ANNUAL REPORT ON HEALTH 2013 – 2014

PINAYMOOTANG FIRST NATION

Submitted by:

Pinaymootang

Health Centre

Pinaymootang First Nation
Annual Report on Health 2013-2014

Annual Report on Health

Pinaymootang First Nation Health Program
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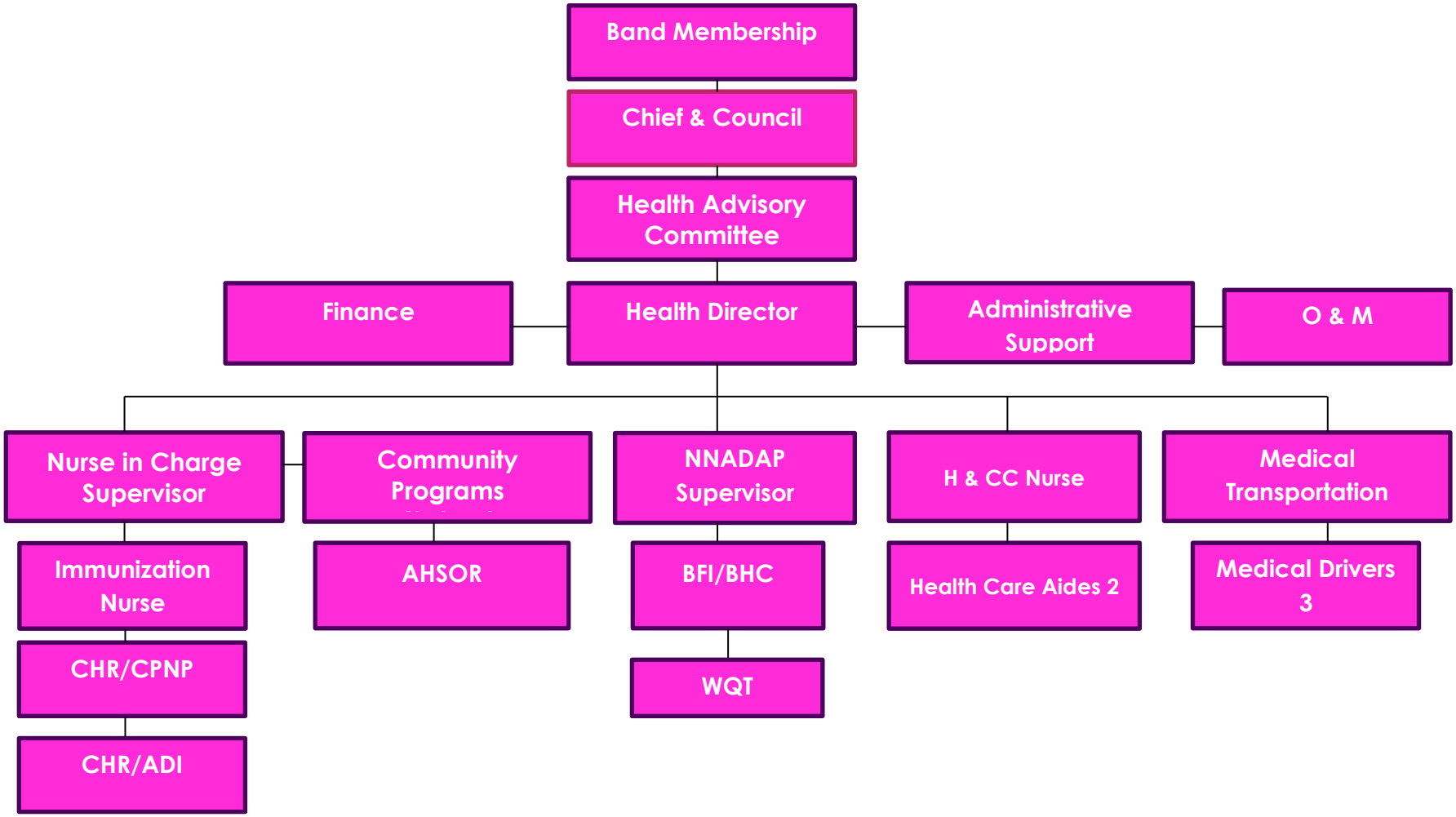
Pinaymootang First Nation Health Program Organizational Chart 2013



Introduction:

We would like to welcome you once again to this year's Annual Report on Health which highlights the various activities that have been undertaken over this past fiscal known as March 31st, 2014.

This report highlights on our commitments to the health and well-being of all and our key accomplishments in health for the Pinaymootang First Nation.

This document follows a similar format to the 2012-13, Annual Report. This Annual Report sets the stage for the 2014-15 program planning and budget process by providing an opportunity to assess the accomplishments, results, and lessons learned, and identifying how to 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!

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Message from Chief

As leader of the community, it is an honor and privilege to once again present to you the Annual Report on Health for fiscal period 2013 – 2014. 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, something that we must protect.

In this report you will find a year filled with continued service delivery, information on the accomplishments and activities of the past year as we 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 accomplishments achieved. Our community health programming 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 efforts in making our health programs a success. Without their care and dedication, it would be impossible to sustain and improve health in our community.

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

Kitchi-Meegwetch!

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 the 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 service system.

We have fine, talented and committed people who have shared their expertise in providing health services to our membership and the community. 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 in the lives of our community members.

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

Thank you,

Ted Woodhouse and John Sanderson

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, 2014.

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 known as at June 30, 2014 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.

Sincerely,

Shirley Cranford – Chairperson
Eva Woodford
Caroline Thompson
Eleanor Maytwayashing

Executive Health Director's Report

Another successful year has gone has we welcome you once again to this year's annual report on health for fiscal period 2013-2014.

Each year brings new challenges and without a doubt, our hands-on approach allows us to quickly direct our resources to where they are most needed. The success we achieve stems from our dedication, responsiveness and our flexibility in continuously adapting to changing needs.

The Pinaymootang First Nation Health Centre strives to be a community based facility, were we are committed in working to create fewer barriers to health care for our community members and assisting them to continue on their quest to improve their health and well-being. The ultimate goal is to become the stepping stone as the first point in contact, towards the ever increasing health care system.

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. We are able to provide this by working collaboratively together.

And for this, I wish to acknowledge my team for their hard work, dedication and expertise. And to our community membership for partaking in the health program activities, community awareness campaigns that the Health Centre has offered.

