ACCREDITATION
AGRÉMENT
CANADA

Accreditation Report

Qmentum Global™ Program

Saskatchewan Health Authority

Report Issued: December 18, 2024

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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 November 3 to 8, 2024.

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 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. SHA has continued to update the organizational structure in order to continue to advance a provincial approach, including the creation of four new Executive Director positions and the inclusion of the Executive Director of First Nations and Metis Health and the Executive Director of Strategy and Innovation to the Executive Leadership Team.

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 serves 1,132,505 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 commenced the first phase of the new four-year Accreditation Cycle in November 2023. 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. Selected criteria from the Leadership and Emergency and Disaster Management standard will also be assessed each survey. This approach ensures a continuation of provincial standardization while focusing on supporting Health Network development within each Service Area.

The first survey visit, in the SHA’s second sequential accreditation cycle included Maternal and Children’s Provincial Programs and SHA Leadership. The focus of the second survey visit in November 2024 is twofold:

- Assessment of clinical services in the Saskatoon Integrated Service Area that align with established service lines.
- Assessment of SHA Governance, Emergency and Disaster Management, Medication Management and Infection Prevention and Control from a provincial lens.

This integrated assessment approach provides a more comprehensive assessment and aligns with different levels accountability for system wide standards. After each accreditation survey, reports are issued to the SHA to support ongoing quality improvement. At the end of the accreditation cycle, in Spring 2027, an overall decision will be issued that includes the SHA’s accreditation award.

Surveyor Overview of Team Observations

The 2024-2025 Saskatchewan Health Authority (SHA) Roadmap is in place and outlines the organization's vision, mission and values, systemic goals and key provincial budget investments. As the system has been evolving and focused on service integration, many structural changes have occurred. In many areas visited during the survey visit, it was noted that new leaders had just begun their roles.

The Saskatchewan Health Authority's (SHA) Commitment to Truth and Reconciliation, was renewed on September 26, 2024 and includes: commitment to reducing systemic healthcare barriers and closing health outcome gaps between Indigenous and non-Indigenous communities, the advancement of Truth and Reconciliation Commission health-specific Calls to Action, respecting Indigenous knowledge, supporting traditional and modern healing, building a culturally inclusive, safe healthcare system with responsive care and more opportunities for Indigenous staff. SHA has a dedicated First Nations and Métis Health Services area. The commitment to collaborating with First Nations and Métis people of Saskatchewan is exceptional and evidence of the commitment towards optimal health and wellbeing of First Nations and Métis communities. In addition, there is a Traditional Knowledge Keepers Advisory Council with nine Knowledge Keepers representing nine linguistic groups in Saskatchewan.

Throughout the visit, there were numerous areas demonstrating a clear commitment to quality, patient safety and excellence. Frameworks and guiding documents are in place. Many sites, however, have been overwhelmed and lack support to operationalize actions to support the strategic priorities. An example is the SHA Management System (Integrated Management System) where staff do not understand the approach.

Throughout the SHA, hybrid charting occurs. In many areas, electronic and hard copy client records are maintained. Complicating this is also the lack of connectivity between system such as home care, public health and primary care. Work is progress to transition to an electronic health record system.

Key Opportunities and Areas of Excellence

Strengths

- A very committed and knowledgeable Board. The Board is actively engaged.
- Commitment to inclusivity such as Indigenous representation on the Board and commitment to progressing on achieving a representative workforce.
- Traditional Knowledge Keepers Advisory Council including nine Knowledge Keepers representing nine linguistic groups in Saskatchewan.
- The statement of Philosophy of Patient and Family Centred Care (PFCC) is in place and has been driven by the vision, mission and values of the organization.
- A Safety Charter (March 1, 2024) has been completed. This is the public commitment to safety and continuous quality improvement.
- The SHA is committed to leveraging the accreditation process to support ongoing actions and quality improvement.

Opportunities

- Implementation and monitoring of the Systemic and Indigenous Specific Anti-racism Action Plan.
- Formalizing and operationalizing quality improvement across the organization.
- At the system/provincial level, there are not structures or processes to support the overall Emergency Disaster Management planning and coordination within the SHA. As a result, there is not a formal plan in place, and this requires ongoing attention.
- Antimicrobial Stewardship program evaluation and spread.
- Policy updates to support medication management and infection prevention and control.
- Support for implementation of Hand Hygiene compliance (Hospital and Community).
- Resources needed to support provincial standardization.

