ACCREDITATION
AGRÉMENT
CANADA
Qmentum

Accreditation Report

Selkirk Mental Health Centre

Selkirk, MB

On-site (Part 2 of 2)

On-site survey dates: June 21, 2022 - June 22, 2022

Report issued: October 3, 2022

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 June 2022. Information from the on-site survey as well as other data obtained from the organization were used to produce this Accreditation Report.

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

Confidentiality

This report is confidential and will be treated in confidence by Accreditation Canada in accordance with the terms and conditions as agreed between your organization and Accreditation Canada for the Assessment Program.

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

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

A Message from Accreditation Canada

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

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

Your Program Manager or Client Services Coordinator is available if you have questions or need guidance.

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

We look forward to our continued partnership.

Sincerely,

Leslee Thompson
Chief Executive Officer

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Executive Summary

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 (Report)

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

About the On-site Survey

- **On-site survey dates: June 21, 2022 to June 22, 2022**

- **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. Worklife Pulse
  2. Canadian Patient Safety Culture Survey Tool
  3. Physician Worklife Pulse Tool
  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)	30	0	0	30
Accessibility (Give me timely and equitable services)	26	0	0	26
Safety (Keep me safe)	172	1	26	199
Worklife (Take care of those who take care of me)	61	2	2	65
Client-centred Services (Partner with me and my family in our care)	102	1	2	105
Continuity (Coordinate my care across the continuum)	22	0	0	22
Appropriateness (Do the right thing to achieve the best results)	278	10	24	312
Efficiency (Make the best use of resources)	24	0	1	25
Total	**715**	**14**	**55**	**784**

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	37 (82.2%)	8 (17.8%)	5	33 (100.0%)	0 (0.0%)	3	70 (89.7%)	8 (10.3%)	8
Leadership	50 (100.0%)	0 (0.0%)	0	96 (100.0%)	0 (0.0%)	0	146 (100.0%)	0 (0.0%)	0
Infection Prevention and Control Standards	55 (100.0%)	0 (0.0%)	12	35 (100.0%)	0 (0.0%)	2	90 (100.0%)	0 (0.0%)	14
Medication Management Standards	60 (100.0%)	0 (0.0%)	18	56 (100.0%)	0 (0.0%)	8	116 (100.0%)	0 (0.0%)	26
Acquired Brain Injury Services	45 (100.0%)	0 (0.0%)	1	87 (100.0%)	0 (0.0%)	1	132 (100.0%)	0 (0.0%)	2
Mental Health Services	47 (94.0%)	3 (6.0%)	0	89 (96.7%)	3 (3.3%)	0	136 (95.8%)	6 (4.2%)	0
Total	**294 (96.4%)**	11 (3.6%)	36	396 (99.2%)	3 (0.8%)	14	690 (98.0%)	14 (2.0%)	50

* 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 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
Medication reconciliation as a strategic priority (Leadership)	Met	3 of 3	2 of 2

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Communication			
Medication reconciliation at care transitions (Acquired Brain Injury Services)	Met	4 of 4	0 of 0
Medication reconciliation at care transitions (Mental Health Services)	Met	4 of 4	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
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
Preventive Maintenance Program (Leadership)	Met	3 of 3	1 of 1
Workplace Violence Prevention (Leadership)	Met	5 of 5	3 of 3

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
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
Patient Safety Goal Area: Risk Assessment			
Falls Prevention Strategy (Acquired Brain Injury Services)	Met	2 of 2	1 of 1
Falls Prevention Strategy (Mental Health Services)	Met	2 of 2	1 of 1
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.

Sellkirk Mental Health Cenre(SMHC) is a 252 bed facility that provides inpatient mental health and acquired brain injury treatment services to residence of Manitoba who's needs cannot be met elsewhere. Mental health services are also provided to individuals from Nunavut.There are five specialized programs; acute, geriatric, rehabilitation, forensics and acquired brain injury.

Currently SMHC is provincially owned and operated by the government of Manitoba .In conjunction with the health system transformation SMHC will be under the governance of the shared health organization. The transition is expected to be finalized at the end of fiscal year 2021. The planning phase has been interrupted by management of Covid and the need to divert time and attention to the pandemic. Nevertheless, SMHC continues to move forward with the development. Governance is currently being managed by the executive team in collaboration with the ADM. All issues relating to quality and safety, risk, finances and decision making are managed through regular and ongoing contact and communication.

The leadership team works diligently with managers and front line staff, Together they.have developed comprehensive strategic plans, operating plans, risk management strategies and safety plans. The plans are reviewed on regularly and progress is monitored.Quality planning extends across the organization and teams understand the importance of continuous quality management Ongoing training on specific tools and processes (LEAN, Six Sigma, newly introduced dashboards, data analysis and utilization) is planned. Incident command meetings are in place to ensure timely communication to all relevant stakeholders is processed in a timely and efficient manner.
The safety incident reporting system…

Programs and services are developed systematically according to best practices and standardized and established procedures by experienced interdisciplinary teams. Goals include involving patients and families in the codesign of services and programs. Processes from admission to discharge are documented and treatment plans are monitored on a weekly basis. Patients are regarded as members of the team. Post discharge plans presents some challenges related to housing and appropriate follow up supports.

To support the resolution of ethical dilemmas and issues, the Ethics framework and decision making tool is integrated across the organization. An Ethics Steering Committee provides oversight and direction to the teams. Continuing to build capacity to embed the framework is an ongoing goal.

IPAC, COVID

Community partners

Client satisfaction, client advisory, family and client engagement, complaint

In terms of work life staff report…

SMHC is commended for the successful application of Accreditation standards ...

Selkirk Mental Health Centre (SMHC) transitioned to Shared Health governance effective April 2022 and the services were officially integrated into the Shared Health - Mental Health and Addiction (SH - MH&A) delivery system. The Health System Governance and Accountability Act established the new role for the government of Manitoba. A detailed planning process that involved stakeholder engagement supported a successful outcome.

A new external board of directors was appointed to provide oversight and support. All board positions are filled and the board has initiated board meetings and reporting expectations. Policies and procedures, bylaws and roles and responsibilities are clearly documented and subcommittees including a quality committee have been put in place.

During the transition, programs and services were provided without interruption except however Covid isolation requirements made it necessary to reduce capacity in DBT and ABI programs. Regardless, patients and families report high levels of satisfaction.Family members suggested a patient advocacy position be considered.The leadership and their teams worked effectively to create new patient care access and flow strategies. SMHC managed to remain Covid free for almost 2 years during a pandemic before an outbreak for occurred. The IPAC resources are easily accessed by the teams. Communication and updates promote compliance with requirements and standards the organization is encouraged however to consider online reporting related to IPAC and control issues for effective tracking and reporting.

Recruitment for clinical vacancies continue to present challenges however staff across all levels of the organizations have maintained their commitment to client and family centred care and collaborate effectively with community partners.Community partners describe the team as professional, competent and compassionate. Focus on staff, client and family member, and community partner engagement is an ongoing goal for the organization.

The leadership is working diligently toward full implementation of the transition to Shared Health. There are still details, processes, procedures and organizational structures to establish and review and evaluation of the progress will be ongoing. Continuing to methodically apply accreditation standards will effectively support the achievement of SMHC's goals and objectives.

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		
13.3	The governing body shares the records of its activities and decisions with the organization.	!
13.4	The governing body follows a process to regularly evaluate its performance and effectiveness.	!
13.5	The governing body conducts or participates in an assessment of its structure, including size and committee structure.	!
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.	!
13.8	The governing body regularly assesses its own functioning using the Governance Functioning Tool.	!
13.8.1	The governing body monitors its team functioning by administering the Governance Functioning Tool at least once every accreditation cycle.	
13.8.2	The governing body has taken action based on its most recent Governance Functioning Tool results.	
13.10	The governing body identifies and addresses opportunities for improvement in how it functions.	!
Surveyor comments on the priority process(es)		

Part 1
Sellkirk Mental Health Centre is under the direct authority of the Government of Manitoba. A governing

council that was established to provide input and consultation to the leadership team is no longer active. It stopped functioning in and about 2019 due to the health system transformation and the transition to Shared Health. The executive team do meet regularly with the ADM to maintain communication and ensure a daily focus on quality and safety is upheld across the operation. All relevant reports related to quality and safety, risk management, strategic planning, ethics, financials, audits, and decision-making processes are with shared with the ADM. In this regard, the operation appears stable, and the leadership is held accountable. Once the transition to Shared Health is completed (expected by the end of fiscal year 2021) a new system of governance will be introduced.

Efforts to deal with COVID 19 have interrupted the transition however change management principles are being applied to.

