ACCREDITATION
AGRÉMENT
CANADA
Qmentum

Accreditation Report

Saskatchewan Health Authority

Saskatoon, SK

On-site survey dates: June 5, 2022 - June 10, 2022

Report issued: August 4, 2022

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 June 2022. 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 will be treated in confidence by Accreditation Canada in accordance with the terms and conditions as agreed between your organization and Accreditation Canada for the Assessment Program.

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

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

A Message from Accreditation Canada

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

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

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

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

We look forward to our continued partnership.

Sincerely,

Leslee Thompson
Chief Executive Officer

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Executive Summary

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: June 5, 2022 to June 10, 2022**

- **Locations**

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

1. Arcola Health Centre
2. Battlefords Union Hospital
3. Battlefords Union Hospital - Ambulatory (Kidney Health)
4. Broadview Union Hospital
5. Cameco Community Renal Health Centre
6. Cypress Regional Hospital
7. Dr. F. H. Wigmore - Ambulatory (Kidney Health)
8. Dr. F. H. Wigmore Regional Hospital
9. Hudson Bay Health Care Facility
10. Humboldt District Health Complex
11. Indian Head Union Hospital
12. Jim Pattison Children's Hospital
13. JPCH - Critical Care (NICU)
14. JPCH - Critical Care (PICU)
15. Kelvington Hospital
16. Kipling Integrated Health Centre
17. La Loche Health Center
18. Lloydminster Hospital
19. Maidstone Health Complex
20. Meadow Lake Hospital
21. Melfort Hospital
22. Nipawin Hospital
23. Outlook & District Health Centre
24. Parkland Integrated Health Centre

25. Pasqua - Ambulatory (1G, PH3F)
26. Pasqua - Ambulatory (PH0G)
27. Pasqua - Inpatient (Medicine)
28. Pasqua - Inpatient (Surgical)
29. Pasqua - Perioperative (4C, 4D)
30. Pasqua - Perioperative (Day Surgery, PACU)
31. Pasqua - Perioperative (Endoscopy)
32. Pasqua Hospital
33. Porcupine Carragana Hospital
34. Redvers Health Centre
35. Regina General Hospital
36. RGH - Ambulatory (Cardio-Neuro)
37. RGH - Ambulatory (Cardiosciences)
38. RGH - Ambulatory (Diagnostic Respiratory)
39. RGH - Ambulatory (Kidney Health)
40. RGH - Ambulatory (Neurosciences)
41. RGH - Ambulatory (Surgical)
42. RGH - Critical Care (Cardiosciences)
43. RGH - Critical Care (ICU)
44. RGH - Inpatient (Cardiosciences)
45. RGH - Inpatient (Medicine)
46. RGH - Inpatient (Neurosciences)
47. RGH - Inpatient (Surgical)
48. RGH - Perioperative (2F)
49. RGH - Perioperative (Day Surgery, PACU)
50. RGH - Perioperative (Endoscopy)
51. Rosetown & District Health Centre
52. Rosthern Hospital
53. Royal University Hospital
54. RUH - Ambulatory (Cardiosciences)
55. RUH - Ambulatory (Day Centre)

56. RUH - Ambulatory (Diagnostic Respiratory)
57. RUH - Ambulatory (Medicine)
58. RUH - Ambulatory (Neurosciences)
59. RUH - Critical Care (Cardiosciences)
60. RUH - Critical Care (ICU)
61. RUH - Inpatient (Cardiosciences)
62. RUH - Inpatient (Medicine)
63. RUH - Inpatient (Neurosciences)
64. RUH - Perioperative (Cardiosciences)
65. Saskatoon City Hospital
66. SCH - Ambulatory (Diagnostic Respiratory)
67. SCH - Ambulatory (Neurosciences)
68. Southeast Integrated Care Centre
69. St. Anthony's Hospital
70. St. Joseph's Health Centre (Ile-a la-Crosse)
71. St. Joseph's Hospital of Estevan
72. St. Joseph's of Estevan - Ambulatory (Kidney Health)
73. St. Paul's - Ambulatory (Kidney Health)
74. St. Paul's - Ambulatory (Urology)
75. St. Paul's Hospital
76. St. Peter's Hospital
77. Surgical Assessment Centre
78. Tisdale - Ambulatory (Kidney Health)
79. Tisdale Hospital
80. Victoria Hospital
81. Victoria Hospital - Ambulatory (Kidney Health)
82. Wadena Hospital
83. Wascana Rehabilitation Centre
84. Watrous District Health Complex
85. Weyburn General Hospital
86. Wynyard Hospital

87. Yorkton - Ambulatory (Kidney Health)
88. 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. Infection Prevention and Control Standards

Service Excellence Standards

2. Ambulatory Care Services - Service Excellence Standards
3. Cancer Care - Service Excellence Standards
4. Critical Care Services - Service Excellence Standards
5. Emergency Department - Service Excellence Standards
6. Hospice, Palliative, End-of-Life Services - Service Excellence Standards
7. Inpatient Services - Service Excellence Standards
8. Medication Management (For Surveys in 2021) - Service Excellence Standards
9. Obstetrics Services - Service Excellence Standards
10. Perioperative Services and Invasive Procedures - Service Excellence Standards
11. Reprocessing of Reusable Medical Devices - Service Excellence Standards

- **Instruments**

The organization administered:

Indicators

1. 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)	12	8	0	20
Accessibility (Give me timely and equitable services)	73	9	2	84
Safety (Keep me safe)	436	51	6	493
Worklife (Take care of those who take care of me)	60	24	0	84
Client-centred Services (Partner with me and my family in our care)	307	35	0	342
Continuity (Coordinate my care across the continuum)	71	4	0	75
Appropriateness (Do the right thing to achieve the best results)	519	103	3	625
Efficiency (Make the best use of resources)	31	3	0	34
Total	**1509**	**237**	**11**	**1757**

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
	# (%)	# (%)	#	# (%)	# (%)	#	# (%)	# (%)	#
Infection Prevention and Control Standards	38 (95.0%)	2 (5.0%)	0	27 (87.1%)	4 (12.9%)	0	65 (91.5%)	6 (8.5%)	0
Medication Management (For Surveys in 2021)	82 (85.4%)	14 (14.6%)	4	44 (91.7%)	4 (8.3%)	2	126 (87.5%)	18 (12.5%)	6
Ambulatory Care Services	31 (68.9%)	14 (31.1%)	2	57 (73.1%)	21 (26.9%)	0	88 (71.5%)	35 (28.5%)	2
Cancer Care	78 (96.3%)	3 (3.7%)	0	106 (93.8%)	7 (6.2%)	2	184 (94.8%)	10 (5.2%)	2
Critical Care Services	47 (78.3%)	13 (21.7%)	0	89 (84.8%)	16 (15.2%)	0	136 (82.4%)	29 (17.6%)	0
Emergency Department	65 (90.3%)	7 (9.7%)	0	102 (95.3%)	5 (4.7%)	0	167 (93.3%)	12 (6.7%)	0
Hospice, Palliative, End-of-Life Services	38 (84.4%)	7 (15.6%)	0	99 (92.5%)	8 (7.5%)	1	137 (90.1%)	15 (9.9%)	1
Inpatient Services	53 (88.3%)	7 (11.7%)	0	76 (89.4%)	9 (10.6%)	0	129 (89.0%)	16 (11.0%)	0

Standards Set	High Priority Criteria *			Other Criteria			Total Criteria (High Priority + Other)		
	Met	Unmet	N/A	Met	Unmet	N/A	Met	Unmet	N/A
	# (%)	# (%)	#	# (%)	# (%)	#	# (%)	# (%)	#
Obstetrics Services	72 (98.6%)	1 (1.4%)	0	88 (100.0%)	0 (0.0%)	0	160 (99.4%)	1 (0.6%)	0
Perioperative Services and Invasive Procedures	92 (80.0%)	23 (20.0%)	0	84 (77.1%)	25 (22.9%)	0	176 (78.6%)	48 (21.4%)	0
Reprocessing of Reusable Medical Devices	69 (78.4%)	19 (21.6%)	0	25 (62.5%)	15 (37.5%)	0	94 (73.4%)	34 (26.6%)	0
Total	**665 (85.8%)**	110 (14.2%)	6	797 (87.5%)	114 (12.5%)	5	1462 (86.7%)	224 (13.3%)	11

* 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: Communication			
Client Identification (Ambulatory Care Services)	Met	1 of 1	0 of 0
Client Identification (Cancer Care)	Met	1 of 1	0 of 0
Client Identification (Critical Care Services)	Met	1 of 1	0 of 0
Client Identification (Emergency Department)	Met	1 of 1	0 of 0
Client Identification (Hospice, Palliative, End-of-Life Services)	Met	1 of 1	0 of 0
Client Identification (Inpatient Services)	Met	1 of 1	0 of 0
Client Identification (Obstetrics Services)	Met	1 of 1	0 of 0
Client Identification (Perioperative Services and Invasive Procedures)	Met	1 of 1	0 of 0
Information transfer at care transitions (Ambulatory Care Services)	Met	4 of 4	1 of 1
Information transfer at care transitions (Cancer Care)	Met	4 of 4	1 of 1

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Communication			
Information transfer at care transitions (Critical Care Services)	Unmet	1 of 4	0 of 1
Information transfer at care transitions (Emergency Department)	Unmet	3 of 4	1 of 1
Information transfer at care transitions (Hospice, Palliative, End-of-Life Services)	Met	4 of 4	1 of 1
Information transfer at care transitions (Inpatient Services)	Unmet	1 of 4	0 of 1
Information transfer at care transitions (Obstetrics Services)	Met	4 of 4	1 of 1
Information transfer at care transitions (Perioperative Services and Invasive Procedures)	Unmet	2 of 4	0 of 1
Medication reconciliation at care transitions (Ambulatory Care Services)	Met	5 of 5	0 of 0
Medication reconciliation at care transitions (Cancer Care)	Met	9 of 9	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 (Hospice, Palliative, End-of-Life 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 (Inpatient Services)	Unmet	2 of 4	0 of 0
Medication reconciliation at care transitions (Obstetrics Services)	Met	4 of 4	0 of 0
Medication reconciliation at care transitions (Perioperative Services and Invasive Procedures)	Met	4 of 4	0 of 0
Safe Surgery Checklist (Obstetrics Services)	Met	3 of 3	2 of 2
Safe Surgery Checklist (Perioperative Services and Invasive Procedures)	Unmet	0 of 3	0 of 2
The “Do Not Use” list of abbreviations (Medication Management (For Surveys in 2021))	Met	4 of 4	3 of 3
Patient Safety Goal Area: Medication Use			
Antimicrobial Stewardship (Medication Management (For Surveys in 2021))	Met	4 of 4	1 of 1
Concentrated Electrolytes (Medication Management (For Surveys in 2021))	Met	3 of 3	0 of 0
Heparin Safety (Medication Management (For Surveys in 2021))	Met	4 of 4	0 of 0

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Medication Use			
High-Alert Medications (Medication Management (For Surveys in 2021))	Met	5 of 5	3 of 3
Infusion Pumps Training (Ambulatory Care Services)	Unmet	3 of 4	1 of 2
Infusion Pumps Training (Cancer Care)	Met	4 of 4	2 of 2
Infusion Pumps Training (Critical Care Services)	Met	4 of 4	2 of 2
Infusion Pumps Training (Emergency Department)	Met	4 of 4	2 of 2
Infusion Pumps Training (Hospice, Palliative, End-of-Life Services)	Met	4 of 4	2 of 2
Infusion Pumps Training (Inpatient Services)	Met	4 of 4	2 of 2
Infusion Pumps Training (Obstetrics Services)	Met	4 of 4	2 of 2
Infusion Pumps Training (Perioperative Services and Invasive Procedures)	Met	4 of 4	2 of 2
Narcotics Safety (Medication Management (For Surveys in 2021))	Met	3 of 3	0 of 0
Patient Safety Goal Area: Infection Control			
Hand-Hygiene Compliance (Infection Prevention and Control Standards)	Unmet	0 of 1	0 of 2

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Infection Control			
Hand-Hygiene 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 (Cancer Care)	Met	2 of 2	1 of 1
Falls Prevention Strategy (Critical Care Services)	Unmet	2 of 2	0 of 1
Falls Prevention Strategy (Hospice, Palliative, End-of-Life Services)	Met	2 of 2	1 of 1
Falls Prevention Strategy (Inpatient Services)	Met	2 of 2	1 of 1
Falls Prevention Strategy (Obstetrics Services)	Met	2 of 2	1 of 1
Falls Prevention Strategy (Perioperative Services and Invasive Procedures)	Unmet	2 of 2	0 of 1
Pressure Ulcer Prevention (Cancer Care)	Met	3 of 3	2 of 2
Pressure Ulcer Prevention (Critical Care Services)	Unmet	3 of 3	1 of 2
Pressure Ulcer Prevention (Hospice, Palliative, End-of-Life 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 (Perioperative Services and Invasive Procedures)	Unmet	3 of 3	1 of 2
Suicide Prevention (Emergency Department)	Met	5 of 5	0 of 0
Venous Thromboembolism Prophylaxis (Cancer Care)	Met	3 of 3	2 of 2
Venous Thromboembolism Prophylaxis (Critical Care Services)	Met	3 of 3	2 of 2
Venous Thromboembolism Prophylaxis (Inpatient Services)	Met	3 of 3	2 of 2
Venous Thromboembolism Prophylaxis (Perioperative Services and Invasive Procedures)	Unmet	3 of 3	1 of 2

Summary of Surveyor Team Observations

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

The team members, family and client partners, physician, and leaders at the Saskatchewan Health Authority (SHA) are acknowledged for preparing for and participating in the Qmentum accreditation program, using a sequential format. The survey goals include identifying; 1. What is working well, 2. Where can we improve, and 3. Where can we celebrate. Commitment, openness and embracing change were at the forefront as they continue the accreditation and quality journey. The SHA team welcomed the accreditation process, and they were proud to share the successes and opportunities of the programs and services. Prior to 2018, the twelve former health regions were accredited as separate organizations. As a new provincial health authority, they commenced the first accreditation cycle in 2019 with two surveys per year anticipated. However, the COVID-19 pandemic resulted in changes to the accreditation cycle. The commitment of SHA to the accreditation journey remains steadfast.

