

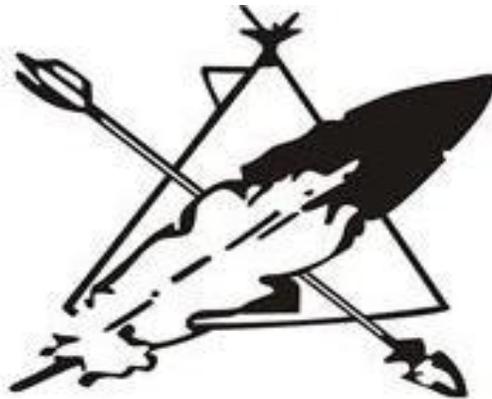
# ANNUAL REPORT ON HEALTH 2014 – 2015

*PINAYMOOTANG FIRST NATION*



**Pinaymootang First Nation  
Annual Report on Health 2014-2015**

# **Annual Report on Health**



**Pinaymootang First Nation Health Program  
General Delivery  
FAIRFORD, Manitoba  
R0C 0X0**

**Phone: (204) 659-5786**

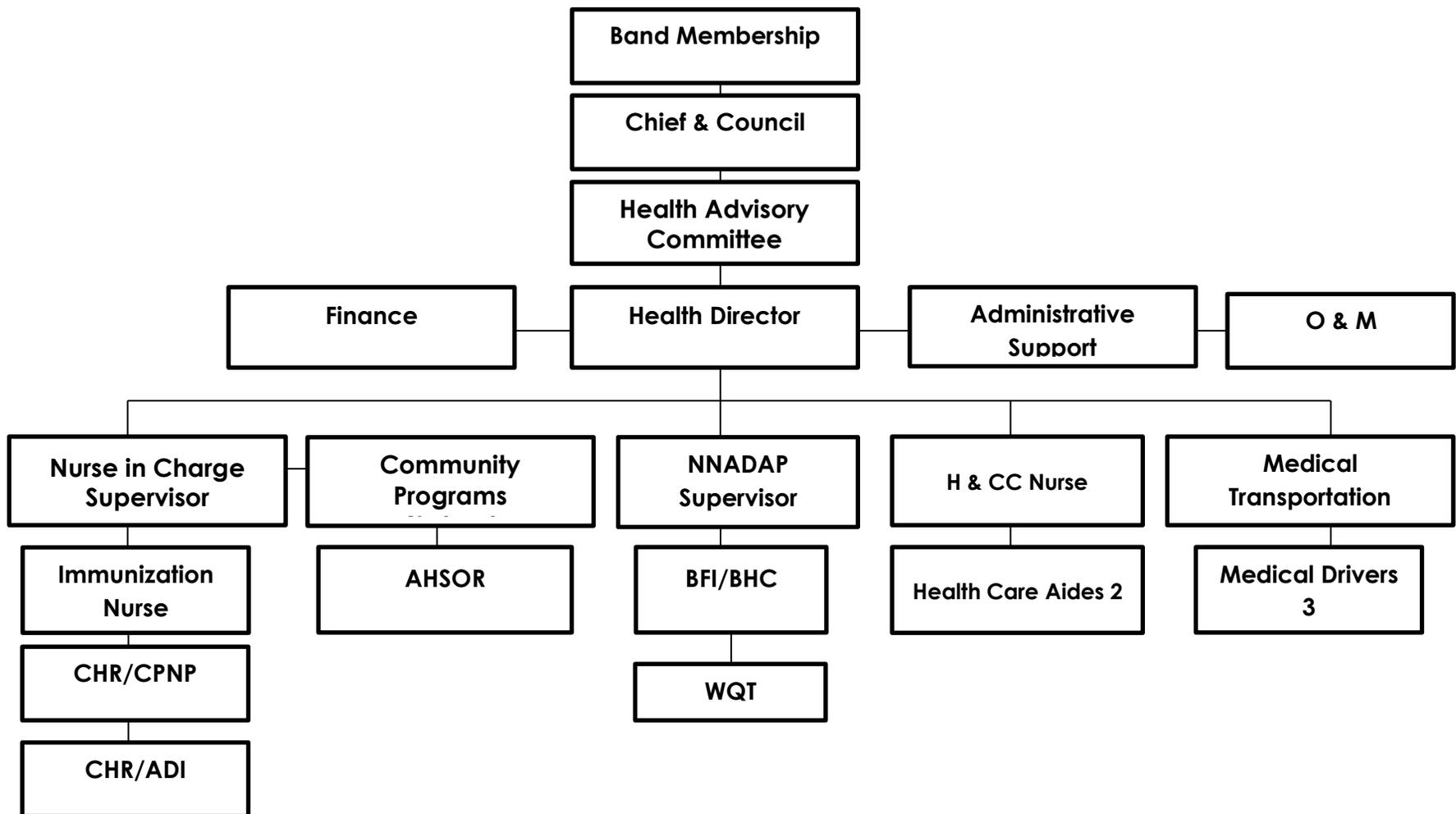
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# Pinaymootang First Nation Health Program Organizational Chart



## **Introduction:**

We like to welcome you once again to this year's Annual Report on Health which highlights the many accomplishments that have been undertaken over this fiscal year of April 1, 2014 to March 31<sup>st</sup>, 2015.

This report emphasizes on our commitments to health, the well-being of our community, partnerships with our stakeholders and achievements to health programming.

This document follows a similar format to the 2013-14, Annual Report. This Annual Report also sets the stage for the 2015-2016 program planning and annual budget processes by providing an opportunity to assess accomplishments, identify lessons learned and build on past successes for the benefit of the community.

On behalf of the Pinaymootang First Nation Chief and Council, the Health Advisory Committee and the Pinaymootang Health Centre Staff we hope that you find this information useful.

Meegwetch!

**Pinaymootang First Nation Health Program  
General Delivery  
Fairford, Manitoba R0C 0X0**

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## Message from Chief

It is an honor and privilege to once again present to you the Annual Report on Health for fiscal period 2014 – 2015. As leader of this community I am privileged to be involved in an organization that plays such an active role in the lives of our community members. The health and well-being of each one of us is a gift, a treasure that we have been blessed with, good health is the best gift you can give and receive from yourself.

In this report you will find a year filled with continued service, information on the many activities and work undertaken, has we continue to work towards common goals for the benefit and well-being of health. Teamwork, dedication and perseverance have always been the key, which have resulted in our many successes achieved.

Our community health intent will continue to:

- ✓ Provide open communication efficiently and effectively;
- ✓ Be guided by principles of fairness and equity;
- ✓ Encourage and support participation in activities;
- ✓ Actively grow in unity; and
- ✓ Be transparent and accountable to the general public to whom we serve.

The mission and vision of Pinaymootang Health Centre is to advance health knowledge, build capacity by promoting awareness, self-care, develop tools and processes in health education.

Our common goal is to *“Take Pride in What We Do”*.

I thank the Health Centre Staff for their hard working and dedication for our health programs success. Without their care, it would be impossible to sustain and improve health in our community.

I thank you for this opportunity has we are here to ensure that the future in health is prosperous and filled with hope and determination.

**Chief Garnet Woodhouse**



## **Message from Health Council Portfolio Holders**

We would like to welcome you to this year's annual report on health. Over the past year the Health Program has once again shown its capabilities in delivering services to our community.

This annual report identifies activities that follow on the heels of the transfer agreement initiative and activities leading to the creation and maintenance of a sustainable health care service system.



We have many fine talented and committed people who have shared their expertise in providing health services to our membership and to the community as a whole. We want to acknowledge and express our appreciation to the staff for their efforts in facilitating change, implementing the vision of leadership and positively impacting the health and well-being our community.

We hope that you will find this annual report on health useful and that you might share with others who may be interested in such information.

**Ted Woodhouse & John Sanderson  
Health Portfolio Council Holders**



## **Message from Health Advisory Committee**

We have the honor and privilege to present to you once again the Annual Report on Health on behalf of Pinaymootang First Nation Health Program for fiscal period ending March 31, 2015.

This Annual Report was prepared under the guidance and approval of the Health Advisory Committee, in accordance with reporting criteria as outlined in Contribution and Health Transfer Agreements.

All material and fiscal implications have been considered in preparing the Annual Report on Health.

On behalf of the Pinaymootang First Nation Health Advisory Committee we hope that you find this information useful.

Meegwetch,

**Eleanor Maytwayashing - Chairperson**



**Eva Woodford**



**Caroline Thompson**



**Shirley Cranford**



## Executive Health Director's Report

Well another year has come and gone. We welcome you, once again to this year's annual report on health for fiscal period ending 2014-2015.

Every year brings many new challenges and without a doubt, our hands-on approach allows us to quickly direct our resources to where they are most needed.

The Pinaymootang First Nation Health Centre strives to be a community based facility, where we are committed in working to create fewer barriers towards the health care system for our community members and assisting to continue on their quest to improve their health.

Our policy is to ensure that patient rights for safe and adequate health care needs are met for all those that step into our facility, in which we strive to prevent and reduce risks to individual health. We have taken steps to strengthen our services and we are able to provide this by working collaboratively.

And for this, I wish to acknowledge my health team for being champions in health and to our community membership for partaking in the health program activities that we had to offer.

### Governance Structure

The Pinaymootang First Nation established a Health Advisory Committee to oversee and ensure the proper operation and management of the Pinaymootang Health Program.

The Health Advisory Committee meets on a regular monthly basis every last Tuesday of each month to review reports, policies, staffing issues and other related concerns. The role of the committee is to represent Chief and Council to whom it is accountable, in that role the committee is responsible for providing recommendations on health and management. Through the terms of reference the committee defines the parameters within which the organization will carry out its work.

### Health Program Overview

*Nursing Treatment & Prevention* – the Nurse in Charge continues to demonstrate her nursing abilities way and beyond. The Health Centre has become a very active facility. The public health program continues to meet its criteria with; visiting new parents, well women's clinics, facilitating new baby care; providing immunization; encouraging physical activity; facilitating community education sessions; providing care services for common conditions during scheduled clinics; and attending to all emergency needs. We are also pleased to report that our immunization nurse position has become permanent funding.

Dr. Emadi who has been our visiting physician is no longer with us, due to the physician shortage in the area during this time. But with the hire of new physicians that took place in March 2015 by the IERHA we are hoping and anticipating that we can discuss the possibility of having a physician revisit our facility again.

*Community Health Representative* – The CHRs continue to play a major role in health programming both employees oversee additional programs within their scope of work. One CHR Margaret Anderson focuses on children, youth and school setting while taking on the CPNP program and the other CHR Alfred Pruden focuses on adult and elder care as well as the ADI program. Both CHR's have committed themselves in ensuring excellent program service delivery in their respective roles.

