JULY 2022

Primary and Community Care Services and Population Health

Sequential Survey

Northern Health Authority

British Columbia

ACCREDITATION AGRÉMENT CANADA

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About this Accreditation Report

Northern Health Authority (referred to in this report as “the organization”) is participating in Accreditation Canada’s Qmentum accreditation program. As part of this ongoing process of quality improvement, an on-site survey was conducted July 10th, 2021 – July 15th, 2022. Information from the survey, as well as other data obtained from the organization, were used to produce this Accreditation Report.

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

Confidentiality

This report is confidential and is provided by Accreditation Canada to the organization only.

Accreditation Canada does not release the report to any other parties.

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

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

About the Accreditation Cycle

2018 Survey	2020 Survey Postponed to 2022
Acute Care Component: Core and Clinical Acute Standards	**Community Care Component: Primary and Community Care Services and Population Health**
1. Cancer Care Services 2. Critical Care Services 3. Emergency Department 4. Governance 5. Infection Prevention and Control 6. Inpatient Services 7. Leadership 8. Long Term Care Services 9. Medication Management 10. Mental Health Services 11. Obstetrics Services 12. Perioperative Services and Invasive Procedures 13. Reprocessing of Medical Devices 14. Substance Abuse and Gambling Problem	**Regional-Corporate Leadership:** • Public Health (Customized Standard) • Population Health and Wellness (Customized Standard) • Primary Care (Customized Standard) **Community Leadership:** • Public Health (Customized Standard) • Population Health and Wellness (Customized Standard) • Service excellence **Service Delivery**: • Primary Care • Aboriginal Integrated Primary Care (Customized Standard) • Home Care (Customized Standard) • Community Based Mental Health (Customized Standard) • Public Health (Customized Standard) • Substance Abuse and Problem Gambling (Customized Standard) • Infection Prevention and Control for Community Organizations (Customized Standard) • Medication Management for Community Organizations (Customized Standard)

Northern Health 2022 Integrated Primary Care Assessment

Northern Health Authority (NHA) has been working towards improved primary care — and integrated health services (IHS) — for several years. Improved coordination of services earlier in a patient's care contributes to better health outcomes; alleviates pressures on the acute care system; and improves cost-effectiveness.

In June 2018, Northern Health (NH) started a significant service reorganization. As with many organizations, Northern Health has recognized the need to realign their services in the primary care and community service areas to be more person-centred, team-based and integrated. Northern Health is unique in that they have taken this direction not as a pilot or incremental project – but as a whole system change. Interprofessional Teams (IPTs) have been established in each of the communities by realigning and integrating partners from "siloed" service areas including mental health & substance use, home & community care and public/population health.

Having structured the teams NH asked and supported their teams to work together with primary care physicians to meet the diverse needs of their communities and services. They were asked to work outside of their original restrictive departmental structures and build an integrated team.

Northern Health BC has challenged Accreditation Canada to design an accreditation assessment that will align with this new redesign of Primary Care Services in the region. Recognizing the uniqueness of the Integrated Health model, an Assessment Manual was developed in collaboration by both parties, AC and Northern HA. It includes criteria from several applicable standards, avoiding duplication of criteria, and focusing on the integrated way that services can be delivered

Sites Visited

- Burns Lake Primary Care Clinic
- Chetwyind Primary Care Clinic
- Dawson Creek Health Unit
- Fort St. James Health Centre
- Fort St. John Health Unit
- Fort Nelson Health Unit
- Fraser Lake Community Health Centre
- Houston Health Centre and Primary Care Clinic
- Kitimat General Hospital and Health Centre
- McBride and District Hospital and Health Centre
- Northern Interior Health Unit – Prince George
- Northern Health Corporate Office
- Parwood Mall
- Quesnel Community Health Services
- Smithers Community Health Services
- Stewart Health Centre and Primary Care Clinic
- Terrace Health Unit
- Urgent Primary and Community Care
- Valemount Health Centre
- Vanderhoof Health Centre

Executive Summary

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

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

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

Accreditation Decision

Northern Health Authority's accreditation decision is:

Accredited (Report)

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

Surveyor Observations

The Northern Health Authority (NHA) has developed an integrated primary care service that has focused on improving the care of clients and residents in its large geographic community. The goal of the integrated primary care teams is to better coordinate the care across the continuum, alleviate pressures on the acute care system, improve the cost effectiveness of the system, and better support clients and families to live healthier lives in the community. The survey took place between July 11th – July 15th, 2022, and was conducted by seven surveyors from outside of the province. There were over 60 tracers conducted throughout the week with hundreds of interviews and discussions completed throughout the region. Over 15 community partners were engaged in a dialogue about health services provided within the region including representatives from municipal governments, philanthropic partners, divisions of family practice, regional hospital districts, first nations community, non-governmental organizations, and academic institutions.

Uniformly, the feedback was Northern Health has been an exceptional partner in promoting the health of the community. NHA leadership at all levels (regional, health service delivery area, and locally) was commended for the willingness to collaborate and partner to address the health and well-being of the community. The willingness to consider innovative approaches was identified as an area of strength and Northern Health’s courage to implement novel programs was greatly appreciated. The commitment to engagement and partnership with community leaders was also identified as an area of excellence.

Some of the opportunities for improvement identified included greater transparency in communication of localized operational matters that the region may be working on, or changes in service levels for reasons such as staffing challenges. With Northern Health’s significant staffing challenges in some local health areas, community partners indicated a desire to assist in helping address some of the

community-based barriers to recruitment. Another opportunity identified was in relation to cultural safety and humility and opportunities to address stigma throughout the region. Community partners commended NHA for its ongoing work in these areas and expressed a desire to continue to promote this work through supporting staff and clinicians.

Health human resources is a challenge throughout Canada and NHA is encouraged to continue efforts to fill vacancies and address workload issues. In some local areas, it was noted there was a full complement of staffing. In these areas, it was clear that the level of collaboration, support from local leadership, performance conversations, and recognition were performed exceptionally well in these communities.

It was observed there was a high degree of variability related to performance conversations across the region. NHA is encouraged to engage with the local leadership in these communities to identify any opportunities for learning that could be spread throughout the region. Northern Health is to be commended for the educational supports that are available to staff through the learning hub. Staff commented on the completeness of the resources. Some team members expressed a desire for more interactive educational resources (e.g., virtual conferences, in-person educational sessions) to augment their expertise in areas of practice. NHA is encouraged to review opportunities to continue to support staff beyond the resources available through the learning hub. Possible opportunities might include in-services “lunch and learns” between community area teams / leadership to share best practices and areas of local quality improvement.

Northern Health has undertaken significant work at the regional level in Quality Improvement (QI). The 2022/23 to 2024/25 Operational Plan that includes operational priorities in the areas of strengthening care models and pathways, workforce sustainability, realizing reconciliation & enhancing cultural safety, SaferCare, acute care stabilization and optimizing surgical services clearly address key strategic imperatives within the region. These operational plans have identified leads, specific goals and measurable outcomes identified with them. During the survey, many pockets of excellence were seen. It was clear that leaders, physicians, and staff are engaged and committed to quality and patient safety.

Quality improvement activities at the local level varied significantly. Leadership at the local level may benefit from regional support to establish a more consistent approach to quality improvement initiatives within the community. In some parts of the region, local quality improvement activities were being undertaken in partnership with the community and clients and families. These also included some documented measurement and evaluation. While implementing QI initiatives, all leaders are encouraged to enhance outcome measurement and evaluation of the effectiveness of the QI initiatives. In these efforts to improve safety and quality of patient care NHA is encouraged to continue to seek client, family, and community input to further strengthen programs and services.

Tracers were conducted at each site visited. The surveyor team was impressed with the level of cohesion the integrated primary care teams demonstrated in delivering services to the community. Clients and families interviewed throughout the process expressed overwhelming satisfaction with the services provided by the care teams. The integrated primary care teams truly embodied the NHA values in their day-to-day work. The NH values were also clearly reflected in the relationships the teams had with each other, clients and families, First Nations communities and community partners.

Teams were very engaged in the quality and patient safety journey and were able to support clients and families despite managing staffing challenges in some communities. The level of competence,

knowledge, and expertise displayed by the staff was truly impressive. They were very aware of broader organizational policies, best practices, and required organizational practices. While there was excellent awareness of required organizational practices, it was observed that the application of the practices was inconsistent throughout the region. Some areas are excelling in meeting the standards while in some communities there are opportunities for improvement. The required organizational practices of the use of two client identifiers, medication management, information transfer, and home care safety risk assessment were being met well in some communities, while in others presented an opportunity for improvement. Suicide risk assessment and hand hygiene compliance audits were the two required organization practices that were most inconsistently applied throughout the region.

One area Northern Health may wish to consider reviewing from a regional perspective is the process by which clients are transitioned from one integrated primary care team to another within the region. Some clients engaged through the tracer process identified they were in the process of moving communities within NHA. Neither the client nor care team could articulate the process by which a client would transition from one care team to another. It was not clear to staff or clients whether there was a regional process for this care transition to occur, or if NHA needed to develop a standard operating procedure for these circumstances.

