance is regularly evaluated and documented in an objective, interactive, and constructive way.	!
5.12	Team members are supported by team leaders to follow up on issues and opportunities for growth identified through performance evaluations.	!

8.4	Access is provided to hand hygiene supplies, including properly functioning soap and towel dispensers and alcohol-based hand rub stations in the working environment.	!
8.5	Hand hygiene is performed before beginning and after completing work activities, as well as at other key points, to prevent infection.	!
8.6	Eating and drinking, storing food, applying cosmetics, and handling contact lenses are all prohibited in the reprocessing area.	!
8.8	Appropriate and properly maintained PPE is worn in the decontamination area.	!
9.3	Contaminated medical devices are sorted before reprocessing.	
11.2	All flexible endoscopic reprocessing areas are physically separate from patient care areas.	!
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.	
11.8	Flexible endoscopic devices are appropriately stored following manufacturers' instructions in a manner that minimizes contamination and damage.	!
12.1	The MDR department has an appropriate storage area for sterilized medical devices and equipment.	!
12.2	Access to the sterile storage area is limited to authorized team members.	!
14.3	All sterilized items in storage, or transported to patient service areas or other organizations, can be tracked.	!

Surveyor comments on the priority process(es)

The leaders and team members of the Medical Device Reprocessing Departments (MDRD) are committed to the quality of medical device and equipment reprocessing. Each team member spoke of being proud to contribute to high-quality patient care. The reprocessing areas are clean and well maintained. Team members commented positively on the training and education provided. Leaders are proud of the quality boards they have created with their teams. There are multiple examples of great work, effectiveness, and quality throughout the reprocessing units.

There is strong evidence of team resiliency in times of adversity; not only during recent tragic events experienced but ongoing when there is concern regarding water conditions, thus leading to non-functioning washers. Further examples of resiliency were seen in areas where staff have to deal with intermittent flooding due to faulty valves and repetitive unit malfunctions due to aging equipment.

St. Paul's Hospital has renovated the area in diagnostic ultrasound where the internal probes are cleaned. This is now a suitable area for reprocessing these items.

Regina General Hospital renovated their endoscopy suite since their last accreditation survey. The Registered Nurses working in this area have their competency assessed with respect to reprocessing and cleaning practices every three months as they are required at times to perform such duties while on call.

At the Lloydminster site, the team seemed well organized and knowledgeable about their areas of responsibilities in both the MDRD and endoscopy unit.

At the Kindersley site, the team performs reprocessing of endoscopic devices following the manufacturer's recommendation for scope cleaning. All staff are trained by the manufacturer and are Certified Medical Devices Reprocessing Technicians as well as have all received the Pentax-GI Scope Handling and Reprocessing Essentials Course.

Moose Jaw has a committed and dedicated team, evidence of commitment to quality education training was seen at the staff and leader levels. The team members reported feeling safe at work. A new facility was built in 2015, however, there is limited space in the endoscopic reprocessing area.

Estevan staff provided good discussion around how processes are done. They have two and a half well-trained staff. There are posted instructions on the wall depicting departmental processes. There is good flow of equipment with a proper pass through from the soiled to clean area.

Humboldt site's MDRD has an excellent, modern appearance with current equipment. Staff are well trained on standard operating procedures (SOP) and are committed to patient safety. They have a good relationship with peri-op services to manage volumes, instrumentation purchases, and the development of new SOPs.

The aging infrastructure and equipment at various sites are by far key opportunities to address. Many areas continue to have pressboard for cabinetry and shelving which is cracking and chipping; which is an infection prevention and control concern.

Two MDRD sterile equipment areas, at St. Paul's and Royal University hospitals, share their areas with distribution departments. While there is good control of the reprocessing departments' team members going in and out of the sterile area, foot and cart traffic from the distribution department in and out of this area is not controlled. The distribution department also uses corrugated boxes for storage of bulk items which is an infection prevention and control concern.

Currently, the reprocessing departments within Saskatoon do not have the ability to track their equipment. It was stated by several team members that there is a large quantity of instruments going missing daily.

In Moose Jaw, the reprocessing areas for flexible endoscopes have limited space for their reprocessing activities. There are separate clean and soiled areas, however, the door between the clean and soiled area was removed because the space did not allow the door to open into the work area. Additionally, there is no hand hygiene sink located in this work area. The team members use alcohol-based hand hygiene products or use the hand hygiene sink located outside the endoscopic reprocessing area. The organization is encouraged to physically fully separate the clean and soiled areas.

At the Royal University Hospital, the MDRD has had several incidents of needles and scalpel blades coming to the department on contaminated trays from the Operating Room. Some of these incidents have led to needlestick injuries and cuts to team members. It was noticed that the area for endoscope cleaning had many chipping surfaces of pressboard, paint chipping from the windows, blinds with dust, and ceiling tiles with water stains. There were no handwashing opportunities between the soiled and clean area. A pass-through window is suggested to be installed. The diagnostic ultrasound area reprocesses the diagnostic probes in a soiled room shared with the diagnostic imaging department soiled equipment. On the day visited, it was noted the surgical trays with instruments were left on the counter rather than being placed into the provided covered bins used for soiled transport. The bins are also kept on the counter which minimized the space for other users of this area. At the same time, the ultrasound probes are cleaned in a single sink beside this counter. Soiled linen is also in this room leaving the technicians a very tight working space. The organization is encouraged to review the available cleaning technologies on the market or the opportunities within the site for a solution.
Prince Albert does the reprocessing for many of the northern hospitals. It is very hard to have multiple casual staff capable of performing at the required level. Recruitment and training are completed internally in Prince Albert. If the staff and Director agree it is appropriate, the staff may continue on to complete a formal reprocessing course and exam.

Saskatoon City Hospital has a busy endoscopy unit. The scope soiled room has a lot of foot traffic in and out from the adjacent clean hall storage area. The storage of the clean scopes is at the end of a hallway where patients travel to access the toilet, and where staff transfer stretcher patients in and out of the cystoscopy room. Soiled scopes moving from other parts of the hospital are transported to the soiled room through the clean area.

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

Standards Set: Ambulatory 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 clients and families where appropriate.	

14.5	A record of each use of flash sterilization is kept and documented in the client record.	!
Priority Process: Competency		
3.10	Team member performance is regularly evaluated and documented in an objective, interactive, and constructive way.	!
3.12	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		
6.5	The number of clients who fail to present at scheduled appointments is monitored and strategies to improve attendance are implemented with input from clients and families.	
7.13	Clients and families are provided with information about their rights and responsibilities.	!
10.8	The effectiveness of transitions is evaluated and the information is used to improve transition planning, with input from clients and families.	
14.4	Flash sterilization in the ambulatory care area is only used in an emergency, and never for complete sets or implantable devices.	!
Priority Process: Decision Support		
11.8	There is a process to monitor and evaluate record-keeping practices, designed with input from clients and families, and the information is used to make improvements.	!
Priority Process: Impact on Outcomes		
13.2	The procedure to select evidence-informed guidelines is reviewed, with input from clients and families, teams, and partners.	
13.3	There is a standardized process, developed with input from clients and families, to decide among conflicting evidence-informed guidelines.	!
13.4	Protocols and procedures for reducing unnecessary variation in service delivery are developed, with input from clients and families.	!
13.5	Guidelines and protocols are regularly reviewed, with input from clients and families.	!

14.6	Safety improvement strategies are evaluated with input from clients and families.	!
15.1	Information and feedback is collected about the quality of services to guide quality improvement initiatives, with input from clients and families, team members, and partners.	
15.2	The information and feedback gathered is used to identify opportunities for quality improvement initiatives and set priorities, with input from clients and families.	
15.4	Indicator(s) that monitor progress for each quality improvement objective are identified, with input from clients and families.	
15.6	New or existing indicator data are used to establish a baseline for each indicator.	
15.7	There is a process to regularly collect indicator data and track progress.	
15.10	Information about quality improvement activities, results, and learnings is shared with clients, families, teams, organization leaders, and other organizations, as appropriate.	
15.11	Quality improvement initiatives are regularly evaluated for feasibility, relevance, and usefulness, with input from clients and families.	

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

There is an excellent relationship between the staff and their direct managers who support the programs. There are generic role descriptions for the regions but they do not specifically identify the specific qualifications and roles in a specific clinic.

Priority Process: Competency

Education and opportunities for continuing education are supported by the organization and staff take these opportunities to advance their knowledge.

Priority Process: Episode of Care

There is a strong collaborative multidisciplinary culture in each clinic and the immediate management is closely involved with a high interpersonal support for each of the clinics. Ongoing skill building occurs both formally and informally. Care is focused on the needs of the patient, family, and flexes safely to accommodate this. As part of the Health Authority the staff has access to all the organizational supports. As well, each clinic has highly specialized skills which are developed on-site or are existing prior to hire.

The ambulatory clinics are all sub-specialty clinics. Their focus is still largely on Saskatoon patients, but they are beginning to build connections to serve the larger provincial population. They have not quite made the jump to looking at serving the need as opposed to serving those who come through the door. Each clinic had active patient and family involvement in their origin, and all have some continued involvement; although, the pelvic floor health and mid-life clinics need to refocus in this area. Each clinic has some partnerships and is developing others.

Care is available in a timely way at each clinic. The clinics are monitored and are running mostly on time. During the survey no one waited and when patients were asked about the wait, they all commented on the timely access, minimal wait, and respectful way in which they were managed. Consent is formally obtained at both the breast clinic and the surgical clinic but is informal at the other two clinics. Information given to patients is done informally and verbally for many topics. Most patients stated that although they do not remember a specific discussion about rights, responsibilities, safety, or the complaint process, they felt that they had their issues dealt with respectfully.

Priority Process: Decision Support

Each clinic has excellent documentation regarding care provision. Each clinic is a mix of paper and electronic record keeping, with varied amounts of each. One of the clinics is on an entirely separate electronic medical record (EMR) system which coordinates with their surgeons' offices. Transition of care information is managed well internally and there is a strong desire to work around difficulties and get information out to the primary care providers at transition out of the service time. Most of the programs can post on eHealth through their physicians. Regular notes were generated at each clinic by the care provider.

