ACCREDITATION
AGRÉMENT
CANADA
Qmentum

# Accreditation Report

## Selkirk Mental Health Centre

Selkirk, MB

On-site survey dates: September 11, 2016 - September 15, 2016

Report issued: November 25, 2016

# About the Accreditation Report

Selkirk Mental Health Centre (referred to in this report as “the organization”) is participating in Accreditation Canada's Qmentum accreditation program. As part of this ongoing process of quality improvement, an on-site survey was conducted in September 2016. Information from the on-site survey as well as other data obtained from the organization were used to produce this Accreditation Report.

Accreditation results are based on information provided by the organization. Accreditation Canada relies on the accuracy of this information to plan and conduct the on-site survey and produce the Accreditation Report.

# Confidentiality

This report is confidential and is provided by Accreditation Canada to the organization only. Accreditation Canada does not release the report to any other parties.

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

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

# A Message from Accreditation Canada

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

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

Your Accreditation Specialist is available if you have questions or need guidance.

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

We look forward to our continued partnership.

Sincerely,

Leslee Thompson
Chief Executive Officer

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# Executive Summary

Selkirk Mental Health Centre (referred to in this report as “the organization”) is participating in Accreditation Canada's Qmentum accreditation program. Accreditation Canada is an independent, not-for-profit organization that sets standards for quality and safety in health care and accredits health organizations in Canada and around the world.

As part of the Qmentum accreditation program, the organization has undergone a rigorous evaluation process. Following a comprehensive self-assessment, external peer surveyors conducted an on-site survey during which they assessed this organization's leadership, governance, clinical programs and services against Accreditation Canada requirements for quality and safety. These requirements include national standards of excellence; required safety practices to reduce potential harm; and questionnaires to assess the work environment, patient safety culture, governance functioning and client experience. Results from all of these components are included in this report and were considered in the accreditation decision.

This report shows the results to date and is provided to guide the organization as it continues to incorporate the principles of accreditation and quality improvement into its programs, policies, and practices.

The organization is commended on its commitment to using accreditation to improve the quality and safety of the services it offers to its clients and its community.

## Accreditation Decision

Selkirk Mental Health Centre's accreditation decision is:

**Accredited with Exemplary Standing**

The organization has attained the highest level of performance, achieving excellence in meeting the requirements of the accreditation program.

# About the On-site Survey

- **On-site survey dates: September 11, 2016 to September 15, 2016**

- **Locations**

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

  1. Acquired Brain Injury Transitional Residence
  2. Administration Building
  3. Alfred Barnett Building
  4. Community Rehabilitation Services (CRS)
  5. Dr. David Young Building
  6. Materials Management Building
  7. Tyndall Building
  8. Vocational Shop

- **Standards**

  The following sets of standards were used to assess the organization's programs and services during the on-site survey.

  ***System-Wide Standards***

  1. Governance
  2. Infection Prevention and Control Standards
  3. Leadership
  4. Medication Management Standards

  ***Service Excellence Standards***

  5. Acquired Brain Injury Services - Service Excellence Standards
  6. Mental Health Services - Service Excellence Standards

- **Instruments**

  The organization administered:

  1. Governance Functioning Tool (2011 - 2015)
  2. Canadian Patient Safety Culture Survey Tool
  3. Worklife Pulse
  4. Client Experience Tool

## Overview by Quality Dimensions

Accreditation Canada defines quality in health care using eight dimensions that represent key service elements. Each criterion in the standards is associated with a quality dimension. This table shows the number of criteria related to each dimension that were rated as met, unmet, or not applicable.

| Quality Dimension | Met | Unmet | N/A | Total |
|---|---|---|---|---|
|  Population Focus (Work with my community to anticipate and meet our needs) | 31 | 0 | 0 | 31 |
|  Accessibility (Give me timely and equitable services) | 26 | 0 | 0 | 26 |
|  Safety (Keep me safe) | 155 | 0 | 36 | 191 |
|  Worklife (Take care of those who take care of me) | 63 | 1 | 1 | 65 |
|  Client-centred Services (Partner with me and my family in our care) | 104 | 0 | 1 | 105 |
|  Continuity of Services (Coordinate my care across the continuum) | 21 | 0 | 1 | 22 |
|  Appropriateness (Do the right thing to achieve the best results) | 280 | 5 | 21 | 306 |
|  Efficiency (Make the best use of resources) | 25 | 0 | 0 | 25 |
| **Total** | **705** | **6** | **60** | **771** |

# Overview by Standards

The Qmentum standards identify policies and practices that contribute to high quality, safe, and effectively managed care. Each standard has associated criteria that are used to measure the organization's compliance with the standard.

System-wide standards address quality and safety at the organizational level in areas such as governance and leadership. Population-specific and service excellence standards address specific populations, sectors, and services. The standards used to assess an organization's programs are based on the type of services it provides.

This table shows the sets of standards used to evaluate the organization's programs and services, and the number and percentage of criteria that were rated met, unmet, or not applicable during the on-site survey.

Accreditation decisions are based on compliance with standards. Percent compliance is calculated to the decimal and not rounded.

| Standards Set | High Priority Criteria * | | | Other Criteria | | | Total Criteria (High Priority + Other) | | |
|---|---|---|---|---|---|---|---|---|---|
| | Met | Unmet | N/A | Met | Unmet | N/A | Met | Unmet | N/A |
| | # (%) | # (%) | # | # (%) | # (%) | # | # (%) | # (%) | # |
| Governance | 42 (95.5%) | 2 (4.5%) | 6 | 36 (100.0%) | 0 (0.0%) | 0 | 78 (97.5%) | 2 (2.5%) | 6 |
| Leadership | 48 (98.0%) | 1 (2.0%) | 0 | 95 (99.0%) | 1 (1.0%) | 0 | 143 (98.6%) | 2 (1.4%) | 0 |
| Infection Prevention and Control Standards | 43 (100.0%) | 0 (0.0%) | 14 | 30 (100.0%) | 0 (0.0%) | 4 | 73 (100.0%) | 0 (0.0%) | 18 |
| Medication Management Standards | 53 (100.0%) | 0 (0.0%) | 25 | 57 (100.0%) | 0 (0.0%) | 7 | 110 (100.0%) | 0 (0.0%) | 32 |
| Acquired Brain Injury Services | 46 (100.0%) | 0 (0.0%) | 0 | 87 (100.0%) | 0 (0.0%) | 1 | 133 (100.0%) | 0 (0.0%) | 1 |
| Mental Health Services | 49 (98.0%) | 1 (2.0%) | 0 | 90 (98.9%) | 1 (1.1%) | 1 | 139 (98.6%) | 2 (1.4%) | 1 |
| **Total** | **281 (98.6%)** | 4 (1.4%) | 45 | 395 (99.5%) | 2 (0.5%) | 13 | 676 (99.1%) | 6 (0.9%) | 58 |

* Does not includes ROP (Required Organizational Practices)

## Overview by Required Organizational Practices

A Required Organizational Practice (ROP) is an essential practice that an organization must have in place to enhance client safety and minimize risk. Each ROP has associated tests for compliance, categorized as major and minor. All tests for compliance must be met for the ROP as a whole to be rated as met.

This table shows the ratings of the applicable ROPs.

| Required Organizational Practice | Overall rating | Test for Compliance Rating | |
|---|---|---|---|
| | | Major Met | Minor Met |
| **Patient Safety Goal Area: Safety Culture** | | | |
| Accountability for quality (Governance) | Met | 4 of 4 | 2 of 2 |
| Patient safety incident disclosure (Leadership) | Met | 4 of 4 | 2 of 2 |
| Patient safety incident management (Leadership) | Met | 6 of 6 | 1 of 1 |
| Patient safety quarterly reports (Leadership) | Met | 1 of 1 | 2 of 2 |
| Patient safety-related prospective analysis (Leadership) | Met | 1 of 1 | 1 of 1 |
| **Patient Safety Goal Area: Communication** | | | |
| Client Identification (Acquired Brain Injury Services) | Met | 1 of 1 | 0 of 0 |
| Client Identification (Mental Health Services) | Met | 1 of 1 | 0 of 0 |
| Information transfer at care transitions (Acquired Brain Injury Services) | Met | 4 of 4 | 1 of 1 |
| Information transfer at care transitions (Mental Health Services) | Met | 4 of 4 | 1 of 1 |

