Quality Improvement Plan (QIP)

Narrative for Health Care Organizations in Ontario

March 19, 2025

Ontario Health

OVERVIEW

The overall theme of our Quality Improvement Plan is "moving forward together", after the upheaval that healthcare faced during the pandemic, health human resource shortages and threats of emergency department closures it felt like a great time for a reset. The hospital has always worked well together and with our community partners, it was time to return to basics and remember our Mission statement of "Compassionate, quality care - every patient, every time". Our vision remains to work together for excellence in Northern Healthcare and we remain committed to that statement. Our partnerships have enhanced and improved over time, and we know that when we strive for improvement we do so as a community.

ACCESS AND FLOW

To be successful in creating better access and flow for our patients we need to work together to understand the problem. We will be monitoring the data to ensure patients who are waiting in the emergency department for an inpatient bed receive one within a timely manner. Patient care reviews will be triggered in the event that patients are waiting in areas that are not best suited to their care needs with standardized processes put in place to ensure review and improvements take place.

Collaboratively we will work with the Red Lake Health Hub access and Flow working group to assess how we can eliminate barriers to access and flow on a community level, across systems, to improve care pathways for our patients. The purpose of the working group will be to see how the community can implement Home First Operational Guidance from Ontario Health. The Red Lake Health Hub is part of the larger Kiiwetinoong Healing Waters Ontario Health Team that represents health and social services across the Red Lake, Dryden and Sioux Lookout region.

EQUITY AND INDIGENOUS HEALTH

Last year the hospital restarted its, largely dormant Indigenous Working Group with the intent of creating a work plan. The theme of "Hearing voices, while building trust" has resonated throughout our conversations and patient survey data and is something we plan to address through several avenues. Our staff need to be in a place where they can hear what is being said and provide safe spaces for conversations. Training in equity, diversity and inclusion will occur for all staff to ensure they are better able to provide these safe spaces. New survey methods, have also been put in place that will be more accessible sent electronically across multiple platforms. Future work may include providing this access at common sites where patient populations feel most comfortable so that voices can continue to be heard. Policies will be created so that the expectation of staff from executive level to front line is clear and equity, diversity and inclusion is the standard of care at our facility. The work plan will continue to build relationships as it evolves continually striving towards reconciliation and we are open to where those conversations and relationships will lead us.

PATIENT/CLIENT/RESIDENT EXPERIENCE

The hospital strives to embed a patient centered approach in all that we do and this year, our patients have told us they want more from us as they transition from our environment to a new environment. One of the trends we have noticed through data and our conversations told us that it is time to review our discharge processes to ensure we are meeting the needs of those we care for. Concentrating on reviewing every piece of the process and how it flows together in a way that makes sense to our patients and their needs. After review and implementation of improvements for the discharge process review, our plan is to have 60% of Inpatients and 60% of emergency department patients responding “completely” to the question: Did you receive enough information from hospital staff about what to do if you were worried about your condition or treatment after you left the hospital?”

The hospital is also adding a position to act in the capacity of withdrawal and addictions support, currently there are not enough resources in place to adequately support this sector of our population and the creation of a new targeted position will not only help with support but with recovery. This will align with the start of the Safe Beds program at the organization providing a greater continuity of care for those seeking care.

PROVIDER EXPERIENCE

The provider is the most crucial component of patient centered care and if we don't adequately care for our providers, we cannot best serve our patients. Our providers are telling us they are still in recovery mode from the trials faced during the pandemic and Health human Resource shortages. Psychological safety has decreased, and burnout has increased among staff as reported in a recent survey, they also want to know we are investing in them. Rebuilding the tools our staff need to feel safe, comfortable and competent will be our priority for the upcoming year.

The hospital believes that one violent incident is too many and that the best way to approach violence is to prevent its occurrence in the first place. One of the ways we are planning to achieve this is to continue to ensure that our staff remain up to date on recommended training around resiliency and violence prevention. Prevention is not the whole story though and therefore we are concentrating on our responses and debriefing should violence occur. Multiple training sessions and huddles with staff to ensure we are focusing on the right things for their needs will work towards recovery and appreciation for this amazing team.

