ACCREDITATION AGRÉMENT CANADA

Accreditation Report

Qmentum Global™ for Canadian Accreditation Program

Saskatchewan Health Authority

Report Issued: January 9, 2026

Confidentiality

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About Accreditation Canada

Accreditation Canada is a global, not-for-profit organization with a vision for safer care and a healthier world. Our people-centred programs and services have been setting the bar for quality across the health ecosystem for more than 60 years. We continue to grow in our reach and impact. Accreditation Canada empowers and enables organizations to meet national and global standards with innovative programs that are customized to local needs. Accreditation Canada's assessment programs and services support the delivery of safe, high-quality care in health systems, hospitals, laboratories and diagnostic centres, long-term care, rehabilitation centres, primary care, home, and community settings. Our specialized accreditation and certification programs support safe, high-quality care for specific populations, health conditions, and health professions.

About the Accreditation Report

The Organization identified in this Accreditation Report (the "**Organization**") has participated in Accreditation Canada's Qmentum Global™ for Canadian Accreditation program.

As part of this program, the Organization has partaken in continuous quality improvement activities and assessments, including an on-site survey from November 2, 2025, to November 7, 2025. This Accreditation Report reflects the Organization's information and data, and Accreditation Canada's assessments, as of those dates.

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

Program Overview

The Qmentum Global Program enables your organization to continuously improve quality of care through the sustainable delivery of high-quality care experiences and health outcomes. The program provides your organization with standards, survey instruments, assessment methods and an action planning feature that were designed to promote continuous learning and improvement, and a client support model for on-going support and advice from dedicated advisors.

Your organization participates in a four-year accreditation cycle that spreads accreditation activities over four years supporting your organization to maintain its focus on planning, implementing, and assessing quality and improvements. It encourages your organization to adopt accreditation activities in everyday practices.

Each year of the accreditation cycle includes activities that your organization will complete. Accreditation Canada provides ongoing support to your organization throughout the accreditation cycle. When your organization completes year 4 of the accreditation cycle, Accreditation Canada's Accreditation Decision Committee determines your organization's accreditation status based on the program's accreditation decision guidelines. The assessment results and accreditation decision are documented in a final report stating the accreditation status of your organization. After an accreditation decision is made, your organization enters year 1 of a new cycle, building on the actions and learnings of past accreditation cycles, in keeping with quality improvement principles.

The assessment manual (Accreditation Canada Manual) which supports all assessment methods (self-assessment, attestation, and on-site assessment), is organized into applicable Standards and ROPs/RSPs. To promote alignment with the assessment manual, assessment results and

surveyor findings are organized by Standard, within this report. Additional report contents include a comprehensive executive summary, the organization’s accreditation decision, locations assessed during the on-site assessment, required organizational practices results, and conclusively, People-Centered Care and Quality Improvement Overviews.

Executive Summary

About the Organization

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

The SHA implemented a new organizational structure with the creation of four Integrated Service Areas (ISAs) as well as the creation of 32 Health Care Networks within the ISAs. SHA has continued to update the organizational structure in order to continue to advance a provincial approach.

The SHA is guided by their vision “Healthy People, Healthy Saskatchewan”, their mission “We work together to improve health and wellbeing. Every day. For everyone”, and the values (C.A.R.E.S) of Compassion, Accountability, Respect, Equity, and Safety. The philosophy of care is a commitment to Patient and Family Centred Care is at the heart of everything the SHA does, serves as the foundation for these values. “This philosophy of care is in essence our culture – who we are, the shared purpose that brings us all together and how our patients and families experience care every day. Through meaningful engagement and co-creating mutually beneficial partnerships among employees, physicians, patients, families, clients and residents, together we ensure a seamless health system that supports Healthy People, Healthy Saskatchewan.”

The SHA serves 1,132,505 people. It is comprised of around 45,647 employees, 2761 physicians with SHA privileges and 25,000 volunteers. The SHA oversees 63 hospitals, 2833 acute care patient beds, 156 long-term care homes, 9000 long-term beds and 133 health centres.

The SHA completed five surveys between 2019 -2023 and commenced the first phase of the new four-year Accreditation Cycle in November 2023. Each of the surveys is a combination of provincial-level leadership assessment with standards assessed at the program-level across one Integrated Service Area at a time. System wide standards, including Infection Prevention and Control, Medication Management and Population Health will be assessed every survey. Selected criteria from the Leadership and Emergency and Disaster Management standard will also be assessed each survey. This approach ensures a continuation of provincial standardization while focusing on supporting Health Network development within each Service Area.

The first survey visit, in the SHA’s second sequential accreditation cycle included Maternal and Children’s Provincial Programs and SHA Leadership. The focus of the second survey visit in November 2024 included assessment of clinical services in the Saskatoon Integrated Service Area as well as SHA Governance, Emergency and Disaster Management, Medication Management and Infection Prevention and Control from a provincial lens.

The November 2025 survey visit will focus on assessing clinical services within the Integrated Northern Health Service Area that align with established service lines.

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

Surveyor Overview of Team Observations

Since the last survey for the Saskatchewan Health Authority, several successes have been achieved. The core values were updated following broad input with the addition of equity. In recognition of their ongoing commitment to Truth and Reconciliation, a Vice President for First Nations and Métis Health has been appointed.

The local structure of leadership has been modified and guided by span of control principles. Additionally, improvements have been made in the Physician Leadership Structure which has improved authentic physician engagement, and partnerships.

The SHA Quality and Safety Framework has been introduced and is based on six domains: patient experience, equitable, safe and effective, integrated and accessible, workforce wellbeing, and sustainable. This framework is aimed at strengthening measurement, information flow, and visibility related to quality, safety and accountability. Visibility management has been adopted.

There has also been significant advancement in the development of policies and procedures.

The organization needs to continue to strengthen their collaborative working relationships between SHA and all levels of the INH organization.

The SHA is encouraged to continue to expand the implementation of visual management at the local level.

Continued progress in developing policies and procedures is also encouraged.

There has been extensive progress made in the development of the SHA Emergency and Disaster Management Program. It is important that the SHA move to full approval and implementation of the Emergency Disaster Management Program.

There is a need to meet performance management targets by March 2026.

SHA is supported in their endeavors to optimize the utilization of operational software such as scheduling and preventative maintenance. There is a critical need for the SHA to continue in their quest to have an integrated electronic health record due to the patient care risk of hybrid charting. Connectivity between systems requires consideration such as information flow that supports the SHA's four Integrated Service Areas and their focus on patient centered care.

Key Opportunities and Areas of Excellence

During the Integrated Northern Health survey visit key areas of strengths and opportunities were identified. These are presented below using the SHA's new values of CARES which is anchored in their philosophy of care; "Our commitment to a philosophy of patient and family centred care is at the heart of everything we do and provides the foundation of our values.

Key Strengths

Compassion: Staff demonstrate a strong commitment to excellence, maintaining a comprehensive focus on patient-centered and client-engaged care. The organization adheres firmly to a well-defined Philosophy of Care, reflecting its dedication to compassion.

Accountability: Integrated Northern Health has enhanced capacity for quality improvement initiatives. The SHA has developed the SHA Quality and Safety Framework as well as the 2025/26 Integrated Quality & Safety Plan. Visual Management has begun to be utilized to monitor progress and support quality improvement.

Four Integrated Service Areas have been established and will support standardized practice across Primary Care, Mental Health, Continuing Care, and Acute Care. Robust Professional Practice Leadership further supports accountability and standards of practice.

Respect: Cultural Safety Training remains an ongoing priority. There is a sustained commitment to Truth and Reconciliation through continual learning opportunities. Local partnerships with Indigenous communities are actively fostered. Senior Leadership ensures visibility, and Site Leadership teams maintain a strong presence.

Equity: Equity forms a foundational commitment, embedded as a core value through input from staff and community members alike.

Safety: The organization effectively manages and delivers capital projects. Comprehensive risk assessments that focus on safety and security have been completed.

Key Opportunities

Compassion: There is a need to sustain and reinforce the current commitment to compassionate care throughout the organization.

Accountability: It is important to continue to strengthen relationships with sites to formalize quality improvement processes. Ensuring consistent dissemination and application of the Quality and Safety Framework and related indicators at the frontline level will need to be prioritized.

Access to quality improvement support will be enhanced guided by the Quality Improvement Deployment Plan for 2025-2026.

Increasing the visibility and clarifying the roles of Professional Practice Leaders is also suggested as an area for continued development.

Respect: The SHA is encouraged to continue to support their commitment to Truth and Reconciliation through the continuous implementation of training, policies, and initiatives that promote inclusivity and respect. Further development of local partnerships with Indigenous communities is needs to continue. The SHA needs to continue to support site leadership in fostering respectful relationships between service lines and the broader community.

Equity: Population health profiles need to be applied to inform strategic planning and operational decisions at the local level. There is a need for organizational support that will accommodate geographic diversity and recognizing that fairness may require differentiated approaches.

Addressing disparities in access by leveraging technology, including internet-based solutions, is vital.

Technological innovation needs to occur to enhance virtual education and access to specialized expertise.

Safety: Facilitating access to and sharing aggregate safety data across sites and programs needs to be a key goal. The organization needs to respond proactively to findings from safety and security risk assessments.

The SHA is encouraged to optimize the use of operational software for scheduling and preventative maintenance.

Furthermore, advancing the integration of health records is necessary and will further improve continuity of care. The organization is encouraged to continue to aggressively pursue this to also support quality and safe patient care.

People-Centred Care

“At the heart of everything they do”, the Saskatchewan Health Authority (SHA) is committed to a philosophy of Patient and Family-Centred Care (PFCC). The SHA Leadership Team has revitalized the foundation of the organization’s values to include equity alongside compassion, accountability, respect, and safety. This refresh has served as a prompt to staff, patients, residents, and the community that SHA, C.A.R.E.S.

Guiding the quality and safety improvement work across the Health Authority is the ‘The ‘Why’: Quality and Safety Framework’, which encompasses six defined dimensions and respective targets related to: Patient Experience, Equity, Safe and Effective Care, Integrated and Accessible Care, Workforce Well-being, and Sustainability. The organization, in collaboration with Patient Family Partners (PFP), has developed the Patient-Centred Measurement (PCM) Framework. The measurements within this framework aim to prioritize people’s experiences and care outcomes resulting from care delivery, research, and policy decisions. Since there is ample engagement happening across SHA and within Integrated Northern Health (INH), exploring ways to measure and capture the impact of PFP engagement on quality improvement initiatives will also inform the outcomes for patients.

There is a robust culture of engagement within the SHA. PFPs receive onboarding, orientation, and mentoring. There are tools and resources available to support staff and PFPs along the continuum of engagement. The organization is also partnering with patients, families, the community, and the public in patient-oriented research (POR) through the Saskatchewan Centre for Patient-Oriented Research Partner Advisory Council (PPAC). Patient Partner Advisors (PPA) can be recruited from the SHA corporate PFP program to become a PPA and remain active in both engagement spheres. PPAs receive onboarding specific to research, and the opportunity to receive mentorship (from a peer PPA) as a mentee. Booklets and process maps defining the mentor-mentee relationship and expectations are available for both roles. The organization may explore approaches to augment or align, where possible strategically, the PPAC across the SHA and INH as it continues its journey to becoming a learning health system.

SHA has much to celebrate about its partnerships with PFPs, including the Better Together Experience Survey 2.0, the integration of PFLC into the work of the Patient and Family-Centred Care Team, the three co-created versions of Our Commitment To Each Other, and an improved Engagement Request process for Leaders and Teams, among many others. Over 500 Patient Family Partners (PFPs) contributed nearly 6,000 hours to quality and safety initiatives, supported by councils such as the Patient Family Leadership Council and Youth Partnership Council that includes members from across Saskatchewan.

Regarding policy development, the SHA Policy Framework describes PFPs as having healthcare experience(s) as a patient/resident/client or a family member/support person. It is important that the core principles of patient and family-centered care are reflected in all policy and procedure work. To support this, the Policy Specialist requests a PFP from the Patient and Client Experience team to join the working group.

PFPs expressed that their involvement has been worthwhile, and they are eager to create an impact. There is desire to leverage experienced PFP as a peer support/ warm touch point, or to support patient feedback as early as the Emergency Department at the bedside. Leaders are encouraged to identify ways to close the loop with PFPs by sharing the outcomes of engagement.

People-Centred Care Strengths by Service Line

Acute Care: Several sites (including Northwest Health Centre, Battlefords Union Hospital, La Ronge) have an Indigenous Navigator to support patient care and engage with the community to gather input and help shape care delivery. The navigator supports patient-centred care by encouraging, promoting, and speaking with and/or on behalf of the patient. This role fosters communication between health professionals and communities to support/promote the best patient care. The Navigator is the link between the patient's home community, health care professionals, and staff. There are examples of integration of cultural practices (e.g., smudging areas, medicine gardens) that demonstrate progress toward Truth and Reconciliation.

The Victoria Hospital redevelopment project is underway and PFPs have been involved in the co-design of the new building, alongside engineers, architects, and the SHA redevelopment team. PFPs have trialled Paper Models of the hospital rooms to identify the orientation of the space, equipment, and bed positioning for different service lines/programs, with opportunities to explore interior colours and shower flooring. First Nations, Métis members, Elders, and First Nations Métis Health (FNMH) have also collaborated to identify and orient cultural spaces, including the FNMH office location, art, and other attributes. Conversations are ongoing about the medicine garden for traditional healing practices. The SHA is encouraged to authentically engage with PFPs to inform functional planning and to meet accessibility requirements.

Continuing Care: Depending on the population of residents, the homes are working hard to ensure activities are more meaningful to residents and providing choices around meal times and preferences. There are Resident Family Councils, where residents and their families can participate in a “town hall”-style meeting.

Mental Health & Addictions: Innovative programs and partnerships were observed such as Melfort’s award-winning food share program that received the 2024 SHA Innovation Award. This program was developed in partnership with patients, families and the community. Teams are working hard to overcome the stigma of mental health within the community by building trust and reducing barriers for community members to access Mental Health services.

Primary Health Care: Several sites (Rose Garden Hospice, Paradise Hill Health Centre) received commendation from patients and families for the compassionate care received and gratitude for the services available to them.

People-Centred Care Opportunities by Service Line

Acute Care: At many sites there is no formal patient and family engagement program, nor is there a designated patient partner. Opportunities exist to deepen engagement and embed processes to fully optimize PFP involvement in policy development, service improvement, and quality improvement.

There are opportunities for teams to leverage the existing structures and processes available through Translation Services and continue building cultural competency skills.

Continuing Care: LTC teams are encouraged to move their councils, where they exist, from their current format toward more focused engagement activities. Considering there is variability in their PCC journey, the organization needs to continue educating, coaching, and mentoring leaders, staff, and physicians. Opportunities exist to deepen engagement with Residents and Families through consultation on policies and other significant initiatives.

Mental Health & Addictions: The SHA is encouraged to review gaps that remain in child/adolescent psychiatry and stigma reduction.

Primary Care: There are opportunities to meaningfully engage patients and families in co-design of spaces and services. The SHA is encouraged to review gaps that remain in stigma reduction and cultural safety.

In summary, the SHA demonstrates a strong culture of Patient and Family-Centred Care, meaningful engagement with Indigenous communities, and innovative partnerships. Continued focus on standardizing engagement processes, and addressing mental health service gaps will strengthen patient outcomes and organizational performance.

Accreditation Decision

Saskatchewan Health Authority's accreditation decision continues to be:

Accredited

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

Locations Assessed during On-Site Assessment

The following locations were assessed during the organization's on-site assessment:

- Arborfield Special Care Lodge
- Battleford District Care Centre
- Battleford Mental Health Centre
- Battlefords Union Hospital
- Battlefords Union Hospital - Inpatient Medicine
- Big River Health Centre
- Cut Knife Health Complex
- Diabetes Education Centre and FitLife
- Don Ross Centre
- Evergreen Health Centre
- Hafford Special Care Centre & Primary Care Site
- Hudson Bay Health Care Facility
- L. Gervais Memorial Health Centre
- La Ronge Health Centre
- Lloydminster Hospital
- Macklin Primary Health Clinic
- Melfort Hospital
- Melfort Hospital - Surgical Operative Care
- Melfort Hospital – Medicine/Surgical
- Melfort Public Health Services
- Mental Health and Addictions Provincial Strategy

- Nipawin Hospital
- Nipawin Hospital – Medicine
- Northwest Health Facility
- Northwest Health Facility – Medicine/Surgical
- Paradise Hill Health Centre
- Parkland Integrated Health Centre
- Porcupine Carragana Hospital
- Prairie North Plaza
- Prince Albert Community Wellness Bus
- Prince Albert Home Care
- Red Deer Nursing Home - Porcupine Plain
- Riverside Health Complex
- Rose Garden Hospice
- Rosthern Hospital
- Rosthern/Wakaw Home Care
- Saskatchewan Health Authority
- Saskatchewan Hospital - Forensics
- Saskatchewan Hospital - Integrated Correctional Service
- Saskatchewan Hospital North Battleford
- Spiritwood and District Health Complex
- St. Joseph's Health Centre - Macklin
- St. Walburg Health Complex
- Tisdale Hospital
- Unity and District Health Centre
- Victoria Hospital
- Victoria Hospital – Medicine Level 5
- Victoria Hospital – Mental Health Inpatient
- Victoria Hospital – Surgical Operative Care
- Wakaw Primary Care Centre and CEC
- Wheatland Lodge
- Wilkie & District Health Centre

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

Required Organizational Practices

Required Organizational Practices (ROP) are essential practices that an organization must have in place to enhance client safety and minimize risk. ROPs contain multiple criteria, which are called Tests for Compliance (TFC).

Table 1: Summary of the Organization's ROPs

ROP Name	Standard(s)	# TFC Rating Met	% TFC Met
Adhering to a Do-Not-Use List of Abbreviations, Symbols, and Dose Designations	Medication Management	3 / 5	60.0%
	Medication Management for Community-Based Organizations	2 / 5	40.0%
Antimicrobial Stewardship	Medication Management	0 / 5	0.0%
Cleaning and Low-Level Disinfecting Medical Equipment	Infection Prevention and Control	2 / 5	40.0%
	Infection Prevention and Control for Community-Based Organizations	3 / 5	60.0%

ROP Name	Standard(s)	# TFC Rating Met	% TFC Met
Client Identification	Ambulatory Care Services	1 / 1	100.0%
	Cancer Care	1 / 1	100.0%
	Critical Care Services	1 / 1	100.0%
	Emergency Department	0 / 1	0.0%
	Home Care Services	1 / 1	100.0%
	Inpatient Services	1 / 1	100.0%
	Long-Term Care Services	1 / 1	100.0%
	Mental Health and Addictions Services	1 / 1	100.0%
	Obstetrics Services	1 / 1	100.0%
	Palliative Care Services	1 / 1	100.0%
	Perioperative Services and Invasive Procedures	1 / 1	100.0%
	Primary Health Care Services	1 / 1	100.0%
Home Safety Risk Assessment	Home Care Services	5 / 5	100.0%
Improving Hand Hygiene Practices	Infection Prevention and Control	2 / 5	40.0%
	Infection Prevention and Control for Community-Based Organizations	2 / 5	40.0%

ROP Name	Standard(s)	# TFC Rating Met	% TFC Met
Infection Rates	Infection Prevention and Control	3 / 3	100.0%
	Infection Prevention and Control for Community-Based Organizations	3 / 3	100.0%
Information Transfer at Care Transitions	Ambulatory Care Services	5 / 5	100.0%
	Cancer Care	5 / 5	100.0%
	Critical Care Services	5 / 5	100.0%
	Emergency Department	1 / 5	20.0%
	Home Care Services	1 / 5	20.0%
	Inpatient Services	2 / 5	40.0%
	Long-Term Care Services	4 / 5	80.0%
	Mental Health and Addictions Services	4 / 5	80.0%
	Obstetrics Services	5 / 5	100.0%
	Palliative Care Services	5 / 5	100.0%
	Perioperative Services and Invasive Procedures	5 / 5	100.0%
	Primary Health Care Services	4 / 5	80.0%

ROP Name	Standard(s)	# TFC Rating Met	% TFC Met
Infusion Pump Safety	Service Excellence for Ambulatory Care Services	6 / 6	100.0%
	Service Excellence for Cancer Care	6 / 6	100.0%
	Service Excellence for Critical Care Services	6 / 6	100.0%
	Service Excellence for Emergency Department	6 / 6	100.0%
	Service Excellence for Home Care Services	5 / 6	83.3%
	Service Excellence for Inpatient Services	6 / 6	100.0%
	Service Excellence for Long-Term Care Services	6 / 6	100.0%
	Service Excellence for Mental Health and Addictions Services	6 / 6	100.0%
	Service Excellence for Obstetrics Services	6 / 6	100.0%
	Service Excellence for Palliative Care Services	5 / 5	100.0%
	Service Excellence for Perioperative Services and Invasive Procedures	6 / 6	100.0%
	Service Excellence for Primary Health Care Services	N / A	N /A
Limiting High-Concentration and High-Total-Dose Opioid Formulations	Medication Management	3 / 5	60.0%
	Medication Management for Community-Based Organizations	N / A	N / A

ROP Name	Standard(s)	# TFC Rating Met	% TFC Met
Maintaining an Accurate List of Medications during Care Transitions	Ambulatory Care Services	5 / 5	100.0%
	Cancer Care	5 / 5	100.0%
	Critical Care Services	5 / 5	100.0%
	Emergency Department	5 / 5	100.0%
	Home Care Services	2 / 5	40.0%
	Inpatient Services	4 / 5	80.0%
	Long-Term Care Services	0 / 5	0.0%
	Mental Health and Addictions Services	4 / 5	80.0%
	Obstetrics Services	5 / 5	100.0%
	Palliative Care Services	5 / 5	100.0%
	Perioperative Services and Invasive Procedures	5 / 5	100.0%
	Primary Health Care Services	4 / 5	80.0%
Managing High-Alert Medications	Medication Management	2 / 5	40.0%
	Medication Management for Community-Based Organizations	2 / 5	40.0%

ROP Name	Standard(s)	# TFC Rating Met	% TFC Met
Optimizing Skin Integrity	Cancer Care	5 / 6	83.3%
	Critical Care Services	6 / 6	100.0%
	Emergency Department	0 / 6	0.0%
	Home Care Services	5 / 6	83.3%
	Inpatient Services	3 / 6	50.0%
	Long-Term Care Services	2 / 6	33.3%
	Mental Health and Addictions Services	3 / 6	50.0%
	Obstetrics Services	3 / 6	50.0%
	Palliative Care Services	6 / 6	100.0%
	Perioperative Services and Invasive Procedures	6 / 6	100.0%
	Primary Health Care Services	1 / 6	16.7%

ROP Name	Standard(s)	# TFC Rating Met	% TFC Met
Preventing Falls and Reducing Injuries from Falls	Cancer Care	5 / 7	71.4%
	Critical Care Services	7 / 7	100.0%
	Emergency Department	0 / 7	0.0%
	Home Care Services	7 / 7	100.0%
	Inpatient Services	6 / 7	85.7%
	Long-Term Care Services	7 / 7	100.0%
	Mental Health and Addictions Services	6 / 7	85.7%
	Obstetrics Services	7 / 7	100.0%
	Palliative Care Services	7 / 7	100.0%
	Perioperative Services and Invasive Procedures	7 / 7	100.0%
	Primary Health Care Services	2 / 7	28.6%

ROP Name	Standard(s)	# TFC Rating Met	% TFC Met
Preventing Venous Thromboembolism	Cancer Care	4 / 5	80.0%
	Critical Care Services	5 / 6	83.3%
	Emergency Department	2 / 6	33.3%
	Inpatient Services	5 / 6	83.3%
	Mental Health and Addictions Services	1 / 6	16.7%
	Obstetrics Services	6 / 6	100.0%
	Perioperative Services and Invasive Procedures	6 / 6	100.0%
Preventive Maintenance Program	Leadership	3 / 4	75.0%
Reprocessing	Infection Prevention and Control	2 / 2	100.0%
Safe Surgery Checklist	Obstetrics Services	5 / 5	100.0%
	Perioperative Services and Invasive Procedures	4 / 5	80.0%

ROP Name	Standard(s)	# TFC Rating Met	% TFC Met
Suicide Prevention Program	Service Excellence for Ambulatory Care Services	5 / 5	100.0%
	Service Excellence for Cancer Care	0 / 5	0.0%
	Service Excellence for Critical Care Services	3 / 5	60.0%
	Service Excellence for Emergency Department	2 / 5	40.0%
	Service Excellence for Home Care Services	3 / 5	60.0%
	Service Excellence for Inpatient Services	1 / 5	20.0%
	Service Excellence for Long-Term Care Services	5 / 5	100.0%
	Service Excellence for Mental Health and Addictions Services	5 / 5	100.0%
	Service Excellence for Obstetrics Services	1 / 5	20.0%
	Service Excellence for Palliative Care Services	5 / 5	100.0%
	Service Excellence for Perioperative Services and Invasive Procedures	0 / 5	0.0%
	Service Excellence for Primary Health Care Services	3 / 5	60.0%

Assessment Results by Standard

The following section includes the outcomes from the attestation (if applicable) and on-site assessments, at the conclusion of the on-site assessment.