People-Centred Care

The SHA has committed to Patient and Family Centred Care (PFCC) as central to their philosophy of care. They have publicly embedded it as foundational to their mission, vision, and values. Advancing this priority sits appropriately within the Patient and Client Experience portfolio. Leadership across Patient and Family Centred Care, Program Support and Development, and Accreditation demonstrate a strong commitment to best practices in PFCC. Many Engagement Specialists support programs across SHA to build and sustain partnerships with those sharing lived experience.

Their most recent Better Together Patient Experience Survey elicited favorable feedback from patients, families, and residents around inclusion in care decisions, feeling respected and culturally safe. They acknowledge that the limited amount of survey responses must be considered when assessing true experience across the broad range of care types and locations across Saskatchewan. SHA is encouraged to consider expanding program-level or site-specific surveys to provide more actionable feedback.

Surveyors observed great variation in awareness of PFCC, engagement opportunities and capacity to partner with patients and families. In several areas of care, there is a lingering legacy of having engaged previously and a curiosity in staff and volunteers why it has either waned or ceased. SHA is encouraged to consider mapping a current state that shows where, when, and how engagement is happening. Identifying exemplars and opportunities for improvement can inform a structured approach to expansion of best practices.

To that end, there are abundant examples of standing committees and councils that demonstrate authentic partnerships. The Patient and Family Leadership Council (PFLC) works closely with executive leadership, program managers, and the board. Its purpose is to lead, connect and partner with the SHA to embed the principles and practices of Patient and Family Centred Care. Program level committees in mental health or resident councils in long-term care are illustrations of established partnerships.

Currently over 450 volunteers serve as Patient Family Partners (PFPs). They are recruited and trained to share their lived experiences and offer unique perspectives on committees, working groups, one-off consultations on educational materials or signage, hiring panels, and staff orientation among many others. SHA acknowledges the power of human stories and shares them with profound impact. SHA is encouraged to continue expanding their pool of PFPs to reflect the growing diversity of the communities they serve. More will be needed to meet the eventual demand as more programs, sites, and planning levels embrace these meaningful partnerships.

While identified as a core principle of care, PFCC remains, to some extent, in preliminary stages of development. There are strong organizational structures developed from careful consideration of best practices. Great care has been taken to build resources, toolkits, and pathways to engaging. System pressures and competing priorities have forced many programs, managers, and leaders to deprioritize engagement. However, where it is done, it is done well. SHA is encouraged to continue their journey by recommitting their considerable skills and passion advancing toward PFCC as a true cultural norm.

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. As a driver for continuous quality improvement, the action planning feature has been introduced to support the identification and actioning of areas for improvement.

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 and required organizational practices results.

Accreditation Decision

Saskatchewan Health Authority's accreditation decision continues to be:

Accredited

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

Locations Assessed in Accreditation Cycle

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

Table 1: Locations Assessed During On-Site Assessment

Site	On-Site
Saskatchewan Health Authority	☑

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
Hand-hygiene Compliance	Infection Prevention and Control	1 / 3	33.3%
	Infection Prevention and Control for Community-Based Organizations	3 / 3	100.0%
Infection Rates	Infection Prevention and Control	3 / 3	100.0%
	Infection Prevention and Control for Community-Based Organizations	3 / 3	100.0%
Antimicrobial Stewardship	Medication Management	4 / 5	80.0%
High-alert Medications	Medication Management	6 / 8	75.0%
	Medication Management for Community-Based Organizations	5 / 6	83.3%
Heparin Safety	Medication Management	4 / 4	100.0%
	Medication Management for Community-Based Organizations	7 / 7	100.0%
Narcotics Safety	Medication Management	3 / 3	100.0%
Concentrated Electrolytes	Medication Management	3 / 3	100.0%
	Medication Management for Community-Based Organizations	3 / 3	100.0%

ROP Name	Standard(s)	# TFC Rating Met	% TFC Met
The ‘Do Not Use’ List of Abbreviations	Medication Management	7 / 7	100.0%
	Medication Management for Community-Based Organizations	5 / 6	83.3%
Accountability for Quality of Care	Governance	5 / 5	100.0%

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.

