Provincial Hoshin:
Improve access for patients and reduce ED waits by 60%, necessary improvements in key areas will be achieved by 2019.

PAPHR Hoshin #1 (Overview)

Acute Care Flow (by March 31, 2018)

- **Appropriateness - Decreasing Consults** - Decrease re-consults in acutely ill adult inpatients by 50%
- **Meeting ELOS For Non-admitted ED Patients** - ED LOS @ 90th percentile  
  CTAS I-III = 8 hrs (non-adm pts) CTAS IV-V = 4 hrs (non adm pts)
- **Decreasing Hospital Utilization Of COPD Patients** - 10% decrease in hospital utilization for patients managing COPD
- **Decreasing wait time for psychiatry** – 10% reduction from baseline for psychiatry wait times for clients triaged as moderate (T3) and mild (T4).
- **Suicide Prevention** – 100% of all residents will have the Suicide Prevention screening and assessment protocol.
- **HIV Testing** – 10% increase from previous year’s values for completed HIV screening tests.
By March 31, 2018 fully implement a provincial Safety Alert/Stop the Line (SA/STL) in All Acute Care Units provincially. Zero Harm to all patients/staff by Mar. 31, 2020.

PAPHR Hoshin #2 (Overview for Patients and Staff)

Reduce Workplace Injuries by March 31, 2018:
• Implement elements 1-3 of SMS in all PAPHR facilities
• Implement elements 1-6 in HBH, Whispering Pines Place & Birchview

Sick Time Reduction
• 10% reduction in sick time hours from previous years rates.

Hand Hygiene – 80% audited hand hygiene compliance rate across the organization.

Implement SA/STL System in test site by March 31, 2018:
• Roll-out of STL to all Acute Care units
• 100% of incident report actions closed with report writers
• 10% Increase of “Near Miss” Reporting vs. Actual Harm
• Operationalize Safety Huddles across Region (daily for key clinical areas)

Clinical Support Services

ED Waits & Access...by March 31, 2018

• Timely results will be provided to all patients so they can be discharged from the ED.

• Improve COPD patients’ access to Pharmacist services.
  → % of COPD patients readmitted to hospital with 28 days of seeing Pharmacy. (collecting baseline data)
Computed Tomography (CT) Wait - days

Ultrasound Waits - days

June 2017 Vis Wall
Echo Waits - days

June 2017 Vis Wall

PAPHR Overall Hand Hygiene Compliance Rate by Year

June 2017 Vis Wall
Senior Medical Officer

ED Waits & Access...by March 31, 2018

- Target: Appropriateness – increased cooperative management of acutely ill adult inpatients
  - Reduce by 50% the # of re-consults to specialists in acute care
  - Target 7% re-consult rate
% Acutely Ill Adult Inpatients Reconsulted from same Specialty & Diagnosis (2016)

Source: Senior Medical Officer. Data provided by M. Chicoine Health Records as available & analysed by C. Leschyshyn
Operational Definition: # of adult inpatients reconsulted by same specialty/total adult inpatients consulted x 100.

Concern

Appropriateness of Care - Pre-Operative Evaluation Guideline Compliance
By March 31, 2018, there will be 80% compliance with the agreed upon pre-operative evaluation guidelines in the four selected health regions that implemented the guidelines.

Target: ≥ 80% Compliance

Operational Definition: # of surgical patients following the Elective Surgery Preoperative Testing Guidelines compared to the total sample of surgical patient charts audited. Charts will be audited following the launch of the Guide.
By March 31, 2018, each RHA will complete implementation of at least two clinical quality improvement projects.

By March 31, 2018, each RHA will have at least one physician participating in clinical quality improvement training.

Target: ≥ 1 physician(s)

Target: ≥ 2 projects

Senior Medical Officer

Safety...by March 31, 2018

- Target: Hand Hygiene 80% compliance
Physician Hand Hygiene Compliance by Department

Data Current as of: November 2016
Report Contact: Dr. Randall Friesen
Source: Hand Hygiene Audits
Operational Definition: Percent of Physicians observed in compliance with Hand Hygiene best practices.
Primary Health Care
ED Waits & Access...by March 31, 2018

- Decrease in hospital utilization for patients managing COPD – 10% decrease from 2016-17 baseline

- Decrease in wait times for psychiatry -- 10% reduction from baseline in psychiatry wait times for clients triaged as Moderate (T3) and Mild (T4)
Wait times for Adult referrals to Psychiatry not meeting benchmark by Triage Level - May 2017

Operational Definitions
CDM-QIP = Chronic Disease Management Quality Improvement Program

Flowcharts (visits) can be submitted for the following chronic conditions: Coronary Artery Disease, Diabetes, Chronic Obstructive Pulmonary Disease (COPD) & Heart Failure

% was calculated as follows: total # of clinicians with 2 or more visits submitted & saved / total # of clinicians with clinic days that month

June 2017 Vis Wall
### Wait times for Child & Youth referrals to Psychiatry not meeting benchmark by Triage Level - May 2017

