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 4 – 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 systems 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

Areas of Excellence

- Highly engaged teams with caring, compassionate and dedicated staff.
- Many new leaders are in place and there is commitment to a representative workforce.
- Staff were very aware of local disaster management plans at their sites.
- There are numerous strategies in place to support effective patient flow as well as established patient flow metrics and monitoring processes.
- SHA is committed to leveraging the accreditation process to support ongoing actions and quality improvement.

Opportunities

- As the new leaders and structures evolve, it will be important to ensure clarity regarding accountabilities. It is suggested that the organization consider change management strategies as change fatigue was noted. Staff are overwhelmed with numerous initiative such as AIMS. The change management approaches must include clear and simplified terminology/nomenclature and communication.
- In most service areas, white boards to support wall walks, staff huddles and quality are in place. The full potential of the use of the Saskatchewan Health Authority Management System (SHAMS) will not be realized however without further education regarding quality improvement processes, the development of measurable quality objectives, the establishment of targets and the use of information from these data to monitor the outcomes of the quality activities.
- System wide, most areas have not yet updated performance review processes. This is encouraged to ensure staff are supported in identifying their professional development needs. Individual engagement and recognition are also important in retaining staff.
- The hybrid recording processes currently in place pose several patient care risks. There is a need for reliable communication between sites and services to support care transitions and as a result, integration of services. There is a need to continue to work on a provincial electronic health recording system that can reduce duplication of recording efforts and enable communication between sites and services.
- Several areas do not meet all Required Organizational Practices (ROPs) and some associated tests for compliance, for example hand hygiene, safe surgical checklist and falls prevention. There is a need to support work plan development in these areas.
- In identified areas, there remains infrastructure shortcomings. These require attention as capital project plans proceed. It will be important to ensure IPAC is engaged in all small and large capital projects.

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 favourable 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 parentships.

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[1] assessed during the organization's on-site assessment.

Table 1: Locations Assessed During On-Site Assessment

Site	On-Site
Acute Care Provincial Strategy	☑
Borden Primary Health Centre	☑
Calder Centre	☑
Central Haven Special Care Home	☑
Circle Drive Special Care Home	☑
Community Adult Programs	☑
Community Health Centre at Market Mall	☑
Community Outreach and Support Teams (COAST)	☑
Idylwyld Centre	☑
Idylwyld Centre - STBBI Services and Resources (SSAR)	☑

Site	On-Site
Irene & Leslie Dubé Centre for Mental Health	☑
Irene & Leslie Dubé Centre for Mental Health - Short Stay Unit	☑
Jim Pattison Children's Hospital - Day Surgery and Same Day Surgery, PAC & PACU	☑
Jim Pattison Children's Hospital - Surgical Operative Care, PAC & PACU	☑
Jubilee Residences- Stensrud Lodge	☑
McKerracher Centre - Residential and Recovery Services	☑
Oliver Lodge	☑
Parkridge Centre	☑
Parkridge Centre - Geriatric Re-Enablement Unit (GRU)	☑
Preston Special Care Home	☑
Royal University Hospital	☑
Royal University Hospital - 6100 Oncology Ward	☑
Royal University Hospital - Ambulatory Care Medical/Surgical	☑
Royal University Hospital - Cardiac Short Stay Unit (CSSU)	☑
Royal University Hospital - Cardiosciences Inpatient 6000	☑
Royal University Hospital - Chronic Disease Management	☑
Royal University Hospital - Coronary Care Unit (CCU)	☑
Royal University Hospital - Day Surgery & Same Day Surgery, PAC & PACU	☑
Royal University Hospital - Emergency & Transitional Services	☑

Site	On-Site
Royal University Hospital - Endoscopy	☑
Royal University Hospital - Intensive Care Unit	☑
Royal University Hospital - Neurosciences Inpatient 6300	☑
Royal University Hospital - Outpatient Cardiology Services, Heart Function Clinic	☑
Royal University Hospital - Surgical Inpatient 5300	☑
Royal University Hospital - Surgical Operative Care, PAC & PACU	☑
Saskatchewan Health Authority	☑
Saskatoon City Hospital	☑
Saskatoon City Hospital - Day Surgery and Same Day Surgery, PAC & PACU	☑
Saskatoon City Hospital - MS Clinic	☑
Saskatoon City Hospital - Non-Invasive Cardiology Services	☑
Saskatoon City Hospital - Rehabilitation Outpatient Specialized Services	☑
Saskatoon City Hospital - Spine Pathway Clinic	☑
Saskatoon City Hospital - Surgical Inpatient 3100	☑
Saskatoon City Hospital - Surgical Operative Care, PAC & PACU	☑
Sherbrooke Community Centre	☑
South East Health Centre	☑
St. Paul's Hospital	☑
St. Paul's Hospital - Day Surgery and Same Day Surgery, PACU	☑

Site	On-Site
St. Paul's Hospital - Kidney Transplant Assessment	☑
St. Paul's Hospital - Medicine 5th	☑
St. Paul's Hospital - Medicine 6th	☑
St. Paul's Hospital - Non-Invasive Cardiology Services	☑
St. Paul's Hospital - Palliative 5P	☑
St. Paul's Hospital - Post Transplant Clinic	☑
St. Paul's Hospital - RAAM	☑
St. Paul's Hospital - Surgical 5A	☑
St. Paul's Hospital - Surgical Operative Care, PACU	☑
West Winds Primary Health Centre	☑
World Trade Centre Operational Stress Injury Clinic (OSI)	☑
Youth Resource Centre	☑

[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	0 / 0	0.0%

Table 2: Summary of the Organization's ROPs

ROP Name	Standard(s)	# TFC Rating Met	% TFC Met
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%
	Long-Term Care Services	1 / 1	100.0%
	Mental Health and Addictions Services	1 / 1	100.0%
	Organ Donation for Living Donors	1 / 1	100.0%
	Organ and Tissue Transplant	1 / 1	100.0%
	Perioperative Services and Invasive Procedures	1 / 1	100.0%
	Primary Health Care Services	0 / 1	0.0%
	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	1 / 5	20.0%
	Cancer Care	5 / 5	100.0%
	Critical Care Services	4 / 5	80.0%
	Emergency Department	2 / 5	40.0%
	Home Care Services	2 / 5	40.0%
	Inpatient Services	4 / 5	80.0%
	Long-Term Care Services	5 / 5	100.0%
	Mental Health and Addictions Services	5 / 5	100.0%
	Organ Donation for Living Donors	4 / 5	80.0%
	Organ and Tissue Transplant	4 / 5	80.0%
	Perioperative Services and Invasive Procedures	2 / 5	40.0%
	Primary Health Care Services	3 / 5	60.0%
	Rehabilitation Services	3 / 5	60.0%

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	3 / 4	75.0%
	Inpatient Services	0 / 4	0.0%
	Perioperative Services and Invasive Procedures	4 / 4	100.0%
	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	3 / 3	100.0%
	Organ and Tissue Transplant	0 / 0	0.0%
	Perioperative Services and Invasive Procedures	2 / 3	66.7%
	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	4 / 4	100.0%
	Critical Care Services	4 / 4	100.0%
	Inpatient Services	3 / 5	60.0%
	Organ Donation for Living Donors	0 / 0	0.0%
	Organ and Tissue Transplant	0 / 0	0.0%
	Perioperative Services and Invasive Procedures	5 / 5	100.0%
Pressure Ulcer Prevention	Cancer Care	5 / 5	100.0%
	Critical Care Services	5 / 5	100.0%
	Inpatient Services	4 / 5	80.0%
	Long-Term Care Services	5 / 5	100.0%
	Perioperative Services and Invasive Procedures	4 / 5	80.0%
	Rehabilitation Services	5 / 5	100.0%
Medication Reconciliation at Care Transitions - Emergency Department	Emergency Department	0 / 1	0.0%

Table 2: Summary of the Organization's ROPs

ROP Name	Standard(s)	# TFC Rating Met	% TFC Met
Suicide Prevention	Emergency Department	5 / 5	100.0%
	Long-Term Care Services	0 / 5	0.0%
Home Safety Risk Assessment	Home Care Services	5 / 5	100.0%
Medication Reconciliation at Care Transitions - Home and Community Care Services	Home Care Services	4 / 4	100.0%
Skin and Wound Care	Home Care Services	8 / 8	100.0%
	Long-Term Care Services	7 / 8	87.5%
	Primary Health Care Services	2 / 2	100.0%
Hand-hygiene Education and Training	Infection Prevention and Control	1 / 1	100.0%
	Infection Prevention and Control for Community-Based Organizations	1 / 1	100.0%
Hand-hygiene Compliance	Infection Prevention and Control	0 / 3	0.0%
	Infection Prevention and Control for Community-Based Organizations	0 / 3	0.0%
Infection Rates	Infection Prevention and Control	3 / 3	100.0%
	Infection Prevention and Control for Community-Based Organizations	3 / 3	100.0%

Table 2: Summary of the Organization's ROPs

ROP Name	Standard(s)	# TFC Rating Met	% TFC Met
Reprocessing	Infection Prevention and Control	2 / 2	100.0%
	Infection Prevention and Control for Community-Based Organizations	2 / 2	100.0%
Client Flow	Leadership	5 / 5	100.0%
Preventive Maintenance Program	Leadership	3 / 4	75.0%
Antimicrobial Stewardship	Medication Management	0 / 5	0.0%
High-alert Medications	Medication Management	1 / 8	12.5%
	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	1 / 3	33.3%
Concentrated Electrolytes	Medication Management	3 / 3	100.0%
	Medication Management for Community-Based Organizations	3 / 3	100.0%

Table 2: Summary of the Organization's ROPs

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%
	Primary Health Care Services	5 / 6	83.3%

Table 2: Summary of the Organization's ROPs

ROP Name	Standard(s)	# TFC Rating Met	% TFC Met
Infusion Pump Safety	Organ Donation for Living Donors	0 / 0	0.0%
	Organ and Tissue Transplant	0 / 0	0.0%
	Service Excellence for Ambulatory Care Services	6 / 6	100.0%
	Service Excellence for Cancer Care	6 / 6	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	0 / 0	0.0%
	Service Excellence for Inpatient Services	6 / 6	100.0%
	Service Excellence for Long-Term Care Services	5 / 5	100.0%
	Service Excellence for Mental Health and Addictions Services	6 / 6	100.0%
	Service Excellence for Palliative Care Services	6 / 6	100.0%
	Service Excellence for Perioperative Services and Invasive Procedures	6 / 6	100.0%
	Service Excellence for Primary Health Care Services	0 / 0	0.0%
	Service Excellence for Rehabilitation Services	6 / 6	100.0%

Table 2: Summary of the Organization's ROPs

ROP Name	Standard(s)	# TFC Rating Met	% TFC Met
Safe Surgery Checklist	Organ Donation for Living Donors	0 / 0	0.0%
	Organ and Tissue Transplant	0 / 0	0.0%
	Perioperative Services and Invasive Procedures	2 / 5	40.0%
Hand-Hygiene Compliance	Primary Health Care Services	0 / 3	0.0%
Medication Reconciliation at Care Transitions – Long-Term Care Services	Long-Term Care Services	4 / 4	100.0%
Fall Prevention and Injury Reduction – Long-Term Care Services	Long-Term Care Services	6 / 6	100.0%
Preventing Falls and Reducing Injuries from Falls	Mental Health and Addictions Services	7 / 7	100.0%
Optimizing Skin Integrity	Mental Health and Addictions Services	6 / 6	100.0%
Preventing Venous Thromboembolism	Mental Health and Addictions Services	6 / 6	100.0%
Maintaining an Accurate List of Medications during Care Transitions	Mental Health and Addictions Services	4 / 5	80.0%
Suicide Prevention Program	Service Excellence for Mental Health and Addictions Services	4 / 5	80.0%

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: 78.6% Met Criteria

21.4% of criteria were unmet. For further details please review the table at the end of this section.

Assessment Results

All facilities, units and departments are to be commended on having Emergency and Disaster Preparedness plans in place and accessible to all staff. Staff interviewed had the appropriate knowledge to respond to an emergency code or disaster scenario.

Several of the leadership and management staff have received Incident Command System (ICS) training. The organization is encouraged to continue to promote and offer this training where appropriate.

Some of the areas visited profile the emergency code of the month at which time they review and highlight key information related to emergency response for that code. When mock exercises or real events occur an evaluation of the exercise or a debriefing of the event occurs. This is documented and improvements are made when required.

Site Emergency Preparedness and Planning committees have been reinstated at Royal University Hospital and Saskatoon City Hospital. Regular meetings are now being initiated.

There is collaboration with community partners, such as the City of Saskatoon Emergency Management Organization. The teams are encouraged to continue to strengthen relationships with partners to ensure there is a seamless and coordinated approach to risk assessment and management. This includes establishing regular simulations and mock code exercises involving all the key internal and external partners particularly at the acute care sites. The SHA is encouraged to conduct regular exercises to validate processes, increase knowledge and identify challenges within the existing plan to make improvements.

Although the Saskatchewan Public Safety Agency provides information to the public on how to prepare for emergency and disasters, the SHA is encouraged to look for opportunities to enhance this information relative to the clinical setting.

It was also noted that even though there is one Health Emergency Management (HEM) consultant to support the sites, programs and units within the Saskatoon area, the organization may wish to evaluate whether the appropriate resources are in place to support Emergency and Disaster management functions. There are a total of four HEM consultants across the province.

Table 3: Unmet Criteria for Emergency and Disaster Management

Criteria Number	Criteria Text	Criteria Type
1.3.8	The organization provides patients and clients with information that enables them to be prepared to take care of their health needs in emergencies and disasters.	NORMAL
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
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

Infection Prevention and Control

Standard Rating: 83.9% Met Criteria

16.1% of criteria were unmet. For further details please review the table at the end of this section.

Assessment Results

Saskatoon City Hospital

Infection Prevention and Control (IPAC) has a dynamic team that has expanded resources for scope and scale. Hospital staff are appreciative of the expertise of the IPAC team and acknowledge the importance of Safety Talks that highlight IPAC projects and approaches. The distributive approach to the Hand Hygiene program requires further evaluation including administrative support or safety auditing as hand hygiene results and action planning were not posted on two of the three areas visited. The inpatient surgery unit had an excellent safety wall including hand hygiene statistics and managers who showcased ownership of the program. Nursing and patient care staff on all visited units appreciate the ready online access to IPAC policies and follow procedures for cleaning equipment and separating clean and dirty laundry. Outbreak processes and communications are well understood. Environmental services are welcomed members of safety teams and huddles, including those on the Continuing Care units. Housekeeping staff talk passionately about their roles in infection prevention.

Similarly, an environmental services staff member conducting air vent cleaning in the hallways fully understood his role and contributions.

The physical environment supports infection and control practices on the units. One exception was in a hallway where multiple cloth wall hangings hung, posing an infection control risk. These wall hangings should be placed in wipeable frames to allow more easy cleaning.

Family and patient involvement in IPAC programming is noted with the recognition of the new initiative to include education and hand hygiene wipes on patient trays. Dissemination of this program to other hospitals and community-based organizations is encouraged moving forward.

Royal University Hospital

Infection Prevention and Control (IPAC) has a strong presence within the hospital which has limitations due to age and space. IPAC management coordinates provincial and local projects using a robust planning digital board. Patient care staff voice that they are well supported with IPAC and know where to locate policies and procedures online.

There are concerns about the physical environment and infection prevention controls. Newer areas of the hospital, such as the location of Maternal Services, are well designed for IPAC considerations. Maternal Services had a well-organized wall board which features excellent hand hygiene results. A review of the cleaning and disinfection area for sonography reveal a well-designed area. A focus on ongoing probe cleaning retraining of sonographers and ensuring proper trans-vaginal probe cleaning and disinfection is suggested. Although clean probes are placed within the cabinet, a higher risk practice of using the same probe cover for a clean probe and then using the same cover for a used probe should be reconsidered. A logbook with printed cleaning material generated by the Tryphon is maintained. In the event of a probe or reagent recall, suggest that a digital recall method be explored.

The Intensive Care Unit (ICU) and ICU Flex 3 and 4 units were visited. The ICU Nurse Manager is passionate about IPAC and tries to maximize infection prevention measures in a cramped and temporary areas. Due to the severe limitations of the physical space and impact on infection prevention, the renovation or relocation of ICU, including flex units, should be a high priority. The main ICU area has a functioning hopper which should be decommissioned, and bedpan disinfectant units installed in each patient room along with a functioning toilet and washroom. Hand hygiene and hand washing sinks should be installed that are accessible for staff. Open, noncovered linen carts are stocked in the crowded hallways. There are no hand hygiene statistics posted as auditing has gotten behind. The flex ICU units are contained within pediatric-designed spaces such that the curtains rest on the end of the patient beds and small non-useable toilets are contained in the cupboards under small sinks. Given the ICU volume demands, additional attention to the flex layout and IPAC considerations should be planned.

St. Paul's Hospital

The IPAC team members are an integral part of the patient care areas and building service teams. The IPAC team and building services are commended for their local work to build capacity and knowledge about infection prevention and control procedures for renovation and capital builds. Both teams flag concerns if construction-related IPAC controls are not maintained by other units, increasing the risk of patient and staff harm such as when air handlers are turned off on night shifts. A construction or renovation prioritization matrix, with IPAC insight, is recommended for the SHA given the aging infrastructure of hospitals in Saskatoon.

The IPAC team appreciates the provincial and local projects that highlight a culture of distributive project leadership such as the Level 4 Pathogen planning. Recognition is given that planning for an Ebola outbreak is unsettling and anxiety-provoking and that the IPAC professionals and teams are moving forward masterfully.