Emergency and Disaster Management

Standard Rating: 67.4% Met Criteria

32.6% of criteria were unmet. For further details please review the table at the end of this section.

Assessment Results

The Saskatchewan Health Authority's (SHA) Health Emergency Management (HEM) team are to be commended on their passion and commitment in supporting emergency disaster management (EDM) services. This is a small and mighty team which includes four HEM specialists, a new Provincial Manager plus a newly appointed Director who started the day of this accreditation survey. The HEM team has the education and competencies to support and deliver on the EDM functions.

This is a time of rebuilding for the HEM team and the opportunity to re-establish a solid foundation for EDM planning and execution of plans within the SHA. The team has been working on several initiatives while supporting teams across the SHA respond to emergency incidents. They have authored the On-Call Reference Manual and Resources for Directors and Executive Directors and the HEM Evacuation Guide to support evacuations affecting communities and health care facilities.

The HEM team's role and responsibilities include preparedness, response, mitigation and recovery. Activities includes assisting with and or facilitating debriefs, testing response plans, supporting the provincial director on call, committee support, liaising with the Ministry of Health's Health Emergency Management Unit, training coordination and support, incident response, emergency planning and preparation, assisting with site/department response plans, providing subject matter expertise, resource coordination and coordination with external partners.

It was evident that there is a lack of structure and processes to support the overall EDM planning and coordination within the SHA. The organization's EDM plan is currently incomplete and contains areas requiring further development. It is suggested that an overall coordinating body be established with key functions represented to work in partnership with the HEM program. It was evident that functional areas such as communication, human resources, public health, system flow, infection control have plans on how they support EDM response but there is no formal mechanism or forum to bring it all together to support an organizational EDM plan. It is important to note that operations must be at the table as HEM does not own the operations response, but the HEM team is responsible in facilitating the components of preparedness, response, mitigation and recovery. It is suggested that to support this work consideration be given for Executive co-sponsorship with Provincial Clinical Support Services and Operations. Once the overall the SHA organizational plan and structures are developed, consideration should be given to replicating this model in each of the integrated service areas.

The SHA will need to ensure that the appropriate structure and resources are in place to support EDM as this can pose a significant risk to the organization. Development of an all-hazards approach to EDM risk assessment and expanding EDM training are encouraged. In addition, formal structures need to be in place to engage internal and external partners. The organization is encouraged to reach out and learn from similar organizations. The organization is also encouraged to use the Accreditation Canada Emergency and Disaster Management standards to guide this work.

Table 3: Unmet Criteria for Emergency and Disaster Management

Criteria Number	Criteria Text	Criteria Type
1.1.1	The organization establishes and maintains a holistic culture of emergency and disaster preparedness that integrates emergency and disaster planning throughout its operations.	HIGH
1.2.2	The organization has a multidisciplinary and interprofessional emergency planning committee to coordinate emergency and disaster planning prior to an event.	NORMAL
1.2.3	The organization defines and communicates roles, responsibilities, input structures, and reporting relationships of the emergency planning committee.	NORMAL
1.3.1	The organization follows a structured and inclusive process to engage with internal and external stakeholders in emergency and disaster planning.	NORMAL
1.3.5	The organization engages with all programs, services, and teams in the organization to understand their emergency and disaster planning needs.	NORMAL
1.3.6	The organization uses an inclusive approach to engage with the community in emergency and disaster planning, to gain an understanding of the community's diverse needs in emergencies and disasters.	HIGH

Criteria Number	Criteria Text	Criteria Type
2.1.1	The organization engages with stakeholders and uses an all-hazards approach to conduct a comprehensive emergency and disaster risk assessment, to identify, analyze, and prioritize its emergency and disaster risks.	HIGH
2.1.2	The organization regularly reviews and updates as needed its emergency and disaster risk assessment.	HIGH
2.1.3	The organization shares the results of its emergency and disaster risk assessment with internal and external stakeholders, to keep them informed.	HIGH
2.2.1	The organization engages with stakeholders to establish, regularly review, and update as needed an emergency and disaster risk management plan, to reduce and address the risks that it identified and prioritzed based on its emergency and disaster risk assessment.	HIGH
2.2.3	The organization allocates funds in its annual operating budget for emergency and disaster management on the basis of the results of its emergency and disaster risk assessment.	HIGH
3.1.1	The organization engages with stakeholders to establish, regularly review, and update as needed an emergency and disaster plan, based on an all-hazards approach, that can be activated to respond to and recover from an emergency or disaster.	HIGH
3.1.2	The organization integrates its emergency and disaster plan with community emergency and disaster plans, to ensure a coordinated response to and recovery from an event.	NORMAL
3.1.3	The organization maintains an up-to-date version of its emergency and disaster plan in locations that are known and accessible to all staff, to ensure the plan can be easily accessed during an event.	HIGH