#### May 2017 Child & Youth Psychiatry T4

<table>
<thead>
<tr>
<th>Triage Level</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
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</thead>
<tbody>
<tr>
<td>Mild</td>
<td>9</td>
<td>22</td>
<td>44</td>
<td>46</td>
<td>37</td>
<td>62</td>
<td>50</td>
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<tr>
<td>Target</td>
<td>50</td>
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<td>50</td>
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<td>50</td>
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</table>

<table>
<thead>
<tr>
<th>Triage Level</th>
<th>1</th>
<th>2</th>
<th>3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mild</td>
<td>1</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Target</td>
<td>10</td>
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<td>10</td>
</tr>
<tr>
<td>Triage Level</td>
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</tbody>
</table>

### May 2017 Child & Youth Psychiatry T3 Moderate

#### May 2017 Child & Youth Psychiatry T2

<table>
<thead>
<tr>
<th>Triage Level</th>
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<th>3</th>
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</thead>
<tbody>
<tr>
<td>Severe</td>
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<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Target</td>
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<td>10</td>
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</tr>
<tr>
<td>Triage Level</td>
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<td>11</td>
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</table>

<table>
<thead>
<tr>
<th>Triage Level</th>
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<th>2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Very Severe</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Target</td>
<td>20</td>
<td>20</td>
</tr>
<tr>
<td>Triage Level</td>
<td>20</td>
<td>20</td>
</tr>
</tbody>
</table>

### June 2017 Vis Wall

#### Primary Health Care

**Safety...by March 31, 2018**

- **Increase Childhood Immunization Rates** -- 1% increase from 2016 RHA coverage rate for:  
  - Pertussis – 1 valid dose by 91 days of age  
  - Measles– 1 valid dose by 2 years of age  
  - Measles– 2 valid doses by 5 years of age

- **Increase in # of HIV Tests performed** – 15% increase from 2016-17 Ministry Target

- **Promote Take Home Naloxone Kit (THNK) distribution within region**
% infants in PAPHR with one valid dose of Pertussis-containing vaccine by 91 days of age

% children in PAPHR with one valid dose of Measles containing vaccine by 2 years of age

% children in PAPHR with one valid dose of Measles containing vaccine by 5 years of age

June 2017 Vis Wall

Number of Lab Tests Performed in PAPHR for HIV per Month 2017-2018

Operational Definitions:
Graph based on data from Sask Disease Control Laboratory (SDC). Includes all HIV tests that were drawn in PAPHR labs. Includes tests ordered by providers both inside & outside of region.

2017-18 PAPHR Goal: 15% increase in # of HIV tests from the Ministry Target (> 583 tests/month)

June 2017 Vis Wall
Integrated Health Services
ED Waits & Access...March 31, 2018

- Target: Meet expected length of Stay (ELOS) for non-admitted ED patients @ 90th percentile.
  → CTAS I-III = reduce to 8 hours
  → CTAS IV-V = reduce to 4 hours

- Target: 100% of all LTC residents will have the suicide prevention screening and assessment protocol.
ED length of stay: non-admitted: CTAS IV/V: 90th percentile in hours

Deaths in ED, transfers, and patients that left against medical advice or without being seen are not included.

For patient safety, the 5K target is capped at 4 hours rather than a 60% reduction from 2013-14 base.

ED length of stay: admitted patients: 90th percentile in hours

Deaths in ED, transfers, and patients that left against medical advice or without being seen are not included.

June 2017 Vis Wall
Integrated Health Services

Safety...March 31, 2018

- Target: Implementation of Safety Management System
  - By March 31, 2018 continued implementation of elements 1-6 of Safety Management System at Herb Bassett Home, Whispering Pine Place, and Birchview.
  - See Human Resources

Human Resources

ED Waits & Access...by March 31, 2018

- Target: 75% of all managers will be trained on recruitment and retention.
  - # of new managers trained on R&R
  - wage driven premium hours
  - sick time hours
Target: 75% of all managers will be trained on recruitment and retention.

→ # of new managers trained on R&R

June 2017 Vis Wall
Human Resources
Safety...by March 31, 2018

Target: Reduce Workplace Injuries:
→ 50% of accepted WCB shoulder and back claims
→ 100% of accepted WCB shoulder and back claims investigated to Root Cause Analysis (RCA)
→ 75% of accepted WCB workplace injury claims

Target: Safety Management System (SMS):
→ 100% of SMS implemented – Herb Bassett Home
Outcome: By March 31, 2020, Zero Workplace Injuries

Workplace Injury Claims - 75% Reduction in 2017-18

- 2011-12 WCB Baseline - 239 injury claims
- 75% reduction in 2017-18 (not exceeding 60 accepted injury claims)

Outcome: By March 2020, Zero Workplace Injuries

Accepted WCB Shoulder and Back Injury Claims - 50% Reduction in 2017-18

- 2016-17 Baseline - 71 shoulder & back injury claims
- 50% reduction in 2017-18 (not to exceed 35 shoulder & back claims)
### Corporate Services

