ACCREDITATION
AGRÉMENT
CANADA
Qmentum

Accreditation Report

Northwest Territories Health and Social Services Authority

Yellowknife, NT

On-site survey dates: April 21, 2024 - April 26, 2024

Report issued: May 31, 2024

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 April 2024. 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 will be treated in confidence by Accreditation Canada in accordance with the terms and conditions as agreed between your organization and Accreditation Canada for the Assessment Program.

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
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: April 21, 2024 to April 26, 2024**

- **Locations**

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

  1. Beaufort Delta Region - Fort McPherson
  2. Beaufort Delta Region - Inuvik Public Health Office
  3. Beaufort Delta Region - Inuvik Regional Hospital
  4. Deh cho Region - Fort Providence
  5. Deh Cho Region - Fort Simpson Health Centre
  6. Fort Smith Region - Fort Smith Health Centre
  7. Fort Smith Region - Northern Lights Special Care Home
  8. Goga Cho Building
  9. Jan Stirling Building
  10. Joe Tobie Building
  11. Rosie Ovayuak Health Centre
  12. Sahtu Got'ine Regional Health and Social Services Centre
  13. Sahtu Region - Deline Health Centre
  14. Sahtu Region - Deline Wellness Centre
  15. Sahtu´ Dene Necha´ Ko´ Long Term Care Facility
  16. Stanton Region - Stanton Territorial Hospital
  17. Yellowknife Child Youth and Family
  18. Yellowknife Region - Yellowknife Public Health Department
  19. Yellowknife Region - YK Primary Care Clinic
  20. Yellowknife Rehab

- **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 for Remote/Isolated Health Services
5. Medication Management Standards

Service Excellence Standards

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

- **Instruments**

  The organization administered:

  1. Worklife Pulse
  2. Canadian Patient Safety Culture Survey Tool
  3. Governance Functioning Tool (2016)
  4. 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)	96	7	8	111
Accessibility (Give me timely and equitable services)	176	3	1	180
Safety (Keep me safe)	919	20	43	982
Worklife (Take care of those who take care of me)	187	26	1	214
Client-centred Services (Partner with me and my family in our care)	692	9	4	705
Continuity (Coordinate my care across the continuum)	146	3	2	151
Appropriateness (Do the right thing to achieve the best results)	1431	57	34	1522
Efficiency (Make the best use of resources)	74	2	8	84
Total	**3721**	**127**	**101**	**3949**

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	46 (92.0%)	4 (8.0%)	0	35 (97.2%)	1 (2.8%)	0	81 (94.2%)	5 (5.8%)	0
Leadership	49 (98.0%)	1 (2.0%)	0	92 (95.8%)	4 (4.2%)	0	141 (96.6%)	5 (3.4%)	0
Infection Prevention and Control Standards	39 (97.5%)	1 (2.5%)	0	28 (90.3%)	3 (9.7%)	0	67 (94.4%)	4 (5.6%)	0
Medication Management for Remote/Isolated Health Services	56 (86.2%)	9 (13.8%)	8	40 (90.9%)	4 (9.1%)	5	96 (88.1%)	13 (11.9%)	13
Medication Management Standards	71 (97.3%)	2 (2.7%)	5	61 (100.0%)	0 (0.0%)	3	132 (98.5%)	2 (1.5%)	8
Ambulatory Care Services	42 (91.3%)	4 (8.7%)	1	76 (98.7%)	1 (1.3%)	1	118 (95.9%)	5 (4.1%)	2
Biomedical Laboratory Services	68 (95.8%)	3 (4.2%)	1	101 (96.2%)	4 (3.8%)	0	169 (96.0%)	7 (4.0%)	1

Standards Set	High Priority Criteria *			Other Criteria			Total Criteria (High Priority + Other)		
	Met	Unmet	N/A	Met	Unmet	N/A	Met	Unmet	N/A
	# (%)	# (%)	#	# (%)	# (%)	#	# (%)	# (%)	#
Cancer Care	74 (97.4%)	2 (2.6%)	5	114 (99.1%)	1 (0.9%)	0	188 (98.4%)	3 (1.6%)	5
Child, Youth, and Family Services	75 (97.4%)	2 (2.6%)	7	96 (98.0%)	2 (2.0%)	1	171 (97.7%)	4 (2.3%)	8
Community-Based Mental Health Services and Supports	45 (100.0%)	0 (0.0%)	0	94 (100.0%)	0 (0.0%)	0	139 (100.0%)	0 (0.0%)	0
Critical Care Services	57 (98.3%)	1 (1.7%)	2	94 (100.0%)	0 (0.0%)	11	151 (99.3%)	1 (0.7%)	13
Diagnostic Imaging Services	63 (100.0%)	0 (0.0%)	5	62 (91.2%)	6 (8.8%)	1	125 (95.4%)	6 (4.6%)	6
Emergency Department	66 (93.0%)	5 (7.0%)	1	96 (98.0%)	2 (2.0%)	9	162 (95.9%)	7 (4.1%)	10
Home Care Services	44 (91.7%)	4 (8.3%)	0	73 (97.3%)	2 (2.7%)	0	117 (95.1%)	6 (4.9%)	0
Home Support Services	47 (94.0%)	3 (6.0%)	0	72 (96.0%)	3 (4.0%)	0	119 (95.2%)	6 (4.8%)	0
Inpatient Services	59 (98.3%)	1 (1.7%)	0	85 (100.0%)	0 (0.0%)	0	144 (99.3%)	1 (0.7%)	0
Long-Term Care Services	55 (98.2%)	1 (1.8%)	0	94 (95.9%)	4 (4.1%)	1	149 (96.8%)	5 (3.2%)	1
Mental Health Services	48 (96.0%)	2 (4.0%)	0	92 (100.0%)	0 (0.0%)	0	140 (98.6%)	2 (1.4%)	0
Obstetrics Services	71 (100.0%)	0 (0.0%)	2	87 (100.0%)	0 (0.0%)	1	158 (100.0%)	0 (0.0%)	3
Perioperative Services and Invasive Procedures	112 (97.4%)	3 (2.6%)	0	104 (96.3%)	4 (3.7%)	1	216 (96.9%)	7 (3.1%)	1
Point-of-Care Testing	38 (100.0%)	0 (0.0%)	0	46 (100.0%)	0 (0.0%)	2	84 (100.0%)	0 (0.0%)	2
Primary Care Services	57 (96.6%)	2 (3.4%)	0	90 (98.9%)	1 (1.1%)	0	147 (98.0%)	3 (2.0%)	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
	# (%)	# (%)	#	# (%)	# (%)	#	# (%)	# (%)	#
Public Health Services	39 (90.7%)	4 (9.3%)	4	59 (92.2%)	5 (7.8%)	5	98 (91.6%)	9 (8.4%)	9
Rehabilitation Services	45 (100.0%)	0 (0.0%)	0	80 (100.0%)	0 (0.0%)	0	125 (100.0%)	0 (0.0%)	0
Remote/Isolated Health Services	50 (89.3%)	6 (10.7%)	1	81 (91.0%)	8 (9.0%)	0	131 (90.3%)	14 (9.7%)	1
Reprocessing of Reusable Medical Devices	83 (96.5%)	3 (3.5%)	2	39 (97.5%)	1 (2.5%)	0	122 (96.8%)	4 (3.2%)	2
Transfusion Services	71 (100.0%)	0 (0.0%)	5	60 (90.9%)	6 (9.1%)	3	131 (95.6%)	6 (4.4%)	8
Total	**1570 (96.1%)**	63 (3.9%)	49	2051 (97.1%)	62 (2.9%)	44	3621 (96.7%)	125 (3.3%)	93

* 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)	Met	4 of 4	2 of 2
Patient safety incident disclosure (Leadership)	Met	4 of 4	2 of 2
Patient safety incident management (Leadership)	Met	6 of 6	1 of 1
Patient safety quarterly reports (Leadership)	Met	1 of 1	2 of 2
Patient Safety Goal Area: Communication			
Client Identification (Ambulatory Care Services)	Met	1 of 1	0 of 0
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

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Communication			
Client Identification (Emergency Department)	Met	1 of 1	0 of 0
Client Identification (Home Care Services)	Met	1 of 1	0 of 0
Client Identification (Home Support 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 (Ambulatory Care Services)	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 (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
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 (Home Support 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

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Communication			
Information transfer at care transitions (Remote/Isolated Health Services)	Unmet	4 of 4	0 of 1
Medication reconciliation as a strategic priority (Leadership)	Met	3 of 3	2 of 2
Medication reconciliation at care transitions (Ambulatory Care Services)	Met	5 of 5	0 of 0
Medication reconciliation at care transitions (Cancer Care)	Met	5 of 5	0 of 0
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

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Communication			
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
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 for Remote/Isolated Health Services)	Met	4 of 4	3 of 3
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)	Met	4 of 4	1 of 1
Concentrated Electrolytes (Medication Management for Remote/Isolated Health Services)	Met	3 of 3	0 of 0
Concentrated Electrolytes (Medication Management Standards)	Met	3 of 3	0 of 0

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Medication Use			
Heparin Safety (Medication Management for Remote/Isolated Health Services)	Met	4 of 4	0 of 0
Heparin Safety (Medication Management Standards)	Met	4 of 4	0 of 0
High-Alert Medications (Medication Management for Remote/Isolated Health Services)	Met	5 of 5	3 of 3
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
Infusion Pumps Training (Long-Term Care Services)	Met	4 of 4	2 of 2
Infusion Pumps Training (Mental Health Services)	Met	4 of 4	2 of 2
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

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Medication Use			
Infusion Pumps Training (Rehabilitation Services)	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 for Remote/Isolated Health Services)	Met	3 of 3	0 of 0
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)	Met	5 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
Home Safety Risk Assessment (Home Support Services)	Met	3 of 3	2 of 2
Pressure Ulcer Prevention (Critical Care 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 (Inpatient Services)	Met	3 of 3	2 of 2
Pressure Ulcer Prevention (Long-Term Care Services)	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)	Unmet	3 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.

The Northwest Territories Health and Social Services Authority [NTHSSA] was formed in 2016 as an amalgamation of several previously separate health authorities. NTHSSA strives to provide quality health and social services across the Northwest Territories that are culturally safe, collaborative and centered around continuous improvement. The organization has a well-developed set of values and guiding principles to help it realize best health, best care, better future for the people it was created to serve.
In addition to the challenges of providing care and services to a population of less than fifty thousand people [of which 51% are indigenous], spread over a vast geographic region in the Canadian north, NTHSSA operates in a unique relationship with the Government of the Northwest Territories [GNWT] wherein key functions such as human resource management, finances, procurement, information technology and information services are provided by GNWT under a shared services model. NTHSSA's nearly two thousand employees are part of the NWT Government wide union. Physician contract to provide primary care and specialist services are negotiated between NWT Medical Association and GNWT. The organization's strategic planning and annual operating planning are closely guided by GNWT's mandates and expectations.
The governing body, referred to as the Leadership Council is appointed by government. Members of the Leadership Council are comprised of individuals representing Regional Wellness Advisory groups established in local areas. Council members possess diverse backgrounds, skills, knowledge and perspectives and have a solid understanding of issues impacting the health of the populations they represent. The Council understands its governance responsibilities. There is regular reporting of patient safety and quality assurance indicators to the Council. Trending of measures has also been included in regular reports at the request of Council members. Sub-committees have been established to work with the operational arm of the organization. The Council has undertaken evaluation of its functioning in line with best practices in governance.
NTHSSA works closely with the GNWT Department of Finance. The organization is facing significant operating deficits that are multifactorial in nature. Work is underway within NTHSSA and all of government to sustain operations and return to a balanced position.
The organization accomplishes its work with the collaboration of a myriad of partners. Partners interviewed during the survey described NTHSSA using adjectives that included: resolute, purposeful, tenacious, professional, flexible, collaborative and client-centred. Partners also identified many strengths such as ensuring patient experience is at the forefront, leadership is not afraid to take difficult decisions, maintaining excellence, having strong co-ordinating and communicating skills. The partner focus group made several suggestions for improvement that included: ensuring they are an employer of choice to recruit and retain staff, ensured population served do not feel marginalized, increasing communication with patients in ways that patients understand, addressing the ongoing challenges of medical travel and escorts, become more proactive rather than reactive. Partners also suggested the NTHSSA develop an overall service plan with five- and ten-year horizons so partners can see where the organization is headed. All partners were very generous in their praise for how the organization responded to the series of emergencies faced by the region over the time since the last accreditation survey. Surveyors strongly echo that praise and commend

the leaders, managers, staff and providers of NTHSSA for their stellar ability to adapt, pivot and respond to a myriad of emergencies that have impacted their workplace, families and communities. The resilience demonstrated and the ability to maintain focus on supporting the health needs of others under the most trying circumstances imaginable has been nothing short of outstanding. It is not lost on surveyors that maintaining “normal business operations” has been challenging and the organization is commended for maintaining it commitment to accreditation.

NTHSSA’s unique governance structure ensures the voice and insights of clients are heard at the highest levels in the organization. A multifaceted communication strategy has been developed. The organization is encouraged to increase its focus on internal communications and seek innovative ways to engage staff and providers. A commitment to people-centred care is evident and more can also be achieved. The Office of Client Experience appear to be key initiative to bridging cultural divides or disconnects between populations and providers. Their potential in helping drive organizational learning so care and interactions are culturally safe is significant and appears to be making positive impacts. This group can be utilized to further embed the voice of clients in all aspects of the organization’s operations and governance. Increased engagement of clients in areas such as quality improvement projects, recruitment performance monitoring and committees is suggested.

NTHSSA staff display professional in maintaining and sustaining the physical environment of its facilities. They show pragmatism and practicality in understanding and confronting contextual challenges providing health and social services in the Canadian North. A “will do” and “can do” approach was clearly evident to surveyors and reinforced by NTHSSA partners. The following report identifies the many strengths of NTHSSA and also makes suggestion for improvements in the areas surveyed. Drawing on the same professionalism, tenacity, and concern for providing the best care possible in the face of the incredible series of emergencies of the past few years, the staff, management and leadership of NTHSSA will contribute greatly for the better futures they envision for the people of the Northwest Territories.

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: Communication	
Information transfer at care transitions Information relevant to the care of the client is communicated effectively during care transitions.	· Remote/Isolated Health Services 10.12
Patient Safety Goal Area: Risk Assessment	
Suicide Prevention Clients are assessed and monitored for risk of suicide.	· Child, Youth, and Family Services 18.16

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		
9.6	When reviewing and approving resource allocation decisions, the governing body assesses the risks and benefits to the organization.	!
12.3	The governing body ensures that an integrated risk management approach and contingency plans are in place.	!
12.7	The governing body demonstrates a commitment to recognizing team members for their quality improvement work.	
13.6	The governing body regularly evaluates the performance of the board chair based on established criteria.	!
13.7	The governing body regularly reviews the contribution of individual members and provides feedback to them.	!

Surveyor comments on the priority process(es)

Leadership Council is the overall governing body of the Northwest Territories Health and Social Services Authority [NTHSSA] appointed by the Government of the Northwest Territory [GNWT]. The organization has a unique governance model, formed following a comprehensive consultation process, many engagement points and is rooted in local communities and regional structures. The Leadership Council is comprised of individuals representing local areas. They possess diverse backgrounds, skills, knowledge and perspectives. Members have a solid understanding of issues impacting the health of the populations they represent. Council members have been involved in strategic plan creation and approvals of operating plans and organization-wide frameworks such as ethics.
The Council holds the CEO accountable for established goals and objectives that include targets and regular reporting. The Council has established committee structures and a corporate calendar. Members have seen improvements in the use of data and key performance indicators that includes a scorecard and trends. Patient safety incidents are regularly reported to the Council. Checks and balances are in place to

help fulfill oversight responsibilities. NTHSSA is working with GNWT on the development of a sustainability plan. The auditor General of Canada performs a yearly audit of finances.
The Council is encouraged to work with operational leadership to further develop and implement a formal process for integrated risk management that would include a high-level risk registry and heat map to assist in protecting the organization and regular planning.
The organization recognizes it has not implemented a system-wide quality improvement framework. The Council is encouraged to be champions of quality improvement by setting expectations, providing supports and recognizing success. The Council is commended for completing the Governance Functioning tool and beginning to implement an evaluation of how the Council conducts its business. The Council is encouraged to ensure the performance of the Chairperson and individual members are regularly evaluated. This is recognized best practice in governance.
Leadership Council possesses a strong sense of self-awareness, particularly with respect to understanding where the organization has come from and having a vision for NTHSSA going forward. They also recognize the need to share information with the public and to make themselves more accessible. NTHSSA is a relatively young organization whose growth has been obstructed by having to respond to a series of significant emergencies. The organization appears to have responded well and its governors appear willing and able to contribute to its ongoing development and success.

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		
4.12	Policies and procedures for all of the organization's primary functions, operations, and systems are documented, authorized, implemented, and up to date.	
6.5	Formal strategies or processes are used to manage change.	