Criteria Number	Criteria Text	Criteria Type
3.1.4	The organization engages with stakeholders to establish, regularly review, and update as needed a business continuity plan to ensure the continuation of essential care services during and following an emergency or disaster.	HIGH
3.1.23	The organization ensures that each site, department, or unit establishes and maintains its own emergency and disaster plan that is aligned and coordinated with the organizational emergency and disaster plan.	HIGH
3.2.1	The organization has a multidisciplinary and interprofessional emergency management team that is responsible for managing its response and recovery operations during an emergency or disaster.	NORMAL
3.4.2	The organization establishes, regularly tests, and updates as needed an activation plan and related policies and procedures, to activate and deactivate the emergency and disaster plan.	HIGH
3.6.1	The organization establishes or adopts a competency-based framework to guide the development and deployment of emergency and disaster management training for all staff.	NORMAL
3.6.2	The organization identifies and implements best practices in the development and deployment of emergency and disaster management training, and shares its best practices with stakeholders.	NORMAL
3.6.3	The organization ensures that its emergency and disaster management training is inclusive, accessible to all staff, and delivered in a respectful manner that is free from discrimination.	HIGH
3.6.4	The organization assesses and documents individual learning to ensure that required competencies for emergency and disaster management are achieved and kept up to date.	NORMAL

Criteria Number	Criteria Text	Criteria Type
3.6.5	The organization validates its emergency and disaster management training to ensure training objectives are met.	NORMAL
3.6.6	The organization incorporates evidence acquired on an ongoing basis into its competency-based framework for emergency and disaster management training, to make improvements and keep it up to date.	NORMAL
3.6.7	The organization maintains records of its emergency and disaster management training and exercises, to track training deployment.	NORMAL
3.7.1	The organization conducts regular exercises to validate the effectiveness of its emergency and disaster plan and processes and ensure they meet expectations and objectives.	HIGH
3.7.5	The organization shares and compares evaluation results with other similar organizations, to promote knowledge exchange and learning.	NORMAL
4.1.1	The organization follows its established emergency and disaster plan, and related policies and procedures, to respond to and recover from an emergency or disaster.	HIGH

Governance

Standard Rating: 95.2% Met Criteria

4.8% of criteria were unmet. For further details please review the table at the end of this section.

Assessment Results

The Saskatchewan Health Authority (SHA) has a committed, engaged and knowledgeable board. The board is committed to monitoring and celebrating the accomplishments of the SHA. The board challenges the organization to be the best that they can be and to remain true to the vision, mission, values and philosophy of care.

The board has confidence in the CEO and the Executive Leadership team. The briefings brought forward by the leadership team are provided with enough time and information for the board to make recommendations and decisions. All decisions go through a comprehensive process that examines quality and safety. The enterprise risk framework as well as the ethics framework is used to assist the board in their deliberations and decisions.

All board members receive a comprehensive orientation as well as ongoing continuing education. The Board Resource Manual is very comprehensive and is a valued resource for all the board members. Performance reviews for the board members and the chair occur. Board meetings are regularly evaluated. On an annual basis, the board reviews the CEOs performance.

The board takes their roles and responsibilities very seriously and members truly care for the SHA. There is an atmosphere of openness within the board. The board ensures that they keep in touch with the community that they serve by having their board meetings scheduled in different locations throughout the province. The board is looking forward to increasing the community engagement through the health networks. The members are also encouraged to continue to be visible to the SHA staff, physicians and volunteers.

The board is fortunate to have three Indigenous members. Their contributions and insights are valued. The SHA has recently adopted two frameworks to address systemic racism and Indigenous specific systemic racism. Action plans have been developed and will be implemented shortly. The organization is encouraged to monitor action plan progress.