Core Standards

Qmentum Global™ for Canadian Accreditation has a set of core assessment standards that are foundational to the program and are required for the organization undergoing accreditation. The core assessment standards are critical given the foundational areas of high quality and safe care they cover.

The core standards are always part of the assessment, except in specific circumstances where they are not applicable.

Emergency and Disaster Management

Standard Rating: 21.4% Met Criteria

78.6% of criteria were unmet. For further details please review the table at end of this section.

Assessment Results

Emergency and Disaster Management (EDM) was assessed at 16 sites across Integrated Northern Health. Selected criteria were assessed at a sampling of locations.

In 2025, the Saskatchewan Health Authority (SHA) faced multiple provincial emergencies, including site evacuations during the wildfire crisis. Managing the scale of this emergency and ensuring continuity of critical services during recovery consumed significant organizational resources and time. SHA is commended for successfully navigating these challenges while continuing to advance initiatives and manage other organizational changes.

There is a clear need to strengthen the SHA's EDM strategies, and the organization is encouraged to prioritize the development of updated policies and procedures. Many sites have emergency code binders dated between 2013 and 2018. While some sites rely on provincially developed guidelines, others have proactively created site-specific plans, particularly those impacted by recent emergencies.

Recent emergency events include Lloydminster Hospital managing a Code Orange involving multiple patients admitted for carbon monoxide poisoning, Tisdale Hospital experiencing three Code Oranges including a multi-vehicle collision, and La Ronge Health Centre, Victoria Hospital, and Battlefords Union Hospital being significantly affected by the recent wildfire.

The SHA is encouraged to develop a comprehensive provincial EDM strategy that cascades to regional, site-based, and unit-level responses for all emergency codes. Plans must include frontline teams, clients, families, and leverage multi-level partnerships. For example, Tisdale Hospital's Environmental Services team created a Code cheat sheet to clarify staff responsibilities, demonstrating strong ownership and engagement.

A full EDM risk assessment across all SHA operations and sites is recommended to identify current risks and opportunities. While staff are aware of policies and training, they report limited time to complete education and review policies. Leadership at each site is responsible for developing unit-specific responses but faces similar time constraints.

Emergency response is at risk due to outdated resource lists. Some fan-out lists have not been updated since 2018. SHA should mandate regular updates and consider adopting electronic mass-notification tools used in other industries, enabling rapid communication and tracking staff availability.

During emergencies, inconsistent documentation practices—particularly in paper-based charting—pose risks to safe client care. Additionally, business continuity planning is underdeveloped at many sites. The SHA is encouraged to ensure that every site has a plan for maintaining critical services during disruptions.

Emergency response planning is recommended to be co-designed with local partners. The SHA sites are encouraged to integrate with community-level response plans and share risk assessment results with internal and external stakeholders. Hudson Bay Health Care Facility has worked with local community partners - collaborating with RCMP, Fire, EMS, and municipal partners - maintaining an up-to-date fan-out list organized by response capability and updated monthly.

Policies and risk assessments should translate into action through regular drills. Currently, drill frequency and types vary significantly across sites. Some sites do not conduct regular exercises to validate the effectiveness of its emergency and disaster plan. The SHA is encouraged to use creative approaches such as tabletop exercises and cue-card audits to reinforce staff knowledge without requiring extensive dedicated time. Some sites assign security or maintenance staff to conduct random knowledge checks, while others hold regional tabletop exercises for scenarios like Code Orange.

Debriefing after drills or real emergencies is critical. While some sites conduct debriefs following drills (e.g., Code Red). It is suggested that the SHA integrate crisis incident stress debriefing into its emergency response plans. Victoria Hospital provides a strong example, having updated 12 disaster plans, conducted tabletop exercises on wildfire management, and held a post-incident debrief to identify improvements. The team is also advocating for a weapons screening system due to rising local violence highlighting the importance of preparing for diverse emergency codes.

The SHA is encouraged to review organizational resourcing to support these improvement opportunities.

Table 2: Unmet Criteria for Emergency and Disaster Management

Criteria Number	Criteria Text	Criteria Type
1.1.1	The organization establishes and maintains a holistic culture of emergency and disaster preparedness that integrates emergency and disaster planning throughout its operations.	HIGH
1.3.8	The organization provides patients and clients with information that enables them to be prepared to take care of their health needs in emergencies and disasters.	NORMAL
2.1.3	The organization shares the results of its emergency and disaster risk assessment with internal and external stakeholders, to keep them informed.	HIGH

Criteria Number	Criteria Text	Criteria Type
3.1.2	The organization integrates its emergency and disaster plan with community emergency and disaster plans, to ensure a coordinated response to and recovery from an event.	NORMAL
3.1.3	The organization maintains an up-to-date version of its emergency and disaster plan in locations that are known and accessible to all staff, to ensure the plan can be easily accessed during an event.	HIGH
3.1.23	The organization ensures that each site, department, or unit establishes and maintains its own emergency and disaster plan that is aligned and coordinated with the organizational emergency and disaster plan.	HIGH
3.4.8	The organization establishes, regularly reviews, and updates as needed policies and procedures to communicate patient and client information in a manner that is safe and facilitates care during an emergency or disaster.	HIGH
3.4.10	The organization maintains an accurate and up-to-date database of contact information for all staff, to be able to notify them in case of an emergency or disaster.	HIGH
3.7.1	The organization conducts regular exercises to validate the effectiveness of its emergency and disaster plan and processes and ensure they meet expectations and objectives.	HIGH
3.7.3	The organization regularly evaluates the effectiveness of its emergency and disaster planning based on the outcomes of completed exercises and past events, and uses the results to make improvements.	NORMAL
3.7.4	The organization shares evaluation results with internal and external stakeholders including staff, patients, clients, families, and the community, to promote transparency and learning.	NORMAL

Infection Prevention and Control

Standard Rating: 80.5% Met Criteria

19.5% of criteria were unmet. For further details please review the table at end of this section.

Assessment Results

Infection Prevention and Control (IPC) was assessed at 13 sites across Integrated Northern Health.

The Saskatchewan Health Authority (SHA) has an updated and comprehensive IPC policy and program that includes processes, educational support, and quick-reference handouts accessible to teams across the province. These resources are publicly available through the document finder on the SHA website. SHA is commended for reducing outdated policies by 88.7% and engaging approximately 60 staff and system partners in this work. It is recommended that the SHA continue removing outdated policies to reinforce adoption of the updated ones and maintain momentum on developing Antimicrobial Stewardship guidelines.

There is widespread awareness of IPC resources available on-site or remotely, and the IPC Committee includes physician oversight. However, a significant challenge is sustaining a strong network of IPC specialists with site-specific support. Currently, one IPC resource may cover up to 16 sites, some separated by four hours of travel. Responsibilities such as construction support further reduce the time available for site-specific quality improvement. This gap often shifts responsibility to frontline managers, who may be working in isolation in rural settings. The SHA should consider creative strategies to develop layers of IPC competency, such as nurturing site champions beyond the IPC resource and frontline managers.

Hand hygiene, identified as a priority under the SHA's Quality and Safety Framework and supported by updated IPC policies, shows varying levels of implementation success. The provincial hand hygiene program launched in October 2024, but not all team members and volunteers have access to dedicated hand-washing sinks. Alcohol-based solutions and antibacterial soaps are consistently available across sites, but compliance audits, tracking, and education vary significantly. Many sites struggle to implement basic audits, creating risk for outbreaks and health care-acquired infections. SHA is encouraged to establish or strengthen site-specific IPC teams that include clients, patients, and families. Recruiting patient and family representatives can be challenging, but SHA could explore patient or family-based audits where clients participate in real-time observations during care delivery.

The SHA has implemented "Clean Hands" an electronic audit system that should be expanded widely. At full maturity, this system would allow audit results to be easily accessible and monitored centrally and locally. Currently, audits are often completed on paper and then entered electronically before submission to IPC leads. The SHA should ensure audit results are communicated back to frontline staff and clients to reinforce understanding of their role in achieving organizational goals.

The SHA has also acted on prior survey feedback by approving the purchase of hand sanitizer wipe packets for all patient trays in acute care, expanding a successful trial conducted in Saskatoon hospitals. Despite these positive steps, quality improvement plans and indicators for IPC goals are not yet established. Developing these plans would support meaningful progress, particularly through engagement with staff, physicians, clients, and families. Additional recommendations include introducing rewards and recognition programs and appointing site champions to promote hand hygiene.

Cleaning and disinfecting common medical devices is primarily performed by clinical staff but labeling of cleaned devices is inconsistent across sites. Continuous learning activities on cleaning and low-level

disinfection of medical equipment are not consistently implemented. Policies and procedures for environmental cleaning are not fully up to date and are scattered under different titles, with no evidence of regular evaluation. Similarly, outdated policies remain for sharps disposal at the point of use in appropriate puncture-, spill-, and tamper-resistant containers.

Health care-acquired infection surveillance is in place at all sites and reported provincially. The surveillance system has successfully reduced 1,000 staff hours annually, improving efficiency and promoting better IPC processes. Outbreaks are managed collaboratively by IPC committees, public health, and site teams, with documented debriefs conducted post-outbreak. The SHA is encouraged to ensure that lessons learned from outbreaks are consistently shared with site teams and supported by evidence of quality improvement goals and indicators to drive continuous improvement.

Environmental Services teams play a critical role in IPC implementation but are not consistently recognized or involved. Compliance with site cleanliness standards varies, and issues such as crossover in laundry and loading areas have been observed. Strengthening IPC communication and engagement will further advance SHA's progress toward a robust IPC system. The SHA is encouraged to leverage frontline staff, clients, and families as creative partners in addressing resource and process challenges.

Table 3: Unmet Criteria for Infection Prevention and Control

Criteria Number	Criteria Text	Criteria Type
1.2.8	Environmental services and the infection prevention and control team are involved in maintaining processes for laundry services and waste management.	HIGH
2.2.2	Team members, clients and families, and volunteers are engaged when developing the multi-faceted approach for infection prevention and control .	NORMAL
2.4.6	There are policies and procedures for disposing of sharps at the point of use in appropriate puncture-, spill-, and tamper-resistant sharps containers.	HIGH
2.5.1	Improving Hand Hygiene Practices 2.5.1.3 The organizational leaders ensure that a hand hygiene quality improvement plan is developed. 2.5.1.4 The organizational leaders monitor hand hygiene improvement activities over time based on identified indicators 2.5.1.5 The organizational leaders ensure the infection prevention and control program is informed by learnings from hand hygiene improvement activities.	ROP

Criteria Number	Criteria Text	Criteria Type
2.5.4	Team members, and volunteers have access to dedicated hand-washing sinks.	NORMAL
2.5.5	Reminders are posted about the proper techniques for hand-washing and using alcohol-based hand rubs.	NORMAL
2.6.1	Cleaning and Low-Level Disinfecting Medical Equipment 2.6.1.2 Teams coordinate activities to ensure medical equipment is effectively cleaned and low-level disinfected. 2.6.1.4 Teams participate in continuous learning activities about cleaning and low-level disinfection of medical equipment. 2.6.1.5 Teams participate in activities to improve the organization’s procedure to clean and low-level disinfect medical equipment.	ROP
2.6.6	Compliance with policies and procedures for cleaning and disinfecting the physical environment is regularly evaluated, with input from clients and families, and improvements are made as needed.	NORMAL
3.3.1	There is a quality improvement plan for the infection prevention and control program.	HIGH
3.3.3	Input is gathered from team members, volunteers, and clients and families on components of the infection prevention and control program.	NORMAL
3.3.4	The information collected about the infection prevention and control program is used to identify successes and opportunities for improvement, and to make improvements in a timely way.	NORMAL
3.3.5	Results of evaluations are shared with team members, volunteers, clients, and families.	NORMAL

Infection Prevention and Control for Community-Based Organizations

Standard Rating: 63.8% Met Criteria

36.2% of criteria were unmet. For further details please review the table at end of this section.

Assessment Results

Infection Prevention and Control (IPC) was assessed at 13 community-based sites across Integrated Northern Health.

The Saskatchewan Health Authority (SHA) has an updated and comprehensive Infection Prevention and Control (IPC) policy and program that includes processes, educational support, and quick-reference handouts for teams across the province. SHA is commended for reducing outdated policies and is encouraged to continue its work on developing Antimicrobial Stewardship guidelines.

Dedicated teams working in rural communities take pride in their facilities. This was evident in the clean physical environments observed. Environmental Services staff work closely with IPC to ensure proper cleaning is performed for all tasks. Patient rooms and general areas were well maintained, contributing positively to infection prevention and control. Regular equipment cleaning schedules were followed, although smaller facilities rely heavily on nursing staff for cleaning tasks. Within primary care, the SHA is encouraged to review IPC principles with external contractors e.g., Prince Albert Community Wellness Bus.

Within continuing care, food safety compliance was demonstrated by all staff, aligning with established standards. Alcohol-based hand rub dispensers were strategically placed throughout units.

Hand hygiene auditing was the most consistent audit staff were aware of. However, auditing practices vary by facility due to the absence of a formal provincial auditing process. Monitoring of hand hygiene indicators over time occurs at the provincial level. Further promotion of hand hygiene should include placing reminders in strategic areas at sites that are visible to patients, staff, and visitors. Development of a provincial quality improvement plan with identified actions to improve hand hygiene practices is encouraged

Several facilities have wooden surfaces such as wall handrails that are peeling and rough, and countertops in washrooms require replacement. Cluttered areas make proper cleaning difficult. Teams ensure medical equipment is cleaned and low-level disinfected to minimize cross-contamination and mitigate the risk of transmission of health care associated infections. However, there were noted inconsistencies in ensuring that teams coordinate activities to ensure medical equipment is effectively cleaned and low-level disinfected. Teams also do not consistently participate in continuous learning activities about cleaning and low-level disinfection of medical equipment.

Education and training have been provided for staff caring for patients requiring chemotherapy, and biohazard disposal procedures are identified when needed, though this is not consistent across all facilities. Policies for sharps disposal at the point of use in appropriate puncture-, spill-, and tamper-resistant containers exist but are outdated. The Pharmaceutical Waste Procedure document (SHA-08-010P2), revised in October 2025, does not specifically address sharps disposal at the point of use.

SHA is encouraged to expand the IPC team to ensure resources are readily available for rural sites.

Staff should also assess personal protective equipment (PPE) supplies for expiration dates, as expired PPE was found in some facilities. Spill kits were not optimally located, making them difficult to access during emergencies. Managers have been instructed in the LEAN process; however, there is no formal quality improvement support for initiatives. At some sites, the information collected about the infection prevention and control program is not used to identify successes and opportunities for improvement, and to make improvements in a timely way.

Home care and primary care maintain close links with public health and the Communicable Disease Control (CDC) team, ensuring immediate communication during community outbreaks. There is a symptom-based screening tool-for all healthcare settings however it is not used consistently to screen clients in all locations.

Overall, rural facilities strive to follow IPC procedures but lack education and awareness of quality assurance processes. Staff reported being unaware of required audits. SHA has made significant progress since the last survey and is encouraged to continue updating policies and collaborating with rural facilities to ensure their voices are heard.

Table 4: Unmet Criteria for Infection Prevention and Control for Community-Based Organizations

Criteria Number	Criteria Text	Criteria Type
1.2.3	Optimal environmental conditions are maintained within the physical environment.	NORMAL
2.1.6	Compliance with infection prevention and control policies and procedures is monitored and improvements are made to the policies and procedures based on the results.	NORMAL
2.2.2	Team members, clients/residents and families, and volunteers are engaged when developing strategies for promoting infection prevention and control activities.	NORMAL
2.2.3	There are comprehensive infection prevention and control education activities tailored to priorities, services, and client/resident populations.	NORMAL
2.3.3	Clients/residents are screened to determine if additional precautions are required based on the risk of infection.	HIGH

Criteria Number	Criteria Text	Criteria Type
2.4.6	There are policies and procedures for the disposal of sharps at the point of use in appropriate puncture-, spill-, and tamper-resistant sharps containers.	HIGH
2.5.1	Improving Hand Hygiene Practices 2.5.1.2 The organizational leaders invest in resources to improve hand hygiene practices. 2.5.1.3 The organizational leaders ensure that a hand hygiene quality improvement plan is developed. 2.5.1.5 The organizational leaders ensure the infection prevention and control program is informed by learnings from hand hygiene improvement activities.	ROP
2.6.1	Cleaning and Low-Level Disinfecting Medical Equipment 2.6.1.4 Teams participate in continuous learning activities about cleaning and low-level disinfection of medical equipment. 2.6.1.5 Teams participate in activities to improve the organization's procedure to clean and low-level disinfect medical equipment.	ROP
2.6.6	Compliance with policies and procedures for cleaning and disinfecting the physical environment is regularly evaluated, with input from clients/residents and families, and improvements are made as needed.	NORMAL
3.3.1	Infection prevention and control activities are regularly evaluated.	NORMAL
3.3.2	Performance measures are monitored for infection prevention and control.	NORMAL
3.3.3	Input is gathered from team members, volunteers, and clients/residents and families on the effectiveness of infection prevention and control activities.	NORMAL

Criteria Number	Criteria Text	Criteria Type
3.3.4	The information collected about infection prevention and control activities is used to identify successes and opportunities for improvement, and to make improvements in a timely way.	NORMAL
3.3.5	Results of evaluations are shared with team members, volunteers, clients/residents, and families.	NORMAL

Leadership

Standard Rating: 83.3% Met Criteria

16.7% of criteria were unmet. For further details please review the table at end of this section.

Assessment Results

Integrated Quality Management

The provincial Mental Health and Addictions portfolio is one of four newly established provincial portfolios. Since its establishment in the summer of 2025, the Provincial Mental Health and Addictions Executive Director portfolio has demonstrated substantial progress in advancing mental health and addictions services across the province. Anchored in the Provincial Mental Health and Addictions Roadmap and informed by multiple system reviews, the portfolio is strategically focused on capacity building and service expansion.

Key initiatives include the creation of approximately 400 new treatment spaces dedicated to addictions services and the launch of virtual addictions treatment programs to improve accessibility and responsiveness to community needs. These developments demonstrate a strong commitment to expanding the continuum of care and addressing service gaps in both urban and rural settings.

In addition, the portfolio is enhancing system-level integration and care quality through the implementation of standardized clinical care pathways and the advancement of the Saskatchewan Health Authority (SHA) Suicide Prevention Program. These efforts are designed to improve the consistency, safety, and effectiveness of care delivery across the province.

To ensure accountability and continuous improvement, the portfolio has implemented structured quality monitoring and quality improvement frameworks. These mechanisms support data-driven decision-making and foster a culture of excellence in service delivery.

Physical Environment

Twelve acute care sites, four continuing care sites, and one mental health and addictions site were assessed for physical environment.

The condition of many facilities and their ability to comply with safety standards are closely linked to the age of the infrastructure. The Ministry of SaskBuilds and Procurement is responsible for facility condition assessments, while maintenance oversight falls under the Saskatchewan Health Authority (SHA), with site-specific teams managing daily maintenance responsibilities.

Two sites were identified that would benefit from SHA support to mitigate safety risks including significant leaks that require urgent attention (Lloydminster Hospital, Post-Anesthetic Care Unit and other areas) as well as controlled access in multiple areas (Battlefords Union Hospital).

L. Gervais Memorial Health Center, an older facility, was noted to have one wing without hot water, another without heating which impact optimal environmental conditions. Arborfield Special Care Lodge is undergoing painting and minor renovations, but progress has been slow, and hoarding was easily accessible. SHA is encouraged to expand its maintenance team to accelerate renovations.

Many sites struggle with limited storage for equipment. Smaller facilities face additional challenges in obtaining timely services from trades personnel, resulting in delays for both major and minor repairs. The

SHA could consider creating a wayfinding and accessibility task force to improve navigation for patients, clients, and families.

Cleaning and disinfecting policies are largely outdated and do not provide comprehensive guidance for different service areas. It is recommended that the SHA develop policies and procedures that clearly outline overarching expectations, including protocols for specific service areas.

Despite these challenges, there is evidence of SHA's continued investment in improving physical spaces, as demonstrated by construction projects observed in some facilities.

Medical Devices and Equipment

Seventeen sites were assessed on the preventive maintenance (PM) program.

The PM program consists of two service areas: biomedical equipment and medical devices under Clinical Engineering, and physical plants under Building Services. The program currently uses the Computerized Maintenance Management System (CMMS) for work orders, scheduled PMs, and asset tracking. Equipment that falls outside the program's scope or is under warranty is supported by vendors, with compliance tracked by the team.

SHA has demonstrated a strong commitment to building a robust PM program and is commended for the progress made to date. There is widespread awareness of the program, including clarity on responsibilities for biomedical equipment maintenance and repairs. The team has done an excellent job ensuring its roles and functions are well understood across SHA.

Several opportunities for improvement remain. The PM Framework is still in draft form, and SHA is encouraged to finalize it with provisions for ongoing review and updates. It is also recommended to include a plan for regularly evaluating the quality of the PM program, incorporating feedback from staff and, where appropriate, patients and families. While the framework outlines thorough processes, simplified versions should be made available to site teams to support adherence, particularly at smaller sites where a single manager is responsible for multiple organizational directives.

Some sites are struggling with the transition to the new system, including navigating CMMS and recovering prior site-specific PM schedules. Staff turnover has resulted in the loss of historical knowledge, requiring re-establishment of foundational practices. Strengthening relationships between the PM team, infection prevention and control teams, and frontline clinical staff is recommended. Clinical staff who maintain biomedical equipment would benefit from regular training and engagement. Supporting site teams through these changes will help ensure compliance.