*Support to Nurses* – One Administrative Assistant is employed to oversee the day to day secretarial operations of the organization, her activities include but not limited to the following; support services to nurses, physician's and visiting professionals; provide support to program managers, booking all specialty visits, organizing meetings, and all general required duties.

*Operation and Maintenance of Health Facilities* – The role of the custodian is to ensure the upkeep of capital facilities. We welcome Gordon Letandre, as the new custodian who will be providing this service effective April 7, 2015.

One of the areas, we have expressed many times is the lack of office space of our facility, we hope that our funders take this into consideration in the near future.

*National Native Alcohol and Drug Abuse Prevention* – the goal of the NNADAP is to support our membership and the community to establish and operate programs aimed at stopping high levels of alcohol, drug and solvent abuse. Most of the NNADAP activities focus on the four areas of emphasis: prevention, treatment, training, research and development. The NNADAP program continues to support community designed and operated projects in alcohol prevention, treatment and rehabilitation in order to arrest and reverse the present destructive physical, mental, social and economic trends. The coordinator continues to provide the needed support and works closely with the visiting professionals in the area of mental health.

*Brighter Futures Initiative/Building Healthy Communities* (Mental Health; Home Care Nursing; Solvent Abuse) – the Health Program currently employs one person to oversee the roles in the BFI and BHC program, the purpose of the BFI is to improve the quality of and access to culturally sensitive wellness services in the community. These services help create healthy family and community environments which support child development. The components and objectives of the BFI are mental health, child development, injury prevention, healthy babies and parenting skills. A variety of projects have been held throughout the year aimed specifically in these areas.

The role of the BHC program is to address gaps in the range of mental health services and activities related to crisis intervention and post-vention on reserve. A common area identified was to improve the First Nations capacity to address crisis and we have been working diligently in creating an external crisis plan with community stakeholders.

*Environmental Health Drinking Water Safety Program* – The Health Program currently employs an individual on a half time level. The Drinking Water Program continues to meet its components as outlined in the agreements, such as sampling, testing drinking water, recording results on water quality, providing monthly reports to Environmental Health Officer, Robert Reed of First Nations and Inuit Health Branch - Health Canada, for interpretation and recommendations in determining E. Coli and total coliforms, inspecting and reporting on general sanitation, providing public awareness, develop contents for school, supports action on health status inequalities affecting members according to identified priorities and ensuring all pertinent procedures are followed, maintained and updated.

*Canada Prenatal Nutrition Program (CPNP)* - this program is designed to improve the health of pregnant women and their babies, the objective is to improve the adequacy of diet of prenatal, to promote breast feeding, to increase the access to nutritional information, to increase the number of infants fed aged appropriate foods in the first twelve months of life. Some of the activities have included; mommy and me programs, milk programs, prenatal clinics, traditional teachings, building skills in preparing nutritious foods, group sessions, parenting, cooking demos and providing information and promotion of the CPNP program.

*In Home and Community Care Program* – the H & CC Program currently employs; 1 H & CC Nurse Supervisor, 1 LPN (half time) and 2 Health Care Aides. Changes will be occurring in the new fiscal; Mary Bezemer and Janice Lowry have both decided to semi retire and have decided to share the position of Nurse in Charge effect April 2015. And with this new change we welcome Tanis Letandre in her new role as the H & CC Nurse Supervisor.

This program has been increasing drastically and at times overwhelming. Home visits are conducted on a daily basis, assessments completed, medical equipment purchased based on needs and most importantly getting our elderly involved in programs. During this fiscal year, the H & CC Service Delivery plan has been completed and ready to be submitted to our funders.

*NIHB Medical Transportation* – is administered by one Medical Transportation Coordinator and three medical drivers. The purpose of the MT Program is to provide transportation benefits to eligible First Nation members to the nearest access to medically required services that cannot be obtained in community. The program continues to intake medical appointments, verifying, scheduling in coordination of transportation based on the guidelines of FNIHB. A policy handbook has been completed and will be distributed by the fall of the new fiscal.

*Aboriginal Diabetes Initiative* – the ADI Program is designed to improve the health status of First Nations individuals, families and communities through actions aimed at reducing prevalence and incidence of diabetes and its risk factors. Diabetes is the biggest health challenge currently facing First Nations and this is one area we focus on, is the preventative measures that diabetes can be prevented. Diabetic awareness activities continue to take place, foot care is held bi-weekly, risk factors, assessments, surveys, physical activities, prevention and awareness, healthy eating habits, and gardening projects all have been implemented.

*HIV/AIDS* – The HIV/AIDS Program has continued to meet its components of the program, workshops, information sessions, awareness to promote safer activities, counseling, testing and health education classes have been conducted.

*Aboriginal Head Start On-Reserve (AHSOR)* – the AHSOR Home Visitor Coordinator is available to provide screening of all families pre-natal or very early after the birth of a child from 0 to 6 years of age to identify risk factors and assist these families with supports such as expanding and enhancing programs and support services for mothers, pregnant women, caregivers, parents, parents to be, children and their families. The AHSOR Program is active in community and has become a participant in the Dolly Parton Imagination Library.

### **Other Initiatives:**

*Communications* – the health program continues to find innovative ways in communicating with community member. We have initiated a website page at [www.pfnhealth.com](http://www.pfnhealth.com) as well as a Facebook page for health related information on programs, workshops or events.

*Accreditation* – I am happy to report that we have accomplished one of the most difficult tasks we have ever endured during the past five years. YES! The Pinaymootang Health Centre is now a fully Accredited Facility for the next four years, in meeting excellence in standards of health services. This is something that we are so proud of.

*Mustimuhw Community Electronic Medical Record* – the Health Centre utilizes a member-centered Community Electronic Medical Record (cEMR). We also have access to e-chart and most recently have been set up in Tele-health. We will be moving towards Panorama in the new fiscal year.

*Network Meetings* – the Health Program is involved in community network meetings which consist of the Pinaymootang School, Health Centre, Band and Child & Family Services where these organizations get together to work in unity on partnering in community programming, this group meets on a monthly basis.

*Interlake-Eastern Regional Health Authority (IERHA)* - the Health Program continues to work with the IERHA in partnership in dealing with issues and concerns to ensure improved health services.

Finally, a lot of hard work has been undertaken during this fiscal. I hope that those that read this find this information useful and I strongly encourage you to visit our website to access more information on your Health Centre. features. Meegwetch!

**Gwen Traverse**  
**Executive Health Director**



## **Accreditation Coordinator's Report**

The Pinaymootang First Nation (PFN) Health Centre made a commitment in 2010 to complete the accreditation process with Accreditation Canada, to ensure that the highest quality of services are provided to the community members in a safe health care environment. 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.

In 2014-2015, the PFN Health Centre team worked diligently to meet the 200 system-wide and service excellence standards set out in specific areas related to health services and supports provided in a First Nations Health Centre, including:

- Leadership for Aboriginal Health Services
- Home Support Services
- Aboriginal Community Health and Wellness
- Customized Infection Prevention and Control

### **Accreditation Initiative:**

Program Leads from within the Health Centre worked as the Accreditation team to ensure that all policies and procedures were developed in accordance with the standards. The Health Centre contracted a part-time person to provide technical support and overall coordination.

As part of the Qmentum Accreditation Program, the Health Centre has undergone an in-depth evaluation process. Following a comprehensive self-assessment, external surveyors with expertise in Aboriginal health service delivery conducted an on-site survey during which they assessed the organization's leadership, governance, clinical programs and services against Accreditation Canada requirements for quality and safety. These requirements include national standards of excellence; required safety practices to reduce potential harm; and questionnaires to assess the work environment, patient safety culture, governance functioning and client experience.

The Pinaymootang First Nation Health Centre received full Accreditation on September 29, 2014. This report will be used to guide the Health Centre as it continues to incorporate the principles of accreditation and quality improvement into its programs, policies, and practices.

### **Objectives:**

The objectives of this initiative for 2014-2015 were to:

- Review health policies to ensure they reflected the best interests of community members, staff members, and the community as a whole;
- Develop new policies to address areas where quality and safety are important such as infection prevention and control, collaboration in risk and disaster management, medication management, and disclosure of adverse events;
- Implement policies to establish best practices for our community to make the Health Centre the safest and highest quality service available to community members; and
- Generate ideas for quality improvement moving forward.

### **Activities Completed:**

#### (1) Accreditation Team Meetings

Members of the Accreditation Team engaged in 6 planning and preparation meetings throughout the year: **June 7th:** Planning of Staff Development Workshop on new policies; **June 24th:** Reviewed Draft Agenda for the September Survey and made a work plan for all activities to be completed in preparation for the Survey; **June 29th:** Presentation to the Health Centre Staff to keep them fully informed of the Accreditation process and requirements including how staff could prepare for the Survey process; **July 14th:** Pre-survey conference call to meet surveyors to discuss the process, and establish expectations for the September visit; **August 1st:** Review of 13 draft new and enhanced policies, planning of process for Mock Survey with staff on August 15<sup>th</sup>; **October 28th:** Review of Accreditation report and follow-up recommendations.

#### (2) Staff Development Workshops

The Accreditation Coordinator prepared and facilitated a total of 4 staff workshops throughout the year to work with staff in reviewing enhanced policies and developing new policies to meet the needs of community members: **June 19<sup>th</sup>:** Staff Workshop on infection prevention and control, and emergency preparedness and response; **July 7<sup>th</sup>:** Staff Workshop on Survey Process; **August 15<sup>th</sup>:** Mock Survey with Staff on areas of: Leadership for Aboriginal Health Services, Home Support Services, Aboriginal Community Health and Wellness, Customized Infection Prevention and Control; **January 30:** Development of Disclosure Policies

#### (3) Survey Process

All staff participated in hosting two Surveyors from Accreditation Canada from September 15th to 17th. The survey began with an initial meeting with Chief and Council and Health Advisory Committee. Staff, were engaged in one and a half days of interviews, file audits, policy reviews, observation of services provided, client interviews, and home visits. In addition, the Surveyors met with 3 community partners from Mental Health, Education, and Child and Family Services to assess how the Health Centre works together with other organizations and service providers in the community. A final presentation of the Surveyors' observations and impressions was provided at the end of the third day.

The Health Centre receives formal notification of becoming a fully accredited health institution on September 29th, 2015.

#### (4) Community Feast and Celebration

On November 21st, the Chief and Council, Health Advisory Committee and Health Centre staff celebrated on this momentous occasion to celebrate the hard-earned success.

#### (5) Follow-Up Activities

Accreditation Canada requested that the Health Centre submit final evidence of their disclosure policies and practices. These activities were completed on February 17th and accepted and approved by Accreditation Canada. PFN Health Centre will undergo a review every 4 years to ensure that the organization is maintaining their standards of practice and service delivery.

**Challenges:** The Accreditation process is long and detailed. Staff, were required to review information and assess the effectiveness of policies as they were being implemented. The journey was very labor intensive but the accomplishments in quality improvement and safety made the work rewarding.