A visit to the endoscopy suite revealed energetic and patient-oriented staff. The endoscope cleaning area is small for its functions and does not have a separate hand washing sink. There is no pass through for clean scopes and the mask/visor combination is not the recommended mask with separate visor. Other staff use the garbage in the cleaning area for general garbage disposal and the cleaning room contains carboard boxes instead of plastic bins and storage of other items which should be removed. A new scope storage cabinet with ventilation is expected to be installed soon. An IPAC review of the area is recommended moving forward.

A visit to the emergency area showcased patient-care oriented nursing, medical and environmental service staff. The emergency entrance hand hygiene area is located near the security guard to the left. A more centralized hand cleaning and masking area is recommended although this will be a challenge given space. The Environmental Services staff clean the waiting room and patiently move around those waiting in chairs in the room. There were several patients in treatment lounge chairs in an area marked triage, some of whom were coughing and were not wearing masks. Due to the cramped space, masking of patients showing respiratory symptoms is important. The emergency area and emergency minor assessment and care (MAC) physical space lacks sufficient staff and patient washrooms, hand washing spaces and storage spaces. Linen and other carts are open and located in hallways. Some remodeling with IPAC consultation is recommended moving forward.

Hand hygiene results were not visible in Emergency, and staff have their wall huddle board in the nursing lounge. Staff are encouraged to have the daily huddles in a hallway so that staff from other departments such as environmental services, IPAC, Pharmacy can participate. Respiratory illness protocols have evolved since the pandemic and staff have concerns about the alignment of protocols with practice especially for patient flow and admissions from emergency. Staff voice that patient screening, including MRSA and CPO, in emergency prior to admission may improve patient flow so patients have the correct isolation as inpatients.

Environmental service policies should be reviewed as some were last revised in 2018 and Safety Data Sheets (SDS) within the SDS binders date back to 2019 and 2018.

The Leslie and Irene Dubé Centre for Mental Health

This department truly understands the importance of monitoring and adhering to infection prevention control standards. Their visual management boards post up to date Hand Hygiene rates as well as Infection rates. This information is visible to patients, families and staff. They have excellent support from an IPAC practitioner who is readily available to them when required.

Through the unit's Patient and Family Advisory Council, members are kept informed on information related to infection prevention control such as isolation procedures, current outbreaks as well as post evaluation information following an outbreak. Staff are aware of adherence to appropriate isolation precautions. Housekeeping staff who were interviewed are well aware of appropriate housekeeping practices. They receive up to date education on changes or new information for them to carry out their duties. It was noted that there is a lot of paper memos and posters, posted throughout the facility. This practice poses an IPAC risk. The team is encouraged to look for ways to reduce the amount of paper postings and to consider having required material laminated.

Table 4: Unmet Criteria for Infection Prevention and Control

Criteria Number	Criteria Text	Criteria Type
2.5.4	Team members, and volunteers have access to dedicated hand-washing sinks.	NORMAL
2.5.6	Hand-hygiene Compliance 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). 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

Criteria Number	Criteria Text	Criteria Type
2.7.9	When cleaning, disinfection, and/or sterilization of medical devices or equipment is done in-house, team members involved in these processes are provided with education and training in how to do so when they are first employed and on an ongoing basis.	HIGH
2.7.10	When an organization cleans, disinfects, and/or sterilizes devices and equipment in-house, there are designated and appropriate area(s) where these activities are done.	HIGH
2.7.11	The area where cleaning, disinfection, and/or sterilization of medical devices and equipment are done is equipped with hand hygiene facilities.	HIGH
2.7.13	Items that require cleaning, disinfection, and/or sterilization are safely contained and transported to the appropriate area(s).	HIGH
2.7.14	Appropriate personal protective equipment is worn when cleaning, disinfecting, or sterilizing medical devices and equipment.	HIGH
2.7.20	Sterilized packages are clearly identifiable and distinguished from non-sterilized items.	HIGH

Infection Prevention and Control for Community-Based Organizations

Standard Rating: 82.8% Met Criteria

17.2% 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.

Across all long-term care homes and most community sites visited, hand hygiene compliance was being measured, results were shared and used to make improvements to hand-hygiene practices. At the primary health care teams visited during the onsite survey, there is opportunity to share information collected about infection prevention and control activities and share results of evaluations with team members, clients, and families. The team at the Idylwyld Centre is working towards fully implementing hand hygiene audits that will include sharing of results and evaluation approaches. Regular evaluation of priority activities such as external cleaning contract quality and auditing, and hand hygiene compliance is also recommended.

At the long-term care homes visited during the survey week, the leadership teams and staff demonstrated dedication to resident, staff and family safety which extends to an observable commitment to infection prevention and control standards. Infection prevention and control policies and procedures are made readily available to team members. Facilities are clean and welcoming with optimal environmental conditions maintained. Food preparation areas are clean, physically separated and the necessary protocols for the safe preparation of food are followed.

Staff and family are well informed around isolation precautions and the appropriate use of personal protective equipment (PPE). Appropriate signage and supplies are readily available and visible to support isolation precautions. Processes are in place to manage outbreaks. This includes appropriate communication and notification to the resident's family as well as evaluating the outbreak and sharing this information with staff, residents and their families. Staff follow processes for disposal of sharps and soiled linen.

In the community-based programs visited, alcohol-based hand sanitizers were present, and personal protective equipment (PPE) is available as necessary. At South East Health Centre, the physical space requires a review to optimize environmental conditions such as carpet removal and corkboards. Wooden surfaces showing signs of wear at South East Health Centre and the Youth Resource Centre may benefit from being replaced with a different non-porous surface to support cleaning and disinfection. At the Youth Resource Centre, documentation of cleaning the physical environment could be strengthened by clearly documenting dates and times of previous cleaning and when next due.

Table 5: Unmet Criteria for Infection Prevention and Control for Community-Based Organizations

Criteria Number	Criteria Text	Criteria Type
1.2.3	Optimal environmental conditions are maintained within the physical environment.	NORMAL

Criteria Number	Criteria Text	Criteria Type
2.5.4	Hand-hygiene Compliance 2.5.4.1 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). 2.5.4.2 Hand-hygiene compliance results are shared with team members and volunteers. 2.5.4.3 Hand-hygiene compliance results are used to make improvements to hand-hygiene practices.	ROP
2.6.5	Compliance with policies and procedures for cleaning and disinfecting the physical environment is regularly evaluated, with input from clients/residents and families, and improvements are made as needed.	NORMAL
3.3.1	Infection prevention and control activities are regularly evaluated.	NORMAL
3.3.2	Performance measures are monitored for infection prevention and control.	NORMAL
3.3.3	Input is gathered from team members, volunteers, and clients/residents and families on the effectiveness of infection prevention and control activities.	NORMAL
3.3.4	The information collected about infection prevention and control activities is used to identify successes and opportunities for improvement, and to make improvements in a timely way.	NORMAL

Criteria Number	Criteria Text	Criteria Type
3.3.5	Results of evaluations are shared with team members, volunteers, clients/residents, and families.	NORMAL

Leadership

Standard Rating: 72.7% Met Criteria

27.3% of criteria were unmet. For further details please review the table at the end of this section.

Assessment Results

Patient Flow

System flow is managed provincially to optimize patient flow across the system, to manage capacity demand, to standardize processes, to leverage data and analytics to support decision-making and to leverage virtual care. The organization has various initiatives and strategies to support system flow. This includes overcapacity protocols blending Emergency Department risk with facility capacity, real time demand and capacity, beds need analysis which highlighted a significant deficit in beds to meet demand, the Saskatoon Capacity Action Plan, patient flow algorithms, bed management framework and patient placement, bed capacity dashboard, communication flow, huddles and reporting, and system flow as part of the ELT Wall Walks. The Provincial System Flow team is to be congratulated on their innovative and progressive approach to patient flow within Saskatoon and across the Saskatchewan Health Authority. The team is encouraged to follow monitor the effectiveness of their strategies, make improvements as required and to share this work internally and externally.

Integrated Quality Management

The provincial Acute Care Portfolio is one of four newly established provincial portfolios. The aim of these portfolios is to enable equitable access to high quality health care services for all people by aligning strategies and priorities, connecting people, reducing unwanted variation, deconstructing silos across service lines and geographical boundaries. In addition, the portfolios aim to improve lines of communication, knowledge transfer and collaboration as well as optimize the allocation and use of services and resources while leveraging evidence, science and innovation. The key functions for the Acute Care Portfolio are provincial strategy and planning, provincial system design and infrastructure and service planning, policy and clinical care standards, provincial partnerships and engagement, clinical quality improvement, monitoring, evaluation and reporting, innovation, and research.

As the evolution of this portfolio is in its early days, the team is encouraged to align with the Accreditation Canada Leadership standard, specifically criteria on Integrated Quality Management to guide their work. With the aggressive work plan that the team has outlined, they are commended for placing a risk and change management lens on all activity. As this work will result in significant changes, concerns have been raised that the organization is not equipped with the appropriate resources to support change. The SHA is encouraged to ensure that a change management program is in place. It will be exciting to see the maturity of this new program to support the provision of Acute Care Services within the Saskatchewan Health Authority. As this is a small and mighty team committed to the task that they have been given, the organization will need to ensure that appropriate supports and resources are in place for them to achieve the expected outcome.

Medical Devices and Equipment

The organization has implemented a new provincial preventative maintenance computer system. The SHA is now moving towards a reporting, analysis, and evaluation system for this preventative program. It was not evident that an evaluation of the effectiveness of the preventative maintenance program had yet occurred. The SHA is encouraged to implement a process to evaluate the effectiveness of the preventative maintenance program across all sites.

One of the principal activities of the preventative maintenance program at St. Paul's Hospital is the management of hemodialysis machines. The service also looks after a large community dialysis unit closely aligned to the hospital. There are also several satellite hemodialysis units across Northern Saskatchewan. The organization is currently completing a request for proposal for new dialysis machines. Most of the medical equipment including most life critical equipment is covered by the preventative maintenance program. As of now, preventative maintenance practices are based on the manufacturer's recommendations.

Saskatoon City Hospital has a smaller but newer preventative maintenance department than the other two hospitals visited. While there is no formal process to evaluate the effectiveness of the preventative maintenance program the staff indicated that the program has extended the life of many machines. There is a decrease in equipment referrals for many of the machines that undergo preventative maintenance and the time to failure of the machines has increased.

Physical Environment

In general, the organization ensures that the physical spaces are safe and meets laws and regulations. It was noted that there is excellent working relationships and good communication between facilities and the programs in addressing any issue. However, it was noted that during the survey that there are units situated in areas that may not be meeting legislative requirements as well as supporting quality and safety. Of note is the Intensive Care Unit (ICU) and ICU Flex at the Royal University Hospital (RUH) and the endoscopy unit at the RUH. It is suggested that these areas be reviewed. As well, the organization needs to ensure that infection prevention control and occupational health and safety standards are being met during construction and renovations.

Table 6: Unmet Criteria for Leadership

Criteria Number	Criteria Text	Criteria Type
4.3.1	The organization ensures its physical spaces are safe and meet relevant laws and regulations.	HIGH
4.3.3	The organization protects client and staff health and safety during construction or renovation.	HIGH
4.3.8	Preventive Maintenance Program 4.3.8.3 There is a process to evaluate the effectiveness of the preventive maintenance program.	ROP

Medication Management

Standard Rating: 84.7% Met Criteria

15.3% of criteria were unmet. For further details please review the table at the end of this section.

Assessment Results

The SHA Medication Use and Safety Interdisciplinary Steering Committee (MUSIC) has established area MUSIC Committees for Regina, Saskatoon, Northwest, Northeast, and Integrated Rural Health to discuss practice issues in these areas, respectively. Each committee reviews the safety data and makes recommendations for improvements in the medication system to prevent further errors. Medication safety walk abouts have been established in Saskatoon where pairs of committee members visit a unit and discuss medication safety issues with front line staff. This serves as an opportunity to re-enforce awareness of any new safety initiative e.g., the anaphylaxis protocol. In addition, any potential safety concerns are brought back to the MUSIC committee for discussion and input.

There are two designated medication safety staff at the Saskatoon City Hospital who review all the medication related incidents within the electronic system across the city and provide for awareness of potential quality improvements or action that are needed to enhance patient safety.

Automated Dispensing Cabinets (ADC) have been deployed in most of the acute care hospitals within the province although there are many units which do not yet have an ADC. The SHA is encouraged to continue further procurement of these Automated Dispensing Cabinets for storage of narcotics, and high alert medications as resources become available to mitigate risks and support medication safety.

The sterile compounding rooms for hazardous (chemotherapy) and non-hazardous intravenous products at Saskatoon have been reviewed and RUH pharmacy has been designated as one of the sites to receive the required funding to become NAPRA compliant. All sites are encouraged to ensure chemotherapy medications are stored in a separate negative pressure room with adequate ventilation and separated from other supplies where possible.

Within Saskatoon, not all acute care sites have implemented an antimicrobial stewardship program. There is opportunity for implementation at St. Paul’s Hospital and for all acute care sites to evaluate the antimicrobial stewardship program and share results. In addition, there is opportunity across sites to establish a structured program to reduce the risks associated with polypharmacy, especially with frail or vulnerable clients.

Several policies are currently under review and updates are pending (management of high-alert medications, infusion pump alert override). At one site (Parkridge Centre) there is opportunity to conduct audits for high-alert medications.

With regards to medication storage, the team at the Calder Centre is encouraged to review current practices for storage of narcotics and other controlled substances to meet requirements for safety and efficiency.

Recruitment of staffing for pharmacists and technicians continues to be a challenge due to some expanded funding and limited graduates from the respective programs. Clinical pharmacist services are allocated to programs/areas where designated funding has supported the staffing. The clinical priority areas have been established and are reviewed by the clinical specialists/managers.

Table 7: Unmet Criteria for Medication Management

Criteria Number	Criteria Text		Criteria Type
1.2.3	Antimicrobial Stewardship		ROP
	1.2.3.1	An antimicrobial stewardship program has been implemented.	
	1.2.3.2	The program specifies who is accountable for implementing the program.	
	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.	
	1.2.3.4	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).	
	1.2.3.5	The program is evaluated on an ongoing basis and results are shared with stakeholders in the organization.	
1.2.5	High-alert Medications		ROP
	1.2.5.1	There is a policy for the management of high-alert medications.	
	1.2.5.2	The policy names the role or position of individual(s) responsible for implementing and monitoring the policy.	
	1.2.5.3	The policy includes a list of high-alert medications identified by the organization.	
	1.2.5.4	The policy includes procedures for storing, prescribing, preparing, administering, dispensing, and documenting each identified high-alert medication.	
	1.2.5.5	Concentrations and volume options for high-alert medications are limited and standardized.	
	1.2.5.6	Client service areas are regularly audited for high-alert medications.	
	1.2.5.7	The policy is updated on an ongoing basis.	

Criteria Number	Criteria Text	Criteria Type
4.1.4	Narcotics Safety 4.1.4.1 An audit of the following narcotic products in client service areas is completed at least annually: • Fentanyl: ampoules or vials with total dose greater than 100 mcg per container • HYDROmorphone: ampoules or vials with total dose greater than 2 mg • Morphine: ampoules or vials with total dose greater than 15 mg in adult care areas and 2 mg in paediatric care areas. 4.1.4.3 When it is necessary for narcotic (opioid) products to be available in select client service areas, an interdisciplinary committee for medication management reviews and approves the rationale for availability, and safeguards are put in place to minimize the risk of error.	ROP
4.3.2	A policy that specifies when and how to override smart infusion pump alerts is developed and implemented.	HIGH
5.1.6	Medication storage areas meet legislated requirements and regulations for controlled substances.	HIGH
5.2.3	Chemotherapy medications are stored in a separate negative pressure room with adequate ventilation and are segregated from other supplies where possible.	HIGH
6.1.1	A structured program has been implemented to reduce the risks associated with polypharmacy, especially with frail or vulnerable clients.	HIGH
6.1.4	Standardized, pre-printed forms shall be used to order medications that are commonly prescribed or have been identified as high risk.	HIGH
6.1.11	The organization uses regular, documented audits to assess the accuracy of medication order documentation and makes improvements as needed as part of a continuous quality improvement program.	HIGH

Medication Management for Community-Based Organizations

Standard Rating: 92.6% Met Criteria

7.4% 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 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 SHA Medication Use Safety Interdisciplinary (MUSIC) Continuing Care Committee has been established to support safe medication in these facilities across the province.

The SHA MUSIC Continuing Care Committee has developed tools for the long-term care (LTC) homes to audit high alert medications including narcotics, heparin and concentrated electrolytes. To improve compliance with these audits at the local level, the SHA may wish to employ a centralized process for the individual facilities to submit their completed data. There is opportunity to implement audits for the 'Do Not Use' List of Abbreviations at some sites and spread audit tools to primary health care teams that also manage medications.

For LTC homes, contracted community pharmacies provide daily deliveries of medications in unit dose packaging or blister packages support safe practices. In addition, they supply either paper or electronic medication administration records for nurses to document medications. The clinical pharmacist will provide quarterly reviews of each client's current medication for appropriateness. Posters, education and training about safe use of medications is provided by SHA and the local community pharmacy. There is opportunity to ensure medications carts within all long-term care homes have functioning locks to mitigate safety risks.

In LTC homes where intravenous antibiotic treatment is provided to clients, the Community Paramedicine or Community Home Care Nurse are often available to initiate the IV and initial dose of medication. This avoids unnecessary visits to the Emergency Department.

As medication management practices are standardized throughout the province, there is a need to ensure primary care team members involved in medication management activities have input into developing medication management policies and procedures. Recently, a Primary Care MUSIC Committee has been created to discuss safe medication practices in these care settings. In addition, within primary health care, there is an opportunity to standardize the process to report medication safety incidents as well as review and analyze these events should they occur.

