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ACCREDITATION
AGRÉMENT
CANADA
Qmentum

Accreditation Report

Northwest Territories Health and Social Services Authority

Yellowknife, NT

On-site survey dates: December 8, 2019 - December 13, 2019

Report issued: January 29, 2020

About the Accreditation Report

Northwest Territories Health and Social Services Authority (referred to in this report as "the organization") is participating in Accreditation Canada's Qmentum accreditation program. As part of this ongoing process of quality improvement, an on-site survey was conducted in December 2019. Information from the on-site survey as well as other data obtained from the organization were used to produce this Accreditation Report.

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

Confidentiality

This report is confidential and is provided by Accreditation Canada to the organization only. Accreditation Canada does not release the report to any other parties.

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

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

A Message from Accreditation Canada

On behalf of Accreditation Canada's board and staff, I extend my sincerest congratulations to your board, your leadership team, and everyone at your organization on your participation in the Qmentum accreditation program. Qmentum is designed to integrate with your quality improvement program. By using Qmentum to support and enable your quality improvement activities, its full value is realized.

This Accreditation Report includes your accreditation decision, the final results from your recent on-site survey, and the instrument data that your organization has submitted. Please use the information in this report and in your online Quality Performance Roadmap to guide your quality improvement activities.

Your Program Manager or Client Services Coordinator is available if you have questions or need guidance.

Thank you for your leadership and for demonstrating your ongoing commitment to quality by integrating accreditation into your improvement program. We welcome your feedback about how we can continue to strengthen the program to ensure it remains relevant to you and your services.

We look forward to our continued partnership.

Sincerely,

Leslee Thompson

Leslee Thompson
Chief Executive Officer

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Executive Summary

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

As part of the Qmentum accreditation program, the organization has undergone a rigorous evaluation process. Following a comprehensive self-assessment, external peer surveyors conducted an on-site survey during which they assessed this organization's leadership, governance, clinical programs and services against Accreditation Canada requirements for quality and safety. These requirements include national standards of excellence; required safety practices to reduce potential harm; and questionnaires to assess the work environment, patient safety culture, governance functioning and client experience. Results from all of these components are included in this report and were considered in the accreditation decision.

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

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

Accreditation Decision

Northwest Territories Health and Social Services Authority's accreditation decision is:

Accredited (Report)

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

About the On-site Survey

- **On-site survey dates: September 22, 2019 to September 27, 2019 and December 8, 2019 to December 13, 2019**

- **Locations**

  The following locations were assessed during the on-site survey. All sites and services offered by the organization are deemed accredited.

  1. Aklavik Susie Husky Health and Social Services Centre
  2. Beaufort Delta Region - Inuvik Regional Hospital
  3. Dehcho Region - Fort Simpson - Stanley Isaiah Wellness Center
  4. Dehcho Region - Fort Simpson Elder's Care Home
  5. Dehcho Region - Fort Simpson Health Centre
  6. Fort Providence Health Centre
  7. Fort Smith Region - Fort Smith Health Centre
  8. Goga Cho Building
  9. Inuvik Public Health
  10. Jan Stirling Building
  11. Long Term Care Facility - Sahtú Dene Nechá Kǫ́
  12. Sahtu Region - Norman Wells Health Centre
  13. Stanton Region - Stanton Territorial Hospital
  14. Yellowknife Child Youth and Family
  15. Yellowknife Region - Yellowknife Public Health Department
  16. Yellowknife Region - YK Primary Care Clinic
  17. Stanton Rehabilitation Program

- **Standards**

  The following sets of standards were used to assess the organization's programs and services during the on-site survey.

  System-Wide Standards

  1. Governance
  2. Infection Prevention and Control Standards
  3. Leadership

4. Medication Management Standards

Service Excellence Standards

5. Biomedical Laboratory Services - Service Excellence Standards
6. Cancer Care - Service Excellence Standards
7. Child, Youth, and Family Services - Service Excellence Standards
8. Community-Based Mental Health Services and Supports - Service Excellence Standards
9. Critical Care Services - Service Excellence Standards
10. Diagnostic Imaging Services - Service Excellence Standards
11. Emergency Department - Service Excellence Standards
12. Home Care Services - Service Excellence Standards
13. Inpatient Services - Service Excellence Standards
14. Long-Term Care Services - Service Excellence Standards
15. Mental Health Services - Service Excellence Standards
16. Obstetrics Services - Service Excellence Standards
17. Perioperative Services and Invasive Procedures - Service Excellence Standards
18. Point-of-Care Testing - Service Excellence Standards
19. Primary Care Services - Service Excellence Standards
20. Public Health Services - Service Excellence Standards
21. Rehabilitation Services - Service Excellence Standards
22. Remote/Isolated Health Services - Service Excellence Standards
23. Reprocessing of Reusable Medical Devices - Service Excellence Standards
24. Transfusion Services - Service Excellence Standards

- **Instruments**

The organization administered:

1. Worklife Pulse
2. Canadian Patient Safety Culture Survey Tool: Community Based Version
3. Governance Functioning Tool (2016)
4. Physician Worklife Pulse Tool
5. Client Experience Tool

Overview by Quality Dimensions

Accreditation Canada defines quality in health care using eight dimensions that represent key service elements. Each criterion in the standards is associated with a quality dimension. This table shows the number of criteria related to each dimension that were rated as met, unmet, or not applicable.

Quality Dimension	Met	Unmet	N/A	Total
Population Focus (Work with my community to anticipate and meet our needs)	99	6	2	107
Accessibility (Give me timely and equitable services)	162	1	0	163
Safety (Keep me safe)	812	28	32	872
Worklife (Take care of those who take care of me)	179	13	3	195
Client-centred Services (Partner with me and my family in our care)	594	31	5	630
Continuity (Coordinate my care across the continuum)	134	1	3	138
Appropriateness (Do the right thing to achieve the best results)	1277	64	41	1382
Efficiency (Make the best use of resources)	67	2	9	78
Total	3324	146	95	3565

Overview by Standards

The Qmentum standards identify policies and practices that contribute to high quality, safe, and effectively managed care. Each standard has associated criteria that are used to measure the organization's compliance with the standard.

System-wide standards address quality and safety at the organizational level in areas such as governance and leadership. Population-specific and service excellence standards address specific populations, sectors, and services. The standards used to assess an organization's programs are based on the type of services it provides.

This table shows the sets of standards used to evaluate the organization's programs and services, and the number and percentage of criteria that were rated met, unmet, or not applicable during the on-site survey.

Accreditation decisions are based on compliance with standards. Percent compliance is calculated to the decimal and not rounded.

Standards Set	High Priority Criteria *			Other Criteria			Total Criteria (High Priority + Other)		
	Met	Unmet	N/A	Met	Unmet	N/A	Met	Unmet	N/A
	# (%)	# (%)	#	# (%)	# (%)	#	# (%)	# (%)	#
Governance	40 (88.9%)	5 (11.1%)	5	28 (82.4%)	6 (17.6%)	2	68 (86.1%)	11 (13.9%)	7
Leadership	48 (96.0%)	2 (4.0%)	0	84 (88.4%)	11 (11.6%)	1	132 (91.0%)	13 (9.0%)	1
Infection Prevention and Control Standards	40 (100.0%)	0 (0.0%)	0	29 (93.5%)	2 (6.5%)	0	69 (97.2%)	2 (2.8%)	0
Medication Management Standards	72 (98.6%)	1 (1.4%)	5	60 (98.4%)	1 (1.6%)	3	132 (98.5%)	2 (1.5%)	8
Biomedical Laboratory Services	67 (95.7%)	3 (4.3%)	2	100 (97.1%)	3 (2.9%)	2	167 (96.5%)	6 (3.5%)	4
Cancer Care	77 (100.0%)	0 (0.0%)	4	112 (98.2%)	2 (1.8%)	1	189 (99.0%)	2 (1.0%)	5
Child, Youth, and Family Services	81 (96.4%)	3 (3.6%)	0	97 (98.0%)	2 (2.0%)	0	178 (97.3%)	5 (2.7%)	0
Community-Based Mental Health Services and Supports	43 (95.6%)	2 (4.4%)	0	93 (98.9%)	1 (1.1%)	0	136 (97.8%)	3 (2.2%)	0

Standards Set	High Priority Criteria *			Other Criteria			Total Criteria (High Priority + Other)		
	Met	Unmet	N/A	Met	Unmet	N/A	Met	Unmet	N/A
	# (%)	# (%)	#	# (%)	# (%)	#	# (%)	# (%)	#
Critical Care Services	53 (91.4%)	5 (8.6%)	2	91 (95.8%)	4 (4.2%)	10	144 (94.1%)	9 (5.9%)	12
Diagnostic Imaging Services	63 (96.9%)	2 (3.1%)	3	65 (95.6%)	3 (4.4%)	1	128 (96.2%)	5 (3.8%)	4
Emergency Department	70 (97.2%)	2 (2.8%)	0	98 (99.0%)	1 (1.0%)	8	168 (98.2%)	3 (1.8%)	8
Home Care Services	48 (100.0%)	0 (0.0%)	0	72 (97.3%)	2 (2.7%)	1	120 (98.4%)	2 (1.6%)	1
Inpatient Services	57 (95.0%)	3 (5.0%)	0	83 (98.8%)	1 (1.2%)	1	140 (97.2%)	4 (2.8%)	1
Long-Term Care Services	54 (98.2%)	1 (1.8%)	1	94 (95.9%)	4 (4.1%)	1	148 (96.7%)	5 (3.3%)	2
Mental Health Services	46 (93.9%)	3 (6.1%)	1	81 (89.0%)	10 (11.0%)	1	127 (90.7%)	13 (9.3%)	2
Obstetrics Services	64 (90.1%)	7 (9.9%)	2	81 (93.1%)	6 (6.9%)	1	145 (91.8%)	13 (8.2%)	3
Perioperative Services and Invasive Procedures	106 (93.8%)	7 (6.2%)	2	101 (93.5%)	7 (6.5%)	1	207 (93.7%)	14 (6.3%)	3
Point-of-Care Testing	36 (94.7%)	2 (5.3%)	0	45 (93.8%)	3 (6.3%)	0	81 (94.2%)	5 (5.8%)	0
Primary Care Services	58 (98.3%)	1 (1.7%)	0	90 (98.9%)	1 (1.1%)	0	148 (98.7%)	2 (1.3%)	0
Public Health Services	47 (100.0%)	0 (0.0%)	0	66 (95.7%)	3 (4.3%)	0	113 (97.4%)	3 (2.6%)	0
Rehabilitation Services	43 (97.7%)	1 (2.3%)	1	76 (97.4%)	2 (2.6%)	2	119 (97.5%)	3 (2.5%)	3
Remote/Isolated Health Services	56 (98.2%)	1 (1.8%)	0	87 (98.9%)	1 (1.1%)	1	143 (98.6%)	2 (1.4%)	1
Reprocessing of Reusable Medical Devices	78 (92.9%)	6 (7.1%)	4	40 (100.0%)	0 (0.0%)	0	118 (95.2%)	6 (4.8%)	4

Standards Set	High Priority Criteria *			Other Criteria			Total Criteria (High Priority + Other)		
	Met	Unmet	N/A	Met	Unmet	N/A	Met	Unmet	N/A
	# (%)	# (%)	#	# (%)	# (%)	#	# (%)	# (%)	#
Transfusion Services	**65 (97.0%)**	**2 (3.0%)**	**9**	**55 (91.7%)**	**5 (8.3%)**	**9**	**120 (94.5%)**	**7 (5.5%)**	**18**
Total	1412 (96.0%)	59 (4.0%)	41	1828 (95.8%)	81 (4.2%)	46	3240 (95.9%)	140 (4.1%)	87

*** Does not includes ROP (Required Organizational Practices)**

Overview by Required Organizational Practices

A Required Organizational Practice (ROP) is an essential practice that an organization must have in place to enhance client safety and minimize risk. Each ROP has associated tests for compliance, categorized as major and minor. All tests for compliance must be met for the ROP as a whole to be rated as met.

This table shows the ratings of the applicable ROPs.

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Safety Culture			
Accountability for Quality (Governance)	Unmet	2 of 4	2 of 2
Patient safety incident disclosure (Leadership)	Unmet	4 of 4	0 of 2
Patient safety incident management (Leadership)	Unmet	4 of 6	0 of 1
Patient safety quarterly reports (Leadership)	Unmet	0 of 1	0 of 2
Patient Safety Goal Area: Communication			
Client Identification (Biomedical Laboratory Services)	Met	1 of 1	0 of 0
Client Identification (Cancer Care)	Met	1 of 1	0 of 0
Client Identification (Critical Care Services)	Met	1 of 1	0 of 0
Client Identification (Diagnostic Imaging Services)	Met	1 of 1	0 of 0
Client Identification (Emergency Department)	Met	1 of 1	0 of 0

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Communication			
Client Identification (Home Care Services)	Met	1 of 1	0 of 0
Client Identification (Inpatient Services)	Met	1 of 1	0 of 0
Client Identification (Long-Term Care Services)	Met	1 of 1	0 of 0
Client Identification (Mental Health Services)	Met	1 of 1	0 of 0
Client Identification (Obstetrics Services)	Met	1 of 1	0 of 0
Client Identification (Perioperative Services and Invasive Procedures)	Met	1 of 1	0 of 0
Client Identification (Point-of-Care Testing)	Met	1 of 1	0 of 0
Client Identification (Rehabilitation Services)	Met	1 of 1	0 of 0
Client Identification (Remote/Isolated Health Services)	Met	1 of 1	0 of 0
Client Identification (Transfusion Services)	Met	1 of 1	0 of 0
Information transfer at care transitions (Cancer Care)	Met	4 of 4	1 of 1
Information transfer at care transitions (Community-Based Mental Health Services and Supports)	Met	4 of 4	1 of 1

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Communication			
Information transfer at care transitions (Critical Care Services)	Met	4 of 4	1 of 1
Information transfer at care transitions (Emergency Department)	Met	4 of 4	1 of 1
Information transfer at care transitions (Home Care Services)	Met	4 of 4	1 of 1
Information transfer at care transitions (Inpatient Services)	Met	4 of 4	1 of 1
Information transfer at care transitions (Long-Term Care Services)	Met	4 of 4	1 of 1
Information transfer at care transitions (Mental Health Services)	Met	4 of 4	1 of 1
Information transfer at care transitions (Obstetrics Services)	Met	4 of 4	1 of 1
Information transfer at care transitions (Perioperative Services and Invasive Procedures)	Met	4 of 4	1 of 1
Information transfer at care transitions (Rehabilitation Services)	Met	4 of 4	1 of 1
Information transfer at care transitions (Remote/Isolated Health Services)	Met	4 of 4	1 of 1
Medication reconciliation as a strategic priority (Leadership)	Met	3 of 3	2 of 2
Medication reconciliation at care transitions (Cancer Care)	Met	5 of 5	0 of 0

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Communication			
Medication reconciliation at care transitions (Community-Based Mental Health Services and Supports)	Met	3 of 3	1 of 1
Medication reconciliation at care transitions (Critical Care Services)	Met	4 of 4	0 of 0
Medication reconciliation at care transitions (Emergency Department)	Met	1 of 1	0 of 0
Medication reconciliation at care transitions (Home Care Services)	Met	3 of 3	1 of 1
Medication reconciliation at care transitions (Inpatient Services)	Met	4 of 4	0 of 0
Medication reconciliation at care transitions (Long-Term Care Services)	Met	4 of 4	0 of 0
Medication reconciliation at care transitions (Mental Health Services)	Met	4 of 4	0 of 0
Medication reconciliation at care transitions (Obstetrics Services)	Met	4 of 4	0 of 0
Medication reconciliation at care transitions (Perioperative Services and Invasive Procedures)	Met	4 of 4	0 of 0

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Communication			
Medication reconciliation at care transitions (Remote/Isolated Health Services)	Met	5 of 5	0 of 0
Safe Surgery Checklist (Obstetrics Services)	Met	3 of 3	2 of 2
Safe Surgery Checklist (Perioperative Services and Invasive Procedures)	Met	3 of 3	2 of 2
The "Do Not Use" list of abbreviations (Medication Management Standards)	Met	4 of 4	3 of 3
Patient Safety Goal Area: Medication Use			
Antimicrobial Stewardship (Medication Management Standards)	Unmet	4 of 4	0 of 1
Concentrated Electrolytes (Medication Management Standards)	Met	3 of 3	0 of 0
Heparin Safety (Medication Management Standards)	Met	4 of 4	0 of 0
High-Alert Medications (Medication Management Standards)	Met	5 of 5	3 of 3
Infusion Pumps Training (Cancer Care)	Met	4 of 4	2 of 2
Infusion Pumps Training (Critical Care Services)	Met	4 of 4	2 of 2
Infusion Pumps Training (Emergency Department)	Met	4 of 4	2 of 2
Infusion Pumps Training (Inpatient Services)	Met	4 of 4	2 of 2

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Medication Use			
Infusion Pumps Training (Obstetrics Services)	Met	4 of 4	2 of 2
Infusion Pumps Training (Perioperative Services and Invasive Procedures)	Met	4 of 4	2 of 2
Infusion Pumps Training (Remote/Isolated Health Services)	Met	4 of 4	2 of 2
Narcotics Safety (Medication Management Standards)	Met	3 of 3	0 of 0
Patient Safety Goal Area: Worklife/Workforce			
Client Flow (Leadership)	Met	7 of 7	1 of 1
Patient safety plan (Leadership)	Met	2 of 2	2 of 2
Patient safety: education and training (Leadership)	Met	1 of 1	0 of 0
Preventive Maintenance Program (Leadership)	Met	3 of 3	1 of 1
Workplace Violence Prevention (Leadership)	Unmet	3 of 5	3 of 3
Patient Safety Goal Area: Infection Control			
Hand-Hygiene Compliance (Infection Prevention and Control Standards)	Met	1 of 1	2 of 2
Hand-Hygiene Education and Training (Infection Prevention and Control Standards)	Met	1 of 1	0 of 0

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Infection Control			
Infection Rates (Infection Prevention and Control Standards)	Met	1 of 1	2 of 2
Patient Safety Goal Area: Risk Assessment			
Falls Prevention Strategy (Cancer Care)	Met	2 of 2	1 of 1
Falls Prevention Strategy (Critical Care Services)	Met	2 of 2	1 of 1
Falls Prevention Strategy (Inpatient Services)	Met	2 of 2	1 of 1
Falls Prevention Strategy (Long-Term Care Services)	Met	5 of 5	1 of 1
Falls Prevention Strategy (Mental Health Services)	Met	2 of 2	1 of 1
Falls Prevention Strategy (Obstetrics Services)	Met	2 of 2	1 of 1
Falls Prevention Strategy (Perioperative Services and Invasive Procedures)	Met	2 of 2	1 of 1
Falls Prevention Strategy (Rehabilitation Services)	Met	2 of 2	1 of 1
Home Safety Risk Assessment (Home Care Services)	Met	3 of 3	2 of 2
Pressure Ulcer Prevention (Critical Care Services)	Met	3 of 3	2 of 2
Pressure Ulcer Prevention (Inpatient Services)	Met	3 of 3	2 of 2

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Risk Assessment			
Pressure Ulcer Prevention (Long-Term Care Services)	Met	3 of 3	2 of 2
Pressure Ulcer Prevention (Perioperative Services and Invasive Procedures)	Met	3 of 3	2 of 2
Pressure Ulcer Prevention (Rehabilitation Services)	Met	3 of 3	2 of 2
Skin and Wound Care (Home Care Services)	Met	7 of 7	1 of 1
Suicide Prevention (Child, Youth, and Family Services)	Met	5 of 5	0 of 0
Suicide Prevention (Community-Based Mental Health Services and Supports)	Met	5 of 5	0 of 0
Suicide Prevention (Emergency Department)	Met	5 of 5	0 of 0
Suicide Prevention (Long-Term Care Services)	Met	5 of 5	0 of 0
Suicide Prevention (Mental Health Services)	Met	5 of 5	0 of 0
Suicide Prevention (Remote/Isolated Health Services)	Met	5 of 5	0 of 0
Venous Thromboembolism Prophylaxis (Critical Care Services)	Met	3 of 3	2 of 2
Venous Thromboembolism Prophylaxis (Inpatient Services)	Met	3 of 3	2 of 2

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Risk Assessment			
Venous Thromboembolism Prophylaxis (Perioperative Services and Invasive Procedures)	Met	3 of 3	2 of 2

Summary of Surveyor Team Observations

The surveyor team made the following observations about the organization's overall strengths, opportunities for improvement, and challenges.

Board of Directors

The 8 voting members and 1 ex officio member of the Northwest Territories Health and Social Services Authority Leadership Council have advanced, from a Governance Perspective in leaps and bounds over the past few years. From the creation of the Authority in 2016 to the development of by-laws in 2017 to the approval of a Governance Manual in 2019, all steps taken have moved the Council along the continuum towards being a high functioning Governance Board.
The introduction of Council Sub-Committees in Governance/Human Resources, Finance and Quality have added some discipline to the Council's structure that will allow it to focus more responsibly on the duties in front of it, notably quality improvement, risk mitigation, system leadership and fiscal integrity.

Community engagement is strong through the Regional Wellness Councils across the geography of the NTHSSA. Having representation from the other 2 Territorial Authorities will complement this engagement and will help all Authorities streamline and better coordinate care. Given the recent focus on quality, including the endorsement of an Ethics Framework and the 1st receipt at the Board level, of quality indicators, the Survey Team is confident that the many initiatives started by the Council will continue to develop momentum moving forward. Not only will this momentum be good for the Council as it grows as a Board, it will also be important for the organization to have in setting the tone for the next few years. A great example of how the Council can set the tone is around the ongoing focus on Cultural Sensitivity Training, something of which the organization should be very proud.

Lastly, with Governance, the survey team was very impressed with the addition of a Senior Adviser to support the Leadership Council. This role will be key in continuing to support the Board as it assumes more accountabilities moving forward.

Leadership

To say that the NTHSSA has and continues to undergo massive change is an understatement. On top of the significant energy and effort currently being expended to move a relatively new, geographically disparate organization forward on multiple fronts, the leadership has been faced with multiple challenges: opening a brand new hospital, major government employee unrest, ongoing funding challenges, a very tight recruitment market, operating in likely the most culturally diverse region in Canada, preparing for accreditation and, ensuring that the quality of care offered to the thousands of people who look to the organization for care and support is maintained. The organization should be proud of what it continues to accomplish however needs to also recognize that there are implications when undergoing the level of change currently being experienced. As such, strengthening the resources available to team members to effectively deal with change should be a priority. The organization is certainly commended for the efforts it is making in supporting team members through Assistance Programs and making sure Occupational Health and Safety policies and frameworks are reflective of the realities of the day. There are numerous, strong programs that team members can access and enhanced efforts in making sure that this is happening will be important.

