ACCREDITATION
AGRÉMENT
CANADA

Accreditation Report

Qmentum Global™ Program

Saskatchewan Health Authority

Report Issued: December 8, 2023

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About Accreditation Canada

Accreditation Canada (AC) is a global, not-for-profit organization with a vision of safer care and a healthier world. Together with our affiliate, Health Standards Organization (HSO), our people-centred programs and services have been setting the bar for quality across the health ecosystem for more than 60 years, and we continue to grow in our reach and impact. HSO develops standards, assessment programs and quality improvement solutions that have been adopted in over 12,000 locations across five continents. It is the only Standards Development Organization dedicated to health and social services. AC empowers and enables organizations to meet national and global standards with innovative programs that are customized to local needs. Our assessment programs and services support the delivery of safe, high-quality care across the health ecosystem.

About the Accreditation Report

The Organization identified in this Accreditation Report is participating in Accreditation Canada's Qmentum Global™ accreditation program.

As part of this ongoing process of quality improvement, the organization participated in continuous quality improvement activities and assessments, including an on-site survey from 05/11/2023 to 10/11/2023.

Information from the cycle assessments, as well as other data obtained from the Organization, was used to produce this Report. Accreditation Canada is reliant on the correctness and accuracy of the information provided by the Organization to plan and conduct the on-site assessment and produce this Report. It is the Organization's responsibility to promptly disclose any and all incidents to Accreditation Canada that could impact its accreditation decision for the Organization.

Confidentiality

Executive Summary

About the Organization

The Saskatchewan Health Authority (SHA) was established on December 4, 2017, with the amalgamation of 12 Regional Health Authorities. It is a single health authority responsible for the delivery of health services in the province of Saskatchewan. The SHA provides provincially coordinated quality patient centred services such as Acute hospital-based care, Long Term Care, Mental Health and Addiction Services, Primary Health Care, Public Health, and many other community-based clinical programs designed to promote and maintain the health of the population.

The SHA is guided by their vision “Healthy People, Healthy Saskatchewan”, their mission “We work together to improve health and wellbeing. Every day. For everyone”, and the values of safety, accountability, respect, collaboration, and compassion. The philosophy of care where Patient and Family Centred Care is at the heart of everything the SHA does, serves as the foundation for these values.

The SHA implemented a new organizational structure with the creation of four Integrated Service Areas (ISAs) as well as the creation of 32 Health Care Networks within the ISAs. The SHA is commended for their commitment to supporting diversity, equity, and inclusiveness. The Executive Director of First Nations and Métis Health and the Executive Director Strategy & Innovation are full members of the Executive Leadership Team.

The SHA serves 1,123,505 people. It is comprised of around 45,647 employees, 2761 physicians with SHA privileges and 25,000 volunteers. The SHA oversees 63 hospitals, 2833 acute care patient beds, 156 Long-Term Care Homes, 9000 Long-Term Beds and 133 Health Centres.

The SHA completed five surveys between 2019 -2023 and is now commencing the first phase of the new four-year Accreditation Cycle.

The first survey visit in the SHA’s second sequential accreditation cycle included Maternal and Children’s Provincial Programs and SHA Leadership.

Each of the surveys will see a combination of provincial-level leadership assessment with standards assessed at the program-level across one Integrated Service Area at a time. System wide standards, including Infection Prevention and Control, Medication Management and Population Health will be assessed every survey.

This approach ensures a continuation of provincial standardization while focusing on supporting Health Network development within each Service Area.

The following Accreditation Objectives will guide this approach over the next four years:

- Aligning Accreditation with the SHA Management System.
- Advancing People-Centered Care.
- Using accreditation data to drive local and system improvement.

The SHA’s goals for the first onsite survey included the following:

- Prioritize areas for provincial standardization.
- What is working well and celebrate innovation and excellence to identify where the good work is happening.
- Advance a culture of accreditation ready.

Surveyor Overview of Team Observations

General Observations:

The SHA is congratulated on finalizing their executive leadership team and the recruitment of new leaders throughout the organization who are excited and committed to support the SHA mission, vision, and values. The inclusion of the Executive Director of First Nations and Métis Health on the Executive Leadership Team as well as the engagement of Traditional Knowledge Keepers and First Nations and Métis Partners in planning and service delivery is commendable and was evident throughout the onsite visit. Frontline staff are more engaged and the socializing of the SHA being accreditation ready is permeating throughout the organization.

The Community Partners interviewed during the survey process represented a broad constituency of SHA partners. All partners appreciated the opportunity to be invited to share their respective perspectives about the SHA and the relationships they have with the organization. The SHA is encouraged to continue to engage partners in visioning work and consultation whether this be with hospital foundations, communities, or Métis Nation Saskatchewan. The SHA CEO has worked to build these relationships.

The SHA is encouraged to explore collaborations with rural and urban municipalities, and to have discussions about the social determinants of health and the challenges facing these communities. Collaboration with the Saskatchewan Cancer Agency (SCA) is positive. The SHA is open in working together with the SCA to implement new programs such as CAR T-cell and the sustainability of the Community Oncology Program which is hosted by the SHA and delivered in locations across Saskatchewan.

Given the health human resource challenges, some SHA staff members are concerned that they may be in contravention with the registering colleges regarding their ability to meet the required competencies and practices. Enrollments are increasing in health provider colleges and programs, and with the rise in the recruitment of international health care providers such as nurses; consideration will be needed to support how clinical practicums and placements will be accommodated.

With the amount of change and demands on leaders, the SHA is encouraged to support a work life balance for these individuals. The SHA is also encouraged to continue investing in education and awareness regarding what it means to co-design with patients and families.

Although the SHA continues to mature as a single health authority which includes the need to standardize policies and procedures as well as address health human resource challenges, there is a sense of stability across the organization. The SHA is encouraged to continue their journey of being a learning organization committed to diversity, equity, and inclusion.

Key Opportunities and Areas of Excellence

Strengths

- There is a strong safety culture
- Formal structures for Patient & Family Partnership are in place
- Hired first specialist for environmental stewardship
- Commitment to Truth and Reconciliation
- Clients and families appreciate care closer to home
- Dedicated and committed team members, leaders and physicians
- Patient flow and capacity processes
- Major capital projects are proceeding

Opportunities

- Completion of performance reviews
- Aging Infrastructure
- Quality Improvement not advancing at a rate that would be expected
- Provincial electronic record
- More timely/available decision support tools for managers
- Developmental support for new leaders
- Accelerate standardization of policies and procedures
- Continue to embed Patient and Family partnership at the unit level
- Continue to enhance diversity, equity and inclusion
- Planning for current and future growth
- Continue to enhance staff and patient security mechanisms

Program Overview

The Qmentum Global™ program was derived from an intensive cross-country co-design process, involving over 700 healthcare and social services providers, patients and family members, policy makers, surveyors, clinical, subject matters experts, Health Standards Organization and Accreditation Canada. The program is an embodiment of People Powered Health™ that guides and supports the organization's continuous quality improvement journey to deliver safe, high-quality, and reliable care.

Key features of this program include new and revised evidence based, and outcomes focused assessment standards, which form the foundation of the organization's quality improvement journey; new assessment methods, and a new digital platform OnboardQi to support the organization's assessment activities.

The organization will action the new Qmentum Global™ program through the four-year accreditation cycle the organization is familiar with.

To promote alignment with our standards, assessments results have been organized by core and specific service standards within this report. Additional report contents include, the comprehensive executive summary, the organization's accreditation decision, locations assessed during the on-site assessment, required organizational practices results and conclusively a Quality Improvement Overview.

Accreditation Decision

Saskatchewan Health Authority's accreditation decision continues to be:

Accredited

The organization has met the fundamental requirements of the accreditation program.

Locations Assessed in Accreditation Cycle

The following table provides a summary of locations[1] assessed during the organization's on-site assessment.

Table 1: Locations Assessed During On-Site Assessment

Site	On-Site
Al Ritchie Health Action Centre	☑
Ellis Hall	☑
Idylwyld Centre	☑
Jim Pattison Children's Hospital	☑
Kinsmen Children's Centre - Alvin Buckwold Child Development Program	☑
Regina General Hospital	☑
Saskatoon City Hospital	☑
Victoria Hospital	☑
Wascana Rehab Centre - Children's Programs	☑
West Winds Primary Health Care Clinic	☑

[1]Location sampling was applied to multi-site single-service and multi-location multi-service organizations.

Required Organizational Practices

ROPs contain multiple criteria, which are called Tests for Compliance (TFC). ADC guidelines require 80% and above of ROP's TFC to be met.

Table 2: Summary of the Organization's ROPs

ROP Name	Standard(s)	# TFC Rating Met	% TFC Met
Medication Reconciliation at Care Transitions - Ambulatory Care Services	Ambulatory Care Services	5 / 5	100.0%
	Cancer Care	5 / 5	100.0%
Client Identification	Ambulatory Care Services	1 / 1	100.0%
	Cancer Care	1 / 1	100.0%
	Critical Care Services	1 / 1	100.0%
	Emergency Department	1 / 1	100.0%
	Home Care Services	1 / 1	100.0%
	Inpatient Services	1 / 1	100.0%
	Obstetrics Services	1 / 1	100.0%
	Perioperative Services and Invasive Procedures	1 / 1	100.0%
	Rehabilitation Services	1 / 1	100.0%

Table 2: Summary of the Organization's ROPs

ROP Name	Standard(s)	# TFC Rating Met	% TFC Met
Information Transfer at Care Transitions	Ambulatory Care Services	4 / 5	80.0%
	Cancer Care	3 / 5	60.0%
	Critical Care Services	5 / 5	100.0%
	Emergency Department	4 / 5	80.0%
	Home Care Services	4 / 5	80.0%
	Inpatient Services	4 / 5	80.0%
	Intellectual and Developmental Disabilities Services	5 / 5	100.0%
	Obstetrics Services	5 / 5	100.0%
	Perioperative Services and Invasive Procedures	5 / 5	100.0%
	Rehabilitation Services	5 / 5	100.0%

Table 2: Summary of the Organization's ROPs

ROP Name	Standard(s)	# TFC Rating Met	% TFC Met
Medication Reconciliation at Care Transitions Acute Care Services (Inpatient)	Cancer Care	4 / 4	100.0%
	Critical Care Services	4 / 4	100.0%
	Inpatient Services	4 / 4	100.0%
	Obstetrics Services	4 / 4	100.0%
	Perioperative Services and Invasive Procedures	3 / 4	75.0%
	Rehabilitation Services	4 / 4	100.0%
Falls Prevention and Injury Reduction - Inpatient Services	Cancer Care	3 / 3	100.0%
	Critical Care Services	3 / 3	100.0%
	Inpatient Services	2 / 3	66.7%
	Obstetrics Services	3 / 3	100.0%
	Perioperative Services and Invasive Procedures	3 / 3	100.0%
	Rehabilitation Services	3 / 3	100.0%

Table 2: Summary of the Organization's ROPs

ROP Name	Standard(s)	# TFC Rating Met	% TFC Met
Venous Thromboembolism (VTE) Prophylaxis	Cancer Care	0 / 0	0.0%
	Critical Care Services	0 / 0	0.0%
	Inpatient Services	0 / 0	0.0%
	Perioperative Services and Invasive Procedures	3 / 4	75.0%
Pressure Ulcer Prevention	Cancer Care	0 / 0	0.0%
	Critical Care Services	5 / 5	100.0%
	Inpatient Services	1 / 5	20.0%
	Perioperative Services and Invasive Procedures	5 / 5	100.0%
	Rehabilitation Services	5 / 5	100.0%
Medication Reconciliation at Care Transitions - Emergency Department	Emergency Department	1 / 1	100.0%
Suicide Prevention	Emergency Department	5 / 5	100.0%
Home Safety Risk Assessment	Home Care Services	5 / 5	100.0%
Medication Reconciliation at Care Transitions - Home and Community Care Services	Home Care Services	2 / 4	50.0%
Skin and Wound Care	Home Care Services	7 / 8	87.5%

Table 2: Summary of the Organization's ROPs

ROP Name	Standard(s)	# TFC Rating Met	% TFC Met
Hand-hygiene Education and Training	Infection Prevention and Control	1 / 1	100.0%
Hand-hygiene Compliance	Infection Prevention and Control	1 / 3	33.3%
Reprocessing	Infection Prevention and Control	2 / 2	100.0%
Infection Rates	Infection Prevention and Control	3 / 3	100.0%
Client Flow	Leadership	5 / 5	100.0%
Workplace Violence Prevention	Leadership	8 / 8	100.0%
Medication Reconciliation as a Strategic Priority	Leadership	5 / 5	100.0%
Patient Safety Education and Training	Leadership	1 / 1	100.0%
Patient Safety Incident Disclosure	Leadership	3 / 6	50.0%
Patient Safety Incident Management	Leadership	7 / 7	100.0%
Preventive Maintenance Program	Leadership	4 / 4	100.0%
Antimicrobial Stewardship	Medication Management	0 / 5	0.0%
High-alert Medications	Medication Management	8 / 8	100.0%
Heparin Safety	Medication Management	4 / 4	100.0%

Table 2: Summary of the Organization's ROPs

ROP Name	Standard(s)	# TFC Rating Met	% TFC Met
Narcotics Safety	Medication Management	3 / 3	100.0%
Concentrated Electrolytes	Medication Management	3 / 3	100.0%
The 'Do Not Use' List of Abbreviations	Medication Management	7 / 7	100.0%
Safe Surgery Checklist	Obstetrics Services	2 / 5	40.0%
	Perioperative Services and Invasive Procedures	2 / 5	40.0%
Infusion Pump Safety	Service Excellence for Ambulatory Care Services	4 / 6	66.7%
	Service Excellence for Cancer Care	5 / 5	100.0%
	Service Excellence for Critical Care Services	6 / 6	100.0%
	Service Excellence for Emergency Department	6 / 6	100.0%
	Service Excellence for Home Care Services	6 / 6	100.0%
	Service Excellence for Inpatient Services	6 / 6	100.0%
	Service Excellence for Obstetrics	6 / 6	100.0%
	Service Excellence for Perioperative Services and Invasive Procedures	6 / 6	100.0%
	Service Excellence for Rehabilitation Services	0 / 0	0.0%

Assessment Results by Standard

Core Standards

The Qmentum Global™ program has a set of core assessment standards that are foundational to the program and are required for the organization undergoing accreditation. The core assessment standards are critical given the foundational functions they cover in achieving safe and quality care and services. The core standards are always part of the assessment, except in specific circumstances where they are not applicable.