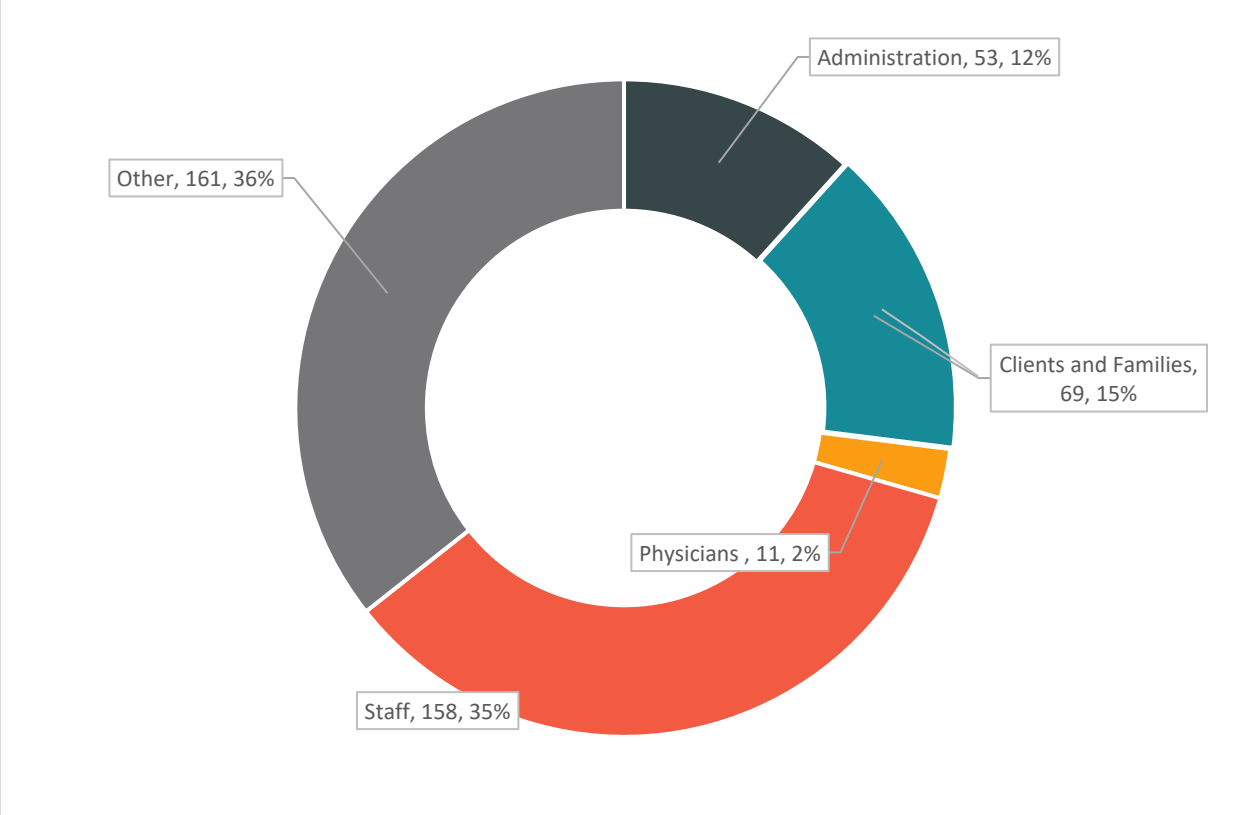
Northern Health is to be commended on its focused investment in the deployment of a consistent clinical information system. The Medical Office Information System (MOIS) is well used throughout the region to enhance and promote cross-discipline collaboration in the care of the clients in the community. There appears to be some variability in the utilization of the system based on the instance of the installation in each community. The organization is encouraged to continue to standardize the workflow and deployment of the system, enhance the education and adoption amongst team members, and look at opportunities to create a more seamless integration between the various installations of MOIS and other clinical systems throughout the region (e.g., Panorama, Cerner).

The integrated teams are providing exceptional service in varying facilities throughout the region. The physical environment in which services are provided vary by the age and design of the facilities. NHA is encouraged to continue reviewing the physical environment in which services are delivered to optimize the client experience and create an inviting, culturally safe space.

Survey Methodology

The Accreditation Canada Surveyors spent five days in Northern Health BC conducting tracers which included input from various levels of leadership, staff, clients and families.

To conduct their assessment, the survey team gathered information from the following groups[1]



[1] "Other" interviewees refer to individuals such as students or volunteers

# of Interviews	Administration	Clients	Physicians	Staff	Other
Burns Lake Primary Care Clinic	2	3	1	7	
Chetwyind Primary Care Clinic	1	2		8	
Dawson Creek Health Unit	1	2		7	1
Fort St. James Health Centre	2	3	2	12	
Fort St. John Health Unit	1	1		9	
Fort Nelson Health Unit	1			2	
Fraser Lake Community Health Centre	2	3	1	8	
Houston Health Centre and Primary Care Clinic	11 leadership	3	1	12	2 partners
Kitimat General Hospital and Health Centre	8	3		6	
McBride and District Hospital and Health Centre	2	7		6	26 leadership
Northern Interior Health Unit – Prince George	3	4	1	14	14 team huddle
Northern Health Corporate Office					15 community partners; 19 Leaders (Ch. 1); 31 Leaders (Ch. 2)
Parkwood Mall	2	4		8	
Quesnel Community Health Services	1	4		9	
Smithers Community Health Services	5 leadership	3		10	
Stewart Health Centre and Primary Care Clinic	1	2	1	3	4 leaders
Hudson Hope		1		5	
Terrace Health Unit	3	6	1	10	
Urgent Primary and Community Care	4	2	2	9	5 virtual with patient engagement leadership; 13 morning huddle; 10 afternoon huddle; 8 patient partners
Valemount Health Centre	1	10	1	7	13 morning huddle
Vanderhoof Health Centre	2	6		6	
Total	**53**	**69**	**11**	**158**	**161**

Key Opportunities and Areas of Excellence

The Accreditation Canada survey team identified the following key opportunities and areas of excellence for this site:

Key Opportunities

1. Increasing access to Services: hours of service, access to diagnostics.
2. Addressing staff vacancies and consistent performance evaluation to support professional growth and development of staff.
3. Continue to seek client, family, and community input to further strengthen programs and services.
4. Enhance the linkage between regional and zone supports, and local operations to optimize consistency of care and knowledge dissemination.
5. Investment in information technology (applications) and physical infrastructure.
6. Consistently applying the required organizational practices
7. Formalizing and re-establishing relationships with some partners.

Areas of Excellence

1. Well integrated teams concentrating on access to care with services focused on a client-centred practice promoting health and wellness.
2. Strong interdisciplinary teams who are compassionate and dedicated to the care of clients and families.
3. Robust community and First Nations engagement, relationships, and partnerships.
4. Commitment to supporting staff with professional development and recognition.
5. Quality improvement initiatives at the regional level with an organizational scorecard.
6. COVID-19 response: testing, immunization, & outbreak containment.

Results at a Glance

This section provides a high-level summary of results by standards, priority processes and quality dimensions.

Compliance Overall[1]

Percentage of criteria		
Attested 90% met	On-Site 95% met	Overall 94% met
Number of attested criteria		
Attested 1019 Criteria	Audited 135 Criteria	

Attestation:

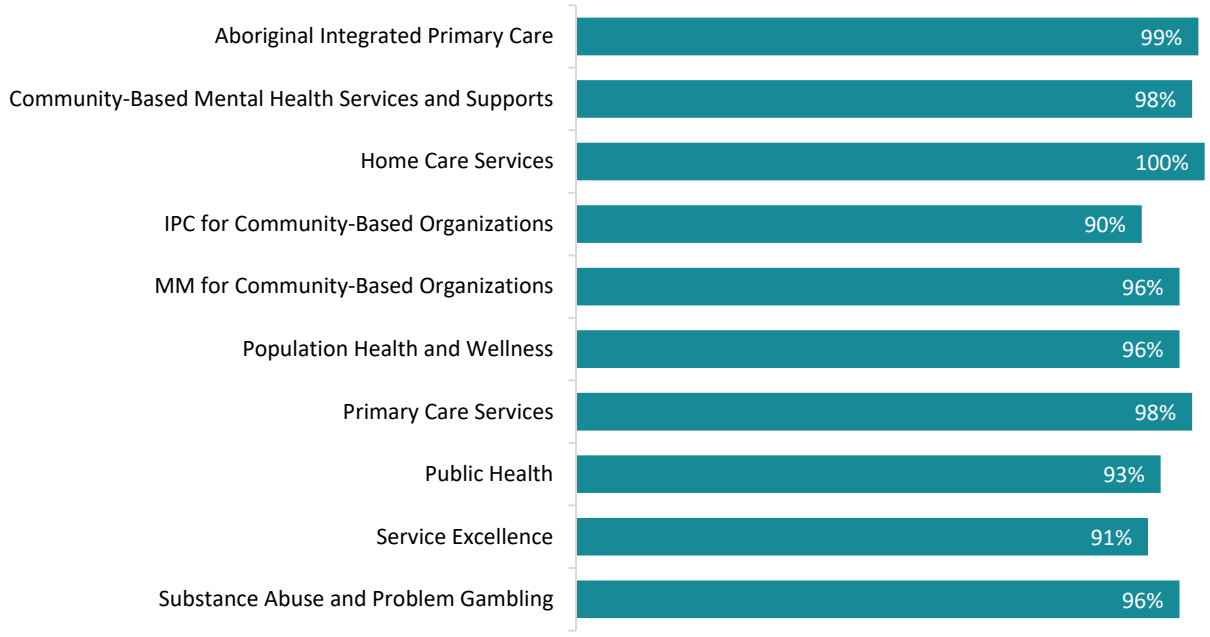
A form of conformity assessment that requires organizations to conduct a self-assessment on specified criteria and provide a declaration that the assessment is accurate to the best of the organization's knowledge. This data is used to inform an accreditation award.

