ACCREDITATION AGRÉMENT CANADA
Qmentum

# Accreditation Report

## Saskatchewan Health Authority

Saskatoon, SK

On-site survey dates:

September 25, 2022 - September 30, 2022

October 2, 2022 - October 7, 2022

Report issued: November 17, 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 October 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 and Focused Visit)**

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

## About the On-site Survey

- **On-site survey dates: September 25, 2022 to September 30, 2022 and October 2, 2022 to October 7, 2022**

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

- **Locations**

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

1. Assiniboia Union Hospital - Integrated Facility
2. Balcarres Integrated Care Centre
3. Bengough Health Centre
4. Birch View Home
5. Broadview Centennial Lodge
6. Canora Gateway Lodge
7. Carrot River Health Centre
8. Centennial Special Care Home - Langenburg
9. Central Butte Regency Hospital
10. Central Haven Special Care Home
11. Chateau Providence- St. Brieux
12. Cudworth Nursing Home
13. Cupar and District Nursing Home Inc.
14. Davidson Health Centre
15. Dinsmore Health Centre
16. Eastend Wolf Willow Health Centre
17. Echo Lodge Special Care Home
18. Elrose Health Centre
19. Estevan Regional Nursing Home
20. Eston Health Center
21. Extendicare Elmview
22. Extendicare Parkside

23. Extendicare Sunset
24. Fillmore Health Centre
25. Foam Lake Jubilee Home
26. Foyer d'Youville / St. Joseph's Hospital
27. Galloway Health Centre
28. Golden Acres
29. Golden Prairie Home
30. Goodwill Manor
31. Grasslands Health Centre
32. Gull Lake Special Care Centre
33. Hafford Special Care Centre & Primary Care Site
34. Herb Bassett Home (Prince Albert)
35. Herbert and District Integrated Health Facility
36. Hospice at Glengarda
37. Invermay Health Centre
38. Ituna Pioneer Health Care Centre
39. Jubilee Home
40. Jubilee Lodge
41. Jubilee Residences- Porteous Lodge
42. Kamsack Hospital
43. Kidney Health Center
44. Kindersley & District Health Centre
45. Kipling Integrated Health Centre
46. Kyle District Health Centre
47. La Ronge Health Centre
48. Lady Minto Health Care Center
49. Lafleche & District Health Centre
50. Lakeside Manor Care Home
51. Lampman Community Health Centre
52. Langham Care Home
53. Lestock Primary Health Care Centre

54. Loon Lake Health Centre and Special Care Home
55. Luther Care Communities
56. Maidstone Health Complex
57. Mainprize Manor
58. Mennonite Nursing Home
59. Mont St Joseph
60. Montmartre Health Centre
61. Moose Mountain Lodge
62. New Hope Pioneer Lodge
63. Newmarket Place- Tisdale
64. Nokomis Health Centre
65. Norquay Health Centre
66. Northwest Community Lodge
67. Oliver Lodge
68. Parkland Place - Melfort
69. Parkridge Centre
70. Pineview Lodge - Nipawin
71. Pineview Terrace Lodge
72. Pioneers Lodge
73. Pleasant View Care Home
74. Prairie Health Care Centre
75. Preeceville and District Health Centre (LTC)
76. Providence Place
77. Quill Plains Centennial Lodge
78. Radville Marian Health Centre
79. Redvers Health Centre
80. Regina General Hospital
81. Regina Pioneer (Mental Health)
82. Regina Pioneer Village
83. Riverside Health Complex
84. Rosetown & District Health Centre

85. Ross Payant Nursing Home
86. Royal University Hospital
87. Samaritan Place
88. Santa Maria Senior Citizens Home Inc.
89. Sask City - Rehab (Convalescent Care)
90. Sask City - Rehab (Inpatient)
91. Sask City - Rehab (Outpatient Clinics)
92. Sask City - Rehab (Outpatient)
93. Saskatchewan OSI Clinic
94. Saskatoon City Hospital
95. Saskatoon Convalescent Home
96. Shaunavon Hospital and Care Centre
97. Sherbrooke Community Centre
98. Silver Heights Special Care Home
99. Southeast Integrated Care Centre
100. Spiritwood and District Health Complex
101. Spruce Manor Special Care Home
102. St. Ann’s Senior Citizens’ Village
103. St. Joseph's Home-Saskatoon
104. St. Joseph's Hospital of Estevan
105. St. Mary's Villa
106. St. Paul's Hospital
107. Sunnyside Adventist Care Centre
108. Sunset Haven
109. Tatagwa View
110. Theodore Health Centre
111. Unity & District Health Centre
112. Villa Pascal
113. Wascana - Long-Term Care (Dementia)
114. Wascana - Rehab (Convalescent Care)
115. Wascana - Rehab (Inpatient)

116. Wascana - Rehab (Outpatient Clinics)
117. Wascana - Rehab (Outpatient)
118. Wascana Rehabilitation Centre
119. Wawota Memorial Health Centre
120. Weyburn Special Care Home
121. Whispering Pine Place (Canwood)
122. Whitewood Community Health Centre
123. Wilkie & District Health Centre
124. William Booth Special Care Home
125. Wolseley Memorial Integrated Care Centre
126. Yorkton and District Nursing Home

- **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
2. Medication Management Standards

***Service Excellence Standards***

3. Ambulatory Care Services - Service Excellence Standards
4. Community-Based Mental Health Services and Supports - Service Excellence Standards
5. Hospice, Palliative, End-of-Life Services - Service Excellence Standards
6. Long-Term Care Services - Service Excellence Standards
7. Organ and Tissue Donation Standards for Deceased Donors - Service Excellence Standards
8. Organ and Tissue Transplant Standards - Service Excellence Standards
9. Organ Donation Standards for Living Donors - Service Excellence Standards
10. Rehabilitation Services - 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) | 18 | 6 | 3 | 27 |
| Accessibility (Give me timely and equitable services) | 57 | 6 | 0 | 63 |
| Safety (Keep me safe) | 252 | 66 | 26 | 344 |
| Worklife (Take care of those who take care of me) | 54 | 20 | 1 | 75 |
| Client-centred Services (Partner with me and my family in our care) | 332 | 25 | 2 | 359 |
| Continuity (Coordinate my care across the continuum) | 55 | 2 | 0 | 57 |
| Appropriateness (Do the right thing to achieve the best results) | 445 | 119 | 13 | 577 |
| Efficiency (Make the best use of resources) | 23 | 2 | 1 | 26 |
| **Total** | **1236** | **246** | **46** | **1528** |

## 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 | 32 (56.1%) | 25 (43.9%) | 10 | 23 (67.6%) | 11 (32.4%) | 3 | 55 (60.4%) | 36 (39.6%) | 13 |
| Medication Management Standards | 48 (70.6%) | 20 (29.4%) | 10 | 33 (55.0%) | 27 (45.0%) | 4 | 81 (63.3%) | 47 (36.7%) | 14 |
| Ambulatory Care Services | 43 (97.7%) | 1 (2.3%) | 3 | 76 (100.0%) | 0 (0.0%) | 2 | 119 (99.2%) | 1 (0.8%) | 5 |
| Community-Based Mental Health Services and Supports | 44 (100.0%) | 0 (0.0%) | 1 | 90 (100.0%) | 0 (0.0%) | 4 | 134 (100.0%) | 0 (0.0%) | 5 |
| Hospice, Palliative, End-of-Life Services | 41 (91.1%) | 4 (8.9%) | 0 | 107 (99.1%) | 1 (0.9%) | 0 | 148 (96.7%) | 5 (3.3%) | 0 |
| Long-Term Care Services | 26 (46.4%) | 30 (53.6%) | 0 | 60 (60.6%) | 39 (39.4%) | 0 | 86 (55.5%) | 69 (44.5%) | 0 |
| Organ and Tissue Donation Standards for Deceased Donors | 48 (88.9%) | 6 (11.1%) | 0 | 86 (90.5%) | 9 (9.5%) | 1 | 134 (89.9%) | 15 (10.1%) | 1 |

| Standards Set | High Priority Criteria * | | | Other Criteria | | | Total Criteria (High Priority + Other) | | |
|---|---|---|---|---|---|---|---|---|---|
| | Met | Unmet | N/A | Met | Unmet | N/A | Met | Unmet | N/A |
| | # (%) | # (%) | # | # (%) | # (%) | # | # (%) | # (%) | # |
| Organ and Tissue Transplant Standards | 81 (93.1%) | 6 (6.9%) | 0 | 107 (90.7%) | 11 (9.3%) | 0 | 188 (91.7%) | 17 (8.3%) | 0 |
| Organ Donation Standards for Living Donors | 60 (90.9%) | 6 (9.1%) | 0 | 107 (91.5%) | 10 (8.5%) | 0 | 167 (91.3%) | 16 (8.7%) | 0 |
| Rehabilitation Services | 40 (88.9%) | 5 (11.1%) | 0 | 63 (78.8%) | 17 (21.3%) | 0 | 103 (82.4%) | 22 (17.6%) | 0 |
| **Total** | **463 (81.8%)** | 103 (18.2%) | 24 | 752 (85.7%) | 125 (14.3%) | 14 | 1215 (84.2%) | 228 (15.8%) | 38 |

* 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 (Hospice, Palliative, End-of-Life Services) | Met | 1 of 1 | 0 of 0 |
| Client Identification (Long-Term Care Services) | Met | 1 of 1 | 0 of 0 |
| Client Identification (Organ and Tissue Transplant Standards) | Met | 1 of 1 | 0 of 0 |
| Client Identification (Organ Donation Standards for Living Donors) | Met | 1 of 1 | 0 of 0 |
| Client Identification (Rehabilitation Services) | Met | 1 of 1 | 0 of 0 |
| Information transfer at care transitions (Ambulatory Care Services) | Met | 4 of 4 | 1 of 1 |
| Information transfer at care transitions (Community-Based Mental Health Services and Supports) | Met | 4 of 4 | 1 of 1 |
| Information transfer at care transitions (Hospice, Palliative, End-of-Life Services) | Unmet | 4 of 4 | 0 of 1 |

| Required Organizational Practice | Overall rating | Test for Compliance Rating | |
|---|---|---|---|
| | | Major Met | Minor Met |
| **Patient Safety Goal Area: Communication** | | | |
| Information transfer at care transitions (Long-Term Care Services) | Unmet | 1 of 4 | 0 of 1 |
| Information transfer at care transitions (Organ and Tissue Transplant Standards) | Met | 4 of 4 | 1 of 1 |
| Information transfer at care transitions (Organ Donation Standards for Living Donors) | Met | 4 of 4 | 1 of 1 |
| Information transfer at care transitions (Rehabilitation Services) | Unmet | 4 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 (Hospice, Palliative, End-of-Life Services) | Unmet | 1 of 4 | 0 of 0 |
| Medication reconciliation at care transitions (Long-Term Care Services) | Unmet | 0 of 4 | 0 of 0 |
| Medication reconciliation at care transitions (Rehabilitation Services) | Unmet | 3 of 4 | 0 of 0 |
| The “Do Not Use” list of abbreviations (Medication Management Standards) | Unmet | 2 of 4 | 0 of 3 |
| **Patient Safety Goal Area: Medication Use** | | | |
| Antimicrobial Stewardship (Medication Management Standards) | Unmet | 0 of 4 | 0 of 1 |
| Concentrated Electrolytes (Medication Management Standards) | Met | 3 of 3 | 0 of 0 |

| Required Organizational Practice | Overall rating | Test for Compliance Rating | |
|---|---|---|---|
| | | Major Met | Minor Met |
| **Patient Safety Goal Area: Medication Use** | | | |
| Heparin Safety (Medication Management Standards) | Met | 4 of 4 | 0 of 0 |
| High-Alert Medications (Medication Management Standards) | Unmet | 0 of 5 | 0 of 3 |
| Infusion Pumps Training (Long-Term Care Services) | Unmet | 1 of 4 | 0 of 2 |
| Infusion Pumps Training (Rehabilitation Services) | Unmet | 3 of 4 | 0 of 2 |
| Narcotics Safety (Medication Management Standards) | Unmet | 1 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 |
| Hand-Hygiene Education and Training (Infection Prevention and Control Standards) | Met | 1 of 1 | 0 of 0 |
| Infection Rates (Infection Prevention and Control Standards) | Unmet | 0 of 1 | 0 of 2 |
| Reprocessing (Infection Prevention and Control Standards) | Met | 1 of 1 | 1 of 1 |
| **Patient Safety Goal Area: Risk Assessment** | | | |
| Falls Prevention Strategy (Hospice, Palliative, End-of-Life Services) | Met | 2 of 2 | 1 of 1 |

| Required Organizational Practice | Overall rating | Test for Compliance Rating | |
|---|---|---|---|
| | | Major Met | Minor Met |
| **Patient Safety Goal Area: Risk Assessment** | | | |
| Falls Prevention Strategy (Long-Term Care Services) | Unmet | 0 of 5 | 0 of 1 |
| Falls Prevention Strategy (Organ and Tissue Transplant Standards) | Met | 2 of 2 | 1 of 1 |
| Falls Prevention Strategy (Rehabilitation Services) | Unmet | 0 of 2 | 0 of 1 |
| Pressure Ulcer Prevention (Hospice, Palliative, End-of-Life Services) | Met | 3 of 3 | 2 of 2 |
| Pressure Ulcer Prevention (Long-Term Care Services) | Unmet | 0 of 3 | 1 of 2 |
| Pressure Ulcer Prevention (Rehabilitation Services) | Met | 3 of 3 | 2 of 2 |
| Suicide Prevention (Community-Based Mental Health Services and Supports) | Met | 5 of 5 | 0 of 0 |
| Suicide Prevention (Long-Term Care Services) | Unmet | 0 of 5 | 0 of 0 |
| Venous Thromboembolism Prophylaxis (Organ Donation Standards for Living Donors) | Met | 3 of 3 | 2 of 2 |

# Summary of Surveyor Team Observations

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

During this two-week survey, 110 Long-Term Care (LTC) sites were visited and surveyed (representing 70% of Saskatchewan's LTC sites). This is an unprecedented number for Saskatchewan. For some sites, this was their first time being surveyed. Various sites were assessed against the following standards: Long-Term Care services, Infection Prevention and Control (IPC), Rehabilitation Services, Ambulatory Care Services, Community Based Mental Health Services and Supports, Hospice, Palliative, End-of-Life Services, Medication Management, and Organ and Tissue Donation and Transplant.

The structure of the newly formed Saskatchewan Health Authority (SHA) has included a number of services under the umbrella of Continuing Care. Throughout the survey sites were dealing with outbreaks of COVID-19 as well as other infections. Staff soldiered on and did their best to continue to provide high quality care and meet with surveyors. The organization is hoping that the survey can assist them to identify areas where there is excellence and areas that may need more immediate attention.

In LTC there is wide variability in terms of the Accreditation Standards. There has been much turnover in the front-line manager group with many managers being there less than one year. The physical infrastructure of some sites requires immediate attention and much of the Quality Improvement work has been on hold throughout the global pandemic. A number of Required Organizational Practices or ROPs will be requiring attention as the organization recovers from the pandemic. Other issues to address include improving the completion of performance reviews, filling vacancies, working on training issues and continuing to roll out SHA policies and procedures.

The SHA is doing a great job in Emergency Preparedness when executing protocols around the pandemic. Information is communicated in a timely manner around outbreaks to others. They would include residents, public health, family, colleagues, partners, volunteers, and other organizations. Policies and Protocols are followed with support from IPC.

Disposable medical devices such as dressings and catheter trays are used in homes for dressing and catheter insertion. A few sites do send their reusable devices to a larger centre to sterilize, these sites follow protocol when doing so. Some sites have bedpan disinfectors, which is highly encouraged.

COVID-19 certainly proved that the great work of Infection Prevention and Control's (IPC) dedicated and supportive team to the frontline staff was and continues to be a success. This IPC support and practices must be sustained post pandemic. Outbreaks are managed quickly with best practices and standards followed. The support of the sites throughout the province with adding additional IPC Practitioners has been invaluable in continuing the important work. IPC Quality Improvement strategies have been initiated throughout, including the implementation of iPads for hand hygiene auditing, expanded surveillance work, and standardization of policies and procedures in SHA, just to name a few.