Part 2
The governance for Sellkirk Mental Health Centre was officially transferred to Shared Health April 1,2022. An extensive planning process supported the transition. As a result of provincial planning, an external board of directors was appointed. The board acknowledges however that their orientation to SMHC will continue and is not yet complete. Members of the board are a team of qualified individuals with diverse backgrounds and experiences. Currently, all positions are filled, and consideration is being given to recruiting a consumer in the future, if possible. The required policies and procedures, bylaws, and roles and responsibilities of board members are all officially documented and in place. Given the newness of the board, formal evaluations for individual and board functioning have not occurred. In relation to the board, utilizing the Governance Functioning Tool will enable them to identify areas to improve and effectively manage their performance. It is important to recognize the CEO of Shared Health reports to the board and the COO of Sellkirk Mental Health Centre reports to the CEO, this which results in some criteria not being applicable to SMHC.

The board understands its accountability in relation to quality and safety. A Quality, Risk and Performance Management committee has been established. Adding Quality as a stand-alone board agenda item will further demonstrate their commitment to quality and promote the focus on quality improvement. In time, the board will receive quarterly safety reports from Sellkirk Mental Health Centre for review and discussion.

Shared Health continues to grow and expand, and the scope of the board continues to develop. An inclusive strategic planning process is tentatively planned for the fall of 2022 and the vision and future directions will be formalized.

Priority Process: Planning and Service Design

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

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

Part 1
The team at Sellkirk Mental Health Centre is clearly committed to client and family centred care. Patient feedback gathered formally and informally is used effectively to support quality and safety.

Comprehensive strategic plans and operating plans have been developed and implemented across the organization at the unit and program level. The leadership structure supports regular monitoring of the plans. Standardized policies and procedures for functions, operations and systems have been developed and implemented.

Programs and services are developed methodically and according to organization wide policies and procedures that have been formalized (Evidence Informed Practice policy). Once implemented services and programs are evaluated and improvements are made as indicated. The leaders utilize existing data to support planning and are encouraged to promote data analysis skills so that data can be used to support decision-making across the organization effectively and efficiently. Involving families and patients in co-design of programs is a goal that may present challenges and may require innovative approaches.

Teams are skilled in change management principles which support the clinical and operational transition to Shared Health governance.

Part 2
Clients and families can contribute to policy and procedures informally and through family committee structures, surveys, and questionnaires. Family members are interested in continued participation and involvement in decision making processes. The organization intends to include clients and relevant stakeholders throughout the transition with Shared Health to support ongoing policy and procedure development. Programs and services are planned and revised based on community needs. Covid has disrupted some planning processes and has created the need to temporarily divert some resources including space from programs including Dialectical Behavioral Therapy and Acquired Brain Injury (DBT and ABI). Community partners hope to continue their involvement in planning and service delivery needs with SMHC and teams anticipate that the integration with Shared Health will offer an opportunity to streamline services and collaboratively access resources to enhance patient care.

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)

Part 1
A regular planning cycle is directed by the government of Manitoba and is organized according to set criteria. Policy and procedures formalize cash flow, funding requests and reporting requirements. Resource allocation is dictated by the provincial government however Selkirk Mental Health (SELME) can request increases to operating budgets through an established procedure. The organization abides by all established government guidelines.

The finance team expects changes and updates to the budgeting procedures when the transition to Shared Health is complete. Training and education may be required to comply with new practices however the team anticipate some improvements to the budgeting process including additional flexibility and a more inclusive planning process.

Part 2
Resource management including the budgeting process and financial performance will monitored by the Shared Health board of directors effective April 2022. Policy and procedures are clearly documented and are in place to standardize practices including set criteria for allocating resources. The board will verify Selkirk Mental Health Centre meets legal requirements for managing resources and financial reporting. Given that the board has only very recently been instated it will be necessary to review the processes relating to Selkirk Mental Health Centre to ensure practices are effective and efficient.

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)

Part 1
Evidence of relevant and accessible resources and opportunities to support employee health and wellness, orientation, training, and professional development. There is a process supporting up-to-date job descriptions and employee records. The organization benefits from two regular source of employee engagement feedback to assess improvement needs.

Part 2
Selkirk Mental Health Centre transitioned to Shared Health April 1, 2022. During the on-site portion of this survey the HR Director for Mental Health and Addictions for Shared Health participated in our discussion and commented directly on focused efforts by Shared Health to address recruitment and retention issues provincially. Representatives from the site commented enthusiastically about recent improvements to their vacancy rates providing specific examples of 26 nursing vacancies recently being reduced to 13. The site offers exit interviews to any staff member who voluntarily leaves their position as a means of gathering information that can help focus their recruitment and retention efforts.

Recent economic changes including increased gas prices have triggered creative discussions about attention to local recruitment initiatives to increase interest among potential employees who live locally to consider
Selkirk Mental Health Centre as an employer.

Staff identified wage disparity between positions at Selkirk Mental Health Centre and comparable positions in Winnipeg as a factor that requires attention to ensure the stability of their workforce. Shared Health is encouraged to work on resolving this variability where possible.

Student placements are reported to be an effective recruitment strategy, leadership commented over 90% of students have historically been hired by the site following graduation. Leadership expressed being encouraged by the current public health guidelines that have renewed opportunities for in person recruitment drives with all provincial educational facilities and Brandon University in particular.

Policies are accessible to staff in hardcopy binders at the site as well as through the SharePoint site. Staff are trained on how to access policies during new employee orientation and ongoing training offered by the site educators. Updates to policies are widely shared via email, through team meetings, and using wall mounts or posters in highly visible areas. Patients and their families provide input on the content of policies and procedures through the site-based consumer advisory and patient advisory committees.

Leadership is committed to supporting staff and have been intentional in their efforts to communicate with staff during the transition to Shared Health. Town halls were held and recorded for staff not able to attend for access at a later time. Leadership has committed to a communication series through the summer months to provide updates and create a frequently asked questions forum. Welcome packages were also created for each staff member in advance of the transition to Shared Health.

Mandatory education is tracked by the education department and captured in a database to ensure requirements are met and maintained for one time and ongoing training.

The site completes performance conversations for all employees. These conversations are expected to occur annually, and staff files shared with the surveyor during the onsite portion contained evidence of completed performance conversations. The tool used to record the performance conversation lists the organizations mission, vision, and core values.

HR files are securely maintained in a locked area and access is provided to HR staff and a small group of senior leaders.

Priority Process: Integrated Quality Management

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

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

Part 1
An organization wide strategic plan has been developed and has been extended until 2022. In addition, each program area has developed specific strategic plans that detail operating plans. The development of these plans was an inclusive process and involved all relevant stakeholders including clients and families. These plans are monitored regularly to ensure consistency in practice and to reduce variation and risk. Once the transition to Shared Health is completed these plans will be updated accordingly.

It is apparent that the organization is committed to promoting a culture of safety and quality. All plans including the operating, risk management and safety plan are documented and shared across the organization's has applied Accreditation Canada criteria and guidelines effectively to support the development of these plans.

To support efficient quality management and reporting dashboards are being introduced across the organization. It is likely that additional training and education will be required to successfully implement the utilization of the dashboards. The team has also been indicated that ongoing training on LEAN and Six Sigma are also planned to fully develop these structures.

Staff at
Selkirk Mental Health Centre are engaged, patient satisfaction questionnaires indicate high rates of satisfaction, and the organization is well positioned to move forward and transition effectively with Shared Health.

Part 2
The organization has quality boards located in unit areas where staff can see and speak to managers on QI initiatives from a unit and corporate level. Clients and families can look at this space. QI reports are identified on the board such as patient safety indicator reports, and specific unit-based QI reports.
The organization evaluates the effectiveness of the boards informally and are encouraged to formalize this process such as by adding a question to experience surveys for staff and patients/families.
A family advisory committee has a standing item on quality improvement, lean projects, and policy/procedures. Families can direct feedback such as a specific initiative through this forum or through the program manager and staff members. This is an excellent forum to dialogue on practice and gain feedback from families.
A consumer advisory committee consists of clients that meet to review initiatives and provide input.
If a new initiative is brought on, IT is used to pull data to determine status and to identify the targets for

indicators. QI has an action plan that is shared centre wide.
The organization has a policy on abbreviations where they need to be spelled out in documentation so that there is consistency across the organization. Health Information Systems can run reports on abbreviations and have set up a home page that highlights stats on abbreviations and drive practice change.
QI involves staff, family, and patients to design and develop initiatives and provide feedback on the outcomes. Staff have opportunities to participate on QI initiatives.
Center wide emails and quality boards recognize staff who have contributed to QI initiatives. Shout out boards are used to provide recognition to staff on contributions.
QI initiatives involve stakeholders who are impacted on the initiative.
Gold Service Awards is an opportunity to recognize staff for contributions that staff have made annually.
New employee training provides QI education on the process and the goals of a just culture and continuous quality improvement.
The organization has a quality and safety committee that staff can participate on. Staff can reach out to the quality team as well as their manager. The nursing advisory committee is another route that drives QI work especially related to best practices and associated policies and procedures.
The risk registry is evaluated twice in a year with leadership. Action plans are created to address risks.
Dashboard communicates indicators that are being tracked that need to be reviewed, monitored, and analyzed by key stakeholders. Each dimension has a focus that is monitored. Information is posted on quality boards that highlights specific indicators to staff that pertain to their work such as falls for geriatrics.
A snapshot of the patient safety plan is highlighted in a one-page Patient Safety Action Plan informatics.
A policy on patient safety disclosure outlines communication to family and other key caregivers. A critical incident checklist is in place to guide staff on the communication steps. All the incidents are tracked, monitored, and brought up at Quality and Patient Safety Committee.
A process is in place for clients and families to provide compliments and complaints. Patient advocates can bring forth concerns that are directed to the QI team to review, monitor, track, and analyze. Families can communicate concerns through the improvement tracker.
Reports are shared to all stakeholders including staff, leadership, clients, and families.
The organization is encouraged to design quality boards with a focus on pertinent and relevant information that focuses on the needs of the unit such as the board displayed in geriatrics.
Continue to encourage further education and knowledge translation related to quality improvement and the associated benefits and processes.