On-site Assessment:

Peer Surveyors from Accreditation Canada visit one or more facilities to assess compliance against applicable standards.

[1] In calculating percentage compliance rates throughout this report, criteria rated as 'N/A' and criteria 'NOT RATED' were excluded. Data at the 'Tests for Compliance' level were also excluded from percentage compliance calculations. Compliance with ROPs and their associated 'Tests for Compliance' are detailed in the section titled *Detailed Results: Required Organizational Practices (ROPs).*

Compliance by Standard



STANDARD	MET	UNMET	N/A	NOT RATED
Aboriginal Integrated Primary Care	380	5	96	44
Community-Based Mental Health Services and Supports	258	4	15	164
Home Care Services	58	0	0	26
Infection Prevention and Control for Community-Based Organizations	170	18	26	36
Medication Management for Community-Based Organizations	403	16	136	25
Population Health and Wellness	205	9	5	36
Primary Care Services	1050	18	78	96
Public Health Services	465	34	33	94
Service Excellence	1244	117	7	76
Substance Abuse and Problem Gambling	25	1	4	24

Compliance by Quality Dimension

DIMENSION	MET	UNMET	N/A	NOT RATED
Accessibility	302	7	23	66
Appropriateness	1115	113	108	162
Client Centered Services	1008	21	28	156
Continuity of Services	433	7	19	52
Efficiency	50	6	4	1
Population Focus	362	28	40	120
Safety	1572	135	495	208
Worklife	171	15	2	17

Compliance by Required Organizational Practice (ROP)

ROP	STANDARD	RATING
COMMUNICATION		
Client Identification	Aboriginal Integrated Primary Care	UNMET
The 'Do Not Use' list of Abbreviations	Medication Management	UNMET
Medication reconciliation as a strategic priority	Aboriginal Integrated Primary Care	UNMET
Information Transfer at Care Transitions	Aboriginal Integrated Primary Care	UNMET
MEDICATION USE		
Heparin Safety	Medication Management for Community-Based Organizations	UNMET
High-alert Medications	Medication Management for Community-Based Organizations	UNMET
Infusion Pump Safety	Service Excellence	UNMET
INFECTION CONTROL		
Hand-hygiene Compliance	Infection Prevention and Control for Community-Based Organizations	UNMET
Hand-hygiene Education and Training	Infection Prevention and Control for Community-Based Organizations	MET
Reprocessing	Infection Prevention and Control for Community-Based Organizations	UNMET
RISK ASSESSMENT		
Suicide prevention	Aboriginal Integrated Primary Care	UNMET
Home safety risk assessment	Home Care	UNMET
Skin and wound care	Home Care	MET

Detailed Results: System-level Priority Processes

Accreditation Canada defines priority processes as critical areas and systems that have an impact on the quality and safety of care and services. System-level priority processes refers to criteria that are tagged to People-Centred Care Priority Process.

People-Centred Care Priority Process

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

Surveyor Comments

Northern Health has undergone a significant transformation in the development of their approach to people centered care through community engagement and the establishment of interprofessional team-based care. Each community depending on their unique primary care services have embedded people centered care at the point of care and built trusting relationships within the interprofessional team and this by extension to the clients and community where care is provided. To augment service delivery, each community has Community Collaborative committees that support the needs of the community. The impact and interface of this wrap around care has enabled clients and community members to be in partnership with care services resulting in better care, closer to home, that is the right care.

Resilience, resolve, and reliance on self-management support healthy communities and sustainability of health resources. Primary care foundations include health and well-being all of which are part of health promotion and health prevention. Satisfaction with care services was evident in comments from clients and family:

"Dad is grumpy and sometimes hard to get along with. He loves his 'home care girls' and they get along really well. They have saved my life and they always ask about me."

"I am 83 years old, and I want to stay independent in my home. I need help to get up in the morning and to go to bed at night. After next week I worry who will help me."

"Getting an appointment with doctor takes a long time. I am so glad the Clinic has two days a week for walk in appointments."

Access to primary care that is culturally responsive is a cornerstone of a healthy community. Some communities are facing critical shortages of staff and challenges in maintaining current service levels. Transparency in communities allows for those difficult conversations around care service delivery and around work life balance for staff.

The Accreditation Canada survey team identified the following key opportunities and areas of excellence for the organization:

Key Opportunities

1. Opportunity to embed patient partners at the regional level with a mechanism for on-boarding, orientation, training, and ongoing support. This would support the partnership within the interprofessional care team at the point of care with collaboration in operational services.
2. Opportunity to engage patient partners in quality improvement initiatives at the point of care through the co-design of quality improvements with their lived experience and expertise.
3. Opportunity to enhance community collaborations with patient partners by including patient partners on the community collaboratives.
4. Opportunity to build a community of practice with patient partners.

Areas of Excellence

1. Clients understanding of the wrap around services provided to them on their care journey in their partnership with the inter professional care team.
2. Trusting relationships with care providers and their commitment to providing services and programs. Relationships where history and connection matter.
3. Clients' ability to adapt to changes in access to care.

STANDARD	UNMET CRITERIA	CRITERIA
Primary Care Services	5.13	A comprehensive and individualized care plan is developed and documented in partnership with the client and family.

Chapter I- Detailed Results

Overall

Leadership, staff, and physicians working in Public Health and Primary Care are clearly committed to the health and wellbeing of the clients and communities they serve. Their response during the pandemic highlighted this commitment. During the survey, team members acknowledged the need to recover but also described work either underway or planned to address health issues including the underlying determinants of health they had to shift their focus away from during the pandemic response.

Collaborations that existed before the pandemic were strengthened during it and new partnerships and collaborations were also developed. We heard about the importance that is attached to these collaborations and relationships by the community and the desire to work with Northern Health to address issues impacting on the health of their communities and/or the clients that they serve. One of the challenges facing Northern Health is the large number of partnerships and collaborations to establish and maintain. For example, 36% of BC First Nations are located in the geographical area that Northern Health is responsible for serving with 55 First Nations communities and nine Tribal Organizations. Northern Health's ongoing focus on Cultural Humility is critical.

Northern Health has higher than expected Standardized Mortality Ratios for most conditions compared to the rest of BC ranging from 1.27 to 1.43. They have used this information along with the directions provided by the Ministry of Health in identification of priorities at the regional level.

Local Population Health Improvement plans provide an opportunity to strengthen that population health approach with a focus on the issues that are affecting communities. In discussion with Primary Care staff, they described screening and chronic disease prevention programs, but they did not describe how they were using health information about the issues impacting on their communities and addressing root causes. There is opportunity for greater consistency in and evaluation of local population health improvement plans.

There is a well established all hazards emergency response approach that is regularly reviewed and improved based on recent responses to the pandemic, flooding, and forest fires. There has been broad consultation as Northern Health developed its heat emergency response plan.

As mentioned previously, Northern Health is experiencing similar staffing pressures along with other health organizations nationally. There are some core public health functions such as Environmental Health where the staffing vacancies mean that critical services cannot be delivered in accordance with accepted standards of practice. Measures have been implemented to mitigate the risks associated with vacancies as an interim measure. Mid-term and longer-term solutions are required.

Two recent external reviews of Northern Health community licensing role have identified the need for urgent improvements in Northern Health's processes related to inspection, documentation, and enforcement. The reports have recommended specific actions and timelines.