There are an array of inpatient and outpatient rehabilitation programs and services throughout Saskatchewan. The program serves people with a variety of physical, cognitive, and psychological impairments and disabilities. There are strong interdisciplinary teams supporting clients and families. The leaders and team members are acknowledged for their commitment to reducing barriers, increasing access, and supporting people to meet their full potential. Virtual care has assisted in supporting clients in rural Saskatchewan. Clients and families have spoken highly about the rehabilitation care provided. There is a strong commitment to working with partners to improve the rehabilitation program. There is a strengths-based and solution-focused approach to supporting the needs of clients and families.

The Operational Stress Injury Clinic (OSI) is one of a national network of 10 clinics and 9 satellite sites across Canada established to address operational stress for members and veterans of the Canadian Armed Forces (CAF) and RCMP. A strength of the program is the data collected at the individual level, using standardized screening and assessment tools, many of which are patient-reported, to inform clinical decision-making/goal setting and aggregated at a national level to inform service planning and program evaluation. As the program is a provincial resource, care is provided mostly virtually (75%) by an interdisciplinary team of specialized mental health professionals. Reasons for referral include Post-traumatic Stress Disorder (PTSD), mental health issues, and substance use or concurrent disorders. Comprehensive diagnostic assessments are conducted by the team to assess OSI, including PTSD, and to determine if mental health issues are related to the client's RCMP or CAF service. Some clients find the wait long for services.

The Hospice at Glengarda opened in January 2021 as the first freestanding hospice in Saskatchewan with 15 beds purpose built to serve patients at end of life from Saskatoon and the surrounding area; this location is owned and operated by Emmanuel Health. The Regina Wascana Grace Hospice is a 10-bed hospice located in the William Booth Special Care Home that serves patients in the Regina and surrounding area; this location is owned and operated by the Salvation Army. Both programs serve patients who have a life expectancy of less than eight weeks and require support for pain and symptom management and stabilization. Both programs have forged strong relationships with community partners and hospital based palliative care units to ensure a seamless continuum of care for patients at end of life in both regions. The Regina Wascana Grace Hospice is commended for the education provided by the Clinical Resource Nurse that has expanded the scope of practice of the clinical team to manage issues on site, thereby precluding transfer of patients to acute care.

The SHA has a highly developed centralized People Centred Care approach that has been established and growing since 2017. Key components of the province wide approach include recruitment, retention, education/competency development and partnership building. The survey team reviewed PCC criteria across 120 sites, which included Long Term Care (110), Rehabilitation Services (7) Hospice and Palliative Care (2), Ambulatory Care (1), Community Based Health Services and Supports (1) and Organ and Tissue Transplant (4). Across the service areas that were reviewed, there were consistently positive statements from patients/clients and their families regarding the quality and compassionate care received from health care providers. There was clear evidence of innovation and respect for patient/client preferences and culture. Patients, clients and residents and their families were actively engaged in the development of plans of care and goals for discharge. In the Rehabilitation Services, Ambulatory Care, Hospice and Palliative Care

and Community Based Health services there were multiple examples of interdisciplinary teams working collaboratively to provide the highest quality care for patients/clients and families using emerging technologies and grounded in best practice principles.

In Long-Term Care there was a greater range in the quality and expressed satisfaction from residents and family members regarding the physical environment, staffing compliments, access to specialized services, responsiveness to urgent needs and the basic amenities provided. Across the 110 locations which spanned each integrated service area within the province, there were many examples of exemplary care with LTC homes well supported and engaged in their communities and incorporating unique cultural traditions, ceremonies, food options, spiritual care, preferred decors, physical plane enhancements and incorporation of technology for seniors and youth residents reflecting their needs and preferences. In several locations, the adequacy of care, physical environment, staffing compliment, responsiveness to resident and family concerns, cultural and spiritual preferences and access to critical professional support were not adequate to meet the needs. There are many opportunities for improvements within the spectrum of Long-Term Care. A province wide review of standard expectations for quality care applied to all sites regardless of geographic location would promote a greater equity of care for all residents.

The SHA's Provincial Donation and Transplant Program is congratulated on the provision of donation and transplant services in the province of Saskatchewan. The program adheres to the required regulations and standards. They have made significant gains in cornea donations and transplants. The program continues to have a world class program in Kidney Transplantation and Living Kidney Donors. The program is commended on the establishment of an interdisciplinary clinic to support the pre-assessment and post-transplant follow up for patients who receive lung, kidney, and heart transplants out of province. The interdisciplinary team is passionate about the mission of the donation and transplant program. The program is encouraged to look for opportunities to engage patients and families at the program level and to seek regular feedback from them. The Donation and Transplant program is also supported in their desire to mature their quality improvement program.

# 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**<br>Information relevant to the care of the resident is communicated effectively during care transitions. | · Hospice, Palliative, End-of-Life Services 9.11<br>· Rehabilitation Services 9.12<br>· Long-Term Care Services 9.19 |
| **The Do Not Use list of abbreviations**<br>A list of abbreviations, symbols, and dose designations that are not to be used have been identified and implemented. | · Medication Management Standards 14.6 |
| **Medication reconciliation at care transitions**<br>Medication reconciliation is conducted in partnership with clients and families to communicate accurate and complete information about medications across care transitions. | · Hospice, Palliative, End-of-Life Services 8.5<br>· Long-Term Care Services 8.5<br>· Rehabilitation Services 8.5 |
| **Patient Safety Goal Area: Medication Use** | |
| **Infusion Pumps Training**<br>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. | · Long-Term Care Services 3.8<br>· Rehabilitation Services 3.8 |
| **Narcotics Safety**<br>The availability of narcotic products is evaluated and limited to ensure that formats with the potential to cause patient safety incidents are not stocked in client service areas. | · Medication Management Standards 9.4 |

| Unmet Required Organizational Practice | Standards Set |
|---|---|
| **Antimicrobial Stewardship**<br>There is an antimicrobial stewardship program to optimize antimicrobial use. NOTE: This ROP applies to organizations providing the following services: inpatient acute care, inpatient cancer, inpatient rehabilitation, and complex continuing care. | · Medication Management Standards 2.3 |
| **High-Alert Medications**<br>A documented and coordinated approach to safely manage high-alert medications is implemented. | · Medication Management Standards 2.5 |
| **Patient Safety Goal Area: Infection Control** | |
| **Infection Rates**<br>Health care-associated infections are tracked, information is analyzed to identify outbreaks and trends, and this information is shared throughout the organization.NOTE: This ROP only applies to organizations that have beds and provide nursing care. | · Infection Prevention and Control Standards 12.2 |
| **Hand-Hygiene Compliance**<br>Compliance with accepted hand-hygiene practices is measured. | · Infection Prevention and Control Standards 8.6 |
| **Patient Safety Goal Area: Risk Assessment** | |
| **Falls Prevention Strategy**<br>To prevent falls and reduce the risk of injuries from falling, universal precautions are implemented, education and information are provided, and activities are evaluated. | · Long-Term Care Services 8.6<br>· Rehabilitation Services 8.6 |
| **Pressure Ulcer Prevention**<br>Each client's risk for developing a pressure ulcer is assessed and interventions to prevent pressure ulcers are implemented. | · Long-Term Care Services 8.8 |
| **Suicide Prevention**<br>Clients are assessed and monitored for risk of suicide. | · Long-Term Care Services 8.9 |

# 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: 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)** |
| The teams have shown great success in emergency preparedness and executing processes during the COVID-19 outbreaks. Current policies are in place and available to all staff on the Saskatchewan Health Authority (SHA) intranet - there are printed versions in some areas for easy access. Information surrounding outbreaks is well communicated to the residents, families, team members, partners, and volunteers. One site had an “outbreak kit” with everything required for immediate action. Support staff are engaged and involved. Kudos to the housekeeping, laundry, and dietary teams for supporting the nursing and clinical staff during these challenging times. |

## 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: Hospice, Palliative, End-of-Life Services** | | |
| 15.7 | Patient safety incidents are analyzed to help prevent recurrence and make improvements, with input from clients and families. | ! |
| **Standards Set: Long-Term Care Services** | | |
| 1.1 | Services are co-designed with residents and families, partners, and the community. | ! |
| 1.7 | Barriers that may limit residents, families, service providers, and referring organizations from accessing services are identified and removed where possible, with input from residents and families. | |
| 3.3 | A comprehensive orientation is provided to new team members and resident and family representatives. | |
| 7.5 | Complete and accurate information is shared with the resident and family in a timely way, in accordance with the resident's desire to be involved. | |
| 8.3 | Goals and expected results of the resident's care and services are identified in partnership with the resident and family. | |
| 8.18 | A comprehensive and individualized care plan is developed and documented in partnership with the resident and family. | ! |
| 16.8 | Patient safety incidents are analyzed to help prevent recurrence and make improvements, with input from residents and families. | ! |
| 17.3 | Measurable objectives with specific timeframes for completion are identified for quality improvement initiatives, with input from residents and families. | ! |
| **Standards Set: Organ and Tissue Donation Standards for Deceased Donors** | | |
| 19.3 | Measurable objectives with specific timeframes for completion are identified for quality improvement initiatives, with input from clients and families. | ! |

| | | |
|---|---|---|
| **Standards Set: Organ and Tissue Transplant Standards** | | |
| 22.5 | Measurable objectives with specific timeframes for completion are identified for quality improvement initiatives, with input from clients and families. | ! |
| **Standards Set: Organ Donation Standards for Living Donors** | | |
| 22.3 | Measurable objectives with specific timeframes for completion are identified for quality improvement initiatives, with input from clients and families. | ! |
| **Standards Set: Rehabilitation Services** | | |
| 1.1 | Services are co-designed with clients and families, partners, and the community | ! |
| 3.12 | Client and family representatives are regularly engaged to provide input and feedback on their roles and responsibilities, role design, processes, and role satisfaction, where applicable. | |
| 15.3 | 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 (SHA) has a highly developed centralized people-centred care approach that has been established and growing since 2017. Key components of the provincial approach include recruitment, retention, education/competency development and partnership building.

There is a centralized database that facilitates the recruitment and matching of patient and family partners to the opportunities available and requested by units and health centers across all regions. SHA continually reviews the profiles of patient and family advisors with an equity lens. Efforts are underway to ensure that the membership of advisors reflect the broader community.

This framework for partnership is strengthened by the Patient Family Leadership Council. This council is comprised of highly skilled and competent Patient Family Leaders to provide advice at the provincial level. SHA is currently launching a comprehensive training program entitled “Elements-Program Essentials” that will be rolled out to all staff to promote Patient and Client Experience.

People-Centred Care (PCC)- Program Level

PCC criteria were reviewed within the following standard sets: Ambulatory Care, Community-Based Mental Health Services and Supports, Hospice, Palliative, End-of-Life services, Long-Term Care, Organ and

Tissue Donation and Transplant, and Rehabilitation Services. Across the service areas that were reviewed, patients/clients and their families provided consistent positive statements regarding the quality and compassionate care received from healthcare providers. There was clear evidence of innovation and respect for the patient/client's preferences and culture. Patients, clients, residents, and their families were actively engaged in the development of plans of care and goals for discharge. Throughout all the areas of care that were assessed during the survey there were multiple examples of interdisciplinary teams working collaboratively to provide the highest quality care for the patients/clients and their families using best practice principles and emerging technologies.

Ambulatory Care: The Ambulatory Care Day Program is an excellent resource that is patient focused. Patients stated that they are treated with care, dignity, and respect. Patients and family representatives on the council reported that they are very engaged in the program.

Community Based Mental Health and Supports: Family members are included in treatment programming under strict criteria that examine whether the persistent psychological difficulties experienced by the client require involvement of their family in the care plan; as such, the impact of operational stress on the family and family functioning is taken into consideration. Client feedback validated that the program is highly valued. When asked "what one thing could be changed to improve the care experience?", clients responded that the wait time to begin working with the physician to adjust medication dosing was "quick", but the wait time to begin treatment with the psychologist was "a really long time".

Hospice and Palliative Care: There are two sites for Hospice in Saskatchewan and multiple palliative care beds across the LTC network. All locations adopted best practices for hospice and palliative care with the stand-alone site in Saskatoon being a model of patient-centred care. Hospice at Glengarda leadership teams have made an intentional effort to welcome diverse cultural groups with physical space upgrades that include a multi-Faith Room which is available to patients, families, and staff.

The current designation of this hospice location as a health care organization has particularly negative implications for the patients whose families are accountable for costs associated with ambulance transfers (transfers to the program from community or hospital; transfers out of the program if patients live beyond the 8-week length of stay threshold for the Hospice). There is an opportunity to review the implications for the status and the impact on patients and families.

A patient at the Regina Wascana Grace Hospice described the care as "compassionate" and indicated that staff were not only responsive, but they were also proactive in anticipating needs. The patient and family indicated they were treated with dignity and respect, that their choices were respected, and information was presented in a way that was understandable.

Organ and Tissue Donation and Transplant: The Saskatchewan Health Authority's Donation and Transplant program is a provincial program operating at two sites: one in Saskatoon (North) and one in Regina (South). The program includes patients and families at the provincial program level as well as the

respective leadership tables for Saskatoon/North and Regina/South. The program also engages Indigenous patients and families. The patients and families interviewed have the highest regard for this program and indicated that they truly demonstrate a culture of patient and family-centred care. It is strongly encouraged that they establish their quality improvement framework and engage patients and families with formalized feedback.

Long-Term Care: There was a greater range in the quality and expressed satisfaction from residents and family members regarding the physical environment, staffing compliments, access to specialized services, responsiveness to urgent needs, and the basic amenities provided. There were many examples of exemplary care with LTC homes well supported and engaged in their communities and incorporating unique cultural traditions, ceremonies, food options, spiritual care, preferred decors, facility enhancements, and incorporation of technology for seniors and youth residents reflecting their needs and preferences. In several locations, the adequacy of care, staffing compliment, responsiveness to resident and family concerns, cultural and spiritual preferences, physical environment, and access to critical professional support were not adequate to meet the needs. There are many opportunities for improvements within the spectrum of Long-Term Care. A province-wide review of standard expectations for quality care applied to all sites regardless of geographic location would promote a greater equity of care for all residents. Consideration could be given to the launching of quality initiatives with the input of residents and family members.

Rehabilitation Services: While services are delivered in a manner that reflects the preferences of clients and families, there is opportunity to strengthen active engagement of patient/client and family members in an advisory or consultative role across all rehabilitation programs.

## 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: Infection Prevention and Control Standards** | | |
| 10.1 | Clear and concise policies and procedures are developed and maintained for cleaning, disinfecting, and sterilizing reusable medical devices and equipment. | ! |
| 10.3 | Required training, education, and experience are defined for all team members that participate in cleaning, disinfecting, and/or sterilizing medical devices and equipment. | ! |
| 10.5 | Policies, SOPs and manufacturers' instructions are accessible to all team members. | |
| 10.7 | If cleaning, disinfection, or sterilization of reusable medical devices and equipment is contracted to external providers, a written agreement or contract is maintained with each provider that outlines requirements and respective roles and responsibilities. | ! |
| 10.8 | When cleaning, disinfection, or sterilization of reusable medical devices and equipment is contracted to external providers, the organization regularly monitors the quality of the services provided. | ! |
| 10.9 | When, cleaning, disinfection, and/or sterilization of medical devices or equipment is done in-house, team members involved in these processes are provided with education and training in how to do so when they are first employed and on an ongoing basis. | ! |
| 10.10 | When an organization cleans, disinfects, and/or sterilizes devices and equipment in-house, there are designated and appropriate area(s) where these activities are done. | ! |
| 10.12 | Eating and drinking, food storage, cosmetics application, and the contact lens handling are all prohibited in the area where cleaning, disinfection, and/or sterilization of medical devices and equipment are done. | ! |
| 10.13 | Items that require cleaning, disinfection, and/or sterilization are safely contained and transported to the appropriate area(s). | ! |
| 10.14 | Appropriate Personal Protective Equipment (PPE) is worn when cleaning, disinfecting, or sterilizing medical devices and equipment. | ! |

10.17 For each detergent, solution, sterilant, and disinfectant, manufacturers' instructions for use are followed. !

**Surveyor comments on the priority process(es)**

Overall, training and education on new equipment and process reviews of old equipment have continued during the COVID-19 pandemic. However, there have been some gaps identified associated with manual cleaning and disinfecting of reusable equipment such as bedpans and urinals. There are more training opportunities with regards to following manufacturer instructions. Dirty and clean utility rooms should be clearly marked and the space in each room should follow Canadian Standards Association (CSA) standards.