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

Criteria Number	Criteria Text	Criteria Type
1.1.5	The 'Do Not Use' List of Abbreviations 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	High-alert Medications 1.1.7.1 The organization has a policy for the management of high-alert medications.	ROP
1.3.5	Medication storage areas meet legislated requirements and regulations for controlled substances.	HIGH
3.2.4	The organization uses regular, documented audits to assess the accuracy of medication order documentation and makes improvements as needed as part of a continuous quality improvement program.	HIGH
7.1.11	Patient safety incidents that occur when team members are assisting a client with medications are reported and incorporated into the organization's patient safety incident management system.	HIGH
8.1.1	Patient safety incidents involving medications are reported in accordance with the organization's patient safety incident management system.	HIGH
8.1.2	All patient safety incidents and near misses are reported, reviewed, and analyzed.	HIGH

Criteria Number	Criteria Text	Criteria Type
8.1.3	Patient safety incidents involving medications are reviewed and established criteria are used to prioritize those that will be analyzed further.	HIGH
8.1.4	Teams are involved in the analysis of patient safety initiatives involving medications.	NORMAL

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: 88.3% Met Criteria

11.7% of criteria were unmet. For further details please review the table at the end of this section.

Assessment Results

Ambulatory care clinics in Saskatoon were assessed including medical/surgical clinics, outpatient cardiosciences and neurosciences as well as ambulatory rehabilitation services. These clinics offer specialized services and resources supporting patients and families accessing outpatient services.

The goal of many of these clinics is to support early detection and diagnosis. The heart function clinic is one example, and the team is working towards expanding their reach to capture people at an earlier phase of the disease through enhanced community partnerships including rural Saskatchewan.

Other clinics have been effective in contributing to reduced surgical wait-times. The Spine Pathway clinic at Saskatoon City Hospital has decreased the wait for surgery from 18months to 3 months. In addition, this clinic has done exceptional work and created huge successes in reducing wait times to access the clinic (3 weeks to 10 days).

Patient preferences and options for services are discussed as part of the assessment, in partnership with the patient and family. At the Saskatoon City Hospital Multiple Sclerosis (MS) clinic, patients expressed feeling like a partner in their care, feeling open to express concerns and provided with the support to make informed decisions.

There is an opportunity for several clinics to start tracking appointment no show rates (the number of clients who fail to present at scheduled appointments) or appointments that do not start on time. Teams are encouraged to monitor this information and collaborate with patients and families to identify opportunities for improvement.

There is variation in the sharing of information was evident presenting an opportunity to standardize information transfer at care transitions, including documentation tools, communication strategies and defining information to be shared at care transitions. It is suggested that teams have a process in place to share information with accepting areas when a decision is made to admit an ambulatory care client to hospital during their ambulatory care appointment. Team leadership at RUH is encouraged to collaborate with other areas to implement processes already in place within the organization. The effectiveness of communication is not presently being evaluated across ambulatory clinics visited. The teams are encouraged to perform chart audits to assess completeness, consistency, and effectiveness and this information used to improve transition planning, with input from clients and families. Although many teams continue to be challenged by the hybrid charting.

Table 9: 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
1.1.6	The length of time clients wait for services beyond the time the appointment was scheduled to begin is monitored and work is done to reduce that time as much as possible.	NORMAL
1.4.10	Information Transfer at Care Transitions 1.4.10.1 The information that is required to be shared at care transitions is defined and standardized for care transitions where clients experience a change in team membership or location: admission, handover, transfer, and discharge. 1.4.10.2 Documentation tools and communication strategies are used to standardize information transfer at care transitions. 1.4.10.4 Information shared at care transitions is documented. 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: 78.8% Met Criteria

21.2% of criteria were unmet. For further details please review the table at the end of this section.

Assessment Results

There is strong leadership at all ambulatory care clinics. Teams are highly engaged, providing quality, safe services.

Staff are well trained and complete a fulsome orientation. Staff attend all mandatory education activities this includes hand hygiene, cultural awareness, and CPR recertification. There is extensive and ongoing education for staff – for example certification in Advance Cardiovascular Life Support (ACLS). Performance reviews are done inconsistently, the organization is encouraged to take a structured approach to completing performance reviews and discuss development opportunities with staff.

More effort could be put into establishing clinic specific service goals, objectives and indicators consistently across clinics. While leadership is engaged in quality improvement (QI) activities, measurement of indicators is not consistent limiting opportunities for monitoring and evaluation. There are some good examples of projects that have been successful including developing a rural remote cardiac device interrogation clinic to support care closer to home and decreasing the need for patient travel. Another example is focused attention to standardize criteria for patients requiring holter testing and a concerted effort to increase testing output to reduce waiting times.

Guidelines are well developed in the cardiac services. The SHA has used and adapted the heart failure action plan for Canada to improve heart failure care in Saskatchewan. In addition, some research activity is underway with external academic partnerships. Two projects related to ST elevation myocardial infarction and direct transmission of ECGs from EMS to cardiologists using an app were shared.

Within the non-invasive cardiology service, both sites (Saskatoon City Hospital and St. Paul’s Hospital) are encouraged to review procedures for securely storing and protecting privacy of client records including storage of paper files and locking of computer workstations when unattended. The team is using hybrid charting which reduces productivity and increases workload.

Plans are underway to improve patient engagement. Some clinics have patient experience surveys, with results analyzed quarterly, for example at the Saskatoon outpatient cardiology clinic. The RUH ambulatory care clinic has a suggestion box that facilitates client and family input into the functioning of the unit. A routinely available survey regarding client and family experience in the various clinics would further support co-design and input into clinic services.

Table 27: Unmet Criteria for Service Excellence for Ambulatory Care Services

Criteria Number	Criteria Text	Criteria Type
1.1.2	The team uses information about the service needs of clients and the community to guide its service design.	NORMAL
1.1.3	The team develops its service-specific goals and objectives.	NORMAL
1.1.4	The team monitors and evaluates its services for appropriateness.	NORMAL
1.1.7	The team works with the organization to identify and remove barriers that may limit clients, families, service providers, and referring organizations from accessing its services.	NORMAL
2.1.5	The team leadership ensures that staff are provided with education and training on the organization's ethics framework.	NORMAL
2.1.10	The team leadership regularly evaluates and documents each staff member’s performance in an objective, interactive, and constructive way.	HIGH
2.1.12	The team leadership supports staff to follow up on issues and opportunities for growth identified through performance evaluations.	HIGH
3.1.6	The team leadership ensures that staff follow organizational policies and procedures for securely storing, retaining, and destroying client records.	HIGH
4.3.3	The team identifies measurable objectives for its quality improvement initiatives including specific timeframes for their completion.	HIGH

Criteria Number	Criteria Text	Criteria Type
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
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
4.3.11	The team regularly evaluates quality improvement initiatives for feasibility, relevance, and usefulness.	NORMAL

Cancer Care

Standard Rating: 100.0% Met Criteria

0.0% of criteria were unmet.

Assessment Results

The 29-bed oncology unit at Royal University Hospital consists of 23 beds and six bed closed stem cell unit. There is a large team of approximately 150 nurses, social workers, care aides, and other allied health. Very close working relationship exists with the pharmacy program, with the benefit of several pharmacists being assigned to the oncology unit.

Patients are referred for admission through the ambulatory clinic or the emergency department. The intake process is comprehensive and streamlined. Diagnostic and lab testing is accessible in a timely manner to support a comprehensive assessment of patients. Charts are standardized and comprehensive. Individual care plans are developed with the patient and their family. The information that is required to be shared at care transitions is well defined and standardized.

Staff have access to and can retrieve policies quite easily as needed. They have access to clinical and practice guidelines and protocols that are needed for patient care and service delivery. Staff voiced concern that they have paper-based documentation and other disciplines have electronic charting. The organization would benefit from full adoption of an electronic medical record.

The unit is to be commended on the development and adoption of an exceptional number of order sets, medication reconciliation compliance, pain management and assessment for risk of venous thromboembolism (VTE). With the support of the pharmacists embedded in the oncology unit, a Best Possible Medication History (BPMH) is generated upon admission, utilized during transitions in care and upon discharge. At least two person-specific identifiers are being used to confirm that patients receive the care intended, all infusion pumps are clearly labelled to ensure provision of safe care, and established guidelines are followed for the safe handling of systemic cancer therapy medications.

The unit provides adequate space for patients with large private rooms in the stem cell unit. A patient/family room is located on the unit which is utilized for patient/family private conversations and meetings. Appropriate follow up services for patients are effectively coordinated during transitions of care and upon discharge

The unit has indicators that they report to the Saskatchewan Cancer Agency for access, systemic therapy safety, bone marrow transplant volumes to name a few. There is a vast number of chart audits completed by the clinical educator, the pharmacist and a staff member that could be shared more broadly on a regular and consistent basis. A visual management board exists in the middle of the unit that could be leveraged to post audit results or trending of indicators. The manager does not routinely receive audit reports from pharmacy on medication reconciliation compliance, heparin safety, and narcotic use but is aware that the audits are being completed. Hand Hygiene audits have not been completed for a significant period of time until last month. It is recommended that audit results be shared with front-line staff and quality initiatives identified to address areas of concern timely.

Table 10: Unmet Criteria for Cancer Care

There are no unmet criteria for this section.

Service Excellence for Cancer Care

Standard Rating: 88.8% Met Criteria

11.2% of criteria were unmet. For further details please review the table at the end of this section.

Assessment Results

The RUH oncology unit operates in partnership with the Saskatchewan Cancer Agency. The partnership facilitates the collection and utilization of data such as demographics, client specific data and patient care which is collated into a provincial database. The unit typically functions at full capacity every day. A recent demand versus capacity and bed mapping analysis was recently completed. It was identified that 10 additional beds are needed to meet current and future need.

The staff morale is excellent, and it was evident during the visit. Leaders and team members are dedicated, caring and committed. Patients were very complimentary of the staff and the care provided.

There is a very strong orientation and onboarding process with a Learning pathway that aligns with the cancer care services accreditation standards. It ensures staff receive all the necessary training for competency and success. As well, there is built in progressive learnings as staff become more experienced in the unit that allows for advanced roles in patient care.

Performance reviews have not been completed in recent years; the manager has identified this as a priority but acknowledges the challenge with a span of control of 150 staff. It is recommended that a consistent plan be developed to start the reviews in coming weeks.

Pharmacy team members complete regular auditing of venous thromboembolism (VTE) compliance, heparin safety and medication reconciliation compliance but the data is not routinely shared. A significant amount of information is collected and sent to the Cancer Agency but there was limited evidence that regular auditing is completed on the oncology unit.

No quality improvement initiatives have been identified or are in progress. Additional resourcing could help support this work. It is also suggested that a quality committee with patient/family partners, staff and leaders be established to review audit and indicator data, identify opportunities for quality improvement initiatives and setting of priorities to strengthen quality of care. If there are challenges with staff joining committees or attending meetings on their days off perhaps consideration could be given for compensating staff for their time in- lieu to ensure staff feel valued and are engaged in committees and unit activities.

Table 28: Unmet Criteria for Service Excellence for Cancer Care

Criteria Number	Criteria Text	Criteria Type
2.1.10	The team leadership regularly evaluates and documents each staff member's performance in an objective, interactive, and constructive way.	HIGH
2.1.12	The team leadership supports staff to follow up on issues and opportunities for growth identified through performance evaluations.	HIGH
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
4.3.11	The team regularly evaluates quality improvement initiatives for feasibility, relevance, and usefulness.	NORMAL

Critical Care Services

Standard Rating: 90.2% Met Criteria

9.8% of criteria were unmet. For further details please review the table at the end of this section.

Assessment Results

The RACE (Rapid Assessment of Critical Events) program is a valuable program that has recently been initiated at the Royal University Hospital (RUH), spreading the concept of an early intervention team from St. Paul's Hospital (SPH). The data collected from this program can help inform areas within the hospital that may have safety or care concerns that the team can help address.

The teams are commended on their work to implement Spontaneous Awakening Trials as well as Spontaneous Breathing trials, these are important interventions to manage sedation levels as well as supporting the prevention of delirium.

While the two critical care areas at RUH and SPH have embedded client and family participation in multidisciplinary rounds as a part of their culture, this remains physician dependent on the coronary care unit at RUH. The team is encouraged to explore the value of this practice, as well as involving client and family partners to support embedding this change.

Some teams do struggle with the fact that there is no patient survey mechanism that reviews critical care-specific or general patient and family satisfaction measures. This information is valuable to routinely include into many types of decision-making. Support for standardization of this client and family feedback mechanism throughout services is encouraged.

Families spoken with on two units were not aware of the process to file a complaint or a violation of their rights. Although the client right and responsibility poster was posted near or on the unit, the link/phone number/email for the client concerns office could be made more accessible in the rooms and directly provided to clients and families. This could take the form of a section in a welcome package, a business card to hand out with the contact information, or QR codes posted in the rooms.

During the on-site visit to RUH, on one unit none of the patient charts reviewed had any documentation in the section that indicates who the information was verified with. The unit process is that physicians complete the best possible medication history (BPMH), which is verified by the supporting pharmacist within about 24 hours of patient admission, but they do this virtually by reviewing the records they have access to and do not visit the unit to complete a patient and family verification process. Audits completed by the organization simply verify whether the BPMH is complete, not whether it was completed in partnership with clients and families. It is recommended that the organization explore how this component of the Medication Reconciliation process can be improved in areas that do not have on-unit pharmacist support to ensure client safety regarding medication orders. There is an opportunity on another unit to establish a process to evaluate the effectiveness of communication at transitions in care.

There is also an opportunity to establish a set process or guide that all units use to ensure the appropriate personnel, medication, and equipment accompany the transport of a critical care patient. Such a process would support staff to consistently include the correct safety precautions and mitigate the safety risks of transporting a critically ill patient. The current elevator situation for RUH Intensive Care Unit (ICU) poses a potentially significant safety risk to transporting critically ill patients and their life-support equipment within the hospital (for example to the MRI area or operating room). This requires immediate attention to ensure the appropriate personnel and equipment can accompany the patient in the elevator.

Current policies regarding organ and tissue donation were unavailable and updates are planned to address this.

Table 11: Unmet Criteria for Critical Care Services

Criteria Number	Criteria Text	Criteria Type
1.1.4	Critical care units are designed with input from clients and families to be self-contained and dedicated to the 24-hour care of clients with life threatening or potentially life threatening conditions.	NORMAL
2.2.2	Family presence is promoted within the critical care environment based on the wishes of the client and family.	NORMAL
2.2.16	Clients and families are provided with information about how to file a complaint or report violations of their rights.	HIGH
2.3.6	Medication Reconciliation at Care Transitions Acute Care Services (Inpatient) 2.3.6.1 Upon or prior to admission, a Best Possible Medication History (BPMH) is generated and documented in partnership with clients, families, caregivers, and others, as appropriate.	ROP
2.4.3	Daily rounds are conducted by the team in partnership with the client and family.	HIGH

Criteria Number	Criteria Text	Criteria Type
2.4.23	Information Transfer at Care Transitions 2.4.23.5 The effectiveness of communication is evaluated and improvements are made based on feedback received. Evaluation mechanisms may include: • Using an audit tool (direct observation or review of client records) to measure compliance with standardized processes and the quality of information transfer • Asking clients, families, and service providers if they received the information they needed • Evaluating safety incidents related to information transfer (e.g., from the patient safety incident management system).	ROP
2.6.8	Clients are safely transported to and from critical care units.	HIGH
2.6.9	The effectiveness of transitions is evaluated and the information is used to improve transition planning, with input from clients and families.	NORMAL
2.7.1	There are policies and procedures on organ and tissue donation.	NORMAL
2.7.3	There is a policy on donation after cardiovascular death (DCD).	NORMAL
2.7.4	There is a policy on neurological determination of death (NDD).	NORMAL

Service Excellence for Critical Care Services

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

The critical care team in Saskatoon is a strong team of multidisciplinary health professionals dedicated to providing excellent care to their clients and families. The critical care services in Saskatoon serve an extremely vast catchment area, and often are caring for clients and their families from outside of the Saskatoon urban area. Clients and families interviewed commended the critical care teams for their dedication and excellence as well as emphasized the caring attitude they have received at all stages of their journey within critical care.

Not all teams could not provide examples of service co-design. Access to a client experience survey was inconsistent throughout critical care areas. Although the team has plans to include clients and families in the future stages of the work of designing a new ICU space, there is currently not a mechanism for clients and families to provide input or feedback about the existing unit at RUH ICU. Family members interviewed noted that there is currently an absence of a quiet night-time area for family members to rest.

Team members have access to information about palliative and end of life care and are proud of their ability to offer access to spiritual care and space for spiritual practices to meet the needs of their clients and families.

The teams are well supported by various educational opportunities to maintain basic competency, prevent violence, and develop advanced clinical skills as part of the critical care team. The critical care leadership is commended on their support of advancing skills of the unit Registered Nurses to be able to support extracorporeal membrane oxygenation (ECMO) for patients, including training that took place in Edmonton. Training and education can be enhanced by ensuring that there is engagement with clients and families to define the training and education for all team members. Although team members were aware of how to access an ethics team, they were not aware of the existence of an ethics framework within the organization.

The variety of platforms that online education is hosted poses a challenge for leaders and staff to be able to adequately support and monitor team progress on education. The organization is encouraged to support consolidation of online educational platforms, and to engage frontline leaders and educators in how they can best be supported in this. All leadership teams described ways that they were individually attempting to address this challenge which could be more efficiently supported at a corporate level.

Informal conversations about performance and professional development happen often on the unit; however, formal, documented performance reviews are not occurring with these large teams. The organization is encouraged to look at how to support leaders who, at times, have over 100 staff that they are supporting, to complete regular performance reviews to invest in the development and retention of their valuable critically care trained workforce.

Clinical documentation has been standardized across similar units in the critical care programs in Saskatoon. Despite the ability of the critical care areas to accomplish this, they work within the context of a broader clinical information system that can lead to fragmented records that impact communication of information between care providers in the province. The organization is encouraged to support improvement of standard clinical information systems across the province to reduce delays in communicating important information about a client's health history.