The survey team was very impressed with the advances that have been made across the Authority during these formative years and recognized that the NTHSSA is still very early on in its evolution. If we use the analogy of the four phases of effective team development - form, storm, norm and perform, it is not surprising that the organization remains in the "storming phase." It is not unreasonable to assume a –five-seven-year window for the changes contemplated with the formation of the Authority to make their way fully through the organization to the patient. There is a "tipping point" however where the work that is currently being undertaken will suddenly take hold. The Survey Team felt that the organization was putting all the key supports in place around quality, engagement, risk mitigation, ethics, resource integrity, education, recruitment and retention, governance, relationships, and policy frameworks and that the challenges faced with change will begin to dissipate. That said, clear investment strategies around information technology and capital infrastructure need are not contemplated through the ever-greening program will be necessary. The standardized financial systems and the resulting ability to better mine data and develop decision supports will be key in this evolution, as will a strong, contemporary, standardized policy framework.

A visible and responsive leadership team is key in times of major change and while these areas are strong, specific strategies, such as leader rounding should be contemplated to help reinforce communication channels.

Community and Community Partnerships

All of the Community Partnerships witnessed were respectful and committed to doing what is in the best interests of those being served. Strong partnerships existed with Public Health, and the Regional Wellness Councils.

The overall tone of discussions with Partners was very positive. Everyone understands the implications of change – all are undergoing it and recognize that with change comes new relationships. All are keenly interested in growing these relationships to benefit the communities they serve.

Staffing and Worklife

Strong, interdisciplinary teams were noted across all organizations and programs visited by the Survey Team. There was a clear belief that the organization valued safety and staff were very appreciative of the increases noted in training and development. As healthcare professionals that work closely together, there was a noted spirit of collegiality and support. On-boarding (orientation) was mentioned as being strong, particularly by locum staff attending the organization for short periods of time.

The organization is commended for moving forward with a number of key corporate initiatives, such as the new Ethics Framework, and staff look forward to having education opportunities around this and other organizational priorities.

Surveyors did note some challenges with morale and, although this may be expected due to the transformation. Employee opinion surveys have reinforced the need for stronger communication, and this is being assessed. Staff at the Stanton Territorial Hospital are also dealing with the pressures of getting used to new space and new relationships, both of which create stress. There were also some recent labor challenges through the collective agreement process, and this too would certainly impact work life. Overall, the Survey Team felt that the organization had, or would be developing the right tools to support staff through various changes and to make sure that they were looking after their own well-being.

One key priority area for the organization is advancing its quality agenda, focusing on quality improvement and risk mitigation. The program is in its infancy and what to expect is not clearly understood across the organization. It might be beneficial therefore to consider doing some Plan-Do-Study-Act (PDSA) cycles with some units to look at Incident reporting, feedback and closing the loop. The staff could then inform the process moving forward, strengthen the use of quality boards for their units, and broaden the emphasis of huddle discussions to include not only education but also general updates and reviews of metrics.

Supporting staff through processes such as Performance Appraisals also needs to be raised. The organization is commended for introducing an electronic platform; however, completion rates remain low. This could be impacted by spans of control and/or competing priorities however growth and development depends to a large degree to feedback on performance.

Delivery of Care and Services

To a person, every patient and family member engaged throughout the accreditation process reinforced the care and compassion exhibited by the NTHSSA Team in all aspects of the organization. Enhancing the involvement of patients/families in the overall operation of the organization will further strengthen this relationship. Considering bedside transfer of accountability, where patients and family members can engage first hand in care discussions is another consideration for strengthening the staff-patient relationship. As noted above, trialing through a PDSA cycle might alleviate some of the anxiety with a change of this type.

There were no patient flow issues noted across the organization and people very much valued the efforts to ensure care closer to home through visiting specialists and other healthcare professionals to rural and remote communities. The Med-Response service was highly regarded, and a number of team members highlighted the residency training program in place as one more way to strengthen immediate and future delivery of care and services.

Client Satisfaction

All clients engaged said that they received excellent care. Patient satisfaction was very strong, with all saying they were treated with care, dignity, and respect. Ongoing efforts are made to support cultural needs and expectations, with food always being a major focus.

The Survey Team commends the entire Team of the Northwest Territories Health and Social Services Authority for its commitment to delivering compassionate, high-quality care to the population it supports. Significant advances have been made since the last accreditation visit and all can be proud of the organization NTHSSA has become. It was a privilege visiting your organizations and communities, and meeting as many engaged, enthusiastic people as we did.

Detailed Required Organizational Practices

Each ROP is associated with one of the following patient safety goal areas: safety culture, communication, medication use, worklife/workforce, infection control, or risk assessment.

This table shows each unmet ROP, the associated patient safety goal, and the set of standards where it appears.

Unmet Required Organizational Practice	Standards Set
Patient Safety Goal Area: Safety Culture	
Patient safety quarterly reports The governing body is provided with quarterly reports on patient safety that include recommended actions arising out of patient safety incident analysis, as well as improvements that were made.	· Leadership 15.10
Patient safety incident management A patient safety incident management system that supports reporting and learning is implemented.	· Leadership 15.4
Patient safety incident disclosure A documented and coordinated approach to disclosing patient safety incidents to clients and families, that promotes communication and a supportive response, is implemented.	· Leadership 15.6
Accountability for Quality The governing body demonstrates accountability for the quality of care provided by the organization.	· Governance 12.1
Patient Safety Goal Area: Medication Use	
Antimicrobial Stewardship There is an antimicrobial stewardship program to optimize antimicrobial use. NOTE: This ROP applies to organizations providing the following services: inpatient acute care, inpatient cancer, inpatient rehabilitation, and complex continuing care.	· Medication Management Standards 2.3

Unmet Required Organizational Practice	Standards Set
Patient Safety Goal Area: Worklife/Workforce	
Workplace Violence Prevention **A documented and coordinated approach to prevent workplace violence is implemented.**	· Leadership 2.12

Detailed On-site Survey Results

This section provides the detailed results of the on-site survey. When reviewing these results, it is important to review the service excellence and the system-wide results together, as they are complementary. Results are presented in two ways: first by priority process and then by standards sets.

Accreditation Canada defines priority processes as critical areas and systems that have a significant impact on the quality and safety of care and services. Priority processes provide a different perspective from that offered by the standards, organizing the results into themes that cut across departments, services, and teams.

For instance, the patient flow priority process includes criteria from a number of sets of standards that address various aspects of patient flow, from preventing infections to providing timely diagnostic or surgical services. This provides a comprehensive picture of how patients move through the organization and how services are delivered to them, regardless of the department they are in or the specific services they receive.

During the on-site survey, surveyors rate compliance with the criteria, provide a rationale for their rating, and comment on each priority process.

Priority process comments are shown in this report. The rationale for unmet criteria can be found in the organization's online Quality Performance Roadmap.

See Appendix B for a list of priority processes.

INTERPRETING THE TABLES IN THIS SECTION: The tables show all unmet criteria from each set of standards, identify high priority criteria (which include ROPs), and list surveyor comments related to each priority process.

High priority criteria and ROP tests for compliance are identified by the following symbols:

!	High priority criterion
ROP	Required Organizational Practice
MAJOR	Major ROP Test for Compliance
MINOR	Minor ROP Test for Compliance

Priority Process Results for System-wide Standards

The results in this section are presented first by priority process and then by standards set.

Some priority processes in this section also apply to the service excellence standards. Results of unmet criteria that also relate to services should be shared with the relevant team.

Priority Process: Governance

Meeting the demands for excellence in governance practice.

Unmet Criteria		High Priority Criteria
Standards Set: Governance		
7.9	The governing body oversees the development of the organization's talent management plan.	!
8.5	The governing body verifies that documented processes for appeals of decisions regarding privileges are followed.	!
10.3	The governing body addresses recommendations made in the organization's quarterly patient safety reports.	
10.4	The governing body regularly reviews the frequency and severity of safety incidents and uses this information to understand trends, client and team safety issues in the organization, and opportunities for improvement.	!
12.1	The governing body demonstrates accountability for the quality of care provided by the organization.	ROP
12.1.3	The key system-level indicators that will be used to monitor the quality performance of the organization are identified.	MAJOR
12.1.4	At least quarterly, the quality performance of the organization is monitored and evaluated against agreed-upon goals and objectives.	MAJOR
12.3	The governing body ensures that an integrated risk management approach and contingency plans are in place.	!
12.4	The governing body receives summary reports of client and family complaints received by the organization.	

12.5	The governing body monitors and provides input into the organization's strategies to address client flow and variations in service demands.	
12.6	The governing body promotes learning from results, making decisions that are informed by research and evidence, and ongoing quality improvement for the organization and the governing body.	

Surveyor comments on the priority process(es)

No area within the NTHSSA has gone through as much change as the Leadership Council. Since the formation of the Authority in 2016, there has been a constant evolution of the Council to what we see today.

Comprised of 6 Regional Wellness Council Chairs, the Chair of the Tlicho Community Services Agency, a Chair of the Council and the Territories Deputy Minister in an ex officio capacity, the Council has been steadily putting into the place, the governance components that will move it along the continuum of best practice. The introduction of comprehensive by-laws in 2017 assured that the structure and function of the Council were focused on the appropriate governance accountabilities. Now operating with 3 sub-committees - Finance, Quality, and Governance and Human Resources, the Council is beginning to implement the structures necessary to meet governance expectations.

Key in the evolution of the Council has been the appointment of a Senior Advisor, Governance. In this role, the incumbent provides strategic advice to the Chair and Council Members, acts as a liaison with the Department of Health, and plans and directs the operation of the Council in relation to all of its various activities, including communicating same across the NTHSSA and the Territories more broadly.

With the Council being "early days" with a number of initiatives, there is a significant opportunity to grow skills and expertise over time. Good examples of this are in the areas of quality, patient safety, and risk mitigation. It is noted with approval that the Council is beginning to receive structured information in the areas noted above. There is not enough of a body of work however to feel confident that the Council is receiving what it needs to effectively administer its oversight role in these important areas. The organization, therefore, is urged to continue to develop these areas and to formalize quarterly, action-oriented reports for the Council's review and action.

The internal operations of the Council are evolving nicely. Commendations for the in-meeting evaluations and it is important to see the approval of a self assessment process moving forward. Board orientation appears appropriate and with the introduction of an education piece at the beginning of each meeting, Members are given the opportunity to develop a detailed understanding of key issues. A good example of this is the recent Ethics training undertaken by the Council resulting in changes to the Ethics framework and a clear appreciation of the need to run decisions through a structured framework when making them. Of particular note, the Council is commended for the leadership it is exhibiting in cultural sensitivity training.

An area that the Council can take a further leadership role is with Person/Family Centered Care. The organization has a real opportunity to strategically engage patients and family members in broader

organization has a real opportunity to strategically engage patients and family members in broader NTHSSA planning. In some Boards, Patient Partners are now showing up as ex officio Members, to ensure that this important voice is heard directly at the governance table. Regardless of whether or not the Council determines this a wise decision, ensuring a strong framework across the organization will be important. One of the leading practices of this Council is how it engages its communities through the Regional Wellness Council. The benefits of this type of community engagement to the organization can be mirrored in the area of patients and family participation with the right philosophy.

There are a number of areas of accountability where the Council is continuing to strengthen its mandate. These include the areas of Talent Management and Quality oversite. Both areas are key operational areas of focus and it is expected that the Council will begin to see more structured reports moving forward. It is expected that the reporting supports will move towards those currently received through the financial reporting processes i.e. variance reporting. On the issue of financial reporting, the information does seem comprehensive however the fiscal reality faced by the organization is going to require continued Council Leadership. Notably, while the organization has benefited significantly through the Ever-Green Program with the government, there are a number of capital investments that fall outside this Program that require NTHSSA attention. Leading the way are the organization's Information Technology infrastructure needs. Staff is aware of investment requirements, and a corporate, Council endorsed strategy to address this will be important. This is one of a number of areas that attention will be required, as is the reality for all Healthcare Boards across the country.

A number of the questions addressed in the Governance Priority Process speak to the Credentialing of Members of the Professional Staff. While the processes reviewed meet the expectations in the standards, the one area that should be revisited is the Board's ultimate role in approving privileges. Currently, the process falls exclusively under the purview of the Medical Staff. Given the accountability that rests with the Council for the quality of care and the fiscal integrity of the organization, to be outside of this process is viewed as a risk. Council Members are not required to have a detailed understanding of medicine to approve privileges however they are accountable for ensuring that the processes in place for appointing and removing members of the Medical Staff apply the appropriate level of rigor. Elevating the final approvals to the Council level will also support the organizations' medical leadership should specific legal concerns arise as a result of the credentialing process.

The Council should be very proud of the wonderful care being provided across the NTHSSA and of its role in ensuring this occurs. Incredible advances have been made over the past 3 years in Governance and with the Authority.

Priority Process: Planning and Service Design

Developing and implementing infrastructure, programs, and services to meet the needs of the populations and communities served.

Unmet Criteria		High Priority Criteria
Standards Set: Leadership		
1.5	Policies addressing the rights and responsibilities of clients are developed and implemented with input from clients and families.	
1.6	Input is sought from clients and families during the organization's key decision-making processes.	
4.1	There is a process to develop or update the mission statement with input from team members, clients, families, and key stakeholders.	
6.5	Formal strategies or processes are used to manage change.	

Surveyor comments on the priority process(es)

This organization has done a tremendous amount of work on its mission, vision, values and strategic planning. Collaboration on the same came from many sectors of the organization and external partners. It is encouraged that patients and families be further included in these important processes in a more robust manner.
Services are very in touch with the communities in which they operate. Staff and leaders gather information about their communities through various means. This success in community engagement can be used to leverage enhanced patient and family engagement. A Community Partners Focus Group was held with representatives of the following: Tlicho; Nunavut; Indigenous Advisory Board; Inuvialuit Regional Corporation; Alberta Health Services; Yellowknife Women's Centre; Department of Health & Social Services; and Northwest Territories Disabilities Council. Comments shared included:

-the relationship is good, it isn't hierarchical – trying to figure some things out – engage with all 3 Authorities and involved in the strategic plan

-lots of back and forth dialogue – involved in quarterly business planning discussions; part of weekly executive management calls; doing MOU's with Authority – looking at further agreements i.e. IT structural supports; roles and responsibilities being defined;

-Knowing who does what would be beneficial – amalgamation has influenced the relationships;

-Some people are being sent "south" when services would be better offered locally

-catalyst around developing framework for persons with disabilities; very involved in the framework and action plan– lots of work ongoing;

-work with post-secondary; core funding is a challenge – dealing with salary and job security; NGO's not given the same status; pay equity;

-the amalgamation of Boards has changed service delivery – hard to contact people – in the community seems like services are being centralized to Yellowknife – lab as an example from Fort Smith;

-Indigenous Advisory Council – hard to have meetings when people are so disparate; cultural competence and safety; smudging protocols not widely subscribed – need to make space for things like this

-have the Indigenous Health and Wellness Department – does a great job; lots of work around image;

-Regional Wellness Councils accessible to all, and communication has improved.

Priority Process: Resource Management

Monitoring, administering, and integrating activities related to the allocation and use of resources.

Unmet Criteria	High Priority Criteria
Standards Set: Leadership	
8.10 Reports on financial performance include an analysis of the utilization of resources and outline opportunities to improve the effective and efficient use of resources.	!

Surveyor comments on the priority process(es)

A good discussion with NTHSSA staff took place, focusing on highlights of the budgeting processes, strengths and opportunities in front of the organization.

Each fall, the NTHSSA receives a "Call Letter" from the Department of Health and Social Services that initiates the annual budgeting cycle. This provides context to the financial support the Authority can expect during the coming year and allows for internal planning. This planning primarily engages the Leadership Council, Regional Wellness Councils and the Senior Leadership. The ultimate approval of the budget to submit to the government is through the Leadership Council. As the process evolves, more active engagement of front line managers should be contemplated.

Once approved and authorized, the organization monitors the budget through Quarterly Variance Reports that are developed in consultation with Managers and Leaders across the organization. This is facilitated by the development of an Annual Operational Plan that defines key priority areas of focus falling out of the Territorial Health and Social Services Strategic Plan. An Operational Priority Tracker has been implemented to further assist in the variance reporting processes, as well as year-end financial projections.

On the formation of the NTHSSA in 2016, the accumulated debt, and the "in-year" operating deficits of the founding Authorities were transferred to the new organization. This legacy funding shortfall when comparing actual expenses to actual revenues now sits at close to $100 million across all 3 Health Authorities. There are no current plans in place to address this funding shortfall however there is an elevated appreciation of the need to begin focusing on efficiency and effectiveness opportunities driven by quality. Documents such as "Budget Pressure Mitigation," and Toward a Better Future – Strengthening the HSS are starting to focus discussions more on the sustainability of the Territorial Health System. The latter, a Joint Planning Task Force of Finance, the NTHSSA and HSS begin to look at opportunities across the system to better utilize resources, to improve the overall value of the system and, to improve quality and access to care.

Key in addressing any opportunities to enhance quality through efficiency and effectiveness of service

delivery is the soon to be implemented "SAM" financial system. This will allow for the elimination of disparate legacy financial systems from the founding Authorities, and the introduction of one, integrated financial system. The team is commended for their energy and effort in moving this installation forward to reality early in 2020. The system, combined with the internal restructuring undertaken across the Finance portfolio – aligning accountabilities around an Analytical Group, an Operational Group and a Procurement and Contracting group, will place the team in a much better place to support the ongoing fiscal and planning needs of NTHSSA. On the latter point, an expectation of the new system is the generation of more real time reports for front line managers that will allow for more proactive resource planning and decision making. A precursor to this will be an effort to work with managers and leaders within the NTHSSA to determine which indicators and reports will best allow for the proactive management of the organization.

Despite an imperative to address the ongoing NTHSSA deficit, the organization very much appreciates that opportunities exist to "bend the cost curve" while maintaining and enhancing the quality of care. As such, significant effort will be placed standardizing care and processes across the NTHSSA in the coming years. Initiatives such as joining HealthPro are supported, as are efforts to streamline through enhanced warehousing opportunities, best practice implementation, such as Choosing Wisely Canada and Primary Care Reform, critically assessing spending patterns in the new Stanton Territorial Hospital, implementing overall systems alignment and, moving forward on recommendations in Reports such as the previously noted "Toward a Better Future." In this report, a number of opportunities have been identified that warrant further discussion. Issues such as maximizing 3rd Party payment for drugs issued by the Authority where Pharmacies do not exist locally, and better coordinating care for patients requiring multiple touches into the system have the opportunity to save millions while only enhancing patient/client satisfaction i.e. travel coordination, NP vs GP monthly clinics.

The organization is also urged to continue to discuss opportunities with the GNWT to streamline and standardize care and systems across the Territories. These discussions also need focus on the funding pressures faced across the healthcare system, notably salaries and benefits. As an example, current Territorial revenue calculations are based on staff being at Step 4 of their salary grid when, in fact, most staff are on higher pay grids. This built in deficit will continue to put additional fiscal pressure on the NTHSSA and will expedite the need to address the ongoing, annual operating deficit.

The organization will also need to closely monitor the relationship between it and Dexterra through the Stanton Territorial Hospital. Short term experience highlights the need to strengthen relationships and to get a clearer picture of the financial implications of the arrangements in place. There will always be a creative tension between care providers and building operators and it will be important for NTHSSA to strike the right balance into the future.

The Team is to be commended for the effort and focus they are bringing to the Resources portfolio of the NTHSSA. Ongoing restructuring and system investments are placing the organization in a much better place when it comes to Decision Support and proactive planning, and the passion and commitment of all involved are noted.

Priority Process: Human Capital

Developing the human resource capacity to deliver safe, high quality services.

Unmet Criteria		High Priority Criteria
Standards Set: Leadership		
2.12	A documented and coordinated approach to prevent workplace violence is implemented.	ROP
2.12.1	There is a written workplace violence prevention policy.	MAJOR
2.12.2	The policy is developed in consultation with team members and volunteers as appropriate.	MAJOR
2.14	Process and outcome measures related to worklife and the work environment are identified and monitored.	
10.5	There is a talent management plan that includes strategies for developing leadership capacity and capabilities within the organization.	

Surveyor comments on the priority process(es)

When bringing multiple, disparate organizations together, one of the most challenging pieces of the process is the creation of standardized practices and approaches relative to human resource management and oversight. The NTHSSA has made significant strides in this area and is urged to continue with the directions being pursued.

Human Resources is provided by both the NTHSSA and the Government of the Northwest Territories. There are clear delineations of accountabilities and both parties work very well together. The recent hiring of a Territorial Lead, Occupational Health and Safety will go a long way towards standardizing and updating materials and processes in this important area. The most recent Worklife Pulse results reinforced that it is an area that requires attention, and discussions with staff highlighted a desire to see more structure and consistency in this area. Policies reviewed highlighted variability so it is important that the organization refreshes all policies at the NTHSSA level. Good examples are the Prevention of Workplace Violence policy shared – a policy from the Stanton Territorial Health Authority, last reviewed in 2015, and the Code of Conduct, a GNWT Policy developed in 2008. The organization is commended for the broad approach it is taking to work life culture, including in areas such as Duty to Accommodate, domestic leave embedded in collective agreements, addressing family violence and the 2019 Operation Plan. On this latter point, the organization is commended for the increased emphasis being placed on cultural safety. The organization is also commended for the roll-out of RL6 and it was good to see that the system is starting to be used for trending and priority setting. Moving forward, developing robust reports for all in the organization to review, including the Leadership Council will be important.

The organization is commended for the introduction of ePerformance Reporting. Files reviewed

highlighted a streamlined approach to performance management. The completion rate of Performance Reporting is an area of focus for the organization. With spans of control in some cases of upwards of 90 staff, plus the remoteness of many regions of the Authority, staying on top of this is a challenge. That said, contemplating introducing processes such as Rounding with Staff and Huddles on floors may make this process easier.

Kudos are extended to the organization for their ongoing efforts to strengthen both on-boarding and the training and development opportunities for staff. On the latter, this is a key area of focus for retention and the additional efforts and resources dedicated to this important area are noted with approval. Many processes within the organization are manual and the organizations' efforts to automate more of their learning programs are supported. Recent staffing additions in this area reflect the organization's commitment to learning, and they are noted.
Patient safety training for staff is being strengthened, with the involvement of quality and nurse educators. There are training opportunities on the website and work with the department of finance around a learning management system is ongoing. The Plan is to have this system online by April 2020, with the goal being more continuity, staff development officers within major areas, nurse educator mentors and train the trainers.