Surveyor comments on the priority process(es)

Northwest Territories Health and Social Services Authority [NTHSSA] leaders regularly demonstrate the values of their organization. They participate and support community initiatives to promote health and prevent disease. Leaders are visible to the public and attend public events. Relationships with indigenous leaders and politicians are encouraged. The organization is active in the government planning process and has supported the education of new government members. There have been extensive consultations with patients, clients and stakeholders in the development of client's rights and responsibilities. The organization is encouraged to pursue formal review and adoption of this important document.
Efforts are made to ensure validity and reliability of information used for planning. Strategic and operational plans are aligned with directions mandated by government however further work is required in this realm. Operational plans exist however there is no standard workplans for the organization. There are many recognized key performance indicators [KPIs] monitored and reported. Clear opportunities exist to establish KPIs that are directly aligned to Operational plans. The organization is aware of the challenges of communicating operational directions to staff due to its large geography and, transient nature of many staff. Leaders are encouraged to make concerted efforts to increase visibility on sites. Risks are informally identified and shared with Leadership Council and monitored. The organization is encouraged to further develop and implement its enterprise risk management framework. Further efforts are required to refine the general orientation program and ensure locums and transient employees receive a full orientation. The organization is encouraged to develop a staff recognition program based on organizational values. The NTHSSA is also encouraged to review models of change and adopt and utilize a formal approach to change management.

There were several areas where policies were outdated. According to leadership there is a bottleneck and updating is underway. This presents a significant risk and the organization is encouraged to allocate additional resources to address. Staff also perceive the process to be unnecessarily onerous.

Priority Process: Resource Management

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

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

The NTHSSA Finance department works closely with the GNWT Dept of Finance as 94.4% of the health revenues are from the government. The annual budget and quarterly reports and variances are vetted through the NTHSSA Leadership Council, and then the budget is submitted to the government for approval.

There is extensive education and explanation of the fiscal cycle provided to members of the Leadership Council and to regional leads. Currently (2022/23) there is an accrued deficit of almost $250 million over an expenditure of almost $500 million for the 2023 fiscal year, which was itself almost $50 million over budget. This level of deficit accrual has concerned both the department itself and the Auditor General, who has deemed the department at risk of not being “a going concern”. The reasons for the growing deficit are multi-factorial, in large part due to recurring major crises facing the organization, including the pandemic, floods and major fires, but there are also other areas the organization is addressing as it moves into the next budget cycle. The budget itself will reflect more accurately the anticipated expenditures (last year the nursing compensation expense was 50% over budget).

There are plans for creating efficiencies leading to sustainability. Unfunded programs are under review for alternate funding sources. Canada (NIHB) and Nunavut have historically underfunded the services provided by NTHSSA and these deficiencies are being addressed. Some of the challenges facing the organization in re-directing funds in the budget are that approximately 40% of funds are restricted so there is not much flexibility with budget allocations. Capital costs and allocations for all projects in the Territory are reviewed regularly, new projects are ranked by several teams, and existing infrastructures and the fleet are regularly assessed and replaced to maintain an ‘evergreen’ system. The SAM System Accountability Management system ensures data safety and has built-in redundancies to avoid system failures or data loss.

Priority Process: Human Capital

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

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

Northwest Territories Health and Social Services Authority [NTHSSA] works with the Government of the Northwest Territory [GNWT] on many initiatives related to human resource management. A talent management plan exists. All job offers contain job descriptions. Reporting relationships are clearly identified.

The organization and GNWT are commended for their efforts to recruit and retain staff in a challenging and highly competitive global environment. Both partners strive to provide a quality work life. Remote work policies and guidelines exist. There are opportunities for learning and education support, general leaves, compressed schedules and movement within government. The organization utilizes the GNWT occupational health and safety approach as well as local policies. Occupational Health and Safety [OHS] specialized support for sites exist. Regular OH&S meetings are held and records maintained.

A workplace violence policy has been developed with clear accountabilities identified. There is hazard identification for various environments and mitigation plans established. Resources and an approach to respond to issues that might arise are in place. Training is provided and the organization is encouraged to take advantage of special management training offered by GNWT to ensure a continued proactive approach.

The staff and management of the organization is commended for its stellar ability to adapt, pivot and respond to a myriad of emergencies that have impacted their workplace, families and communities. The resilience demonstrated and the ability to maintain focus on supporting the health needs of others under the most trying circumstances imaginable has been nothing short of outstanding.

The leadership of the organization appreciates the work of its staff and management and the need to help re-establish worklife balance and wellness. The voice of staff is encouraged and actively sought through a variety of surveys. Opportunities exist for staff to bring complaints and concerns forward in a confidential manner. Personnel records are controlled by the GNWT. A review of records during the survey demonstrated that records are secure, complete and well maintained.

There are several opportunities for improvement. NTHSSA is encouraged to work on ensuring staff understand their responsibilities and behavior expectations, particularly related to matters of conflict of interest. Performance reviews process follows GNWT expectations however the process is cumbersome and highly time-consuming in a health care environment. This serves as a significant barrier to effective feedback and performance management. The organization is encouraged to implement its Learning Management System throughout the organization so it is available to all employees. The culture of NTHSSA is in transition and needs concrete actions to support an emerging amalgamated organization. NTHSSA is encouraged to launch its employee engagements strategy utilizing a well-established model of change management.

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		
3.11	Team members, clients, and families who participate in quality improvement initiatives are recognized for their work.	
12.5	The effectiveness of the integrated risk management approach is regularly evaluated and improvements are made as necessary.	
15.3	A strategy to prevent the abuse of clients is developed and implemented.	!

Surveyor comments on the priority process(es)

The Quality Management Frameork of The Northwest Territories Health and Social Services Authority [NTHSSA] identifies quality assurance, client safety, risk management and quality improvement as integral components of quality. Quality assurance practices and reporting of several key performance indicators have been well-established for some time however other components have not matured as anticipated. The team and leaders are clearly passionate about safety and quality. They are deeply committed to culturally safe and competent care. There are many examples of innovative programs that support clients and families. It is also clear that leaders of NTHSSA are supportive of quality improvement. They model commitment and have allocated resources to advance quality improvement throughout the health system. Facilitators have been trained to enable a standard approach, expecting sites to integrate quality improvement initiatives with organizational directions and local needs to realize system level improvements. The Organizational Quality Risk Management Committee (OQRMC) is comprised of regional leadership and has potential to drive system-wide quality improvement initiatives. An incident management reporting system and follow-up processes are well established for the NTHSSA and staff are aware of how to use it. There are timely investigations, follow-up and reporting throughout the organization. Timeliness of disclosures can be enhanced.

There is a well-developed framework for risk management that is conceptually sound and consistent with best practices. There are also several unique examples that demonstrate risk management. However, it is not evident that enterprise risk management has been fully implemented throughout the system to the extent it was envisioned. The organization has plans to clarify the scope and definition of risk for management and staff and it is encouraged to complete the risk assessment, through its insurer HIROC, scheduled for 2024-25. The organization's leadership [governance and operations] is encouraged to set expectations for system-wide risk management and quality improvement projects in all areas and follow-up to ensure the standard approaches are utilized, supported, results shared and then recognized. The organization and its sites are encouraged to develop risk registries that are updated and shared regularly. While there are several documents related to client abuse, there does not appear to be a clear strategy

that supports achieving its goal of zero tolerance.
NTHSSA's Patient Safety Plan is in need of update and clarity on the approach, goals and indicators to be used. This process is underway in conjunction with the Department of Health and Social Services (DHSS). The CEO's yearly objectives include quality and patient safety measures that are regularly reported on to the governing body.
The organization is commended for its establishment of the Office of Client Experience and the inclusion of indigenous advocates within a broader department that also has oversight of quality and risk. The potential for organizational learning from the role and efforts of the advocates and those they help is significant and appears to be underway. In general, there is an opportunity for greater involvement of clients and family in all aspects of quality and the overall operations of NTHSSA. The Office of Client Experience has potential to recruit and support clients who could be invited to be involved in and part of expanded opportunities in many more aspect of quality improvement, safety and general operations.
Contracted services are evaluated and align with GNWT's procurement processes. Many contracts contain embedded review processes. Regular audits of medication reconciliation are undertaken and consistently reported and reviewed by the administrative and medical dyad leads. Organizational performance is tracked and reported at appropriate levels within the organization and with government. The informative annual report provides examples of performance and quality improvement activities.

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)

The Northwest Territories Health and Social Services Authority [NTHSSA] formed its Ethics Committee in 2019 with the support of a clinical ethicist group from a neighboring province. The NTHSSA group has maintained a strong relationship with this external ethics service. Together they are overseeing the evolution of the committee into a broader community of practice model that will see the organization support ethical decision-making, education and support in clinical care as well as in all aspects of its operations. This model will develop internal ethics champions with a focus on raising awareness of clinical and operational ethics across the Territories and ensure there is expeditious responses to consult requests and educational opportunities for healthcare staff.

There is a well-developed Ethics Framework and a recently completed Territorial Ethical Decision-Making Workbook. The materials state that all decisions made through the NTHSSA need to ensure that the values of NTHSSA are reflected and there is a systematic and thorough approach to difficult decisions. It is recognized and commendable that Leadership Council had a significant influence in the design of the Framework, particularly with the inclusion of Step Two related to respecting cultural traditions and beliefs.

Since 2019, data indicates increased ethics consult volumes and education sessions year over year. Leaders of the organization are aware of current trends in health ethics and are working to embed ethical decision making. Senior executives provided examples of how the framework has aided their work. It is also clear that upcoming decisions related to NTHSSA sustainability and restoring balance in Territorial financing will necessitate an approach to decision making that will benefit from the ethical decision-making framework and tools.

The organization is encouraged to continue to formalize its efforts to ensure all staff understand ethical decision making and to embed the use of decision-making tools found in the workbook. The simplicity of a poster promoting ethics is commendable and reflects attempts to make ethics understandable and accessible. Areas of particular importance recognized for ethical dilemmas are in the movements of patients for care, and equity of care issues arising from potential biases regarding what constitutes appropriate care.

NTHSSA works with partners to ensure research activities receive proper review and approvals that meet appropriate regulations and guidelines. Principle based care and decision making appears to be a strength for NTHSSA.

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)

The Communications program at NTHSSA has a three-pronged approach to delivering services. It supports the Executive committee in transmitting concerns of a significant nature, such as a developing problem with a Health Centre staffing; it also serves as the general communication arm of the organization, to promote services, announce changes to services and other notices; and it responds to requests from outside agencies such as media or MLA's for specific information.
The public facing part of the Communications team aims to have a no-surprises approach, be transparent and get the information out early and correctly, ideally including a person delivering the message, to avoid catching up or refuting stories from other sources.
The internal arm of Communications is faced by challenges getting the message through to staff members who works shifts and who don't always review the messages in the intranet. Alternate forms of communication are being used to coach and enable middle position leaders to be the agents of communication to their team members.
Access to the EMR has roles-based controls. There are policies and procedures around sharing patient health records and these are strictly adhered to. The inappropriate access auditing system is ongoing and concerns are vetted through channels appropriately, including disclosure to the affected individual.

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 NTHSSA is commended for the recruitment and retention of higher level managers and front line staff charged with the responsibilities of maintaining and sustaining the physical environment of its facilities. This is remarkable in maintaining and sustaining the physical plant while protecting the environment. From a leadership perspective there is a level of pragmatism and practicality that permeates their understanding of the contextural challenges facing the provision of health services in the Canadian North. Their "Can-Do" and "Will-Do" attitude and philosophy is refreshing. There is no problem/challenges they will not make the best of.

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)

Northwest Territories Health and Social Services Authority [NTHSSA] is commended for its response to a multitude of significant events that include the world-wide pandemic, flooding and wildfires. As a result, the organization has maintained a very high level of emergency and disaster preparedness. These real and threatening events required a high degree of flexibility and the establishment of structures and role placement of many personnel.

Incident Command training has been emphasized at various ranks throughout the organization. Various other training is ongoing and attendance is tracked through the new Learning Management System or at site level. The levels of training are established depending on a person's role and position. Mock drills and tabletop exercises occur and are tracked at a facility level. The Department of Health and Social Services (DHSS) for the Government of the Northwest Territory [GNWT] also tracks emergency preparations. The organization is proactive in anticipating risks and vulnerabilities and having contingent plans in place. A Wildfire Response Summary Review is underway and the organization is encouraged to expedite its completion to ensure lessons learned are incorporated into ongoing planning processes.

The organization has strengthened its relationships with other departments of the territorial government, municipalities and indigenous groups, other non government agencies and groups. Representatives of NTHSSA sit at various local, regional and territorial emergency management structures. A variety of mutual aid agreements, contracts and ongoing working relationships have been established and maintained to ensure optimal emergency response. NTHSSA has been designated as a significant partner in leading and supporting much of the communities' and territorial emergency response plans. While their response has been remarkable, this is a challenging role for NTHSSA to play while also ensuring ongoing health and social service needs of the population are addressed regardless of where patients present. Other agencies may already exist whose mandate and capacity may be better suited to take on the coordinating roles. NTHSSA is commended for proactively attempting to clarify roles and expectations among the myriad of agencies and partners involved in emergency response. It must be recognized and appreciated that planning for future potential events is challenging when key staff in leadership roles are still very much in a response mode and have been for several years and under continuous emergency circumstances.

NTHSSA has identified is key vulnerabilities and has plans to mitigate and respond. These plans are continually being assessed at the local and organizational level. Standards, checks and balances have been developed based on recent experiences. The organization supports a low threshold for activating appropriate responses. NTHSSA representatives are an integral part of emergency response plans built at the communities' level.

Infection prevention and control have been significantly involved in planning and the actual responses. Medical staff also work with local leadership on business continuity planning and responses. NTHSSA makes concerted efforts to ensure transient care providers are made aware of potential risks.

Communication plans exist related to specific hazards and incidents that may arise. The organization is encouraged to accelerate its roll out of direct communication to all staff with respect to baseline expectations during responses. Public Health are part of daily interactions with the executive. The organization is commended for receiving bilateral CIRT funding to support planning and logistics. These resources are actively engaged at many levels within the organization and with the broader communities served by NWTHSSA.

NTHSSA has anticipated normalization and re-entry challenges. They are encouraged to utilize lessons learned and to avail of popular mediums for communication with its public while also being cognizant of cultural safety needs.

Self care of staff and management is addressed in several appropriate ways such as debriefings, wellness plans, external supports and flexibility in light of recent challenges. NTHSSA has availed of the experiences of partners and others and now appear to be well-placed to share NTHSSA learnings with other jurisdictions. Congratulations NTHSSA on your very professional emergency responses under extremely trying circumstances.

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: Ambulatory Care Services		
15.3	Measurable objectives with specific timeframes for completion are identified for quality improvement initiatives, with input from clients and families.	!
Standards Set: Child, Youth, and Family Services		
10.3	Measurable objectives with specific timeframes for completion are identified for quality improvement initiatives, with input from clients and families.	!
Standards Set: Emergency Department		
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		
2.4	Space is co-designed with clients and families to ensure safety and permit confidential and private interactions with 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		
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.	
16.3	Measurable objectives with specific timeframes for completion are identified for quality improvement initiatives, with input from clients and families.	!
Standards Set: Public Health Services		

16.3	Measurable objectives with specific timeframes for completion are identified for quality improvement initiatives, 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)

The Northwest Territories Health and Social Services Authority [NTHSSA] is commended for many advances in people-centred care. Surveyors saw examples where the needs, expectations and the voice of clients are embedded in governance structure, clinical care and administrative operations. Efforts are made to see the client as experts on their life and to be supported in taking control of their health in a culturally safe environment. An Office of Client Experience has been established as part of the Government of Northwest Territories highly publicized Cultural Safety Action Plan of which NWTHSSA is a signatory. This council attempts to address gaps in the current complaint process and systemic racism. A cultural safety collaborative has also been established. Clients shared their perspectives on several aspects of their involvement with the Northwest Territories Health and Social Services Authority [NTHSSA]. They commented on feeling safe and felt NTHSSA were cautious, caring and responsive to their needs. Examples were provided where clients were kept appraised of developments in care and afforded choices and options. One client was appreciative of being able to give birth in her community with the assistance of a midwife. Others raised concerns about all the challenges of having to travel and significant delays and barriers in obtaining approvals for escorts. The work of the NTHSSA navigation team was referenced favorably. While there is evidence of materials translated to French in the communities, when speaking with clients as well as staff, it was noted that there was a lack of materials translated into the local indigenous language. The organization is encouraged to continue developing materials in the local indigenous language in order to address barriers when accessing information about services and participating in client feedback mechanisms. For example, translating the hand hygiene feedback card into the local languages to provide an opportunity to collect important client feedback. This will further support cultural safety within the system.