Infection Prevention and Control

Standard Rating: 93.0% Met Criteria

7.0% of criteria were unmet. For further details please review the table at the end of this section.

Assessment Results

Infection Prevention and Control (IPAC) was assessed at the Jim Pattison Children's Hospital (JPCH). The IPAC team consists of 2.5 full-time equivalent (FTE) Infection Control Practitioners and a physician. The culture of collaboration and teamwork was palpable among the team and within the organization. This team is supported by a provincial IPAC Committee. Patient and family engagement with this committee has been strong. Quality improvement activities have included a Family Presence Framework based on outbreak levels. This framework was developed by patients and families was brought forward for organizational approval and implementation.

The team is well trained and follow provincial and national standards for surveillance and IPAC activity. The team shares this expertise broadly by training and supporting clinicians and support staff across the hospital. There are weekly IPAC huddles with the facilities team at the Royal University Hospital where there are frequent renovations and remediation required.

The organization has recently implemented a new "Clean Hands" software. This software appears to be quite robust however, it has not been fully adopted across the JPCH at this time, leaving gaps in hand hygiene surveillance.

The Environmental Services team is well trained in best practices as it relates to cleaning. Staff recognize and respond appropriately to precautions. Cleaning audits are completed on a routine basis and include visual inspection in addition to the use of black light checks.

The team tracks Hospital Acquired Infections closely, seeking to identify the source of infections and implement measures to prevent and contain. A recent initiative to conduct Outbreak Prevention Roadshows using Smartsheet functionality should be spread and scaled as the team looks to get back to preventative approach to infection safety.

There is a continued strong desire to accelerate standardization of IPAC guidelines, training materials, and communications. Significant work must continue and ideally accelerate to review and consolidate approximately 500 of the 600+ former regional health authority policies and procedures.

Table 3: Unmet Criteria for Infection Prevention and Control

Criteria Number	Criteria Text	Criteria Type
2.4.5	Policies, procedures, and legal requirements are followed when handling bio-hazardous materials.	HIGH
2.4.6	There are policies and procedures for disposing of sharps at the point of use in appropriate puncture-, spill-, and tamper-resistant sharps containers.	HIGH
2.5.6	Hand-hygiene Compliance 2.5.6.2 Hand-hygiene compliance results are shared with team members and volunteers. 2.5.6.1 Compliance with accepted hand-hygiene practices is measured using direct observation (audit). For organizations that provide services in clients' homes, a combination of two or more alternative methods may be used, for example: • Team members recording their own compliance with accepted hand-hygiene practices (self-audit). • Measuring product use. • Questions on client satisfaction surveys that ask about team members' hand-hygiene compliance. • Measuring the quality of hand-hygiene techniques (e.g., through the use of ultraviolet gels or lotions).	ROP

Leadership

Standard Rating: 92.0% Met Criteria

8.0% of criteria were unmet. For further details please review the table at the end of this section.

Assessment Results

Human Capital

The SHA is supported by a dynamic, knowledge-based, and energetic team that leads and supports the Human Resource functions across the organization. The SHA has developed a 2022-2026 Health Human Resources Operational Plan to address the Government of Saskatchewan's Health Human Resources Action Plan. The SHA plan is focused on three goals that include stabilizing and enhancing critical services, strengthening a commitment to provide care closer to home and creating a representative, diverse, inclusive, and culturally responsive workforce.

The Human Resource team is continuously exploring, evaluating, and implementing innovative approaches to support staff retention, recruitment, staff safety and wellbeing. Key functions of this team include understanding and monitoring workforce trends within the organization, developing and implementing professional development and learning opportunities, creating a culture of staff safety by developing a comprehensive suite of policies and procedures including a workplace violence policy and procedure, supporting staff wellbeing and facilitating staff engagement, and engaging with First Nations and Métis to develop and implement strategies for recruiting and retaining First Nations and Métis employees.

The team has implemented strategies and processes to support and embed a culture of diversity, equity, and inclusiveness. The team needs to ensure that they continue to monitor and sustain this organizational commitment.

The team has excellent processes in place for the credentialing of new physicians. The team is commended for including patients and families in the development of the Health Human Resources plan, embedding patients and families as voting members in the Medical Affairs Division, assisting in the development of the workplace violence prevention policy as well as being involved in the interviews to hire into positions. The team is encouraged to engage clients and families in policy and procedure development as it relates to occupational health and safety.

The team is commended on implementing a Business Partnership model to support front line managers. To date, the SHA has been able to implement this across half of the organization. Managers have expressed this model has liberated them to be able to focus more on the clinical aspects of managing their areas and where the Business Partner has been able to assume most of the human resource transactions. The SHA is encouraged to fully complete the implementation of the Business Partner model.

The Human Resource team has identified key performance indicators that they are regularly monitoring and using this information to make improvements and changes to approaches when warranted. The SHA conducted the SCORE Culture of Safety Survey in April 2023 with 16488 Respondents or 47% response rate. The survey measures important dimension of organizational culture. Based on the results, units and departments will be developing action plans. The SHA is commended for engaging staff in the development of these action plans and encouraged to follow through on ensuring the action plans are developed and monitored.

The team is also encouraged to continue working on succession planning and improve performance

appraisal completions throughout the organization. The SHA will be implementing a 360-performance review process starting with the CEO. The organization has plans to cascade this approach throughout the organization and is encouraged to follow through on these initiatives.

Communication

The SHA Community Engagement and Communications Team (CEC) is comprised of four specialty units: Community and Stakeholder Engagement, Media Relations and Public Affairs, Communications Services, and Online Strategy and Creative Services. This small but mighty team utilizes qualitative and quantitative data to support quality improvement within their division. An excellent example is the 1500 individuals who participated in a recent survey on internal communications. The team uses several approaches to support communication and engagement internally and externally. Internal strategies include specific newsletters for staff and leaders, daily cascading messages for team huddles, self-serve tools and key internal distribution lists. External strategies include the annual report using stories to highlights many accomplishments, consolidation of the former health region websites into the one SHA public website, using corporate social media channels, media releases, stakeholder engagement sessions and health campaigns. The CEC Team is to be commended for replacing 47 former regional policies and procedures into a single Corporate Communications Policy, as well as developing a standardized approach to communicate service disruptions, province wide. In the spirit of the SHA's commitment to providing a culture of diversity, equity, and inclusiveness, it is suggested that the CEC team ensures that the visual and written language used is appropriate for the intended audience. With the SHA's commitment to diversity, equity and inclusion, the organization is encouraged to ensure that language used is also gender inclusive.

The SHA has put in place sound processes and policies to ensure the privacy and confidentiality of client's health information. All staff must undertake privacy training every three years. A privacy training program for physicians has recently launched and where approximately 700 physicians have completed the training. Robust auditing functions are in place. The team collaborates with eHealth to provide cybersecurity training, to mature the SHA's cybersecurity posture and ensure systems are up to date. The team recently released the Access and Disclosure Operating Manual. Patients and families participate in the Release of Information working group. The SHA is challenged with having to work within multiple clinical information systems that causes fragmentation. They have recognized the need for and importance of having one clinical information system and how this is important for the delivery of seamless care across the continuum as well as fostering innovation, quality improvement and health outcomes.

The team is commended on the development of the video "Welcoming Clients into the SHA" to improve the customer experience at registration. The team also monitors transcription turnaround times including achieving 2-hour stat requests 75% of the time. The team has developed processes to facilitate timely response to patient and external requests for health records information.

Principle Based Decision Making

The SHA is commended for the development of an ethics framework that clearly defines the processes to manage ethical issues across the organization. The SHA has a Provincial Ethics Committee (PEC) as well as 13 Ethics Committees throughout the province comprising of 160 members. These committees which include representatives from patients, families, staff, and physicians contributed to the development of the Ethics framework. The IDEA ethical decision-making guide is utilized and works for anyone who needs to make a decision. The team provides ethics consultations for health care providers, leaders, patients, and families. The Ethics team continues to support ongoing education such as the Monthly Ethics Exchanges. The team has a desire to have an online mandatory staff education module that would include the introduction to the Ethics Framework and the IDEA decision- making guide.

During the survey it was identified that there is still an opportunity to provide education on ethics to staff so an online mandatory approach may be strategy for the SHA to consider. As part of the Ethics team quality journey, they have conducted a Local Ethics Committee (LEC) Experience Survey. They will use

this information to look for improvement opportunities for the LEC. The team is currently undertaking an ethics needs assessment with the goal of evaluating the ethics services used by service providers.

Through the SHA planning processes the team is in the process of developing a 5-year plan. The PEC provides guidance by reviewing policies and new initiatives supporting LEC's, informing the identification and presentation of systemic issues to leadership and supporting the SHA Board. The Ethics team has identified that early involvement of an Ethicist in policy development and new initiatives would be welcomed rather than having the ethics review as one of the final steps. This may streamline the process and assist in building ethics capacity at the Senior and Executive Leadership level. The SHA is encouraged to use the Ethics Checklist that the Ethics team has developed and for which the SHA Board uses as part of their decision-making process.

Planning and Service Design

It is evident that the SHA's mission, vision and values are foundational to all the work they undertake and woven in the fabric of the organization. The Board recently reviewed the mission, vision, and values. Once this was completed the organization communicated the reaffirmed mission, vision, and values across the SHA, with no changes made. It is suggested that the next time the vision, mission and values is being reviewed, the SHA consider engaging clients, families, staff, and community partners to gather their feedback and input prior to the Board's final review.

The SHA is congratulated for developing and implementing a robust planning framework that identifies key elements to support the plan development and operationalization of the 2023-2028 strategic plan. Patient and family partners are engaged in the process. The voice of the patient as captured through patient reported experience measures such as the Better Together Experience Survey, the Long-Term Care Experience Survey, and the Concern Handling Data has informed the planning process. The goal is to plan, develop and implement infrastructures, programs, and services that meet the needs of the populations and communities served by the SHA ensuring alignment with the SHA's roadmap and vision. The 2023 -2024 SHA Roadmap Goals are: investing in our most valuable resource – Our People; responsive Mental Health and Addictions Services; provide seamless care as close to home as possible; and enhance patient care through better flow of information and renewed facility infrastructure.

The framework has been developed so that leaders can see how they can contribute to the SHA roadmap and at the same time they can also identify their burning platforms. Tools and resources have been developed to support leaders and to make their plans and actions visible. Key performance indicators have been developed that are monitored and reported to the SHA Board of Directors.

The SHA conducted extensive community engagement as well as an eSCAN to inform the planning and priority process. The team is congratulated for the maturing and use of the Health Networks to understand the demographics, trends, inequities, and population needs. Due to the robust engagement framework and teams in place, approximately 500 people were reached through the Health Networks consultation process. The team is planning to conduct a Health Network Survey and pilot in four of the Health Networks.

It was recognized that the SHA is still operating under several policies and procedures from the legacy organizations some of which have not been updated since 2004. The SHA is encouraged to implement processes for the timely review and development of SHA policies and procedures that are current to support its primary functions, operations, and systems and to remove and repeal policies and procedures from the previous regional health authorities.

The SHA continues to work with multiple clinical information systems presenting challenges. The organization has recognized the benefits from a quality and safety perspective of the importance of one unified health information system. The SHA is supported in their efforts to move this forward.