Using disposable, sterile trays for sterile procedures such as dressing trays and catheterization is best practice because it eliminates the room for error.

Continued work to update policies and Standard Operating Procedures (SOPs) is encouraged to be available provincially on the intranet in one location.

# 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:

**Living Organ Donation**

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

**Organ and Tissue Transplant**

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

**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** | |
| The organization has met all criteria for this priority process. | |
| **Priority Process: Competency** | |
| 3.10 Team member performance is regularly evaluated and documented in an objective, interactive, and constructive way. | ! |
| **Priority Process: Episode of Care** | |
| The organization has met all criteria for this priority process. | |
| **Priority Process: Decision Support** | |
| The organization has met all criteria for this priority process. | |
| **Priority Process: Impact on Outcomes** | |
| The organization has met all criteria for this priority process. | |

**Surveyor comments on the priority process(es)**

**Priority Process: Clinical Leadership**

The Geriatric Evaluation and Management (GEM) Services provides ambulatory services for patients aged 65 years and older through a variety of program initiatives. Ambulatory care services include the day program, outpatient clinics, community assessments, and in-reach consultation services.

The day program and outpatient clinics are located at the Saskatoon City Hospital. The team members, physicians, and leaders are deeply committed to providing quality and safe ambulatory care services. The team members, physicians, and leaders are passionate about reducing barriers and increasing access for clients and families. This includes strong partnerships with community organizations to enhance care provided both during and following participation in the ambulatory programs. There is strong collaboration with patients, families, partners, and community organizations. This includes the input and participation of clients and families when the day program and outpatient clinic were re-established during the COVID-19 pandemic. The team members stated that they “love working here” and that it is “like a family.” They particularly valued working together as a team. A team member stated, “I love working with seniors. Especially when they [clients] gain confidence through attending the program.”

There is a strong interdisciplinary team with an appropriate mix of skill levels and experience. The team includes physical therapists, occupational therapists, social workers, recreation coordinators and workers,

physicians, geriatricians, nurses, and administrative support professionals. The team members noted that they have the resources to do their work. The team supports central intake and patient flow. However, this has created an increased demand on the team members and leaders. For example, the team is supporting central intake with an increased responsibility of coordinating 97 beds, up from 50 beds. The leaders are encouraged to monitor the impact of this change and to adjust accordingly.

**Priority Process: Competency**

There is a strong and competent interdisciplinary team supporting the Geriatric Evaluation and Management (GEM) services. This program is viewed as "a great place to work" by team members. The leaders are visible and supportive of team members. The physicians and gerontologists are engaged in client care, safety, and quality. The leaders are acknowledged for supporting the education and learning needs of team members. The team members spoke highly of the education and training provided including ethics, occupational health and safety, violence prevention, and transfer, lifting and repositioning, to name a few. Orientation is provided to team members. A team member stated that "the orientation is really good. It prepared me to work here." Team members stated that they felt safe at work and that they have received Workplace Assessment and Violence Education (WAVE) training. Furthermore, they stated that they have received education on infection prevention and control including personal protective equipment and hand hygiene education.

Performance evaluations are not regularly completed; however, performance conversations are held. The leaders are encouraged to continue to implement their plan to complete performance appraisals for team members.

**Priority Process: Episode of Care**

The within Geriatric Evaluation and Management (GEM) services, the day program and outpatient department is located at the Saskatoon City Hospital. The area is clean, well maintained, and free from clutter. There is natural light with large windows and beautiful views of the outdoors. There is a commitment to a universally accessible environment with wide corridors and wheel-chair accessible washrooms. There are spaces for client interaction and activities and team member interaction. There are hand hygiene stations with posters outlining the appropriate hand hygiene processes. The environmental services team are acknowledged for their commitment in ensuring a clean and safe environment for clients and families.

The GEM services see patients aged 65 years and older. There is a comprehensive array of services including the assessment and treatment of complicated medical issues, physical movement, functional ability, the environment, social supports, mental health, and medication issues. The day program/hospital sees clients for two mornings per week for approximately eight weeks. A physician referral is required to access the program. Clients and families are called prior to their appointments to reduce the no-show rates. A strong interdisciplinary team provides comprehensive care. The team members have received proactive ethics education and have access to ethics resources. The team members noted that they have the resources to do their work. However, it was suggested that a medical leader be appointed to support

the team along with a leader dyad to enhance best and evidence-informed practice. Furthermore, the leaders are encouraged to seek opportunities to enhance access of this program to other communities.

The GEM services are person-centered. Client satisfaction surveys and feedback are obtained. The clients stated that they are treated with care, dignity, and respect. The clients have spoken very highly of the support and services provided. A client stated, “The program is more than I expected. We are treated very special. They [team members] are patient, friendly, and professional. It is a good atmosphere. I feel part of the team”. Another client viewed the flexibility of the program as being very important. The client noted “If I have any limitation that day then there is no pressure. We will reschedule and do more the next day.” There is a wait list, which the team members work very hard to reduce and to ensure that the most urgent person receives care. Although, there is a waitlist a client stated that the process of being admitted to the program was “easy.” A client poignantly described the success of the program. They stated “I was terrified before I came here. I thought that I would look like a fool. I now feel confident. It is wonderful. I feel like I want to carry on. I am delighted.” The team members and leaders are encouraged to continue to engage clients and families in the co-design of programs and services.

**Priority Process: Decision Support**

There is a strong commitment to use decision support to enable quality care. Training is provided to the team on the use of technology. There is hybrid charting (electronic and paper) used in the Geriatric Evaluation and Management (GEM) Services and ambulatory care. The need for an electronic health record has been communicated to the organizational leaders with plans for implementation identified. The team members and leaders are excited about the new electronic health record and the resulting improvement to coordinated care and improved workflow. The organization is encouraged to continue to implement the plan for an electronic health record.

The client charts are comprehensive and up to date. Standardized client information and assessments are collected. The Comprehensive Outreach Geriatric Assessment is completed. Care plans are developed and updated. Daily huddles occur to enhance case management, safety, quality, and decision support.

**Priority Process: Impact on Outcomes**

There is a strong commitment to safety with the GEM Services. There are a number of initiatives that support safety and quality including development of best practices, quality boards, client satisfaction surveys, auditing, and risk assessment. Safety huddles occur on a proactive basis.

There are patient and family partners who are involved in safety and quality initiatives. One example of such involvement was the input and engagement of clients and families into the restart of the program during the COVID-19 pandemic. Their input was highly valued by the team and leaders resulting in a person-centered approach to this program. There are quality improvement boards which are visible for clients, families, and team members. The team and leaders develop work standards. A value stream map was completed for the day hospital. The leaders are encouraged to continue with the quality improvement journey and to continue to seek the input and engagement of clients and families.

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

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

**Surveyor comments on the priority process(es)**

**Priority Process: Clinical Leadership**

The Operational Stress Injury (OSI) Clinic in Saskatoon operates as a satellite service site of the Winnipeg Deer Lodge OSI Service Site. The Saskatoon clinic is part of a national network of 10 clinics and 9 satellite sites across Canada. The Saskatoon clinic opened in June 2018 and serves retired and active members of the RCMP (approximately 35% of the active caseload) and active members and veterans of the Canadian Armed Forces (65% of caseload) from across Saskatchewan. The Saskatoon Satellite Clinic is the only OSI clinic serving Saskatchewan. In 2021-2022, 247 unique clients were served by the program. The Saskatoon Clinic is wholly funded through Veteran's Affairs Canada which delegates responsibility for the program to Saskatchewan Health Authority. This program was specifically established to address the operational stresses for members and veterans of the Canadian Armed Forces (CAF) and RCMP. As such, mental health promotion for the community at large is outside the scope of this program. The program does forge partnerships with community services that support clients while waiting for service. Data at the individual level collected using standardized assessment and screening tools is used to inform clinical practice support at the point of care; this data is also aggregated at a national level to inform service planning at macro (national), meso (provincial) and micro (clinic) levels.

The Saskatoon OSI program operates during business hours Monday through Friday. Although there are

no services outside of these hours/days, clinicians conduct risk assessments that include suicidality and ensure clients are linked to appropriate resources in the community as required. Clients who wish to address substance usage are also linked to appropriate service providers in the community.

**Priority Process: Competency**

There is a strong and highly committed interdisciplinary team in place in the Saskatoon OSI clinic. Care is mostly provided virtually (75%) by a team of specialized mental health professionals, including clinical psychologists, psychiatrists, clinical social workers/mental health clinicians, occupational therapists, and administrative staff. Student practicums are supported, and students may be involved in evaluations of new initiatives. The clinic waitlist is impacted by shortages in the professional groups that make up the clinical team.

A strong commitment to excellence in care provided to the clients was evident supported by feedback from the clients interviewed and from interdisciplinary notes reviewed. Staff reported being well supported by their leadership team, as well as having timely information and mentorship to do their job. Staff encountered reported that they feel safe working with clients in-person in 1:1 sessions as they have panic buttons and have conducted mock exercises to ensure timely response from the onsite team. All members of the team have training in non-violent crisis intervention.

All members of the team interviewed reported feeling involved in decision making regarding their work and reported feeling listened to when they have suggestions for improvement. There was a very strong sense of camaraderie evident amongst the team members.

**Priority Process: Episode of Care**

Referrals to the Saskatoon OSI clinic are made by Veterans Affairs Canada, RCMP Health Services, and the Canadian Armed Forces medical team. Family members are included in treatment programming under strict criteria that examine whether the persistent psychological difficulties experienced by the client require involvement of family in the care plan; as such, the impact of operational stress on the family and family functioning are considered. Reasons for referral include Post-traumatic Stress Disorder (PTSD) caused by traumatic experiences or prolonged high stress, or fatigue related to service in the RCMP or CAF, mental health issues, and substance use or concurrent disorders. Comprehensive diagnostic assessments are conducted by the team to assess OSI and to determine if mental health issues are related to the client's RCMP or CAF service. Although the program does not administer medications, clients' medications are reviewed and may be adjusted as needed by the team psychiatrist.

The interdisciplinary team meets weekly to discuss newly referred and newly assessed clients and to consider cross referrals within the team or referrals to community resources. Current clients are also reviewed, leveraging the expertise of the entire team. Intake involves a phone screening conducted by a social worker. The goal at intake is to match the expressed need of the client with the services offered by the OSI Clinic, to screen for risks (the OC-45 screening tool is used to screen for suicidal ideation,

substance abuse, and anger and violence), to explain the next steps to the client, and to request consent to communicate by email. At intake meetings, the team applies priority criteria to determine the placement of the individual on the waitlist. While a client waits for service the social worker follows up with the client monthly to reassess placement on the waitlist and to support referrals to other resources in the client's local community; examples include linking clients to supportive counselling sessions in the community and facilitating access to Employee and Family Assistance Program (EFAP) supports. Treatment planning is client focused with goals set by the client and the team.

Physicians and psychiatrists conduct medication history reviews and prescribe medications. Clients self-administer their own medications outside of the program. Patient safety incidents are reported though the Saskatchewan Health Authority's channels (call 618, report incident, follow protocols for reporting, disclosure, and root cause analysis). Reporting to referrers occurs after intake (initial assessment report), after every six treatment sessions, and at discharge. Clients may choose to discontinue treatment and may reengage at a later date. More commonly, clients require encouragement to transition out of service.

**Priority Process: Decision Support**

National review of trending data on indicators related to both wait-times and clinical outcomes from all clinics is done nationally out of Ottawa. This allows for benchmarking comparisons between all the clinics and for the sharing of best practices. All documentation related to the client record is electronic (Telus Med Access).

**Priority Process: Impact on Outcomes**

Validated, scientifically rigorous patient reported outcome measures (PROMs) inform treatment planning and progress at the individual level and can be aggregated to inform evaluation of the Clinics. These are standardized tools used across the national network including the PTSD scale (PCL-5), PHQ-5, OQ-45. In addition, the network of OSI clinics across Canada submit data on quality domain indicators that allows for comparison of outcomes. Indicators include information about the profile of registered clients, clinical utilization, access/wait-time to service initiation under 15 days, and hours of direct intervention by clinician. The Saskatoon OSI clinic does have a webpage under the Saskatchewan Health Authority website. The program is encouraged to populate this page to present outcome data to the public and to showcase results to those making referrals.

An Occupational Therapy/Social Work co-led Transition Group is currently being evaluated; the Group is conducted over six months with virtual meetings once a month. This is an example of a national program/model that is being tailored and evaluated in the context of the needs of the clients served in Saskatchewan. The program is commended for building on an approach to group interventions used in other jurisdictions and testing innovative models of care tailored to its service in the context of what will best meet the needs of RCMP and CAF members and retirees/veterans in Saskatchewan.

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

| Unmet Criteria | | | High Priority Criteria |
|---|---|---|---|
| **Priority Process: Clinical Leadership** | | | |
| The organization has met all criteria for this priority process. | | | |
| **Priority Process: Competency** | | | |
| 3.14 | 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** | | | |
| 8.5 | Medication reconciliation is conducted in partnership with clients and families to communicate accurate and complete information about medications across care transitions. | | ROP |
| | 8.5.1 | Upon or prior to admission, a Best Possible Medication History (BPMH) is generated and documented in partnership with clients, families, caregivers, and others, as appropriate. | **MAJOR** |
| | 8.5.2 | The BPMH is used to generate admission medication orders or the BPMH is compared with current medication orders and any medication discrepancies are identified, resolved, and documented. | **MAJOR** |
| | 8.5.3 | The prescriber uses the BPMH and the current medication orders to generate transfer or discharge medication orders. | **MAJOR** |
| 9.11 | Information relevant to the care of the client is communicated effectively during care transitions. | | ROP |

| | | |
|---|---|---|
| 9.11.5 | The effectiveness of communication is evaluated and improvements are made based on feedback received. Evaluation mechanisms may include:<br>• Using an audit tool (direct observation or review of client records) to measure compliance with standardized processes and the quality of information transfer<br>• Asking clients, families, and service providers if they received the information they needed<br>• Evaluating safety incidents related to information transfer (e.g., from the patient safety incident management system). | **MINOR** |
| 11.11 | The effectiveness of transitions is evaluated and the information is used to improve transition planning, with input from clients and families. | |
| **Priority Process: Decision Support** | | |
| | The organization has met all criteria for this priority process. | |
| **Priority Process: Impact on Outcomes** | | |
| 16.8 | Indicator data is regularly analyzed to determine the effectiveness of the quality improvement activities. | ! |
| **Surveyor comments on the priority process(es)** | | |
| **Priority Process: Clinical Leadership** | | |

The Hospice at Glengarda opened in January 2021 as the first freestanding hospice in Saskatchewan, housing fifteen beds. They serve patients from Saskatoon and the surrounding area who have a life expectancy of less than eight weeks. The physical building was purposely designed as a hospice with large private rooms. Each room has its own gas fireplace and ceiling lift tracks. One room was designed and designated as a room for bariatric patients. The entire building has fabulous natural lighting and large spaces for family visits in communal or private settings both indoors and outdoors. The Hospice has provided care to 213 unique patients and their families/supporters. Leadership noted that the age of the population being served is becoming younger as they are seeing more patients presenting at end of life due to cancer. The Hospice is designated as a “healthcare organization”. There is a complex organization structure in place with many organizations. The Hospice is operated by Samaritan Place, which oversees human resources, is owned by St. Paul’s Hospital, is under contract with the Saskatchewan Health Authority (SHA), and led by Emmanuel Health, a faith-based Catholic healthcare organization which oversees fifteen other healthcare facilities in the province under a single governance structure. A local Council for the Hospice at Glengarda reports to the Board of Emmanuel Health. Public funding from SHA supports operations at the site and additional funds are raised by the St. Paul’s Hospital Foundation. The Hospice has good working relationships with the Palliative Care Unit at St. Paul’s Hospital for the sharing of best practices.