In this fiscal year, I am happy to report that the Health Program is moving into its third year of the Block Funding Model of the transfer agreement. The Block Funding Model is having the ability to reallocate funds of the transfer agreement and the ability to retain surpluses for reinvestment in priorities as listed in the approved Health Plan.

Governance

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. The committee delegates most of the operation management in Health Programming to the Health Director.

The current Health Advisory Committee consist of the following; Caroline Thompson, Eva Woodford, Shirley Cranford and Eleanor Maytwayashing.

Transferred Programs

Nursing Treatment & Prevention – the CHN, Janice Lowry continues to demonstrate her nursing abilities way and beyond. The Nursing Treatment and Prevention continues to meet its criteria, such as; 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 emergency needs.

A total of 1588 clients were seen during our clinics and unfortunately our physician Dr. Sami Faltas is no longer with us, but here to fill on a one day per week is Dr. Emadi.

On October 2012, the community received additional funding on a term basis to hire a part time nurse Roxanne Rawluk, to assist with some of the nursing functions at the Health Centre. Her role is to focus on facilitating new baby care and providing immunizations and by having Roxy, on board we have seen such a significant increase in the immunization rates.

Community Health Representative – The CHR does continue to play a major role in the health programming both employees oversee additional programs within their job descriptions. 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 personnel; 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, the custodian provides the general cleaning and sanitary services such as cleaning of premises, including carpets, furniture, windows, washrooms and floors. Repairs to the facility are contracted out on a

need be basis. In the new fiscal year we will be giving the exterior of the building a new facelift.

One common area we have expressed is the lack of office space of our facility, back in 2009, a Class A estimate was approved on an expansion to the Health Centre and to date no action was taken from our funders, we hope that this will be reconsidered 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 focused 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. An assistant was hired on an interim basis to help due to the increase in services. We welcome, Cheyenne Gould to the Health Program during this fiscal.

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, this area will be targeted for the next fiscal year. All components in the areas of solvent addiction, healthy living, injury prevention and alternatives to a healthier lifestyle were met.

Contribution Programs:

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 and testing drinking water, recording results on water quality, providing monthly reports to EHO, Robert Reed, FNIHB, for interpretation and recommendations, 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 ensure all pertinent procedures are followed, maintained and updated.

Canada Prenatal Nutrition Program – The CPNP program is designed to improve the health of pregnant women and their babies, the objectives of this program 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 has been in full implementation since 2006, the increase in homecare clients have increased and are seen on a regular basis. They are currently; 1 H & CC Nurse Supervisor, 1 LPN (half time) and 2 Health Care Aides that make up the team in the H & CC Program.

Home visits have been conducted on a daily basis, assessments completed, medical equipment have been purchased based on client needs. This program has been running exceptionally well, one area in particular we will be focusing on is the Homemaking Services which are currently being run by the Bands Social Program. We have been informed that this program will be amalgamated into the Home and Community Care Program in health. The Health Program will come up with innovative ways to ensure that there is a smooth transition and will ensure that this program is run effectively and efficiently. Policy writing and guidelines for this specific program will commence and the community will be informed of its working progress.

NIHB Medical Transportation – this program 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 maintain client files, intake of appointment information, verifying, scheduling and booking of appointments in coordination for transportation based on the guidelines of FNIHB.

A policy guidebook on Medical Transportation has been completed which requires revisions it is anticipation that this be reviewed and implemented by leadership in the new fiscal year.

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 as a health team focus on is the preventative measures that diabetes can be prevented.

Diabetic awareness activities continue to take place, foot care is held every bi weekly Wednesday with Nancy Tindall. Risk factors, assessments, surveys, physical activities, prevention, healthy eating habits, and gardening projects 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 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 families; to ensure access to additional support; addressing priority gaps ins programs and services for children and their families; promoting wellness and health being through education, prevention, screening, harm reduction, social and economic determinants; to provide specialized services such as training and support and to build on the foundation of current programs. The AHSOR Program is active in community and has become a participant in the Dolly Parton Imagination Library.

Other Initiatives:
Communications – the health program has its own website page, please visit www.pfnhealth.com or like our Facebook at Pinaymootang Health Centre for all health related information on programs, workshops or events.

Accreditation – In January 2011, Chief & Council have signed the Health Centre on to proceed into an accreditation process, accreditation is an on-going journey a process that health organizations use to assess and improve the quality of their services in a team environment; a tool that examines everyday activities and services against standards of excellence; a means to provide valuable measures to use within and among organizations. An Accreditation Coordinator has been contracted out, to help oversee and implement this process. In September 2012, the health program was surveyed and met all its requirements and received its Accreditation Primer Award. And in September 2014 we will be doing another review on Quality Assurance, we look forward to this as we have been working hard in enhancing our services.

Mustimuhw Community Electronic Medical Record – As of one of three First Nation Communities selected in 2012/13 the Health Centre is now using a comprehensive member-centered Community Electronic Medical Record (cEMR) based on First

Nations values and the Health Centre's mission and goals. We also have the use of e-chart in our Health Centre, eChart Manitoba is a secure electronic system that allows authorized health-care providers access to your health information when needed. And we are waiting for the arrival of our tele-health equipment.

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 - the Health Program continues to work with the IERHA in dealing with issues and concerns.

Interlake Reserves Tribal Council – Continues to be a supportive in some community programming initiatives.

Dental – I am happy to report that a Dentist will be visiting our facility on a two day a month basis commencing in May 2014. Dr. Sheri Mckinstry is a First Nation dentist who is from the Sagkeeng First Nation. Dr. Mckinstry received her license in 2005 and has been practicing ever since. By having a dentist closer to home will help elevate time and travel. Please help us welcome Sheri to our community.

And last but not least, I received my certification as a certified health manager with the First Nations Health Managers Association in September 2014. And I must say a lot of hard work has been undertaken during this fiscal, I hope you find this information useful, and I encourage you to visit our Facebook and website pages for more information on our programs and services.

Meegwetch!

Gwen Traverse
Executive Health Director

Accreditation Coordinator's Report

The Accreditation Coordinator position was established in April 2011 to oversee and implement the accreditation process. The Health Centre is seeking accreditation status that will improve their programs and services for the membership of Pinaymootang. This simply means that the Health Centre is striving to make things better to ensure quality improvement in all aspects of health services in serving our people.

The Health Centre was required from Accreditation Canada to complete a staff questionnaire which asked what areas in programming and services will need improvement. The results of the survey showed that some things need to be improved. This means that policies, procedures or guidelines must be in place in meeting certain standards.