The organization is commended for the establishment of the Indigenous Patient Advocate Program embedded in the Office of Client Experience. The program is indigenous designed and led. The Office has a mandate for system level change and offers a suite of services that include system navigation, client and family advocacy, increased access to cultural, spiritual, and emotional supports, increased access to language supports as well as assistance in connecting clients with family, elders and community organizations. Staff in the Office use a centralized intake process and have been empowered to act, escalate and engage in enabling structures in support of clients. Expected outcomes have been established and their efforts are backed by data tracking and quality and theme analysis. Resolution of issues are encouraged and there is reporting of performance. The organization is encouraged to continue to promote this innovative practice within its jurisdiction and share its successes throughout the nation as a potential leading practice. It is recommended the organization seek stabilized funding for the program,

establish electronic tracking and ensure advocates are available in all areas of the authority.
Several other examples of innovative practices were noted where the organization was responsive to the people it serves. These include: a generic birth plan for expectant mothers in Inuvik where four generations of indigenous women are included in the practice of planning for a birth to take place, with supports, in their home community. The Perioperative program in Inuvik displayed care, consideration and compassion in the booking, information sharing, and recovery of the clients by the staff. Issues with "no shows" are considered and as much as possible, and those who need OR Care and are homeless, or have no ability to have transportation post op, are accommodated by the site. Examples include staying the night prior to be able to perform bowel prep, (pre-Gastroscopy) or staying longer in recovery (abdominal surgery) to be able to return home on their own, or an overnight post op stay. Supportive pathways are developed in long term care so staff get to know individuals and use tools to tailor care plans. Living well learning modules have been mandated in cancer care and have been well received. As well, Cancer care plans are individualized.
There are formal and informal mechanisms to obtain client feedback. Surveys on discharge have strong completion rates. Comments are tracked and action items developed. There are areas across the authority where quality improvement initiatives have been established. However, surveyors at several sites and within several programs, have been unable to verify consistent client and family input into establishing measurable objectives and indicator selection. There is an opportunity for the teams to consider ways to include more clients and family into QI initiatives. People-centred care is a guiding principle of NTHSSA and it is clear a positive philosophical shift is underway. The NTHSSA is encouraged to assess its structures and programs to seek ways to further engage and embed clients in even more aspects of the authority's operations. The organization is encouraged to have clients as members of committees and quality improvement initiatives. The Office of Client Experience is well positioned to recruit and prepare clients for the many roles that could be filled by clients and family members.

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)

Oversight of patient flow at the Northwest Territories Health and Social Services Authority NTHSSA; in addition to local leadership; is through the Northwest Territories Patient Flow Committee.
Supported by a Terms of Reference, that outlines key responsibilities, the group meets bi-weekly and will identify issues with a view towards improvement. Among the key data indicator reviewed is the number of acute beds occupied by patients requiring an Alternate Level of Care (ALC), acute care utilization, outbreaks and other communicable diseases that may impact available resources. In-the-moment direction is offered to respond to acute care surges; to include authorization of alternate site supports.
Partners include the Med-Response program which manages all intra- and inter- jurisdictional NWT air ambulance services [emergency medical communications] as well as access to clinical expertise for all NWT healthcare providers.
The NTHSSA has historically facilitated a comfortably smooth and timely movement of clients and families through all service settings. Service needs have changed of late and the organization describes itself as suffering from "..unprecedented numbers..". With this, they have had to respond by pivoting and seeking out ways to manage this burden.
Patient Care Coordinators (PCCs) manage all transfers through the region and provide bed management and patient flow support in their locales. Daily bed meetings take place to review census reports and assess for need and if the organization is in surge this is increased to twice a day.
Data to include bed census, discharges and any issues causing holds on beds in the communities are collected and sent daily by an Acute Care Territorial Specialist. Discharge planning begins on admission and there are focused interdisciplinary and inter site discussions to assure that patients are accessing the care; to include rehabilitation; to optimize a safe discharge.
Upstream solutions have been crafted for patient flow. One example is the upskilling of the staff in the Community Health Centres (CHCs). The team also shared that improved point-of-care testing capacity; such as with i-stat machines; has the potential to reduce the burden on the acute centres.
At the Stanton Territorial Hospital (STH), the numbers of patients requiring admission are increasing and "bed blocking" is becoming a term used by the team and something that they need to address, for the first time. In the context of perioperative services at STH, "bed blocking" has led to cancelled cases.
During bed meetings, surgery bed availability is considered. Wait times for total joint procedures were not clear as patient lists are held by the physician's offices. It is worth considering a centralized approach to surgical bookings to maximize upon flow and assure equity in access to care.
In the STH diagnostic imaging (DI) department, patients line up and give their name which is handwritten on a ledger. They then wait until their name is called to be registered. Those doing the registration have to walk to the other area to get the name of the next person. Then the person is registered and goes to their appointment area. In the appointment area, they then check-in at the desk (lab, DI, day surgery, etc). Patients are often late for their appointments as they are delayed in registration. The organization is

aware of at least part of this issue as they get complaints about the bottleneck at registration. There is an opportunity to solve the first part of this process with signage in addition to a more formal “Take a Number” system. Alternatively, registration could be moved to remove congestion from the front area.
The Inuvik DI department prioritizes tests and procedures for clients in the emergency department and inpatient beds. They have participated in Bed Management meetings. They collect and analyze data on wait times. As it is a small site and they noted that communication is good and people are very willing to assist in the event of overcrowding and emergency situations.
The ED group has developed and implemented a “Code Gridlock”, to be activated when there is an inability to safely assess and treat patients due to a lack of resources. Once activated, relevant team members are brought together to address the lack of patient flow from the ER to in-patient units. Decision making and thresholds are part of the response plan and feedback from staff after introduction was gathered to refine and improve this.
The Northwest Territories Patient Flow Committee is keenly aware of the barriers to flow, uses data to understand and address areas of system improvement and is aware of the effectiveness of those improvements. Continued real time management, combined with an overall strategy based on the learnings of late will serve the organization well and more importantly, assure that every patient is bed spaced safely.

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: Diagnostic Imaging Services		
8.1	The individual responsible for the overall coordination of reprocessing and sterilization activities within the organization reviews and approves the team's set up and policies and procedures for cleaning and reprocessing.	
8.12	The individual responsible for the overall coordination of reprocessing and sterilization activities within the organization oversees the team's compliance with the organization's policies and procedures on cleaning and reprocessing.	
Standards Set: Reprocessing of Reusable Medical Devices		
2.4	A designated individual is accountable for quality oversight and for coordinating all reprocessing services across the organization, including those performed outside the MDR department.	!
3.6	The MDR department has floors, walls, ceilings, fixtures, pipes, and work surfaces that are easy to clean, non-absorbent, and will not shed particles or fibres.	!
5.11	Team member performance is regularly evaluated and documented in an objective, interactive, and constructive way.	!
6.1	The workload of each team member is assigned and reviewed in a way that ensures client and team safety and well-being.	
Surveyor comments on the priority process(es)		

The reprocessing team is a great example of successful integration of two acute teams. They have standardized equipment, standardized processes for each type and brand of equipment, selection of capital equipment, and onboarding of staff. Their leadership team has clear reporting and staff know who they can go to if encountering a concern.
At Inuvik the pre cleaning of diagnostic imaging devices and equipment is completed in the medical device reprocessing department. The team members are aware of the processes to be followed. Of note Stanton DI does not send their probes to the main reprocessing unit but processes their own equipment. Consideration may be made to have one department or person oversee the process for standardization. Sterilized storage space is monitored and back up plans exist in both sites for equipment malfunction. Preventative maintenance is completed by vendors as part of a service contact or by biomedical services.

Routine maintenance and repairs are documented and tracked. Equipment is replaced as it ages out or unable to be repaired. Education and training occur on new equipment and devices. All staff have been certified in reprocessing.
Reprocessing IQ, OQ and PQ documents are kept for 7 years. The data is manually entered into an excel flowsheet for management to track equipment usage numbers. Spot checks are done to ensure equipment sterility.
The organization is encouraged to consider the installment of an equipment tracking system to track the specific equipment used on specific clients in the event of postoperative infection, and to be able to accurately track the equipment on hand and the location.
There are some opportunities noted in Inuvik for consideration.
At this time there is only one MDR person who can perform the duties. If there was to be a sick call or need for this staff to be away from work on short notice, there would be no one to back fill. The organization is encouraged to have a suitable substitute from the community or organization in Inuvik who would be able to cover. Consideration to the soiled work rooom may be made to replace the wooden cupboards.

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: Ambulatory 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		
3.10	Team member performance is regularly evaluated and documented in an objective, interactive, and constructive way.	!
4.4	Standardized communication tools are used to share information about a client's care within and between teams.	!
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

There is a strong leadership team supporting the ambulatory clinics, including the Director, Manager, Clinical Coordinator and a Physician Leader. The clinics are clean and well organized, with generic clinic rooms and subspecialty rooms for services such as OBS/Gyne, urology and ENT.

The specialty physician support relies heavily on locum coverage, but the team has developed clear and standardized tools and pathways to ensure smooth transitions and care coordination for patients and families.

Priority Process: Competency

There is a comprehensive orientation program for staff, and significant support throughout the organization for ongoing professional development. There is a Targeted Academic Support Program (TASP)

and a Professional Development Initiative (PDI) that provides financial support for staff pursuing further education and training.

The nurses in the renal dialysis unit receive ongoing educational support through their partnership with Alberta Health.

My Learning is utilized for ongoing competency evaluation and is tailored to each employee and their role. Ambulatory staff have 4 hours a month to review and update their required competencies.

The eye care clinic is a teaching facility that offers a two year Optical technology program with a return of service commitment. This has been a successful program with respect to recruitment and retention.

Priority Process: Episode of Care

The Ambulatory Care Program at NTSSA consists of both permanent and visiting clinic services. The clinics are specialized and include General Surgery, Orthopedics, Obs/Gyne, Internal Medicine, Pediatrics, ENT, Ophthalmology, dialysis, NP nephrology and gastroenterology. There are several visiting clinics, including cardiology, neurology and pediatric subspecialties.

The staff have a strong commitment to patient and family centered care, working to ensure appointments are booked and coordinated to reduce travel for families. The team was able to pivot quickly to virtual care during the covid 19 pandemic and have continued to utilize technology to meet the complex needs of the patients they serve.

Several specialty clinics also offer 'travel clinics' to reduce the travel burden on patients and families.

The team is able to accurately track wait times and have made great progress in reducing wait times and improving access to care.

Many of the specialty services utilize locums for physician coverage. Standardized processes have been developed to ensure a smooth care transition between providers occurs and the patient's care path is not impacted negatively.

Priority Process: Decision Support

The Ambulatory Clinics use an EMR and the dialysis unit uses a paper based charting system. Chart audits are completed and key performance indicators are reviewed and reported.

Wait times are tracked as are no show rates. Virtual care and telehealth is utilized when possible to support care closer to home to assist patients and families from unnecessary travel.

Priority Process: Impact on Outcomes

The ambulatory teams track several key performance and safety indicators through routine chart audits. They are involved in several quality improvement initiatives, including care closer to home, reducing no show rates, coordination of appointments to reduce patient travel, and ultrasound guided cannulation in the dialysis unit (supported by the vascular access nurse in Edmonton), to help preserve vascular access.

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.	
1.3	The team meets at least every two years to review information collected from clients and laboratory users to identify strengths and areas for improvement in service needs, and makes changes accordingly.	
7.1	The organization limits access to the laboratory areas to authorized team members only.	!
29.1	The team has a comprehensive quality management system.	!
29.2	The team defines the elements of the quality management system in a quality policy statement and makes it available in a quality manual.	!
29.16	The team shares information about its quality improvement activities, results, and learnings with clients, families, staff, service providers, organization leaders, and other organizations, as appropriate.	
29.17	The team regularly reviews and evaluates its quality improvement initiatives for feasibility, relevance and usefulness.	

Surveyor comments on the priority process(es)

Priority Process: Episode of Care

Universal fall precautions are identified and implemented in the Biomedical Laboratory Service. There is strong commitment to ensure a safe environment that prevents falls and reduces the risk of injuries from falling. The leaders and team members were unable to recall a recent client fall. The leaders are encouraged to continue to implement universal fall precautions.

Priority Process: Diagnostic Services: Laboratory

The team members, physicians, and leaders of biomedical laboratory services are committed to providing safe and quality services for clients. Biomedical laboratory services are provided at the Stanton Territorial Hospital, the Inuvik Regional Hospital, and the Fort Smith Health Centre. The biomedical laboratories at the Stanton Territorial Hospital and the Inuvik Regional Hospital were surveyed during this accreditation.

All laboratories have regularly scheduled outpatient collection services and hours of operation. There is an after-hours emergency call back system to provide emergency laboratory services after hours. Stanton Territorial Hospital is licensed as a Class 2 laboratory facility with additional licensure for tuberculosis. The laboratory programs offered include; bacteriology, coagulation, hematology, molecular biology, point of care testing, routine chemistry, special chemistry, transfusion medicine, urinalysis and virology. The Inuvik Regional Hospital provides the following laboratory programs; coagulation, environmental water testing, hematology, point of care testing, routine chemistry, transfusion medicine and urinalysis. The services and programs are supported by a dedicated team which varies across sites and may include, medical laboratory technologists, certified medical laboratory assistants, and technical specialists. There are strong partnerships and networks with Alberta Precision Laboratories, and the Northwest Territories Health and Social Services Authority.

The biomedical laboratory service is located at two hospitals. The areas are welcoming with waiting room spaces and access to washrooms. The laboratories are well organized, clean and has adequate work spaces for team members. The layout of the laboratory supports the easy cleaning and disinfection of work areas, equipment, floors and walls. At one hospital the blood collection service is located in a room within the laboratory. The leaders are encouraged to review the location of the blood collection area to ensure that access to the laboratory is limited to authorized personal. Furthermore, the counter in the blood collection area is porous therefore, is difficult to clean and disinfect.

The team and leaders are committed to safety and quality. A Quality Team meets every two weeks. Current initiatives include; revising the Policy and Procedure, Safety and Quality Manuals. Turnaround times are monitored. The team members and leaders have made significant progress in the development of a comprehensive quality management system. It is anticipated that the new program will be implemented in 2024. They are encouraged to continue with this important work. The team is encouraged to share information about its quality improvement activities, results and learnings with clients, families, and staff. The teams are in the initial phases of using quality boards to communication information about their quality improvement results. They are encouraged to use the quality boards as a communication tool to share results and encourage feedback on their quality journey.

The team has identified the need to solicit feedback from client users to better align their services with client need. The demand for services and complexity of care has increased thus, the laboratory intends to align services to meet the unique and varied needs of clients. The team is encouraged to collect information from laboratory users and clients about their needs for laboratory services. Furthermore, this information from clients and laboratory users will assist in identifying strengths and opportunities for improvement.

The team has been diligent in revising policies and procedures. However, there are a considerable number of policies and procedures that are waiting for final approval and document control. The leaders are encouraged to ensure that revised polices and procedures are approved and available for team members. At one site there was excessive paper with binders containing outdated information. The leaders are encouraged to ensure that paper based information is current, clear and well organized.

Human resource recruitment and retention is challenging. However, at one hospital the leaders have implemented an innovative job sharing initiative that supports stable staffing. The teams advised that the workload is increasing including; an increased demand for laboratory testing and overnight emergency call back. The organization is encouraged to continue to monitor the workload of team members and to make changes accordingly.

The team members and leaders are passionate about providing quality care. This includes a commitment to people centred and culturally safe and competent care. One new initiative is the online booking system which is anticipated for the fall of 2024. The team members stated that they receive education and training to support their work. This is an opportunity to provide additional education to team members on the availability of TB molecular testing versus cultures which is less labour intensive and faster. The team noted that they felt safe at work. Team members described the value of the orientation process in supporting them in their work.

There was exceptional work completed by the team to address the increase in laboratory testing during COVID 19. The team is acknowledged for their work in consistently reporting one of the best turnaround times for test results in the country. Additionally, the team is commended for their outstanding work during the wildfires and the evacuation of Yellowknife. They are proud of their work in reinstating laboratory services. Lastly, the team is acknowledged for the success of expanding their role in processing all respiratory samples that used to be sent out of the NWT.

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	
8.11 Team member performance is regularly evaluated and documented in an objective, interactive, and constructive way.	!
Priority Process: Episode of Care	
18.4 A policy is followed to identify critical client information and ensure that this information is always available to team members providing services.	!
24.4 Technologies, systems, and software are interoperable.	
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

The cancer care leadership team is a strong and committed group of leaders who have made significant progress in quality outpatient oncology care since 2018 when the program was temporarily placed on hold.

Yellowknife Primary Care Centre (YPCC) is lead by the Territorial Manager and includes a small Navigation and Medical Oncology Clinic team that includes a Territorial Specialist, Navigator, Oncology Clinic Nurse and a recently hired Medical Oncology Social Worker. The team works either out of the Yellowknife Primary Care Centre or the Stanton Territorial Hospital.

The oncology team at Stanton includes the medical oncology clinic, the outpatient chemotherapy program, an oncology clinical pharmacist, dedicated GP Oncologist and a Medical Oncologist.

There is a strong partnership with the Alberta Health Cancer Care program where policies, procedures, chemotherapy order protocols, and staff education is supported.

Priority Process: Competency

New staff undergo a rigorous and supportive orientation to the program during onboarding and all have received DeSouza training.

Staff receive a comprehensive orientation that includes general hospital orientation, unit specific orientation, and online learning in partnership with Alberta Health Cancer Care.

Annual competencies are tracked and recorded in the My Learning Portal. Staff are expected to complete Foundations of Oncology through the de Souza Institute and nurses are encouraged with become oncology certified through the Canadian Nurses Association.

The staff are committed to ongoing professional development. There should be intentional focus placed on performance appraisals as a tool for ongoing professional development and establishment of professional goals at the Stanton site. Two members of the team attended the 2023 CAN conference; with one of them delivering a presentation on Cancer Care in the NWT.