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)

Part 1
The organization has in place an ethics committee that meets regularly as well as an ethics team that addresses consults from staff, patients, and families.

The session included three leaders from across the organization plus the Chaplain who is the chair of the Selkirk Ethics Steering Committee. The other members are part of the Selkirk Ethics Steering Committee. The Ethics Steering Committee and the Ethics Team are the same.

The ethical framework provides guidance with an ethical decision-making tool. The tool is provided to the teams to support them in managing ethical issues. The tool has been beneficial in guiding staff on their decision points, outcomes, and the pros/cons of the decisions.

Education and training are provided to teams on the ethical framework. The framework has assisted in providing direction for key areas such as inclusion, and sensitivity to multi-culturist. The organization has done work on communicating messaging related to the LGBTQ community and inclusiveness. Gender identifiers have been removed from duty sheets. New employee orientation provides information on the ethics team and the ethical framework and associated resources. Training and education are provided with regard to safe spaces. The organization tracks education participants who have attended events.

The organization will push out communication-related to ethics such as ethics week and key ethic presentations are circulated to all staff.

The Ethic Team receives consults from staff, clients, and families, and brings forth ethical dilemmas. The team will walk through the ethical decision-making tool and the pros/cons of various perspectives and outcomes. The team receives one to two consults on an annual basis.
The organization is proactive in staying ahead of potential legislative changes that could create potential ethical dilemmas. This was extremely helpful for MAID and other recent legislation changes.

The consults that are received and addressed, do have a feedback mechanism.

All RHP disciplines within the organization have ethics integrated into their competencies.

The organization is embracing an education approach around moral residue and distress. This approach is encouraged to build in case study methodology.

The pandemic has thrown the organization into numerous ethical discussions. The one outcome is that the ethics committee is a valuable service and resource for the organization.

The Research Ethics Board (REB) for research at the organization is directed through the universities REB such as the University of Manitoba and the University of Winnipeg. The organization has a research policy and procedure. The policy has processes in place to support researchers who exploring the involvement of clients in research activity.

The organization is encouraged to reach out to their university partners to explore a partnership that integrates implementation science. A starting point would be to host a research symposium with researchers involved in areas of interest such as Mental Health Services and Acquired Brain Injury (MHS and ABI).

Part 2
The organization has an ethics committee that has representation from a variety of disciplines such as nursing, spiritual care, psychiatry, social work, information system, quality improvement, program managers, indigenous services, and support services. The committee's practice is guided by policy.
If staff encounter an ethical dilemma, they will follow the ethical decision-making framework and reach out to the chair of the committee. The next step is completing an ethics team referral form. The committee will invite additional key stakeholders to review, discuss, and provide next steps on the dilemma. The Ethics committee will provide a written summary of findings and response. This evidence-based approach is incorporated into staff education and training. The outcomes are directed back to the referral source and the referral source will document issue and outcomes in the Electronic Medical Reports (EMR) progress notes. The consults are tracked and monitored.
Education is provided to staff on ethics through brown bag lunches, virtual education sessions, and spring and fall education sessions.
The organization has completed work related to indigenous healing practices related to ethics.
The organization provides onboarding education related to code of conduct. There are a variety of policies that outline the intended conduct of staff working within the organization. As well, disciplines affiliated with colleges have a code of conduct to adhere to.

The organization is encouraged to formalize the monitoring of ethical dilemmas to track potential trends and shape future education opportunities.
The organization is encouraged to meet with clinical units to discuss ethical dilemmas especially ones that are resolved on the units as these are valuable lessons learned that could be disseminated corporately.

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)

Part 1

Incident command meetings have enhanced communication with all of the daily changes coming forth during the pandemic. This group heard from staff that they were feeling overwhelmed by emails and implemented a plan to send out Infection Prevention and Control (IPAC) emails on Tuesdays. The organization put processes in place to reduce emails.

The top-down communication is excellent and excessive in detail along with being extremely accessible by all stakeholders which have helped to stabilize the environment. The organization has shifted to a virtual platform that has provided enhanced communication throughout the organization including patients and families.

The IM plan is a living document that was created ten years ago by the management team but since that time, new projects are added, and finished projects are removed. Key stakeholders are involved in developing and implementing an initiative into the plan. High-level results are uploaded into the plan.

The organization has processes in place to gather input into the communication plan such as the menu advisory committee which includes staff and patient representation.

The communication plan was developed in 2012 and an annual action plan would be established. The accreditation standards are incorporated into the action plan and is reviewed annually. Communication processes have been consistent over the years and have incorporated an annual review from multiple stakeholders. The consumer reviews the plan advisory and family advisory councils and reviewed on an annual basis.

The tracking of the IM plan is tracked by the branch management committee on a quarterly basis. The communication plan is tracked on a quarterly basis and reported to the executive management team. The teams track key metrics associated with the plan and one example is having one Electron Medical Records (EMR) system for clinical documentation. The communication plan captures outputs that identify the key metrics including the person that is responsible for the particular metric.

The organization has a process to communicate information out to its external stakeholders. An external communication draft is created that is reviewed by other senior leaders that would then get emailed out to outside stakeholders. At times, reach out to specific families for input and direction.

Communication that is extremely sensitive needs to be framed through the Manitoba government.

Communication is sent out to families and clients that are put through the senior leadership process.

The organization uses the work-life pulse survey that is directed out to physicians and staff. The surveys are collated in the portal by Accreditation Canada. The yellow and red flag standards were identified. This information was presented to managers, supervisors, and team leaders. The group was asked to meet with their teams to explore plans to improve the work-life results. There were a lot of themes shaped from the narrative results. Deliverables were flagged that were incorporated into an action plan. The organization focused on the red flags. A number of the suggestions provided by staff addressed a number of line items in the survey. It would be good to administer the tool on a more frequent basis such as annually. The one concern that was flagged was to have increasing access to psychological services is the portal for staff identified as “not feeling myself.” Question 17, the organization completed this by having each service do their strategic plan that filtered down to the front-line staff.

There are patient and family satisfaction surveys are completed on an annual basis. The results from the family satisfaction survey and patient satisfaction survey are communicated through the family advisory committee. The staff and families work together on the identified areas of concern such as the complaint process. The organization hosts in each program area, the plans, and results on their bulletin. Information is communicated out to patients through the patient assemblies.

An informal process is in place to seek input on the content captured in the Wellness Newsletter. The newsletter is circulated out to staff via email and shared on Share point.

Improvement tracker monitors and tracks complaints and issues brought by patients and families.

Processes are in place to seek out input from community stakeholders such as the general public and referral services.

Processes are in place for clients and families to access health records. The organization has a privacy officer. Processes are in place to protect the privacy and confidentiality of the client’s medical records.

Checks and balances are in place to protect both staff and client information and who has access to this information.

There is an evidence-informed practice policy are in place to ensure information is meeting the necessary standards to guide practice.

The organization has strong relationships with all external stakeholders including the government of Manitoba, Manitoba Brain Injury Association, partner hospitals, community agencies, home care, families, and clients. The family advisory council provides direct input into everyday clinical planning and the impact of policies on clients and families. As well, the organization runs a quarterly stakeholder advisory committee. The strategic planning exercises integrated input and direction from external stakeholders.

The organization is responsive in providing timely communication to all stakeholders.

There is an evidence-informed practice policy in place to ensure information is meeting the necessary standards to guide practice.

The organization has a comprehensive and extensive health information services policy and procedure manual.
Part 2
The organization has a number of processes in place to gather input and solicit feedback from team members, families, clients, and community partners. The organization uses a number of processes to gather input from stakeholders such as the family advisory committee, the consumer advisory committee, town hall sessions, and community forums.
The processes are regularly assessed for effectiveness for the information systems utilized. Experience surveys for staff, clients and families gather input on the effectiveness of the IS process with regards to meetings its desired results.

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)

Part 1
Reports of challenges related to existing client physical space or construction include proactive measures to mitigate risks to privacy, confidentiality breach, health, and safety, respectively. The organization's back-up system is ready to support electrical failure and critical functions. The organization provides evidence of concern for the environment in their selection of equipment.

Part 2
Accessibility issues noted in the 2016 Accreditation Report remains, notably those related to dormitory settings and lack of elevators for the Administration building. Plans continue to be in motion with the province towards the development of plans to replace these facilities. There is an opportunity for continual and targeted consultation with all prospective users and particularly patients, families, and front-line staff in the development of the future space.