For product procurement, it is suggested that the PM team be included as mandatory members of committees such as Product and Equipment Review. This would allow timely input on the appropriateness of equipment purchases before investments are made, reducing the risk of acquiring equipment that is costly or difficult to maintain. This approach would also help minimize variations in equipment across sites, which can increase maintenance risks.

Table 5: Unmet Criteria for Leadership

Criteria Number	Criteria Text	Criteria Type
4.3.1	The organization ensures its physical spaces are safe and meet relevant laws and regulations.	HIGH
4.3.8	Preventive Maintenance Program 4.3.8.1 There is a preventive maintenance program for all medical devices, medical equipment, and medical technology.	ROP

Medication Management

Standard Rating: 62.0% Met Criteria

38.0% of criteria were unmet. For further details please review the table at end of this section.

Assessment Results

Medication Management was assessed at 15 acute care sites across Integrated Northern Health (INH). The Pharmacy Executive Director leads a team of Directors and Managers who oversee Pharmacy Services. There are several key structures and committees which provide oversight on the Medication Management System across the SHA.

The Drugs and Therapeutics Committee (DTC) oversee the SHA formulary system and has amalgamated multiple regional formularies into one. The pharmacy teams have completed excellent work on standardization of many key distribution activities such as procurement, back-order management, unit dose packaging, intravenous preparation and Infusion pump standardization.

The Medication Use and Safety Interdisciplinary (MUSIC) Steering Committee gives oversight of the SHA Medication Management policies and Accreditation Canada Medication Management Standards to improve safety of medication use system and audit safe medication practices. Over the past year, the MUSIC Policy Working group has made significant progress updating SHA medication policies and procedures notably, Medication-Related Abbreviations, Symbols, Dose Acronyms Procedure and High-Alert Medication Procedure.

The Integrated Northern Health (INH) MUSIC Committee is responsible for auditing medication use standards approved by DTC and MUSIC Steering Committee as well as monitoring safety risk issues and assisting local acute sites with safe practices. A standardized medication audit tool has been developed which will be received at the local level.

Overall, there is inconsistent adherence to the do-not-use list of abbreviations, symbols and dose designations in all medication related communication, in particular handwritten orders across INH locations. The INH MUSIC Committee is encouraged to create a quality improvement plan or strategies to improve safety practices related to both do-not-use abbreviations, symbols and dose designations, high-alert medications and Limiting High-Concentration and High-Total-Dose Opioid Formulations which can be implemented at the local level. Regular auditing of medication documentation is inconsistent among all the locations and the SHA is encouraged to roll out a plan for this to occur as part of the quality improvement program. The INH MUSIC committee is also encouraged to provide clinical teams with learning activities about risk mitigation strategies on use of high-concentration and high-total dose opioid formulation based on events and trends arising from safety incidents.

There is opportunity to establish a structured programs across the INH related to reducing risks associated with polypharmacy, especially with frail or vulnerable clients and formalize an intravenous to oral conversion program that has been approved by the interdisciplinary committee. SHA is encouraged to develop the policy and procedures which support self-administration of medications.

Patient safety incident reports are paper based. Although the Managers review all the incidents, and discuss with their respective teams, there is limited ability to track and trend all the actual and near misses across the SHA.

Highly skilled and committed pharmacists, pharmacy technicians and pharmacy assistants support the interdisciplinary teams either on-site or remotely for some of the more rural locations. All locations have

access to on-call clinical pharmacist coverage after hours, 7 days per week. The SHA is encouraged to consider pharmacy personnel presence quarterly at the smaller facilities to check expiry dates, review medication stock levels, assist in destruction of narcotics and provide education to the nursing teams.

Automated Dispensing Cabinets (ADC) provide excellent safety storage of narcotics and high alert medications. They are currently available on a few units at the Victoria Hospital and several other hospitals. There is a plan to roll out ADCs to all units with the opening of the new Victoria hospital facility in 2028. SHA is encouraged to consider further deployment of the Automated Dispensing Cabinets throughout the Integrated North as resources become available.

The Provincial Antimicrobial Stewardship Program (ASP) does not extend to hospitals in INH. There are antimicrobial stewardship activities occurring on sites which are staffed with onsite pharmacists. The SHA is encouraged to consider further expansion of the Antimicrobial Stewardship Program (ASP) potentially at the larger hospitals such as Victoria Hospital, and Battleford Union Hospital who support larger catchment areas with more complex patients who may benefit from the provincial ASP.

The Community Oncology Program of Saskatchewan pharmacies are encouraged to consider installation of cameras or other similar solutions within the hazardous sterile IV room, to ensure that doses can be visually validated by second pharmacy personnel outside the clean room prior to being injected into the final IV bag. This issue should be addressed at the Victoria Hospital where the issue was observed.

The SHA is encouraged to continue upgrading the sterile compounding rooms for hazardous and non-hazardous products to meet NAPRA standards in pharmacy locations which provide sterile compounding.

It is recommended that these pharmacies all provide full Centralized Intravenous Admixture (CIVA) Service for non-hazardous products to prepare ready-to-administer IV medications in a centralized, sterile environment. This supports safety by reducing the risk of errors and contamination, minimizing the need for nursing to prepare IVs on the patient care unit.

The SHA is encouraged to ensure there is appropriate space to control medication access at all locations. There were a few hospitals with very space constrained medication storage areas including Battlefords Union Hospital, Melfort Hospital, Nipawin Hospital and Parkland Integrated Health Centre.

Table 6: Unmet Criteria for Medication Management

Criteria Number	Criteria Text	Criteria Type
1.2.3	Adhering to a Do-Not-Use List of Abbreviations, Symbols, and Dose Designations 1.2.3.2 The organizational leaders ensure clinical teams follow the organization’s procedure to adhere to the do-not-use list of abbreviations, symbols, and dose designations in all medication-related communication. 1.2.3.5 The organizational leaders ensure the organization’s medication management quality improvement plan includes activities to improve adherence to the do-not-use list of abbreviations, symbols, and dose designations.	ROP

Criteria Number	Criteria Text	Criteria Type
1.2.4	Managing High-Alert Medications 1.2.4.1 The organizational leaders provide clinical teams with a current list of high-alert medications available in the organization. 1.2.4.4 The organizational leaders provide clinical teams with continuous learning activities about the organization's risk mitigation strategy to safely manage high-alert medications. 1.2.4.5 The organizational leaders ensure the organization's medication management quality improvement plan includes activities to improve safety practices related to high-alert medications.	ROP
1.2.5	Limiting High-Concentration and High-Total-Dose Opioid Formulations 1.2.5.4 The organizational leaders provide clinical teams with continuous learning activities about the organization's risk mitigation strategy to limit the availability of and access to high-concentration and high-total-dose opioid formulations. 1.2.5.5 The organizational leaders ensure the organization's medication management quality improvement plan includes activities to improve safety practices related to the availability of and access to high-concentration and high-total-dose opioid formulations.	ROP

Criteria Number	Criteria Text	Criteria Type
1.2.6	Antimicrobial Stewardship 1.2.6.1 An antimicrobial stewardship program has been implemented. 1.2.6.2 The program specifies who is accountable for implementing the program. 1.2.6.3 The program is interdisciplinary, involving pharmacists, infectious diseases physicians, infection control specialists, physicians, microbiology staff, nursing staff, hospital administrators, and information system specialists, as available and appropriate. 1.2.6.4 The program includes interventions to optimize antimicrobial use, such as audit and feedback, a formulary of targeted antimicrobials and approved indications, education, antimicrobial order forms, guidelines and clinical pathways for antimicrobial utilization, strategies for streamlining or de-escalation of therapy, dose optimization, and parenteral to oral conversion of antimicrobials (where appropriate). 1.2.6.5 The program is evaluated on an ongoing basis and results are shared with stakeholders in the organization.	ROP
1.2.15	There is a procedure to handle medications brought into the organization by clients and families.	HIGH
1.3.1	The organization integrates pharmacists into designated interprofessional clinical teams to provide proactive care for client-engaged medication management.	NORMAL
1.3.2	Pharmacists collaborate with clients and interprofessional clinical teams to provide care using evidence-informed care activities associated with improved client and system outcomes.	HIGH
1.3.3	The organization has developed local implementation action plans that include prioritizing which high-risk client populations or units receive the evidence-informed care activities from pharmacists.	NORMAL

Criteria Number	Criteria Text	Criteria Type
1.4.2	The organization has a process to provide non-formulary medications in a timely manner.	NORMAL
3.1.1	The team gathers information about allergies and previous adverse drug reactions and it is recorded in the client medication profile, as part of the client record.	HIGH
5.1.1	Access to medication storage areas is limited to authorized team members.	HIGH
5.1.2	Medication storage areas are clean and organized.	HIGH
5.1.4	The organization maintains medication storage conditions that protect the stability of medications.	HIGH
5.1.7	Separate storage in client service areas and in the pharmacy is used for look-alike medications, sound-alike medications, different concentrations of the same medication, and high-alert medications.	HIGH
5.1.9	Multi-dose vials are used only for a single client in client service areas.	HIGH
5.2.3	Chemotherapy medications are stored in a separate negative pressure room with adequate ventilation and are segregated from other supplies where possible.	HIGH
5.2.4	Anesthetic gases and volatile liquid anesthetic agents are stored in an area with adequate ventilation, as per the manufacturer's instructions.	HIGH

Criteria Number	Criteria Text	Criteria Type
6.1.1	A structured program has been implemented to reduce the risks associated with polypharmacy, especially with frail or vulnerable clients.	HIGH
6.1.2	The team regularly evaluates intravenous therapy in clients using an established intravenous to oral conversion program that has been approved by the interdisciplinary committee.	HIGH
6.1.10	The organization uses regular, documented audits to assess the accuracy of medication order documentation and makes improvements as needed as part of a continuous quality improvement program.	HIGH
7.1.1	The pharmacist reviews each medication order prior to the first dose being administered.	HIGH
7.1.2	The pharmacist performs an independent double check for the dosing calculations of pediatric weight-based protocols.	HIGH
7.2.1	Medication preparation areas are clean and organized.	HIGH
7.2.2	Appropriate ventilation, temperature, and lighting are maintained in the medication preparation areas.	HIGH
7.2.3	There is a separate negative pressure area for preparing hazardous medications, with a 100 percent externally vented biological safety cabinet.	HIGH
7.2.4	Sterile products are prepared in a separate area that meets standards for aseptic compounding.	HIGH

Criteria Number	Criteria Text	Criteria Type
8.1.3	Unit dose oral medications are kept in manufacturer or pharmacy packaging until they are administered.	HIGH
9.1.1	The pharmacy has a quality assurance process to ensure that medications are accurately dispensed as ordered.	HIGH
10.1.2	At the time of admission, information on how to prevent patient safety incidents involving medications is provided to and discussed with clients and families.	HIGH
10.2.2	Established criteria are used to determine which medications clients can self-administer.	NORMAL
10.2.3	Established criteria are used to assess whether a client is able to self-administer medications.	NORMAL
10.2.4	Medications that are self-administered by clients are stored and labelled safely and appropriately.	NORMAL
10.2.5	Each client who self-administers medications is provided with appropriate education and supervision prior to self-administration, and this is documented in the client record.	HIGH
10.2.6	The process for self-administering medications includes documenting in the client record that the client took the medication and when it was taken.	NORMAL
10.3.7	When using any medication intended for injection, it is drawn into the syringe from the original vial and labelled immediately prior to use.	HIGH
11.1.2	All patient safety incidents and near misses are reported, reviewed, and analyzed.	HIGH

Criteria Number	Criteria Text	Criteria Type
11.2.1	Teams are informed about the value of and their role in reporting adverse drug reactions, specifically unexpected, expected, or serious reactions to recently marketed medications.	NORMAL
11.2.2	Teams are provided with information on how to identify and report adverse drug reactions.	NORMAL

Medication Management for Community-Based Organizations

Standard Rating: 75.2% Met Criteria

24.8% of criteria were unmet. For further details please review the table at end of this section.

Assessment Results

Medication Management was assessed at 14 community-based sites with the continuing care and primary health care team service lines.

Strengths identified in the 2024 Survey have been sustained including smart pump standardization and library creation. Do Not Use abbreviations and high alert medication efforts are in place and socially accepted. The spread of Antimicrobial Stewardship into rural is challenging to see. There are great opportunities to grow medication management quality improvement initiatives but will require the elevation of basic quality improvement literacy across the workforce.

The High Alert Medication Policy has been robustly implemented across sites. This includes the use of informative posters and the integration of the policy into Medication Administration Records (MAR) and inventory systems, ensuring consistency and safety in medication handling.

Awareness of Do Not Use (DNU) abbreviations is widespread, supported by visible posters that reinforce correct practices and reduce the risk of misinterpretation in documentation.

The Medication Use and Safety Interdisciplinary (MUSIC) Committee for Continuing Care is now operational, contributing to increased standardization and creating development opportunities for highly sought-after Quality Improvement (QI) projects. This initiative is expected to strengthen care delivery and foster innovation.

Relationships between sites and pharmacies are generally strong, promoting collaboration and efficient medication management. Medication and pharmacist accessibility remains strong, including after-hours support, which enhances continuity of care. Regular interdisciplinary team meetings for medication review are productive and demonstrate a strong commitment to person-centred care.

Clear instructions are consistently provided to clients and residents regarding medications they bring in, ensuring safety and compliance. Additionally, medication rooms and carts are well-lit, appropriately maintained for temperature and humidity, clean, and secure.

Where implemented, medication assistance works effectively and safely. Furthermore, basic quality improvement literacy is beginning to emerge, driven by ongoing discussions around audits and performance indicators, signaling a positive shift toward continuous improvement.

While these strengths are celebrated, there are also opportunities to improve medication management at community-based sites as described below.

Overall, there is inconsistent adherence to the do-not-use list of abbreviations, symbols and dose designations in all medication related communication, in particular handwritten orders across INH locations. The INH MUSIC Committee is encouraged to create a quality improvement plan or strategies to improve safety practices related to both do-not-use abbreviations, symbols and dose designations, and high-alert medications which can be implemented at the local level. Regular auditing of medication

documentation is inconsistent among all the locations and the SHA is encouraged to roll out a plan for this to occur as part of the quality improvement program. The INH MUSIC committee is also encouraged to provide clinical teams with learning activities about risk mitigation strategies on use of high-concentration and high-total dose opioid formulation based on events and trends arising from safety incidents.

The development and implementation of foundational quality improvement (QI) knowledge is essential to support the creation of standardized medication management initiatives. Building this knowledge base will enable teams to design and execute projects that improve safety and efficiency across all sites. Standardizing medication management auditing practices, including data collection, reporting, analysis, and distribution to stakeholders, will create a consistent framework for monitoring and improvement. The reporting of near misses should be standardized to produce indicators that can be analyzed and used to inform medication management initiatives. Leveraging available automation and technology will further improve efficiency and accuracy in these activities.

Clearly defining the role of pharmacy at the site level, strengthening collaboration, and engaging pharmacy teams in medication management QI initiatives will improve integration and outcomes. Expanding on-call pharmacy services will further support safe and timely medication practices. Some sites have access to an on-call pharmacist or prescriber to answer questions about medications or medication management; however, these services were not being used. It is encouraged that the teams review the contracts with the pharmacy and provide education to staff as needed. Fostering relationships between sites and their pharmacies will increase awareness, education, and shared knowledge of the SHA medication management practices, policies, and QI initiatives.

Developing standardized, easily understood medication information for patients, clients, and families covering topics such as patient-owned medications, allergies, and safety incidents is suggested to be prioritized.

Establishing a structure to reduce polypharmacy risks is suggested to be developed and implemented, supported by processes and clear guidelines.

Exploring opportunities for Continuing Care Assistants (CCAs) to assist with medication administration when nurses are unavailable, while ensuring safeguards and adherence to scope of practice, can enhance care delivery.

Expanding the availability and use of infusion pumps at sites where they would provide significant benefit is recommended.

Lastly, when developing provincial medication management policies and procedures, it is important to incorporate the rural perspective to ensure equitable and practical solutions.

Table 7: Unmet Criteria for Medication Management for Community-Based Organizations

Criteria Number	Criteria Text	Criteria Type
1.1.3	Team members involved in medication management activities have input into developing medication management policies and procedures.	HIGH

Criteria Number	Criteria Text	Criteria Type
1.1.5	Adhering to a Do-Not-Use List of Abbreviations, Symbols, and Dose Designations 1.1.5.2 The organizational leaders ensure clinical teams follow the organization's procedure to adhere to the do-not-use list of abbreviations, symbols, and dose designations in all medication-related communication. 1.1.5.3 The organizational leaders ensure the use of misinterpreted abbreviations, symbols, and dose designations that could have harmed or did harm a client are reported as medication safety incidents. 1.1.5.5 The organizational leaders ensure the organization's medication management quality improvement plan includes activities to improve adherence to the do-not-use list of abbreviations, symbols, and dose designations.	ROP
1.1.6	Managing High-Alert Medications 1.1.6.2 The organizational leaders ensure clinical teams follow the organization's procedure to safely manage high-alert medications. 1.1.6.4 The organizational leaders provide clinical teams with continuous learning activities about the organization's risk mitigation strategy to safely manage high-alert medications. 1.1.6.5 The organizational leaders ensure the organization's medication management quality improvement plan includes activities to improve safety practices related to high-alert medications.	ROP
1.2.4	The organization has developed and implemented a controlled substance policy.	HIGH
1.3.6	Separate storage in client service areas is used for look-alike medications, sound-alike medications, different concentrations of the same medication, and high-alert medications.	HIGH
2.2.2	Teams have access to an on-call pharmacist or prescriber to answer questions about medications or medication management.	HIGH

Criteria Number	Criteria Text	Criteria Type
3.1.2	A structured program has been implemented to reduce the risks associated with polypharmacy, especially with frail or vulnerable clients.	HIGH
3.2.4	The organization uses regular, documented audits to assess the accuracy of medication order documentation and makes improvements as needed as part of a continuous quality improvement program.	HIGH
5.1.2	The team gathers information about allergies and previous adverse drug reactions and it is recorded in the client's medication profile, as part of the client record.	HIGH
6.1.6	The team protects the safety of team members who have access to medications or who administer medications.	HIGH
6.4.3	A readily accessible hazardous spill kit is located wherever cytotoxic or other hazardous medications are dispensed and administered.	HIGH
7.1.11	Patient safety incidents that occur when team members are assisting a client with medications are reported and incorporated into the organization's patient safety incident management system.	HIGH
8.1.1	Patient safety incidents involving medications are reported in accordance with the organization's patient safety incident management system.	HIGH
8.1.2	All patient safety incidents and near misses are reported, reviewed, and analyzed.	HIGH
8.1.3	Patient safety incidents involving medications are reviewed and established criteria are used to prioritize those that will be analyzed further.	HIGH

Criteria Number	Criteria Text	Criteria Type
8.1.4	Teams are involved in the analysis of patient safety initiatives involving medications.	NORMAL
8.1.5	Information about recommended actions and improvements made following incident analysis is exchanged with clients, families and other team members.	NORMAL
8.2.1	Teams are informed about the value of and their role in reporting adverse drug reactions, specifically unexpected, expected, or serious reactions to recently marketed medications.	NORMAL
8.2.2	Teams are provided with information on how to identify and report adverse drug reactions.	NORMAL
8.3.3	Process and outcome indicators for medication management are monitored.	NORMAL
8.3.4	The information collected about the medication management system is used to identify successes and opportunities for improvement, and to ensure that improvements are made in a timely way.	NORMAL
8.3.5	Evaluation results, areas of success, and opportunities for improvement are shared with teams.	NORMAL

Service Specific Assessment Standards

The Qmentum Global™ for Canadian Accreditation program has a set of service specific assessment standards that are included in the accreditation program based on the services delivered by different organizations. Service standards are critical to the management and delivery of high-quality and safe care in specific service areas.

Ambulatory Care Services

Standard Rating: 100.0% Met Criteria

0.0% of criteria were unmet.

Assessment Results

A review of ambulatory and outpatient services was conducted at both Victoria Hospital and Northwest Health Facility.

The assessment included site visits to ambulatory care clinics such as Colposcopy, Orthopedics, Urology, Family Physicians, and Wound Care at Victoria Hospital. At Northwest Health Facility, the review focused on ambulatory visits, which are currently conducted in spaces such as the community oncology program room and the emergency department.

Northwest Health Facility demonstrates a strong commitment to adaptability in its ambulatory services. A key strength is the cross-training of staff, which enables team members to apply quality improvement practices typically associated with inpatient and emergency settings. Leadership is actively engaged in improvement initiatives and daily huddles around a robust visual management wall, fostering a culture of responsiveness. While some staff prefer legacy systems, the transition to the SHA systems is progressing steadily. Ambulatory visit orders are primarily initiated through the emergency department, specialist referrals, pharmaceutical coordinators, and an external family medicine clinic, and these visits are tracked manually using paper-based processes.

One notable quality improvement initiative at Northwest Health Facility was its proactive response to patient no-shows. After identifying transportation as the primary barrier, staff collaborated with community liaisons to arrange transport services, improving appointment compliance. Staff also demonstrate a strong understanding of the population they serve, accommodating walk-ins with flexibility and without stigma, which enhances accessibility and patient-centered care. Although a formal ambulatory care program has not yet been established, staff manage these visits proactively and with a patient focus. To ensure consistency and sustainability, it is recommended that the SHA formalize ambulatory services by defining scope and objectives, standardizing roles and responsibilities, developing appropriate assessments and documentation tools, and implementing structured processes to optimize resources and improve continuity of care.

Victoria Hospital also demonstrated a strong commitment to improving patient access and experience within its ambulatory care services. A notable initiative focused on enhancing the Pre-Admission Clinic (PAC) after patients reported needing multiple visits to access services such as nursing, physiotherapy, and physician consultations. In response, the team conducted a Value Stream Mapping exercise to analyze the patient journey, leading to a redesign of the scheduling process and streamlined access. The new model, scheduled for implementation in winter, is expected to significantly improve patient convenience and reduce unnecessary visits. In Endoscopy, the team is actively participating in a

province-led initiative to centralize waitlist management. Previously, waitlists were maintained in individual physician offices; the transition involves integrating these lists into the organization’s existing operating room management system. Recruitment and training of staff are underway to support this change, which aims to improve scheduling efficiency.

Both Victoria Hospital and Northwest Health Facility demonstrate a strong commitment to improving ambulatory care through responsive, patient-centered initiatives. Continued efforts to formalize processes, enhance coordination, and implement standardized tools will further strengthen service delivery and support long-term quality improvement.

Table 8: Unmet Criteria for Ambulatory Care Services

There are no unmet criteria for this section.

Service Excellence for Ambulatory Care Services

Standard Rating: 98.8% Met Criteria

1.2% of criteria were unmet. For further details please review the table at end of this section.

Assessment Results

The ambulatory clinics visited exemplify a shared commitment to service excellence through proactive leadership, innovative practices, and a focus on continuous improvement. These facilities demonstrate how adaptability and a commitment to quality can drive meaningful improvements in care delivery. Despite challenges such as informal ambulatory structures, staff have shown remarkable initiative in adapting services to meet patient needs. Establishing formal structures including role definitions, service offerings, and technology for scheduling would reinforce existing strengths and unlock greater potential for sustainable, high-quality care.