Priority Process: Episode of Care

The oncology program at NWTSSA consists of the Breast Screening and Colorectal Screening Programs, the Cancer Navigation Program, Medical Oncology Clinics, and the Stanton Territorial Chemotherapy Unit. The program is supported by an interdisciplinary team that consists of Territorial Specialists, Navigators, Registered Nurses, Mammography Techs, Clinical Coordinator, Social Worker, Pharmacist, GP Oncologists and a Medical Oncologist.

Patients can access the Cancer Navigation Program through a referral from any health care provider or through self-referral.

Patients will be referred to an oncology physician following a positive biopsy and cancer diagnosis. There is a partnership with Alberta Health Cancer care program. Policies, procedures, chemo protocols, and patient education material mirror that of the Alberta program.

The Navigator, Medical Oncology clinics and chemo unit apply standardized assessment criteria. All activities are documented in the EMR or paper chart in standard fields. Clinics are conducted both in person and virtually and staff assure that privacy is preserved in both contexts. Best Possible Medication History and Medication Reconciliation is conducted and was validated by chart review. Client Identification is documented in the EMR and paper chart. Good education for patients as a means to self support is a guiding principle for this team and they provide a Care Plan binder (formally Survivorship

plan) to all patients.

Timely access to diagnostic results is essential for the efficient running of the Medical Oncology Clinic and timely informed decision making for patients. Staff shared that they often have to pursue these results; specifically, DI; to reduce the chance that this important information is missing. This adds to the burden of staff. The Cancer Care Program is strongly encouraged to work with partners in DI to understand the barriers with a view to resolve.

Priority Process: Decision Support

The cancer care program at Stanton utilizes a paper-based chart for health record documentation. Standardized health information is collected on all patients and standardized assessment tools and an SBAR approach for transfer of accountability is utilized.

Navigation and medical Oncology clinic teams at the Yellowknife Primary Care Centre (YPCC) utilize the Wolff EMR. The team has been included in the preliminary meetings to search for the new NTHSSA EMR platform.

Access to data was noted to be a challenge in assessing and evaluating performance and in setting goals for quality improvement.

The volume of patients actively receiving chemotherapy treatment has increased. Utilizing data to do predictive modelling on current and future oncology service needs will help with future service planning to meet the growing demands.

Priority Process: Impact on Outcomes

The Breast and colorectal screening programs, the Navigation and Medical Oncology Clinic team as well as the chemotherapy unit monitors and evaluates a number of key performance indicators that are aligned with the overall goals of the Cancer Care program. There are open and transparent conversations at 1:1 meetings and huddles on the data.

The Breast Screening and Colorectal Screening programs collect statistics on screening rates, cancer rates, and use this data to provide direction on program priorities.

The team shared some opportunities for improvement observed in their own discreet pathways and they are encouraged to pursue these as they directly impact their work and the experience of care for their patients.

Policies and procedures are under review and informed by Alberta Health Services best practices. Patient and family input comes via the Regional Wellness and Leadership Councils.

Priority Process: Medication Management

Systemic therapy protocols are supported through a partnership with Alberta Health Cancer Care. The chemotherapy unit has the support of an oncology pharmacist and the systemic therapy is prepared in the pharmacy department.

Policies and procedure for the safe handling, administration and disposal of chemotherapy are followed.

Standards Set: Child, Youth, and Family 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			
18.16	Clients are assessed and monitored for risk of suicide.		ROP
	18.16.1	Clients at risk of suicide are identified.	**MAJOR**
	18.16.2	The risk of suicide for each client is assessed at regular intervals or as needs change.	**MAJOR**
Priority Process: Decision Support			
The organization has met all criteria for this priority process.			
Priority Process: Impact on Outcomes			
10.1	Information and feedback is collected about the quality of services to guide quality improvement initiatives, with input from clients and families, team members, and partners.		
10.11	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 Leadership team is enthusiastic about the variety of services they provide at their various locations in the Territory. The team and leaders are passionate about safety and quality. They are deeply committed to culturally safe and competent care.
They have worked very hard to improve their image to their clients as not just providing income support or intervening in child safety issues, but they are passionate to meet their clients where they are and move with them on their journeys in dealing with the stumbles they face as their life unfolds. There are many examples of innovative programs that support clients and families. They are very proud of the work that they do in fostering traditional ways and medicines.

As the team shifts and grows their approach to clients, they are facing the need to provide more inviting and culturally appropriate meeting spaces that still keep safety as a priority. They are meeting this challenge with more indigenous staff both in leadership and as case workers, having robust cultural awareness training, and recognizing and admitting to the historical harms that the service has performed. They are encouraged to include clients and families in the planning and design of their service areas and programs.

Priority Process: Competency

Team members are a passionate group of individuals, many of whom are social workers and others have various levels of training in associated expertise. There is ongoing training in Child Protection and other specialized roles within the department. Staff leaders include Indigenous persons, and all members are thoroughly oriented to the unique circumstances of their roles in the communities of NWT.
There is a high (23%) vacancy rate and retention is an ongoing concern.
The organization is encouraged to have a simple to use, single process performance evaluation system.
The low completion rate is not from lack of trying. At one of the surveyed sites the team members meet with their team lead bi-weekly to review cases and to receive feedback on their work with their clients. Annual performance appraisals are up to date and they focus on personal growth and professional development goals.
At another site: The team members stated that they feel safe at work. They described a strong orientation
process. They noted that they receive education and training to do their job.
There are strong partnerships with the community, the Chiefs, and mental health and addictions.

Priority Process: Episode of Care

The approach to Child, Youth and Families care has evolved significantly in the last 10 years, particularly since Bill C92 from the federal government of Canada mandated an indigenous focus of attention. Indications to start services have evolved to a prevention lens, with a cooperative approach to the client, to meet them where they are at, and intervene, when necessary, with a preventive approach. When more forceful interventions are necessary, the approach to fostering has been to involve the family first and seek voluntary supports.
Children in indigenous homes may be raised by other family or community members in a cultural adoption. This is an acceptable culturally appropriate practice and these do not go through the rigorous process of an outside adoption.

Suicide risk assessments are performed in a granular way. Several team members indicated the NWT Suicide risk assessment form is too prescriptive and is not age appropriate nor culturally appropriate for the clientele. It requires the subject of suicide ideation be brought up in an upfront way, which is not culturally sensitive, especially to those whose culture communicates with nods of the head, eye movements or facial expressions, and who have a softer approach to communication. It is not age appropriate for youth. The organization is challenged to develop a suicide risk score that may recognize

the impulsive nature of many clients, especially youth, which might alert staff members to potential suicidality if the client is facing a new crisis in their life.

The teams work collaboratively with other branches of government services as well as NGO's. There is good collaboration between different service areas within the department. Children and youth in care are regularly assessed and supports are encouraged to maintain contacts with their family and cultural home. The Youth Justice programs and addiction programs collaborate well with the team.
There have been remarks that there should be better parity of financial compensation for kinship programs as for foster programs.
Interviews with clients were heartwarming, in particular those who have noticed the change in approach, from a service to be feared to one that is considered collegial. Individual stories affirmed the respect and dignity the clients are afforded.

Priority Process: Decision Support

The organization uses a hybrid charting system, some on line and some on paper record. All documents are printed and stored in the filing room. The NTHSAA uses an electronic I-file system, Matrix, which has been in place since 2017.

Priority Process: Impact on Outcomes

Not all locations use feedback to guide QI initiatives. Exposing youth to activities has been a focus.
The Child, Youth and Family Services Strategic Direction and Action Plan 2023-2028 was released in October 2023. Exposing youth to activities has been a focus. There is a need for evidence that quality improvement initiatives are regularly evaluated for feasibility, relevance and usefulness. The leaders are encouraged to evaluate quality improvement initiatives. The "On the Land" program is provided by an NGO and has delivered great feedback from participants. At one location Team members have partnered with the local school to provide family cooking classes twice per week. In addition to cooking a meal this was an opportunity to provide education on health families and parenting tips. The families were able to eat a meal together and bring home
leftovers, they also received a bag of groceries at the end of the session.

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	
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

The team in Yellowknife has strong connections with its clients and community stakeholders and each plays a role in determining service design for the team. There is ongoing communication with the local government in Deline that helps with decisions around services. When I met with a client of the service, she felt that the community is not as aware as they should be about what services are offered at the wellness center. She said if more people knew that this was for everyone in the town, more people would access. Recent grief session was asked for the community in Deline by the government, the staff offered the session to the community as asked. There are times when the staff provide the education session, and the government then uses Elders and provides a cultural response to the issue to ensure they keep with traditions.

The Community Based Mental Health Team in Yellowknife has changed their approach to service based on the feedback from clients and families on wanting services in real time and through more walk-in appointments. They review and modify the approach to care regularly and have changed to more afternoon offerings due to less attendance in the am. In Deline, the team has access to family support workers, child protection staff and the health center team. The Team in Yellowknife has a mix of staff that has various skills for youth, and adult care. There is a large skill set here that works to provide care for mental health in the region.

There is concern around the space for the team in Yellowknife, small offices, and lack of counselling rooms for the adult team, with close quaters impacts the teams ability to provide confidential care, while ensuring their own personal space is secure

Priority Process: Competency

There is a strong focus on working with diversity and being inclusive. Staff in Deline had a recent Performance Appraisal. Many of the staff in Yellowknife have had performance appraisals and those who have not had them have had one on one performance conversations with their managers. There is room in the community of Deline to work more collaboratively with the health clinic staff, there is ongoing support with transfer of patients from time to time, but a gap seems to exists on a collaborative approach to care.
The team has access to individual funding up to 2000 per person for education, and the team has access to 1500 for educational advancement. The clinic staff remembers a more structured approach to team in the past but does not occur now. Staff in Yellowknife work with many stakeholders and provide a collaborative approach to care in the area. There is a strong connection with the schools, and the primary care teams.
The policy is clear on the communication tool and when it is to be used, the charts reviewed today did not have any of the forms attached to them. Charts in all sites did not have the SBAR tool attached, however there is evidence of conversation with providers when needed and secured file transfers when material needs to be sent to other providers.
The wellness center is next to prophet's land as well as the local church which is special to the people in Deline. There is a recognition by the team that these places need to be used when needed in the care plan, and have respect for the role these 2 sites play in the lives of the Deline people.
Space is a challenge for the Yellowknife team, there are office spaces that can be used for private time, however this space is limited.

Priority Process: Episode of Care

The mental health service has established a walk in service for its clients. The hours are set for services from the mental health program, after hours services are met through the health centers, or health systems in the communities. There is a list of telephone supportive resources like 811 provided to the clients to allow for support after hours as well. People can walk in and seek services based on self determined needs. The team has a " No wrong door" policy and works within the team to ensure the clients get the service they need.

The team is aware of how to access an ethical consult if needed to help navigate the care of the client.

With regard to Medication Reconciliation ROP, the organization have reviewed this ROP with Accreditation Canada and have decided this does not fit with the services they provide in this program. There are many disciplines working in this area, and the only staff who administer any medication is the mental health nurse and that is injection only. The primary care team has this role for Mental Health clients and have this ROP in their purview.

We did discuss at the leadership level how to capture the lists of medications on all clients who seek services in order to ensure the clinicians have the holistic knowledge of the client and can respond if concerns around medication safety arises.

There is a process to screen for suicide risk, then if screened positive a risk assessment occurs. The immediate needs are assessed, and plans are made with support from the health care center to ensure a follow up assessment is completed. Clinicians have safety plans for clients who identified as low risk, and work with their consultant group as needed if further interventions is required.

Upon the chart review, the option of “Not screened” is listed on the form, and seems to be misinterpreted the clinicians, as the clinician did screen for suicide risk, however deemed no assessment required, but picked the wrong box on the form (ticked " not screened"). Reviewed with the leadership and looked at ways to improve the form to help make the boxes clearer for staff to ensure the chart reflects the work they completed.

There is a clear policy for information sharing on transitions, the staff are able to speak to the requirements and the importance of using the tools in the policy to communicate. The charts reviewed today were of new clients who did not have the need of this form today, the other chart reviewed had an historic process for information sharing on it, showing that the process was completed as needed. Staff speak to using telephone calls as the main source of handover and secure fax of the health record as they are paper based and the hospital system is electronic.

Priority Process: Decision Support

The Community Based Mental Health Team uses paper charting and is not using any electronic documentation for the health record. The leadership team is aware of the limitations this is having on communication within the health care team.
In Yellowknife the charts are going through a process to sort and standardize placement in the record. This process helps to see the forms in the health record more easily.

Priority Process: Impact on Outcomes

There are many groups that provide feedback and input to program decisions for the team, inclusive of governments, clients, community partners.

Clients had provided feedback to services in real time and not be on wait lists, and there was an adjustment on service delivery model based on this feedback. The team has a quality lens on the care it provides and looks to best practice for validity and guidence if needs be.

There is a " props" wall within the program for staff to acknowledge each other's work and celebrate it.

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	
3.12 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.	
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

There is a strong, committed leadership team within the Stanton Territorial Hospital ICU. The team has demonstrated impressive resilience and commitment to safe, quality care, given the significant challenges over the past year.

The team and its ability to move quality improvement initiatives forward would benefit from stabilization of the unit manager role, as this position has experienced considerable transitions over the past 2 years. The clinical coordinator has also recently left the role which has resulted in a gap with respect to ongoing monitoring and reporting of key performance indicators.

Priority Process: Competency

The ICU is staffed by RNs, RTs and Physicians on locum. There are currently no permanent ICU physicians, however there has not been any service disruption and the medical coverage has been maintained through locums. The ICU also uses locum nurses to fill current vacancies.

The nurses have all completed the critical care nursing program and receive a comprehensive orientation when onboarding to the Stanton ICU. The hospital utilizes the SNTP to fund the specialty nursing program with a two year return of service agreement. This has been a successful process to assist nurses in their ongoing education and transition into specialty nursing areas that are often difficult to recruit to.

The ICU staff are up to date in their required annual and biannual competencies but many are quickly approaching their renewal deadline. The stabilization of the manager role and the clinical coordinator role could help to ensure these competencies are tracked and completed.

Priority Process: Episode of Care

The Stanton Territorial Hospital ICU is a 4 bed med/surg/trauma critical care unit that has the ability to surge to 6 beds with appropriate staffing and COO approval.
The organization has faced inpatient capacity challenges over the past 6 months so the 2 unfunded ICU beds are utilized at times as part of the surge protocol for 'gridlock'.

The ICU receives patients from across the Territories, frequently by medivac. Families are included and involved in care and decision making, however this can be challenging as family are often unable to be present or there are delays in their arrival.

The team of nurses and RTs are highly skilled and passionate about their patients and the quality of care they provide. They are a cohesive team that takes great pride in their work. The team needs some focused attention on completing their competency reviews which are quickly approaching.

Priority Process: Decision Support

The Stanton Territorial Hospital ICU utilizes paper-based documentation and chart. Review of patient charts demonstrated a standardized assessment and documentation and manual chart audits were routinely completed by the clinical coordinator.

Several key performance indicators are monitored and reported, including a 0% rate of pressure injury, 0% rate of central line infections, and 0.01% incidence of ventilator acquired pneumonia.

Many patients are transported by medivac to and from Edmonton Alberta. Lack of electronic connectivity between Alberta and Yellowknife can create challenges in accessing patient care information.

Priority Process: Impact on Outcomes

Several key performance indicators are monitored and reported, including a 0% rate of pressure injury, 0% rate of central line infections, and 0.01% incidence of ventilator acquired pneumonia.

The unit is using the general organizational patient satisfaction survey and are in the process of modifying question from a critical care specific survey to ensure it is culturally appropriate for the patient and family

population they serve.

The staff were unable to identify any current quality improvement initiatives so this is an area of opportunity for the team to move toward a culture of continuous quality improvement.

Priority Process: Organ and Tissue Donation

Organ and tissue donation is not an option for patients and families. There may be opportunity to explore options for tissue donation that may not have the same prohibitive time requirements that are associated with organ donation. This is an important end of life option that could be very meaningful for families.

Standards Set: Diagnostic Imaging Services - Direct Service Provision

Unmet Criteria		High Priority Criteria
Priority Process: Diagnostic Services: Imaging		
1.3	The team meets at least annually to review information collected from clients and medical professionals to identify strengths and areas for improvement in service needs, and make changes accordingly.	
2.3	The team regularly seeks input from referring medical professionals about how to improve access to diagnostic imaging services and address delays in reporting diagnostic imaging results.	
3.10	The team evaluates and documents each team member's performance in an objective, interactive, and constructive way.	
17.1	The team collects information and feedback from clients, families, staff, service providers, organization leaders, and other organizations about the quality of its services to guide its quality improvement initiatives.	
Surveyor comments on the priority process(es)		
Priority Process: Diagnostic Services: Imaging		

The team members and leaders of the diagnostic imaging service are committed to providing safe and quality services to clients. Diagnostic imaging services are provided at the Stanton Territorial Hospital, the Inuvik Regional Hospital, and the Fort Smith Health Centre. The modalities provided include: general radiography, fluoroscopy, mammography-screening and diagnostic, computed tomography, and C-Arm at Stanton Territorial Hospital; general radiography, ultrasound and mammography at Inuvik Regional Hospital; and, general radiography and ultrasound at Fort Smith Health Centre. The services and programs are supported by a dedicated team which varies across sites and may include, medical radiation technologist, mammography technologists, sonographers, PACS administrator, and administrative support professionals, depending on the services provided. The Fort Smith Health Centre has a unique staffing model to support the laboratory and diagnostic imaging departments. The role is a combined laboratory/x-ray technologist. The team members and leaders spoke highly of the support provided by BEAM which is a contracted radiology service which remotely supports Northwest Territories Health and Social Services Authority. The team does not regularly seek input from referring medical professionals about how to improve access to diagnostic imaging services and to address delays in reporting diagnostic imaging results. The leaders and teams are encouraged to seek input from referring medical professions and to use this information to improve access to diagnostic imaging services. Health human resources such as vacant positions and frequent turnover were identified as major challenges for leaders and team members. They noted that they have had success in attracting long term locums however, there is frequent turnover which results in an increased demand for onboarding.