**ED Waits & Access...by March 31, 2018**

- **Target:** 100% of the time the right diet tray will be provided to the right patients.  
  → # of diet errors to patients (internal & external to department)

- **Target:** Reduce number of unresolved helpdesk tickets by 50% by March 31, 2018  
  → # of unresolved helpdesk tickets on the first day of each month
Operational Definition: Diet errors (defects) that have been identified by Nutrition and Food Services. Potential errors were caught before reaching the patient and actual errors did reach the patient. High Risk errors are those that could potentially c

PAPHR: Diet Errors in Nutrition and Food Services 2017/18

Operational Definition: Chart represents # of unresolved helpdesk tickets. Target is to reduce
Corporate Services

Safety...by March 31, 2018

- Target: XX% preventative maintenance and planned work on beds and lifts region wide.
  - % of PM on beds and lifts
  - % of work order for equipment breakdown for beds and lifts
  (graphs under development)

- Target: Complete cleaning procedure audits on 100% Environmental Services staff by March 31, 2018.
  - # of completed audits of cleaning procedures at the end of each month
  - # of staff who passed the audit of cleaning procedures (mark of 85% or higher) each month

June 2017 Vis Wall

PAPHR 2017/18 ES Audits - Cleaning Procedure

Operational Definition: This graph shows the number of completed audits of cleaning procedure by ES staff. The goal is to audit a minimum of eight (8) staff per month so as to completely carry out the audits on all 90 ES staff complement before the end.
Operational Definition: This graph shows the number of ES staff who have been audited per month as well as the number who of those who passed the cleaning audits which is over 85% mark. Goal is that every audited staff will achieve at least 85%.
Present: Merv Bender  
Don Code  
Larry Fladager  
Marcie Kreese  
Alan Tanchak  
Cecile Hunt, Chief Executive Officer  
Cheryl Elliott, Vice President of Finance  
Kevin Blechinger, Director of Finance  
Kathy Holmgren, Executive Assistant (Recorder)  

Regrets: Hugh Otterson  

1. Call to Order  

- The meeting was called to order by Don Code, Chairperson at 9:30 a.m.  

2. Consideration of the Proposed Agenda  

Motion: “THAT the agenda be approved as circulated.”  
M. Bender/M. Kreese, ..........................................................carried  

3. Approval of Previous Minutes  

Motion: “THAT the Board Finance Audit Committee meeting minutes dated May 23, 2017 be approved as circulated.”  
M. Kreese/L. Fladager............................................................carried  

4. Business Arising from the Minutes  

- None  

5. Work Plan  

5.1 Monthly Financial Statements  

- Ministry of Health has provided all health regions with a template that is to be used to submit monthly financial information. The previous template started being used by PAPHR Board’s Finance Audit Committee in September 2015. The Ministry of Health also requested that review of financial information occur in an in-camera session.  

Motion: “THAT the Board Finance Audit Committee move in-camera at 9:05 a.m.”  
M. Bender/L. Fladager..................................................................................carried  

Motion: “THAT the Board Finance Audit Committee move out-of-camera at 10:05 a.m.”  
M. Kreese/A. Tanchak..................................................................................carried
- Prince Albert Parkland Health Region has an operating deficit of $1,302,991 for the month ended April 30, 2017. After required transfers to capital for long term care reserves, mortgage payments, parking equipment purchases and energy performance loan payments the deficit increases to $1,389,386.

5.2 Review the entire annual report for consistency with the financial statements

- Finance staff have reviewed the draft 2016/2017 Annual Report and concur that the report is consistent with the financial statements.

5.3 Review of Financial Policies

- The following Finance Policies were reviewed by the Board Finance Audit Committee:
  - Direct Deposit
  - Electronic Fund Transfer
  - Estimate of Doubtful Accounts

5.4 Monitor and Review of Authority Policies

- The following Monitoring Reports were provided for information.
  - EE-4 – Financial Planning
  - EE-6 – Asset Protection
  - EE-6.2 - Capital

6. New Business

- None

7. Informational Items

- Transition Team - Insurance Strategy

8. Education

- None

9. Next Meeting

- Tentatively scheduled for Wednesday, September 20, 2017; Main Floor Meeting Room; 1521 – 6 Avenue West; 9:30 a.m.

10. Adjournment

- The meeting adjourned at 10:20 a.m.
Prince Albert Parkland Regional Health Authority
Minutes of Quality and Safety Committee
Monday, June 26, 2017
Diabetes Meeting Room, 1521 – 6 Avenue West (Prince Albert)

Present:  Mervin Bender, Board Member
          Don Code, Board Member
          Claudia Driscoll, Patient/Family Advisor Representative
          Marcie Kreese, Board Member
          Dr. J. Rye, Medical Staff Representative
          Darcy Blahut, Manager of Planning, Quality and Patient Safety
          Carol Gregoryk, Vice President of Integrated Health Services
          Don McKay, Vice President of Human Resources
          Pat Stuart, Vice President of Clinical Support Services and Quality Performance
          Kathy Holmgren, Executive Assistant (Recorder)

Regrets:  Hugh Otterson, Board Member
          Mona Selanders, Board Member

1. Call to Order
   - The meeting was called to order by Carol Gregoryk, Vice President of Integrated Health Services at 1:00 p.m.