Client Flow

One of the strengths of the SHA is its province-wide flow strategy. The “North Star” aims to have patients receive the care they want when and where they need it. The strategy is led by an executive director and a physician lead of Provincial System Flow. They are currently undergoing a review to optimize the system flow portfolio structure and processes.

A number of strategies have already been implemented such as the development of a Bed Capacity Dashboard. This dashboard provides leadership with a real time look at where there may be bed capacity in the province. Daily huddles and emails assist in managing movement within the system. The Bed Management Software (Altera Patient Flow) has been implemented. However, one of the challenges for the team is that the province continues to use legacy systems that do not all integrate. The team is working towards all of SHA using one integrated system. In the meantime, the team does its best with the systems currently in place. Additionally, the team has implemented Patient Flow Algorithms which are currently in paper binders. The next step would be to digitalize these algorithms.

The Executive Director provides monthly updates to the Executive Leadership Team (ELT) in the form of “Wall Walks.” The “Walls” are updated with the latest data and reviewed. Barriers and progress are escalated to the Chief Operating Officer. One of the recent areas of focus has been work focusing on Alternate Level of Care (ALC) patients, which has reduced to 14% by the work of the team and hospital staff/clients and families.

The team is in the process of implementing a Real Time Demand and Capacity (RTDC) process. In this process the discharge planning begins immediately at the time of admission. The discharge date is predicted based on a number of criteria and multidisciplinary huddles, which include patient/families. Currently, the RTDC is live in Saskatoon, Regina, Moose Jaw, and Prince Albert. The plan is to have the rest of the regional hospitals participating by March 2024. The team will then perform audits to monitor their performance and evaluate the strategy.

Another tool implemented by the team is an Overcapacity Protocol. This protocol highlights triggers and associated actions based on capacity risk factors at each of the acute care sites. The stop light methodology is used with green indicating low safety risk due to overcapacity, yellow indicating medium safety risk and red highlighting high safety risk. The team is working on Version 2.0 to be released in 2024. The team may wish to consider adding an additional column. Currently when the system is green it still assumes up to 50% of beds in the emergency department (ED) could be filled with admitted patients. However, some ED staff might consider green to be that there are no admitted patients in the ED. This model normalizes ED overcrowding. If the “low risk” category remains green with up to 50% admitted patients, the staffing model may need to be changed.

Resource Management

The SHA receives a Mandate Letter from the government that outlines the health budget and associated directions for SHA. There is an understanding that the target is a balanced budget. However, with the formation of SHA from 12 previous regional health authorities, the SHA has an accumulated (inherited) debt of $382 million. With the subsequent global pandemic and then unusually high inflationary pressures, the SHA has not been able to eliminate that debt.

The finance team is currently working with 82 legacy systems across the province. They have initiated a large project to implement an Administrative Information Management System (AIMS). Going forward with AIMS, the team will be able to standardize processes.

The SHA budget is decentralized and then rolled up centrally. The budget is presented to the board’s Audit Finance Committee and this committee presents it to the Board for approval. Once approved, it is submitted to the government for approval and funding. The finance team works closely with the government, and there is monthly reporting on the SHA budget. This provides an opportunity to highlight new pressures and unanticipated issues that might arise. The team provides training at the Vice President and Executive Director level; however, there is recognition that the middle management layer requires more support in fiscal management.

There is an in-depth planning process for Capital budgeting that begins with a three-day kick-off in August of each year. There is an on-line process for managers to submit capital projects. These projects are scrutinized using a risk management lens (including probability and timeliness) and projects are reviewed with Vice Presidents and Executive Directors.

During the pandemic, the team developed a matrix and principles to assist with reallocation of resources, including staff and services to maintain services. They also used the ethics framework as they identified what was needed most to maintain safety and decrease risk.

The team has been working on their Key Risk Indicators. Some of the monitoring is achieved through Wall Walks, reporting to the ELT and the Measurement Portfolio.

Physical Environment

The Saskatchewan Health Authority (SHA) has begun its journey towards sustainability with the hiring of a specialist who reports to the Manager of Energy & Infrastructure in Saskatoon. Green teams are being formed and sustainability initiatives are early in the implementation phase or still in planning phases. An example of a new initiative is organics diversion as well as the “78 Green Roof” project– the plan is to grow some of the vegetables used in the kitchen at RGH on the roof next year. The team has implemented Variable Frequency Drive (VFD) in the plant area. With 40% of the total energy consumption coming from this plant area, the VFD has assisted the organization to reduce their energy consumption significantly. In addition, the staff ensure that plant equipment is well maintained and kept clean to maximize operational efficiencies resulting in savings for the organization in multiple ways. The staff are to be commended for this work.

The next step for SHA is to develop written principles of sustainability that are shared broadly across the organization. The team can then develop metrics to be able to benchmark and monitor their progress towards environmental stewardship.

The facilities visited were clean and the building services team members are commended for the work they do to keep all systems operating as efficiently as possible. These teams manage large areas and systems with the patient at the center of everything they do. Currently there is an Electrical Master Planning exercise underway to assist the Regina General team in being more proactive rather than reactive. The plan is to do the same for other areas such as plumbing and sewers.

Medical Devices and Equipment

The Saskatchewan Health Authority (SHA) is in the process of tagging all their equipment and standardizing their equipment. Some of this work has been completed (e.g., SMART Pumps) and they are in the process of standardizing other equipment including beds, lifts, tubs to name a few. They are using the World Health Organization (WHO) Risk Classification Matrix.

The team was able to provide examples of preventive maintenance (PM) documentation on equipment. They meet the minimum requirements as per the vendor. As the equipment ages, the PM may be performed more frequently than is recommended by the vendor to ensure safety.

One of the things the team is most proud of is the Clinical Engineering Team, described as “small, but mighty!”. The team is passionate about what they do and understands the impacts on the front line when equipment does not perform as it should.

The team is faced with the challenge of standardizing the PM work conducted in 12 different regions into one unified system, but they are making progress. They are building a Computerized Medical Maintenance System (CMMS).

The team monitors incidents related to medical equipment and devices, particularly critical incidents, as

one of the measures of how they are doing with equipment maintenance. Whenever there is an incident reported related to medical devices and equipment, it is reviewed by the team and recommendations provided to address and prevent reoccurrence. The number of tickets for repairs and items out of service is another indicator of their overall effectiveness in their preventive maintenance.

Table 4: Unmet Criteria for Leadership

Criteria Number	Criteria Text	Criteria Type
2.3.7	The organization develops, implements, regularly reviews, and updates as needed policies, procedures, and plans for all its primary functions, operations, and systems.	NORMAL
2.3.9	The organization uses management systems and tools to implement the operational plans, and to monitor and report on the progress made towards goals and objectives.	HIGH
2.7.2	The organization develops, implements, regularly reviews, and updates as needed policies and principles to guide its environmental stewardship.	NORMAL
2.7.4	The organization uses defined performance indicators to regularly evaluate the effectiveness of its environmental stewardship initiatives, and uses the results to make improvements.	NORMAL
2.7.5	The organization regularly evaluates the impact of climate change on the organization and on the health of the community, and uses the information to adapt to and mitigate climate change.	NORMAL
2.7.6	The organization provides leaders and staff with education and training to build organizational capacity to support environmental stewardship initiatives, and adapt to and mitigate climate change.	NORMAL
3.2.3	The organization has a balanced budget, to ensure available funds are appropriately allocated to match spending.	NORMAL
3.3.1	The organization selects and implements information systems that meet its current needs and take into consideration its future needs.	NORMAL

Criteria Number	Criteria Text	Criteria Type
3.3.7	The organization implements a mechanism to match and link all parts of each individual client's health information stored in the organization's information systems to enable teams to have more complete information about the client's health.	NORMAL
3.4.1	The organization engages with clients and families to identify key characteristics and values of all positions, to embed people-centred care across the organization.	NORMAL
3.4.13	The organization provides staff with opportunities to participate in performance reviews of the organizational leaders to give the leaders a more complete assessment of their performance.	NORMAL
4.1.10	The organization engages with staff, clients, and families to define organizational health and safety related responsibilities for each position to embed organizational health and safety activities throughout the organization.	NORMAL
4.2.2	Patient Safety Incident Disclosure 4.2.2.6 Feedback is sought from clients, families, and team members about their experience with disclosure and this information is used to make improvements, when needed, to the disclosure process. 4.2.2.4 Communication occurs throughout the disclosure process with clients, families, and team members involved in the patient safety incident. Communication is documented and based on their individual needs. 4.2.2.2 The disclosure process is reviewed and updated, as necessary, with input from clients, families, and team members.	ROP

Medication Management

Standard Rating: 93.7% Met Criteria

6.3% of criteria were unmet. For further details please review the table at the end of this section.

Assessment Results

The pharmacy department at Jim Pattison Children's Hospital (JPCH) was well organized and despite being just four years old, it could benefit from additional space. The medication rooms on the clinical units are of sufficient size and are clean and well organized. The pharmacy has fully implemented unit dose and IV admixture programs. Chemotherapy will be transferred in the coming years from the provincial cancer agency.

The pharmacy team provides 24-hour on-site coverage, seven days a week, which is of tremendous benefit to patient safety. A very collegial culture is noted between clinical staff and the pharmacy. Clinical pharmacists are deployed across the building and are seen as essential members of the care team.

Drug shortages remain a pressure for pharmacy team members. Resources (2.2 FTE) are assigned to manage ongoing shortages on a daily basis. A formalized policy in support of this work would be beneficial.

Automated dispensing cabinet technology has been implemented across the hospital. The organization should consider investing in narcotic diversion software to assist in the detection of narcotic diversion.

The organization is commended for the Safety Response System that supports a response to any actual or near miss incident. It is suggested that consideration be given for the implementation of well-established technologies such computerized provider order entry and closed loop medication administration.

The program for management of smart infusion pumps is very robust. Drug libraries are updated frequently, and data is utilized to adjust soft and hard limits with a deliberate focus on reeducation of alert fatigue.

Lastly, there is a notable gap in the implementation of Antimicrobial Stewardship at JPCH. The organization is strongly encouraged to extend this program to JPCH.

Table 5: Unmet Criteria for Medication Management

Criteria Number	Criteria Text	Criteria Type
1.2.14	The organization has a policy and procedure to manage medication shortages.	HIGH

Criteria Number	Criteria Text	Criteria Type
1.2.3	Antimicrobial Stewardship 1.2.3.5 The program is evaluated on an ongoing basis and results are shared with stakeholders in the organization. 1.2.3.4 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). 1.2.3.3 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. 1.2.3.2 The program specifies who is accountable for implementing the program. 1.2.3.1 An antimicrobial stewardship program has been implemented.	ROP
11.2.1	Teams are informed about the value of and their role in reporting adverse drug reactions, specifically unexpected, expected, or serious reactions to recently marketed medications.	NORMAL
5.2.1	Raw materials used for compounding are regularly assessed to determine if they should be discarded when they are not regularly used or are considered dangerous.	HIGH

Service Specific Assessment Standards

The Qmentum Global™ program has a set of service specific assessment standards that are tailored to the organization undergoing accreditation. Accreditation Canada works with the organization to identify the service specific assessment standards and criteria that are relevant to the organization's service delivery.

Ambulatory Care Services

Standard Rating: 91.7% Met Criteria

8.3% of criteria were unmet. For further details please review the table at the end of this section.

Assessment Results

Several ambulatory care services were visited at four locations in Saskatoon and Regina including provincial programs such as RSV immunization, pediatric kidney health and metabolics/genetics. All teams were enthusiastic about sharing information on their programs. Clinical services were patient centered, holistic, and appropriate.

Several clinics are still using paper documentation which presents challenges to service delivery as well as data management. There is no single EMR program across the services including between clinics within the same location. Progression to electronic documentation is encouraged to streamline the patient record and mitigate the risk of gaps in the communication of information. The organization is also encouraged to explore ways to evaluate the effectiveness of care transitions that include patients and families, and make improvements where required.

Medication reconciliation was generally well done, although further clarity is required on which ambulatory care services require medication reconciliation to support patient safety including clinics where high-risk medications are being prescribed (e.g., Maternal Outpatient and Maternal Fetal Medicine).

There are a number of clinics where no shows are not tracked or investigated presenting an opportunity for the program to both track and evaluate to determine what barriers may be preventing patients from accessing care.

The SHA has drafted a rights and responsibilities document after broad engagement with staff and partners however, this has yet to be implemented across the SHA including the ambulatory care areas visited.

Table 6: Unmet Criteria for Ambulatory Care Services

Criteria Number	Criteria Text	Criteria Type
1.1.5	The number of clients who fail to present at scheduled appointments is monitored and strategies to improve attendance are implemented with input from clients and families.	NORMAL
1.2.13	Clients and families are provided with information about their rights and responsibilities.	HIGH
1.2.15	A process to investigate and respond to claims that clients' rights have been violated is developed and implemented with input from clients and families.	HIGH
1.4.10	Information Transfer at Care Transitions 1.4.10.5 The effectiveness of communication is evaluated and improvements are made based on feedback received. Evaluation mechanisms may include: • Using an audit tool (direct observation or review of client records) to measure compliance with standardized processes and the quality of information transfer • Asking clients, families, and service providers if they received the information they needed • Evaluating safety incidents related to information transfer (e.g., from the patient safety incident management system).	ROP
1.5.8	The effectiveness of transitions is evaluated and the information is used to improve transition planning, with input from clients and families.	NORMAL

Service Excellence for Ambulatory Care Services

Standard Rating: 73.8% Met Criteria

26.2% of criteria were unmet. For further details please review the table at the end of this section.