The Hospice's "healthcare organization" designation was noted as a "grey zone" because the Hospice does not meet the definition of a "long term care" or "acute care" organization. It is noteworthy that both the Emmanuel Health and Hospice at Glengarda leadership teams have made an intentional effort to welcome diverse cultural groups with physical space upgrades that include a multi-Faith Room which is available to patients, families, and staff. The space includes items associated with the Catholic, Muslim, Buddhist, Sikh, and Hindu faiths. An outdoor space has been designated to reflect Indigenous practices. Support for gender diverse patients and families at end-of-life is another area being explored. Although medical assistance in dying (MAiD) is not offered in the Hospice, patients who wish to receive MAiD are supported by the Hospice team for transfer to another facility or home.

The Regina Wascana Grace Hospice is a ten-bed hospice/palliative care unit located in the William Booth Special Care Home. They serve patients in the Regina and surrounding area who have a life expectancy of less than eight weeks and require support for pain and symptom management and stabilization. The Hospice is owned and operated by the Salvation Army as an affiliate organization of the SHA with its own Community Council and management structure. Leaders and team members of the Hospice reported excellent working relationships with the team members from the Palliative Care Unit at Pasqua Hospital. The population served by the Hospice reflects a primarily older adult population. Average length of stay on the unit is three to four weeks with waitlists averaging four to five individuals. Cultural and religious practices at end-of-life are supported; an example provided included a smudging ceremony that was organized on the grounds in the outdoor gazebo. The staff support patients who request MAiD by liaising with the provincial MAiD coordinator, as MAiD is not performed in this Salvation Army operated Hospice. Policies have been developed that outline the steps to be taken to ensure patients requesting MAiD are supported with a timely transfer to the community or an acute care bed. Special Care Home Standards form the basis for the Salvation Army policies.

**Priority Process: Competency**

The leadership of the Hospice at Glengarda have clearly articulated program goals that focus on facilitating a "good death" for both patients and their families by being a vital player in the system of care that ensures the right care at the right time in the right place. Pain control and holistic care are central tenets of the philosophy of care at the Hospice. The model of care is based on a family nursing model of care. A Holistic Care team comprised of spiritual care, creative arts, recreation therapy, and music therapy offers programming to both patients and families. Overall, nursing staff to patient ratios are high and holistic care programming is available six days per week. Food services, housekeeping and building maintenance services and staff are on contract from Sodexo. Sodexo also leads emergency planning on the site, including fire drills.

Support for ethically challenging situations is guided by the SHA Ethical Decision-Making Framework and an Ethicist is available through St. Paul's Hospital (SPH). The Hospice at Glengarda Social Worker participates on the SPH Ethics Committee that meets every three months and brings learning back to the team at the Hospice. Education for the team at the Hospice about trauma informed care is in planning. Two physicians with enhanced palliative training support the Hospice Monday through Friday and were noted as valued members of the team by staff and families. The current model of physician care is under

review as patients under the current model cannot be admitted on evenings and weekends.

Probationary evaluations of new staff have not been conducted consistently. The site leader indicated that performance conversations are held with staff regularly. These conversations are encouraged to be documented and used to guide personal and professional goal setting.

At the Regina Wascana Grace Hospice both best practices and personnel resources (palliative care physician support, palliative care social worker, music therapist, etc.) are shared and augment the nursing, recreation, volunteer, spiritual care, and food services staff of the Hospice and the Dietician and infection prevention and control resources are contracted from the Continuing Care program. The team members of the Hospice are actively involved in regional palliative care forums, e.g., sitting on the Board of the Saskatchewan Hospice Palliative Care Association, and share their expertise and supporting knowledge translation. The sense is that all parties work well together to offer a seamless continuum of care for patients at end of life in Regina and the surrounding region. The site leader indicated that performance conversations are held with staff regularly and this was validated by staff.

**Priority Process: Episode of Care**

At the Glengarda site, daily huddles occur at afternoon shift change; the site lead plans the topics for discussion at the huddles. There is opportunity for frontline clinical staff to raise issues for discussion that relate to never or always events and/or near misses. A daily morning report reviews the census of patients, each patient's palliative status, any planned new admissions for the day, and nurse to nurse report if patients are being admitted from hospital. A registered nurse (RN), Care Partner (care aide) and licensed practical nurse (LPN) welcome new patients. Standardized assessments are conducted on admission to screen for pain, pressure sores, and falls. The Bereavement Risk Assessment Tool (BRAT) is used by care team members to communicate personal, interpersonal, and situational factors that may place a caregiver or family member at risk for a negative bereavement experience. Support is available to the team from a Wound Care RN from Home Care.

Some members of the team expressed a desire to expand the services provided by the Hospice to include direct support to families in their bereavement as a final step in the continuum of care at end-of-life. At this point, the team has forged linkages with bereavement support for families with other community resources and services. When asked what one thing they would change to improve care for patients and families and to improve quality of work life for themselves, several staff indicated that they would like to see longer lengths of stay permitted for patients both up and downstream. The desire to develop more longitudinal relationships with both patients and families to better understand their wishes and their needs, when they can communicate them, as well as to avoid the need to transfer patients whose length of stay exceeds eight weeks. Another area being actively pursued is a program that integrates volunteers into the Hospice; the development of a volunteer program was curtailed by the COVID-19 pandemic.

At the Glengarda site, a standardized Emmanuel Health Quality Safety Dashboard tracks administrative and a range of quality of care and risk management/safety indicators. The Dashboard is populated quarterly by the site leader and reviewed by the Local Council. Although the indicator on medication reconciliation (med rec) on admission has consistently trended in this report at 100%, med rec forms and Best Possible Medication History (BPMH) forms were not evident during the visit. The site does not have an interdisciplinary medication management committee however, there is opportunity to leverage the community pharmacist to provide quarterly in-service education to the clinical Hospice staff on topics relevant to the unique nature of the population served. The idea of case studies related to medication management was raised and eagerly embraced by both the pharmacist and the site lead.

A designated Community Infection Prevention and Control (IPC) Nurse from Saskatoon City Hospital provided support during the construction phase of the building (e.g., location of hand hygiene stations) and although available to the Hospice, as needed, has not been called on for regular IPC onsite reviews. Hand hygiene audits are not conducted in the Glengarda Hospice, however, there is a plan for the IPC nurse to train staff in the Hospice to become in situ auditors. Training in-house auditors and conducting regular hand hygiene audits is encouraged. It was also noted that the Glengarda site has not implemented swabbing of newly admitted patients for MRSA.

At the Regina Wascana Grace Hospice site, although there is no formal interdisciplinary medication management committee in place, the contracted community pharmacy is a valued member of the care team. Medication reviews are conducted at admission based on the Medication Administration Record (MAR) received for each patient admitted either from the hospital or Home Care. The MARs are compared to the Pharmacy Information Record generated by the pharmacy before physician orders are confirmed. No Best Possible Medication History was found on patient charts. “Do not use” abbreviations lists were posted in the medication room and are included in chart audits. There is a robust process of assigned accountability for auditing of a plethora of indicators and processes that engages leaders and frontline staff. This is an excellent example of shared accountability that ensures that there is monitoring of key processes and commitment to quality and safety in clinical and support services.

Although the focus of care on the unit is to provide support for pain and symptom management and stabilization, the Regina Wascana Grace Hospice is commended for the education provided by the Clinical Resource Nurse that has expanded the skill of the clinical team to manage issues on site in the Hospice, thereby precluding transfer of patients to acute care. Examples include gastric tube and suprapubic catheter changes now being done on site; a bladder scanner was purchased, and staff trained to use it for assessments; improved care for complex wound management (staff trained in initiating and changing VAC dressings); staff are able to flush and perform cap changes of PICC/TIC lines; Coban compression wraps.

**Priority Process: Decision Support**

Hospice at Glengarda: This site has state of the art equipment that promotes technology enhanced safety, such as edge of the bed alerts that are set for patients assessed as being high risk for falls. Transfer Lift Repositioning (TLR) level is assessed and noted via cards posted in the patient room. Every patient room is equipped with ceiling lifts that provide access to the bed and the bathroom. Although fall risk is assessed for all newly admitted patients, and staff were able to demonstrate and articulate how they would manage and then report a fall as well as disclose the fall (or any patient safety incident) to family, the information collated from incident reports that is presented to the Local Council is not posted for staff. It does not appear that incidents are entered into the Saskatchewan Health Authority AIMS (Administrative Information Management System) because the Hospice has their own electronic medical records (EMR). "Info Anywhere" is the platform for the Hospice at Glengarda's EMR. The combination of paper forms and checklists and the EMR present risks associated with a hybrid documentation system.

Staff at the Regina Wascana Grace Hospice were able to demonstrate and articulate how they would manage and report a fall, as well as disclose the fall (or any patient safety incident) to family. "Point Click Care" is the platform for the Hospice's EMR. Nursing staff work together to complete admission assessments using standardized screening tools for pain, pressure sores, and falls. No standardized suicide screening tool is used.

**Priority Process: Impact on Outcomes**

Hospice at Glengarda: Although the team is aware of standardized and validated instruments to collect feedback from families after the passing of a loved one, these tools are not used to collect retrospective self-reports of experiences of families while their loved one was in care, nor proxy responses on behalf of their deceased family member. A Family Feedback Box initiative is in the planning stages, although presumably this will yield "real time" and not retrospective feedback and as such would not allow examination of the full care experience in the Hospice. Two Patient and Family Partners have been recruited to advise the Hospice.

At the Regina Wascana Grace Hospice, a centrally located Visibility Wall is the "home" for a range of administrative, quality of care, risk management and safety indicators. Staff across the Hospice, LTC Home, and Convalescent Care Unit huddle around the Visibility Wall twice daily at shift change to share information between team members and between leadership and clinical and support staff, as well as for troubleshooting daily and ongoing issues. When asked to share what they were most proud of, members of the team commented on how well they work together as a team and their commitment to compassionate care. When asked to share what one thing they would change to make quality of life better for their patients and for themselves as care providers the unanimous response was "more staff".

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

| Unmet Criteria | | High Priority Criteria |
|---|---|---|
| **Priority Process: Infection Prevention and Control** | | |
| 1.1 | IPC program components are regularly reviewed based on a risk assessment and organizational priorities. | ! |
| 2.1 | There is an IPC team responsible for planning, developing, implementing and evaluating the IPC program. | ! |
| 2.7 | Input is gathered from the IPC, and the OHS teams to maintain optimal environmental conditions within the organization. | |
| 2.8 | Environmental services and the IPC team are involved in maintaining processes for laundry services and waste management. | ! |
| 2.9 | Input is gathered from the IPC team to maintain processes for selecting and handling medical devices/equipment. | ! |
| 3.2 | Trends in health care-associated infections and significant findings are shared with other organizations, public health agencies, clients and families, and the community. | |
| 4.1 | A risk assessment is completed to identify high-risk activities, and the activities are addressed in policies and procedures. | ! |
| 4.2 | There are policies and procedures that are in line with applicable regulations, evidence and best practices, and organizational priorities. | ! |
| 4.3 | There are policies and procedures for using aseptic techniques when preparing, handling, and administering sterile substances both within the preparation area and at the point of care. | ! |
| 4.6 | Compliance with IPC policies and procedures is monitored and improvements are made to the policies and procedures based on the results. | |
| 4.7 | IPC policies and procedures are updated regularly based on changes to applicable regulations, evidence, and best practices. | ! |
| 5.2 | Team members, clients and families, and volunteers are engaged when developing the multi-faceted approach for IPC. | |

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| 5.5 | Team members and volunteers are required to attend the IPC education program at orientation and on a regular basis based on their IPC roles and responsibilities. | ! |
| 5.6 | The effectiveness of the multi-faceted approach for promoting IPC is evaluated regularly and improvements are made as needed. | |
| 6.3 | Clients are screened to determine whether additional precautions are required based on the risk of infection. | ! |
| 8.3 | Team members, client, families, and volunteers have access to alcohol-based hand rubs at the point of care. | ! |
| 8.4 | Team members, and volunteers have access to dedicated hand-washing sinks. | |
| 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:<br>• Team members recording their own compliance with accepted hand-hygiene practices (self-audit).<br>• Measuring product use.<br>• Questions on client satisfaction surveys that ask about team members' hand-hygiene compliance.<br>• 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. | |
| 12.1 | There is a surveillance plan that is in line with applicable regulations, evidence and best practices, and organizational priorities. | ! |
| 12.2 | Health care-associated infections are tracked, information is analyzed to identify outbreaks and trends, and this information is shared throughout the organization.<br><br>NOTE: This ROP only applies to organizations that have beds and provide nursing care. | ROP |

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| 12.2.1 | Health care-associated infection rates are tracked. | **MAJOR** |
| 12.2.2 | Outbreaks are analyzed and recommendations are made to prevent recurrences. | **MINOR** |
| 12.2.3 | Information about relevant health care-associated infections and recommendations from outbreak reviews are shared with team members, senior leadership, and the governing body. | **MINOR** |
| 12.7 | There are policies and procedures to contain and prevent the transmission of microorganisms by applying routine practices to all clients and additional precautions as necessary. | ! |
| 13.4 | Policies and procedures address how to manage emerging, rare, or problematic organisms, including antibiotic-resistant organisms. | ! |
| 14.1 | There is a quality improvement plan for the IPC program. | ! |
| 14.2 | IPC performance measures are monitored. | |
| 14.3 | Input is gathered from team members, volunteers, and clients and families on components of the IPC program. | |
| 14.5 | Results of evaluations are shared with team members, volunteers, clients, and families. | |

**Surveyor comments on the priority process(es)**

**Priority Process: Infection Prevention and Control**

The Saskatchewan Health Authority (SHA) has worked diligently setting their priorities and resuming old and adding new initiatives. The COVID-19 pandemic certainly proved that the dedicated and supportive work that the Infection Prevention and Control (IPC) teams provided to the frontline staff was and continues to be a success. Outbreaks are managed quickly with best practices and the standards followed. The SHA intranet houses current IPC policies and those are a good resource for the teams during an outbreak.

The support to each facility throughout the province, with adding additional IPC Practitioners, has been extremely valuable. Human Resources is encouraged to continue with their proactive planning and turn temporary positions into permanent ones as there has been instabilities with temporary staff and ongoing challenges with recruitment/retention.

A Quality Improvement Strategy has been initiated throughout SHA with surveillance work on healthcare-associated infections (HAIs). Surveillance work is underway however, surveillance needs to be standardized using a standard auditing tool. More work will need to be done to get all sites on board. Real-time data could be submitted to the Canadian Institute for Health Information (CIHI) as a way of keeping this information together and available for searching.

New implementation of a hand hygiene auditing protocol has been initiated using an iPad/new software. A trial was completed in June 2022. Throughout the province, it was noted that some of the sites are not completing hand hygiene audits. Reasons include lack of staff, staff feel they don't have time, "staff are burnt out", and an iPad (electronics) is intimidating. One site has a resident completing these audits.

There is a provincial interdisciplinary committee that provides guidance around the IPC program; communication to the sites is encouraged to be strengthened. Many sites do not have a formal IPC interdisciplinary committee that meets regularly to evaluate the programs functions/make recommendations as needed. It is done very well at provincial level.

Continued work is in progress on standardizing policies and procedures. Each site has access to the SHA intranet which includes a mix of SHA, former health region and site-specific policies. Policies are difficult to find, and the majority are outdated.