Although there are examples of ongoing data collection, usually collected by other groups (such as IPAC) intentional quality improvement in critical care requires significant support. The critical care team struggles with regular access to data, which has resulted in an inconsistently implemented quality improvement focus. Manual auditing is required, and while certain projects may be resourced for points in time, they have limited data that is used to set measurable objectives that inform quality improvement (QI) initiatives.

Measurable objectives for QI initiatives with specific timeframes were not described or presented in all units visited. The organization is encouraged to build a fulsome understanding of quality improvement principles at all levels of the organization. Data indicators collected by IPAC is reviewed and utilized, but the team did not describe a specific objective they were working towards achieving with this data. This is linked to the fact that quality improvement objectives are not well defined, thus it was difficult to point to a specific indicator to monitor progress. The organization is encouraged to further implement QI capacity building across sites and supporting frontline teams and quality committees to do this type of work.

Table 29: 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
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
2.1.5	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
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

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
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
4.3.3	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
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
4.3.11	The team regularly evaluates quality improvement initiatives for feasibility, relevance, and usefulness.	NORMAL

Emergency Department

Standard Rating: 81.7% Met Criteria

18.3% of criteria were unmet. For further details please review the table at the end of this section.

Assessment Results

Patients have 24/7 access to the necessary specialist, diagnostic imaging and lab services appropriate to the level of care being provided at the sites. Patient charts are comprehensive, with assessments and required documentation included in a timely manner. The Emergency Department (ED) team currently work with a hybrid chart, with order entry and medication administration documentation completed on paper. There is noted risk to having a hybrid charting system and SHA is encouraged to adopt a fully electronic system.

Despite prolonged waiting times for admissions, patients and families interviewed express nothing but appreciation and commendations around the care received in the department. Patients felt welcome and heard, treated with respect, well informed, and were active participants in their care. The EDs are encouraged to resume pre-pandemic patient and family engagement activities and find ways to strengthen the patient and family voice throughout the program. Regular audits, surveys, and leader rounding are ways in which patient and families' experiences can be obtained which should be used to inform opportunities for improvement. Once opportunities for improvement are identified, the team is encouraged to engage patients and families in the development, planning, execution, and evaluation of quality improvement activities.

Patient flow through the EDs is nonexistent across the three hospitals in Saskatoon and is identified as a significant concern that SHA need to address. There are severe bottlenecks downstream in the patient journey that is creating the inability to provide the population safe access to emergency care. These bottlenecks result in high emergency inpatient volumes and prolonged Emergency Medical Service (EMS) offload delays. All sites are encouraged to establish clear criteria for triggering overcapacity and surge protocols and more importantly, develop impactful patient movement actions resulting from the protocol trigger. The solutions to overcrowding in the ED often lie outside of the department itself, where engagement with inpatient teams, physicians, consultants, continuing care facilities, EMS, primary care, community addiction and mental health, and other community partners is vital to success. The SHA is encouraged to evaluate visit volume by time across all three sites to ensure adequate access to emergency care is available all hours in the day and analyze what the anticipated impact of an additional urgent care centre will do to address the demand.

Across the nation, there is an increased prevalence of staff being victims of violence in emergency departments. The SHA is strongly encouraged to prioritize the level of protection and security for the EDs. All EDs should have fully secured access, and at a minimum one secured care space to support patient safety and staff safety. In addition, patients identified requiring isolation precautions at triage should be appropriately separated and not managed in the waiting room for prolonged periods of time.

The best possible medication history (BPMH) is not consistently being completed upon admission to hospital in the departments. The program is encouraged to explore ways to generate buy-in and compliance with completion to mitigate risks and support patient safety.

The information that is required to be shared at shift handover and admission is not defined or standardized. The team is encouraged to adopt simple reference tools such as SBAR, or I-PASS that are extremely effective in delivering succinct crucial patient handover details. The intra-facility report form is available but not consistently used and documented on admissions. The quality and quantity of information shared at care transitions is variable and inconsistencies are identified between staff.

Baseline compliance data is required and following implementing improvement efforts surrounding information transfer, the process needs to be monitored and evaluated.

Recent work at the sites to increase the education, awareness and compliance of potential donor identification is being undertaken with good uptake from front line staff. There continues to be a gap in having up to date policies surrounding organ and tissue donation currently.

Table 12: 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
2.1.5	Barriers within the emergency department that impede clients, families, providers, and referring organizations from accessing services are identified and addressed, with input from clients and families.	NORMAL
2.1.8	Standardized processes and procedures are followed to coordinate timely inter-facility client transfers and transfers to other teams within the organization.	NORMAL
2.1.10	There are established protocols to identify and manage overcrowding and surges in the emergency department.	HIGH
2.1.11	Protocols to move clients elsewhere within the organization during times of overcrowding are followed by the team.	HIGH
2.1.13	Protocols to manage overcrowding and surges are followed before requesting aid from alternative health care sites or diverting ambulances.	NORMAL
2.2.1	Entrance(s) to the emergency department are clearly marked and accessible.	HIGH
2.2.3	Clients are offloaded from Emergency Medical Services (EMS) and an initial assessment is conducted and documented by a nurse or other medical professional in a timely way.	NORMAL
2.2.4	Pertinent client information is transferred in collaboration with Emergency Medical Services (EMS).	NORMAL

Criteria Number	Criteria Text	Criteria Type
2.3.8	Clients waiting in the emergency department are monitored for possible deterioration of condition and are reassessed as appropriate.	NORMAL
2.4.8	Seclusion rooms and/or private and secure areas are available for clients.	HIGH
2.5.5	Medication Reconciliation at Care Transitions - Emergency Department 2.5.5.1 Medication reconciliation is initiated for all clients with a decision to admit. A Best Possible Medication History (BPMH) is generated in partnership with clients, families, or caregivers, and documented. The medication reconciliation process may begin in the emergency department and be completed in the receiving inpatient unit.	ROP
2.6.1	There are established protocols and policies on organ and tissue donation.	NORMAL
2.6.2	There is a policy on neurological determination of death (NDD).	NORMAL
2.6.3	There is a policy to transfer potential organ donors to another level of care once they have been identified.	NORMAL
2.7.3	Client privacy is respected during registration.	NORMAL
2.7.5	Assigned roles and responsibilities are adhered to during the resuscitation of clients.	HIGH
2.7.8	Clients with known or suspected infectious diseases are identified, isolated, and managed.	HIGH

Criteria Number	Criteria Text	Criteria Type
2.7.17	Information Transfer at Care Transitions 2.7.17.1 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. 2.7.17.2 Documentation tools and communication strategies are used to standardize 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: 88.8% Met Criteria

11.2% of criteria were unmet. For further details please review the table at the end of this section.

Assessment Results

Between the Royal University Hospital, St. Paul's Hospital, and Saskatoon City Hospital located in Saskatoon, there are 90 adult Emergency Department (ED) beds, supporting almost 100,000 visits per year. The EDs have access to robust interdisciplinary team that includes support staff, respiratory, nursing, physicians, allied health, mental health, pharmacy and social work with all team members working to their full scope of practice. All the EDs are noticeably under resourced and facing significant space constraints currently.

There is a robust orientation process at the three sites, a mix of didactic e-learning modules, hands on skills practice and buddy shifts that are completed to ensure new staff are well equipped to deliver safe quality care in the specialized setting. Some training and annual education provided include cultural sensitivity training, trauma informed care, ethics, privacy, personal protective equipment, information systems, specialized equipment, infusion pumps, palliative and end of life care, occupational health and safety, fall prevention and injury, emergency preparedness, and workplace violence and reporting.

Regular follow-up and connection with leadership occur early and during the orientation and post orientation period. Following the orientation period, there is some informal performance check-ins with educators. The program is encouraged to implement a formalized annual performance evaluation process that builds upon existing informal practices and provides dedicated time to recognize contributions, identify areas of growth or support that are required.

The front-line staff describe a significant decline in staff morale and high level of burnout. Several team members describe near-daily moral distress and injury, identifying system capacity struggles over the last years and staff violence as the leading causes. Creating stable health human resources continues to be a priority for the leadership team. Staff voiced feeling well supported by their direct leader's day to day, and feel very supported from their peers/colleagues, regardless of profession or departmental experience. There is strong teamwork noted, with some sites adopting a team nursing model with some success.

The program leadership have done an excellent job identifying some gaps in care delivery within the department and will be introducing several new roles such as the nurse navigator, clinical resource nurse and geriatric nurse to support some of identified challenges noted by the team. The team have also collaborated on the development of the Saweyihtotan Program for vulnerable and unhoused populations. The leadership team is encouraged to ensure that following the addition of specialized positions or programs, there are metrics and outcomes that can be tied to the role to support and quantify the impact. If there is quantifiable success, the team is encouraged to continue with spread and scale not just between the three sites in Saskatoon but also with sites in Regina as well.

There is access to department-specific data and metrics and support from the digital health team to be able pull this information. The challenge is that there is minimal action from the data. The SHA is strongly encouraged to dedicate quality improvement (QI) resources to the ED portfolio to be able to focus on capacity, flow, turnaround times, efficiencies, safety strategies, process standardization, and pathway development throughout the departments. QI resources can support plan-do-study-act (PDSA) cycles in a meaningful way that defines success, monitors progress, differentiates between value-add and non-value-add activities that are performed, eliminate the non-value-add, and support the ability to sustain results.

Table 30: Unmet Criteria for Service Excellence for Emergency Department

Criteria Number	Criteria Text	Criteria Type
2.1.10	The team leadership regularly evaluates and documents each staff member's performance in an objective, interactive, and constructive way.	HIGH
2.1.12	The team leadership supports staff to follow up on issues and opportunities for growth identified through performance evaluations.	HIGH
4.2.4	The team evaluates its safety improvement strategies.	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
4.3.3	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
4.3.7	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
4.3.11	The team regularly evaluates quality improvement initiatives for feasibility, relevance, and usefulness.	NORMAL

Home Care Services

Standard Rating: 90.1% Met Criteria

9.9% of criteria were unmet. For further details please review the table at the end of this section.

Assessment Results

The Home Care team is a team of dedicated leaders and staff who are committed to providing high quality care within the networks either at home or at clinics. Staff are proud of the work they are providing, and the feedback from clients echo the same results. There is an opportunity to strengthen patient and staff safety with clarity around the reporting of patient/staff incidents. Ensuring the team is aware of how to bring forward errors and having a system that allows for leadership to follow up and create learnings for all is a key element of patient safety. Furthermore, nurses are provided a cell phone while working in the field, however the care aides only have access to a pager. This impacts the ability for the care aid to call for help if the situation becomes unsafe while on a home visit.

The challenges of the multiple charting platforms are evident within the home care program. They use a paper and electronic system but not all of the team has access to the electronic system, and the hospitals do not have access to the paper documentation. This leads to potential gaps in communication and information that can impact care.

There is no standardized process or tool for transfer of information within this program. Information transfer occurs through personal contacts, and the staff's connections with partners in the care team. Having a clear standardized tool to assist in handover will help ensure the right information is shared at the right time and closed loop information is flowing to and from the home care team with its partners.

There are no standardized pain assessments. Pain is self-managed by the client on an individual basis with the primary care provider. There is opportunity to create standardized clinical measures to evaluate the client's pain in partnership with the client and family.

Partners, clients and families have engagement with the director level and above around improvements to its service delivery for this program. There is an opportunity to engage the staff at the frontline to be a part of this process as well.

Table 13: Unmet Criteria for Home Care Services

Criteria Number	Criteria Text	Criteria Type
1.3.2	The assessment process is designed with input from clients and families.	NORMAL
1.3.5	Standardized clinical measures are used to evaluate the client's pain in partnership with the client and family.	NORMAL
1.4.4	Treatment protocols are consistently followed to provide the same standard of care in all settings to all clients.	HIGH
1.4.10	Information Transfer at Care Transitions 1.4.10.1 The information that is required to be shared at care transitions is defined and standardized for care transitions where clients experience a change in team membership or location: admission, handover, transfer, and discharge. 1.4.10.2 Documentation tools and communication strategies are used to standardize 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: 64.9% Met Criteria

35.1% of criteria were unmet. For further details please review the table at the end of this section.

Assessment Results

The home care team has very dedicated staff and managers, they are excited about the future building of the networks and look forward to the next steps in their development. The home care team ensures access of services 7 days a week for 16 hours a day. They work flexible start times and try to provide client-specific care with adjustments to the time of visit and consistency in staff assignments. They have a blend of care aids and nurses supported by a strong team of nurse leaders, educators and managers.

The home care program receives feedback on their services from their clients and families and some sites do adjust services based on this feedback. However, there is no evidence of formal engagement with the community partners to help in system design and improvement opportunities. Staff are not aware if this is occurring at a higher level in the organization. The organization is encouraged to help frontline teams participate with their clients and partners to look at ways to improve service design and develop service-specific goals and objectives. Creating a culture of quality improvement will help in future development of the program and allow for data to help trend the needs to help in advocating for future growth. Having established indicators and goals for the home care team and regularly evaluating them to make improvements to the services will help with engagement and set the team on the path for excellence in the care they provide.

There is confusion within the team around services offered by the program. There are individual consultations occurring around specific clients and their care needs however, the establishment and review of guidelines around best practice was not evident. As there are multiple lines of business under the home care portfolio, and as some nurses move around in the multiple lines, it gives them the experience to offer more treatment options than what the home care program identifies. Having a clear list of services that are offered by the home care nurse will help ensure that partners know where to refer for the right care.

Clarity is required on the pathway the team should follow to report and document safety incidents. As well, the teams were unaware of a standardized procedure to decide between conflicting evidence-informed guidelines and how it would work for the home care program or how decisions are made.

There are no standardized tools or processes that help guide communication within the team. There are tools developed to ensure consistency with documentation of wounds, hazards, etc., however, there are no evident handover tools.

Staff report not having performance appraisals - there are coaching moments in response to concerns, but nothing is formally documented.

Table 31: Unmet Criteria for Service Excellence for Home Care Services

Criteria Number	Criteria Text	Criteria Type
1.1.1	The team co-designs its services with its partners and the community.	HIGH
1.1.2	The team uses information about the service needs of clients and the community to guide its service design.	NORMAL
1.1.3	The team develops its service-specific goals and objectives.	NORMAL
1.1.4	The team monitors and evaluates its services for appropriateness.	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
2.1.10	The team leadership regularly evaluates and documents each staff member's performance in an objective, interactive, and constructive way.	HIGH
2.1.12	The team leadership supports staff to follow up on issues and opportunities for growth identified through performance evaluations.	HIGH
2.2.3	The team leadership ensures that staff use the organization's standardized communication tools to share information about a client's care within and between teams, as consented to by the client.	HIGH
2.2.4	The team evaluates the effectiveness of its collaboration and functioning, and identifies opportunities for improvement.	NORMAL
2.3.4	The team leadership ensures that staff follow organizational policy on bringing forward complaints, concerns, and grievances.	NORMAL
4.1.1	The team leadership ensures that staff follow the organizational standardized procedure to select evidence-informed guidelines for their services.	HIGH
4.1.2	The team works with the organization to review the organizational standardized procedure to select evidence-informed guidelines.	NORMAL

Criteria Number	Criteria Text	Criteria Type
4.1.3	The team follows the organizational standardized procedure to decide between conflicting evidence-informed guidelines.	HIGH
4.1.5	The team regularly reviews its evidence-informed guidelines and protocols for service delivery.	HIGH
4.2.5	The team leadership ensures that staff follow organizational policy to report and document safety incidents.	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
4.3.3	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

Criteria Number	Criteria Text	Criteria Type
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
4.3.11	The team regularly evaluates quality improvement initiatives for feasibility, relevance, and usefulness.	NORMAL

Inpatient Services

Standard Rating: 89.8% Met Criteria

10.2% of criteria were unmet. For further details please review the table at the end of this section.

Assessment Results

Several inpatient units were visited across Saskatoon including St. Paul's Hospital (SPH) surgical, medical and palliative care units, Royal University Hospital (RUH) surgical, cardiosciences, and neurosciences units as well as one surgical inpatient unit at Saskatoon City Hospital.

The venous thromboembolism prophylaxis (VTE) policy, while outdated, is being implemented consistently on all admissions. There is opportunity to expand auditing in the palliative care unit at SPH. While most patients are screened for pressure ulcer risk and appropriate measures are taken to prevent, or treat using established protocols, this was not consistently evident on the inpatient neuroscience unit at RUH. It is important for all teams to be able to identify and mitigate risks related to VTE and pressure ulcers to prevent harm and support safe, high-quality care.

Medication reconciliation is being done consistently on inpatient units with a dedicated pharmacy resource in place such as medicine 5th and 6th at SPH and cardiosciences unit at RUH. At the departments that do not have designated pharmacy support it was noted that a best possible medication history (BPMH) is not consistently generated or documented (e.g., surgical unit 5300 at RUH or surgical 5A at SPH). Audits of medication reconciliation are completed by pharmacy at RUH however, there is opportunity to share results with the unit to drive quality improvement. At SPH unit 5A, medication discrepancies are not consistently identified, resolved, and documented, creating significant risk for patients and the SHA.

Patient records are standardized on each unit and although the transfer documentation may vary, there is excellent compliance on their completion. There is opportunity to evaluate the effectiveness of communication of information transfer at care transitions. Chart audits were not being completed consistently across sites to validate compliance with the standardized process and the quality of information transfer which creates risk for the organization.

The team is currently utilizing a hybrid model for documentation with all nursing documentation being paper-based and other disciplines being electronic. An electronic system for all should be expedited to allow for improved and more efficient communication and transfer of information. Leadership is very supportive of standardization of policies, procedures and clinical pathways. There is significant opportunity to develop clinical pathways in several inpatient units.