Priority Process: Impact on Outcomes

The care process is highly documented with flow diagrams and is constantly being improved. Transitions back to the community are good and are improved by the staff, but, the effectiveness from the point of view of the receiver is not consistently evaluated.

Not all quality improvement activities are done with an active framework applied to the program. Most of the activity has been focused on improving the process through flow diagrams and data that gives utilization and access details. Patients and families have not always been involved in most of the quality improvement activities but there is evidence that this is beginning to happen in some places.

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	
3.12 Team member performance is regularly evaluated and documented in an objective, interactive, and constructive way.	!
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	
The organization has met all criteria for this priority process.	
Priority Process: Organ and Tissue Donation	
The organization has met all criteria for this priority process.	
Surveyor comments on the priority process(es)	
Priority Process: Clinical Leadership	

The NICU at Regina General Hospital (RGH) is funded for 25 beds but has a surge capacity for 30-33 beds, which includes the special care nursery. The average length of stay is 14-15 days and they run an average census of 24 patients. The teams meet daily for a province-wide teleconference to discuss census, pressures in overcapacity, and during this discussion make decisions to transfer and discharge patients. The NICU in RGH has space and extra isolettes/incubators to be able to ensure that an emergency bed is always available as part of their plan to manage surge capacity. The NICU tries to avoid transferring patients as much as possible in order to minimize travel for families.

At Victoria Hospital there are challenges with space and managing surge capacity plans within the special

care nursery. The team has organized the current special care nursery to accommodate a surge however the equipment and staffing are an issue. In the long term, this will be addressed with the redesign of the new nursery. The team follows best practices in ensuring access to maternal supplements and breast milk through the milk bank by providing a drop-off area for human milk.

The team contributes data to the Canadian Neonatal Network, and they receive regular reports which are used to make patient care decisions and provided to leadership for their annual reporting.

In order to prevent errors during a shift change, the team has implemented a policy and checklist for double-checking of all infusions, rates, solutions, and medications.

Parents of children in the NICU have access to accommodation quarters located within the hospital. Families have access to kitchen and lounge facilities. The team is challenged in finding a Patient Family Advisor and the manager would like to strengthen the ties with the provincial Patient Family Advisor group.

Priority Process: Competency

The team works closely with home care, social work, and the family to provide palliative and end-of-life care needs through their 'Lasting Legacy' program.

The NICU has two clinical educators who both work on the unit on a regular basis in order to maintain competency and have a good understanding of the challenges and concerns that arise. The staff receive training from trainers regionally that specialize in neonatal care.

The Pediatric High Acuity Unit has an educator who also provides support to the staff in the Pediatric Out-Patient Unit. All staff in this area are trained in Pediatric Advanced Life Support (PALS).

Priority Process: Episode of Care

The NICU admits patients directly from the birthing unit and collaborates closely with the labour and delivery team. They provide nursing support for high-risk deliveries.

The team provides families with a welcome binder containing relevant orientation to the unit written in a user-friendly format. They provide information about common conditions and use this as a teaching tool for parents of newborns in the NICU. The binder is full of resources and families can write notes as their child's journey progresses throughout the admission.

The team in the Pediatric High Acuity Unit is working on a Pediatric Acuity Assessment tool in order to better identify children that need to be transferred to a higher level of care.

Priority Process: Decision Support

The team has a comprehensive assessment tool that includes documentation of patient and family

involvement. The patient care plans are individualized and focused on the patient's needs and priority actions. These are well documented, current, and easy to follow. Managers audit charts regularly to monitor the standard of care and compliance to documentation standards.

Priority Process: Impact on Outcomes

The NICU team at Regina General Hospital participates in data collection for the Canadian Neonatal Network and contributes data to this network. Reports are provided to the NICU and used to make decisions around patient care and shared with leadership for the annual report. Data generated from patient safety incident reports are used to make timely changes and decisions around quality improvement and patient care. For example, the team implemented a checklist used during shift change where two nurses verify IV solution, drip rate, medication, and infusions in order to prevent errors.

Priority Process: Organ and Tissue Donation

Organ and tissue donation is not performed. In the Pediatric High Acuity Unit when there is a situation where organ donation is being considered, the team contacts the Transplant Coordinator and the patient is transferred to another centre.

Standards Set: Emergency Department - Direct Service Provision

Unmet Criteria			High Priority Criteria
Priority Process: Clinical Leadership			
1.7	Information on services is available to clients and families, partner organizations, and the community.		
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			
9.14	Clients and families are provided with information about their rights and responsibilities.		!
12.6	Working in partnership with clients and families, at least two person-specific identifiers are used to confirm that clients receive the service or procedure intended for them.		ROP
	12.6.1	At least two person-specific identifiers are used to confirm that clients receive the service or procedure intended for them, in partnership with clients and families.	**MAJOR**
Priority Process: Decision Support			
The organization has met all criteria for this priority process.			
Priority Process: Impact on Outcomes			
18.12	Information about quality improvement activities, results, and learnings is shared with clients, families, teams, organization leaders, and other organizations, as appropriate.		
Priority Process: Organ and Tissue Donation			
The organization has met all criteria for this priority process.			

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

The Emergency Department Program fulfils a traditional role within the health care system as well as supplying advanced high-tech care. It is the door to the acute care system and a support to community care.

In Saskatoon, each of the Emergency Departments provide general level of care as well as some high-tech care. St. Paul's Hospital is a centre of excellence for Nephrology, Urology, Vascular programs, etc. Saskatoon City Hospital does not have a General Medicine service but is the centre for Ophthalmology and has restricted hours. Royal University Hospital along with the Jim Pattison Children's Hospital is responsible for most of the other specialized services including Cardiology, Neurology, Maternity, and Pediatrics. Ambulance Destination Guidelines have been distributed to accommodate for these differences, but the population at large does not understand the differences in care available.

As the SHA moves to providing a more robust Primary Care system through its Primary Health Networks, there will be an opportunity to partner differently with the community to better manage upstream demand for Emergency Department care.

The departments have become better organized over the last few years by standardizing equipment, carts, medication, and processes. This supports the staff who often move and work at one of the three sites. Physicians all work in each site for part of the time.

Priority Process: Competency

The Emergency Departments reviewed supported the Saskatoon and Humboldt areas as well provided highly specialized care for the northern part of the province. Some sub-specialties oversee care for all of Saskatchewan. The staff of these departments requires high levels of skill and coordination. They are well trained and supported to do their work. Appropriate and specialty trained individuals are hired. There is also a strong in-house program of orientation and ongoing re-certification is provided for each level of skill required. Ongoing maintenance of competency is monitored but, in some situations, the high workload makes it difficult for some individuals to attend educational sessions. New areas of competency are being added as needed to meet to the needs of the population.

Ongoing informal evaluation and commendation occurs. Many things have been done to modify work patterns to reduce the impact of burnout in this high stress job. Psychological support is available through the Critical Incident Stress Management (CISM) Program which is increasingly accessible.

Many of the staff would appreciate a more formal annual review with a career development component. Management is aware of this but does not have the time to accomplish this considering the ongoing bed management activities. The high acuity of the patients in the Emergency Department means that they are often awaiting specialist consultation. Discussions to explore the efficiency of the required consultation would support more timely consultations and perhaps find alternative ways to provide the expertise.

The Emergency Departments are blessed with an electronic medical record (EMR) which supports good communication and an integrated team-based care approach.

Priority Process: Episode of Care

The Emergency Departments visited give excellent person-centred care. Patients expressed their

appreciation of the respectful interactions which gave them appropriate information and a discussion about choices.

On admission, a full assessment of the presenting concern and a standardized information-gathering process is completed and recorded in the EMR. All aspects of the history, physical, and investigations are in this EMR, avoiding a paper file in most cases.

Information about the department and the organization is given to the patient verbally, informally, and often indirectly. Patients felt empowered and felt that their rights were respected. Responsibilities were often not understood. A formal method of sharing this information is suggested to the organization. As well, when questioned, most patients could not say how to register a complaint but were quick to mention that they could probably find out if they had one. Again, a more formal method of sharing this information, perhaps in written format, would help ensure the information was shared.

At the end of service, sharing of information is standardized, especially with the care provider; however, information sharing with the patient could be strengthened.

Priority Process: Decision Support

Documentation of the patient record is supported by a common electronic medical record (EMR) which is connected to eHealth. This common record supports standardization, and sharing of information both within the team, the institution and externally to the community providers. As it is electronic-based it supports evaluation and research activities.

Policies and procedures protect the rights of patients to their information.

Priority Process: Impact on Outcomes

The Emergency Department Program has made significant investment in quality improvement activities. In the past, Saskatchewan has invested in broad education in quality programming. The Kaizen network and the Lean program were two. Support for the wide implementation of these was reduced in 2015; however, the quality improvement office has remained and has continued to support the Emergency Department Program.

The program maintains quality indicators for the provincial programs and for managing the various sites. The indicator wall which has been developed is relevant and useful for day to day management, as well as reporting provincially. Many of these indicators reflect utilization, access, and risk measures.

With the opening of the new Jim Pattison Children's Hospital the entire staff and community was encouraged to come up with ideas for improvement to clinical processes as the new site was opened and the new Emergency Department became functional. Hundreds of ideas were presented and catalogued and then acted on. As well, Accreditation requires management and evaluation of required organizational practices and these were monitored. Clinical programs were more difficult to monitor in a data dependent

way. The Information Technology (IT) department cannot support all the requests in a timely way.

Evidence-based guidelines are not produced in Saskatchewan, but functional clinical care pathways are developed from guidelines for local use. These have significant patient and family input into the details of their implementation.

The team is encouraged to share their good work more broadly with the staff, patients, and their families.

Priority Process: Organ and Tissue Donation

A year and a half ago, the organ and tissue donation function was split off from the transplant program. Saskatchewan is significantly below the national average for available solid organs and has a large back log of need for corneal transplants.