Through this process, the Chief and Council recognized the need to further improve on community partnerships across sectors with the identification of strategic planning as an important goal.

**Successes:** Pinaymootang First Nation Health Centre is one of few to become fully accredited by Accreditation Canada. This success is a depiction of the trust and faith that the Chief and Council as in its organizational management and its employees. In addition, the commitment of the Health Advisory Committee members demonstrate the involvement and commitment from community members to provide guidance, direction, and support to their local service organization to best serve the community.

Finally, the commitment and effort put forth by the staff is indicative of their dedication to the health and well-being of the community.

#### **Next Steps:**

The next steps for 2015-2016 will involve:

- (1) The design and production of user-friendly policy manuals for all staff and leadership;
- (2) Continuous performance monitoring; and
- (3) Strategic planning with the community.

**Kathleen Bluesky**  
**Accreditation Coordinator**



## **Nursing Annual Report**

The Health Centre continues to strive to be a place community members feel comfortable coming to address their health care needs and as staff we work hard to try to assist community members in getting the best health care possible.

As a Health Centre, we often advocate for community members with other health care professionals outside the community and work to assist them to address their health care needs.

This year, tele-health capabilities were established which now enables community members to connect with specialists and education opportunities that otherwise were not available to them in community. Tele-health is done by connecting to a site and talking to a specialist or following an educational lecture visually. Tele-health is expanding and more physicians are starting to use to deliver health care and assessments to individuals outside of the city so this means in the future regular appointments with pediatricians, dermatologist, endocrinologist, cardiologist etc. will be able to be done right in the community.

The Health Centre also has continued to do phlebotomy (drawing blood) and this also assists community members with specialists and doing fasting blood work. Pre-natal care is also available in the community from pregnancy testing to delivery and follow ups once the Mom and baby return home. Wound dressing can also be done for community members on a Monday to Friday basis and can continue over the weekend if needed at Lakeshore E.R., so this decreases the need to travel outside the community.

Medication education and reviews can be done as needed, diabetes education, healthy weights, nutrition, exercise are all education capabilities at the Health Centre. Monitoring blood pressure, blood sugars, and most health conditions can also be done. So, as you can see the Pinaymootang Health Centre is working hard to try to deliver services that assist individuals to maintain a healthy path for them to walk.

Diabetes is still very prevalent in the community but more and more community members are taking healthy steps to get control of their diabetes. This year there was a definite increase in the use of the Wellness Center and community members are taking steps towards healthier weights and trying to increase their nutritional knowledge. Hopefully in the future we will see a decrease in diabetes numbers with the young people and fewer community members will have to go on dialysis and have major complications.

The Health Centre has two clinic rooms now and this has facilitated faster care for community members. Four nurses work and this also helps address the workload. Dr. Emadi continues to support the Health Centre by accepting referrals and ordering treatments by nursing assessments.

This year there was an MD shortage in Ashern, so the workload has been very busy but I feel the Health Centre has worked hard to try to address as many issues as possible.

As the Nurse-in-charge I try to keep the nursing aspect of the Health Centre functioning as well as to ensure supplies and equipment is functioning. We have become accredited and therefore there are many standards that need to be met and maintained. I also work with community members with pre-natal care, women's health, PAP tests and B.C. counselling and clinic visits to address many health conditions.

The following are the stats for 2014-2015 for Nurse-in-Charge position:

- Communicable Disease 108
- Pre-natal/Post-partum 266
- Women's Health 188
- Diabetic 176
- Infant/Child Care 303
- Adult Health 512
- Home & Community Care 14

Total encounters with community members 1560 and number of members served 1009.

Electronic charting is running efficiently and this increases community member's confidentiality as well as helps us to keep stats about activity. As community members I hope you feel proud about the Health Centre and continue to use it to the best of its ability and realize how it can help you attain optimal health.

Every year I enjoy working and I cannot say enough about the pleasure I get working with community members. In the near future I will be decreasing my time here at the Health Center and will be working part-time instead of full time and I hope that I can continue to meet the health care needs of individuals when I am here. My biggest hope is that chronic disease decreases in the community and Pinaymootang can become a model community for other communities to strive to be.

**Janice Lowry**  
**Nurse in Charge**



## **Immunization Nurse Coordinator**

As I continue to become more familiar with the families of Pinaymootang, I not only have the opportunity to assess the needs of the community through the concerns of the families, but I am also able to observe the great strengths. One of the greatest strengths I have seen is the love the community showers upon its children. It is an honour to be able to support the families of Pinaymootang in learning how to optimize their care of this most precious treasure.

I am grateful for the support the community has for childhood immunizations; a few moments of hurt to protect a child from the unnecessary risk of vaccine preventable illnesses. I see so many parents who despair of seeing their children in pain show great strength in making a decision that will give their child a potentially life-saving vaccine. Please be proud of having the courage to stand strong and choose health for your children.

This year, I would like to take time to encourage families; parents, grandparents, aunties and uncles to consider another way to help the children of Pinaymootang be the absolute best people that they can be in order to ensure a strong future for the community itself. One way is by encouraging the mothers of Pinaymootang to make the choice to commit to exclusive breastfeeding for the first 6 months of their baby's life.

Breastfeeding can also be called the baby's first vaccine. Breastmilk allows a mother to share her immunity with her baby offering protection from many life threatening illnesses. Babies only receive a manufactured vaccine at 2 months of age. Even then, the manufactured vaccine cannot protect a baby from nearly as many illnesses as a mother's own milk.

Breastmilk also aids in completing the development of baby's digestive tract while creating a barrier to allergens. Breastfeeding significantly decreases a baby's risk of developing obesity and diabetes in adulthood and decreases the risk of death by SIDS in early infancy. No commercial formula can offer any of this protection.

Research continues to find more and more benefits to breastfeeding including higher IQ due to better brain development; better pain control; better jaw and dental development; better use of vaccines; fewer skin rashes, allergies, ear infections, stomach flu and colds; decreased risk of development of asthma, celiac or Crohn's disease. Breastfeeding means a healthier baby, which also means fewer trips to wait in a waiting room to see a doctor.

Moms also benefit from breastfeeding. Abnormal blood sugars normalize faster; pregnancy weight is lost more easily; reduces post pregnancy bleeding; lowers the risk of osteoporosis and breast cancer; saves money and time and is always the right temperature!!

Moms and babies need the support of the rest of their families in order to succeed at using nature's method of feeding. At the Health Centre, we would love to answer any questions you

have before and after a new baby arrives to bless your family. Please let us help you to prepare for breastfeeding and also to elp you through any issues you might have.

**Immunizations Coordinator Stats:**

820 immunizations: 479 various vaccines; 352 flu vaccines.

656 clinic visits: 342 adults; 314 children.

14 dressing changes: 5 adults; 9 children.

80 injections of various medications for adults.

7 home visits: 4 adults; 3 children.

58 blood draws: 51 adults; 7 children.

19 referrals: 1 adult; 18 children.

6 preoperative assessments: 3 adults; 3 children.

232 telephone consults for various concerns: 119 adults; 113 regarding children.

In the coming year, I look forward to continuing to share my knowledge and experience with you. I hope to also continue learning so that each year I can serve the families of Pinaymootang better, supporting you all in your pursuit of happy, healthy lives.

**Roxie Rawluk**  
**Immunization Nurse**



## Community Health Representative Report

The Pinaymootang First Nation Health Centre employs two Community Health Representatives who play a major role in health programming. Each CHR oversees additional programming in their job descriptions. My role focuses on school health, baby clinics, and youth of the community while taking on the Canada Pre-Natal Program (CPNP).

The role of the CHR position is responsible for the delivery of high standard community health surveillance programs and to provide quality health prevention and treatment in community.

Weekly Fluoride Rinse Program and Daily Tooth brushing Program are still being done, every Wednesday morning. New toothbrushes are given out every 4 months or as needed. Toothpaste is also given out as needed as the students do their daily tooth brushing from Nursery - Grade 4.

Updates of immunizations are requested from Manitoba Immunization Monitoring System (MIMS) for all children that need immunizations. Sometimes requests are made daily as mom brings in child for immunization, to make sure that they have not received same. Immunization cards are updated and placed in their personal charts. MIMS requests are done for new families moving back to the community or if they are from a different band affiliation. MIMS requests are also used for newborns to get medical numbers.

MIMS updates are requested for Hep B's, Adacel, Gardasil, Meningococcal, influenza and regular immunizations for babes when they are, 2 months, 4 months, 6 months, 12 months, 18 months and 5 years. In the new upcoming fiscal year there is going to be a change from MIMS to Panaroma which will allow the Health Centre for easier access to this information.

A total of 352 flu vaccines were given to band members and non-band members in October to February. Charted and recorded in consent forms for personal charts, seasonal influenza and pneumococcal immunization.

Preschool list is made and a copy is faxed over to the school for the teacher. A preschool clinic is set up for the kids to get a Denver Development Test and immunization is given to preschoolers before school starts and this is done by the Nurse and CHR.

Head checks are done by CHR's. A total of 122 students were checked.

A number of STD's were phoned or looked for to come in and see the nurse for interview and treatment.

Chronic Disease Register is checked through by Nurse's, CHR's and Health Care Aides, which people are seen and if there are any additions or deletions required then it is done by the CHR and mailed out to FNIHB Data Entry Clerk.

All staff is requested to provide yearly Criminal Record Check and Child Abuse Registry.

Pre-checks are done on clients before seeing the community physician, by CHR or Health Care Aides, such as blood pressures, blood sugars, weights and are then recorded on personal chart.

Transportation is always provided for clients wanting to come in for Doctor's clinics, Dental, NADAP, Nurses, Child Health Clinic's, Diabetic clinics, Blood Pressures, Workshops or as needed.

**Meetings/Workshops/Conferences:**

- Staff Meetings Monthly
- Professional Development Forum
- Creating Harmony in the work place
- Treaty Days Health Fair
- First Nation Health Managers Association
- e-Chart Training
- Medical Transportation Training
- COHI meeting
- Health Centre Community Presentation
- Manitoba Learning Match
- Staff Development, Creating a culture of safety
- Community- based FMR/Toothbrush coordinators
- Chronic Disease Education & Training session
- Networking- Quarterly Meets
- Assist Training

## **Canada Prenatal Nutrition Program Annual Report**

The Canada Prenatal Nutrition Program (CPNP) is designed to improve the health of prenatal and postnatal women and their babies. We strive for well-nourished pregnant women, more women breastfeeding, and for as long as possible, greater access to nutrition information, services, increased knowledge and skill-building opportunities and the best infant feeding practices to ensure health babies.

Three main program areas in the program are;

- Nutrition Screening, Education and Counselling;
- Maternal Nourishment; and
- Breastfeeding Promotion, Education and Support.