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

| Unmet Criteria | | High Priority Criteria |
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| **Priority Process: Clinical Leadership** | | |
| 1.3 | Service-specific goals and objectives are developed, with input from residents and families. | |
| 1.4 | Services are reviewed and monitored for appropriateness, with input from residents and families. | |
| 2.1 | Resource requirements and gaps are identified and communicated to the organization's leaders. | |
| 2.3 | An appropriate mix of skill level and experience within the team is determined, with input from residents and families. | |
| 2.4 | The physical space is designed with input from residents and families and is safe, comfortable, and reflects a home-like environment. | |
| 2.6 | The effectiveness of resources, space, and staffing is evaluated with input from residents and families, the team, and stakeholders. | |
| 2.8 | A universally-accessible environment is created with input from residents and families. | |
| 5.2 | Work and job design, roles and responsibilities, and assignments are determined with input from team members, and from residents and families where appropriate. | |
| **Priority Process: Competency** | | |
| 3.1 | Required training and education are defined for all team members with input from residents and families. | ! |
| 3.2 | Credentials, qualifications, and competencies are verified, documented, and up-to-date. | ! |
| 3.4 | Education and training are provided to team members on how to work respectfully and effectively with residents and families with diverse cultural backgrounds, religious beliefs, and care needs. | |
| 3.5 | Education and training are provided on the organization's care delivery model. | |
| 3.6 | Education and training are provided on the organization's ethical decision-making framework. | |

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| 3.7 | Education and training are provided on the safe use of equipment, devices, and supplies used in service delivery. | ! |
| 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 |
| 3.8.2 | Initial and re-training on the safe use of infusion pumps is provided to team members:<br>• Who are new to the organization or temporary staff new to the service area<br>• Who are returning after an extended leave<br>• When a new type of infusion pump is introduced or when existing infusion pumps are upgraded<br>• When evaluation of competence indicates that re-training is needed<br>When infusion pumps are used very infrequently, just-in-time training is provided. | **MAJOR** |
| 3.8.3 | When residents are provided with resident-operated infusion pumps (e.g., patient-controlled analgesia, insulin pumps), training is provided, and documented, to residents and families on how to use them safely. | **MAJOR** |
| 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:<br>• Investigating patient safety incidents related to infusion pump use<br>• Reviewing data from smart pumps<br>• Monitoring evaluations of competence<br>• Seeking feedback from residents, families, and team members. | **MINOR** |
| 3.8.6 | When evaluations of infusion pump safety indicate improvements are needed, training is improved or adjustments are made to infusion pumps. | **MINOR** |
| 3.12 | Education and training on safe techniques for moving and lifting residents are provided to the team. | |
| 3.13 | Education and training are provided on information systems and other technology used in service delivery. | |

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| 3.15 | Team member performance is regularly evaluated and documented in an objective, interactive, and constructive way. | ! |
| 3.16 | Resident and family representatives are regularly engaged to provide input and feedback on their roles and responsibilities, role design, processes, and role satisfaction, where applicable. | |
| 3.17 | Team members are supported by team leaders to follow up on issues and opportunities for growth identified through performance evaluations. | ! |
| 3.18 | Ongoing professional development, education, and training opportunities are available to each team member. | |
| 4.4 | Standardized communication tools are used to share information about a resident's care within and between teams. | ! |
| 5.3 | Team members are recognized for their contributions. | |
| 9.14 | Access to spiritual space and care is provided to meet residents' needs. | |
| **Priority Process: Episode of Care** | | |
| 7.7 | Translation and interpretation services are available for residents and families as needed. | |
| 7.11 | Residents and families are provided with opportunities to be engaged in research activities that may be appropriate to their care. | |
| 7.19 | The use of anti-psychotic medications is assessed for appropriateness and the information is used to make improvements. | ! |
| 8.2 | The assessment process is designed with input from residents and families. | |
| 8.4 | Standardized assessment tools are used during the assessment process. | |
| 8.5 | Medication reconciliation is conducted in partnership with the resident, family, or caregiver to communicate accurate and complete information about medications across care transitions. | ROP |
| 8.5.1 | Upon or prior to admission, a Best Possible Medication History (BPMH) is generated and documented in partnership with the resident, family, health care providers, or caregivers (as appropriate). | **MAJOR** |
| 8.5.2 | The BPMH is used to generate admission medication orders or the BPMH is compared with current medication orders and any medication discrepancies are identified, resolved, and documented. | **MAJOR** |

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| | 8.5.3 | Upon or prior to re-admission from another service environment (e.g., acute care), the discharge medication orders are compared with the current medication list and any medication discrepancies are identified, resolved, and documented. | **MAJOR** |
| | 8.5.4 | Upon transfer out of long-term care, the resident and next care provider (e.g., another long-term care facility or community-based health care provider) are provided with a complete list of medications the resident is taking. | **MAJOR** |
| 8.6 | To prevent falls and reduce the risk of injuries from falling, a risk assessment is conducted for each resident and interventions are implemented. | | ROP |
| | 8.6.1 | An initial fall prevention and injury reduction risk assessment is conducted for residents upon admission, using a standardized tool. | **MAJOR** |
| | 8.6.2 | A standardized process is followed to reassess residents at regular intervals and when there is a significant change in their health status. | **MAJOR** |
| | 8.6.3 | Protocols and procedures (based on best practice guidelines when available and applicable to the setting) are implemented to prevent falls and reduce injuries from falling. | **MAJOR** |
| | 8.6.4 | Interventions to prevent falls and reduce injuries from falling are documented in the resident record and communicated to the team. | **MAJOR** |
| | 8.6.5 | Team members and volunteers are educated, and residents, families, and caregivers are provided with information to prevent falls and reduce injuries from falling. | **MAJOR** |
| | 8.6.6 | The effectiveness of fall prevention and injury reduction activities (e.g., risk assessment process and tools, protocols and procedures, documentation, education, and information) are evaluated, and results are used to make improvements when needed. | **MINOR** |
| 8.8 | Each client's risk for developing a pressure ulcer is assessed and interventions to prevent pressure ulcers are implemented. | | ROP |
| | 8.8.1 | An initial pressure ulcer risk assessment is conducted for clients upon admission, using a validated, standardized risk assessment tool. | **MAJOR** |

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| | 8.8.2 | The risk of developing pressure ulcers is assessed for each client at regular intervals and when there is a significant change in the client's status. | **MAJOR** |
| | 8.8.3 | Documented protocols and procedures based on best practice guidelines are implemented to prevent the development of pressure ulcers. These may include interventions to prevent skin breakdown; minimize pressure, shear, and friction; reposition; manage moisture; optimize nutrition and hydration; and enhance mobility and activity. | **MAJOR** |
| | 8.8.5 | The effectiveness of pressure ulcer prevention is evaluated, and results are used to make improvements when needed. | **MINOR** |
| 8.9 | Clients are assessed and monitored for risk of suicide. | | ROP |
| | 8.9.1 | Clients at risk of suicide are identified. | **MAJOR** |
| | 8.9.2 | The risk of suicide for each client is assessed at regular intervals or as needs change. | **MAJOR** |
| | 8.9.3 | The immediate safety needs of clients identified as being at risk of suicide are addressed. | **MAJOR** |
| | 8.9.4 | Treatment and monitoring strategies are identified for clients assessed as being at risk of suicide. | **MAJOR** |
| | 8.9.5 | Implementation of the treatment and monitoring strategies is documented in the client record. | **MAJOR** |
| 8.14 | Each resident's mental health status, including risk of harm and care requirements, is assessed in partnership with the resident and family. | | ! |
| 8.16 | Diagnostic and laboratory testing and expert consultation are available in a timely way to support a comprehensive assessment. | | |
| 9.6 | There is a least-restraints policy that is followed by the team. | | ! |
| 9.7 | A procedure is followed to appropriately implement restraints, monitor a resident in restraint, and document the use in the resident's record. | | ! |
| 9.8 | A process to monitor the use of restraints is established by the team, and this information is used to make improvements. | | ! |
| 9.12 | There are regular, standardized interdisciplinary reviews of each resident's medications and adjustments are made as necessary. | | ! |
| 9.15 | Residents and families have access to psychosocial and/or supportive care services, as required. | | |
| 9.18 | Strategies are used to reduce avoidable admissions/readmissions to the hospital. | | |

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| 9.19 | Information relevant to the care of the resident is communicated effectively during care transitions. | ROP |
| 9.19.1 | The information that is required to be shared at care transitions is defined and standardized for care transitions where residents experience a change in team membership or location: admission, handover , transfer, and discharge. | **MAJOR** |
| 9.19.2 | Documentation tools and communication strategies are used to standardize information transfer at care transitions. | **MAJOR** |
| 9.19.4 | Information shared at care transitions is documented. | **MAJOR** |
| 9.19.5 | The effectiveness of communication is evaluated and improvements are made based on feedback received. Evaluation mechanisms may include:<br>• Using an audit tool (direct observation or review of resident records) to measure compliance with standardized processes and the quality of information transfer<br>• Asking residents, families, and service providers if they received the information they needed<br>• Evaluating safety incidents related to information transfer (e.g., from the patient safety incident management system). | **MINOR** |
| 10.3 | A pleasant dining experience is facilitated for each resident. | |
| 10.5 | Residents are involved in menu planning. | |
| 11.1 | Policies and procedures for POCT are developed with input from residents and families. | |
| 12.7 | The effectiveness of transitions is evaluated and the information is used to improve transition planning, with input from residents and families. | |
| **Priority Process: Decision Support** | | |
| 7.12 | Ethics-related issues are proactively identified, managed, and addressed. | ! |
| 13.1 | An accurate, up-to-date, and complete record is maintained for each resident, in partnership with the resident and family. | ! |
| 13.3 | Policies and procedures to securely collect, document, access, and use resident information are followed. | ! |
| 13.6 | Policies and procedures for securely storing, retaining, and destroying resident records are followed. | ! |

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| 13.8 | There is a process to monitor and evaluate record-keeping practices, designed with input from residents and families, and the information is used to make improvements. | ! |
| **Priority Process: Impact on Outcomes** | | |
| 15.5 | Guidelines and protocols are regularly reviewed, with input from residents and families. | ! |
| 15.6 | There is a policy on ethical research practices that outlines when to seek approval, developed with input from residents and families. | ! |
| 16.1 | A proactive, predictive approach is used to identify risks to resident and team safety, with input from residents and families. | ! |
| 16.2 | Strategies are developed and implemented to address identified safety risks, with input from residents and families. | ! |
| 16.5 | Safety improvement strategies are evaluated with input from residents and families. | ! |
| 16.6 | Patient safety incidents are reported according to the organization's policy and documented in the resident and the organization record as applicable. | ! |
| 17.1 | Information and feedback is collected about the quality of services to guide quality improvement initiatives, with input from residents 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 residents and families. | |
| 17.4 | Indicator(s) that monitor progress for each quality improvement objective are identified, with input from residents 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. | ! |

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| 17.10 | Information about quality improvement activities, results, and learnings is shared with residents, families, teams, organization leaders, and other organizations, as appropriate. | |
| 17.11 | Quality improvement initiatives are regularly evaluated for feasibility, relevance, and usefulness, with input from residents and families. | |

**Surveyor comments on the priority process(es)**

**Priority Process: Clinical Leadership**

Long-Term Care (LTC) consistently works with residents and families to determine the goals of care. The admission process could take several days to complete to be comprehensive. During this time, conversations are held as appropriate to identify the goals of the residents and families relating to end-of-life care. These are difficult discussions; however, teams do a good job of this consistently across the sites surveyed.

At most sites (more than 90%) staff are trained on Transfer, Lift, and Repositioning (TLR) as well as the Gentle Persuasion Approach (GPA).

At many sites, there appeared to be the right mix of staff except for occupational therapy (OT), physiotherapy (PT) and physicians. Decreased mobility was observed to be more pronounced at some sites versus others. This could be related to the low availability of the OT/PT resources observed at some sites. There was limited evidence of input from residents and families in determining the staff mix that was required unless it was in the form of complaints. There was also variability across sites in the availability of onsite visits from physicians. This ranged from no onsite visits to up to fifteen physicians visiting a site.

Saskatchewan is like the rest of the country in that there are staff shortages in LTC with one of the consequences being the need to close beds. The organization has worked hard to recruit qualified staff, however, there are still many vacancies. To mitigate the shortage, the organization has taken in untrained individuals to work in LTC with the agreement they will complete the Health Care Aide course within two years. There have been several unintended consequences as a result. One of the consequences is that the usual orientation may have been abbreviated or skipped which means the individual misses out on required training and education. Another consequence is that they may not understand how to use equipment properly. Finally, there is a morale issue. Staff who have obtained their certification as a Health Care Aide may be working along someone who has worked for two years without their certification, and they are making the same wage.

The organization has tried to improve the types of meaningful activities that take place in LTC. One of the steps is to ensure the recreation staff have the proper education and training to meet the job qualifications. Again, some staff may be obtaining a similar wage to the individuals who come to the area with the appropriate education and training. Some residents and families do not feel there is enough recreation, particularly in the evenings and on the weekends.

In addition to human resources, it was noted that many sites did not have enough ceiling lifts and lacked a universally accessible environment. There are a few buildings identified that require immediate attention to address health and safety concerns.

**Priority Process: Competency**

The Long-Term Care (LTC) sector has a large list of required training and opportunities for training. During the COVID-19 pandemic, the organization made as many of the training opportunities digital as possible. While the COVID-19 pandemic accelerated the opportunities to have education available digitally, the unintended consequences include the fact that there may now be an expectation that mandatory training is completed at home instead of at work. This is problematic for staff. Additionally, for staff where English is a second language, this may not always be the best way to offer training.

Several of the trainings stand out as being consistently done. Workplace violence training has been implemented broadly and staff report having done the training and it being helpful. Occupational health and safety training appears to be disseminated widely as well. There is opportunity to strengthen education and training specifically in mental health and ethics. Staff face ethical dilemmas in their daily work and a large portion have had training on how to deal with ethical issues. Some of the teams' report involving an ethicist in complex and difficult cases. The teams need to ensure all staff receive initial and follow up training on recognition of ethical dilemmas and are aware of the resources available to support them.

Many policies were reviewed and there is a mix of strategies being used. Some staff use their "old" policies, some are looking to the new Saskatchewan Health Authority policies, and still others are using a combination. This is resulting in some confusion and could add risk. Many regional policies are quite outdated and some of the affiliate policies may differ (e.g., High Alert Meds - in the requirements to affix labels to high alert medications). The SHA is encouraged to continue work in progress to standardize policies.

There are a small number of sites who deliver medications and nutrition via infusion pumps. The standards around infusion pumps require that there is evidence of ongoing competency. Several sites visited were unable to produce the evidence of competency.

The COVID-19 pandemic has been difficult for staff. It is difficult to understand what the impact has been, but staff have been feeling burdened. Unfortunately, because of the need to remain physically distant from each other, staff satisfaction events have been paused and this may have compounded the issue of feeling over-worked and feeling under-appreciated. Some sites have found ways around this and given out small tokens of appreciation, such as certificates. This is an area the organization could look at to improve, especially with staff who have gone above and beyond, particularly during outbreaks, and some staff having to work extra shifts and overtime to help maintain operations.

The organization is to be commended for working so hard to keep up with the constantly changing environments during the COVID-19 pandemic. Up-to-date materials both in hard copy and digitally to give staff the tools to do their jobs, particularly around outbreaks were evident.

Credentialling of staff, in particular Health Care Aides and Recreation Therapists, has emerged as an issue during site visits. Some members of staff who have not yet achieved the required certification working alongside qualified staff while potentially making the same wage. Additionally, they may not be able to deliver the expected standard of care without the comprehensive training required.

Another way of measuring competency is to use performance appraisals. There were a small number of sites that have performance appraisals completed regularly and they are to be commended. Unfortunately, many sites we observed where staff have not had performance evaluations in years, if ever. The organization has many new managers and one of the areas they will need to focus on is a strategy to bring performance appraisals up to date. Potential strategies could include providing training to new managers, ensuring use of an efficient and meaningful tool, delegation to license staff to assist, or spreading it out over the year. There is opportunity to update position profiles as some of them are approaching twenty years since they have been updated.

**Priority Process: Episode of Care**

Throughout this two-week survey, many acts of kindness and compassion were noted. Residents and families have some very complex needs, sometimes challenging behaviors, and many shifts are not able to be filled. The staff have been resilient and remain kind and caring throughout.

Families interviewed were aware of where and how to make their concerns known. Most of the time, they felt heard and saw action to address their concerns.