The Manager role is often the most difficult one from a training perspective and the organization is commended for looking at a leadership series for front line managers.

The organization is commended for regularly surveying the organization around work life. Most recently, kudos were received around staff feeling they are treated with respect, staff wanting to refer the organization to friends, and understanding expectations. The flip side of this is the desire for more communication and feedback, and a greater emphasis on occupational health and safety. By proactively collecting this information, the organization is able to set appropriate priorities across the human resources portfolio, something it is doing well at this point in time.

The Employee and Family Assistance Program is noted with approval and the services offered appear comprehensive and well subscribed. The updating of the internal website has been well received, and the focus on social activities and employee recognition are viewed positively.

The organization is commended for its efforts in recruitment. Creating interest in health with students and youth is a focus, using social media as a key engagement tool. Significant work is focusing on strengthening analytics, allowing the organization to model various staffing scenarios in the future. While there is not a formal Talent Management Plan, the goal is to develop one in line with the soon to be refreshed Territorial strategic plan. Visibility of the organization is good at conferences and recruitment fairs, with efforts to "virtually recruit" increasing. This increased emphasis is also with youth through initiatives such as the REACH program to students, youth career fairs, and take you kid to school day. Practicum placements are supported, with growth seen over the recent months, notably with Aurora College. One of the recognized challenges moving forward is recruiting local people to the organization.

The Human Resources Team is to be commended. Engagement levels are improving, uptake on learning

opportunities has at least doubled, there is a commitment to investing further in staff retention and the commitment to automation is going to significantly advance the organization on multiple fronts. The organization has come a long way in a short period of time, and it is commended for this. Efforts to strengthen communication will further advance important standardization efforts and the refreshed strategic plan will help significantly in resetting priorities.

Priority Process: Integrated Quality Management

Using a proactive, systematic, and ongoing process to manage and integrate quality and achieve organizational goals and objectives.

Unmet Criteria		High Priority Criteria
Standards Set: Leadership		
12.2	The organization's leaders implement an integrated risk management approach to mitigate and manage risk.	!
12.5	The effectiveness of the integrated risk management approach is regularly evaluated and improvements are made as necessary.	
15.4	A patient safety incident management system that supports reporting and learning is implemented.	ROP
15.4.1	A patient safety incident management system is developed, reviewed, and updated with input from clients, families, and team members, and includes processes to report, analyze, recommend actions, and monitor improvements.	MAJOR
15.4.5	All recommended actions resulting from the analysis of patient safety incidents are reviewed and the rationale to accept, reject, or delay implementation is documented.	MAJOR
15.4.7	The effectiveness of the patient safety incident management system is evaluated and improvements are made based on feedback received. Evaluation mechanisms may include: • Gathering feedback from clients, families, and team members about the system • Monitoring patient safety incident reports by type and severity • Examining whether improvements are implemented and sustained • Determining whether team members feel comfortable reporting patient safety incidents (e.g., based on results from the Canadian Patient Safety Culture Survey Tool).	MINOR
15.6	A documented and coordinated approach to disclosing patient safety incidents to clients and families, that promotes communication and a supportive response, is implemented.	ROP

	15.6.2	The disclosure process is reviewed and updated, if necessary, once per accreditation cycle, with input from clients, families, and team members.	MINOR
	15.6.6	Feedback is sought from clients, families, and team members about their experience with disclosure and this information is used to make improvements, when needed, to the disclosure process.	MINOR
15.10	The governing body is provided with quarterly reports on patient safety that include recommended actions arising out of patient safety incident analysis, as well as improvements that were made.		ROP
	15.10.1	Quarterly patient safety reports are provided to the governing body.	MAJOR
	15.10.2	The quarterly patient safety reports outline specific organizational activities and accomplishments in support of the organization's patient safety goals and objectives.	MINOR
	15.10.3	The governing body supports the patient safety activities and accomplishments and acts on the recommended actions in the quarterly patient safety reports.	MINOR

Surveyor comments on the priority process(es)

Quality Improvement is a top priority for this organization. They acknowledge that fulsome family engagement is in the early stages and are constantly discussing ways in which to improve this. There are several examples of patient feedback and the ways in which patients are involved in the direction of their healthcare. Some sectors are demonstrating family engagement, however, this is not evident throughout the entire organization.

Patient, client, resident engagement is more evident throughout the organization and there are plans to enhance this on an ongoing basis.

Feedback comes to the organization in many forms including satisfaction surveys upon discharge, online via the patient relations office, through the MLAs or Minister's office and other means.

Due to geography and other realities such as inconsistent phone and Internet service to some communities, there are real obstacles to family engagement. However, the organization must place this at the highest priority in order to have a well-rounded patient experience.

Every department at Stanton Hospital has a Quality Board which is used to inform the public about Quality Initiatives. There is also a virtual suggestion box on the public and the internal websites.

Community relations are of high priority. The Inuvik team met with community members in order to discuss the design options for a new build that is planned there. Long Term Care in Norman Wells changed the auto-lock hours on the front door at that site as a result of feedback from families who were visiting residents.

There were several examples of impressive QI projects that have been trialed and then implemented as standard throughout the healthcare organization.

Priority Process: Principle-based Care and Decision Making

Identifying and making decisions about ethical dilemmas and problems.

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

NTHSSA has recently adopted a new Ethics Framework and entered into a partnership with Alberta Health Services to access the services of an Ethicist. The organization is commended for the approach it has taken in adopting the framework, notably the work done with the Leadership Council to ensure strong engagement and support at that level. Changes were made to the draft Framework as a result, with a clear strengthening of the focus on cultural awareness and sensitivity. The Committee incorporates a very good representation from across the Territory, and it is noted with approval that the Territorial Ethics Committee supports both Health Authorities and the Agency, thereby encompassing all providers and the entire population of the Northwest Territories. An Ethics Working Group has also been established to help with "on the ground" supports for the program. As presented, the membership is limited to the NTHSSA which may want to be revisited to include representation from the Hay River Health and Social Services Authority and the Tlicho Community Services Agency moving forward.

The Team is commended for ensuring a good mix of staff and community members on the Committee, including the Resident Elder, Traditional Cultural Advisory, and Facilitator – Indigenous Wellness Program. Ensuring the cultural perspective during all deliberations will be key and is acknowledged. Consideration of expanding community representation as well as including individuals with lived experience should be undertaken.
The Committee and Working Group Members are aware that significant work lies ahead in ensuring that the momentum established during the formative months of the program continues. To date, there have been consultations, with one example shared and discussed with the Surveyor. All involved in the process were remarkably impressed with the results achieved, and it was clearly reinforced that while the Ethics Program is not there to provide answers, it very much focuses on asking the right questions and providing the information necessary for those involved directly in the ethical situation, to reach the answers appropriate for their situation. This fact reinforces that a strong Ethics Program is reflective of a strong person-centered care culture.

Rolling the program out through a structured education program is next on the Plan. The logistics of this will be challenging, as will responding to specific situations in smaller communities where access is a challenge. Policy work will continue and the Committee will begin to address policy issues as well as case consultations. With the latter, significant emphasis will be placed on privacy, particularly in light of the size of the communities across the Territories. The process will however be comprehensive, with all undergoing training over the coming months.
Research activities will be indirectly addressed through the Committee, with the major focus of this resting with the Aurora Research Institute and Research Ethics Advisory Boards located in the academic centers engaged in research activities.

All Members engaged in the discussion were rightly proud of the accomplishments to date and the directions being pursued. The relationship with Alberta Health Services, the diversity of membership, the embedding of ethical thinking in all decision-making, the evolution of leadership focus, the bringing alive of the Program at the front lines and the legacy the ongoing efforts will create were all noted as highlights of ongoing efforts.

One area where the organization requires attention in this Priority Process is with the Code of Conduct. The Surveyors were able to review a 2008 GNWT Code of Conduct. With the Policy being over 10 years old, and developed prior to the creation of the NTHSSA, evaluating and updating it will be important, particularly in light of the increased emphasis being placed on Occupational Health and Safety.

All are to be commended for the commitment to date and it is anticipated that by the next Survey visit, this could be a Leading Practice for the Country.

Priority Process: Communication

Communicating effectively at all levels of the organization and with external stakeholders.

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

Communication is of high priority to this organization. There are several policies and laws that dictate the information flow both internally and externally. The Communications department appears to be extremely active and is embedded in committees throughout the entire system.

There are challenges that are met in the area of communications. Besides English and French, there are several Indigenous languages spoken in the Territories. There are great efforts to serve people in the language of their preference. Translators are contracted in local communities and a national service is also utilized.

Signage for the new hospital was placed on a temporary basis, with the goal of having signage gradually updated to reflect the languages spoken by patients. It is noted that much of the current signage is small and hard to read, hopefully, this will be corrected during the revision phase. An Indigenous Advisory Body gives feedback to the health system.

A major privacy breach occurred earlier this year. The Authority took control of the messaging around the same, in its communication to patients affected, to the communities and to the public. A number of lessons were learned from this incident and are being shared throughout the organization in efforts to ensure this does not happen again. The organization is strongly encouraged to use learnings from this breach in their quality improvement initiatives.

With the amalgamation into a single health authority from several smaller entities, such things as signage, documents, and templates needed to be brought together and standardized. Regional websites were recently combined into one website.

A pilot project in Inuvik has an Active Offer being made to all patients in English, French and an Indigenous Language.

Confidentiality and adherence to privacy legislation are of high priority to the organization. Recently blue (recycle) bins were removed from beside desks in order to decrease the likelihood of documents intended for shredding end up being inadvertently being left in these bins. This change came about when Risk and Privacy Dept did site rounds of health services.

New hires are trained on the rule of Immediate Circle of Care and how this reflects the type and amount of personal health information that can be shared among service providers.

Priority Process: Physical Environment

Providing appropriate and safe structures and facilities to achieve the organization's mission, vision, and goals.

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

The Physical Environment Priority Process included assessments of both the Stanton Territorial Hospital and the Inuvik Regional Hospital. While processes and policies were reviewed in general for the NTHSSA, only these 2 specific sites were assessed.

The Stanton Regional Hospital was opened May 26, 2019, so staff continues to orient themselves to the new space. The building was constructed through a "P3" Partnership and is operated by Dexterra and company that also provides facility services in housekeeping, laundry, nutrition and food services and plant.

The facility is very welcoming, with spaces developed conducive to the role of the organization. Efforts were made to involve staff in the development of the building although this involvement was later in the process focusing on fitting out predetermined space. Staff are beginning to adjust to the new space, which is often quite a bit larger than the previous facility. The practice of ensuring staff have worked in the space for a minimum of 6 months before any modifications are considered is supported. That said, one area requiring attention appears to be signage as numerous signs were noted to be taped to walls and doors throughout the building. It is also suggested that overall signage be reviewed from an accessibility perspective if it has not been already as the font size made reading a challenge in a number of areas. Exterior exit doors in some locations were also flagged as needing re-work as the seals utilized were not adequate for the external temperatures, resulting in cool air coming into various work areas, such as the Intensive Care Unit.

All systems and infrastructure were noted with approval. Back up systems were in place throughout, with appropriate testing of the same. Storage appeared to be a bit of a challenge in some spaces i.e. Laboratory, however, efforts to address were ongoing. Space assignments to programs such as Materials Management were appropriate, with very good use of shelving in the receiving area.

All patients, clients and family members engaged loved the new space and were very proud of the organization in general. Moving forward, as all become more used to the spaces in the facility, efforts will continue to be made in ensuring clear delineations of accountability and responsibility between the NTHSSA and Dexterra vis-a-vie roles and responsibilities within the organization. It will be key moving forward that Dexterra and NTHSSA operate as "one" entity in the eyes of staff, patients and the community alike.

The "Evergreening" Program in place through the Government of the Northwest Territories was noted with approval. Equipment throughout the facility was current and all involved in the acquisition processes need to be commended. The Program does focus on replacement of equipment, not the introduction of

need to be commended. The Program does focus on replacement of equipment, not the introduction of new technology, with processes to address the latter in place. With respect to acquisition of technology, there are clearly very stringent purchasing guidelines at the Territorial level. While this is noted with approval, it is important to reinforce that the NTHSSA needs to focus on standardization moving forward, and that staff and person-centred care should drive acquisition decisions. The commitment to facility replacement and upgrades through the government is also a highlight, something from which all provinces and territories could learn.

Facilities were noted to be very clean and well maintained, a testament to the pride staff hold in the work that they do on behalf of the organization and patients that they serve.

Inuvik Regional Hospital is clean and well maintained. There is hand sanitizer and hand washing sinks available. The entrances are clearly marked with appropriate way finding. There are back up systems including two gas and two diesel generators. Additionally, there is a back-up water source. There is regular testing of systems.

Cleaning is completed by the contracted cleaning staff in the afternoon at the end of the morning surgical cases. The operating room nurses complete the OR cleaning between cases. The leaders are encouraged to explore the most appropriate staff person to clean the operating rooms between surgical cases.

Kudos are extended to all associated with the Physical Plants across the NTHSSA. Safe, clean facilities are a major contributing factor to safe, high quality care, and they are encouraged to maintain the excellent work being done.

Priority Process: Emergency Preparedness

Planning for and managing emergencies, disasters, or other aspects of public safety.

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

The organization has a thorough and robust Emergency and Hazards Plan. The teams at Health Care sites are very well connected to their community first responders and are well integrated with the plans of the towns, departments, and agencies. The Emergency Plan is readily available to staff and can be found in logical places throughout the facilities. Codes are tested regularly and lessons learned are documented, and plans adjusted according to outcomes.

A recent Code Orange was tested at Stanton Hospital. Lessons learned from this included issues with the fan out list (discovering that many staff do not answer phone calls), identifying that there needs to be more discussion with Dextera regarding which party is responsible for what actions during a code, and that there needs to be thought put into how many staff to call in at once. All of these concerns were discussed at length in teams and alternative plans are being identified to mitigate these issues.

Risk Management strategies include the completion of a risk registry for each centre.

The organization has firm linkages with the Department of Health, other government departments, and local agencies. Each site has identified its evacuation locations. A recent report had outlined in detail where all thirty-eight Health service sites would shelter in place, use as evacuation sites on both short term and long term, and resources needed for each scenario.

Emergency Response mobile clinics are readily available locally through the federal government and more supplies can be brought in on an as needed basis.

Staff was able to list a number of emergency situations they have dealt with over the years and in all cases, identified learning from each scenario as well as how the entire organization used the lessons learned.

The organization is to be commended for its comprehensive emergency response plan and is encouraged to leverage the expertise of staff who have a great passion for the subject to provide education to all staff.

Training on Emergency Preparedness is provided upon staff orientation and as part of ongoing staff development. Corporate services are setting a tone for a safety culture by starting each meeting with reminders of where the exits and muster points are located.

The organization is encouraged to find creative means by which to involve patients and families in their emergency preparedness discussions.

Priority Process: People-Centred Care

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

Unmet Criteria		High Priority Criteria
Standards Set: Cancer Care		
2.4	Space is co-designed with clients and families to ensure safety and permit confidential and private interactions with clients and families.	
Standards Set: Community-Based Mental Health Services and Supports		
16.7	Patient safety incidents are analyzed to help prevent recurrence and make improvements, with input from clients and families.	!
17.3	Measurable objectives with specific timeframes for completion are identified for quality improvement initiatives, with input from clients and families.	!
Standards Set: Critical Care Services		
2.6	Space is co-designed with clients and families to ensure safety and permit confidential and private interactions with clients and families.	
3.13	Client and family representatives are regularly engaged to provide input and feedback on their roles and responsibilities, role design, processes, and role satisfaction, where applicable.	
16.7	Patient safety incidents are analyzed to help prevent recurrence and make improvements, with input from clients and families.	!
17.3	Measurable objectives with specific timeframes for completion are identified for quality improvement initiatives, with input from clients and families.	!
Standards Set: Governance		
2.2	There are established mechanisms for the governing body to hear from and incorporate the voice and opinion of clients and families.	
2.3	The governing body includes clients as members, where possible.	
10.5	The governing body regularly hears about quality and safety incidents from the clients and families that experience them.	!

Standards Set: Home Care Services		
1.9	Barriers that may limit clients, families, service providers, and referring organizations from accessing services are identified and removed where possible, with input from clients and families.	
2.4	Space is co-designed with clients and families to ensure safety and permit confidential and private interactions with clients and families.	
Standards Set: Inpatient Services		
1.1	Services are co-designed with clients and families, partners, and the community.	!
2.5	Space is co-designed with clients and families to ensure safety and permit confidential and private interactions with clients and families.	
16.3	Measurable objectives with specific timeframes for completion are identified for quality improvement initiatives, with input from clients and families.	!
Standards Set: Leadership		
4.3	Services are planned with input from clients, families, and the broader community.	
6.2	When developing the operational plans, input is sought from team members, clients and families, and other stakeholders, and the plans are communicated throughout the organization.	
9.2	There are mechanisms to gather input from clients and families in co-designing new space and determining optimal use of current space to best support comfort and recovery.	
10.4	Education and training are provided throughout the organization to promote and enhance a culture of client- and family-centred care.	
Standards Set: Long-Term Care Services		
16.8	Patient safety incidents are analyzed to help prevent recurrence and make improvements, with input from residents and families.	!
Standards Set: Obstetrics Services		
2.4	Space is co-designed with input from clients and families to ensure safety and permit confidential and private interactions with clients and families.	
3.13	Client and family representatives are regularly engaged to provide input and feedback on their roles and responsibilities, role design, processes, and role satisfaction, where applicable.	

17.9	Patient safety incidents are analyzed to help prevent recurrence and make improvements, with input from clients and families.	!
18.3	Measurable objectives with specific timeframes for completion are identified for quality improvement initiatives, with input from clients and families.	!
Standards Set: Perioperative Services and Invasive Procedures		
1.1	Services are co-designed with clients and families, partners, and the community.	!
2.4	Space is co-designed with clients and families to ensure safety and permit confidential and private interactions with clients and families.	
6.3	A comprehensive orientation is provided to new team members and client and family representatives.	
6.12	Client and family representatives are regularly engaged to provide input and feedback on their roles and responsibilities, role design, processes, and role satisfaction, where applicable.	
24.7	Patient safety incidents are analyzed to help prevent recurrence and make improvements, with input from clients and families.	!
25.3	Measurable objectives with specific timeframes for completion are identified for quality improvement initiatives, with input from clients and families.	!
Standards Set: Primary Care Services		
2.5	Space is co-designed with clients and families to ensure safety and permit confidential and private interactions with clients and families.	
15.7	Patient safety incidents are analyzed to help prevent recurrence and make improvements, with input from clients and families.	!
Standards Set: Remote/Isolated Health Services		
16.3	Measurable objectives with specific timeframes for completion are identified for quality improvement initiatives, with input from clients and families.	!

Surveyor comments on the priority process(es)

Person centred care is a key priority for this organization and one which is reflected at every level of the service. Multiple examples of patients being invited to contribute to their own care plan were evident. Feedback is obtained from patients in various modes and adjustments to plans made as a result. early stages and there needs to be concerted efforts focused on the same. There is an acknowledgment that fulsome integration of patient and (especially) family engagement is in early stages and there needs to be concerted efforts focused on the same.

Priority Process: Patient Flow

Assessing the smooth and timely movement of clients and families through service settings.

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

The team members, physicians, and leaders are acknowledged for their commitment to ensuring effective patient flow. There is a seamless transfer of clients requiring admission from the emergency department to an inpatient bed. There is no overcrowding in the emergency department. The team members strive to have a client placed in an inpatient bed thirty minutes after the decision to admit is made in the emergency department.

The team has initiated processes to continue to support patient flow. This includes the implementation of the Emergency Department Surge Process, Gridlock Process, multidisciplinary meetings, ensuring appropriate discharge and working with partners to support discharge planning and care across the continuum. Additionally, same day access for low acuity patients is provided in outpatient clinics to ensure the appropriate and efficient use of the emergency departments. There are currently plans to increase access to new long-term care beds in Yellowknife, Hay River, and Inuvik. The leaders are encouraged to continue to involve clients, families, and team members in the design and build of long-term care homes.

The transfer of high-risk clients requiring transfer to another facility is provided by Med-Response. The Med Response system has met the stringent CAMTS standards for medical air transport and is one of the few air ambulance programs to do so. The Med Response team monitors air ambulance response times and causes for delays as well as the time to off load patients. Innovative processes to support effective use of air plane resources including ramp transfers are used. The team works closely with Alberta Health Services.

Emergency department (ED) overcrowding is not a system-wide issue. Inpatient beds are available and timely access to diagnostic services is available. Dates are tracked and benchmarking occurs. The team members and leaders are encouraged to continue to ensure appropriate patient flow and the efficient use of inpatient beds and resources.

The team and leaders are proud of their work reduce wait times for colorectal screening. There is a commitment to providing the procedure "close to home." A team member has developed client friendly resources using pictures to support the proper diet preparation for colonoscopy procedures. There has been a significant reduction in wait times for colonoscopies and the "no show" rate has improved. The team and leaders are encouraged to continue with this important work.

Priority Process: Medical Devices and Equipment

Obtaining and maintaining machinery and technologies used to diagnose and treat health problems.

Unmet Criteria		High Priority Criteria
Standards Set: Perioperative Services and Invasive Procedures		
4.1	Surgical equipment and medical devices are regularly calibrated according to the manufacturers' instructions.	!
4.11	Immediate-use (or "flash") sterilization is used in the operating/procedure room only in an emergency, and never for complete sets or implantable devices.	!
Standards Set: Reprocessing of Reusable Medical Devices		
1.1	Information about service volumes is collected at least annually from all areas in the organization that require reprocessing services, and is shared with the MDR department.	!
1.2	Information collected about services offered and their volumes is used to determine the range of reprocessing services and how they are delivered.	!
3.5	Appropriate environmental conditions are maintained within the MDR department and storage areas.	!
5.11	Team member performance is regularly evaluated and documented in an objective, interactive, and constructive way.	!
7.4	Immediate-use steam sterilization (IUSS) is limited to emergencies only, and never for complete sets or implantable devices in line with the organization's policy and the provincial/territorial regulations.	!
12.1	The MDR department has an appropriate storage area for sterilized medical devices and equipment.	!