This is like saying, what needs to be done to 'fix things and make it better'. In follow-up to the staff survey, a client survey was completed to assess the Health Centre's performance – the results showed that clients appear to be satisfied with services provided.

Besides developing policies, we have been assessing our programs and delivery of services, reviewing work plans, and finding ways to address gaps. And in September 2012 a review was done which resulted in the Health Centre receiving it "Accreditation Primer Award". As we continue to look at ways to improve, our next step in this process is the quality assurance with our next review scheduled for September 2014. We have been able to implement a number of changes and some of which you may already noticed.

The Health Director and staff are committed to ensuring that the people of Pinaymootang receive quality services and programs. And our goal to is;

To ensure that Pinaymootang First Nation Health Centre meets the standards of excellence in the provision of health care services to the membership.

- *"TAKING PRIDE IN TEAMWORK AND IN SERVING YOU, OUR MEMBERSHIP"*
- *"WORKING TOWARD PATIENT SAFETY"*
- *"WORKING TOWARD QUALITY IMPROVEMENT"*
- *"WORKING TOWARD A SAFE AND HEALTHY WORKPLACE"*

Accreditation Coordinator

NURSE IN CHARGE ANNUAL REPORT

The Pinaymootang Health Centre is a team of individuals with different skills and areas of expertise and we strive to serve the community with their health care needs. As Nurse in Charge, I am responsible for ensuring that preventative programs are being delivered and the initiatives are relevant to the needs of the community members.

As a team we have worked very hard to identify the major health concerns in the community and have tried to establish programs to address these health concerns.

This year we have gone to Mustimuhw, also known as the electronic charting system. Health Staff use this to access information that is only relevant to their programs. The physician and nurses have access to all health care information but non-health care professionals only have access to a client's identification information for example: name, PHIN & MHSC numbers, and contact information. We have over 3,000 community members inputted into the charting system and a chart summary was done on each individual. So there is history of health concerns on the system which took many hours of data entering by nursing staff.

The Health Center also attained access to E-Chart this year and this means that nursing staff can access information on tests done in other locations is Manitoba, such as; chest x-ray, blood work, EKG, medications prescribed, immunizations done, hospitalizations this assists in a client's care and prevents tests being repeated. Both of these initiatives have been a great improvement in client care services.

The Health Center continues to assist community members with phlebotomy (drawing blood) so that community members do not have to travel to Ashern fasting. The important thing is that community members needing blood work done need to come to the Health Center before NOON as our blood goes to the laboratory at noon to ensure quality results. Community members with requisitions from the physician can access this service and all 4 nurses in the Health Center can provide this service.

There have been a few community members that have had to undergo the treatment for dog bites, which consists of several needles. This is done in cases where the animal that bit the individual cannot be found or was destroyed before 10 days of observation.

Influenza immunizations have decreased in the community since 2009 when most of the community received vaccination for H1N1. Flu vaccines are offered every fall from October to March to try to prevent the spread of the virus. Only 330 community members got vaccinated and this year there were pockets of flu outbreaks in the community and caused some hospitalizations. There is a new vaccine called Flu Mist that is given by the nasal route so there is no needle, so this could be an option for most community members if the thought of a needle prevents you from getting the immunization. Protect yourself and your family by getting the flu vaccine every fall.

There have been several meetings this year with the Interlake Eastern Regional Health Authority to develop better working relationships with Lakeshore Hospital in Ashern. We are striving to improve client care and advocate for our community members to try to ensure the best care possible.

A new physician arrived in our community, Dr. Emadi who will be offering clinics every Tuesdays.

The following is some of the stats for client care done by N.I.C.

- Pre-natal/Post-natal care 260
- Women's Health 157
- Diabetic Health 123
- Adult Health 457
- Communicable Disease 142
- Infant/Child care 169

Once again would like to stress the importance of maintaining your health. The health center is there to assist individual's to attain good health but it is up to the individual to initiate healthy choices for themselves. Good nutrition, exercise and weight management are some of the issues each individual needs to address.

It is hard to realize another year has come and gone but it has been great to work in the community and continue to get to know you and assist with your health care needs. Let's make 2014-2015 a progressive year

Janice Lowry
Nurse in Charge

Immunization Nurse Coordinator

This past year has been a great year of beginnings. I am beginning to work out the kinks of running a child health clinic in order to offer the families of Pinaymootang more efficient and effective service. I am beginning to recognize who belongs to which family in the community. As I become more familiar with the people of Pinaymootang, I am beginning to understand what some of the needs are in the community in terms of child health and immunizations. As I put all of this new learning together, I am beginning to seek ways to address some of these needs.

This past April, my hours were changed in order to allow for increased interaction with our new doctor to address many of the needs of the children I see during the well baby and immunization clinics as well as the clients that I see at other times at the clinic. I now work Tuesday through Thursday the first three weeks of the month and Monday, Wednesday, Thursday the last week of the month.

The First Nations Inuit Health Branch has recommended that health care providers test the hemoglobin of all babies between 9-15 months of age in order to assess their iron intake, one of the most important nutrients needed for optimal growth and development of children. Iron helps to make up the molecule in a persons blood that carries oxygen throughout the body. If there is not enough iron, the blood is not able to carry to carry oxygen to the growing brain, kidneys, liver, heart, muscles, bones; everything needs an oxygen rich blood supply in order to develop properly.

At the 13 month immunization appointment, I will be performing a simple hemoglobin test that is very similar to a blood sugar test. Most babies tolerate this test far better than the immunizations that follow! The result will let us know whether an increase in iron rich foods in a child's diet is required and if an appointment with the doctor is needed for a prescription for supplemental iron.

Another new recommendation from FNIHB and Manitoba Health is the addition of an immunization against rotavirus, the leading cause of severe diarrhea in children under the age of 5 years. It is an oral vaccine with a limited timeframe in which to give 2 doses to babies. The first dose must be given before 3 and a half months of age and the second dose must be given prior to 7 and a half months of age. This timing is in order to reduce the risk of reactions to the vaccine.

If you have any questions or concerns about these new practices that I will be implementing, please call or come talk to me!

A gentle reminder for the adults: summer time is coming!! That often means that more time is spent outside and often we have more skin to earth contact than we do while cooped up over winter. Soil can carry the bacterium, tetanus, and infect people through small cuts or scrapes even after vigorous handwashing to remove the visible dirt. Please! If you have not had a tetanus booster in the last 10 years (or if you cannot remember the last time that you had one), please come in and talk to one of the nurses about it!