The teams find respectful ways to work with residents and families to work out if the resident has capacity to make their own decisions. If it is determined that a resident does not have this capacity, the teams respectfully find out who should be responsible. This can be challenging when the organizations are short of key staff (e.g., Social Work positions not filled).

During the intake process (and any time later) residents can provide their preferences. Sometimes those preferences may lead the resident to live at risk (e.g., smoking). There is a process for residents choosing to live at risk and their rights are protected to do so. In speaking with numerous residents and families, more and more are choosing their own bedtime and what time they will awaken and eat their breakfast. One resident interviewed asked staff to not check in at night and only come in at 0930 hours. The resident and the team talked about the potential consequences of the staff not checking in (potential urinary or fecal incontinence, falls, etc.) and the resident/family chose to live with those risks.

Most of the sites are offering meaningful activities. During the height of the COVID-19 pandemic many activities had to be paused and this was very distressing for residents, families, and staff. As they emerge from the physical restrictions imposed by the pandemic, many are looking forward to having their activities completely reinstated. There are several sites where the teams shine in the activities departments.

Care plans are comprehensive and done in partnerships with the resident/family. Meals at the sites vary broadly and the happiness about them varies widely as well. More than half the residents surveyed thought the food was quite good while others found it bland or unappealing.

There are several ROPs (Required Organizational Practicess) under the Episode of Care Priority Process. The first one is Medication Reconciliation (Med Rec). Many sites are adopting the Med Rec on discharge from the hospital; however, this is not a Best Possible Medication History (BPMH) as it does not involve the resident and family. Ideally, the team would use a BPMH form on admission and use the document from the hospital as one piece of the data that is reviewed. In addition, it is encouraged that the team consult the resident and family in case there were any medications (specifically vitamins and other over-the-counter products) that were never restarted during their hospital stay. Also, the residents Pharmaceutical Information Program (PIP - list from the retail pharmacy) could be consulted to complete the BPMH.

At most sites there was a Fall Assessment completed and documented on admission; however, there were pockets of sites where this did not happen. Chart audits could be an important tool to raise awareness about ensuring the initial and periodic assessments are completed and documented. The response to falls appears to be quite well done and documented.

The risk of pressure ulcers is completed and documented at most sites; however, there are pockets of sites that are not documenting their assessment for pressure ulcer risks. Again, regular auditing of the charts would identify those not being completed.

The risk of suicide needs to be assessed and documented on admission and periodically throughout the resident's stay. Some sites report using the Long-Term Care Facilities tool which includes a section on mood and behaviour; however, that is not an actual risk of suicide assessment. Performing regular chart audits would identify these not being completed.

Information at care transitions is done well except for the evaluation component. Most sites are assuming a lack of complaints means they are doing a good job. While this may be true, more robust evaluation needs to occur.

Finally, the use of antipsychotic medications without a diagnosis is high in some sites. For example: in one site the rate was 51.9%. The national average is 22% and the provincial average is 30.5% based on 2020-2021 data from the Canadian Institute of Health Information. Doing a deep dive on sites where the average is high would be an important first step to addressing this gap.

**Priority Process: Decision Support**

One of the strengths of the teams observed this week is their attention to resident and family privacy and autonomy. Many sites were observed contacting families of residents who could not speak for themselves to obtain consent for vaccination. This is a lot of work for the staff, but they know it is the right thing to do. The staff are mindful of the resident and family's right to choose, and they ensure there is consent before performing such things as vaccination.

Obtaining direction on consent is very important at the time of admission and this is done well. Sometimes a family member is appointed as the substitute decision-maker and other times a proxy is obtained for medical choices. Staff are diligent about getting these decisions made and communicated.

In almost all charts, there is a 'green sleeve' that documents the resident and family wishes for end-of-life care and staff follow the wishes as written when considering a transfer out to hospital or another level of care. Looking for ways to seek input from residents and families around record keeping practices is encouraged.

**Priority Process: Impact on Outcomes**

One of the areas of strength for the organization is the appearance of staff reporting incidents consistently. Some sites noted that there has been an increase in reporting near misses and this is appreciated as it could prevent an incident from occurring in the future. When an incident does occur, residents and families report that disclosure is done well.

Evidence-informed guidelines and protocols are selected by a Continuing Care Committee. There is limited understanding about this process at the sites and it is not clear if there has been involvement of residents and families. It would be important to involve them and include their perspectives.

The Quality Improvement (QI) work of LTC is in its infancy. The organization has chosen five main indicators to measure: use of antipsychotics without a diagnosis, pain, pressure ulcers, use of restraints, and challenging behaviors. The team is working on their strategies, and most have implemented this work while others plan to do so early in the new year. There are several new managers, and it will be important to support the teams with education around QI as well as assisting them with strategies and measurement.

Another unintended consequence of the COVID-19 pandemic has been that "quality work" has had to be paused or stopped as staff "did not have enough time for QI". This included such things as hand hygiene and chart auditing. There is more than one way to accomplish this work, but comprehensive audit tools could make a significant difference. Some of the items that need to be audited in resident charts include risk of suicide assessment at admission and then routinely or as the resident's condition warrants and assessment for risk of pressure ulcer/injury upon admission and routinely during care. Another area to audit is around fall risk and injury prevention. Tracking audit data raises awareness with staff and identifies gaps for leaders to implement changes as required to improve quality and client outcomes.

It will be important moving forward to assist the staff to develop a culture of quality being embedded into "everything we do" and not something that is "on top of the work we do".

## Standards Set: Medication Management Standards - Direct Service Provision

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

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| | 2.3.4 | The program includes interventions to optimize antimicrobial use, such as audit and feedback, a formulary of targeted antimicrobials and approved indications, education, antimicrobial order forms, guidelines and clinical pathways for antimicrobial utilization, strategies for streamlining or de-escalation of therapy, dose optimization, and parenteral to oral conversion of antimicrobials (where appropriate). | **MAJOR** |
| | 2.3.5 | The program is evaluated on an ongoing basis and results are shared with stakeholders in the organization. | **MINOR** |
| 2.4 | | The interdisciplinary committee establishes procedures for each step of the medication management process. | ! |
| 2.5 | | A documented and coordinated approach to safely manage high-alert medications is implemented. | ROP |
| | 2.5.1 | There is a policy for the management of high-alert medications. | **MAJOR** |
| | 2.5.2 | The policy names the role or position of individual(s) responsible for implementing and monitoring the policy. | **MINOR** |
| | 2.5.3 | The policy includes a list of high-alert medications identified by the organization. | **MAJOR** |
| | 2.5.4 | The policy includes procedures for storing, prescribing, preparing, administering, dispensing, and documenting each identified high-alert medication. | **MAJOR** |
| | 2.5.5 | Concentrations and volume options for high-alert medications are limited and standardized. | **MAJOR** |
| | 2.5.6 | Client service areas are regularly audited for high-alert medications. | **MINOR** |
| | 2.5.7 | The policy is updated on an ongoing basis. | **MINOR** |
| | 2.5.8 | Information and ongoing training is provided to team members on the management of high-alert medications. | **MAJOR** |
| 2.7 | | The interdisciplinary committee provides standard order sets for medications. | |
| 2.8 | | The interdisciplinary committee standardizes critical information found in medication orders, medication labels, and medication administration records. | |
| 2.9 | | The interdisciplinary committee establishes standard administration schedules for time-sensitive medications in line with manufacturers' instructions. | ! |

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| 2.13 | The interdisciplinary committee develops a process for handling medications brought into the organization by clients and families. | |
| 2.16 | The interdisciplinary committee monitors compliance with each step of the medication management process. | |
| 3.1 | The interdisciplinary committee sets criteria for adding and removing medications to the formulary. | |
| 3.2 | The interdisciplinary committee develops a process to assess, approve, and purchase in a timely manner medications that are not on the formulary when they are therapeutically necessary. | |
| 3.3 | The interdisciplinary committee regularly reviews and updates the formulary. | |
| 3.4 | The interdisciplinary committee ensures that teams are informed about any changes to the formulary. | ! |
| 4.4 | The effectiveness of training activities for medication management is regularly evaluated and improvements are made as needed. | |
| 6.1 | Teams are provided with access to the medication management processes and the formulary, both in the pharmacy and clinical service areas. | |
| 6.5 | Teams can access an on-site or on-call pharmacist at all times to answer questions about medications or medication management. | ! |
| 9.4 | The availability of narcotic products is evaluated and limited to ensure that formats with the potential to cause patient safety incidents are not stocked in client service areas. | ROP |
| 9.4.1 | An audit of the following narcotic products in client service areas is completed at least annually:<br>• Fentanyl: ampoules or vials with total dose greater than 100 mcg per container<br>• HYDROmorphone: ampoules or vials with total dose greater than 2 mg<br>• Morphine: ampoules or vials with total dose greater than 15 mg in adult care areas and 2 mg in paediatric care areas. | **MAJOR** |
| 9.4.3 | When it is necessary for narcotic (opioid) products to be available in select client service areas, an interdisciplinary committee for medication management reviews and approves the rationale for availability, and safeguards are put in place to minimize the risk of error. | **MAJOR** |

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| 10.1 | The potential harms and benefits of medication delivery devices are assessed and documented before purchase. | ! |
| 11.2 | A policy that specifies when and how to override smart infusion pump alerts is developed and implemented. | ! |
| 12.1 | Access to medication storage areas is limited to authorized team members. | ! |
| 12.2 | Medication storage areas are regularly cleaned and organized. | |
| 12.3 | Conditions appropriate to protect medication stability are maintained in medication storage areas. | |
| 12.4 | Lighting in medication storage areas is sufficient for teams to read medication labels and information sheets. | |
| 12.5 | Medication storage areas meet any applicable legislated requirements and regulations for controlled substances. | ! |
| 12.6 | Look-alike, sound-alike medications; different concentrations of the same medication; and high-alert medications are stored separately, both in the pharmacy and client service areas. | ! |
| 12.8 | The use of multi-dose vials is minimized in client service areas. | ! |
| 12.10 | Medication storage areas are regularly inspected and improvements are made if needed. | |
| 13.3 | Chemotherapy medications are stored in a separate negative pressure room with adequate ventilation, and are segregated from other supplies. | ! |
| 14.6 | A list of abbreviations, symbols, and dose designations that are not to be used have been identified and implemented. | ROP |
| 14.6.1 | The organization's Do Not Use list is inclusive of the abbreviations, symbols, and dose designations, as identified on the Institute of Safe Medication Practices (ISMP) Canada's “Do Not Use List”. | **MAJOR** |
| 14.6.2 | The Do Not Use List is implemented and applies to all medication-related documentation when hand written or entered as free text into a computer. | **MAJOR** |
| 14.6.5 | Team members are provided with education about the Do Not Use list at orientation and when changes are made to the list. | **MINOR** |
| 14.6.6 | The Do Not Use list is updated and necessary changes are implemented to the medication management processes. | **MINOR** |

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| | 14.6.7 Compliance with the Do Not Use List is audited and process changes are implemented based on identified issues. | **MINOR** |
| 14.7 | A policy that specifies when telephone and verbal orders for medications are acceptable and how they are to be transcribed is developed and implemented. | ! |
| 14.9 | Compliance with the policies and procedures regarding medication orders is regularly monitored, and improvements are made as needed. | ! |
| 15.1 | The pharmacist reviews all prescription and medication orders within the organization prior to administration of the first dose. | ! |
| 16.1 | Medication preparation areas are regularly cleaned and organized. | |
| 16.2 | Appropriate ventilation, temperature, and lighting are maintained in the medication preparation areas. | |
| 19.2 | A pharmacist or other qualified team member verifies, as soon as possible, that the correct medications were dispensed after hours. | |
| 20.1 | Medications are safely delivered from the pharmacy to client service areas. | |
| 20.2 | Steps are taken to protect the health and safety of team members who transport, administer, and dispose of chemotherapy medications. | ! |
| 20.3 | A readily accessible hazardous spill kit is located wherever chemotherapy medications are dispensed and administered. | ! |
| 23.2 | Each medication is verified against the client's medication profile prior to administration. | ! |
| 23.3 | An independent double check is conducted at the point of care before administering high-alert medications. | ! |
| 24.2 | The effects of medications on each client's treatment goals are monitored and documented. | |
| 25.3 | The interdisciplinary committee determines which team members to involve in the analysis of patient safety incidents involving medications. | |
| 25.4 | The interdisciplinary committee supports information-sharing with clients, families, and team members about recommended actions and improvements made. | |
| 26.1 | Teams are informed of the value of, and their role in, reporting adverse drug reactions to Health Canada; specifically unexpected or serious reactions to recently marketed medications. | |

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| 26.2 | Teams are provided with information on how to detect and report ADRs to the Health Canada Vigilance Program. | |
| 27.1 | Resources needed to support quality improvement activities for medication management are provided. | |
| 27.8 | The interdisciplinary committee shares evaluation results with teams. | |

**Surveyor comments on the priority process(es)**

**Priority Process: Medication Management**

There is progress at the provincial level with the implementation of committees. The Multidisciplinary Clinical Practice Oversight Committee exists to positively influence clinical behaviors that will enhance the quality of care. An example would be through Antimicrobial Stewardship and High Alert Medications.

This year, the Drugs and Therapeutics committee combined twelve formularies into one formulary. They established criteria to add and remove medications. This is a huge step forward, however, more communication is encouraged across the sites to ensure staff are familiar with the changes and how to process requests to add and delete medications from the formulary. All sites were not aware of the work happening at the provincial level so leadership and visibility will be important to the frontline staff to be engaged.

The Medication Use and Safety Interdisciplinary Committee (MUSIC) was established to provide oversight and coordination of the geographic interdisciplinary committees. There is opportunity to strengthen communication at the site level or for site level interdisciplinary committees to support and strengthen medication management and quality improvement. Presently, there are very few interdisciplinary committees in place at the site level with most sites supported by a contracted community pharmacy.

The Medication Reconciliation Committee was established to develop, administer, and update the medication reconciliation policies and procedures. The present practice for medication reconciliation is not standardized. There is opportunity to standardize the process across geographic areas with provincial oversight under this committee. The implementation of a new contract for community pharmacies will help standardize interdisciplinary work and medication reconciliation and also support audits for High Alert Medications and Narcotic Use.

Two sites visited (Parkridge Centre and Wascana Rehab Centre) that provide complex continuing care (e.g., a higher level of care such as for clients on long-term ventilation), are encouraged to implement a complete Antimicrobial Stewardship plan as defined provincially and include auditing and tracking for improvements and reporting.

At some sites, the medications storage and preparation areas are a concern. They are small, narrow, poorly organized due to limited space and places to store medications and supplies, and very restrictive due to medications carts being stored there. Assessment and modifications are encouraged with input

from the staff to ensure safe environments.

The medication delivery times, the packaging and the supports provided from the community pharmacies, and some SHA pharmacies are inconsistent. The updated provincial pharmacy contract should help to address this. At some sites, the packaging observed that included the medications listed, resident information, and photo established a good practice.

There are several Required Organizational Practices that are not met because regular auditing is not being completed. These include High Alert Medications, Antimicrobial Stewardship, narcotic products, and 'Do Not Use' abbreviations compliance. High Alert medication stickers were not in place at all sites. For example, insulin pens did not have a sticker to identify as High Alert. Attention to support Double Checks of High Alert Medications as outlined in the policy is needed. This was not present at all sites due to short staffing. At the Hospice at Glengarda, "Do Not Use" abbreviations lists were not prominently posted in the medication room and staff could not locate the list when asked about the abbreviations that should not be used; "Do Not Use" abbreviation usage is also not audited. There is opportunity to provide targeted education sessions related to "Do Not Use" abbreviations, to post signage of the abbreviations and monitor usage with chart audits.

The sites are encouraged to review existing policies and procedures to ensure they have only one in use, and it is the most up-to-date copy to guide staff.

Under the provincial medication management portfolio, the sites require education around what this will look like going forward and what their responsibility is with respect to all aspects of medication management. It should be clearly defined what sites are required to report on, when, to whom, and what resources they need to comply with. The staff require information on reporting Adverse Drug Reactions to the Health Canada Vigilance Program and what the benefits of doing this are.