2. Selection of Quality and Safety Committee Chairperson
   
   Motion:
   "THAT the Quality and Safety Committee appoint Don Code as Chairperson."
   M. Bender/M. Kreese .................................................................carried

3. Consideration of the Proposed Agenda
   
   Motion:
   "THAT the agenda be approved as circulated."
   M. Kreese/M. Bender .................................................................carried

4. Approval of Previous Minutes
   
   Motion:
   "THAT the Quality and Safety Committee meeting minutes dated March 27, 2017 be approved as circulated."
   M. Bender/M. Kreese .................................................................carried

5. Business Arising from the Minutes
   - None
6. **New Business**

6.1 **Critical Incidents / Litigations**

- Darcy Blahut, Manager of Planning, Quality and Patient Safety provided a verbal update on PAPHR’s Critical Incidents and litigations.

6.2 **Evaluate Strategic Issues and Advise the Authority on Matters Related to:**

<table>
<thead>
<tr>
<th>1. The Region’s Strategic Priority: Client Experience</th>
</tr>
</thead>
<tbody>
<tr>
<td>The region is committed to the provision of the best possible health care experience for all clients. The delivery of exceptional care and service that is consistent with both best practice and client expectations is the region’s focus.</td>
</tr>
</tbody>
</table>

- Darcy Blahut, Manager of Planning, Quality and Patient Safety provided information on the Client Experience Surveys.

**Client Experience Survey Summary for 2017-18**

There are different types of client satisfaction surveys utilized throughout the Region (all of them approved through Accreditation Canada as meeting their requirements for both content and unbiased survey methodology; and each vetted through the Region’s PFCC committee). A generic 10 question survey form is used on most units with some departments using a slightly amended version for client-friendliness or an alternate format:

- Acquired Brain Injury (ABI) program uses the generic template with some plain language modifications.
- Primary Health Care (PHC) uses the Health Quality Council (HQC) approved long-survey format.
- The Operating Room has developed their own format specific to the OR client.
- Long Term Care (LTC) uses two different surveys specific to end-of-stay and ongoing resident experience (with the generic survey questions incorporated directly into this longer format); each vetted through resident and family councils.
- The Emergency Department uses a variation of the Region’s generic template.

**Analysis of Client Experience Surveying includes:**

- Recent turn-over in the management of some acute units saw a degree of non-compliance. Corrective action has been taken over the last quarter of 2016-17 to get these units on track and compliance in preparation for the June 2017 Accreditation site-visits.
- Quality Management monitors the individual results of each unit’s compliance and assures that there is a process for reviewing the numerical and narrative content of each area, for the purpose of improvement and concern handling.
- A current change to the Region’s generic survey template is pending input of the Region’s Patient Family Centered Committee (PFCC); a general question around “staff treating safety concerns seriously” is being amended to reflect more specific language around the Region’s Strategic Priority of Safety Alert/Stop the Line roll-out on all Acute Care Units. The question will allow each acute unit to gauge how patients and families understand Stop the Line (STL) and their right and willingness to speak up. Currently, STL is focused primarily around providers; this survey amendment will enable us to measure the spread of STL among patients and families.
- In keeping with previous fiscal years, Quality Management does not offer a general roll-up of all survey percentages, as this number would not provide meaningful content for the purpose of a performance measure or corrective action. Review is monitored unit by unit.
2. Annual Review of Client Concerns / Privacy Breaches

- Darcy Blahut, Manager of Planning, Quality and Patient Safety provided information on Client Concerns.

April 1, 2016 to March 31, 2017 Concern Report

Of the 340 concerns received in the 2016/17 fiscal year, 339 were resolved in an average of 22.7 days; 256 were resolved in an average of 6.4 days; and 83 were resolved in an average of 73.0 days. There was a 20% rise in the total number of concern received over the prior fiscal year; however this number did not exceed the 2013-14 year in which Quality saw its greatest number of concerns. There was no significant proportional change compared to the previous fiscal year in the average time to resolve concerns.

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</thead>
<tbody>
<tr>
<td># concerns received</td>
<td>271</td>
<td>355</td>
<td>276</td>
<td>280</td>
<td>340</td>
</tr>
<tr>
<td># concerns closed</td>
<td>259</td>
<td>348</td>
<td>271</td>
<td>276</td>
<td>339</td>
</tr>
<tr>
<td>Avg # days to resolve</td>
<td>17.4</td>
<td>21.1</td>
<td>19.9</td>
<td>20.3</td>
<td>22.7</td>
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Satisfaction with resolution:

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</thead>
<tbody>
<tr>
<td>Satisfied</td>
<td>131 (57.2%)</td>
<td>175 (67.6%)</td>
<td>212 (60.2%)</td>
<td>170 (62.7%)</td>
<td>209 (75.7%)</td>
</tr>
<tr>
<td>Not Satisfied</td>
<td>23 (10%)</td>
<td>32 (12.4%)</td>
<td>41 (11.6%)</td>
<td>26 (9.6%)</td>
<td>13 (4.7%)</td>
</tr>
<tr>
<td>Unknown</td>
<td>75 (32.8%)</td>
<td>51 (19.7%)</td>
<td>1 (1%)</td>
<td>1 (0.3%)</td>
<td>5 (1.5%)</td>
</tr>
</tbody>
</table>

Note: The Ombudsman’s 2016 Annual Report includes the findings and recommendation of a de-identified case review from PAPHR. This case was referred to the Ombudsman in 2014-15, and is accounted for in that fiscal year.

The following are the types of concerns received:

<table>
<thead>
<tr>
<th>Type of Concern</th>
<th>2012-13</th>
<th>2013-14</th>
<th>2014-15</th>
<th>2015-16</th>
<th>2016-17</th>
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<tr>
<td>Care Delivery</td>
<td>102 (37.6%)</td>
<td>120 (33.8%)</td>
<td>40 (14.5%)</td>
<td>109 (38.9%)</td>
<td>132 (38.8%)</td>
</tr>
<tr>
<td>Access to Service</td>
<td>48 (17.7%)</td>
<td>57 (16.1%)</td>
<td>110 (39.9%)</td>
<td>51 (18.2%)</td>
<td>54 (15.9%)</td>
</tr>
<tr>
<td>Non-Jurisdictional</td>
<td>47 (17.3%)</td>
<td>52 (14.6%)</td>
<td>14 (5.1%)</td>
<td>19 (6.8%)</td>
<td>48 (14.1%)</td>
</tr>
<tr>
<td>Environmental</td>
<td>10 (3.7%)</td>
<td>28 (7.9%)</td>
<td>21 (7.6%)</td>
<td>30 (10.7%)</td>
<td>43 (12.6%)</td>
</tr>
<tr>
<td>Communication</td>
<td>26 (9.6%)</td>
<td>44 (12.4%)</td>
<td>36 (13.0%)</td>
<td>27 (9.6%)</td>
<td>40 (11.8%)</td>
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<tr>
<td>Cost</td>
<td>19 (7.0%)</td>
<td>22 (6.2%)</td>
<td>34 (12.3%)</td>
<td>31 (11.1%)</td>
<td>18 (5.3%)</td>
</tr>
<tr>
<td>Other</td>
<td>19 (7.0%)</td>
<td>32 (9.0%)</td>
<td>21 (7.6%)</td>
<td>13 (4.6%)</td>
<td>5 (1.5%)</td>
</tr>
<tr>
<td>TOTAL</td>
<td>271</td>
<td>355</td>
<td>276</td>
<td>280</td>
<td>340</td>
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</table>

Concerns were in the following areas:

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<th></th>
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</thead>
<tbody>
<tr>
<td>Acute Care</td>
<td>57 (21.0%)</td>
<td>87 (24.5%)</td>
<td>63 (22.8%)</td>
<td>55 (19.6%)</td>
<td>84 (24.7%)</td>
</tr>
<tr>
<td>-medical</td>
<td>39 (14.4%)</td>
<td>45 (12.7%)</td>
<td>40 (14.5%)</td>
<td>36 (12.9%)</td>
<td>47 (13.8%)</td>
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<tr>
<td>-surgical</td>
<td>18 (6.6%)</td>
<td>42 (11.8%)</td>
<td>23 (8.3%)</td>
<td>19 (6.8%)</td>
<td>37 (10.9%)</td>
</tr>
<tr>
<td>Non-Jurisdictional</td>
<td>47 (17.3%)</td>
<td>52 (14.6%)</td>
<td>36 (13.0%)</td>
<td>19 (6.8%)</td>
<td>48 (14.1%)</td>
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<tr>
<td>Emergency Services</td>
<td>58 (21.4%)</td>
<td>65 (18.5%)</td>
<td>57 (20.7%)</td>
<td>39 (13.9%)</td>
<td>45 (13.2%)</td>
</tr>
<tr>
<td>Supportive Care</td>
<td>21 (7.5%)</td>
<td>36 (10.1%)</td>
<td>25 (9.1%)</td>
<td>23 (8.2%)</td>
<td>41 (12.1%)</td>
</tr>
<tr>
<td>Mental Health</td>
<td>14 (5.2%)</td>
<td>16 (4.5%)</td>
<td>13 (4.7%)</td>
<td>14 (5.0%)</td>
<td>24 (7.1%)</td>
</tr>
<tr>
<td>Diagnostics</td>
<td>11 (4.1%)</td>
<td>18 (5.1%)</td>
<td>20 (7.2%)</td>
<td>15 (5.4%)</td>
<td>17 (5.0%)</td>
</tr>
<tr>
<td>General</td>
<td>5 (1.8%)</td>
<td>10 (2.8%)</td>
<td>9 (3.3%)</td>
<td>35 (12.5%)</td>
<td>14 (4.1%)</td>
</tr>
<tr>
<td>Case Management</td>
<td>8 (3.0%)</td>
<td>0</td>
<td>6 (2.2%)</td>
<td>9 (3.2%)</td>
<td>14 (4.1%)</td>
</tr>
<tr>
<td>PHC</td>
<td>13 (4.8%)</td>
<td>21 (5.9%)</td>
<td>11 (4.0%)</td>
<td>23 (8.2%)</td>
<td>13 (3.8%)</td>
</tr>
<tr>
<td>Ambulance</td>
<td>12 (4.4%)</td>
<td>19 (5.4%)</td>
<td>12 (4.3%)</td>
<td>12 (4.3%)</td>
<td>14 (3.8%)</td>
</tr>
<tr>
<td>Home Care</td>
<td>8 (3.0%)</td>
<td>13 (3.7%)</td>
<td>10 (3.6%)</td>
<td>4 (1.4%)</td>
<td>11 (3.2%)</td>
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<tr>
<td>Support Services</td>
<td>14 (5.2%)</td>
<td>12 (3.4%)</td>
<td>12 (4.3%)</td>
<td>21 (7.5%)</td>
<td>8 (2.4%)</td>
</tr>
<tr>
<td>Community Health</td>
<td>0</td>
<td>1 (0.3%)</td>
<td>2 (0.7%)</td>
<td>5 (1.8%)</td>
<td>4 (1.2%)</td>
</tr>
<tr>
<td>Rehabilitation</td>
<td>2 (0.7%)</td>
<td>3 (0.8%)</td>
<td>0</td>
<td>3 (1.1%)</td>
<td>2 (0.6%)</td>
</tr>
<tr>
<td>Addiction Services</td>
<td>0</td>
<td>1 (0.3%)</td>
<td>0</td>
<td>3 (1.1%)</td>
<td>2 (0.6%)</td>
</tr>
<tr>
<td>Cancer Care</td>
<td>1 (0.4%)</td>
<td>1 (0.3%)</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>TOTAL</td>
<td>271</td>
<td>355</td>
<td>276</td>
<td>280</td>
<td>340</td>
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</table>
Upward Trends: In 2016-17, compared to the previous year, there was a notable increase of 7.3% in the number of Non-jurisdictional concerns. Examples of non-jurisdictional concerns include issues with private physician clinics, and municipal, provincial, federal processes. In clinical services, concerns with Supportive Care rose 3.9%.

Downward Trends: There was a decline of 4.4% in concerns related to Primary Health Care (Quality received less concerns in general related to the Collaborative Emergency Centre than it did in the previous year). There was a drop of 5.1% in concerns related to Support Services (such as Environmental Services, Maintenance, and Client Access). There was also a notable drop of 8.4% in General concerns (of which parking lot issues had trended in the previous fiscal year).

Percentage of issues raised with the Quality Management Department resolved within 30 days.

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<tbody>
<tr>
<td># of CIs</td>
<td>14</td>
<td>11</td>
<td>15*</td>
<td>21</td>
<td>29</td>
<td>34</td>
<td>37</td>
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</tbody>
</table>

*Excludes one Children’s Advocate case (not formally considered a Critical Incident)

Safety Alert Stop the Line Baseline Progress Report for 2017-18 based on the Provincial Maturity Matrix

- Dana Doucette, Privacy and Freedom of Information officer provided a presentation on PAPHR Audits and Privacy Breaches.

3. The Region’s strategic priority: Staff & Patient Safety
   The Region is committed to achieving zero defects and zero harm to both patients and staff.

- Darcy Blahut, Manager of Planning, Quality and Patient Safety provided information on Safety Alert/Stop the Line.

Safety Alert/Stop the Line (STL) remains an area of strategic priority for PAPHR in 2017-18. A continued roll-out of the Safety Alert/Stop the Line (SA/STL) program continues on all Acute Units in throughout the Region, and follows the roll-out on Level 4 in 2016-17. SA/STL is targeted for completion all acute unit by March 31, 2018; with zero harm to all patients and staff the stretch goal for March 31, 2019. The managers and educators of each acute unit have been met and shared the education package developed, which includes scenario-based learning for huddles, standard work and policy. Patient and Family Advisors will be utilized again this year to assist with culture safety surveys, and the PFCC Committee involved in the revision of a client satisfaction survey question which will provide better data around the patient’s and family’s ability to speak up and stop the line. The means of monitoring progress (in the above report) includes elements taken directly from the Province’s Maturity Matrix.
6.3 Review the organizations progress toward developing and implementing a Patient and Family Centered Care (PFCC) framework and plan. (includes update from PFCC Committee)

- Pat Stuart, Vice President of Clinical Support Services and Quality Performance provided information on PAPHR’s PFCC.