Immunization Coordinator stats:

- 29 home visits. 11 included adults; 18 also included children.
- 20 dressing changes for adults.
- 283 immunizations for children.
- 39 various injections for adults.
- Blood work drawn from 27 clients. 4 children; 23 adults.
- 11 preoperative assessments for children.
- 182 clients seen in clinic for injury, illness and other various issues. 96 adults; 86 children.
- 4 referrals made to a pediatrician. 3 referral letters written for adults.
- 50 telephone consults.
- 105 immunizations completed at the school.
- 67 information entries made to Mustimuhw charts to scan documents received from other facilities.

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 and support you all, children and adults alike, in your pursuit of happy, healthy lives!

Sincerely,

Roxie Rawluk
Immunization Nurse

Community Health Representative
Annual 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.

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, Nursery to grade 4's.

Updates of immunizations are requested from Manitoba Immunization Monitoring System 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 reserve 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. MIMS updating is an ongoing task, which we constantly use. This is so that the child or client doesn't receive the same needle.

A total of 330 flu vaccines were given to band members and non-band members in October to February. We chart and record in all consent forms.

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 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 interviews and treatments.

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, this is then done by the CHR and mail 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
- Mustimuhw data training
- 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 healthy babies.

Three main program areas in the program are;

1. Nutrition Screening, Education and Counseling,
2. Maternal Nourishment (providing pregnant women and breastfeeding moms with healthy foods),
3. Breastfeeding Promotion, Education and Support.

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

Baby's Best Chance books are given out to all expectant moms. Followed up is provided by a physician on a monthly basis. Prenatal 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 conduct home visits to newborns and moms as soon as they return to the community and Welcome Home Packages are given. Assessments are conducted to babe/mom, to see if there are any concerns that need to be addressed.

During this fiscal year, we handed out 51 Welcome Home Packages which included receiving blankets, wipes, nose bulbs, socks, bibs, mittens, t-shirts, nail clippers sets, shampoo, body wash, baby lotion, sleepers, thermometers, immunization schedule and a complete baby information package.

New Year's Baby - Boy or Girl receive a special Welcome Home Package.

Ultrasounds are booked in Eriksdale Hospital and at times second ultrasounds may be requested.

Most prenatals are found in their first trimester every odd one will be found during their last trimester. Information packages on 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 are given during clinics.

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

Milk coupons are also offered once a week.

Manual Breast pumps are given to mom at her request as she will be breastfeeding, usually a couple of months for some and some past 9 months.
Star blankets are also given to breastfeeding moms, if they've breastfed 9 months or over.

The CPNP has incentive for mother to have their child immunizations they are @ 6 months - baby wraparounds, 12 months-, and 18months- baby gauntlets

Baby Food Making - (Fruits & Vegetables) was held with only a few showing up. But will keep trying again. We give out incentives for the attending moms that show, (blenders). Gave out ice cube trays to moms, to show them how to freeze left over baby food and store in bags for later use. These were moms with 7 - 9 month old babes.

Mom's Cooking class - how to cook healthy meals for their families. Incentives are drawn for the participants like, crock pots or slow cookers.

Dental Therapy services- dental therapy services were initiated at the initial newborn visit packages are given to the Mom's with tender cloths for mouth hygiene an information is given.

Successes:

- Among the 55 prenatal mothers who consented to the program, 51 have participated; None of the prenatal mothers do prohibited drugs;
- Booklet developed on Growing Healthy Together Baby and Me which facilitates bonding between mother and baby even during prenatal stages;
- The increase in care for pre and post natal;
- Mommy and Me Support Gathering;
-

Some continue to smoke and drink we have offered a preventive incentive for smoking cessation;

Milk program;
Group activities;
Cooking class for moms and dads;

- 2013 - April - December – 23-Boys & 16 Girls were born (39)
- 2014- January - March - 7-Boys & 5- Girls were born (12)
- Total babies born was 51
- New Year's Baby is a boy Born January 2/14

Meetings/Workshops/Conferences:

- Staff Meeting
- Mustimuhw data training
- Train the Trainer-Traditional Family Parenting
- Treaty Days Health Fair
- e-Chart Training
- Med. Trans Training
- COHI meeting
- Health Centre Community Presentation

Meegwetch!

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 11 years and I really enjoy my work. I act as a role model when I provide teachings on diet and exercise as well as traditional teachings.

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 all community health events, cleanup, health fair, workshops, treaty days, etc.;
- Diabetic clinics and care;
- 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 HIV/AIDS and 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:

- 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.

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 option 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.

Meegwetch!

Alfred Pruden
CHR/ADI/HIV/AIDS Coordinator

Support to Nurses Annual Report

Hello, my name is Carol Woodhouse I have been employed with the Pinaymootang Health Program since 2008. The purpose of this position is to assistant 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;
- 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.

Walk-in Clinic Visits	1588

During the course of this fiscal year our physician services have decreased due to the doctor away on vacation and leaving the Province. Dr. Faltas is an exceptional doctor with a very high degree in patient care. This is what our facility is all about is providing good client care service. Dr. Faltas is no longer with us and the health organization was able to attain a new physician Dr. Emadi who will be servicing our community.

The new electronic charting system is such an enhancement to the program..

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);

Submitted by,

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 now has, an interim custodian, 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 program installed new carpeting throughout and for the next fiscal year, plans are in place to provide the facility with a new exterior paint job. 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.

Recommendations:

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

Brighter Futures Initiative
Building Healthy Communities
Annual Report

Hello, my name is Stephen Anderson; 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 the BFI/BHC program, in partnership with various community agencies and other Health Centre programs, provides a variety of different activities for community members to participate in. These are some of the events/programming held in the past year:

- The BFI/BHC kicked off the start of the fiscal year programming with the Gardening program, 61 community members took part in this year's Garden Project. The Gardening project is done in partnership with the ADI and BFI programs. Clients are given various types of seeds to plant along with seed potatoes in their own garden; clients can take pride in growing and harvesting their own food. For the past few years this program has seen an increase in the number of community members taking part and we look forward to continuing that trend in the coming years.
- The annual Community Spring Clean-up. Approximately 75 community members took part in the activity which has been an annual spring activity in the community, after the clean-up a BBQ lunch was provided to those that took part in the event.
- Muskeg Tea picking/making activity. This is done in conjunction with the ADI program and provides community members with traditional Muskeg Tea.
- Swimming lessons at Steep Rock wharf. These lessons are an annual activity in the summer months. The Pinaymootang Health Centre is a member of the Interlake Swim Association which provides the instructors and location where the lessons take place. This year 30 participants took part in this annual activity.
- Immunization Fair. This program was held in partnership with other Health Centre programs, clients took part in various games and activities with their children

aged 0-6. Fifty-two community members took part in this event that promoted child wellness.