Policies and procedures are currently being standardized and sites are actively looking forward to standardization. Staff indicated that they are aware of their policies and can easily access and retrieve when needed.

Safety huddles are taking place daily during change of shift. They are excellent examples of effective information sharing that could be expanded to accommodate additional key team members such as physicians and other health disciplines. On some units, team bedside rounding occurs daily with patients and families involved.

There is a dedicated spiritual care space at SPH which has regular smudging ceremonies and at patient/family request. The spiritual care space is multicultural and serves all faiths. The site is to be commended for the service which includes music therapy, art therapy, a healing arts therapy program and has a writer in residence.

Table 14: Unmet Criteria for Inpatient Services

Criteria Number	Criteria Text	Criteria Type
3.3.7	Medication Reconciliation at Care Transitions Acute Care Services (Inpatient) 3.3.7.1 Upon or prior to admission, a Best Possible Medication History (BPMH) is generated and documented in partnership with clients, families, caregivers, and others, as appropriate. 3.3.7.2 The BPMH is used to generate admission medication orders or the BPMH is compared with current medication orders and any medication discrepancies are identified, resolved, and documented. 3.3.7.3 The prescriber uses the BPMH and the current medication orders to generate transfer or discharge medication orders. 3.3.7.4 The client, community-based health care provider, and community pharmacy (as appropriate) are provided with an accurate and up-to-date list of medications the client should be taking following discharge.	ROP
3.3.9	Pressure Ulcer Prevention 3.3.9.1 An initial pressure ulcer risk assessment is conducted for clients upon admission, using a validated, standardized risk assessment tool.	ROP

Criteria Number	Criteria Text	Criteria Type
3.3.10	Venous Thromboembolism (VTE) Prophylaxis 3.3.10.1 There is a written venous thromboembolism (VTE) prophylaxis policy or guideline. 3.3.10.3 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
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
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: 81.0% Met Criteria

19.0% of criteria were unmet. For further details please review the table at the end of this section.

Assessment Results

The inpatient teams are multidisciplinary, are well established and working to full scope. The staff are committed to providing excellent care to their patients and families. Patients' rights and responsibilities are emphasized on admission and displayed at the point of entry to the inpatient units.

Several managers are new in their roles with coaching and mentoring buddy identified for support. Such support is beneficial to provide emerging leaders with the added confidence to address the many complex situations in the current healthcare system. The commitment of leaders, physicians and staff to provide compassionate, comprehensive care is evident throughout the sites visited. The clinical areas have dedicated clinical educators who support staff in their orientations and learning needs throughout the year. The SHA is encouraged to consider increasing dedicated education days to meet the needs of staff.

Many of the staff have not had performance reviews in years. Some have not had one completed since date of hire. Managers would benefit from prioritizing the completion of these reviews to understand their staff' needs and future career development needs and goals. Several managers have significant spans of control which contributes to the challenge of completing the reviews. Of note, performance reviews have been completed on Medicine 6th at St. Paul's hospital.

Quality improvement initiatives are in progress in several areas (i.e., inpatient surgery at RUH and Saskatoon City Hospital), however there are few or no quality improvement activities taking place at the unit frontline level in other areas. The presence of visual management boards varies with little focus on patient-centric boards. Consideration should be given towards the deployment of standardized visual management boards, located in a public area. Key performance indicators related to quality, safety and efficiency need to be consistently tracked and displayed. Data is collected at a site-level focusing on 'alternate level of care', 'expected length of stay', and 'actual length of stay' but this is not regularly shared with staff at the unit level. Access to such data can drive change.

There is opportunity to include patients and families in planning, designing, and evaluating clinical care, as well as be encouraged to question providers on the safety of their care (e.g. handwashing). The inpatient services teams are encouraged to consider additional mechanisms to engage patients and families.

Table 32: Unmet Criteria for Service Excellence for Inpatient Services

Criteria Number	Criteria Text	Criteria Type
2.1.10	The team leadership regularly evaluates and documents each staff member's performance in an objective, interactive, and constructive way.	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

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
4.2.4	The team evaluates its safety improvement strategies.	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
4.3.3	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

Criteria Number	Criteria Text	Criteria Type
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
4.3.11	The team regularly evaluates quality improvement initiatives for feasibility, relevance, and usefulness.	NORMAL

Long-Term Care Services

Standard Rating: 90.2% Met Criteria

9.8% of criteria were unmet. For further details please review the table at the end of this section.

Assessment Results

All the long-term care homes visited have similar criteria and processes for accessing their program. Standardized assessment tools are used upon admission and residents care plans are reviewed and updated regularly. Teams look different depending on what home you are in; however, each team member has a clear job description that outlines their roles and responsibilities. It was apparent that all teams take a resident-first approach to their job. There is an opportunity here for SHA to review team composition, roles and responsibilities, and resource allocation to ensure that all clients that SHA serves have access to high quality health care.

Some long-term care homes do not have access to adequate skin and wound care education, products, and advanced wound care therapy. The organization is encouraged to review access to wound care education and enterostomal therapy to ensure all their clients have access to the highest quality of care.

The SHA has been successful in developing a bundle which was rolled out in September 2024 for suicide risk and prevention but only some long-term care homes were able to show evidence of this roll out. Suicide risk assessment is still in the early stages of the roll out and it may be too soon for formal evaluation opportunities. The South Ridge 2 neighborhood at Parkridge Center is an example of a successful roll out of the suicide risk bundle. The organization is encouraged to celebrate this positive advancement and leverage their success throughout the other long-term care homes. The organization is encouraged to support systems that formally audit and track these important safety practices.

Table 15: Unmet Criteria for Long-Term Care Services

Criteria Number	Criteria Text	Criteria Type
2.5.3	Skin and Wound Care 2.5.3.2 Team members have access to education on appropriate skin and wound care, including products and technologies, assessment, treatment, and documentation.	ROP

Criteria Number	Criteria Text		Criteria Type
2.5.5	Suicide Prevention		ROP
	2.5.5.1	Clients at risk of suicide are identified.	
	2.5.5.2	The risk of suicide for each client is assessed at regular intervals or as needs change.	
	2.5.5.3	The immediate safety needs of clients identified as being at risk of suicide are addressed.	
	2.5.5.4	Treatment and monitoring strategies are identified for clients assessed as being at risk of suicide.	
	2.5.5.5	Implementation of the treatment and monitoring strategies is documented in the client record.	

Service Excellence for Long-Term Care Services

Standard Rating: 94.9% Met Criteria

5.1% of criteria were unmet. For further details please review the table at the end of this section.

Assessment Results

Engagement with clients and families is happening, formally and informally. In the spirit of true co-design of services, the SHA is encouraged to regularly seek feedback and input from their clients, families and staff.

The SHA has advanced their clinical standard workplan and has started on the journey to review and update their policies, guidelines and protocols. Some of the guidelines and protocols for service delivery provided by SHA remain out of date and have not been reviewed for more than 4 years, for example: Smart Pump (Feb 2017), High Alert Medications (June 2017), Pressure Ulcer Prevention (April 2012). Some affiliates have processes in place to adopt the SHA policies, protocols and guidelines and are reviewing and updating them regularly (e.g., Jubilee Residences - Stensrud Lodge, Sherbrooke Community Centre, Central Haven Special Care Home). The organization is encouraged to continue with the clinical standards workplan.

There is a large variation with regards to leaders' span of control. Most long-term care homes that were surveyed were not conducting and documenting regular performance evaluations. As a result, staff are missing out on the opportunity to improve and grow in their practice. Staff interviewed stated that they would appreciate feedback and the opportunity to improve in their practice. The organization is encouraged to create action plans to help their leaders to meet regularly with their staff for performance evaluations.

Table 33: Unmet Criteria for Service Excellence for Long-Term Care Services

Criteria Number	Criteria Text	Criteria Type
1.2.6	The team leadership ensures that team members have access to information about community services, including palliative and end-of-life care.	NORMAL
2.1.10	The team leadership regularly evaluates and documents each staff member's performance in an objective, interactive, and constructive way.	HIGH
2.1.12	The team leadership supports staff to follow up on issues and opportunities for growth identified through performance evaluations.	HIGH
4.1.5	The team regularly reviews its evidence-informed guidelines and protocols for service delivery.	HIGH

Mental Health and Addictions Services

Standard Rating: 91.0% Met Criteria

9.0% of criteria were unmet. For further details please review the table at the end of this section.

Assessment Results

Mental Health and Addictions services are provided in a caring, respectful, patient-centered, recovery-oriented manner that promotes hope, attainment of personal goals, social inclusion, and supportive relationships. The passionate dedication of the teams is visible in their interactions with patients and their attention to the environment and their practices.

Patient and family goals are discussed and respected, and patients are enabled to take responsibility for their own care and recovery as much as possible. One example is the development and display of patient-focused educational materials and resources which are prominently displayed in patient care areas at the Irene and Leslie Dubé Centre for Mental Health. Patients can readily see the information and resources available on a variety of subject matters which they can access using a QR code or they can request written materials.

Patient and Family Councils are active and have opportunity to provide input and feedback regularly. In addition, questionnaires and surveys are used regularly to gather patient and family input and feedback. It is evident that teams are responsive to the issues identified through these mechanisms, as well as through complaints processes and patient safety incident reports. Much of the patient and family input into operational decisions and evaluation is generated in an ad hoc, anecdotal and informal way. The organization is encouraged to consider mechanisms to engage patient and family input more proactively and involve them more directly into decision-making and the evaluation of services.

Treatment plans, or care plans are developed recognizing patients goals and wishes, however these are not formulated or documented in a consistent way and do not consistently articulate measurable goals and activities. This can make it challenging for all team members to be unified in their care delivery and approach and can make it challenging to monitor progress toward goal attainment. The teams are encouraged to review individualized treatment planning processes and documentation.

Family members are engaged in the care of the patient in keeping with the wishes and consent of the patient. The organization is encouraged to consider additional strategies toward more fully engaging and supporting family members who have an ongoing role of caregiver to adult patients, who have been identified by the patient as their designated support person.

The value of embedding lived experience through the mental health care journey is recognized and leveraged through the introduction of structured peer support offered in the community or on-site. A formal peer support program exists in addition to referrals to community-based peer support services.

Mental health and addictions services are provided in an integrated way. In addition to those experiencing concurrent mental health and substance use diagnoses, all patients benefit from screening in both areas and more thorough assessment and intervention when needed and wanted. Standardized, evidence-based tools and resources are used for screening and assessment. Recently, a part-time addiction counsellor has been added to support teams and patients at the Irene and Leslie Dubé Centre, initially through a six-month pilot and recently made permanent.

The team is dedicated to medication safety through medication reconciliation. Medication reconciliation is consistently conducted upon admission, during transition between services along the continuum of care, and at the end of service or discharge. In addition, patients receiving injectable medications over an extended period also benefit from nurse-led medication reconciliation on an annual basis. While medication reconciliation is well done generally, on opportunity exists in some areas to improve the process by consistently employing a second source of information, such as the Pharmaceutical Information Program (PIP), as outlined in the SHA work standard procedure to validate the best possible medication history.

Services are provided in clean, pleasant, attractive physical spaces that are well cared for. It is evident that team members take pride in ensuring a pleasant and respectful environment for clients, with evidence of their efforts toward constantly improving the environment. One notable exception is the space currently used by the Community Outreach and Support Teams (COAST) team. That team is split over two leased community locations, one of which is overcrowded, cramped, cluttered, poorly maintained, and unclean. The organization is working toward finding a new location which will allow for the full COAST team to be co-located and is encouraged to continue in its efforts to secure a more suitable location as soon as possible.

Table 16: Unmet Criteria for Mental Health and Addictions Services

Criteria Number	Criteria Text	Criteria Type
1.1.5	The organizational leaders establish approaches to recognize the role of designated support persons that clients have chosen to participate in their care.	HIGH
1.3.1	The team follows the organization's procedures to enable the client to identify their designated support person(s) as part of the dedicated mental health and addictions team.	NORMAL
1.3.2	The team provides appropriate mental health and addictions resources to the designated support person(s) in a timely way.	NORMAL
1.3.3	The team facilitates access to appropriate services that meet the needs of the designated support person(s).	NORMAL
3.1.3	The organizational leaders provide teams with a standardized template to develop individualized care plans with clients.	NORMAL
3.2.3	The team follows the organization's procedures to provide a safe and secure environment for all.	HIGH
3.5.2	Maintaining an Accurate List of Medications during Care Transitions 3.5.2.1 The team follows the organization's procedure to obtain a best possible medication history during care transitions.	ROP

Service Excellence for Mental Health and Addictions Services

Standard Rating: 87.1% Met Criteria

12.9% of criteria were unmet. For further details please review the table at the end of this section.

Assessment Results

Patient care documentation is thorough and complete, however is recorded in a variety of paper-based or electronic systems, making information sharing across the continuum of care challenging. In several cases, patient documentation in a single unit or clinic is recorded across multiple electronic platforms and paper-based files. For example, at the Irene and Leslie Dubé Centre for Mental Health, nurses and physicians use a paper medical record for documentation and medical orders, while allied health professionals, patient registration and pharmacy use electronic records. There is a lack of interoperability between electronic platforms. The organization is encouraged to develop and implement a strategy toward a unified single approach to patient documentation.

The use of visual management boards has been reignited across mental health and addiction services and are being used as a mechanism to enhance transparent communication. In some areas, regular huddles are being held. While there are some pockets of excellence in terms of using the visual management board to monitor performance of specific quality indicators against targets, not all areas have established quality improvement goals with measurable objectives and specific time frames for completion. The organization is encouraged to consider mechanisms to support teams in formalizing a standardized approach to their quality monitoring and improvement activities.

Suicide risk screening is completed regularly, and suicide risk assessments and safety plans are completed as necessary. The organization is encouraged to move forward with its plans to finalize a Suicide Prevention Protocol to guide staff.

Teams have processes in place to provide clinical and overall support of one another to maintain the psychological health and well-being of team members. Across all sites, performance evaluations are not completed on a regular basis. Management is aware and have a plan to ensure regular, documented evaluations occur to support opportunity for team member growth and development.

Table 34: Unmet Criteria for Service Excellence for Mental Health and Addictions 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
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
2.1.12	The team leadership supports staff to follow up on issues and opportunities for growth identified through performance evaluations.	HIGH
4.1.5	The team regularly reviews its evidence-informed guidelines and protocols for service delivery.	HIGH
4.2.2	Suicide Prevention Program 4.2.2.1 The team leadership ensures the team follows organizational procedures to minimize safety risks and ensure a secure environment for all.	ROP
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

Organ Donation for Living Donors

Standard Rating: 90.5% Met Criteria

9.5% of criteria were unmet. For further details please review the table at the end of this section.

Assessment Results

The Living Donor Program at St. Paul's Hospital in Saskatoon works collaboratively with their partner site in Regina. The Living Donation Program is licensed under Health Canada. There is excellent compliance and maintenance of all standard operating procedures. Staff are very familiar with the Transplant and Living Kidney Donation standard operating procedure (SOP) manual. There is a dedicated part-time educator who supports both Saskatoon and Regina.

The Living Donor Program has seen a decrease over the past year in organ donation. They have only had two living organ donations to date (November 2024), with a goal to achieve one donation a month or 12 annually. Staff have indicated more resources are needed to enhance public awareness around organ donation, which they feel is the number one contributing factor. There is no provincial social media platform, scarce public campaigning and lack of investment in advertising for organ donation. Staff have many great ideas about increasing not only public awareness but also awareness among healthcare providers. There is opportunity for the SHA to promote increased public awareness related to organ donation within the province of Saskatchewan.

Regular performance evaluations of staff are not carried out. Staff indicated they would appreciate the opportunity to discuss their career path and understand their strengths and areas for improvement. Leadership is encouraged to invest in carrying out regular performance evaluations for staff. It was evident through interviews with clients and families that they felt respected and involved in their care. They also emphasized how compassionate staff were. For example, one client said, "the donation coordinator took such good care of me, made me feel valued, and always got back to me and answered my million questions". Tremendous work to be proud of!

The Living Donor program is completely paper based which contributes to an increased burden due to significant documentation requirements. This was identified as the biggest challenge for staff. Time is wasted managing the paper-based health record which is impacting workflows and time spent caring for clients and families. The SHA is encouraged to invest in an integrated electric health record. There was no evidence provided (e.g., audit tool) regarding the quality of information transfer being evaluated. There is opportunity to review the effectiveness of communication and make improvements based on feedback received.

Quality improvement is not translated at the local level. There is lack of knowledge related to quality improvement principles coupled with lack of dedicated resources. Consideration to investing in a quality consultant to support Organ and Tissue Donation and Transplant would assist with creating a culture of continuous quality improvement.