Victoria Hospital has demonstrated a proactive approach to improving patient access and experience. The redesign of the Pre-Admission Clinic (PAC) aligns with key goals such as coordinated same-day scheduling, reduced wait times, and improved communication during transitions. In Endoscopy, the team is participating in a province-led initiative to centralize waitlist management, transitioning from physician-maintained lists to integration within the OR management system. Recruitment and training are underway to support this change. The site has also identified performance appraisal completion as a strategic goal, with the ambulatory care team lead working toward weekly targets; current completion stands at 16%.

Northwest Health Facility reflects strong local leadership and a culture of continuous improvement. The unit benefits from an engaged leader who uses visual management boards and daily huddles to foster team involvement and drive improvements. Nursing staff are cross-trained across multiple sectors including Emergency, Obstetrics, Ambulatory visits, and Medical-Surgical units enhancing flexibility and coverage. Staff demonstrate strong clinical knowledge, and education programs align with patient safety principles and service-specific needs. However, educator availability for specialized services is limited, and the transition to SHA has increased training demands. Additional support would help ensure staff remain well-equipped during this period of change.

While many criteria for service excellence are being met through strong leadership and adaptable staff, ambulatory services remain informal and lack defined structures. Staff have shown commendable initiative in creating a quasi-clinic to meet patient needs, but without formalization, productivity, comprehensive care delivery, and resource access are limited. Developing a standalone ambulatory program with clearly defined services, dedicated resources, appropriate infrastructure, and technology would strengthen care delivery, improve coordination, and align services with broader health system standards.

Table 9: Unmet Criteria for Service Excellence for Ambulatory Care Services

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

Cancer Care

Standard Rating: 96.5% Met Criteria

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

Assessment Results

Community oncology services were assessed at three locations – Lloydminster Hospital, Nipawin Hospital, and Victoria Hospital.

The staff providing services through the Community Oncology Program of Saskatchewan (COPS) are highly competent and well trained to deliver systemic therapy at their local centers. Ongoing education and training are provided by the Saskatchewan Cancer Agency (SCA) COPS leadership, ensuring that teams are prepared for new regimens or treatments before first administration. COPS teams have access to the SCA's COPS navigator when needed, and communication between the SCA Cancer Centre and COPS sites is strong, with smooth transitions of care plans and readily available online resources.

COPS centers deliver a comprehensive range of systemic therapy services, including high-risk and high-intensity treatments such as chemotherapy and immunotherapy. They also provide non-chemotherapy services such as bloodwork, hormone injections, nursing assessments, central venous access device maintenance, and pump disconnections. Clinic orders are transmitted electronically, printed, and validated by nursing personnel. When patient concerns arise, nursing staff consult with the SCA COPS nurse navigator, who liaises with the attending oncologist as needed. Patients presenting with infections are directed to the local emergency department, where physicians have direct access to the SCA on-call oncologist.

Chemotherapy orders are sent from the Cancer Centre to the COPS pharmacy for validation by an oncology pharmacist in Saskatoon, who checks dosages and clinical parameters before entering them into the system. The pharmacy team then processes and labels the preparations. At Victoria Hospital, a NAPRA-compliant hazardous preparation sterile room is in operation, with one technician preparing and another verifying doses. However, the verifying technician does not visually confirm the actual drug volume in syringes. Given the risks associated with chemotherapy preparation, it is recommended that cameras be installed at IV hoods to enable independent dose verification.

COPS teams consistently demonstrate effectiveness in assessing and implementing interventions related to falls prevention, skin integrity optimization, and venous thromboembolism prevention. However, these centers are not currently integrated into SHA's broader quality improvement programs focused on these areas. It is recommended that SHA incorporate COPS into its overall quality improvement initiatives to ensure alignment and consistency.

At Lloydminster Hospital, "Stop the Line Shoutouts" are used during daily huddles to recognize staff contributions to safety and quality. This approach should be shared with other COPS centers. Reliable access to translation services is also recommended to reduce reliance on internal resources.

The Nipawin Hospital COPS center recently moved to a new location that offers a comfortable and inviting environment for patients. Feedback highlights the abundance of windows with prairie views and private areas that ensure confidentiality during treatment and personal conversations.

Overall, COPS staff should be proud of the care and compassion they provide to cancer patients in Integrated Northern Health. Their work exemplifies excellence in quality, safety, and patient- and family-centered care.

Table 10: Unmet Criteria for Cancer Care

Criteria Number	Criteria Text	Criteria Type
2.2.7	Systemic therapy only: Each prescription is reviewed for completeness and accuracy before preparing, dispensing, and administering systemic cancer therapy medications.	HIGH
3.3.5	Preventing Falls and Reducing Injuries from Falls 3.3.5.6 The team participates in continuous learning activities about the program to prevent falls and reduce injuries from falls. 3.3.5.7 The team participates in activities to improve the program to prevent falls and reduce injuries from falls as part of the organization's integrated quality improvement plan.	ROP
3.3.6	Optimizing Skin Integrity 3.3.6.6 The team participates in activities to improve the program to optimize skin integrity as part of the organization's integrated quality improvement plan.	ROP
3.3.7	Preventing Venous Thromboembolism 3.3.7.6 The team participates in activities to improve the program to prevent venous thromboembolism as part of the organization's integrated quality improvement plan.	ROP

Service Excellence for Cancer Care

Standard Rating: 81.2% Met Criteria

18.8% of criteria were unmet. For further details please review the table at end of this section.

Assessment Results

The Saskatchewan Cancer Agency (SCA) administers the Community Oncology Program of Saskatchewan (COPS), except at Lloydminster Hospital, where oversight is jointly provided by Cancer Care Alberta and the SCA. The primary objective of COPS is to meet patients' treatment needs within their home communities, reducing travel and enabling care in familiar, supportive environments. This approach significantly contributes to patient satisfaction. For example, in 2024–2025, chemotherapy and non-chemotherapy treatments delivered at COPS centers reduced patient travel by an estimated six million kilometers provincially.

Referrals to COPS sites originate from the SCA, provided eligibility criteria are met and approved medications are available for administration. Multidisciplinary teams including specially trained nurses, pharmacists, social workers, and physicians maintain regular communication with the referring cancer center. Laboratory results and medication records are forwarded to the oncologist after each treatment session. The program also encourages family and friends to accompany patients during care.

To capture patient feedback, the SCA conducts ambulatory oncology satisfaction surveys, and local COPS sites are encouraged to implement their own surveys. These initiatives are essential for informing site-specific quality improvement efforts. COPS teams are also encouraged to engage clients and families in discussions about roles, responsibilities, processes, and satisfaction. To promote transparency and engagement, visibility boards displaying key data such as wait times, patient volumes, and satisfaction metrics should be used to foster a culture of continuous improvement. Leadership should involve COPS team members in reviewing safety incidents and using this information to guide quality improvement.

The organization is currently implementing a new clinical standard for suicide prevention, with staff training scheduled for completion in December 2025. Achieving this milestone is strongly encouraged. Quality improvement is supported through performance indicator data from the SCA, and leaders are advised to involve teams in safety reviews, engage patients and families, and share improvement projects with peers across the province. Performance appraisals for COPS staff are not consistently completed at all sites; compliance with SHA policy in this area is recommended.

A patient interview highlighted challenges related to appointment availability at COPS centers, resulting in unnecessary travel. Exploring options to optimize capacity utilization across geographically proximate sites could help minimize travel distances. Operational complexities exist at Lloydminster Hospital due to its jurisdictional position between Alberta and Saskatchewan, requiring navigation of two distinct models, separate electronic medical record systems, and differing clinical leadership structures. Staff must exercise diligence in managing dual patient records and mitigating associated risks.

As COPS continues to expand within Integrated Northern Health, ongoing monitoring and appropriate resource allocation are essential to ensure safe patient care. Considering the planned facility expansion at Victoria Hospital, the organization may wish to review the space allocated to the COPS center to effectively manage anticipated growth.

Table 11: Unmet Criteria for Service Excellence for Cancer Care

Criteria Number	Criteria Text	Criteria Type
2.1.10	The team leadership regularly evaluates and documents each staff member's performance in an objective, interactive, and constructive way.	HIGH
2.1.11	The team leadership regularly engages with client and family representatives to gather input and feedback on their roles and responsibilities as well as role design, processes, and satisfaction.	NORMAL
2.1.12	The team leadership supports staff to follow up on issues and opportunities for growth identified through performance evaluations.	HIGH
4.2.2	Suicide Prevention Program 4.2.2.1 The team leadership ensures the team follows organizational procedures to minimize safety risks and ensure a secure environment for all. 4.2.2.2 The team leadership ensures the team receives appropriate training and education to deliver safe suicide prevention services. 4.2.2.3 The team leadership ensures the team conducts standardized routine screening for suicide risk, using evidence-informed tools provided by the organizational leaders. 4.2.2.4 The team leadership ensures the team refers clients who screen positive for suicide risk to a person with the competencies to do a suicide risk assessment and put the necessary safety plan in place. 4.2.2.5 The team leadership ensures the team develops an individualized safety plan, based on the goals, abilities and preferences of the person.	ROP
4.2.8	The team leadership follows organizational policy and engages with team members to analyze safety incidents and use the results to make improvements and prevent recurrence.	HIGH

Criteria Number	Criteria Text	Criteria Type
4.3.1	The team collects information and feedback from its members and its partners about the quality of services to guide quality improvement initiatives.	NORMAL
4.3.2	The team uses information and feedback about the quality of services to identify opportunities for quality improvement initiatives and set priorities.	NORMAL
4.3.3	The team identifies measurable objectives for its quality improvement initiatives including specific timeframes for their completion.	HIGH
4.3.4	The team identifies indicators to monitor progress for each quality improvement objective.	NORMAL
4.3.5	The team leadership works with staff to design and test quality improvement activities to meet objectives.	HIGH
4.3.9	The team leadership works with staff to implement throughout their services the quality improvement activities that were shown to be effective in the testing phase.	HIGH
4.3.10	The team leadership ensures that information about quality improvement activities, results and learnings are shared with staff, clients and families, organizational leaders, and partners, as appropriate.	NORMAL

Critical Care Services

Standard Rating: 96.7% Met Criteria

3.3% of criteria were unmet. For further details please review the table at end of this section.

Assessment Results

During the on-site survey, two Critical Care units within Integrated Northern Health were reviewed: Victoria Hospital ICU, which has nine beds and is considered a four-tier ICU site, and Battlefords Union Hospital ICU, which has three beds.

Leadership ensures that staff designations, credentials, competency assessments, and training are consistently monitored and maintained to support safe and effective service delivery. Significant investment has been made in staff training and ICU orientation. “Buddy shifts” allow registered nurses interested in ICU work to shadow ICU staff for one or two shifts to assess their interest. The organization funds an eleven-week Critical Care Nursing Program offered by Saskatchewan Polytechnic and provides mentoring shifts based on staff needs.

The units maintain an expert skill mix with nurse-to-patient ratios of 1:1 or 1:2. Patients interviewed expressed high satisfaction with the care received and appreciated the support provided to their families during their stay.

Critical Care staff at both Victoria Hospital and Battlefords Union Hospital are trained to identify patients who meet criteria for organ or tissue donation and understand their role in the process. They liaise with the Provincial Organ Donor Program when a potential donor is identified.

Admission criteria guide decisions to ensure services align with patient needs and preferences regarding life-sustaining treatment, identify urgent needs, and establish priorities for care. The team and leadership were able to clearly articulate ICU admission criteria; however, the related policy is outdated, last revised in 2016. The organization is encouraged to review and update this policy with input from all team members, including physicians, nurses, and respiratory therapists.

Victoria Hospital has a local ICU Quality Improvement Committee that meets regularly. At Battlefords Union Hospital, efforts have been made to establish a site-based Critical Care committee to include quality improvement activities; however, a physician lead has not yet been secured. The organization is encouraged to explore alternative leadership and engagement options to ensure quality improvement initiatives continue. At the provincial level, the Critical Care Executive Council sets priorities and strategic plans for Critical Care services within the Provincial Programs Tertiary Care portfolio.

Leadership recognizes a gap in patient advisor representation on these committees. Engaging patients and family representatives for input and feedback is essential to quality care. The organization is encouraged to seek patient advisor participation at both local and provincial levels.

Laboratory testing at Battlefords Union Hospital is available around the clock, and phlebotomy response times are generally good. However, both the Emergency Department and the Critical Care unit expressed concerns about delays in receiving laboratory results in a timely manner. For example, blood draws performed at 6:00 a.m. often do not have results available for the 9:00 a.m. multidisciplinary rounds. In the Critical Care unit, point-of-care testing is available, but certain capabilities, such as electrolyte testing, are not utilized because a decision was made not to perform quality assurance monitoring on this function of the device. The organization is encouraged to consider enabling the full capacity of point-of-care testing in the Critical Care unit.

The Critical Care unit at Battlefords Union Hospital is very small and crowded. The medication room, supply room, staff lounge, and kitchen share the same limited space, which does not comply with current standards. Staff lounge and kitchen areas should not be in the same space as a medication room. Additionally, the unit lacks a quiet space for families. During procedures such as intubation, families are either in the hallway or in a family room located on a distant unit. The organization is encouraged to explore options to address these patient safety and family-centered care concerns and implement solutions that mitigate these risks.

At Victoria Hospital, a standardized screening tool for assessing the risk of venous thromboembolism is in place. However, during the visit and review of patient charts, this form had not been completed. Audit data indicate that 100 percent of patients receive venous thromboembolism prophylaxis, but the screening tool was completed only 55 percent of the time. Engagement from the physician group will be necessary to meet this requirement.

Table 12: Unmet Criteria for Critical Care Services

Criteria Number	Criteria Text	Criteria Type
1.1.4	Critical care units are designed with input from clients and families to be self-contained and dedicated to the 24-hour care of clients with life threatening or potentially life threatening conditions.	NORMAL
2.1.1	There is a process to screen potential clients against admission criteria for critical care.	NORMAL
2.3.8	Preventing Venous Thromboembolism 2.3.8.1 The team follows the organization's procedure to conduct screening for risk of venous thromboembolism.	ROP
2.7.12	Data gathered on all intensive care unit (ICU) deaths is accessible and there is a process for reviewing the data to identify lost opportunities for donation and refer the information appropriately.	HIGH

Service Excellence for Critical Care Services

Standard Rating: 88.2% Met Criteria

11.8% of criteria were unmet. For further details please review the table at end of this section.

Assessment Results

At Victoria Hospital, a local Intensive Care Unit Quality Improvement Committee meets regularly. At Battlefords Union Hospital, there has been an effort to establish a site-based Critical Care Committee to support quality improvement activities. Although a physician lead has not yet been secured, this should not be considered a barrier. The team is encouraged to explore alternative options for leadership, participation, and engagement to ensure that quality improvement initiatives continue. Additionally, the team at Battlefords Union Hospital is encouraged to integrate feedback on the quality of services into a local program committee or quality structure that aligns with provincial initiatives. The site is also encouraged to include two patient or family partners with lived intensive care experience on the committee.

At the provincial level, the Critical Care Executive Council sets priorities and develops strategic plans for critical care services within the Provincial Programs Tertiary Care portfolio. Leadership teams have identified a gap in patient advisor representation on these committees. Engaging patients and family representatives to provide input and feedback is an essential component of delivering high-quality patient care. Leadership is encouraged to seek patient advisor representation at both local and provincial levels.

Battlefords Union Hospital and Victoria Hospital have identified completing performance reviews as a strategic goal. The Critical Care team leaders at both sites are working toward this goal by setting weekly completion targets. At Battlefords Union Hospital, the manager is currently completing training on the new Saskatchewan Health Authority performance review system and plans to conduct staff appraisals in the coming months. Victoria Hospital has similarly prioritized performance reviews, and its Critical Care team leader is actively working toward completion through weekly targets.

To strengthen quality improvement and patient-centered care, it is recommended that both sites formalize their committee structures to ensure consistent engagement and accountability. This includes appointing leadership for quality initiatives, integrating patient and family partners with lived experience, and aligning local feedback mechanisms with provincial strategies. Additionally, timely completion of performance reviews should remain a priority, supported by clear timelines and monitoring to ensure progress toward strategic goals.

Table 13: Unmet Criteria for Service Excellence for Critical Care Services

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

Criteria Number	Criteria Text	Criteria Type
2.1.11	The team leadership regularly engages with client and family representatives to gather input and feedback on their roles and responsibilities as well as role design, processes, and satisfaction.	NORMAL
4.2.2	Suicide Prevention Program 4.2.2.2 The team leadership ensures the team receives appropriate training and education to deliver safe suicide prevention services. 4.2.2.3 The team leadership ensures the team conducts standardized routine screening for suicide risk, using evidence-informed tools provided by the organizational leaders.	ROP
4.3.2	The team uses information and feedback about the quality of services to identify opportunities for quality improvement initiatives and set priorities.	NORMAL
4.3.3	The team identifies measurable objectives for its quality improvement initiatives including specific timeframes for their completion.	HIGH
4.3.4	The team identifies indicators to monitor progress for each quality improvement objective.	NORMAL
4.3.5	The team leadership works with staff to design and test quality improvement activities to meet objectives.	HIGH
4.3.6	The team leadership works with staff to use new or existing indicator data to establish a baseline for each indicator.	NORMAL
4.3.8	The team leadership works with staff to regularly analyze indicator data to evaluate the effectiveness of its quality improvement activities.	HIGH

Emergency Department

Standard Rating: 59.1% Met Criteria

40.9% of criteria were unmet. For further details please review the table at end of this section.

Assessment Results

Ten Emergency Departments and two Collaborative Emergency Centres (Spiritwood and District Health Complex and Wakaw Primary Care Centre and CEC) were visited.

Staff across the sites report that new employees receive a comprehensive orientation and training program upon hire, with ongoing professional development opportunities offered through organization-sponsored courses on the online learning platform. However, there is little or no on-site educator support, and all sites would benefit from enhanced educator presence and increased access to both formal training and “just-in-time” learning opportunities. Strengthening these resources would also support standardized procedures and quality improvement initiatives. The organization is encouraged to fund programs that help staff advance their credentials, such as moving from care aide to licensed practical nurse or from licensed practical nurse to registered nurse, as this would assist with recruitment and retention.

Positive relationships among team members and strong collaboration in care delivery were observed, extending to partners such as community care, home support, emergency medical services, and law enforcement. The Battleford Union Hospital operates a unique model where a nurse practitioner and a physician work collaboratively from 7:30 a.m. to 7:30 p.m. daily, providing care to approximately 90 patients in the emergency department. This model is highly effective and should be considered for expansion to other sites. Smaller facilities maintain excellent relationships with patients and families, who report feeling involved and heard in their care. However, many sites struggle to identify a Patient and Family Partner to participate in site-level service improvement. The sites should continue efforts to achieve this level of engagement. At Victoria Hospital, a complaint regarding Indigenous racism was transformed into a positive outcome, with the family member now serving as a patient advisor and contributing to improvements in the emergency department environment.

Overcrowding is not a consistent issue, though treatment bays can occasionally be full. Most sites use overcapacity and surge protocols developed by the regional System Flow team, which has been instrumental in standardizing processes and facilitating transfers. Some sites still lack these protocols, and the organization should continue expanding this work. For sites with available capacity, resources should be considered to allow earlier acceptance of patients from larger centers, supported by allied health staff to improve system flow.

Access to consultants is generally strong, but challenges remain in accessing acute psychiatric care. The organization should explore regional solutions to improve access to this critical service. Allied health resources are limited, with many disciplines available only one or two days per week, particularly physical therapy, social work, and mental health. Enhancing these resources would improve access and capacity. The Virtual Emergency Physician program helps smaller sites remain open when local physician coverage is unavailable, but improvements such as larger telehealth devices and clearer public communication during diversions are needed. Recruitment and retention remain essential to reduce reliance on this program.

Translation services are inconsistently used, with some sites relying on family members for interpretation. Expanding telephone or virtual translation services would address this gap. Falls prevention programs are at varying stages of implementation, with most sites lacking formal programs, audit data, and

standardized goals. Practices around skin integrity optimization and venous thromboembolism prevention also vary, and formal quality improvement plans are needed. Many sites lack processes to evaluate service delivery or access to data for improvement. The organization is encouraged to work with sites to identify useful data and provide it regularly. Organ and tissue donation protocols exist, but most sites cannot participate due to distance from transplant centers, representing a missed opportunity.

Most sites are aware of the ethical framework, but some lack alignment. Education should continue to ensure awareness. Many sites lack seclusion or secure rooms despite increasing mental health presentations, and a system-wide evaluation is recommended. Safety measures such as cameras and alarms are in place, and workplace violence prevention training is noted. Practices around rights violation processes and care transition documentation vary, and standardized tools are needed. Discharge planning occurs, but there are no validated tools to assess readmission risk, which is critical for aging populations. Outdated regional policies remain in use, and audits should support compliance with updated provincial policies.

Spiritwood and Wakaw require clarification of service descriptions to avoid confusion and ensure patient safety. Both sites demonstrate strong collaboration and adherence to processes, with opportunities to expand quality improvement efforts, enhance data use, and involve patients and families more systematically. Staff at these sites expressed interest in greater access to education and professional development.