There is a strong commitment to the vision, mission, and values of SHA. The team members, family and client partners, physicians and leaders support the values which include, safety, accountability, respect, collaboration, compassion, and philosophy of care. The mission is, “We work together to improve health and well-being. Everyday. For everyone.” The mission is a foundational statement which helps guide the development of provincial and regional programs and services. The inspiring vision states, “Healthy People, Healthy Saskatchewan.” The SHA is commended for their commitment to Truth and Reconciliation and the requirement that all employees are required to undertake trauma informed training. The First Nations and Metis Health Teams based in Prince Albert, Saskatoon and Regina support the integration of traditional medicine into the care practices of these clients. The SHA is encouraged to consider spreading this model and making this valuable resource available.

There have been several leadership changes at the SHA including the appointment of an interim CEO in December 2021. The CEO and leadership team are engaged with team members, physicians, and client and family partners. Additionally, there are also new leaders throughout the SHA. This provides an opportunity for the SHA to continue to support the educational and learning needs of new and emerging leaders. Furthermore, the leaders are encouraged to support team members though visible leadership especially at rural sites. Visibility is critical to build trust and ensure accountability and safety. The leaders are compassionate and committed to the mission, vision, and values of SHA. They have a deep commitment to improve health care for the Saskatchewan people. This includes a multi-year journey of working collaboratively to better co-ordinate health services across the province ensuring that people receive the right care, in the right place, at the right time, and by the right provider. This includes initiatives to provide care “closer to home.” The leaders are commended for the development of three goals to guide the SHA through 2021-2022. This includes the recovery of our workforce and advancing integrated People-centred care, connected care for the people of Saskatchewan, and system stabilization.

The SHA is the largest organization in Saskatchewan. The physical infrastructure is vast and includes six

tertiary hospitals, six regional hospitals, nine district hospitals, forty community hospitals and four northern hospitals, with over 3,565 inpatient beds. They are located throughout a large geographical land mass. The hospitals are clean with the environmental services team very proud of their work in ensuring a safe environment for clients, residents and team members. There is variation in the physical condition of the hospitals including aging infrastructure, shared client rooms, limited space for client interactions, lack of storage, clutter in hallways, lack of appropriate infrastructure to support medical device reprocessing, lack of medication rooms, and pharmacy and unit preparation areas for systemic cancer treatments. These challenges have implications for patient safety, people centered care, infection prevention and control and client flow. The organization is encouraged to review the infrastructure needs of their facilities and develop plans for facility improvement based on the principles of patient safety, infection prevention and control, quality, and client flow.

Patients and families uniformly, across all locations and areas of care, express deep gratitude for the compassionate and person-centered care they receive. They feel valued and recognized as unique individuals with needs and preferences that are acknowledged and respected. They feel informed and supported through their care journeys. They are very aware of the extraordinary lengths their health care teams have gone to in challenging times to deliver exceptional care that placed their safety as a priority.

The SHA has invested considerable time and resources to build a robust framework for engaging patients and families as valued partners. Six hundred committed patient and family partners are key members of many councils, working groups and committees. They offer invaluable insight into how care informed by the patient voice is safer and of a higher quality. Innovations such as the Accountable Care Units and the Saskatchewan Centre for Patient Oriented Research exemplify authentic engagement. There are opportunities to cascade those best practices down to the program level in a more robust way. Many programs and areas of care would enthusiastically partner with patients and families on space design process improvement, safety incident investigation, and patient education materials, for example, with more fulsome support. The organization is encouraged to consider the entire spectrum of engagement pathways including, but not limited to, patient and family partners and formal patient and family advisory councils. Real time interviews, patient surveys, focus groups, and community town halls are all opportunities to better understand what matters most to patients. There is abundant creativity and passion in the staff and leaders that will build new pathways if supported.

The SHA is committed to the quality journey. There is a culture of safety, quality, and risk management. The team members and leaders are encouraged to continue to embed and cascade quality improvement at the facility and program level. This includes continuing to involve clients, families and partners in the co-design, implementation, and evaluation of quality improvement initiatives. This also includes ensuring that quality improvement and analytic resources are available for all programs and facilities as it was noted that this was a significant deficit at the rural and regional sites. Additionally, there is variation in the delivery of pharmacy services across the SHA with significant challenges at the rural sites. This includes issues regarding availability of pharmacist and pharmacy technicians, medication preparation areas, and auditing, to name just a few. Therefore, it is encouraged that a provincial roadmap for medication management be developed and implemented.

The commitment to quality improvement was especially evident during the challenges of the COVID 19 pandemic and subsequent ongoing recovery. They are acknowledged for their work to provide safe client, resident, and community care during this unprecedented time. This includes flexibility to meet the everchanging demands of the COVID 19 pandemic. Safety and creativity were at the forefront of the pandemic planning, implementation, and recovery. These included initiatives supporting client, resident and team member safety, comprehensive and robust infection prevention and control programs and strategies, and the provision of COVID 19 testing and immunization clinics, to name just a few. The team members and leaders are very proud of their work during the COVID 19 pandemic. This includes comments such as, “We worked well as a team and the support of infection prevention and control was excellent,” and “We are really proud of what our little site [Name of facility] achieved.” Furthermore, the community acknowledged the work of the SHA. The Southwest Integrated Healthcare Facility was a recipient of the 2021 Maple Creek Community Award. This prestigious award acknowledged the efforts of the team in serving their community by helping patients and residents with the upmost devotion and respect during the COVID 19 pandemic. The challenges of the COVID 19 pandemic remain, including human resources, continued infection prevention and control processes, wait time management, bed management challenges, and health system recovery. The team members, physicians and leaders are encouraged to continue with this important work.

The leaders and team members are committed to fostering partnerships to further the reach of programs and service. This includes the many interactions with the Saskatchewan Cancer Agency, eHealth Saskatchewan, and other health and community organizations. Of particular note is the relationships with the health care auxiliaries and foundations who proudly support health care facilities across the province. One team member stated, “They really support our hospital. They have really made a difference to the quality of care we provide.” The community members are very proud of their local hospitals.

The leaders and team members are acknowledged for identifying and reducing barriers to access to programs and services. This includes initiatives to provide care throughout the province thus reducing travel costs and enhancing client access. Effective client flow is a priority for the leaders and team members of SHA. There have been processes implemented to support effective client flow including the System Flow Coordination Centre, policy, and procedure development, rounding and flow meetings. However, client flow continues to be challenging, including, the wait times for clients transferring from acute care to a more appropriate care setting and variation in the effectiveness of the strategies. The organization is encouraged to develop a provincial utilization strategy with dissemination throughout the SHA. Additionally, the development of a provincial strategy for centralized peri-operative waitlist management is encouraged.

There are a comprehensive array of programs and services provided at SHA. There are strong provincial initiatives which support clinical guidelines, best practices, and systemic strategies. The client records are combination of paper and electronic based formats. There is a gap in the availability of electronic health records and the intra-operability between electronic systems. As there are inherent risks with paper and electronic charting systems the SHA is encouraged to have one client record system. Clients and families have spoken highly about the care provided. They have described their care as “wonderful” with “excellent staff.” Furthermore, they stated that they were treated with care, dignity, and respect. The SHA is supported in their goal to have provincial standardization with local implementation. The strength of provincialization was evident in Saskatoon and Regina. The SHA is encouraged to accelerate the visibility and implementation

of provincial standardization for all clinical services at the regional and rural sites.

There is an environment of innovation in the quest to provide program and services to meet the needs of clients, families, and communities. This includes the development of innovative programs and services such as the development of a new provincial hand hygiene audit platform which is currently being piloted in hospitals in the northern integrated area. This innovative approach is anticipated in enhanced hand hygiene auditing and provide solution focused interventions. The Critical Care Program is commended on their plans to pilot a virtual ICU recovery clinic for specific clients who have been discharged from the ICU. There is a comprehensive array of services including, kidney health, surgical services, acute care, and tertiary services. The strength of the SHA is the quality of team members, physicians, family and client partners, and leaders. They are excited to provide quality programs and services and improve access for clients and families. There is evidence of strong inter-professional teams. Team members have described the work environment as "supportive" and being "like a family." They noted that they are supported in their learning and development. The team members stated that they were provided with support to address ethical issues and concerns. They identified processes that supported ethical decision making. However, at some sites there are concerns expressed by team members regarding their physical safety. The leaders are encouraged to continue with plans to enhance initiatives to support team member safety. Additionally, there are human resource challenges including pandemic recovery and recruitment and retention. The organization is encouraged to continue to support creative human resources strategies.

It has been an honor and privilege for the survey team to work with the leaders, physicians, family and client partners, and team members especially during the COVID 19 pandemic and recovery. They are encouraged to continue their quality journey as they embrace their vision of "Healthy People, Healthy Saskatchewan."

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.	· Inpatient Services 10.16 · Perioperative Services and Invasive Procedures 12.11 · Emergency Department 12.16 · Critical Care Services 9.23
Safe Surgery Checklist A safe surgery checklist is used to confirm that safety steps are completed for a surgical procedure performed in the operating room.	· Perioperative Services and Invasive Procedures 14.3
Medication reconciliation at care transitions Medication reconciliation is conducted in partnership with clients and families to communicate accurate and complete information about medications across care transitions.	· Inpatient Services 9.7
Patient Safety Goal Area: Medication Use	
Infusion Pumps Training A documented and coordinated approach for infusion pump safety that includes training, evaluation of competence, and a process to report problems with infusion pump use is implemented.	· Ambulatory Care Services 3.8
Patient Safety Goal Area: Infection Control	
Hand-Hygiene Compliance Compliance with accepted hand-hygiene practices is measured.	· Infection Prevention and Control Standards 8.6

Unmet Required Organizational Practice	Standards Set
Patient Safety Goal Area: Risk Assessment	
Falls Prevention Strategy To prevent falls and reduce the risk of injuries from falling, universal precautions are implemented, education and information are provided, and activities are evaluated.	· Perioperative Services and Invasive Procedures 11.11 · Critical Care Services 8.7
Pressure Ulcer Prevention Each client's risk for developing a pressure ulcer is assessed and interventions to prevent pressure ulcers are implemented.NOTE: This ROP does not apply for outpatient settings, including day surgery, given the lack of validated risk assessment tools for outpatient settings.	· Perioperative Services and Invasive Procedures 11.10 · Critical Care Services 8.8
Venous Thromboembolism Prophylaxis Medical and surgical clients at risk of venous thromboembolism (deep vein thrombosis and pulmonary embolism) are identified and provided with appropriate thromboprophylaxis.NOTE: This ROP does not apply for pediatric hospitals; it only applies to clients 18 years of age or older. This ROP does not apply to day procedures or procedures with only an overnight stay.	· Perioperative Services and Invasive Procedures 11.12

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: Physical Environment

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

Unmet Criteria		High Priority Criteria
Standards Set: Perioperative Services and Invasive Procedures		
3.3	Heating, ventilation, temperature, and humidity in the area where surgical and invasive procedures are performed are monitored and maintained according to applicable standards, legislation, and regulations.	
3.6	Airflow and quality in the area(s) where surgical and invasive procedures are performed are monitored and maintained according to standards applicable for the type of procedures performed.	!
3.7	Rooms where surgical and invasive procedures are performed have at least 20 complete air exchanges per hour.	!

Surveyor comments on the priority process(es)

Where surgical procedures are performed, the operating room and equipment are designed with consideration for client flow, traffic patterns and the types of procedures performed. Staff were well educated as to how to maintain heating, ventilation, humidity, and temperature in the surgical area. They were aware of the number of air exchanges required in the operating room and who to contact if problems arise. The Yorkton hospital is encouraged to review the heating and cooling system, along with backup. At some of the smaller sites, it was also noted that the procedure rooms were small and cramped.

There is a process in place for doing terminal cleaning of rooms at the end of the day when procedures are completed. A restricted access area for sterile storage of supplies is present.

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)

There is a strong connection with IPAC at the highest levels for COVID-19 pandemic and outbreak work.

During the COVID-19 pandemic, efforts and commitment to managing ongoing outbreaks and responding to changing directions, when needed, is commendable. All levels of the IPAC team have played a key role for the SHA, the province, and the public to ensure all needed activities occur. This has been demonstrated in many ways such as: in leadership roles; communication/reporting activities; support activities; information/evidence provision; in-person site visits; and reassessment processes. Policies, procedures, and processes have been applied and communicated on an ongoing basis. At this time, lessons learned over these years should now be utilized to assist with ongoing learning opportunities, opportunities for improvement, and to plan reviews and procedure updates.

Within emergency preparedness efforts, as the SHA progresses, there was some confusion and mixed tool use noted for emergency plans and colour coding. Code Silver is top of mind for many sites yet is not fully implemented or understood. With visitation and building access opening, ensure all sites use similar codes and that they are understood, shared, and practiced as per the SHA guidelines.

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: Cancer Care		
2.4	Space is co-designed with clients and families to ensure safety and permit confidential and private interactions with clients and families.	
27.3	Measurable objectives with specific timeframes for completion are identified for quality improvement initiatives, with input from clients and families.	!
Standards Set: Critical Care Services		
1.2	Services are co-designed with clients and families, partners, and the community.	!
2.6	Space is co-designed with clients and families to ensure safety and permit confidential and private interactions with clients and families.	
3.13	Client and family representatives are regularly engaged to provide input and feedback on their roles and responsibilities, role design, processes, and role satisfaction, where applicable.	
17.3	Measurable objectives with specific timeframes for completion are identified for quality improvement initiatives, with input from clients and families.	!
Standards Set: Hospice, Palliative, End-of-Life Services		
16.3	Measurable objectives with specific timeframes for completion are identified for quality improvement initiatives, with input from clients and families.	!
Standards Set: Inpatient Services		
1.1	Services are co-designed with clients and families, partners, and the community.	!
2.5	Space is co-designed with clients and families to ensure safety and permit confidential and private interactions with clients and families.	

16.3	Measurable objectives with specific timeframes for completion are identified for quality improvement initiatives, with input from clients and families.	!
Standards Set: Perioperative Services and Invasive Procedures		
1.1	Services are co-designed with clients and families, partners, and the community.	!
2.4	Space is co-designed with clients and families to ensure safety and permit confidential and private interactions with clients and families.	
6.3	A comprehensive orientation is provided to new team members and client and family representatives.	
6.12	Client and family representatives are regularly engaged to provide input and feedback on their roles and responsibilities, role design, processes, and role satisfaction, where applicable.	
11.1	Each client's physical and psychosocial health is assessed and documented using a holistic approach, in partnership with the client and family.	!
11.3	Goals and expected results of the client's care and services are identified in partnership with the client and family.	
24.7	Patient safety incidents are analyzed to help prevent recurrence and make improvements, with input from clients and families.	!
25.3	Measurable objectives with specific timeframes for completion are identified for quality improvement initiatives, with input from clients and families.	!