Surveyor comments on the priority process(es)

There are 2 sites in the NTHSSA where reprocessing of medical devices takes place. Inuvik Regional Hospital (IRH) and Stanton Territorial Hospital (STH). A Territorial MDRD Committee has been established. Hay River MDRD staff participate in the Committee. The main focus is the standardization of policies and procedures across the region. Staff in STH have made tremendous gains in pulling together the comprehensive manuals and supporting documentation. It would be beneficial to share this work with other sites. The Program is overseen by the Territorial Manager of IPAC and a Technical Specialist of MDRD. The STH site has a Manager and IRH has an MDRD Lead. The program also provides support to Hay River HSSA and Nunavut.

The program is now beginning to collect service volumes in order to have a better understanding of needs. Volumes from the OR, Sterilizer and incident reports will be collected. Staff competencies are in the development process. Competency forms are almost completed, and the review process will begin in 2020.

There is a Territory wide comprehensive preventative maintenance program. A large percentage of biomedical equipment is purchased through the "Evergreen" Program with the Government, with the NTHSSA being responsible for paying the resulting service contracts. The BioMed team supports most equipment, other than Lab and DI that have Service Contracts.
The PM System used is first-rate and meets all ROP requirements. Staff are well trained and supported, and all can assume responsibility for maintaining all equipment across the Territory. An online inventory of equipment manuals is available giving the team access to the information they need. When traveling remotely, they will take hard copies of any required materials in case technology links fail. Communication within the Program was spoken of positively, with weekly Staff Meetings that all start with Occupational Health discussion. Relationships with clinical services and the acquisition team in the government were noted to be good.

In MDRD at STH there is a comprehensive preventative maintenance program support by detailed logs. Information is easy to access. A similar log is being developed for all scopes. It may be beneficial for purchasing forms to include a spot for approval by IPAC and MDRD to ensure that any new devices that come into the organization are able to be sterilized or appropriately cleaned.

The records for immediate use sterilization at both STH and IRH were not clear. It was not clear if the sterilizer was being used on the full cycle or for immediate use. There may be some benefit to having the responsibility for the sterilizer fall under MDRD staff where it can be managed according to MDRD standards and processes.
There was evidence of items returning from the OR and Obstetrics at STH that were not properly pre-cleaned. In order to prevent damage to the instruments and minimize health exposure for MDRD staff, attention to this concern should be addressed in a timely manner. The MDRD has communicated to the appropriate departments without success. Implants are located adjacent to the Washer Disinfector. There is a risk that moisture may affect the implants and the department is encouraged to look at another location for these devices.

The new department at STH has good workflow. There are separate areas for scope cleaning and for the Trophon. Staff are encouraged to use the LMS to take courses relevant to their work. A SharePoint has updated policies and procedures. Each work area has manuals with visuals aids. A MDRD Liaison RN from the OR provides support. Staff participate in daily huddles.

Service Excellence Standards Results

The results in this section are grouped first by standards set and then by priority process.

Priority processes specific to service excellence standards are:

Point-of-care Testing Services

- Using non-laboratory tests delivered at the point of care to determine the presence of health problems

Clinical Leadership

- Providing leadership and direction to teams providing services.

Competency

- Developing a skilled, knowledgeable, interdisciplinary team that can manage and deliver effective programs and services.

Episode of Care

- Partnering with clients and families to provide client-centred services throughout the health care encounter.

Decision Support

- Maintaining efficient, secure information systems to support effective service delivery.

Impact on Outcomes

- Using evidence and quality improvement measures to evaluate and improve safety and quality of services.

Medication Management

- Using interdisciplinary teams to manage the provision of medication to clients

Organ and Tissue Donation

- Providing organ and/or tissue donation services, from identifying and managing potential donors to recovery.

Infection Prevention and Control

- Implementing measures to prevent and reduce the acquisition and transmission of infection among staff, service providers, clients, and families

Diagnostic Services: Imaging

- Ensuring the availability of diagnostic imaging services to assist medical professionals in diagnosing and monitoring health conditions

Diagnostic Services: Laboratory

- Ensuring the availability of laboratory services to assist medical professionals in diagnosing and monitoring health conditions

Public Health

- Maintaining and improving the health of the population by supporting and implementing policies and practices to prevent disease, and to assess, protect, and promote health.

Transfusion Services

- Transfusion Services

Standards Set: Biomedical Laboratory Services - Direct Service Provision

	Unmet Criteria	High Priority Criteria
Priority Process: Episode of Care		
	The organization has met all criteria for this priority process.	
Priority Process: Diagnostic Services: Laboratory		
1.2	The team collects information at least every two years from laboratory users and clients about their needs for laboratory services.	
11.3	The team updates its SOPs every two years or more often if required.	
11.4	The team has a process to review and approve revisions to the SOPs.	
27.6	The team annually reviews its risk-reduction strategies as well as incidents that have occurred, and makes required changes to its policies or training activities.	!
29.1	The team has a comprehensive quality management system.	!
29.12	As part of the quality management system, the team evaluates its services using formal internal audits, evaluations, and improvement processes.	!
Surveyor comments on the priority process(es)		
Priority Process: Episode of Care		

Facility Falls Prevention is implemented.

Priority Process: Diagnostic Services: Laboratory

The Staff at Inuvik Regional Hospital are very engaged and have a pleasant working environment.
The tracer of inpatient blood collection confirmed the two identifiers are used for the client. Sharps containers are available in the patient room, a tourniquet is disposable and used once per client. Gloves are not worn during blood collection. Consideration of adopting a policy to wear gloves should be considered, studies have shown the potential for viral exposure a needlestick injury is reduced when wearing gloves.
Although the temperature is recorded daily in the biomedical lab, the current thermometer used to monitor the room temperature and humidity in the lab at Beaufort delta calibration expired on January 7, 2017.
The lab should develop a program to maintain current calibration certificates for all thermometers, log the serial number on the record sheet to match equipment or area.
Specimen labels are printed for blood collection relabel. When Softlab label is unavailable. Medipatient labels are used and when received in the lab a softlab label is added to the tube, which does not cover the original.
The Quality Management system appears to be fairly new, and a territorial program. There is a Beaufort Delta Lab Quality Manual, and a list of Quality SOP's. Management of the document control system is not clearly defined, there are different templates for SOP's in use and review or acknowledge of document not consistent.
Process Improvements were created from a quality indicator data on turn around time for rereferred in specimens.
Document control needs to be monitored, in my review of documents, there are 3 Critical Values SOP's in the electronic, " Our Northwest Territories Health & Social services " file, all with different critical values, the list used on the bench was different than appendix in POCT SOP. It is important for Staff to have the current approved SOP. The review of SOP also varies, the template used may be Northwest Territories Health & Social Services Authority, with no signature of approval. The example template used Inuvik Regional Hospital for Venipuncture Collection effective 2019 next review 2022 approved by Chief Operating Officer.
Specimens referred out to Dyna Lab/ CBs & Stanton Territorial Hospital lab have a paper copy report maintained when report returned or in EMR, pending lists are monitored to track the return of the report. Pending tracking is managed well, MLT's ensure the referred out results are received in an appropriate time frame.
Staff have access to continuing education via Stanton Territorial Hospital lab, and they are registered with CSMLS. The Northwest Territories do not require licensing for MLT. No evidence of data collection on service volumes.
A Good quality control program for the Biomedical lab.
The Laboratory in Yellowknife had a full complement of very positive and engaged staff with clearly defined accountabilities, technology is current.
Physical space is cluttered due to size, however, it appears safe. Staff meetings are weekly.
Good professional development support and Manager tracks all staff to ensure that they read all relevant materials. Lab keeps their own policy file as they do not "like" SharePoint.

They are dealing with a major issue right now with an EPIC issue in Alberta which prevents them from receiving electronic results from Dynalife. This appears to be close to a resolution.

Territorial standardization of analyzers is complemented for process improvements within the authority advantages to implementation, reagents, reporting and training.

Standards Set: Cancer Care - Direct Service Provision

Unmet Criteria	High Priority Criteria
Priority Process: Clinical Leadership	
The organization has met all criteria for this priority process.	
Priority Process: Competency	
8.6 Education and training are provided on the organization's ethical decision-making framework.	
Priority Process: Episode of Care	
The organization has met all criteria for this priority process.	
Priority Process: Decision Support	
The organization has met all criteria for this priority process.	
Priority Process: Impact on Outcomes	
The organization has met all criteria for this priority process.	
Priority Process: Medication Management	
The organization has met all criteria for this priority process.	

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

Cancer care at Stanton has been through a major revamping process. It has re-opened in a step-wise fashion starting in April 2018.
Services are closely aligned and supervised by Cancer Care Alberta and Cross Cancer Institute (CCI) in Edmonton.

Data and statistics on the burden of illness are available and have helped set priorities. Expertise and resources are jointly provided from the CCI program and trained staff at Stanton.

Staff at Stanton are thrilled to be part of the program and feel comfortable handling care closer to home while always having backup expertise available either with the monthly Oncologist visits or on teleconferences.

Priority Process: Competency

Nurses, doctors, patient navigators and including the cleaning staff have attended training events in hospital and out-of-Territory to develop sufficient expertise and skill set to handle the day program chemotherapy unit and assist with the care of hospitalized patients.

The Cancer Care team are justifiably proud of this program and are committed to further solidifying ties or partnerships with the Oncology centres in Alberta to have a more seamless cancer care-at-home while benefiting from the expertise and support services of the major Oncology program in Alberta.

Priority Process: Episode of Care

Cancer Care at Stanton is a day program service which delivers chemotherapy cycles in a purpose built area of the new Stanton Hospital.

Initial staging and treatment planning takes place in Edmonton at CCI where discussions and services for genetic testing and fertility preservation take place. The program at Stanton is designed to continue chemotherapy cycles to keep patients closer to home and includes trained nurses for chemotherapy delivery and support with immediate supervision by a GP-Oncologists or FP-Oncologist. There is a monthly visiting Oncologist and discussions are in place to formally develop a shared care model with part-time services of one or 2 Edmonton Oncologists.
There is great enthusiasm over the success of this program which may become a model for shared care in other jurisdictions.

The patient navigators have become essential to the success of the program by ensuring patients can flow smoothly through the system in their Care Pathway and all patient information is available at all locations of care (in 1 province and 2 Territories) in a timely way.

Priority Process: Decision Support

The Cancer Care program is fortunate to have caught the attention of the Canadian Partners against Cancer group and secured funding for further development.
In the next few months the organization must decide whether to join the Alberta wide "Connect Care" program which would then allow direct use of all Alberta Order Sets and guidelines, and the sharing of client medical information between all providers whether located in NWT or at the Oncology centre in Edmonton.
Another scenario would involve waiting to see if the NWT government makes a decision to legislate such a move or not. Implications are the loss of autonomy to develop NWT-specific guidelines (with much added cost) but the benefit of far greater depth of expertise in Alberta for their development.

Priority Process: Impact on Outcomes

After the first diagnosis, the patient is referred to Oncology services in Alberta for the completion of

staging and initial treatment decisions. The team in Stanton then support and follow the patient with their treatment cycles at Stanton. The visiting Oncologist maintains the direction of chemotherapy care while the Cancer Care team at Stanton monitors the delivery of the chemo and any related illness or concerns. There is a very good rapport among team members and support in Edmonton and further afield.
Staff members are supported with educational opportunities.

As this is essentially a new program at Stanton, Benchmarks and QI statistics are still being collected.

Priority Process: Medication Management

The Pharmacy at Stanton and the chemotherapy pharmacists are well equipped and trained at a modern facility to deliver cancer chemotherapy.
Stanton pharmacists are supported and share information with CCA and CCI.

Standards Set: Child, Youth, and Family Services - Direct Service Provision

Unmet Criteria	High Priority Criteria
Priority Process: Clinical Leadership	
2.8 Access to spiritual space and care is provided to meet clients' needs.	
Priority Process: Competency	
5.2 Work and job design, roles and responsibilities, and assignments are determined with input from team members, and from clients and families where appropriate.	
Priority Process: Episode of Care	
The organization has met all criteria for this priority process.	
Priority Process: Decision Support	
6.8 There is a process to monitor and evaluate record-keeping practices, designed with input from clients and families, and the information is used to make improvements.	!
Priority Process: Impact on Outcomes	
8.3 There is a standardized process, developed with input from clients and families, to decide among conflicting evidence-informed guidelines.	!
8.5 Guidelines and protocols are regularly reviewed, with input from clients and families.	!

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

Child, Youth and Family Services is a program which provides a spectrum of both prevention and protection services to children, youth and their families, in accordance with the recently revised and updated Child and Family Services Act. Significant improvements have been achieved in the last three years to restructure and better align resources across the Territory to meet the explicit population needs in each of the service areas. For example, Beaufort Delta has a population of 6,700 and includes the communities of Inuvik, Pautatuk, Ulukhaktok, Sachs Harbour, Fort McPherson, Tsligehtchic, Tuktoyaktuk, and Aklavik, whereas Yellowknife area communities encompass a population of 20,000.

Significant efforts have been made to better align and ensure that the right mix of staff is available and supported in each of the regional service areas as population health needs, economic status and cultural

differences are recognized as being community-specific. That is a strength of the service team in the Child Youth and Family Services Teams visited by surveyors during the September 2019 component of the Qmentum Survey.

In January 2017 and February 2019, The Structured Decision- Making System(SDM) for Child Protection was adapted specifically for the NWT population with the NCCD Children's Research Center and input from Territorial frontline staff and community advisory groups, clients and families. It is recognized as an evidence-based best practice approach to child protection with a balanced effort to identify and build upon the strengths of the family system and unit. The SDM is clearly aligned with the Child and Family Services Act and the Ministry of Health and Social Services Action Plan: "Building Stronger Families". This is significant accomplishment is applauded as it promises to address long-standing issues in child protection policy and practice that really require system level strategy.

Strengths that were unanimously validated in all tracers with all teams included: the value of the new electronic system MATRIX: investment in staff education particularly in the areas of standardized assessment protocols and documentation improvements; making contacts with children, youth and families more meaningful in line with removing child from the home as an absolute last resort; and the Territorial Supervisor On- Call Model.

The Clinical Supervision Model introduced in 2019 is a best practice and continued attention to the further development of the model and applying experiental learning to targeted quality improements is very much encouraged. In doing so it will be critical to continue to monitor and measure so as to know whether the changes are moving practice and outcomes in the directions you intend.

All staff could readily speak to their appreciation to the Territorial Leadership for improved communication, engagement of staff, investment in learning and supports, and for validating their contributions to the whole of the system for the people they serve. Particular appreciation was centered on active efforts to reduce the 35% vacancy rate to 18% in less than one year for Social Work positions in CYFS.

There is encouragement to continue to strengthen the integration of CYFS with those networks, partnerships and operatiponal departments you regularly interface with.

Priority Process: Competency

Impressive training and development has been and continues to be provided to Child, youth and family services staff. As a result, staff feels competent in carrying out their functions in relation to the Child and Family Services Act. New staff are mentored and clinical supervision and consultation up the line works well. This is very important as the needs of children and families are complex and cultural considerations are a must. Kudos to the team and to the Health and Community Services leadership and governance team for actively and strategically supporting the strengthening of the front line teams in prevention and child protection.

Having said that it will be critically important to keep the quality improvement efforts moving and to measure progress and outcomes over time and to celebrate small but significant improvement gains.

The team is integrating well as important services in the Territory and are encouraged to further strengthen ways to collaborate with other health services in each community as you share common clients. This will be most beneficial to improved client and family outcomes and to the team as well.

Priority Process: Episode of Care

The episode of care standards have been fully met. There is encouragement to continue to refine and improve processes within the service as you apply the new ways of working with children, youth, families and other services in each of your regions. You are already beginning to see the increases in parents and families self referral and engagement with you along with reductions in court mandated orders. It is still early days and it will be critical to continue to monitor, measure and adjust as the new approach takes hold.

Priority Process: Decision Support

Impressive decision support is in place with the Matrix System and explicitly linked to the legislative requisites and the expected professional practice standards.

Priority Process: Impact on Outcomes

The standardization of guidelines used in the redeveloped approach to CYFHS is impressive and referenced and all training, auditing, clinical supervision, and trends are derived from the evidence-based approach, which has been intentionally refined against the territorial Act. The service is encouraged to take this opportunity to explore ways to engage in qualitative research related to your own lived experiences with the renewed model for practice and the associated impacts for those children and families who may have post-traumatic inter-generational family and parenting considerations that could be explored. You will know best how to develop the research questions and the methodology with families, Wellness Councils and researchers should you choose to take this idea further.

Standards Set: Community-Based Mental Health Services and Supports - Direct Service Provision

Unmet Criteria	High Priority Criteria
Priority Process: Clinical Leadership	
The organization has met all criteria for this priority process.	
Priority Process: Competency	
10.6 Access to spiritual space and care is provided to meet clients' needs.	
Priority Process: Episode of Care	
The organization has met all criteria for this priority process.	
Priority Process: Decision Support	
The organization has met all criteria for this priority process.	
Priority Process: Impact on Outcomes	
The organization has met all criteria for this priority process.	

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

Mental Wellness and Addictions programs in Fort Simpson benefit from a small, but inspired professional team that is grounded in local culture and traditions and guided by the protocols of the people served. Identified challenges include developing a Territory wide model of clinical supervision and implementing an electronic documentation system that is linked with, for example, primary and acute care to facilitate seamless transitions in care. Moreover, an after hours mental wellness councilor/crisis intervention worker is identified as a pressing need. Currently, on-call clinic nurses and the local RCMP are the only recourse. Additionally, access to local resources (beds) for stabilization, detoxification and transition (from treatment back to independent living) remains an identified and critical gap in service delivery. A burgeoning community based review board, a community based treatment plan and child and youth counselor (s) bode well for meeting the complex care needs of a complex and geographically isolated population.

Priority Process: Competency

Team members in Fort Simpson are professionally trained and certified and include a member from the local community, which is very helpful in supporting a culturally safe and inclusive approach to care. Caseloads are currently quite high for each of the team, due to position vacancies. Clients reported feeling

uneasy with the number of professional providers coming and going from the community but are currently very satisfied with the current, small, but stable contingent of mental wellness team members. Team members reported feeling supported in professional development and ongoing learning in their respective roles and benefit from regular team huddles, one-on-one supervision sessions and periodic social activities. The local team is well integrated with health clinic teams, including long term care, where one of the mental wellness counselors provides one one one support to staff and residents on a weekly basis. Interagency collaboration and linkages with surrounding communities and external programs is an identified ongoing priority. The team is supported in ongoing professional development and benefits from participating in local cultural and community events and activities.

Priority Process: Episode of Care

Continuity, consistency, and comprehensiveness are chronic issues in mental health and wellness services and programs throughout NWT. Further, access to core services and programs, like detox, psychiatry, drug and alcohol residential treatment and 'sobering center,' stabilization and transition beds are limited and often only available away from the community and more than often outside of NWT and into the neighboring province of Alberta. Efforts have been made to address some of these chronic access deficiencies and service gaps via telehealth and by actively engaging and supporting communities in developing and implementing land based healing programs. Suicide ideation remains an issue throughout NWT. Mental Wellness teams have been trained in awareness and assessment and supporting the community in the same and a Territory wide crisis response plan is currently being developed. In the meantime, the nurse on call in Fort Simpson, is available for after hour crisis calls, although staff and community have been very forthright about the need for an after hours mental wellness councillor and access to 24 hour crisis response. An Inter-disciplinary team approach, although mostly informal, supports clients and their families in their respective wellness journeys.

Priority Process: Decision Support

Planning has commenced to move from a paper based to a standardized electronic record keeping system that will support monitoring programs and services over time and contribute to better coordination of programs and services across professional and program areas and better facilitate seamless transitions of care. It has only been since 2018, for example, that there has been access to Territory wide mental health and wellness data. In the meantime, regular paper file quality assurance audits are completed to ensure compliance with standards. Staff reported being up to date on current legislation and orientation to new, emerging program developments, and best practices.

Priority Process: Impact on Outcomes

An updated NWT Mental Health Act (2018) instigated the requirement for a quick turnaround in operational policies and procedures and the creation of a number of Territory wide Action Plans, like improved mental wellness pathways of care, towards improving outcomes for patients and clients. Data and health information challenges have translated into monitoring challenges but have also created opportunities for developing markers or indicators, like wait times, now that there is territory wide access to (limited data). Work continues in this area, stewarded by a Mental Health Quality Committee

populated with representatives from NWT Health Department and Health Authority Senior Leadership. Further, the NWT Health Governance structure through Regional Wellness Councils and the NWT Health and Social Services Leadership Council ensure meaningful community input into mental health and wellness program and services development.

Standards Set: Critical Care Services - Direct Service Provision

Unmet Criteria		High Priority Criteria
Priority Process: Clinical Leadership		
The organization has met all criteria for this priority process.		
Priority Process: Competency		
3.6	Education and training are provided on the organization's ethical decision-making framework.	
3.12	Team member performance is regularly evaluated and documented in an objective, interactive, and constructive way.	!
Priority Process: Episode of Care		
7.14	Ethics-related issues are proactively identified, managed, and addressed.	!
Priority Process: Decision Support		
The organization has met all criteria for this priority process.		
Priority Process: Impact on Outcomes		
16.4	Safety improvement strategies are evaluated with input from clients and families.	!
17.11	Quality improvement initiatives are regularly evaluated for feasibility, relevance, and usefulness, with input from clients and families.	
Priority Process: Organ and Tissue Donation		
The organization has met all criteria for this priority process.		

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

The only Intensive Care Unit in the Territory is at Stanton.
It serves adults only. Agreements are in place for med-evac and care of infants and children to Alberta for ICU care.
The ICU is staffed by specialty trained nurses and Internal Medicine doctors with occasional locum Intensivists.

Staff were invited to the partially built building in the previous year to help map out the flow of patients to and from DI and ED departments and for provider work flow. They felt many of their recommendations

were followed. The larger space and closed off Medication room has led to a successful bid to increase the number of nurses on shift from 2 to 3 which is greatly appreciated.

There were probably missed opportunities by the design and construction team to involve clients and families in all aspects of the design and programming of Intensive Care Services. Stanton would benefit from the existence of an informed, properly oriented and trained, client and family advisory team to assist management in improving client and their family's experiences in the ICU setting.

There is an opportunity to develop ICU Program guidelines and criteria for levels of care, which cases to serve and which to refer, and procedural activities that could be provided or should be referred. This is particularly sensitive as both doctors and nurses are often locums who otherwise work in larger southern centres and are not fully aware of the remoteness of Stanton and the limitations of air transport.

Priority Process: Competency

The professionalism and competence of the team of providers in the ICU is remarkable. Several team members who have worked in other provinces are impressed by the pride of work and team-manship that exists at the unit.
With this pride in performance comes the request to be more involved in program planning that ultimately affects the team's practice.