Standards included in Chapter I:

Population Health and Wellness

Northern Health has a good process of collecting information about the service needs of the population it serves at the regional level. Partnerships with numerous community organizations across the region allow it to garner information about the needs of priority populations. These partnerships include academic affiliation agreements with universities and colleges, connections with the Provincial Health Services Authority research institutions, philanthropic partnerships with their nine foundations and numerous health care auxiliaries, partnerships with the six geographically located divisions of family practice, local governments, regional hospital districts and other ministries (Health, Child and Family Development), and non-profit organizations (e.g., BC Housing, Connexus, Friendship centers). The region also has a working partnership with Indigenous communities and organizations through the Northern Partnership Accord that was renewed in 2022. Flowing from this partnership, a number of key priorities were established focusing on priorities such as cultural safety, primary care population health, mental wellbeing, and maternal / child health.

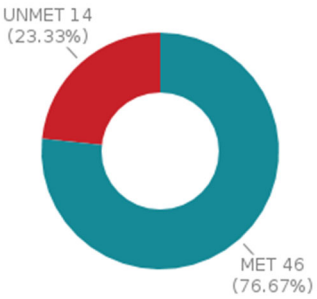
The information that is captured through these engagements is used to develop high-level strategic goals that are established annually. The Ministry of Health sends the NHA board an annual mandate letter that lays out the expectations for the health authority for the year. In turn, the organization develops annual objectives that are assigned to key leaders. While the organization establishes these objectives, there is an opportunity to better define clear timelines, milestones, and deliverables associated with them. It is understandable that given the response to the COVID-19 pandemic, many initiatives may have been impacted. As the organization transitions into the recovery phase, it will be crucial to re-establish processes and structures that have been utilized in the past. In response to the numerous activities underway within the organization, NHA has established a project portfolio office to support the prioritization of work.

Within the funding provided to the organization by the Ministry of Health, NHA assigns resources to addressing the needs of its community. Good educational resources are available to team members through the robust learning hub that is available to staff through the online portal.

The organization is in the process of standardizing clinical information systems across the region. The acute care systems are standardized with a single instance of Cerner. Multiple primary and community care instances of the Medical Office Information System (MOIS) are present across the region. Some of them are integrated with “private” primary care practices while others are separate instances with no digital connectivity. The organization is encouraged to continue exploring options to integrate the numerous clinical systems to enable a seamless medical record across the continuum of care.

STANDARD	UNMET CRITERIA	CRITERIA
Population Health and Wellness	2.1	The organization sets measurable and specific goals and objectives for its services for its priority population(s).
Population Health and Wellness	2.5	The organization provides resources for education and ongoing professional development to enhance staff and service providers' knowledge and skills related to providing services for its priority population(s).
Population Health and Wellness	5.1	The organization has a process to select evidence-based guidelines for its services for its priority population(s).

Public Health



Northern Health has several major industrial projects occurring within its service area that are significant to the future of the province and to the country. There is a large transient/mobile worker population associated with these projects that bring an additional set of challenges. Northern Health has established a dedicated resource, the Office of Health and Development to enable it to fulfill its responsibilities related to these projects particularly regarding their impact on health and the social determinants of health including the environment.

The Office of Health and Development shared how by working with the industry groups on pandemic measures, industries were able to avoid the shutdowns that occurred in other jurisdictions. There was recognition of the evidence informed approach supported through the Office of Health and Development.

An innovation that has been developed since the last accreditation is the Communicable Disease Virtual Support Unit that is able to support local primary care with required communicable disease investigation and follow up. This has helped relieve the workload on local primary care staff for this function. The approach is currently under evaluation.

There are many acute issues that public health is currently responding to. There is the urgency to increase childhood immunization coverage rates that decreased during the pandemic, and to implement or strengthen programs to address the toxic drug crisis. This impacts the ability to shift upstream and focus on the determinants of health even when there is both the commitment and opportunity to do so. The Northern Health community grant program continues to be an important tool for Northern Health to support a population health approach in the health authority.

STANDARD	UNMET CRITERIA	CRITERIA
Public Health Services	1.1	A population health assessment is conducted at least every five years.
Public Health Services	1.5	Health equity gaps that exist between and within populations are identified.
Public Health Services	1.8	As part of the population health assessment, information about the social environment and its health implications is accessed and analyzed.
Public Health Services	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.
Public Health Services	2.2	There are agreements with partner organizations to access external surveillance data as necessary.
Public Health Services	3.3	Information collected about the community is used to define the scope of public health services and to set priorities when multiple service needs are identified.
Public Health Services	3.5	The resources needed to achieve public health goals and objectives are identified.
Public Health Services	3.7	Public health services are designed to be easily accessible by the population, with input from the community.
Public Health Services	3.12	Utilization reviews are regularly completed to ensure resources have been used appropriately.
Public Health Services	6.3	A population health improvement plan is jointly developed and implemented with partners, stakeholders, and the community.
Public Health Services	10.9	Disease prevention activities are regularly evaluated and improvements are made as a result.
Public Health Services	12.3	Organizations' compliance with public health laws, regulations and ordinances is monitored.
Public Health Services	12.8	Immediate action is taken to ensure organizations' compliance with public health laws and practices, when necessary.
Public Health Services	14.1	Standards, policies, and procedures are adhered to for collecting and managing information to maintain reliable, comparable, accurate, and valid data.

Primary Care

There were no unmet criteria for this Priority Process.

Primary care services across Northern Health are designed as Primary Care Homes with the primary care practice and primary care team integrated as a cohesive unit designed to meet the needs of the person and family. These Primary Care Homes partner with the community and First Nations communities to deliver unified services to the patient and support for caregivers / family. Para-professional supports such as home support and life skills workers augment the primary care team in addressing the holistic needs of the patient. Specialized services focusing on complex conditions are available to the Primary Care Home should these services be required for the client. Partnerships with community-based organizations (such as the food bank, meals on wheels, and housing) support the client in living independently in the community. Clients reported great satisfaction with the integrated primary care model.

Care for the client is well supported within the community where they are served. There is opportunity for the organization to assess the processes related to the transition of clients from one integrated primary care team to another within Northern Health. Information flow for the client is well managed locally through the various instances of the MOIS information system. However, when a client needs to transition between teams (e.g., because of a move from one community to another), the processes for that transition are unclear to clients and team members. This could also be supported by a strategy to link the disparate primary clinical information systems across NHA.

Chapter II – Detailed Results

Overall Comments

The Northern Health Authority's Primary care model has truly been realized at the local level. There is an impressive amount of commitment and integration noted within the primary care teams. Some sites are continuing to evolve in their integration strategies; this is supported.

Communities have been consulted in the development of integrated primary care services. In some communities, formal committees and collaborative groups are in place with public representatives as well as a community partner representative. In other communities, there is the opportunity to develop more formal mechanisms to engage the public and partners. In large communities, it may be helpful to consider targeted areas and a flexible approach to this engagement.

All sites demonstrated an excellent interprofessional approach to delivering care. Well done!

In Prince George, several Inter-Professional Teams (IPTs) are co-located with an Urgent and Primary Care Centre (UPCC). This has further enhanced integrated services with primary medical care and many family physicians. A 3-party agreement is in place supporting this ongoing collaboration.

All sites were observed to work in collaboration with clients and families. Client feedback and input is routinely encouraged.

At all sites visited, information is available on services available at the site as well as other community resources off-site delivered by the organization or others, to clients and families.

Several Electronic Medical Record/Electronic Health Record (EMR/EHR) platforms are in place (MOIS, Procura). Currently, these platforms do not share information thus requiring manual entry of data. One site reported training is not provided on all software. (e.g., Procura) and staff learn from each other or learn as they go instead of receiving formalized training. It is encouraged that ongoing and routine training in information systems be provided to ensure that their use is maximized and consistent.

There is an opportunity to confirm client demographics on a regular basis to ensure client information is current. There is also the opportunity to consider maximizing the data collected in the determinants of health section of the electronic health record. This would further support the organization's primary care principles of client centred service delivery and acknowledgment of the client's context.

Attestation comments indicated at some sites, ongoing work is required to determine skill level and mix within each team. Including client input would be of benefit to this initiative. There are critical staff shortages at sites which have led to reduced service, which also requires ongoing support and attention.

Services vary from site to site. Where services are co-located with acute and long-term care, dedicated spiritual space is on site. In others, space is flexible and spiritual spaces are created as required. It is encouraged that access to spiritual space and care be reviewed with flexible options developed at each site to support these needs.

There is a recent ethics policy and terms of reference for the regional ethics committee which includes within the appendix a decision-making tool. The organization is encouraged to embed this decision-

making tool within the EMR or within 'Our NH' with appropriate training of staff members on its use. Staff at some sites were very aware of the framework, how they have applied it, and have accessed ethics support and guidance. There are some sites however, where staff were not aware of the framework and its application. It is suggested that ongoing education across all sites occur.

Staff performance conversations/appraisals have not been routinely completed across sites. COVID-19 has contributed to the lapse of completions. Several sites have plans in places to address this challenge, the organization is encouraged to promote and support this important initiative. Staff noted that they are supported in identifying learning needs and growth for development.

Many standardized communication tools are in place. Sites noted there is a need to further develop system wide communication tools that highlight communication between health care service sectors as well as between health service delivery areas.