Table 17: Unmet Criteria for Organ Donation for Living Donors

Criteria Number	Criteria Text	Criteria Type
1.1.3	Service-specific goals and objectives are developed, with input from clients and families.	NORMAL
1.1.4	There are policies, developed with input from clients and families, that specify which organs are recovered as part of the program.	NORMAL
2.1.17	Team member performance is regularly evaluated and documented in an objective, interactive, and constructive way.	HIGH
2.1.18	Living donation team members demonstrate their competence as a part of their performance evaluation.	NORMAL
2.1.20	Team members are supported by team leaders to follow up on issues and opportunities for growth identified through performance evaluations.	HIGH
2.3.2	Work and job design, roles and responsibilities, and assignments are determined with input from team members, and from clients and families where appropriate.	NORMAL
3.11.3	Information Transfer at Care Transitions 3.11.3.5 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
5.3.2	The information and feedback gathered is used to identify opportunities for quality improvement initiatives and set priorities, with input from clients and families.	NORMAL
5.3.3	Measurable objectives with specific timeframes for completion are identified for quality improvement initiatives, with input from clients and families.	HIGH
5.3.4	Indicator(s) that monitor progress for each quality improvement objective are identified, with input from clients and families.	NORMAL
5.3.5	Quality improvement activities are designed and tested to meet objectives.	HIGH
5.3.6	New or existing indicator data are used to establish a baseline for each indicator.	NORMAL
5.3.7	There is a process to regularly collect indicator data and track progress.	NORMAL
5.3.8	Indicator data is regularly analyzed to determine the effectiveness of the quality improvement activities.	HIGH
5.3.9	Quality improvement activities that were shown to be effective in the testing phase are implemented broadly throughout the organization.	HIGH
5.3.10	Information about quality improvement activities, results, and learnings is shared with clients, families, teams, organization leaders, and other organizations, as appropriate.	NORMAL
5.3.11	Quality improvement initiatives are regularly evaluated for feasibility, relevance, and usefulness, with input from clients and families.	NORMAL

Organ and Tissue Donation for Deceased Donors

Standard Rating: 90.3% Met Criteria

9.7% of criteria were unmet. For further details please review the table at the end of this section.

Assessment Results

The Organ Donation for Decreased Donors Program at Royal University Hospital in Saskatoon works in collaboration with the team in Regina who also offers this program. The staff working at Royal University Hospital are commended for their ongoing efforts to achieve high standards of practice related to organ donation policies and procedures which is guided by Health Canada. Staff demonstrated sound knowledge related to standard operating procedures, donor assessment process and exceptional distribution.

There is a comprehensive orientation developed for new staff which takes approximately six months to complete. A dedicated donor coordinator supports education and provides orientation. This coordinator also guides quality assurance. There is high staff turnover and burnout among donation coordinators which creates increased demand for orientation. This impacts the ability to spend focused time on quality improvement work. Opportunity exists for the Organ Donation for the Deceased Donors Program to try and understand what is contributing to high staff turnover rates among donor coordinators. While the team is cohesive and support each other there is opportunity to engage staff about what matters most to them and what challenges they are facing. This may go a long way with staff retention.

Regular performance evaluations of staff are not carried out. This is a missed opportunity to engage staff and support their growth and development. Some staff indicated they have never had one. Leadership is encouraged to develop an actionable plan to implement performance evaluations.

A culture of quality improvement (QI) does not exist within the Deceased Donors Program. Staff did not have a clear understanding of a QI project and how to identify indicators and establish a baseline. There is no QI committee and no patient advisor supporting the Deceased Donor Program. While strides have been made with dedicating a donor coordinator to support quality assurance reviews, a stronger commitment to continuous QI is recommended. Staff have expressed a strong desire to contribute to QI work.

There is a plea from staff related to moving to an electronic charting system. The current paper-based health record creates significant burden related to documentation and takes away time spent with clients and families. SHA is encouraged to invest in an electronic health record.

The Deceased Donor Program is doing an excellent job with supporting families during their journey through organ and tissue donation. Families of deceased donors that were interviewed spoke of the incredible compassion and empathy they felt from staff. Well done!

Table 18: Unmet Criteria for Organ and Tissue Donation for Deceased Donors

Criteria Number	Criteria Text	Criteria Type
2.1.14	Team member performance is regularly evaluated and documented in an objective, interactive, and constructive way.	HIGH
2.1.15	As a part of their performance evaluation, donation team members demonstrate their competence.	NORMAL
2.1.17	Team members are supported by team leaders to follow up on issues and opportunities for growth identified through performance evaluations.	HIGH
7.3.1	Information and feedback is collected about the quality of services to guide quality improvement initiatives, with input from clients and families, team members, and partners.	NORMAL
7.3.2	The information and feedback gathered is used to identify opportunities for quality improvement initiatives and set priorities, with input from clients and families.	NORMAL
7.3.3	Measurable objectives with specific timeframes for completion are identified for quality improvement initiatives, with input from clients and families.	HIGH
7.3.4	Indicator(s) that monitor progress for each quality improvement objective are identified, with input from clients and families.	NORMAL
7.3.5	Quality improvement activities are designed and tested to meet objectives.	HIGH
7.3.6	New or existing indicator data are used to establish a baseline for each indicator.	NORMAL

Criteria Number	Criteria Text	Criteria Type
7.3.7	There is a process to regularly collect indicator data and track progress.	NORMAL
7.3.8	Indicator data is regularly analyzed to determine the effectiveness of the quality improvement activities.	HIGH
7.3.9	Quality improvement activities that were shown to be effective in the testing phase are implemented broadly throughout the organization.	HIGH
7.3.10	Information about quality improvement activities, results, and learnings is shared with clients, families, teams, organization leaders, and other organizations, as appropriate.	NORMAL
7.3.11	Quality improvement initiatives are regularly evaluated for feasibility, relevance, and usefulness, with input from clients and families.	NORMAL

Organ and Tissue Transplant

Standard Rating: 91.3% Met Criteria

8.7% of criteria were unmet. For further details please review the table at the end of this section.

Assessment Results

The Organ and Tissue Transplant Program has done an exceptional job at ensuring all policies and practices are adhered to by all staff. Staff maintain competencies and there is opportunity offered to support education requests. Weekly interdisciplinary rounds occur which also provides educational learnings. It was remarkable to witness the professionalism and cohesiveness among staff members. However, there is opportunity to review the effectiveness of communication at care transitions to ensure to make improvements as needed. There was no evidence of any audit tools or any evaluation of information transfer between handover of care being carried out.

Staff interviewed indicated they do not receive regular performance evaluations and there is a lack of succession planning. It is recommended that leadership invest in doing regular performance evaluations which provides opportunity to have meaningful one on one dialogue with staff.

There is lack of quality improvement (QI) knowledge and awareness among staff. No QI initiatives or projects have been carried out. Limited resources exist to assist the program in creating a culture of continuous quality improvement. An opportunity to support a dedicated quality consultant position for the Organ and Tissue Transplant Program would help drive QI work and strengthen SHA's objective to advance a culture of continuous quality improvement.

The Organ and Tissue Transplant Program offers kidney transplants based out of St. Paul's Hospital in Saskatoon. The program partners with Human Organ Procurement and Exchange (HOPE) program based in Edmonton, Alberta to support clients needing liver, lung or heart transplants. The program has recently expanded their pre-assessment clinics to these clients as well as historically, this was being done in Edmonton. They are commended for growing their pre-assessment clinic which is helping those clients and families stay closer to home while reducing financial costs. They support a post-transplant clinic for clients that have received a kidney, lung, liver or heart transplant and follow these clients for life. Clients interviewed indicated they feel supported, informed and involved in their care. Excellent job! There are limited community resources for chronic disease management to support the clients on the waitlist particularly for liver transplants. There is opportunity to review service design and include chronic disease management resources for this population.

There is a regular Transplant and Donation Leadership meeting where physicians and the leadership team collaborate to discuss operational challenges and service delivery. There is minimal strategic planning for the future occurring within the Organ and Tissue Transplant Program. There is opportunity to set a vision for the future and develop long-term goals to demonstrate the SHA is striving to meet the needs of the people of Saskatchewan.

Table 19: Unmet Criteria for Organ and Tissue Transplant

Criteria Number	Criteria Text	Criteria Type
1.1.1	Services are co-designed with clients and families, partners, and the community.	HIGH
1.1.2	Information is collected from clients and families, partners, and the community to inform service design.	NORMAL
1.1.3	Service-specific goals and objectives are developed, with input from clients and families.	NORMAL
1.2.10	The effectiveness of resources, space, and staffing is evaluated with input from clients and families, the team, and stakeholders.	NORMAL
2.1.14	Team member performance is regularly evaluated and documented in an objective, interactive, and constructive way.	HIGH
2.1.16	Team members are supported by team leaders to follow up on issues and opportunities for growth identified through performance evaluations.	HIGH
3.10.3	Information Transfer at Care Transitions 3.10.3.5 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
5.3.4	The information and feedback gathered is used to identify opportunities for quality improvement initiatives and set priorities, with input from clients and families.	NORMAL

Criteria Number	Criteria Text	Criteria Type
5.3.5	Measurable objectives with specific timeframes for completion are identified for quality improvement initiatives, with input from clients and families.	HIGH
5.3.6	Indicator(s) that monitor progress for each quality improvement objective are identified, with input from clients and families.	NORMAL
5.3.7	Quality improvement activities are designed and tested to meet objectives.	HIGH
5.3.8	New or existing indicator data are used to establish a baseline for each indicator.	NORMAL
5.3.9	There is a process to regularly collect indicator data and track progress.	NORMAL
5.3.10	Indicator data is regularly analyzed to determine the effectiveness of the quality improvement activities.	HIGH
5.3.11	Quality improvement activities that were shown to be effective in the testing phase are implemented broadly throughout the organization.	HIGH
5.3.12	Information about quality improvement activities, results, and learnings is shared with clients, families, teams, organization leaders, and other organizations, as appropriate.	NORMAL
5.3.13	Quality improvement initiatives are regularly evaluated for feasibility, relevance, and usefulness, with input from clients and families.	NORMAL

Palliative Care Services

Standard Rating: 100.0% Met Criteria

0.0% of criteria were unmet.

Assessment Results

Palliative Care is a 12-bed unit at St. Paul's Hospital and has a partnership with a 15-bed Hospice that is owned and operated by Emmanual Health. This allows for and ensures a seamless continuum of care for patients at end-of-life in Saskatoon and the surrounding area.

The multidisciplinary team (physicians, registered nurses, licensed practical nurses, care coordinator, and volunteer services among others) work exceptionally well together in a collaborative environment. The physical unit is very well designed with very spacious rooms to accommodate large family visits or stays. There are several spaces for families to have meetings or private conversations as needed and the patients' rooms are equipped to meet all of their needs. Decorative artwork of patient and family preference is placed in their rooms to provide additional comfort. This is a beautiful initiative by the program. Many educational materials for patients and families have been developed and are accessible on the unit.

The unit has a total of seven dedicated volunteers who provide many services such as art therapy, music therapy, book delivery, food delivery, or other tasks that patients and families may request. This service receives exceptional praise from the patients and their families.

The patient chart is a very comprehensive paper-based document. The chart is inclusive of an individualized care plan that outlines patient/family wishes, current treatment plan, pain assessment and management strategies. Members of the team identified challenges with communication to and from partners in the community without an electronic documentation system. There is strong advocacy from the team for an electronic medical record to support safe care.

The team respects and is very much aware of any cultural, religious and spiritual preferences of all patients. There is a dedicated spiritual care space at St. Paul's Hospital for the patients. Patients and families are very complimentary of the care received and the supports in place for them during this challenging time.

Table 20: Unmet Criteria for Palliative Care Services

There are no unmet criteria for this section.

Service Excellence for Palliative Care Services

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

The multidisciplinary team at St. Paul's Hospital is a relatively small team of 30 staff with a skill mix of registered nurses, licensed practical nurses, and continuing care assistants. The unit has been successful in the retention of some very experienced staff that have remained there for an exceptional number of years. The current complement meets the patients' needs but there is a significant gap of a clerical resource for the unit. Nursing staff are required to complete all such clerical related duties (creating charts, answering telephone, appointment booking and other tasks) which takes away from integral patient care. Another resource reduced in recent years is a dedicated clinical educator - a resource is currently shared with an inpatient medicine unit.

The palliative care unit is providing much more complex care than it has historically. Staff orientation is reduced to a general site orientation with being co-signed to a "buddy" for seven shifts. The new staff member has to rely heavily on transfer of knowledge from a colleague and limited self-directed online learning. It is suggested that a part-time clinical educator resource be considered to ensure adequate training is provided and competency of new and existing staff is maintained.

Performance reviews are not being completed. Several staff indicated that such discussions have not taken place in four or five years. Staff indicated a need to hear how they are performing in their roles.

The palliative care team do not participate in any quality improvement initiatives. There are no chart audits taking place, the pharmacy does not audit medication reconciliation compliance, and it was indicated that venous thromboembolism (VTE) compliance auditing on the palliative care unit is identified as one of their "exemptions" and the team is encouraged to reconsider. The only evidence of any auditing is hand hygiene with excellent rates of compliance noted.

A staff education board is present on the unit which also provides educational material for patients and families but there is no evidence of a patient-facing visual management board. The unit does not have a quality committee or council or any patient advisors. There was reference to a "patient advocate" who focuses on patient concerns. It is recommended that the team explore options to start to quality improvement initiatives.

Table 35: Unmet Criteria for Service Excellence for Palliative Care Services

Criteria Number	Criteria Text	Criteria Type
2.1.10	The team leadership regularly evaluates and documents each staff member's performance in an objective, interactive, and constructive way.	HIGH
2.1.12	The team leadership supports staff to follow up on issues and opportunities for growth identified through performance evaluations.	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
4.3.3	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
4.3.11	The team regularly evaluates quality improvement initiatives for feasibility, relevance, and usefulness.	NORMAL

Perioperative Services and Invasive Procedures

Standard Rating: 92.7% Met Criteria

7.3% of criteria were unmet. For further details please review the table at the end of this section.

Assessment Results

Perioperative services were assessed at the Royal University Hospital (RUH), Jim Pattison Children's Hospital (JPCH), Saskatoon City Hospital and St. Paul's Hospital (SPH) including day surgery, same day surgery, surgical operative care, post anesthesia care unit (PACU) and pre-assessment clinics (where applicable). In addition, invasive procedures performed RUH (endoscopy) was also assessed.

Patients and families interviewed as part of the accreditation survey shared their gratitude for the compassionate care they received across these sites and services. While there are many exciting and positive initiatives underway, such as expanding robotic surgery and having provincial orthopedic pre-printed orders and supports, using ERAS (Enhanced Recovery After Surgery) for some services, there are also challenges such as patient flow and bed capacity. Daily operational bed meetings and ongoing efforts are often not enough to avoid the overcapacity and overflow use of overnight stays in recovery areas.

Some peri-operative physical plants are new and conducive to optimizing patient care, such as at JPCH, while other sites are older and more challenging in transporting patients and soiled post-operative items, with structural space limitations. Across Saskatoon, the surgical waitlist is decreasing with more (and record-breaking) volumes of surgeries performed and provincial targets being met. It is through the dedicated efforts of all leaders and team members across perioperative services that this has been made possible, and the teams are congratulated for their passion and commitment.

Patients report their appreciation for the pre-admission program, with some patients driving hundreds of kilometers investing in their pre-op preparations. In addition to two on-site services, virtual screening and pre-operative assessments have supported both pediatric and adult patients. There is currently planning underway to support a single site for a pre-admission clinic that may be more convenient for patients and provide a more conducive space than hospital-based locations. The organization is encouraged to continue to engage patient partners in this planning. By expanding the surgical screening program, it is anticipated that there will be fewer surgical postponements and greater efficiency. Other successes shared include improvements in achieving operating room start times, through reviewing the instruments required and ensuring sterilized and reprocessed carts are ready, there are fewer delays. The collaboration with the medical device and reprocessing departments located at each site have helped enact these improvements.

Some perioperative services have embarked on developing and deploying patient and family surveys. This will serve as an opportunity to garner the patient perspective and to learn from their experience. Committed to patient safety, many of the required organizational practice tests for compliance were met across the various perioperative services. There is more work and support required to evaluate the effectiveness of these safety efforts through audits and evaluations. Experts with quality improvement, data and evaluation skills could support the clinicians and leaders in evaluating fall prevention strategies, information at care transitions and the safe surgery checklist for example.

At RUH there are significant issues with the ventilation and temperature systems in the endoscopy procedure room. There is no evidence of restricted-access area for sterile storage of supplies. Nursing picks up medications from pharmacy to bring back to the unit and medication carts have not been standardized in this area. Another area of concern to be address is the practice of transporting used endoscopes through the main corridor which is a high traffic area.

Table 21: Unmet Criteria for Perioperative Services and Invasive Procedures

Criteria Number	Criteria Text	Criteria Type
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
1.1.9	The operating/procedure room has a restricted-access area for the sterile storage of supplies.	HIGH
1.2.9	Contaminated items are transported separately from clean or sterilized items, and away from client service and high-traffic areas.	HIGH
1.3.3	The contents of medication carts for the surgical area are standardized across the organization.	NORMAL
2.3.10	Falls Prevention and Injury Reduction - Inpatient Services 2.3.10.3 The effectiveness of fall prevention and injury reduction precautions and education/information are evaluated, and results are used to make improvements when needed.	ROP
2.3.11	Pressure Ulcer Prevention 2.3.11.5 The effectiveness of pressure ulcer prevention is evaluated, and results are used to make improvements when needed.	ROP

Criteria Number	Criteria Text	Criteria Type
2.4.11	Information Transfer at Care Transitions 2.4.11.1 The information that is required to be shared at care transitions is defined and standardized for care transitions where clients experience a change in team membership or location: admission, handover, transfer, and discharge. 2.4.11.2 Documentation tools and communication strategies are used to standardize information transfer at care transitions. 2.4.11.5 The effectiveness of communication is evaluated and improvements are made based on feedback received. Evaluation mechanisms may include: • Using an audit tool (direct observation or review of client records) to measure compliance with standardized processes and the quality of information transfer • Asking clients, families, and service providers if they received the information they needed • Evaluating safety incidents related to information transfer (e.g., from the patient safety incident management system).	ROP
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
2.12.17	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 Perioperative Services and Invasive Procedures

Standard Rating: 86.1% Met Criteria

13.9% of criteria were unmet. For further details please review the table at the end of this section.

Assessment Results

Leaders working within the perioperative services across Saskatoon are aware of the populations they serve and are working hard to increase the volume of surgeries performed, decrease the surgical wait lists and provide the best care to patients from across Saskatchewan. There are efforts underway, in the early stages to involve clients and families in service design to learn from and improve the patient experience. It will be important to measure both patient experience and patient outcomes going forward. Perioperative services work closely with internal partners such as other departments within the health authority and external partners such as vendors and contractors.