Areas without functional air conditioning (e.g., Administration, Tyndall in places) are equipped with fans and some windows can open. Management is informed and working to address the Tyndall building functionality to enhance privacy and confidentiality and ready access to medication rooms within patient units, in consultation with future users. More pressing heat management and panic button hook-ups issues are also in progress but frequent communication to staff to report on up-dates is desirable to promote patience and understanding.

The campus facilities are otherwise bright, accessible, and inviting with indoor and outdoor facilities. Locked areas are locked and fully monitored by security staff and a full camera system. Evidence was provided about routine and preventative maintenance practice.

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)

Part 1
The pandemic - while challenging for Selkirk Mental Health Centre, has also created opportunities for change for the better. The ability for the emergency preparedness group of Selkirk Mental Health Centre to be innovative and nimble - changing procedures to adapt to pandemic situations is commendable. They are very ahead of the game in this department.

Some examples of this are: doing paper fire drills instead of in person fire drills (and reaching night staff by having one of these at 6 am), doing virtual training for fire drill activity completing the business continuity plan, adapting security processes to pandemic situations.
Other items of note:
They initiated a PA system for all buildings which has been highly successful especially for Code Whites.
Initiated one entrance right at the beginning of the pandemic, as well as acted early to shut everything down and they feel this contributed to their ability to have no outbreaks.
The have done (pre-pandemic) many types of mock disasters (tornado, Code Grey, etc.) and were incredibly happy to see the staff using a code card to understand actions needed to be taken.
They used Hazard Risk and Vulnerability Assessment (HRVA)- to assess for potential hazards and Risks (from Kaiser Permanente) prior to the pandemic.
They also managed other incidents very successfully - a water problem with the city, a heat problem in the middle of winter.

The areas under emergency management report work very well together, pulling together when problems arise of any kind, bridging gaps between staff and leaders as much as possible.
They would like to up their training of their own staff (security officers especially), so folks are prepared for potential problems in the future.

They would also like to be more connected to the community of their peers.

The head of security has adapted police training for managing challenging and some violent situations to address mental health issues. This sounded very apropos and creative.

Part 2
The organization had no unmet criteria within this priority process. Selkirk Mental Health Centre is well prepared for unexpected or unanticipated emergencies. Their teams have recent experiences to draw on, documented evaluations of implemented strategies and processes from the COVID-19 pandemic and have invested in skilled and knowledgeable staff to support their efforts.

Priority Process: People-Centred Care

Working with clients and their families to plan and provide care that is respectful, compassionate, culturally safe, and competent, and to see that this care is continuously improved upon.

Unmet Criteria	High Priority Criteria
Standards Set: Governance	
10.5 The governing body regularly hears about quality and safety incidents from the clients and families that experience them.	!

Surveyor comments on the priority process(es)

Part 1
Clients and families were sought out to provide input and direction to the strategic plan being developed by the corporation. Engaged clients and families from a consumerism forum so that their perspectives were included. The families completed a Strength, Weakness, Opportunity, Threat (SWOT) analysis to provide direction to the strategies. The clients and families were reached out to in the early going of developing the strategies.

Clients and families have processes for bringing forwards ideas, concerns, and issues. These would be addressed by the specific area that the concern/issue pertains to. For example, families have had input into the organization's processes related to the visitor policy, especially during the COVID-19.

Family advisory and patient advisory sessions are held on a regular basis to gather input and feedback in a formal way. As well, there are many organic processes that input, and feedback are captured from patients and families. This input has shaped/reshaped policies and processes. The organization uses an improvement tracker to monitor, track and follow through with issues and concerns that were submitted.

The service coordinator oversees each client within the ABI program. The ABI program has a number of processes to actively engage and integrate input and direction from clients and families.

Clients and families are actively involved in the progress of their goals and objectives including discussions/decisions related to transition planning.

Mechanisms such as the family and consumer advisory councils are examples of how the organization solicits and incorporates feedback and direction from clients and families.

Part 2
The organization is clearly focussed on client and families maintaining a culture of client and family

centred care. Clients and families are routinely involved in the codesign of programs and services when appropriate however due to Covid-19 some of these opportunities have been disrupted and have resulted in some concerns related to space planning and access. Feedback from clients and families is collected anecdotally and formally through surveys. The feedback is used to support service development, decision-making, and quality improvement. Generally, clients and families report high rates of satisfaction. The newly appointed board of directors intends to continue to focus on clients and families and include them as collaborative partners. This will also involve hearing directly from families and clients about their experiences relating to quality and safety.

Community partners support Selkirk Mental Health Centre's service delivery initiatives and they anticipate that the collaborative practice will continue under the Shared Health governance.

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)

Part 1
Patient flow assessed on virtual survey.

the Required Organizational Practice (ROP) that was N/A.

On-site needs to validate unrated criteria.
Part 2
Processes are in place to monitor and track patient flow including continuity of care.
The organization has established partnerships with other service providers to support transitions from SMHC to the community.
The organization does not have an emergency department.
Processes have been streamlined to support efficiencies with admissions because of COVID-19.
The organization communicates on a daily basis with other organizations to support point of care to point of care transitions.

The organization is encouraged to continue developing strategies resulting from unintended consequences of COVID-19 (staff shortages, bed closures) that address current Length of Stay (LOS) issues, Alternate level of care (ALC), and flow in and out of the organization.

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)

Part 1
Overall, there is evidence of required policies, procedures and standard work and training program to support optimal cleaning and disinfecting processes. Use of disposable products eliminated the need to outsource sterilizing services. On site examination of processes is required to confirm application and outcome.
Part 2
Selkirk Mental Health Centre does not conduct reprocessing on site. Cleaning and disinfecting of medical devices and equipment occurs and the site has policies, procedures, and education in place to ensure staff participating in cleaning and disinfection do so safely, in a standardized way and in accordance with manufacturers instructions. Easy to understand directions in poster format are located in clinical areas where specific equipment is in use. Chemical supplies in use are stored in secure locations. Material safety data sheets (MSDS) are available to staff in hard copy and electronic formats. Routine MSDS resources are mounted in easily accessible locations as an example, housekeeping carts.

All medical devices and equipment are tagged for tracking purposes to ensure access to warranty information, repair records and to assist with strategic planning for rotational replacement and equitable use of equipment to extend product life and mitigate the risk of widespread, simultaneous equipment failure. Selkirk Mental Health Centre conduct, track and record preventative maintenance and have created a small supply of back up equipment to reduce service disruption. During COVID-19 and since, the teams at Selkirk Mental Health Centre regularly monitor their inventory and proactively plan possible alternatives when supply issues are suspected.

Auditing and tracking of PPE supplies was instituted during the pandemic when supplies were unstable. Considerable education was implemented and evaluated during this time to assist with conservation of supplies and to reduce the risk of COVID-19 spread (as an example examining equipment carefully to reduce where possible the use of aerosol generating medical procedures).

Where contracts exist for equipment to be provided by a third party - Selkirk Mental Health Centre team members work closely with their agency contacts to ensure regular maintenance of the equipment.

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	

Part 1
The organization has strong partnerships with key referral sources such as subacute and acute care hospitals.

A policy was adopted for tele-practice for supporting clients for discharge.

The team attends functions/events put on by the Manitoba Brain Injury Association and will bring along clients to participate. The team gets involved in fundraising events. The team provides education and resources related to lifestyle choices. The team will ensure that the discharge environment fits the needs of the client especially in relation to accessibility, safety, and independence. The Business Impact Analysis (BIA) offers a lot of resources online such as support groups.

Respite care services are not offered by the service.

Clients are provided with palliation support and direction when required.

Processes are in place that conveys and communicate information about the Acquired Brain Injury (ABI) program to potential clients and families, community organizations, and other key stakeholders.

Strong lines of communication are in place to highlight resources needs for the ABI program especially in relation to patient flow and optimizing successful client outcomes such as returning to their designated discharge environment.

Part 2
Clients and families have opportunities to provide input and direction into all of the clinical processes. The unit has a number of mechanisms to gather input from clients and families around service planning and design.
The organization has processes to review, monitor and adjust programming that includes feedback from clients and families.
The program is lead by a physiatrist who has a strong inter-professional team that brings together a comprehensive care plan that includes goals of care.
The client environment is accessible and has built in additional resources (e.g., exercise equipment and games) that were conveyed by families and clients. The program takes steps to ensure the environment is home-like for the clients.
A kitchen is set up so clients can practice and develop skills in preparation for the next transition stage.

Priority Process: Competency

Part 1
The clinical lead for the team is a regulated health professional. The medical/clinical director is a physiatrist who has expertise and knowledge in assessing and treating persons with an ABI.

Education and training were provided to staff at the onboarding when the program was initiated. The staff has received Ontario Brain Injury Association (OBIA) training such as the level one training. Brain Basics is provided to staff. Education is a big piece of the program, and the program does education to families and communities. Professional development is provided to staff and to provide opportunities to strengthen staff skills and expertise.