The program has some dedicated staff and is concentrating initially on starting the conversation with all appropriate candidates or families. Over the past year of operation, they have increased their rate of achieving an initial conversation with appropriate individuals or families to about 80 percent. Currently, they have been able to obtain about one to two new transplant organs per month.

Staff are aware of the program and all can describe their involvement in some aspect of the program. Most of the tissue donation work is initiated by the attending nurse who fills out the forms and calls the donation team. Solid organ transplant discussions follow a firm medical decision made by a team of physicians that the patient is at the end of their life. At this time, forms are completed, and the team is called.

All deaths are reviewed to ensure that the discussion has been initiated in all appropriate cases. This review occurs within one or two days of death and discussions with the team occurs to see what could have been done differently if a donation had not been requested and where it could have been.

The program is in its early stages and will likely have more success over time. They are considering how to roll these processes out to the smaller centres in Saskatchewan and to widen the program to more types of tissues collected.

Standards Set: Home 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.	
Priority Process: Competency	
3.6 Education and training are provided on the organization's ethical decision-making framework.	
3.10 Team member performance is regularly evaluated and documented in an objective, interactive, and constructive way.	!
Priority Process: Episode of Care	
9.10 Information relevant to the care of the client is communicated effectively during care transitions. 9.10.1 The information that is required to be shared at care transitions is defined and standardized for care transitions where clients experience a change in team membership or location: admission, handover, transfer, and discharge.	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 Antepartum High-Risk Home Care Program was initiated in late 2017. The need for this program was identified in the modelling exercises done as part of the planning for the new Jim Pattison Children's Hospital. The program has effectively supported care in the home instead of in hospital. Since its inception the program has continued to expand to identify women who may not be referred, and to support additional populations.

The Pediatric Home Care Program is also a specialized program for high-risk children. Similarly, this program has identified additional populations and may want to explore expanding their program.

Priority Process: Competency

The Antepartum High-Risk Home Care Program's nurses and referring physicians work closely together. The home visits are done by experienced nurses who have previously worked in the labour and delivery area. The Medical Director provides detailed oversight of the program. The team meets regularly and when there is a need to review any unexpected outcomes.

The Pediatric Home Care Program supports teamwork through daily huddles and provides significant support to families. This specialized program is also seeing an increase in patients with challenging needs and is working to support staff to meet these needs.

Priority Process: Episode of Care

A significant part of the antepartum care focuses on enabling the patient to be involved in their care. This includes self care, monitoring of symptoms, understanding procedures related to labour and delivery, and caring for their baby.

The Pediatric Home Care Program has a strong focus on safety in the home for staff and children and in developing a safe visit plan.

Priority Process: Decision Support

For the Antepartum High-Risk Home Care Program documentation materials are developed and refined on an ongoing basis by staff. As the program matures the organization could consider reviewing documentation templates for alignment with those in other services that will be part of the client's journey.

The Pediatric Home Care Program may want to consider adapting the adult Challenge Case Protocol for children.

Priority Process: Impact on Outcomes

There is a strong focus on quality improvement in the antenatal program. There are multiple initiatives encompassing improving access, ensuring all eligible clients are referred, expanding to additional appropriate populations, and improving workflow.

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

Unmet Criteria		High Priority Criteria
Priority Process: Infection Prevention and Control		
2.9	Input is gathered from the IPC team to maintain processes for selecting and handling medical devices/equipment.	!
5.2	Team members, clients and families, and volunteers are engaged when developing the multi-faceted approach for IPC.	
7.2	An immunization policy is developed or adopted to screen and offer vaccinations to team members.	!
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.	
14.3	Input is gathered from team members, volunteers, and clients and families on components of the IPC program.	
Surveyor comments on the priority process(es)		
Priority Process: Infection Prevention and Control		

Prior to the formation of the Saskatchewan Health Authority (SHA), Infection Prevention and Control (IPC) Programs were specific to each of the 12 former regional health authorities. As of December 2018, a new Provincial Director was hired to establish consistency and standardization of IPC processes and policies across the SHA. Consequently, reporting lines have not fully been established but are in progress.

During this period of transition, the former Regional Health Authorities (RHAs) continue to use existing policies and processes while waiting for standardized provincial policies to be reviewed and developed. IPC Program priorities consist of program development and establishing a steering committee membership by December 2019.

IPC policies are current and to standard from the previous Health Authorities. As the provincial policies are developed, they will replace the regional policies preceded by staff education and training.

There is evidence of very good IPC practices across the SHA and strong partnerships. Programs are well developed at some sites with good collaboration with Occupational Health and Safety, Public Health, IPAC Canada, and Medical Health Offices (MHO). Some centres have interdisciplinary Steering Committees that meet regularly to discuss issues and make improvements. Some sites have IPC committees that meet on a regular basis.

All staff must complete the annual mandatory hand hygiene e-learning module. Managers track attendance and reported close to 100% participation. When patients are asked if they witness staff using the hand sanitizers, the answer is yes. Regular education sessions occur with patients and staff on personal protective equipment (PPE) use and compliance with IPC policies and procedures.

There is evidence of effective surveillance of healthcare-associated infections. This data and outbreak management efforts are shared with front-line staff via quality boards and huddles. Yorkton Regional Health Centre led a clinical trial that led to a significant reduction in surgical infection rates (c-sections); the team should be encouraged to publish their findings in a peer-reviewed journal.

While some older sites undergo renovations and construction, local leadership and the IPC team is engaged to manage potential risk to the environment and ensure patient and staff safety.

Programs are struggling with waiting for further development until the Provincial Mandate and IPC Program are fully established. Some centres do not have IPC practitioners on-site, therefore, they lack the support needed to move forward with continuing evaluations and monitoring.

Hand hygiene compliance results vary across the province from 65 to 100 percent. There are continuous issues with hand washing in some sites. In some cases, an IPC practitioner covers a few sites and workload limits regular hand hygiene compliance and evaluation. Some sites do not have an infection control practitioner; therefore, no one is given the responsibility to assure compliance. The SHA is reviewing and developing a provincial hand hygiene policy and is encouraged to ensure appropriate support is provided to all sites. A standardized tool and designated staff to complete the audits would benefit the areas of poor compliance and assure compliance sustainability.

Some sites do not have negative pressure rooms for isolation and there are issues with one-way flow of dirty to clean equipment especially within endoscopy scopes.

The SHA is moving towards a provincial approach for oversight of IPC with three initial areas of focus: 1) standardized policy for hand hygiene; 2) standard signage across all sites; 3) management of Antibiotic-Resistant Organisms (ARO).

Standards Set: Inpatient Services - Direct Service Provision

Unmet Criteria		High Priority Criteria
Priority Process: Clinical Leadership		
1.5	Service-specific goals and objectives are developed, with input from clients and families.	
1.6	Services are reviewed and monitored for appropriateness, with input from clients and families.	
2.4	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.	
6.2	Work and job design, roles and responsibilities, and assignments are determined with input from team members, and from clients and families where appropriate.	
Priority Process: Competency		
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.	!
6.7	Education and training are provided to team members on how to prevent and manage workplace violence, including abuse, aggression, threats, and assaults.	!
6.8	The organization's policy on reporting workplace violence is followed by team members.	!
Priority Process: Episode of Care		
9.14	Diagnostic and laboratory testing and expert consultation are available in a timely way to support a comprehensive assessment.	
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**
Priority Process: Decision Support		
12.6	Policies and procedures for securely storing, retaining, and destroying client records are followed.	!
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.	!
16.8	Indicator data is regularly analyzed to determine the effectiveness of the quality improvement activities.	!

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

The formation of the Saskatchewan Health Authority (SHA) provides opportunity to co-design patient care across the province. The SHA connects pediatricians (by phone) in Saskatoon to their rural colleagues providing advice and assistance in these rural communities. Many communities north of Saskatoon would benefit from additional sub-specialist expertise. This is especially needed in the areas of children and adolescent mental health and developmental pediatrics. These sub-specialists could provide rural on-site clinics or permanently establish practices in the larger rural communities.

Staffing continues to be a challenge. With the opening of the new pediatric hospital in Saskatoon, several many northern hospitals are worried about their ability to retain and recruit junior staff.

Allied Health staffing also continues to be a significant challenge with increased requirements for social workers, respiratory technicians, and Licensed Practical Nurses (LPNs).

I would encourage the SHA to ensure that all sites reach out to their clients and families as part of the planning and evaluating process at the local levels.

Many sites are older and the configuration of these hospitals and space constraints are very evident. The SHA is aware.

Priority Process: Competency

The Saskatchewan Medical Association's Practice Enhancement Program (PEP) provides mandatory peer assessment of all physicians every five years.

Many of the staff across the province have not had performance reviews for many years. Once the organizational structure has been confirmed, the managers would benefit from prioritizing the completion of these reviews to understand their staffs' needs and future career goals.

Policies and procedures will eventually be standardized across the province and many sites are actively looking forward to standardization. Currently, staff are aware of their local policies.

Many staff felt they would benefit from enhanced cultural safety training and the adoption of "Trauma Informed Care".

Priority Process: Episode of Care

The staff are committed to providing excellent care for their patients and families. Rural communities have extremely engaged primary care physicians and nurse practitioners who provide and coordinate the hospital care and facilitate seamless transitions of care.

There are effective protocols and documentation to allow safe transfer of care for high-risk patients needing to travel to Prince Albert, Regina, or Saskatoon. These protocols are not yet standardized.

The organization is beginning the work on developing a tiered clinical program for Maternal and Children's Provincial Programs' clinical service lines recognizing the needs in the various communities. This process will help identify the levels of care at each inpatient location and facilitate the appropriate skill mix, equipment, and diagnostic services required. The SHA will need to find the right balance in developing provincial standards (i.e. policies) while also ensuring local circumstances can be reflected, especially in rural settings. Rural leadership should be involved in developing provincial policies and procedures.