- The community Health Fair, held during annual community Treaty Day celebrations, showcases all Health Centre programs and gives community members a chance to interact with health staff. Approximately 150 people took part in the event.
- Canadian Gun Safety Course was bought to the community to give community members access to a course that is a requirement to obtain a Possession and Acquisition License (gun license), 20 people took part in the course and all participants passed the course requirements.
- Winnipeg Aboriginal Film Festival (WAFF). Done in partnership with Pinaymootang School, 9 students were selected to take part in the WAFF. As part of the festivities students attended various workshops where they learned about filming techniques and the film production process.
- Christmas Cooking class. In this activity attendees took part in making meatballs, perogies and cabbage rolls. This class was attended by 30 community members.
- Lunch with Santa. This event gave community members to bring their young ones in for Santa pictures and to enjoy a complimentary lunch courtesy of the health program. Forty-eight people took part in this event.
- Christmas Baking class. In this class, clients were able to make rice crispy squares; butter tarts squares and confetti cake.
- Christmas Open House. This event gives community members an opportunity to come into the Health Centre and interact with staff and get information on what each program area does.
- Ice Fishing Derby. This annual event is fast becoming a community favorite with 158 participants taking part in this year's derby, attendees had an opportunity to get outdoors and have a chance to win some prizes.
- South of the Border Party. This event gives participants an opportunity to take part in various activities such as cooking and face painting all while enjoying each other's company. Fifty-four community members attended this event.

Monthly networking meeting are also attended with representatives from various community agencies and other health program areas. These meetings give attendees an opportunity to share upcoming events and a chance to create partnerships for future events. The success of these partnerships show the importance of community teamwork as we strive to bring forward new and interesting programs for community members to take part in.

In closing, the BFI/BHC Program would like to thank all of those who have attended this past year's activities. If it were not for your participation, these events would not be having the success that they are experiencing. As we move forward, the BFI/BHC

program will continue to make every effort to bring out new and exciting programs for community members to enjoy and take part in.

Thank you!

Stephen Anderson
Brighter Futures Initiative/ Building Healthy Communities Coordinator

NNADAP Annual Report

The National Native Alcohol and Drug Abuse Program evolved from a pilot project that was first implemented in 1975 and has been in operation for the last 39 years. This program was designed to provide balanced professional support prevention, maintenance and treatment programs. Throughout the years this program has evolved into various avenues to address the issues faced by our communities. However, the funding has always been kept on minimum basis and therefore, the outcomes vary.

During the inception of the program the Indian Residential School systems negative impacts were never taken into consideration. And yet many of the problems faced by the communities in terms of alcohol and drug abuse are directly related to the outcomes of the system. As an extension to the Native Alcohol and Drug Abuse, I worked on a proposal through the IRS to purchase a monument to honour the school survivors. This monument was erected in front of the Health Centre. It is our hope that this monument will serve as a reminder to the future generations and will motivate them to continue with the healing journey. For the simple reason that we can never attain healing until the hurts and trauma from the past are validated and dealt with. However, dealing with the past takes courage, persistence and a commitment.

When I see the courageous steps that are often made by the clientele that I serve, I sometimes have to stand back and watch in awe as the hurdles are made and see the changes happening before me. For this reason, this is why I love doing what I am doing. I know I cannot change anyone or make another person quit their alcohol and drug abuse. But, I can only offer guidance and advice. To see the changes that people are willing to make from their hearts is very gratifying!

The following are some of the workshops and events that were presented the last fiscal year:

- Residential School Workshop and Gathering
- Gambling Prevention Workshop
- Smoking Prevention Workshop
- Professional Development Workshop
- Honouring our Grand Mothers Event
- Community Health Fair

- Scared Straight Worksop (Prevention of Alcohol and Drug Abuse & Gang Awareness)
- Addictions Awareness Week (Workshop on Prescription Drug Abuse)
- Winnipeg Aboriginal Festival Week (Students were taken on a trip to view role models).
- Community Work Plan Development
- Career Fair (To provide opportunities for positive changes for youth)

The Pinaymootang Health Centre has a very dedicated team and we will continue in working together in this new fiscal year to bring new initiatives to our community.

In complying with the requirements of First Nations Health, the following are the monthly statistics for the NNADAP program for the period of April 1, 2013 to March 31, 2014:

Month	Counseling	Referrals	Other Community Members
April	3		3
May	11	4	
June	10	6	2
July	7		
August	5		
September	9	4	2
October	8	3	
November	5	2	
December	3		
January	2	1	
February	3		
March	11	7	4
Total	**87***	27	11

*The data is for first time clients, and repeated sessions with each client is not included.

Sincerely

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

Since taking over this position, the program has switch to online charting. 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

MT Coordinator Contact Number: 204-792-4666

Medical Transportation Contact Information:

Ashern:	**204-768-0229**
Winnipeg:	**204-792-7057**
Dauphin/Selkirk:	**204-792-1366**

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

Program Activity Report

1st	2nd	3rd	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: **2013 - 2014** **April 1 – August 31, 2013**	Recipient: **Pinaymootang First Nation** **Contribution Agreement: MB0700072**	
# of requests: **6377**	# of exceptions requested: **24 clients reimbursed**	# of appeals: **0**
# of requests approved: **6377**	# of exceptions approved: **15**	# of favorable appeals: **0**

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:

A major increase in dental appointments. This may be due to the fact that we had a meeting with Cameron and were told that we can provide travel for Dental appt's provided that there are actual specialists appointments booked the same day. If no specialists' appointments scheduled, ALL dental appointments for that day will be rescheduled for a later date.

Increase usage in all three shifts of medical transport. This has resulted in having to hire a part-time driver to help alleviate the schedule for our regular on-call medical drivers.

Major Challenges in delivering the program during this reporting period:

One of the major challenges in this reporting period is the weekly vehicle repairs for all three vehicles. Our 2011 Chevrolet Traverse broke down on route to a medical appointment. This van was taken in to the dealership for inspection and was discovered

to have the motor seize. All documents are available to view the maintenance for this vehicle. The Chevrolet Traverse was not in use from July 24, 2013 – October 2, 2013. This has left us with a huge bill for a rental vehicle that was utilized for at least 4 days a week.