| Required Organizational Practice | Overall rating | Test for Compliance Rating | |
|---|---|---|---|
| | | Major Met | Minor Met |
| **Patient Safety Goal Area: Communication** | | | |
| Medication reconciliation as a strategic priority (Leadership) | Met | 4 of 4 | 2 of 2 |
| Medication reconciliation at care transitions (Acquired Brain Injury Services) | Met | 5 of 5 | 0 of 0 |
| Medication reconciliation at care transitions (Mental Health Services) | Met | 5 of 5 | 0 of 0 |
| The "Do Not Use" list of abbreviations (Medication Management Standards) | Met | 4 of 4 | 3 of 3 |
| **Patient Safety Goal Area: Medication Use** | | | |
| Antimicrobial stewardship (Medication Management Standards) | Met | 4 of 4 | 1 of 1 |
| Concentrated electrolytes (Medication Management Standards) | Met | 3 of 3 | 0 of 0 |
| Heparin safety (Medication Management Standards) | Met | 4 of 4 | 0 of 0 |
| High-alert medications (Medication Management Standards) | Met | 5 of 5 | 3 of 3 |
| Narcotics safety (Medication Management Standards) | Met | 3 of 3 | 0 of 0 |
| **Patient Safety Goal Area: Worklife/Workforce** | | | |
| Patient safety plan (Leadership) | Met | 2 of 2 | 2 of 2 |
| Patient safety: education and training (Leadership) | Met | 1 of 1 | 0 of 0 |

| Required Organizational Practice | Overall rating | Test for Compliance Rating | |
|---|---|---|---|
| | | Major Met | Minor Met |
| **Patient Safety Goal Area: Worklife/Workforce** | | | |
| Preventive maintenance program (Leadership) | Met | 3 of 3 | 1 of 1 |
| Workplace violence prevention (Leadership) | Met | 5 of 5 | 3 of 3 |
| **Patient Safety Goal Area: Infection Control** | | | |
| Hand-hygiene compliance (Infection Prevention and Control Standards) | Met | 1 of 1 | 2 of 2 |
| Hand-hygiene education and training (Infection Prevention and Control Standards) | Met | 1 of 1 | 0 of 0 |
| Infection rates (Infection Prevention and Control Standards) | Met | 1 of 1 | 2 of 2 |
| Reprocessing (Infection Prevention and Control Standards) | Met | 1 of 1 | 1 of 1 |
| **Patient Safety Goal Area: Risk Assessment** | | | |
| Falls prevention (Acquired Brain Injury Services) | Met | 3 of 3 | 2 of 2 |
| Falls prevention (Mental Health Services) | Met | 3 of 3 | 2 of 2 |
| Suicide prevention (Mental Health Services) | Met | 5 of 5 | 0 of 0 |

# Summary of Surveyor Team Observations

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

Selkirk Mental Health Services (SMHC) is a provincially owned and operated psychiatric facility in Manitoba. It was opened in 1886 with 167 beds. The property is located in the City of Selkirk and has a variety of SMHC buildings scattered on its site. It now provides services to 252 people from the Province of Manitoba and the Territory of Nunavut in the following areas of; Acquired Brain Injury, Geriatric, Forensic, Acute, Dialectical Behaviour Therapy (DBT), and Rehabilitation programs. The five service programs are located in various buildings scattered around the grounds.

The Selkirk Mental Health Centre is under the direct authority of the Government of Manitoba. A governing council has been established to provide an opportunity to provide input and consultation services to the leadership team. It reviews the fiscal position but has no authority.

The organization is the only psychiatric facility in Manitoba that is under the auspices of the provincial government. This provides a number of administrative and planning challenges. The construction of the Tyndall building in 2008 which houses the Acquired Brain Injury program (ABI), Geriatrics and DBT is leading edge and provides a welcoming environment for patients. The aging infrastructure and the presence of dormitory rooms within the other SMHC buildings present challenges which include but are not limited to, patient privacy, difficulties carrying out individualized patient programs, and infection control concerns. The buildings are owned and maintained by the provincial government. Numerous efforts to advocate for funding to replace 'the dormitory' rooms have not yet been successful. There is considerable evidence that such housing is inappropriate and puts both the patients and staff members at risk. The replacement of this accommodation is considered a priority.

Consideration is being given to moving SMHC from a directly operated government organization to a part of a regional health authority. This will have wide spread, long range implications for the centre particularly from a change management perspective.

Leadership capacity in the organization is proactive and there is evidence that the organization has been dedicating a considerable amount of effort to prepare for the Accreditation Canada survey. Staff are commended for their incredible achievements.

SMHC has embraced recovery-oriented practices and psychosocial rehabilitation (PSR) which is well supported by staff across all program areas. Plans to create a staff position that will support on-going PSR education and practices are in place.

A major challenge facing the team as they move forward will be to sustain staff momentum created by the many innovative initiatives recently undertaken by the centre. An associated challenge will be to completely operationalize the new and revised policies and processes resulting from these initiatives.

There was considerable effort involved in the preparation of the new Strategic Plan. Many stakeholders including patients, family members, and partners were involved. The Plan now awaits final approvals and should be released in approximately a month. The organization is encouraged to circulate this plan widely and in a timely manner to provide information regarding the new strategic directions for SMHC. Feedback received during this survey suggests that stakeholders, including staff, are anxiously awaiting this document's release.

The leadership team has worked diligently to implement changes that promote a culture of quality and safety. Efficiencies are planned but due to the lengthy process to obtain decisions from the government office there is limited success in this planning. The budget must be approved by the Manitoba Treasury Board. The Chief Executive Officer, (CEO) has limited authority in approving expenditures. Purchase orders must be approved by the government department and all cheques are issued through the government. Fiscal reporting on site is limited to cash flow statements and budget comparisons.

There was a high level of engagement in the staff, who felt that managers listen to their concerns and welcome their input. Staff is clearly valued and this is evident in the high levels of engagement and enthusiasm demonstrated during the survey. Health and well-being initiatives are planned regularly and there is a gym available for staff to use. Staff meetings are held regularly and include updates on the broader organizational developments and successes, which supports engagement. SMHC has various methods of internal and external communication some of which is reflected in the organizational communication plan.

The organization faces a challenge with respect to lack of funding resources to meet its ongoing staffing needs. Wage parity is also a concern with recruitment efforts. These issues are compounded by the government's recent hiring freeze leaving both patients and existing staff members at risk. Situations requiring staff members to work a double shift sometimes occur. This impacts worklife balance and also contributes to the organizational deficit.

Due to the centre's lengthy history as a mental health provider and its provincial oversight, there is a degree of stigma within the community regarding the organization. This seems to vary depending on individual experience with SMHC. There is acknowledgement from partners that the actions of former leadership staff members isolated the organization. In the past five to eight years, it was noted that there has been a positive change. The organization is now considered a valuable part of the health system. Outreach and consultation with partners, sharing of resources, and taking leadership roles in provincial initiatives is appreciated.

The organization is well prepared to move forward on fully implementing its many new initiatives.

# Detailed On-site Survey Results

This section provides the detailed results of the on-site survey. When reviewing these results, it is important to review the service excellence and the system-wide results together, as they are complementary. Results are presented in two ways: first by priority process and then by standards sets.

Accreditation Canada defines priority processes as critical areas and systems that have a significant impact on the quality and safety of care and services. Priority processes provide a different perspective from that offered by the standards, organizing the results into themes that cut across departments, services, and teams.

For instance, the patient flow priority process includes criteria from a number of sets of standards that address various aspects of patient flow, from preventing infections to providing timely diagnostic or surgical services. This provides a comprehensive picture of how patients move through the organization and how services are delivered to them, regardless of the department they are in or the specific services they receive.

During the on-site survey, surveyors rate compliance with the criteria, provide a rationale for their rating, and comment on each priority process.

Priority process comments are shown in this report. The rationale for unmet criteria can be found in the organization's online Quality Performance Roadmap.

See Appendix B for a list of priority processes.

**INTERPRETING THE TABLES IN THIS SECTION: The tables show all unmet criteria from each set of standards, identify high priority criteria (which include ROPs), and list surveyor comments related to each priority process.**

**High priority criteria and ROP tests for compliance are identified by the following symbols:**

| | |
|---|---|
| ! | High priority criterion |
| ROP | Required Organizational Practice |
| **MAJOR** | Major ROP Test for Compliance |
| **MINOR** | Minor ROP Test for Compliance |

# Priority Process Results for System-wide Standards

The results in this section are presented first by priority process and then by standards set.

Some priority processes in this section also apply to the service excellence standards. Results of unmet criteria that also relate to services should be shared with the relevant team.

## Priority Process: Governance

Meeting the demands for excellence in governance practice.

| Unmet Criteria | | High Priority Criteria |
|---|---|---|
| **Standards Set: Governance** | | |
| 13.6 | The governing body regularly evaluates the performance of the board chair based on established criteria. | ! |
| 13.7 | The governing body regularly reviews the contribution of individual members and provides feedback to them. | ! |

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

Selkirk Mental Health Centre is under the direct authority of the Government of Manitoba, Department of Health, Seniors, and Active Living. A governing council was established after the last accreditation survey. This accountability structure provides some challenges for the board to operate under a policy governance model. Elements such as communication (issuing of a comprehensive annual report which can be widely distributed) and fiscal authority are limited. The creation of the governing council has proven to be highly successful despite the limitations of the reporting structure.

The composition of the governing council is predetermined. Assistant Deputy Ministers from various divisions are present as well as other health service representatives. Representation from the Stakeholders and Family Advisory Committees are also appointed.