Patients and their parents appreciate the navigator assistance during transitions of care. Some communities might benefit from involving a "Traditional Healer" to be involved in the care of clients and their families.

Several units are in older facilities. The configuration of these units provides some unique safety concerns putting clients and staff at risk. It is recommended that staff are provided with individual safety alarms and audits should be performed to ensure the devices are worn.

Abductions, although rare, do occur and the organization is encouraged to review safety options to prevent infant and children from being removed from the ward.

Clients, families, and staff have all commented that the food served to the pediatric population is not "child friendly." The organization might benefit from a pediatric nutritionist to assist in planning children and adolescent hospital meals.

The organization is encouraged to develop a strategy to ensure two person-specific identifiers are used

when treating this patient population. It is not infrequent that a child is admitted without a parent or guardian. Staff are aware this is a significant risk.

Most sites are using the Braden Scale for pressure injury assessment/monitoring. The organization is encouraged to adopt the Braden Q which is specifically designed for the pediatric population.
In Swift Current, a 'Hospital Pediatric Passport' has been developed to be used for children with complex needs, particularly those who may have emergency department visits, or have visits to other referrals sites. Families are very pleased with this innovative passport as it avoids the parents having to tell "their child's clinical history story over and over".

Priority Process: Decision Support

Patient records are standardized in each unit and although the transfer documentation may vary from site to site there is excellent compliance on their completion.

The SHA still relies heavily on paper-based medical records and when appropriate a truly paperless electronic province-wide system will allow faster communication and transfer of information across all sites.

Very few sites have completed chart audits; these audits not only help determine compliance with documentation requirements but the lack of audit could put the SHA at risk.

Priority Process: Impact on Outcomes

The leadership across the various sites are very supportive to standardize policies, procedures, and clinical care pathways across the province. They are all focusing on various quality projects and the organization is encouraged to prioritize one or two that could be implemented provincially.

Data is collected by the SHA on pre- and post- quality initiatives, but some staff felt the results (data) were not provided back to the individual units in a timely way. The access to data is a great motivator for change.

The client and family involvement in planning and designing the future "look" of clinical care across the SHA could be encouraged.

Standards Set: Intellectual and Developmental Disabilities - Direct Service Provision

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

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

The Children's Rehabilitation Program at the Wascana Rehabilitation Centre provides comprehensive therapy programs to children who reside in southern Saskatchewan, including First Nations communities; the Alvin Buckwold Child Development Program (located at the Kinsmen Children's Centre) services northern Saskatchewan, including many remote and First Nations communities. Services are provided to children and youth who have or are at risk of physical, intellectual, and developmental and/or communication challenges. Services include assessment, individual and group treatment, parent/caregiver education, and access to specialty clinics, such as a Neonatal Follow-Up Clinic for high-risk neonates. Services are also provided through Telehealth Saskatchewan, which links patients in rural and remote communities to health care professionals. Typically, youth are seen up to age 18 at which time transition to adult services occurs; although, youth who remain in school are seen up to age 22. Both programs espouse a "family-centred" approach designed to respect the role of family in the lives of their children, to support families in their caregiving role, and to promote a partnership of respect and support between families and staff.

Although the Saskatchewan Health Authority's (SHA's) Maternal and Children's Provincial Program was described during tracers as being at the developmental stage, it was nonetheless seen as holding

significant promise, specifically for providing “a voice” for pediatric rehabilitation. It is anticipated it will not only acknowledge children as “not just little adults” (rather, a specific focus on children and youth), but also will be responsive to family reports that more services and better access to services are needed in Saskatchewan (for example, community-based home care, complex care, respite care, palliative and end of life care, all working in partnership with the rehabilitation centres and the acute care sector). A provincial intake process is under development, as there is acknowledgement that current guidelines in place for follow-up of children at the end of treatment and as they are transitioning out of service are not being consistently met. A positive change reported since the implementation of the SHA is the shift in mindset across all levels (leaders and clinicians) from operating in silos to bringing the Regina and Saskatoon teams together to improve access and reduce variation in service availability and delivery; for example, two Developmental Pediatricians based in Saskatoon now travel to Regina (one every 6 weeks, running clinics for 3 days). A Developmental Pediatrics Visioning Session took place in April 2019 with involvement from front-line staff and leaders from both the Saskatoon and Regina programs, two mothers of patients, and quality initiative (QI) team members. Leaders reported that during this session the “walls came down”, as it became apparent that the two sites faced the same challenges and that shared solutions would result in a “better us” and a “better province”. Navigation, for example, was a common challenge and the 'Moms and Kids Health Saskatchewan' website (currently under development) was described as intending to address the recognized need for a tool to support parents to improve navigation.

There is a strong leadership team within the Children’s Rehabilitation Program. Front-line clinical and non-clinical staff commented on how approachable and visible the leaders are across the program. Everyone encountered during tracers demonstrated a sincere commitment to the safety of their patients and families, to one another, and to the quality of patient care.

Priority Process: Competency

Every member of the team encountered, serving children and youth with Intellectual and Developmental Disabilities, demonstrated exceptionally strong commitment to providing high quality evidence-based care to their patients and families. They expressed genuine interest in tailoring their evaluations and therapeutic interventions to better serve their individual patients. Interactions between front-line staff and managers seemed very positive and staff members interviewed indicated genuine enthusiasm for exploring and testing creative ideas to continually address patient and family needs. An example of innovation in action at Wascana Rehabilitation Centre was a collaborative project involving researchers at the University of Regina’s Faculty of Engineering and Applied Science and Occupational Therapists and Physiotherapists at the Centre, known as the ‘Zoom Kids’ project. Graduate students modify purchased toy cars and adapt them to make the vehicle’s operation suited to the skill and capability levels of the children. Other examples included the development of standards and protocols that focus on transitions in care at age transitions being led by the Social Workers and the Exercise Therapy community-based local Exercise and Sporting Programs for children and youth (e.g., adapted sailing, sledge hockey, tennis, etc.).

The care teams on both sites are multidisciplinary and include Developmental Pediatricians, a Physiatrist, Clinical Psychologists, Physiotherapists, Occupational Therapists, Speech Language Pathologists, Social

Workers, Dietitians, an Exercise Therapist, Music Therapist, and Equipment Technicians. In addition to individual and group sessions, specialty teams are in place, such as the Feeding and Swallowing Specialty Team and the Assistive Devices Specialty Team.

Performance appraisals include a chart review/audit, self-evaluation, and peer review. Staff interviewed expressed appreciation for the breadth of training/education opportunities offered.

Priority Process: Episode of Care

The Wascana Rehabilitation Centre and the Alvin Buckwold Child Development Program (Kinsmen Children's Centre) teams are congratulated for bringing together the perspectives of patients, families, and healthcare professionals to design/redesign, implement, and evaluate their care processes, their patient and family experiences of receiving care and services, and their staff experiences of providing care and services. Leaders and front-line staff, four families of patients, and quality improvement managers all participated in an Experience Based Co-Design (EBCD) event. A local Patient and Family Advisor, who took on the role of a patient surveyor for the EBCD project, conducted interviews with a sample of staff and patient/families. The Patient Surveyor's data collection (families who participated in interviews were approached in the waiting room of the Centres) took place in advance of the event and results were collated by the quality initiative (QI) team and shared at the event. Patients and families were asked during the interviews about their experiences of routine care, follow up, therapy appointments, etc. At the EBCD event the team defined improvement opportunities around care transitions, communication, parking, booking processes, waitlists, staff training, charting, and referrals. The improvement ideas have been incorporated into the QI Plans at the various centres. The team is encouraged to consider whether the population of patients who provided input (via the interviews in advance of the EBCD event) and those who participated in the event itself are representative of the population of patients served by the organization. For example, during the on-site visit, it was noted that non-English speaking families now represent 47% of the total population. As such, it is important to be certain that non-English speaking patients and families, patients from all regions served by the centres, families with infants, children and youth, families with higher and lower levels of socioeconomic status, etc. were given a voice in the process that is now guiding improvement plans into the future. The team is also encouraged to examine the correlation between areas identified as problematic (e.g., parking) with the overall satisfaction of families with the quality of care and services.

As noted, non-English speaking, new to Canada immigrants were described as having increased in the population served over time. CanTalk is a phone translation service that is available to clinicians, and settlement services often accompany and send translators to appointments. The Centre is encouraged to make written materials (brochures and other materials) available in the most common "mother-tongue still spoken at home" languages of their region and to expand use of teach-back methods to ensure key messages, care/treatment plans, and techniques are understood by parents.

The Educator in the Children's Program leverages Telehealth to develop teaching opportunities for rural partners; these sessions are usually case-based, and sessions can be recorded to expand the reach of the knowledge translation effort. The potential to expand the use of Telehealth beyond case-based uses to

provide teaching and outreach opportunities to rural and remote communities is recognized by the team. In addition, the Centres have had teams come to observe and learn. The Children's Rehabilitation Program also hosts an annual Pediatrics Conference; clinicians across the province are surveyed for topic ideas and clinicians are brought together for this face to face annual event.

Formal assessment of family/caregiver burden is an area that is not formally assessed; use of assessment tools to quantify and measure the extent and impact of burden and the results of interventions is an opportunity for further exploration.

Priority Process: Decision Support

The Children's Rehabilitation Program has a clear process to ensure requirements are met for informed consent and privacy.

The leadership conducted an environmental scan of other pan-Canadian Rehabilitation facilities to define targets for workload of the multidisciplinary team members. Based on the results role-based targets were established and the expectation was set that all appointments were to be scheduled to a 90% threshold; this is challenging, as programs operate with no casual staff to backfill scheduled vacations or unplanned absences.