SAFETY

The hospital's theme for patient safety this year is "back to basics". With staffing changes and staffing shortages, the hospital focused on the immediate, now that stability has returned, we are focusing on what made us great in the first place, our systems. To ensure these systems are working as they have in the past, we are reviewing the entire patient incident management process with staff, leadership, patients and family. The results of our training and consultation blitz's will inform us where the greatest focus needs to be in terms of next steps for patient safety.
The pharmacy is also a spotlight area in patient safety this year as we review the "never events" checklist recommendations to ensure we are inline with best practices. How these processes are trained and maintained to be more resilient during turbulent times will ensure our patients will continue to benefit from our patient safety systems.

PALLIATIVE CARE

This year, in terms of palliative care, the hospital is focused on patient and family experience, especially at “end of life”. Through patient consultation we have identified a gap in our ability to provide a comfortable space for patients and their families during end of life. Identifying this need for improvement our CEO reached out to local stakeholders who also recognized the importance of the ability to improve the experience for everyone at this stage of life. With the help of our local stakeholders and community partners we are proud to announce that we are undertaking renovations to make one of our patient rooms more conducive to the end of life processes. This will include providing more privacy, a quieter environment and a more welcoming atmosphere for families experiencing this stage of the care journey.

POPULATION HEALTH MANAGEMENT

This year the hospital has focused on specific health populations that include ALC or alternative level of care patients as well as patients experiencing substance abuse issues. The hospital is also contributing to work around patient access and flow collaboratively with our Ontario Health Team. While reviewing the topic of population health it came to our attention that a review of our area’s population and specific health needs has not been completed in quite some time. Before we are able to begin to focus on more work targeted at our population health needs a re-assessment of those needs is required. It’s the hospital’s intent to work with our stakeholders and community partners to develop a process.

EMERGENCY DEPARTMENT RETURN VISIT QUALITY PROGRAM (EDRVQP)

The hospital is in the "baseline" phase of implementing the Emergency Department Return Visit Quality Program. It is our intent this year to begin the auditing process on any patient experiencing a sentinel diagnosis (subarachnoid hemorrhage, acute myocardial infarction, and pediatric sepsis). If no sentinel events occur, the hospital will audit any return visits within 7 days of discharge from the initial Emergency Department non-admit visit, with a minimum of 10 audits conducted per month. The purpose of this process will be to find areas of improvement to address preventable causes in order to improve clinical outcomes, increase patient satisfaction and provide high value care.

EXECUTIVE COMPENSATION

The executive compensation this year is tied to two change projects:
1) Achieving Exemplary Status during our Accreditation process and;

2) Training for all staff members in supervisory positions in equity, diversity and inclusion.

Quality Dimension	Objective	Target 2025-2026	100%	50%
Safety and Quality 50%	RLMCMH achieving Exemplary Status during the accreditation process	Exemplary Status	Achievement of "Exemplary Status"	Achievement of "accredited with commendation"
Equity 50%	Training for all staff members in supervisory positions in equity, diversity and inclusion	Completion by the leadership team of the following 3 courses: 1) Indigenous History and Political Governance 2) Cultural competence in healthcare - First Nations, Inuit and Metis Culture 3) Colonization and the determinants of health	Completion of all required courses	Completion of 2 out of 3 required courses

CONTACT INFORMATION/DESIGNATED LEAD

Amanda Kaczmarek
Director of Quality, Risk and Support Services
akaczmarek@redlakehospital.ca
807-727-3804

SIGN-OFF

It is recommended that the following individuals review and sign-off on your organization's Quality Improvement Plan (where applicable):

I have reviewed and approved our organization's Quality Improvement Plan on **March 31, 2025**

Trevor Zhukrovsky, Board Chair

Holly Stamarski, Board Quality Committee Chair

Angela Bishop, Chief Executive Officer

Taylor Smith, EDRVQP Lead

Access and Flow | Timely | Optional Indicator

Indicator #1

90th percentile ED length of stay (The Red Lake Margaret Cochenour Memorial Hospital)

Last Year		This Year		
10.28	**9**	**NA**	**--**	**NA**
Performance (2024/25)	Target (2024/25)	Performance (2025/26)	Percentage Improvement (2025/26)	Target (2025/26)

Change Idea #1 ☐ Implemented ☑ Not Implemented

Creation of a process whereby ED patients in need of an EKG could be diverted to Diagnostic imaging department for the service freeing up nursing resources for the next patient

Process measure

- Implementation of the new process for ED patients

Target for process measure

- 75% of patients requiring this service being diverted to DI for the procedure by mid-point of Q4

Lessons Learned

We had staffing shortages in the department and in the leadership team which left us with inadequate staffing to start the project

Comment

Change idea is not feasible with current staffing complement, new change ideas/areas will be assessed.