Members of the governing council are well informed regarding their work as board members. They are knowledgeable and participate in providing direction to the CEO. They commend the CEO and the assistant who prepares information for the meetings. The CEO is excellent in providing the support to the board and promoting innovative opportunities. Council members feel well connected to the work and issues facing the organization. In particular, family members feel engaged and involved in discussions and decision-making. Ample information regarding quality indicators, safety incidents, outcome measures, and other summaries of operations are provided.

The Governing Council is poised to begin to use the ethics framework. There are plans to provide a table top exercise to demonstrate the use of the framework.

The patient/consumer voice is provided by the CEO who regularly attends patient assemblies, gathers input regarding issues, provides the information to the council and reports on actions taken back to the assemblies.

Government of Manitoba structures are used for the selection of the CEO but the council oversees performance reviews.

The Governing Council has undertaken many policy revisions and created new policies very recently.

## Priority Process: Planning and Service Design

Developing and implementing infrastructure, programs, and services to meet the needs of the populations and communities served.

| Unmet Criteria | High Priority Criteria |
|---|---|
| **Standards Set: Leadership** | |
| 4.10 Goals and objectives at the team, unit, or program level align with the strategic plan. | |

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

There is considerable emphasis on a process to engage all stakeholders in the planning, implementation and evaluation of services. Family, patients, and community partners indicated that they feel included in the organization's work. The strategic planning process was very thorough. It began with an environmental review done by an internal party. The review included interviews with many partners, family members, staff members, and patients. The document provided the input received as well as leading practice literature.

Quality improvement is well entrenched throughout the organization and the leadership demonstrates commitment to it.

The Patient Safety Plan is very good and provides an excellent framework for the patient safety culture. One staff person is entirely dedicated to patient safety which underscores the organization's dedication to this issue.

Patient and family stakeholders are involved in various planning tables. It is recognized that patient support may be required for involvement. An option to promote further engagement by patients and family members is to have representatives at the various planning meetings. Seeking input from the various advisory committees is helpful but actually including several people at the planning, quality, and evaluation meetings might be more engaging.

Partners appreciate the culture change that has occurred at the SMHC in the past few years. The leadership has used a collaborative and integrative approach in working with other organizations. Of particular note is the CEO's involvement in outreach to them and providing them an opportunity to tour the grounds. Communication via the newsletter is appreciated. Regular meetings are provided to receive input regarding services and to do planning. Further opportunities to facilitate better transitions between hospital and community settings would be appreciated. Peer support workers from other organizations are involved in services on the site and an increase of this resource would be welcomed. It was acknowledged by the partners that issues of insufficient staff resources and problems with dorm accommodation does depend upon government funding. There was positive feedback regarding the

quality of the staff members and the openness of the leadership team members. The approach of moving to a recovery-oriented system is welcomed.

## Priority Process: Resource Management

Monitoring, administering, and integrating activities related to the allocation and use of resources.

The organization has met all criteria for this priority process.

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

The senior leadership staff members of Selkirk Mental Health Centre (SMHc) have an excellent knowledge of their financial systems. They recognize that they are in an awkward position due to their reporting responsibilities as they are under the direct supervision of the Government of Manitoba.

They ensure that reports are submitted as required. They must use bureaucratic policies and procedures which were not designed for a health facility. They have taken the government documentation to ensure that staff members with procurement responsibilities understand the required processes.

The ability to make the required purchases to operate the organization is severely impacted by the cumbersome requirement to obtain purchase orders from the government department. Cheques for accounts payable are issued by the government which must work through its long process of approvals. A lack of timely payments for services and goods does result in vendors' complaints and thus impacting the reputation of the organization.

There is an on-going deficit of 3.3 million dollars. In the past, this budget shortfall has been covered by their government department. It is hoped that with the strong possibility of SMHC being transferred out of direct government oversight that the budget will be fully funded.

The involvement of government in the direct operation of SMHC also leads to a slow decision making process regarding use of resources. For example, it was suggested to reduce the beds in the acquired brain injury program due to the lack of demand. While waiting for a decision to be made, the beds are being kept empty and now a waiting list is building. The lack of decision from the government regarding the program is leaving patients without services and an organization not able to use its resources as demands are mounting.

A government freeze on the filling of vacant staff positions is also leaving programs understaffed which is a risk to the health of both staff members and patients. It is also leading to a greater use of overtime as staff members must cover for the lack of people available to do the work. This increases the salary deficit.

Staff positions must be approved by the Treasury Board. This process impacts the ability of the organization to address issues quickly.

The Governing Council receives reports on a timely basis although it has no power to make decisions. The management team works together with the Governing Council to decide on priorities for the budget.

The organization has the leadership to understand and cope with its situation. It is well positioned to take on the work to create a stand-alone organization under the authority of the Regional Health Authority.

## Priority Process: Human Capital

Developing the human resource capacity to deliver safe, high quality services.

The organization has met all criteria for this priority process.

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

The impact of the government ownership of the SMHC and its program is seen in the operation of the Human Resource Team. The staff members are hired by the government and report to it, not the CEO of the SMHC. Despite this, there is considerable engagement of the team in the organization's planning and operational committees.

The new government has placed a freeze on all hiring. This has considerable impact on SMHC as it is unable to fill vacancies. As people leave their positions and there is no ability to hire new staff members, current employees must provide the required services leading to over-time remuneration. This contributes to the on-going deficit.

Issues of pay equity with allied health staff members has placed stress on the organization. Staff members leave the organization due to the inequity of the compensation provided by SMHC. The current vacancy of the physiotherapist in the acquired brain injury program is a risk for the patients.

The Human Resource Plan is very ambitious but does encourage participation from various management team members. Regular biennial surveys of staff members and the use of the Accreditation Canada tool provided input into the development of the plan.

A trending of the numbers of staff members resigning may be helpful to indicate the movement of staff members.

The organization has been very creative in developing strategies to recruit and retain staff members. Of particular notice is the ability of staff members to choose their amount of work hours. For example a full time staff person may choose to reduce their hours to work part-time or casual. There are numerous programs to promote health and well-being. Bursaries are offered to assist people in furthering their education with the commitment of 24 months of employment with the organization.

The process of recruiting and selecting staff members is very thorough and reflects the organization's values of fairness, merit, and equity.

There is a lack of sufficient funding to provide the number of staff required at some programs. This leads to a situation of stress and could affect patient safety.

## Priority Process: Integrated Quality Management

Using a proactive, systematic, and ongoing process to manage and integrate quality and achieve organizational goals and objectives.

| Unmet Criteria | High Priority Criteria |
|---|---|
| **Standards Set: Leadership** | |
| 16.3 The organization's leaders require, monitor, and support service, unit, or program areas to monitor their own process and outcome measures that align with the broader organizational strategic goals and objectives. | ! |

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

The organization has a comprehensive quality improvement plan, a risk management plan and, a patient safety plan. The team dedicated to developing and implementing the plans is remarkable in their passion. They have an excellent understanding of the elements required for the plans to be successful. In addition to elements from their own strategic plan there are items as prescribed by their provincial government.

The planning has been comprehensive. The plans are well linked to the strategic plan and the outcomes required by the province of Manitoba. Patient involvement could be augmented by including patients at the planning tables rather than only at the advisory group consultation.

There is a formal complaint process and family members and patients are notified in their orientation to the organization. The process is not yet on the website. There are also alternative ways to provide input. The Family Advisory Committee and the Consumer Advisory Committee provided input into the strategic plan.

Some of the teams have individual program goals and objectives. Other teams do not. There is no evidence that there are team plans based on the Strategic Plan as it has not yet been released.

Staff members have received training on the disclosure of incidents and the provincial Apology Act to patients and family members. A no-blame culture is promoted.

The staff members demonstrate their ability to provide an evidence-based practice in their plans. This skill has been shared with other organizations as they have taken provincial leads in such initiatives as a incorporating a universal falls prevention strategy.

An example of a development of a quality initiative is the Clinical Information Management Application (CIMA). A team of staff members from various departments and a team member from e-health was brought together to build a system that would provide easy access to information in patients' records. Over several years this group of people built a file that would reduce the repetition of patients telling

their stories. The system allows staff members to access each patient's file and become familiar with the needs of the person. Patients are also permitted to view their files. As this project nears the completion of its original goal, the team members are already making plans to include more modules that would provide greater and easier access to information. A patient being a part of this team could provide additional information for future considerations.

## Priority Process: Principle-based Care and Decision Making

Identifying and making decisions about ethical dilemmas and problems.

The organization has met all criteria for this priority process.

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

There is a robust Ethical Decision-Making Framework at the SMHC. The Ethics Committee is well designed with representatives from the various program services, patients, family members, and community.

Education is provided to all members of the SMHC's community including patients and family members. The committee is working on building every individual's capacity to engage in conversations regarding principle-based decisions. When required, consults can be requested from the committee for issues that require further input.

Trending is completed of these requested consults. It may be helpful to also trend the discussions that occur at team meetings. Issues that keep reoccurring throughout various programs may provide information regarding training needs. It would also indicate the success of the use of the ethical framework.