Pregnancy tests are done by nurse at the request of clients and if found that they are pregnant they are put on a prenatal list card for follow up. All bloodwork is done and Healthy Baby Prenatal Benefit Application is given and mail out to Health Baby Manitoba, which in return they receive a supplement of \$80.00.

Expected mothers are seen according to the weeks they are pregnant:

- 12 Weeks - Pre & Post Natal Testing Blood work
- 16 Weeks - Maternal Serum Screening & Ultrasound
- 20 Weeks - Referral to Obs. (Fax Letter & Blood work)
- 28 Weeks - 50 gm Glucose Test
- 38 Weeks - Leave to Winnipeg to deliver

Nurse and CPNP Coordinator conduct home visits to newborns and moms as soon as they return to the community and a Welcome Home Package is provided. Assessments are done to see if there are any concerns that need to be addressed.

Welcome Home Packages given consist of a receiving blanket, wipes, nose bulbs, socks, bibs, mittens, t-shirts, nail clippers sets, shampoo, body wash, baby lotion, sleepers, thermometers and information packages that are related to the importance of immunization, healthy eating calendars and food guides, safety in car/home, dental care, SIDS, breast/formula, baby manual for dads, pamphlets or booklets and fridge magnets with a, immunization schedule.

Ultrasounds are booked at the Eriksdale Hospital. Expected mothers are advised to be in Winnipeg for delivery as Ashern does not provide this. Most of our prenats are found in their first trimester and every odd one in their last trimester.

We have had a total of 3 miscarriages this annual reporting year.

The CPNP initiates a milk coupon to its prenats once a week, to ensure healthy development.

To ensure update child immunizations, the CPNP offers incentives for mother and child such as 6 month immunization baby receives traditional wraparound slippers; 12 - 18 month immunizations baby receives gauntlets or blanket.

Programming we have offered are; Baby Food Making - (Fruits & Vegetables), Mom's Cooking class; Mommy and Me Support Gatherings, Milk Programs, Labor and Delivery Classes, One on one counselling, Growing Healthy Together, Dental Therapy, Prenatal Stages, Dangers during pregnancy, Baby First.

Among the 50 prenatal mothers who have consented, a total of 48 participated.

2014 - April - December – 10-Boys & 11 Girls were born (21)

2015- January - March - 4-Boys & 2- Girls were born (6)

New Year's Baby is a boy Born January03/15

Total babies born was 27

**Meetings/Workshops/Conferences:**

Health Centre Community Presentation

Community based FMR/Toothbrush Coordinators Conference

Chronic Disease Education & Training session

Community Health Representatives Professional Development Forum

Standard First Aid & CPR C

Prenatal workshop on Breast-feeding

Labor & Delivery classes

**Margaret Anderson**

**CPNP/WYWW**



## Community Health Representative 2 Annual Report

The Pinaymootang First Nation Health Program currently employs two Community Health Representatives (CHR's) were one CHR oversees adult and community health care while the other takes on the responsibility of school health, children and youth.

And as part of the health care team, I am responsible in liaising between patients, families and health care providers to ensure patients and families understand their conditions and are receiving appropriate care. I have been working as a CHR for many years now and I really enjoy what I do.

The scope of the CHR Program directly impacts individuals and the community as a whole and by working with health care providers and the community to provide education, information and support on the health and well-being to individuals, families and communities based on a holistic approach to health and health care. The CHR supports services that encourage prevention, intervention and provide up to date information and resources to promote healthy living lifestyles through education, immunization, and clinics.

As a CHR, I also perform a broad range of duties in the community. Some of my duties throughout the fiscal year have included the following:

- Acting as liaison and coordinator for the community, residents and professional staff;
- Providing information about childcare, nutrition, sanitation, communicable disease and other health matters;
- Conducting home visits to teach and demonstrate family health care and referring medical health problems to health professionals;
- Assisting with immunization consent forms;
- Translation;
- Participating in health information drives;
- Assisting in Health Education;
- Assisting with community health events (cleanup, health fair, workshops, etc.);
- Participated in the Accreditation Process;
- Monthly reporting and attending staff meetings;
- Nutritional and Physical Activity

And over the course of the year we have seen an increase in all of our services and at times we are overwhelmed, but we see this has a justification and proof that the services offered is needed in our community. Other than the CHR role I also take on the ADI Programming.

## Aboriginal Diabetes Initiative Report

The role of the ADI is to provide an integrated, coordinated diabetes program in the community in the area of diabetes prevention, health promotion, lifestyle support, care and treatment. As the ADI Coordinator my role is to reach the short term and long term goals which include;

- Raising awareness of diabetes;
- Risk factor assessments;
- The value of healthy lifestyle practices;
- Supporting the development of a culturally appropriate approach to care and treatment;
- Diabetes prevention;
- Health promotion; and
- Building capacity and linkages in the components of the program.

They are three types of diabetes;

- Type 1 is where the body makes little or no insulin;
- Type 2 is where the body makes insulin but cannot use it properly; and
- Gestational diabetes is where the body is not able to properly use insulin.

*Diabetes is a lifelong condition but one that can easily be managed and maintained by eating healthy and getting physically active.*

During the course of this fiscal year report, the ADI Program provided the following with a total of 2789 clients being seen:

- Weekly Doctor Visits on Diabetes Referrals;
- Information Drives;
- Foot Care Prevention;
- Cooking Classes on Proper Nutrition;
- Shopping Tours (Label Reading);
- Physical Activity Challenges;
- Mobile Wellness Clinic;
- School Health Education;
- School Based Feeding Programs;
- Bike Share Program
- Community Garden Projects;
- Canning Classes;
- Diabetic Screening;
- Diabetic Care Clinics;
- Workshop activities on the value of nutrition;
- Weight Loss Challenges;
- One on One Counseling;
- World Diabetes Day Initiatives;
- Diabetes and Risk Factor Management;

- Wellness Fitness Centre Promotion;
- Traditional Harvesting, Food Preparation, Food Preservation;
- Muskeg Tea;
- Development of Resource Materials;
- Screening for complications, i.e., retinal screening;
- Screening for complications, i.e., renal screening;
- Diabetes self-management sessions;
- Networking with the IERHA;
- Nutritionist

The Health Program has been very active in implementing the ADI Program to the community as we look forward to another successful year.

Meegwetch!

**Alfred Pruden**  
**CHR/ADI Coordinator**



## **Support to Nurses Annual Report**

My name is Carol Woodhouse I have been employed with the Pinaymootang Health Program since 2008. The purpose of this position is to assist the public health nurse, health professionals and program supervisors with their roles and responsibilities.

My duties as Administrative Support Worker include the following tasks:

- All appointment bookings; Tele-health Appointments
  - Assist the CHN on charting;
  - Preparing correspondence;
  - Typing;
- 
- Distributing copies of incoming and outgoing correspondence or reports accordingly;
  - Help coordinate and organize specialty programming as instructed;
  - Maintaining a high level of confidentiality at all times;
  - Prepare various forms and documents;
  - All required front desk duties.

During the course of this fiscal year our physician services have decreased due to the physician shortage, but we continued to stay a very active health facility.

### **RECOMMENDATIONS**

- Require more training in clinical management;
- Additional Administrative Support Worker due to the increase in health services;
- Additional office space for our Professional staff (Mental Health);

**Carol Woodhouse**  
**Administrative Support to Nurses**

## **Operations and Maintenance Report**

It has been a challenge in maintaining staff to take on this position. The program hired an interim custodian (Carol Woodhouse) to oversee the general cleaning, operation and maintenance of the health facility.

The general duties conducted are; general cleaning and sanitary services, on a daily basis, both indoor and outdoor cleaning of premises including; carpets, furniture, windows, washrooms and floors. Waxing and buffing are conducted twice per year and the restocking of cleaning and washroom supplies are ordered as needed.

Removing of litter and garbage to the local landfill is done, daily. The custodian ensures a high confidentiality level. Other maintenance that is required such as lawn maintenance, HRV cleaning, lighting fixture change, snow removal, drainage, door fixtures, grading of parking lot are conducted through a need be basis by short term contract work.

The upkeep to the facilities has been a demanding task, to ensure that the facility is at its finest and ensuring that the facility's infection control standards are followed.

The Health Program has made every effort to maintain this facility. A new storage pod has been purchased to help with the overflow of supplies and equipment. Renovations have also taken place to convert the existing multi-purpose room into an additional clinic room and the purpose of this is to follow the standards of infection control.

In the new upcoming fiscal year the health program has hired Gordon Letandre into the role of custodian.

### **Recommendations:**

- Concern on the overstock of supplies and equipment, the Health Centre requires more storage area.
- Overcrowding of offices.

### **Operations and Maintenance**



## **Brighter Futures Initiative Building Healthy Communities Annual Report**

Greetings, my name are Stephen Anderson and I am the Brighter Futures and Building Healthy Communities Coordinator.

The objective of the BFI/BHC program is to increase awareness in mental health, child development, healthy babies, injury prevention and parenting skills; improve the knowledge and skills of community members in the areas of mental health, child development, healthy babies, injury prevention and parenting skills; address the health problems affecting children and families in a community-based holistic and integrated manner and support optimal health and social development of infants, toddlers and pre-school aged children.

To increase awareness in these different areas and to meet the goals set out by the BFI/BHC programs, we offer several different events and training that is open for community members to attend. Some of the events/programming held in the past year includes:

- The annual Gardening program was once again bought to community members that were interested in gardening. This past year we had 49 community members take advantage of our offerings of garden tilling, seed potatoes and a variety of vegetable seeds that we provide to community members. Unfortunately the dry spell of weather we experienced the past summer made for a dismal return of community member's garden crops. We look to bounce back this year and return to previous year's garden crop yields.
- The Annual Community Clean-up event was open to all community members; about 50 community member took part. This annual event is a time in which community members can come together and take pride in their community by picking up waste that is left along roadways and community buildings.
- Traditional Muskeg Tea picking. Another program held in conjunction with other health centre programming. In this program we go out and pick Muskeg/Labrador tea, and learn of the health benefits of this traditional medicine.
- In partnership with other health programs, the annual Immunizations Fair was held at the Pinaymootang Arena. This event continues to grow and this year over 75 community members took part. The event helps parents recognize the importance of having their children up-to date on their immunizations and also gives parents and children a chance to interact with their peers. We look forward to the continued growth of this event.