Access and Flow | Efficient | Custom Indicator

Indicator #2

Accreditation leadership standards implemented (The Red Lake Margaret Cochenour Memorial Hospital)

Last Year		This Year		
CB	**CB**	**88.00**	**--**	**NA**
Performance (2024/25)	Target (2024/25)	Performance (2025/26)	Percentage Improvement (2025/26)	Target (2025/26)

Change Idea #1 ☑ Implemented ☐ Not Implemented

Completion and implementation of both required organizational practices and high priority items for the Leadership Standard from Accreditation Canada

Process measure

- completion and implementation of all ROP's and HP's for accreditation Canada's leadership standard

Target for process measure

- 100% achievement of these standards by end of Q4

Lessons Learned

It was successful to bring it to the weekly leadership team meeting but there was not a full leadership team including an accreditation lead for approximately the first seven months of the the fiscal year which created challenges in terms of timelines for completion.

Equity | Equitable | Custom Indicator

Indicator #8	Last Year		This Year		
	CB	**CB**	**6.00**	**--**	**NA**
Re-start dormant Indigenous Working Group (The Red Lake Margaret Cochenour Memorial Hospital)	Performance (2024/25)	Target (2024/25)	Performance (2025/26)	Percentage Improvement (2025/26)	Target (2025/26)

Change Idea #1 ☑ Implemented ☐ Not Implemented

Re-start the Indigenous working group and turn it into a committee

Process measure

- Sustainable committee with clear objectives set for the upcoming fiscal year

Target for process measure

- Full implementation including 6 meetings held by end of the fiscal year

Lessons Learned

A project workplan is actively being worked on and the committee is meeting regularly. Community partners were instrumental in this initiative as they are invested in the success of the committee.

Experience | Patient-centred | Custom Indicator

Indicator #4

improve interdisciplinary team communication (The Red Lake Margaret Cochenour Memorial Hospital)

Last Year		This Year		
32.00	**40**	**39.00**	**--**	**NA**
Performance (2024/25)	Target (2024/25)	Performance (2025/26)	Percentage Improvement (2025/26)	Target (2025/26)

Change Idea #1 ☑ Implemented ☐ Not Implemented

Improve interdisciplinary team communication

Process measure

- Increased interdisciplinary communication top box score on staff survey

Target for process measure

- Increase to 60% of nursing staff in attendance on at least 3 out of 5 weekdays

Lessons Learned

Huddle boards were implemented for clinical staff with communication that escalated to the appropriate departments.
Frontline staff appreciated the huddle boards and they were well attended, less so the nursing staff based on patient care needs but we know we need them to be there. We do think it improved morale and we are re-visiting the questions based on feedback.

Comment

It is believed that communication was affected by large amounts of staff turnover including vacancies in key positions.

Indicator #9

Wellness incentive policy uptake (The Red Lake Margaret Cochenour Memorial Hospital)

Last Year		This Year		
30.00	**55**	**56.00**	**--**	**NA**
Performance (2024/25)	Target (2024/25)	Performance (2025/26)	Percentage Improvement (2025/26)	Target (2025/26)

Change Idea #1 ☑ Implemented ☐ Not Implemented

Improve uptake of staff wellness policy use

Process measure

- uptake of policy by staff

Target for process measure

- 55% of full-time and part-time staff utilizing the wellness policy incentives

Lessons Learned

Staff uptake was improved as staff were encouraged and made more aware of the use of the policy. Huddles and staff meetings were a great driver for information sharing for this project.