Surveyor comments on the priority process(es)

The Saskatchewan Health Authority has identified people-centred care as a key pillar of their work toward improving health and well-being every day, for everyone. A holistic approach to assessing, understanding, acknowledging, and caring for people as unique individuals is apparent throughout all care areas assessed. A common refrain was, “We meet people where they are at”.

There is immense good will in the communities across Saskatchewan toward the health care system and the thousands of providers, staff, and leaders that worked tirelessly to keep people safe and supported during the COVID-19 pandemic. Health care workers are spoken of as “heroes”, and “worth their weight in gold”. Patients and families at the direct care level were unanimous in their feeling safe and well-cared for wherever they accessed services. Surveyors heard, often, that the communities served by health care facilities, large or small, local or regional, trusted their providers; “They would always do the right thing”.

The abundant resources and structures that support patient engagement were addressed in the previous

survey. The SHA continues to recruit, onboard, train, and present exciting engagement opportunities to a large pool (approximately 600) of committed patient and family partners. Those programs that have partnered with these volunteers speak glowingly of their collegial spirit, generosity with their time, and shared passion for improving care. Specifically, patient and family partners are compensated for their time and their costs are mitigated. Removing barriers to engagement speaks to demonstrating a true recognition of the valuable work they do. Some patient and family partners (PFP's) expressed concern that their diversity did not reflect the breadth of the populations served and the SHA is encouraged to continue their good work to bringing more voices to the table.

There are abundant examples of innovations made with the assistance of patients and families. Patient surveys using QR codes for programs like Neurosciences and Endoscopy make offering feedback simpler for many. Other care areas seem to have let capturing feedback lapse and would benefit from recommitting to either adopting such innovations or exploring their own patient populations.

Many patient and family committees, councils, and advisory groups have demonstrated immense value co-creating educational materials, designing spaces, participating in hiring and orientation of staff, and rethinking processes from a patient perspective. Nipawin and Melfort illustrate two communities and local health service providers that are hungry to engage, as partners, with patients and families, but feel disconnected from the PFP framework. There is value in committing to renewed awareness of all the engagement tools. The quality of engagement at the provincial level is "leading edge", but it does not always cascade appropriately. Not every service or site needs a Patient and Family Advisory Council, but many would like to explore the idea, or perhaps find other ways to engage. The SHA is encouraged to scan their organization to understand where engagement is embedded, and where it needs attention.

Many units have created great orientation packages for new patients and families. These purpose-built educational materials provide important information on how care is delivered, who comprises the care team, the geography of the care setting, and what to expect during an inpatient stay. These packages tend to improve patient satisfaction, make care safer, and generate good discussions between the provider and the patient/family. The SHA is encouraged to assess which units or programs have not yet undertaken such work and align resources to move it forward. Healthcare is complex and often frightening.

Accountable Care Units illustrate a truly people-centred approach to care. Making unit routines and processes predictable allows for purposeful conversations, brings family and patients into planning their efforts toward regaining health and discharging home.

Sharing information about unit performance, key quality and safety metrics, and ongoing efforts to improve the patient experience is one area of potential growth for the SHA. Consistent messaging, for those receiving care, is not present for hand hygiene compliance, falls and safety incidents, pressure wounds, for example.

The Kidney Care program has created a "Patient Passport". This is an example of supporting patients outside of their episode of care in the hospital. This allows someone living with a chronic disease to have access to a concise summary of their diagnosis, care plan, and current medications. Simplifying travels

through the health care system allows for safer and easier transitions into other care settings, for those with a complex medical history. This idea was brought forward by a patient and family partner and illustrates the value of including the “end-user” in quality improvement.

The Palliative Care Unit at Pasqua Hospital is rightly acknowledged as living people-centred care to its core. A collaborative team of dedicated providers takes time to understand the needs and preferences of each patient and family and works hard to create a passage through end-of-life care that reflects the values of those involved. Creating meaningful memories, hand-painted pillowcases, fingerprint jewellery, heartbeat bookmarks are ways that allow families to feel supported as they move into and through the death of a loved one. The interconnectedness of cancer care, palliative, and hospice services allows for seamless transitions to care where the patient receives what they need, when they need, in a way that is meaningful to them.

The SHA is to be commended for building a strong foundation for patient engagement that has already produced significant advances toward universally present person-centred care. SHA is encouraged to focus on rebuilding toward the level of engagement for which it is known.

Priority Process: Patient Flow

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

Unmet Criteria		High Priority Criteria
Standards Set: Emergency Department		
3.11	Protocols to move clients elsewhere within the organization during times of overcrowding are followed by the team.	!
3.12	Protocols are followed to manage clients when access to inpatient beds is blocked.	
3.13	Protocols to manage overcrowding and surges are followed before requesting aid from alternative health care sites or diverting ambulances.	
Standards Set: Perioperative Services and Invasive Procedures		
9.5	Scheduling strategies, such as block times, are used to achieve an optimal flow of clients.	
9.6	There is a standardized, proactive process to prioritize and schedule elective procedures.	
9.7	Wait lists are regularly monitored and updated, and clients are kept informed about the anticipated date of their scheduled procedure.	
9.9	Wait times for service are monitored and compared to identified targets (e.g., provincial wait-time targets).	

Surveyor comments on the priority process(es)

For the health system to improve patient outcomes, patient flow is a priority. It is managed through daily huddles, provincial bed coordination, and electronic tracking tools.

There is a bed coordination service in Saskatchewan which is known as the System Flow Coordination Centre (SFCC). This center coordinates the bed assignments for the province. The SFCC is comprised of three satellite teams which includes SFCC Urban, SFCC North, and SFCC Rural. There is one phone number for all sites. Their focus, based on the Tiers of Service, is “right service, right location”.

The patient flow center is located remotely from the hospitals in Regina. It is staffed by registered nurses who have worked at least five years in either intensive care or the emergency department. The beds available for use are listed on an Oracle board. The board indicates patients who will be discharged or being admitted, either through the emergency department, postsurgical procedure, or direct admission from medical. The staff are, therefore, able to plan for discharges and occupancy of beds. A strong alliance has been formed with the nursing homes in the areal; they can access the system and obtain patient

information prior to their transfer.

Currently there are three such centers in place, listed above, which deal with transfers and bed occupancy. Unfortunately, these are not all available 24/7. Only the center in Regina is operational 24/7. After midnight, the Regina Centre would call the outlying hospitals to check on availability of beds, if a transfer becomes necessary. The process is well understood, especially in Regina and area, where it was first initiated. Physicians who call into the center requesting transfer to the Regina hospitals are connected with the appropriate consultants, following a brief nursing history.

There is, currently, a process in place which electronically links this center with Saskatoon to support better integration of the patient flow and bed management system. Eventually there will be one system throughout the province to allow movement of patients, regardless of which area they are in, to obtain the proper care and follow-up required.

Staff and families shared, that there are challenges in repatriating patients back to their communities, especially if they are awaiting a long-term care bed. This practice does not align with people-centered care and should be clarified.

There are several examples of good patient flow in the province:
Cypress Regional Hospital has a strong focus on patient flow and is an active participant in the SHA approach. They work with SFCC to ensure patients are in the right bed at the right time. They participate in two daily SHA Huddles on flow; an organizational one at 0900 and a critical care one at 1245. There are daily huddles on their units and weekly interprofessional rounds on the combined medical surgical units. Another good process was observed at the Regina General Hospital (RGH).

Wait times are monitored closely and benchmarks are in place. The province is attempting to reset following the COVID-19 pandemic. The goals are lofty and are beginning to materialize, as they move forward with their provincial structure and plans.

There seems to be a disconnect between the provincial level and the frontline staff and patients. It would be beneficial for all levels to become more involved in planning and to ask how they can support the process. The awareness and input of staff, patients, and families is important. At the Royal University Hospital Neurosciences Unit, where they provide tertiary neurology and neurosurgery, there is value in increasing communication between the sending and receiving sites which may be achieved through the Tiers of Service.

There are opportunities to support patient and family expectations and decision making in transitions of care, through patient and family involvement. To enhance patient and family experience, and to support unit level staff, physicians and leadership, some potential areas of focus may include provincial standards around higher level of care and repatriation decisions, written patient and family information about resources at sending and receiving sites. Early participation, by sending and receiving site medical staff, in developing any new standards and processes to improve patient flow between these sites, may be beneficial.

Several challenges impact patient flow. For example, Meadow Lake is restricted to elective surgery only, other than the need for C-sections, which are currently on bypass. The biggest issue here is the number of "no shows" for surgical bookings which negatively impacts patient flow. An OR booking tool may be beneficial to ensure maximum capacity and efficiency is maintained.

There are hospitals where capacity is an ongoing issue. This results in long waits in the emergency departments. Most hospitals have surge policies in place to support the movement of patients out of the emergency department and into an inpatient bed. Some hospitals indicated they did not have a major issue with patient flow nor occupancy levels. That said, staff shortages have created some challenges in fully operating inpatient services at some locations. There have also been closures and relocations of services due to the COVID-19 pandemic and trying to capitalize on limited space. These have negatively impacted patient flow in some areas.

The province is encouraged to review these relocations of services to determine next steps. Some services for example Community Oncology Programs of Saskatchewan (COPS) sites that have been displaced, feel the new location is not meeting the patients' needs and that decisions and plans need to be defined.

The OR bookings are centralized in some areas for efficiencies and to prioritize the caseload. The rollout of OR manager in RGH and Pasqua Hospital (PH) has been positively accepted by staff, physicians, and the public. The public like to be aware of the flow of their loved ones.

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		
4.8	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.	!
Standards Set: Reprocessing of Reusable Medical Devices		
1.1	Information about service volumes is collected at least annually from all areas in the organization that require reprocessing services, and is shared with the MDR department.	!
1.2	Information collected about services offered and their volumes is used to determine the range of reprocessing services and how they are delivered.	!
2.5	The effectiveness of resources, space, and staffing is evaluated with input from the team, and stakeholders.	
3.3	Access to the MDR department is controlled by restricting access to authorized team members only and being identified with clear signage.	!
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.	!
5.1	Position profiles with defined roles, responsibilities, and scope of employment or practice exist for all positions.	
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.	!
5.13	Ongoing professional development, education, and training opportunities are available to each team member.	
6.2	Work and job design, roles and responsibilities, and assignments are determined with input from team members, and stakeholders where appropriate.	

7.3	The organization has policies and procedures for loaned, shared, consigned, and leased medical devices.	!
7.9	Policies and SOPs are regularly updated, and signed off according to organizational requirements, as appropriate.	!
7.10	Compliance with policies, SOPs and manufacturers' instructions are regularly evaluated and changes made as needed.	
8.2	The reprocessing area's designated hand-washing sinks are equipped with faucets supplied with foot-, wrist-, or knee-operated handles, electric eye controls, automated soap dispenser and single-use towels.	
8.9	Workplace assessments of the MDR department are regularly conducted for ergonomics and occupational health and safety.	!
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.	!
14.1	There is a system that allows for the recall of medical devices associated with a sterilization cycle.	!
14.2	SOPs are applied for inventory control of sterilized devices.	
14.3	All sterilized items in storage, or transported to patient service areas or other organizations, can be tracked.	!
14.5	SOPs are applied to recall sterilized items that may have been compromised.	!
15.1	There is a quality improvement program for reprocessing services that integrates the principles of quality control, risk management, and ongoing improvements.	
15.2	Information and feedback is collected about the quality of services to guide quality improvement initiatives with input from stakeholders and team members.	

15.3	The information and feedback gathered is used to identify opportunities for quality improvement initiatives and set priorities with input from stakeholders.	
15.4	Measurable objectives with specific timeframes for completion are identified for quality improvement initiatives with input from stakeholders.	!
15.5	Indicator(s) that monitor progress for each quality improvement objective are identified, with input from stakeholders.	
15.6	Quality improvement activities are designed and tested to meet objectives.	!
15.7	New or existing indicator data are used to establish a baseline for each indicator.	
15.8	There is a process to regularly collect indicator data and track progress.	
15.9	Indicator data is regularly analyzed to determine the effectiveness of the quality improvement activities.	!
15.10	Quality improvement activities that were shown to be effective in the testing phase are implemented broadly throughout the organization.	!
15.11	Information about quality improvement activities, results, and learnings is shared with stakeholders, teams, organization leaders, and other organizations, as appropriate.	

Surveyor comments on the priority process(es)

Medical Device Reprocessing (MDR) is provided in many sites across Saskatchewan. All staff working there have the required qualifications or are working on attaining them. All new staff being hired are required to have the course.

MDR units have dedicated managers and educators with the necessary training. These are competent teams who are very proud of the work they do to support the delivery of safe, quality care. The team takes pride in meeting and exceeding the standards.

There is a quarterly MDR Provincial Forum meeting including Saskatoon, Regina, Prince Albert, and Meadow Lake. They have a partnership with Saskatchewan Polytech for their staff education and training.

Endoscopy services are provided in 21 facilities. There are no third-party providers for this service, currently. There is a plan to form a Provincial Endoscopy Executive Committee in 2022/23. Reprocessing of the scopes is done very well in many areas. There is a good path of soiled to clean and the areas are divided into different rooms. In Rosetown Ambulatory, there is a clear and concise standard operating procedure (SOP) on scope cleaning. The three cleaning units are maintained by contract. The one

opportunity here would be for the gastroenterologist to provide a schedule of planned endoscopy days. This would enable the site to arrange staffing of the CSD staff and OR nursing.

There are very few external contracts, however, Cypress Regional Hospital provides medical reprocessing services for the SHA regional hospitals and has a contract with Heartland area. In Cypress, staff in MDR are cross trained as OR attendants. The organization is encouraged to review the roles and responsibilities with their staff to standardize. Provincial collaboration and coordination have started, and sites are beginning to share orientation and training for nursing staff and sterile process workers.

The province is encouraged to review and standardize policies and procedures for the one provincial health system to ensure best practice. They are currently using policies and procedures developed when they were regional authorities. It would be beneficial to involve the staff and physicians who do this work and have them reviewed by patient advisors. It is important that any input from patients and families happens at all levels and that this information is communicated across the system.

Some medical reprocessing areas need attention. The provincial system is encouraged to prioritize and address these ongoing issues. Areas of concern include reprocessing removed from where the service is delivered, drywall with chips and cracks, staining on walls from leakage, limited space in some areas, no enclosed sterile storage, sterile storage areas with outside windows indicating no temperature control, very limited storage overall in some areas, hand washing sinks not conveniently located in all areas, many hand washing sinks do not have hands free activation, and prep surfaces that cannot be cleaned properly should be replaced with stainless steel.

In Lloydminster Hospital, reprocessing for scopes is done on a different floor from where procedures are done and there is not a dedicated elevator. Transporting dirty equipment in public elevators is a concern and should be assessed.