Increase in amputees a lot of coordination has been made in ensuring no double booking for our medical van which currently has wheelchair lift. This lift has been of great assistance to our programming. A medical van that is wheel-chair accessible is needed in the community. If another van was to be purchased we would like to have one with a wheel chair lift installed.

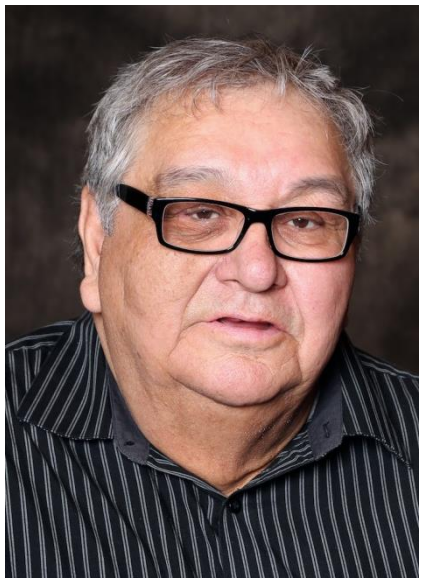
A major increase in medical transportation usage has been detected as from the previous report we have had an increase of 400+ clients using the transportation service.

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
·Increase in dialysis clientele with limited mobility
·Increase in amputees of 12

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

There also has been an increase with clients that are now on dialysis and the medical transportation program is assisting with these clients as much as possible.



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

Program Activity Report

1st	2nd	3rd	Final
For Period Apr 1 to August 1	**For Period Sept 1 to Nov 30**		**For Period Dec 1 to Mar 31**
Due Oct 15	**Due Jan 15**		Due no later than 90 days after the end of the agreement

Fiscal Year: **2013 - 2014** **Sept 1 to Nov 30**	Recipient: **Pinaymootang First Nation** **Contribution Agreement: MB0700072**	
# of requests: **3815**	# of exceptions requested: **21 clients reimbursed**	# of appeals: **0**
# of requests approved: **3815**	# of exceptions approved: **0**	# of favorable appeals: **0**

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 and 2 casual employees that are on call on a need-to-be basis that work on a rotating basis. Each driver receives a daily schedule of appointments.

Major Accomplishments in the program during the reporting period:

Acquired a new medical vehicle as the 2010 Chevrolet Express has been having problems on a weekly basis, this van will be utilized for trips going to Dauphin, Selkirk and any additional trips going to various medical facilities.

A slight increase in the usage of meal tickets. This may be due to the fact that dental clients are now allowed on the medical van, providing there is a scheduled specialist appointment. If they are no scheduled specialist appointments then all scheduled dental appointments are rescheduled to the next specialist appointment date.

Major Challenges in delivering the program during this reporting period:

There has been a slight increase in surgeries for the time frame. These include Medical, Dental and vision surgeries. Private travel has been utilized for most that require an

overnight stay in the city. Hotel accommodations have also increased slightly.

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
·Increase in population status in community
·Doctor Shortage Ashern District
· 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

1st	2nd	3rd	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: **2013 - 2014** **December 1 – March 31**	Recipient: **Pinaymootang First Nation** **Contribution Agreement: MB0700072**	
# of requests: **3324**	# of exceptions requested: **24 clients reimbursed**	# of appeals: **0**
# of requests approved: **3324**	# of exceptions approved: **15**	# of favorable appeals: **0**

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:

A major increase in day surgery procedures and extended stays in hospital. Pinaymootang Medical Transportation covers the first two days of stays in the city and FNIHB covers after the first two days.

A new 2014 Chevrolet Savana 11 passenger vehicle has been purchased. This van would enable the program to have an additional van (2011 Chevrolet Express) to be on stand-by for any emergency appointments and/or to prevent the Winnipeg van from overcrowding situations.

More clients have been utilizing the medical transportation program for local and Winnipeg trips, but this also means that there is an increase in the usage of meal tickets

and medical vans at capacity.

Major Challenges in delivering the program during this reporting period:

A major increase in surgeries has put the program budget over capacity. These appointments are made via referrals from our in-office doctor and other doctors in the area.

Medical appointment trips have increase this past fiscal year with members of the community utilizing the service more. The usage of meal tickets that are provided for Winnipeg medical van runs has also increased.

Another major challenge would be that some members are required to travel by private vehicle due to mobility issues and have presented a note from their doctors confirming the disability. This has left me with the dilemma of providing private travel or consulting with one of the nurses.

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

The factors currently impacting medical transportation program budget:

- Increase in fuel
- Repairs/Maintenance vehicles
- Increase in dialysis clientele

Other relevant observations, comments or information to this program:

A relief worker is needed within the program to help with any extra work. After attending the Medical Transportation meeting in Winnipeg in November, I noticed that most communities smaller than Pinaymootang have assistants helping run their program, if the budget would be increased this would help with filling and coordination of the program.

HOME AND COMMUNITY CARE PROGRAM
ANNUAL REPORT

Staff:
Mary Bezemer RN - Nurse Supervisor
Nancy Tindall LPN – Maternity Leave
Angie Meisner LPN - Temporary
Pam Sumner - Certified Health Care Aide
Dot Sumner - Certified Health Care Aide

This is my 5th year working in the Home and Community Care program, and during this past fiscal year, I had decreased my working hours to .4 EFT. Our health care aides provide excellent direct, personal care such as bathing, monitoring our client's general health and well-being. We also provide some social interacting educational programming for our elderly.

The home and community care staff work as a team, to provide in home care service to our elders, to those living with acute and chronic illnesses or members with disabilities to enable them to remain independent in their homes. We do this by assisting 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.

As nurse supervisor to the program, I assess and assist with requests for personal care home placement 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 807 client encounters in the past year, of which 223 were home visits.

Stats for the reporting period:

Month	Home visit	Clinic Visit	Phone call	Hospital visit	Total client encounters
April 2013	18	57	29	8	112
May 2013	11	38	15	0	64
June 2013	13	52	20	2	87
July 2013	33	51	37	4	125
August 2013	38	37	5	0	80
Sept 2013	11	22	0	0	33
Oct 2013	36	36	0	9	81
Nov/13	16	26	14	16	61
Dec/13	4	10	37	3	20
Jan./14	17	24	7	3	44
Feb/14	18	23	7	3	57
March/14	8	22	12	1	43
Total	223	105	183	49	807

Two clients have been panelled and transferred to a personal care home to live as they were no longer able to be cared for at home, and 3 have been assisted in applications for care home placement and remain on a waiting list.