Indicator #3

Implementation of Qualtrics patient experience survey (The Red Lake Margaret Cochenour Memorial Hospital)

Last Year		This Year		
CB	**CB**	**100.00**	**--**	**NA**
Performance (2024/25)	Target (2024/25)	Performance (2025/26)	Percentage Improvement (2025/26)	Target (2025/26)

Change Idea #1 ☑ Implemented ☐ Not Implemented

Implementation of the Qualtrics patient experience survey for the Emergency Department

Process measure

- implementation and results collected

Target for process measure

- full implementation with results being gathered by end of Q4

Lessons Learned

project was successfully implemented with official go-live scheduled for April 1st 2025
It was great working with the OHA and Qualtrics on this project.

Comment

Project completed as planned

Experience | Patient-centred | Optional Indicator

Indicator #6

Percentage of respondents who responded “completely” to the following question: Did you receive enough information from hospital staff about what to do if you were worried about your condition or treatment after you left the hospital? (The Red Lake Margaret Cochenour Memorial Hospital)

Last Year		This Year		
65.63	**75**	**51.85**	**-21.00%**	**60**
Performance (2024/25)	Target (2024/25)	Performance (2025/26)	Percentage Improvement (2025/26)	Target (2025/26)

Change Idea #1 ☐ Implemented ☑ Not Implemented

24-48 hour follow up phone calls for inpatients over 75 who were discharged.

Process measure

- percentage of phone calls made based on total population of patients matching this category

Target for process measure

- 80% of inpatients under this category receiving a follow up phone call within 24-48 hours

Lessons Learned

Staffing shortages resulted in a gap in the position that was supposed to conduct this project and it was not feasible to complete.

Change Idea #2 ☑ Implemented ☐ Not Implemented

Our Nurse practitioner completed follow up phone calls for her patients that were considered vulnerable or "at-risk".

Process measure

- No process measure entered

Target for process measure

- No target entered

Lessons Learned

This was received really well by the community and continues to be a practice we would like to continue. The tracking of the practice needs to be reviewed in order to produce some better data around patients contacted, but we do know a minimum of 220 patient phone calls were made.

Comment

We are reviewing our entire discharge process including information flow in order to identify all areas for improvement. The original change idea will be added to next years Quality Improvement Plan with the intent to try follow up phone calls for all Inpatient Discharges

Safety | Safe | Custom Indicator

	Last Year		This Year		
Indicator #5 Patient Identification errors (The Red Lake Margaret Cochenour Memorial Hospital)	**24.00** Performance (2024/25)	**12** Target (2024/25)	**5.00** Performance (2025/26)	**--** Percentage Improvement (2025/26)	**NA** Target (2025/26)

Change Idea #1 ☑ Implemented ☐ Not Implemented

Decrease the amount of patient identification errors that occur during patient care

Process measure

- Reduction of patient identification errors

Target for process measure

- reduction of patient identification errors by 50%

Lessons Learned

There was a gap in staffing that postponed our original change idea leading to the change idea listed below.

Change Idea #2 ☑ Implemented ☐ Not Implemented

Lab was paged to audit in real-time all pathology collections to ensure the process was seamless and labeling was done correctly

Process measure

- No process measure entered

Target for process measure

- No target entered

Lessons Learned

Real time audits with pathology processes and educational campaigns resulted in a decrease in patient identification errors

Comment

There is a greater awareness of the correct processes around this thanks to collaboration between departments

Safety | Safe | Optional Indicator

Indicator #7

Rate of workplace violence incidents resulting in lost time injury (The Red Lake Margaret Cochenour Memorial Hospital)

Last Year		This Year		
0.00	0	0.00	#Error	0
Performance (2024/25)	Target (2024/25)	Performance (2025/26)	Percentage Improvement (2025/26)	Target (2025/26)

Change Idea #1 ☐ Implemented ☑ Not Implemented

Ensure staff training for non-violent crisis intervention is up to date for staff in the organization

Process measure

- percentage of full time and part time staff receiving NVCI training

Target for process measure

- 70% of all full-time and part-time staff

Lessons Learned

We conducted a big training push which helped keep the staff up-to-date but we fell shy of our target of 70%. We did manage to train over half the staff with 51.5% trained

Change Idea #2 ☑ Implemented ☐ Not Implemented

Train nursing on the Gentle Persuasive Approach program

Process measure

- The amount of Full-time and Part-Time staff receiving this training

Target for process measure

- 70% of all Full-time and part-time nursing staff receiving training by end of Q4

Lessons Learned

Nurses attended training and it was well received and has been added to our QIP for next year.