The diagnostic imaging departments were clean and well maintained. They are well designed from a patient flow perspective. There were waiting room spaces for clients and families. There were spaces to have private conversations. Clients and families had access to areas to prepare for procedures. The equipment is well maintained with preventative maintenance completed. The atmosphere was very welcoming.

There is an organizational structure for the diagnostic imaging service with accountability and reporting relationships outlined. The physicians are imaging specialists credentialed by the appropriate professional college. The organization is encouraged to continue plans to contract a virtual radiologist to provide technical support and oversight to the team. Collaboration and "really good people working together as a team," was described as reasons why team members enjoy working in the diagnostic imaging department. The team members stated that they received education and training to support them in their work. The onboarding process was described as strong. The team members stated that they feel safe at work. They described having appropriate personal protective equipment. Team members and leaders discussed the value of simulations and their work in practicing mock codes. The team members noted that performance evaluations are not completed on a regular basis. The leaders are encouraged to continue their plan to evaluate and document team member's performance in an objective, interactive and constructive way.

The leaders are visible and engaged in quality and safety of the diagnostic imaging service. A Diagnostic Services Quality Team meets every two weeks. Initiatives include; the revision of the Policy and Procedure, Safety and Quality Manuals. The leaders are encouraged to continue with this important work to ensure that team members have current resources. Choosing Wisely education has been provided to team members. Key performance indicators are reported quarterly to the Territorial Director of Lab and DI Services including; reject rates and no show rates. There are safety officers who support quality and safety. Wait times are monitored. There is a strong commitment to partnerships. An external review was conducted which will assist in guiding priorities. The leaders are encouraged to continue to implement robust quality assurance processes. Quality boards are located in the diagnostic imaging departments with information provided on hand hygiene rates, and mammography wait times, to name just a few. However, there is opportunity for the information to be enhanced to include additional quality improvement results and providing information on how clients can assist in supporting quality such as reducing no show rates. The leaders are encouraged to continue to support the team members in quality improvement activities. This includes quality improvement education, training and support.

There is evidence of people centered care. Clients spoke highly of the care provided. This included the shortened wait times and the ability to walk in for services. A client commented that staff were child friendly. There is waiting rooms and spaces for private and confidential discussions. The team members work diligently to coordinate appointments for clients and families who travel from remote communities to access care. The team has not collected information and feedback from clients, families, staff, and service providers to guide its quality improvement initiatives. The team members and leaders are encouraged to ensure that information and feedback from clients and families is obtained to assist in its quality improvement initiatives. Additionally, they are encouraged to continue to embed people centered care in the diagnostic imaging service.

The team members and leaders are commended for their work during significant events that have occurred in the NWT. This includes COVID 19, wildfires, evaluations and the implementation of the PACS upgrade in 2024. They are to be congratulated for their excellent work.

Standards Set: Emergency Department - Direct Service Provision

Unmet Criteria		High Priority Criteria
Priority Process: Clinical Leadership		
2.6	Seclusion rooms and/or private and secure areas are available for clients.	!
Priority Process: Competency		
4.14	Team member performance is regularly evaluated and documented in an objective, interactive, and constructive way.	!
4.16	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		
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		
18.4	Indicator(s) that monitor progress for each quality improvement objective are identified, with input from clients and families.	
18.7	Quality improvement activities are designed and tested to meet objectives.	!
18.13	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 Northwest Territories Health and Social Services Authority (NTHSSA) operates three (3) Emergency Department (ED) locations at the Stanton Territorial Hospital (STH), The Inuvik Regional Hospital (IRH) and the Fort Smith Health Centre (FSHC). Oversight is with both territorial and regional leadership groups. Goals and objectives are linked to the NTHSSA strategic directions and at the time of the onsite survey, priorities include recruitment and retention of ED trained staff, reducing wait times for patients triaged as

CTAS 2, improving staff comfort with suicide risk screening, territorial document standardization and improvements to orientation for staff. Partnerships reflect the scale, demographics and geographical distribution of the population served. The Eds support Community health Centres and cabins with decision making in the event that urgent or emergent care is indicated. Decisions to transfer patients are taken in collaboration with the Med Response service and if indicated, transfer is then facilitated to and from all EDs and to higher levels of care. Two EDs were visited during the onsite survey.
The IRH ED provides services and has approximately 7000 annual visits take place. Care is provided in private and semi-private rooms; with urgent cases treated in a dedicated fully equipped trauma room. Emergency equipment and supplies are in place and maintained for both adult and pediatric populations. Staff take pride in the management of their space. There are no dedicated isolation room. Staff have a targeted room that they can quickly utilize, with an isolation cart stocked with the required supplies. Access to medication is appropriately controlled. There is no dedicated seclusion room in situ so staff work in real time to troubleshoot, requesting the help of security (at nighttime only) or securing a nurse from the unit to act as 1:1 sitter. The balancing effect of this is to take resources away from the bedside of others. The organization is encouraged to pursue an alternate approach. Staff safety is an area of improvement cited by the clinical team at IRH. The medication room can be used for staff refuge, however the absence of a phone was noted. The ED door is locked at night, but access can be gained from the front door of the facility. Screecher alarms are not available for use. The organization is encouraged to seek out ways in which to assuage the concerns of their staff.

The new Emergency Department at STH, which opened in 2019, is an 18 bed/chair department that includes 2 trauma rooms, 1 negative pressure room and a seclusion room. The unit is staffed with an all-RN model that consists of permanent nurse and locum nurses, as well as a mix of permanent and locum emergency room physicians. The nurses are supported to complete the specialty emergency nursing program with a return of service agreement. The department provides care to adults and children, and receives patients from all part of the Territories, frequently by medivac. With recent capacity challenges at the site, there is an increase in 'boarded' admitted patients in the department and longer wait times for patients to be seen in the emergency department. The site is encouraged to develop clear surge protocols to ensure patients are receiving timely care in the right place with the right team.

Priority Process: Competency

All nursing staff are trained in the essential ED specific practices. Cross training with staff from the acute care areas ensures that in periods of need, staff can be redeployed to level load the burden. Specialty training takes place to meet the context specific needs in addition to mandatory training that assures the safe use of equipment; to include infusion pumps. An area of pride at IRH is with respect to the orientation of nurses to the ED that includes mentorship, standardized buddied shifts, checklists, and a final needs assessment. The program is encouraged to share this approach with other programs. Multidisciplinary mock codes are run by a newly onboarded clinical educator. Many requests are being sent her way by the care team, indicating a desire for continuous education and commitment to improving skills. Additional educational opportunities are generated by audit, feedback, just in time redirection and self generated requests. Performance evaluations are lagging.

Priority Process: Episode of Care

At both sites assessed, patients are registered before triage and nursing assessment. It is advised that the organization reviews this flow to assure best practice standards are maintained. There was variation in compliance with application of the standardized suicide risk screening. Multiple charts were accessed at each site to validate. The preliminary screening question was either blank or for some, checked of as not applicable. At STH, staff indicated lack of privacy as the reason. At IRH, this was not a factor. This process has undergone a recent improvement; supported by education. The organization is strongly encouraged to partner with the care team to actively pursue the elimination of all variation.
Patient assessments are informed by best practice standards and in partnership with the patient themselves. Documentation was viewed in the health record and the required information is populated in a standardized manner as the patient moves through the care plan. The ED nurses generate a Best Possible Medication History in partnership with patients per the organizational policy. Information transfer occurs at all care transitions and documentation is included in the patient record to maintain communication among the care team. Patients are coached by the team at discharge with a view to self management.

Priority Process: Decision Support

The EDs use paper records. The current EMR is accessed to review documentation input by the community teams. Standardized documentation fields are utilized and the patient record is accessible to all in the circle of care and privacy expectations are met. There is a move to search for another more intuitive and user friendly EMR.

Priority Process: Impact on Outcomes

Many key performance indicators are monitored and reported, including time to triage, time to nurse, time to physician, time to disposition, and ambulance off load times. Chart audits are performed by the patient care coordinator but with this position vacant at STH, and a gap in audits, consideration should be given to assigning this quality work to others.

The team is compliant with expectations to the organization's incident reporting system. When asked about quality initiatives, staff gave varied responses to include the changes to the suicide screening, work done to rearrange the triage room at IRH to improve privacy and code blue debriefs. At STH, the team identified two priorities; the establishment of a formal incident debrief program and the development of a mass transfusion/ hemorrhage protocol.

Priority Process: Organ and Tissue Donation

The Northwest Territories Health and Social Services Authority does not participate in an organ and tissue donation program. The organization is encouraged to engage with partners to explore the feasibility of this.

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		
3.10	Team member performance is regularly evaluated and documented in an objective, interactive, and constructive way.	!
3.12	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		
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		
15.4	Indicator(s) that monitor progress for each quality improvement objective are identified, with input from clients and families.	
15.5	Quality improvement activities are designed and tested to meet objectives.	!
15.9	Quality improvement activities that were shown to be effective in the testing phase are implemented broadly throughout the organization.	!
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		

There is a high degree of flexibility between home care services and local bands to meet the specific needs of the community. The organization has consulted with the bands, the Hay River and Health and Social Services Authorities, and the Tlicho Community Services Agency in the development of new home care services standards. The organization is encouraged to engage in culturally appropriate ways to continue to strengthen their relationships with all communities they interact with.

Where all standards were met in this section, there is an opportunity to improve upon the communication between urban and rural/remote settings. Communication around plan of care and discharge planning from inter-territorial and inter-provincial health care facilities could be improved upon. The home care team in Yellowknife developed a discharge planning tool which has improved the communication around discharge planning and goals of care for clients coming from Stanton Hospital. There is an opportunity here to learn from this team's experience and see how it could be applied to create success in other teams throughout the organization.

Priority Process: Competency

There is a great deal of support of continuing education within the organization. Home care teams conduct team huddles each day which allows for peer support and shared learning opportunities.

Performance evaluations are not up to date as per the organizational policy. The current HR performance evaluation system is not designed for health care specific roles, and this creates barriers in its utilization by managers and staff. The organization is encouraged to prioritize performance evaluations to help their team members continue to grow in their practice. Barriers to compliance can be removed by simplifying the process to make the evaluation meaningful to the health care workforce. There are examples of success within the home care teams. The organization could leverage the positive variance and share the process with other areas in the organization.

Priority Process: Episode of Care

All of the standards were met during the Episode of Care. The program is easily accessed in a variety of ways to refer including phone, email, in-person and by fax and anyone can make a referral, including self-referral from clients and families. There is a fulsome and standardized intake process used that includes many safety and risk assessments. The safety and wellbeing of clients and team members is valued and this contributes to a strong culture of safety. The home care and home support teams work together and there is a tight camaraderie witnessed in this team based care model.

The home care teams are providing client and family centered care in a culturally sensitive way to meet the needs of their communities. Many the staff speak the local dialects, and family members are also called upon to assist with language interpretation. Some documents have been translated into French and English. The organization could help improve their ability to provide culturally relevant care by providing more access to professional interpreter service and translating all written material into the local languages.

The home care teams can refer and consult with allied health team members, but there is along wait time to be seen in consultation. The organization is encouraged to review the wait list management for allied health consults and to consider how technology could be leveraged to provide more equitable access.

Priority Process: Decision Support

All standards were met in this section. There is a fulsome standardized intake process that includes

standardized assessments for all clients and families who utilize home care programs. The home care programs would benefit from the full implementation of the InterRai program.

The patient resource book titled "Electronic Medical Record, One Record, Better Care" clearly outlines the features of the Electronic Medical Record, this is available translated in eleven languages. The resource includes information on how clients can pose questions and concerns about the policies around health records.

Priority Process: Impact on Outcomes

From a program point of view, there has been a great deal of work done to improve the quality of home care program specific standards, moving them out from the continuing care standards. In addition, there has been movement towards implementing the InterRai program will improve the quality of the client assessments.

There is a culture of safety and risk prevention witnessed throughout the home care program. There is a clear process for disclosure of any adverse events that may occur and employees feel comfortable with utilizing this process.

There is evidence of some quality improvement work being done at a leadership level, but we were not able to consistently witness involvement of the client and family voice in the design and evaluation of QI initiatives in all the areas that were visited during the survey. The organization is encouraged to implement quality improvement initiatives that are structured to include that include input from clients and families. There are Home Care Teams in your organization that are succeeding in this and there is a valuable opportunity to learn from their successes and to share more broadly throughout the organization. Quality Improvement leaders are encouraged to seek out the positive variances throughout the organization to discover those opportunities.

Standards Set: Home Support Services - Direct Service Provision

Unmet Criteria		High Priority Criteria
Priority Process: Clinical Leadership		
9.5	There are policies and procedures regarding the safe handling of a client's money and property, where applicable.	
Priority Process: Competency		
3.6	Education and training are provided on the organization's ethical decision-making framework.	
3.10	Team member performance is regularly evaluated and documented in an objective, interactive, and constructive way.	!
3.12	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		
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		

Home Support services takes great pride with the engagement of their clients and families as they develop the services they provide. There is input and collaboration evident in all aspects of the care plan. The staff have a strong commitment to learning, and are all up to date on all required education. There is work being completed with the policies for this area, and some of the policies are being divided from the larger portfolio to the more program based policies. There is no up to date policy on the handling of money, there is an historic policy from 2012 and the staff know about the practices and provided a sign in sheet for the times they are in possession of clients money for groceries etc. Would be beneficial to have the SOP or policy updated and ensure all staff review and are aware.

Priority Process: Competency

There is a strong commitment to education within this team and support from leadership in this program exists as well for continued learning. The opportunity for access to individual funding for professional development is a great asset for this organization which is further augmented by team development. All staff speak highly of this. The team in Yellowknife were able to speak about the process and the pathway to ensure an ethics consult is obtained if needed. There was concern at Norman Wells site that the staff did not have this knowledge. Every person that was at the Yellowknife location and at the Norman Wells site had a performance appraisal within the last year. This is not the case at the Fort Simpson site.
Staff know a clear process of who to speak with around concerns should they arise. The workload is adjusted regularly to ensure the team has a balanced case load. There is a strong safety culure present within the team, they assess for staff and client safety and work to address concerns in real time and solve as a team.

Priority Process: Episode of Care

There is a strong sense of team amongst the Home Support workers, they have team motivational boards, they have many pictures on their walls that represent significant events in their unit, and there is a feeling of pride and ownership among the team that is easy to see. This was an amazing team to sit with and see how they work together and with the organization. There is a list of services in the community kept in the office to help facilitate any service that is needed for the clients if it is outside of the role of the team. The team looks to ensure the clients accesses whatever they need while living at home.

The team in Yellowknife has worked hard to improve the 2 person identifier to make it easier for clients and staff. The feedback from the clients and families with the adoption of the picture identifier for clients with cognitive impairment. With the home visit I attended, the worker clearly demonstrated the 2 person identification process.

Norman Wells is a community with a shrinking population due to the decrease in activity by the local major employer, Esso petroleum.

The Home Support and Home Care model of care and system is well organized and staff members well oriented. Home support services are provided to 6 clients at the moment, and occasionally a nurse or doctor is asked to do home visits for clinical concerns. There is one dedicated home support worker who coordinates home visits and performs duties as contracted with the client and/or their family. Staff members, administrators and patients themselves are pleased with the program: it being small, is very flexible. There is a move to add a nurse to the team to improve the services available on a continuous and recurring level.

There seems to be variability in services available bases on location, some teams have strong debriefing after a loss, while others feel services can be enhanced.

The ability to have care in your own language is a strength for Fort Simpson, and the team is to be

acknowledged for that. Each team member at all sites are aware of translation services and many of the teams have employees that speak mutliple languages that is an assest to the program.

Priority Process: Decision Support

Staff are aware of policies surrounding privacy and protection of the health record. Chart audits occur within the program and feedback is shared within the team.

Priority Process: Impact on Outcomes

There was not a clear process around the selection of evidence informed guidelines within all teams, some reference to best practices exist but this is an area to focus on for the teams to help the team understand why they are doing what they are doing. Adding to this would be the opportunity to focus on how to decide amongst conflicting evidence when developing care plans. There is an opportunity for more closed loop communication when the safety incident reports go to other managers, or programs for their input. Not always do the front line staff get the feedback on improvements once it gets assigned to a manager outside of their immediate supervisor.