- Community Health Fair. The BFI/BHC program set up an informational booth at the annual Health Fair that is held during the community's Treaty Days, this year over 200 participants came by the booth. They had the opportunity to ask questions of the programs or to enquire of any potential programming that may be coming up or to give suggestions for future programming that they would like to see. This is a great way to interact with community members who otherwise may not know about the programs we offer here at the Health Centre.
- The Suicide Awareness Walk was held once again and participant numbers increased from the year prior. This is an important event that not only brings people together but helps bring awareness to suicide.
- We had the Life Saving Society of Manitoba come and bring their Winter Smart Program to the community. The program consisted of CPR, First Aid & AED Training and school presentations on the topics of winter preparedness and cold weather survival. Three sessions were held throughout the day and was well received by the students in attendance. We look forward to bringing this event back in the winter months.
- Injury Prevention Workshops.
- Community Activities and Programming.
- School Education Awareness Programs.
- Family Day Ride was conceived with the idea of getting people out during the cold winter months and to take advantage of the Family Day holiday. In this event we joined participants on a snowmobile ride that took us around the community. This was a well-received event as it gave people a chance to get out of the winter doldrums and enjoy the outdoors.
- Eagle Bay Snow Camp was once again utilized and spots were reserved to send young community members to this annual camp.
- A Father/Son outing, this was a great way for fathers and sons to get out and interact with their peers.
- The Annual Ice Fishing Derby was once again held. In the 8th year since its conception, this event continues to grow year after year with many community members coming out and taking the opportunity to enjoy the outdoors and interact with each other. Over 150 participants took advantage of the event's warm weather and came out for the chance to win some great prizes. The success of this event is one reason we will continue organizing it for community members to attend.

The BFI/BHC program is also part of the community networking group and events like these are made easier with the partnership of other outside agencies. The community networking group has meetings every month where ideas are shared and upcoming events are announced. With this

kind of collaboration we are able to further each other's programming and bring out ideas that may not have been realized without the input of our partners.

Other ways that I look to expand my knowledge in relation to the goals of the BFI/BHC programs is by attending various training workshops and conferences. By attending these events I am able to not only able to gain knowledge by the sessions they offer but to also network with other community workers from all parts of Manitoba and Canada. These are some of the training workshops and conferences I attended this past year:

- Applied Suicide Intervention Skills (ASIST)
- De-Escalating Potentially Violent Situations
- Transportation of Dangerous Goods (TDG)
- Health Youth Relationships Training- Red Cross
- Wellness Cluster Gathering- a gathering of First Nation community wellness workers from across Manitoba.
- Commercial Tobacco Reduction Strategy Conference
- Assembly of First Nations Mental Health Forum- a health forum on mental health that is attended by First Nation mental health workers from across Canada.

As we look forward the BFI/BHC program hopes to bring out more fun, exciting and informational programs and events to the community. In addition, I am always open to community member's ideas or suggestions to bring new programming to the community and can always be reached at the Health Centre.

In conclusion, I would like to thank everyone that attended our events. Without your continued participation we would not be enjoying the success that these events have experienced.

Meegwetch,

Stephen Anderson



## NNADAP Annual Report

This year in June will be the completion of nine (9) years working here at Pinaymootang Health Centre.

When I first started working, I often asked myself what brought me back to my home community. During these last nine years, I have seen many changes occur at the Health Centre. Many times it is overwhelming to see the many services that are offered. When time has allowed, we have had Doctor Clinics, Dentists, Dental Therapists, and many programs offered to the membership.

With the Accreditation process, this was another challenging task. Developing policies and implementation seemed never ending. All of this hard work by my colleagues has been challenging but it has also provided many other opportunities. We now use electronic charting, Tele-Health and other professional services. I am thankful to work in a place that I enjoy and to see team work involved in bringing positive changes to our community. By witnessing these changes and playing a role in the team work that is required gives me the resolution as to why I come back.

As the NNADAP worker it gives me the opportunity to work in a supervisory capacity for the Brighter Futures, Building Healthy Communities and Water Quality Program. In addition I chair the Networking Committee meetings and organize and coordinate professional development programs for the Health Centre staff.

The NNADAP program is entering its 40 years anniversary since it was developed. There have been many studies and reports of the program. But the vision has remained the same and that is to provide a service to those that are seeking help in overcoming addictions. Addictions are not limited to alcohol and drug abuse; it comes in many other forms. My tools in doing my work vary. Genograms are tedious but helpful in understanding family of origins. This helps individuals understand that we must know the past to understand the present and to face the future. The Residential schools have played a major role in the cause of family and individual dysfunctions. In addition, policies and acts from various Governments affect the health of community members. Floods and other environmental changes also cause problems which may lead to harmful addictive situations.

My hope is to continue working for my community and play a continuous role in bringing positive changes.

The following are a list of workshops under the NNADAP Program:

- Vision Quest

- Anti-Smoking
- Grief and Loss
- Share and Care with Ashern Hospital
- Deescalating Clients
- Debriefing for near drowning
- CPR/First Aid for Community Members
- Health Fair
- Entertainment for Treaty Day
- Rob Nash for Pinaymootang School
- Health Appreciation Day
- Anxiety Workshop
- High Risk Clients Workshop
- Open House for Health Centre
- Family Violence
- Prescription Drug Abuse and Alternative Medicines
- Smoking Cessation
- Elders Gathering
- Mental Health Wellness

The following is the client data collection for the 2014 – 2015:

Month	Counseling	Referrals	Other Community Members
April	10	02	01
May	05	01	
June	09	04	
July	06	06	02
August	06	05	
September	12	12	
October	08	08	
November	04		01
December	07		
January	08	08	01
February	08	08	01
March	04	04	02
<b>Totals</b>	<b>87</b>	<b>58</b>	<b>08</b>

*Alvin Thompson*  
**Addictions Coordinator**



## **Medical Transportation Annual Report**

Hello, my name is Rhea Klyne and I am employed as the Medical Transportation Coordinator for the Pinaymootang First Nation Health Program.

The Medical Transportation Program provides transportation benefits to eligible clients with access to required services that cannot be obtained within the community. This program is administered by one Medical Transportation Coordinator and four Medical Drivers; three full-time and one on a need be basis.

The Pinaymootang First Nation Medical Transportation Program currently operates a three van system 24-7 one is used for the Ashern route, one for the Winnipeg route and a smaller van for all others i.e. Selkirk, Dauphin, Eriksdale and Winnipeg (when it is at full capacity).

Medical Transportation is provided only to access health services approved by Non-Insured Health Benefits (NIHB) – FNIHB Health Canada. Requests for Medical Transportation to access services that are not provincially insured or which do not fall under the parameters of (NIHB) will be denied except for Medical Transportation to Traditional Healers and Medical Transportation to NADAP.

First Nations and Inuit Health Branch (FNIHB – Health Canada) will not provide transportation to clients On-Reserve if services are available within the community. Client's Off-Reserve will need to contact FNIH – 1-877-983-0911 regarding travel for their appointments as they are not eligible for travel through the Medical Transportation Program On-Reserve.

### **MEDICAL TRANSPORTATION OVERVIEW**

Assistance with Medical Transportation services are provided to members who live On-Reserve for medical travel and associated services for the following:

- To the nearest appropriate facility – General Practitioners are NOT covered in Winnipeg for travel as they are Doctors in Ashern and the community holds walk-in clinics once a week;
- The most economical and practical means of transportation considering the clients health condition, must be used. The use of scheduled and/or coordinated transportation is required when considering this;
- The medical transportation in a non-emergency situation has been prior approved by the medical transportation coordinator based on eligibility criteria of FNIH – health Canada;
- The medically required health services are not available in the home community.

### **DAILY ACTIVITIES**

- Performing own administrative duties, maintaining client files;

- Providing services to eligible Pinaymootang First Nation Band Members as well as other First Nation members living on reserve;
- Booking, verifying and rescheduling of appointments which are then coordinated for the medical van or private travel;
- Recording and providing meal tickets for clients with Winnipeg appointments;
- Accommodations are provided with either private home or hotel, according to eligibility of client (Surgery preps or post op care);
- Preparing OCA forms for private travel and appointment verification slips for medical van clients;
- Recording all returned private travel forms;
- Preparing daily passenger logs for medical driver for Winnipeg log.

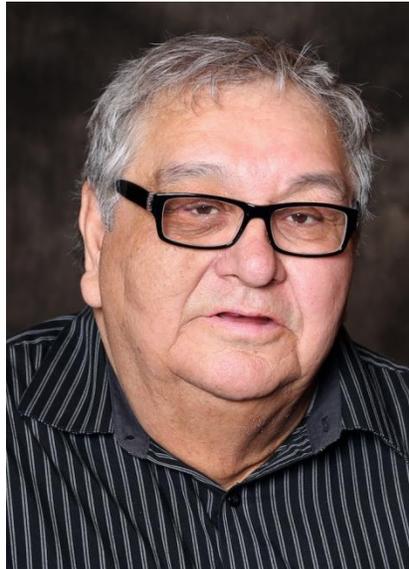
## **OTHER**

Using this system has been easier to keep track of certain items that are needed to complete my reports.

In closing, I have enjoyed working alongside the staff of the Pinaymootang Health Centre and look forward to assisting the community members with their future appointments.

Meegwetch!

**Rhea Klyne**  
**Medical Transportation Coordinator**



Allen R. Anderson  
 John R. Thompson  
 Patrick McMahan

**APPENDIX NIHB/MT-A** NIHB Program Reports, Progress Activity Reports Due Dates and Progress Activity Report Requirements

**Program Activity Report**

1 <sup>st</sup>	2 <sup>nd</sup>	3 <sup>rd</sup> Final
<b>For Period Apr 1 to Aug 31</b>	<b>For Period Sept 1 – Nov 30</b>	<b>For Period Dec 1 – Mar 31</b>
<b>Due Oct 15, 2014</b>	<b>Due Jan 15</b>	<b>Due June 30</b>
Fiscal Year: <b>2014 - 2015</b> <b>April 1 – August 31, 2014</b>	Recipient: <b>Pinaymootang First Nation</b> <b>Contribution Agreement: MB0700072</b>	
# of requests:  <b>2818</b>	# of exceptions requested:  <b>156 clients reimbursed</b>	# of appeals:  <b>0</b>
# of requests approved:  <b>2818</b>	# of exceptions approved:  <b>3</b>	# of favorable appeals:  <b>0</b>

**How are the benefits being provided:**

One full time Medical Transportation Coordinator is currently on hand to provide and assist clientele of appointment bookings, coordinating of medical transportation, and acting as a supervisory capacity of medical drivers currently employed with the First Nation.

Currently employed are 3 full time driver transporting clients to appointments, each driver works on a rotating basis. Each driver has a monthly schedule they follow and they provides services on a need be basis, if the medical transport is at full capacity then an additional van is required, this worker also provides transport to the Eriksdale Hospital for ultra sound as well as Selkirk and Dauphin areas.

**Major Accomplishments in the program during the reporting period:**

Based on last fiscal year’s numbers it shows a slight decrease in Medical Travel but an increase in day surgeries, CT scans and MRI appointments.

Both medical vans have shown an increase of usage in transportation to Winnipeg, Eriksdale, Dauphin as well as an increase in Meal Tickets.