Change Idea #3 ☑ Implemented ☐ Not Implemented

Workplace violence prevention risk assessment recommendation implemented

Process measure

- Implementation of list items

Target for process measure

- 90% of all recommendations implemented by the end of Q4

Lessons Learned

The goal was to achieve 90% implementation of recommendations and this was achieved utilizing JHSC, leadership and Mandatory training opportunities.

Comment

By adding the training to the Quality Improvement plan we were able to make it a focus and although we did not achieve our target we believe by leaving it on the plan and monitoring progress we can achieve our original target. We also changed the way that the education was tracked to provide a clearing picture of how the training process is going.

Access and Flow

Measure - Dimension: Timely

Indicator #6	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
90th percentile emergency department length of stay for nonadmitted patients with low acuity	O	Hours / ED patients	CIHI NACRS / ERNI hospitals: Dec 1, 2023, to Nov 30, 2024/Non-ERNI hospitals: Apr 1, 2024, to Sept 30, 2024 (Q1 and Q2)	5.75	5.25	Health Human resources affects our ability to improve this target, we will evaluate the system to assess is in our control that can be improved	

Change Ideas

Change Idea #1 Implement patient review and assessment for all patients who are nonadmitted with low acuity at the 24 hour mark

Methods	Process measures	Target for process measure	Comments
Creation of assessment and follow up actions for any patient that hits the 24hr mark in our ED without admission	Number of patients who stayed in our Emergency Department for 24hrs without admission that were followed up on for further assessment action	60% of all patients reaching the 24hr mark having some standardized follow up implemented by Q3	Implementing the same change idea as stated for high acuity patients in this workplan

Measure - Dimension: Timely

Indicator #7	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
90th percentile emergency department length of stay for nonadmitted patients with high acuity	O	Hours / ED patients	CIHI NACRS / ERNI hospitals: Dec 1, 2023, to Nov 30, 2024/Non-ERNI hospitals: Apr 1, 2024, to Sept 30, 2024 (Q1 and Q2)	16.67	15.00	Access to health human resources are limited but we would like to understand where the barriers may occur	

Change Ideas

Change Idea #1 Implement patient review and assessment for all patients who are nonadmitted with high acuity at the 24 hour mark

Methods	Process measures	Target for process measure	Comments
Creation of assessment and follow up actions for any patient that hits the 24hr marks in our ED without admission	Number of patients who stayed in our Emergency Department for 24hours without admission that were followed up on for further assessment or action	60% of all patients reaching the 24 hour mark having some standardized follow up implemented by Q3	These reports are generated for review from data that is in the health record, through meditech

Measure - Dimension: Timely

Indicator #8	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
90th percentile emergency department wait time to physician initial assessment	P	Hours / ED patients	CIHI NACRS / ERNI hospitals: Dec 1, 2023, to Nov 30, 2024/Non-ERNI hospitals: Apr 1, 2024, to Sept 30, 2024 (Q1 and Q2)	2.27	2.20	We would like to review the target through a change project to assess for standardization and consistency in our processes. The belief is our data collection may be the issue but it is unknown without a deeper assessment.	

Change Ideas

Change Idea #1 Data entry assessment

Methods	Process measures	Target for process measure	Comments
1) establish current baseline and procedures 2) meet to address any procedures that have not been standardized and standardize them 3) create a performance report based on above results for reporting purposes	Number of charts without discrepancies Percentage increase in current performance based on new standardized procedure	awaiting baseline data to insert results	We are not sure this is being completed in a standardized and consistent way by all parties involved, this process needs to be assessed first before improvements can be made

Equity

Measure - Dimension: Equitable

Indicator #1	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Percentage of staff (executive-level, management, or all) who have completed relevant equity, diversity, inclusion, and anti-racism education	O	% / Staff	Local data collection / Most recent consecutive 12-month period	25.00	90.00	This type of training is a priority for our organization.	