Priority Process: Impact on Outcomes

The Children's Rehabilitation Program is highly specialized. Sharing of evidenced-based guidelines occurs, and staff are aware of the value this brings to their work. A provincial intake process is under development to create a provincial process that standardizes intake processes between the Alvin Buckwold Child Development Program (located at the Kinsmen Children's Centre) in Saskatoon and the Wascana Rehabilitation Centre in Regina. "Current" state mapping of intake processes and validation of the current state processes are now complete; the next step is to develop the "future state" for the process. Two Patient Family Advisors have been involved. Eligibility criteria for admission of children and youth with Intellectual and Developmental Disabilities are well defined and are used to guide admission decisions. Wait list data is tracked. For the most part, flow of communication and accountability to ensure appropriate and timely transfer and management of patients accepted for admission is in place; utilization and workload are tracked. In Regina, both the Child and Youth Centre for Mental Health and Wascana Rehabilitation Centre are involved in the care of children requiring diagnostic and therapeutic services for Autism Spectrum Disorder, whereas, these services are provided by the Alvin Buckwold Child Development Program (located at the Kinsmen Children's Centre) in Saskatoon as a "one stop shop"; navigation in Regina was described as "tricky", as parents (and community providers) are unsure of "who sees which kids and who does what care". By contrast, care was seen as seamless for children and families presenting with a child with autism in Saskatoon. End-of-life and palliative care needs of patients were noted as an increasing service need. Teams work closely with pediatric home care and community teams. They are involved in case review calls every second month that include a palliative care physician in Saskatoon and the rehab team to address equipment and other needs. The team is encouraged to explore expanding the use of clinical assessment data and information from standardized assessment instruments

to compare performance with other rehab facilities serving patients and families in other provinces in Canada with Intellectual and Developmental Disabilities.

The team is involved in quality improvement initiatives, which range from informal changes to more formal projects and data collection, such as the Experienced Based Co-Design (EBCD) event held this year. Metrics are posted related to patient safety and reviewed during a weekly “huddle” involving staff and leaders, called the “Wall Walk”, which occurs each Wednesday at the Wascana Rehabilitation Centre lasting 15 to 30 minutes. The “Wall Walk” includes a safety component, review of metrics related to hand hygiene, workload, and “occupancy” (percentage of available appointments scheduled) by discipline, patient and patient incidents (including falls), and a weekly rotating “discipline” report.

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

Unmet Criteria		High Priority Criteria
Priority Process: Clinical Leadership		
2.4	The physical space is designed with input from residents and families and is safe, comfortable, and reflects a home-like environment.	
2.8	A universally-accessible environment is created with input from residents and families.	
Priority Process: Competency		
3.15	Team member performance is regularly evaluated and documented in an objective, interactive, and constructive way.	!
Priority Process: Episode of Care		
9.12	There are regular, standardized interdisciplinary reviews of each resident's medications and adjustments are made as necessary.	!
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 Long Term Care facilities at Central Parkland Lodge, Circle Drive Special Care Home, and Warman Mennonite Special Care Home are all aging and have been renovated to meet the need of clients with higher needs. At the Warman Mennonite Special Care Home, due to space restrictions, the bathrooms are not fully accessible. Also, upgrades are planned for some equipment. Installation of ceiling lifts is ongoing to support higher acuity patients at all locations.

At all the facilities staff have decorated the spaces to give a home-like feel, but at Central Parkland Lodge and Warman Mennonite Special Care Home the feel is still very institutional due to the basic building construction.

Priority Process: Competency

At all the locations reviewed, staff are dedicated and teamwork is evident. The organization may want to

review staffing levels where there is a larger number of patients with dementia.

Priority Process: Episode of Care

There is excellent collaboration with residents and families in the provision of care and activities of daily living. Residents and families report they are well informed. Menu selections are customized according to resident preference. At all locations, there are dedicated resources for providing varied activities each day. Circle Drive Special Care Home has an excellent range of activities.

There is a strong focus at all locations on reducing falls, reducing the use of restraints, and reducing the use of antipsychotics. Assessment for the risk of suicide is in place, but the organization may want to explore developing a standardized tool to support this in long-term care.

The Community Paramedicine Program at Circle Drive and Warman Mennonite Special Care Homes is enabling residents to stay in their homes during exacerbations of their illnesses by providing intravenous medication therapy and/or diagnostic services.

Resident and family councils at all the facilities gather informal feedback on daily living and on care.

Priority Process: Decision Support

Priority Process: Impact on Outcomes

The facilities are supported with care related guidelines by Support Care Project Coordinators who specialize in long-term care.

The organization has transitioned to Long Term Care Convergence (LTCF) Momentum for documentation. Staff report that this tool is patient-centred and anticipate it will provide the data to refine care for individual patients and for program planning.

Standards Set: Medication Management Standards - Direct Service Provision

Unmet Criteria		High Priority Criteria
Priority Process: Medication Management		
1.1	The interdisciplinary committee has defined roles and responsibilities for medication management that are in line with legislation and applicable regulations.	!
1.2	The interdisciplinary committee includes representatives from a variety of teams involved in medication management.	!
1.3	The roles and responsibilities of the interdisciplinary committee are regularly evaluated and improvements are made as needed.	
2.1	The interdisciplinary committee works with the organization to ensure there is a process to update medication management processes based on any changes to applicable laws, regulations, and standards of practice.	
2.2	The interdisciplinary committee has a process to monitor literature reviews and best practice information on medication management and uses the information to update medication management processes.	
2.3	There is an antimicrobial stewardship program to optimize antimicrobial use. NOTE: This ROP applies to organizations providing the following services: inpatient acute care, inpatient cancer, inpatient rehabilitation, and complex continuing care.	ROP
2.3.1	An antimicrobial stewardship program has been implemented.	**MAJOR**
2.3.2	The program specifies who is accountable for implementing the program.	**MAJOR**
2.3.3	The program is interdisciplinary, involving pharmacists, infectious diseases physicians, infection control specialists, physicians, microbiology staff, nursing staff, hospital administrators, and information system specialists, as available and appropriate.	**MAJOR**

	2.3.4	The program includes interventions to optimize antimicrobial use, such as audit and feedback, a formulary of targeted antimicrobials and approved indications, education, antimicrobial order forms, guidelines and clinical pathways for antimicrobial utilization, strategies for streamlining or de-escalation of therapy, dose optimization, and parenteral to oral conversion of antimicrobials (where appropriate).	**MAJOR**
	2.3.5	The program is evaluated on an ongoing basis and results are shared with stakeholders in the organization.	**MINOR**
2.4	The interdisciplinary committee establishes procedures for each step of the medication management process.		!
2.5	A documented and coordinated approach to safely manage high-alert medications is implemented.		ROP
	2.5.6	Client service areas are regularly audited for high-alert medications.	**MINOR**
8.4	The pharmacy computer system is regularly tested to make sure the alerts are working.		!
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**
9.4	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**
12.1	Access to medication storage areas is limited to authorized team members.		!

12.6	Look-alike, sound-alike medications; different concentrations of the same medication; and high-alert medications are stored separately, both in the pharmacy and client service areas.	!
12.9	The availability of concentrated electrolytes is evaluated and limited to ensure that formats with the potential to cause patient safety incidents are not stocked in client service areas.	ROP
12.9.1	An audit of the following concentrated electrolytes in client service areas is completed at least annually: • Calcium (all salts): concentrations greater than or equal to 10% • Magnesium sulfate: concentrations greater than 20% • Potassium (all salts): concentrations greater than or equal to 2 mmol/mL (2 mEq/mL) • Sodium acetate and sodium phosphate: concentrations greater than or equal to 4 mmol/mL • Sodium chloride: concentrations greater than 0.9%.	**MAJOR**
13.3	Chemotherapy medications are stored in a separate negative pressure room with adequate ventilation, and are segregated from other supplies.	!
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**
14.6.5	Team members are provided with education about the Do Not Use list at orientation and when changes are made to the list.	**MINOR**
14.6.6	The Do Not Use list is updated and necessary changes are implemented to the medication management processes.	**MINOR**
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.	!
16.2	Appropriate ventilation, temperature, and lighting are maintained in the medication preparation areas.	
16.3	There is a separate negative pressure area with a 100 percent externally vented biohazard hood for preparing chemotherapy medications.	!

16.4	Sterile products and intravenous admixtures are prepared in a separate area with a certified laminar air flow hood.	!
22.5	The process for self-administering medications includes documenting in the client record that the client took the medication and when it was taken.	
25.2	The interdisciplinary committee reviews patient safety incidents involving medications and uses established criteria to prioritize those that will be analyzed further.	!
27.5	The interdisciplinary committee monitors process and outcome indicators for medication management.	
27.6	The interdisciplinary committee prioritizes and completes medication use evaluations.	
27.7	The interdisciplinary committee uses the information it collects about its medication management system to identify successes and opportunities for improvement, and makes improvements in a timely way.	
27.8	The interdisciplinary committee shares evaluation results with teams.	

Surveyor comments on the priority process(es)

Priority Process: Medication Management

The Saskatchewan Health Authority (SHA) has established the Vice President Programs/Services and Physician Dyad, and the role of Executive Director for Pharmacy Services responsible for the Provincial Pharmacy Program. A draft of the proposed Pharmacy Organization Structure has been created with Functional Management of the operations and provincial oversight of Clinical Services and Programs. During the interim, the hospitals are continuing to work within the former Health Authority alignment. A Provincial Drugs and Therapeutics (DTC) Committee with a Physician and Pharmacy Director Co-lead Module has been drafted and is expected to be rolled out early 2020. Reporting to the Provincial DTC, will be regional Medication Use Safety Committees, Provincial Antimicrobial Stewardship Committees, Medication Reconciliation Committee, and other committees.

During the interim, the former regions Pharmacy and Therapeutics (P&T) Committees continue to function as previously but in other areas P&T Committees and Medication Safety Committees have been collapsed into quality committees or suspended as they anticipate the Provincial Drugs and Therapeutics Committee. There may be benefit in re-establishing the Medication Safety Committees at these local levels.