**Major Challenges in delivering the program during this reporting period:**

The major challenges we are currently facing during this reporting period are letters from Physicians that are requested by clients to receive private travel, these letters are not honored. I have taken the initiative to contact these Physicians advising them of our policies and procedures regarding private transportation.

The increase in pre-natal care have increased we no longer provide private travel at 32 weeks, but at 38 weeks, this has saved the program some travel dollars. We do provide for high risk pregnancies. We continue to provide private transportation for one dialysis patient who transports to and from Winnipeg, this has become a concern in our program and we have advised FNIHB of situation, in which we were advised that this matter will be looked into, to date we have received no response.

The current physician shortages happening in the IERHA region have impacted our service deliver to the program. There has not been any word on when this crisis will be fixed. The Pinaymootang Medical Transportation program has been transporting client to Eriksdale or even as far as Arborg and Dauphin when there is no Doctor on call in Ashern for emergencies.

**Identify the factor (s) that may be impacting the budget:**

The factors currently impacting medical transportation program budget:

- Cost of Fuel
- Repairs/Maintenance of Medical Vehicles
- Community member who is currently on dialysis
- Increase in population status in community

Doctor shortage to the nearest appropriate facility which is Ashern, MB has affected the medical fuel budget as now when there is no doctor available in Ashern, clients are transported to E.M. Crowe Memorial Hospital or the next site which is Arborg or Dauphin Hospitals. These types of trips usually happen in the evening or after midnight.

**Other relevant observations, comments or information to this program:**

Every year there is an increase in the amount of newly diagnosed diabetics and some of these cases can be challenging or in need of advanced care, although the Health Centre's ADI program continues to work hard in program implementation and awareness sometimes it is not enough as these cases are in the advanced level.

Since the development of the new housing units, we have noticed an increase in services, with community members moving back to community it impacts services both in health and social. The demands for the program has increased this may be due to that more and more displaced clients are returning home and not having the support In their own communities for services.

**APPENDIX NIHB/MT-A** NIHB Program Reports, Progress Activity Reports Due Dates and Progress Activity Report Requirements

**Program Activity Report**

1 <sup>st</sup>	2 <sup>nd</sup>	3 <sup>rd</sup> Final
For Period Apr 1 to Aug 31	For Period Sept 1 – Nov 30	For Period Dec 1 – Mar 31
Due Oct 15, 2013	Due Jan 15	Due June 30
Fiscal Year: <b>2014 - 2015</b> <b>Sept 1 – November 30, 2015</b>	Recipient: <b>Pinaymootang First Nation</b> <b>Contribution Agreement: MB0700072</b>	
# of requests:  <b>1360</b>	# of exceptions requested:  <b>21 clients reimbursed</b>	# of appeals:  <b>0</b>
# of requests approved:  <b>1360</b>	# of exceptions approved: <b>15</b>	# of favorable appeals:  <b>0</b>

**How are the benefits being provided:**

One full time Medical Transportation Coordinator is currently on hand to provide and assist clientele of appointment bookings, coordinating of medical transportation, and acting as a supervisory capacity of medical drivers currently employed with the First Nation.

Currently employed are 3 full time driver transporting clients to appointments, each driver works on a rotating basis. Each driver has a monthly schedule they follow and they provides services on a need be basis, if the medical transport is at full capacity then an additional van is required, this worker also provides transport to the Eriksdale Hospital for ultra sound as well as Selkirk and Dauphin areas.

**Major Accomplishments in the program during the reporting period:**

Increase in Medical Appointments to Winnipeg, Selkirk and Dauphin. Doctor shortage is one of the main reasons this is occurring.

Utilizing all three medical vans during this period.

**Major Challenges in delivering the program during this reporting period:**

IERHA doctor shortage in the region has resulted in clients who have emergencies being transported to the next closest facility, which is in Arborg, Manitoba. This results; in higher fuel consumption and longer wait times for other emergencies in the community.

More clients utilizing the medical van for general practitioners in Winnipeg, this was before not allowed because we had adequate physicians at the Lakeshore General Hospital (Ashern). We try fit everyone who has appointments in the medical vehicles and sometimes clients will get “bumped” off due to the medical van being at full capacity.

**Identify the factor (s) that may be impacting the budget:**

The factors currently impacting medical transportation program budget:

- Cost of Fuel
- Doctor Shortage Ashern District
- Repairs/Maintenance of Medical Vehicles
- Increase in community members who is currently on dialysis

**Other relevant observations, comments or information to this program:**

Every year there is an increase in the amount of newly diagnosed diabetics and some of these cases can be challenging or in need of advanced care, although the Health Centre's ADI program continues to work hard in program implementation and awareness sometimes it is not enough as these cases are in the advanced level.

**APPENDIX NIHB/MT-A** NIHB Program Reports, Progress Activity Reports Due Dates and Progress Activity Report Requirements

**Program Activity Report**

1 <sup>st</sup>	2 <sup>nd</sup>	3 <sup>rd</sup> Final
For Period Apr 1 to Aug 31	For Period Sept 1 – Nov 30	For Period Dec 1 – Mar 31
Due Oct 15, 2013	Due Jan 15	Due June 30
Fiscal Year: <b>2014 - 2015</b> <b>December 1 – March 2015</b>	Recipient: <b>Pinaymootang First Nation</b> <b>Contribution Agreement: MB0700072</b>	
# of requests:  <b>920</b>	# of exceptions requested:  <b>5 clients reimbursed</b>	# of appeals:  <b>0</b>
# of requests approved:  <b>920</b>	# of exceptions approved:  <b>5</b>	# of favorable appeals:  <b>0</b>

**How are the benefits being provided:**

One full time Medical Transportation Coordinator is currently on hand to provide and assist clientele of appointment bookings, coordinating of medical transportation, and acting as a supervisory capacity of medical drivers currently employed with the First Nation.

Currently employed are 3 full time drivers transporting clients to appointments, each driver works on a rotating basis. Each driver has a monthly schedule they follow and they provides services on a need be basis, if the medical transport is at full capacity then an additional van is required, this worker also provides transport to the Eriksdale Hospital for ultra sound as well as Selkirk and Dauphin areas.

**Major Accomplishments in the program during the reporting period:**

Adding an additional 2 casual drivers to the roster to take on additional shifts which include the Selkirk, Dauphin & Eriksdale runs. This has helped our full-time drivers a rest period in between shifts to prevent burn-out.

An increase of clients utilizing the medical transport to Winnipeg for various types of medical appointments.

Increased usage of meal tickets being handed out to include private travel trips.

**Major Challenges in delivering the program during this reporting period:**

Applying new changes to the program has been difficult due to not have the proper policies in place for community. We are anticipating that these policies get amended and approved by C & C so they can be properly implanted in the community.

Increase of usage of all three medical vans.

Letters from physicians are required for all clientele using the private travel, these medical certificates will be used to help in deciding who is eligible to receive private travel assistance for medical appointments, unless the client has a permanent disability i.e. wheelchair, amputee they will need to submit a new doctor letter to re-apply for these benefits.

Misuse of our Ashern medical van by clients is on the rise, clients have been calling this office to inform of appointments at the Ashern clinic, transportation was provided only to have clients not actually going to see any doctor in the facility, we have informed the driver's that they will need to call ahead to confirm appointments if they get called at last minute.

Increase in usage to the emergency room after hours, clients insist on going to the emergency room for minor ailments, a couple of the clients received letters from the ER stating not to come to the ER and to come the next day.

Ambulance diversion has been in place on a bi-weekly basis, thus increasing the need to transport clients to the next emergency room which is an additional half hour away.

**Identify the factor (s) that may be impacting the budget:**

Cost of Fuel  
Repairs/Maintenance of Medical Vehicles  
Increase in dialysis clientele with limited mobility

**Other relevant observations, comments or information to this program:**

The demands of the program have increased over the past few months, due to the physician shortage within the IERHA region. There have been 2 new physicians added to the Lakeshore General Hospital in mid-February but will not be starting until late March or by early April, we are hoping that these new physicians will help reduce the usage for General Practitioner appointments in Winnipeg, Dauphin and/or Selkirk.



## HOME & COMMUNITY CARE PROGRAM ANNUAL REPORT

This has been my 6th year working in the Home and Community Care program, this past year I have been working part time (4 days per week).

The health care aides provide direct personal care, such as bathing and also monitor our client's general health and well-being, reporting back to the nurses as necessary. We also provide some social programming such as day gatherings, elders breakfasts and a joint annual elders gathering with neighboring communities.

The home and community care staff work as a team to provide in home care to our elders and to those living with acute and chronic illnesses or disabilities to enable them to remain independent in their homes through assistance with activities of daily living, wound care, medication assistance and/or administration and any assistance we can give to enable them to maintain optimum health status.

I also assess and assist with requests for personal care home placement if needed and help with obtaining necessary medical equipment. Foot care is offered twice a month.

Statistics for the annual reporting period are compiled using the Mustimuhw electronic charting system which tracks type of visit and client encounters. Most of the nursing activities continue to be for wound care, medication administration, case management and health assessments.

I had 971 client encounters in the past year, of which 207 were home visits.

Month	Home visit	Clinic Visit	Phone call	Hospital visit	Total client encounters
April/14	18	38		2	58
May/14	18	33	7	2	60
June/14	11	15	10	1	37
July/14	33	36	21	3	93
August/14	20	35	16	0	71
Sept./14	26	81	22	0	129
October/14	15	14	4	1	34
Nov./14	28	46	31	3	108
Dec./14	15	34	13	2	64
Jan./15	12	17	12	2	43
Feb/15	5	132	35	0	172
March/15	6	74	22	0	102

We currently have 3 clients awaiting PCH placement.

**Activities:**

- Elders gathering held in June;
- Elders gathering with elders from Lake Man, Little Saskatchewan, Lake St. Martin, Dauphin River held at Lake Manitoba Band hall on May 2014, 47 elders from Pinaymootang attended;
- An elders gathering held in March 2015 in Winnipeg – providing an opportunity for our elders to meet with elders from Lake St. Martin, Little Sask. And Dauphin River and talk about the impacts of flooding in our communities.
- Participation in Health Centre Events;
- Helped with community clean up in May;
- Assisted with the annual influenza clinics in October;
- Assisted with the Accreditation on the on-going accreditation process. Site inspection was held in September and full accreditation achieved.
- Participated in the ‘Share the Care’ initiative with the IERHA, Ashern Hospital promoting an understanding of each care facility and how we can work together to improve client care, as partners in the health care team.
- Participated in the annual health fair held in August.

**Educational Activities**

- Attended the Home and Community Care program meeting in Winnipeg, held in November 2014;
- Attended educational sessions on Tele-health;
- Took ASSIST training ( suicide prevention);
- Re certified CPR;
- Attended a workshop on improving physical assessment skills.