Client interviews consistently confirmed their involvement in co-designing individual care. At some sites, it was not evident that clients were a part of the documentation within the medical record as care plans were not clearly seen in the record. There is the opportunity to explore how this can be improved with clear documentation of the client as a partner.

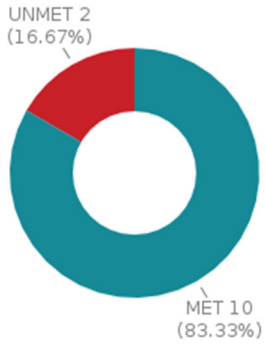
Processes to monitor and evaluate record-keeping practices, designed with input from clients and families, and the information is not consistent at all sites. There is a community health record dashboard in the EMR that generates reports related to charts that are not completed. Many sites do not regularly perform chart audits due to time constraints and in some sites, critical staff shortages. In other sites, there is a lot of work underway to enhance consistent record keeping practices. An excellent example is the Urgent Care and Primary Care Centre and the Northern Interior Health Unit in Prince George.

It was noted that in some sites, guidelines and care pathways are not consistently used. The use is dependent on the health care team member's decision to select and use a guideline. There is a need to ensure that ongoing education regarding guidelines is provided and staff are supported in integrating them consistently into service delivery for a standardized approach across the organization.

At many sites, there is an excellent understanding of quality improvement processes. Measurable objectives with associated indicators are not consistently present for all quality improvement activities, the organization is encouraged to support sites and teams in identifying measurable objectives and indicators. The organization is also encouraged to examine the level of engagement of clients and families participate in quality improvement activities for input, as there likely is opportunity to increase this collaboration. Regional resources could be helpful in further supporting sites in including these components in their work.

Standards included in Chapter II

Population Health and Wellness



Interior Prince George

The communities collaborate with community partners to provide population health and wellness services. The partnerships are robust and span across the continuum of care and address social determinants of health. Community partners commented on the extraordinary level of engagement and consultation that Northern Health undertakes with them. Formal and informal consultations support the identification of gaps in the continuity of care and allow for the identification of improvement opportunities. While the organization shares some information about its successes and opportunities for improvement with community partners, there is an opportunity for NHA to further engage staff, service providers, clients and families in their quality improvement activities and learnings.

Services appear to be well communicated throughout the community through the primary care network and community partners. Where appropriate, Northern Health offers self-managed care programs with the associated training for the clients to meet their care needs. The quality of the services is assessed through discussions with clients, their families, and community members. The processes for the collection of this feedback are informal, the organization is encouraged to consider mechanisms to systematically collect feedback on the quality of services across the health service delivery area. There is also an opportunity to review the feedback from community to community to better understand areas of strength and growth.

Northwest

The Northwest region population includes the largest percentage of First Nation peoples, with 26 First Nation communities. Leadership for this region includes the overall strategy for integration of the services of Public Health, Home Care, and Primary Care into a central Community Care matrix, incorporating the Infection Prevention and Control and Population Health teams. Subsequently, each community fulfills the mandate and fits within the matrix based on local demographics and population characteristics and needs.

It is recognized that the clinics in these regions are facing two enormous Public Health crises: the COVID-19 pandemic and its related outfall, and the drug overdose death crisis.

It became evident that the Northwest region is realizing the “Healthy communities Health People” vision and is commended on moving forward with excellent wellness initiatives with partners in their communities through the integrated primary health care services.

Most communities were observed to have active community groups that met regularly, planned, and executed wellness activities based on community priorities and needs, often related to the determinates of health or the public health crisis.

The following were some examples shared:

- Smithers participated in setting up a tent camp for the homeless
- Houston's Harm Reduction efforts included putting safe disposal boxes throughout the community and provided easy access to harm reduction supplies
- Stewart worked on food security issues with the development of a greenhouse and meal progrm.
- Kitimat worked on the COVID-19 vaccine immunization process which resulted in increased vaccination rates
- Terrace offered a very low barrier Opioid Agonist Treatment clinic

Clients are encouraged to self-manage chronic conditions with education and support from health providers.

Leaders and staff are commended for their passion, strong advocacy, and for not being afraid to try new and creative ideas for improved primary health care. The organization is encouraged to continue to work on the connections and collaborations with First Nations communities.

Northeast

Communities in the Northeast corridor of Northern Health are working hard to support the health and wellness among its population. The Northeast is home to many First Nation, Metis, and Inuit communities that work in partnership with NH to support its commitment to build a health system that honors diversity and provides culturally safe services. The South Peace Collaborative Services Committee is an example where collaboration occurs with many community partners including first nations, municipalities, physicians, and community members to discuss population health and wellness prevention services and identify gaps.

Overall, there was good access to primary care services at most sites visited. There was a noted exception of one site not being able to offer home care and palliative care services within the community due to staffing challenges. This had resulted in palliative clients having to leave their home in certain circumstances to seek those services.

The level of primary care integration was remarkable at all sites. The interprofessional teams go above and beyond to try and ensure good coordination of health services and follow-up for their clients.

There are excellent resources made available to clients and families regarding managing chronic conditions such as diabetes. This includes education materials, clinical teaching, and how to self-manage.

The pandemic has resulted in increased demand for Mental Health services across many Northeast communities, particularly in Dawson Creek. To address this, they initiated a quality improvement project aimed at reducing the intake and waitlist for mental health and substance use referrals by using the

virtual care clinic. They have seen a significant decrease in the waitlist over a few months. Congratulations to the team for this great work!

STANDARD	UNMET CRITERIA	CRITERIA
Population Health and Wellness	7.2	The organization obtains feedback from clients about their perspectives on the quality of its services.
Population Health and Wellness	7.6	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.

Public Health

Interior Prince George

Communities in Interior Prince George vary in how integrated their system of primary care is. Prince George was not included in the initial integration in 2017, instead it was integrated at a later stage. For communities outside of Prince George, there has been good integration of public health within the primary care team. There was a well-integrated response to the COVID-19 pandemic which was supported in some communities by a rapid response team that worked closely with the local primary care team to provide surge capacity for testing, follow up, and vaccination. Some communities are restarting their school-based immunizations while other communities are not able to do so based on current staffing levels. For those communities, staff are working with the schools to enable students to be provided with services at the health center. Health centers are partnering with BC Cancer to provide mobile screening services. They are piloting offering other screening services such as cervical cancer screening at the same time. There is variability between communities on the scope of services that are provided in response to the toxic drug crisis. There are opportunities for communities to share their effective strategies such as peer-based supports with other communities whose services are not as developed. There is a resilient community grant program that the Population Health program/team uses to support groups and organizations who need assistance adapting, maintaining, or establishing practices in response to emerging community health and wellness needs.

Northwest

Communities in the Northwest have actively embraced the integrated model of care. Despite the pandemic, Public Health activities including childhood vaccinations schedules were maintained. Public health was instrumental in achieving high vaccination rates for first and second doses of the COVID-19 vaccine. The more traditional activities of public health such as healthy lifestyles, health maintenance, smoking cessation, and injury prevention have been supported by campaigns delivered at the regional level, though several communities have now reinstituted annual fairs and attendance at gatherings where the public health unit has had a promotional booth or presence. School visits have also been reintroduced prior to summer holidays.

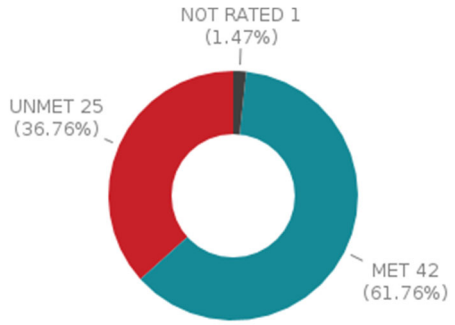
Northeast

Communities in the Northeast are actively engaged in unique community collaboratives. These collaboratives include public representatives, schools, RCMP and many others. Intersectoral collaborations have supported many efforts to address health and social determinants and primary prevention local activities. Health promotion activities are numerous and community specific.

Child immunization strategies are actively being implemented. The team is commended for its commitment to the COVID-19 management in each of the Northeast communities while remaining cognizant of specific community needs and preferences.

STANDARD	UNMET CRITERIA	CRITERIA
Public Health Services	3.9	Public health services are designed to address risks that impact health in the social environment identified in the population health assessment, with input from the community.
Public Health Services	6.4	There is a documented strategy to engage partners in implementing the population health improvement plan.
Public Health Services	7.5	There is a process to collaborate with partners to provide accurate and consistent messaging when communicating public health information to the public.
Public Health Services	9.1	Health promotion programs that address the determinants of health are delivered at various levels of the population.
Public Health Services	9.4	Activities that create supportive physical and social environments are implemented with input from the community.
Public Health Services	12.10	Policies and procedures to safely collect, label, store, and transport laboratory samples are followed for the protection of public safety.