Table 14: Unmet Criteria for Emergency Department

Criteria Number	Criteria Text	Criteria Type
2.1.4	There is access to the emergency department 24 hours a day, seven days a week.	HIGH
2.1.5	Barriers within the emergency department that impede clients, families, providers, and referring organizations from accessing services are identified and addressed, with input from clients and families.	NORMAL
2.1.10	There are established protocols to identify and manage overcrowding and surges in the emergency department.	HIGH
2.1.11	Protocols to move clients elsewhere within the organization during times of overcrowding are followed by the team.	HIGH
2.1.12	Protocols are followed to manage clients when access to inpatient beds is not available.	NORMAL

Criteria Number	Criteria Text	Criteria Type
2.1.13	Protocols to manage overcrowding and surges are followed before requesting aid from alternative health care sites or diverting ambulances.	NORMAL
2.2.1	Entrance(s) to the emergency department are clearly marked and accessible.	HIGH
2.3.2	A standardized pediatric-specific tool is used to conduct the triage assessment of pediatric clients.	NORMAL
2.3.7	There is ongoing communication with clients who are waiting for services.	NORMAL
2.4.7	Translation and interpretation services are available for clients and families as needed.	NORMAL
2.4.8	Seclusion rooms and/or private and secure areas are available for clients.	HIGH
2.4.13	Ethics-related issues are proactively identified, managed, and addressed.	HIGH
2.4.15	Clients and families are provided with information about their rights and responsibilities.	HIGH
2.4.16	Clients and families are provided with information about how to file a complaint or report violations of their rights.	HIGH
2.4.17	A process to investigate and respond to claims that clients' rights have been violated is developed and implemented with input from clients and families.	HIGH

Criteria Number	Criteria Text	Criteria Type
2.5.2	The assessment process is designed with input from clients and families.	NORMAL
2.5.5	Preventing Falls and Reducing Injuries from Falls 2.5.5.1 The team follows the organization's procedures for providing a safe physical environment to prevent falls and reduce injuries from falls. 2.5.5.2 The team follows the organization's procedure to conduct screening for risk of falls and injuries from falls. 2.5.5.3 The team follows the organization's procedure to ensure a comprehensive assessment is conducted for a client who screens positive for risk of falls or injuries from falls. 2.5.5.4 The team implements interventions to prevent falls and reduce injuries from falls as part of the client's individualized care plan. 2.5.5.5 The team follows the organization's procedure to report falls and injuries from falls as safety incidents. 2.5.5.6 The team participates in continuous learning activities about the program to prevent falls and reduce injuries from falls. 2.5.5.7 The team participates in activities to improve the program to prevent falls and reduce injuries from falls as part of the organization's integrated quality improvement plan.	ROP

Criteria Number	Criteria Text	Criteria Type
2.5.6	Optimizing Skin Integrity 2.5.6.1 The team follows the organization's procedure to conduct screening for risk of impaired skin integrity. 2.5.6.2 The team follows the organization's procedure to ensure a comprehensive assessment is conducted for a client who screens positive for risk of impaired skin integrity. 2.5.6.3 The team implements interventions to optimize skin integrity as part of the client's individualized care plan. 2.5.6.4 The team follows the organization's procedure to report health care associated impaired skin integrity as a safety incident. 2.5.6.5 The team participates in continuous learning activities about the program to optimize skin integrity. 2.5.6.6 The team participates in activities to improve the program to optimize skin integrity as part of the organization's integrated quality improvement plan.	ROP
2.5.7	Preventing Venous Thromboembolism 2.5.7.1 The team follows the organization's procedure to conduct screening for risk of venous thromboembolism. 2.5.7.2 The team follows the organization's procedure to use clinical decision support tools to determine appropriate interventions for a client who screens positive for risk of venous thromboembolism. 2.5.7.5 The team participates in continuous learning activities about the program to prevent venous thromboembolism. 2.5.7.6 The team participates in activities to improve the program to prevent venous thromboembolism as part of the organization's integrated quality improvement plan.	ROP
2.6.1	There are established protocols and policies on organ and tissue donation.	NORMAL

Criteria Number	Criteria Text	Criteria Type
2.6.2	There is a policy on neurological determination of death (NDD).	NORMAL
2.6.3	There is a policy to transfer potential organ donors to another level of care once they have been identified.	NORMAL
2.6.4	There are established clinical referral triggers to identify potential organ and tissue donors.	NORMAL
2.6.5	Training and education on organ and tissue donation and the role of the organization and the emergency department is provided to the team.	NORMAL
2.6.6	Training and education on how to support and provide information to families of potential organ and tissue donors is provided to the team, with input from clients and families.	NORMAL
2.6.7	When death is imminent or established for potential donors, the Organ Procurement Organization (OPO) or tissue centre is notified in a timely manner.	NORMAL
2.6.8	All aspects of the donation process are recorded in the client record, including the family's decision about organ and tissue donation.	NORMAL
2.7.3	Client privacy is respected during registration.	NORMAL
2.7.4	An established procedure, such as the use of armbands, is used to identify clients in the emergency department.	NORMAL

Criteria Number	Criteria Text	Criteria Type
2.7.6	Client Identification 2.7.6.1 At least two person-specific identifiers are used to confirm that clients receive the service or procedure intended for them, in partnership with clients and families.	ROP
2.7.13	Access to spiritual space and care is provided to meet clients' needs.	NORMAL
2.7.17	Information Transfer at Care Transitions 2.7.17.1 The information that is required to be shared at care transitions is defined and standardized for care transitions where clients experience a change in team membership or location: admission, handover, transfer, and discharge. 2.7.17.2 Documentation tools and communication strategies are used to standardize information transfer at care transitions. 2.7.17.4 Information shared at care transitions is documented. 2.7.17.5 The effectiveness of communication is evaluated and improvements are made based on feedback received. Evaluation mechanisms may include: • Using an audit tool (direct observation or review of client records) to measure compliance with standardized processes and the quality of information transfer • Asking clients, families, and service providers if they received the information they needed • Evaluating safety incidents related to information transfer (e.g., from the patient safety incident management system).	ROP
2.8.8	The client's risk of readmission is assessed, where applicable, and appropriate follow-up is coordinated.	HIGH

Criteria Number	Criteria Text	Criteria Type
2.8.9	The effectiveness of transitions is evaluated and the information is used to improve transition planning, with input from clients and families.	NORMAL
3.1.1	Specific goals and objectives regarding wait times, length of stay (LOS) in the emergency department, client diversion to other facilities, and number of clients who leave without being seen are established, with input from clients and families.	NORMAL
3.1.2	Ambulance offload response times are measured and used to set target times for clients brought to the emergency department by Emergency Medical Services.	NORMAL
3.1.3	Data on wait times for services, the length of stay in the emergency department, and the number of clients who leave without being seen is tracked and benchmarked.	NORMAL

Service Excellence for Emergency Department

Standard Rating: 69.4% Met Criteria

30.6% of criteria were unmet. For further details please review the table at end of this section.

Assessment Results

Many of the sites surveyed do not have a formal process for engaging with community partners or agencies. Hudson Bay Health Care Center previously held regular meetings, but these have been paused. Porcupine Carragana Hospital conducts quarterly meetings with community partners, sharing information about services and gathering feedback to inform service delivery. Sites without a formal process are encouraged to learn from those that have successfully implemented such practices.

Most sites do not have a site-specific document that serves as a service plan outlining priorities, goals, and objectives. Ideally, each site should clearly identify priorities that reflect the mission, vision, and values of the Saskatchewan Health Authority and align with the organization's strategic plan.

Currently, teams primarily engage with clients and families through day-to-day care interactions, with little intentional involvement in service design initiatives. In some cases, this is due to challenges in recruiting local patient partners. Without these dedicated resources, it is difficult to engage clients and families in a structured way. Patients experience surveys, where observed, were typically distributed to admitted patients rather than those in emergency departments. Expanding surveys to include emergency department patients presents another opportunity for engagement. Overall, involvement of client and family representatives in service design is inconsistent. Hudson Bay and Porcupine Carragana have struggled to identify local representatives, making it difficult to obtain meaningful input. In contrast, Riverside and Victoria have successfully engaged patient and family representatives, and it is recommended that these sites share their processes to help others replicate their success.

Teams report having input into space requirements, staffing needs, and equipment needs. Equipment needs are generally well supported by hospital auxiliaries, and staff describe having excellent equipment, except for a transport ventilator. Some physical space requests have remained unresolved for an extended period, such as the nursing station, which is in poor condition and poses an infection control risk, and the need for ceiling lifts, which is both a safety concern and an opportunity to improve geriatric care. Staffing is not considered critical, but there are opportunities to focus on recruitment and retention, particularly for allied health resources such as occupational therapy and physiotherapy.

Infusion pump training and education are consistently well delivered. The organization has a comprehensive program with strong adherence to ongoing training and an evaluation process in place.

Orientation and education programs for new staff are robust, and there are ample opportunities for ongoing education and professional development. Staff expressed a need for increased funding for continuing education, particularly for career advancement, which would support recruitment and retention. On-site educator support would further enhance ongoing education and professional development. Staff consistently follow clinical guidelines, adhere to evidence-informed practices, and comply with organizational safety protocols.

Education and training related to the organization's ethics framework were inconsistently observed. The Saskatchewan Health Authority is encouraged to provide ongoing education in this area. For rural sites, the lack of dedicated clinical educator support is a limiting factor, and additional investment would help ensure staff receive essential training. Workplace violence training is consistently in place, but safety support varies across sites. Several sites have installed physical safety measures such as locked doors,

cameras, and panic alarms. Many sites lack on-site security services and rely on community law enforcement or emergency medical services, which can be risky if these resources are unavailable. It is recommended that the Saskatchewan Health Authority conduct emergency department violence risk assessments at all sites and develop plans to implement appropriate safety measures.

Approaches to suicide prevention are inconsistent. Some teams have received education and conduct screenings, while others have not. Teams are aware that new guidelines will be introduced in December 2025, and the organization is encouraged to ensure implementation is comprehensive and supportive. Additionally, smaller rural emergency departments should have adequate mental health resources to fully implement the guidelines.

A new performance appraisal system has been introduced by the Saskatchewan Health Authority, but most managers have not had time to complete appraisals. Competing demands make prioritization challenging, and additional support for managers would help them complete this important task.

Most sites do not have a formal process to evaluate service delivery or identify opportunities for quality improvement, and priorities have not been established. Visual management boards are used at most sites but would benefit from a stronger focus on quality improvement as teams become more comfortable with the process. While a few sites have consistent access to data to drive quality improvement, many have limited access to information about services and their effectiveness. The SHA is encouraged to work closely with sites to determine which data would be most useful and how to provide it regularly so it can be used to guide service improvements.

Table 15: Unmet Criteria for Service Excellence for Emergency Department

Criteria Number	Criteria Text	Criteria Type
1.1.1	The team co-designs its services with its partners and the community.	HIGH
1.1.3	The team develops its service-specific goals and objectives.	NORMAL
1.1.4	The team monitors and evaluates its services for appropriateness.	NORMAL
1.2.3	The team leadership engages with clients and families to determine the required mix of skill levels and experience within the team.	NORMAL
1.2.4	The team works with the organization to co-design its physical spaces to meet its safety and service needs including confidential and private interactions for clients and families.	NORMAL

Criteria Number	Criteria Text	Criteria Type
1.2.5	The team leadership engages with team members and other stakeholders to evaluate the effectiveness of its resources, including staffing and space.	NORMAL
2.1.5	The team leadership ensures that staff are provided with education and training on the organization's ethics framework.	NORMAL
2.1.10	The team leadership regularly evaluates and documents each staff member's performance in an objective, interactive, and constructive way.	HIGH
2.1.11	The team leadership regularly engages with client and family representatives to gather input and feedback on their roles and responsibilities as well as role design, processes, and satisfaction.	NORMAL
2.1.12	The team leadership supports staff to follow up on issues and opportunities for growth identified through performance evaluations.	HIGH
2.2.3	The team leadership ensures that staff use the organization's standardized communication tools to share information about a client's care within and between teams, as consented to by the client.	HIGH
2.2.4	The team evaluates the effectiveness of its collaboration and functioning, and identifies opportunities for improvement.	NORMAL

Criteria Number	Criteria Text	Criteria Type
4.2.2	Suicide Prevention Program 4.2.2.2 The team leadership ensures the team receives appropriate training and education to deliver safe suicide prevention services. 4.2.2.3 The team leadership ensures the team conducts standardized routine screening for suicide risk, using evidence-informed tools provided by the organizational leaders. 4.2.2.5 The team leadership ensures the team develops an individualized safety plan, based on the goals, abilities and preferences of the person.	ROP
4.3.1	The team collects information and feedback from its members and its partners about the quality of services to guide quality improvement initiatives.	NORMAL
4.3.2	The team uses information and feedback about the quality of services to identify opportunities for quality improvement initiatives and set priorities.	NORMAL
4.3.3	The team identifies measurable objectives for its quality improvement initiatives including specific timeframes for their completion.	HIGH
4.3.4	The team identifies indicators to monitor progress for each quality improvement objective.	NORMAL
4.3.5	The team leadership works with staff to design and test quality improvement activities to meet objectives.	HIGH
4.3.6	The team leadership works with staff to use new or existing indicator data to establish a baseline for each indicator.	NORMAL
4.3.7	The team leadership works with staff to regularly collect indicator data and track progress towards quality improvement objectives.	NORMAL

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

Home Care Services

Standard Rating: 74.4% Met Criteria

25.6% of criteria were unmet. For further details please review the table at end of this section.

Assessment Results

During the on-site survey, home care services were assessed at nine sites. Home care services include nursing care with home support, providing clients with essential assistance for daily living and clinical needs. Staffing levels and capacity remain a challenge in several locations, with some teams operating at or near their limits. Despite these challenges, staff demonstrate strong commitment and community engagement, often volunteering to deliver Meals on Wheels to their home care clients. This reflects a dedicated workforce that prioritizes client well-being and connection.

Overall, the relationships between clients and home care staff were observed to be open, respectful, and supportive. These relationships are vital, especially as many clients live independently with limited social support. The strong rapport between clients and staff represents a key strength of the program and contributes significantly to client satisfaction and trust in home care services.

Access to resources and partnerships varies significantly across program locations and communities. Some programs have well-established collaborations with partners such as paramedics, Meals on Wheels, and SaskAbilities, which supplies equipment for home care clients. In other areas, partnerships are limited, creating challenges in accessing services such as physiotherapy, occupational therapy, transportation, and replacing broken equipment. These gaps can affect client and staff safety and the overall quality of care.

Communication between acute care and home care is inconsistent, and not all sites are routinely notified of client discharges. These communication gaps can delay medication reconciliation, interrupt continuity of care, and increase safety risks. An after-hours on-call system is in place to support care outside regular hours; however, on-call staff currently do not have access to client records, limiting their ability to make fully informed decisions during urgent calls.

The home care team demonstrates a collaborative approach to care delivery, but there are opportunities to strengthen communication between nurses and Continuing Care Assistants (CCAs) particularly regarding updates to care plans and client information. Inconsistent information sharing can lead to gaps in coordination and reduced efficiency. Improving interdisciplinary communication and ensuring all team members actively participate in care planning will support more consistent and person-centered service delivery.

A new safety assessment tool has been introduced to help staff identify hazards and develop safety plans based on risk levels. It is recommended that this assessment be completed and updated consistently with active engagement from clients and family members. Similarly, updates to mobility records and care plans should include regular participation from clients, families, and CCAs to ensure accuracy and shared understanding.

Education and guidance documents are available to help staff identify safety risks in the home care environment; however, additional training and resources are needed to manage specific challenges, including physical hazards in clients' homes and the lack of proper equipment such as appropriate beds for safe care delivery.

Medication reconciliation is performed during intake and transitions, however the home care team relies primarily on physicians to provide updated orders rather than systematically verifying and reconciling medications. This dependency can create delays and increase the risk of medication errors, particularly

when communication between care settings is inconsistent. Strengthening medication reconciliation practices and ensuring timely updates would improve safety and continuity of care.

Assessment and care planning for clients with impaired skin integrity are conducted routinely, yet there is no evidence that these cases are reported as safety incidents. This gap may lead to underreporting, missed opportunities for learning, and limited data for tracking trends or developing preventive strategies. Reporting could enhance quality improvement efforts and reduce risks for clients.

Care transitions represent another area for improvement. While some care transitions are well-managed and involve active client participation, there is no standardized process for sharing information at key transition points such as discharges or transfers. Currently, transfers of care are managed primarily through verbal communication, and evaluations occur on an ad hoc basis, often in response to discrepancies or complaints. Developing standardized transfer documentation, communication protocols, and feedback mechanisms will help ensure that care transitions are handled systematically and effectively across all settings.

Not all staff are familiar with the organization's ethics framework or understand how to identify and address ethical issues in care delivery. Most ethics education and communication are directed toward nursing staff, leaving gaps for other care providers, such as CCAs, who play a critical role in daily client interactions. Comprehensive ethics training for all staff is recommended to support consistent ethical decision-making across the team.

A home care client handbook is available for all new clients in the region. Staff should ensure that both new and existing clients, as well as their families, have access to the updated handbook to promote awareness of available services, rights, and responsibilities. Outreach sessions are conducted to engage seniors and local service providers, including primary care teams, particularly in communities where there is capacity for additional home care support.

A Patient and Family Partner contributed to the development of the client handbook, but currently there are no client or family representatives involved in ongoing consultation. Reinstating client and family involvement through advisory groups or engagement activities would strengthen service planning and reinforce a client-centered approach.

Table 16: Unmet Criteria for Home Care Services

Criteria Number	Criteria Text	Criteria Type
1.2.11	Clients and families are provided with opportunities to be engaged in research activities that may be appropriate to their care.	NORMAL
1.2.12	Ethics-related issues are proactively identified, managed, and addressed.	HIGH
1.2.13	Clients and families are provided with information about their rights and responsibilities.	HIGH
1.2.14	Clients and families are provided with information about how to file a complaint or report violations of their rights.	HIGH

Criteria Number	Criteria Text	Criteria Type
1.2.15	A process to investigate and respond to claims that clients' rights have been violated is developed and implemented with input from clients and families.	HIGH
1.3.2	The assessment process is designed with input from clients and families.	NORMAL
1.3.6	Optimizing Skin Integrity 1.3.6.4 The team follows the organization’s procedure to report health care associated impaired skin integrity as a safety incident.	ROP
1.3.7	Maintaining an Accurate List of Medications during Care Transitions 1.3.7.3 The team follows the organization’s procedure to report incidents that could have harmed or did harm a client related to maintaining an accurate list of medications during care transitions as safety incidents. 1.3.7.4 The team participates in continuous learning activities about the medication reconciliation procedure to maintain an accurate list of medications during care transitions. 1.3.7.5 The team participates in activities to improve the medication reconciliation procedure to maintain an accurate list of medications during care transitions as part of the organization’s integrated quality improvement plan.	ROP
1.3.12	A comprehensive and individualized care plan is developed and documented in partnership with the client and family.	HIGH
1.4.1	The client's individualized care plan is followed when services are provided.	NORMAL
1.4.3	All services received by the client, including changes and adjustments to the care plan, are documented in the client record.	NORMAL

Criteria Number	Criteria Text	Criteria Type
1.4.4	Treatment protocols are consistently followed to provide the same standard of care in all settings to all clients.	HIGH
1.4.6	Client progress toward achieving goals and expected results is monitored in partnership with the client, and the information is used to adjust the care plan as necessary.	NORMAL
1.4.10	Information Transfer at Care Transitions 1.4.10.1 The information that is required to be shared at care transitions is defined and standardized for care transitions where clients experience a change in team membership or location: admission, handover, transfer, and discharge. 1.4.10.2 Documentation tools and communication strategies are used to standardize information transfer at care transitions. 1.4.10.3 During care transitions, clients and families are given information that they need to make decisions and support their own care. 1.4.10.5 The effectiveness of communication is evaluated and improvements are made based on feedback received. Evaluation mechanisms may include: • Using an audit tool (direct observation or review of client records) to measure compliance with standardized processes and the quality of information transfer • Asking clients, families, and service providers if they received the information they needed • Evaluating safety incidents related to information transfer (e.g., from the patient safety incident management system).	ROP
1.5.7	The effectiveness of transitions is evaluated and the information is used to improve transition planning, with input from clients and families.	NORMAL

Service Excellence for Home Care Services

Standard Rating: 67.9% Met Criteria

32.1% of criteria were unmet. For further details please review the table at end of this section.

Assessment Results

Greater integration of electronic health records would support seamless access to health information and improve coordination among acute care, primary care, and home care teams. Expanding the use of Procura and exploring electronic charting options for all staff, including Continuing Care Assistants, would help ensure that client documentation is complete and accessible. Currently, there are inconsistencies in clinical documentation, including incomplete or outdated entries related to allergies, medications, and other essential client details.

Clients are not consistently engaged in updating their care plans, which are primarily revised by the nursing team with limited participation from Continuing Care Assistants, clients, or their families. Strengthening client involvement and ensuring regular interdisciplinary updates will improve accuracy, accountability, and the overall quality of care planning. There is no evidence that teams develop their own service-specific goals and objectives. At present, there is no documented or standardized process showing how team members participate in creating, reviewing, and evaluating goals that align with organizational priorities and client needs.

Structured education and training are available for staff, but inconsistencies exist in onboarding and education for Continuing Care Assistants. Annual home care education is provided three times each year and includes key clinical training such as infusion pump education. Just-in-time training is also available for staff who use infusion pumps occasionally, ensuring timely skill refreshers when needed. The biomedical engineering team performs annual maintenance of infusion pumps, and any incidents or malfunctions are documented through the incident reporting system. However, this process is not consistent across all locations.

Performance appraisals for staff are currently overdue, and there is no formal process to identify individual or team growth opportunities. While professional development opportunities exist, they are not systematically linked to performance evaluations or identified learning needs. Leadership is in the process of implementing a newly redesigned performance appraisal process.

Quality improvement initiatives within home care vary by program and site. Broader quality improvement activities and client or staff engagement efforts are primarily driven at the organizational level. There is limited evidence of local ownership or systematic evaluation of quality improvement initiatives for feasibility or impact at the team level. To advance a culture of continuous improvement, the organization is encouraged to strengthen quality improvement structures within home care by linking local activities to broader organizational goals while addressing site-specific risks, needs, and gaps. Making the visual management board relevant to local quality priorities will further engage staff in daily improvement activities.

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

Criteria Number	Criteria Text	Criteria Type
1.1.1	The team co-designs its services with its partners and the community.	HIGH
1.1.3	The team develops its service-specific goals and objectives.	NORMAL
1.2.3	The team leadership engages with clients and families to determine the required mix of skill levels and experience within the team.	NORMAL
2.1.5	The team leadership ensures that staff are provided with education and training on the organization's ethics framework.	NORMAL
2.1.7	Infusion Pump Safety 2.1.7.5 The effectiveness of the approach is evaluated. Evaluation mechanisms may include: • Investigating patient safety incidents related to infusion pump use • Reviewing data from smart pumps • Monitoring evaluations of competence • Seeking feedback from clients, families, and team members	ROP
2.1.10	The team leadership regularly evaluates and documents each staff member's performance in an objective, interactive, and constructive way.	HIGH
2.1.11	The team leadership regularly engages with client and family representatives to gather input and feedback on their roles and responsibilities as well as role design, processes, and satisfaction.	NORMAL

Criteria Number	Criteria Text	Criteria Type
2.1.12	The team leadership supports staff to follow up on issues and opportunities for growth identified through performance evaluations.	HIGH
2.2.4	The team evaluates the effectiveness of its collaboration and functioning, and identifies opportunities for improvement.	NORMAL
2.3.3	The team leadership recognizes staff members for their contributions to safe and quality care.	NORMAL
2.3.6	The team leadership ensures that staff are provided with education and training on how to identify, reduce, and manage safety risks.	HIGH
3.1.1	The team maintains accurate, up-to-date, and complete records for each client.	HIGH
3.1.5	The team ensures that clients are able to actively participate in documenting information in their record.	NORMAL
4.1.5	The team regularly reviews its evidence-informed guidelines and protocols for service delivery.	HIGH
4.2.2	Suicide Prevention Program 4.2.2.2 The team leadership ensures the team receives appropriate training and education to deliver safe suicide prevention services. 4.2.2.3 The team leadership ensures the team conducts standardized routine screening for suicide risk, using evidence-informed tools provided by the organizational leaders.	ROP
4.2.8	The team leadership follows organizational policy and engages with team members to analyze safety incidents and use the results to make improvements and prevent recurrence.	HIGH

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

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

Inpatient Services

Standard Rating: 81.8% Met Criteria

18.2% of criteria were unmet. For further details please review the table at end of this section.

Assessment Results

During the on-site survey, ten inpatient service units within the Integrated North Saskatchewan Health Authority were reviewed. Inpatient services across Integrated Northern Health are performing exceptionally well despite resource challenges. Teams demonstrate creativity and a strong commitment to problem-solving, reflecting a rural mindset of getting the job done. This was evident at Melfort Hospital, where there is no clinical nurse educator. In response, many frontline staff have independently obtained instructor-level training in various courses to maintain certifications such as Advanced Cardiac Life Support, Basic Life Support, and Neonatal Resuscitation Program. Their efforts and dedication to maintaining nursing competencies are commendable. Staff consistently highlighted excellent teamwork and peer support during interviews.

Overall, staff demonstrated knowledge and application of Required Organizational Practices across acute care inpatient departments. However, there were inconsistencies in meeting compliance requirements, particularly in areas such as evaluation and implementing activities to improve practice. There is an opportunity for Integrated Northern Health to identify gaps in data collection through audits and staff feedback, then use this information to guide quality improvement initiatives.

There was inconsistency in obtaining consent for treatments across sites as well as access to translation services. Several hospitals do not participate in activities to improve the program related to preventing or reducing patient falls, optimizing skin integrity, medication reconciliation procedure or preventing venous thromboembolism. There is an opportunity to strengthen continuous learning activities related to topics.