Assessment Results

Many of the clinical leaders within ambulatory care are new to their positions and are still learning their roles. Performance appraisals have not been consistently completed in some areas. While feedback may be provided informally in real time, leadership is encouraged to commence routine formal performance appraisals and provide staff an opportunity to follow up on opportunities for growth.

Various quality improvement projects have been successfully implemented with excellent results. However, teams are encouraged to develop and track service specific indicators to advance objectives and improve programs and services. Support from Quality Improvement (QI) specialists in ambulatory care areas would also be helpful.

Teams are encouraged to actively monitor/evaluate their record-keeping practices and auditing in all service areas. Engagement of Patient Partners across ambulatory care areas is also encouraged to gather input and feedback to strengthen clinic processes and services.

The following projects notably improved the quality and access of services:

- The Indigenous Birth Support Worker Program based in Saskatoon developed to provide Indigenous women culturally responsive care and support during labor and delivery has had impressive success and broad engagement with over 1000 clients in the first year of service.
- The Ambulatory pediatric blood pressure monitoring program that is available across the province and managed by the kidney program has allowed for close to home screening and management of this issue.
- The Mainstream genetic testing for Breast and Ovarian Cancers program is also available to primary care providers across the province for screening and selecting appropriate referrals.

Table 15: Unmet Criteria for Service Excellence for Ambulatory Care Services

Criteria Number	Criteria Text	Criteria Type
1.2.3	The team leadership engages with clients and families to determine the required mix of skill levels and experience within the team.	NORMAL
1.2.5	The team leadership engages with team members and other stakeholders to evaluate the effectiveness of its resources, including staffing and space.	NORMAL

Criteria Number	Criteria Text	Criteria Type
2.1.1	The team leadership engages with clients and families to define the required training and education for all team members.	HIGH
2.1.11	The team leadership regularly engages with client and family representatives to gather input and feedback on their roles and responsibilities as well as role design, processes, and satisfaction.	NORMAL
2.1.12	The team leadership supports staff to follow up on issues and opportunities for growth identified through performance evaluations.	HIGH
2.1.13	The team leadership makes opportunities for ongoing professional development, education, and training available to each staff member.	NORMAL
2.1.5	The team leadership ensures that staff are provided with education and training on the organization's ethics framework.	NORMAL
2.1.7	Infusion Pump Safety 2.1.7.4 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. 2.1.7.5 The effectiveness of the approach is evaluated. Evaluation mechanisms may include: • Investigating patient safety incidents related to infusion pump use • Reviewing data from smart pumps • Monitoring evaluations of competence • Seeking feedback from clients, families, and team members	ROP
2.1.10	The team leadership regularly evaluates and documents each staff member’s performance in an objective, interactive, and constructive way.	HIGH

Criteria Number	Criteria Text	Criteria Type
2.3.4	The team leadership ensures that staff follow organizational policy on bringing forward complaints, concerns, and grievances.	NORMAL
3.1.8	The team monitors and evaluates its record-keeping practices, and uses the results to make improvements.	HIGH
4.3.11	The team regularly evaluates quality improvement initiatives for feasibility, relevance, and usefulness.	NORMAL
4.3.3	The team identifies measurable objectives for its quality improvement initiatives including specific timeframes for their completion.	HIGH
4.3.4	The team identifies indicators to monitor progress for each quality improvement objective.	NORMAL
4.3.5	The team leadership works with staff to design and test quality improvement activities to meet objectives.	HIGH
4.3.6	The team leadership works with staff to use new or existing indicator data to establish a baseline for each indicator.	NORMAL
4.3.7	The team leadership works with staff to regularly collect indicator data and track progress towards quality improvement objectives.	NORMAL
4.3.8	The team leadership works with staff to regularly analyze indicator data to evaluate the effectiveness of its quality improvement activities.	HIGH
4.3.9	The team leadership works with staff to implement throughout their services the quality improvement activities that were shown to be effective in the testing phase.	HIGH

Criteria Number	Criteria Text	Criteria Type
4.3.10	The team leadership ensures that information about quality improvement activities, results and learnings are shared with staff, clients and families, organizational leaders, and partners, as appropriate.	NORMAL

Cancer Care

Standard Rating: 98.5% Met Criteria

1.5% of criteria were unmet. For further details please review the table at the end of this section.

Assessment Results

The Pediatric Oncology Program provides oncology care to children across the province, with services primarily centralized at the Jim Pattison Children's Hospital (JPCH) in Saskatoon. Since the transition of services from the Saskatchewan Cancer Agency in 2019, the program has been realigned under the SHA and has accomplished a great deal of work in stabilizing program leadership, physician and staff models of care and standard work. Many of the leaders are new in their leadership roles and are building strong and competent teams.

The teams are commended for their focus on creating a compassionate people-centred approach to service delivery. Collaborative and culturally safe partnerships with clients and families were apparent when connecting with teams, clients, and families.

The leadership team is commended for their strong leadership with the magnitude of change across SHA over the last few years and through challenging times. Many of the leaders at the Manager and Director levels are in new roles or new portfolios and very supportive of one another. Wellness supports and work life balance is encouraged across the board.

An excellent quality improvement project was undertaken for Chemotherapy Order Writing to reduce risks/incidents and improve safety. It is recommended that SHA consider prioritizing a Digital Health strategy as the multiple platforms and electronic systems where clinicians are documenting are not connected creating inefficiencies and risk including the hybrid nature of paper and electronic systems, and the use of fax machines. There is an opportunity to standardize documentation tools being used at care transitions.

Although SHA staff work collaboratively to redesign the pediatric oncology service, clients and families were not engaged in co-designing this work. The program is encouraged to engage with Patient and Family Partners with lived experience to further integrate their perspectives and feedback on planning and service design, quality improvement initiatives, recruitment, and more to fully adopt a People-Centred Care approach.

The multidisciplinary team does an excellent job of working collaboratively to support clients and families and help to reduce barriers to accessing services. This includes assisting clients and families with travel and accommodation when traveling from Regina to Saskatoon for initial assessment and treatment. There is a nearby Ronald McDonald House and other hotel accommodation as needed. However, many complex challenges still exist for families and their siblings. To help minimize barriers with access to care and provide more seamless care closer to home for clients and families in the southern part of the province, SHA should consider repatriating some services and volumes back to RGH once the recruitment of Pediatricians with specialized training is complete. The newly redeveloped outpatient clinic space and procedure room at RGH is lovely and has capacity for both inpatient and outpatient care. This will also support ongoing recruitment and retention of skilled multidisciplinary team members.

Table 7: Unmet Criteria for Cancer Care

Criteria Number	Criteria Text	Criteria Type
3.10.9	Information Transfer at Care Transitions 3.10.9.1 The information that is required to be shared at care transitions is defined and standardized for care transitions where clients experience a change in team membership or location: admission, handover, transfer, and discharge. 3.10.9.2 Documentation tools and communication strategies are used to standardize information transfer at care transitions.	ROP

Service Excellence for Cancer Care

Standard Rating: 78.5% Met Criteria

21.5% of criteria were unmet. For further details please review the table at the end of this section.

Assessment Results

There is excellent support for on-going education for staff in the program. Staff can attend annual skills days and conferences with access to funds to do so. There is a comprehensive orientation program for new staff that includes skills development specific to cancer oncology, onsite training with a clinical educator, return demonstration of hands-on skills, and chemotherapy medication delivery. Staff also have access to a “buddy” as they transition into working independently in the clinics. However, performance appraisals are not up to date. Leadership is encouraged to regularly meet with and evaluate staff performance as well as identify and follow up on any issues or opportunities for growth that have been identified through the performance appraisals.

Family members and clients interviewed spoke very highly of the skilled teams and the empathetic, collaborative partnerships.

The cancer program is encouraged to engage Patient and Family Partners to further integrate their perspectives and feedback on planning and service design, quality improvement initiatives, recruitment, and more to fully adopt a people-centred care approach.

The Pediatric Oncology Program is planning a Program Review Day soon to create a strategy and develop program priorities. This will include developing quality improvement initiatives with measurable targets and metrics. Quality Boards (physical or electronic) can be a great way to display data for staff and physicians and promote continuous improvement. Support from a Quality Improvement Specialist will be required to support the leadership and team.

Table 16: Unmet Criteria for Service Excellence for Cancer Care

Criteria Number	Criteria Text	Criteria Type
1.1.1	The team co-designs its services with its partners and the community.	HIGH
1.1.3	The team develops its service-specific goals and objectives.	NORMAL

Criteria Number	Criteria Text	Criteria Type
1.2.4	The team works with the organization to co-design its physical spaces to meet its safety and service needs including confidential and private interactions for clients and families.	NORMAL
2.1.11	The team leadership regularly engages with client and family representatives to gather input and feedback on their roles and responsibilities as well as role design, processes, and satisfaction.	NORMAL
2.1.12	The team leadership supports staff to follow up on issues and opportunities for growth identified through performance evaluations.	HIGH
2.1.10	The team leadership regularly evaluates and documents each staff member's performance in an objective, interactive, and constructive way.	HIGH
4.3.1	The team collects information and feedback from its members and its partners about the quality of services to guide quality improvement initiatives.	NORMAL
4.3.2	The team uses information and feedback about the quality of services to identify opportunities for quality improvement initiatives and set priorities.	NORMAL
4.3.11	The team regularly evaluates quality improvement initiatives for feasibility, relevance, and usefulness.	NORMAL
4.3.3	The team identifies measurable objectives for its quality improvement initiatives including specific timeframes for their completion.	HIGH
4.3.4	The team identifies indicators to monitor progress for each quality improvement objective.	NORMAL

Criteria Number	Criteria Text	Criteria Type
4.3.5	The team leadership works with staff to design and test quality improvement activities to meet objectives.	HIGH
4.3.6	The team leadership works with staff to use new or existing indicator data to establish a baseline for each indicator.	NORMAL
4.3.7	The team leadership works with staff to regularly collect indicator data and track progress towards quality improvement objectives.	NORMAL
4.3.8	The team leadership works with staff to regularly analyze indicator data to evaluate the effectiveness of its quality improvement activities.	HIGH
4.3.9	The team leadership works with staff to implement throughout their services the quality improvement activities that were shown to be effective in the testing phase.	HIGH
4.3.10	The team leadership ensures that information about quality improvement activities, results and learnings are shared with staff, clients and families, organizational leaders, and partners, as appropriate.	NORMAL

Critical Care Services

Standard Rating: 99.1% Met Criteria

0.9% of criteria were unmet. For further details please review the table at the end of this section.

Assessment Results

Several areas were visited in Regina, Saskatoon, and Prince Albert. Parents spoke very highly of the care their children received.

The Regina Pediatric High Acuity team has a robot “Teladoc”, a unit used to interface with the PICU in Saskatoon during resuscitations, and other circumstances of patient decline to support safety. Organ donation is an area that may be considered for review regarding potential lens donation.

In the Regina General NICU, families are engaged on team rounds pertaining to their own child, and to take part in care as appropriate. The team supports families in planning for discharge through the demonstration of care provision and securing post discharge appointments. The team is encouraged to re-engage a parent support group to help parents connect with others in similar situations.

Neonatal Transport Teams respond to critical calls for neonatal assistance and transportation as well as movement of neonates within and out of the province including pre and post operative cardiac surgeries, and those requiring MRIs, or PICC line insertions. This highly trained team has filled a huge gap within the province. When called to move an infant, the team is responsible for securing a transport vehicle (ambulance, fixed wing, or helicopter). The team has tried multiple interventions to decrease their mobilization time, currently 25 minutes over the national average impacted by the lack of available ambulances.

Pediatric Transport Teams serve children between 0 and 17 years old, primarily serving 35% of the population of Saskatchewan between 0–4-years old who are in non-population centers. While in transport the team uses standardized practices to stabilize the child, and then the decision is made on the best fit of care closest to the home community. This model of care has had the benefits of improving not only the triaging processes but also educating the care providers in rural areas. The philosophy of the team is bringing the ICU to the child. The team is commended for this great work.

Table 8: Unmet Criteria for Critical Care Services

Criteria Number	Criteria Text	Criteria Type
2.7.12	Data gathered on all intensive care unit (ICU) deaths is accessible and there is a process for reviewing the data to identify lost opportunities for donation and refer the information appropriately.	HIGH

Service Excellence for Critical Care Services

Standard Rating: 91.2% Met Criteria

8.8% of criteria were unmet. For further details please review the table at the end of this section.