There is an opportunity for managers, doctors and team members to develop a baseline admission criteria and list of what types of Critical care cases can be handled and which to refer; and a policy on who makes the ultimate decision for patient placement, to pre-empt some discussions that sometimes take place with Physicians (sometimes locums unaware of the limitations) in the ICU and ED and other areas, and between managers at other levels of care; and to aid discussions at times of bed crunches.

On the other hand team members are very pleased with the opportunities they have had to develop the MET (Medical Emergency Team response system) which is still in early development and evaluation.

Priority Process: Episode of Care

Patients and family members are appreciative of the care they receive at the ICU. They feel very safe and professionally but lovingly cared for.
There is good rapport among team members and they feel they belong to a close knit family.

Priority Process: Decision Support

Paper based record keeping is used in the unit.
There is also WOLFF EMR which is used for some lab values.
There is an EMR which the doctors have access to but it is not the complete medical record.
The Territory is watching where Alberta's EHR/EMR decision will go in order not to have a clash of systems.

Priority Process: Impact on Outcomes

The data that is collected on VAP, pressure ulcer prevention and other QI indicators are posted in the ICU nursing area. While this is important, the next step, which is to determine how relevant this data is to this Unit, should be reviewed with staff and, ideally with a client and family representative team.
Audits for central line or catheter prevention of infections are not posted.

It would be useful to gather feedback data from a post-discharge questionnaire that might better inform providers and administrators which Quality activities may be of concern to the patient public and for which interventions could be made.

Priority Process: Organ and Tissue Donation

Organ and tissue donation is not a priority in this remote location.
There are no policies and procedures for organ and tissue donation.
There are no facilities to make a neurological determination of death.
There are no facilities for organ and tissue retrieval and safe storage in the NWT.

On exceptional and rare circumstances there have been anecdotal occasions (perhaps 4 in the past 14 years) when an individual who was deemed potentially neurologically deceased was transported on a ventilator ("life support") to Alberta for the purpose of a neurological determination of death and consequent organ and/or tissue retrieval.

Standards Set: Diagnostic Imaging Services - Direct Service Provision

Unmet Criteria		High Priority Criteria
Priority Process: Diagnostic Services: Imaging		
2.1	The team tracks wait times and average response times for elective, urgent and emergent requests for diagnostic imaging services.	!
6.7	The team annually reviews and updates the Policy and Procedure Manual.	
11.12	The team uses diagnostic reference levels to optimize radiation protection of adult and pediatric clients.	
15.4	The team prepares for medical emergencies by participating in simulation exercises.	!
17.6	The team reviews its diagnostic reference levels at least annually as part of its quality improvement program.	

Surveyor comments on the priority process(es)

Priority Process: Diagnostic Services: Imaging

The Diagnostic Imaging department in the Stanton Territorial Hospital (STH) provides general Radiology, Fluoroscopy, Screening, and Diagnostic mammography, Ultrasound, CT and C-Arm procedures. The Primary Care Clinic provides minimal x-ray services and until the move to the new hospital had the ability to provide Ultrasounds. This changed to address issues of underutilization and no shows and has demonstrated improvement. The Clinic provides Bone Density testing once per month and all DI staff have been crossed trained to provide this service. Inuvik Hospital provides General Radiology and locum-based Ultrasound. There are 4 mammography clinics held annually which are locum based. There may be an opportunity to advertise in the community about the importance of mammography in order to reduce the no shows. Fort Smith Health Centre provides general radiology and locum-based ultrasound. Equipment is standardized and is on the Evergreening program. The team spoke of the positive partnerships and relations with all of the DI Centres in the Territory including Hay River.

The new department at STH is bright and well laid out. Signage is small and difficult to read. The waiting room and change rooms are adjacent to each other. The policy and procedure manuals are in the process of being updated. There are hard copies in the procedure rooms as well on the shared drive as the approval process is long. The organization is encouraged to ensure that all outdated version of the policies and procedures are removed and replaced with NTHSSA policies. While this does take resources, this is a safety concern and the organization is encouraged to priorize this work. Emergency spots are held daily for CT patients from emergency. This has improved the workflow. CTAS priority is attached to all requests from emergency to help prioritize requests.

There is one Radiologist in the Territory. The organization also uses the services provided by Mayfair Diagnostics out of Calgary. Mayfair interprets and reports on approximately 50% of the diagnostic imaging for the NTHSSA. Radiologists with Mayfair read results and provide reports when The NTHSSA Radiologist is not available. Mayfair understands the scope of services and the procedures that are provided in the Territory. Community based health clinics provide basic radiology services which are performed by non MRTs, who are nurses who have completed a targeted training program. There is an annual competency that is required that is tracked and monitored. There are defined out of scope procedures that the non MRTS are not allowed to provide.

Improvement has been noted in the reject rate. The benchmark has been set at 5% and results are below the benchmark. Work to improve the no show rate focused on working with patients to find suitable appointment times as well as a reminder call 2 days prior to the procedure. Ultrasound wait times have been reduced from 10 months to 4 months as a result of direct booking with patients, reminder calls and radiologist triaging. Staff at the different sites are encouraged to broadly share their improvements and learnings. At this time Ultrasound wait times are the only modality that is being tracked as it has to be completed manually.

There is no Radiology Information System. Data is difficult to pull from the MediPT system and all data except for volumes has to be manually extracted. There is no capability to capture workload data such as isolated patients, pediatric patients or time spent in the Operating Room. The Breast Screening data base is DOS based, while other areas use excel spread sheets.

Physicians are surveyed to understand their radiology needs. The program is currently looking at the feasibility of performing Carotid Ultrasounds. The team has conducted Code Reds and may want to consider conducting a Code Blue exercise in the department. The Manager participates in the STH Clinical Practice Advisory Committee.

Standards Set: Emergency Department - Direct Service Provision

Unmet Criteria	High Priority Criteria
Priority Process: Clinical Leadership	
The organization has met all criteria for this priority process.	
Priority Process: Competency	
4.14 Team member performance is regularly evaluated and documented in an objective, interactive, and constructive way.	!
Priority Process: Episode of Care	
9.12 Ethics-related issues are proactively identified, managed, and addressed.	!
12.3 Client privacy is respected during registration.	
Priority Process: Decision Support	
The organization has met all criteria for this priority process.	
Priority Process: Impact on Outcomes	
The organization has met all criteria for this priority process.	
Priority Process: Organ and Tissue Donation	
The organization has met all criteria for this priority process.	

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

The clinical leaders are proud of their work to provide quality emergency care throughout the Northwest Territories. There have been new initiatives supporting quality care including; the opening of the emergency department at the Stanton Territorial Hospital in May 2019, the implementation of behavioral support workers, and processes to support the diversion of clients with low acuity from the emergency department to outpatient clinics.

The leaders and team members are committed to providing quality emergency care to clients and families. The team noted that they have the appropriate resources to do their work. However, they noted that the recruitment and retention of physicians and nurses is important in providing emergency care. Partnerships and relationships have been established with other health care organizations to support the appropriate transfer of clients. This includes Med-Response and collaboration with Alberta Health Services.

The emergency departments are clean and well organized with appropriate signage. There are seclusion rooms available. The team is proud of the work in ensuring an efficient flow of clients through the emergency departments with either appropriate discharge or admission.

Client satisfaction surveys are completed. The information received is used to make improvements to programs and services. The addition of behavioral support workers is an improvement to the emergency department. The initial anecdotal evidence of success with data being collected for further review. The leaders are encouraged to continue to seek feedback on the effectiveness of resources, space, and staffing with input from clients and families.

Priority Process: Competency

Strong interdisciplinary teams provide quality emergency services to clients and families throughout the Northwest Territories. The team members spoke highly of the education and training provided. The team members commented on the value of the orientation process. The locum staff described the benefit of mentorship by an experienced nurse. The physicians noted the collaborative support from collogues both on site and at other emergency departments. Education and training are provided to team members on how to prevent workplace violence. Safety measures include the presence of security staff and security call alarms. Behavioral support workers with a background in justice and corrections as well as training in de-escalation are welcome additions to the emergency department at Stanton Territorial Hospital. The team members noted that they feel safe at work.

Performance appraisals are not consistently completed for team members. Team member performance is not regularly evaluated and documented. The leaders are encouraged to evaluate team member performance in an objective, interactive, and constructive way.

The team members are proud of the quality of the care provided. The teams are commended for the strong commitment to infusion pump training. The SBAR tool is implemented. Culturally competent and respectful care is provided.

Priority Process: Episode of Care

The team members, physicians, and leaders are to be commended for their commitment to quality emergency services for clients and their families. There is collaboration within and across emergency departments. The team members have a strong work ethic and foster a supportive culture. The team members are aware of staff vacancies and are trying to recruit to the emergency departments. The team members are strong ambassadors for the organizations.

There are effective working relations with the RCMP, Med-Response, and other healthcare organizations. There is a commitment to providing care "closer to home." The clients stated that they were treated with care, dignity and respect. Furthermore, they were aware of the follow up plan of care. The clients did not have recommendations for improvement.

There is a strong commitment of the leaders, team members, and physicians to ensure the efficient flow of patients through the emergency departments. Clients have limited wait times for an inpatient bed once the decision to admit is made. Inpatient beds are available. The teams are involved in facilitating the efficient transfer of clients including the repatriation of clients from other healthcare organizations. Innovative solutions to decrease wait times in the emergency departments include the transfer of low acuity patients to outpatient clinics facilitating improved access to primary care. The effectiveness of transitions is evaluated and the information used to improve transition planning.

The entrances to the emergency departments are clearly marked. The physical spaces are spacious, clean and organized. All clients are triaged using the CTAS. The team are commended for their commitment to medication reconciliation. Laboratory and diagnostic imaging resources are available. Negative pressure isolation rooms are available. The emergency departments have access to seclusion rooms.

The organization is to be commended for the development of a new ethics framework however, the ethics framework has not consistently been implemented across the organization. The leaders are encouraged to continue to implement the ethics framework to ensure that ethics-related issues are proactively identified, managed, and addressed.

Stanton Hospital has a new and spacious emergency department. The team members are generally pleased with their input during the building process to improve patient flow. Privacy during triage is important to ensure confidential and private client interactions. The leaders are encouraged to review privacy at triage areas and to make improvements as required.

Priority Process: Decision Support

The staff and leaders are committed to using decision support to enable quality emergency services. Paper medical records or a hybrid charting process are used in the emergency departments. The organization is encouraged to continue with the plans to explore the implementation of electronic systems to support collaborative client care and clinical decision making.

Standardized client information is collected. Comprehensive and up to date health information is collected with the input of clients and families. Care plans are developed and updated with the input of clients and families.

Priority Process: Impact on Outcomes

A Territorial Quality Improvement Emergency Department Team is established and meets on a monthly basis. The team will assist in the development of quality initiatives and the selection of evidence-informed guidelines. Data are collected and compared with benchmarks. The leaders and team are encouraged to continue the quality improvement journey with the input of clients and families.

Patient Satisfaction Surveys are completed with the results shared with clients and families. The team

uses the results of patient satisfaction surveys to make improvements. A Quality and Risk Board, located in the client waiting room is used to share quality improvement indicators and initiatives with the team members, clients and families. An electronic incident reporting system is used by the team to report quality and risk issues. Hand hygiene audits are completed with the results visible.

The emergency department teams are encouraged to continue to support the co-design of services with clients and families. Clients and families will offer important insights into the design of programs, services and quality and safety initiatives.

Priority Process: Organ and Tissue Donation

Organ and tissue donation does not occur at the Northwest Territories Health and Social Services Authority. The leaders are encouraged to explore opportunities to implement organ and tissue donation.

Standards Set: Home Care Services - Direct Service Provision

Unmet Criteria	High Priority Criteria
Priority Process: Clinical Leadership	
The organization has met all criteria for this priority process.	
Priority Process: Competency	
The organization has met all criteria for this priority process.	
Priority Process: Episode of Care	
The organization has met all criteria for this priority process.	
Priority Process: Decision Support	
The organization has met all criteria for this priority process.	
Priority Process: Impact on Outcomes	
The organization has met all criteria for this priority process.	

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

NTHSSA has four home care teams located in Beaufort-Delta region, Dehcho region, Fort Smith region and Yellowknife region.
These teams are located in the hub communities of Inuvik, Fort Simpson, Fort Smith, and Yellowknife. All regions, except Fort Smith, have home support services in their satellite communities. The hours of operation vary from site to site and depends on available resources and demand. The number of clients requiring services is increasing. All supplies and equipment for home care clients are funded.
A territorial home care review has recently been completed in spring/summer 2019. The report will be available shortly and will provide a road map for the service delivery model.

The home care team is well integrated and collaborative across other health services. The approach to care and service is standardized and includes input from their clients, families and partners, both internal and external. The staff has a good understanding of their community and the needs of the people. They have regular meetings to discuss clients and service needs (daily huddles).

The clients and families are very happy with the services and support they receive from home care. They trust those staff that provide services and describe them as knowledgeable, caring and supportive.
The staff assists the clients to define what services they require.
The staff say the social interaction is important as well and that was validated by the clients I visited.

They complete risk assessments in the home initially, annually and if changes are noted in the clients' condition or at the home.

The staff skill mix varies from one region to another but most include registered nurses, and home support workers as a minimum. Some also have a dietician, pt/ot, medical social worker, LPN's, and intake coordinator on their team. Other regions can access these additional services but they are not part of the home care team.

Priority Process: Competency

The staff receive a good orientation and are provided with opportunities for ongoing professional development. Onboarding is one of their initiatives going forward. The region is encouraged to ensure that all staff receives a similar orientation, no matter what area they work in. Mentoring for new staff is a valuable support to those staff.
The territorial wound care nurses are trained at a Canadian certification level and are very knowledgeable in the service area. There has been an additional position hired that will be great support across the territories. There is a Contract for an advanced wound care course and training sessions will be offered in different regions throughout.
There is a new Home Care brochure outlining services offered – this helps decrease unrealistic expectations and was requested by the community.
The standardization of work across all areas has begun and includes a consent process and home risk assessment.
There is partnering with CPAC to enhance and improve Palliation across NWT. Staff share examples of how their work is benefiting these end of life clients. The home care staff are encouraged to build a strong collaboration with acute care services in how to manage end of life clients. This will ensure there are no gaps in the service delivery between home and acute.

Priority Process: Episode of Care

The integrated home care team is familiar with the needs of their community. They consult with various community partners like acute care, NWT Seniors Society, DHSS, consultations with clients and families, review client satisfaction surveys and indicator results.
Home care provides a wide range of services including various types of assessments (home risk), medication management, diabetic care, personal care, foot care, dressings and wound care, ostomy care, health education, palliative care, catheter care, post surgical and trauma care, home supports and advocacy. The hours of operation vary depending on the resources available and the demand. Some regions work Monday to Friday days, while other regions provide extended hours every day and on weekends.
There was a Territorial Home Care and Home support review completed in the spring/summer 2019. This report will be available shortly and should serve as a road map for a service delivery model approach.
There is a working group in place to implement IntraRAI across the territories. There is also a new standardized consent in place for home and community care.

The medication reconciliation process that is being used is an older version; however, it meets the requirements for the standard. The process will be updated and standardized at some point, along with many other policies and procedures, as they move to integrate several regions.
All staff are trained in using the NTHSSA Suicide Risk Assessment, one for adults and one for child & Youth. This assessment is done by the first contact with staff where the concern is noted.

Successes for the home care team include new home care brochure outlining services that will help decrease unrealistic expectations in the community, daily team huddles, meeting their indicator data benchmarks, standardization work around consents and home risk assessment, they have added a second wound care nurse to support NWT, they have a contract for an advanced wound care course to be offered in several regions, ABI/TPI available in all regions, and partnership with CPAC to enhance and improve palliation (end of life).

Areas for improvement as identified by the team include further standardization of policies and procedures, onboarding and orientation, standardization of job profiles and position titles, to address transportation issues raised by the public, and the need for improved geriatric specific services such as psychogeriatrics, a geriatrician and capacity assessments.

Priority Process: Decision Support

The home care records are well organized and up to date. The organization is encouraged to integrate a fully electronic community health record to enhance communication and timely sharing of client information. The home care nurses enter information electronically while others on the team document on paper. The team is assuming risk by maintaining a hybrid file. The team is encouraged to review the transportation of paper files to the home and how they maintain their security and safety. The model used in Yellowknife, where files are locked in a briefcase and then locked in the vehicle is a good approach and should be available in all regions.
Attention is given to protecting client privacy at all levels when discussing and visiting clients. Staff state that this is particularly important in smaller communities where everyone knows each other.
Policies and procedures are in place to guide client access to their own information and these are aligned with NWT legislation. Consents are required for some information sharing.

Priority Process: Impact on Outcomes

There are a number of overarching quality indicators collected quarterly and these include the percentage of residents with new pressure ulcers, the percentage of residents who sustain injuries related to falls, and the percentage of time information transferred when the change of shift was complete.
There are a number of quality initiatives underway that including palliative care education, the InterRAI project, EMR versus paper charts, standardization of processes like home risk assessment and falls prevention program.
They have a pilot project starting this fall which allows for paid family caregiver support in response to feedback from the community.
The team and the NTHSSA listen to the publics' input which is very important to the community

stakeholders and clients I spoke to.
One concern heard from the clients in Yellowknife was access to foot care. The clients wait a long time to access foot care in their home and they would like to see some improvement. The other comments from clients across the regions were very positive and most felt that they could not be in their own home without home care support. They felt encouraged and supported to do as much for themselves as possible therefore, promoting their independence.

Standards Set: Infection Prevention and Control Standards - Direct Service Provision

Unmet Criteria	High Priority Criteria
Priority Process: Infection Prevention and Control	
14.3 Input is gathered from team members, volunteers, and clients and families on components of the IPC program.	
14.5 Results of evaluations are shared with team members, volunteers, clients, and families.	
Surveyor comments on the priority process(es)	
Priority Process: Infection Prevention and Control	

Infection Prevention and Control are demonstrated to be of high importance to this organization. There are effective collaborations and partnerships with allied health services and agencies in the communities. Staff was able to give examples of outbreaks that have occurred and of lessons learned from them.'
An outbreak of C Diff in the newly opened hospital was of great concern. Extensive resources were deployed to deal with and identify the source of the outbreak.
There are firm plans being carried out on how to ensure that all levels of staff have appropriate IPC related education. Visitors and patients are given information in ways that appear meaningful to them.
The new hospital has handwashing sinks in each room.
It would appear that continued collaboration with the building of the Stanton Hospital is required to ensure that precautions are taken and reactions to potentially environmentally hazardous concerns are reacted to in a timely and thorough manner.

Standards Set: Inpatient Services - Direct Service Provision

Unmet Criteria	High Priority Criteria
Priority Process: Clinical Leadership	
The organization has met all criteria for this priority process.	
Priority Process: Competency	
3.11 Team member performance is regularly evaluated and documented in an objective, interactive, and constructive way.	!
Priority Process: Episode of Care	
The organization has met all criteria for this priority process.	
Priority Process: Decision Support	
The organization has met all criteria for this priority process.	
Priority Process: Impact on Outcomes	
The organization has met all criteria for this priority process.	

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

The Medical Inpatient Unit at Stanton Territorial Hospital expanded to 24 beds in the new building. Common diagnoses are Cardiac, Respiratory and Chronic Diseases. The unit has telemetry monitoring capability. 8-11 of the patients are ALC and awaiting placement. The program is seeing an increase in an aging population and patients with dementia. The inpatient unit at Inuvik is a combination medical surgical unit.

Priority Process: Competency

Staff complete a hospital and unit orientation prior to working alone. The orientation process was viewed as being beneficial for all team members but in particular locum staff, in assisting them in providing quality care. The new team members were partnered with a buddy to support them during the beginning shifts. All staff have been oriented on the new infusion pumps that have a new drug library. There is access to LMS where staff can find specific courses. The unit at STH is led by two Hospitalists. The staff at STH spoke of the adjustment to the new building. It is a larger footprint and they have more beds. At night, with fewer staff on shift, there are concerns about safety as the elevators are not locked. There are numerous alarms on the unit relating to patient safety such as bed or seat alarms, infusion pumps and telemetry. All of the doors are alarmed as well and staff feels overwhelmed with alarms going off at all

times. The Manager is aware and is working with the Facility to try to address the issue.

Team member performance is not regularly evaluated and documented in an objective, interactive and constructive way. The leaders are encouraged to provide the team members with a performance evaluation that is documented in an objective, interactive and constructive way.

Priority Process: Episode of Care

Inpatient services are provided by a committed interdisciplinary team. The physicians are engaged in providing quality inpatient care. The team members noted that they have the resources to do their work. The team commented positively on the training and education opportunities provided. At STH, staff spoke highly of the support from the Pharmacists. The STH now has all single rooms for patients each with their own bathroom and overhead lift. Some rooms have anterooms and can be used for negative pressure.

The client health records were up to date and comprehensive. A paper-based chart is used. The team had strong processes in place for the completion of medication reconciliation, infusion pump training and pressure ulcer prevention. SBAR is implemented. Shift report at Stanton takes place behand closed doors for approximately 30 minutes. The unit may want to look at other options for providing shift handover information that is more transparent and open such as bedside report.

The clients commented on the excellent care they received from the team members. They stated they were treated with care, dignity and respect. Furthermore, they were aware of their follow up care. There was a suggestion to include more "country food" on the patient menu. While there are few flow issues, patients who have gone to Alberta are being repatriated much quicker than in the past. Patients who may be going to Inuvik will often stop at STH to ensure they are suitable to be discharged to a more remote location. There is a high reliance on Medivac for patient transfers.

At Inuvik, there are fifteen inpatient beds. There are no issues with patient flow or bed availability. The unit is well organized and clean.

Priority Process: Decision Support

The client heath records were up to date and comprehensive. A paper-based chart is used.

Priority Process: Impact on Outcomes

Quality Boards are a recent addition to the unit. The Manager is looking at how to present indicators and data in a way that would be easier to read and attract discussion. Clinical Coordinators spend time rounding with all the patients. This has helped them to gain a better understanding of the needs of the patients.

Standards Set: Long-Term Care Services - Direct Service Provision

Unmet Criteria		High Priority Criteria
Priority Process: Clinical Leadership		
2.4	The physical space is designed with input from residents and families and is safe, comfortable, and reflects a home-like environment.	
5.2	Work and job design, roles and responsibilities, and assignments are determined with input from team members, and from residents and families where appropriate.	
Priority Process: Competency		
3.6	Education and training are provided on the organization's ethical decision-making framework.	
Priority Process: Episode of Care		
The organization has met all criteria for this priority process.		
Priority Process: Decision Support		
The organization has met all criteria for this priority process.		
Priority Process: Impact on Outcomes		
17.11	Quality improvement initiatives are regularly evaluated for feasibility, relevance, and usefulness, with input from residents and families.	