Activities:

- Elder Programming
- Community clean;
- Annual influenza clinics;
- Assisted as an accreditation committee member meetings;
- IERHA Meetings;
- Diabetes;
- Annual Health Fair;
- Attended the twice yearly Home and Community Care program meeting in Winnipeg, held in November and February;
- Attended a Chronic Care education session in March in Winnipeg,
- Took park in the Manitoba e-chart training session in October;
- Attended and presented a Shared Care workshop at the Ashern hospital;

Over the past year I also assisted in transferring all of our paper charts to the electronic charting system, this system is working well and is a great benefit to our program.

We have 110 elders in our community, who are aged 60 or older and we see 25 of them regularly, with the remainder being involved in our activity programming and seen less often.

I have 88 clients on my active eSDRT report that have been admitted to the home care program – this includes clients seen only for foot care.

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.

I look forward to another productive year, and hope that we can continue to improve our program.

Submitted by;

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 Center. I have been working as a Health Care Aide for many years now, six years on and seven years off reserve. 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; Bathing, grooming, toileting. Basically, getting clients ready for the day.
- Taking vitals which include; blood pressures, temperatures, blood sugars, respirations, pulse, and oxygen levels.
- During home visits, making sure the clients are taking their medication, and documenting any changes to medication.
- Assisting clients with equipment when needed to make life easier. Example; mobility aides, wheelchairs, walkers, canes, shower heads, bath seats, etc.

Recording and Reporting:

- After each home visit I 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.

Home and Community Care Activities

April 2013

Home visits-63
April 4- Elder Programming – 5
April 29- Staff meeting

May 2013

Home visits-41
May 16- Elder Programming - 31
May 22- Elder Programming - 4
May 23- Community clean- Up
May 26- 27- Staff development workshop

June 2013

Home visits – 49
June 12- Elder Programming - 120
June 20- Elder Programming - 10

July 2013

Home visits-51
July - Diabetes Walk

August 2013

Home visits- 63
August 22-Health Fair

September 2013

Home visits-44
September 26- Elder Programming - 24

October 2013

Home visits-72
October 3- Cancer Walk
October 4- Meeting with IERHA
October 17- Elder Programming - 42
October 28 – Staff meeting

November 2013

Home visits-74
November 14- Diabetes Walk
November 25- Staff meeting

December 2013

Home visits- 43
December 5- Elder Programming
December 11- Information Sharing

January 2014

Home visits-86
January 22- Elder's Wellness Day- 3 attended

February 2014

Home visits-53
February 20-21-Accreditation meeting

March 2014

Home visits-57

Respectfully submitted by;

Pamela Sumner
Health Care Aide

Home and Community Care Program
Annual Report

Hello, my name is Dorothy (Dot) Sumner, I am a Health Care Aide for Pinaymootang Health Centre, and I have been employed since January 2012. I work with the Home and Community Care Program, under the supervision of the HCC Coordinator. I work with elders and persons living with acute and chronic conditions. I take great pride in helping people and value, what I do. It has been 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 homes 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 our 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 2013

Home Visits – 54
April 4 – Elder Programming – 5
April 11 – Foot Care

May 2013

Home Visits – 41
May 22 & 30 – Foot Care
May 16 – Elder Programming – 31
May 23 – Community Clean-up Day
May 27 & 28 – Creating Harmony Wksp

June 2013

Home Visits – 44
June 12 – Elder Programming - 120
June 13 & 27 – Foot Care

July 2013

Home Visits – 48
July 31 – Diabetes Marathon

August 2013

Home Visits – 39
August 7 & 15 – Foot Care
August 21 – 23 – Treaty Days
August 21 – Community Gathering
August 22 – Health Fair

September 2013

Home Visits – 50
Sept 7 & 18 – Foot Care
Sept 26 – Elder Programming - 24

October 2013

Home Visits – 48
October 3 – Breast Cancer
October 4 – IERHA Meeting
October 9, 16 & 24 – Foot Care
October 17 – Elder Programming - 42

November 2013

Home Visits – 46
November 14 – Diabetes Walk
November 18 – Accreditation Meeting
November 20 – Foot Care

December 2013

Home Visits – 14
December 4 & 18 – Foot Care
December 5 – Elder & Youth Gathering
December 11 – Open House
Community Program Information Sharing

January 2014

Home Visits - 60
January 16 – Information Session
January 29 - Hoyer Lift Training

February 2014

Home Visits – 42
February 12 – Foot Care
February 20 & 21 – Accreditation Workshop

March 2014

Home Visits – 60
March 11, 12 &13 – Collaborative Chronic Disease Education and Training Session

Dot Sumner
Health Care Aide

Community Health Program Coordinator
Annual Report

Hello my name is Angie Meisner, I am a Licensed Practical Nurse and was employed with Pinaymootang Health Center from October 2012 – January 2014. While employed with Pinaymootang, I had many different roles. One of my roles was filling in as the Community Health Program Coordinator while Nancy Tindall was away. My main focus in this role was at the School. I had been in and out of all the classes from preschool to grade 12, informing students on a variety of health topics, so they can make informed decisions about their own health.

The information I discussed with the students was always age appropriate and did not go beyond student's developmental level. Some of the topics I discussed were puberty and self-esteem, "sun sense" a program that informed students about sun safety, hand washing and flu etiquette sessions, sexual education, and diabetic screening. I also helped with a few events at the school, such as having the Manitoba Lung Association and Cancer Society come to the school to do a presentation on smoking and chewing tobacco. As part of "World No Tobacco Day" the students from the S.W.A.T. (students working against tobacco group) designed place mats that were used at Powderhorn Creek Restaurant as awareness of the day.

Another role I performed while working at the Pinaymootang Health Center was assisting in the BHC and NNADAP roles, some programs held while in this role was a HIV/AIDS presentation to grades 7-12. Bra fitting clinic's for the students, staff and community members. On National Child Day, I planned some fun events for students at the school from Nursery to Grade 5, which included each student going home with a brand new book of their choice at the end of the event. In lieu of National Addictions Awareness week, Cynthia Murdock from IRTC and me did a presentation to the high school on addictions, at the end of the event students released yellow balloons into the air in remembrance of someone they knew that suffered from addictions. Another event that I organized was the "BE PINK" presentation, which was presented by Tanis Letandre from IRTC, teenage girls from Pinaymootang School were informed about breast health and breast cancer, the students also had a chance to win gift certificates to buy a new bra next time they are in Winnipeg.

I am always willing to assist other programs when needed, some other events I helped at was, doing first aide for the ACFS Family Fun Day, the Community Breast Cancer walk in October, the Diabetic Walk, also helping Roxie the Immunization Nurse with Kindergarten Testing.