Change Ideas

Change Idea #1 Training for all staff members in supervisory positions in equity, diversity, and inclusion

Methods	Process measures	Target for process measure	Comments
Completion, by the leadership team of the following 3 courses: - Indigenous History and Political Governance - Cultural Competence in Healthcare - First Nations, Inuit and Metis Culture, Colonization and the Determinants of Health	percentage of supervisors on site receiving EDI training	90% of all supervisors on site receiving relevant EDI training by end of Q4 2026	

Change Idea #2 Creation of a palliative end of life care space better suited to patient needs

Methods	Process measures	Target for process measure	Comments
Environmental design changes to better support population and caregivers	Co-design of project with from patients and families to include family/caregiver space, a dedicated room washroom, literature for families	Completion of project by Q4	

Experience

Measure - Dimension: Patient-centred

Indicator #2	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Percentage of respondents who responded “completely” to the following question: Did you receive enough information from hospital staff about what to do if you were worried about your condition or treatment after you left the hospital?	O	% / Survey respondents	Local data collection / Most recent consecutive 12-month period	51.85	60.00	We have low survey responses which affects our data but we would like to make a larger improvement in this area	

Change Ideas

Change Idea #1 Create an interdisciplinary working group to conduct a mapping exercise for our current discharge process and it will include the information sharing with patient process

Methods	Process measures	Target for process measure	Comments
Process mapping	Completion of this process with at least one improvement project implemented as a result	Improvement project identified as part of mapping implemented by the end of Q3	Total Surveys Initiated: 27

Change Idea #2 Compile data and conduct a discharge focus group

Methods	Process measures	Target for process measure	Comments
Create data parameters for assessment Collect data from new patient survey to identify which population to conduct a focus group with.	Take data from Q1 and Q2, review to identify discharge focus group Conducting a focus group with that population and creating an improvement plan from the results	Completed data review by end of Q3 and completed focus group by end of Q4	We will work collaboratively with an Interdisciplinary Team on this project.

Safety

Measure - Dimension: Safe

Indicator #3	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Rate of delirium onset during hospitalization	O	% / Hospital admitted patients	CIHI DAD / April 1 to September 30, 2024 (Q1 and Q2), based on the discharge date	X	0.00	process review while collecting baseline	

Change Ideas

Change Idea #1 process mapping of patient journey for vulnerable populations

Methods	Process measures	Target for process measure	Comments
process mapping	completion of mapping session with identification of gaps	Gaps identified with working plan created for improvements by Q3	This is a collaborative project with the Red Lake Health Hub

Measure - Dimension: Safe

Indicator #4	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Rate of workplace violence incidents resulting in lost time injury	O	% / Staff	Local data collection / Most recent consecutive 12-month period	0.00	0.00	We believe that any number other than zero is unacceptable and that zero should always be our target	

Change Ideas

Change Idea #1 Conduct Code White Skills drills for staff to enhance Code white knowledge and response

Methods	Process measures	Target for process measure	Comments
Creation of skills drills and delivery of drills to different departments tailored to potential roles held during a Code	% of FT and PT staff having received a skills drill training session	60% of all FT and PT staff undergoing a skills training session for Code White	

Change Idea #2 We will continue to offer Non-Violent Crisis intervention to the staff

Methods	Process measures	Target for process measure	Comments
Provide course onsite and keep staff up to date with their training as per local policy	% of FT and PT staff who have current training in NVCI	60% of all FT and PT staff current with NVCI course by end of Q4	

Change Idea #3 Continue with Gentle Persuasive Approach training

Methods	Process measures	Target for process measure	Comments
Deliver course to patient care staff that do not have current certification	% of staff current in GPA course	60% of patient care staff current in GPA by end of Q4	

Measure - Dimension: Safe

Indicator #5	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Achievement of Exemplary status during the Accreditation Canada process	C	Other / All patients	In house data collection / Q3	CB	CB	Our goal, to ensure we are providing the best care possible to all patients, is the achievement of the highest possible rating from Accreditation Canada. We believe this achievement ties all areas of quality together.	

Change Ideas

Change Idea #1 Achievement of exemplary status during the hospitals accreditation cycle.

Methods	Process measures	Target for process measure	Comments
meeting required guidelines of accreditation Canada to achieve exemplary status	Achievement rating provided after onsite visit	Exemplary status achieved	We believe this is an indicator of our mission to provided "excellence in northern healthcare"