Service Excellence



Communities have been consulted in the development of integrated primary care services. In some communities, formal committees and collaborative groups are in place with public representatives as well as community partners. In Prince George, there is the opportunity to develop more formal mechanisms to engage the public and partners. Given the size of the population, it may be helpful to consider targeted areas and a flexible approach to health partners engagement. At all sites visited, information is available on services to clients and families.

In Prince George, there is an excellent team known as the Rapid Mobilization Team for short term home support. This is an innovative practice in supporting patient flow, service navigation, and continuity of care across health service sectors.

Several EMR/EHR platforms are in place (MOIS, Procura). These platforms do not share information thus requiring manual entry of data. There is an opportunity to explore consolidation of the MOIS system thus supporting care continuity between sites and across service areas.

STANDARD	UNMET CRITERIA	CRITERIA
Service Excellence	2.3	An appropriate mix of skill level and experience within the team is determined, with input from clients and families.
Service Excellence	2.8	Access to spiritual space and care is provided to meet clients' needs.
Service Excellence	3.1	Required training and education are defined for all team members with input from clients and families.
Service Excellence	3.2	Credentials, qualifications, and competencies are verified, documented, and up-to-date.
Service Excellence	3.6	Education and training are provided on the organization's ethical decision-making framework.
Service Excellence	3.9	Education and training are provided on information systems and other technology used in service delivery.
Service Excellence	3.11	Team member performance is regularly evaluated and documented in an objective, interactive, and constructive way.
Service Excellence	3.13	Team members are supported by team leaders to follow up on issues and opportunities for growth identified through performance evaluations.
Service Excellence	4.4	Standardized communication tools are used to share information about a client's care within and between teams.

Service Excellence	4.5	The effectiveness of team collaboration and functioning is evaluated and opportunities for improvement are identified.
Service Excellence	5.2	Work and job design, roles and responsibilities, and assignments are determined with input from team members, and from clients and families where appropriate.
Service Excellence	5.5	Education and training on occupational health and safety regulations and organizational policies on workplace safety are provided to team members.
Service Excellence	6.5	Information is documented in the client's record in partnership with the client and family.
Service Excellence	6.8	There is a process to monitor and evaluate record-keeping practices, designed with input from clients and families, and the information is used to make improvements.
Service Excellence	8.1	There is a standardized procedure to select evidence-informed guidelines that are appropriate for the services offered.
Service Excellence	8.2	The procedure to select evidence-informed guidelines is reviewed, with input from clients and families, teams, and partners.
Service Excellence	8.3	There is a standardized process, developed with input from clients and families, to decide among conflicting evidence-informed guidelines.
Service Excellence	10.4	Indicator(s) that monitor progress for each quality improvement objective are identified, with input from clients and families.
Service Excellence	10.5	Quality improvement activities are designed and tested to meet objectives.
Service Excellence	10.6	New or existing indicator data are used to establish a baseline for each indicator.
Service Excellence	10.7	There is a process to regularly collect indicator data and track progress.
Service Excellence	10.8	Indicator data is regularly analyzed to determine the effectiveness of the quality improvement activities.
Service Excellence	10.9	Quality improvement activities that were shown to be effective in the testing phase are implemented broadly throughout the organization.
Service Excellence	10.10	Information about quality improvement activities, results, and learnings is shared with clients, families, teams, organization leaders, and other organizations, as appropriate.
Service Excellence	10.11	Quality improvement initiatives are regularly evaluated for feasibility, relevance, and usefulness, with input from clients and families.

Chapter III – Detailed Results

The primary health care model is well implemented in most sites visited throughout the region. Various versions are emerging as full partnerships develop. Work will need to continue to bring physicians and nurse practitioners into all primary care homes. Passionate, creative staff with a strong work ethic was evident throughout the survey.

Clients were very pleased with the service they received and continually complemented staff for their caring and respectful manner. They felt involved in their care planning and often commented on the options they were given.

Collaboration with secondary, acute, and specialized health services has improved the provision of coordinated and continuous care for clients and families. Mental health and addictions care are fully integrated within the region. Staff in these areas have moved to the primary health care team model and the influence on the overall team working together has “opened more doors for clients”. Overall, the Community Mental Health Service for Adults works with the Mental Health Advisory Council and many community partners linked to various service areas.

Home care services were a large part of the primary care team, working on evidence-based wound care and support to complex clients and palliative care.

It was not evident that clients were a part of the documentation within the medical record. Care plans were not clearly seen in the record. This may be related to the electronic chart components; however, improvement is encouraged to plan and document care clearly with the client as a partner.

Excellent work was noted in improving quality, and the organization is encouraged to create timelines and measurable targets as of the quality improvement process. NH regional resources could be beneficial in supporting how teams could include these components in their work.

Standards included in Chapter III

Aboriginal Integrated Primary Care

The organization is commended for its commitment to ongoing cultural awareness and humility. Integrated primary care with a focus on client and community involvement is of paramount importance. Numerous interprofessional teams are in place and are truly collaborative in nature. In some areas, work continues to focus on continuing to fully integrate services.

Medication reconciliation processes are in place; however, audits have found it is not consistent across the organization. Sites are encouraged to regularly audit the medication reconciliation processes to confirm it is being used, ensuring client safety.

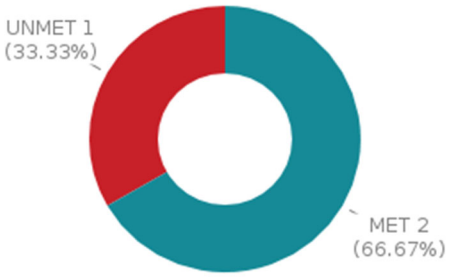
The suicide risk assessment is not routinely performed on all Primary Health clients as indicated by the organization wide guideline. Two client identifiers was another noted area for improvement. It is encouraged all sites review these processes to ensure the guidelines and policies in place are implemented.

The process for care transitions between different care areas within the NHA was not always clear to the team or the client. While the information that should be shared may be defined, it is encouraged that a standardized process be developed to ensure that the client information is shared seamlessly from one care team to another.

STANDARD	UNMET CRITERIA	CRITERIA
Aboriginal Integrated Primary Care	5.6	There is a system in place that provides team members reminders about clients needing follow-up services.
Aboriginal Integrated Primary Care	5.11	A process to track clients through the referral process and consult with service providers is followed to monitor each client's progress.
Aboriginal Integrated Primary Care	7.7	Drills, simulations or similar tests of the emergency response and recovery plan are held at least annually, with input from clients and families.
Aboriginal Integrated Primary Care	7.8	The primary care component of the emergency response and recovery plan is reviewed and updated at least annually, with input from clients and families.

Community-Based Mental Health and Substance Abuse

Community-Based Mental Health Services and Supports



Substance Abuse and Problem Gambling

Mental health and addictions care are fully integrated within the region. Staff in these areas have moved to the primary health care team model and the influence on the overall team working together has "opened more doors for clients".

Partnerships with clients are strong. Mental Health Advisory councils, which have people with lived experience as members, are present in the larger communities. Smaller communities like Houston worked with a person with lived experience to develop the Substance Abuse Disorders clinic. Smithers has client partnerships developing the Addictions Day Treatment program. Many communities visited were working together with partners to raise awareness about mental health wellness and services in addition to addictions resources.

The toxic drug crisis has been significant in the region, and numerous harm reduction strategies have been implemented in communities. Media alerts and education on naloxone education and addictions day treatment are being formed, and clients with lived experience have been part of the strategies moving forward. This crisis has brought many health providers and community partners together to focus on harm reduction, safe supply, and providing support when someone is ready for more help.

Teams which do not have onsite mental health staff in the community have virtual visit capacity and regular visits to the community from councilors to psychiatrists. NH has made Mental Health a priority and is encouraged to work with communities to develop more options for crisis services in all communities. The CAR 60 program with RCMP as partners for mental health staff has been an excellent strategy. Mobile teams, virtual access, contracted community partners, and other creative options could also be considered, especially in smaller communities.

The Community Acute Stabilization Team (CAST) program has done some excellent work in quality improvement projects. A project to review a group program streamlined the process and decreased the time line for clients getting into a group. Tools for group readiness were developed and education was done with referral sources which resulted in much better use of this modality. Measures were not monitored as well as they could have been, however the second project incorporates measures and targets.

The CAST program, which is meant to be outpatient acute stabilization for mental health, has up to a 10 month wait list. Once clients enter this program, they often remain for over a year. The team is working on treatment planning and looking for ways to decrease the waitlist. Northern Interior is encouraged to review the entire community mental health options and develop a pathway to address this bottleneck in the system

The option of having flexible hours in services offered continues to be an area to improve. NH is encouraged to work with clients and families to find ways to meet this need. A person-centered care model where clients direct the care was evident in the locations visited. This is good work, and sites are encouraged to keep looking for creative ways to involve all aspects of the care provided.