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

Unmet Criteria		High Priority Criteria
Priority Process: Infection Prevention and Control		
2.5	The interdisciplinary committee regularly evaluates the program's structure and functions and makes improvements as needed.	
4.6	Compliance with IPC policies and procedures is monitored and improvements are made to the policies and procedures based on the results.	
5.6	The effectiveness of the multi-faceted approach for promoting IPC is evaluated regularly and improvements are made as needed.	
9.1	The areas in the physical environment are categorized based on the risk of infection to determine the necessary frequency of cleaning, the level of disinfection, and the number of environmental services team members required.	!
Surveyor comments on the priority process(es)		
Priority Process: Infection Prevention and Control		

The NTHSSA IPAC team has made significant progress in developing the IPAC program over the last several years. The IPAC team has supported the organization through the challenges of a pandemic and a significant territorial evacuation. Through this, they were able to demonstrate exceptional responsiveness that resulted in reinforcement and expansion of their team capacity, as well as an innovative IPAC post-evacuation checklist. The IPAC post-evacuation checklist is an important piece of work, and the team is commended for their commitment to infection prevention and control in the midst of a stressful situation.

Although there is not a dedicated IPC team member at every site, the organization has been innovative in supporting their rural and remote context with the implementation of a travelling territorial specialist. This role performs on site assessments, develops relationships, is a point of contact, and has been working with the sites to ensure consistency of IPAC standards across the territory. The organization is to be commended for initiating and resourcing such a program to support quality IPAC service delivery and support regardless of the size of the facility.

The program components and strategy are developed based on a mix of risk assessments, site visits and audits, the IPAC committee and various other methods of collecting data. Now that the IPAC team has the required policy developed, a focus on sustainable implementation using change management theory is encouraged.

NTHSSA IPAC is supported by AHS documents and standards to achieve evidence-based practice. This is a valuable relationship that is augmented by access to a qualified IPC physician for case management support. The team is working on access to a qualified IPC physician for policy and guideline consultation purposes and is encouraged to finalize this work.

The territorial IPAC committee has recently restarted. This is a valuable way to engage and involve the regions in IPAC activities. Further, this will support implementation and capacity building in the regions. Not all frontline teams were aware of this committee, and it has not yet had an opportunity to regularly evaluate the program's structure, functions and make improvements as needed. The organization is encouraged to continue to develop and meaningfully sustain this committee process.

Since the last survey, mandatory IPAC education has been implemented and is well understood as a requirement by frontline staff interviewed. The team has also attempted to address a challenging user experience to access IPAC resources with the creation of an IPAC hub with input from staff.

At the site level, evidence regarding monitoring of compliance with IPC policies beyond hand hygiene audits was not demonstrated consistently. The organization is encouraged to continue to support the use of the environmental checklist, as well as developing other tools. This may be due to lack of awareness from some frontline staff about this environmental checklist. An audit and feedback process to frontline staff may help support this, with a focus on feedback mechanisms.

The use of a QR code to invite participation by clients, families, and all staff in hand hygiene audits is an innovative practice that is commended. Hand hygiene compliance was quite low at several sites, in part this was affected by participation rates in the survey. It is recommended that the organization delegate responsibility of adequate response rates to a leader within each region to support accurate monitoring of hand hygiene. Solutions to provide adequate response rates for analysis might include: monitoring consolidation of certain small sites within a region, or analyzing data over a longer time frame (every 2-3 months). Finally, sensitivity to lack of internet connection, personal technology, and language barriers is recommended in further development of this program to enable all clients that are served by NTHSS to participate.

The IPAC program has made progress in developing mechanisms for collecting input on components of the IPC program from clients and families via the QR code program. They are encouraged to continue to develop competency and accessing NTHSSA resources that support processes for meaningful client and family engagement in healthcare program and policy development.

Some facilities experience challenges to maintain IPAC standards due to the current use of wood structures, all of the teams in this situation were aware of this and have plans to replace these surfaces or structures. Some sites delegated IPAC responsibility to a facilities manager, and the organization is encouraged to review structures of responsibility at each site to ensure that appropriate clinical connections and oversight are maintained. On inspection, the use of closed systems to clean bedpans and other equipment were not consistent across sites. The leaders are encouraged to ensure that a closed system is available to clean bed pans and other equipment. Finally, one site did report that they disposed of anatomical and biohazardous waste in sharps containers. The organization is advised to closely review this practice and monitor the implementation of appropriate waste disposal policy across the territory.

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

There is evidence at all levels of collaboration, partnerships and great teamwork to ensure that the care delivery and range of services meet the needs of the residents and their families. In particular, the Regional Wellness Committees are very effective at bringing information to the community and in bringing the voice of those community members back to leadership. It is noted that in-patient units have seen an increase in acuity and volume at all the sites. Staffing shortages have necessitated the increased used of locum and agency nursing to keep units open.

Inpatient units surveyed were clean and clutter free with wide corridors. There is good signage. Quality initiatives were posted high visibility areas. In some locations on the inpatient unit there are wooden counters. The leaders advised that they are implementing a plan to replace the wooden structures. Additionally, in one location the bedpans and other equipment are cleaned in a system which is not closed thus, team members may be exposed to bodily fluids. The leaders are encouraged to ensure that a closed system is available to clean bed pans and other equipment. The team members advised that they are working with the housekeeping department to ensure that anatomical and biohazardous waste are placed in the appropriate containers for disposal. The leaders are encouraged to continue with this important work to ensure the safety of team members and clients.

It is understandable that the priority for the health authority has been focused on emergency and disaster mitigation over the last few years. However, another area for improvement is in the review and updating

of Standard Operating Procedures, guidelines, general policy and forms. Leadership has been transparent and open about work that still needs to be done on updating policies.
The team members and leaders are encouraged to continue to co-design services to meet the needs of an aging population. Opportunities include planning for the needs of inpatient clients with dementia, and mental health and addictions. The team members have identified the need for increased education and training on mental health and addictions as there has been an increase in the complex care needs of clients.
Additionally, team members described the need for behavioral support workers. While the Stanton Territorial Hospital does employ one of these workers, there may be benefit in adding this support to other sites.

Priority Process: Competency

Team member performance is not regularly evaluated and documented. However, there were many examples of informal reviews giving encouragement, allowing work on learning plans and career planning. The leaders are encouraged to regularly evaluate and document team member performance, both formally and informally.
Another area for review and further consideration, is in the evaluation of competency in the infusion pumps and the use of drug libraries associated with them. Currently the data from the pumps are downloaded manually once a year and evaluated at that time. A process to download pump information in a more timely or electronic method may be helpful.

Priority Process: Episode of Care

Signage and translations services are exceptionally well done. Of note was the signage with multiple languages including several indigenous languages.
There is a good understanding of the ethical framework and how to ask for support on ethical issues. Teams are regularly discussing ethical topics at team huddles and meetings.
Despite some challenges with staffing and having come through several challenging years, clients and families report overall satisfaction with their care. They speak highly of the staff and site leadership.
While local health care is rated well, community members have ongoing issues with transportation to other locations. Air travel is inconsistent, and people are often given short notice of transportation plans making logistics such as childcare difficult.
Medication Reconciliation is being done routinely. Infusion pump training is up to date. Other ROP's are being met consistently. However, it is recommended the health authority review best practice guidelines for protocols on regular skin breakdown assessments. Forms need to be updated and consistent across all sites.
Team member performance is not regularly evaluated and documented. However, there were many examples of informal reviews giving encouragement, allowing work on learning plans and career planning. The leaders are encouraged to regularly evaluate and document team member performance, both formally and informally.
Another area for review and further consideration, is in the evaluation of competency in the infusion pumps and the use of drug libraries associated with them. Currently the data from the pumps are

downloaded manually once a year and evaluated at that time. A process to download pump information in a more timely or electronic method may be helpful.
Bed availability was good in Fort Smith. There were some bed challenges at the Yellowknife facility with patients waiting in the Emergency Department for beds. The number of Alternate Level of Care patients was affecting patient flow, but this is likely to be improved with the opening of the new facility.

Priority Process: Decision Support

Charts are paper based. Patient charts are well organized, and documentation is thorough.

Priority Process: Impact on Outcomes

The leaders and team members are encouraged to continue to work on quality improvement activities with clients, families, team members and organizational leaders.

Standards Set: Long-Term 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		
3.15	Team member performance is regularly evaluated and documented in an objective, interactive, and constructive way.	!
3.16	Resident and family representatives are regularly engaged to provide input and feedback on their roles and responsibilities, role design, processes, and role satisfaction, where applicable.	
Priority Process: Episode of Care		
8.16	Diagnostic and laboratory testing and expert consultation are available in a timely way to support a comprehensive assessment.	
9.18	Strategies are used to reduce avoidable admissions/readmissions to the hospital.	
10.5	Residents are involved in menu planning.	
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

Leadership and care teams working within the Long-Term Care homes provide caring and compassionate environments that residents are thriving in. Overall residents and families felt safe and were very happy with their care.

Of note are quality initiatives across the health authority on low incidents of pressure ulcers, injuries sustained during falls, and residents without psychiatric who receive an antipsychotic. The NWT is meeting benchmarks and has achieved admiral results.

The team members and leaders are encouraged to continue to seek input from residents, family and the community on services, physical spaces designs, resources, as well as work and job designs. The Regional Wellness Committees are effective at providing some of this input. However, care home may benefit from

having resident and family councils. Fort Smith had a council that existing a few years ago but may want to consider reactivating this.
Norman Wells LTC unit is one half of the Health Care complex which was built in 2019. It is bright and spacious, with 2 wings, with capacity for 16 residents, 2 palliative beds and 2 respite beds. Currently there are 14 residents. The unit provides Level 3-4 care but cannot accommodate severe dementia clients. The manager supervises a staff of LPN's and Care Aides. When necessary, the on-call RN from the adjacent Health Centre provides clinical services and the doctor is available for medical concerns and routine follow-up care.

Priority Process: Competency

Infusion pump are used in some of the long term care units but not in other. For example, the Care Home in Fort Smith does not use infusion pumps and residents requiring this type of care would be transferred to the health center.
Staff numbers and ratios of staff to residents follow NWT policy and positions are filled. Staff members are recruited through the centralized Human Resource department in Yellowknife.
At Sahtu´ Dene Necha´ Ko´ Long Term Care Facility, all staff members are up to date with their annual performance evaluations. They appreciate the opportunities for growth and education that they have received.
At the Fort Smith Northern Lights Special Care Home, Clinical Leadership is being provided currently by the COO, as the manager position is vacant at this site. However, she is supported by some of the RN's at the health care center and together with the staff they work together as a team to provide excellent care to all the residents. Team member performance is not regularly evaluated and documented. The leaders are encouraged to regularly evaluate and document team member performance.
There is a least restraints philosophy used in care homes.

Priority Process: Episode of Care

It is recommended the health authority review best practice guidelines for protocols on regular skin breakdown assessments.
At the Norman Wells unit, there is an active Activity room with programming twice a day. Currently residents do not have a say in meal planning, though indirectly staff members try to accommodate requests for rabbit stew, for example. The complaints and escalation system is active and currently there is a complainant whose concerns are being investigated by 3 different reviews, with results still pending for 2 of them. Falls are reviewed immediately and monthly by the department, with ongoing training and implementation of measures to reduce the incidence of both falls and their severity. Residents are checked every half hour overnight, and those at risk have beds and chairs equipped with alarms. The unit has a zero incidence of pressure ulcers.
At the Fort Smith home, a recent survey of food preferences, likes and dislikes was used to revamp the menus. New and more varied menus were designed with this data. Residents and family reported a high satisfaction with the meals. Family often join residence for meals being served or bring in their own to enjoy with family members living in the home.
The vacant manager position at the Fort Smith home did create some confusion about who to escalate

concerns to. Residence and family felt that in most cases the nurses on staff could resolve most issues. However, some further messaging and information on the current leadership model may benefit this group.
Of note in Fort Smith is the signage in four languages. Interpreters are available as well in all four languages. Residents have activities twice a day during the week.

Priority Process: Decision Support

Charts are paper based except for medical concerns which are documented in the patient EMR. Units are looking forward to getting Inter-RAI. Patient charts are well organized, and documentation is thorough.

Priority Process: Impact on Outcomes

Information on quality improvement initiatives is located on the Quality Board located in the corridors or areas of high visibility. The leaders and team members are encouraged to continue to work on quality improvement activities with clients, families, team members and organizational leaders.

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

Unmet Criteria		High Priority Criteria
Priority Process: Medication Management		
1.6	The team has access to a pharmacist on a 24-hour basis to answer questions about medications or medication management.	!
1.7	Team members and service providers who participate in the medication use process have access to internal or external training related to the organization's medication use processes.	!
1.9	The organization orients team members and service providers to the medication use process before they are permitted to work independently.	!
7.5	Emergency medications and supplies are standardized, consistently available, and kept secure in client service areas.	!
12.4	Team members follow established procedures to avoid direct physical contact with loose oral solid products such as tablets.	!
12.5	The organization has and follows a policy requiring the final inspection of prepared medications that states who conducts the inspection and what needs to be checked.	
12.6	Team members maintain accurate and up-to-date records of all medications prepared in the health facility.	!
13.1	The organization develops policies and procedures to ensure medications are dispensed safely.	
13.2	The organization's policies and procedures for dispensing medications meet applicable laws, regulations, and professional standards.	!
13.4	The organization has quality control procedures to prevent and report dispensing errors.	!
14.6	The organization has a policy and process to manage how medications are received and tracked by the organization.	
20.2	The organization monitors medication use with an ongoing medication utilization review.	!
20.4	The organization identifies and addresses areas for improvement based on the data collected and analyzed.	

Surveyor comments on the priority process(es)

Priority Process: Medication Management

All 5 ROPs were met. There is standardization with the drug formulary and regular systematic reviews of the formulary and to up to date information accordingly. The medication rooms were neat, tidy and well organized.

The organization is encouraged to review opporunities uncovered from the survey to improve the Medication Management for Remote/Isolated Health Services in NWT. The unmet criterial can be themed around accessibility of the standards in all regions of the territory, consistency of audits and monitoring to ensure compliance with standards and outdated technology and computerized systems. The organization is encouraged to standardize policies, increased monitoring and audits and update technology for the medication management for remote and isolated health services throughout the territory.

Standards Set: Medication Management Standards - Direct Service Provision

Unmet Criteria		High Priority Criteria
Priority Process: Medication Management		
15.1	The pharmacist reviews all prescription and medication orders within the organization prior to administration of the first dose.	!
15.2	When preparing medications for pediatric patients, the pharmacist double checks the dosing calculations of weight-based protocols.	!
Surveyor comments on the priority process(es)		
Priority Process: Medication Management		

The pharmacy and medication management team accreditation is separated for hospitals and rural and community programs. This section refers to the medication management systems at Stanton Territorial Hospital (STH), Inuvik Regional Hospital (IRH) and the Northern Lights Special Care Home in Fort Smith.

The Interdisciplinary Pharmacy and Therapeutics (P&T) Committee continues to oversee the formulary for the three primary hospitals and the 26 rural sites. The P&T Committee is recognized for improving the communication between departments and sites and for their success in moving medication management programs forward. In a review of their team processes, the P&T Committee has adjusted to improve function and flow. The Physician Executive Committee designates a representative who commits to being informed on P&T agenda topics and advises on behalf of the physician group. This streamlines meetings and facilitates quorum. Physician champions are identified to support programs and have been vital in the success of new initiatives.

Staffing is a concern across the NWT. Fort Smith has a pharmacist vacancy and is supported through STH virtually and with annual visits for inventory and audits. The effectiveness of this support and communication between the Community Health Centre and STH (and other sites) should be reviewed to identify areas and ways to improve support.

The organization may identify opportunities to improve support to the regional hubs and community health centres through metrics and frontline communication. Expanded site access to the Pharmacy Information System, pharmacy technician utilization, and virtual pharmacist oversight through live video feed are a few considerations that may improve support. Additionally, the use of automated dispensing machines, unit dose and/or training on stock bottle dispensing may better support medication management in some areas.

The Northern Lights Special Care Home is contractually supported by the community pharmacy and

pharmacist. LTC homes may benefit from a formulary to support the purchase of stock items, clear procedures on managing expired and waste medications and support to ensure that required audits are completed regularly.

At one LTC site, narcotic audits were not completed and narcotics were found on site, contrary to policy. The narcotic management policy for LTC sites across the Territory has not been updated and should be prioritized. The policy should include audit requirements, the mechanism for monitoring audit completion and clear lines of accountability.

Pharmacists perform a clinical role on the floor, supporting prescribers, reviewing charts and participating in patient care as part of the multidisciplinary team. There is an opportunity to advocate for Territorial recognition of allied health professionals and legislative change to support professionals, including pharmacists, to work to their full scope of practice and support evidence-based best practice guidelines.

Medication errors and near misses are captured through the incident reporting system. While the specifics of each incident are investigated locally, the trends are captured and forwarded for P&T awareness and review. There may be an opportunity for the P&T Committee to take a more fulsome look at trends to determine potential QI initiatives.

The Antimicrobial Stewardship Program has developed since the last accreditation review and data collected supports improvement in practice and process surrounding antibiotic utilization.

Development and standardization of order sets is recognized as a significant success for the team and new order sets are prioritized for development.

Medication reconciliation is completed throughout the organization. There is an opportunity to leverage the Pharmacy Information System to support the Medication Reconciliation program and limit the requirement for manually transcribing medications.

The STH pharmacy is bright and spacious. The Chemotherapy preparation and storage areas are separate from the admixture preparation area and the rest of the pharmacy. Anterooms with appropriate safety features including eyewash stations and showers are present. The Territory has also worked to standardize medication rooms across the organization.