At the front line, staff and managers are sometimes overwhelmed with workload, staff shortages, and the lack of influence they feel over their work. It is encouraged that staff are engaged in discussions regarding their work, the residents they care for, the structures they work in, and their ongoing professional development and time off. The organization is encouraged to communicate with staff any planning for upgrades and replacements of facilities, and how they put forward a request for ongoing improvements.

Quality Improvement is challenging at some sites. However, some great work is happening. There is good communication with staff, residents, and families; this is evident by what the staff and families relayed to the surveyors during the onsite visits as well as evidence posted on their white boards or in newsletters. Consistency and the spread of information are encouraged throughout the province. Supports and resources are required to get some teams back up to the standard they were operating at prior to the pandemic and maintain quality improvement.

The staff and leaders are very committed to their residents, families, and their team. They often advocate for the residents when they have no one else to do that for them. The residents and families respect and appreciate this level of caring and support. Keep up the good work!

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

| Unmet Criteria | | High Priority Criteria |
|---|---|---|
| **Priority Process: Clinical Leadership** | | |
| The organization has met all criteria for this priority process. | | |
| **Priority Process: Competency** | | |
| 5.14 | Team member performance is regularly evaluated and documented in an objective, interactive, and constructive way. | ! |
| 5.15 | As a part of their performance evaluation, donation team members demonstrate their competence.<br>CSA Reference: Z900.1-03, 4.2. | |
| 5.17 | Team members are supported by team leaders to follow up on issues and opportunities for growth identified through performance evaluations. | ! |
| 6.5 | The effectiveness of team collaboration and functioning is evaluated and opportunities for improvement are identified. | |
| **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** | | |
| 19.1 | 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. | |
| 19.2 | The information and feedback gathered is used to identify opportunities for quality improvement initiatives and set priorities, with input from clients and families. | |
| 19.4 | Indicator(s) that monitor progress for each quality improvement objective are identified, with input from clients and families. | |
| 19.5 | Quality improvement activities are designed and tested to meet objectives. | ! |

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| 19.6 | New or existing indicator data are used to establish a baseline for each indicator. | |
| 19.7 | There is a process to regularly collect indicator data and track progress. | |
| 19.8 | Indicator data is regularly analyzed to determine the effectiveness of the quality improvement activities. | ! |
| 19.9 | Quality improvement activities that were shown to be effective in the testing phase are implemented broadly throughout the organization. | ! |
| 19.10 | Information about quality improvement activities, results, and learnings is shared with clients, families, teams, organization leaders, and other organizations, as appropriate. | |
| 19.11 | Quality improvement initiatives are regularly evaluated for feasibility, relevance, and usefulness, with input from clients and families. | |

**Priority Process: Organ and Tissue Donation**

The organization has met all criteria for this priority process.

**Surveyor comments on the priority process(es)**

**Priority Process: Clinical Leadership**

The Saskatchewan Health Authority's (SHA) Donation Program is coordinated out of two offices: one in Saskatoon and one in Regina. There is a dedicated team comprising of donation coordinators, social workers, quality assurance, and medical leadership.

The program is guided by the mission, vision, values, and philosophy of care of the SHA and has developed a mission, vision, values, and goals for the Donation Program which guides their planning, implementation, and program evaluation. These are:

Mission:

- To enable patients and /or their families to make an informed decision about organ and/or tissue donation.
- To support healthcare professionals in implementing the patient/family's intention to donate.
- To maximize organ and tissue donation in Saskatchewan in a respectful manner through education, research, services, and support.

Belief:
End of life care should be compassionate in nature. This includes honoring a patient's decision to donate organ(s) and/or tissue(s) after death or by ensuring that the opportunity for donation has been provided to families when a patient is not able to make the decision.

Values:

- Save and transform lives through organ and/or tissue donation.
- Honor the decision and values of patients and their families.
- Foster collaborative relationships with all members of the healthcare team to provide education and support the process of organ and tissue donation.

Goals:

- All potential donors are made aware of and given the opportunity to donate.
- Integration of organ and/or tissue donation into the delivery of quality end of life care for potential donor patients and their families.
- Optimize the donation opportunities in Saskatchewan in collaboration with communities and stakeholders.
- Provide education and support best practices in the care of the organ and/or tissue donor.
- Participate in quality and research pursuits to better the future in donation provincially and nationally.

Donation physicians were introduced in 2018. Today there are five physicians who support organ donation. They provide on-call support as well as guidance and advice to provincial colleagues and the donation coordinators in Regina and Saskatoon.

A Provincial Organ Donation Executive Council is supported by patient family partners, leadership from the government, IT partners, and operational teams. Input from patient and families occurs at this Executive Committee as well as engagement at the local program level. The program is encouraged to continue to engage with First Nations and Metis stakeholders. The program is also encouraged to explore strategies to provide access to culturally responsive resources.

The Executive Director of Tertiary Programs is also a member of the Acute Care Executive where organ donation is a standing item. This facilitates awareness and collaboration with the SHA acute care services with regards to organ donation.

The team is commended on the efforts they have made to increase cornea donations. Their efforts have significantly reduced the cornea transplant wait list in Saskatchewan.

The Donation Team is continually exploring ways to increase the awareness of the gift of donation. In 2021, the team worked to collaborate with the MAiD program and have had MAiD donors. Where appropriate, the power of story can be impactful. The team is encouraged to explore opportunities where those who were involved in the donation process can tell “their story”. The team is also supported in their efforts to continue to do outreach and education with healthcare services across the province.

The program reports metrics related to the number of donations after circulatory determination of death (DCD) and neurologic determination of death (NDD) in Regina and Saskatoon; the percentage of patients

who met the GIVE criteria (Glasgow Coma Scale < 5, Injured Brain, Ventilated, End of life discussion) and were referred; the number of cornea donations and the number of tissue referrals. The SHA organ donation program is supported in their policy work to have mandatory reporting of all deaths.
The program is also commended on the development of the DCD program in Regina in early 2021.
The program has been involved in the request for proposal (RFP) and procurement of a National Donor Software program.
As the awareness of the importance of donation increases this will most likely lead to an increase in service demand. The donation service for both living kidney donors and deceased donors is encouraged to continually monitor the service demand and ensure that appropriate resources are available to support program growth and sustainability.

**Priority Process: Competency**

All staff involved in the Donation Program meet the required credentials and clinical experience and have received an appropriate orientation and mentorship.

With new leaders at both the Saskatoon and Regina programs, performance appraisals have yet to be completed. Informal feedback is provided to staff; however, managers are encouraged to initiate the formal performance appraisal process.

It is evident that all members of the donation team work very well together. They have excellent processes in place to communicate but an evaluation of the effectiveness of team collaboration and functioning is encouraged to validate team function and determine whether improvements are required.

**Priority Process: Episode of Care**

Standardized questionnaires and processes are followed to obtain the necessary information about the donor and their history.

**Priority Process: Decision Support**

The team has clear standard operating procedures (SOPs) to guide their decisions and actions. Health Canada Regulations are followed.

**Priority Process: Impact on Outcomes**

The program conducts audits for all deaths and action plans are developed for any missed referrals. The team started in 2021 to collaborate on MAiD donations.

The program saw the initiation of a provincial registry for organ donation in 2020. Currently there are about 20, 000 registered individuals which is around 2 % of the provincial population. The program is providing education in communities outside of Saskatoon and Regina to assist teams in early identification and awareness. They have also identified a possible opportunity to use the Med Line to identify potential

deceased donors in rural communities. They are encouraged to explore the potential of implementing this strategy.

The program is encouraged to develop processes to follow up with families to obtain information and feedback that will assist the program in identifying the strengths as well as opportunities for improvement. It was noted that in Saskatoon, the social worker provides a post donation survey for families to complete. Upon review of some of these surveys, it was noted that families acknowledged the strength of the program and the incredible support they received during the time of donation as well as the support that they continue to receive. The families also provided suggestions for the program to consider.

There is an absence of a culture of quality improvement at the program level. The program is encouraged to establish and implement a quality improvement program with the necessary resources to support successful implementation and sustainability. They have dedicated resources for quality assurance functions however quality improvement support is not evident.

**Priority Process: Organ and Tissue Donation**

Neurological Determination of Death (NDD), Donation after Cardiac Death (DCD), and Ocular retrievals are performed in Saskatoon and Regina. The program is commended on the efforts they have taken to achieve a level of self-sufficiency with tissue retrievals provincially to the point that they no longer need to purchase corneas from out-of-province or out-of-country.

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

| Unmet Criteria | | High Priority Criteria |
|---|---|---|
| **Priority Process: Organ and Tissue Transplant** | | |
| The organization has met all criteria for this priority process. | | |
| **Priority Process: Clinical Leadership** | | |
| 2.10 | The effectiveness of resources, space, and staffing is evaluated with input from clients and families, the team, and stakeholders. | |
| **Priority Process: Competency** | | |
| 4.14 | Team member performance is regularly evaluated and documented in an objective, interactive, and constructive way. | ! |
| 4.15 | A demonstration of competence is included as part of the performance evaluation.<br>CSA Reference: Z900.1-03, 4.2. | |
| 4.17 | Team members are supported by team leaders to follow up on issues and opportunities for growth identified through performance evaluations. | ! |
| 5.5 | The effectiveness of team collaboration and functioning is evaluated and opportunities for improvement are identified. | |
| **Priority Process: Episode of Care** | | |
| The organization has met all criteria for this priority process. | | |
| **Priority Process: Decision Support** | | |
| 2.2 | Technology and information systems requirements and gaps are identified and communicated to the organization's leaders. | |
| **Priority Process: Impact on Outcomes** | | |
| 22.1 | 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. | |
| 22.4 | The information and feedback gathered is used to identify opportunities for quality improvement initiatives and set priorities, with input from clients and families. | |

| | | |
|---|---|---|
| 22.6 | Indicator(s) that monitor progress for each quality improvement objective are identified, with input from clients and families. | |
| 22.7 | Quality improvement activities are designed and tested to meet objectives. | ! |
| 22.8 | New or existing indicator data are used to establish a baseline for each indicator. | |
| 22.9 | There is a process to regularly collect indicator data and track progress. | |
| 22.10 | Indicator data is regularly analyzed to determine the effectiveness of the quality improvement activities. | ! |
| 22.11 | Quality improvement activities that were shown to be effective in the testing phase are implemented broadly throughout the organization. | ! |
| 22.12 | Information about quality improvement activities, results, and learnings is shared with clients, families, teams, organization leaders, and other organizations, as appropriate. | |
| 22.13 | 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: Organ and Tissue Transplant**

Excellent processes are in place to support the assessment of potential kidney transplant patients in Saskatchewan. Detailed patient records are kept, and once assessment is completed, and the patient is placed on the transplant wait list, ongoing monitoring and communication between the patient and the team occurs.
The Saskatchewan transplant program in Saskatoon provides post-transplant follow up for patients who receive out of province lung, liver, and heart transplants. The team is currently developing a program to conduct the pre-assessment phase of patients requiring lung, liver, and heart transplants. They view both programs as supporting care closer to home for those patients who need to travel out of province for these types of transplants. They are working very closely with the HOPE (Human Organ Procurement and Exchange) program based in Alberta.

Patients have 24-hour access to the transplant teams in Saskatoon and Regina. Any issues or concerns can be addressed any time. The patients interviewed have the highest regard for the transplant teams in Regina and Saskatoon. They feel very supportive and have confidence in the care that they are being given by this highly competent team.

Patient appointments are being provided through the virtual appointments and in-person visits. The team is encouraged to continue to explore and establish criteria for virtual and in person visits

**Priority Process: Clinical Leadership**

The Donation and Transplant program falls under the Saskatchewan Health Authority's (SHA) Tertiary Care Portfolio. The Donation and Transplant program functions as a provincial program with coordination between two sites: one in Saskatoon and one in Regina.

With the establishment of the SHA, the donation and transplant services in Saskatoon separated in 2018 and Regina in 2021. The Saskatoon program coordinates services from Saskatoon and North regions while Regina supports donation and transplant services Regina and South regions.

There is clear evidence that this is a strong provincial program where the North and South support each other. The program is preparing for the March 2023 Health Canada Audit for deceased, living, and tissue donation.

The transplant offices in Saskatoon and Regina are organized with an Assessment Office, A Recipient Office, and a Living Kidney Donation Office. Clinics operate in Saskatoon and Regina with in-person and virtual visits. The transplant nephrologist, surgeon, coordinator, social workers, and pharmacists participate in these clinics.

Saskatoon hosts the out-of-province patients who receive heart, lung, and liver transplants. The team includes a respirologist, hepatologist, cardiologist, coordinator, pharmacist, and social worker. The team is currently working on implementing the Pre-Assessment Office and functions for these patients who are being considered for heart, lung, or liver transplants.

The program is commended for the significant increase in corneal transplants. The data presented during the survey indicated that there were 31 patients on the corneal wait list in Saskatchewan. The team integrated these surgeries into normal operating room schedules rather than using after-hours work to enhance capacity and timing.

With the ongoing growth in the transplant arena, the program is encouraged to continually monitor the service demand and ensure that appropriate resources are available to support quality and safety.

**Priority Process: Competency**

All staff receive the necessary orientation and education to perform their specific roles. Staff receive infusion pump training. Performance appraisals and the evaluation of team effectiveness needs to be initiated.

As donation awareness increases, it will be important that the program ensures that appropriate resources are in place to manage the demand.

**Priority Process: Episode of Care**

Clients and families are encouraged to be involved in the plan of care. Clients and families are aware of their rights and responsibilities. Diagnostic and Laboratory services are readily available. The team has access to operative and inpatient services.

**Priority Process: Decision Support**

Processes are in place to support the privacy and confidentiality of clients and families. Clear policies are in place for disclosing health information for secondary use. Staff are aware of these policies and follow them. Health Canada Regulations are adhered to.

The teams are currently working with an outdated electronic documentation system as well as a paper chart. Working with two charting processes can impact continuity of care and quality and safety. The program is encouraged to explore a solution for one patient record.

**Priority Process: Impact on Outcomes**

The Saskatchewan Transplant Program is encouraged to develop and implement a formal process to obtain client and family input and feedback on the quality of services to inform quality improvement initiatives. Indicators need to be identified and a baseline established.

The program is encouraged to develop a formalized quality improvement program including the appropriate resources to support indicator development and reporting and quality improvement initiatives.

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

| Unmet Criteria | | High Priority Criteria |
|---|---|---|
| **Priority Process: Living Organ Donation** | | |
| The organization has met all criteria for this priority process. | | |
| **Priority Process: Clinical Leadership** | | |
| 2.6 | The effectiveness of resources, space, and staffing is evaluated with input from clients and families, the team, and stakeholders. | |
| **Priority Process: Competency** | | |
| 4.17 | Team member performance is regularly evaluated and documented in an objective, interactive, and constructive way. | ! |
| 4.18 | Living donation team members demonstrate their competence as a part of their performance evaluation.<br>CSA Reference: Z900.1-03, 4.2. | |
| 4.20 | Team members are supported by team leaders to follow up on issues and opportunities for growth identified through performance evaluations. | ! |
| 5.5 | The effectiveness of team collaboration and functioning is evaluated and opportunities for improvement are identified. | |
| **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** | | |
| 22.1 | 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. | |
| 22.2 | The information and feedback gathered is used to identify opportunities for quality improvement initiatives and set priorities, with input from clients and families. | |

| | | |
|---|---|---|
| 22.4 | Indicator(s) that monitor progress for each quality improvement objective are identified, with input from clients and families. | |
| 22.5 | Quality improvement activities are designed and tested to meet objectives. | ! |
| 22.6 | New or existing indicator data are used to establish a baseline for each indicator. | |
| 22.7 | There is a process to regularly collect indicator data and track progress. | |
| 22.8 | Indicator data is regularly analyzed to determine the effectiveness of the quality improvement activities. | ! |
| 22.9 | Quality improvement activities that were shown to be effective in the testing phase are implemented broadly throughout the organization. | ! |
| 22.10 | Information about quality improvement activities, results, and learnings is shared with clients, families, teams, organization leaders, and other organizations, as appropriate. | |
| 22.11 | 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: Living Organ Donation**

The team has developed handouts and information to support the patient throughout the living donation process and the patient can access the coordinator at any time. The patient is able to withdraw at any time.