Another part of my job was supervisor of the Aboriginal Head Start Program, this program is intended for families and their children from 0-6 years old. I am there to offer help and support to the outreach program worker Cheryl Anderson. Aboriginal Head Start consists of 6 components which we focused on, social support, nutrition, health promotion, education & school readiness, culture & language and parental and family involvement. While the programs supervisor I've helped deliver many programs with Cheryl such as, the ALAPSE course, playdo & gak making classes, homemade baby tag blankets & raddle making classes, baby food making classes, afternoons of soccer, brunch and story time with an elder, learning how to make homemade baby wipes, baby pillows, smoothies and bannock. We also held Christmas Cooking and Christmas Baking classes, with help from other programs at the Health Center. The head start program along with help from other programs started a "mom & tot" group, which is running every week, this is a very popular program and has had great attendance. If you or someone you know would be interested in attending some of these head start programs please contact Cheryl or Nancy at the Health Center.

Another part of my job is to assist with Community Health and the Home & Community Care Program. What this means is I provide nursing care through home visits, walk in's and scheduled clinic visits. The following are my stats for April 2013 to January 2014.

Community Health 292 Clients Seen

Clients Seen

Assessments: 126
Injections: 50
Procedures: 9
Pregnancy Tests: 14
Phone Consults: 45
Dressing Changes: 38
Home Visits: 6
STI Testing: 1
Health Info: 3

Home & Community Care 161

Dressing Changes: 51
Assessments: 25
Phone Consults: 5
Home Visits: 59
Injections: 14
Baths: 5
Health Info: 2

I would like to thank the Pinaymootang Health Center and the Pinaymootang First Nation for giving me the opportunity to work for your community, I gained tons of

experience and knowledge from working here. Everyone was so welcoming, patient and supportive during my employment, these are memories that last forever. Thank you to everyone for making my employment an unforgettable great experience. I wish everyone great health and well-being. I'll see you around!

Sincerely,

Angie Meisner, LPN

Angie Meisner, LPN

Community Health Program Coordinator

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;

<u>155 Clients seen in the clinic:</u>
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

<u>112 Clients seen on home visits & in clinic</u>
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,

Nancy Tindall LPN
Community Health Program Coordinator

Aboriginal Head Start On-Reserve Report
Annual Report for

My name is Cheryl Anderson, I am the Aboriginal Headstart On-Reserve Outreach Program (AHSOR) Home Visitor.

The AHSOR Program is designed to meet the needs of the children and their families. The program focuses on children 0-6 years and their families. The program has six major components that need to be met. The components: 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 visits. Home visits usually consist of the home visitor the child or children and the parent/s or grandparents. Educational resources, arts and crafts, etc are brought on each home visits that should meet the six components of the program.

During this fiscal, I have partnered with Child & Family for ALAPS parenting training. This program usually runs twice a year and all parents who participated successfully completed the program.

Brunch and Story time was held a couple times this year. It is for children 0-6 years and their parents. For Brunch and Story Time we invite an elder to read to the children or tell stories in our language.

In June and July, the AHSOR program hosts summer activities for children 3-6 years to help motivate and have children interact prior to school year beginning or if they are being enrolled in the daycare program.

In partnership with the CPNP program we held a one day Immunization Fair. The purpose was to promote the importance of immunizations and promote safety. Manitoba Public Insurance was on hand to hold car seat safety and a mini car town so children were aware of motor vehicle pro-cautions.

Treaty days were held in August and we held our Annual Health Fair.

I participated in the Breast Cancer Walk in October.

Community Information Sessions were held in December.

The Program held a Mom and Dad Fitness Challenge, which ran every Monday and Tuesday for 12 weeks. The purpose was to promote health and wellbeing for moms and dads.

The Program started a "Mom and Tot Program" at the school. This is a group where moms can relate to one another to discuss and provide input and advice on child development. Various activities take place during this time, activities such as: tag blanket making, baby blanket making, baby food making, mommy and me cooking, various arts and crafts, homemade baby wipes, etc. and on every special occasion we offer children gatherings with moms and tots.

Attended the Family Literacy day at the school and promoted the program.

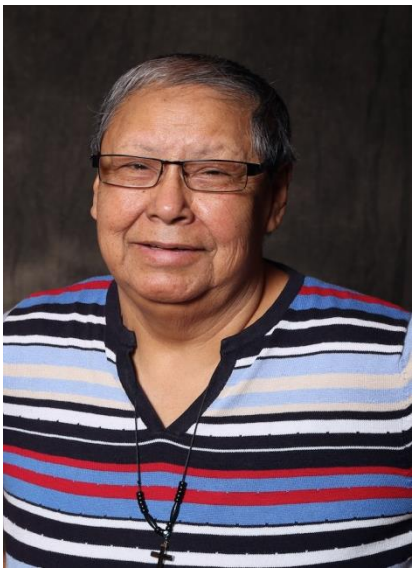
We also try and promote elder teachings with the children at least three times a year, to promote the seven sacred teachings and grandparents day.

In partnership with the CPNP, we held a South of the border party to promote our programming, healthy eating, gardening (tomato plants), and the importance of immunization, health and safety.

Meetings/Workshops/Conferences:

- Weekly COHI visits;
- Monthly Staff Meetings;
- Monthly Community Networking Meetings;
- AHSOR Program Review;
- Home visits to provide ASQ assessments

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 FHIHB. 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	WELLS-S	WELLS-US	C/B-S	C/B – US	OTHERS-S	OTHERS-S	TOTAL-S	TOTAL-US
APRIL	22	3			20	4					42	7
MAY	18	2			33	1					51	3
JUNE	27	1			30	0					57	1
JULY	45	3			51	3					96	6
AUGUST	29	1			54	1					83	2
SEPTEMBER	23	2			42	1					65	3
OCTOBER	37	1			45	0					82	1
NOVEMBER	25	2			28	0					53	2
DECEMBER	25	0			30	0					55	0
JANUARY	40	1			30	1					70	2
FEBRUARY	39	3			30	1					69	4
MARCH	37	2			50	5					87	7
TOTALS	367	21			443	17					810	38

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

Pinaymootang First Nation Health Professional Services

This is Lenore Berscheid who is our Mental Health Counselling Services expert, Lenore provides counselling services in the community one day per week (every Tuesdays) any referrals for services can be made through the Health Centre and anyone wishing to utilize these services please contact the Health Centre.

This is 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.