Anesthetic gases at the STH site are stored on a low shelf but some bottles are close to the edge and are at risk of falling. Adding a lip to the shelf or re-configuring storage to mitigate this risk is suggested.

At STH, the pharmacist does provide weight-based checks for pediatric patients. Audits demonstrate low compliance with the prescriber specifying the dose in mg/kg or the weight of the patient though this is improving with continued education. At IRH, the physician and nurse complete the double-check for weight-based dosing.

The team completes multiple audits and provides ongoing education to support quality improvements

including the minimization of DNU abbreviations, and programs including Antimicrobial stewardship.

The medication management team notes that some audit fluctuation is due to locum utilization. Orientation of physicians, including locums, should be formalized to ensure critical areas are covered. The multidisciplinary teams should be involved in prioritizing topics across disciplines.

Standards Set: Mental 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	
3.14 Team member performance is regularly evaluated and documented in an objective, interactive, and constructive way.	!
3.16 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	
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 Mental Health Inpatient team is high-functioning and cohesive. Registered Nurses with mental health training, Behavioural Health Workers (BHWs), unit clerks, a transition coordinator and a manager are supported by psychiatrists who manage inpatient care and consultation support for the organization.

The MH unit has ample space for provided programs and potential future expansion. The ten single-patient rooms have access to outdoor space and two indoor recreational and group activity areas. There are two seclusion rooms, consultation rooms and adjacent access to a medical treatment room for patients who require non-psychiatric medical attention.

The vast geography of the NWT is a significant challenge for care delivery. While the team regularly communicates with providers in rural areas to support transitions, there are challenges. Quantifying these challenges may help support additional community resources and programs to reduce patient transfers. The organization is encouraged to continue to identify opportunities to improve training and add resources to supported communities.

Weekly grand rounds include community partners to discuss care plans and identify resources to support individuals during their transition. The improved communication has built partnerships and improved the working relationships between hospitals and the network of community support.

Pediatric inpatient support is not a funded program and the NWT faces the same challenges as the rest of the country in finding beds and supports for this population. The team is developing a working group to review pediatric psychiatric requirements and determine the physical infrastructure and skill set requirements to support a pediatric program within the territory.

The team is commended on the development of BHWs to fill an identified gap within the MH team. The redesign of security personnel into relationship management specialists who work within the MH team is commendable. Their role in early recognition of concerning behaviour patterns, de-escalation techniques, expansion of the support workers available to admitted patients and patient safety is recognized by the team and locum clinicians as a significant value add. The team is encouraged to quantify the success of the BHW program and consider submitting these successes as a leading practice.

Admission and discharge of patients are coordinated by the Transition Coordinator in conjunction with the team. Strong partnerships have been developed with a wide range of community partners in the supported communities. One significant barrier identified is resources within many of the supported communities in terms of safe housing and further clinical support specific to mental health. The team may consider utilizing data from readmission rates, extended patient stays, patient surveys and other pertinent quality data to support the integration of a step-down unit or resources to support individuals and families who no longer require inpatient resources but who still require support not available in their community.

Priority Process: Competency

The multidisciplinary team includes professionals with different backgrounds and designations. The team may benefit from more comprehensive policies and procedures to support decision-making.

The team has extensive training and cultural awareness surrounding the needs and requirements of the Indigenous community and benefits greatly from the resources offered through the Indigenous Wellness Program. With continued immigration to the territory, the organization is cognizant of the multicultural demographic shift and should support staff awareness of resources to help manage patients of diverse backgrounds.

The team has done extensive work around least restraint management and avoidance of seclusion room utilization. The entire team coordinates efforts to support patients and minimize the requirement for these modalities.

Performance appraisals are a multi-step process and pose a barrier to staff and manager completion. This leads to low completion rates as many performance appraisals are stuck in progress. The organization is encouraged to continue the discussion with the NWT government to develop a simple and meaningful

process to facilitate completion.

Clients have access to spiritual leaders, a spiritual space and gardens. When gaps are identified through mechanisms such as the Chit Chat Cafe, the team works with clients and community resources to identify and develop solutions.

Priority Process: Episode of Care

The MH Inpatient facility is bright and spacious. Clients are provided with individual rooms and have access to a secure outdoor space and two well-appointed recreational areas which include a kitchenette, exercise and recreational equipment, television and games.

The team prides itself on providing person-centred care. Since the last Accreditation Cycle, they have taken steps to more formally ensure that the patient and family's voice is heard through the Chit Chat Cafe and discharge surveys. There is a Lived Experience Advisory Group that is utilized by the team to provide feedback on policies, procedures and initiatives. The team may consider proactively inviting individuals with lived experience to sit on committees and working groups to gain their voice throughout the process, in addition to receiving feedback on the final product. Working groups including the pediatric psychiatric review may benefit from early involvement from patients, families and communities to identify opportunities through their perspective.

The team works with the patient and their family to develop a care plan based on their goals. Identification of potential barriers to care and required support begins at admission.

One opportunity identified by the team through communications with clients is to increase the variety and frequency of recreational activities. The On the Land program supported by indigenous partners was highly appreciated by interviewed clients. The team is encouraged to review opportunities both in-house and in the community to keep patients motivated, interested and engaged.

There may be an opportunity to review occupational skill sets available to the MH team and to include more psychotherapy and group therapy programming to support inpatient and transitional care. This may be considered as part of a team skill set review or as part of a program review. Engaging patients to be proactive and take responsibility and accountability for their care may be considered as part of the care plan to support discharge readiness.

The team identifies the lack of a MH step-down unit as a barrier to transition. Individuals may occupy an acute bed longer due to a lack of resources available in their community. The organization may choose to review available length of stay and repeat admission data to determine if a step-down unit is supportable, in conjunction with community partners, patients and families.

Priority Process: Decision Support

The MH inpatient unit has a paper-based chart, as do the majority of community mental health resources.

Some community providers including psychiatry and MH Nursing have access to the electronic health record, which is also shared with the emergency department.

While the team has developed many communication workarounds to ensure that admission and discharge information is shared appropriately, the hybrid chart remains a significant safety risk. Implementing a comprehensive electronic health record would be ideal for managing patient information and communication. The team is encouraged to work with community mental health partners to ensure strong advocacy for an integrated health record to facilitate communication on a single platform.

Chart audits are completed on every file on discharge to identify when there are gaps in documentation or inadequate completion. This information is electronically compiled and shared to enable quality review and identify opportunities for improvement.

Priority Process: Impact on Outcomes

The MH team collects data on key indicators and demonstrates success in adhering to best practices including medication reconciliation and least restraint utilization.

Hospital-wide, the procedure for selecting evidence-informed guidelines is scheduled for review to ensure that best practices are followed with consideration of resource availability. Engagement with the Policy Coordinator is scheduled to begin following this survey to ensure that guidelines are subjected to the same rigour and review of other policies and procedures.

Patient surveys are routinely provided upon discharge. This information is transcribed to facilitate trend analysis and sharing. Utilization of technology such as a tablet, or QR code accessible survey on a smartphone may be considered to augment the paper-based system and may also be useful for inpatient feedback on specific programs or topics.

Quality boards are newly introduced and the team is encouraged to develop an approach that works for them to ensure the board facilitates communication. It is encouraging that staff and patients are already using the board to post suggestions and identify opportunities.

Quality assurance data is displayed prominently for review by staff, patients and their advocates. The Chit Chat Cafe is a popular mechanism for staff and clients to informally meet and discuss concerns. Items identified during these conversations are posted and include the status of progress or resolution of identified concerns. The Chit Chat Cafe is notable for successfully identifying and addressing gaps as well as improving the patient experience.

The Quality Improvement program within the Mental Health unit has matured and demonstrated success in identifying successes and opportunities. The team is encouraged to continue to grow the quality program and identify metrics to support the development of new initiatives and programs.

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	
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

Obstetrical Services are provided at 3 sites at NTHSSA. These include Stanton Territorial Hospital, Fort Smith and Inuvik Regional Hospital. All 3 sites were visited. The programs are supported by Family Medicine physicians (Stanton and Inuvik) and Midwifery (Fort Smith). The Inuvik site has a supportive management team with a partnership relationship with the OR. The Fort Smith site has a Midwifery model of care. The acute care manager of the site also provides leadership. The Stanton site is supported by an experienced manager with support from a clinical educator as well as Clinical coordinator.

Priority Process: Competency

MoreOB remains the principle training program in both Stanton and Inuvik. Staff at the Fort Smith site state that only the midwives attend skills learning days that are provided at the Stanton site. This would be an opportunity to have staff attend from both the Fort Smith and Inuvik sites to increase competency. The midwifery model of care at the Fort Smith site as well as the family medicine physician-based models at the other sites are examples of how the collaborative approach is used to deliver service. Due to low birth numbers at Fort Smith, the site is on track to have 17 births this year, it is a recommendation the team incorporates mock drills based on scenarios that will support ongoing competency of staff. All RNs at the Fort Smith site have received training that certifies them as a 2nd birth attendant. They have NRP as well as Fetal Health Surveillance. This provides support to the midwifery team.

Clinical educators/Managers ensures competencies are up to date, performance appraisals were completed two years ago at the Inuvik site with review of competency checklists occurring at the other sites.
There is both indoor and outdoor space that allows clients to access spiritual or culturally significant practice across the sites.

Priority Process: Episode of Care

All sites were aware of Ethicist support if required. The medication reconciliation process was evident on all client charts reviewed as well as supported by conversations with staff and clients. The teams emphasize a low intervention physiologically driven birth experience that is guided by the client and their families. This is evident in their C-Section rates below the SOGC guidelines and high client satisfaction scores. At the Inuvik site the OB team has worked with the OR staff to create the surgical safety checklist for C-sections.as well as created a falls check list for each patient includes monitoring the infants for transport only in the cots.
Culturally competent care is a priority for this program. The Inuvik team won an award for creating prenatal rounds on all expectant clients in their region. Mothers are encouraged to be admitted to the transient unit in the hospital at the 36-week mark. If they choose not to do so, there is a discussion of potential consequences so the client can make an informed decision. If the client chooses not to this is accepted. This is a small, isolated community who tailors the care of their clients and families to what the clients believe and need. This community of care closely resembles the indigenous way with the least interference to culture and harm to clients and families.
Clients at the Inuvik site are admitted to the same unit as Mental Health clients some of which are waiting for transition to Stanton's mental health units. This is a potential safety issue for mothers and infants and should be reconsidered. The second opportunity is to create a process for the management of neonatal death.

Priority Process: Decision Support

Chart audits, BFI audits are performed that identify opportunities for education for supportive documentation. Of note and excellence, all admitted delivering mothers are screened for suicide risk in maternal clinics or as admitted. This occurs at all sites.

Priority Process: Impact on Outcomes

Audits are completed for all ROPs and used to monitor care along with feedback from families. C- section, Induction and breastfeeding rates are monitored. Staff are encouraged to report incidents into the RL6 reporting system to identify opportunities to increase patient safety.

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

Unmet Criteria		High Priority Criteria
Priority Process: Clinical Leadership		
1.3	Service-specific goals and objectives are developed, with input from clients and families.	
Priority Process: Competency		
6.11	Team member performance is regularly evaluated and documented in an objective, interactive, and constructive way.	!
Priority Process: Episode of Care		
11.9	Each client is assigned an American Society of Anesthesiologists (ASA) physical status classification level.	!
Priority Process: Decision Support		
The organization has met all criteria for this priority process.		
Priority Process: Impact on Outcomes		
25.4	Indicator(s) that monitor progress for each quality improvement objective are identified, with input from clients and families.	
25.10	Information about quality improvement activities, results, and learnings is shared with clients, families, teams, organization leaders, and other organizations, as appropriate.	
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

Inuvik has three nurses on during the day who do pre-admission, admission on, OR preparation, float, and scrub, and the recovery. One of these three nurses is also the coordinator who leads the front line who also completes the audits, books the OR, orders the equipment and consequently has a difficult time with staff oversight and education on OR specific topics. The team relies on the leadership at Stanton to work on the policies and procedures.

The Stanton team is much larger and has the program leadership team located with them. They utilize the office of the client experience and the patient navigation advisor, the Rainbow coalition and the Regional Wellness Council for input, however within the past year have dealt with a large forest fire threatening the city creating a need to evacuate the site. The site has been experiencing challenges with inpatient capacity issues which has resulted in some surgical cancellations. Recruitment and retention of the RN nursing staff has been successful with no current vacancies. The OR and PACU staff rotate between both areas and the staff are supported financially to obtain their specialty nursing program with a Return of Service agreement.

Both teams have multiple partnerships with their vendors, communities, and other health authorities. The journey to consolidate seven health regions into one health authority was started in 2016. Due to multiple major catastrophic events a pause to this work happened. Consideration may now continue to nurture the relationship between the two OR Teams, to foster trust and respect and at the same time have consideration for the differences in communities, populations and staffing models.

Priority Process: Competency

Training and education is provided to the staff and includes pay for hours spent. Team member participate in mandatory education is tracked. Team members demonstrate respect to each other and to clients and families. Staff are aware of the ethical framework and when to use it. The opportunity for management is to provide performance appraisals on a regular basis.

Priority Process: Episode of Care

The teams are very proud of the care they provide. Patients' safety was placed first as care was provided with compassion. The staff are aware of policy and procedure and were noted to adhere to it. Work was carried out efficiently, and precisely as their professionalism showed through.

Preparations for the procedures were presented to the clients in the surgeon's office or in the pre-op clinics at the same time the consents were obtained. Med reconciliation and suicide assessments were completed for both day surgery and those spending overnight in the hospital.

Pick lists were available for each surgeon for the procedures, and the equipment was pulled prior to the start of the day. Staff were aware of the processes for miscounts and equipment malfunctions.

Priority Process: Decision Support

Technology and information systems requirements and gaps are communicated to the organization. At this time the staff utilize the electronic software of the EMR to monitor the waitlists. In real time they utilize paper documentation. Documentation is precise and timely. Patient records are audited regulary to audit the adherence to the ROPs.

Priority Process: Impact on Outcomes

There are guidelines and protocols from the legacy regions, and at this time the leadership team at Yellowknife, have taken on the task to update these and place onto the new NWTHSS template. There are policies that are varied due to the service delivery models, size of the communities and populations of the two sites. The perioperative leadership stated the outfacing documents are the ones that have input from clients and families.

Many quality improvement projects are completed due to feedback and concerns with patient safety. The teams also collect data on falls, wait times, failure to show, however there were no formal QI projects spoken of during our initial discussion when asked, that include indicators with input from clients and families, with results shared with clients and families.

Priority Process: Medication Management

Medication Management is well managed in these periop units. Anaesthetic machines and supply are stocked the same in the OR suites. Staff were noted to double check and label all medication placed onto the sterile field.

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

Unmet Criteria	High Priority Criteria
Priority Process: Point-of-care Testing Services	

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)
Priority Process: Point-of-care Testing Services

POCT services are available across all health sites within NTHSSA. It is a large geographical region in which weather may cause delays for shipping consumables. Each site has a process in place for inventory control to minimize impact. There is standardization of point of care operating procedures across the sites. Each site has access to a POCT resource/Territorial Specialist. The Territorial Specialist monitors monthly quality control logs, and provides education, support, and training. Competency reviews are completed. There is a select menu for the type of point of care tests that are completed for all sites. Validation of all POCT is completed at Stanton Territorial Main Lab. There is no policy on POCT client self-testing. The Territorial Specialists are encouraged to develop a policy on POCT client self-testing. All POCT instruments are regularly calibrated using certified reference materials. Staff who perform POCT are trained thoroughly on instrument use, quality control procedures, and troubleshooting. Competency of staff is assessed and documented. Each user has a unique identification number that is assigned by the Territorial Specialist. Proper storage conditions are in place for reagents and control materials across all sites. There is work in progress to have an NTHSSA POCT Leadership committee developed.

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	
3.10 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

These comments are supplemented by also spending time and interviewing clinician colleagues in the ER at IGH, the Family Clinic, and the Health Centre in Fort McPherson. The NTHSSA has a very committed and enthusiastic management team and an exemplary clinician base from which primary care and primary health care services are organized and delivered. While there is clear interest in Quality, Safety and Quality Improvement (QI) activities there is a great deal of regional and local variability in its actualization. This is not surprising given the adage "when you're up to your arse in alligators it's difficult to remember that your initial objective was to drain the swamp".

QI can be markedly improved within the NTHSSA as evidenced by the Inuvik visit. Your Accreditation Canada Surveyors are all appreciative of what the people of the NWT have been through over the past few years. That, coupled with the background challenges of recruitment and retention to the North is a reality.

Clinician QI champions are key to the success of any organization wishing to be to be involved in Quality Improvement activities.

The whole organization may wish to consider adopting the primary care/primary health care language of "Significant Events" instead of the conventional hospital-centric language of Critical Incidents/Never Events and Route Cause Analysis. Events are rarely the result a single cause.

A Significant Event is anything anybody on the health care team, including patients and their families, see

as important in terms of the quality of care or the conduct of the practice. With a Significant Event Analysis, we all need to know-what happened?, why did it happened?, what has been or can be learned and what needs to be done to prevent it from happening again?
In the case of a good or exemplary Significant Event we need to know how to endure it reliably happens the same way again and again and again.
Fostering Significant Event dialogues rather than rating issues as to levels of seriousness is more likely to nurture a Quality Improvement Culture and activities.