At some locations, the information required to be shared during care transitions is not clearly defined or standardized. While some sites use the SBAR communication tool, others do not use any structured approach to support standardization. It was noted at a few sites there is no evidence that the effectiveness of communication during care transitions is evaluated.

The SHA is commended for updating clinical pathways. However, some sites are not familia with these updates. Increasing awareness at the local level would help ensure staff are informed. Standardized assessments were observed during admissions, but there is an opportunity to align assessments with the populations served. For example, many inpatient units lacked tools for comprehensive geriatric needs assessments, even though several patients were awaiting alternate levels of care and could benefit from such evaluations.

The absence of dedicated protective services at some acute care facilities, particularly those identified as high-risk, is a concern among staff. Currently, staff rely on the Royal Canadian Mounted Police, whose response times are not always adequate in urgent situations. Allocating resources for increased surveillance at high-risk sites would help staff feel safer and more supported.

Daily team huddles occur consistently at most sites, with interdisciplinary team members invited. These meetings provide an excellent opportunity to share information and address barriers to patient discharge.

Table 18: Unmet Criteria for Inpatient Services

Criteria Number	Criteria Text	Criteria Type
1.1.1	Services are co-designed to meet the needs of an aging population, where applicable.	NORMAL
2.1.3	Education and training are provided on established clinical care pathways.	HIGH
3.2.7	Translation and interpretation services are available for clients and families as needed.	NORMAL
3.2.9	The client's informed consent is obtained and documented before providing services.	HIGH
3.3.2	A comprehensive geriatric needs assessment is completed, when appropriate, in partnership with the client and family.	HIGH
3.3.3	The inpatient services team works with the emergency department team to initiate the geriatric needs assessment, where appropriate, for clients who enter into the organization through the emergency department.	HIGH
3.3.4	The assessment process is designed with input from clients and families.	NORMAL
3.3.7	Preventing Falls and Reducing Injuries from Falls 3.3.7.7 The team participates in activities to improve the program to prevent falls and reduce injuries from falls as part of the organization’s integrated quality improvement plan.	ROP

Criteria Number	Criteria Text	Criteria Type
3.3.8	Optimizing Skin Integrity 3.3.8.4 The team follows the organization's procedure to report health care associated impaired skin integrity as a safety incident. 3.3.8.5 The team participates in continuous learning activities about the program to optimize skin integrity. 3.3.8.6 The team participates in activities to improve the program to optimize skin integrity as part of the organization's integrated quality improvement plan.	ROP
3.3.9	Preventing Venous Thromboembolism 3.3.9.6 The team participates in activities to improve the program to prevent venous thromboembolism as part of the organization's integrated quality improvement plan.	ROP
3.3.10	Maintaining an Accurate List of Medications during Care Transitions 3.3.10.5 The team participates in activities to improve the medication reconciliation procedure to maintain an accurate list of medications during care transitions as part of the organization's integrated quality improvement plan.	ROP

Criteria Number	Criteria Text	Criteria Type
3.4.18	Information Transfer at Care Transitions 3.4.18.1 The information that is required to be shared at care transitions is defined and standardized for care transitions where clients experience a change in team membership or location: admission, handover, transfer, and discharge. 3.4.18.2 Documentation tools and communication strategies are used to standardize information transfer at care transitions. 3.4.18.5 The effectiveness of communication is evaluated and improvements are made based on feedback received. Evaluation mechanisms may include: • Using an audit tool (direct observation or review of client records) to measure compliance with standardized processes and the quality of information transfer • Asking clients, families, and service providers if they received the information they needed • Evaluating safety incidents related to information transfer (e.g., from the patient safety incident management system	ROP
3.5.8	The client's risk of readmission is assessed, where applicable, and appropriate follow-up is coordinated.	HIGH
3.5.9	The effectiveness of transitions is evaluated and the information is used to improve transition planning, with input from clients and families.	NORMAL

Service Excellence for Inpatient Services

Standard Rating: 78.8% Met Criteria

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

Assessment Results

There is a strong sense of teamwork and collaboration among staff and physicians. Although several sites do not currently have patient and family partners participating in local committees, patients interviewed reported feeling actively engaged in their care and considered part of the healthcare team. At Riverside Health Complex, patients and families expressed high satisfaction with the services provided, particularly palliative care and the dedicated spaces for families. There is an opportunity for inpatient acute care units to recruit Patient and Family Partners to be involved in committees and quality improvement at the local level.

Staff reported feeling supported and recognized by their managers. However, some staff observed that managers carry a significant workload, which can lead to burnout. In some hospitals, staff appreciation is highlighted through displays of acts of kindness and professional achievements, which teams value.

Compliance with regular performance appraisals requires improvement across Integrated Northern Health. Several inpatient units reported that staff have not received appraisals for many years. Performance appraisals provide opportunities for feedback, goal setting, and career development. Managers have committed to completing these appraisals by the end of the fiscal year, as this is an organizational priority.

The organization offers a comprehensive orientation program for staff, and many certifications must be completed annually. Tracking and coordinating these courses is challenging at the local level due to limited or no dedicated nurse educators, leaving managers to assume this responsibility. Staff appreciate educational opportunities and are able to attend conferences and workshops. There is an opportunity to evaluate education resources across Integrated Northern Health. Increasing the number of educators to support best practices and maintain high standards of care will positively impact patient and family outcomes.

There is an opportunity to strengthen efforts around suicide prevention. Staff training related to suicide prevention and safety plan implementation was inconsistent across acute care sites. Some staff indicated they had not been provided with culturally safe training to deliver suicide prevention and support services that match the goals, abilities, and preferences of the population they serve.

Quality improvement is well established on some inpatient units, but others lack understanding of its purpose and have no active initiatives. Implementation of a Quality and Safety Improvement Plan connected to the sites is encouraged. The SHA offers a basic quality improvement course that is mandatory for staff. There is an opportunity to create simple tools that staff can use when initiating quality improvement projects. This would help apply principles effectively and increase knowledge, particularly for those without prior training.

There are several hospitals that do not have geriatric specific design principles in place to meet the needs of this population. There is an opportunity at many sites to engage patient partners co-designing space and services to meet the needs of the aging population.

Table 19: Unmet Criteria for Service Excellence for Inpatient Services

Criteria Number	Criteria Text	Criteria Type
1.1.1	The team co-designs its services with its partners and the community.	HIGH
2.1.5	The team leadership ensures that staff are provided with education and training on the organization's ethics framework.	NORMAL
2.1.10	The team leadership regularly evaluates and documents each staff member's performance in an objective, interactive, and constructive way.	HIGH
2.1.12	The team leadership supports staff to follow up on issues and opportunities for growth identified through performance evaluations.	HIGH
4.2.2	Suicide Prevention Program 4.2.2.2 The team leadership ensures the team receives appropriate training and education to deliver safe suicide prevention services. 4.2.2.3 The team leadership ensures the team conducts standardized routine screening for suicide risk, using evidence-informed tools provided by the organizational leaders. 4.2.2.4 The team leadership ensures the team refers clients who screen positive for suicide risk to a person with the competencies to do a suicide risk assessment and put the necessary safety plan in place. 4.2.2.5 The team leadership ensures the team develops an individualized safety plan, based on the goals, abilities and preferences of the person.	ROP
4.3.2	The team uses information and feedback about the quality of services to identify opportunities for quality improvement initiatives and set priorities.	NORMAL

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

Long-Term Care Services

Standard Rating: 72.0% Met Criteria

28.0% of criteria were unmet. For further details please review the table at end of this section.

Assessment Results

Fourteen long-term care homes across Integrated Northern Health were assessed. The review identified areas of excellence and opportunities for improvement across care delivery, compliance, infrastructure, and organizational practices.

Since the previous survey, most sites have advanced people-centred care. Homes are increasingly involving residents and families in decisions such as meal planning and activity scheduling, and staff are listening to residents' preferences, including flexibility in sleep and mealtimes. Conversations about autonomy and the right to live at risk are occurring, supported by risk management approaches to balance individual choice with resident safety. These decisions remain complex, but residents who are cognitively aware and competent are permitted to make informed choices.

Compliance with Required Organizational Practices has improved, though some gaps remain. Teams consistently meet requirements for two client identifiers and fall prevention. However, at several sites, expected practices related to evaluating communication during care transitions and optimizing skin integrity are not being met.

At care transitions, many teams assume communication is effective unless complaints arise. A proactive approach such as contacting referral sites and families would validate assumptions and address issues promptly. Sites do have complaint processes in place; however, at some sites not all complaints were addressed in a timely or satisfactory manner. Another opportunity is to consider ensuring residents and families are aware they can also submit compliments. This may provide a more balanced overview of the care and services provided.

Significant progress has been made in trauma-informed care training, enabling staff to understand residents' histories and avoid triggers. Residents generally report satisfaction with services, and food quality, a common concern, was not a major issue during this visit. Homes have worked to offer choices, provide culturally appropriate meals, and allow flexibility at mealtimes, with snacks and beverages available between meals. Some sites partner with municipalities to enable residents to participate in community activities, though others lack transportation and should explore options beyond their immediate area.

Medication reconciliation practices require attention. At one facility, records are kept at a local retail pharmacy and are inaccessible to staff, while another site uses discharge orders as a substitute. Teams must ensure consistent access to completed medication reconciliation records supported by continuous learning activities about the medication reconciliation procedure during care transitions.

Antipsychotic medication use continues to be monitored, and one site has the highest rate in the province. The organization should investigate contributing factors and consider a quality improvement initiative to reduce usage. Restraint use also requires monitoring, and policies should be updated to reflect current standards.

Support from clinical educator nurses and infection prevention resources are valuable where available, but some sites report inconsistency. Facilities in the southern part of the northern region often face

uncertainty about whether support should come from the south or north, sometimes resulting in gaps in service. Physical infrastructure remains a challenge in several homes, with issues such as excessively hot laundry areas, lack of heat or hot water, insufficient space for spiritual care, and rooms or toilets that are not wheelchair accessible.

Resident councils have become more active since being suspended during the pandemic, and sites are encouraged to continue revitalizing these committees and ensure strong representation from residents and families. Volunteer programs have not been reinstated in some homes, and sites are encouraged to recruit volunteers to enrich residents' lives.

Finally, many facilities have not conducted emergency drills beyond fire drills. Broader emergency preparedness, including evacuation drills, is strongly recommended to improve outcomes during unexpected events.

Table 20: Unmet Criteria for Long-Term Care Services

Criteria Number	Criteria Text	Criteria Type
1.4.2	The LTC home leaders ensure timely translation and interpretation services are available to meet residents' needs.	NORMAL
1.4.4	Teams address residents' complaints in a timely manner.	HIGH
2.1.1	The LTC home leaders ensure the home's physical environment meets residents' comprehensive needs to enhance their quality of life.	HIGH
2.1.4	The LTC home leaders enable meaningful mealtime experiences that meet residents' needs and preferences.	NORMAL
2.1.6	Teams promote access to nature and outdoor activities that meet residents' goals, needs, and preferences.	NORMAL
2.1.7	The LTC home leaders support the role of volunteers in enabling residents' meaningful quality of life.	NORMAL
2.1.10	Teams facilitate access to appropriate transportation services that meet residents' needs, abilities, and preferences.	NORMAL

Criteria Number	Criteria Text	Criteria Type
2.1.11	The LTC home leaders communicate the results of annual quality-of-life surveys to teams.	NORMAL
3.2.4	Optimizing Skin Integrity 3.2.4.3 The team implements interventions to optimize skin integrity as part of the client's individualized care plan. 3.2.4.4 The team follows the organization's procedure to report health care associated impaired skin integrity as a safety incident. 3.2.4.5 The team participates in continuous learning activities about the program to optimize skin integrity. 3.2.4.6 The team participates in activities to improve the program to optimize skin integrity as part of the organization's integrated quality improvement plan.	ROP
3.2.8	The team follows the LTC home's procedure on the use of least restraint.	HIGH

Criteria Number	Criteria Text	Criteria Type
3.2.10	Maintaining an Accurate List of Medications during Care Transitions 3.2.10.1 The team follows the organization's procedure to obtain a best possible medication history during care transitions. 3.2.10.2 The team follows the organization's procedure to resolve medication discrepancies during care transitions in a timely way. 3.2.10.3 The team follows the organization's procedure to report incidents that could have harmed or did harm a client related to maintaining an accurate list of medications during care transitions as safety incidents. 3.2.10.4 The team participates in continuous learning activities about the medication reconciliation procedure to maintain an accurate list of medications during care transitions. 3.2.10.5 The team participates in activities to improve the medication reconciliation procedure to maintain an accurate list of medications during care transitions as part of the organization's integrated quality improvement plan.	ROP
3.2.14	The team conducts regular simulations of the LTC home's emergency procedures.	HIGH
3.3.3	Information Transfer at Care Transitions 3.3.3.5 The effectiveness of communication is evaluated and improvements are made based on feedback received. Evaluation mechanisms may include: • Using an audit tool (direct observation or review of client records) to measure compliance with standardized processes and the quality of information transfer • Asking clients, families, and service providers if they received the information they needed • Evaluating safety incidents related to information transfer (e.g., from the patient safety incident management system).	ROP

Criteria Number	Criteria Text	Criteria Type
3.3.4	The team designates a team member to coordinate the resident's care before, during, and after a consultation with a health care professional outside the LTC home.	NORMAL
4.1.1	Teams have a quality improvement plan for improving residents' quality of life.	HIGH
4.1.2	Teams have a quality improvement plan for improving residents' quality of care.	HIGH

Service Excellence for Long-Term Care Services

Standard Rating: 68.2% Met Criteria

31.8% of criteria were unmet. For further details please review the table at end of this section.

Assessment Results

Performance reviews are essential for ensuring competency, providing formal feedback, and identifying education and training needs. Currently, the completion rate for these reviews in long-term care ranges from 0 to 33 percent. Managers are aiming for full completion by March 31, 2026.

All records in long-term care are paper based. Patient information may be stored in multiple locations, such as binders and charts, which create risk. Medication and treatment orders are transcribed by hand, a process that is time-consuming, prone to legibility issues, and increases the risk of errors. Paper-based records also make it difficult to collect and analyze statistical data on quality indicators.

Maintaining safe staffing levels has been a challenge. Some staff have expressed interest in establishing minimum staffing requirements. Focused efforts are needed to recruit and retain staff to ensure safe and sustainable care delivery. Frequent changes in leadership have also created unintended consequences, such as incomplete performance reviews, gaps in mandatory training, and limited support for staff career development. Many current managers reported that they did not receive a thorough orientation, which has contributed to unresolved issues from previous leadership.

All teams have achieved compliance with suicide prevention practices and infusion pump requirements. This accomplishment reflects a strong commitment to quality and safety and is worthy of commendation.

Most long-term care sites work with retail pharmacies. The health authority is managing contracts, but there is still variability in services provided. The organization needs to monitor these contracts closely and ensure 24/7 pharmacy support, potentially through nearby hospitals.

There is a strong culture of reporting incidents and near misses, and staff should be commended for this. Reporting helps improve safety and quality for residents, families, and staff. However, the next step is to close the feedback loop. Staff who report incidents need to know what actions are taken as a result. Trending data should be used to guide quality improvements. It was noted that staff are not consistently receiving feedback on their reports, which presents a missed opportunity.

Since the last survey, long-term care homes have introduced visibility boards and regular staff huddles. Teams should be congratulated on this progress. However, some boards are in areas that are not easily visible to residents and staff. Ideally, they should be placed in prominent locations.

Visibility boards are one component of a strong quality improvement plan. It was observed that most teams are still early in their quality improvement journey. While some basic information is displayed on the boards, written plans are missing. Providing all staff with basic quality improvement training and ensuring one or two trained individuals at each site could strengthen team capacity. Training on indicators, setting objectives and targets, and developing SMART goals would be valuable. Some staff have shown strong interest in quality improvement work, and investing in these individuals would be beneficial.

Table 21: Unmet Criteria for Service Excellence for Long-Term Care Services

Criteria Number	Criteria Text	Criteria Type
1.2.1	The team leadership identifies and informs the organizational leaders about the team's resource requirements and service gaps.	NORMAL
1.2.3	The team leadership engages with clients and families to determine the required mix of skill levels and experience within the team.	NORMAL
1.2.4	The team works with the organization to co-design its physical spaces to meet its safety and service needs including confidential and private interactions for clients and families.	NORMAL
1.2.7	The team works with the organization to create a universally accessible service environment.	NORMAL
1.2.8	The team leadership ensures that clients are provided with access to spiritual care and space for spiritual practices to meet their needs.	NORMAL
2.1.5	The team leadership ensures that staff are provided with education and training on the organization's ethics framework.	NORMAL
2.1.10	The team leadership regularly evaluates and documents each staff member's performance in an objective, interactive, and constructive way.	HIGH
2.1.11	The team leadership regularly engages with client and family representatives to gather input and feedback on their roles and responsibilities as well as role design, processes, and satisfaction.	NORMAL

Criteria Number	Criteria Text	Criteria Type
2.1.12	The team leadership supports staff to follow up on issues and opportunities for growth identified through performance evaluations.	HIGH
2.3.1	The team leadership assigns and reviews the workload of each staff member in a manner that ensures client and staff safety and well-being.	NORMAL
2.3.3	The team leadership recognizes staff members for their contributions to safe and quality care.	NORMAL
2.3.7	The team leadership ensures that staff are provided with education and training on how to prevent and manage workplace violence, including abuse, aggression, threats, and assaults.	HIGH
3.1.2	The team collects and documents a standardized set of health information to ensure client records are consistent and comparable.	NORMAL
3.1.8	The team monitors and evaluates its record-keeping practices, and uses the results to make improvements.	HIGH
4.2.5	The team evaluates its safety improvement strategies.	HIGH
4.2.8	The team leadership follows organizational policy and engages with team members to analyze safety incidents and use the results to make improvements and prevent recurrence.	HIGH
4.3.1	The team collects information and feedback from its members and its partners about the quality of services to guide quality improvement initiatives.	NORMAL

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

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

Mental Health and Addictions Services

Standard Rating: 85.9% Met Criteria

14.1% of criteria were unmet. For further details please review the table at end of this section.

Assessment Results

Mental health and addictions services were assessed at six sites, including three inpatient units (Saskatchewan Hospital, Battlefords Union Hospital, Victoria Hospital) and three outpatient sites (Don Ross Centre, community-based services in Melfort and Tisdale). Teams were consistently commended for their client-centered, recovery-oriented approach and for fostering respectful relationships with clients.

Patient and resident councils are established and primarily function as forums for raising concerns and providing suggestions. Expanding their role to actively engage clients in shaping process improvements, informing new initiatives, and contributing to quality monitoring would strengthen client involvement. Care planning practices would benefit from greater cohesion and multidisciplinary collaboration, with an emphasis on co-developing plans that reflect each patient's goals, strengths, and preferences.

In inpatient settings, clinical records are maintained in a hybrid format, with risk assessments, care plans, consents, and medications documented on paper while progress notes are entered electronically. Transitioning to a unified electronic health record would improve continuity and efficiency. Intermittent internet connectivity issues hinder access to clinical systems, policies, and communication tools; contingency plans should be developed to ensure safe operations during disruptions. At the Don Ross Centre, assessments and care plans are documented in the notes section of the electronic health record without a standardized format. While content alignment is evident, reducing variability in documentation structure is encouraged.

Quality improvement activities are present across inpatient and outpatient settings but vary in consistency; standardizing tools and documentation practices would strengthen these efforts. Visual management boards should be more accessible and used to communicate performance indicators, goals, measures, and outcomes while recognizing quality improvement achievements. Peer support is currently offered informally during therapeutic and activity groups; formalizing peer support as a structured component of programming could enhance recovery outcomes.

Risk screening practices require improvement. Standardized screening for venous thromboembolism is not currently implemented in Integrated Correctional Services, Forensic Services, and Inpatient Mental Health Services, and skin integrity screening is inconsistently applied at Battlefords Union Hospital. Screening related to venous thromboembolism is also not evident for all clients of the Battlefords Union Hospital Mental Health Inpatient Service or Saskatchewan Hospital. Comprehensive risk screening protocols, staff education, and integration into quality improvement initiatives are recommended.

Teams are encouraged to explore quality improvement opportunities, such as using chart audit data to monitor and improve compliance with screening for risk of falls. Communication during transitions in care varies across programs. Teams are encouraged to evaluate the effectiveness of transition planning and information exchange to improve continuity and safety. Sites are encouraged to consider strategies to engage teams in activities that strengthen medication reconciliation processes.

Policies and procedures are accessed through a centralized search platform that includes Saskatchewan Health Authority policies, legacy regional documents, and site-specific policies hosted on the local intranet at Saskatchewan Hospital North Battleford. While progress has been made in consolidating policy access, several documents have not been reviewed for more than four years.

Although the inpatient unit at Battlefords Union Hospital is designed for adults, it occasionally admits children and youth; strategies should be considered to ensure timely access to specialized child and youth mental health expertise when needed.

Outpatient services at the Don Ross Centre, Melfort, and Tisdale are difficult to locate due to insufficient signage; improving wayfinding and directional signage would enhance accessibility for clients and families.

Table 22: Unmet Criteria for Mental Health and Addictions Services

Criteria Number	Criteria Text	Criteria Type
3.3.1	Preventing Falls and Reducing Injuries from Falls 3.3.1.7 The team participates in activities to improve the program to prevent falls and reduce injuries from falls as part of the organization's integrated quality improvement plan.	ROP
3.3.2	Optimizing Skin Integrity 3.3.2.1 The team follows the organization's procedure to conduct screening for risk of impaired skin integrity. 3.3.2.2 The team follows the organization's procedure to ensure a comprehensive assessment is conducted for a client who screens positive for risk of impaired skin integrity. 3.3.2.6 The team participates in activities to improve the program to optimize skin integrity as part of the organization's integrated quality improvement plan.	ROP

Criteria Number	Criteria Text	Criteria Type
3.3.3	Preventing Venous Thromboembolism 3.3.3.1 The team follows the organization's procedure to conduct screening for risk of venous thromboembolism. 3.3.3.2 The team follows the organization's procedure to use clinical decision support tools to determine appropriate interventions for a client who screens positive for risk of venous thromboembolism. 3.3.3.3 The team implements interventions to prevent venous thromboembolism as part of the client's individualized care plan. 3.3.3.5 The team participates in continuous learning activities about the program to prevent venous thromboembolism. 3.3.3.6 The team participates in activities to improve the program to prevent venous thromboembolism as part of the organization's integrated quality improvement plan.	ROP
3.5.1	Information Transfer at Care Transitions 3.5.1.5 The effectiveness of communication is evaluated and improvements are made based on feedback received. Evaluation mechanisms may include: • Using an audit tool (direct observation or review of client records) to measure compliance with standardized processes and the quality of information transfer • Asking clients, families, and service providers if they received the information they needed • Evaluating safety incidents related to information transfer (e.g., from the patient safety incident management system).	ROP
3.5.2	Maintaining an Accurate List of Medications during Care Transitions 3.5.2.5 The team participates in activities to improve the medication reconciliation procedure to maintain an accurate list of medications during care transitions as part of the organization's integrated quality improvement plan.	ROP

Service Excellence for Mental Health and Addictions Services

Standard Rating: 95.3% Met Criteria

4.7% of criteria were unmet. For further details please review the table at end of this section.