The pharmacy teams are strong and present in most hospitals. Clinical pharmacists attend rounds and provide leadership to the medication management standards. Pharmacy has hired students and residents who conduct audits and complete medication safety quality improvement projects. There are many areas

of excellence which could serve as best practice models for expansion throughout the SHA. The Royal University Hospital, Saskatoon City Hospital, and St. Paul's Hospital (former Saskatoon Health Authority) have invested in a Backorder Pharmacist position. This pharmacist monitors all the current back orders with impact on clinical practice, creates Medication Safety Alerts for practitioners, and works with the inventory technicians to coordinate sharing of medications among the three hospitals. There are daily telephone huddles between the leadership team with updates on key workload issues, safety concerns, and the opportunity to share staff resources. Some medication packaging and preparation is distributed between sites to level load the workload across the three hospitals.

The pharmacy team supported the successful opening of the Jim Patterson Children's Hospital in September 2019. Automated Dispensing Cabinets (ADCs) were deployed throughout the facility and additional clinical pharmacist positions were added to enhance the service in the NICU and pediatric units.

In the Regina General Hospital, there is strong cohesive team. The professional teamwork and mutual respect are impressive. Recently, a Patient Safety Coordinator was hired, and this has made a significant difference in the functioning of the pharmacy. One of the key responsibilities this new role has is to review all incident reports. Recently, the Pharmacy Department established an Opioid Stewardship Committee. Some of the Quality Improvement projects include work on sepsis, narcotic wastage (with plan to trial wastage sinks), and implementation of insulin pens. The Pharmacy Department at Dr. F.H. Wigmore Hospital has experienced significant change over the past five years, transitioning from a traditional dispensing system, to a unit dose system, and then to ADCs. This transition required significant commitment by the team and investment in staff education and training but has been very successful with ADCs now implemented in most clinical areas. ADCs have been implemented at many hospitals throughout the SHA and were well received by the nursing teams. The organization is encouraged to continue further implementation of ADCs as resources become available.

Medication reconciliation on admission is supported by pharmacists and pharmacy technicians throughout the SHA. The interprofessional team is looking forward to the development of the plan for full implementation along the required resources and supports. At the Saskatoon sites, there are some Accountable Care Units which have been funded for an interprofessional team, including a pharmacist. The clinical pharmacist plays a key role in the discharge medication reconciliation process, connecting with the physician, patient, and community pharmacy. Pharmacists provide training on completion of the Best Possible Medication History (BPMH) during nursing orientations which has improved the quality of the process.

Antimicrobial Stewardship Programs (ASPs) have been implemented at the local level in many hospitals, however, the teams are anticipating the provincial Antimicrobial Stewardship Program will provide direction, priorities, and re-engage many physicians who have become disillusioned with the lack of a formalized structure and corresponding clinical supports. ASP clinical rounds are effective at changing prescribing practices and require the Infectious Disease (ID) Physician and ASP Pharmacist at key scheduled times. The regular provision of ASP reports such as intravenous (IV) to PO (by mouth) step down or antibiotic usage (daily defined doses) to the local Medical Advisory Committee (MAC) would be

helpful.

The National Association of Pharmacy Regulatory Authorities (NAPRA) has issued national sterile compounding standards for hazardous (chemotherapy) and non-hazardous compounds. The SHA is encouraged to consider creating a Provincial Compounding Sterile Supervisor position as required by NAPRA to oversee the implementation and adherence to people and processes contained within these standards. Further, the SHA may consider reviewing the IV compounding hospital/sites in order to plan for future capital infrastructure required to meet these standards with an initial focus on the compounding of hazardous (chemotherapy) sterile products.

Standards Set: Obstetrics Services - Direct Service Provision

Unmet Criteria		High Priority Criteria
Priority Process: Clinical Leadership		
2.3	An appropriate mix of skill level and experience within the team is determined, with input from clients and families.	
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.	!
4.4	Standardized communication tools are used to share information about a client's care within and between teams.	!
5.7	Education and training are provided to team members on how to prevent and manage workplace violence, including abuse, aggression, threats, and assaults.	!
5.8	The organization's policy on reporting workplace violence is followed by team members.	!
Priority Process: Episode of Care		
9.2	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
9.2.1	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**
9.16	Information relevant to the care of the client is communicated effectively during care transitions.	ROP
9.16.1	The information that is required to be shared at care transitions is defined and standardized for care transitions where clients experience a change in team membership or location: admission, handover, transfer, and discharge.	**MAJOR**
9.16.2	Documentation tools and communication strategies are used to standardize information transfer at care transitions.	**MAJOR**

	9.16.3	During care transitions, clients and families are given information that they need to make decisions and support their own care.	**MAJOR**
	9.16.4	Information shared at care transitions is documented.	**MAJOR**
	9.16.5	The effectiveness of communication is evaluated and improvements are made based on feedback received. Evaluation mechanisms may include: • Using an audit tool (direct observation or review of client records) to measure compliance with standardized processes and the quality of information transfer • Asking clients, families, and service providers if they received the information they needed • Evaluating safety incidents related to information transfer (e.g., from the patient safety incident management system).	**MINOR**
10.7		There is a policy and procedure for sponge and needle counts both before and after all vaginal births.	!
Priority Process: Decision Support			
14.3		Policies and procedures to securely collect, document, access, and use client information are followed.	!
14.8		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			
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.	!
18.4		Indicator(s) that monitor progress for each quality improvement objective are identified, with input from clients and families.	
18.7		There is a process to regularly collect indicator data and track progress.	
18.8		Indicator data is regularly analyzed to determine the effectiveness of the quality improvement activities.	!

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

Information is collected by clients and families in a variety of ways. The most common way, for the many organizations visited, was by using client surveys. Some of the organizations have Patient Family Advisors that provide support for many different initiatives. Services, goals, and partnerships are developed and maintained using the information gathered by the organizations. Some organizations have a more robust process.

Leadership in the different organizations have been open about sharing their gaps in resources. A common gap is the lack of physicians and nursing in rural areas, particularly those with expertise in obstetrics. Rural sites are concerned about maintaining this needed service without consistent coverages. Some strategies that have been useful to recruit and maintain staffing levels are inexpensive housing for medical and nursing students, and, increasing staff levels to ensure there is support for obstetrical services.

In large sites, overcapacity is a concern. The large centres are consistently overcapacity and are dealing with complex high-risk patients. In some cases, the nurses do not have the knowledge to manage complex medical issues beyond obstetrics. In Regina, the antenatal patients are with postpartum patients. Staffing can be a challenge with a variety of acuity and limited staff to provide the care. A separate antenatal unit or a high acuity unit with appropriate staff and training would help to improve the quality and safety of care for patients. In Saskatoon, the Midwifery program cannot fulfill the requests of the community. Patients are not given equal access to the care they would like. In Prince Albert, they work within aging infrastructure and there are equipment concerns. They serve a largely rural area with the limited resources they have.

Staff try their best to ensure that families have rooming-in and open visiting. Families are welcome and encouraged to participate in care in most centres. Most centres complete assessments in the room with the parents and engage them in care. This practice should be ensured throughout the Authority. In Moose Jaw, if they are over capacity patients are admitted to the surgical unit which is next door and the patient call system is diverted to the obstetrical unit where care is provided by the team and infants remain with their parents.

A review of resources must be considered before implementing new initiatives that impact capacity and workload. The maternal iron initiative, although great for the patient, has significantly increased bed capacity and nursing workload.

Priority Process: Competency

Good educational support is seen in the organization and orientation at the regional and provincial levels cover some of the basic requirements. Leaders strive to ensure their staff can manage any situation with the necessary qualifications, especially in rural areas. Infusion pump and equipment training are examples seen throughout the Authority. For obstetrics, the staff have extra training including neonatal resuscitation. Some of the sites within the organization have been working in the MoreOB program for many years.

many years.

Communication tools could be an initiative to standardize across the province. Consistent practices for communication were not seen throughout the province.

Priority Process: Episode of Care

The obstetrical teams at the different sites are committed to providing the best care to their clients. Each of the sites have specific needs and processes in place to mitigate issues that they face. Escalation procedures are in place even in rural areas. Servicing the rural areas and getting mothers the appropriate care in a timely manner can be a challenge. Having the appropriate resources for care such as physicians and nurses is a challenge as well.

The sites have appropriate policies and procedures to provide care. Some teams have more standardized processes which are well developed with clients and families. The Osteochondral Autograft Transfer System (OTAS) Assessment has been implemented at one site and could be leveraged by the other sites.

The transfer of information in at some sites needs to be reviewed. Some sites are doing huddles and using standardized processes for sharing information, but this is not consistent.

Communication tools are not in place at some sites. This could be a good provincial initiative to develop a framework around the transfer of information process, keeping in mind site-specific needs.

Priority Process: Decision Support

All patient documentation remains in paper format. Most sites have standardized order sets for physician orders. For nursing care, flow sheets vary from simple nursing notes to standardized flow sheets. Some staff at different sites would like to develop their flow sheets. It will be important to leverage the expertise and well-researched flow sheets from other sites. Policies, procedures, and education material were seen in both electronic and paper copy. Patient and family materials are most often in paper copies in the form of booklets and pamphlets. A review of the storage of patient charts should be considered. Having client records in public accessed areas should be reviewed with the view of legislative requirements and privacy considerations.

Priority Process: Impact on Outcomes

The teams are using their current regional protocols and processes if they are in place. Some of the teams that do not have these processes are excited to embrace collaboration with other teams to move their programs forward.

Teams that have already embraced MoreOB collect indicators and work on quality improvement within that framework. Other quality improvement work includes the Osteochondral Autograft Transfer System (OTAS) Assessment process and Crisis Intervention Training for staff to be able to deal with difficult situations. They also support other units with this training.

Quality improvement has been part of the Saskatchewan landscape for a long time. Moving to a provincial structure will help all sites move toward a consistent approach to quality improvement. The daily Webex meetings between the large mother-baby sites are a great example of a quality improvement initiative. Using the data from these meetings could drive change at a provincial level.