Also at Lloydminster Hospital, Sterile supplies are stored in an area where there are windows to the outside, allowing for sunlight to enter. This is a concern as there is no temperature control and this can impact the sterile package and needs modifications.

Adjustable tables, sinks, wrapping areas, lighting being replaced by LED, temperature-controlled environment, fatigue matts, are all good initiatives for staff work. There are examples of improvements underway. At the Victoria Hospital, the team is looking forward to the new Acute Care Tower that is approved to be built. This will provide new space for the MDR and Operating Room. This will address the issue of being able to move sterile and contaminated items in separate corridors and in dedicated service elevators.

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		
1.2	Information is collected from clients and families, partners, and the community to inform service design.	
1.3	Service-specific goals and objectives are developed, with input from clients and families.	
1.6	Information on services is available to clients and families, partner organizations, and the community.	
2.3	An appropriate mix of skill level and experience within the team is determined, with input from clients and families.	
5.2	Work and job design, roles and responsibilities, and assignments are determined with input from team members, and from clients and families where appropriate.	
Priority Process: Competency		
3.1	Required training and education are defined for all team members with input from clients and families.	!
3.6	Education and training are provided on the organization's ethical decision-making framework.	
3.8	A documented and coordinated approach for infusion pump safety that includes training, evaluation of competence, and a process to report problems with infusion pump use is implemented.	ROP
3.8.4	The competence of team members to use infusion pumps safely is evaluated and documented at least every two years. When infusion pumps are used very infrequently, a just-in-time evaluation of competence is performed.	**MAJOR**
3.8.5	The effectiveness of the approach is evaluated. Evaluation mechanisms may include: • Investigating patient safety incidents related to infusion pump use • Reviewing data from smart pumps • Monitoring evaluations of competence • Seeking feedback from clients, families, and team members.	**MINOR**

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.	!
4.5	The effectiveness of team collaboration and functioning is evaluated and opportunities for improvement are identified.	
Priority Process: Episode of Care		
6.2	When scheduling services, set criteria are followed and input is gathered to ensure clients with the most urgent needs are seen first.	
6.3	When scheduling services, same-day scheduling of multiple services for individual clients is coordinated with other service areas in the organization in partnership with the client and family.	
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.	
6.6	The length of time clients wait for services beyond the time the appointment was scheduled to begin is monitored and work is done to reduce that time as much as possible.	
7.13	Clients and families are provided with information about their rights and responsibilities.	!
7.14	Clients and families are provided with information about how to file a complaint or report violations of their rights.	!
8.6	Universal fall precautions, applicable to the setting, are identified and implemented to ensure a safe environment that prevents falls and reduces the risk of injuries from falling.	!
9.11	Specific processes are used for transferring information when clients do not have a regular health care provider.	!
10.7	Team members, referring service providers, and other teams work together to manage pain experienced by the client outside of the ambulatory care environment, e.g., in the home.	
10.8	The effectiveness of transitions is evaluated and the information is used to improve transition planning, with input from clients and families.	
Priority Process: Decision Support		

The organization has met all criteria for this priority process.

Priority Process: Impact on Outcomes		
13.1	There is a standardized procedure to select evidence-informed guidelines that are appropriate for the services offered.	!
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.	!
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.	
15.5	Quality improvement activities are designed and tested to meet objectives.	!
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.	
15.8	Indicator data is regularly analyzed to determine the effectiveness of the quality improvement activities.	!
15.9	Quality improvement activities that were shown to be effective in the testing phase are implemented broadly throughout the organization.	!
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

Nephrology
The Kidney Care program is provincially led. There are 12 satellite clinics to reduce the travel time for Saskatchewan residents in the rural areas. The main hubs are Saskatoon and Regina. Excellent work has been done to work with the indigenous population in Fort Qu'Appelle with Indigenous Health Care. There are five focuses of the kidney health program with the overall vision of providing "Care for everyone in Saskatchewan". There are well thought out program goals for the teams to work towards in quality initiatives. Kidney Services are planned provincially and then spread to the areas where the population will gain the best service with the least patient travel. Saskatoon and Regina would be recommended to be very deliberate to ensure that the satellite sites feel connected and engaged in the planning and operationalizing of plans, education, and supporting services.

The satellite teams are supported with biweekly meetings with the Kidney Care team in the cities. The nephrologist visits the clinics once per month and reviews all the patient care plans with the interdisciplinary team at that time. The renal teams are very committed to provide the best care and are supportive of each other. The clinics have continued with their service throughout the pandemic for this life sustaining treatment.

Areas of strengths include involving clients and families in care and decisions; communication with clients on their care; rural team support available from city centres for nurse liaisons, ethicists, and nephrologists; regular support from the biomedical staff on-site.

Opportunities include interface the MISQ with a provincial electronic documentation system; formalize the patient and family participation at the sites; implement the quality initiatives, defined indicators, and timelines; standardize the clinic access to nursing educators, social workers, Indigenous coordinators, and pharmacists; strengthen connections with satellite units.

Cardiology
The non-invasive cardiology clinics provide ECG, Echo/Doppler, stress testing, Holter/Event monitoring, and Pacemaker Clinic. The team provides comprehensive people-centred care. Quality boards are visible for patients and families to review. Indicators are monitored and reported. Wait lists are monitored. Further follow up and investigation of patients who miss appointments occurs. The team is supported in their plans to expand remote pacemaker interrogation in communities throughout Saskatchewan. The team is also working on trialing a "virtual waiting room" using SMS texting to reduce the number of phone calls and mailouts. Patients and families have access to a QR code whereby it takes them to a patient satisfaction survey which they can complete. There is an opportunity to review the booking model to a centralized system to allow for better utilization of staffing and space access.

Neurology
The clinics are staffed with a multidisciplinary team including a psychologist, social worker, dietitian, EEG

and EMG technicians. This MS Clinic provides the only tertiary level services for Saskatchewan residents with multiple sclerosis which is delivered by a highly motivated multidisciplinary team. There is a strong team with support from provincial planning. Succession planning is recommended to plan for upcoming retirements.

Respirology
The team members and leaders are very dedicated to providing diagnostic respiratory services to clients with coordinated patient centered care. The paper and electronic charts are unavailable to other centers. Clients have described the service as wonderful, diligent, and thorough.

The wait lists are well-managed. Team members describe this as an “excellent” place to work. There is a strong commitment to quality improvement including quality boards, daily huddles, and a strong commitment to wellness. Multiple clients in the cities described parking as “challenging.”

Medical Clinics
The clinics include minor surgical procedures and urology. The physicians' offices book the patients directly to the clinics. The clinics are unaware of how many patients are scheduled for what day ahead of time. SHA staff provide minimal support taking the clients weight, vitals, and planning laboratory tests and ECGs prior to physician visit. The clinics are not in charge with the flow of the clients in booking or follow-up. This leads to a problem with the clinics either being over or understaffed. There are no guidelines or operating processes for these physician clinics. There is no input from clients and family into service design. There is no work on Quality Improvement.

Consideration could be made to improve the flow of outpatients to increase efficiency and standardization of processes and resources. Provincial strategies could determine procedures to be done at an acute site and what could be moved elsewhere based on patient and family considerations. Clarity of strategic direction for ambulatory care will be of value in setting the direction for quality improvement. There may be opportunities to improve patient safety, enhance efficiencies, and reduce variation in practice.

Priority Process: Competency

Overall there are standardized processes to have staff education days where the staff receive the compulsory training required. There are some sites that are not tracking a documented trace of these, and this is recommended. Performance appraisals are lacking throughout the ambulatory sites. It is highly recommended to commence performance appraisals to improve staff satisfaction and communication during this time of transition to the SHA.

Priority Process: Episode of Care

A mix of clinics were visited. It would be beneficial for the organization to perform a review of the clinics

to determine the focus of the clinics and to ensure these are the most efficient and responsible uses of the SHA available manpower, clinic space, and surgical needs. The clinics are staffed with resilient people who care for their communities and want to provide high quality patient care. There are many rural clinics to serve the needs of the communities and to reduce the clients need to travel. There are clinics developed in partnership with Indigenous populations. Many have formalized program to guide quality improvements and are vastly incorporating the voice and opinions of the clients and their families. A lot of what was noted also saw how the staff and clinics have been versatile and adaptable to the pandemic.

Priority Process: Decision Support

The clinics have identified the need for a provincial electronic charting system for the clinics to have the ability to interact with the provincial programs. An electronic chart is highly recommended to be able to share client information through out the client journey.

Priority Process: Impact on Outcomes

There is significant difference in the level of development of the quality improvement (QI) work seen in the ambulatory care clinics. Ambulatory clinics based on specific programs are highly advanced, for example in Cardiology, Neurology, and Kidney Care. The QI is largely linked to input from clients and families.

In conjunction with both the site and overarching programs, the medical clinics have large opportunities to build the QI processes with input from both clinical staff clients and families. Building standardized care models would be a benefit because it will allow the medical clinics to be utilized as a division rather than individual physicians. This is a goal for the acute program.

For the diagnostic clinics in respiratory, there is excellent work in QI including peer reviews with technologists and feedback surveys for clients. There is an opportunity to expand these activities to quality initiatives with staff training. Creation of a physician peer review for the reading of raw data might be considered. This a practice seen across the provinces.

Standards Set: Cancer Care - Direct Service Provision

Unmet Criteria		High Priority Criteria
Priority Process: Clinical Leadership		
2.5	The effectiveness of resources, space, and staffing is evaluated with input from clients and families, the team, and stakeholders.	
Priority Process: Competency		
8.11	Team member performance is regularly evaluated and documented in an objective, interactive, and constructive way.	!
17.12	Access to spiritual space and care is provided to meet clients' needs.	
Priority Process: Episode of Care		
14.14	Clients and families are provided with information about their rights and responsibilities.	!
18.5	Environmental distractions are minimized for team members who are performing critical tasks requiring concentration.	
24.4	Technologies, systems, and software are interoperable.	
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		
5.2	Systemic therapy only: Established guidelines are followed for the safe handling of systemic cancer therapy medications.	
7.2	Systemic therapy only: Established professional guidelines for the safe preparation and dispensing of systemic cancer therapy medications are followed.	
Surveyor comments on the priority process(es)		
Priority Process: Clinical Leadership		

The leaders and team members of the cancer care program are committed to providing safe and quality care. The cancer program is supported by committed and engaged team members and leaders. The

leaders are visible and supportive of team members and clients. There is a strong commitment to developing and maintaining partnerships to meet the needs of clients. One such partnership is the strong collaborative working relationship with the Saskatchewan Cancer Agency. Information on the programs and services provided by cancer care is available. There is variation across the sites in the development of client and family partners. The organization is encouraged to continue to seek the input of clients, families, and team members in the design and future direction of the cancer care program.

The Saskatchewan Cancer Agency supports the COPS (Community Oncology Programs of Saskatchewan) sites by providing the statistics on the number of patients and types and number of treatments. This information is used to inform staffing. For example, at a one-nurse site, certain treatments are not able to be offered. To accommodate treatments in such a situation the emergency department nurse may also assist. Furthermore, the team works with pharmacy to coordinate medication preparation. If a center cannot safely provide a treatment a wait list can be created. There is a strong emphasis of treatment "closer to home" which the client's value and appreciate. The wait lists are reviewed weekly. There is also an "Exception Policy" which focuses on ensuring the safe administration of medication not normally provided at a COPS centre. This includes education, training, and resources to ensure that this is done safely. Currently, a jurisdiction scan of other cancer agencies is being completed to identify staffing workload and models to better inform staffing ratios and adjust accordingly.

There are physical infrastructure challenges at some facilities. This includes, aging infrastructure, multi-patient shared rooms, shared washrooms, small systematic therapy rooms, limited storage, lack of medication rooms, and pharmacy and unit preparation areas for systemic cancer treatments. These challenges have implications for patient safety, people-centered care, infection prevention and control and client flow. The organization is encouraged to review the infrastructure needs of their facilities and develop plans for facility improvement based on the principles of patient safety, infection prevention and control, quality, and client flow.

Priority Process: Competency

There are strong inter-disciplinary teams supporting cancer care. Team members take great pride in providing care to clients "closer to home." They described working collaboratively to meet the needs of clients and families. The leaders and teams are committed to providing quality and safe services for clients. The leaders are to be acknowledged for their commitment to supporting the education and learning needs of the cancer care team. Education and training opportunities are available with clinical nurse educators available to supporting learning needs. An orientation is provided to all new team members. The team members stated that they feel safe at work and that their safety is protected by the organization. The team members were proud of their work during COVID-19 as they continue to provide important systemic cancer therapy to clients.

There is a strong collaborative approach between Saskatchewan Health Authority and the Saskatchewan Cancer Agency in providing education and training to team members of the Community Oncology Program of Saskatchewan (COPS). This includes the completion of modules, on-site support, and a two week education and practicum on systemic cancer therapy. Buddy shifts are also supported. Education is

also provided on demand and includes training when new drugs are introduced. There is also a weekly education session. A Clinical Liaison Nurse supports the COPS staff. There are also quarterly meetings with the COPS nurses and pharmacy staff at facilities providing systemic cancer therapy. Infusion pump training is completed and documented.

Spiritual care is available to meet the needs of clients, as required. However, there is no designated spiritual space for clients and families to observe spiritual practices, at all facilities. The leaders are encouraged to identify space within a facility to be used as a spiritual space.

Performance appraisals are not consistently completed on a regular basis at all sites. The leaders are encouraged to continue with their plans to ensure that regular performance appraisals are completed.

Priority Process: Episode of Care

Cancer care is provided at both rural and urban cancer care sites throughout Saskatchewan. This includes the Community Oncology Program of Saskatchewan (COPS) located at sites throughout Saskatchewan and inpatient cancer care. The COPS is a program of the Saskatchewan Cancer Agency and has a proud history of providing systemic cancer therapy. The primary goal of the COPS program is to treat clients close to their home communities. This enables clients to be treated in a more familiar and supportive environment. An engaged inter-disciplinary team supports the cancer care with resources available provincially. The team members stated that they have the resources to do their work. There are strong provincial initiatives which support clinical guidelines, best practices, and systemic strategies. However, team members noted the importance of being able to access ARIA, an electronic health record for cancer care. The client records are combination of paper and electronic based formats. There is a gap in the availability of electronic health records and the intra-operability between electronic systems. As there are inherent risks with paper and electronic charting systems the SHA is encouraged to have one client record system.

At some sites there is not a medication room in which the team members can prepare medications without distractions. The leaders are encouraged to identify space at such sites to be used as a medication room to enable the safe preparation of medications.