I have 96 clients on my active eSDRT report that have been admitted to the home care program – this includes clients seen only for footcare. We have 74 clients who receive regular (monthly or every two months) visits and 22 receiving more frequent scheduled visits

The Home Care Program continues to grow with clients discharged home from hospital with complex care needs and we are happy to provide any assistance we can.

This will be my last year with the H&CC program as I am moving forward to part time employment in the community health, nursing program, I have enjoyed working with the H&CC program and especially getting to know and working closely with the elders in the community.

I look forward to my new role in the Health Centre.

**Mary Bezemer**  
*H & CC Nurse Supervisor*



## **Home & Community Care Program Report**

Hello my name is Pamela Sumner, and I am a certified Health Care Aide here at the Pinaymootang Health Centre. I have been working as a Health Care Aide for many years now. I enjoy working for the elder's in our community, and learning from them as well. I work to the best of my abilities, and always strive to do better for the people in the community.

### **The Home and Community Care's Objectives are:**

To provide holistic and personal care services with respect and compassion in order to allow individual community members to remain healthy & live independently in their own home as long as possible.

Assist clients and their families to participate in the development and implementation of the client's care plan to the fullest extent and to utilize available community support services where available and appropriate in the care of clients.

Assisting community members living with chronic and acute illness and disabilities by providing service that help them maintain optimum health, well-being and independence in their homes and community.

### **Supportive care:**

- Making home visits, and visiting elders;
- Activities of daily living such as: bathing, grooming, toileting and assisting clients ready for the day;
- Taking vitals which include; blood pressures, temperatures, blood sugars, respirations, pulse;
- During home visits, making sure the clients are taking their medication, and documenting any changes to medication to our Home Care Nurse;
- Assisting clients with equipment when needed such as; mobility aides, wheelchairs, walkers, canes, shower heads, bath seats, etc.

### **Recording and Reporting:**

After each home visit we report to the nurse for any assistance needed for the client, or if any concerns that need to be addressed. I chart on any home visits made or done, after reporting to the supervisor. Make referrals for clients to the right program area, or to the Home Care Nurse.

### **Activities;**

#### **April 2014**

Home visits-74

April 16-17- Assist Workshop

April 28- Staff meeting

#### **May 2014**

Home visits-88

May 15- Elder's Gathering in Lake Manitoba

May 26- Staff meeting

May 29- Share the Care meeting in Ashern

**June 2014**

Home visits – 54  
June 2- Community Clean Up  
June 11- Elders H & CC – 54 attended  
June 19- Accreditation Meeting

**August 2014**

Home visits- 64  
August 21- Health Fair

**October 2014**

Home visits-70  
October 22- attended “Cancer Walk for the Cure”

**December 2014**

Home visits- 32  
December 1- attended Health Research Meeting  
December 9- Open House

**February 2015**

Home visits-71

**July 2014**

Home visits-82  
July 7- Accreditation meeting  
July 10 - De-escalating Violence workshop  
July 23- attended TDG workshop  
July 28- Staff meeting

**September 2014**

Home visits- 62  
September 15-17- Accreditation survey

**November 2014**

Home visits-50  
November 14- attended “Diabetes Walk”

**January 2015**

Home visits-67  
January 26- staff meeting  
January 30- Accreditation meeting

**March 2015**

Home visits-44  
March 16-17- Elders Gathering in Winnipeg  
“Gathering of Communities”  
March 19-20- Staff Development

Respectfully submitted by;

*Pamela Sumner*  
**Health Care Aide**



## **Home & Community Care Program Annual Report**

Hello, my name is Dorothy (Dot) Sumner; I am a Health Care Aide and have been employed at Pinaymootang Health Centre for the past three years.

I work with the Home and Community Care Program, under the supervision of the HCC coordinator. I mostly work with elders and persons living with acute or chronic conditions and persons with special needs. I've enjoyed working here and take great pride in helping people and value what I do. It is a pleasure serving the people of my community.

### **The Home and Community Care's Objectives are:**

- To provide care for clients who need assistance in the home after hospital discharge;
- To provide community care and support to a range of people: including elders, families with children who have special needs and people with short term and long term medical conditions;
- To enable clients to remain in their own homes as healthy and as independent for as long as possible and also to delay and prevent admission to a health care facility;
- To promote dignity, independence, preferences, privacy and safety at all times when in the clients home.

### **Supportive Care:**

- We provide personal care services, such as bathing, grooming and dressing; to help prepare clients get on with their day;
- We make daily home visits to various clients' homes, to provide support for clients who may have concerns, including some respite during working hours;
- We check client's feet and I arrange appointments for those who need foot care.
- I communicate with the elders in their language;
- We check and record vital signs which include: blood pressures, temperatures, pulse and respirations and also do blood sugars and oxygen levels;
- We assist with range of motion exercises;
- We provide mobility aides to meet the client's needs with wheelchairs, canes and walkers;
- Other equipment provided includes: shower heads, bath seats, bath mats, safety toilet rails, raised toilet seats, commodes, reachers, mechanical beds and bed safety rails.

### **Recording and Reporting:**

- Following a home visit, I report and direct any concerns or changes to the HCC supervisor;
- Charting and documentation is done after a home visit;
- Report foot care referrals to the foot care nurse.

## **Program Activities:**

### **April 2014**

Home Visits – 51  
April 16 & 17 – ASIST  
April 10 & 23 – Foot Care

### **June 2014**

Home Visits – 70  
June 2 – Community Clean Up  
June 12 – Elders Gathering 54 Attending  
June 19 – Accreditation Meeting

### **August 2014**

Home Visits – 25  
August 19 – Foot Care  
August 19 - 22 – Treaty Days  
August 20 – Community Breakfast sponsored by Pinaymootang Health Centre  
August 21 – Health Fair

### **October 2014**

Home Visits – 57  
October 22 – Cancer Walk  
October 24 – Cancer Awareness Day

### **December 2014**

Home Visits – 56  
December 1 – Primary Health Care Wksp  
December 9 – Open House  
December 11 – Elders with AHSOR

### **February 2015**

Home Visits – 68  
February 10 – Life Saving 1<sup>st</sup> Aid

### **May 2014**

Home Visits – 49  
May 14 – Foot Care  
May 15 – Elders Gathering in Lake Manitoba

### **July 2014**

Home Visits – 25  
July 7 – Accreditation Meeting  
July 10 – De-escalating Potentially Violent Situations

### **September 2014**

Home Visits – 46

### **November 2014**

November 14 – Diabetes Walk  
November 21 – Accreditation Ceremony

### **January 2015**

Home Visits - 58  
January 14 – Diabetes Workshop  
January 15 – Yearly Work Planning Session  
January 28 – Food Handlers Training  
January 30 – Review Accreditation Standards

### **March 2015**

Home Visits – 46  
March 2, 3, & 4 – Computer Training  
March 16 & 17 – Elders “Gathering of Communities”  
in Winnipeg  
March 19 & 20 – Staff Development Workshop  
March 30 & 31 – CPR Training

**Dot Sumner**  
**Health Care Aide**



## Community Health Program Coordinator Annual Report

Hello everyone! It is so good to be back! I returned to work October 2013 after my Maternity Leave and I am back in full swing! As many of you know I am a Licenced Practical Nurse and a Foot Care Nurse; I am employed at the Pinaymootang Health Centre as a Community Health Program Coordinator.

Part of my role as Community Health Program Coordinator is to focus on the Pinaymootang School, throughout the school year I go into classes from preschool to grade 12 providing workshops as well as bringing in speakers to provide the students with the knowledge of a wide variety of health related topics so they can make informed decisions regarding their own health and well-being. Some examples of topics that have discussed this past year are Anti-Smoking, Puberty Growth & Development, Nutrition Education, Hand washing and cough etiquette

As a Foot Care Nurse I provide foot care to the Elders & Diabetics in the community two to three times a month; 85 clients were seen in the months of October 2013 to March 2014. Clients are seen every two to three months or on an need be basis, if you or someone you know in the community are in need of foot care I strongly encourage you to contact the Health Centre to schedule an appointment.

When the Community Health Nurse and Home and Community Care Coordinator are not available I provide assistance; this means I provide nursing care through individualized home visits, walk ins and scheduled clinic visits. The following are my stats for clients seen from October 2013 to March 2014;

### 155 Clients seen in the clinic:

33 Dressing Changes  
57 Assessments  
5 Vital Signs  
40 Injections  
4 Phlebotomies  
1 Suture Removal  
1 Referrals  
10 Pregnancy Test  
3 Urine Tests  
2 Phone Consults

### 112 Clients seen on home visits & in clinic

56 Dressing Changes  
15 Assessments  
8 Vital Signs  
16 Injections  
6 Assisting HCAs with Baths  
1 Tele-health Accompany  
4 Patient Teaching  
9 Phone Consults  
2 Hospital Visits  
1 Referral

1 STI Testing  
1 Baby Weight  
1 Prenatal Assessment

1 Family Conference  
1 Hospital Discharge Planning  
4 Calls to Hospital re: client care/condition  
1 Updated drug profile

Another part of my role is to supervise the Aboriginal Head Start On-Reserve program; I provide support to the Head Start worker/Home Visitor and assist with planning and implementing programs for families in the community. The Head Start program is an outreach program that is offered to families with young children ages 6 and under; it is a truly great program that I strongly encourage all families with children that fall within the age category to participate in. Through arranging home visits and planning activities outside the homes the Home Visitor provides support and educational resources to children and their families while focusing on culture and language; education and school readiness; health promotion; nutrition; social support; and parental and family involvement.

This past fall the Head Start Program started a Moms & Tots Program held one to two times a week in the Pinaymootang School Multi-purpose room, this program ran in the afternoons during the months of October through April. This program offered a safe environment for young families to socialize & learn outside of the home. Educational activities that were held during Moms & Tots time were; cooking, baking, crafts, homemade baby food & baby wipes making, sewing projects included tag blanket making, pillow making & baby blanket making, In addition to the Moms & Tots program the Head Start Program is always busy holding a variety of other programs too such as nutrition workshops, brunch & story time, moccasin making, soccer, cupcake decorating, soup making, outdoor sports, gardening, grandparents outdoor tea & bannock, Saulteaux language class and parenting classes. I look forward to seeing many more new families become involved in this program as it is a fantastic way to provide young parents and children with the knowledge and skills for a brighter and healthier future.

I would like to thank the Community and my co-workers for their continued support; I look forward to many more years of employment at the Pinaymootang Health Centre.

Thank you,

## **HIV/AIDS Annual Report**

The purpose of the HIV/AIDS program is to develop initiatives to control and prevent the spread of HIV infection on-reserve, to reduce the health, social and economic impacts of HIV/AIDS, to encourage and support the active involvement of community, to identify options and strategies for the provision of treatment, care and support programs that will facilitate knowledge that will provide timely and comprehensive education and preventative programs, to increase knowledge and educate to ensure that skills exist at the community level to develop a coordinated approach.