The ABI program has a comprehensive and thorough education and training program that incorporates new staff onboarding, annual mandatory training, and continuing education to build expertise and competence. The program is encouraged to evaluate its existing training resources so that they meet current evidence-informed and leading practices.

The organization utilizes several tools to track, monitor, and evaluate staff performance. One tool is the performance conversation that outlines three key areas of professional conduct, communication and teamwork, and patient and recovery focused. The tool is completed at 3 months, 5 months, annually, and biannually thereafter. A learning plan is generated at the end of the discussion.

The ABI program has a collaborative and highly invested inter-professional team that provides a comprehensive assessment and treatment for clients living with a brain injury. The team is actively involved in all phases including the intake process, and brain injury awareness, and preventive initiatives.

The team has integrated the clients and families into each and every clinical process. The clients and families are the focal points of all clinical decisions and input/direction is sought out at each decision point.

Education and resources are provided to team members to support their safety within the ABI program.

A policy and procedure are in place to support staff with workplace violence.

Part 2
The staff receive a number of education and training sessions related to orientation for new hires, annual training, ethical decision making, and on using equipment and devices safely.
Staff are evaluated on a regular basis with respect to their performance. As part of the process, opportunities for growth and development are discussed including paths to strengthen knowledge for other organizational job opportunities.
Processes are in place to recognize staff for their contributions and accomplishments. As well, the organization has shout out boards so that peers and other staff can recognize team members.
The program reviews staff workload and adjusts to fit the needs of clients accounting for client safety and quality of care.
Education is provided on workplace violence and prevention including processes to report violence.
The program has integrated cultural aspects into their service that include spiritual space and care such as smudging ceremonies in the courtyard and reconciliation ceremonies.

The organization needs to develop a process to formally evaluate the functioning of its team to determine effectiveness and efficiencies in client delivery.

Priority Process: Episode of Care

Part 1
The organization has strong partnerships with key referral sources such as subacute and acute care hospitals.

A policy was adopted for tele-practice for supporting clients for discharge.

The program has processes to access and touch base with clients who are on the waiting list.

The program is referral based and the referral form is accessed from the website. The intake team consists of members such as physiatrist, Occupational Therapist, (OT), Social Worker (SW), Speech Language Pathologist (SLP), dietician, program. The review determines if a client is accepted or not accepted. If they

are not accepted, the clients are directed to another service. There is a waitlist management approach for clients who are on the waitlist. Clients can access the transitional rehab beds by skipping over the inpatient beds. There is a priority process to identify clients who need service sooner than later. The key team members visit the client at the hospital and access the client. From that assessment, a team discussion occurs to determine if the patient meets the criteria, and if they meet the criteria, they are accepted. The organization has strong relationships with its other hospital referrals sources. Patients across the province have access to the Acquired Brain Injury (ABI) program.

Clients are coming into the program, usually 4 to 5 months post-injury. If capacity is not done, every patient is admitted under the mental health act, and a capacity assessment is completed. As a result of MHA, the clients might have a decision-maker for care and finances. The organization has access to clinicians who can administer the capacity assessment. Most of the clients have access to a neuropsychological assessment and recommendations.

Patients on the waiting list are offered community services to support them during the transition phase. Some services utilized are home care, community support services, mental health services, and Manitoba Brain Injury Association. There are limited resources available in the community.

The client arrives in area 1 or area 2 and usually arrives from the hospital. The doctor will do a medical admission and determine if the patient is medically stable. Blood work is completed and will writes a prescription for medication. The physiatrist will complete an assessment of the patient, pending history, identify initial goals, and a referral to all disciplines including a primary nurse.

The primary nurse will get a list of medications from the current hospital so that medication reconciliation is completed. The nurse will provide orientation to the unit and make sure all the necessary paperwork is completed for the client. Communication is sent out to each team member to set up a time with the client. A meal assessment is completed to determine safety with swallowing and eating. The dietician gets involved in accessing the patient and look at the weight (loss, gain) and if there are eating/swallowing concerns, and if need a therapeutic diet. The dietician does consult on a regular basis based on input from the team. Clients are observed for their first three meals. SLP is involved in providing an assessment and associated recommendations. Special considerations are flagged for the clients. Communication issues are assessed, and a communication plan is put in place to support communication between client and team. All assessments include the families to determine existing strategies and how to incorporate them into the treatment plan. Social Worker reviews a number of items such as financial, insurance, support systems, and housing. Discharging planning starts on the first day of admission in terms of where the client is going and what needs to be put in place. The client is provided rights and responsibilities and an ABI handbook that outlines key resources. OT has the organization referring to complete a preadmission functional assessment that outlines the current status including equipment being utilized. The OT prepares equipment required for the client arriving on the first day. An initial transfer and fall assessment are completed with the patient and the results are communicated to the team. A functional assessment pertaining to the Activities of Daily Living (ADL's) is completed such as toileting and showering. A cognitive assessment is commenced a few days into the admission process. Physical Therapy (PT) and Occupational Therapy (OT) collaborate on the transfer and fall assessments, especially with the mechanical lifts. The

team uses the NRS to guide the assessment process.

The service Coordinator oversees the completion of clinical tools such as the RAI-MH and the NRS and this person oversees the completion of the assessments.

Families are always involved in the process, and they are continuing to be involved with formal contacts every two months. Clients and families participate in the admission process especially in generating the treatment plan. Each team member develops rehab goals which are discussed at weekly rounds and the client is invited in every two to three weeks. Families and clients receive information on the roles and responsibilities of each team member.

Clients have whiteboards that communicate various items. Each client will have a transfer and fall decal that identifies the level of support required.

A rounds sheet is generated each week and there is a line at the top that flags a potential discharge date and successes/challenges with it. The funding is a key element in achieving success and the program rarely gets insured Patients. Thus, family support and other supports become critical in having a successful discharge. The two parts need to come together with one part being the client is ready and secondly, the supports need to be placed. If a discharge destination is not available, a Patient will become Alternate Level of Care (ALC). The province has limited resources to support clients in the community. There are limited resources to support patients especially as the caregivers are aging.

When patients are discharged from the services, there was an opp
Part 2
The program provides services to clients with ABI and involves an inter-professional team to deliver evidence-based care.
As a result of COVID-19, the program had ten of its inpatient beds reduced to support COVID-19 flow. As well, the 5 community transitional care beds were closed. As a result, the Acquired Brain Injury (ABI) program is at present is only operating ten beds. They have had staffing issues especially in recruiting nurses, Speech Language Pathologist (SLP), and Physical Therapy (PT). These vacancies have made it difficult to bring on board the ten previously closed beds.
The closures and COVID pandemic have resulted in patient flow issues especially with new admissions. Also, the program has encountered Alternate Level of Care (ALC) issues in identifying and locating appropriate discharge destinations and currently 70% of the beds are designated as ALC.
The average length of stay has tripled from pre-COVID Length of Stay (LOS) to the present LOS.
70% of the clients have a personal care home identified as their potential discharge environment.
The program has collaborated with other services in the community/region to support flow from one point of care to the next point of care.
Client complexity has increased over the last few years, with a number of clients requiring one to one support.
The program has a low readmission rate as a result of comprehensive care planning and progressive discharge planning.
The program has incorporated passes where clients can be allowed to go to their discharge environment

or home to support a safe, and sustainable discharge.
Ethical issues and dilemmas are discussed on a regular basis with team including strategies to resolve them that incorporate a person-centered approach.
The program has done a remarkable job in improving the quality of life and function of its clients. For example, clients enter the program wheelchair bound and progress to walking independently and focuses on implementing strategies to reduce the burden of care associated with the client's everyday functioning.
Each client has a white board in their rooms to support communication, goal planning, and progress on performance.
Falls risk is assessed at admission with a standardized tool and communicated to the team through documentation and signage in the client's room.
There are photos of each client throughout the documentation systems which is incorporated as one of the two identifiers when doing clinical encounters with the clients. The second one is name recognition when being greeted.

Priority Process: Decision Support

Part 1
The Acquired Brain Injury (ABI) program has strong processes in place that let each clinical team member document into the medical record. Clear processes are outlined to each member in terms of their roles and responsibilities. The team has a service coordinator who oversees and monitors the progress of each client.

The team meets weekly at rounds to review and update the clinical progress being made by their clients. The clients attend these sessions every two to three weeks so that they have an opportunity to provide input and direction.

Processes are in place for clients and families to access their medical records.

There are processes in place to capture all relevant documentation at each phase of the patients journey.

Part 2
Processes are in place for documenting and sharing progress with clients and families.
The organization needs to move to creating one medical record as currently there is an electronic medical record (EMR) and a manual medical record. The potential for risk increases when information is in multiple locations and best addressed with a consolidated clinical record. As well, the medication management system operates with the Medical Administration Records (MARs) being done manually and medication management including reconciliation being captured within the electronic medical record.
The program has weekly rounding that outputs a written document outlining each client's progress and areas to focus on with their individual care plans including risk areas.