The board is supported by six committees. The Quality and Safety Committee as well as the Practitioner Liaison Committee have a patient family partner. The board is encouraged to consider having patient family partners on all their committees. In addition, there is an opportunity to build processes and metrics for the board to monitor people-centred care adoption across the organization.

Table 4: Unmet Criteria for Governance

Criteria Number	Criteria Text	Criteria Type
5.1.2	The governing body implements an action plan, in partnership with community partners, to address systemic racism in the organization.	HIGH
5.1.5	The governing body monitors its action plan for addressing systemic racism.	HIGH
6.1.2	The governing body implements an action plan, in partnership with Indigenous partners, to address Indigenous-specific systemic racism in the organization.	HIGH
6.1.5	The governing body monitors its action plan for addressing Indigenous-specific systemic racism.	HIGH

Infection Prevention and Control

Standard Rating: 85.7% Met Criteria

14.3% of criteria were unmet. For further details please review the table at the end of this section.

Assessment Results

Infection Prevention and Control (IPAC) has had a work-intensive few years with the pandemic and keeping staff, patients, families, and visitors safe in the new Saskatchewan Health Authority (SHA). This empowered and leading IPAC Team prioritizes provincial and local efforts through its IPAC Operations and Oversight Committees and regular reporting to the Quality and Safety Oversight Committees of the Executive Leadership Team and the Board of Directors. The IPAC Team is to be commended on its strategic resource planning to ensure interdisciplinary and Infectious disease specialization/support as well as IPAC presence and leadership in critical programming including major capital planning. Additionally, the team is standardizing approaches to healthcare-associated infection trigger points or thresholds at which point IPAC team performance of investigation and corrective actions for leadership will follow. The IPAC team is also recognized for its provincial Level 4 Pathogen Planning including work standardization, training, communication and tabletop exercise planning.

Corporately, SHA has introduced a provincial hand hygiene program using the Clean Hands System. While the provincial program is well developed, implementation at the local level is not complete and staff note that hand hygiene reporting and corrective action follow-up are lacking. Additional administrative and IPAC supports are required to allow this Required Organizational Practice to thrive on all hospital and community based organizational levels. Cascading huddles from the patient care units to management and to the executive team allow for IPAC troubleshooting and communications to flow throughout the organization. A patient partner is included on the IPAC Oversight Committee with additional patient and family perspectives coordinated through the PFCC team. These committees are recognized for their recent project to educate and include hand wipes on patient dining trays to improve patient hand hygiene. Additional patient and family feedback about increasing their involvement in infection prevention is a next step for local and provincial programming.

There is some evidence in patient care areas of IPAC indicator data. The SHA is encouraged to explore electronic data boards for patient care areas that could include real-time advisories on outbreaks as well safety indicators. Policy and procedure reconciliation and development is underway with the need to update and revise a staff immunization program and education along with standardization of IPAC quality and auditing for external partner environmental cleaning contracts. The SHA is encouraged to refocus on medical device reprocessing review for hospital and community organizations to ensure evidence-based standards, training, audit, and quality, especially for non-centralized reprocessing in consultation with the IPAC team.

An urgency to resume the capital renovation/construction of the Royal University Hospital relocated Intensive Care Units (ICU) and ICU Flex units, and St. Paul’s Hospital Emergency Department are recommended given the infection risks due to crowding, lack of handwashing facilities and limited number of bathrooms and flushers/disinfectants in each room. Environmental Services are commended for their tireless attention to infection control measures and their contributions to safeguarding the units against outbreak-causing pathogens.

Table 5: Unmet Criteria for Infection Prevention and Control

Criteria Number	Criteria Text	Criteria Type
2.1.4	There are policies and procedures for loaned, shared, consigned, and leased medical devices.	HIGH
2.4.2	An immunization policy is developed or adopted to screen and offer vaccinations to team members.	HIGH
2.5.6	Hand-hygiene Compliance 2.5.6.2 Hand-hygiene compliance results are shared with team members and volunteers. 2.5.6.3 Hand-hygiene compliance results are used to make improvements to hand-hygiene practices.	ROP
2.6.6	When cleaning services are contracted to external providers, a contract is established and maintained with each provider that requires consistent levels of quality and adherence to accepted standards of practice.	NORMAL
2.6.7	When cleaning services are contracted to external providers, the quality of the services provided is regularly monitored.	NORMAL
2.7.2	If neurosurgical services are provided, there are policies and procedures to prevent the transmission of Creutzfeldt-Jakob Disease (CJD).	HIGH
2.7.3	Required training, education, and experience are defined for all team members that participate in cleaning, disinfecting, and/or sterilizing medical devices and equipment.	HIGH

Infection Prevention and Control for Community-Based Organizations

Standard Rating: 91.8% Met Criteria

8.2% of criteria were unmet. For further details please review the table at the end of this section.