There is an extensive and detailed psychosocial assessment provided by the social worker. The primary goals of the assessment are to see whether the potential donor fulfills the criteria for providing informed consent for donation; to assess whether the potential donor's expectations of donation and transplantation appear to be realistic; to identify any psychosocial risks related to donation; to review social circumstances that may be affected by donation; and to establish the need for any educational or therapeutic interventions before donation.

Following the procurement of the kidney, the donor is followed up with by the team. Post discharge instructions and follow up are provided.

**Priority Process: Clinical Leadership**

The Living Donor Programs based out of Saskatoon and Regina are commended for their commitment to providing excellence in patient and family-centered care. This was affirmed by the patients interviewed

during the survey process. The Living Donor teams in Saskatoon and Regina demonstrate a high level of teamwork and collaboration and work well together.

The Living Donor program keeps to the following criteria:

- Donors must come forward voluntarily.
- Donors must not be under any pressure to be forced to donate.
- Donors must be in good physical and emotional health.
- Donors must be able to give informed consent for the transplant procedure.
- There is no strict upper age limit.
- At any step, a donor can decide not to move forward.

Four steps are followed in the living kidney donation process and the potential living donor is guided by the team through this process.

- Step 1: referral process, initial contact, and screening by the team
- Step 2: donor suitability testing
- Step 3: medical imaging and evaluation from the transplant team
- Step 4: pre-operative preparation and surgery

A standard operating procedure (SOP) manual is available, and all staff are orientated to the SOPs. These SOPs are reviewed and updated as required by the Canadian Standards Association (CSA). The Medical Director approves all new and revised SOPs.

**Priority Process: Competency**

Team members receive an extensive orientation as well as ongoing professional education. The team has access to an ethicist when required.

Many staff indicated that they had not received a performance appraisal. Although informal feedback is provided to staff, the program is encouraged to implement a formalized appraisal process. Staff also indicated that they were very comfortable in bringing forward any issues or concerns to their manager. The staff take great pride in the work they do and are committed to the mission of the program.

No formal team evaluation has occurred. The program is encouraged to evaluate the effectiveness of the team working in the Living Donation program.

**Priority Process: Episode of Care**

The team responds in a timely fashion to all inquiries from clients who are interested in considering being a living donor. The team provides a very detailed orientation/education session on the various steps and processes that need to be undertaken when one is considering being a living donor. They are available to respond to any questions the client may have. They are mindful of the pace that each client may need as they determine whether to consent to be worked up as a living donor. An important part of the process is

ensuring that there is no coercion from any aspect of the process. Psychological and psychiatric assessments are available and provided when indicated. Standardized assessment tools are used.

**Priority Process: Decision Support**

The appropriate consents are in place from the living donor client so that information can be shared within the team and other organizations. Each living donor receives a unique identification number. The team adheres to the various CSA standards. Client records are kept secure.

**Priority Process: Impact on Outcomes**

The Living Donation Program is vigilant in following Health Canada's Regulations with regards to the Safety of Human Cells, Tissues, and Organs for Transplantation. Quality and safety are at the forefront of all actions to support the Living Donor process. Patients have a high degree of trust and confidence in this program.

The Living Donation Program is encouraged to develop formal processes to facilitate input from clients and families to gain input and feedback into the various aspects of the program. This could include regular client and family satisfaction surveys. Currently, there is no formal process at the local program delivery level. Clients and families are formally engaged at the executive and regional level. The program is encouraged to develop and implement processes to obtain feedback from clients about their satisfaction throughout all phases of the living donation pathway.

The Living Donation program is encouraged to establish a quality improvement program in collaboration and with input from clients and families.

The Program is encouraged to develop indicators with a baseline. The team may wish to consult similar Living Donation programs across Canada to learn more about what indicators they are collecting and their baseline. The staff have acknowledged the importance of quality improvement initiatives and the engagement of clients and families.

With the current service demand, the team may need quality improvement support and expertise. The leadership is encouraged to explore strategies that would provide the program with quality improvement expertise so that quality improvement initiatives can be started and supported.

Although there are program objectives, quality improvement activities are not evident. The program is encouraged to develop quality improvement activities that support the program objectives.

## Standards Set: Rehabilitation Services - Direct Service Provision

| Unmet Criteria | | High Priority Criteria |
|---|---|---|
| **Priority Process: Clinical Leadership** | | |
| 1.4 | Services are reviewed and monitored for appropriateness, 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. | |
| 2.5 | The effectiveness of resources, space, and staffing is evaluated with input from clients and families, the team, and stakeholders. | |
| 2.7 | A universally-accessible environment is created with input from clients and families. | |
| 5.2 | Work and job design, roles and responsibilities, and assignments are determined with input from team members, and from clients and families where appropriate. | |
| **Priority Process: Competency** | | |
| 3.1 | Required training and education are defined for all team members with input from clients and families. | ! |
| 3.4 | Education and training are provided to team members on how to work respectfully and effectively with clients and families with diverse cultural backgrounds, religious beliefs, and care needs. | |
| 3.6 | Education and training are provided on the organization's ethical decision-making framework. | |
| 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.<br>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. | ROP<br>**MAJOR** |

| | | |
|---|---|---|
| | 3.8.5 The effectiveness of the approach is evaluated. Evaluation mechanisms may include:<br>• Investigating patient safety incidents related to infusion pump use<br>• Reviewing data from smart pumps<br>• Monitoring evaluations of competence<br>• Seeking feedback from clients, families, and team members. | **MINOR** |
| | 3.8.6 When evaluations of infusion pump safety indicate improvements are needed, training is improved or adjustments are made to infusion pumps. | **MINOR** |
| 3.11 | Team member performance is regularly evaluated and documented in an objective, interactive, and constructive way. | ! |
| 3.13 | Team members are supported by team leaders to follow up on issues and opportunities for growth identified through performance evaluations. | ! |
| 4.3 | Position profiles with defined roles, responsibilities, and scope of employment or practice exist for all positions. | |
| 9.8 | Access to spiritual space and care is provided to meet clients' needs. | |
| **Priority Process: Episode of Care** | | |
| 7.11 | Clients and families are provided with opportunities to be engaged in research activities that may be appropriate to their care. | |
| 8.2 | The assessment process is designed with input from clients and families. | |
| 8.5 | Medication reconciliation is conducted in partnership with clients and families to communicate accurate and complete information about medications across care transitions. | ROP |
| | 8.5.1 Upon or prior to admission, a Best Possible Medication History (BPMH) is generated and documented in partnership with clients, families, caregivers, and others, as appropriate. | **MAJOR** |
| 8.6 | 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 |
| | 8.6.1 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. | **MAJOR** |

| | | | |
|---|---|---|---|
| | 8.6.2 | Team members and volunteers are educated, and clients, families, and caregivers are provided with information to prevent falls and reduce injuries from falling. | **MAJOR** |
| | 8.6.3 | The effectiveness of fall prevention and injury reduction precautions and education/information are evaluated, and results are used to make improvements when needed. | **MINOR** |
| 9.12 | | Information relevant to the care of the client is communicated effectively during care transitions. | ROP |
| | 9.12.5 | The effectiveness of communication is evaluated and improvements are made based on feedback received. Evaluation mechanisms may include:<br>• Using an audit tool (direct observation or review of client records) to measure compliance with standardized processes and the quality of information transfer<br>• Asking clients, families, and service providers if they received the information they needed<br>• Evaluating safety incidents related to information transfer (e.g., from the patient safety incident management system). | **MINOR** |
| 10.8 | | The effectiveness of transitions is evaluated and the information is used to improve transition planning, with input from clients and families. | |
| **Priority Process: Decision Support** | | | |
| | | The organization has met all criteria for this priority process. | |
| **Priority Process: Impact on Outcomes** | | | |
| 15.4 | | Indicator(s) that monitor progress for each quality improvement objective are identified, with input from clients and families. | |
| 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** | | | |

The rehabilitation program is provided at sites throughout the Saskatchewan Health Authority (SHA). Rehabilitation services were assessed in Moose Jaw, Regina, Saskatoon, and Yorkton. The COVID-19 pandemic provided increased opportunities to use virtual care to extend the reach of the program

throughout the province. The rehabilitation teams work in collaboration across the sites to support clients and families. There is a strong commitment to developing and maintaining partnerships including the University of Regina, University of Saskatoon, the SHA, and community organizations and groups. At some rehabilitation programs, information on the services provided is not available to clients and families, partner organizations, or the community. The organization is encouraged to use media such as a brochure or social media to communicate the scope of rehabilitation services. Additionally, they are encouraged to seek the input of clients and families in the development and evaluation of this information.

There are strong and engaged leaders, team members, and physicians supporting quality rehabilitation services. They have a deep commitment and passion for this important work. There are strong trans-disciplinary teams with a commitment to people-centered care. The leaders are visible and supportive of team members, patients, clients, and families. The team members noted that they have access to the required resources to do their work. However, the input of clients and families is not always obtained regarding the effectiveness of resources, space, and staffing. The leaders are encouraged to seek the input from clients and families into these important processes as they can provide unique insights.

Monitoring and evaluating of the rehabilitation program, under the lens of safety and quality improvement, is a priority for the team. However, the feedback and input from clients and families is not always obtained. This information is essential to assist the team in examining what services are being offered and used by clients and to identify areas for improvement. The leaders are encouraged to continue to monitor and evaluate the rehabilitation program with the input of clients and families.

There are infrastructure challenges at some sites including small rooms, shared bathrooms, and narrow doorways and hallways. The lack of storage space means that clutter and equipment must be stored in the hallways. The organization is encouraged to review the infrastructure needs for the rehabilitation program in keeping with infection prevention and control, people-centered care, patient safety, and further growth.

**Priority Process: Competency**

The rehabilitation program is provided by a strong and committed trans-disciplinary team. The team has been described as an “excellent team” and “working well together.” They are proud to work in the rehabilitation program and it was viewed as a “great place to work.” The team members and physicians have described the value of working as a collaborative team and respecting the contributions of all members. The rehabilitation team actively engages clients and their families in the development of treatment plans. The clinical and family conferences are inclusive, goal-oriented, and person-centered. The leaders, physicians, and team members are committed to providing quality and safe services for clients and families. An orientation is provided to all new team members, and they felt this prepared them to work in the rehabilitation program. The team members stated that they felt safe at work. The COVID-19 pandemic was a challenging time for the rehabilitation team. They were very proud of their ability to respond to the needs of clients and families including the use of virtual care. Some programs involved clients and families as partners in the reestablishment of the rehabilitation program. Leaders, physicians, and team members are engaged in COVID-19 recovery.

Education and training opportunities are available for team members with required training and education defined for all team members. However, at several sites the input from clients and families at the local level was not obtained. The organization is encouraged to obtain the input from clients and families on required training and education for team members. This may include, through advisory committees or groups, formal surveys, focus groups, or informal day-to-day feedback. Additionally, education and training on how to work respectfully and effectively with clients and families with diverse cultural backgrounds, religious beliefs, and care needs is not provided to team members and leaders at all sites. The leaders are encouraged to ensure that such education and training is provided to team members. Furthermore, education and training are not provided to all team members on the organization's ethical decision-making framework. The leaders are encouraged to provide training and support for team members to address ethical issues.

The team members performance is not regularly evaluated at all rehabilitation services. The leaders are encouraged to continue the plan to complete team members performance reviews. Since this is not done in a timely way, team members are not supported by leaders to follow up on issues and opportunities for growth identified through performance evaluations.

Infusion pumps are used at many of the rehabilitation sites. However, infusion pump training has not consistently been documented at several sites. The leaders are encouraged to ensure 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.

**Priority Process: Episode of Care**

There is a comprehensive array of rehabilitation services provided by the Saskatchewan Health Authority and affiliates. This includes inpatient and outpatient rehabilitation services based in Moose Jaw, Regina, and Saskatoon, with an inpatient program provided in Yorkton.

The team members, physicians, and leaders are commended for their strong commitment to quality and safety. Engaged trans-disciplinary teams support the rehabilitation program across the various sites. The team members vary across teams but may include social workers, nurses, occupational therapists, physical therapists, recreation coordinators, rehabilitation assistants, speech language pathologists, dieticians, physiatrists, and physicians. The trans-disciplinary teams provide excellent clinical and family conferences with very positive feedback from clients and families. A client described their care team as, “Super kind and empathetic. They understand what I am going through, even if I don’t yet completely understand all of the implications of my injury yet myself. It’s a great program.” The team members stated that they have the resources to do their work. However, there were suggestions to improve human resources such as a physician/leader dyad and the addition of mental health and addiction professionals, social workers, and more physicians, to name a few. There is opportunity to enhance the cultural competence and safety education and training for team members. Additionally, the embedding of cultural competence, diversity, and inclusion in the rehab program with the input of clients and families is encouraged.

The criteria for admission to the rehabilitation service is identified. A client described her admission process as “easy” and “better than I expected.” No shows and cancelations are monitored. There is opportunity to address urgent admissions. At some sites, the effectiveness of transitions is not evaluated, and so the information cannot be used to improve transition planning. Some processes to evaluate transitions include developing an audit toot, adding questions to a client satisfaction survey, or creating a focus group. The leaders are encouraged to implement a process to evaluate transitions.

The clients and families spoke highly of the care provided by team members and physicians. They described being treated with care, dignity, and respect. The clients noted that they felt comfortable asking questions and felt like a partner in care. Clients and families report a high level of satisfaction with the care provided by rehabilitation services. A client described the benefit of the rehab services as “making me well” to describe how important the program philosophy was in meeting their needs. Another client stated “It is a wonderful place. The staff are excellent.” The leaders are encouraged to continue to co-design programs and services with the input of clients and families.

There is a commitment to auditing and acting on the results at most sites, but the team members and leaders are encouraged to develop more robust auditing processes to help inform quality improvement and safety initiatives. Medication reconciliation is implemented. However, the medication reconciliation is not always completed at admission (when a client is transferred from an acute care hospital). The leaders are encouraged to ensure that all medication reconciliation processes are implemented.

Fall risk assessments are conducted at most sites upon admission. The team members are encouraged to ensure that universal fall precautions are identified, implemented, and evaluated to ensure a safe environment that prevents falls and reduces the risk of injuries from falling.

**Priority Process: Decision Support**

There is a strong commitment by the leaders, physicians, and team members to use decision support to enable quality care. The team has access to evidence-based guidelines. Comprehensive and 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. Hybrid charting (paper and electronic) is used in the rehabilitation program. The leaders are encouraged to continue the plan for the implementation of an electronic health record. Prior to this development, the leaders are encouraged to review and evaluate the current paper-based charts and to make improvements accordingly.

**Priority Process: Impact on Outcomes**

There is a strong commitment to staff and client safety. The team members reported feeling safe at work. They noted that they have the appropriate personal protective equipment to support their safety. There are hand hygiene products for team members, clients, and families. Hand hygiene audits are completed, and the results are posted. The initiatives to support quality and safety vary across the program areas. Examples of initiatives include safety huddles, post fall huddles, auditing, family conferences, white

boards, bed side shift reports, quality boards, and interdisciplinary rounds. There is opportunity to standardize best practices in safety and quality across the rehabilitation program. For example, best practices in end-of-shift reporting can be spread across sites with the processes standardized.

There is a strong commitment to best practices, research, and evidence informed decision making. There are many initiatives being implemented across the rehabilitation program including the stroke rehab pathway and speech language pathology review, to name just a few. However, quality initiatives have been impacted by the COVID-19 pandemic due to service and program restrictions. Therefore, at several sites, information about quality improvement activities, results, and learnings were not shared with clients, families, teams, organization leaders, and other organizations. There are plans to re-establish quality initiatives and involving clients and families. The organization is encouraged to continue with this important work. Additionally, there is opportunity to cascade quality improvement initiatives and priorities to frontline staff and managers.

# 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 fourth on-site Accreditation Survey, the third on-site survey to have taken place during the COVID-19 pandemic.

We are proud of the our teams for prioritizing accreditation during this challenging time. The Saskatchewan Health Authority is using the results of this survey to advance standardization in several areas.

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 |