There are patient and family advisors for the COPS program. This includes a PFAC member being a part of the COPS Review and Assessment Project. It was noted that they provide excellent input and feedback. At some sites there is also local participation from clients, families, and local axillaries. The wait lists are reviewed weekly and if clients are 100 kilometers from a Saskatchewan Cancer Agency site, they are offered to receive treatment at a COPS center.

There is an ability to address urgent admissions. Clients and families are not consistently provided with information about their rights and responsibilities at some sites. The leaders are encouraged to ensure that clients and families are provided with information and their rights and responsibilities including the right to have privacy and confidentiality protected; be aware of how client information is used; have

access to their record and information about them; be treated with respect and care; maintain cultural practices; pursue spiritual beliefs; live at risk; and be free from abuse, exploitation, and discrimination. Additionally, client and family rights regarding service delivery include the right to refuse service or refuse to have certain people involved in their service; participate in all aspects of their service and make personal choices; have a support person or advocate involved in their service; appeal a care plan decision or file a complaint; take part in or refuse to take part in research or clinical trials; receive safe, competent service; and raise concerns about the quality of service.

The clients and families spoke highly of the "excellent care" provided by team members. They described the benefit of receiving their systemic treatment close to home with the resulting decrease in the burden of care. Family members described feeling welcomed and supported by the team members. and reported high levels of client satisfaction. A caregiver stated, "It is a wonderful place. They are all approachable. I feel welcome here." Another client stated, "The care is excellent, I couldn't ask for better." Clients and caregivers stated that they are treated with care, dignity, and respect. They felt comfortable asking questions. There were no suggestions for improvement.

There is a commitment to auditing and acting on the results. However, COVID-19 impacted some of the established auditing processes. The leaders are encouraged to continue to implement robust auditing processes. The team members and leaders are encouraged to continue the quality improvement journey and to seek the input and participation of clients and families.

Priority Process: Decision Support

The leaders and team members are committed to using decision support to enable quality care. Data is used to support decision making. Education and training are provided to the team on the use of technology. There is a strong collaborative working relationship with the Saskatchewan Cancer Agency. All team members of the Community Oncology Program of Saskatchewan (COPS) have access to ARIA, an electronic health record used by the Saskatchewan Cancer Agency. The team members at the COPS program highlighted the value of access to the ARIA in coordinating care for clients. Paper based charting is used at the cancer care inpatient units located at the Royal University Hospital and Pasqua Hospital. There is a gap in the availability of electronic health records and the intra-operability between electronic systems. As there are inherent risks with paper and electronic charting systems, the SHA is encouraged to have one client record system.

Standardized client information is collected. Up to date information is collected with the input of clients and families. The care plans are developed and updated with the input of clients and families. The leaders are encouraged to explore the implementation of an electronic health record. There is a strong commitment to protecting the privacy of client information. Privacy education is provided to team members. Clients are supported in accessing their health information in a client-centered manner.

Priority Process: Impact on Outcomes

For cancer care, evidence-based guidelines are developed with the input of clients and families. The

guidelines support the provision of systemic cancer therapy provided at the Community Oncology Program of Saskatchewan and the cancer care inpatient units at Royal University Hospital and Pasqua Hospital. The Saskatchewan cancer registry collects cancer information on the people of Saskatchewan. This registry monitors cancer trends and provides valuable information to plan appropriate cancer control strategies. This information is shared with and available to the SHA.

There is a strong commitment to team and client safety. The team members stated that they feel safe at work. There are a variety of quality initiatives implemented to support safety and quality including huddles, family conferences, white boards on inpatient units, and interdisciplinary rounds. Post-fall huddles occur. Hand hygiene audits are completed. There are quality boards located on the cancer care inpatient units. Quality initiatives for the COPS are implemented in conjunction with the Saskatchewan Cancer Agency. The team members and leaders are encouraged to continue to embed and cascade quality improvement at the facility and program level. This includes continuing to involve clients, families, and partners in the co-design, implementation, and evaluation of quality improvement initiatives.

Priority Process: Medication Management

A provincial pharmacy committee provides direction to the Community Oncology Program of Saskatchewan (COPS). A provincial manager of pharmacy operations supports this important work. The committee meets every two months with the facility leadership and pharmacy staff. A quality initiative, COPS Review, and Assessment Project is ongoing including reviewing pharmacy and the NAPRA standards. This will include updating and or changing medication processes. A patient and family partner participates in this initiative.

Systemic cancer therapy medications are administered at the Community Oncology Program of Saskatchewan and the inpatient cancer units for clients who require a hospital admission for the administration of chemotherapy. The systemic therapy may be prepared by the Saskatoon Cancer Agency and transported to the COPS and inpatient cancer units or prepared at facility pharmacies. There is variation within the preparation process by the facility pharmacies. In some facilities the systemic chemotherapy is being prepared in the pharmacy department within a ventilated hood; however, it is open to the rest of the pharmacy and not enclosed. Other team members are in working in the same physical environment during medication preparation. The NAPRA standards are not consistently being met. The organization is strongly encouraged to review the guidelines and best practices for the appropriate and safe preparation of systemic therapy. Furthermore, they are encouraged to implement the best practice standards to ensure client and team member safety.

Bulk bottles of chemotherapy required for compounding must be stored under negative pressure. At some sites, the bottles are stored in the same area as other medications which are not stored under negative pressure. The leaders are encouraged to identify a process to ensure bulk bottles of chemotherapy are stored under negative pressure.

Standards Set: Critical Care Services - Direct Service Provision

Unmet Criteria		High Priority Criteria
Priority Process: Clinical Leadership		
1.4	Service-specific goals and objectives are developed, with input from clients and families.	
1.7	There is a framework for providing outreach critical care within the organization and/or to other organizations, if applicable.	
Priority Process: Competency		
3.5	Education and training are provided on the organization's care delivery model.	
3.11	Education and training are provided on how to identify palliative and end-of-life care needs.	!
3.12	Team member performance is regularly evaluated and documented in an objective, interactive, and constructive way.	!
4.6	Standardized communication tools are used to share information about a client's care within and between teams.	!
4.7	The effectiveness of team collaboration and functioning is evaluated and opportunities for improvement are identified.	
Priority Process: Episode of Care		
6.1	There is a process to screen potential clients against admission criteria for critical care.	
8.7	To prevent falls and reduce the risk of injuries from falling, universal precautions are implemented, education and information are provided, and activities are evaluated. 8.7.3 The effectiveness of fall prevention and injury reduction precautions and education/information are evaluated, and results are used to make improvements when needed.	ROP **MINOR**
8.8	Each client's risk for developing a pressure ulcer is assessed and interventions to prevent pressure ulcers are implemented. NOTE: This ROP does not apply for outpatient settings, including day surgery, given the lack of validated risk assessment tools for outpatient settings.	ROP

	8.8.5	The effectiveness of pressure ulcer prevention is evaluated, and results are used to make improvements when needed.	**MINOR**
9.23		Information relevant to the care of the client is communicated effectively during care transitions.	ROP
	9.23.1	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**
	9.23.2	Documentation tools and communication strategies are used to standardize information transfer at care transitions.	**MAJOR**
	9.23.4	Information shared at care transitions is documented.	**MAJOR**
	9.23.5	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**
10.3		One or more interdisciplinary meetings are scheduled with clients and their family members in a private setting.	
11.9		The effectiveness of transitions is evaluated and the information is used to improve transition planning, with input from clients and families.	
Priority Process: Decision Support			
13.3		Policies and procedures to securely collect, document, access, and use client information are followed.	!
13.6		Policies and procedures for securely storing, retaining, and destroying client records are followed.	!
13.8		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			
16.4		Safety improvement strategies are evaluated with input from clients and families.	!

17.1	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.	
17.2	The information and feedback gathered is used to identify opportunities for quality improvement initiatives and set priorities, with input from clients and families.	
17.4	Indicator(s) that monitor progress for each quality improvement objective are identified, with input from clients and families.	
17.5	Quality improvement activities are designed and tested to meet objectives.	!
17.6	New or existing indicator data are used to establish a baseline for each indicator.	
17.7	There is a process to regularly collect indicator data and track progress.	
17.8	Indicator data is regularly analyzed to determine the effectiveness of the quality improvement activities.	!
17.9	Quality improvement activities that were shown to be effective in the testing phase are implemented broadly throughout the organization.	!
17.10	Information about quality improvement activities, results, and learnings is shared with clients, families, teams, organization leaders, and other organizations, as appropriate.	
Priority Process: Organ and Tissue Donation		
12.10	When death is imminent or established for potential donors, the OPO or tissue centre is notified in a timely manner.	
12.12	Data gathered on all ICU deaths is accessible and there is a process for reviewing the data to identify lost opportunities for donation and refer the information appropriately.	!
Surveyor comments on the priority process(es)		
Priority Process: Clinical Leadership		

The SHA Tertiary Care Program, which is comprised of Critical Care, Cardiosciences, Neurosciences, and Respiratory Services, is commended on their efforts to develop provincial standardization for these services. The Critical Care Services includes four tertiary sites and five regional sites. This program is extremely proactive and committed to process improvement. Quality boards and huddles are readily used to communicate at the unit level. There is an opportunity to strengthen and support the linkages between the Tertiary and Regional sites.

The program is supported and encouraged in their desire to develop and implement a Provincial Critical Care Network. This network could be a catalyst to accelerate provincial standardization and clinical support for critical care across the SHA as well as maximize resources in regional sites with the support from Tertiary services. Implementing a shared operational standard is supported. The team has developed a plan to expand ICU services and develop tiers of services with extensive engagement from patients and families. The SHA is adding 11 permanent ICU beds as a part of a larger goal of adding 31 beds by 2024-25. The 1245 Critical Care Huddle continues and brings together tertiary and regional critical care units.

Priority Process: Competency

The Critical Care and Cardiac Care Units have high-functioning, collaborative, interdisciplinary teams. Although they have been challenged with staff shortages in nursing and the impact of the pandemic, work is underway to train and orientate many new nurses. The orientation and training of critical care nurses is extensive. Staff indicated that they felt well prepared because of their orientation and buddy shifts. The interdisciplinary team participates in daily bed side rounds with each member of the team contributing their expertise leading to a comprehensive care plan being reviewed and revised. The majority of units exhibited an elevated level of staff morale, pride in their team and a commitment to excellence in patient and family-centred care. There are still opportunities, particularly in some of the regional sites, to support and implement standard processes developed by the provincial critical care program.

The teams ensure that the patient's family is kept informed by welcoming and including the family in the bedside rounds. Patients and families interviewed confirmed that they are included and well informed on their plan of care. They have the highest regard for the care team.

Staff participate in annual mandatory training facilitated through online programming as well as education days coordinated by a Nurse Educator. Some units had performance appraisals completed annually while there were other units where performance appraisals had not been done. These units are encouraged to initiate the performance appraisal process.

Priority Process: Episode of Care

The Critical Care Teams are providing safe, high quality, intensive care. They are proud of what they have been able to accomplish throughout the pandemic and the opportunities that partnering with other critical care units is providing to them and their community. There is still a need to support the Regional ICU's and to ensure they have the support to meet the standards of care. The teams have appreciated the expertise and support from the First Nations and Metis Health Team based in Prince Albert, Saskatoon, and Regina. The First Nations and Metis Health Team support the health needs of these patients and families and support the integration of traditional medicine into care practices.

At Regina General Hospital (RGH), a First Nations and Metis Health educator is dedicated to the SICU, MICU, and CCU. The organization is commended for their commitment to support the needs of First

Nations and Metis people. Patients and families are engaged in the Critical Care Management Committee as well as the Critical Care Executive Committee. Of note was the illuminated green ear in SICU, MICU, and CCU where it is a visible cue but also will indicate if the noise level reaches an unacceptable level. The Unit is commended on the clinical pathway they have developed for incarcerated patients as well as the tremendous amount of process improvement they have undertaken.

Across many sites, there are excellent processes in place to support the transfer or information. Areas for improvement include relocating the medication room at RUH to an enclosed location. The Yorkton site is encouraged to monitor ongoing compliance to established policies and standardized communication tools/processes with follow up as appropriate to ensure optimal and consistent patient outcomes are achieved. The Moose Jaw site is encouraged to review the standardized intensive care unit package which was developed to be used province-wide in Saskatchewan as well as availability of security services and social work.

Priority Process: Decision Support

The Critical Care Units are working within two charting systems; one being electronic, and one paper based. This current charting process creates potential for communication and safety issues. The organization is encouraged to continue to move forward with their plan to implement an information system to support an electronic medical record. The service is also encouraged in ensuring that patient records are secure. The Cardiosciences program has been challenged with a delay or lack of response from Digital Health and eHealth to keep upgrades and technology functioning as well as email access for new hires. There appears to be a lack of clarity and understanding on the accountabilities and responsibilities of eHealth and Digital Health.

Priority Process: Impact on Outcomes

The units are commended for their commitment to quality. Quality boards are visible throughout several of the units and are often visible for the patients and families to review. The program is encouraged to gather indicator data, more closely review the results of regular audits, and post these results and to look at strategies to support the data in a patient friendly way. The creation of quality boards provides the opportunity for the team, clients, and families to be aware of the efforts that are being undertaken to support safe, quality care. Of note, the Jim Pattison Children's Hospital PICU has a Safety Committee which tracks unplanned extubation complications during intubation and audits the use of skin prevention breakdown strategies. The NICU quality improvement projects include bedside safety checks, unplanned extubation reduction, and procedural huddles.

To have an effective quality program, appropriate resources to support quality improvement, data collection and analysis needs to be considered. These resources should be available at the tertiary and regional sites.

Priority Process: Organ and Tissue Donation

All units have an excellent understanding with regards to the Organ and Tissue Donation program. All the

policies and processes are documented and in place. Staff have support from the Organ and Tissue Donation Team at the unit level. Indicators are monitored regarding missed opportunities.

At the Regina General Hospital MICU, the team is aware and enacts the process for organ and tissue donation when appropriate. There is a dedicated family room available for families to support private conversations and when patients are end of life.

The Yorkton site is encouraged to review current practices and provide further education regarding patient centred care, end-of-life care, and organ donation to ensure corporately approved policies and protocols are consistently implemented to the benefit of optimal patient care and performance outcomes.