Priority Process: Impact on Outcomes

Part 1
The Acquired Brain Injury (ABI) Program had a number of meetings in developing the strategic plan and identifying the objectives for the deliverables. The plan has had it hiccups as a result of the COVID-19 pandemic. Discharge of clients from the ABI program poses challenges for this population as a result of a lack of services. A number of items on the action plan have moved forward and been addressed. The plans were not adapted for COVID-19 but rather the goals were deferred if they could not be addressed.

The patient incident reporting system is in place that provides feedback to the ABI program regarding key metrics being tracked and monitored.

A number of communication mechanisms provide direction to the service with respect to improving the quality of their clinical service delivery.

The organization has a number of dashboards in place to track performance metrics for the ABI program such as wait times, readmission rates, Average length of stay (ALOS), occupancy, and restraint utilization. The data is tracked on a quarterly basis and can be trended with the previous year's data collection.

Patient and family satisfaction surveys are conducted on an annual basis.

The ABI has strong processes in place to optimize the safety of their patients and incorporate steps to include feedback from both clients and families.

Part 2
The program gathers input and feedback from the clients and families to identify opportunities to improve services.
Indicators are monitored and tracked on key areas such as falls and medication errors.
A quality board is located in the unit and shares information such as the quality improvement action plan, the ABI strategic plan, and any Quality Improvement (QI) initiatives occurring that focus on improving care for clients.

The program is encouraged to redesign the quality board so that information shared is relevant to this specific program. This could apply to indicators tracked and the progress the program is doing in meeting the identified target.

The program would benefit from identifying a quality improvement initiative and work with QIR in rolling out the QI processes that focuses on improving one of the processes related to clinical service delivery.

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

Part 1
The Infection Prevention group is multi-disciplinary and reports a busy year with the pandemic! The Pandemic Plan was created as the pandemic raged (and built upon a basic pandemic description that had been created in the past). This is a comprehensive 27-page document that is practical in nature - outlining procedures in all areas of Selkirk Mental Health Centre.

They report being very conscientious with PPE's during this time and prior to the pandemic (with MSRA, C Difficile and bed bug challenges)

They make effective use of the organization-wide “improvement tracker" - encouraging patients, families, and staff to make suggestions for higher standards or new ways of doing things, overall, this area is conscientiously managed in all areas.

There are a few innovative things to note - Annual Bug Day is a day when all information about viruses and germs, etc. and how to manage them is created and enjoyed, by all the staff. There was an environmental audit of cleaning put in place some time ago - with an 80% goal- that is now embraced by staff in a kind of friendly competitive way and seen to be contributing to a cleaner workplace.
They are immensely proud of the fact that they have completely moved to single use devices and stopped all past-needed reprocessing.

This committee also feels it is contributing to the construction that is being planned for the future (post pandemic).

They are also proud of the fact that during the entire pandemic they did not have one outbreak with all patients or staff - very commendable!
They plan to go ahead with a bold immunization policy re: COVID-19 that would require all staff to be vaccinated.

The organization also moved very quickly at the start of the pandemic to create "quarantine" placement and single entrances to reduce the infection spread, and this in fact did occur.

They do offer immunizations pre-pandemic - to staff and patients.

Their hand hygiene practices were in place before the pandemic and of course, were emphasized lately. They have an "auditor" group that is mostly made up of managers and they would like more front-line people to be involved going forward which goes along with their desire to have connections throughout the organization, at all levels.

Part 2
Selkirk Mental Health Centre has an infection prevention and control team that includes representation from various disciplines and service delivery areas. This team existed prior to COVID-19 and met regularly. The frequency of these meetings increased during COVID-19 and members of the Infection Prevention &Control (IP&C) team were actively involved in the site-based Incident Command. The site has 2.00 FTE (Full Time Equivalent) of infection prevention and control resources with one of the full-time positions added during COVID-19 to support the sites efforts to reduce the risk of COVID-19 and to contain spread where infection occurred. Site leadership and frontline service providers all spoke with pride about the period their site was COVID-19 free, more than 600 days. While the site declared three outbreaks at the end of 2021 and early 2022 the team was able to contain the spread through the routines and practices established. Learnings form these outbreaks were recorded and shared and will assist the teams as they continue to work on new and routine risks in their environment such as bed bugs, MRSA, and flu.

The team at Selkirk Mental Health Centre participate in regular IP&C reporting internally and externally. Information is shared with staff at meetings, via email communication and through regular unit communication. The site IP&C resources were described as easily accessible, and processes are in place to ensure consistent information is shared with staff. Specifically, the IP&C officer routinely checks in with staff working on units in outbreak at least twice a day to share updates, provide guidance and answer questions. The site relies on paper-based reporting by staff to identify IP&C concerns. The information is tracked and can be collated for reporting purposes however, this work falls to the IP&C officer or professional to complete. The site is encouraged to consider online reporting of occurrences including those related to infection prevention and control issues.

The IP&C team are encouraged to continue their creative approaches to knowledge translation namely the approach to sharing IP&C information using engaging methods such as face to face discussions with frontline staff, tree ornaments or quality boards.

The IP&C team collaborates effectively with environmental services. Ongoing communication and established practices help to ensure regular cleaning of high frequency area and prioritizing supports in outbreak locations where possible. Sharing these practices with frontline staff to support them acting as adjunct supports to housekeeping services has occurred.

Hand Hygiene audits are in place and the site sets a target of 200 moments annually per units. Audits are conducted by trained staff members and completed audit reports are analyzed and shared with staff. The site is encouraged to consider assigning responsibility of collating this information and generating

outcome reports to support staff roles rather than IP&C professionals to free up their time to maximize their skill in guiding, supporting, and educating teams.

The site ensures information about IP&C issues is shared with patients and their families. During outbreaks specific contact with patients and their families occurred, often by the manager or other most knowledgeable team member with follow up letters sent to families.

Hand wash stations exist in patient care areas although staff identify the age of their physical structures limit the number of sinks, they would like to have. In the meantime, additional wall mount dispensers were put in place and small personal size hand sanitizer are available to staff.

Educational resources and guidelines are taken directly from Shared Health resources and where necessary modifications are made to ensure the resource applies to the unique environmental and patient care needs of Selkirk Mental Health Centre. Staff appreciate the support available from Shared Health to guide practice and processes but expressed their desire to maintain Selkirk Mental Health Centre specific practices where appropriate and access to providers (IP&C professionals) on site.

Selkirk Mental Health Centre partner with Interlake Regional Health Authority, Public Health, Manitoba Health, Medical Officers of Health, Federal and Nunavut to identify, respond, report and support (IP&C) activities.

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

Part 1
Note - There are many areas here that cannot be rated until there is an onsite visit.

The medication management team takes a multidisciplinary approach. Roles are clear and they have many meetings where things are checked and double checked. They pay attention to the variety of knowledges that exist on their team (nurses, pharmacists, etc.) Inhouse Pharmacy plays a very big role in the coordinating of these processes and is given many accolades by other members for their consistent flexibility, availability, and ability to make things work.

The pharmacy hours are from 8:30am - 4:30pm, but they are also available when needed and there are automated dispensers for which there is a very comprehensive accessibility process and also auditing daily.

Medication reconciliation is done at intake and discharge. At recovery planning, conversations with patients by pharmacists occur to assist with medication management and ensuring medications are tailored to the environment and capabilities of each patient.
They noted that the discharge reconciliation process was not working so well some time ago and so improvements were made. There are no transfers internally and any other transfers to other settings - for example, seem to have a problem with the form but not the process. They are changing that form.

During the pandemic, many changes needed to be made about the medication dispensing. The Pharmacy took this on and created an IPP system that in the end, saved a great amount of money and shown how little wastage of medication occurred. This process is time consuming and somewhat awkward for staff but generally seen to be a welcome change.
The audits occurring in this arena are many and comprehensive. There is good security for the automatic dispensing of medications (access by password or fingerprint).

There is a general sense of good collaboration between all people involved in medication in all areas and this makes for a good ability to manage changes (and pandemic issues) more easily and find new ways of doing things. There is a general consensus that better office space is needed, and some electronic

processes could be improved.

Medication reviews are done monthly (other places it is quarterly). this area is changing rapidly - so does training and they note they are keeping up.
They worry about nursing shortages and some equipment problems going forward - as that could affect their collaborative approach internally and externally.

Part 2
Selkick Mental Health Centre uses a combination of an individual patient prescription process and automated AcuDose cabinets. Staff did not articulate concerns with the hybrid system although some expressed interest in migrating to an automated system that is standardized across Shared Health.

Security measures are in place to ensure the safe administration, storage and wasting of medications and in particular narcotics. Staff were able to describe the process of narcotic management and high alert medication administration easily and consistently. Staff discussed receiving training on admission and ongoing education on the safe administration of medication including those used in a code blue response or psychiatric emergency.

No compounding of medications occurs on site and heparin is not prescribed. Staff were able to easily describe processes to mitigate risk of look alike, sound alike medications including the provision of alert stickers on medications and medication administration records (MAR).