Assessment Results

This standard is used for assessment of infection prevention and control (IPAC) activities in a health care setting outside of a hospital/acute care. Community-based sites visited for IPAC assessment include those that provide long-term care (LTC) (e.g., affiliate LTC homes, SHA owned and operated LTC homes), primary health care and community mental health and addictions services.

The SHA Infection Prevention and Control (IPAC) team works collaboratively to build system and local capacity. The IPAC team is to be commended on its strategic resource planning to ensure interdisciplinary and infectious disease specialization/support as well as IPAC presence and leadership in critical programming including major capital planning and renovations which is provided to capital projects. Infection Control Practitioners extend their expertise and leadership to community-based outbreak control management. IPAC leadership identify challenges with the capacity to provide IPAC services for all the sites in the service area and are encouraged to develop a standardized service offering and resource requirements.

Corporately, the SHA has introduced a provincial hand hygiene program using the Clean Hands System. While the provincial program is well developed, implementation at the community organization level is not complete and staff note that hand hygiene reporting and corrective action follow-up are lacking. Additional administrative and audit support are required to allow this Required Organizational Practice to thrive in all settings. Daily wall huddles allow for IPAC troubleshooting and communications to flow throughout the organizations. IPAC leadership is encouraged to disseminate patient and family inspired projects to all locations like the education and inclusion of hand wipes on patient dining trays in hospitals to improve patient hand hygiene. Additional patient/resident/client and family feedback to increase their involvement in infection prevention is a next step for local and provincial programming. This may also lead to their involvement in hand hygiene audits.

Policy and procedure reconciliation and development is underway with the need to create and disseminate a staff immunization policy, education, and program. A centrally developed policy and procedure for staff education and support regarding the loan, sharing, consignment or leasing of medical devices is lacking and should be developed. A standardized contract for these loaned or leased medical equipment including services provided by the vendor is a next step.

From a policy development, dissemination and support perspective, there is an observed need to ensure fidelity between SHA policies long-term care affiliate policies. This will involve interpretation of IPAC standards to facilitate alignment with the local context and culture, for example, a resident home in a long-term care facility. Additionally, developing requirements for ventilation in renovation and larger equipment installations along with regular maintenance and cleaning of ventilation is encouraged. Environmental Services are commended for their attention and contribution to reducing the incidence of infections and outbreaks. Should externally cleaning contracts be awarded the development of a centralized contract and routine audits to ensure quality is recommended.

Table 6: Unmet Criteria for Infection Prevention and Control for Community-Based Organizations

Criteria Number	Criteria Text	Criteria Type
2.1.4	There are policies and procedures for the use of loaned, shared, consigned, and leased medical devices, when applicable.	HIGH
2.4.2	An immunization policy is developed or adopted that includes providing information to clients/residents and team members about how to access vaccinations.	HIGH
2.6.6	When cleaning services are contracted to external providers, a contract is established and maintained with each provider. This contract requires consistent levels of quality and adherence to accepted standards of practice.	NORMAL
2.6.7	When cleaning services are contracted to external providers, the quality of the services provided is regularly monitored.	NORMAL

Medication Management

Standard Rating: 92.5% Met Criteria

7.5% of criteria were unmet. For further details please review the table at the end of this section.

Assessment Results

The Saskatchewan Health Authority (SHA) has developed a robust oversight committee structure to oversee the provincial standardization of all aspects of the medication management system. This includes the SHA Drugs and Therapeutics Committee and the Medication Use and Safety Interdisciplinary (MUSIC) Steering Committee, Poison Information Advisory Committee, Pediatric Advisory Committee and Antimicrobial Advisory Committee. These are further supported by local MUSIC Committees across the province for Acute and Continuing Care services, Medication Audit, SMART pump program, Accreditation Committee and Medication Reconciliation Committees. A patient and family partner participates on the MUSIC Steering Committee. The Drugs and Therapeutics Committee focuses on formulary management and has reviewed and standardized most of the drug formulary.