The committee is not responsible for issues regarding research. There is a Research Ethics Committee which has this responsibility.

The Ethics Committee is well positioned to provide support as recovery-oriented practices are fully integrated throughout the organization.

## Priority Process: Communication

Communicating effectively at all levels of the organization and with external stakeholders.

The organization has met all criteria for this priority process.

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

Communication at Selkirk Mental Health Centre ( SMHC ) is in good standing.
External stakeholders are represented in the Governing Council, The Stakeholder Advisory Committee and the CEO meets with the Governing Council bi-monthly and Senior Leadership team monthly.

SMHC works collaboratively with all the external stakeholders. For example they consult with them, provide education and workshops, does workshops, invites them to all events that take place in the centre and participate in the community events.

The organization has developed an elaborate Communication plan that addresses all aspects of Communication needs. There is a regular quarterly general staff meeting that the CEO attends.

Information management systems is selected and provided by the Ministry of Health, Manitoba Government. The access and the limit is monitored by the ministry and if more room is needed by a particular staff or manager, it is increased and also the access is removed if the staff moves to a different location or leaves the job altogether. Sometimes if there is extra or old emails clogging up some accounts the manager of Health Information can request the staff to delete old files to create room. Each program has its own W- drive.

Both paper charts and electronic charts exist in the organization. Paper charts are kept locked in protected areas particularly of the discharged patients. Electronic chart access is monitored by the Privacy officer on a regular basis and unusual activities are investigated.

Review or updates are done when the legislation changes or every 2 years.

Clients need to put the request in writing to access their health records. There is a seven day turnaround time unless, for any reason it cannot be done. In that case the Medical Director needs to get authorization from the Mental Health Review Board to block access.

The final authority rests with Manitoba Health but locally the organization can manage access and distribute info using Share point, emails, voice messaging, bulletin boards posters and distributing hard copies of info to be shared. Network outages are rare and updates are done during non-business hours. Teams are provided with information regarding up to date research, evidence based practices and regular journals and publications.

Monthly meeting of the Business Transformations and Technology, BTT under the auspices of Manitoba Health are conducted and a representative from SMHC attends and participates to bring the organizational needs and perspective to the discussion at the senior level.

A strength is the well constructed website that is widely used by staff and management.

Opportunities are: to move to Electronic Health Records completely instead of dual charts and the limitations imposed by being under Manitoba Health e.g. limited wireless or no wi fi.

## Priority Process: Physical Environment

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

| The organization has met all criteria for this priority process. |
|---|
| **Surveyor comments on the priority process(es)** |

All Physical Environment standards have been met across the sites with particular strengths seen in the newest facility which was co-designed with staff and patients. Regular maintenance is supported with work requests completed by staff, and by representatives of the Accommodation Service Division of the Manitoba government. Regular audits of the facilities through the Fire Marshall to ensure legislative requirements are met. The HVAC system is maintained by an external agency.

Accessibility issues have been identified as a challenge in the older buildings e.g. lack of elevator and entrance way ramp in the Administration Building.

Staff is commended for their commitment to providing a clean environment. It was evident during this survey that staff interviewed take pride in this accomplishment.

Attention to environmental health including recycling and air quality testing as required forms part of IPAC and Occupational Health and Safety mandates.

Back-up generators are available across the organization.

The development of three new medication rooms at the Tyndall building is noted.

In the older facilities, site specific challenges exist around lack of patient privacy as a result of the dormitory rooms. These rooms create challenges in the implementation of individualized patient programs. Challenges around implementing infection control practices are also a concern. Staff is commended for their commitment and efforts to ensuring client-centred quality care in this environment.

It is recognized that the organizations leaders have been working with the Manitoba government to obtain funding for the redevelopment of the SMHC. The CEO has recently received approval from the government to begin working on a master plan for a new SMHC. A comprehensive environmental scan has been completed and a role statement is being developed to identify services which will be offered at the new campus. This is exciting and encouraging news and the organization is wished well in its endeavours to secure funding for its new buildings.

## Priority Process: Emergency Preparedness

Planning for and managing emergencies, disasters, or other aspects of public safety.

The organization has met all criteria for this priority process.

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

Regular inspections of the fire detection and extinguishing systems are completed by the Fire Department. All systems are inspected annually and any malfunctioning areas are repaired by certified contracted companies, with documentation completed and left at the centre. The generator is also tested weekly and serviced by a contracted service annually.

There are well-developed, comprehensive disaster preparedness and fire prevention plans in place. Fire drills are held weekly on the day shift, with documentation completed on the actual fire drill. The organization is encouraged to extend these drills to all shifts to ensure all staff are knowledgeable in their roles and responsibilities during times when there are less resources available to assist. Timing could be selected to minimize patient disruption, for example early in the evening shift and close to the end of the night shift.

A tabletop exercise was conducted for the Tyndall building in July followed by a full scale mock evacuation of the Dr. David Young building in August. The follow up reports provided valuable feedback for all involved and resulted in quality improvements opportunities for the overall plans. Staff are commended for the comprehensiveness of these exercises which included the use of external partners as evaluators.

A new fire system has been implemented. This allows for standardization across the organization, a noted improvement since the last accreditation survey.

Training and education on emergency management, including all universal codes, is taught during orientation, and at least annually to all staff. It is positive that students are given training when they start work placements at the SMHC

The Business Continuity Plan is well defined and the plans to move forward with the Enterprise Risk Management (ERM) is applauded. Since last accreditation an Incident Command System (ICS) has also been implemented.

There is an active Workplace Safety and Health (WPSH) Committee which has a dedicated resource of a Workplace Safety and Health Coordinator. Education and training on WPSH policies and procedures is comprehensive and serves to equip staff with the knowledge and skills necessary to promote a safe work environment.

The security system at SMHC is undergoing upgrades. The enhanced features will include more cameras, a unified surveillance system for all sites, and relocation of the security command centre at the Barnett building.

Pandemic planning has been done with staff in the organization and with all levels of staff, representing an interdisciplinary team approach. Roles and responsibilities for staff are clearly identified. Pandemic supplies and products that could become outdated, such as disposable gloves, are rotated. All new employees are mask-fit tested and staff are re-tested regularly. Plans can be accessed by all staff in the infection control manual.

SMHC has a very open and positive relationship with Public Health (PH) and they are prompt in notifying of an outbreak. All partners and other health organizations are made aware of the outbreak. Review is done of any outbreaks to identify the need to revise policies and procedures.

## Priority Process: Patient Flow

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

The organization has met all criteria for this priority process.

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

The Selkirk Mental Health Centre is the only provincial body which provides longer term services for people who require more intensive services. As such, the demands on its programs often results in waiting lists.

The lack of appropriate supports outside of SMHC results in inability to discharge patients. These people who require an alternative level of care remain at the centre until appropriate supports can be found. This situation obviously impacts the waiting list.

The Family Advisory Committee and the community partners are very aware of this situation. There is frustration about the limited access to the services. The organization is well aware of these issues and is working on solutions.

## Priority Process: Medical Devices and Equipment

Obtaining and maintaining machinery and technologies used to diagnose and treat health problems.

The organization has met all criteria for this priority process.

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

There is a comprehensive preventive maintenance program in place which is coordinated by the Medical Equipment Technician. This position has been integral to the success of this program. In May of this year a FEMA was completed to look at the process from when medical equipment malfunctions are reported to the point at which they are repaired. This led to quality improvement and risk management initiatives related to equipment such as carenado chairs and tubs.

There is a limited need for reprocessing/sterilization of equipment. A contract is in place with Selkirk General Hospital to address this need as it arises. Procedures for preparing and receiving this equipment are in place. These processes are monitored for effectiveness and quality improvement opportunities.

Equipment such as glucometers and blood pressure apparatus are cleaned with appropriate disinfectants.

Staff education and training is provided on all new equipment. Vendors are included in this process.

There is an open and transparent process for the selection of medical devices and equipment which involves staff input. Trialling of equipment is sometimes done before commitment to purchase is made.

Evidence of tag and lock out of equipment was noted during tours of the various sites.

# Service Excellence Standards Results

The results in this section are grouped first by standards set and then by priority process.

Priority processes specific to service excellence standards are:

**Clinical Leadership**

- Providing leadership and direction to teams providing services.

**Competency**

- Developing a skilled, knowledgeable, interdisciplinary team that can manage and deliver effective programs and services.

**Episode of Care**

- Partnering with clients and families to provide client-centred services throughout the health care encounter.

**Decision Support**

- Maintaining efficient, secure information systems to support effective service delivery.

**Impact on Outcomes**

- Using evidence and quality improvement measures to evaluate and improve safety and quality of services.