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

Long Term Care services are highly evolved and professional. The care team has a firm appreciation and understanding of the residents and triggers that may result in responsive behaviours from residents. The person centred care plans are thorough and ever flexible in response to the changing needs of the residents.
It is evident that Long Term Care staff strive for excellence in care and are well versed in policies and best practices.
Residents report feeling safe and well cared for in the homes. A competent team of professionals work together to create a team that is providing high quality care.
It is recommended that there be enhanced access to a geriatrician who would enhance the service even more. The aging population only increases the need for the same.
One thing of note is the remarkably low rate of antipsychotic use in long term care. While many places in Canada are dealing with an extreme problem of overprescribing of antipsychotics in the elderly, this

organization has been able to keep the use to a minimum and restricted to those who have a mental health diagnosis. The teams at all levels are to be commended for this reality. The rest of Canada could learn from the practices here.
While it can be extremely challenging to draw in family involvement when residents may originally be from a community that is very distant from the site where there loved one lives in Long Term Care, efforts are made to engage families in a meaningful way. The organization is encouraged to continue to find creative ways in which to engage family members from geographic distances.

Priority Process: Competency

Staff at all levels are extremely well versed in dealing with responsive behaviours of clients. They express insight into the types of triggers that may cause these behaviours and work hard to ensure each resident is treated in a manner that minimizes reactions.
The addition of enhanced Geriatrician services would only add to the competency level of the team.
Many staff at the Stanton site have been working with Long Term Care for many years. They have a wealth of knowledge about the residents and how to best care for them. New employees are welcomed into the group with enthusiasm. Staff at Stanton expressed great appreciation for the access they have to continued education. They are given two days per six weeks to do ongoing competency courses. Also, they have a generous employee education fund which they can access. This is much appreciated by the staff and is a symbol of the importance that the organization places on competency.

Priority Process: Episode of Care

A resident satisfaction survey was recently completed and results are currently being tabulated. The organization is encouraged to have a robust communication plan so that results of the survey are shared in a meaningful way with residents and their families. Ongoing engagement strategies with families is highly recommended as a priority.
Technology such as Telehealth is being used to enable residents to have visits with family members who are unable to visit in person. Telehealth is also being leveraged to meet a new standard where family are involved with yearly care plan updates.
A traditional food platform enables residents to enjoy foods they are more familiar with and this becomes a recreational activity for all.

Long Term Care has an incredibly low use of antipsychotic medications; while this is a challenge that the rest of Canada aspires to master. The organization is to be commended for this fact and also for the overall low use of prescribed medications in LTC.

Priority Process: Decision Support

Privacy and other resident rights are held in high regard as priority for this service.
Using the Supportive Pathways Model of Care, the service displays high standards and output.
A great deal of information about communities and about upcoming trends is available for planning purposes.
Patient charts are thorough and well organized.

Priority Process: Impact on Outcomes

Balancing a resident's right to make decisions about their own care is balanced effectively with the priority of providing a safe environment for all.

Standards Set: Medication Management Standards - Direct Service Provision

Unmet Criteria	High Priority Criteria
Priority Process: Medication Management	
2.3 There is an antimicrobial stewardship program to optimize antimicrobial use. NOTE: This ROP applies to organizations providing the following services: inpatient acute care, inpatient cancer, inpatient rehabilitation, and complex continuing care.	ROP
2.3.5 The program is evaluated on an ongoing basis and results are shared with stakeholders in the organization.	**MINOR**
2.10 The interdisciplinary committee develops a process for using sample medications.	
15.1 The pharmacist reviews all prescription and medication orders within the organization prior to administration of the first dose.	!
Surveyor comments on the priority process(es)	
Priority Process: Medication Management	

The Pharmacy at Stanton Territorial Hospital (STH) provides services to Yellowknife, Deh Cho, Tlicho, and Fort Smith, while Inuvik Regional Hospital (IRH) supports Beaufort Delta and Sahtu. Currently, there is no pharmacist support at Fort Smith and discussions are in place on how to support the site for 4 hours per week.

The Territory Interdisciplinary Pharmacy and Therapeutics Committee has been in place since the late fall of 2018. The committee oversees the formulary for the NTHSSA that provides medications to 3 primary care hospitals and 26 Rural Health Centres. Formulary medications are based on the facility classification from the Ministry. All formularies are approved by the Ministry of Health. At this time this committee is also the committee addressing medication management practices and standards as there is no Territory Interdisciplinary Committee. The intent is to have a territory wide committee to address issues on a broader scale. Pharmacy staff participates in the STH Clinical Practice Advisory Committee. There are local P&T Committees at STH and IRH.

Pharmacy practices and policies are being standardized. Legacy policies were uploaded to the new policy system with many of them being outdated. Some clinical areas have a binder of hard copies many of which are also outdated. The organization is encouraged to ensure that the processes in place support the newest updated NTHSSA medication management policies and remove outdated policies. While this will take resources to complete it is a safety issue if outdated policies are being used by staff.

The Pharmacy Clinical system has been updated in STH. Inuvik and Hay River have outdated pharmacy systems, that are no longer supported by the vendor. There are discussions occurring about the value of adopting the Connected Care System in Alberta Health Services. This could provide the Territory with order sets and clinical pathway documents. A business case will be presented to the Legislative Assembly in March 2020. Until a decision is made any new technology is on hold. Order sets based on Clinical Pathways are to be developed with the surgical program beginning in January 2020. Members have developed linkages with Alberta Health Services and may adopt ones that are applicable in the Territory.

The Antimicrobial Stewardship Program is in the beginning phase. Both sites are working on AMS and the work is not consolidated. A guidance document has been developed with treatment algorithms. Data collection is underway with the next steps of feedback to practitioners. Resources are challenged as other priorities compete for the same pharmacy resource. There is no physician leader identified for AMS. There is no committee in place to lead this initiative and the organization is encouraged to look at how this can be done as it is currently being supported by P and T.

The new STH was opened in May 2019 with a new pharmacy. The area is bright and spacious and has dedicated IV Add mixture rooms as well as separate chemotherapy preparation and storage rooms. All are equipped with an anteroom and eyewash stations and showers. Medications are administered as unit dose into a pyxis system on the units. Pharmacy technicians work to a full scope of practice. There is a lot of cardboard boxes with supplies in the department. Staff are encouraged to look at options for storage and ensure that cardboard is raised off of the floor. The IRH pharmacy department is well organized with appropriate lighting. There is a sole pharmacist who provides support and dispenses medications to 12 Health Centres. There are good processes to prevent medications from freezing during delivery to the 12 Health Centres. The pharmacist is a contracted employee with an employment contract. The actual pharmacy processes are not contracted out.

Medications are procured from two different companies. Some of the Health Centres have service agreements with suppliers not used by STH. They are encouraged to consider not renewing these contracts when possible and having all medications ordered from the same supplier.

Pharmacy coverage ends at 1600 during the week. There is no coverage on the weekend. All medication orders are reviewed the following day or after the weekend. There is a long gap of no pharmacy review and the organization may want to consider those high-risk medications or patient conditions that may benefit from a conversation with the on call pharmacist prior to the administration of medications. Clinical pharmacy support focuses on patients with missing medication information, where there has been an error in the medication order and patients who have more than 6 medications. Pharmacists try to support the areas clinically with the resources that are currently in place. There are areas of the hospital such as Emergency, Medical day Care and Chemotherapy that do not have any clinical pharmacist support. The department is encouraged to have medication incidents reviewed on a regular basis to understand trends and share learning and improvements.

It is important that the Medication Management Team receive information on medication incidents in

order that they can understand issues and concerns that should be addressed. It would be beneficial for this information to be shared with the team on an ongoing basis.

Standards Set: Mental Health Services - Direct Service Provision

Unmet Criteria		High Priority Criteria
Priority Process: Clinical Leadership		
1.4	Information is collected from clients and families, partners, and the community to inform service design.	
1.6	Processes and policies to meet the diverse needs of the clients and families served are established with input from clients and families.	
1.7	Services are reviewed and monitored for appropriateness, with input from clients and families.	
3.12	A strategy to reduce stigma of mental illness among the team is developed with input from clients and families.	
5.2	Work and job design, roles and responsibilities, and assignments are determined with input from team members, and from clients and families where appropriate.	
Priority Process: Competency		
3.1	Required training and education are defined for all team members with input from clients and families.	!
3.6	Education and training are provided on the organization's ethical decision-making framework.	
Priority Process: Episode of Care		
10.9	The effectiveness of transitions is evaluated and the information is used to improve transition planning, with input from clients and families.	
Priority Process: Decision Support		
The organization has met all criteria for this priority process.		
Priority Process: Impact on Outcomes		
13.2	The procedure to select evidence-informed guidelines is reviewed, with input from clients and families, teams, and partners.	
13.3	There is a standardized process, developed with input from clients and families, to decide among conflicting evidence-informed guidelines.	!
14.3	Verification processes are used to mitigate high-risk activities, with input from clients and families.	!

15.2	The information and feedback gathered is used to identify opportunities for quality improvement initiatives and set priorities, with input from clients and families.	
15.11	Quality improvement initiatives are regularly evaluated for feasibility, relevance, and usefulness, with input from clients and families.	

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

The clinical leadership at the Mental Health Inpatient Unit is stellar. There are highly skilled staff with various professional designations working as a team. The well staffed team is close and appear to have very good communication between each other.
Two psychiatrists support the unit and other units within the hospital as well. The patients have access to a diverse team in an extremely timely manner.
Patients who were interviewed for this survey reported feeling extremely well cared for, taken care of, and safe at this service.
Patient charts are complete and thorough. The organization is to be commended for its high quality mental health inpatient and outpatient services that are offered to the citizens of the territory.
One area which is a challenge for all services, and to a degree with Mental Health, is the need to involve patients and families in revisions to services and garnering their input into program design.
Barriers such as geographic distances are very real. At times there is no way timely to communicate with families of patients if the satellite is down. It is suggested that the entire organization continue to find creative ways in which to involve patients and families at every level of the service; from program design to program revision. This includes QI initiatives and the planning that results from data generated.

Priority Process: Competency

The team consists of an extremely impressive array of Mental Health professionals.

Priority Process: Episode of Care

This well staffed unit is the essence of person centred care. All patients interviewed for this survey report feeling welcome and safe in this environment. Staff goes to great extremes to care for each patient and to customize their treatments in accordance with patient wishes.
Psychiatrist coverage is outstanding, with two psychiatrists being of service to this unit and to other units in the hospital.
The addition of behaviour specialists is impressive as a measure to mitigate responsive behaviours and patient safety. The organization is encouraged to closely track this initiative as it may be a leading practice.

Priority Process: Decision Support

Patient confidentiality is of high priority and this is reflected in the work done by all.

Priority Process: Impact on Outcomes

The Mental Health Service collects an impressive amount of data and uses this to make quality improvements. The entire Mental Health Leadership team has a passion and commitment to quality initiatives. There is much evidence of changes to projects and initiatives based on findings from data gathered.
The team is strongly encouraged to continue to find ways in which to involve patients and families in these quality initiatives. Evidence of family involvement was not observed in all of the standards under this section.

Standards Set: Obstetrics Services - Direct Service Provision

Unmet Criteria		High Priority Criteria
Priority Process: Clinical Leadership		
The organization has met all criteria for this priority process.		
Priority Process: Competency		
3.6	Education and training are provided on the organization's ethical decision-making framework.	
3.8	The orientation to equipment and devices includes the medical devices used by the team and how they are disposed of or reprocessed.	!
3.12	Team member performance is regularly evaluated and documented in an objective, interactive, and constructive way.	!
3.14	Team members are supported by team leaders to follow up on issues and opportunities for growth identified through performance evaluations.	!
Priority Process: Episode of Care		
7.13	Ethics-related issues are proactively identified, managed, and addressed.	!
11.9	Established policies on handling, storing, labelling, and disposing of medications and breast milk safely and securely are followed.	!
Priority Process: Decision Support		
The organization has met all criteria for this priority process.		
Priority Process: Impact on Outcomes		
18.4	Indicator(s) that monitor progress for each quality improvement objective are identified, with input from clients and families.	
18.10	Information about quality improvement activities, results, and learnings is shared with clients, families, teams, organization leaders, and other organizations, as appropriate.	
18.11	Quality improvement initiatives are regularly evaluated for feasibility, relevance, and usefulness, with input from clients and families.	

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

Obstetric services for NTHSSA are provided at 3 sites: Stanton Territorial Hospital (STH), Inuvik Regional Hospital (IRH), and Fort Smith Health Centre (FSHC). The surveyor team visited both STH and IRH Obstetrics services.
The bulk of prenatal, intrapartum and postnatal care is provided by family practice doctors with Obstetric interests. At Stanton Territorial Hospital there are Obstetricians available for consultation 24 hours a day for urgent care and on consult for complex care. Some very complex cases are referred to Edmonton.

At STH, the recent move to the new hospital has provided more spacious facilities. However, opportunities exist to improve retention at the managerial level and fill nursing positions in Labour and Delivery area.

The involvement of Clients and Families as a resource to help inform all aspects of service delivery within Obstetric services should be a priority for leadership.

Priority Process: Competency

Staff at both Stanton and Inuvik obstetric care teams are fully supported and trained within the MoreOB framework.

At Stanton, there is a very strong bond and pride of performance within the team providing care in Labour and Delivery. They note there has been a series of managers for the unit but recently there is more stability. The lack of performance evaluations has led to feelings of missed opportunities for development or, in the past, a lack of transparency in the awarding of professional development opportunities.

At the Inuvik Regional Hospital, there is a strong inter-disciplinary team committed to a quality obstetrical program. A highlight of the commitment to quality is the implementation of the MORE-OB program. The team is to be commended for receiving the Baby Friendly Hospital Initiative designation. A Baby Friendly/ Quality Improvement Committee has been established.

The team commented on the value of the education and training opportunities provided by the Northwest Territories Health and Social Services Authority. The team members stated that they feel safe at work. The team stated that they have the resources to do their work. The clients commented positively on the care provided. They stated that they were treated with care, dignity, and respect.

Although team member performance is not regularly evaluated and documented, the team members noted that leaders follow up on issues and opportunities for growth. The leaders are encouraged to evaluate team member performance in an objective, interactive, and constructive way and to follow up on issues and opportunities for growth identified through performance evaluations.

Priority Process: Episode of Care

The organization is justifiably proud of its Obstetric services and results at both Stanton and Inuvik.

The improvement of the Caesarian Section rate from over 40% to around 15 - 17% is a great achievement.

Inuvik's designation as a Baby Friendly hospital is a great achievement and both Fort Smith and Stanton are on their way to similar designations.

The implementation of More OB has greatly aided the determination and resolve of the care teams at both hospitals.

There are plans to bring Midwives to the program at Stanton and perhaps attempt to develop more culturally appropriate prenatal programming into the fly-in communities.

Priority Process: Decision Support

Both Stanton and Inuvik rely on paper based charting in Labour and Delivery.
Charts are compiled and audited for completeness. Some of the audit results are posted in nursing areas to demonstrate compliance with ROP's.
Handovers and transfers are both oral and written, using the SBAR system.

Priority Process: Impact on Outcomes

Obstetric services safety practices and consistency in care and outcomes at both Stanton and Inuvik are greatly aided by adherence to More OB training drills and memory aids.

The Caesarian Section rate tracking and reduction over time is a great example of quality indicator tracking with a positive outcome from the feedback loop.
Another QI strategy at Stanton that has not been formally announced but has been successfully implemented includes increased patient hydration to reduce assisted delivery rates.
The Perinatal Database provides a useful baseline data set.

There are opportunities to formally develop a Client and Family Advisory team to further inform programming improvements or change.

At Inuvik, Quality indicators have been developed. The results of the quality initiatives are posted on quality and risk boards. The team and leaders are encouraged to continue to seek the input of clients and families into the co-design of programs and services.

Standards Set: Perioperative Services and Invasive Procedures - Direct Service Provision

Unmet Criteria		High Priority Criteria
Priority Process: Clinical Leadership		
The organization has met all criteria for this priority process.		
Priority Process: Competency		
6.5	Education and training are provided on the organization's care delivery model.	
6.6	Education and training are provided on the organization's ethical decision-making framework.	
6.11	Team member performance is regularly evaluated and documented in an objective, interactive, and constructive way.	!
Priority Process: Episode of Care		
10.14	Ethics-related issues are proactively identified, managed, and addressed.	!
Priority Process: Decision Support		
The organization has met all criteria for this priority process.		
Priority Process: Impact on Outcomes		
25.10	Information about quality improvement activities, results, and learnings is shared with clients, families, teams, organization leaders, and other organizations, as appropriate.	
25.11	Quality improvement initiatives are regularly evaluated for feasibility, relevance, and usefulness, with input from clients and families.	
Priority Process: Medication Management		
The organization has met all criteria for this priority process.		

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

The surgical services performed at Stanton have not changed since the move to the new hospital. Surgical procedures are performed by general surgeons as well as specialists. However, there is a proposed re-design and surgery Program Review process planned to begin in January 2020 to reassess the entire

surgical program.

The administration acknowledges the growing pains at the new hospital Operating room space, particularly in the areas of flow of personnel and building issues.
The space is more divided up than at the old hospital which provides improved privacy and confidentiality but this has then led to a greater sense of isolation of staff after hours if they would need urgent back-up support for their patient.
Issues with poorly functioning phones drains backing up, malfunctioning toilets, an elevator which randomly stops, exit doors without re-entry options, automatic doors which are slow to open and lack sensors to stop for people in their path have led or almost led to incidents which staff feel should have been responded to in a timely fashion by the building owner/managers.

Administration may wish to consider keeping statistics on response times for repairs and communicate these in the form of weekly bulletins of these action items and their status to Peri-Op staff to acknowledge the efforts made to remedy these concerns.

Administration is also keenly aware of staffing shortages and making efforts with Agencies to provide interim staffing.

The perioperative team at the Inuvik Regional Hospital is engaged and passionate about providing quality perioperative services. There is one operating room and one endoscopy room. Surgical procedures are provided four mornings per week, with dental procedures comprising one of the operating room slots. Surgeries are provided by GP Surgeons or visiting surgical specialists. Three operating nurses will support the surgical program. This increase in staffing will occur in January 2020. The team describe feeling safe at work. Additionally, they commented on the benefit of education and training. There are strong orientation and mentorship programs. The clients spoke positively about the care provided. They stated that they were treated with care, dignity and respect. The benefit of providing services closer to home was identified. The clients had no suggestions for improvement.

Team member performance is not regularly evaluated and documented in an objective, interactive and constructive way. The leaders are encouraged to provide the team members with a performance evaluation that is documented in an objective, interactive and constructive way.

Priority Process: Competency

The OR team at Stanton is well skilled and trained in their roles. They are highly functioning as a team and anticipate each other's and the surgeon's needs in a way that demonstrates good team functioning.

Due to the acknowledged staffing challenges some locum nurses have not received as much orientation to the organization as they would otherwise have received has they not immediately been deployed into the work area.

Priority Process: Episode of Care

A well organized multi-disciplinary team manages the patient from arrival to transition to the floor at both hospitals surveyed.
The professionalism and dedication of staff is admirable. Despite some concerns that have come up within the building at Stanton, staff are consistently absolutely focused and concentrated on providing best patient care.
There is no formal outcome data collection performed by Leadership.
This is something the Surgical leadership may wish to address when they review the program as planned in January 2020.

Priority Process: Decision Support

Stanton has a hybrid charting system.
Some electronic records are available at some stations but in practice are usually used for lab results or by the doctors for access to remote patient charts.

Electronic tools and records are used by Orthopedics in the OR when prepping for total joint replacement.

Priority Process: Impact on Outcomes

There are opportunities for the Peri-operative team and Clients and Families to be more involved in Quality Improvement activities.

The organization could use the Accreditation process to further define QI projects, especially with the upcoming Surgery program review.

The Pre-op checklist was recently changed and there is now an opportunity to review its merits over the previous one and seek input from the staff who use it and the managers who use its completion for data gathering. Input from Clients and Families must also be kept in mind.

Audits are done for compliance data accumulation, the data should also be reviewed for relevance and with a focus on opportunities for improvement.

Priority Process: Medication Management

Medication Management standards are respected in all areas of the perioperative area at both hospitals.

Standards Set: Point-of-Care Testing - Direct Service Provision

Unmet Criteria		High Priority Criteria
Priority Process: Point-of-care Testing Services		
1.4	The interdisciplinary committee review POCT quality control data on an annual basis and make improvements as needed. CSA Reference: Z22870:07, 5.6.6.	
4.6	The lab director or suitably qualified health care professional annually reviews and evaluates the effectiveness of the SOPs and adjusts the SOPs, training activities, or monitoring processes as necessary.	
5.9	When the organization uses different types of POCT equipment for the same procedure, the lab director or suitably qualified health care professional works with a central biomedical lab to verify that each type of equipment gives the same result in all cases.	!
10.8	Health professionals delivering POCT regularly compare and correlate their quality control results with a central lab.	!
10.9	The organization participates in an external POCT quality control program. CSA Reference: Z22870:07, 5.6.	

Surveyor comments on the priority process(es)

Priority Process: Point-of-care Testing Services

A comprehensive review of Point of care testing (POCT) in the region began in the spring of 2018 when a POC Specialist was hired. All sites providing POCT were audited and environmental scans completed to help inform the work plan. To date, there has been the standardization of POC testing kits, materials and devices. There is a POC Leadership Committee that continues to address outstanding issues such as inventory control and management of devices. Support is provided by Dynalife, an external contract. Learning materials have been developed and placed on a POC Hub on the NTHSSA website. The program is in the beginning phase of data collection, effectiveness is not reviewed yet and they are identifying key performance indicators
Quality indicator monitoring is occurring with the review of the performed quality control.