STANDARD	UNMET CRITERIA	CRITERIA
Community-Based Mental Health Services and Supports	2.2	Hours of operation are flexible and address the needs of the clients and families it serves.
Community-Based Mental Health Services and Supports	4.9	Clients and/or families are assisted in securing arrangements to meet their basic needs (e.g. income, food, clothing, shelter, etc.), as identified by the client and their family.
Substance Abuse and Problem Gambling	1.2	Essential services can be accessed by current and potential clients and their families 24 hours a day, seven days a week.

Home Care Service

There are no unmet criteria for this standard.

Each site visited had a unique demographic and varying degrees of integration of Home Care services within the Community Health Centres. Nursing, home support, and rehabilitation services were fully implemented at the centres with outreach to catchment communities and First Nation communities. In some instances, scheduling was a concern, as this was done from a regional office which was unaware of the layout of the towns and could lead to visits widely distanced apart. There is a project to allow the schedule to be developed locally to mitigate this concern.

Overall, the Home Care component of the integrated teams has benefitted significantly from belonging to the Community Health Centres. Greater interdisciplinary support has been noted among primary care providers and it has improved the patient/clients' independence and ability to live at home.

There has been significant staff turnover and this has created a risk in loss of transfer of safe practices. To assist with this challenge, the organization has created alternate forms of client support at the home, including care provided by paramedics.

Interviews with Home Care clients were universally grateful for the companionship, reassurance, care, and expertise provided by the staff members who provided Home Care visits.

Infection Prevention and Control for Community Based Organizations

Infection Prevention and Control (IP&C) team members are regionally coordinated, and team members are assigned to each Health Centre. It was noted some sites do not have and IP&C team member presence where others are well supported. There is a robust communication system from regional to local services and a good transfer of local situations to the regional offices. The COVID-19 pandemic has placed significant spotlight on the activities and policies of the IP&C team.

All sites were aware of hand hygiene requirements and posters were present in washrooms and other strategic locations. The hand hygiene audits were not completed at all sites visited, and sometimes the results of audits not readily available, with no analysis of the results or tracking of trends. The organization is encouraged to support the hand hygiene process across all sites, which includes regular audits, sharing of the results and developing action plans for improvement.

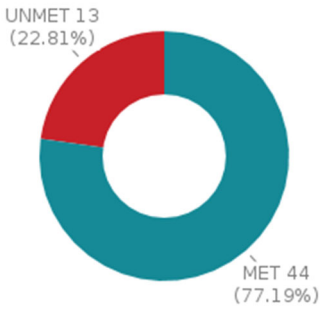
Most sites visited had satisfactory levels of cleaning and disinfection of the physical environment. Staff members at several sites indicated that they have not conducted or received audit results of indicators of adequate infection prevention. If this data is gathered at the regional level, it would be of benefit to share widely to enhance awareness and support improvement efforts.

The organization is encouraged to support regional IP&C committee members in ensuring staff members handling soiled equipment, instruments, and linen have completed essential courses in safe handling and cleaning of these items.

STANDARD	UNMET CRITERIA	CRITERIA
Infection Prevention and Control for Community-Based Organizations	2.3	Optimal environmental conditions are maintained within the physical environment.
Infection Prevention and Control for Community-Based Organizations	2.4	Protocols are established for the safe handling of soiled linen where applicable.
Infection Prevention and Control for Community-Based Organizations	5.2	Team members, clients/residents and families, and volunteers are engaged when developing strategies for promoting infection prevention and control activities.
Infection Prevention and Control for Community-Based Organizations	9.1	Areas of the physical environment are categorized based on the risk of infection to determine frequency of cleaning and the level of disinfection required.
Infection Prevention and Control for Community-Based Organizations	9.2	Roles and responsibilities are assigned for cleaning and disinfecting the physical environment.

Infection Prevention and Control for Community-Based Organizations	9.3	There are policies and procedures for cleaning and disinfecting the physical environment and documenting that cleaning has been done.
Infection Prevention and Control for Community-Based Organizations	9.5	Compliance with policies and procedures for cleaning and disinfecting the physical environment is regularly evaluated, with input from clients/residents and families, and improvements are made as needed.
Infection Prevention and Control for Community-Based Organizations	13.2	Performance measures are monitored for infection prevention and control.

Medication Management for Community Based Organizations



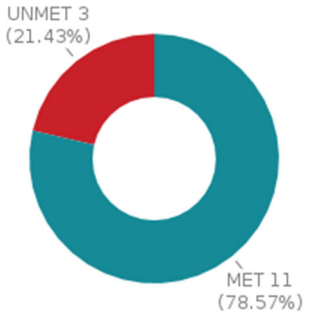
Most sites visited did not have many medications stored on site with the exception of birth control, Sexually Transmitted Infection (STI) treatments and patient prescriptions supplied by the retail pharmacy for injections at the health centre. Generally, these products were stored in locked cupboards with limited access in well-lit and temperature controlled clean rooms.

There is a need for some sites to undergo a thorough review of the medication storage areas which did not meet standards for storing narcotics. Other areas for improvement noted include ensuring expired medications are removed in a timely manner, and ensuring pharmacist support is available to improve staff member training and supervision. Hospital and retail pharmacists could also be involved in encouraging prescribers to avoid the 'Do Not Use' abbreviations.

STANDARD	UNMET CRITERIA	CRITERIA
Medication Management for Community-Based Organizations	3.1	Access to medication storage areas is limited to authorized team members.
Medication Management for Community-Based Organizations	3.10	Expired, damaged, and contaminated medications are stored separately from medications in current use, pending removal.
Medication Management for Community-Based Organizations	3.11	When the organization is notified that medications have been discontinued or recalled by the manufacturer, the affected medications are stored away from medications in current use, pending removal or disposal.
Medication Management for	3.12	Medication storage areas are regularly inspected and improvements are made if needed.

Community-Based Organizations		
Medication Management for Community-Based Organizations	7.3	The team regularly assesses local attitudes toward non-injectable medications and, when necessary, addresses misconceptions about the efficacy of non-injectable medications through education and training.
Medication Management for Community-Based Organizations	16.3	The use of multi-dose vials is minimized as much as possible.
Medication Management for Community-Based Organizations	17.1	Soft and hard dose limits are set for high-alert medications in the smart infusion pumps.
Medication Management for Community-Based Organizations	17.2	A policy that specifies when and how to override smart infusion pump alerts is developed and implemented.
Medication Management for Community-Based Organizations	17.3	The medication information stored in the smart infusion pumps is regularly updated.
Medication Management for Community-Based Organizations	17.4	The limits set for soft and hard doses are regularly tested to make sure they are working in the smart infusion pump.
Medication Management for Community-Based Organizations	17.5	The limits set for soft and hard doses are regularly reviewed and changes made as required.
Medication Management for Community-Based Organizations	20.7	Team members who assist with medications are provided with basic information about the medications and the reasons for taking it.
Medication Management for Community-Based Organizations	20.9	Team members who assist with medications are given training and education on how to watch for allergic or adverse reactions, and how to respond if a reaction occurs.
Medication Management for Community-Based Organizations	23.2	Focused audits of the medication management system are regularly conducted.

Public Health

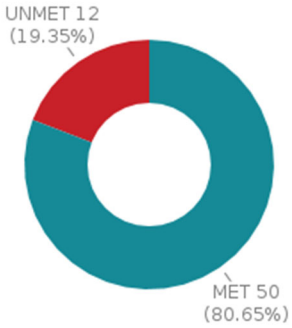


Most sites visited had the required measures in place for cold chain protection. There are well established protocols to quarantine vaccine if there is concern about a potential cold chain break. Vaccine fridges are temperature monitored with alarms. In some cases, the alarms are monitored 24 hours a day remotely while others have a local alarm that alerts persons who may be in the facility. Some sites are replacing their existing vaccine fridges with ones that can maintain acceptable temperatures for 72 hours in the event of a power outage.

There was a noted discrepancy regarding vaccination information entered into electronic information systems that are not integrated. The organization is encouraged to explore requiring all healthcare providers who deliver vaccines to clients report that information to Panorama, which is the electronic information system considered to be the source of truth for vaccination information. This requirement could be included for consideration in future development plans for primary care. There are also opportunities to use existing primary care information to identify opportunities for improved screening and interventions. This includes using features in the electronic system in primary care to prompt recommended screening for clients or using the system to identify clients who smoke and offering them cessation support. There are also opportunities to identify specific performance measures, measure the progress over time and report them publicly to enhance organizational accountability and transparency.

STANDARD	UNMET CRITERIA	CRITERIA
Public Health Services	10.7	Services that support smoking avoidance and cessation are provided.
Public Health Services	11.1	The population's immunization coverage is monitored at regular intervals by reviewing immunization data.
Public Health Services	11.4	The vaccine cold chain is monitored and maintained according to regional legislation.

Primary Care



Northern Health has been restructuring their primary care and community health services over the past several years. Their vision is to create a comprehensive integrated primary care model. Most sites in Northern Health have demonstrated excellent integration of primary care services. This is augmented by having established interprofessional teams work closely together and alongside clients and families to ensure all wrap around services are well coordinated.