The goals and objectives at the local levels within perioperative services align with the broader goals of Saskatchewan Health Authority's tertiary services related to increasing surgical through-put and decreasing waitlists. When visiting various service and procedure areas, teamwork and collaboration is palpable, amongst staff, surgeons, anesthetists – all working to improve access to and outcomes of surgery. Orientation is provided to staff, along with specific education days and/or dedicated education time to ensure competence and currency of staff. Exciting initiatives such as robotic surgery at St. Paul's Hospital has expanded the knowledge and skillset of numerous staff and physicians.

Performance reviews are not regularly conducted within most of the services visited during this on-site survey. Communicating and documenting staff reviews supports professional development and accountability and is encouraged. Workload has been heavy while staffing up to provide more surgeries than ever before. The health human resource shortage, particularly for anesthesia is a challenge.

Evidence based practices are used, including Enhanced Recovery after Surgery (ERAS) for some services. Care pathways and standard work are helping support consistency. Access to accurate, up to date policies is more challenging and confusing, with legacy health region policies mixed in with newer Saskatchewan Health Authority standards. Huddles, newsletters, white boards help communicate important and timely information. There is opportunity for the RUH endoscopy program to develop indicators to measure, monitor and evaluate quality improvement activities.

Currently there is a hybrid of electronic health records in the operating rooms (OR Manager), with paper-based charts in other services. Moving to an electronic record should help support efficiency, accuracy (single source of truth), while making auditing and data collection less labour intensive for quality improvement/patient safety projects.

Table 36: Unmet Criteria for Service Excellence for Perioperative Services and Invasive Procedures

Criteria Number	Criteria Text	Criteria Type
2.1.10	The team leadership regularly evaluates and documents each staff member's performance in an objective, interactive, and constructive way.	HIGH
2.1.12	The team leadership supports staff to follow up on issues and opportunities for growth identified through performance evaluations.	HIGH
2.2.4	The team evaluates the effectiveness of its collaboration and functioning, and identifies opportunities for improvement.	NORMAL
3.1.5	The team ensures that clients are able to actively participate in documenting information in their record.	NORMAL
4.3.4	The team identifies indicators to monitor progress for each quality improvement objective.	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
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
4.3.11	The team regularly evaluates quality improvement initiatives for feasibility, relevance, and usefulness.	NORMAL

Population Health and Wellness

Standard Rating: 56.4% Met Criteria

43.6% of criteria were unmet. For further details please review the table at the end of this section.

Assessment Results

The organization is commended on the launch of the Trauma Provincial Care Network in April 2024. The vision for the Trauma Care System is to “reduce the burden of injury for patients and families experiencing traumatic injury, through the development of an integrated provincial trauma care system that will work seamlessly to deliver responsive, timely, equitable, safe, and appropriate care”. This is particularly important for Saskatchewan, who has the highest rate of hospitalization for traumatic injury compared to all Canadian provinces.

The network has ambitious aims that involves improving quality along the continuum of care, involving partners from across the province. This survey occurred shortly after the launch of the Provincial Care Network (PCN) and therefore is interested in opportunities of focus as the network develops and is resourced. Careful consideration of appropriate resources required to accomplish the aims of this network, supported by an in-depth analysis of the economic benefits of improving patient care outcomes is recommended. The Trauma PCN has made significant efforts to consult broadly with community partners and allied agencies around existing and emerging needs to address trauma across a broad geography. The organization is encouraged to incorporate Accreditation Canada standards as the Trauma PCN develops.

The rural trauma education and outreach is an excellent way to support rural care providers to improve their ability to deliver quality trauma care. The team emphasized their ability to support visited health centers to improve and overcome some limitations the teams at these sites may face. The teams are encouraged to take a systemic view of outlying centers to map and collect data on what system supports may be required to support the continuum of care. Although excellent, this program is resource intensive. The PCN is encouraged to explore various ways of supporting the education and competency of providers with and without on-site team support. This may take the form of virtual courses, as well as clinical guidelines or modules. Further, while focused on the acute phase of an individual’s injury, the network is encouraged to evaluate education needs further along in the continuum of care including rehabilitation and primary care.

Although there is some engagement with community partners that occurred in the development of the Trauma PCN, many community partners or team members did not yet know about it. As the PCN develops, it will be important to map partners within all sectors related to the trauma patient’s care pathway and include this in network engagement strategies.

It was mentioned that patients can be discharged into homelessness from the hospital, and although this was not a specific observation related to trauma patients, the network is within a system that is struggling to meet the needs of vulnerable patients and requires careful planning and co-creation with community partners to ensure this can be addressed for trauma network patients. Further, the work that this network can achieve can serve as an important model to scale and spread change throughout SHA. Patient partners also identified the discharge process as an area of concern within the system.

It was not clear where all the components of self-management exist within the areas that are involved in the client care journey. One area visited was clearly able to describe self-management for their rehab clients. The network is encouraged to include this concept in program planning and design.

Although coordination of care is occurring in the hospital by the trauma services, coordination of care across the continuum is an important focus for this priority population. Notably, for clients who do not reside in either Regina or Saskatoon and who likely face more challenges accessing appropriate follow up services. These clients are also more affected by the fragmentation of the current clinical information system.

As the Trauma PCN is in its infancy as a network, the selection and development of evidence-based guidelines that apply provincially has not yet had a chance to occur. The network is encouraged, especially as the first provincial care network in Saskatchewan, to engage with all its partners, including knowledge translation and implementation science experts, to support the development of this process.

Although Public Health and the Ministry of Health are partners with the Trauma PCN, the degree to which the Trauma PCN has been able to advocate for healthy public policies was not fully described. As the network matures, the performance measures, data, and patient experiences can help drive public policy action. This should remain a key component to the activities of the network.

Clinical Information and Performance

Trauma system intelligence has been identified as an area of strategic focus for the Trauma PCN. The PCN sits within a broader healthcare system that is struggling with various clinical information systems that can lead to gaps in the continuity of care. One team member described the fact that a client may present for service, and the care provider doesn't realize until that appointment that they don't have access to the health records required to provide full care as this individual has come from a separate region. Clients can be faced with delays in their care, or a lengthened time of care since the required information is not accessible and requires follow-up to access the information.

Although certainly identified as a priority, the team has not yet integrated information systems - especially with primary care providers. This is within the context of the broader SHA which is struggling to manage multiple information systems. The Trauma PCN is well-positioned to provide a unique perspective on the benefits of clinical information system integration and will be bolstered by work across the system to address this challenge.

The PCN is actively working to define the minimum data set required across the province as they reconcile two separate trauma registry databases in Saskatoon and Regina. Although identified as an objective for the Trauma PCN, this is not yet possible due to the challenges with data collection and analysis. This will support performance monitoring to drive improvements in care and outcomes for this population, including the definition of high-risk groups to support improvement of equity. The organization is encouraged to engage in meaningful co-design with patients, families and communities affected by trauma to set measurable and specific goals and objectives. The organization is encouraged to continue its work to be able to participate in the Trauma Quality Improvement Program as this will be the basis upon which improvements in care and outcomes for the trauma population will be based.

Once regular collection, analysis, and feedback of information about the quality of trauma services is available, the team is encouraged to build meaningful feedback mechanisms of this information back to clinicians. The network may consider building this strategy by incorporating implementation science and knowledge translation principles.

People-Centered Care (PCC)

Trauma care partners have acknowledged the importance of considering client and family perspectives when designing and removing programs. The SHA is encouraged to continue embedding those with lived experience within established working groups and planning bodies. Consider, as well, seeking inclusion of patients and family in Network evaluation, establishing and assessing performance measures, and ongoing evolution. Establishing metrics that define the presence and progress of advancing PCC are important as a core philosophy of care to capture what "person-centered care" looks like in the trauma domain.

The team is encouraged to consider establishing communication strategies with communities and partners that explain the SHA's approach to trauma integration. Leveraging existing connections with agencies to understand what community members need to know about managing risk, modifying behaviours, and accessing services will be integral.

Where appropriate, look for data to inform advocacy and potential policy changes and resource allocation. Consider the value of stories, told by patients and families in their own words, which illustrate the importance of this network "getting it right". Stories can also serve to reinforce, to providers and leaders, that their work has merit and is delivering person-centered outcomes and experiences of care.

Table 22: Unmet Criteria for Population Health and Wellness

Criteria Number	Criteria Text	Criteria Type
1.1.4	The organization targets groups of its priority population(s) that may be high-risk or hard-to-reach.	NORMAL
1.2.1	The organization sets measurable and specific goals and objectives for its services for its priority population(s).	NORMAL
2.2.2	The organization coordinates services and follow-up for its priority population(s).	NORMAL
3.1.1	The organization has a process to select evidence-based guidelines for its services for its priority population(s).	NORMAL
3.1.2	The organization makes information about evidence-based guidelines and how to implement them available to staff and service providers.	NORMAL
3.1.3	The organization reviews its guidelines to make sure they are up to date and reflect current research and best practice.	HIGH
3.1.5	The organization shares benchmark and best practice information with its partners and other organizations.	NORMAL

Criteria Number	Criteria Text	Criteria Type
4.1.1	The organization maintains a clinical information system and longitudinal client records.	NORMAL
4.1.4	The organization works with primary care providers, partners, and other organizations to integrate information systems.	NORMAL
4.1.5	The organization uses the information system to generate regular reports about performance and adherence to guidelines, and to improve services and processes.	NORMAL
4.1.6	The organization monitors and validates the quality of data in the clinical information system.	NORMAL
5.1.1	The organization identifies and monitors performance measures for its services for its priority population(s).	HIGH
5.1.2	The organization obtains feedback from clients about their perspectives on the quality of its services.	NORMAL
5.1.3	The organization consults regularly with its partners to collect information, identify gaps in the continuum of care, and improve services for its priority population(s).	NORMAL
5.1.4	The organization compares its results with other similar interventions, programs, or organizations.	NORMAL
5.1.5	The organization uses the information it collects about the quality of its services to identify successes and opportunities for improvement, and makes improvements in a timely way.	NORMAL
5.1.6	The organization shares information about its successes and opportunities for improvement, improvements made, and what it is planning for the future with staff, service providers, clients and families.	NORMAL

Primary Health Care Services

Standard Rating: 89.4% Met Criteria

10.6% of criteria were unmet. For further details please review the table at the end of this section.

Assessment Results

The organization is committed to supporting the concept of a patient's medical home thus supporting comprehensive continuous care. While Borden Primary Health Centre provides care continuity, the Idylwyld Centre - STBBI Services and Resources (SSAR) team are not intended to provide ongoing care. Instead, Idylwyld Centre – SSAR links clients with other primary care sites that provide ongoing care. Even so, this team has the opportunity to track electronic medical record (EMR) data to determine the number of clients who attend on numerous occasions.

Idylwyld Centre primary care services work very closely with many intersectoral partners such as housing, shelters and protective services. Ongoing attention is paid to health promotion and disease prevention services and integrated into every client encounter. This team also provides extensive outreach services. There is an outreach van in place and the new mobile primary care wellness bus will be put into place in the very near future. These are excellent services in taking primary care to locations where vulnerable persons reside. The intent is to deliver culturally responsive, stigma free, non-judgmental and trauma informed services.

At Borden Primary Health Centre care transitions may occur with specialists. Clients are fully engaged through all referral processes and care transitions may also occur when other services are engaged (e.g., home care, mental health counselling, and family physicians). The team may wish to consider seeking feedback from clients regarding the current referral processes in place. Families are certainly fully engaged in planning individualized services as was evidenced in client interviews.

Charts reviewed noted excellent communication and collaboration with numerous services. Links with multiple specialists were very well documented for clients with numerous co-morbidities. Ongoing wound care is not provided by the primary care clinics, but should a minor wound need to be addressed, the nurse practitioner accesses regional protocols. Given some of the high-risk clients seen at these clinics, collaboration is clearly in place with wound care resources in home care. Access to a specialist is also in place and was evident on files reviewed.

Virtual care is currently very limited to telephone follow up with some clients. It is suggested that reinstatement of some chronic disease management supports (e.g. dietitian counselling) could be explored and that expanded virtual care could be done using virtual care approaches.

Hand hygiene audits are not currently being done. The teams are planning to implement a client engagement and self-audit approach in the near future. This is certainly supported given the size of the primary care service. The results of the hand hygiene practice monitoring can be used to develop a formal quality improvement process.

Excellent population health data is collected by the organization, but it is not clear that all the primary care teams access and use this data to plan services and, where possible, co-design services with priority populations. Based on chart reviews and the age of the population served, the teams may also want to explore electronic medical record (EMR) data specific to chronic disease. For Idylwyld Centre – SSAR, this data and the services provided on the mobile bus service will be of assistance in tracking service demands and types of services provided.

The Idylwyld Centre primary care team serves a vulnerable and very diverse population. All client charts reviewed at the site were extremely well done and indicated a comprehensive and holistic approach. This is key in providing services to the vulnerable population served. As this site does not provide ongoing primary care for clients, medication refills are not a common occurrence. Chart reviews did note a situation where a client required a refill. This service was provided by the nurse practitioners given that the individual did not have an identified family physician.

A formal audit process is not in place to ensure compliance with the organization's medication abbreviation ‘do not use list’. There is an opportunity to develop a chart audit process to address this need.

It was noted at Borden Primary Health Centre that two-person specific identifiers are used at the point of intake for all new clients, but for all subsequent visits, two person identifiers are not used to confirm that clients receive the service or procedure intended for them. Staff are very familiar with all clients given the size of the population served. There is a need however, to implement a process to use two person identifiers consistently to support patient safety.

Table 23: Unmet Criteria for Primary Health Care Services

Criteria Number	Criteria Text	Criteria Type
1.1.2	The organization uses the population health data and the information it obtains about service needs to plan and co-design programs, care pathways, and services.	HIGH
1.1.3	The organization uses a clinical information system or other data source to group clients according to condition and other health-related factors, and to establish service priorities.	NORMAL
1.1.4	The organization demonstrates how it uses population health data and information about service needs to improve its services.	NORMAL

Criteria Number	Criteria Text	Criteria Type
1.3.7	Hand-Hygiene Compliance 1.3.7.1 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) 1.3.7.2 Hand-hygiene compliance results are shared with team members and volunteers. 1.3.7.3 Hand-hygiene compliance results are used to make improvements to hand-hygiene practices.	ROP
5.1.13	The team assesses and documents the client's palliative and end-of-life care needs, including advance care planning, where appropriate.	NORMAL
5.3.1	Client Identification 5.3.1.1 At least two person-specific identifiers are used to confirm that clients receive the service or procedure intended for them, in partnership with clients and families.	ROP

Criteria Number	Criteria Text	Criteria Type
5.3.7	The ‘Do Not Use’ List of Abbreviations 5.3.7.7 Compliance with the organization's ‘Do Not Use' List is audited and process changes are implemented based on identified issues.	ROP
5.6.7	Information Transfer at Care Transitions 5.6.7.2 Documentation tools and communication strategies are used to standardize information transfer at care transitions. 5.6.7.5 The effectiveness of communication is evaluated and improvements are made based on feedback received. Evaluation mechanisms may include: \n • 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
6.2.3	The team evaluates the effectiveness of care transitions and uses the information to improve transition planning.	HIGH
6.2.5	The organization consults regularly with its partners to collect information, identifies and addresses gaps in the continuum of care, and improves services for its underserved populations.	NORMAL
6.2.6	The organization compares its results with other similar services, programs, or organizations.	NORMAL

Service Excellence for Primary Health Care Services

Standard Rating: 73.0% Met Criteria

27.0% of criteria were unmet. For further details please review the table at the end of this section.

Assessment Results

There were no formal quality improvement processes evident yet where priority issues are identified, targets and indicators are established, and data is collected to ensure actions are meeting their intended results. There is a visual management board in the staff room at Borden Primary Health Centre where issues are noted and weekly huddles with the manager occur. Potential areas that the teams identified were hand hygiene audits, diagnostic result tracking, and chart audits exploring compliance of medications abbreviations and the 'Do Not Use' list. The team is encouraged to develop formal quality improvement strategies in these areas. The teams work in a very collaborative manner. There is an opportunity to consider evaluating the effectiveness of the collaboration and functioning and identify opportunities for improvement. There may also be an opportunity to evaluate team functioning with partners. This could be a future quality improvement activity.

At Borden Primary Health Centre and Idylwyld Centre – STBBI Services and Resources (SSAR), performance reviews have not been updated since before the COVID-19 pandemic. It is noted however, that staff have been supported in ongoing personal development and learning. The new leader at Idylwyld Centre – SSAR is acknowledged for the work to date in meeting with each staff member. Formalizing the performance review process will be the next step.

The collaborative approach to all service delivery is exemplary. Observing the staff huddles provided excellent evidence of information sharing and joint problem solving. Clinic staff are remarkably committed to client service and quickly pivot to meet immediate client needs given the vulnerability of the population served. There is opportunity for the teams to evaluate their team functioning and given the close links with public health, visiting mental health counsellors and home care services, it would be valuable in including these partners in such an evaluation.

During the staff discussion, it was identified that there is the opportunity to ensure that the nurse practitioner and other staff have access to education on identifying and addressing palliative and end-of-life care needs and available services.

Local mechanisms are levered to inform the community of services, new staff and education sessions and team members interviewed noted excellent knowledge about community and specialty consultation services. Borden Primary Health Centre holds biannual community meetings that are attended by staff where community members can bring forward suggestions. Leadership used this as an opportunity to inform the community about existing service availability for registered clients.

The Idylwyld Centre – SSAR primary care team works very closely with numerous community partners. This team is exploring additional opportunities to seek input from partners and clients about the quality of services delivery and future quality plans which is highly encouraged. Co-design of services has been key in not only the site's service delivery but also with the primary care bus. The continued work and consultation done with the City of Saskatoon and Protective Services, numerous community organizations and other support organizations such as the Salvation Army has been key to the development of the Saskatoon Wellness Bus services reaching vulnerable populations.