Assessment Results

Clinical leaders are actively engaged in academic research; however, awareness among frontline staff and opportunities for client participation remain limited. Several innovative programs were identified, including Integrated Correctional Services at Saskatchewan Hospital, the Roots of Hope suicide prevention initiatives, the BEATS Encounter program at the Don Ross Centre, and the Food Share Project in Melfort. The team is encouraged to consider formal evaluative research to validate these initiatives as effective and scalable leading practices.

Performance feedback has not been consistently provided to all staff. Leadership is encouraged to continue implementing the new performance review system, with the goal of achieving full completion by March 31, 2026.

Clinical models, guidelines, and pathways are established, and processes exist to assess evidence when selecting and implementing these guidelines and models.

Mental Health and Addictions services have not consistently implemented mechanisms such as visible management walls in an effective way. The teams are encouraged to consider strategies to place the boards walls in accessible areas and use them to stimulate routine discussion of quality improvement activities. There are multiple quality improvement indicators and the results are reviewed by the teams. However, they are not consistently engaged in evaluation of its effectiveness.

Table 23: Unmet Criteria for Service Excellence for Mental Health and Addictions Services

Criteria Number	Criteria Text	Criteria Type
2.1.10	The team leadership regularly evaluates and documents each staff member's performance in an objective, interactive, and constructive way.	HIGH
2.1.11	The team leadership regularly engages with client and family representatives to gather input and feedback on their roles and responsibilities as well as role design, processes, and satisfaction.	NORMAL
4.3.8	The team leadership works with staff to regularly analyze indicator data to evaluate the effectiveness of its quality improvement activities.	HIGH

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

Obstetrics Services

Standard Rating: 95.8% Met Criteria

4.2% of criteria were unmet. For further details please review the table at end of this section.

Assessment Results

Five obstetrical units were assessed at Battlefords Union Hospital, La Ronge Health Centre, Lloydminster Hospital, Nipawin Hospital, and Northwest Health Facility.

The obstetrical program supporting Integrated Northern Health (INH) is well organized, with visible leadership and engaged teams. The organization has made significant investments, including the provincial adoption of the MoreOB program, which is at varying stages of implementation across sites. This platform provides a strong foundation for continuous quality improvement at the unit level. Additional patient-focused initiatives include Spinning Babies and nurse-led positioning techniques that enhance comfort during pregnancy and support smoother progress in childbirth. These practices have been locally driven.

Patients actively participate in developing their birthing plans, and care pathways are standardized. The organization is commended for its collaborative relationships with Indigenous communities in the region and is encouraged to explore further opportunities to engage with other community members to strengthen cultural competence and meet the needs of an increasingly diverse population.

Although birth rates have declined across the region, volumes remain sufficient to maintain team competency. All sites use an on-call roster for physician providers and respiratory therapists after hours. Patients are well informed about the risks and benefits of delivering in rural communities and can make decisions based on the information provided. Some maternity programs have experienced service disruptions since January 2025 due to insufficient staffing and physician resources; however, strong collaboration across regions ensures timely access to care. Midwifery services are not currently utilized within INH.

Nipawin Hospital has the infrastructure and technology to provide obstetrical services, but its maternity program has faced disruptions since January 2025 due to limited staffing and physician resources. The site ensures patients are referred to appropriate services, with caesarean deliveries directed to other facilities, while maintaining staff competencies through regular education and simulation. Despite service interruptions, the hospital manages unplanned deliveries safely (three occurred in October 2025) with post-delivery debriefs to support learning.

The sites are congratulated for achieving compliance with the Required Organizational Practices related to falls prevention, infusion pump safety, venous thromboembolism prophylaxis, safe surgery checklists, medication reconciliation, the use of two patient identifiers, and transfer of information.

Opportunities for improvement include providing training on suicide risk and implementing a comprehensive skin integrity strategy. In the absence of a Saskatchewan Health Authority procedure to support skin integrity, sites are following their previous health authority processes. The SHA is encouraged to develop and implement a comprehensive process for the assessment and management of skin integrity. Additionally, current SHA policies to address the handling, storing, labeling, and disposing of breast milk safely and securely are not in place, and sites are following former health authority guidelines. The SHA is encouraged to develop and implement an updated provincial policy.

The organization is encouraged to disseminate the SHA translation and interpretation services information so that all teams across INH are aware.

Table 24: Unmet Criteria for Obstetrics Services

Criteria Number	Criteria Text	Criteria Type
1.2.7	Translation and interpretation services are available for clients and families as needed.	NORMAL
1.3.6	Optimizing Skin Integrity 1.3.6.1 The team follows the organization's procedure to conduct screening for risk of impaired skin integrity. 1.3.6.2 The team follows the organization's procedure to ensure a comprehensive assessment is conducted for a client who screens positive for risk of impaired skin integrity. 1.3.6.6 The team participates in activities to improve the program to optimize skin integrity as part of the organization's integrated quality improvement plan.	ROP
1.6.9	Established policies on handling, storing, labelling, and disposing of medications and breast milk safely and securely are followed.	HIGH

Service Excellence for Obstetrics Services

Standard Rating: 76.5% Met Criteria

23.5% of criteria were unmet. For further details please review the table at end of this section.

Assessment Results

Across all visited sites, collaborative teamwork was evident. New staff receive extensive orientation, and annual education days are provided specifically for the obstetrical care setting. Performance conversations vary in completeness, and the organization is commended for recognizing this as a priority. Staff in the obstetrical program have access to numerous continuing competency opportunities each year. Dedicated Clinical Nurse Educator resources play a crucial role in supporting and educating the team.

Although feedback is provided at the Director level and above at Northwest Health, where Patient and Family Advisory Committee advisors are embedded, the organization is encouraged to seek feedback from clients and families at the community level. There are additional opportunities to strengthen patient and family engagement to inform planning, service delivery, and quality improvement locally. One suggestion is to conduct patient rounding with individuals who deliver at the site to gather meaningful feedback during their stay.

Obstetrical teams strive to deliver safe and consistent care in across INH. Quality improvement initiatives focused on postpartum hemorrhage have been underway across the north. The MoreOB program supports teams in identifying and mitigating risks, positioning them well to contribute to the development of a comprehensive suicide risk assessment to minimize harm and ensure a safe environment. The organization is encouraged to provide training and education to their Obstetrical teams to deliver safe suicide prevention services.

The hybrid clinical documentation system currently in place poses a patient safety risk during care transitions, particularly in communities serving residents from neighboring provinces. The planned implementation of a standardized system will improve safety and accuracy, allow for more efficient use of staff time, and provide valuable metrics to drive quality improvement. Not all hospitals were engaged in quality improvement activities, and the organization is encouraged to support local sites to scale and spread successes from other obstetrical programs in the organization. Some teams use the MoreOB program for quality improvement initiatives, which may not fully align with Saskatchewan Health Authority's broader quality improvement strategies.

Table 25: Unmet Criteria for Service Excellence for Obstetrics Services

Criteria Number	Criteria Text	Criteria Type
1.1.1	The team co-designs its services with its partners and the community.	HIGH

Criteria Number	Criteria Text	Criteria Type
1.2.3	The team leadership engages with clients and families to determine the required mix of skill levels and experience within the team.	NORMAL
1.2.4	The team works with the organization to co-design its physical spaces to meet its safety and service needs including confidential and private interactions for clients and families.	NORMAL
2.1.10	The team leadership regularly evaluates and documents each staff member's performance in an objective, interactive, and constructive way.	HIGH
2.1.11	The team leadership regularly engages with client and family representatives to gather input and feedback on their roles and responsibilities as well as role design, processes, and satisfaction.	NORMAL
2.1.12	The team leadership supports staff to follow up on issues and opportunities for growth identified through performance evaluations.	HIGH
2.2.4	The team evaluates the effectiveness of its collaboration and functioning, and identifies opportunities for improvement.	NORMAL
4.2.2	Suicide Prevention Program 4.2.2.2 The team leadership ensures the team receives appropriate training and education to deliver safe suicide prevention services. 4.2.2.3 The team leadership ensures the team conducts standardized routine screening for suicide risk, using evidence-informed tools provided by the organizational leaders. 4.2.2.4 The team leadership ensures the team refers clients who screen positive for suicide risk to a person with the competencies to do a suicide risk assessment and put the necessary safety plan in place. 4.2.2.5 The team leadership ensures the team develops an individualized safety plan, based on the goals, abilities and preferences of the person.	ROP

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

Palliative Care Services

Standard Rating: 97.7% Met Criteria

2.3% of criteria were unmet. For further details please review the table at end of this section.

Assessment Results

The Rose Garden Hospice is a 10-bed hospice facility serving the people of Prince Albert and surrounding areas. This facility/program is an excellent example of a citizen/citizens group spearheading the development of an essential service in response to community need. It is also an excellent example of a health authority recognizing the value of a service and developing a services agreement to support, on behalf of the community it serves, the identified essential service. While the community is willing to provide funding for excellent services provided, it is suggested that the SHA review its funding model.

The Rose Garden Hospice demonstrates, the ongoing recruitment and retention of skilled individuals with the attitudes and demeanor suited to palliative/end of life care. Palliative Care services are also provided by home care nurses and a few family physicians, but Rose Garden Hospice is the anchor for Palliative Care Services. The medial director's activity within the community provides easy access to her consultative services both within the acute care sector and the community.

Medication management is ably supported through a contract with a community pharmacy and pharmacist. Required organizational practices for falls prevention, optimizing skin integrity and client identification are in place.

Exemplary person and family-centred focus was demonstrated by all staff (professional, support and administrative). Suggestions for other general spaces are informed by input from clients, families, and/or caregivers. Individuals whose loved one died at Rose Garden Hospice and who had maintained an ongoing mutually supportive relationship was heartwarming.

The team maintains a box for gathering all forms of feedback. Currently, complaints at Rose Garden Hospice are addressed informally and directly by the team when they arise from guests, their families, and/or caregivers. The organization is encouraged to establish a formal process as it continues to mature.

Table 26: Unmet Criteria for Palliative Care Services

Criteria Number	Criteria Text	Criteria Type
3.2.2	The team collaborates with clients, families, and/or caregivers to develop and implement a formal complaints management process to investigate and respond to claims that their rights have been violated.	HIGH

Criteria Number	Criteria Text	Criteria Type
3.2.3	The team provides clients, families, and/or caregivers with information about how to file a complaint or report violations of their rights.	HIGH
3.2.4	The organization has a formal appeal process for clients, families, and/or caregivers who have filed a complaint.	HIGH

Service Excellence for Palliative Care Services

Standard Rating: 90.5% Met Criteria

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

Assessment Results

Clinical excellence is very ably provided by the medical director of Rose Garden Hospice, clinical nurse supervisor and business manager. They are up to date with evidence informed practices specific to palliative care. They could very easily write the book on Best Practices in Palliative Care.

Staff are to be commended for their due diligence and compassionate care and engaging Patient and Family Partners. They have established a reputation as to the place in Central and Northern Saskatchewan to provide such services.

Quality Improvement (QI) activities have been commissioned. However, they are in their infancy. Like many agencies, the clinical and administrative imperatives and person and family-centred focus of care consume much of their time and energy. There are ample opportunities to participate in quality improvement, but they will need some additional support and guidance from the SHA. Practical supports from the SHA might include the use of health sciences students devoting elective time to QI initiatives under medical, nursing and administrative leadership. Rose Garden Hospice, like many components of the health service need practical horsepower to mature its QI activities and learnings.

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

Criteria Number	Criteria Text	Criteria Type
4.3.3	The team identifies measurable objectives for its quality improvement initiatives including specific timeframes for their completion.	HIGH
4.3.4	The team identifies indicators to monitor progress for each quality improvement objective.	NORMAL
4.3.5	The team leadership works with staff to design and test quality improvement activities to meet objectives.	HIGH
4.3.7	The team leadership works with staff to regularly collect indicator data and track progress towards quality improvement objectives.	NORMAL

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

Perioperative Services and Invasive Procedures

Standard Rating: 95.1% Met Criteria

4.9% of criteria were unmet. For further details please review the table at end of this section.

Assessment Results

During the on-site survey, perioperative services and invasive procedures was assessed at Battlefords Union Hospital, Lloydminster Hospital, Melfort Hospital, Northwest Health Facility (endoscopy), and Victoria Hospital.

Overall, perioperative services are functioning effectively across these sites. Equipment is readily accessible, and preventative maintenance is routinely performed. Required Organizational Practices and high-priority criteria are largely integrated into standard workflows. The safe surgical checklist is generally applied, with ten real-time observational audits completed each month; however, at Battlefords Union Hospital, compliance was observed for the first two stages of the checklist, but the third stage was not completed. Full adherence to all three stages is essential to achieve optimal patient safety outcomes.

Operating room utilization data is regularly reviewed and discussed during Surgical Utilization Committee meetings, ensuring that available operating room time is maximized.

Infrastructure challenges were noted at several sites due to aging physical plants, which affect compliance with current standards such as humidity control, proper separation of clean and contaminated areas, and maintaining restricted access. At Battlefords Union Hospital, contaminated items are transported separately from clean and sterilized items; however, both are moved through the same hallway used for patient transfers to and from operating rooms and recovery areas. Staff make every effort to schedule transport during times when the hallway is not in use for patient movement. At Victoria Hospital, contaminated instruments are covered during transport but must pass through a high-traffic area in the operating room to reach a small pre-cleaning reprocessing room outside the operating suite. Instruments are then transported via a support services elevator, which is not dedicated to operating room use, to the Medical Device Reprocessing Department. A new facility is anticipated to open in 2028, which will include expanded space and a dedicated operating room elevator to ensure proper transport of contaminated equipment. Infrastructure deficiencies, including space limitations and transport pathways for contaminated items, should be addressed through interim measures where possible and through the planned new build.

Medication management practices varied across sites. Organization is encouraged to ensure all medication rooms have locked doors and medication labelling practices are standardized. At one site the medication on the sterile field was not labelled and at another site the team keeps medications outside of the sterile field but not labelled.

Follow-up processes for day surgery patients and transitions of care should be reinstated and consistently applied to support continuity of care and improve patient outcomes. At some sites, follow-up calls were previously conducted but discontinued due to staffing changes, while other sites have not implemented this practice in recent memory. At Victoria Hospital, no process for following up with discharged day surgery patients was evident. Similarly, patient follow-up regarding transitions of care was previously in place but has since been discontinued. The organization is encouraged to consider strategies to evaluate the effectiveness of these transitions, such as contacting a sample of patients to gather feedback and using this information to improve services.

Table 28: Unmet Criteria for Perioperative Services and Invasive Procedures

Criteria Number	Criteria Text	Criteria Type
1.1.1	The physical layout of the operating and/or procedure room(s) and equipment are designed to consider client flow, traffic patterns, the types of procedures performed, ergonomics, and equipment movement logistics.	NORMAL
1.1.2	The area where invasive procedures are performed has three levels of increasingly restricted access: unrestricted areas, semi-restricted areas, and restricted areas.	NORMAL
1.1.3	Heating, ventilation, temperature, and humidity in the area where surgical and invasive procedures are performed are monitored and maintained according to applicable standards, legislation, and regulations.	NORMAL
1.2.9	Contaminated items are transported separately from clean or sterilized items, and away from client service and high-traffic areas.	HIGH
1.3.2	Medications in the surgical area are stored in a locked area or similarly secured, as per the organization's policies regarding medication storage.	HIGH
2.6.3	Safe Surgery Checklist 2.6.3.2 The checklist is used for every surgical procedure.	ROP
2.7.3	Every medication and solution on the sterile field is labeled.	HIGH
2.12.16	There is a process to follow up with discharged day surgery clients.	NORMAL

Criteria Number	Criteria Text	Criteria Type
2.12.17	The effectiveness of transitions is evaluated and the information is used to improve transition planning, with input from clients and families.	NORMAL

Service Excellence for Perioperative Services and Invasive Procedures

Standard Rating: 88.2% Met Criteria

11.8% of criteria were unmet. For further details please review the table at end of this section.

Assessment Results

The perioperative services at the sites are recognized for their strong commitment to delivering high quality and safe patient care. Staff consistently demonstrate dedication to patient and family-centered care, which is reflected in positive feedback and data collected through monthly surveys. Leadership within these sites is highly visible and actively engaged, ensuring that employees receive the necessary support and resources to provide surgical services effectively.

Daily visual management huddles are conducted, and quality boards are prominently displayed for staff and public reference. Teams are actively collecting and monitoring performance and outcome data, sharing this information openly with staff and the public. They regularly discuss and plan improvements based on these findings; however, they are encouraged to formalize these processes by documenting their quality improvement activities and reporting on progress. This will help ensure transparency, accountability, and alignment with broader organizational goals. Additionally, sites are encouraged to include patient or family partners in their committee structures to strengthen engagement and collaboration.

The new performance review process has been successfully implemented, and reviews across the various hospitals are currently underway. The initiative is progressing according to plan, with a target completion date of March 31. This process aims to ensure consistency in evaluating staff performance, promote accountability, and support professional development across all sites. Implementing a regular cadence for performance evaluations will promote accountability, support staff development, and ensure that feedback is timely and actionable.

Teams continue to follow the existing policy and guidelines for suicide prevention from the previous health authority, even as the Saskatchewan Health Authority introduces a new policy, procedure, and training for acute care, which is scheduled for implementation in December 2025. The sites are aware of this transition and are encouraged to prepare to meet these updated expectations.

It is suggested that additional strategies be explored to ensure ongoing staff education at perioperative sites, such as developing a standardized virtual education program accessible to all sites, designating regional educators to provide consistent support, and creating collaborative learning opportunities that foster knowledge sharing across facilities.

Table 29: Unmet Criteria for Service Excellence for Perioperative Services and Invasive Procedures

Criteria Number	Criteria Text	Criteria Type
2.1.10	The team leadership regularly evaluates and documents each staff member's performance in an objective, interactive, and constructive way.	HIGH
2.1.12	The team leadership supports staff to follow up on issues and opportunities for growth identified through performance evaluations.	HIGH
4.2.2	Suicide Prevention Program 4.2.2.1 The team leadership ensures the team follows organizational procedures to minimize safety risks and ensure a secure environment for all. 4.2.2.2 The team leadership ensures the team receives appropriate training and education to deliver safe suicide prevention services. 4.2.2.3 The team leadership ensures the team conducts standardized routine screening for suicide risk, using evidence-informed tools provided by the organizational leaders. 4.2.2.4 The team leadership ensures the team refers clients who screen positive for suicide risk to a person with the competencies to do a suicide risk assessment and put the necessary safety plan in place. 4.2.2.5 The team leadership ensures the team develops an individualized safety plan, based on the goals, abilities and preferences of the person.	ROP
4.3.3	The team identifies measurable objectives for its quality improvement initiatives including specific timeframes for their completion.	HIGH
4.3.5	The team leadership works with staff to design and test quality improvement activities to meet objectives.	HIGH

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

Population Health and Wellness

Standard Rating: 94.9% Met Criteria

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

Assessment Results

The Saskatchewan Health Authority selected the Tuberculosis Prevention and Control (TPC) program as the focus for Population Health and Wellness. The tuberculosis (TB) rate per 100,000 population is higher in Saskatchewan than Canada overall. Of note is that this rate is higher in northern Saskatchewan than the south. The distribution of treated latent tuberculosis infection (LTBI) by self-identified ethnicity indicates that the Indigenous and newcomer populations are most affected. This data has assisted the organization in identifying key partners in comprehensive delivery service.

TBC provides tuberculosis (TB) services to all people and communities in Saskatchewan. The intent is to reduce the burden of TB in the province. Working with public health partners, TPC program supports health providers in the early detection of people with TB disease. They prevent, identify, treat and provide follow-up for people with TB infection or TB disease. They prescribe and dispense all anti-tuberculosis medicine in Saskatchewan. Directly observed therapy (DOT) is the standard of treatment for persons with TB disease. Those with TB infection often receive treatment by DOT. The program consists of doctors, nurses, TB workers, a pharmacy, support staff and management.

The aim is to eliminate TB in the province through surveillance, detection, treatment and prevention. Support for a robust public health response to areas and populations disproportionately affected by TB is evident. Care is based on principles of health equity, cultural safety and trauma-informed practice. Strong partnerships are developed and sustained through shared decision-making, respect and understanding

Evidence-informed TB clinical and contact investigation management is the order of the day. In essence, the use of medical evidence creates a feedback loop: clinical data informs public health actions, which in turn are monitored and evaluated to refine future clinical and public health strategies.

Collaboration with partner agencies, including the Medical Health Officers Council of Saskatchewan, population and public health, First Nations health systems and correctional facilities, reveals the comprehensive approach used. Coordination of care and services with all relevant providers including communicable disease teams, community health nurses, public health nurses, home care nurses, TB program workers and other DOT providers, local doctors and nurse practitioners.

The organization is encouraged to continuously review its working relationships with key partners. Saskatchewan manages (LTBI) and active tuberculosis (TB) through its Provincial Tuberculosis Prevention and Control program, which focuses on patient-centred, community-based care. The Saskatchewan Health Authority provides support for TB services, with costs for medication covered by the provincial health card or through federal programs for eligible individuals.

This program is a public health service delivering coordinated and evidence-based tuberculous prevention, surveillance and control services. Importantly, health and social care services are arranged through this office. A matrix service delivery model is in place which includes Public Health, community partners, medical health officers and several federal partners. Well done!

This is an essential and very well coordinated program. Leadership is well connected nationally and internationally, participating in and contributing to scientific meetings. More important is their openness and willingness to participate in critical thinking and review. Data required for an effective TB prevention

and control program is evident. At the same time there is an opportunity for a quality review of data integrity. A recent report (2024) from the Provincial Auditor of Saskatchewan has raised concerns about the data integrity and management of tuberculosis (TB) surveillance, highlighting a need for better tracking, analysis, and reporting to effectively manage the disease in the province. This is an opportunity for the Saskatchewan Health Authority to engage in a data integrity quality improvement initiative in collaboration with the key players in Tuberculosis Prevention and Control. The organization is encouraged to continue to address clinical information system challenges and connectivity between several systems.

The facility space, which is leased in a busy, downtown primary healthcare community practice, is appropriately located and accessible. The area allotted for this clinic is small. The preparation and storage of medicines for dispensing is very cramped for staff and clientele. There is an opportunity to consider space requirements now and for the future.

We met with a community partners focus group specific to corrections, primary health care and TB prevention and control. Discussions with the team identified some information sharing challenges.

The sharing of health information, duly obtained through a health professional relationship may not be easily shared with another health professional with a different jurisdictional identifier. Denying access to health information that has been determined to another health professional because they “are not SHA” is a concern. It is suggested that the SHA review its information sharing barriers and explore potential options to support continuous and comprehensive primary care without roadblocks. There are challenges in some areas regarding jurisdictions.

Activities that foster better collaboration would enhance the impact of Tuberculosis Prevention and Control is encouraged. In Prince Albert, there is a further opportunity to address the stigma and barriers to access to service faced by clients. It is suggested to review of why this experience is different in Regina and Saskatoon may assist in this regard. As well, it is suggested that the SHA review Mental Health and Primary Health services in Prince Albert to evaluate gaps and barriers as partnerships are fragmented.

The earlier comment about follow-up as part of TB identification, prevention, and treatment need reiteration. The impact of continuity on quality and outcome is often not understood. More effective impact would be enhanced with the presence of a dedicated social worker. There are many psychosocial needs not being efficiently addressed. The professional and support staff are aware of this. Currently they are doing the best they can, driven by a sense of responsibility and understanding of the linkages between health and social care. There is a need to better address health determinants such as housing and poverty. Knowledge of available support programs and an individual’s eligibility are key to successes. These issues may be better addressed by additional partnerships. The relationships with Band Councils and Indigenous Health Services and Provincial/Federal agencies are complicated despite sharing an overall goal for the care of people.