The territorial standardization of the devices and program shows improvement for POCT.
Nurses in several remote locations who use POCT spoke positively about the work that has taken place to date. They appreciated the standardization and the multiple learning modalities that are available on the Hub, such as videos, job aids and power points. They identified the support these materials provide to Locum nurses. They would like the opportunity to connect on a quarterly basis to share concerns, get

updates and hear of related topics of interest. They spoke of the positive comments from patients relating to client identification procedures. Patients appreciated the fact that there were diligent in ensuring that they had the right patient. The program is new & therefore review of SOP & effectiveness has not occurred.
Territorial Interdisciplinary Committee meets monthly, there is a plan to build a formal process for the request of POC testing.
SOP's are on "Our Territorial Share File", where staff can access. SOP's territorial or Legacy (older) are in this file. POC Devices with Instructions for use have many appendices added to the end Critical Results which do not match other critical values.
An opportunity to improve is the document control, approval should include POCT experts, review and revision monitored by POCT program. Obsolete documents removed from this file.
Currently, they are unable to perform the correlation of POC Test with Lab test, and external proficiency is not being performed, there is difficulty to get the specimen to sites for testing in the set time. This would be an opportunity to monitor competency in the performance of testing and are strongly encouraged to create a competency program.
Inventory Control and tracking of devices are well maintained.

Standards Set: Primary Care Services - Direct Service Provision

Unmet Criteria	High Priority Criteria
Priority Process: Clinical Leadership	
The organization has met all criteria for this priority process.	
Priority Process: Competency	
The organization has met all criteria for this priority process.	
Priority Process: Episode of Care	
The organization has met all criteria for this priority process.	
Priority Process: Decision Support	
The organization has met all criteria for this priority process.	
Priority Process: Impact on Outcomes	
The organization has met all criteria for this priority process.	

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

Primary Care Services are ever-evolving. The Team A and B design are currently being replaced with an Integrated Care Team Model. This is expected to further advance the priority of person centred care. A Gap Analysis contributed to this direction.
Primary Care has several concrete examples of effective collaboration with the rest of the healthcare system. The EMR system of charting and communication is effective. Clients did express some concern that at times their information concerning other interactions with the health service does not seem to be available to Primary Care providers in a timely manner. One example is a patient who had been admitted to Psychiatry in Yellowknife recently however the information about his time in that service was not on his EMR when he attended his appointment with his Primary Care physician the following week. This is rectified by the Primary Care doctor requesting the documentation from the writer. It does, however, prove a point that even the best of plans and practices can result in gaps.
Being one Health system has allowed for Primary Care to leverage what works in one area and expanding it to other PC sites.
There are eleven official languages spoken in the Northwest Territories. Primary Care has access to interpreters who can be scheduled to accompany patients needing translation services.
The Community Health Nurse model is one that holds great interest and promise.
The Integrated Health Team model is a demonstration project which has a horizontal rather than a vertical structure. Clients will be seen by the most appropriate practitioner, who works to their full scope of

practice.
Another promising service is the same day access clinic which offers extended hours six days per week.
The majority of PC staff have been trained in cultural awareness including cultural safety.
Virtual care is offered to those in remote areas.

Priority Process: Competency

Team members are offered ongoing training on relevant topics.
Collaboration is the cornerstone of Primary Care services.

Priority Process: Episode of Care

Upon registration a client has the option of writing down their reason for coming to Primary Care rather than having to verbally tell the Care Assistant the reason. This enhanced offer of privacy shows value placed on the client's confidentiality and comfort level. This change was the result of client feedback and is to be commended as an ethical practice.

Priority Process: Decision Support

Ethical practices are readily evident. Client confidentiality is high priority. One extremely impressive area of focus has been in the area of "no shows". A targeted approach has resulted in a reduction of no shows. Results are posted for patients to view. Staff say they have had many insightful comments from patients about same. The low no show rate is something that the organization should be very proud of as it is a real sign of an important efficiency.

Priority Process: Impact on Outcomes

Primary Care services offered are extremely impressive. There is freedom shown to try new initiatives as well as the flexibility to change course if the intended outcomes are not evident.
Staff expressed the desire for a nurse educator position so that there is someone defined who will provide ongoing education on new and best practices. They felt this would increase efficiency. Evidently, there used to be such positions however they were lost in the transition to one health authority.
Staff are also proud of the teamwork they have and that they are able to say they go above and beyond to help a patient who comes in the doors. Even someone coming in without an appointment will bring the team together to ensure that the person is seen as soon as possible and with a welcoming attitude.

Standards Set: Public Health Services - Direct Service Provision

Unmet Criteria	High Priority Criteria
Priority Process: Clinical Leadership	
The organization has met all criteria for this priority process.	
Priority Process: Competency	
The organization has met all criteria for this priority process.	
Priority Process: Impact on Outcomes	
The organization has met all criteria for this priority process.	
Priority Process: Public Health	
15.2 Information from research, best practices and evidence is used to guide programming and service development.	
15.3 Knowledge of public health research, best practices and evidence is shared with partners.	
15.4 The organization works with research partners across sectors and at all levels to advance public health research.	

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

The team members roles and responsibilities are clearly defined and established.

Priority Process: Competency

From a competency perspective, the public health team feels very supported by the organization. Appropriate orientation is provided to new staff when they begin their function within the team. All team members are evaluated as part of a performance review and are provided training and education when needed. However, while many educational opportunities are provided there are significant restrictions with regards to accessing training outside of the territories which limits the educational scope. Greater opportunities for training outside of the territories would positively impact the quality of services provided to the clientele of the territory.
The team acknowledges that they do receive recognition for the work they do both from the organization and from their peers which is very appreciated.

Priority Process: Impact on Outcomes

The organization promotes a number of quality improvement initiatives that serve to improve its services to the population. They collaborate with the Ministry of Health and Social Services of the Northwest Territories in implementing a satisfaction questionnaire completed by clients every two years. The results of these questionnaires are posted for staff information and to have a better awareness of how the services they offer impact their clients. The organization has however recently engaged a consultant to review this program with the intent of developing an improved version of the questionnaire to enhance the type of feedback the organization wishes to obtain. The organization has also embarked on the development of an entirely new division of quality assurance which is patient experience. This excellent quality initiative should serve to further improve patient-centered care at all sites of the organization.

Priority Process: Public Health

The organization works with the Northwest Territories Government Department of Health and Social Services to ensure updated population assessments. These assessments are quite comprehensive and include information about the territory in general, ethnicity, population changes, substance use, smoking/ vaping and sexually transmitted diseases. The organization uses a range of statistics to help guide and develop its services across the entire territory that it covers. The organization has developed a number of strategies and action plans in public health to support various populations and address specific issues such as Early childhood development, Oral Health, Chronic disease management, Cancer and STI's to name a few. In the public health domain, the team has demonstrated its commitment to ensuring the removal of any barriers to access services for its clientele. Significant efforts are made in the community to facilitate the clients' ability to receive care and services despite resource challenges that exist.

As was presented at the initial leadership meeting, the various teams throughout the organization have created tremendous partnerships to ensure the success of the public health program including Regional wellness councils, Indigenous leadership, NGOs, and Regional interagency committees. The Department of Health and Social Services is, in fact, a significant partner supporting many territorial initiatives with NTHSSA.

The public health team members work very collaboratively with one another and establish annual goals and objectives. They do however feel the challenge with regards to the absence of a sufficient cohort of nurses which does impact the services being provided. Despite this tremendous challenge, the team members support one another to ensure a successful result.

The Public Health service ensures both prevention and promotion strategies are in place. Numerous programs are promoted such as the Baby Friendly Initiative for breastfeeding mothers, the mass immunization clinics and school flu clinics and the Home visiting program. The team understands the challenge of having the population have confidence in them and their professional interventions and this effort is showing positive signs. An example is the flu vaccination clinic taking place across the territories. While only about 20% of the population (similar to the rest of the Country) receive the flu vaccine there is a sense of optimism that there will be growth as a result of solidifying partnerships and enhanced sense of trust in the territory.

Using the relatively new RL6 forms staff identify, report and record adverse events, accidents/ incidents which are flagged for review by the quality risk manager and her team.

In terms of potential improvement, there was a sense that greater focus would be helpful in further developing an up to date database of evidence-based guidelines and best practice information.

This team, under new leadership from within the team, appears to be a very cohesive group who are quite supportive of one another as well as the clients who rely on them.

Standards Set: Rehabilitation Services - Direct Service Provision

Unmet Criteria	High Priority Criteria
Priority Process: Clinical Leadership	
The organization has met all criteria for this priority process.	
Priority Process: Competency	
9.8 Access to spiritual space and care is provided to meet clients' needs.	
Priority Process: Episode of Care	
The organization has met all criteria for this priority process.	
Priority Process: Decision Support	
The organization has met all criteria for this priority process.	
Priority Process: Impact on Outcomes	
13.2 The procedure to select evidence-informed guidelines is reviewed, with input from clients and families, teams, and partners.	
13.3 There is a standardized process, developed with input from clients and families, to decide among conflicting evidence-informed guidelines.	!

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

The rehab team is integrated, collaborative and made up of varying numbers of professionals, including physio (pt), occupational therapy (ot), speech-language pathologists (slp) , pt/ot/slp assistants, and audiology. The staffing is dependant on the resources available, population and community needs. These care providers have a regional focus.

They also have three Territorial Teams including the Child Development Team (CDT) which coordinates care for children with complex needs, the Fetal Alcohol Spectrum Disorder (FASD) family and community support, and the Autism Spectrum Disorder (ASD) consultation team. These teams have a territorial focus.

The four regional teams are located in Inuvik, Yellowknife, Fort Smith, and Hay River. The service delivery model is broad and includes acute care (hospitals), ambulatory care for community based outpatient services, community health centres, long term care, home care and community mental health, preschools/schools.

These are knowledgeable and committed teams with strong leadership. The teams are creative and

intuitive to their territorial and regional needs and are able to collectively come up with solutions.

The staff roles and responsibilities are clearly defined and staff as was seen in Yellowknife, are generalists and rotate through acute care, home care, outpatient services... Some staff travel more than others to remote areas or to areas without services, on a regular schedule, to ensure services are available in all areas across the North.

The staff are familiar with their communities and work closely with the stakeholders to meet the needs of the clients and their families.
Yellowknife has a podiatrist from BC that comes out monthly to assist clients with orthotics.

The team promotes client and family involvement in their care to support independence and self management.

The team uses mentoring to support new staff and this is greatly appreciated by those staff.

The team is encouraged to continue to involve clients and families in designing and reviewing their services, as they add valuable input into what works.

Priority Process: Competency

The staff are offered ongoing professional development opportunities, as well as a very good orientation program, that includes an onboarding checklist and soon will be provided mentoring. I did see the mentoring model used in Yellowknife and the staff, who is also a new graduate, found it very helpful.

The waitlists for services are getting longer so they are working at initiatives to reduce wait times and improve client flow, including discharge from service. Each discipline takes so many new clients every day to improve wait times so to do this they need to discharge.

The team uses an electronic health record that assists with communication and real time information. They hope to go forward with Alberta in using the Epic software that provides full integration of community services. A project (Connect care) is underway in Alberta, they are at phase six and they would accept NWT into their project. This would provide more capacity than their present system, Wolf, but requires approval and budget support. The NWT is encouraged to continue to enhance and expand an EMR as well as telemedicine. The tele-emerg system will be beneficial.

The staff receive additional education and training as required to meet the communities needs. Staff spoke to their mandatory training, online training, and outside conferences they had attended. A staff in Fort Smith who mainly worked with adults and now would see children, went to Yellowknife for training in that specific area. This is a great resource to the area to have this capacity. The team does a good job of sharing their resources and expertise, as seen in this example plus travelling to ensure all areas are served.

Each professional discipline is credentialed under the province from which they have come.
The rehab team are not responsible for infusion pumps therefore do not require training.

Priority Process: Episode of Care

The rehab team has a project underway in Dehcho to define if the clients there are receiving enough service. The team collaborates with all stakeholders to ensure all communities receive the kind of services they need. The Regional Wellness Councils would provide a client and community role in some of this work. I would encourage more awareness around this approach. Some staff were not familiar with how the Councils could be accessed and utilized.

The team provides the infant hearing program across the regions of Yellowknife, Inuvik and Fort Smith. Audiologists are difficult to recruit at times and because the numbers are low, it is important that they maintain at least one. They are encouraged to research alternate models for audiology in the event they have none available.

The team work hard to enhance client and family input and involvement through individualized care plans, patient satisfaction questionnaires, 2019 Patient Experience questionnaire, leadership council engagement, and the Regional wellness councils. Continuous education and awareness is encouraged around their options for input, as we enhance people centred care. As a community and service area, the rehab team focus on the clients during all aspects of their care.

The rehab team are not required to look after infusion pumps therefore do not require education and training.

The team use two patient identifiers, which are full name, DOB, facial and voice recognition for some clients depending on the diagnosis. There are a number of identifiers that have been approved in the North.

There is a standardized, electronic assessment process in place. The staff find the community based EMR very helpful and they appreciate being able to access real time information about their clients.
The primary care services/physicians also use the electronic health record, Wolf. It would be beneficial is all community services could access EMR.

The rehab team are consultative when it comes to palliation and end of life care. The approach is determined by physicians and nursing, and they may be consulted for support and expertise in their particular areas.

Priority Process: Decision Support

Some teams, like the Stanton Team in Yellowknife, do a lot of traveling to ensure services are provided in all communities. Last year there were 384 travel days which can have huge budget impacts. The staff stays longer when they travel to these areas, rather than making several trips in an attempt to reduce travel

costs.

Some of the rehab successes include onboarding EMR which works for them, self referrals for rehab, territorial priority tool which was developed here in NWT demonstrating attention to problems and creativity with solutions, territorial target wait times established as benchmarks, centralization of all rehab wait lists, standardized collection and reporting of stats, and monthly meetings with regional rehab leads.

Some of the challenges noted to rehab were rehab therapists as generalists that rotate through all areas of service, disproportionate catchment areas where two different teams provide services to one area (Ft Providence), staff vacancies where some positions are difficult to fill therefore leaving gaps. They do have a good capacity to support each other in training for the generalist model.

The rehab team uses an electronic health record, Wolf, which enables them to provide accurate and timely client information, and to centralize their waitlists which is key to defining what staffing levels are required and to reduce waitlists. There is a process in place for clients to access their own health information and record.

Clients are very pleased with the services they receive. They appreciate that the equipment they need is readily available for them and free of charge. Clients state that the staff are knowledgeable, respectful, client centred, and have excellent personalities. Handouts are available for the clients and families to outline exercises and care plans.

Priority Process: Impact on Outcomes

The rehab team have a number of quality initiatives that include: to standardize core services (initial draft was done between NWT and DHSS), rehab services program standards (this is with the stakeholders for their input), expand competency based mentorship models, to improve early identification of pre-school children through Well Child Record (currently in Dehcho), and to evaluate staffing levels/resource allocations and catchment areas.

Some of their quality indicators include waitlist benchmarks (based on the prioritization tool), number of regional referrals, client attendance at appts and no shows, and the infant hearing program volumes. These are reported regularly to staff, leadership, and the Leadership Council. They use this data and benchmark tracking to define and evaluate the services. The staff is interested in enhancing public reporting. They do show their no show rates, etc on a whiteboard for their dept in Yellowknife. The clients found that beneficial and it helped raise their awareness. The team is using a number of initiatives to reduce their waitlists and are encouraged to continue.

Quality and safety are priorities for this team and they work to meet client needs in all communities across NWT.
The team would benefit from enhanced client and family input regarding their program standards and core services. The clients accessing these services could provide input as to what works and bring their

experiences to the discussion which can be very valuable.

There is not a procedure used to select evidence based guidelines at this point. The team is very creative however and often develop and implement their own processes. A procedure would benefit the team to select evidence informed guidelines.
There is also not a formal process in place to help with decisions around conflicting evidence informed guidelines. A process would be helpful and should contain input from clients and families.

Standards Set: Remote/Isolated Health Services - Direct Service Provision

Unmet Criteria	High Priority Criteria
Priority Process: Clinical Leadership	
The organization has met all criteria for this priority process.	
Priority Process: Competency	
10.8 Access to spiritual space and care is provided to meet clients' needs.	
Priority Process: Episode of Care	
The organization has met all criteria for this priority process.	
Priority Process: Decision Support	
The organization has met all criteria for this priority process.	
Priority Process: Impact on Outcomes	
The organization has met all criteria for this priority process.	

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

At the 4 remote and isolated service sites visited by 4 surveyors, there was consensus validation of the impressive integration with communities and hamlets, elders, Indigenous leaders and groups across the board. This is impressive as the local councils provide a very transparent way to engage in meaningful dialogues about community health needs and ways to address them within the collective resource base of each unique and individual community

The Remote and Isolated Service Teams were validated to be both the foundation cornerstone of the NTHSSA and the day to day structural and functional and operational links to the Regional Wellness Councils to strengthen the strategic quest to fully realize a one system Territory.

Community engagement is impressive. The development of the population health strategic plan for the system appropriately titled: "Caring for Our People", addressed the voices of the people in its design. Everyone was able to speak with awareness, understanding and pride about the vision and their contributing role in achieving it.

Impressively the Regional Wellness Council Chairs are members of the NWT Health and Social Services

Leadership Council along with the independent Chairs of the NWTHSS Leadership Council and the Tlicho Community Services Agency. As a result, they serve as both advisors and governors of the system. Although these functions fall under Qmentum Leadership and Governance standards it is appropriate in this structure to reference these foundations within the Remote and Isolated Service Standards themselves as that is where the Regional Councils exist and the relationships are forged and nurtured. The accomplishments of the three year old Health and Social Services Authority is astounding and provides lessons for other Canadian provinces.

The Remote and Isolated Services have fully met all standards without exception. There was a ready expression of appreciation to the Leadership Team and Council for interacting and engaging with remote and isolated communities, partners and services in ways they have not experienced before. This alone promises continuing collaboration in achieving strategic success, and teams were encouraged to engage from the bottom up in proactive ways as they have been to date.

Remote and Isolated Services are provided in Community Health Centres in various forms but with standardized processes. Community Health Nurses provide core services with established connections to primary care physicians. Impressively primary care physicians are available for consultation and support 24/7 through a call system. Although many are locums they are organized in ways that ensure continuity. Trust relationships are being fostered in appreciating the competencies of each provider and clients and family care relationships are nurtured.

The full spectrum of prenatal, healthy baby, immunization, postnatal and general health needs are encompassed in service delivery to name a few. Liasons exist with Community Mental Health, Addictions, Home Care and Child and Youth and Family Services, Police, Elders, Wellness Councils, Community Workers and many others. Examples were cited where communities help each other out in times of need. There is a well established relationship with Medivac Services and others.

There is encouragement to continue to examine the human resource needs of each community in terms of access to specific health knowledge and skillsets required based on population health demographics in the regions as they are so very different. This might include Nutritionists, Occupational Therapists, Geriatricians or others as examples

Another area to continue to work on is the adoption of an integrated Electronic Health Record within the system as a whole. The EMR in CHCs is applauded but there are such rich opportunities to integrate the enterprise systems at Stanton Regional Hospital and other areas to better address the transfer of information at all client/patient transition points. This is considered to be value-added to the delivery of remote and isolated health services as well as all others. In doing so attention to discharge planning is a requisite as there are always instances where things fall through the cracks and clients /patients return to the community without notification. This poses risks for clients and staff in Remote and Isolated Health Services system-wide.

Priority Process: Competency

Across the board, the competency of staff to deliver safe quality remote and isolated services was validated. These are not areas that could readily introduce inexperienced staff at all. There is a good mix of Indigenous staff from the communities in the majority of areas which is a strength.
Ongoing attention to monitoring skill mix gaps and finding "just in time ways" and "new models for longer term sustainability is encouraged.

Priority Process: Episode of Care

In terms of access to service and assessment of individual risk, the Remote and Isolated Service teams are exemplary. In these communities, the Community Health Centers and the Community Health Nurses are so well integrated and linked to all services both health and otherwise, which provides them with a comprehensive understanding of population and individual health needs. Clients and families and those in the circle of care are engaged and can articulate very well what that means to them. The values of the Health Authority and those of the communities and the Wellness Councils are emulated in their ways of working. This is a beautiful model for service delivery as a positive, and also poses risk for fatigue for staff as it takes creative ways to escape from thinking about their work as the clients are neighbours, colleagues and family members in these small communities.

The Community Health Nurses maximize their scopes of Nursing Practice and attention to competency development and maintenance is well done. On that note, fiscal restraints require creative ways to ensure ongoing exposure to new and updated evidence-based guidelines and networking and learning from colleagues in other jurisdictions.

Priority Process: Decision Support

Across the board the competency of staff to deliver safe quality remote and isolated services was validated. These are not areas that could readily introduce inexperienced staff at all. There is a good mix of aboriginal staff from the communities in the majority of areas which is a strength.
Ongoing attention to monitoring skill mix gaps and finding "just in time ways" and new models for longer term sustainability is encouraged.

Priority Process: Impact on Outcomes

The Remote and Isolated Health Service Teams are very attentive to outcomes and have a good understanding of trends in their areas. The Service overall is encouraged to work with Territorial colleagues to expand attention on research related to interventions and outcomes as the one system for health unfolds.