Assessment Results

The Maternal Child program is congratulated for its commitment to being “Accreditation Ready” and is encouraged to continue its journey. The team is encouraged to continue to spread Quality Boards noted in some of the Regina Maternal Children’s areas. The cascading huddles are commendable for the communication of service needs throughout the province, using the Winnipeg Assessment of “Neonatal Nursing Tool” (WANNT) to ensure that the right patient receives the right care. The amazing work being done to keep mothers and infants together with the use of a “Thoughtful Pause” will have positive outcomes for many families. Leadership has reported struggles with consistently engaging Patient and Family Partners and are encouraged to continue to include partners as able.

Currently the quality improvement (QI) initiatives are being completed off the side of the managers and physicians’ desks. The number of meaningful initiatives underway was impressive including building accountability for “Medication and IV rates”, “Pain Management”, and aspects of “Childhood Obesity”. It would be helpful to have more support in place for QI projects. Notably, the critical care maternal/child teams have improved capacity and outcomes for pediatrics with the spread of high flow oxygen strategies to pediatric units throughout the province. The Pediatric Transport Team could be the flagship for quality improvement. Data is manually collected and sent to Ground Air Medical Quality Transport (GAMUT) to monitor program performance. They monitor the matrixes and are supported in their research of the ‘robot’ in isolated communities. To better understand the severity of children in distress, and whom to transfer they used the TRAP (Transport Risk Assessment in Pediatrics) scoring guide. This guide uses eight vital signs to determine potential outcomes. The TRAP scoring has been a 13-month pilot and during this time there has been a notable change in enabling children to stay closer to their home communities.

The critical care maternal/child program is encouraged to continue to ensure all staff are trained in violence prevention. Conflict management training has recently been available for interested nursing and allied health and it may be beneficial for physicians to take part in this training as well. Staff are well trained and very capable of handling multiple medical situations. It may be a consideration to combine more training with physicians, nursing, and allied health (e.g., NRP, PALs, and SIM training). Even though there has been changes to management, leadership is encouraged to engage staff in performance appraisals as soon as possible to identify issues or opportunities for growth.

The program utilized the hub and spoke model to support rural communities, inclusive of community partners and Indigenous partners of 56 nations. This model works well for the province with the connections to the community such as Ronald McDonald House, that is building facilities for families in both Prince Albert and Regina. As this model matures the organization is strongly urged to update policies and to archive old ones. Standardization of processes and staffing may be considered for perinatal loss in NICUs, and lactation consultants.

Neonatal and Pediatric transport are included in the critical care teams. Each of the teams reports directly to their site and unit managers. The staff are extremely well trained and perform out of their normal scope of care with delegations from the medical directors of the units. There were disparities between these teams, and it may be considered to have support from coordinators for these programs to support the research, data collection, communications, and transport coordination of the teams. For the NICU transport teams it would be encouraged to have standardization of the roles, scope, education,

curriculum, processes, and reporting structures. The second disparity noted is the costs to the families with the use of transport, between pediatric and neonatal transports with the difference being how the programs are funded (provincially versus Saskatchewan Health Authority).

Table 17: Unmet Criteria for Service Excellence for Critical Care Services

Criteria Number	Criteria Text	Criteria Type
1.1.1	The team co-designs its services with its partners and the community.	HIGH
2.1.12	The team leadership supports staff to follow up on issues and opportunities for growth identified through performance evaluations.	HIGH
2.1.10	The team leadership regularly evaluates and documents each staff member's performance in an objective, interactive, and constructive way.	HIGH
2.3.7	The team leadership ensures that staff are provided with education and training on how to prevent and manage workplace violence, including abuse, aggression, threats, and assaults.	HIGH
4.1.4	The team develops protocols and procedures for reducing unnecessary variation in service delivery.	HIGH
4.3.3	The team identifies measurable objectives for its quality improvement initiatives including specific timeframes for their completion.	HIGH
4.3.4	The team identifies indicators to monitor progress for each quality improvement objective.	NORMAL

Emergency Department

Standard Rating: 96.5% Met Criteria

3.5% of criteria were unmet. For further details please review the table at the end of this section.

Assessment Results

The Emergency Department (ED) at Jim Pattison Children's Hospital is well labelled and easily navigated. The leadership team has worked hard to find the right orientation for the triage space to maximize efficiency, safety, and privacy. The adult and pediatric departments are accessed through the same entrance and waiting areas are very busy. There is a separate space for individuals with suspected infectious diseases.

Patient flow through the organization is well organized and effective. The ED works closely with provincial partners as well as internal departments to ensure ongoing flow even during times of extreme surge. Patients are seen in a very timely way relative to benchmark organizations and EMS offload times are manageable. There is strong collaboration with EMS staff and strong handover processes in place.

Patients are triaged using the standardized Canadian Triage Assessment Score tool. Patients and family are advised as to their triage level and anticipated wait times. Patients are informed about what to do if their condition deteriorates while waiting. Patients are reassessed as per triage acuity. They are screened for falls and universal falls precautions are applied. Suicide risk assessment is completed at the discretion of the triage nurse. Two patient identifiers are used throughout the patient journey. Medication reconciliation is completed for admitted patients.

Care is standardized via evidence-based, comprehensive, and tailored order-sets as well as medical directives and formalized transfer of care processes. There is ready access to specialists and support services including imaging, laboratory, and pharmacy. Point of care testing and portable ultrasounds are available in the department.

There is an opportunity to embed Patient and Family partners. The department just recently identified two individuals who are in the orientation and onboarding process.

As it relates to organ donation, the team works closely with SHA organ donation. It is noted that in 2023 there was a record number of donors over the last fiscal year. The team follows standard processes to alert the organ donation team immediately when it is determined that death may be imminent.

Table 9: Unmet Criteria for Emergency Department

Criteria Number	Criteria Text	Criteria Type
2.1.2	A proactive approach is taken to prevent and manage overcrowding in the emergency department, in collaboration with organizational leaders, and with input from clients and families.	HIGH

Criteria Number	Criteria Text	Criteria Type
2.4.15	Clients and families are provided with information about their rights and responsibilities.	HIGH
2.5.2	The assessment process is designed with input from clients and families.	NORMAL
2.7.17	Information Transfer at Care Transitions 2.7.17.5 The effectiveness of communication is evaluated and improvements are made based on feedback received. Evaluation mechanisms may include: • Using an audit tool (direct observation or review of client records) to measure compliance with standardized processes and the quality of information transfer • Asking clients, families, and service providers if they received the information they needed • Evaluating safety incidents related to information transfer (e.g., from the patient safety incident management system).	ROP

Service Excellence for Emergency Department

Standard Rating: 91.2% Met Criteria

8.8% of criteria were unmet. For further details please review the table at the end of this section.

Assessment Results

The Jim Pattison Children's Hospital emergency department has over 25,000 visits per year. Staffing has stabilized and new resources such as a psychiatric nurse have been added to support patient and family navigation of mental health resources. Staff and leaders report a collaborative, collegial and supportive culture.

The department is very well equipped with access to imaging including a CT scanner in the department. Automated dispensing cabinets are present throughout the department. There is a shared trauma space with adult trauma in the department that supports teamwork and collaboration during trauma events.

The orientation and training of new staff is extensive and tailored to the needs of the individual. As well, nurses are trained in a progressive way from basic orientation up to specialized triage nursing skills. A very seasoned resource nurse is available to support less experienced nurses and a nurse educator is fully engaged in all clinical training. The department is encouraged to find a workspace for the educator in the department to allow for just-in-time training and support of staff.

Staff are very aware of the ethics framework and leverage corporate resources as needed. Staff are also trained in violence prevention and de-escalation techniques. Regular certification and training on all required competencies are current for staff.

Performance reviews are not currently being completed however the manager has a plan to implement a process to ensure this important exercise is completed on a regular basis.

There is a strong culture of safety within the department. Staff members use the safety reporting system (1600) as needed.

The medical records in the emergency department are a hybrid of paper and electronic. The organization is strongly encouraged to move toward a fully electronic health record including computerized prover order entry and closed loop medication administration. With enhanced clinical technology, decision support and clinical intervention tools (like sepsis identification) would further support excellent and safe patient care.

The team follows evidence-based guidelines and has implemented several effective medical directives, reducing variation. The team is in the process of launching a study on parent expectations related to pain management. A focus on supporting more robust quality improvement and evaluation is encouraged across the organization.

The leadership team and frontline staff are committed to people-centred care. Unfortunately, the Patient and Family Advisory council dissolved over the pandemic, however recently two new patient partners have been identified and are being onboarded. The team does engage with the Youth Council and have implemented recommendations from that group including changing language on signage from "Children's Emergency" to Children and Youth Emergency.

Table 18: Unmet Criteria for Service Excellence for Emergency Department

Criteria Number	Criteria Text	Criteria Type
1.1.1	The team co-designs its services with its partners and the community.	HIGH
1.1.4	The team monitors and evaluates its services for appropriateness.	NORMAL
1.2.3	The team leadership engages with clients and families to determine the required mix of skill levels and experience within the team.	NORMAL
1.2.4	The team works with the organization to co-design its physical spaces to meet its safety and service needs including confidential and private interactions for clients and families.	NORMAL
2.1.1	The team leadership engages with clients and families to define the required training and education for all team members.	HIGH
2.1.11	The team leadership regularly engages with client and family representatives to gather input and feedback on their roles and responsibilities as well as role design, processes, and satisfaction.	NORMAL
2.1.10	The team leadership regularly evaluates and documents each staff member’s performance in an objective, interactive, and constructive way.	HIGH

Home Care Services

Standard Rating: 93.0% Met Criteria

7.0% of criteria were unmet. For further details please review the table at the end of this section.

Assessment Results

Recently redirected from Primary Health Care to the Maternal Children's portfolio, with sites in both Regina and Saskatoon, this program provides nursing and supportive care to children with complex medical needs, allowing them to remain in their own home. These programs have dedicated staff and front-line leadership who are passionate about what they do and the care they provide. Patients and families are included as active participants in care and spoke very highly of the teams and the care that is provided.

Transition from pediatric to adult care is facilitated by site-specific nurse coordinators, who are critical members of their respective teams. Transition planning starts well before age 18, working with families to ensure as smooth a transition as possible. It is suggested that this process be evaluated and formalized throughout the program.

Significant up-to-date and relevant wound care resources, guides and education are available on the SHA intranet, which is easily located and cataloged well. However, there are no current wound care policies, procedures, or protocols. In addition, there are no pediatric-specific wound care assessment tools, policies, procedures, or protocols available. Leadership has indicated that pediatric specific home care guidance documents, including wound care, are being developed, in partnership with patient and family advisors/council.

Recently developed to coincide with the opening of JPHC, the West Winds high risk prenatal home care program provides referral based, in-home nursing care to women experiencing complications of pregnancy, and offering an alternative to in-hospital or emergency room care. This program also offers virtual support and assessment to women who have experienced perinatal loss. Patients, families, and the interdisciplinary team were consulted on all aspects of the design of this program. A small team of RNs, all with obstetrics experience, provides an invaluable and patient-centered service, involving patients and families as active participants in care. Patients and families praised the quality of care they received, and the skill set of the nursing team, emphasizing the importance of having this support at home.

A brief home safety risk assessment is completed upon entry into the program and is kept up to date, it is recommended to potentially expand upon this good work to ensure a thorough risk assessment. It is also encouraged to fully implement medication reconciliation upon entry into the program and to look for ways to evaluate the effectiveness of communication at transitions of care, making improvements where indicated.

Table 10: Unmet Criteria for Home Care Services

Criteria Number	Criteria Text	Criteria Type
1.3.6	Medication Reconciliation at Care Transitions - Home and Community Care Services 1.3.6.4 When medication discrepancies are resolved, the current medication list is updated and provided to the client or family (or primary care provider, as appropriate) along with clear information about the changes that were made. 1.3.6.3 Medication discrepancies are resolved in partnership with clients and families or communicated to the client's most responsible prescriber, and the actions taken to resolve medication discrepancies are documented.	ROP
1.3.7	Skin and Wound Care 1.3.7.1 There is a documented and coordinated approach to skin and wound care that supports physicians, nurses, and allied health care providers to work collaboratively and provides access to the range of expertise that is appropriate for the client population.	ROP
1.4.10	Information Transfer at Care Transitions 1.4.10.5 The effectiveness of communication is evaluated and improvements are made based on feedback received. Evaluation mechanisms may include: • Using an audit tool (direct observation or review of client records) to measure compliance with standardized processes and the quality of information transfer • Asking clients, families, and service providers if they received the information they needed • Evaluating safety incidents related to information transfer (e.g., from the patient safety incident management system).	ROP
1.5.7	The effectiveness of transitions is evaluated and the information is used to improve transition planning, with input from clients and families.	NORMAL

Service Excellence for Home Care Services

Standard Rating: 82.3% Met Criteria

17.7% of criteria were unmet. For further details please review the table at the end of this section.