Table 30: Unmet Criteria for Population Health and Wellness

Criteria Number	Criteria Text	Criteria Type
4.1.5	The organization uses the information system to generate regular reports about performance and adherence to guidelines, and to improve services and processes.	NORMAL

Criteria Number	Criteria Text	Criteria Type
5.1.6	The organization shares information about its successes and opportunities for improvement, improvements made, and what it is planning for the future with staff, service providers, clients and families.	NORMAL

Primary Health Care Services

Standard Rating: 77.0% Met Criteria

23.0% of criteria were unmet. For further details please review the table at end of this section.

Assessment Results

Primary health care services were assessed at a total of six sites in Prince Albert (Diabetes Education Centre, Community Wellness Bus), Hafford, Macklin, Spiritwood and Lloydminster (Prairie North Plaza). The SHA is commended for noting Primary Health Care is a priority and its importance as a first point of contact with the health system for many. Several system wide initiatives are underway such as expanding access to STBBI care and the development of a COPD pathway.

The organization is also commended for its ongoing commitment to supporting expansion of Patient Medical Home (PMH) sites. This may assist with improved performance for lowering primary care sensitive conditions emergency department visit rates.

Service needs are based on the population characteristics of the geographic areas served. Further, collaboration with the Ministry has enabled access to data to determine new PMH sites. The organization has developed key priority areas using data. An example has been the development of Chronic Disease Provincial Clinical Network (PCN) where work is underway and encouraged to continue. At the site level, there is the opportunity to enhance the use of aggregate data from the clinical information. This can assist in informing local service priority areas. Each location has various local partnerships with others based on the population and the services available in the surrounding area. Ongoing linkages with First Nations communities are encouraged.

The Prince Albert Community Wellness Bus is an innovative mobile health service launched by the SHA to provide primary and urgent care to those that have difficulty accessing traditional health services. People without a home have learned they can access these services easily. It offers services like basic exams, vaccinations and naloxone kits. It also aims to connect individuals with other community supports. The bus is staffed by a NP, LPN and mental health assessor coordinator. It operates year-round to deliver service in a culturally responsive stigma free manner. Service provision is conducted in a most remarkable non-judgmental and effective way. There are plans to expand availability to students at a local college that do not have access to regular primary care services.

There is an opportunity to ensure all primary care clinics consider determinants of health when undertaking comprehensive health assessments as well as support the application of Choosing Wisely in primary care at all primary care sites.

Patient demands and available primary care resources vary from site to site. Many struggle with equitable access due to excessive community demands for service and a lack of physician/nurse practitioner (NP) resources. As primary care evolves further, there will be a need to apply the Health Equity value.

Many locations were observed to support client self-management. Some do this through the provision of information and/or referrals to other visiting services such as physiotherapy. There is an opportunity to share self-management strategies across sites.

Resource availability as well as population needs impact the ability of many sites to provide after-hours service. Communities are advised and supported to use the provincial HealthLine 811 service.

At the time of the surveyor visit, involvement of clients and families in staff orientation and professional development was not evident. All primary care sites are encouraged to explore opportunities to patient and family involvement. There is an opportunity to enhance communication about clients' rights and responsibilities at some sites. Placement of the new posters should be in patient areas.

Interprofessional practice varies between sites based on available staff resources. In some areas there is a need to further promote team-based care within existing staff. It is suggested that the organization consider mechanisms to enhance team-based care in primary care.

Understanding of the organization's ethics management processes varies between sites. There is an opportunity to ensure all sites are supported in their awareness of the ethics management framework and provided with ongoing education.

All sites were aware of falls prevention. Routine falls risk assessments are not applicable for many primary care visits. Some sites serve a predominantly older adult population. Teams are encouraged to consider falls prevention activities as part of the overall quality plan. It is suggested that this work be done in collaboration with home care and visiting rehabilitation services where they exist.

Routine screening for risk of impaired skin integrity does not occur in primary care and sites are encouraged to add this to their practice. Should any concerns arise, consultations are made immediately to home care.

Medication reconciliation formal processes are not implemented in the current EMR instance. Lists or medications are well recorded. This is an opportunity to explore how the organization's medication reconciliation procedure can be better supported in the primary care EMR. There is an opportunity to ensure consistency between sites on reporting incidents that could have harmed or did harm a client related to maintaining an accurate list of medications during care transitions as safety incidents.

There was limited evidence on the use of information system data use beyond day-to-day practice functions. There is the opportunity to explore how aggregate date gathered from the EMR can inform adherence to evidence-based practice.

The monitoring and validation of the EMR data varies across sites. There is the opportunity to explore this issue and provide guidance to the sites.

Very few transitions of care occur in primary care. Transition do occur when consultant care is accessed and when inpatient admissions occur. There is an opportunity to evaluate the effectiveness of these transitions. Of note is the need to evaluate the timeliness of communication between primary care and inpatient care.

Table 31: Unmet Criteria for Primary Health Care Services

Criteria Number	Criteria Text	Criteria Type
1.1.7	The organization applies a health equity lens to the development of policies, programs, and services to meet population needs.	NORMAL
1.3.5	The organization supports client self-management of their conditions by facilitating their access to education, resources, and tools.	NORMAL

Criteria Number	Criteria Text	Criteria Type
2.1.4	The organization has an out-of-office and after-hours care process for clients and families who require access to primary care services outside of regular business hours.	NORMAL
2.1.7	The team uses a virtual health service to support clients, including vulnerable and remote client populations, in their homes, where feasible and appropriate.	NORMAL
3.1.3	The organization includes clients and families in providing the team with education about the value of people-centred care, as part of initial orientation and through ongoing professional development.	HIGH
3.2.2	The team works collaboratively with interdisciplinary providers to deliver coordinated services to clients who have complex and multiple health needs.	NORMAL
4.1.9	The organization proactively identifies, manages, and addresses ethics-related issues.	HIGH
5.1.3	Preventing Falls and Reducing Injuries from Falls 5.1.3.2 The team follows the organization's procedure to conduct screening for risk of falls and injuries from falls. 5.1.3.3 The team follows the organization's procedure to ensure a comprehensive assessment is conducted for a client who screens positive for risk of falls or injuries from falls. 5.1.3.4 The team implements interventions to prevent falls and reduce injuries from falls as part of the client's individualized care plan. 5.1.3.6 The team participates in continuous learning activities about the program to prevent falls and reduce injuries from falls. 5.1.3.7 The team participates in activities to improve the program to prevent falls and reduce injuries from falls as part of the organization's integrated quality improvement plan.	ROP

Criteria Number	Criteria Text	Criteria Type
5.1.4	Optimizing Skin Integrity 5.1.4.1 The team follows the organization’s procedure to conduct screening for risk of impaired skin integrity. 5.1.4.2 The team follows the organization’s procedure to ensure a comprehensive assessment is conducted for a client who screens positive for risk of impaired skin integrity. 5.1.4.4 The team follows the organization’s procedure to report health care associated impaired skin integrity as a safety incident. 5.1.4.5 The team participates in continuous learning activities about the program to optimize skin integrity. 5.1.4.6 The team participates in activities to improve the program to optimize skin integrity as part of the organization’s integrated quality improvement plan.	ROP
5.1.11	The team assesses and documents clients' social determinants of health.	NORMAL
5.1.12	The team assesses and documents clients' experiences with violence and the consequences of those experiences.	HIGH
5.3.2	Maintaining an Accurate List of Medications during Care Transitions 5.3.2.3 The team follows the organization’s procedure to report incidents that could have harmed or did harm a client related to maintaining an accurate list of medications during care transitions as safety incidents.	ROP
5.3.11	The organization has processes to prevent inappropriate testing.	NORMAL
5.5.4	The organization has a mechanism to follow clients through the referral and consultation processes, to monitor the client's progress.	NORMAL

Criteria Number	Criteria Text	Criteria Type
5.6.7	Information Transfer at Care Transitions 5.6.7.5 The effectiveness of communication is evaluated and improvements are made based on feedback received. Evaluation mechanisms may include: • Using an audit tool (direct observation or review of client records) to measure compliance with standardized processes and the quality of information transfer • Asking clients, families, and service providers if they received the information they needed • Evaluating safety incidents related to information transfer (e.g., from the patient safety incident management system)	ROP
6.1.3	The organization uses the information system to generate regular reports about performance and adherence to evidence-based practice, and use the reports to improve services and processes.	NORMAL
6.1.4	The organization monitors and validates the quality of the data in its clinical information system.	NORMAL
6.1.5	The organization works with the team to regularly review and improve its clinical information system and improve the use of data extracted from the system.	NORMAL
6.2.2	The organization tracks clients' ability to access its services and uses the information to improve its services.	NORMAL
6.2.3	The team evaluates the effectiveness of care transitions and uses the information to improve transition planning.	HIGH
6.2.4	The organization regularly obtains and incorporates feedback from the team about their perspectives on the quality of services and care experiences.	NORMAL

Criteria Number	Criteria Text	Criteria Type
6.2.5	The organization consults regularly with its partners to collect information, identifies and addresses gaps in the continuum of care, and improves services for its underserved populations.	NORMAL
6.2.6	The organization compares its results with other similar services, programs, or organizations.	NORMAL

Service Excellence for Primary Health Care Services

Standard Rating: 69.6% Met Criteria

30.4% of criteria were unmet. For further details please review the table at end of this section.

Assessment Results

Visual management boards were evident throughout the primary care sites. Huddles are occurring but inconsistent as medical staff are stretched and attendance difficult. The SHA is supported in its plans to support quality improvement throughout primary care. There is the opportunity to formalize quality improvement activities in primary care. Opportunities to collaborate with home care services in addressing priority areas of improvement should be investigated.

Education and training on how to work respectfully and effectively with clients and families of diverse cultural backgrounds, religious beliefs, and personal care needs varies between sites. There are numerous opportunities provided by the organization. There is the need to enhance participation of primary care staff in education and training on several topics including suicide prevention, ethics, workplace safety and workplace violence.

As client and family engagement activities evolve in primary care across the organization, it is suggested that leadership explores gathering input regarding training and education for all staff.

Performance evaluations are not up to date and complete at most sites. There is work underway to have these competed in the near future and this is encouraged to continue.

Table 32: Unmet Criteria for Service Excellence for Primary Health Care Services

Criteria Number	Criteria Text	Criteria Type
1.2.3	The team leadership engages with clients and families to determine the required mix of skill levels and experience within the team.	NORMAL
2.1.4	The team leadership ensures that staff are provided with education and training on how to work respectfully and effectively with clients and families of diverse cultural backgrounds, religious beliefs, and personal care needs.	NORMAL
2.1.5	The team leadership ensures that staff are provided with education and training on the organization's ethics framework.	NORMAL

Criteria Number	Criteria Text	Criteria Type
2.1.9	The team leadership ensures that staff are provided with education and training on identifying and addressing palliative and end-of-life care needs.	HIGH
2.1.10	The team leadership regularly evaluates and documents each staff member's performance in an objective, interactive, and constructive way.	HIGH
2.1.11	The team leadership regularly engages with client and family representatives to gather input and feedback on their roles and responsibilities as well as role design, processes, and satisfaction.	NORMAL
2.1.12	The team leadership supports staff to follow up on issues and opportunities for growth identified through performance evaluations.	HIGH
2.3.5	The team leadership ensures that staff are provided with education and training on occupational health and safety regulations and organizational policies related to workplace safety.	HIGH
2.3.6	The team leadership ensures that staff are provided with education and training on how to identify, reduce, and manage safety risks.	HIGH
2.3.7	The team leadership ensures that staff are provided with education and training on how to prevent and manage workplace violence, including abuse, aggression, threats, and assaults.	HIGH
4.2.2	Suicide Prevention Program 4.2.2.2 The team leadership ensures the team receives appropriate training and education to deliver safe suicide prevention services. 4.2.2.3 The team leadership ensures the team conducts standardized routine screening for suicide risk, using evidence-informed tools provided by the organizational leaders.	ROP

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

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

Public Health Services

Standard Rating: 75.9% Met Criteria

24.1% of criteria were unmet. For further details please review the table at end of this section.

Assessment Results

Public health services were assessed at three sites in Melfort, LaRonge and Meadow Lake.

PH clinics manage communicable disease control, immunization, pre & post-natal care, breastfeeding, child health, and harm reduction. All the PH programs have a delegated Medical Health Officer (MHO) working in a matrix format with the Population Health and Primary Care to focus on the SHA directives of aging friendly communities and early childhood.

With the surveillance data the MHOs have determined the primary focus of PH would be Sexually Transmitted Blood-Borne Infections (STBBI), chronic diseases, mental health, women's health and communication with the first nations. Secondary focus would be on disease prevention, environmental health and emergency and disaster planning. The front line is at this time unaware of the PH emergency response as a part of the broader all-utilized disaster and response plan, or awareness related to a formal public health emergency response plan.

At this time in the maturation of the SHA, there seems to be a loss of communication between the corporate and the northern health team. The northern health teams are spread thin, are not standardized and have developed their own focus versus the community needs due to the barriers of care. There is a disconnect between the SHA directives, the MHO priorities and the work being done in the PH clinics.

One example is the testing and treatment of STBBI. The data shows extremely high rates in all the population. For clients to receive testing and treatment the requisitions require a physician order. In Melfort PH when the clients present at the PH clinic and primary care they are sent to the emergency room for treatment. Prince Albert has a STBBI clinic where the MHO has provided the delegated task for nursing to prescribe treatment. This is not the case in any other clinic and there is not equitable access. The SHA is encouraged to find a solution to standardize the testing and treatment for STBBI. This would provide more equity of care, outside of the emergency room.

PH MHO have created their priorities including STBBI. This is an opportunity to have increased communication between the SHA and the MHO to the front-line staff to perhaps standardize and equalize availability for the north to tackle this burden. There is a lot of staff anxiety around the, "growing mountain of STBBI", and suggest something be done as soon as possible, and not wait for a "5-year plan".

The public health inspection team are very diligent with knowledge and years of experience supporting safe and healthy environments across INH through education, consultation, inspection, monitoring, and enforcement of health legislation, regulations, and standards. This includes inspections of restaurants and other types of food facilities, communicable disease investigations, and inspection and monitoring of public recreation facilities, public accommodations, water supplies, and sewage disposal systems. This team feels valued and heard despite the vacancy of positions.

The immunization clinics are a strong point of the care provided. Despite the above concerns the staff in the PH clinics were warm and welcoming. The staff work with the intent to improve the lives of the people in the entire community and surrounding area. They interact with a caring and friendly manner with their new moms, kids in the children's clinics, trying to make vaccinations painless. Despite the workload staff will immediately attend to any urgent requests. With the small number of nurses, they are a mighty team.

There is no evidence that quality improvement initiatives are selected, carried out, and evaluated in a structured way, although there is evidence that selected indicators such as hand hygiene and immunization rates are being monitored. In the PH clinics staff are pleased with the use of huddles and visibility boards being reintroduced. This activity is a helpful starting point for Continuous Quality Improvement (QI) but most criteria for QI are not met because there is not a structured, proactive approach and operations staff do not feel that they can do an adequate job facilitating quality initiatives off the side of their desks. They state that this is because the dedicated resources that they had pre-SHA are no longer available and there has been very little support from the organization to educate and help facilitate quality improvement initiatives.

Lastly, there is an opportunity to regularly evaluate team member performance and document this in an objective, interactive, and constructive way across sites.

Table 33: Unmet Criteria for Public Health Services

Criteria Number	Criteria Text	Criteria Type
1.1.1	A population health assessment is conducted at least every five years.	HIGH
1.1.3	The data from the population health assessment is compared with other jurisdictions to identify potential gaps and priority areas.	NORMAL
1.1.7	As part of the population health assessment, information about the physical or built environment and its health implications is accessed and analyzed.	NORMAL
1.1.8	As part of the population health assessment, information about the social environment and its health implications is accessed and analyzed.	NORMAL
1.1.9	A variety of methods are used to share population health assessment results with the organization's leaders, partner organizations, stakeholders, and the general public.	NORMAL
2.1.6	Public health services are designed to address the particular needs of populations at higher risk, with input from the community.	NORMAL

Criteria Number	Criteria Text	Criteria Type
2.1.7	Public health services are designed to be easily accessible by the population, with input from the community.	NORMAL
2.1.8	Public health services are designed to address risks that impact health in the physical and built environments identified in the population health assessment, with input from the community.	NORMAL
2.1.10	There is access to sufficient laboratory capacity in the community to meet the needs of the local public health system.	HIGH
3.1.3	Team member performance is regularly evaluated and documented in an objective, interactive, and constructive way.	HIGH
4.1.3	A population health improvement plan is jointly developed and implemented with partners, stakeholders, and the community.	HIGH
5.1.1	Communication strategies are developed based on evidence, best practices, research, and the population health assessment.	HIGH
5.1.2	Essential public health information is communicated at multiple levels using messages tailored to the priority audience.	NORMAL
6.1.2	When emerging and immediate risks to population health are identified, prevention services are delivered in a timely way.	HIGH
6.1.5	Services that support communicable disease prevention, including sexually transmitted infections, are provided.	HIGH
7.2.1	There is a public health emergency response plan that is integrated with the organization's broader all-hazard disaster and emergency response plan.	HIGH

Criteria Number	Criteria Text	Criteria Type
7.2.7	The public health emergency response is tested as part of broader all-hazard disaster and emergency response plan drills.	NORMAL
9.2.1	Information and feedback is collected about the quality of services to guide quality improvement initiatives, with input from clients and families, team members, and partners.	NORMAL
9.2.2	The information and feedback gathered is used to identify opportunities for quality improvement initiatives and set priorities, with input from clients and families.	NORMAL
9.2.3	Measurable objectives with specific timeframes for completion are identified for quality improvement initiatives, with input from clients and families.	HIGH
9.2.4	Indicator(s) that monitor progress for each quality improvement objective are identified, with input from clients and families.	NORMAL
9.2.5	Quality improvement activities are designed and tested to meet objectives.	HIGH
9.2.6	New or existing indicator data are used to establish a baseline for each indicator.	NORMAL
9.2.7	There is a process to regularly collect indicator data and track progress.	NORMAL
9.2.8	Indicator data is regularly analyzed to determine the effectiveness of the quality improvement activities.	HIGH
9.2.9	Quality improvement activities that were shown to be effective in the testing phase are implemented broadly throughout the organization.	HIGH

Criteria Number	Criteria Text	Criteria Type
9.2.10	Information about quality improvement activities, results, and learnings is shared with clients, families, teams, organization leaders, and other organizations, as appropriate.	NORMAL
9.2.11	Quality improvement initiatives are regularly evaluated for feasibility, relevance, and usefulness, with input from clients and families.	NORMAL

Reprocessing of Reusable Medical Devices

Standard Rating: 81.9% Met Criteria

18.1% of criteria were unmet. For further details please review the table at end of this section.

Assessment Results

During the on-site survey, reprocessing of reusable medical devices was assessed at three sites: Battlefords Union Hospital, Lloydminster Hospital, and Victoria Hospital.

Staff in these areas demonstrated strong commitment and a proactive attitude in supporting operating rooms, other hospital departments, and external healthcare providers. The workflow from contaminated to clean areas was generally well managed; however, at some sites, contaminated and clean items shared corridors that were also used for patient movement, requiring careful coordination to maintain safety. The sites are encouraged to ensure cleaning schedules are posted at all times.

Onboarding processes were robust, with mandatory certification prior to employment and creative strategies to support continuous learning. Reprocessing services were also provided to local healthcare providers, enhancing patient safety, though these arrangements lacked formal agreements. The organization is encouraged to formalize these services through contracts to ensure accountability.

Infrastructure challenges were evident, including space limitations, porous ceilings, damaged doors, and compromised walls, which increase occupational health and safety risks. The organization is encouraged to prioritize maintaining dedicated handwashing sinks, regularly inspecting eyewash stations, and ensuring spill kits are available. At Lloydminster, Medical Device Reprocessing (MDR) lacks a spill kit and the decontamination area does not have an eye wash station. At Battlefords Union Hospital, a handwashing sink is currently used for scope cleaning; efforts are underway to restore it for hand hygiene. The organization is strongly advised to maintain sinks for their intended purpose and avoid repurposing them.

Policies and standard operating procedures were outdated at Battlefords Union and Lloydminster Hospitals. The organization is encouraged to update these documents, standardize them provincially where appropriate, and harmonize practices across sites. Lloydminster’s Medical Device Reprocessing team does not currently undergo regular performance or competency evaluations. It is recommended that the organization leverage the expertise of certified technicians to conduct routine assessments. At Victoria Hospital, the manager is completing training on the new performance appraisal system and plans to implement staff evaluations soon.

Battlefords Union and Victoria Hospitals are encouraged to establish formal quality improvement processes for reprocessing services, creating a standardized framework that all sites can adopt and implement locally.

Table 34: Unmet Criteria for Reprocessing of Reusable Medical Devices

Criteria Number	Criteria Text	Criteria Type
1.1.1	Information about service volumes is collected at least annually from all areas in the organization that require reprocessing services, and is shared with the Medical Device Reprocessing (MDR) department.	HIGH
1.3.6	The Medical Device Reprocessing (MDR) department has floors, walls, ceilings, fixtures, pipes, and work surfaces that are easy to clean, non-absorbent, and will not shed particles or fibres.	HIGH
1.3.7	The Medical Device Reprocessing (MDR) department is clean and well-maintained.	HIGH
2.1.11	Team member performance is regularly evaluated and documented in an objective, interactive, and constructive way.	HIGH
2.1.12	Team members are supported by team leaders to follow up on issues and opportunities for growth identified through performance evaluations.	HIGH
2.1.13	Ongoing professional development, education, and training opportunities are available to each team member.	NORMAL
2.2.6	Education and training are provided on how to identify, reduce, and manage risks to client and team safety.	HIGH
3.1.1	Clear and concise policies are developed and maintained for reprocessing services.	HIGH
3.1.5	Clear and concise standard operating procedures (SOPs) are developed and maintained for reprocessing services.	NORMAL

Criteria Number	Criteria Text	Criteria Type
3.1.9	Policies and standard operating procedures (SOPs) are regularly updated, and signed off according to organizational requirements, as appropriate.	HIGH
3.2.2	The reprocessing area's designated hand-washing sinks are equipped with faucets supplied with foot-, wrist-, or knee-operated handles, electric eye controls, automated soap dispenser and single-use towels.	NORMAL
5.3.1	There is a quality improvement program for reprocessing services that integrates the principles of quality control, risk management, and ongoing improvements.	NORMAL
5.3.2	Information and feedback is collected about the quality of services to guide quality improvement initiatives with input from stakeholders and team members.	NORMAL
5.3.3	The information and feedback gathered is used to identify opportunities for quality improvement initiatives and set priorities with input from stakeholders.	NORMAL
5.3.4	Measurable objectives with specific timeframes for completion are identified for quality improvement initiatives with input from stakeholders.	HIGH
5.3.5	Indicator(s) that monitor progress for each quality improvement objective are identified, with input from stakeholders.	NORMAL
5.3.6	Quality improvement activities are designed and tested to meet objectives.	HIGH
5.3.7	New or existing indicator data are used to establish a baseline for each indicator.	NORMAL

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