PFCC Update (Year-to-date for April & May 2017)

- Since March 31, 6 new Patient/Family Advisors (PFA) have been recruited. Five of these were recruited for the brand new Mental Health & Addictions Patient/Family Advisory Council (PFAC). This PFAC has met twice already, with a third meeting scheduled for June. The three committees will break for July and August and resume meeting in September.
- The region is proud to see one of the PFAs, Bob Quesnel, featured in the Spring edition of the provincial PFCC newsletter, which is produced by the Health Quality Council. The newsletter is available on the HQC website and has 10 pages of great local and provincial content. [Link](http://hqc.sk.ca/Portals/0/Draft%20Spring%202017%20Newsletter.pdf?ver=2017-04-26-111435-240)
- The region will be looking for more PFAs interested in administering experience surveys across acute care for Quarter 1. Compliance has been low in the past couple of years (10 surveys per quarter are required from each unit). It is hoped that PFA involvement will help bring this to the forefront and encourage managers to use the data for immediate improvement.
- Marilyn Crawford, a member of the Long Term Care PFAC, accompanied Laura Marshall (PFCC lead) to the LTC Site Managers’ meeting in Spiritwood in May to present some of the PFAC’s recent work and invite collaboration with the managers’ group.
- The provincial PFCC Guiding Coalition continues to be very productive and will likely increase its meeting frequency between now and September. One of the main areas of focus for the group now is to attempt to inform the provincial Transition Team and provide our vision of how PFCC and patient engagement should look under the new provincial health authority. PFAs are now being invited to join provincial working groups to inform the Transition Team.
- PFAs continue to share their stories for education and awareness, and all PFCC Steering Committee meetings are now being kicked off with a patient story. New and varied opportunities for PFAs continue to arise at all levels of the health system, and the uptake from our regional PFAs has been very enthusiastic.

6.4 Review and monitor progress of continuous quality improvement deployment in PAPHR and encourage involvement of its members in projects.

Pat Stuart, Vice President of Clinical Support Services and Quality Performance provided an update on the following:

- Continuous Quality Improvement Basics (Kaizen Basics)
  - Two Kaizen Basics sessions were held this Quarter. The half day sessions are meant to capture new hires and anyone participating in upcoming events that have not been trained.
- Lean Leader Certification
  - Was previously reported on being 100% trained, but have since reactivated an inactive participant. She is co-leading a Mistake Proofing project for her last requirement towards certification.
- Lean Improvement Leader Training (LILT)
  - The third cohort of Leader Improvement Leader Training will be completed on June 21. The fifth cohort begins in September. 57 people have enrolled in the program since June 2015.
- 5S Training
  - A week long 5S event was held during the last week in April. Three teams cleaned and organized three separate areas at the Victoria Hospital/Herb Bassett Home site- biomedical engineering, Herb Bassett Home Recreation, and dietary storage. One of the teams did so in preparation for a Kanban event.
Mistake Proofing
- April 24 was the launch of Mistake Proofing project #15, Eliminate Deep Hip Infections Post Orthopedic Surgery. This project is currently in data collection phase, to be followed by the trial phase. 2 LILT graduates are participating on this team.

Kanban
- A Kanban event was held in dietary storage the week of May 29, 2017. This was unique due to Food and Nutrition’s self-sufficiency when it comes to ordering. Materials Management has been in charge of Kanban since it began, and this is the first event not under the Materials Management umbrella. More to follow.

Kaizen Events
- No RPIWs were held during this Quarter.

3P Event
- No 3P events were held during this Quarter.

Strategic Planning
- Kaizen Planning has been progressing in the midst of other priorities such as Essential Services Planning and Accreditation. CIO specialists continue to work with their service line and portfolio leaders to identify and schedule improvement events that support achieving the strategic priorities. See attached, PAPHR Strategic Priorities schematic. September will be the next cycle of RPIWs and a Kanban Kaizen event.

Key Accomplishments:
RPIW #52
Goal: Design process for creation and implementation of CAPS care plan based on Minimum data Set (MDS) in LTC.
Major Changes Implemented:
- Work Standard created for completion of MDS
- Work Standard created for care plan creation
- Work Standard for Resident/Family care plan review meetings
- Work Standard for quarterly medication review
- Revised bedside care plan
- Created script for contacting families to reduce confusion about meetings

Provider Quote: Creating a CAPS care plan, using data collected from the MDS, is an all-encompassing way to effectively provide care for our residents.

RPIW #54
Goal: To reduce the lead time for children to access a Pediatric Team Assessment. Therapies – Pediatric Early Development Services (PEDS)
Major Changes Implemented:
- PEDS Team referral form revised to make it easier to fill out & provide more detailed information on developmental concerns.
- A new database was created for referrals for PEDS Team Assessment. Easier to track progress of referral through intake process & allow for more detailed data analysis for program improvements.
- Two page “Short Caregiver Questionnaire” was developed for those instances when parents/families request a printed form to complete intake process rather than attending an intake interview in person or over the phone.
- Developmental History Form (used during intake process) revised; two versions – one for use with parents and one for children in care
- New form letter created & work standard created to close loop with referral source when child not requiring full Team Assessment (i.e. needs adequately met by individual therapy services)
6.5 PAPHR Organizational Wellness