Standards Set: Emergency Department - 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		
4.14	Team member performance is regularly evaluated and documented in an objective, interactive, and constructive way.	!
4.16	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		
7.1	Entrance(s) to the emergency department are clearly marked and accessible.	!
9.14	Clients and families are provided with information about their rights and responsibilities.	!
10.6	Universal fall precautions, applicable to the setting, are identified and implemented to ensure a safe environment that prevents falls and reduces the risk of injuries from falling.	!
12.3	Client privacy is respected during registration.	
12.16	Information relevant to the care of the client is communicated effectively during care transitions.	ROP
12.16.4	Information shared at care transitions is documented.	**MAJOR**
Priority Process: Decision Support		
The organization has met all criteria for this priority process.		
Priority Process: Impact on Outcomes		
18.11	Quality improvement activities that were shown to be effective in the testing phase are implemented broadly throughout the organization.	!
18.12	Information about quality improvement activities, results, and learnings is shared with clients, families, teams, organization leaders, and other organizations, as appropriate.	

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

Priority Process: Organ and Tissue Donation

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

The Emergency Department at Jim Pattison Children's Hospital was reviewed for this survey and serves the population of Saskatoon and provides tertiary pediatric services for the region. The program functions within a provincial system; daily calls and electronic tracking is used to promote access to pediatric services across Saskatchewan. The new Children's Hospital provides a family-centered environment over a large footprint. The children's triage and waiting areas have been established since the opening of the building in response to patient, family, and staff feedback. There is opportunity to explore further development to enhance privacy at registration and to triage and improve observation of patients awaiting care at times of high volume.

Priority Process: Competency

A comprehensive education program has been developed for orientation of staff new to the children's emergency service and existing staff receive regular resuscitation training. The team works collaboratively, and many staff are experienced in their roles. Supports for mental health patients is available 12 hours a day. All medical care is provided by pediatric emergency physicians, with a single physician present for all CTAS levels, including the resuscitation/trauma bay that is adjacent to the pediatric rooms and physically within the adult emergency department. Delays in care occur at times of high volume and high acuity when nursing staff and the physician are required in the trauma bay.

Priority Process: Episode of Care

The Emergency Department at Jim Pattison Children's Hospital provides family-centered care and is staffed by pediatric-trained nurses and physicians. The department has collaborative relationships with the inpatient unit and pediatric intensive care. Pediatric specialty consultations are available including mental health and palliative care supports. The Emergency Department is challenging to access from both outside and within the hospital. The lack of adjacent parking, appropriate footpaths for pedestrian access from the parking lot, and absence of specific signage for the Emergency Department present challenges to patients and families.

Patients and families recognise the high standard of care provided. There are opportunities to improve the standardization of information at care transitions and to work with inpatient teams to optimize processes.

Priority Process: Decision Support

The Jim Pattison Children's Hospital uses a hybrid of electronic and paper charting. The Sunrise Clinical Manager (SCM) status board and call bell system are used effectively to enhance patient flow through the department. Emergency Department electronic information is visible to other teams within the hospital system, and to community practitioners through eHealth Viewer. Further expansion of the electronic health record will promote information transfer at transitions of care.

Priority Process: Impact on Outcomes

Safe care is a priority and multiple simulation events were held, prior to the move to the new building, in 2019. Patient centred improvement initiatives have continued over the last two years. The introduction of condition-specific, pediatric focused, patient information accessed through QR codes in the patient rooms is a notable example. Patient flow through the department is monitored through metrics provided by Digital Health Analytics. Patient complaint information and a pending patient survey are also being used to develop baseline data for addressing the quality concerns in the triage/waiting room. As with all new buildings, there are opportunities to further improve workflows and optimize the use of space. The teams are encouraged to use metrics to drive and monitor change, with opportunities to increase data visualization, data analysis, and the use of a quality board. A well-functioning dyad leadership model that will support team-based quality improvement in the department is in place.

Priority Process: Organ and Tissue Donation

The protocol for contacting the Saskatchewan Transplant program is readily available in the emergency department for staff and physicians. The process is rarely activated from the Jim Pattison Children's Hospital Emergency Department with consult services. Appropriate referrals to the Transplant Coordinator are made early and consult services are readily available.

Standards Set: Hospice, Palliative, End-of-Life 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		
3.9	Education and training are provided on the organization's ethical decision-making framework.	
3.14	Team member performance is regularly evaluated and documented in an objective, interactive, and constructive way.	!
3.16	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		
The organization has met all criteria for this priority process.		
Priority Process: Decision Support		
The organization has met all criteria for this priority process.		
Priority Process: Impact on Outcomes		
14.4	Protocols and procedures for reducing unnecessary variation in service delivery are developed, with input from clients and families.	!
16.2	The information and feedback gathered is used to identify opportunities for quality improvement initiatives and set priorities, with input from clients and families.	
16.4	Indicator(s) that monitor progress for each quality improvement objective are identified, with input from clients and families.	
16.5	Quality improvement activities are designed and tested to meet objectives.	!
16.6	New or existing indicator data are used to establish a baseline for each indicator.	
16.7	There is a process to regularly collect indicator data and track progress.	

16.8	Indicator data is regularly analyzed to determine the effectiveness of the quality improvement activities.	!
16.9	Quality improvement activities that were shown to be effective in the testing phase are implemented broadly throughout the organization.	!
16.10	Information about quality improvement activities, results, and learnings is shared with clients, families, teams, organization leaders, and other organizations, as appropriate.	
16.11	Quality improvement initiatives are regularly evaluated for feasibility, relevance, and usefulness, with input from clients and families.	

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

St. Paul's Palliative Care unit was one of the original palliative care units in Canada. It has a long history of innovation. In the last few years, it has been losing many of the old-time members and new leadership and staff are coming in. As a result, significant changes have been made in organizational structure and processes.

A new hospice unit of 18 beds opened within the last year. This complements the 12 beds in the palliative care unit. It is affiliated with the palliative care unit at St. Paul's. The unit also manages the consult service at Royal University Hospital, Saskatoon City Hospital and St. Paul's hospital where consults are done throughout the patients within the hospital. As well the consult service serves northern Saskatchewan.

The Palliative Care Unit at the Pasqua Hospital and The Regina Wascana Grace Hospice serve the surrounding communities of Regina through their End-of-Life experiences.

Unit goals and objectives have not been developed as a result of the COVID-19 pandemic and there are a great deal of new leaders across the organization.

Priority Process: Competency

St. Paul's Palliative Care Unit is supported by a clinical coordinator, social worker, OT, PT, and a music therapist. There is a full-time physician available from 0830 to 1630, 7 days per week and there is an on-call service available. The unit provides epidurals and other procedures to manage pain.

The Pasqua Hospital Palliative Care Unit is comprised of a multidisciplinary team of skilled and compassionate professional staff and a full-time physician. They work very collaboratively, and the mutual respect amongst colleagues is impressive. There is strong educational expertise and support. An in-depth orientation is provided for all new staff with extensive training in palliative care.

Staff have access to personal wellness supports, including EPAP and CSIM. Several front-line staff

expressed the "honour and privilege" they feel looking after this population of patients and their families.

Priority Process: Episode of Care

Patient-centred compassionate care is evident. Each patient and their family members are treated as unique individuals with every effort to make the experience the best it can be ("Making Memories"). The entire team performs an "Honour Guard" for the family when a patient passes away, where the staff line the hallway as the patient is taken away from the unit.

Medical Assistance in dying is supported in the location they wish for it to take place. Tissue donation has been encouraged and supported by the team.

Areas to highlight include Pasqua where there is a First Nations and Metis Ceremonial Room on-site, and spiritual care support as requested. There is also a lovely Legacy Wall and a Butterfly Wall that brings comfort to many family members. At St. Paul’s, every weekday morning a phone call between the partners discusses appropriate use of the resources to meet the daily needs for palliative support. This sometimes means movement of patients or resources to meet the needs of palliation for the community. This process allows the resource to meet 90% of the identified needs.

For the past two years with the advent of the pandemic and the risk to vulnerable and fragile patients, the units have done a great deal of planning and restriction of activities. There were no visitors allowed initially and the unit purchased iPads for patients to have virtual visits with their loved ones. Many previously robust activities with the patient and advisory council were discontinued. Volunteers were discontinued and have been greatly missed.

Priority Process: Decision Support

At St. Paul's Palliative Care Unit new processes have begun a shift from a completely paper-based environment. Training of staff has been done to support access to regional online resources within the unit. Communication occurs through daily huddles and formal hand offs. The unit is planning to introduce a method of rounding, called Cyber, which was developed in Regina and involves patients and families in a significant way with the entire care team.

Priority Process: Impact on Outcomes

While staff worked to keep their patients safe and maintain the service, many previously active quality improvement initiatives were put on hold. As we come out of COVID-19 restrictions, many of these activities are being resumed. Most of the current resumed work focuses on the required organizational practices (ROPs).

The units are encouraged to bring back a thoughtful quality management program. This will be especially important as they make the process changes that are already in place so that they can be clear on what is working and what is not.

Quality resources across the organization would be very beneficial to support the teams quality improvement work using quality tools, scoping projects, data analysis, target setting, and so on. People are exhausted and require the support to do this work in a meaningful way. And several the leaders are new to their roles.

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

Unmet Criteria			High Priority Criteria
Priority Process: Infection Prevention and Control			
2.8	Environmental services and the IPC team are involved in maintaining processes for laundry services and waste management.		!
4.6	Compliance with IPC policies and procedures is monitored and improvements are made to the policies and procedures based on the results.		
8.6	Compliance with accepted hand-hygiene practices is measured.		ROP
	8.6.1	Compliance with accepted hand-hygiene practices is measured using direct observation (audit). For organizations that provide services in clients' homes, a combination of two or more alternative methods may be used, for example: • Team members recording their own compliance with accepted hand-hygiene practices (self-audit). • Measuring product use. • Questions on client satisfaction surveys that ask about team members' hand-hygiene compliance. • Measuring the quality of hand-hygiene techniques (e.g., through the use of ultraviolet gels or lotions).	**MAJOR**
	8.6.2	Hand-hygiene compliance results are shared with team members and volunteers.	**MINOR**
	8.6.3	Hand-hygiene compliance results are used to make improvements to hand-hygiene practices.	**MINOR**
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.		
12.3	There is a process to promptly detect suspected health care-associated infections in the organization.		!
12.9	Standard definitions and accepted statistical techniques are used to share and compare information about health care-associated infections.		
14.2	IPC performance measures are monitored.		

Surveyor comments on the priority process(es)

Priority Process: Infection Prevention and Control

COVID-19 and outbreak support were highlighted by teams and staff with appreciation for the help and support it provided. Practitioners made themselves available and whenever possible visited the site in person. Support was provided from beginning to end. This continues to occur as new outbreaks occur and others are lifted.

Hand Hygiene (HH): HH was seen in various states. At most sites HH stations and supplies were evident and placed well. At the same time HH processes for compliance, audits, and follow up were inconsistent. Some sites had stopped activities and have recently restarted. Other sites do it well though staff are not aware of follow up, and some sites are unsure how to submit audits or submit late.

It is timely that the next steps on the HH pilot will begin soon. In the interim, sites that are not assessing compliance or showing results would benefit from coaching and reminders prior to cut off dates so that value is understood, and late submissions are not voided despite staff efforts. In addition to this, consider renewal of education and look for stakeholder engagement beyond nursing. Consider all departments, patients, and families for involvement in the renewal of this important requirement in healthcare.

Human Resources: Infection Prevention and Contol (IPAC) staff were added with COVID-19 and there are several temporary positions. There are concerns at the site level that turnover is frequent and disappointing due to the term nature. Just as orientation and training progresses well, people leave for permanent positions. SHA is encouraged to formalize the positions needed, or work to develop an alternate plan to cover the ongoing IPAC needs of SHA. Some in term positions are so active supporting sites that they struggle to carve out time to complete orientation. Work is growing as opposed to diminishing. Sites appreciate and benefit from physical visits from IPAC staff.

Infrastructure: Aging Infrastructure was observed from major to minor. Many sites noted aging infrastructure, both major and minor in scope. This ranged from rooms or walls to furniture. Examples include walls and counters that were cracked or peeling back (from water) in areas such as utility rooms or sink areas. Furniture was found that was worn and torn beyond IPAC standards.

Environment: In general, environmental services efforts were found to be strong, and most buildings were noted as being clean and well cared for. With older buildings there are areas that are unused or repurposed. This can cause storage without purpose of old and excess equipment, as well as mixed, haphazard, storage of needed items. This weakens work processes, safety (cluttered halls), and cleaning efforts. Consider efforts such as LEAN 5S (Sort, Set in Order, Shine, Standardize, and Sustain). Wadena would be an excellent place to begin.

At the same time, given stretched resources, look for low hanging fruit to address areas when able. For example, move the best IPAC friendly furniture to high use areas, and put cracked, torn or cloth furniture in seldom used areas while awaiting any new furniture opportunities.
Overload of wall spaces has been seen on IPAC safety walks or Occupational Health and Safety tours. There is a need to clean up wall space so that key posters are seen easily, and things are up to date and meet IPAC standards (e.g., laminated or plastic sleeves).

Communication: Despite challenges of turnover of staff at many sites, communication was found to be strong. Over time, connections and awareness of available SHA supports will continue to strengthen. Highlighted tools for communication include group calls, white or wall board huddles, and biweekly safety talks. While relatively new, the huddle process was evident, and staff are finding it helpful. Staff were also aware of the ROP boards which were at the sites and could follow the information for use.

As QI efforts move forward such as the refreshed HH efforts or Healthcare Associated Infection (HAI) data use ensure next steps are communicated. Evaluation and new cycles of improvement need to be ongoing, and these tools will support this.
In person IPAC visits are needed and provide momentum. Visits beyond Outbreak management are now occurring again with all sites eager to be included. For example, Esterhazy, Redvers, Weyburn and Estevan.

Policy and procedure work: During visits, some processes were occurring that require attention in addition to the policy and procedure review that should occur regularly. For example, Watrous is encouraged to review washer and dryer temperatures and procedures for laundry. Procedures and processes for use and cleaning of bedpans and urinals in Wadena, Watrous, and Wynyard are identified for attention and resolution. Assessment at these, and other rural, sites are encouraged as part of safety visits. These findings are good quality improvement projects that could then be shared with other sites as applicable. IPAC will need to share key messaging. These would be great point of care things to see on the QI boards.

IPAC team members, site leaders, and staff are engaged and interested in IPAC work. Teams are encouraged to consider a focused approach for point of care IPAC work to ensure it is manageable and achieves completion. Focus on high-risk areas to begin such as hand hygiene and then key processes and procedures that require a thorough review at some sites such as Laundry and human waste management.

Kudos to all sites, support staff, and point of care staff who continue to work hard together in these changing times for Infection Prevention and Control.