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

Unmet Criteria		High Priority Criteria
Priority Process: Clinical Leadership		
The organization has met all criteria for this priority process.		
Priority Process: Competency		
6.11	Team member performance is regularly evaluated and documented in an objective, interactive, and constructive way.	!
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		
10.15	Clients and families are provided with information about their rights and responsibilities.	!
11.6	Inpatient care only: Medication reconciliation is conducted in partnership with clients and families to communicate accurate and complete information about medications across care transitions.	ROP
11.6.4	The client, community-based health care provider, and community pharmacy (as appropriate) are provided with an accurate and up-to-date list of medications the client should be taking following discharge.	**MAJOR**
20.16	There is a process to follow up with discharged day surgery clients.	
Priority Process: Decision Support		
The organization has met all criteria for this priority process.		
Priority Process: Impact on Outcomes		
The organization has met all criteria for this priority process.		
Priority Process: Medication Management		
The organization has met all criteria for this priority process.		

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

Surgical services are managed by several committees that have responsibility for the three Saskatoon hospitals. This system is a legacy from the previous regional Health Authority and has been in place for many years. Presently, there are three levels of authority: Surgical Executive; Surgical Operational; and Surgical Management. These groups have some personnel overlap and provide considerable oversight to the strategic direction, resource planning, and day to day operations. There is a specific Patient and Family Advisory Council (PFAC) which provides input into all aspects of the surgical service planning and delivery.

Resources at the three sites appear adequate with some requirements for updated equipment and human resource recruitment. Capital equipment is requested within the SHA framework and does not appear to be overly onerous (recent additional monies available to deal with wait lists and over capacity). There is a move to have standardized credentials and certifications for all employees and much of this has also been in place for many years.

Services were allocated to the three sites years ago via the former Saskatoon Health Region and that system remains functional. Patients may be moved from site to site appropriately and EMS is familiar with the process. These sites are also tertiary referral sites for specialized services for other parts of the province; particularly the northern areas.

Priority Process: Competency

Team members throughout the perioperative areas all have the appropriate training and certifications for their position profiles. There are ample opportunities for education updates both internally and externally. There is good organizational support for this. There is an electronic platform that allows individuals to review their educational requirements and to search for upcoming educational events.

The organization has a deficit regarding the completion of performance appraisals. Their requirement is annual, and most staff are well behind in receiving a performance review. This is detrimental both for the organization and the staff member. There are many new/recent managers and this has slowed down the completion of appraisals. Consideration could be given to altering the policy of completion every two years.

Staff all work well together and the care provided is very patient-centred.

Priority Process: Episode of Care

There are consistent processes at all sites for the preoperative period. This begins in the surgeons' offices and proceeds following the Operating Room booking. The decision for patients to be seen in the pre-assessment clinic is dependent on the physician; ideally all patients should be screened by this clinic using set criteria, as some then would only receive a screening phone call and others would require face to face assessment. This process would reduce the number of patients attending without a history/physical or appropriate pre-op testing.

Patients should receive more comprehensive institutional and Operating Room educational materials. There does not appear to be a standard pre-op package provided early that covers topics such as patient safety issues, rights and responsibilities, or contact numbers for the various surgical areas.

There is significant PFAC input into the episode of care topics and there is room for increased input in the design of patient educational materials.

There is evidence of best practice pathways and guidelines with consistent compliance at all sites. Care plans are in place and patients are aware of the various processes. Medication reconciliation is lacking for discharged inpatients and there needs to be a process developed for discharged "Surgical Day Care" patients to receive a post procedure follow-up phone call within 24 hours of discharge. This would significantly reduce angst, reduce potential emergency room visits, and provide continuity of care.

All intra-operative processes were observed to be in place with good compliance and staff working in a collaborative and cohesive fashion. All transitions are done by face to face interaction.

Priority Process: Decision Support

All charting on the three sites reviewed is in a paper format. There are some electronic mechanisms in the Operating Room and for diagnostic testing results. There is no immediate plan to move to a complete electronic system.

In the paper chart there is still separation of various caregivers' progress notes (nurses, physicians, etc.). The organization is encouraged to consolidate these so that the progress notes represent a "team" approach with the patient "story" in continuity. The implementation of the provincial eHealth system allows for all healthcare providers to access patient information across the province in almost real time; a great asset when patients are seeking service in various areas and formats.

Priority Process: Impact on Outcomes

The three Saskatoon sites have had major cooperation regarding guidelines and pathways for many years. There has been patient and family input into their development, implementation, and review. This has been done through the PFAC, both at the institution level and at the surgical group level.

The PFAC also has had input into the oversight of safety issues, education, and review of occurrences. The quality improvement processes have PFAC input and all quality initiative (QI) mechanisms and results are well communicated to staff, patients, and families.

Priority Process: Medication Management

Medication management in the Surgical Program has been standardized across the sites (Saskatoon). The anesthetic carts have standard drugs and configurations (many of the staff work at all three sites). There is a plan to automate pharmaceutical delivery but this has only been implemented partially. The

organization is encouraged to have complete implementation as soon as possible to include inpatient areas as well.

All aspects of medication delivery in both the Operating Room and inpatient areas follow the stated standards.

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	
The organization has met all criteria for this priority process.	

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

The Maternal and Children's Provincial Program provides policy and program direction to the Alvin Buckwold Child Development Program (located at the Kinsmen Children's Centre) and the Wascana Rehabilitation Centre. There is a strong leadership team within the children's rehabilitation program. Front-line clinical and non-clinical staff commented on how approachable and visible the leaders are across the program. The team members demonstrated a sincere commitment to the safety of their clients and families, to one another, and to the quality of care. Rehabilitation services have committed and engaged team members, physicians, and leaders. The interdisciplinary teams work collaboratively to provide care to clients and families. The team members noted that the strength of the team is the reason why they work in children's rehabilitation program. Additionally, they stated that they enjoy working with the children and their families. The team has a strong client-centred focus and are committed to providing quality services. There is a commitment to provide care "close to home." The educator in the children's rehabilitation program leverages telehealth to develop teaching opportunities for rural partners; these sessions are usually case-based, and sessions can be recorded to expand the reach of the knowledge translation effort.

Resources are identified by staff and provided to the clinical leaders. The team noted that they have the appropriate resources to do their work; however, the organization is encouraged to continue to explore the resource needs of this service in keeping with trends of increased program and service demand.

There is a strong commitment to developing and maintaining partnerships to meet the needs of patients and families. Information is collected on clients and families, to inform the children's rehabilitation program. This has resulted in the implementation of innovative programs and services. There is a strong commitment to a universally-accessible environment with wide corridors, child friendly waiting rooms, and accessible washrooms. There is access to a gymnasium. The organization is encouraged to continue to seek the input of the team, clients, and families in the design and future direction of the children's rehabilitation program.

A positive change reported since the implementation of the Saskatchewan Health Authority is the commitment from leaders and clinicians to move from operating in silos to bringing the Regina and Saskatoon teams together to improve access and reduce variation in service availability and delivery. For example, two Developmental Pediatricians based in Saskatoon now travel to Regina (one every 6 weeks, staying for 3 days). The leaders are encouraged to continue with this important work.

Priority Process: Competency

The Children's Rehabilitation services are provided by strong and committed interdisciplinary teams. The leaders and teams are committed to providing quality and safe services for clients and families. The leaders are to be acknowledged for their commitment to supporting the education and learning needs of the team. Training provided includes workplace safety, hand hygiene, and training specific to the pediatric population. There is an annual Provincial Pediatrics Therapy Conference. The staff spoke highly of the education and training provided. An orientation is provided to all new staff and they spoke highly of the value of the orientation process. The team members stated that they feel safe at work and that their safety is protected by the Saskatchewan Health Authority.

Education is provided on the ethical decision-making model. The leaders are encouraged to continue to provide education and training on the ethical decision-making framework.

Performance feedback is provided to the team members through coaching and mentoring. A formal performance appraisal is not completed. The team described the importance of receiving feedback on their performance. The leaders are encouraged to continue to ensure that team members receive performance appraisals.

Priority Process: Episode of Care

The Alvin Buckwold Child Development Program (located at the Kinsmen Children's Centre) serves northern Saskatchewan, including remote and First Nations communities. The Wascana Rehabilitation Centre provides comprehensive child development programs to children who reside in southern Saskatchewan, including First Nations communities. The programs offer diagnostic and treatment services to children as well as support to families. Services are provided to children and youth who have or are at risk of physical, intellectual, and developmental and/or communication challenges. Services include assessment, individual and group treatment, parent/caregiver education, and access to specialty clinics,

such as a Neonatal Follow Up clinic for high-risk neonates. There is a commitment to providing care "closer to home." Service is also provided through Telehealth Saskatchewan, which links patients in rural and remote communities to health care professionals.

Typically, youth are seen up to age 18 at which time transition to adult services occurs, although youth who remain in school are seen up to age 22. Both programs espouse a "family-centred" approach designed to respect the role of family in the lives of their children, to support families in their caregiving role, and to promote a partnership of respect and support between families and staff. Eligibility criteria for admission of children and youth is well defined and is used to guide admission decisions. The flow of communication and accountability to ensure appropriate and timely transfer and management of clients accepted for admission is in place. Goals and expected results are discussed in collaboration and partnership with clients and families. Comprehensive and individualized care plans are developed in collaboration and partnership with clients and families. There are strong processes for planning for care transition. There were excellent interactions observed during group therapy of the participation of parents regarding kindergarten transition.

An engaged interdisciplinary team committed to quality client care supports the Children's Rehabilitation Program. The clients and families spoke highly of the excellent care provided by staff. A family member stated, "the staff are wonderful". The family members noted that they were treated with care, dignity, and respect. They felt comfortable asking questions. Families stated that that they felt included in their children's care planning. A family member started that she felt very comfortable in attending appointments and asking questions.

The team members described how their orientation prepared them to work in the Children's Rehabilitation Program. Volunteers are an asset to support quality client services. A volunteer stated that they were well supported in their volunteer work.

There are private spaces for clients and families. The waiting areas are welcoming and child friendly. There are work spaces for the team members. The team described having the appropriate equipment to provide client services.

There is a strong commitment to partnerships with community groups and agencies. Patient satisfaction surveys are completed. Process improvements have been completed.