Standards Set: Transfusion Services - Direct Service Provision

Unmet Criteria		High Priority Criteria
Priority Process: Episode of Care		
The organization has met all criteria for this priority process.		
Priority Process: Transfusion Services		
1.1	At least every two years, the team collects information about the demand for transfusion services including service volumes, wait times, client perspectives on services, and trends in service needs across different groups such as age or condition-specific populations.	
1.2	At least every two years, the team reviews information collected about the demand for transfusion services to identify strengths and areas for improvement, and makes changes accordingly.	
5.3	The team reviews and updates the SOPs every two years or more often if required.	
5.4	The team follows a document control procedure for developing and maintaining SOPs.	
8.2	The team regularly monitors and records environmental conditions within the laboratory including temperature and humidity levels.	
8.4	The team regularly monitors and records that a functioning emergency backup system is available for equipment used for storing blood components and blood products.	!
18.7	The team stores blood components that do not meet criteria for release in an identified and secured quarantine location until they are released from quarantine or are disposed of appropriately.	!
Surveyor comments on the priority process(es)		
Priority Process: Episode of Care		
Facility Falls Precaution in place.		
Priority Process: Transfusion Services		
The Transfusion Medicine laboratory at the Beaufort Delta Hospital stores and issues Blood and Blood Components, they do not perform blood bank testing of specimens, they are referred to Stanton or Canadian Blood Services. A small inventory of Red Cells for emergency issue are in stock,6 O +, 6 O – RCC, 5 units of FP as well as		

some products such as IVIG, Gammagard, Vz Immune Globulin, Rh Immune Hep B. Crossmatched units for transfusion are sent from Stanton site.
The team lead is very quality engaged she has been developing training documents and records for staff. Two of the staff are hired within the last year, there is a returning locum MLT, as well as an MLA.
The physical space of the laboratory at Beaufort Delta Hospital(BDHSS) is reasonable and avoids cross contamination has clean areas and appears very organized.
An opportunity to improve is in the monitoring of temperature during storage of components or products. The thermometer used to monitor the temperature of Blood components stored in the Sanyo Blood storage fridge and the thermometer for the Freezer which stores frozen plasma have no calibration sticker or certificate.
The Thermo deck used to check the temperature of Red Cell unit when it arrives via transport has a sticker that says calibration was due 09/11/2015.
Sanyo Fridge does have a continuous monitoring graph of weekly temperature which is dated, the time is not recorded. Records from Biomedical maintenance have alarm checked for the Sanyo fridge, however, there is a Standard operating procedure to perform a high and low alarm check on the Blood bank fridge there were no records of this performance. Appears there is not an SOP on the backup plan to store blood components in the event of a failure of current storage.
While the team continues to transition to a territorial authority, improvements to the quality system will occur. Encourage the team to develop formal approval, acknowledge and review structure for documents within the TM services. Currently, the document control process not clearly defined, templates for SOP maybe Stanton transfusion Medicine Templates, Beaufort Delta or Territorial.
The approval and revision process is not clearly described and followed. TM SOP is maintained as a paper format in a binder in the BDHSS Lab, revision review is not documented as performed every two years. The quality framework for Territorial review is 3 years. References for SOP are the previous CSA Z902-10 not the current version.
Many new SOP's specific for BDHSS staff access SOP in paper Binder, some have a sheet to show acknowledged by staff.
Process control and following the written procedures is a quality essential. In observation of the issue log sheet and discussion with the Lab BDHSS team lead, the issue of Red Cells log sheet there is a view consent section that is checked off. Then the lab completes an Issue Notification letter which is given with the first unit. When asked if the unit is not transfused is the letter returned, there is not a process to retrieve this letter. This raises concern the client could be misinformed. Sop states that the letter of notification should be issued by nursing. Incident filed where aa unit of RCC was issued while in Quarantine (no security seal attached when received) to be transfused in Emergency, this was a verbal approval from Dynalife n call pathologist. Follow up corrective action should include formal documentation of authority.

Staff feels the consult with Dynalife specialist is a good working relationship with the lab staff.
Quality Indicator Ratio of xmatch & transfusion currently acceptable, not promoting choosing wisely because transfusions appear appropriate.

Hand washing audits 100%

The Transfusion lab at Stanton Territorial Hospital (STH) is supervised by a Tech II. A thorough review of documents and processes has been undertaken. The shift from a local site to a territorial wide approach has put pressure on daily job demands. A big focus has been on reviewing all policies and converting them to the new NTHSSA format. Many have been completed and are waiting for approval before they can be posted. The organization is encouraged to approve these in a timely manner to ensure that safe up to date transfusion practices occur. The new format recommends policy review every 3 years when lab practice is every two years. A review of SOPs in the Territory is in progress. Many of the SOPs will be a change of practice in some sites and will need to be supported with education. The Tech II is working closely with Nursing to update the Blood Administration form for Nursing. It is outdated from 2014 and it is recommended that it be approved in a timely manner.

There is no Transfusion Safety Officer in the Territory. The core services were moved from the lab at Fort Smith and the transfer of key responsibilities from Inuvik to Stanton. This has increased the workload with no increase in staffing. Workload indicators are being collected to have a better understanding of the changes.

Instrument Results

As part of Qmentum, organizations administer instruments. Qmentum includes three instruments (or questionnaires) that measure governance functioning, patient safety culture, and quality of worklife. They are completed by a representative sample of clients, staff, senior leaders, board members, and other stakeholders.

Governance Functioning Tool (2016)

The Governance Functioning Tool enables members of the governing body to assess board structures and processes, provide their perceptions and opinions, and identify priorities for action. It does this by asking questions about:

- Board composition and membership
- Scope of authority (roles and responsibilities)
- Meeting processes
- Evaluation of performance

Accreditation Canada provided the organization with detailed results from its Governance Functioning Tool prior to the on-site survey through the client organization portal. The organization then had the opportunity to address challenging areas.

- **Data collection period: August 1, 2018 to September 30, 2018**
- **Number of responses: 8**

Governance Functioning Tool Results

	% Strongly Disagree / Disagree	% Neutral	% Agree / Strongly Agree	%Agree * Canadian Average
	Organization	Organization	Organization	
1. We regularly review and ensure compliance with applicable laws, legislation, and regulations.	25	13	63	91
2. Governance policies and procedures that define our role and responsibilities are well documented and consistently followed.	25	0	75	94
3. Subcommittees need better defined roles and responsibilities.	17	0	83	72
4. As a governing body, we do not become directly involved in management issues.	13	0	88	84
5. Disagreements are viewed as a search for solutions rather than a "win/lose".	0	13	88	93

	% Strongly Disagree / Disagree	% Neutral	% Agree / Strongly Agree	%Agree * Canadian Average
	Organization	Organization	Organization	
6. Our meetings are held frequently enough to make sure we are able to make timely decisions.	13	0	88	95
7. Individual members understand and carry out their legal duties, roles, and responsibilities, including subcommittee work (as applicable).	50	13	38	95
8. Members come to meetings prepared to engage in meaningful discussion and thoughtful decision making.	13	13	75	96
9. Our governance processes need to better ensure that everyone participates in decision making.	0	13	88	61
10. The composition of our governing body contributes to strong governance and leadership performance.	0	13	88	94
11. Individual members ask for and listen to one another's ideas and input.	0	0	100	97
12. Our ongoing education and professional development is encouraged.	0	0	100	85
13. Working relationships among individual members are positive.	0	0	100	97
14. We have a process to set bylaws and corporate policies.	13	0	88	94
15. Our bylaws and corporate policies cover confidentiality and conflict of interest.	0	0	100	97
16. We benchmark our performance against other similar organizations and/or national standards.	38	13	50	71
17. Contributions of individual members are reviewed regularly.	50	13	38	68
18. As a team, we regularly review how we function together and how our governance processes could be improved.	13	25	63	82
19. There is a process for improving individual effectiveness when non-performance is an issue.	50	0	50	58
20. As a governing body, we regularly identify areas for improvement and engage in our own quality improvement activities.	13	13	75	84

	% Strongly Disagree / Disagree	% Neutral	% Agree / Strongly Agree	%Agree * Canadian Average
	Organization	Organization	Organization	
21. As individual members, we need better feedback about our contribution to the governing body.	13	0	88	46
22. We receive ongoing education on how to interpret information on quality and patient safety performance.	25	13	63	76
23. As a governing body, we oversee the development of the organization's strategic plan.	25	0	75	93
24. As a governing body, we hear stories about clients who experienced harm during care.	13	0	88	81
25. The performance measures we track as a governing body give us a good understanding of organizational performance.	13	0	88	89
26. We actively recruit, recommend, and/or select new members based on needs for particular skills, background, and experience.	50	50	0	85
27. We lack explicit criteria to recruit and select new members.	0	33	67	75
28. Our renewal cycle is appropriately managed to ensure the continuity of the governing body.	25	0	75	83
29. The composition of our governing body allows us to meet stakeholder and community needs.	13	0	88	91
30. Clear, written policies define term lengths and limits for individual members, as well as compensation.	0	0	100	92
31. We review our own structure, including size and subcommittee structure.	33	17	50	85
32. We have a process to elect or appoint our chair.	67	0	33	84

*Canadian average: Percentage of Accreditation Canada client organizations that completed the instrument from July to December, 2018 and agreed with the instrument items.

Overall, what is your assessment of the governing body's impact over the past 12 months, in terms of driving improvements to:	% Poor / Fair	% Good	% Very Good / Excellent	%Agree * Canadian Average
	Organization	Organization	Organization	
33. Patient safety	57	14	29	77
34. Quality of care	63	13	25	78

*Canadian average: Percentage of Accreditation Canada client organizations that completed the instrument from July to December, 2018 and agreed with the instrument items.

Canadian Patient Safety Culture Survey Tool: Community Based Version

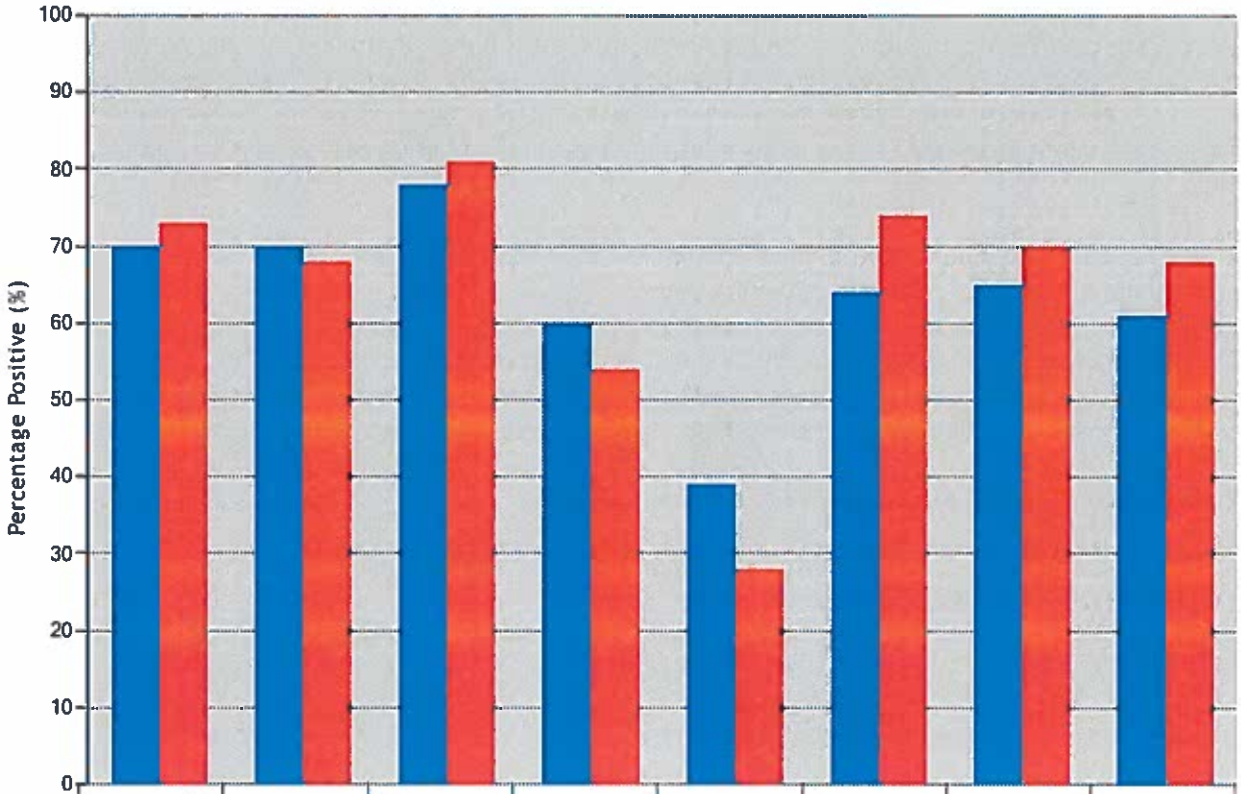
Organizational culture is widely recognized as a significant driver in changing behavior and expectations in order to increase safety within organizations. A key step in this process is the ability to measure the presence and degree of safety culture. This is why Accreditation Canada provides organizations with the Patient Safety Culture Tool, an evidence-informed questionnaire that provides insight into staff perceptions of patient safety. This tool gives organizations an overall patient safety grade and measures a number of dimensions of patient safety culture.

Results from the Patient Safety Culture Tool allow the organization to identify strengths and areas for improvement in a number of areas related to patient safety and worklife.

Accreditation Canada provided the organization with detailed results from its Patient Safety Culture Tool prior to the on-site survey through the client organization portal. The organization then had the opportunity to address areas for improvement. During the on-site survey, surveyors reviewed progress made in those areas.

- **Data collection period: August 1, 2018 to October 5, 2018**
- **Minimum responses rate (based on the number of eligible employees): 278**
- **Number of responses: 585**

Canadian Patient Safety Culture Survey Tool: Community Based Version: Results by Patient Safety Culture Dimension



	Organizational (senior) leadership support for safety	Supervisory leadership for safety	Learning culture	Enabling Open Communi-cation I: judgment-free environment	Enabling Open Communi-cation II: job repercussions of error	Incident follow up	Stand-alone items	Overall Perceptions of Client Safety
	70%	70%	78%	60%	39%	64%	65%	61%
	73%	68%	81%	54%	28%	74%	70%	68%

Legend

Northwest Territories Health and Social Services Authority

* Canadian Average

*Canadian average: Percentage of Accreditation Canada client organizations that completed the instrument from January to June, 2019 and agreed with the instrument items.

Worklife Pulse

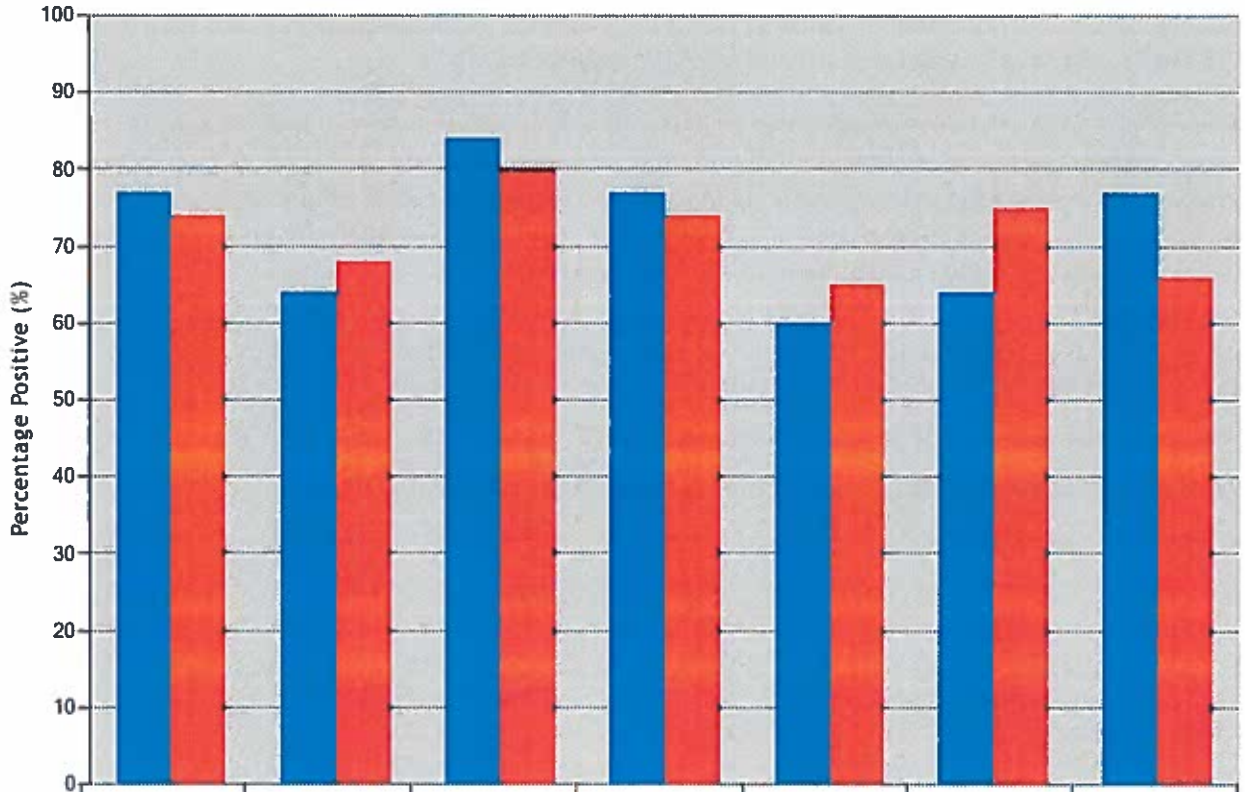
Accreditation Canada helps organizations create high quality workplaces that support workforce wellbeing and performance. This is why Accreditation Canada provides organizations with the Worklife Pulse Tool, an evidence-informed questionnaire that takes a snapshot of the quality of worklife.

Organizations can use results from the Worklife Pulse Tool to identify strengths and gaps in the quality of worklife, engage stakeholders in discussions of opportunities for improvement, plan interventions to improve the quality of worklife and develop a clearer understanding of how quality of worklife influences the organization's capacity to meet its strategic goals. By taking action to improve the determinants of worklife measured in the Worklife Pulse tool, organizations can improve outcomes.

Accreditation Canada provided the organization with detailed results from its Worklife Pulse Tool prior to the on-site survey through the client organization portal. The organization then had the opportunity to address areas for improvement. During the on-site survey, surveyors reviewed progress made in those areas.

- **Data collection period: July 30, 2018 to October 5, 2018**
- **Minimum responses rate (based on the number of eligible employees): 302**
- **Number of responses: 490**

Worklife Pulse: Results of Work Environment



	Job	Training and Development	Coworkers	Immediate Supervisor	Senior Management	Safety and Health	Overall Experience
	77%	64%	84%	77%	60%	64%	77%
	74%	68%	80%	74%	65%	75%	66%

Legend

Northwest Territories Health and Social Services Authority

* Canadian Average

*Canadian average: Percentage of Accreditation Canada client organizations that completed the instrument from January to June, 2019 and agreed with the instrument items.

Client Experience Tool

Measuring client experience in a consistent, formal way provides organizations with information they can use to enhance client-centred services, increase client engagement, and inform quality improvement initiatives.

Prior to the on-site survey, the organization conducted a client experience survey that addressed the following dimensions:

Respecting client values, expressed needs and preferences, including respecting client rights, cultural values, and preferences; ensuring informed consent and shared decision-making; and encouraging active participation in care planning and service delivery.

Sharing information, communication, and education, including providing the information that people want, ensuring open and transparent communication, and educating clients and their families about the health issues.

Coordinating and integrating services across boundaries, including accessing services, providing continuous service across the continuum, and preparing clients for discharge or transition.

Enhancing quality of life in the care environment and in activities of daily living, including providing physical comfort, pain management, and emotional and spiritual support and counselling.

The organization then had the chance to address opportunities for improvement and discuss related initiatives with surveyors during the on-site survey.

Client Experience Program Requirement	
Conducted a client experience survey using a survey tool and approach that meets accreditation program requirements	Met
Provided a client experience survey report(s) to Accreditation Canada	Met

Appendix A - Qmentum

Health care accreditation contributes to quality improvement and patient safety by enabling a health organization to regularly and consistently assess and improve its services. Accreditation Canada's Qmentum accreditation program offers a customized process aligned with each client organization's needs and priorities.

As part of the Qmentum accreditation process, client organizations complete self-assessment questionnaires, submit performance measure data, and undergo an on-site survey during which trained peer surveyors assess their services against national standards. The surveyor team provides preliminary results to the organization at the end of the on-site survey. Accreditation Canada reviews these results and issues the Accreditation Report within 15 business days.

An important adjunct to the Accreditation Report is the online Quality Performance Roadmap, available to client organizations through their portal. The organization uses the information in the Roadmap in conjunction with the Accreditation Report to ensure that it develops comprehensive action plans.

Throughout the four-year cycle, Accreditation Canada provides ongoing liaison and support to help the organization address issues, develop action plans, and monitor progress.

Action Planning

Following the on-site survey, the organization uses the information in its Accreditation Report and Quality Performance Roadmap to develop action plans to address areas identified as needing improvement.

Appendix B - Priority Processes

Priority processes associated with system-wide standards

Priority Process	Description
Communication	Communicating effectively at all levels of the organization and with external stakeholders.
Emergency Preparedness	Planning for and managing emergencies, disasters, or other aspects of public safety.
Governance	Meeting the demands for excellence in governance practice.
Human Capital	Developing the human resource capacity to deliver safe, high quality services.
Integrated Quality Management	Using a proactive, systematic, and ongoing process to manage and integrate quality and achieve organizational goals and objectives.
Medical Devices and Equipment	Obtaining and maintaining machinery and technologies used to diagnose and treat health problems.
Patient Flow	Assessing the smooth and timely movement of clients and families through service settings.
Physical Environment	Providing appropriate and safe structures and facilities to achieve the organization's mission, vision, and goals.
Planning and Service Design	Developing and implementing infrastructure, programs, and services to meet the needs of the populations and communities served.
Principle-based Care and Decision Making	Identifying and making decisions about ethical dilemmas and problems.
Resource Management	Monitoring, administering, and integrating activities related to the allocation and use of resources.

Priority processes associated with population-specific standards

Priority Process	Description
Chronic Disease Management	Integrating and coordinating services across the continuum of care for populations with chronic conditions

Priority Process	Description
Population Health and Wellness	Promoting and protecting the health of the populations and communities served through leadership, partnership, and innovation.

Priority processes associated with service excellence standards

Priority Process	Description
Blood Services	Handling blood and blood components safely, including donor selection, blood collection, and transfusions
Clinical Leadership	Providing leadership and direction to teams providing services.
Competency	Developing a skilled, knowledgeable, interdisciplinary team that can manage and deliver effective programs and services.
Decision Support	Maintaining efficient, secure information systems to support effective service delivery.
Diagnostic Services: Imaging	Ensuring the availability of diagnostic imaging services to assist medical professionals in diagnosing and monitoring health conditions
Diagnostic Services: Laboratory	Ensuring the availability of laboratory services to assist medical professionals in diagnosing and monitoring health conditions
Episode of Care	Partnering with clients and families to provide client-centred services throughout the health care encounter.
Impact on Outcomes	Using evidence and quality improvement measures to evaluate and improve safety and quality of services.
Infection Prevention and Control	Implementing measures to prevent and reduce the acquisition and transmission of infection among staff, service providers, clients, and families
Living Organ Donation	Living organ donation services provided by supporting potential living donors in making informed decisions, to donor suitability testing, and carrying out living organ donation procedures.
Medication Management	Using interdisciplinary teams to manage the provision of medication to clients

Priority Process	Description
Organ and Tissue Donation	Providing organ and/or tissue donation services, from identifying and managing potential donors to recovery.
Organ and Tissue Transplant	Providing organ and/or tissue transplant service from initial assessment to follow-up.
Point-of-care Testing Services	Using non-laboratory tests delivered at the point of care to determine the presence of health problems
Primary Care Clinical Encounter	Providing primary care in the clinical setting, including making primary care services accessible, completing the encounter, and coordinating services
Public Health	Maintaining and improving the health of the population by supporting and implementing policies and practices to prevent disease, and to assess, protect, and promote health.
Surgical Procedures	Delivering safe surgical care, including preoperative preparation, operating room procedures, postoperative recovery, and discharge