Standards Set: Inpatient Services - Direct Service Provision

Unmet Criteria		High Priority Criteria
Priority Process: Clinical Leadership		
2.8	A universally-accessible environment is created with input from clients and families.	
Priority Process: Competency		
3.11	Team member performance is regularly evaluated and documented in an objective, interactive, and constructive way.	!
3.13	Team members are supported by team leaders to follow up on issues and opportunities for growth identified through performance evaluations.	!
3.14	Ongoing professional development, education, and training opportunities are available to each team member.	
4.1	Education and training are provided on how to work with pediatric and youth clients to ensure safe and effective care.	!
5.5	The effectiveness of team collaboration and functioning is evaluated and opportunities for improvement are identified.	
Priority Process: Episode of Care		
8.7	Translation and interpretation services are available for clients and families as needed.	
8.13	Clients and families are provided with information about their rights and responsibilities.	!
8.14	Clients and families are provided with information about how to file a complaint or report violations of their rights.	!
9.7	Medication reconciliation is conducted in partnership with clients and families to communicate accurate and complete information about medications across care transitions.	ROP
9.7.3	The prescriber uses the BPMH and the current medication orders to generate transfer or discharge medication orders.	**MAJOR**
9.7.4	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**

9.14	Diagnostic and laboratory testing and expert consultation are available in a timely way to support a comprehensive assessment.	
10.16	Information relevant to the care of the client is communicated effectively during care transitions.	ROP
10.16.1	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**
10.16.2	Documentation tools and communication strategies are used to standardize information transfer at care transitions.	**MAJOR**
10.16.4	Information shared at care transitions is documented.	**MAJOR**
10.16.5	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**
Priority Process: Decision Support		
	The organization has met all criteria for this priority process.	
Priority Process: Impact on Outcomes		
16.1	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.	
16.2	The information and feedback gathered is used to identify opportunities for quality improvement initiatives and set priorities, with input from clients and families.	
16.11	Information about quality improvement activities, results, and learnings is shared with clients, families, teams, organization leaders, and other organizations, as appropriate.	

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

The Inpatient Service was assessed at 37 sites. These range from very small 10 bed units to the large, specialized, units in major cities. The health authority is working to repatriate as many of the specialized services as possible to Saskatchewan. In addition, they are working to distribute an appropriate level of care as close to home as possible.

Inpatient units have borne the brunt of the recent COVID-19 pandemic and have demonstrated immense flexibility in supporting the care needs of patients. Leadership has supported the creativity on the units to enhance levels of care within the unit, train individuals to have a higher level of skill with acute cases and worked to ensure availability of a bed for the acutely ill. This has been noticed within the units.

Saskatchewan has a historic success with their advisory committees of patients and families. Since COVID-19 the committees have often discontinued meeting. Some areas have begun, again, and all areas are encouraged to restart the Patient and Family Advisory Councils (PFAC) or other mechanisms to ensure patient and family participation. Rural areas often have already formed groups that meet. They are encouraged to continue to work with these groups for local issues. The rotating closures of services secondary to staff shortages have created partnerships with local groups to ensure that the community is aware.

The physical structure of the units varies, and some have a design, size, or infrastructure absence that made it very difficult to provide care. Bed utilization is high and a relative lack of alternative level of care beds has aggravated the problem.

Priority Process: Competency

All areas have centrally required maintenance of skills. These include areas like violence training and cultural sensitivity training. There is a record maintained on all staff with annual reminders of the required training and this is monitored. Individual areas have specific training required and regular re-certification which is also monitored. With COVID-19, many areas have enhanced the training of staff to support the increased acuity of patients.

Some areas have a particular concern with the level of violence. Although there is organization-wide training, the current training does not meet the needs of staff in some of the sites. A review of the level and type of training is recommended.

Specific pediatric training is required for staff if children are admitted. As pediatric programs are introduced in the more peripheral areas, it is important that the training the staff receives matches the pediatric care level.

Review of individual performance is inconsistent throughout the organization and has been reduced in all areas because of COVID-19. Exploring mechanisms to ensure this occurs are encouraged. Fully engaged staff will better support the organization.

There has also been a great deal of new staff in senior positions. These staff will need to be supported in their new responsibilities.

Chronic staff shortages have impacted many areas of the health authority resulting in service changes, difficulties with time off, taking breaks, and managing ongoing maintenance of competence. Some areas have cancelled holidays for prolonged periods of time.

Ongoing training of staff is more often virtual at this time, partly for standardization and partly because of COVID-19. Many staff do not find this method the most effective for them. It would be helpful to support different learning styles with the educational or training requirements.

Priority Process: Episode of Care

Care provision within inpatient services is supported by daily phone conferencing to support movement and service delivery across all institutions. There is great effort by each site to meet the needs of the community. This can mean going above and beyond to meet the continuity of care needs for patients.

Patient information about the hospital is available in some areas but does not, at present, involve a discussion of rights and responsibilities in many areas. Developing this would support the respectful partnerships desired.

There is significant partnership with patients and families at the care level. Patients commented on the respect and care that they felt in their experience with Saskatchewan Health Authority. The organizational PFAC committees that were in existence have often discontinued because of COVID-19. There is a plan to reinstate these.

There is a variable implementation of evaluation of the rates and effectiveness of assessment. Some units are doing a complete job with this, even through COVID-19. Of note, Rosetown has continued the practice with the full assessment and work to improve.

Transitions of care are uneven. Rural units where the hospital and primary care are located have particularly good systems augmented with personal handoffs. Outlook is an example of this.

Priority Process: Decision Support

Inpatient services use a variety of electronic and paper-based records. Most of the rural areas are strictly paper based. Newer facilities have greater access to electronic aspects of the record. There are several electronic servers that carry various parts of the electronic health record or the support documents required. There is a high need to move to a single system that supports care of the patient, interdisciplinary teamwork, and transitions of information support. All areas have work arounds that fulfil these functions, but the health system would benefit from improved unified support.
Transition of information between areas of care vary in effectiveness.

Priority Process: Impact on Outcomes

Saskatchewan Health Authority has initiated a process to select standardized guidelines, policies, and procedures with patient and family input. They are in the early stages of development and dissemination has been slower than planned due to the pandemic. This resulted in many areas of the province seeking guidelines in several places. First, the provincial policies document; then the old health region document and then a local support, often an educator. The educators have been very helpful in supporting the front-line staff to navigate during this time of confusion.

Safety has been a major and early initiative. Evidence of this is seen in many of the units.

Bed management has been a high priority with the pandemic creating stress. There are processes in place to manage this at the provincial level.

Quality management was a strong program within Saskatchewan over the years and many of the units or programs had strong programs. There are remnants in the various areas. Due to workload and staffing shortage most of the effort has gone to monitoring compliance with required organizational practices (ROPs). Areas that have tried to work with indicators have had a difficult time requesting data support. Some programs have continued with this but typically only in the highly specialized areas with university connections.

The base is there in many areas. The organization is encouraged to continue to support these activities with investment in quality improvement support.

Standards Set: Medication Management (For Surveys in 2021) - Direct Service Provision

Unmet Criteria		High Priority Criteria
Priority Process: Medication Management		
3.1	The organization integrates pharmacists into designated interprofessional clinical teams to provide proactive care for client-engaged medication management.	
3.2	Pharmacists collaborate with clients and interprofessional clinical teams to provide care using evidence-informed care activities associated with improved client and system outcomes	!
3.3	The organization has developed local implementation action plans that include prioritizing which high-risk client populations or units receive the evidence-informed care activities from pharmacists.	
5.1	Team members participate in orientation prior to their first shift and receive continuing education and training based on their roles and responsibilities for managing medications within their scope of practice.	!
6.2	Teams have timely access to the client medication profile and essential client information.	!
13.1	Access to medication storage areas is limited to authorized team members.	!
13.2	Medication storage areas are clean and organized.	!
13.7	Separate storage in client service areas and in the pharmacy is used for look-alike medications, sound-alike medications, different concentrations of the same medication, and high-alert medications.	!
13.11	Medication storage areas are regularly inspected, and improvements are made if needed.	
14.3	Chemotherapy medications are stored in a separate negative pressure room with adequate ventilation and are segregated from other supplies where possible.	!
15.1	A structured program has been implemented to reduce the risks associated with polypharmacy, especially with frail or vulnerable clients.	!
16.1	The pharmacist reviews each medication order prior to the first dose being administered	!

16.2	The pharmacist performs an independent double check for the dosing calculations of pediatric weight-based protocols.	!
17.2	Appropriate ventilation, temperature, and lighting are maintained in the medication preparation areas.	!
17.3	There is a separate negative pressure area for preparing hazardous medications, with a 100 percent externally vented biological safety cabinet.	!
17.4	Sterile products are prepared in a separate area that meets standards for aseptic compounding.	!
19.1	The pharmacy has a quality assurance process to ensure that medications are accurately dispensed as ordered.	!
29.1	Resources are provided to support quality improvement activities for medication management.	

Surveyor comments on the priority process(es)

Priority Process: Medication Management

The SHA Drug & Therapeutics Committee is a clinical committee responsible for establishing a provincial formulary of medications and policy and guidelines associated with the safe use of medications. Membership includes physicians, pharmacists, nurses, leaders, and a patient-family partner. Establishment of process to align the 12 former formularies into one common formulary is encouraged.

Antimicrobial Stewardship Program (ASP)
There is an ASP in place for adults. There is not a formalized program in place for pediatric patients. Pharmacists work with infectious disease physicians to review select patients on a case-by-case basis.

There is an ASP app called First Line™ which provides access to recommended antimicrobial treatment for a variety of pathogens and associated guidelines.

An antibiogram is available for the different geographical locations within Saskatchewan to help identify antimicrobial resistance patterns and act as an indicator for the effectiveness of the program.

SHA Medication Use and Safety Interdisciplinary Committee (MUSIC) Steering Committee will be responsible for providing provincial oversight and coordination of geographical MUSICs. Representation includes a patient-family partner.

There are policies in place for the secure storage of controlled substances across the sites. The policies differ depending upon whether automated dispensing cabinet technology has been introduced. It is recommended that automated dispensing cabinet technology be further implemented to ensure compliance with federal storage and documentation requirements for controlled substances.

Oral solid medications are packaged in unit dose packages which are not barcoded. Liquid medications are provided in the original containers. Basic unit dose packaging equipment is in place and at rural sites whereas urban sites have more advanced automated packaging equipment. Bar coding of medication is not carried out where basic packaging equipment is utilized.

Some sites have Pyxis automated dispensing cabinets and open matrix drawers are present. The Institute for Safe Medication Practice does not recommend this type of drawer as medication selection errors can occur. Automated dispensing cabinets offer many safeguards. It is recommended that a rollout to additional prioritized sites be undertaken.

Standardized general infusion smart pumps are in place and training occurs every two years. Pharmacists provide support for the smart pump drug library maintenance.

There are 12 versions of the clinical IT system (Sunrise Clinical Manager) in active use across the province. There is a lack of interoperability between Sunrise Clinical Manager and the Pharmacy BDM system. The Pharmacy BDM system is in every site where there is a Pharmacy.

Locations Without In-House Pharmacy

Arcola Health Center: Service and support is provided by the Weyburn Pharmacy. Pharmacy orders are faxed to the central location and medications are couriered.

Hudson Bay Health Care Facility: Support is provided by Tisdale Pharmacy. Inpatient medications are picked by nurses from bins in the medication room. Long-term care medications (blister packs) are in the same medication room. The long-term care medications are packaged by the Tisdale Pharmacy. These medications could be outsourced to a community pharmacy.

Kelvington & Area Hospital: This facility obtains its medication supply from Tisdale and utilizes the remote pharmacist resource for medication related questions. Prior to first dose verification by the Pharmacist does not occur. The medication room is not well organized. The site in encouraged to re-evaluate the medication room storage setup using certain bins for high alert.

Maidstone Health Complex: The non injectable medications are supplied by the community pharmacy. They have a contract until 2024. The pharmacists in Battleford Hospital do medication order entry and monitor medication use and reconciliation. The Health Authority is encouraged to have the inpatient beds serviced by a SHA Pharmacy. The long-term care beds can be serviced by the community Pharmacy.

Melville: The medication management services at the Melville site are supported by a remote pharmacist who also provides support to two other affiliate hospitals and a pharmacy technician available onsite Monday through Friday. After hours pharmacy coverage is provided via a corporate rotation. The pharmacist participates in daily physician rounds and provides patient teaching when possible. Leaders are encouraged to review the storage of medications and implement further safety measures to minimize

potential errors.

Outlook & District Health Centre: Drugs are ordered and stored in the medication room by the nurses. Medication carts are filled by the nurses. Remote Pharmacy support comes from Moose Jaw. The staff are quite concerned about the added workload to nursing resulting from no pharmacy support on-site.

Parkland Integrated Health Centre: The pharmacist is available by telephone. The audits for high alerts are being done by the pharmacy technician. There is a large medication room with multiple shelves and storage cabinets.

Porcupine Carragana Hospital: Support is provided by Tisdale Pharmacy. Inpatient medications are picked by nurses from bins in the medication room.

Redvers Health Center: The Southeast Integrated Care Centre in Moosomin provides pharmacy services remotely. Orders are faxed to pharmacy and couriered back. A computerized MAR is provided by the Pharmacy. There is a small medication room.

Rosthern Hospital: The medications are packaged in Saskatoon and distributed to Rosthern from Humboldt. The pharmacist visits the facility. The nurses do the Best Possible Medication History (BPMH). The remote pharmacists do order entry, monitor medication reconciliation, and medication orders.

The High Alert and Look Alike medications are well marked; however, they should be more separate to enhance safety.

Rosetown & District Health Centre: The Pharmacy is a medication distribution site for 7 acute sites and 15 LTC sites in this region.

Standards Set: Obstetrics Services - Direct Service Provision

Unmet Criteria	High Priority Criteria
Priority Process: Clinical Leadership	
The organization has met all criteria for this priority process.	
Priority Process: Competency	
The organization has met all criteria for this priority process.	
Priority Process: Episode of Care	
7.14 Clients and families are provided with information about their rights and responsibilities.	!
Priority Process: Decision Support	
The organization has met all criteria for this priority process.	
Priority Process: Impact on Outcomes	
The organization has met all criteria for this priority process.	

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

Obstetrics at the Jim Pattison Children's Centre, was reviewed for this survey. The site provides the core for tertiary obstetrical services in the province of Saskatchewan. They work at the provincial level to support development of province wide processes and guidelines. The specific inpatient unit was developed in response to identified need in the community and had extensive community consultation in several phases. The site has a large footprint and provides single room maternity care for all. Many of the features were developed, specifically, secondary to the community input.