Non-English speaking, newcomers to Canada were described as an increasing population served by the Children's Rehabilitation Program. The leaders are encouraged to make written materials available in the most common languages of their clients and families and to expand use of teach-back methods to ensure key messages, care/treatment plans, and techniques are understood by clients and families.

The medical history including a medication history is completed by physicians on admission to the ambulatory rehabilitation program. This entails input from clients and families. A copy of the prescription is placed on the client's chart. The Nurse Coordinator of the Spinal Cord Clinic collects and documents client medications. The Botox Clinic has written procedures, consent, and utilizes a supplementary

Medication Administration Record (MAR) and physician orders. Of note though, the medication history is not reconciled. The organization is encouraged to identify target populations within the Children's Rehabilitation Program to implement medication reconciliation.

Informal methods are used to obtain feedback on transition points. This includes discussions with clients, families, and referral agencies. Formal mechanisms such as auditing are not in place to evaluate the effectiveness of communication at transition points. The leaders are encouraged to explore the development of formalized methods to obtain feedback on client and family transitions.

Priority Process: Decision Support

The team members and leaders are committed to using decision support to enable quality Children's Rehabilitation services. This includes collecting and using data to support decision making processes. Education and training are provided to the team on the use of technology. Electronic charting is used in the Children's Rehabilitation Program.

Standardized client information is collected. Comprehensive and up to date information is collected with the input of clients and families. Comprehensive and individualized care plans are developed in collaboration and partnership with clients and families. There is a strong commitment to the security of client information. The historical charts are in a locked secure room.

There is a coordinated flow of information both within and outside of the team. This includes: team meetings; huddles; and interdisciplinary and inter-agency meetings.

Priority Process: Impact on Outcomes

The Maternal and Children's Provincial Programs have developed evidence-based guidelines to support quality care. The leaders and team are encouraged to continue to develop and implement evidence-based guidelines with the input of clients and families.

The team members and leaders are acknowledged for their commitment to team and client safety. Wall walks, visibility boards, family conferences, team meetings, and inter-agency meetings are used to support quality and safety. Client satisfaction surveys are completed. The results of surveys are shared with the team. The organization is encouraged to continue to obtain the input and participation of clients and families and to share the results of client satisfaction surveys.

The team members are involved in quality improvement initiatives, which range from informal changes to more formal projects and data collection.

Metrics are posted related to patient safety and reviewed during "huddles" involving the team and leaders. The "Wall Walk" occurs weekly and includes a safety component, review of metrics related to hand hygiene, percentage of available appointments scheduled by discipline, client and team member incidents (including falls), and a weekly rotating "discipline" report.

A Developmental Pediatrics Visioning Session took place in April 2019 with involvement from front-line staff and leaders from both the Saskatoon and Regina programs, two mothers of patients, and quality improvement team members.

A provincial intake process is being implemented to create a provincial process and standardization of intake processes between the Alvin Buckwold Child Development Program (located at the Kinsmen Children's Centre) and the Wascana Rehabilitation Centre. "Current" state mapping of intake processes and validation of the current state processes are now completed, with two family advisors participating in this process. A "future" state mapping event is the next step in this process and will include the participation of Patient Family Advisors.
An Experience Based Co-Design (EBCD) event was held with the participation of the Wascana Rehabilitation Centre, Alvin Buckwold Child Development Program, and Prince Albert Pediatric Unit teams and included: leaders and front-line staff, four families of clients, and QI managers. A member of the Regina Patient and Family Advisory Council (PFAC) took on the role of a Patient Surveyor for the EBCD project, and conducted interviews with a sample of staff, clients, and families. The improvement ideas have been incorporated into the QI Plans for the Centres. The organization is encouraged to continue to consistently share information about quality improvement activities, results, and learning with clients, families, and partners.

There is a commitment to research. Wait list and utilization data are tracked. The team is encouraged to explore expanding the use of clinical assessment data and information from standardized assessment instruments to compare performance with other Children's Rehabilitation facilities.

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)

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: November 8, 2018 to December 31, 2018**
- **Number of responses: 9**

Governance Functioning Tool Results

	% 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	93
2. Governance policies and procedures that define our role and responsibilities are well documented and consistently followed.	0	0	100	94
3. Subcommittees need better defined roles and responsibilities.	89	11	0	72
4. As a governing body, we do not become directly involved in management issues.	0	0	100	88
5. Disagreements are viewed as a search for solutions rather than a “win/lose”.	0	0	100	96

	% 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	11	89	96
7. Individual members understand and carry out their legal duties, roles, and responsibilities, including subcommittee work (as applicable).	0	0	100	95
8. Members come to meetings prepared to engage in meaningful discussion and thoughtful decision making.	0	0	100	95
9. Our governance processes need to better ensure that everyone participates in decision making.	100	0	0	63
10. The composition of our governing body contributes to strong governance and leadership performance.	0	0	100	94
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	11	89	86
13. Working relationships among individual members are positive.	0	0	100	97
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	97
16. We benchmark our performance against other similar organizations and/or national standards.	25	13	63	73
17. Contributions of individual members are reviewed regularly.	13	50	38	66
18. As a team, we regularly review how we function together and how our governance processes could be improved.	0	13	88	76
19. There is a process for improving individual effectiveness when non-performance is an issue.	13	25	63	60
20. As a governing body, we regularly identify areas for improvement and engage in our own quality improvement activities.	0	0	100	82

	% 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.	33	22	44	45
22. We receive ongoing education on how to interpret information on quality and patient safety performance.	13	0	88	80
23. As a governing body, we oversee the development of the organization's strategic plan.	0	0	100	96
24. As a governing body, we hear stories about clients who experienced harm during care.	0	0	100	79
25. The performance measures we track as a governing body give us a good understanding of organizational performance.	0	22	78	89
26. We actively recruit, recommend, and/or select new members based on needs for particular skills, background, and experience.	0	0	100	87
27. We lack explicit criteria to recruit and select new members.	83	0	17	73
28. Our renewal cycle is appropriately managed to ensure the continuity of the governing body.	0	17	83	88
29. The composition of our governing body allows us to meet stakeholder and community needs.	0	13	88	90
30. Clear, written policies define term lengths and limits for individual members, as well as compensation.	0	0	100	91
31. We review our own structure, including size and subcommittee structure.	0	0	100	86
32. We have a process to elect or appoint our chair.	50	25	25	89

*Canadian average: Percentage of Accreditation Canada client organizations that completed the instrument from January to June, 2019 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	56	44	80
34. Quality of care	0	56	44	82

*Canadian average: Percentage of Accreditation Canada client organizations that completed the instrument from January to June, 2019 and agreed with the instrument items.

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.

The Saskatchewan Health Authority (SHA) concluded our first on-site Accreditation Survey on November 29, 2019. This first component of our sequential Accreditation Model included a full review of Governance, Leadership, Infection Control, and Medication Management standards; it included a deep dive into the clinical areas of Maternal and Children's Provincial Programs and a bridging survey of the former Saskatoon Health Region. In 2020, Primary Health Care, Mental Health and Addictions, and other community services will be reviewed, followed by Inpatient Services in 2021, and Continuing Care in 2022. This new sequential approach to surveying was co-designed in 2018 with providers, Patient Family Advisors, and First Nations and Metis partners. The Accreditation Model represents the Medicine Wheel and holistic health, and is founded in the Life Cycle following a continuous process from infancy to end of life. At the core of the model lies the SHA values and philosophy of care, with Patient and Family-Centred Care at the centre of everything we do.

We are excited to begin our journey to being "Accreditation Ready" at all times where all service areas understand the applicable standards, and, these standards of excellence are embedded in our daily work. The SHA views Accreditation as a process to help us all work safer and smarter by following national standards which ensure safe and high-quality patient care.

As we follow up on this report, we are given the opportunity to prioritize and focus on areas for improvement and standardization.

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

Priority processes associated with population-specific standards

Priority Process	Description
Chronic Disease Management	Integrating and coordinating services across the continuum of care for populations with chronic conditions

Priority Process	Description
Population Health and Wellness	Promoting and protecting the health of the populations and communities served through leadership, partnership, and innovation.

Priority processes associated with service excellence standards

Priority Process	Description
Blood Services	Handling blood and blood components safely, including donor selection, blood collection, and transfusions
Clinical Leadership	Providing leadership and direction to teams providing services.
Competency	Developing a skilled, knowledgeable, interdisciplinary team that can manage and deliver effective programs and services.
Decision Support	Maintaining efficient, secure information systems to support effective service delivery.
Diagnostic Services: Imaging	Ensuring the availability of diagnostic imaging services to assist medical professionals in diagnosing and monitoring health conditions
Diagnostic Services: Laboratory	Ensuring the availability of laboratory services to assist medical professionals in diagnosing and monitoring health conditions
Episode of Care	Partnering with clients and families to provide client-centred services throughout the health care encounter.
Impact on Outcomes	Using evidence and quality improvement measures to evaluate and improve safety and quality of services.
Infection Prevention and Control	Implementing measures to prevent and reduce the acquisition and transmission of infection among staff, service providers, clients, and families
Living Organ Donation	Living organ donation services provided by supporting potential living donors in making informed decisions, to donor suitability testing, and carrying out living organ donation procedures.
Medication Management	Using interdisciplinary teams to manage the provision of medication to clients

Priority Process	Description
Organ and Tissue Donation	Providing organ and/or tissue donation services, from identifying and managing potential donors to recovery.
Organ and Tissue Transplant	Providing organ and/or tissue transplant service from initial assessment to follow-up.
Point-of-care Testing Services	Using non-laboratory tests delivered at the point of care to determine the presence of health problems
Primary Care Clinical Encounter	Providing primary care in the clinical setting, including making primary care services accessible, completing the encounter, and coordinating services
Public Health	Maintaining and improving the health of the population by supporting and implementing policies and practices to prevent disease, and to assess, protect, and promote health.
Surgical Procedures	Delivering safe surgical care, including preoperative preparation, operating room procedures, postoperative recovery, and discharge