**Medication Management**

- Using interdisciplinary teams to manage the provision of medication to clients

**Infection Prevention and Control**

- Implementing measures to prevent and reduce the acquisition and transmission of infection among staff, service providers, clients, and families

## Standards Set: Acquired Brain Injury Services - Direct Service Provision

| Unmet Criteria | High Priority Criteria |
|---|---|
| **Priority Process: Clinical Leadership** | |
| The organization has met all criteria for this priority process. | |
| **Priority Process: Competency** | |
| The organization has met all criteria for this priority process. | |

**Priority Process: Episode of Care**

The organization has met all criteria for this priority process.

**Priority Process: Decision Support**

The organization has met all criteria for this priority process.

**Priority Process: Impact on Outcomes**

The organization has met all criteria for this priority process.

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

**Priority Process: Clinical Leadership**

No children or youth are admitted at SMHC.

The team is doing good work with community partners to co-host events to bring education about awareness and prevention strategies for acquired brain injuries. This also includes about stigma reduction about disabilities, head injuries and mental health.

Challenges are; discharge planning for lack of designated housing and no Acquired Brain Injury Case Management for follow up.

**Priority Process: Competency**

Teams are well staffed with qualified and trained personnel where credentials and qualifications are up-to-date.

Trauma informed care is an example of working respectfully with clients.

Performance evaluation starts with the staff filling out their own appraisal and then has a discussion with their respective managers.

Recovery model of care is used throughout the organization.

Spiritual care and space is available and readily provided.

**Priority Process: Episode of Care**

Manitoba Health poses limitations as SMHC is under direct government control and fiscal policies do not allow for unrestricted service delivery.

Good intake process and application forms are available and they are assessed by the intake team. The Program manager is the person to contact for coordination.

Translation & interpretation services are provided internally if a competent staff speaks the same language or the request is made to the Ministry and they provide.

BPMH process is in place and working at care transitions. Falls prevention policy and processes are in place.

The care plan is recorded in the electronic chart and can be easily tracked for progress.

Two person specific identifiers are used thru out the ABI unit. The clients' photo and another staff identification is used.

**Priority Process: Decision Support**

The criteria for the priority processes are met.

**Priority Process: Impact on Outcomes**

No research is done at SMHC. There may be a request from university students to use old records or data for research purposes and the Ethics committee looks into that.

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

| Unmet Criteria | High Priority Criteria |
|---|---|
| **Priority Process: Infection Prevention and Control** | |

The organization has met all criteria for this priority process.

| Surveyor comments on the priority process(es) |
|---|
| **Priority Process: Infection Prevention and Control** |

Selkirk Mental Health Centre (SMHC) has a comprehensive infection prevention and control (IPAC) program, which is coordinated by a dedicated Infection Control Officer (ICO). Under the direction of this ICO the IPAC committee meets quarterly. This committee includes representatives from various disciplines across all program areas including physician services.

Promoting safe IPAC practices for patients, families, staff, and volunteers is instrumental in the success of this program. Staff education is provided regularly on proper hand washing techniques and hand hygiene audits are conducted annually. The most recent audit yielded a 60% compliance rate. The team is encouraged in its efforts to explore new opportunities to raise this compliance rate. Families and volunteers are also provided with information and training on the importance of proper hand washing. Students receive education via SMHC Nurse Educators.

Hand sanitizers have been recently introduced to the Tyndall building, both at entry and exit points as well as at the point of patient care. The older buildings do not have hand sanitizers at the point of care. Staff, however, are provided with individual pocket size sanitizers.

Hand sanitizers, cleaning products and disinfectants are purchased in accordance with industry standards.

The organization links with Public Health to gather information on the types of infections the population it serves may come in contact with as well as for outbreak management activities.

There is an immunization policy however there is no provincial mandate requiring staff to be vaccinated. Immunization clinics are offered onsite. There is also a policy in place which addresses protocols for ill staff members.

The Wellness Committee is commended for its initiatives in promoting worklife balance for staff.

All staff is trained on Workplace Hazardous Materials Information System (WHMIS) and Personal Protective Equipment (PPE) is provided with staff educated in proper usage.

Staff note that the organization considers IPAC to be a system-wide priority. Written material such as pamphlets and educational bulletins are provided in an easy to read and understand format to patients and families. This material is also available in various areas throughout the organization.

The Pandemic plan was developed in collaboration with Public Health. Outbreak management is well defined and has been successfully used in 2015 to contain and eliminate an enteric outbreak and an influenza 'A' outbreak at one program area. Staff can clearly articulate their roles in IPAC and in the implementation of outbreak protocols.

The physical infrastructure of the aging buildings presents challenges around implementing IPAC practices such as isolation protocols required during an outbreak. It is noted that patients in dormitory rooms share many common spaces making it difficult to contain spreading of germs etc. Staff are commended for their commitment to minimizing risks associated with such transmission as is evidenced by the infrequency of outbreaks in these areas.

Sharps are disposed of in sharps container provided. Safety engineered needles are used across the organization.

Reprocessing and sterilization are not carried out at SMHC. Minor equipment such as speculums are sometimes used. When this occurs staff prepare the instrument(s) in accordance with infection control practices for transfer to the external contracted service.

Laundry services are contracted out with the exception of personal clothing. There are good processes in place for the handling of soiled laundry. Where aging infrastructure and adequate space limits the ability to have separate clean and dirty areas staff ensure that clean linen carts are kept covered at all times. This situation was noted specific to one area.

All staff receive Safe Food Handling training as required to participate in food preparation.

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

| Unmet Criteria | High Priority Criteria |
|---|---|
| **Priority Process: Medication Management** | |

The organization has met all criteria for this priority process.

| Surveyor comments on the priority process(es) |
|---|
| **Priority Process: Medication Management** |

Since the last survey, the organization has worked on a number of processes in its medication management system. Of note, the ABI program worked to meet all tests for compliance regarding the medication reconciliation at transfer and discharge. As well, the organization established formal systematic processes for the regular review of its formulary, along with the approval and procurement of medications proposed to be added to the formulary.

A significant work effort was completed to develop the new B-Sharp Pharmacy software system. The information available on the B-Sharp system is comprehensive and interfaces very well with the electronic client record. While research-based drug information is more readily available to physicians and nurses, the pharmacy expects to increase onsite support by its pharmacists when it fully implements other modules including the computerized order entry system. New paper versions of the Medication Administration Record have been successfully introduced in preparation for this module.

Medication storage areas are clean and neatly organized with uncluttered bulletin boards that contain visual cues and reminders about essential administration standards such as the list of high alert medications and the list of abbreviations, symbols and dose designations not used in the organization. New medication storage areas are being renovated for the ABI area of the Tyndall Building. Currently, while not ideal, medication carts in this area of Tyndall are being temporarily stored in locked office spaces. This change is required to ensure the assigned med nurse is preparing medication in an area adjacent to the team station. This will improve staff and client safety and, the space and the conditions under which this medication preparation and administration is completed.

The equipment in the pharmacy area and in the clinical areas including the Acudose machines and PACMED contribute to the safe administration of medications and controlled substances. Team stations have quiet areas for prescribing and transcribing medication orders. The pharmacy, where orders are received via fax is surprisingly small for an organization of this size and the size of the pharmacy team. The space is however well used and maximized to create well identified and defined work stations for the completion of different tasks. The team keeps conversations to a minimum and cell phone use is not permitted. Congestion in the current work space will lessen when pharmacists will attend client service areas more frequently following the full implementation of the modules.

The Geriatric Program is commended for hosting client/family information sessions about most common medications used in dementia care. The Safe Transcription and Administration of Medication training manual is comprehensive and designed to provide education about the organization's system and related practices and processes.

In January of 2016, a concerted and more strategic effort was established to implement a more robust and consistent medication reconciliation process across all clinical areas. New and improved forms were developed and training implemented to ensure the same reconciliation forms were being used across the board. Staff training and compliance support is ongoing to ensure reconciliation is completed at all three key transition points including admission, transfer and pass/discharge. The Med Rec Team was revitalized, ensuring members representing all professional disciplines including a physician champion. Compliance rates measured in July of 2016 are significantly higher than the January 2016 baseline. The organization is encouraged to sustain this work effort and explore further improvements with best practice guidelines in terms of audits and indicators by its ongoing participation in Manitoba's Provincial Strategy Project on Med Rec.

While the organization has a comprehensive antimicrobial stewardship program, it is new having been recently launched in June of 2016. As such, more time is required to measure the full impact on optimizing antimicrobial use. Early qualitative and quantitative data confirms that the organization is well on its way to addressing the inappropriate use of antimicrobials. Clinical areas are commended for having implemented the new Antimicrobial Order Form. The organization is encouraged to ensure all interventions are sustained; a great deal of work has gone into this program which was based on national best practice guidelines and field advice from similar organizations.

The organization's high alert medication strategy was launched in August of 2016. It is comprehensive and staff awareness and understanding is evident in all areas. SMHC is encouraged to ensure audits are sustained in all clinical areas and that the policy is updated as the list of high alert medications is revised by ISMP (Institute for Safe Medication Practices).

Overall, the improvements to the management system have been many and the organization is encouraged to continue applying prospective analyses upon the introduction of additional software and practice changes.