Strong collaboration exists between clinics, acute, and specialized health services which allows for easy transition of care for clients and families when they need to access those services. Clients and families are engaged when planning for transitions of care.

When referring clients for health services, good processes are in place to ensure a comprehensive set of client information is sent in a timely manner, as well as follow-up to ensure referral information was received. Clients are also followed for progress. Good evidence exists of standardized tools such as SBAR and Community Services Discharge Summary being used at most sites during transitions of care.

Numerous sites across NH offer services during regular business hours from Monday to Friday. Some limited services such as Home Care and newborn visits are offered on weekends at a small number of sites. An opportunity to try and expand services to evenings and/or weekends would benefit those that cannot access services during the week. There are, however, virtual care clinics and teletriage that are accessed by clients 24 hours a day, 7 days a week. Most clinics are by booked appointments but some clinics such as Chetwynd keep a few appointments open to accommodate walk-ins.

The majority of sites perform a health risk assessment upon initial visit. Informed consent is consistently obtained when required. Staff, clients and families are aware how to report a complaint, and sites demonstrated good processes on follow-up with clients and families. Feedback is used to make improvements.

Significant variation exists across NH related to access to laboratory and diagnostic services. For example, Hudson Hope have both, while Stewart does not have either and clients are required to travel 3-4 hours to access these services. Working towards increased access to these critical services across sites is recommended. Sites have good processes in place for flagging critical results and informing clients about results.

Work continues across sites to enhance services such as the Palliative Care Program. Chetwynd and Fort St. John are in the process of implementing CADD infusion pumps so they can provide improved pain management to palliative clients in the comfort of their own home. Excellent work teams!

Continue to bolster your integrated primary care services. It is something to be proud of!

STANDARD	UNMET CRITERIA	CRITERIA
Primary Care Services	2.1	There is a process to respond to requests for services in a timely way.
Primary Care Services	2.3	Defined criteria are used to determine when to initiate services with clients.
Primary Care Services	3.3	Clients at risk for preventable health conditions are screened and timely follow up on the results is provided.
Primary Care Services	4.8	Translation and interpretation services are available for clients and families as needed.
Primary Care Services	4.10	The client's informed consent is obtained and documented before providing services.
Primary Care Services	4.13	Ethics-related issues are proactively identified, managed, and addressed.
Primary Care Services	5.5	When prescribing any medication, the team reconciles the client's list of medications.
Primary Care Services	5.8	Diagnostic and laboratory testing and expert consultation are available in a timely way to support a comprehensive assessment.
Primary Care Services	6.6	Access to spiritual space and care is provided to meet clients' needs.
Primary Care Services	6.7	Clients and families have access to psychosocial and/or supportive care services, as required.
Primary Care Services	7.2	A set process is followed to transfer and refer clients, their families, information and records to and from other primary, secondary, acute and specialized health services.
Primary Care Services	7.13	The effectiveness of transitions is evaluated and the information is used to improve transition planning, with input from clients and families.

Criteria for Follow-up in 12 Months

Criteria Identified for **12-Month** Follow-up by the Accreditation Decision Committee:

Standard	Criteria	
Aboriginal Integrated Primary Care	3.6	Medication reconciliation is conducted in partnership with clients and families to communicate accurate and complete information at ambulatory care visits when medication management is a major component of care.
Aboriginal Integrated Primary Care	3.6.1	Ambulatory care clinics, where medication management is a major component of care, are identified by the organization. This designation is documented, along with the agreed upon frequency at which medication reconciliation should occur for clients of the clinic.
Aboriginal Integrated Primary Care	3.6.2	During or prior to the initial ambulatory care visit, a Best Possible Medication History (BPMH) is generated and documented in partnership with the client, family, caregivers, and others, as appropriate.
Aboriginal Integrated Primary Care	3.6.4	Medication discrepancies are resolved in partnership with clients and families or medication discrepancies are communicated to the client's most responsible prescriber and actions taken to resolve medication discrepancies are documented.
Aboriginal Integrated Primary Care	3.6.5	The client and the next care provider (e.g., primary care provider, community pharmacist, home care services) are provided with an accurate and up-to-date list of medications the client should be taking at the last visit or upon discharge from the clinic.
Aboriginal Integrated Primary Care	3.8	Clients are assessed and monitored for risk of suicide.
Aboriginal Integrated Primary Care	3.8.1	Clients at risk of suicide are identified.
Aboriginal Integrated Primary Care	3.8.2	The risk of suicide for each client is assessed at regular intervals or as needs change.
Aboriginal Integrated Primary Care	3.8.3	The immediate safety needs of clients identified as being at risk of suicide are addressed.
Aboriginal Integrated Primary Care	3.8.4	Treatment and monitoring strategies are identified for clients assessed as being at risk of suicide.
Aboriginal Integrated Primary Care	3.8.5	Implementation of the treatment and monitoring strategies is documented in the client record.
Aboriginal Integrated Primary Care	4.13	Information relevant to the care of the client is communicated effectively during care transitions.
Aboriginal Integrated Primary Care	4.13.1	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
Aboriginal Integrated Primary Care	4.13.2	Documentation tools and communication strategies are used to standardize information transfer at care transitions.
Aboriginal Integrated Primary Care	4.13.4	Information shared at care transitions is documented.

Aboriginal Integrated Primary Care	4.13.5	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).
Aboriginal Integrated Primary Care	4.2	Working in partnership with clients and families, at least two person-specific identifiers are used to confirm that clients receive the service or procedure intended for them.
Aboriginal Integrated Primary Care	4.2.1	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.
Home Care Services	1.8.1	A home safety risk assessment is conducted for each client at the beginning of service.
Infection Prevention and Control for Community-Based Organizations	2.4	Protocols are established for the safe handling of soiled linen where applicable.
Infection Prevention and Control for Community-Based Organizations	8.4.1	Compliance with accepted hand-hygiene practices is measured using direct observation (audit). For organizations that provide services in clients' homes, a combination of two or more alternative methods may be used, for example: Team members recording their own compliance with accepted hand-hygiene practices (self-audit). Measuring product use. Questions on client satisfaction surveys that ask about team members' hand-hygiene compliance. Measuring the quality of hand-hygiene techniques (e.g., through the use of ultraviolet gels or lotions).
Infection Prevention and Control for Community-Based Organizations	8.4.3	Hand-hygiene compliance results are used to make improvements to hand-hygiene practices.
Infection Prevention and Control for Community-Based Organizations	9.1	Areas of the physical environment are categorized based on the risk of infection to determine frequency of cleaning and the level of disinfection required.
Infection Prevention and Control for Community-Based Organizations	9.2	Roles and responsibilities are assigned for cleaning and disinfecting the physical environment.
Infection Prevention and Control for Community-Based Organizations	9.3	There are policies and procedures for cleaning and disinfecting the physical environment and documenting that cleaning has been done.
Infection Prevention and Control for Community-Based Organizations	9.5	Compliance with policies and procedures for cleaning and disinfecting the physical environment is regularly evaluated, with input from clients/residents and families, and improvements are made as needed.
Infection Prevention and Control for Community-Based Organizations	10.23	Processes for cleaning, disinfecting, and sterilizing medical devices and equipment are monitored and improvements are made when needed.
Infection Prevention and Control for Community-Based Organizations	10.23.1	There is evidence that processes and systems for cleaning, disinfection, and sterilization are effective.

Infection Prevention and Control for Community-Based Organizations	10.23.2	Action has been taken to examine and improve processes for cleaning, disinfection, and sterilization where indicated.
Infection Prevention and Control for Community-Based Organizations	10.5	Current manufacturers' instructions are upheld when cleaning, disinfecting, or sterilizing medical devices and equipment.
Infection Prevention and Control for Community-Based Organizations	10.6	Policies, procedures, and manufacturers' instructions are accessible to all team members.
Medication Management for Community-Based Organizations	1.5	The organization has identified and implemented a list of abbreviations, symbols, and dose designations that are not to be used.
Medication Management for Community-Based Organizations	1.7	A documented and coordinated approach to safely manage high-alert medications is implemented.
Medication Management for Community-Based Organizations	1.7.2	The policy names the role or position of individual(s) responsible for implementing and monitoring the policy.
Medication Management for Community-Based Organizations	1.7.8	Information and ongoing training is provided to team members on the management of high-alert medications.
Medication Management for Community-Based Organizations	3.11	When the organization is notified that medications have been discontinued or recalled by the manufacturer, the affected medications are stored away from medications in current use, pending removal or disposal.
Medication Management for Community-Based Organizations	17.3	The medication information stored in the smart infusion pumps is regularly updated.
Medication Management for Community-Based Organizations	17.4	The limits set for soft and hard doses are regularly tested to make sure they are working in the smart infusion pump.
Primary Care Services	5.5	When prescribing any medication, the team reconciles the client's list of medications.
Public Health Services	11.4	The vaccine cold chain is monitored and maintained according to regional legislation.