Assessment Results

The home care programs visited work hard to reduce barriers to care and strive to keep patients and families at home, together. Great care happens daily. Staff report high job satisfaction, and balanced caseloads. They are well trained with a robust orientation. However, regular performance appraisals are not completed, and leadership is encouraged to commence routine formal performance appraisals across all home care programs.

Each program has a strong relationship with an interdisciplinary collaborative care team. To strengthen this, the organization is encouraged to continue with its evaluation of potentially co-locating the West Winds Primary Health Care Clinic - High Risk Prenatal Home Care Program with JPCH obstetrics service as they share a manager and from which referrals are received.

The organization is encouraged to facilitate updating policies and procedures, as there are a significant number of outdated documents. It is also recommended to continue to work toward creation of a suite of home care documents with a pediatric focus and to standardize children's home care between sites. All programs currently use a hybrid charting system, which is heavily paper-based and has been identified as a risk by the teams.

Leadership indicates that a focused patient survey, designed with pediatric home care patients and families, is forthcoming in the near future to provide feedback on areas of service need. The organization is encouraged to continue to look for new and creative patient ways to capture the patient voice in all areas of programming and service design.

There is limited evidence of current quality improvement initiatives and indicator tracking. All programs surveyed had new leadership that is eager to integrate quality improvement within their programs, and the organization is encouraged to support these frontline managers in this quality journey.

Table 19: Unmet Criteria for Service Excellence for Home Care Services

Criteria Number	Criteria Text	Criteria Type
2.1.1	The team leadership engages with clients and families to define the required training and education for all team members.	HIGH
2.1.12	The team leadership supports staff to follow up on issues and opportunities for growth identified through performance evaluations.	HIGH

Criteria Number	Criteria Text	Criteria Type
2.1.5	The team leadership ensures that staff are provided with education and training on the organization's ethics framework.	NORMAL
2.1.10	The team leadership regularly evaluates and documents each staff member’s performance in an objective, interactive, and constructive way.	HIGH
4.1.5	The team regularly reviews its evidence-informed guidelines and protocols for service delivery.	HIGH
4.3.11	The team regularly evaluates quality improvement initiatives for feasibility, relevance, and usefulness.	NORMAL
4.3.3	The team identifies measurable objectives for its quality improvement initiatives including specific timeframes for their completion.	HIGH
4.3.4	The team identifies indicators to monitor progress for each quality improvement objective.	NORMAL
4.3.5	The team leadership works with staff to design and test quality improvement activities to meet objectives.	HIGH
4.3.6	The team leadership works with staff to use new or existing indicator data to establish a baseline for each indicator.	NORMAL
4.3.7	The team leadership works with staff to regularly collect indicator data and track progress towards quality improvement objectives.	NORMAL
4.3.8	The team leadership works with staff to regularly analyze indicator data to evaluate the effectiveness of its quality improvement activities.	HIGH

Criteria Number	Criteria Text	Criteria Type
4.3.9	The team leadership works with staff to implement throughout their services the quality improvement activities that were shown to be effective in the testing phase.	HIGH
4.3.10	The team leadership ensures that information about quality improvement activities, results and learnings are shared with staff, clients and families, organizational leaders, and partners, as appropriate.	NORMAL

Inpatient Services

Standard Rating: 86.9% Met Criteria

13.1% of criteria were unmet. For further details please review the table at the end of this section.

Assessment Results

Three sites were visited in Regina, Saskatoon, and Prince Albert. Universally there was a sense of comradery among the teams and a commitment to providing the highest quality patient-centred care. Excellent family engagement in service design of the newborn hearing screening program was evident with the services being co-designed with a breadth of family partners.

Not all inpatient teams completed evaluation of the effectiveness of the intervention or process. Leaders are encouraged that the evaluation can include audits, surveys, and reach outs to community partners to validate the effectiveness of the process or intervention. The leaders are encouraged to ensure that at regular intervals, a sample of clients, families, or referral organizations is contacted to determine the effectiveness of the transition or end of service, monitor client perspectives and concerns after the transition, and monitor follow-up plans. Evaluating transitions is an opportunity to verify that client and family needs were met, and concerns or questions are addressed.

There are several opportunities related to pressure ulcer prevention including standardized processes for risk assessment upon admission, regular reassessment of risk and the implementation of best practices for prevention as published in the literature. The organization is advised to complete an environmental scan of children's hospitals across the country to identify best practices and processes to formalize this work across all sites.

Table 11: Unmet Criteria for Inpatient Services

Criteria Number	Criteria Text	Criteria Type
1.1.2	Services are co-designed to effectively serve pediatric and youth populations, where applicable.	NORMAL
3.2.13	Clients and families are provided with information about their rights and responsibilities.	HIGH
3.3.4	The assessment process is designed with input from clients and families.	NORMAL

Criteria Number	Criteria Text	Criteria Type
3.3.8	Falls Prevention and Injury Reduction - Inpatient Services 3.3.8.3 The effectiveness of fall prevention and injury reduction precautions and education/information are evaluated, and results are used to make improvements when needed.	ROP
3.3.9	Pressure Ulcer Prevention 3.3.9.5 The effectiveness of pressure ulcer prevention is evaluated, and results are used to make improvements when needed. 3.3.9.3 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. 3.3.9.2 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. 3.3.9.1 An initial pressure ulcer risk assessment is conducted for clients upon admission, using a validated, standardized risk assessment tool.	ROP
3.4.18	Information Transfer at Care Transitions 3.4.18.5 The effectiveness of communication is evaluated and improvements are made based on feedback received. Evaluation mechanisms may include: • Using an audit tool (direct observation or review of client records) to measure compliance with standardized processes and the quality of information transfer • Asking clients, families, and service providers if they received the information they needed • Evaluating safety incidents related to information transfer (e.g., from the patient safety incident management system	ROP

Criteria Number	Criteria Text	Criteria Type
3.4.9	There is a least-restraints policy that is followed by the team.	HIGH
3.5.9	The effectiveness of transitions is evaluated and the information is used to improve transition planning, with input from clients and families.	NORMAL

Service Excellence for Inpatient Services

Standard Rating: 75.0% Met Criteria

25.0% of criteria were unmet. For further details please review the table at the end of this section.

Assessment Results

The Newborn Hearing Screening program is engaged with a very strong group of patient and family partners that assist with planning, service design, and quality initiatives. The program has initiated an e-learning module to standardize training for all screeners. This is completed upon hire and subsequently every two years. Key indicators are collected related to expected screening results and drive follow up with screeners as appropriate.

At Victoria Hospital, the team has identified resource requirements and gaps. The team advised that such positions such as Speech Language Pathologists (SLPs), lactation consultants, dieticians, and occupational therapists among others are shared with other service areas resulting in limited services for the clinical area.

The technology and information system requirements and gaps have been identified. The risk of a hybrid record cannot be overstated. The organization is encouraged to move toward a fully integrated electronic health record system.

The team members advised that record-keeping practices are not monitored and evaluated. The team is encouraged to evaluate the accuracy and effectiveness of the record-keeping practices and examine privacy breaches. Evaluation may be done for a sample of records on an irregular or regular basis.

There is an opportunity within the organization to bolster data analytics and decision support capacity to support leaders in decision making as well as quality and safety improvement initiatives.

Staff members reflect that the orientation program is robust and there is evidence in all programs of ongoing training, with yearly education days.

Performance reviews are not being completed on a regular basis across the organization. Leaders are advised to adopt a routine management process to complete these reviews as they are a critical engagement and re-recruitment tool. Further, the opportunity to identify growth opportunities for staff and leaders is limited without a formalized process. Lastly, the organization is encouraged to apportion budget to education and development for staff and leaders.

Staff recognition is not formalized. Some leaders are diligent in ensuring formal recognition of their staff through cards and “kudos” boards, where others are not. A formal recognition program should be considered.

Families universally commented on the exceptional care their child had received at the hospital. There is an opportunity in many programs to build (or in some cases re-build) patient and family partnerships. The organization is encouraged to continue this journey toward meaningful partnerships with patients and families. An excellent example of a co-designed space is the Ronald McDonald room located on the inpatient unit at Victoria Hospital. The team members and leaders are encouraged to continue to co-design services to effectively serve pediatric and youth populations.

Many programs report that they do not have service specific goals and objectives. The team members and leaders are encouraged to develop team goals and objectives in partnership with patients and

families that are service-specific and are aligned with the organization's strategic directions. They should be clear, have measurable outcomes and success factors, and be realistic and time specific. The team should review their goals and objectives annually or as needed and evaluate their progress.

Overall, there is an opportunity to refine and formalize quality improvement across the organization. There are pockets of excellence (Newborn Hearing Screening e-learning and the proposal for Early Hearing Detection and Intervention Program). However, the application of key performance indicators and measurable objectives is not well established. Further, where quality improvement initiatives are in flight, the organization is encouraged to share this information with staff, leaders, physicians, and volunteers as well as patients and families using quality boards and other communication tools.

Table 20: Unmet Criteria for Service Excellence for Inpatient Services

Criteria Number	Criteria Text	Criteria Type
1.1.1	The team co-designs its services with its partners and the community.	HIGH
1.1.3	The team develops its service-specific goals and objectives.	NORMAL
2.1.1	The team leadership engages with clients and families to define the required training and education for all team members.	HIGH
2.1.11	The team leadership regularly engages with client and family representatives to gather input and feedback on their roles and responsibilities as well as role design, processes, and satisfaction.	NORMAL
2.1.12	The team leadership supports staff to follow up on issues and opportunities for growth identified through performance evaluations.	HIGH
2.1.5	The team leadership ensures that staff are provided with education and training on the organization's ethics framework.	NORMAL
2.1.10	The team leadership regularly evaluates and documents each staff member’s performance in an objective, interactive, and constructive way.	HIGH

Criteria Number	Criteria Text	Criteria Type
2.2.2	The team leadership works with the organization to develop staff position profiles that outline the defined roles, responsibilities, and scope of employment or practice for each staff position.	NORMAL
2.2.4	The team evaluates the effectiveness of its collaboration and functioning, and identifies opportunities for improvement.	NORMAL
2.3.7	The team leadership ensures that staff are provided with education and training on how to prevent and manage workplace violence, including abuse, aggression, threats, and assaults.	HIGH
3.1.8	The team monitors and evaluates its record-keeping practices, and uses the results to make improvements.	HIGH
4.3.11	The team regularly evaluates quality improvement initiatives for feasibility, relevance, and usefulness.	NORMAL
4.3.3	The team identifies measurable objectives for its quality improvement initiatives including specific timeframes for their completion.	HIGH
4.3.4	The team identifies indicators to monitor progress for each quality improvement objective.	NORMAL
4.3.5	The team leadership works with staff to design and test quality improvement activities to meet objectives.	HIGH
4.3.6	The team leadership works with staff to use new or existing indicator data to establish a baseline for each indicator.	NORMAL
4.3.7	The team leadership works with staff to regularly collect indicator data and track progress towards quality improvement objectives.	NORMAL

Criteria Number	Criteria Text	Criteria Type
4.3.8	The team leadership works with staff to regularly analyze indicator data to evaluate the effectiveness of its quality improvement activities.	HIGH
4.3.9	The team leadership works with staff to implement throughout their services the quality improvement activities that were shown to be effective in the testing phase.	HIGH
4.3.10	The team leadership ensures that information about quality improvement activities, results and learnings are shared with staff, clients and families, organizational leaders, and partners, as appropriate.	NORMAL

Intellectual and Developmental Disabilities Services

Standard Rating: 100.0% Met Criteria

0.0% of criteria were unmet. For further details please review the table at the end of this section.

Assessment Results

Wascana Rehabilitation Centre has a caseload of approximately 2500 children from across southern Saskatchewan. They have a dedicated, compassionate, and diverse multidisciplinary team of therapists, psychologists, social workers, audiologists, registered nurses (RNs), seating specialists and administrative support who are very proud of the care they deliver. Complex cases have increased and wait times are becoming a challenge. Referrals are prioritized according to criteria, urgency, and funding availability. Single referrals to Speech Language Pathologists (SLPs) are managed in a timely manner. The organization is encouraged to continue focusing on waitlist management through quality improvement (QI), review of intake and other processes.

The Alvin Buckwold Child Development Program provides services to children in Saskatoon, the north and rural areas across the province. The multidisciplinary team provides exceptional care to clients and families. There is an identified gap in Pediatric Physiatry services in Saskatoon at JPCH/Alvin Buckwold Child Development programs, the team is planning to recruit in spring 2024.The wait list for autism spectrum disorders (ASD) has significantly increased over the years without an increase in human resources. A quality project has been initiated to address wait lists for ASD known as the Autism Pre-Assessment project. This pre-screening initiative aims to determine which therapists or other clinicians are needed for assessment, maximizing use of resources, and helping to decrease the wait list. A survey will be sent out to the families to request feedback on this service. The intake nurse will review referrals and redirect them to local therapists if they have them in their communities.