## Standards Set: Mental Health Services - Direct Service Provision

| Unmet Criteria | High Priority Criteria |
|---|---|
| **Priority Process: Clinical Leadership** | |
| 1.5 Service-specific goals and objectives are developed, with input from clients and families. | |
| **Priority Process: Competency** | |
| The organization has met all criteria for this priority process. | |
| **Priority Process: Episode of Care** | |
| The organization has met all criteria for this priority process. | |
| **Priority Process: Decision Support** | |
| 11.8 There is a process to monitor and evaluate record-keeping practices, designed with input from clients and families, and the information is used to make improvements. | ! |
| **Priority Process: Impact on Outcomes** | |
| The organization has met all criteria for this priority process. | |

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

**Priority Process: Clinical Leadership**

SMHC is applauded for having successfully implemented hospital wide recovery oriented practices. Clients, families and staff in all areas have a common recovery language and demonstrate adherence to recovery principles in all aspects of their care. The organization takes pride in its employee-based inventory of cultural and language skills, experience and proficiencies among staff. This facilitates access to services tailored to the diverse needs of its client population.

The organization is encouraged to engage staff, clients and families in contributing to service-based action plans with goals/objectives that are aligned with the centre's strategic plan.

Clinical areas have regular and consistent team meetings with both allied and nursing staff ensuring effective knowledge transfer and communication about client progress, and clinical and safety issues. The coordinators play a key role in facilitating clinical meetings and improvement activities.

The organization's Mental Health First Aid training is available to the public, families and staff is a good indication of its commitment to reducing stigma.

Staffing shortages are frequently the responsibility of nurses in charge. This is particularly challenging on weekends and evenings when staff are already working short. The organization is encouraged to explore more sustainable options including e of the staffing office role's and coordinators to ensure staffing gaps are addressed more proactively. A solution to this issue is important to help improve 'more time to care' at the bedside.

**Priority Process: Competency**

The organization provides a comprehensive orientation and ongoing training and education on hospital-wide initiatives and new practice guidelines.

The client safety plan which is completed at admission and after any occurrence has certainly contributed to a culture of safety and an environment of least restraint and seclusion.

The interdisciplinary team approach is fluid and flexible. Members from community-based organizations and services are part of the clinical teams, engaging with and supporting patients particularly during key transitions.

Students and staff comment about the abundance of training that is available.

Performance evaluations are consistently completed.

**Priority Process: Episode of Care**

Assertive transitional planning is evident in all clinical areas. The rigor with which teams assess for suicide, addiction issues, falls, trauma, safety is commendable. Clients at SMHC have access to a wide range of supports and services that align with their recovery plan. Teams strive to ensure the achievement of individualized and relevant goals. Clients have access to specialized teams such as co-occurring disorders and dialectical behaviour therapy. The organization is encouraged to continue building capacity at the bed side ensuring specialized care principles and interventions are consistently followed through and supported.

Families are truly partners in care and actively involved in many aspects of the service delivery care model. Teams demonstrate great sensitivity to clients and families. Families receive written and verbal information, along with support and education.

Clients demonstrate a sense of empowerment and hope even in the locked areas such as forensics. Access to vocational supports and formal education has been key to the successful discharge and transition of clients. Successful clients stories are celebrated and recognized and is a terrific asset to the organization's stigma work.

Patient flow continues to be an area of concern however, the organization continues to make a concerted effort to work with its partners to improve appropriate referrals and options for discharge and placement. The leadership is encouraged to continue advocating and pursuing more effective system solutions in terms of community-based placement and supported housing options.

**Priority Process: Decision Support**

SMHC has successfully implemented a new electronic medical record which is user friendly and customized to include the organization's electronic recovery planning process and individual client triggers arising out of the Resident Assessment Instrument-Mental Health (RAI-MH).

Improvements are required to ensure the organization establishes a rigorous and relevant audit process of its record-keeping practices which will also help improve and sustain quality and timely documentation.

While it is clearly evident that clients and families are partners in contributing to the documentation process during recovery planning meetings, the organization is encouraged to improve client and family awareness about their right to access and review information in their client clinical record.

**Priority Process: Impact on Outcomes**

Quality improvement strategies and action plans are evident in all clinical areas. The organization's approach to distribute lessons learned from critical incidents or other practice trends across all clinical areas is impressive. This supports a just culture where near misses and occurrences help inform improvements.

Data is shared with teams on a routine and regular basis via team meetings. The organization may consider a means of posting scorecards at the unit level where indicator data is consistently visual to staff, clients and families.

Verification processes such as assessment pre and post off unit privileges are in place to mitigate risk. A culture of transparency and disclosure is evident.

# Instrument Results

As part of Qmentum, organizations administer instruments. Qmentum includes three instruments (or questionnaires) that measure governance functioning, patient safety culture, and quality of worklife. They are completed by a representative sample of clients, staff, senior leaders, board members, and other stakeholders.

## Governance Functioning Tool (2011 - 2015)

The Governance Functioning Tool enables members of the governing body to assess board structures and processes, provide their perceptions and opinions, and identify priorities for action. It does this by asking questions about:

- Board composition and membership
- Scope of authority (roles and responsibilities)
- Meeting processes
- Evaluation of performance

Accreditation Canada provided the organization with detailed results from its Governance Functioning Tool prior to the on-site survey through the client organization portal. The organization then had the opportunity to address challenging areas.

- **Data collection period: September 22, 2014 to November 13, 2015**
- **Number of responses: 3**

**Governance Functioning Tool Results**

| | % Disagree | % Neutral | % Agree | %Agree * Canadian Average |
|---|---|---|---|---|
| | Organization | Organization | Organization | |
| 1 We regularly review, understand, and ensure compliance with applicable laws, legislation and regulations. | 0 | 0 | 100 | 93 |
| 2 Governance policies and procedures that define our role and responsibilities are well-documented and consistently followed. | 0 | 0 | 100 | 96 |
| 3 We have sub-committees that have clearly-defined roles and responsibilities. | 0 | 0 | 100 | 97 |
| 4 Our roles and responsibilities are clearly identified and distinguished from those delegated to the CEO and/or senior management. We do not become overly involved in management issues. | 0 | 0 | 100 | 94 |

| | % Disagree | % Neutral | % Agree | %Agree * Canadian Average |
|---|---|---|---|---|
| | Organization | Organization | Organization | |
| 5 We each receive orientation that helps us to understand the organization and its issues, and supports high-quality decisionmaking. | 0 | 0 | 100 | 93 |
| 6 Disagreements are viewed as a search for solutions rather than a “win/lose”. | 0 | 0 | 100 | 95 |
| 7 Our meetings are held frequently enough to make sure we are able to make timely decisions. | 0 | 0 | 100 | 97 |
| 8 Individual members understand and carry out their legal duties, roles and responsibilities, including sub-committee work (as applicable). | 0 | 0 | 100 | 97 |
| 9 Members come to meetings prepared to engage in meaningful discussion and thoughtful decision-making. | 0 | 0 | 100 | 94 |
| 10 Our governance processes make sure that everyone participates in decision-making. | 0 | 0 | 100 | 95 |
| 11 Individual members are actively involved in policy-making and strategic planning. | 0 | 0 | 100 | 90 |
| 12 The composition of our governing body contributes to high governance and leadership performance. | 0 | 0 | 100 | 93 |
| 13 Our governing body’s dynamics enable group dialogue and discussion. Individual members ask for and listen to one another’s ideas and input. | 0 | 0 | 100 | 96 |
| 14 Our ongoing education and professional development is encouraged. | 0 | 0 | 100 | 90 |
| 15 Working relationships among individual members and committees are positive. | 0 | 0 | 100 | 97 |
| 16 We have a process to set bylaws and corporate policies. | 0 | 0 | 100 | 96 |
| 17 Our bylaws and corporate policies cover confidentiality and conflict of interest. | 0 | 0 | 100 | 98 |
| 18 We formally evaluate our own performance on a regular basis. | 67 | 33 | 0 | 83 |
| 19 We benchmark our performance against other similar organizations and/or national standards. | 33 | 33 | 33 | 71 |

| | % Disagree | % Neutral | % Agree | %Agree * Canadian Average |
|---|---|---|---|---|
| | Organization | Organization | Organization | |
| 20 Contributions of individual members are reviewed regularly. | 0 | 33 | 67 | 66 |
| 21 As a team, we regularly review how we function together and how our governance processes could be improved. | 0 | 33 | 67 | 79 |
| 22 There is a process for improving individual effectiveness when non-performance is an issue. | 0 | 0 | 100 | 62 |
| 23 We regularly identify areas for improvement and engage in our own quality improvement activities. | 0 | 33 | 67 | 79 |
| 24 As a governing body, we annually release a formal statement of our achievements that is shared with the organization's staff as well as external partners and the community. | 67 | 0 | 33 | 81 |
| 25 As individual members, we receive adequate feedback about our contribution to the governing body. | 0 | 0 | 100 | 69 |
| 26 Our chair has clear roles and responsibilities and runs the governing body effectively. | 0 | 0 | 100 | 96 |
| 27 We receive ongoing education on how to interpret information on quality and patient safety performance. | 0 | 0 | 100 | 90 |
| 28 As a governing body, we oversee the development of the organization's strategic plan. | 0 | 0 | 100 | 96 |
| 29 As a governing body, we hear stories about clients that experienced harm during care. | 50 | 0 | 50 | 88 |
| 30 The performance measures we track as a governing body give us a good understanding of organizational performance. | 0 | 0 | 100 | 95 |
| 31 We actively recruit, recommend and/or select new members based on needs for particular skills, background, and experience. | 0 | 0 | 100 | 91 |
| 32 We have explicit criteria to recruit and select new members. | 0 | 0 | 100 | 87 |
| 33 Our renewal cycle is appropriately managed to ensure continuity on the governing body. | 0 | 0 | 100 | 94 |