They are in the early stages of creating the structures for the broader provincial support for the program. Development of tiers of care, education, and policy support through programs like MoreOB will assist in this process. Ensuring good distributed obstetrical care throughout the province is important for the population. Attention to the location, level of service and local support required would strengthen the program for all patients in the maternal-child program.

The services have been monitored and reviewed through the staff and patient advisory committee. The patient advisory committee continued to meet monthly throughout the COVID-19 pandemic. The centralization of these processes in Saskatoon should be more distributed throughout the province. This is especially true for level of service in the various communities. A provincial perspective that took distance

to service into account would be helpful.

The skill mix has been assessed at the Jim Pattison site and with the change of care model has resulted in significant cross training for all staff for any aspect of obstetrical care.

Information on services is available through the website and community. Individual packages are given to patients on arrival.

Priority Process: Competency

Required training and education are defined and most education is either individual online or interdisciplinary. The unit has undergone a change in the model of care from separate groups of skills for pre-natal, intra-partum, and postpartum to a totally cross trained group of staff to care for all the needs of the patients. As part of the cross training, the group has developed virtual lab multidisciplinary online training for one-hour sessions. This has been developed to enhance trust between providers following the staffing changes. The program is supported by the educational and standards developed through More OB.

Introduction of the new model of care was disruptive to many staff and there has been significant changeover of staff. This has been largely resolved but many of the staff refer to the “bump” that they had to address. Informal evaluation of team function is occurring. The group plan to make it more formal.

Training for more active management of labour through positioning has begun through all the disciplines.

As well with their provincial obligation, the group has been part of developing a provincial maternal/newborn care competency indicator syllabus for use in training obstetrical units across the province. The first group to try this on-boarding for maternal education will be in Humboldt. Initiatives such as this will help to provide a single high standard of care through the province.

Priority Process: Episode of Care

As the tertiary unit serving the province, the unit manages care for all the high-risk pregnancies. At present, about 28% of the deliveries are by C-section. This has risen during COVID-19 from the previous level of 26%. Work has begun on developing new interventions to impact this.

This unit supports single room maternity care with room for the family and visiting policies that support the patient with their wishes.

The relationship with the patients is strong and respectful. This is confirmed in all interviews.

Informed consent is obtained, and all required organizational practices are met. Evaluation for some of them like falls prevention is less frequent now as the processes in place have worked.

Patients are assessed for risk and specific techniques are introduced. Mothers with significant social or drug issues are trained in the feed, sleep and soothe triad to assist in managing the infant well during a stressful time. As well they are given extra teaching and hospital time to gain the skills. Records and transitions are standardized.

The unit has enhanced support for indigenous patients. This includes the indigenous support group as well as a support person specifically for introducing the opportunity to practice the traditional practices of the group such as smudging, taking the placenta home, and wrapping the baby in traditional ways. This has been warmly received by the impacted patients.

Documentation to share with patients about rights and responsibilities has not yet been developed for this program. They are encouraged to move ahead in this area.

The unit is supported by on-site specialist physicians, anaesthesiologists, and family physicians. The model of care does not support personal continuity, but the patients are aware and accepting of this model. The model supports timely care decisions and actions.

Priority Process: Decision Support

The obstetrical program has made significant progress toward a single electronic record. The pharmacy is not electronic at this time and the consult service is uneven with some consults in the electronic record and some online. Attention to these areas would be very helpful to move the program to a single source of truth.

The electronic record supports progress notes that can be displayed by profession or by timeline and is significant progress toward interdisciplinary communication.

Flow of information is improved with the electronic record, and they have developed some external connection with public health who does the post-partum community visits.

Priority Process: Impact on Outcomes

The obstetrical program has continued to work on guidelines for the province, standardized processes, and other tools to assist those in the program.

Data is now available to this group through their electronic record. They have two improvement assessments in process now which have the potential for changing and improving practices. One in managing post partum hemorrhage and one for, potentially, reducing the c-section rate.

In collaboration with PFAC, a satisfaction survey was distributed to patients and families during the COVID-19 pandemic. The results have been given back to the committee to assess next steps.

The program is reviewing their ability to create an institute which will support research into the area of maternal-child health. This has proven to be very helpful in other areas of Canada and they are encouraged to continue with this plan.

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

Unmet Criteria		High Priority Criteria
Priority Process: Clinical Leadership		
2.5	The effectiveness of resources, space, and staffing is evaluated with input from clients and families, the team, and stakeholders.	
8.2	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		
6.1	Required training and education are defined for all team members with input from clients and families.	!
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.	!
6.14	Ongoing professional development, education, and training opportunities are available to each team member.	
7.4	Standardized communication tools are used to share information about a client's care within and between teams.	!
12.8	Access to spiritual space and care is provided to meet clients' needs.	
Priority Process: Episode of Care		
10.15	Clients and families are provided with information about their rights and responsibilities.	!
11.10	Each client's risk for developing a pressure ulcer is assessed and interventions to prevent pressure ulcers are implemented. NOTE: This ROP does not apply to outpatient settings, including day surgery, given the lack of validated risk assessment tools for outpatient settings.	ROP
11.10.5	The effectiveness of pressure ulcer prevention is evaluated, and results are used to make improvements when needed.	**MINOR**

11.11	To prevent falls and reduce the risk of injuries from falling, universal precautions are implemented, education and information are provided, and activities are evaluated.	ROP
11.11.3	The effectiveness of fall prevention and injury reduction precautions and education/information are evaluated, and results are used to make improvements when needed.	**MINOR**
11.12	Medical and surgical clients at risk of venous thromboembolism (deep vein thrombosis and pulmonary embolism) are identified and provided with appropriate thromboprophylaxis. NOTE: This ROP does not apply for pediatric hospitals; it only applies to clients 18 years of age or older. This ROP does not apply to day procedures or procedures with only an overnight stay.	ROP
11.12.3	Measures for appropriate VTE prophylaxis are established, the implementation of appropriate VTE prophylaxis is audited, and this information is used to make improvements to services.	**MINOR**
12.5	Treatment protocols are consistently followed to provide the same standard of care in all settings to all clients.	!
12.11	Information relevant to the care of the client is communicated effectively during care transitions.	ROP
12.11.1	The information that is required to be shared at care transitions is defined and standardized for care transitions where clients experience a change in team membership or location: admission, handover, transfer, and discharge.	**MAJOR**
12.11.2	Documentation tools and communication strategies are used to standardize information transfer at care transitions.	**MAJOR**
12.11.5	The effectiveness of communication is evaluated and improvements are made based on feedback received. Evaluation mechanisms may include: • Using an audit tool (direct observation or review of client records) to measure compliance with standardized processes and the quality of information transfer • Asking clients, families, and service providers if they received the information they needed • Evaluating safety incidents related to information transfer (e.g., from the patient safety incident management system).	**MINOR**

14.1	The completeness of the client's health record information is validated, including the assessment and any relevant diagnostic imaging, in partnership with the client.	
14.3	A safe surgery checklist is used to confirm that safety steps are completed for a surgical procedure performed in the operating room.	ROP
14.3.1	The team has agreed on a three-phase safe surgery checklist to be used for surgical procedures performed in the operating room.	**MAJOR**
14.3.2	The checklist is used for every surgical procedure.	**MAJOR**
14.3.3	There is a process to monitor compliance with the checklist.	**MAJOR**
14.3.4	The use of the checklist is evaluated and results are shared with the team.	**MINOR**
14.3.5	Results of the evaluation are used to improve the implementation and expand the use of the checklist.	**MINOR**
20.16	There is a process to follow up with discharged day surgery clients.	
20.17	The effectiveness of transitions is evaluated and the information is used to improve transition planning, with input from clients and families.	
Priority Process: Decision Support		
21.3	Policies and procedures to securely collect, document, access, and use client information are followed.	!
21.8	There is a process to monitor and evaluate record-keeping practices, designed with input from clients and families, and the information is used to make improvements.	!
Priority Process: Impact on Outcomes		
24.4	Safety improvement strategies are evaluated with input from clients and families.	!
25.1	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.	
25.2	The information and feedback gathered is used to identify opportunities for quality improvement initiatives and set priorities, with input from clients and families.	
25.4	Indicator(s) that monitor progress for each quality improvement objective are identified, with input from clients and families.	

25.5	Quality improvement activities are designed and tested to meet objectives.	!
25.6	New or existing indicator data are used to establish a baseline for each indicator.	
25.7	There is a process to regularly collect indicator data and track progress.	
25.8	Indicator data is regularly analyzed to determine the effectiveness of the quality improvement activities.	!
25.9	Quality improvement activities that were shown to be effective in the testing phase are implemented broadly throughout the organization.	!
25.10	Information about quality improvement activities, results, and learnings is shared with clients, families, teams, organization leaders, and other organizations, as appropriate.	
25.11	Quality improvement initiatives are regularly evaluated for feasibility, relevance, and usefulness, with input from clients and families.	
Priority Process: Medication Management		
5.2	Medications in the surgical area are stored in a locked area or similarly secured, as per the organization's policies regarding medication storage.	!
5.3	The contents of medication carts for the surgical area are standardized across the organization.	
5.4	Use of multi-dose vials is minimized.	
15.3	Every medication and solution on the sterile field is labeled.	!
16.2	Emergency equipment and life support systems are available wherever anesthesia is administered.	!
Surveyor comments on the priority process(es)		
Priority Process: Clinical Leadership		

Endoscopy was evaluated at several sites throughout the province. Most sites appeared to be adequately resourced, however the booking system was not standardized. At the Saskatoon City Hospital, the area of pre-evaluation and recovery was well resourced and staffed. There were two rooms present which were well equipped and appropriate for the procedure being planned. All ERCP procedures done in the city are performed at the Saskatoon City Hospital. Patients therefore need to be transferred from other facilities to accomplish this.

At the Royal University Hospital, the endoscopy unit was in an older part of the building. Rooms which

were previously used as patient rooms have been converted to procedure rooms and therefore are cramped. The site is encouraged to review the availability of oxygen and suction in the recovery area to mitigate risks.

At St. Paul's Hospital, the endoscopy suite is situated in a small room. When all the equipment is present, it becomes very tight. The staff indicated that when they required resuscitation equipment in the room there was no space to place it. During COVID-19, the unit was moved to the old obstetrical area. Here, the staff found that the rooms were bigger and provided improved flow and safe care of patients. At other facilities in the province, it was also mentioned that the procedure rooms were cramped. The SHA is encouraged to review these areas to ensure the safety of the procedures.

Priority Process: Competency

All staff working within the endoscopy units and OR who were surveyed undergo an extensive orientation program provided by the hospital. An extensive orientation program also occurs within the unit. The staff within the unit provide coverage 24/7 for emergency cases. All staff are trained and exposed to all units which allows them to work in all endoscopy units within the city. Occasionally when there are shortages within one unit staff may be pulled from one hospital and asked to work at another one performing the same duties which they are used to. Staff working in perioperative services have required education standards to work in the area.

Team member performance and evaluation is not occurring regularly. There are some centres where this is a regular occurrence and other smaller centres where this is not routinely done. Also, it was noted that education and professional development are not routinely available to staff working in smaller areas. Currently online education is available through my connect. Team leaders and educators can easily tract which modules have been completed and which ones are pending.

Priority Process: Episode of Care

Standardized documentation has been developed. Every patient receives the same assessment and documentation. When an anaesthesiologist is involved in the care of a patient, a thorough pre-operative evaluation is done. The patient is assigned an ASA score. In most instances, however, there is no anaesthesiologist present. The sedative medication is usually administered by the physician or by the nurse in the room. The patient is monitored by the nurse and appropriate documentation done. All patients receive pre-procedure education and post-procedure education provided by the nurses. Patients are instructed where they can receive additional care if they experience some sort of adverse reaction. A timeout is not routinely done in endoscopy. The area is developing its own modified preoperative assessment form. It has not yet been tested or used.

Priority Process: Decision Support

The provincial leadership has taken an active role in improving patient access to endoscopic procedures within the province. Several steps have been suggested to improve access and limit weight times.

A new computerized booking system and documentation system is currently in the early stages of development and usage. The staff at Royal University Hospital do not have access to enough computers to be able to document a lot of the activities occurring in the endoscopy unit. Computers have been ordered. However, they are awaiting the establishment of an IT team to be able to proceed with this activity.

At the Saskatoon City Hospital, most of the documentation is done electronically. Surgeons are now able to book their lists electronically with information being sent to the booking clerk.

In many of the rural hospitals, computerized data collection and documentation is inconsistent. Many facilities have both paper and computerized documentation with some of the documentation being available on the computer and other documentation being available on paper. Physicians have expressed frustrations with having to look at two different computer documentation systems to obtain information required for patient care. Some of the patient documentation is available on one computer program and the laboratory and investigative results are available on another computer program.

Priority Process: Impact on Outcomes

Currently, there are no guidelines or protocols which are utilized in the endoscopy department. The admission process and forms are standardized. The booking system has been improved by a computer-generated program. Nurses are aware of all policies and procedures that are required to keep the area safe.

In peripheral hospitals and non-tertiary hospitals, the booking system for endoscopy and surgical procedures remains inconsistent. There are some facilities utilizing OR Manager and there are other facilities that do not have access to this technology. It is, therefore, difficult in some cases to determine which patients are urgent and need to be dealt with quickly and those who are elective and can wait. The hope is that, eventually, the whole province will have a booking system for surgical procedures which is consistent and will improve access to surgical care and intervention.

Not all surgeons utilize standardized order sets. There is a variety of orders ranging from standardized printed orders to handwritten orders. It is, therefore, recommended that the surgical departments within the province get together and develop standardized order sets for various procedures so that care provided to patients is similar in all areas.

Indicator data collection is inconsistent throughout many of the hospitals in the province. There are some facilities that do it very well. There are other areas where the staff is stretched and at the current time quality improvement activities do not occur.

Priority Process: Medication Management

Currently, at the Saskatoon City Hospital, medication is stored in a drug dispenser. At the Royal University Hospital, the medication is locked in a cupboard. They will eventually be getting a drug dispensing machine. The medication used in endoscopy is appropriate both for sedation and for the patient needs. All medication at all sites is accounted for.

All hospitals within the province have developed their own policy for safe management and utilization of high-risk medication. Not all facilities are equipped with automatic Pyxis machines. The hope is that eventually all facilities will be equipped with machines that allow for safe storage of medication.

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) is proud to have completed our third on-site Accreditation Survey, the second on-site survey to have taken place during the COVID-19 pandemic.

Teams are to be commended for keeping accreditation readiness a priority during this challenging time. We look forward to continuing our quality improvement journey as we follow up on the results of this survey and our efforts to ensure we are meeting national standards of quality and safety.

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
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

Priority Process	Description
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
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