The Provincial Antimicrobial Stewardship Program (ASP) currently consists of two dedicated ASP pharmacists, Infectious Disease Physician and a Research Scientist who have accomplished a significant amount of work from the Regina hospital supporting the provincial program. They update the First Line app which assists prescribers with appropriate guidelines, antibiograms, educational sessions, while providing audit and feedback at the Regina weekly ICU rounds. The team reviews the antimicrobial content on most pre-printed orders for appropriateness, has published an annual report and are working on numerous projects in acute and continuing care including treatment of asymptomatic urinary cultures. A project charter has been drafted outlining additional resources required to expand the ASP program throughout the province. The team is encouraged to report outcome data such as audit and feedback acceptance rate or other measurements to monitor the impact of the program.

The interdisciplinary team is actively working on standardization of the SHA medication management policies including those supporting many of the Required Organizational Practices (ROPs) with final approval on most of the work expected to be completed in spring of 2025. There is opportunity to develop a structured program to reduce the risks associated with polypharmacy. The SHA SMART Pump Program oversees the standardization of all infusion pumps, reviews and updates of the drug library with the dose error reduction system (DERS).

Table 7: Unmet Criteria for Medication Management

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.	ROP
1.2.5	High-alert Medications 1.2.5.1 There is a policy for the management of high-alert medications. 1.2.5.7 The policy is updated on an ongoing basis.	ROP
4.3.2	A policy that specifies when and how to override smart infusion pump alerts is developed and implemented.	HIGH
6.1.1	A structured program has been implemented to reduce the risks associated with polypharmacy, especially with frail or vulnerable clients.	HIGH
10.2.1	There is a policy and procedure to ensure client self-administration of medication is safely managed.	HIGH
10.2.2	Established criteria are used to determine which medications clients can self-administer.	NORMAL
10.2.3	Established criteria are used to assess whether a client is able to self-administer medications.	NORMAL

Medication Management for Community-Based Organizations

Standard Rating: 95.7% Met Criteria

4.3% of criteria were unmet. For further details please review the following table.

Assessment Results

This standard is used for assessment of community-based sites providing medication services. Community-based sites visited for medication management assessment include those that provide long-term care (LTC) (e.g., affiliate LTC homes, SHA owned and operated LTC homes), primary health care and community mental health and addictions services.

The Saskatchewan Health Authority (SHA) supports community-based services through the Medication Use and Safe Interdisciplinary Committee (MUSIC) for Continuing Care Committee and the MUSIC Primary Care Committee. Representatives from the various LTC homes and Primary Care facilities participate on these committees and contribute to development of revised policies, practices and safety initiatives.

In addition, LTC homes follow the Ministry of Health LTC Guidelines and are regularly audited for compliance. Service agreements are typically established with local community pharmacies who provide resident specific medications, limited stock, medication room audits, on call services and quarterly reviews of client's current medication for appropriateness.

The provincial Antimicrobial Stewardship program is piloting a project where the treatment of asymptomatic urinary tract cultures is being monitored to decrease the use of inappropriate antibiotics. The province may consider further implementation of the project pending the success of the program. The SHA supports the LTC homes with Infusions Devices including standardization of Drug Libraries and pump maintenance for facilities where Intravenous medications are administered.

The interdisciplinary team is actively working on standardization of the SHA medication management policies including those supporting many of the Required Organizational Practices. There is opportunity to spread the audits of "Do Not Use" abbreviations across all locations to minimize risks within medication documentation and support patient/resident safety.

Table 8: Unmet Criteria for Medication Management for Community-Based Organizations

Criteria Number	Criteria Text	Criteria Type
1.1.5	The organization has identified and implemented a list of abbreviations, symbols, and dose designations that are not to be used in the organization. 1.1.5.6 The organization audits compliance with the 'Do Not Use' List and implements process changes based on identified issues.	ROP
1.1.7	The organization implements a comprehensive strategy for the management of high-alert medications. 1.1.7.1 The organization has a policy for the management of high-alert medications.	ROP
6.2.2	A policy that specifies when and how to override smart infusion pump alerts is developed and implemented.	HIGH