| | % Disagree | % Neutral | % Agree | %Agree * Canadian Average |
|---|---|---|---|---|
| | Organization | Organization | Organization | |
| 34 The composition of our governing body allows us to meet stakeholder and community needs. | 50 | 0 | 50 | 93 |
| 35 Clear written policies define term lengths and limits for individual members, as well as compensation. | 0 | 0 | 100 | 95 |
| 36 We review our own structure, including size and subcommittee structure. | 0 | 0 | 100 | 91 |
| 37 We have a process to elect or appoint our chair. | 0 | 0 | 100 | 93 |

*Canadian average: Percentage of Accreditation Canada client organizations that completed the instrument from January to June, 2015 and agreed with the instrument items.

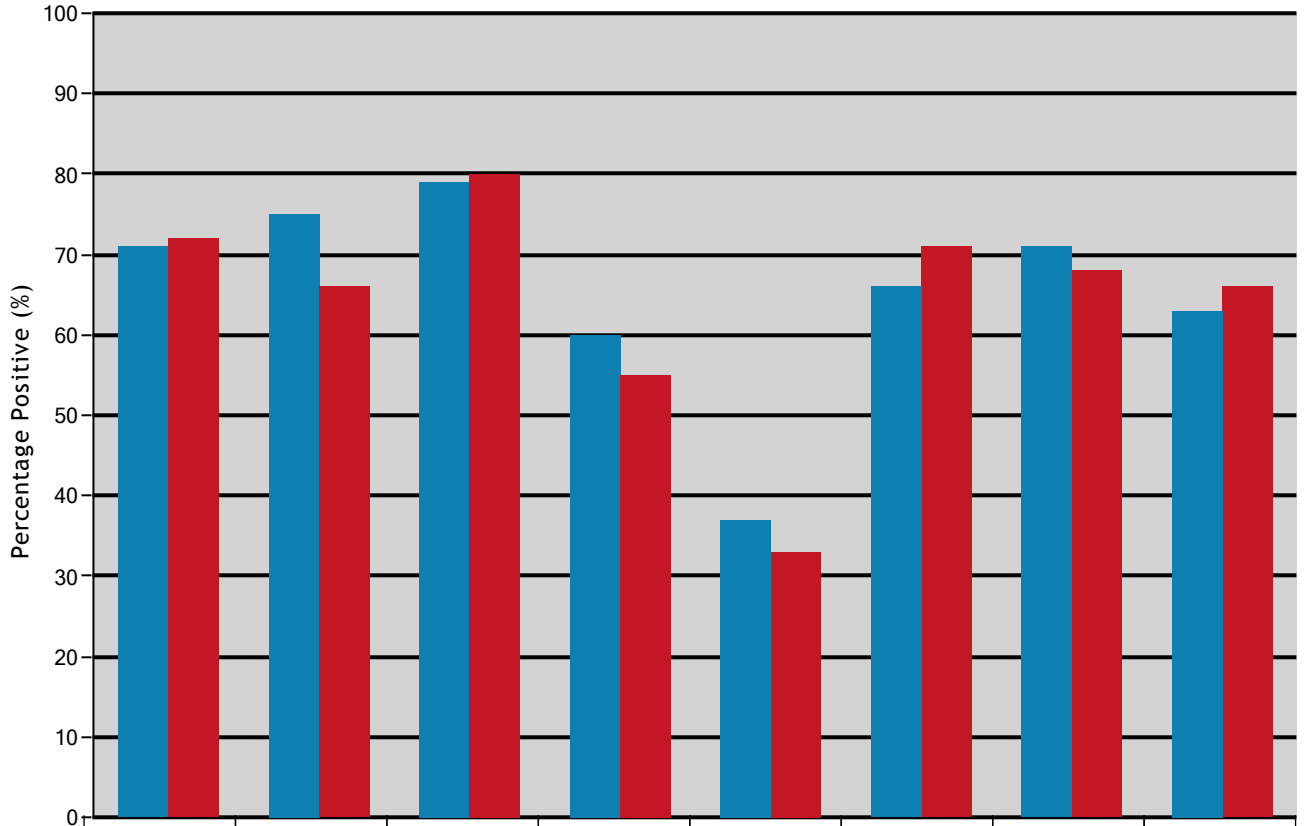
## Canadian Patient Safety Culture Survey Tool

Organizational culture is widely recognized as a significant driver in changing behavior and expectations in order to increase safety within organizations. A key step in this process is the ability to measure the presence and degree of safety culture. This is why Accreditation Canada provides organizations with the Patient Safety Culture Tool, an evidence-informed questionnaire that provides insight into staff perceptions of patient safety. This tool gives organizations an overall patient safety grade and measures a number of dimensions of patient safety culture.

Results from the Patient Safety Culture Tool allow the organization to identify strengths and areas for improvement in a number of areas related to patient safety and worklife. Accreditation Canada provided the organization with detailed results from its Patient Safety Culture Tool prior to the on-site survey through the client organization portal. The organization then had the opportunity to address areas for improvement. During the on-site survey, surveyors reviewed progress made in those areas.

- **Data collection period: September 22, 2014 to April 21, 2015**
- **Minimum responses rate (based on the number of eligible employees): 159**
- **Number of responses: 170**

**Canadian Patient Safety Culture Survey Tool: Results by Patient Safety Culture Dimension**




| | Organizational (senior) leadership support for safety | Supervisory leadership for safety | Unit learning culture | Enabling Open Communication I: judgment-free environment | Enabling Open Communication II: job repercussions of error | Incident follow up | Stand-alone items | Overall Perceptions of Client Safety |
|---|---|---|---|---|---|---|---|---|
| | 71% | 75% | 79% | 60% | 37% | 66% | 71% | 63% |
| | 72% | 66% | 80% | 55% | 33% | 71% | 68% | 66% |

**Legend**

Selkirk Mental Health Centre

* Canadian Average

*Canadian average: Percentage of Accreditation Canada client organizations that completed the instrument from January to June, 2016 and agreed with the instrument items.

## Worklife Pulse

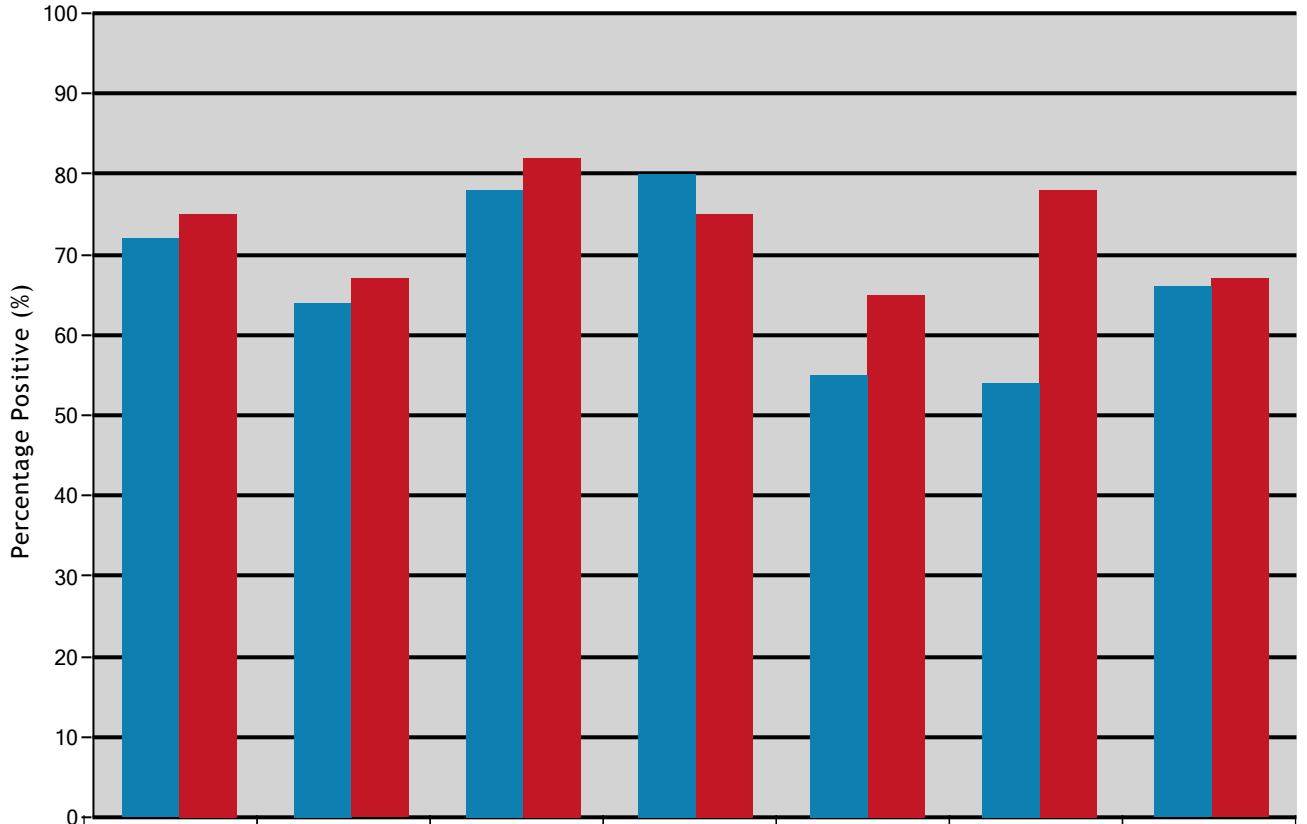
Accreditation Canada helps organizations create high quality workplaces that support workforce wellbeing and performance. This is why Accreditation Canada provides organizations with the Worklife Pulse Tool, an evidence-informed questionnaire that takes a snapshot of the quality of worklife.