An antimicrobial stewardship process is in place and was informed by several members of the interdisciplinary team. Chemotherapy agents are rarely if every in use and only oral preparations have been used. A cytotoxic policy directs the safe use of these agents and appropriate PPE for staff is available and guided by educators and pharmacists.

The site does not use samples and has not for several years.

Emergency medications are available in an emergency tote case. Several cases are available throughout the campus to ensure one is easily accessible regardless of the location of the emergency. Pharmacy is responsible for maintaining the supply of medication in these kits and a process is in place to waste any medication by its expiration date.

The pharmacy is secured and only pharmacists have keys to the locked environment. During COVID-19 the pharmacy team created cohorts to ensure if a pharmacist became ill with COVID-19 the broader team would not be at risk to ensure operations would continue.

Regular medication room audits occur monthly, and the results are reported for follow up action on a quarterly basis. Medication occurrences are reported using a paper process. The site is encouraged to consider an online reporting system for staff to ease the completion of medication related events.

Medication rooms across the campus were described by staff as well lit, organized and set up to facilitate

safe administration. Processes are in place to ensure medication to be wasted is placed in contamination bins. Medications to be returned to pharmacy are placed in marked bins for their safe return. RX destroyer is available in all med rooms for the safe disposal of liquid narcotics.

Standards Set: Mental Health Services - Direct Service Provision

Unmet Criteria		High Priority Criteria
Priority Process: Clinical Leadership		
2.3	An appropriate mix of skill level and experience within the team is determined, with input from clients and families.	
5.2	Work and job design, roles and responsibilities, and assignments are determined with input from team members, and from clients and families where appropriate.	
Priority Process: Competency		
	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		
13.2	The procedure to select evidence-informed guidelines is reviewed, with input from clients and families, teams, and partners.	
13.3	There is a standardized process, developed with input from clients and families, to decide among conflicting evidence-informed guidelines.	!
13.4	Protocols and procedures for reducing unnecessary variation in service delivery are developed, with input from clients and families.	!
13.5	Guidelines and protocols are regularly reviewed, with input from clients and families.	!
Surveyor comments on the priority process(es)		
Priority Process: Clinical Leadership		

Part 1
With improvement activities related to environmental accessibility, human resources, staff education, there is evidence that the program is aligning goals and objectives with the organization's overarching strategic plans. There is an opportunity to strengthen the evaluation of the strategic plan with greater application of LEAN principles and tools, and the selection of common improvement indicators.

While there are mechanisms and structures inviting patient and family input, these have reportedly been minimally active in the last few years primarily on account of the pandemic. There is an opportunity to increase patient and family input perhaps using new methods and approaches, and for a greater number of program processes and features.

On site verification will assist with the evaluation of partner collaboration and the sharing of program alternatives with service users.

Part 2
In alignment with one of the organization's strategic priorities, the interdisciplinary teams consistently demonstrate applications of the Recovery philosophy as reflected in the language, communication and approached to care. The Patient Assembly, the Improvement Tracker are forums to patients and families to weigh in on programming and the teams reported on specific service initiatives born out of this feedback namely those related to education group on medication awareness and equipment review. Formalizing the patient and family voices as part of the team's regular service planning meetings and quality improvement initiatives would bring this practice to the next level.

Priority Process: Competency

Part 1
Evidence was provided to indicate that the program meets most of the standards as it relates to job description review and verification of credentials, staff orientation and training about the program model and on the skills required to manage risks, provide quality care while nurturing a positive working atmosphere.

The team interviewed showed evidence of mutual role awareness and collaboration.

The organization celebrates recognitions on various formal and informal levels.

There are regular opportunities for professional development.

As in many areas, there is an opportunity to increase patient and family input about staff competencies, training, and teamwork.

Teamwork set-up and workload is best evaluated on site.

Part 2
In summary, the staff is re-affirming receiving a fulsome orientation, training in key areas and regular refreshers. There are regular performance reviews with opportunities for professional development. Staff report access to front line supervisors, services, and resources to maintain their wellness; they also report

feeling supported by their peers. Outside of regular clinical team meetings, there does not appear to be a forum for the complete program team to meet to address operational and quality issues; similar monthly meetings were replaced by more pressing forums with Covid-19. Resuming or instituting program meetings having for focus interdisciplinary team development and applications of quality issues provides teams the forum needed to address team functioning and general improvements.

Priority Process: Episode of Care

Part 1
From documents reviewed and team interviews to date, there is evidence that the program meets most standards associated to patient care assessment, care development and care transition.

Evidence provided towards medication reconciliation, falls, seclusion and restraints and suicide prevention illustrate a strong foundation to date.

Verification and inspection of the physical care environment along with patient and family interviews to gather their perception and experience of the care received is needed to complete rating, and this is best captured on site.

Part 2

A key strategic plan goal is met with the implementation of Recovery Model and elements of this approach is evident from the language used, tone of resources (brochures, self-help, and safety information available to patients; client and family input re: Care plan development and group programming)

Patients who were interviewed reported being involved, having a say in their care, and receiving the information they need. We sense that they trust the team and feel safe. We see evidence and patients report on a range of program options to meet recovery goals including explanation with medication, getting the right mobility equipment, social recreation, opportunity to pursuit education, involvement in chores, ability to collaborate towards discharge- connecting with Community MH Service Providers and housing in person or by phone prior to discharge etc.

During Covid-19, care collaboration with partners and family participation was optimized through virtual means (teleconference or video link participation) and at time, perceived to have improved or facilitated this level of engagement. Patient transportation to access specialist consultation was also reduced thereby eliminating many transportation risks while meeting care needs. Programs are encouraged to explore how the use of virtual care can be further optimized in a way to preserve these advantages while optimizing patient and family care experience.

Risk assessment and management including suicide risks and risks of violence are supported by policies

and procedures, regular staff training, documentation, and event tracking.

We can be impressed with the reported, artful management violence occurrences that focuses on rapport building with the patient, understanding of patient triggers, verbal de-escalation, voluntary use of low sensory, isolation rooms, use of restraints as last resort and structured observation protocol and electronic monitoring and report indicating that the frequency and the duration of restraint use has gone down over time!

Teams reported positively on their orientation, training, and refreshers (SAFE-T for suicide risk management; Non-Violent Crisis intervention (NVCI) with regular opportunity professional review and feedback and professional development and support to maintain wellness and safety.

Optimal regional use of patient beds through fluid patient flow was a challenge identified during the 2016 accreditation visit and addressed in the interim and at least in part, with the addition of a bed utilization manager position.

At the front end, the Forensic team also reported promoting appropriate admissions with greater attention to admitting patients whose recovery needs can best be met by the program, thereby promoting successful transition. Front end efforts to plan for discharge upon admission and involvement of key community partners early and often in person or by telephone are best practices to be sustained and developed as much as possible to address the persistent challenge of bed flow.

The Dialectical behavior therapy (DBT) program was interrupted due to the pandemic. Notwithstanding the realities of the pandemic that continues to strain resources including use of all physical spaces to support isolation, the organization is encouraged to work with partners to explore how this specialized program can resume to support community needs.

Priority Process: Decision Support

Part 1
There is evidence for information collected, using standardized and non standardized tools supporting the collection, the documentation, and the sharing of Personal Health Information (PHI).

We seen the evidence of policies and procedures addressing confidentiality, PHI sharing, records management but their day-to-day application is best evaluated on site.

Evidence for service user and family input with electronic communication and the various aspects of PHI management including, collaborative care documentation in the clinical records will best be evaluated on the site.

Part 2
The organization should be congratulated for providing evidence of follow-through on the 2016

Accreditation Canada (AC) report recommendations to develop a rigorous audit monitoring process and develop and communicate a process to facilitate patient access to their medical file. The next level would be for program teams to develop documentation audit relevant to their team goals and objectives, as indicated.

The hybrid nature of the patient file presents challenges linked to efficient patient information access, confidentiality preservation, storage, and Personal Health Information (PHI) risk management. There is an opportunity to continue the progress towards one electronic record to address these challenges.

True to the spirit of the Recovery philosophy, the patient is a regular collaborator in personal care plan development. The team may consider moving to the next level by confirming or co-authoring progress note content, and where appropriate, sharing a written copy of the care plan and goals in a language suitable to the reader.

Priority Process: Impact on Outcomes

Par1
Based on document provided and staff interviewed, this program appears to be proactive in its development, review or improvement of evidence base care guidelines and risk improvement strategies. For a number of standards, there was insufficient evidence provided that would have indicated clear, direct, and active participation of the patients and the families in their development.

An on-site review of the quality project implementation will allow for a better appreciation of the improvement on indicators selected, and the resulting impact on care.

Part 2
The teams' quality boards feature a summary of the strategic plans together with metrics monitored such as those related to infections and falls. Incidents are reviewed with the view to address system's issues and the organization has for goal to continue to develop a culture of transparency and disclosure.