A quality improvement specialist has recently been recruited and is developing a quality improvement plan with metric and targets. Leadership is looking to re-integrate Patient Partners post COVID-19 pandemic.

The leadership team is commended for their strong leadership and support of their teams through challenging times.

The Alvin Buckwold Child Development Program is participating in the provincially approved "Project ECHO". This is an interprofessional learning network and collaboration that takes an "All Teach All Learn" approach to disseminating best practice knowledge through education and recommendations on case-based discussions.

Table 12: Unmet Criteria for Intellectual and Developmental Disabilities Services

There are no unmet criteria for this section.

Obstetrics Services

Standard Rating: 96.0% Met Criteria

4.0% of criteria were unmet. For further details please review the table at the end of this section.

Assessment Results

There is a comprehensive array of Maternal and Children's services provided by the SHA. This includes planned labour and delivery services at 17 sites and Midwifery Services at four sites. A Hub and Spoke Model is used to supporting locally delivered and provincially strengthened care. There were 13,228 newborns in 2022/23. During the survey there were two Midwifery sites visited located in Regina and Saskatoon, and two labour and delivery as well as mother and baby units located at Regina General Hospital and Victoria Hospital. There are three tertiary care centres located in Regina, Saskatoon, and Prince Albert. The criteria for admission to the service are defined. There is a strong commitment to ensuring appropriate patient flow and capacity. The team members and leaders work diligently to ensure safe and quality care. The Managing Obstetrical Risk Efficiently Program is implemented. The team members are proud of working towards the Baby Friendly Initiative. The leaders are encouraged to ensure that polices, and procedures are current and up to date to support team members.

The team members and leaders are acknowledged for their commitment to supporting clients and families in a thoughtful and compassionate manner. For example, clients and families are supported on their journey through a \"thoughtful pause.\" There is a commitment and actioning of culturally safe and competent care. Families expressed feeling welcome in the obstetrics program. Additionally, gentle c-sections and walking epidurals support birthing people and families. The team members and leaders are encouraged to continue their support for thoughtful and compassionate care.

The Midwifery programs provided at the Al Ritchie Health Action Centre and Saskatoon City Hospital provide valuable services, which are in demand in the area. At the Al Ritchie Health Action Centre, having doubled the midwives recently, the team is still at capacity. The team supports 180-200 births annually, both in hospital and at home, with many referrals coming by word of mouth. At the Saskatoon City Hospital there is a strong demand for midwifery services. Approximately 60% of clients wanting to avail of midwifery services are unable to do so. The leaders are encouraged to continue exploring the provision of midwifery services to client and family needs. The Midwifery teams collaborates well and consistently with labour and delivery nursing staff, Obstetricians, Anesthesia, Social Work, and other health care providers. The Midwives assess clients at their clinic, providing care along the trajectory of the birthing journey, and beyond. Patients being cared for by Midwives in the hospital are able to be discharged home sooner due to the rigorous follow up and support. Currently, a Midwifery strategic plan is being developed. The team is encouraged to bring a Patient and Family Partner to the table to ensure the patient voice is embedded. The organization is encouraged to consider expanding this program further.

The physical space varies across sites however, all spaces were welcoming. There is a commitment for single patient rooms. The team endeavours to ensure a safe and comfortable environment for clients and families. At the Victoria Hospital there is a beautiful Ronald McDonald Room that supports clients and families. A client spoke highly of the benefit of this room in supporting her family during a hospital stay. Parents and families are encouraged to visit with sleeping chairs provided as needed. At some sites there are limited workstations for team members. The sites visited were clean and the environmental services team take pride in their work. At some sites there is limited storage space resulting in clutter. The leaders are reviewing the bed allocation for the obstetrics program and are encouraged to continue with this important work. Additionally, the leaders are encouraged to explore the implementation of an infant abduction system.

There is a strong commitment to supporting team members. This includes ensuring a safe working environment. A Staff Safety Plan was developed in 2023. The team members stated that they felt safe at work and that they received training to support safe work practices. The leaders are encouraged to continue supporting a safe and healthy workplace.

A three-phase safe surgical check list is used for surgical procedures performed in the operating rooms. However, compliance auditing is not completed, and the use of the safe surgical checklist has not been evaluated with the results shared with the team. The leaders are encouraged to audit and evaluate the safe surgical check list and to share the results with the team.

Table 13: Unmet Criteria for Obstetrics Services

Criteria Number	Criteria Text	Criteria Type
1.5.6	Safe Surgery Checklist 1.5.6.3 There is a process to monitor compliance with the checklist. 1.5.6.4 The use of the checklist is evaluated and results are shared with the team. 1.5.6.5 Results of the evaluation are used to improve the implementation and expand the use of the checklist.	ROP
1.5.7	There is a policy and procedure for sponge and needle counts both before and after all vaginal births.	HIGH

Service Excellence for Obstetrics

Standard Rating: 90.0% Met Criteria

10.0% of criteria were unmet. For further details please review the table at the end of this section.

Assessment Results

The Obstetrics Program is provided at 17 sites which provide planned labour and delivery services and four sites providing midwifery services. The team members, physicians and leaders are acknowledged for their commitment to support locally delivered and provincially strengthened care across Saskatchewan. The leaders are committed to enhancing partnerships to support care for clients and families. Examples of partnerships include Hope’s Home, Ronald McDonald House Charities, and First Nations leaders and communities. The leadership team is engaged and is comprised of new and experienced leaders and the organization is encouraged to continue to support the training and education needs of both. The leaders are committed to providing a quality Obstetrics Program, ensuring that team members have the resources to do their work. The leaders have identified resource needs at some sites including staff, space, technology, and equipment. They are encouraged to continue to prioritize resource needs to meet program and service demands and ensure that the resources are being appropriately allocated. Additionally, they are encouraged to ensure that there are robust processes to monitor and evaluate the Obstetrics Program.

The Obstetrics Program is supported by an interdisciplinary team including physical therapists, occupational therapists, nurses, dieticians, social workers, respiratory therapists, patient and family advisors, dieticians, physicians, midwives, and pharmacists, to name just a few. However, there is variation as to the level of support provided by the interdisciplinary team across sites. The leaders are encouraged to review the resource needs across all sites. Recruitment and retention of staff is challenging. However, the Midwifery Program has successfully filled all the open positions. Additionally, there has been recruitment and retention success with the Labour and Birth Unit at Regina General Hospital, with nursing positions filled. The families have described the team members as “amazing,” and “exceptional” and noted that they are treated with care, dignity, and respect. One client and their family members spoke of the benefit of identifying a daily care goal which was posted on a white board in the antenatal room. Another client described their experience saying, \"It is clearly excellent. Everyone is so giving. Really enjoyed our stay here. It was amazing.\" The team members are proud to work in the Obstetrics Program saying their team is, \"excellent”, “supportive”, and “family”. A team member stated, \"patients are having one of the best parts of their lives here [Obstetrics]. If we can make them comfortable and confident as parents, it is a privilege.\"

The team members noted that their education and training needs are supported. An orientation is provided for all team members. They described the value of the orientation in preparing them to work in obstetrics. The team members stated that they felt safe at work. This includes the provision of personal protective equipment and safety education. There are hand hygiene products for team members and families. Team member performance evaluations are not completed on a regular basis at some sites. The leaders are encouraged to evaluate and document team members' performance.

The team members, physicians, and leaders are committed to using decision support to enable a quality Obstetrics Program. However, there is limited data available at the unit level. The organization is encouraged to work with the team to ensure data is available for team members to assist them in quality and safety improvement. A combination of paper and electronic health records is used. Leaders are encouraged to explore the implementation of an electronic health record. Privacy education and training is provided to team members but, at some sites, chart or privacy audits are not completed. The team members are encouraged to monitor and evaluate its record-keeping practices, and to use the results to

make improvements.

The teams and leaders are committed to safety and quality, however, at some sites there is an opportunity to explore the implementation of quality and safety initiatives such as huddles, robust auditing, quality improvement boards, client experience surveys, interdisciplinary rounds, and leadership rounding. There is also variation across the Obstetrics program regarding Patient and Family Partners with some sites in the recruitment process for over a year. The leaders are encouraged to support recruitment of Patient and Family Advisors and to co-design programs and services with partners, communities, clients, and families.

Additionally, the team may benefit from education and training on quality improvement. There is variation in the development of quality improvement initiatives at the unit level. The leaders are encouraged to support the development and implementation of quality improvement initiatives including identifying measurable objectives and indicators, collecting indicator data, and tracking progress towards quality improvement objectives. Furthermore, the leaders are encouraged to continue to implement best practices, research and evidence informed decision making.

Table 21: Unmet Criteria for Service Excellence for Obstetrics

Criteria Number	Criteria Text	Criteria Type
2.1.12	The team leadership supports staff to follow up on issues and opportunities for growth identified through performance evaluations.	HIGH
2.1.10	The team leadership regularly evaluates and documents each staff member’s performance in an objective, interactive, and constructive way.	HIGH
2.2.2	The team leadership works with the organization to develop staff position profiles that outline the defined roles, responsibilities, and scope of employment or practice for each staff position.	NORMAL
3.1.8	The team monitors and evaluates its record-keeping practices, and uses the results to make improvements.	HIGH
4.3.11	The team regularly evaluates quality improvement initiatives for feasibility, relevance, and usefulness.	NORMAL
4.3.6	The team leadership works with staff to use new or existing indicator data to establish a baseline for each indicator.	NORMAL

Criteria Number	Criteria Text	Criteria Type
4.3.9	The team leadership works with staff to implement throughout their services the quality improvement activities that were shown to be effective in the testing phase.	HIGH
4.3.10	The team leadership ensures that information about quality improvement activities, results and learnings are shared with staff, clients and families, organizational leaders, and partners, as appropriate.	NORMAL

Perioperative Services and Invasive Procedures

Standard Rating: 92.4% Met Criteria

7.6% of criteria were unmet. For further details please review the table at the end of this section.

Assessment Results

The Maternal operating rooms were assessed at the Prince Albert Victoria Hospital, the Jim Pattison Children's Hospital in Saskatoon, and the Regina General Hospital. The Maternal operating rooms are used primarily for scheduled and urgent cesarean sections.

In all three locations patients were complimentary of the care received. JPCH has a self-administered medication program, which empowers patients to participate in their care. The Regina General Hospital maternal operating room team has created a Maternal Newborn Transfer Handover Tool, and the organization is encouraged to spread this tool to other sites to support effective communication at care transitions.

The transition from the legacy regional health authorities to a Provincial health authority was interrupted by the COVID-19 pandemic, thus further amalgamation and standardization work remains. An example of this would be the quality improvement culture that varies from site to site. All of which would benefit from clear structure of committees, standardized visibility boards, improved data support, and importantly quality improvement leadership training to ensure a consistent approach. Another example of transitioning challenges is the fragmented paper and electronic charting that exists, which is seen across all sites to varying degrees. Clinical practices also vary across sites and as the policies and procedures are standardized, it will be important for local context to be taken into account, especially in consideration of resourcing.

There are additional opportunities to ensure the operating rooms are designed to support high quality services and smooth client flow (e.g., physical layout or air exchanges per hour) as well as measuring and monitoring VTE prophylaxis and use of the safe surgery checklist.

Table 23: Unmet Criteria for Perioperative Services and Invasive Procedures

Criteria Number	Criteria Text	Criteria Type
1.1.2	The area where invasive procedures are performed has three levels of increasingly restricted access: unrestricted areas, semi-restricted areas, and restricted areas.	NORMAL
1.1.3	Heating, ventilation, temperature, and humidity in the area where surgical and invasive procedures are performed are monitored and maintained according to applicable standards, legislation, and regulations.	NORMAL

Criteria Number	Criteria Text	Criteria Type
1.1.4	Medical gas pipeline systems, including low-pressure connecting assemblies, pressure regulators, and terminal units, are certified and checked annually.	HIGH
1.1.6	Airflow and quality in the area(s) where surgical and invasive procedures are performed are monitored and maintained according to standards applicable for the type of procedures performed.	HIGH
1.1.7	Rooms where surgical and invasive procedures are performed have at least 20 complete air exchanges per hour.	HIGH
1.1.8	Ducts have microbic filters whenever sterile fields are required.	HIGH
2.2.17	A process to investigate and respond to claims that clients' rights have been violated is developed and implemented with input from clients and families.	HIGH
2.3.12	Venous Thromboembolism (VTE) Prophylaxis 2.3.12.3 Measures for appropriate VTE prophylaxis are established, the implementation of appropriate VTE prophylaxis is audited, and this information is used to make improvements to services.	ROP
2.3.6	Medication Reconciliation at Care Transitions Acute Care Services (Inpatient) 2.3.6.4 The client, community-based health care provider, and community pharmacy (as appropriate) are provided with an accurate and up-to-date list of medications the client should be taking following discharge.	ROP

Criteria Number	Criteria Text	Criteria Type
2.6.3	Safe Surgery Checklist 2.6.3.3 There is a process to monitor compliance with the checklist. 2.6.3.4 The use of the checklist is evaluated and results are shared with the team. 2.6.3.5 Results of the evaluation are used to improve the implementation and expand the use of the checklist.	ROP
2.7.3	Every medication and solution on the sterile field is labeled.	HIGH

Service Excellence for Perioperative Services and Invasive Procedures

Standard Rating: 83.8% Met Criteria

16.2% of criteria were unmet. For further details please review the table at the end of this section.