Organizations can use results from the Worklife Pulse Tool to identify strengths and gaps in the quality of worklife, engage stakeholders in discussions of opportunities for improvement, plan interventions to improve the quality of worklife and develop a clearer understanding of how quality of worklife influences the organization's capacity to meet its strategic goals. By taking action to improve the determinants of worklife measured in the Worklife Pulse tool, organizations can improve outcomes.

Accreditation Canada provided the organization with detailed results from its Worklife Pulse Tool prior to the on-site survey through the client organization portal. The organization then had the opportunity to address areas for improvement. During the on-site survey, surveyors reviewed progress made in those areas.

- **Data collection period: September 22, 2014 to April 30, 2015**
- **Minimum responses rate (based on the number of eligible employees): 208**
- **Number of responses: 245**

**Worklife Pulse: Results of Work Environment**




| | Job | Training and Development | Coworkers | Immediate Supervisor | Senior Management | Safety and Health | Overall Experience |
|---|---|---|---|---|---|---|---|
| | 72% | 64% | 78% | 80% | 55% | 54% | 66% |
| | 75% | 67% | 82% | 75% | 65% | 78% | 67% |

**Legend**

Selkirk Mental Health Centre

* Canadian Average

*Canadian average: Percentage of Accreditation Canada client organizations that completed the instrument from January to June, 2016 and agreed with the instrument items.

# Client Experience Tool

Measuring client experience in a consistent, formal way provides organizations with information they can use to enhance client-centred services, increase client engagement, and inform quality improvement initiatives.

Prior to the on-site survey, the organization conducted a client experience survey that addressed the following dimensions:

**Respecting client values, expressed needs and preferences,**including respecting client rights, cultural values, and preferences; ensuring informed consent and shared decision-making; and encouraging active participation in care planning and service delivery.

**Sharing information, communication, and education,**including providing the information that people want, ensuring open and transparent communication, and educating clients and their families about the health issues.

**Coordinating and integrating services across boundaries,**including accessing services, providing continuous service across the continuum, and preparing clients for discharge or transition.

**Enhancing quality of life in the care environment and in activities of daily living,**including providing physical comfort, pain management, and emotional and spiritual support and counselling.

The organization then had the chance to address opportunities for improvement and discuss related initiatives with surveyors during the on-site survey.

| Client Experience Program Requirement | |
|---|---|
| Conducted a client experience survey using a survey tool and approach that meets accreditation program requirements | Met |
| Provided a client experience survey report(s) to Accreditation Canada | Met |

# Appendix A - Qmentum

Health care accreditation contributes to quality improvement and patient safety by enabling a health organization to regularly and consistently assess and improve its services. Accreditation Canada's Qmentum accreditation program offers a customized process aligned with each client organization's needs and priorities.

As part of the Qmentum accreditation process, client organizations complete self-assessment questionnaires, submit performance measure data, and undergo an on-site survey during which trained peer surveyors assess their services against national standards. The surveyor team provides preliminary results to the organization at the end of the on-site survey. Accreditation Canada reviews these results and issues the Accreditation Report within 10 business days.

An important adjunct to the Accreditation Report is the online Quality Performance Roadmap, available to client organizations through their portal. The organization uses the information in the Roadmap in conjunction with the Accreditation Report to ensure that it develops comprehensive action plans.

Throughout the four-year cycle, Accreditation Canada provides ongoing liaison and support to help the organization address issues, develop action plans, and monitor progress.

## Action Planning

Following the on-site survey, the organization uses the information in its Accreditation Report and Quality Performance Roadmap to develop action plans to address areas identified as needing improvement. The organization provides Accreditation Canada with evidence of the actions it has taken to address these required follow ups.

## Evidence Review and Ongoing Improvement

Five months after the on-site survey, Accreditation Canada evaluates the evidence submitted by the organization. If the evidence shows that a sufficient percentage of previously unmet criteria are now met, a new accreditation decision that reflects the organization's progress may be issued.

# Appendix B - Priority Processes

## Priority processes associated with system-wide standards

| Priority Process | Description |
|---|---|
| Communication | Communicating effectively at all levels of the organization and with external stakeholders. |
| Emergency Preparedness | Planning for and managing emergencies, disasters, or other aspects of public safety. |
| Governance | Meeting the demands for excellence in governance practice. |
| Human Capital | Developing the human resource capacity to deliver safe, high quality services. |
| Integrated Quality Management | Using a proactive, systematic, and ongoing process to manage and integrate quality and achieve organizational goals and objectives. |
| Medical Devices and Equipment | Obtaining and maintaining machinery and technologies used to diagnose and treat health problems. |
| Patient Flow | Assessing the smooth and timely movement of clients and families through service settings. |
| Physical Environment | Providing appropriate and safe structures and facilities to achieve the organization's mission, vision, and goals. |
| Planning and Service Design | Developing and implementing infrastructure, programs, and services to meet the needs of the populations and communities served. |
| Principle-based Care and Decision Making | Identifying and making decisions about ethical dilemmas and problems. |
| Resource Management | Monitoring, administering, and integrating activities related to the allocation and use of resources. |

## Priority processes associated with population-specific standards

| Priority Process | Description |
|---|---|
| Chronic Disease Management | Integrating and coordinating services across the continuum of care for populations with chronic conditions |

| Priority Process | Description |
|---|---|
| Population Health and Wellness | Promoting and protecting the health of the populations and communities served through leadership, partnership, and innovation. |

## Priority processes associated with service excellence standards

| Priority Process | Description |
|---|---|
| Blood Services | Handling blood and blood components safely, including donor selection, blood collection, and transfusions |
| Clinical Leadership | Providing leadership and direction to teams providing services. |
| Competency | Developing a skilled, knowledgeable, interdisciplinary team that can manage and deliver effective programs and services. |
| Decision Support | Maintaining efficient, secure information systems to support effective service delivery. |
| Diagnostic Services: Imaging | Ensuring the availability of diagnostic imaging services to assist medical professionals in diagnosing and monitoring health conditions |
| Diagnostic Services: Laboratory | Ensuring the availability of laboratory services to assist medical professionals in diagnosing and monitoring health conditions |
| Episode of Care | Partnering with clients and families to provide client-centred services throughout the health care encounter. |
| Impact on Outcomes | Using evidence and quality improvement measures to evaluate and improve safety and quality of services. |
| Infection Prevention and Control | Implementing measures to prevent and reduce the acquisition and transmission of infection among staff, service providers, clients, and families |
| Living Organ Donation | Living organ donation services provided by supporting potential living donors in making informed decisions, to donor suitability testing, and carrying out living organ donation procedures. |
| Medication Management | Using interdisciplinary teams to manage the provision of medication to clients |

| Priority Process | Description |
|---|---|
| Organ and Tissue Donation | Providing organ and/or tissue donation services, from identifying and managing potential donors to recovery. |
| Organ and Tissue Transplant | Providing organ and/or tissue transplant service from initial assessment to follow-up. |
| Point-of-care Testing Services | Using non-laboratory tests delivered at the point of care to determine the presence of health problems |
| Primary Care Clinical Encounter | Providing primary care in the clinical setting, including making primary care services accessible, completing the encounter, and coordinating services |
| Public Health | Maintaining and improving the health of the population by supporting and implementing policies and practices to prevent disease, and to assess, protect, and promote health. |
| Surgical Procedures | Delivering safe surgical care, including preoperative preparation, operating room procedures, postoperative recovery, and discharge |