There is opportunity at Borden Primary Health Centre to use the population profile data to assist in future planning. It is suggested that the population data coupled with the electronic medical record (EMR) patient population data would be helpful in designing services in the future. Formal evaluation of primary care services at this site has not been completed to date.

Table 37: Unmet Criteria for Service Excellence for Primary Health Care Services

Criteria Number	Criteria Text	Criteria Type
1.1.2	The team uses information about the service needs of clients and the community to guide its service design.	NORMAL
1.1.3	The team develops its service-specific goals and objectives.	NORMAL
1.1.4	The team monitors and evaluates its services for appropriateness.	NORMAL
2.1.9	The team leadership ensures that staff are provided with education and training on identifying and addressing palliative and end-of-life care needs.	HIGH
2.1.10	The team leadership regularly evaluates and documents each staff member's performance in an objective, interactive, and constructive way.	HIGH
2.1.12	The team leadership supports staff to follow up on issues and opportunities for growth identified through performance evaluations.	HIGH
2.2.3	The team leadership ensures that staff use the organization's standardized communication tools to share information about a client's care within and between teams, as consented to by the client.	HIGH
2.2.4	The team evaluates the effectiveness of its collaboration and functioning, and identifies opportunities for improvement.	NORMAL
3.1.8	The team monitors and evaluates its record-keeping practices, and uses the results to make improvements.	HIGH
4.2.4	The team evaluates its safety improvement strategies.	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
4.3.3	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
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
4.3.11	The team regularly evaluates quality improvement initiatives for feasibility, relevance, and usefulness.	NORMAL

Public Health Services

Standard Rating: 91.3% Met Criteria

8.7% of criteria were unmet. For further details please review the table at the end of this section.

Assessment Results

Population health data is updated regularly and can be reviewed at the network and community levels. Both sites visited, South East Health Centre immunization services and Idylwyld Centre (Sexually Transmitted Blood Borne Infection/STBBI services) demonstrated an excellent understanding of this data and used it to plan service delivery. This has been key in identifying high risk and stressed populations.

Several intersectoral groups (STBBI) are in place where public health can share population health data and support collaborative planning. Populations that experience barriers to access services are identified and confirmed using many population health indicators. The STBBI services team at Idylwyld Centre is commended for their innovative approaches in supporting accessible services to the population served. Examples include availability of walk in services, transportation support if necessary, and plans for the new mobile bus and outreach van to offer services where the clients are -well done!

Provincial processes are in place to ensure timely notification of potential health threats. Communication at the provincial and local levels are regular and updates are provided in a timely manner. Staff at both sites noted that they are fully informed.

Immunization services are readily accessible throughout the community. An excellent example was provided by the South East Health Centre where the community library requested vaccination services at that location. This has become a very successful approach which has included community development. There is a wonderful opportunity to analyze the immunization data and link the recent improvements noted to innovative approaches with community partners. It is suggested that this could certainly be a formal quality improvement initiative.

Information is collected on an ongoing basis about the community and used to define service priorities. For example, the South East Health Centre is currently monitoring the high-risk post-natal population to determine potential enhanced processes to deliver post-natal services. The STBBI services constantly monitor the prevalence and incidence of STBBIs to inform priorities.

Both sites' staff were very aware of the available ethics supports and noted situations where these resources have been accessed. All staff in public health and primary care at these sites were able to identify numerous ethical issues that they have addressed. All staff also noted their team supports and the many mechanisms in place where they can discuss difficult situations and explore options.

Staff at both sites have access to ongoing professional development opportunities. However, since COVID, performance reviews have not been regularly occurring and documented. The South East Health Centre immunization team has begun the process and is encouraged to continue. The leadership staff at Idylwyld Centre STBBI has changed recently. The new leader's efforts in ensuring that one-to-one meetings have occurred with all staff is acknowledged. There is the need to now formalize the performance review process.

System-wide long-term service recognition is in place. The South East Health Centre team has numerous activities in place to acknowledge staff such as 'Cheers for Peers' and a social committee. The STBBI team huddle on a regular basis and include the sharing of 'kudos'. One member of this team has also created a 'Sparks of Joy' board. It is clear at both sites that these local acknowledgement opportunities support a collaborative team.

Patient safety is embraced by all public health services reviewed. Incident reporting policies and processes are in place as well as disclosure and investigation procedures. Few patient safety incidents were noted at either site. Both sites were fully aware of the local public health emergency plan relevant to their site and service. Binders outlining the public health response and responsibilities were present at both sites.

At the time of the on-site survey, the immunization team at the South East Health Centre and the Idylwyld STBBI team had not formally implemented quality improvement activities. There are several opportunities to formalize quality improvement processes with select existing activities. For example, the immunization team at the South East Health Centre may wish to consider formally setting targets and indicators for its community delivered immunization services at the library. Learnings from this would be very helpful in informing the expansion to other sites. The Idylwyld STBBI team has excellent processes in place to track lab orders and results. This activity is well worth formalizing and evaluating to assist in determining if improvements can be made.

Ongoing education regarding quality improvement processes may be helpful for all staff at both sites. White boards are in place at both sites and very well used to support team communication and guide huddle discussions. As quality improvement activities evolve, it is suggested that indicators and targets be posted on these boards. As both sites implement hand hygiene audits, this data can also be posted on these boards.

Table 24: Unmet Criteria for Public Health Services

Criteria Number	Criteria Text	Criteria Type
3.1.3	Team member performance is regularly evaluated and documented in an objective, interactive, and constructive way.	HIGH
9.2.3	Measurable objectives with specific timeframes for completion are identified for quality improvement initiatives, with input from clients and families.	HIGH
9.2.4	Indicator(s) that monitor progress for each quality improvement objective are identified, with input from clients and families.	NORMAL
9.2.5	Quality improvement activities are designed and tested to meet objectives.	HIGH
9.2.6	New or existing indicator data are used to establish a baseline for each indicator.	NORMAL

Criteria Number	Criteria Text	Criteria Type
9.2.7	There is a process to regularly collect indicator data and track progress.	NORMAL
9.2.8	Indicator data is regularly analyzed to determine the effectiveness of the quality improvement activities.	HIGH
9.2.9	Quality improvement activities that were shown to be effective in the testing phase are implemented broadly throughout the organization.	HIGH
9.2.10	Information about quality improvement activities, results, and learnings is shared with clients, families, teams, organization leaders, and other organizations, as appropriate.	NORMAL
9.2.11	Quality improvement initiatives are regularly evaluated for feasibility, relevance, and usefulness, with input from clients and families.	NORMAL

Rehabilitation Services

Standard Rating: 95.6% Met Criteria

4.4% of criteria were unmet. For further details please review the table at the end of this section.

Assessment Results

The rehabilitation teams monitor its waitlists and have a clear management plan for clients who are waiting for access. The team is very connected with the clients and the families they serve. Clients spoke highly of the care received and felt a part of the care team. Although a best possible medication history (BPMH) is generated and documented upon admission the process for medication reconciliation is a challenge for some sites as they do not administer medications. For example, the Rehabilitation Outpatient Specialized Services (ROSS) at Saskatoon City Hospital does not have a process to compare this list to the list that is kept in the Pharmaceutical Information Program (PIP). The reconciling of the patient list with this PIP list would complete the reconciliation process and provide the opportunity to ensure medications are taken as prescribed.

Universal falls precautions are identified and implemented. The teams are given education and information on how to prevent falls and reduce injuries from falling. It is the same for pressure ulcer prevention, where applicable. As ROSS is an outpatient setting, pressure ulcer prevention is not provided regularly however, the team does provide seating consultations to help reduce pressure risk. In the Geriatric Re-enablement Unit (GRU) at Parkridge Centre which is a short-stay program, the initial pressure ulcer risk assessment is conducted upon admission and at regular intervals. There is good education about the risk factors and protocols/procedures to prevent pressure ulcers provided to the team, clients, and families.

The team is using a variety of methods to transfer information across the continuum of care. There are multiple charting platforms (paper and electronic) and this creates challenges to handovers between providers. A standardized tool to help provide a clear expectation for staff when transferring patients to other care providers is encouraged as it would help the staff in ensuring all necessary information is shared. There is also no process in place to evaluate the effectiveness of transitions. The organization is encouraged to create systems that allow for ongoing sustainable evaluation of the effectiveness of transitions.

The ROSS team offers care to clients with neurological conditions, amputees, complex seating issues, stroke and multiple sclerosis (MS) in various care settings with hospital, virtually and at the field location. The team has engaged in client satisfaction surveys to help in adjusting the hours of the clinic and the services offered at the clinic. They are currently offering a MS care pilot project around early intervention for MS patients. The feedback from the clients able to participate in this project was extremely positive and this is exciting for the team.

Table 25: Unmet Criteria for Rehabilitation Services

Criteria Number	Criteria Text	Criteria Type
1.4.12	Information Transfer at Care Transitions 1.4.12.2 Documentation tools and communication strategies are used to standardize information transfer at care transitions. 1.4.12.5 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 Rehabilitation Services

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

There is mixed feedback from staff and managers as to the completion of performance evaluations. The organization is encouraged to create action plans to help their leaders to meet the standard of yearly evaluations and support staff in identifying growth opportunities.

All the rehabilitation teams are committed to high quality care. The Rehabilitation Outpatient Specialized Services (ROSS) team out of Saskatoon City Hospital have a dedicated team of professionals who work collaboratively for the benefit of their client population. The strong connections between the physicians and the team lends itself to great collaborations and works for the benefit of the client. The clients and families speak highly of the care they are receiving from this site and the staff are proud to be a part of this team.

The challenges that exist for this team would be formalizing the work that is being completed for the staff and clients to see the goals and progress towards them. There are no measurable objectives for the team developed at this time however, there are several activities happening such as patient satisfaction surveys, wait list management, and collaboration with other clinics in the programs. Developing measurable indicators from this work will help the team show progress on the work that is being completed. The team is encouraged to develop a quality improvement (QI) plan to formalize activities. Dedicated support for QI like what the team describes was in place pre-pandemic could also be considered.

A standardized tool to help provide a clear expectation for staff when transferring patients to other care providers is encouraged as it would help the staff in ensuring all necessary information is shared to ensure safe care transitions.

Table 38: Unmet Criteria for Service Excellence for Rehabilitation Services

Criteria Number	Criteria Text	Criteria Type
2.1.10	The team leadership regularly evaluates and documents each staff member’s performance in an objective, interactive, and constructive way.	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
2.2.3	The team leadership ensures that staff use the organization's standardized communication tools to share information about a client's care within and between teams, as consented to by the client.	HIGH
2.2.4	The team evaluates the effectiveness of its collaboration and functioning, and identifies opportunities for improvement.	NORMAL
4.2.4	The team evaluates its safety improvement strategies.	HIGH
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
4.3.3	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
4.3.6	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
4.3.11	The team regularly evaluates quality improvement initiatives for feasibility, relevance, and usefulness.	NORMAL

Reprocessing of Reusable Medical Devices

Standard Rating: 87.4% Met Criteria

12.6% of criteria were unmet. For further details please review the table at the end of this section.

Assessment Results

Preventative Maintenance

SHA has a preventative maintenance program for reprocessing equipment at the three sites that were visited, however, there is no formalized process for the evaluation of the program. It was noted that staff and leadership are informally doing evaluations which includes safely extending the life of the equipment and reducing time between failures of equipment. There is a lot of equipment that the preventative maintenance team needs to take care of on a regular basis. The department had a simple process to evaluate the effectiveness of the preventative maintenance program years ago and the success rates were shared with other teams in the organization however, the organization has a new computer system which is expected to assist with evaluation, but the software is not yet operational. The organization is encouraged to proceed with a process for evaluation of the effectiveness of the preventative maintenance program.

Staff receive training in a two-year program outside of the province as there is currently no educational program for biomedical training in Saskatchewan. Specialized technical training out of province is also offered to staff for some of the highly complex pieces of equipment that must be maintained. The teams do a great job of ensuring cross coverage and backfilling of positions in the department.

Medical Devices Reprocessing

There is ample equipment the medical devices reprocessing (MDR) departments to allow the sites to keep up with the service volumes of equipment needed to be sterilized and cleaned. There are very few contracts with external providers as most machines are serviced in-house.

At Saskatoon City Hospital, the MDR reprocesses flexible cystoscopes, but no gastrointestinal endoscopes or bronchoscopes are done in this MDR. At Royal University Hospital, all the scopes are cleaned by the MDR, including scopes from Jim Pattison Children's Hospital, however there is a separate gastrointestinal endoscopy reprocessing area. The MDR is not reprocessing bronchoscopes as they are waiting for in new air compressor so currently, they receive a high level of disinfection. The gastrointestinal and bronchoscopy flexible endoscopic reprocessing area is in a room next to the patient admission and recovery room. In the endoscopy unit reprocessing area, there is inadequate separation of clean and contaminated work areas, air ventilation is suboptimal, and storage of materials is not adequate. The organization is encouraged to make changes to this area to align with best practices.

As well, there is no direct connection from the MDR to Jim Pattison Children's Hospital surgical operating rooms therefore all instruments and supplies for the operating theatres in Jim Pattison Children's Hospital must be transported along corridors on carts, making this inefficient and time-consuming. There is no dedicated clean elevator whereby clean instruments from the MDR department can reach the operating theatres at Jim Pattison Children's Hospital and while most carts are covered with plastic but some of the larger carts are left uncovered. The organization is encouraged to look for ways to improve the transport of these pieces of equipment and supplies between the MDR at Royal University Hospital and Jim Pattison Children's Hospital operating theatres.

At Royal University Hospital and Saskatoon City Hospital the designated handwashing sinks are hand operated and are not equipped with sensors or foot or knee operated handles or automated soap dispensers. The organization is encouraged to move towards foot or knee operated handles or even motion sensors for handwashing.

At all 3 sites visited (Royal University Hospital, Saskatoon City Hospital, and St. Paul's Hospital), there are surfaces that are not ideal for cleaning and disinfecting. The organization is encouraged to replace the absorbent and porous materials used on ceilings and tabletops to support IPAC practices such as safe cleaning and disinfection as well as ensure the floors are level to better support the MDR processes and staff safety.

There is extensive mandatory educational training that all the staff complete. There is opportunity for the organization to review resources as not all the teams have an educator available to help with training and keeping staff aware of any new educational activities, policies and protocols.

While there is a focus on education and professional development for staff, regular and documented performance appraisals have not been done. St. Paul's Hospital MDR has an interim manager covering from the Royal University Hospital MDR which does make it more difficult for this team to have these conversations, but leadership is encouraged to start regular performance appraisals with staff as soon as possible.

The Saskatoon City Hospital team is very proud of the quality improvement (QI) activity that they are doing. The project is called Indicator Error Rate Evaluation, and it is being done on small wraps, individual wraps, and pans. The change process is about putting indicators into the containers. The team has already done a process map and is into its second 'plan-do-study-act' (PDSA) cycle. The plan is to spread this to the other reprocessing areas in Saskatoon. St. Paul's Hospital MDR team is currently exploring a partnership with Saskatoon City Hospital as it does not have any indicators to monitor progress yet. At Royal University Hospital, the team is considering an initiative of missed internal indicators per month from the equipment and trays that they sterilize. Another initiative includes updating the writeup of assembling trays in an efficient manner, however this has not yet started. There was no evidence that these initiatives are being evaluated.

Table 26: Unmet Criteria for Reprocessing of Reusable Medical Devices

Criteria Number	Criteria Text	Criteria Type
1.3.6	The Medical Device Reprocessing (MDR) department has floors, walls, ceilings, fixtures, pipes, and work surfaces that are easy to clean, non-absorbent, and will not shed particles or fibres.	HIGH
2.1.11	Team member performance is regularly evaluated and documented in an objective, interactive, and constructive way.	HIGH

Criteria Number	Criteria Text	Criteria Type
2.1.12	Team members are supported by team leaders to follow up on issues and opportunities for growth identified through performance evaluations.	HIGH
3.2.2	The reprocessing area's designated hand-washing sinks are equipped with faucets supplied with foot-, wrist-, or knee-operated handles, electric eye controls, automated soap dispenser and single-use towels.	NORMAL
4.3.2	All flexible endoscopic reprocessing areas are physically separate from patient care areas.	HIGH
4.3.3	All flexible endoscopic reprocessing areas are equipped with separate clean and contaminated/dirty work areas as well as storage, dedicated plumbing and drains, and proper air ventilation.	NORMAL
5.3.3	The information and feedback gathered is used to identify opportunities for quality improvement initiatives and set priorities with input from stakeholders.	NORMAL
5.3.4	Measurable objectives with specific timeframes for completion are identified for quality improvement initiatives with input from stakeholders.	HIGH
5.3.5	Indicator(s) that monitor progress for each quality improvement objective are identified, with input from stakeholders.	NORMAL
5.3.6	Quality improvement activities are designed and tested to meet objectives.	HIGH

Criteria Number	Criteria Text	Criteria Type
5.3.7	New or existing indicator data are used to establish a baseline for each indicator.	NORMAL
5.3.8	There is a process to regularly collect indicator data and track progress.	NORMAL
5.3.9	Indicator data is regularly analyzed to determine the effectiveness of the quality improvement activities.	HIGH
5.3.10	Quality improvement activities that were shown to be effective in the testing phase are implemented broadly throughout the organization.	HIGH
5.3.11	Information about quality improvement activities, results, and learnings is shared with stakeholders, teams, organization leaders, and other organizations, as appropriate.	NORMAL
5.3.12	Quality improvement initiatives are regularly evaluated for feasibility, relevance, and usefulness, with input from stakeholders.	NORMAL