Assessment Results

Clinical leadership across all three sites demonstrate strong internal and external partnerships.

Leadership would benefit from stronger decision support, having data about their programs provided to them on a regular basis would aid in quality improvement activities, as the manual nature of data collection could be a deterrent. Some great pockets of quality improvement initiatives do exist such as the skin to skin for c-section patients, and the blood loss weighing and documentation project. As they mature, spreading and scaling these would benefit other sites.

The competencies of their staff are reflected in the job descriptions and consistent mandatory corporate education modules available for staff to complete, inclusive of trauma informed care, ethics, workplace violence. All staff reported regular IV pump training. Orientation in the maternal operating room is inconsistent with some sites completing the full AORN (Association of Perioperative Registered Nurses) training and others not; this is an area of opportunity to provide consistency by moving to a standardized operating room orientation. Staff at two sites had not received performance evaluations.

From a people-centred care lens, all sites had Patient Partner participation, although to varying degrees due to recruitment and retention challenges. Support of patients by way of innovation was noted, especially the Indigenous birth support worker role. As well as the effort to remove barriers for patient such as providing discounted accommodations. All staff were aware of the translation services available.

Staff considered the impact on outcomes by consistently being proactive regarding safety. Any guidelines that came forward were brought to the different committees that exist locally or provincially. Clarity around this process would be beneficial.

Table 24: Unmet Criteria for Service Excellence for Perioperative Services and Invasive Procedures

Criteria Number	Criteria Text	Criteria Type
2.1.12	The team leadership supports staff to follow up on issues and opportunities for growth identified through performance evaluations.	HIGH
2.1.10	The team leadership regularly evaluates and documents each staff member’s performance in an objective, interactive, and constructive way.	HIGH

Criteria Number	Criteria Text	Criteria Type
4.3.1	The team collects information and feedback from its members and its partners about the quality of services to guide quality improvement initiatives.	NORMAL
4.3.2	The team uses information and feedback about the quality of services to identify opportunities for quality improvement initiatives and set priorities.	NORMAL
4.3.11	The team regularly evaluates quality improvement initiatives for feasibility, relevance, and usefulness.	NORMAL
4.3.3	The team identifies measurable objectives for its quality improvement initiatives including specific timeframes for their completion.	HIGH
4.3.4	The team identifies indicators to monitor progress for each quality improvement objective.	NORMAL
4.3.5	The team leadership works with staff to design and test quality improvement activities to meet objectives.	HIGH
4.3.6	The team leadership works with staff to use new or existing indicator data to establish a baseline for each indicator.	NORMAL
4.3.7	The team leadership works with staff to regularly collect indicator data and track progress towards quality improvement objectives.	NORMAL
4.3.8	The team leadership works with staff to regularly analyze indicator data to evaluate the effectiveness of its quality improvement activities.	HIGH

Criteria Number	Criteria Text	Criteria Type
4.3.9	The team leadership works with staff to implement throughout their services the quality improvement activities that were shown to be effective in the testing phase.	HIGH
4.3.10	The team leadership ensures that information about quality improvement activities, results and learnings are shared with staff, clients and families, organizational leaders, and partners, as appropriate.	NORMAL

Rehabilitation Services

Standard Rating: 100.0% Met Criteria

0.0% of criteria were unmet. For further details please review the table at the end of this section.

Assessment Results

Interprofessional Practice (IPP) formally became a team in September 2023 and is comprised of Occupational Therapists (OTs), Physical Therapists (PTs), and Speech-Language Pathologists. This team of dedicated and passionate professionals, along with Child Life Specialists, and Social Workers provide collaborative and integrated therapy services to inpatients and outpatients across JPCH. Most of these services are available seven days per week such as PT, Social Work and OT consults. The team huddles daily to set priorities.

The IPP team members encourage clients and families to be actively engaged in their care and goal setting. The IPP team coordinates treatment planning that aligns with the wishes of the clients and families. Collaborative partnership was demonstrated in an open and respectful way among the therapists, clients, and families. The team actively advocates for patient resources including equipment and promotes safe discharge. Some difficulty was expressed regarding access to specialized equipment (e.g., wheelchairs). Further work with SASK Abilities and other agencies is encouraged to remove barriers and address these access issues.

The digital Health project, \"One Chart Follows One Patient\" needs to become a priority across the SHA. Many hybrid systems that are not connected create risk.

Table 14: Unmet Criteria for Rehabilitation Services

There are no unmet criteria for this section.

Service Excellence for Rehabilitation Services

Standard Rating: 91.9% Met Criteria

8.1% of criteria were unmet. For further details please review the table at the end of this section.

Assessment Results

The team has implemented numerous quality improvements in real time, by using a PDSA (plan-do-study-act) model of testing an idea with the children, getting their feedback, if positive then the idea is immediately implemented and shared with other team members (e.g., Vista collar process, scoliosis protocols for inpatients, traction equipment and procedures, referral pathway between acute and community). Team members have accessed professional development support, attended conferences, and brought back best practices to share with team members, clients, and families.

The program is encouraged to engage a Patient and Family Partner to further integrate their perspectives and feedback on planning and service design, quality improvement initiatives, recruitment, and more to fully adopt a people-centred care approach.

Jim Pattison's Children's Hospital is encouraged to continue to advocate with the University of Saskatchewan for programs for Occupational Therapy, Child Life, and Speech Language Pathology as these positions are hard to fill.

Table 22: Unmet Criteria for Service Excellence for Rehabilitation Services

Criteria Number	Criteria Text	Criteria Type
1.2.4	The team works with the organization to co-design its physical spaces to meet its safety and service needs including confidential and private interactions for clients and families.	NORMAL
4.3.4	The team identifies indicators to monitor progress for each quality improvement objective.	NORMAL
4.3.7	The team leadership works with staff to regularly collect indicator data and track progress towards quality improvement objectives.	NORMAL
4.3.8	The team leadership works with staff to regularly analyze indicator data to evaluate the effectiveness of its quality improvement activities.	HIGH

Criteria Number	Criteria Text	Criteria Type
4.3.9	The team leadership works with staff to implement throughout their services the quality improvement activities that were shown to be effective in the testing phase.	HIGH
4.3.10	The team leadership ensures that information about quality improvement activities, results and learnings are shared with staff, clients and families, organizational leaders, and partners, as appropriate.	NORMAL

Quality Improvement Overview

The SHA is developing and implementing several structures and processes to support quality across the organization and to make the plan and processes visible across the organization. The quality plan is aligned, supports the SHA Roadmap and has been approved by the Executive Leadership Team (ELT). The SHA Management System is the framework that enables the delivery of the quality and safety plan. It is a framework used across the organization that provides the structures, processes, and tools to ensure that the organization is able to assess, evaluate, and improve the safe delivery of care on a day-to-day basis. Quality improvement is evident in some units and programs. There are several examples across the organization where quality improvement is embedded and visible at the unit and program level. There is still room for improvement in continuing to support a culture of quality improvement and to see quality improvement visible throughout the organization. The SHA is encouraged to ensure that the capacity and resources are available to support the organization's quality improvement agenda.

There are sound processes in place for the reporting of adverse events. Staff are aware of the steps that need to be taken when an adverse event occurs. A just and trusting culture is evident throughout the organization. Processes are in place to support all those involved in these situations. A critical incident registry has been implemented and the dashboard is available for Senior Leadership to review. Patients and families participate in client concern work. The SHA is encouraged to engage patients, families, and staff in providing input on the disclosure process and to also implement a process to follow up with patients, families and staff post a disclosure event. The SHA may wish to consider using simulation in disclosure training and engaging patients and families in this work.

The SHA has a robust Enterprise Risk Management (ERM) framework and program. On a quarterly basis, risk is monitored, updated, and documented and informs strategic planning. The ERM Council includes patients and families as members. Risk is viewed from a strategic and operational perspective. Risks are reported to the SHA Board of Directors

The SHA has more work to do with the Required Organizational Practices both in implementation, sustainability, and monitoring. Medication reconciliation policies and processes are in place. The SHA is encouraged to revisit their current auditing of medication reconciliation compliance and consider conducting these audits at the unit level rather than at a facility level so that opportunities for improvement can be identified and implemented at the unit level. The SHA is encouraged to build upon the work that has already started with regards to the required organizational practices (ROPs) and that the ROP auditing needs to occur at the unit level and be used as another strategy to drive quality improvement at the unit level.

The SHA is encouraged to continue with Wall Walks, Cascading Huddles and Daily Huddles using the tools and strategies from the SHA Management System. A culture of spreading and scaling of quality improvement initiatives and strategies and sharing best practices will only make SHA stronger.

People-Centred Care

The Saskatchewan Health Authority's vision of "Healthy People, Healthy Saskatchewan" is supported by their values of safety, accountability, respect, collaboration, and compassion, and founded on a patient and family-centred care philosophy. This philosophy supports a people-centred approach that acknowledges the value of mutually beneficial partnerships amongst employees, physicians, patients, families, clients, and residents.

The Patient and Client Experience Portfolio has developed a comprehensive 5-year strategy that envisions that by 2027, there will be on-going meaningful relationships with patients, families, communities, and staff that allow for improved value, well-being, and optimized experiences and outcomes through the co-development of solutions. The strategy includes five pillars: People-Centred Metrics, People-Centred Leadership, People-Centred Strategy, Patient and Family Centred Care, Patient & Community Engagement, and Accreditation Ready. The following three foundational targets are due to

be achieved by the end of this fiscal year: (1) “Rights and Responsibilities” and Patient and Family Partner Program will have a Truth and Reconciliation target (2) Visibility of Patient and Client Engagement functions will be increased through the development of innovative approaches for education, website enhancement, visual identity, and communications strategy (3) Leader Standard work for Patient and Client Engagement will be advanced with an initial focus on Gemba walks and calendar standard work.

The Patient and Family Partner program currently supports over 450 Patient and Family Partners, many of whom are embedded into key decision-making committees focused on quality and patient safety, policy and clinical standards development, and planning and service design.

The organization should be proud of their efforts to develop a provincial approach to people-centred measurement, and are encouraged to lean into their three-year strategy, including a focus on infrastructure, and meeting their goals at the macro, meso, and micro levels. This work will enable SHA to get a better overall picture of the population’s health and wellbeing, will aid in decision making and service planning, and will allow for care decisions to be informed by data.

After an extensive amount of engagement with people from across the province, including youth and First Nations and Métis, the SHA is due to release the health authority’s first Patient Rights and Responsibilities document. This document acknowledges SHA’s commitment to addressing impacts of racism, discrimination, and trauma, and commits to working to advance the Truth and Reconciliation Commissions’ Calls to Action.

The SHA’s Patient and Family Leadership Council (PFLC) is a group of Patient and Family Partners and SHA staff dedicated to a shared leadership model grounded in respectful and reciprocal relationships.

Their ways of working are based in Indigenous ways of knowing and being and embrace the seasons and the land. Patient and Family Partners of the PFLC are recognized as vital members of the organization’s executive leadership team and are invited to participate in their activities and retreats. With support from Child Life Services and Patient & Client Experience, a Youth Partnership Council made up of youth from across the province has been established to help support incorporating a youth voice into the SHA’s work.

Across SHA’s Women’s, Maternal, and Children’s Programs, many examples of patient and family-centred care practices were noted, including evidence of culturally safe and appropriate care practices. A good example of this was seen in oncology, where a family was supported to have an amputated limb returned home with them for burial. In women’s health, patient-centred practice was evident in medical and surgical abortion services that incorporate the option of self-referral, the opportunity to access care virtually, and a service that offers privacy and confidentiality. Similarly, services available at Alvin Buckwold Child Development Program provide parents the opportunity to self-refer, the option to access virtual care, and the ability to have multidisciplinary team visits.

While some maternal and child services have patient and family partners embedded in committees and advisory groups, and others are gathering client experience data related to specific improvement initiatives, there is inconsistency as it relates to the engagement of patients and family partners in service level planning and design, space design, and safety incident analysis.

Opened in 2019, the Jim Pattison Children’s Hospital is a modern facility designed for the care of comfort of pediatric and maternal patients. In addition to clinical services, it features many child and family focused supports including First Nation & Métis Health, a school room, play spaces, child-minding, and a large Child Life Zone. Child Life Therapists provide support, education, and distraction to patients around medical experience to reduce fears, anxiety, and medical trauma. As a result of offering supportive child life services to children on a waiting list for MRI under general anesthesia, 87% of children were able to be diverted from the general anesthesia waitlist.