Improvement initiatives to reduce suicide risks with the implementation of the SAFE-T approach and manage risk of violence with use of Non-Violent Crisis intervention (NVCI) and e-Restraints tracking have been effectively implemented. The Forensic team in particular reported on data to support evidence that there has been overtime a reduction in the number of occurrences and duration in the use of restraints.

The teams are encouraged to formalize and be creative in the ways that they engage clients and families for input throughout the cycle of development and implementation of improvement ideas.

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.

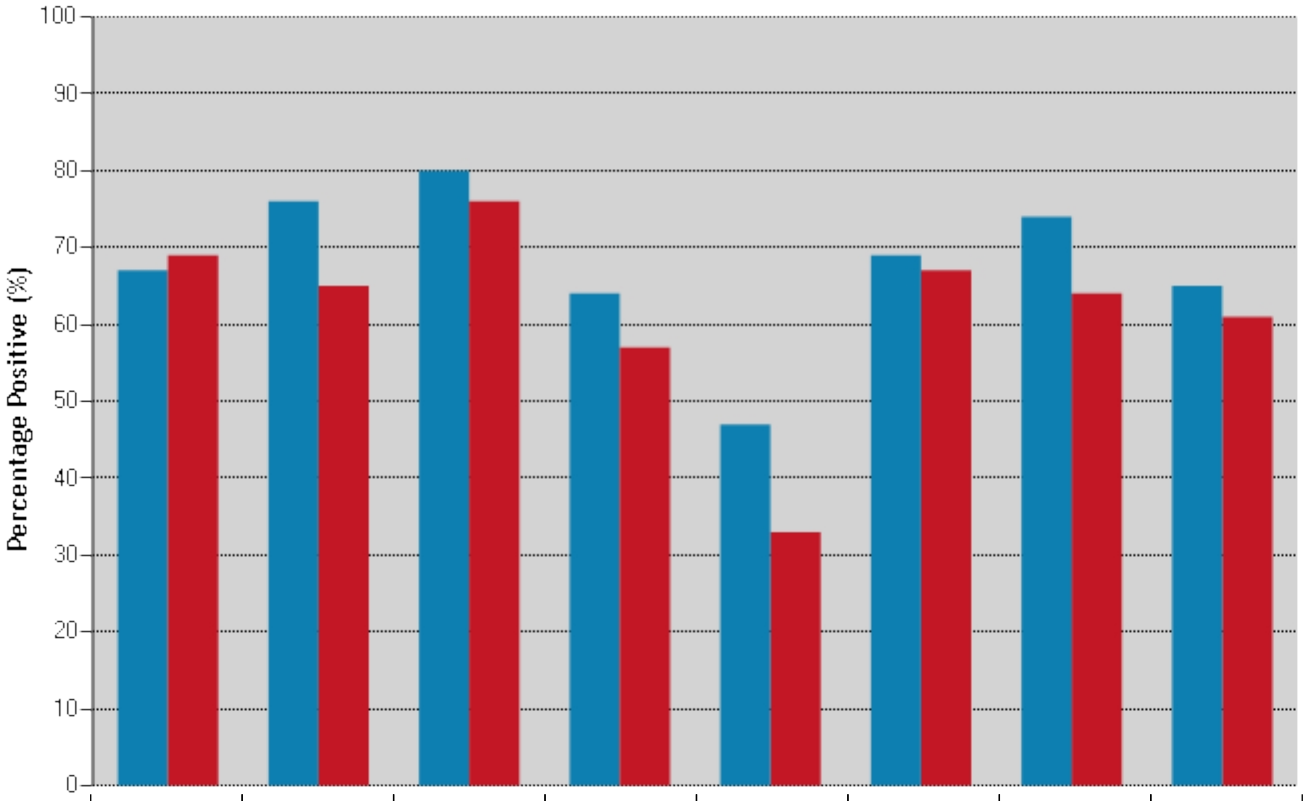
Canadian Patient Safety Culture Survey Tool

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: May 15, 2019 to August 30, 2019**
- **Minimum responses rate (based on the number of eligible employees): 205**
- **Number of responses: 216**

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
	67%	76%	80%	64%	47%	69%	74%	65%
	69%	65%	76%	57%	33%	67%	64%	61%

Legend

Selkirk Mental Health Centre

* Canadian Average

*Canadian average: Percentage of Accreditation Canada client organizations that completed the instrument from July to December, 2021 and agreed with the instrument items.

Worklife Pulse

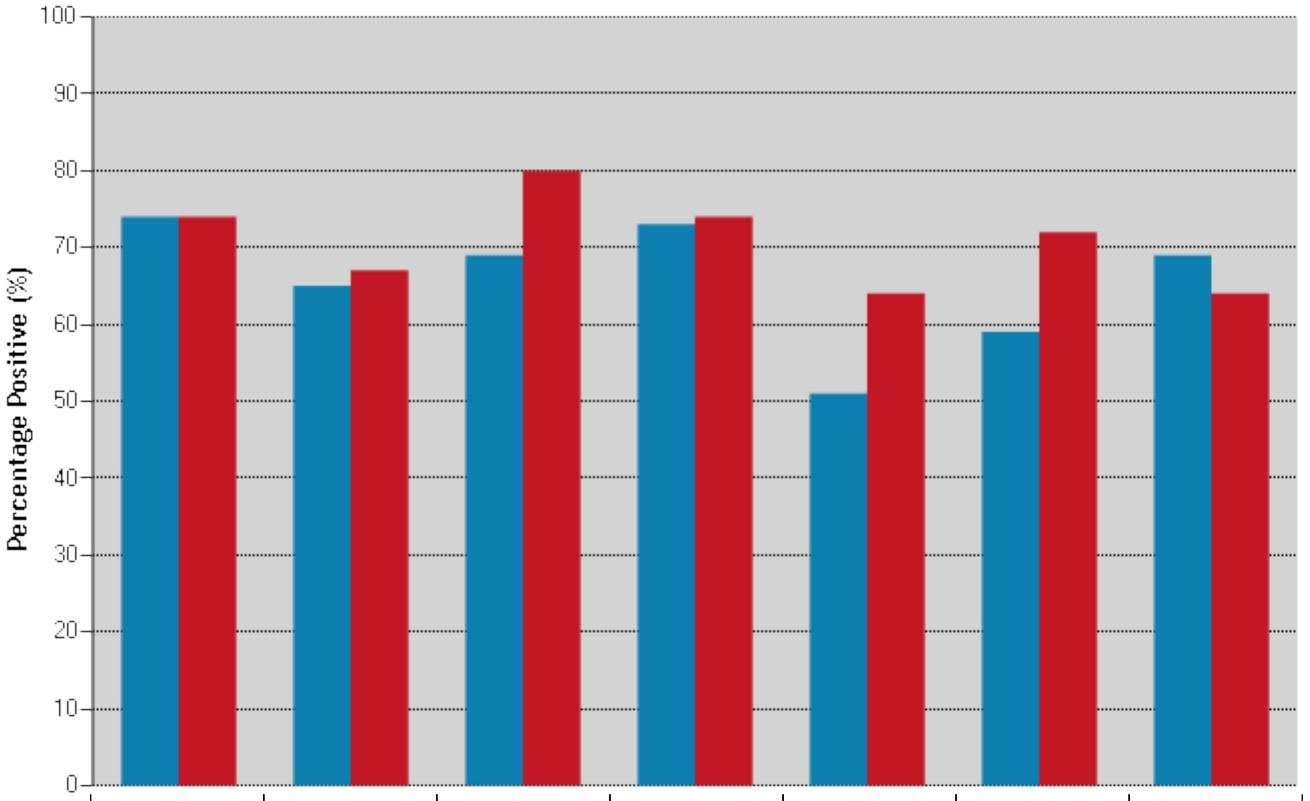
Accreditation Canada helps organizations create high quality workplaces that support workforce wellbeing and performance. This is why Accreditation Canada provides organizations with the Worklife Pulse Tool, an evidence-informed questionnaire that takes a snapshot of the quality of worklife.

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: December 10, 2018 to February 1, 2019**
- **Minimum responses rate (based on the number of eligible employees): 236**
- **Number of responses: 302**

Worklife Pulse: Results of Work Environment



	Job	Training and Development	Coworkers	Immediate Supervisor	Senior Management	Safety and Health	Overall Experience
	74%	65%	69%	73%	51%	59%	69%
	74%	67%	80%	74%	64%	72%	64%

Legend

Selkirk Mental Health Centre

* Canadian Average

*Canadian average: Percentage of Accreditation Canada client organizations that completed the instrument from July to December, 2021 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 15 business days.

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

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

Action Planning

Following the on-site survey, the organization uses the information in its Accreditation Report and Quality Performance Roadmap to develop action plans to address areas identified as needing improvement.

Appendix B - Priority Processes

Priority processes associated with system-wide standards

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

Priority processes associated with population-specific standards

Priority Process	Description
Chronic Disease Management	Integrating and coordinating services across the continuum of care for populations with chronic conditions
Population Health and Wellness	Promoting and protecting the health of the populations and communities served through leadership, partnership, and innovation.

Priority processes associated with service excellence standards

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

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