- Don McKay, Vice President of Human Resources provided an update on the following:
  - PAPHR Safety Hoshins (for Patients and Staff)
    - Reduce Workplace Injuries by March 31, 2018:
      - Implement elements 1-3 of Safety Management System (SMS) in all PAPHR facilities
      - Implement elements 1-6 of Safety Management System (SMS) in Herb Bassett Home, Whispering Pine Place and Birchview Home
      - Sick Time Reduction - 10% reduction in sick time hours from previous years rates.
      - Hand Hygiene – 80% audited hand hygiene compliance rate across the organization.
  - Implement Safety Alert/Stop the Line (STL) System in test site by March 31, 2018:
    - Roll-out of STL to all Acute Care units
    - 100% of incident report actions closed with report writers
    - 10% Increase of “Near Miss” Reporting vs. Actual Harm
    - Operationalize Safety Huddles across Region (daily for key clinical areas)
  - Safety Management System
  - Works Compensation Board (WCB) Claims
  - Sick Hours
  - Wage Driven Premium (WDP) Hours

6.6 Long Term Care Quality Indicators

- The conclusion for Quarter 4 and the 2016-17 year for all Quality Indicators was provided for information.
- Corrective action plans have been submitted to the Ministry of Health
- Daily Physical Restraints – Target is 10.36% for the province. The Region is 8.18%
  Four facilities are over the target – Big River is the highest at 27.59%. 4 resident families have requested restraints. These items considered restraints are those barriers that the resident cannot undo themselves. They come in the form of Broda chairs and tables up across the resident. 1 resident with Huntington’s chorea has frequent uncontrolled movements
- Antipsychotics without a Diagnosis – Target is 28% and the region is 36.8%. This is a consistent rate for the region. Site managers have attended a Webex session on Rx files around this area and there are many options now available for work with physicians and NP’s on reducing this number. This is also identified by recent accreditation as an area to work on.
- Residents who fell in the last 30 days – Target is 9.0% the regional rate is 11.2%. 8 facilities triggered this QI. Evergreen Health Center is the highest at 21.43%. This facility did not trigger for restraint use. They have 3 high risk residents for falls.
- Residents whose pain worsened – Target is 8.0% and the region is at 13.95%. 10 facilities triggered. Parkland Integrated Health Center was highest at 37.93%. Residents involved were experiencing pain flair ups from arthritis, chronic illness or post fall injury. 4 residents pain medications were increased, 1 deceased, 1 was a coding error, 1 was being assessed by a surgeon, the remaining 4 had pain documented but lack of communication to RN/LPN was indicated to provide pain relief.
- Residents whose stage 2-4 pressure ulcer worsened – Target for the province is 2.0%, the region is at 1.68%. 4 facilities did trigger with Evergreen Health Centre being the highest at 7.14%. Note that this and the Resident with a Newly occurring Stage 2-4 pressure ulcer are being reported going forward together on one corrective action plans. Evergreen Health Centre had one resident with deteriorating neuropathy related to development of pressure ulcers.
6.7 Resident and Family Surveys

- Resident and family survey results for Quarter 4 were provided for information. Follow up is occurring where required.
- One of the concerns is Spiritwood where the majority of the negative concerns expressed occurred. The turnover over of managers and lack of follow through has been a factor. Supervision of the kitchen by the Director of Nutritional Services is being planned.

6.8 Long Term Care (LTC) – Implementation of Standards of Care

- All care staff were to have viewed the video by March 31, 2017. The average for the region was 81.4%. Initially the availability of the DVD was very delayed and the ability to play the DVD hampered in some facilities. The LTC Educator developed a YouTube video for staff that was able to be viewed at home. New staff have the viewing as part of their orientation. Residents and staff have viewed together and viewing each module at huddles has also been occurring. All staff are to view the video by March 31, 2018.

6.9 Review Control Weaknesses Detected in the Prior Year’s Audit and Provincial Auditor’s Report and Management’s Plan to Address Them

- Provincial Auditor 2017 Report – Volume 1
  The Senior Management team has outlined current/future regional processes that should proactively address issues related to recommendations directed to:
  - Mamawetan Churchill River Regional Health Authority – Delivering Provincially Funded Childhood Immunizations
  - Saskatoon Regional Health Authority – Overseeing Contracted Special-Care Homes
  - Regina Qu’Appelle Regional Health Authority – Safe and Timely Discharge of Hospital Patients
  - Regina Qu’Appelle Regional Health Authority – Use of Surgical Facilities

7. Information Items

- None

8. Education

7.1 Process to Assess Individuals for Home Care Placement

- Linda Sims, Director of Home Care provided information on the process used to assess individuals for home care placement:
  - Referral
  - Intake Process
  - Completion of Assessment for Home Care
  - First Visit by Assessor Care Coordinator
  - First Visit by the Home Care Nurse
  - Safety Assessments
  - Safety Plans
  - Service Started

9. Adjournment

- The meeting adjourned at 3:45 p.m.