The HIV/AIDS program continues to grow and threaten the lives of our First Nation people as no one is immune from HIV/AIDS. The Pinaymootang First Nation Health program has come to realize that this disease with the infection rate is amongst communities where poverty, family violence and drug/alcohol abuse are present. The indicator of unprotected sexual activity, a very high sexually transmitted disease rate and a high teen pregnancy rate prove that we are at risk of HIV infection.

During the course of the year, we have been promoting that HIV/AIDS as well as Hepatitis C are preventable diseases. We have been educating that in order to prevent transmission we must practice safe precautions.

The following activities were conducted;

- Information drives targeting the youth ages 15 – 21;
- Awareness during community events;
- Health Sex Education Classes;
- Video and Power Point Presentations;
- Promotion of World AIDS Day;
- Providing contraceptives, condom talk demos;
- Testing and Counseling.

*Nancy Tindall LPN*

**Community Health Program Coordinator**



## **Aboriginal Head Start On-Reserve Program**

Hello everyone, my name is Cheryl and I am the Aboriginal Head Start On-Reserve Home Visitor.

The AHSOR program is designed to meet the needs of children and their families. The program focuses on children 0-6 years. The program has 6 major components that need to be met. The components are: Culture and language, Education and School Readiness, Health Promotion, Nutrition, Social Support and Parental and Family Involvement.

The program engages children and families in various activities in addition to home visiting. Home visits usually consist of the home visitor, the child or children and the parents/grandparents. Educational resources, arts and crafts, etc are brought on each home visit that should meet the six components of the program.

### **Activities through the year include:**

- Playgroup (formerly Mom & Tots) has been held on a weekly basis during the winter/spring months. Various activities are held during this program such as arts and crafts, sewing, blanket making, cooking, etc. This program allows young parents to interact with other young parents and their children in turn get to interact with other children.
- Moms Spa Day was held in May to appreciate our young moms who attended our mom and tot program. 10 moms attended.
- A nutrition bingo was held in May. Moms learned nutrition facts and played bingo to take home fruits and vegetables and other food items.
- In partnership with ACFS and ADI we set nets with some dads. It was a good experience for the dads. They set and lifted the nets and also they learned to filet the fish.
- Monthly soup making classes were held from April to June in partnership with the ADI program.
- Walking Wednesdays was initiated during lunch hour to encourage moms and dads to take their children out for a walk or themselves to encourage healthy living.
- Father's day fishing was held at Riviera's. There were 13 participants for this event. The dads brought their children for a day of fishing.

- A mini gardening project was initiated to encourage young families to grow their own vegetables. 10 families started the gardening project. 8 were successful. The families planted in planters to start with and transplanted to a larger garden or larger planter.
- In July, Family Fun Beach Day was held in partnership with ACFS and BFI program. There were 47 participants.
- In August, Immunization Fair was held in partnership with the CPNP program. There were 79 participants. We had a craft station, a bear's balloons and band aids station, a germ buster station, bouncy houses and bean bag toss. We also had MPI's mini car town on site to teach the children about road safety.
- In September, Participated in the Suicide Prevention Walk. There were 56 participants.
- In September, we went with a couple parents to collect medicines.
- In October, in partnership with ADI program we had dads learn to can and smoke fish. There were 6 participants.
- In partnership with ACFS we held the ALAPS/Traditional parenting workshop. This parenting program has been successful so far for the families that we work with. Each participant who attends receives a certificate of completion.
- In December, we held our Annual Christmas party. We had 110 participants. This event is in partnership with HCC and ACFS.
- In December we also held a Christmas Cooking Class. We had 21 participants.
- In February, we held a prenatal/car seat safety workshop. There were 14 participants. This was in partnership with CPNP.

### **Meetings/Workshops/Conferences:**

- Monthly Staff Meetings
- Monthly Community Networking Meetings
- Weekly COHI Visits
- ASQ Assessments
- Assist Training in April
- De-escalating Violent Behavior Workshop in July
- Transportation of Dangerous Goods Workshop in July
- Traditional Parenting Workshop, Train the Trainer, in September
- Seeds of Empathy Refresher Workshop in October
- Growing Great Kids Curriculum Training in November

- Working with High Risk Youth and their Families in November
- Seeds of Empathy Workshop/youth Conference in February
- CPR & First Aid Training in March
- Computer Training in March

Submitted by,

**Cheryl Anderson**  
**AHSOR Homevisitor Coordinator**



## **Drinking Water Safety Program Annual Report**

The Drinking Water Safety Program falls under the jurisdiction of FNIHB. The Health Program receives funding for a part time Community Based Water Monitor (CBWM). The purpose of this program is to ensure safe drinking water and proper services are provided to the Community.

The Drinking Water Safety Program is important in exposing potential risks that may be present in drinking water supplies and are identified through testing of public wells and private well supplies. With the guidance of the Environmental Health Officer from First Nations Inuit Health Branch (FNIHB) has set up a sampling plan that is unique to the community and its environmental situations.

The Pinaymootang First Nation, Drinking Water Safety Program conducts the following:

- Sampling frequencies twice a year for private wells;
- Conducts weekly testing to public building wells and distribution systems;
- Chlorine residual testing is done at four (4) locations once a week in the community; two (2) at the school distribution system and two (2) at the townsite pump houses.
- Community awareness by way of newsletter information;
- Boil water advisories;
- Well Chlorination;
- Hand washing awareness; (Glitterbug);
- Community awareness on hand washing;

Microbiological testing on water samples collected is tested for Total Coli Forms and Escherichia Coli (E-Coli) and is done within the community Health Center. The test detects bacteria in the water sample by using a Coli-sure agent which is provided by FNIHB. The testing process takes 24-28 hours in an incubator with a set temperature at 35 C (+/- .5C). After a minimum of 24 hours in the incubator, samples are taken out of the incubator and results are documented on forms using Water Trax numbers and are submitted monthly to the Environmental Officer (EHO).

Submitted by,

**Louisa Bremner**  
**Water Quality Technician**

**BACTERIOLOGICAL SAMPLES BY WATER SOURCE  
FIRST NATIONS DRINKING WATER SAFETY PROGRAM**

**APRIL 2013 – MARCH 2014**

MONTH	WTP/DS	WTP/DS-US	WDT-S	WDT-US	SPWS	SPWS-US	C/B-S	C/B – US	PRIVATE WS	PRIVATE WS-US	TOTAL-S	TOTAL-US
APRIL	36	1			38	4			11	3	85	8
MAY	26				33	2					59	2
JUNE	29	3			38	4			11		78	7
JULY	27				44	4			10	7	81	11
AUGUST	23				34	2			8	3	65	5
SEPTEMBER	33	1			41	4			10	5	79	10
OCTOBER	25	1			32	3					57	4
NOVEMBER	34	2			36				10	4	80	6
DECEMBER	34				38						72	0
JANUARY	32	1			39	2			10	3	81	5
FEBRUARY	30				42	3			10	1	82	4
MARCH	26	1			43				6	2	75	3
<b>TOTALS</b>	<b>355</b>	<b>9</b>			<b>458</b>	<b>28</b>			<b>86</b>	<b>28</b>	<b>874</b>	<b>65</b>

WTP: Water Treatment Plant  
(Raw & Treated: Sampling recommended Weekly)

DS: Distribution System  
(Monthly sampling recommended: 4 Sites)

WDT: Water Truck Delivery  
(Weekly sampling recommended)

WELL: Private Wells

C/B: CISTERN/BARREL

S: SATISFACTORY BACTI RESULT

US: UNSATISFACTORY BACTI RESULT

COMMUNITY: Pinaymootang First Nation

WORKER: Louisa Bremner

## **Primary Health Care Research Assistant Annual Report**

The Pinaymootang Health Centre works in partnership with the University of Manitoba and the Assembly of Manitoba Chiefs to evaluate the performance of on-reserve health care services within Manitoba.

My name is Maegan Anderson and my role here is the Local Research Assistant, I have had the opportunity to gain experience in the coordination, collection and management of community based data research. There are many tasks and duties that are to be met, some of which include:

- Assisting in the design, test and implementation of a community based research data collection and methods.
- Provide information and communicate with community membership and be a liaison with health and social programs and services in matters related to this research program.
- Collect and provide information and community input to the IPHIT research team to plan for further research projects.
- Organize, collect, administer and provide research assistance for the community based interviews, surveys and sharing circles/focus groups.
- Provide monthly verbal and written updates on local research activity and progress.

During this past year working with the Pinaymootang Health Centre and Assembly of Manitoba Chiefs it has given me a better outlook on the roles and responsibilities that a health care facility needs to manage for the people of the community. The position I have allows me to go out into the community and have one-on-ones with community members to understand more about their perspectives on our health care system and what types of changes can/need to be done, but more importantly to hear all the positive feedback about our local health care facility.

There have been a few projects I have been working on during the course of the year;

Our first project was FNREES surveys: The purpose of these surveys was to get a statistical analysis of our community, such as age, gender, living conditions, etc. This project went on from August/2014 to October/2014 in which time I completed 68 surveys.

During the time of the FNREES surveys we were also working on Primary Health Care interview questionnaires which also went on for the same period of time August/2014 to October/2014 and completed the required amount of 6 interviews. Once these interviews were complete I had organized an information session for the community based on the information gathered from the completed interviews.

Beginning of December/2014 we started our new project which was Mental Health/illness interview questionnaires which carried on to February/2015 in that time had completed our required amount of 6 interviews.

Once the Mental Health Interviews were complete we had many teleconferences with the research team composing our next set of surveys which are set to begin June/2015.

Some of the Duties/Meetings/Workshops I have done throughout this year include:

- Monthly reports
- Weekly teleconferencing
- Charting all data collected
- Treaty Day Health Fair
- Stress Management Workshop
- Food Safety Program
- Community Clean-up
- Community Information Session

In closing, I have really enjoyed working with the Pinaymootang Health Staff over this past year and I am very thankful I got the opportunity to work with the members of this community and will continue my efforts to help within our community.

Sincerely,

**Maegan Anderson**  
**Local Research Assistant**



### **Pinaymootang First Nation Health Professional Services**

**Lenore Berscheid** is the visiting Mental Health Counselling Services expert, Lenore provides counselling services in the community one day per week (every Tuesdays) referrals for services can be made through the Health Centre for anyone wishing to utilize.

**Lucy Diaz** who originates from Nova Scotia, Lucy is our Dental Therapist and is currently based out of Peguis First Nation, Lucy, provides services to the community once a week every Tuesdays for dental care for school aged children and will book adult emergency by appointments.



**Phyllis Wood** is employed through First Nations Inuit Health Branch as the assistant to the Dental Therapist. Phyllis is from Pinaymootang and works closely with Lucy every Tuesday and Wednesday.