Priority Process: Competency

All clinicians with responsibilities in Primary Care/Primary Health Care are well-educated and well-trained and "steeped" and highly functional in team-based care.
Competencies are enhance and sustained by reliance on a "long-term locum" approach. Many clinicians have maintained longer term relationships with the NTHSSA.

Priority Process: Episode of Care

All the characteristics of exemplary engagement are evident here. Patient and Family Centredness are well witnessed.

Priority Process: Decision Support

Decision support in primary care is evolving and brings opportunities for efficiencies.

Priority Process: Impact on Outcomes

There is a wealth of quality-oriented activity in primary care that has the opportunity for novel QI projects. The agency may consider adopting the term-Significant Event rather than critical incident or never event. A Significant Event is anything anybody on the healthcare team, including patients and their families, see as important in terms of the quality of care or the conduct of the practice. A careful analysis of a significant event leads easily to considering quality improvement initiatives. The organization is encouraged to explore different engagement strategies witih staff to identify Significant Events and addressing their analysis, leading to QI opportunities.

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		
4.3	Team member performance is regularly evaluated and documented in an objective, interactive, and constructive way.	!
5.3	Team members are recognized for their contributions.	
Priority Process: Impact on Outcomes		
16.4	Indicator(s) that monitor progress for each quality improvement objective are identified, with input from clients and families.	
16.11	Quality improvement initiatives are regularly evaluated for feasibility, relevance, and usefulness, with input from clients and families.	
Priority Process: Public Health		
2.2	There are agreements with partner organizations to access external surveillance data as necessary.	
3.11	Ethics-related issues are proactively identified, managed, and addressed.	!
3.12	Utilization reviews are regularly completed to ensure resources have been used appropriately.	
11.5	Consent for vaccine administration is obtained and documented.	!

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

The NTHSSA is an integrated system with public health services delivered in all settings where health care is provided. The three public health units were visited during this survey. Public health services within NTHSSA continue to transition from the Office of the Chief Public Health Officer (OCPHO), with the teams collaborating closely to provide public health services for the territory. Within the last year, the Territorial Operations Public Health Unit (TOPHU) has been implemented and is an important step in building capacity and operational support for public health within NTHSSA. It is noted that while only the public health units were surveyed, public health in all healthcare settings is supported by this new territorial team and some comments reflect a public health system view. The public health team is encouraged to maintain a focus on person centered care during their current transition and involve client, families and

their community in the design of the public health system.

Priority Process: Competency

Team competency is taken seriously within public health, with ongoing education provided in a variety of formats. Public health rounds support conversation, knowledge translation, and awareness regarding pertinent public health topics for frontline staff as well as building relationships between communities outside of Yellowknife and their territorial public health leadership.

While informal conversations are occurring with staff regarding performance, regular performance reviews are not completed and documented. Staff cite difficulties navigating the existing platform. There does appear to be a consistent process when onboarding and orientating staff, but the organization is encouraged to ensure a consistent, accessible process with all staff to support retention efforts. Processes exist within NTHSSA to provide formal recognition to team members. The organization is encouraged to support individual and team recognition in regional centers with both informal and formal methods.

Priority Process: Impact on Outcomes

Implementation of the Syphilis/HIV Point of Care tests are an excellent example of testing and implementation broadly throughout the organization. The teams used valuable engagement strategies to collect both quantitative and qualitative data from the community to influence service delivery and design. The organization will benefit from systematic and regular evaluation of public health quality improvement initiatives and supporting the frontline with tools and expertise with which to do so.

Within the NTHSSA, broad quality improvement activities are hampered by the existing data systems. While quality improvement activities exist in public health, a focus on improving this component is recommended. Quality improvement activities are complicated by the current process to access pertinent surveillance information. The public health teams do not currently have a public health information system implemented, relying instead on an EMR that is challenging to extract reliable information from. Teams described manual processes at the site level to pull and analyze data, resulting in a lack of consistency for quality indicators for certain public health topics such as immunization coverage rates. These challenges with data result in inconsistencies of quality indicators, quality improvement activities, and information sharing of relevant public health information at the frontlines. The leadership team is aware of these challenges and is actively collaborating with health system partners, including the OCPHO to resolve these challenges.

There is a process to regularly collect indicator data and in some local initiatives, indicators were being tracked. However, often frontline teams are asked to collect data and report up but do not know where that information goes after it is reported. There may be some gaps in communication back down to the frontline public health workforce, and it is recommended that communication channels for public health information are evaluated to ensure the information is, in fact making it to the frontline effectively. Awareness of this data at the frontline was inconsistent.

Across public health, quality improvement initiatives have been established. However, consistent client and family input into establishing measurable objectives and indicator selection was not observed. As the information systems are enhanced and implemented, the public health team is encouraged to involve clients, families or communities to provide input into the types of indicators that are invested in for quality improvement. Further, although information and feedback are gathered from clients, families and communities, staff reported that they felt that the priorities were being set outside of the NTHSSA and that they may not reflect client, family, and community feedback. Staff also reported that there was not always consistent or clear information communicated from the OCPHO. The territorial public health team is working hard to represent the realities and perspective of the frontline public health teams in their collaboration with the OCPHO, while working within the limitations of the current structure.

Priority Process: Public Health

The population health assessments are the responsibility of the Department of Health and Social Services (DHSS) with the NTHSSA operationalizing the strategy laid out in the business plan. Public health data is provided, including surveillance, populations who experience barriers to access, health equity gaps, populations at higher risk of poor health outcomes, are all supported by the Department of Health and Social Services and the Office of the Chief Public Health Officer.

Required resources are identified and strategies are developed to address these resource needs. The Territorial Operations Public Health Unit (TOPHU) is a clear example of identification of required resources and implementation of new strategies to support public health in the territory. This team includes the role of a Territorial Public Health physician who provides valuable clinical leadership and support to public health operations. The team also has plans to implement a public health nurse role for the regions who do not have a Public Health Unit, this is an excellent initiative to resource and support public health throughout the system.

Partners, including those representing and serving indigenous communities are engaged in supporting public health throughout the territory. Several examples of true community partnership were observed across the territory and the organization is to be commended for supporting local initiatives to improve and protect public health. The health system has supported the role of Community Health Representative, a valuable resource throughout the territory that supports health promotion activities and provides important insight regarding barriers to care.

Services that support communicable disease prevention, including sexually transmitted infections are provided; however, a consistent approach to sexual health education delivered by NTHSSA is not used. This may be an opportunity to implement evidence-based programming.

While information from a variety of sources is analyzed, consistent, timely access to information informing public health decision-making is impeded by layers of administration related to the current state between the OCPHO and NTHSSA. Reporting to the OCPHO is a manual process requiring resources to clean and follow up on missing data. This results in delays to access accurate communicable disease information. The client registries related to communicable diseases are the responsibility of the OCPHO, further

complicating access to required clinical data for follow-up. Currently, certain data can only be shared to a small number of individuals within the NTHSS who hold statutory PH appointments, and these individuals are restricted from sharing this information further. This can result in a delay of public health information communication to the frontline public health teams.

The Department of Health and Social Services is the main custodian of public health data in the territory. Currently, an agreement does not exist to access this data as necessary. Creating an agreement to facilitate access to this data will support public health operational decision-making and its prioritization is recommended. The public health system will benefit from increased analytics and communication of various outcome and process indicators on a regular basis.

The organization is aware of the limitations of their current state and are actively working with the OCPHO to develop process, agreements, and data systems that meet requirements under the public health and safety act as well as privacy legislation. It is recommended that this work is prioritized alongside operational priorities as the structure, roles, and responsibilities of the Territorial Operations Public Health Unit are developed. Maintaining consideration of Accreditation Canada Public Health standards, engagement with frontline providers as well as partnership with client, family, and community representatives will ensure a transition that meets the community's needs as well as quality standards. Designing mechanisms to support awareness of quality indicators and population health data at the frontline service delivery level in a systematic manner will be important to incorporate.

The teams did report some difficulties with the current structure in delivering person-centered care due to separation between operational public health and the OCPHO. For example, a person-centered approach to directly observed therapy for patients with tuberculosis. The team is encouraged to explore how to collaboratively improve person-centered care, while still meeting critical public health and safety requirements.

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	
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

Senior Leadership and front line staff are a committed and professional group dealing with multiple vacancies in their programs. The overall goal of the "standardization" of rehabilitation services in the NWT is a daunting task but one they do not and will not shy away from.
The organization is encouraged to discover novel methods of recognition for Rehab staff as a means of staff retention.

Priority Process: Competency

Competencies and critical appraisal of conventional and unconventional treatment approaches is this ethic of this group.

Priority Process: Episode of Care

Episodes of care were supplemented by engaging three different individuals availing of rehabilitation services. Clinical encounters were characterized by high levels of respect and professionalism with a good sense of humour.
Establishing a goal of "effective cake decorating", a pre-stroke skill, resulting in a child of one of the profesisonals having a nicely decorated cake. This is an example of not only knowing "what's the matter"

but "what matters to me" as a patient/client.

Priority Process: Decision Support

The decision support criteria are well supported. There is a natural curiosity about the assessment of alternative/complimentary approaches and their evaluation.

Priority Process: Impact on Outcomes

This agency is driven by a "best evidence" approach. At the same time they are open to consider alternative/complimentary approaches (the long towel). The next step is a better organized and actuated Quality Improvement process.
QI activity will not only inform themselves but other areas within the NWT and the country as a whole.

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		
3.7	Education and training are provided on the organization's ethical decision-making framework.	
3.14	Team member performance is regularly evaluated and documented in an objective, interactive, and constructive way.	!
3.16	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		
8.10	Diagnostic and laboratory testing and expert consultation are available in a timely way to support a comprehensive assessment.	
10.12	Information relevant to the care of the client is communicated effectively during care transitions.	ROP
10.12.5	The effectiveness of communication is evaluated and improvements are made based on feedback received. Evaluation mechanisms may include: • Using an audit tool (direct observation or review of client records) to measure compliance with standardized processes and the quality of information transfer • Asking clients, families, and service providers if they received the information they needed • Evaluating safety incidents related to information transfer (e.g., from the patient safety incident management system).	**MINOR**
11.9	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		
16.4	Indicator(s) that monitor progress for each quality improvement objective are identified, with input from clients and families.	
16.5	Quality improvement activities are designed and tested to meet objectives.	!
16.6	New or existing indicator data are used to establish a baseline for each indicator.	
16.7	There is a process to regularly collect indicator data and track progress.	
16.8	Indicator data is regularly analyzed to determine the effectiveness of the quality improvement activities.	!
16.9	Quality improvement activities that were shown to be effective in the testing phase are implemented broadly throughout the organization.	!
16.10	Information about quality improvement activities, results, and learnings is shared with clients, families, teams, organization leaders, and other organizations, as appropriate.	
16.11	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 Northwest Territories Health and Social Services Authority (NTHSSA) serves 14 (fourteen) remote and isolated health centers; three (3) of which were visited by surveyors during this onsite survey. These essential resources provide 24-hour remote access to physicians located in regional hubs in addition to speciality via the Med-Response program.

As the single point of care in the local communities, the Community Health Centers (CHRs) provide a range of services that spans health promotion, immunization, screening, well women and well man, school care and general health. Care that cannot be provided on site is facilitated through consultation or medical travel.

Partnerships are essential for success and the CHRs have direct relationships; in addition to the regional hospitals, Med-Response and Alberta Health Services; with Police, Elders, Home Care, Community Mental Health, Addictions, Home Care and Wellness Councils. Underpinning all of these relationships are the communities themselves who step up to meet challenges.

Costs are high, both in human and material resources that are impacted by weather and geographical access. Recruitment and retention is an ongoing challenge and leaders continue to seek out ways to attract registered staff to the areas.

Patient transport, and in particular, the ability be accompanied by an escort when receiving care outside of the community; is an area that is of great importance to many team members. Staff spoke with passion

about their concerns of the impact that separating patients; specifically, elders; from their communities might have on their wellbeing and ability to partner in their care. The organization is encouraged to continue advocating.
There are many areas of pride in the care delivered in the remote and isolated locations. Staff demonstrate strong connection to purpose.

The Rosie Ovayuak Community Health Centre is led by a Nurse in Charge whose team provides scheduled and walk-in care to a community of over 1000 in Tuktoyaktuk. There are strong links with the community and other essential services; not least the Med-Response program; accountable for medical transport in the event a patient requires a higher level of care than the team can provide. Community Health Representatives (CHRs) are a primary conduit between the center and the local community and in addition to their role in health promotion activities, compliment the registered staff by connecting the voice of the patient and supporting the navigation of the team along a pathway of culturally appropriate and informed care. Additional to the CHRs, the centre employs a nurse who originated from the community which further assures appropriate representation. Physician care is provided remotely via phone or by the use of Telehealth. Patients appreciate the availability of Telehealth as it reduces the need to be transported to the Inuvik or Stanton hospitals and beyond.
At Norman Wells the health centre is a new building. It is bright and spacious and designed for growth. The community of Norman Wells has not grown as anticipated so the building is relatively under-occupied. The hallways are spacious and privacy is maintained in the treatment areas. The open-concept provider desk area is a good idea as it promotes discussion and interaction between the clinicians. However, there is also desk space for non-medically trained providers, such as the Community Support Worker and this risks the confidentiality of patients under discussion by the team. The organization is strongly urged to consider a divider in the desk area to maintain patient confidentiality.
The Fort McPherson Public Health team is a team of allied health professionals who wrap their care around each individual of this community serving between 500 – 800 people. Their goal is to support each individual in a holistic manner, and to offer services that work for the people. They offer services to support prenatal health, healthy families, baby wellness, child and youth wellness, adult wellness, chronic disease management and home support for 27 people. The in-person clinic operates in the mornings, with two nurses and there is the opportunity to just call in and talk to a nurse if the appointments are full for the morning.

Priority Process: Competency

At the Rosie Ovayuak Community Health Centre, orientation and continuing education is in place and the quality of the recent onboarding of the Nurse in Charge was cited as an area of celebration. Team members follow the scopes of practice set in place by their regulatory bodies. A new Learning Management System (LMS) will house education materials. Specialty training takes place to meet the context specific needs; for example, at the Rosie Ovayuak Community Health Centre, nurses are trained to perform limited diagnostic imaging procedures, such as chest x-rays and limbs. Targeted education to assure the safe use of equipment is delivered. At the time of the onsite survey, a Clinical Nurse Educator had been filled for the Beaufort Delta Region. Staff spoke of support for educational endeavors. Performance evaluations are lagging overall; impacted by what was described as a cumbersome system.

Staff share that they feel valued and recognized for their contributions. Complaints, concerns, and escalation procedures are observed, and all staff can articulate the process and the location of the reference resources.

"Our CHN (Community Health Nurse) competency list is 57 pages". Staff members have opportunities for professional development available throughout the organization. There is no clinical nurse educator at Norman Wells, this limits staff competency training. There is an opportunity to improve the orientations process and start the training online before the new nurse/staff member recruit arrives on site. Staff member performance evaluations are not completed and staff members do not view them as supporting their career ambitions.

Most of the allied health professionals at Fort McPherson are long tenured and work six weeks in and six weeks out. There is on call through the night of one CHN. The clinic is also a holding space for patients needing more care than can be provided and there is a room set up to resuscitate adults as needed with minimal supplies. There is also an infant warmer in the event of a distressed newborn infant. It would be strongly suggested the investment of a Broslow Kit be purchased to support newborn to youth resuscitations. Secondly to investigate the purchase of a Neo Puff to support infants needing CPAP or assistance breathing for long periods while support arrives.

Priority Process: Episode of Care

At the Rosie Ovayuak Community Health Centre, the standardized processes for registration, assessment and treatment was described/ observed. Patient assessments are informed by best practice standards, aligned with the clinical care context and in partnership with the patient themselves. Access to laboratory services and imaging are limited in the locale. Staff are keen to see an iStat unit at the site as they believe it will positively impact safety. Person centered decision making is supported with sensitivity and compassion. Documentation of assessments were viewed in the health record and the required information; is populated in a standardized manner as the patient moves through the care plan. Medication Reconciliation is conducted per the organizational policy with the Community Health Nurses generating the BPMH; in partnership with the patient. Information transfer occurs at care transitions and documentation is included in the patient record to maintain communication among the care team. Patients are provided with education and coaching to manage their conditions and every effort is made to follow patients until their health goals are achieved.

The facility at Norman Wells is large and well stocked and well-staffed. Patients arrive by booked appointment or walk-in. Usually, the patient is triaged over the phone and given an appointment based on their acuity. There are no delays for patients to be seen. The lack of lab testing equipment, such as for electrolytes or troponins, means patients are sent out by med-evac for diagnostic testing prior to being stabilized. The team wishes they had point-of-care testing for most common presentations as this limits their ability to provide full scope care and reduces staff morale. There is inconsistent support for palliative care and a palliative medication toolbox is not available. There is a shortfall in transfer timeliness. There is no formal evaluation of the effectiveness of transfers. Staff members comment that often they see patients back in community without having received discharge notification or follow-up

recommendations. This is especially true of mental health patients, who may have missed follow-up medication doses and suffered relapses in their condition. There is an opportunity for the organization to streamline essential transfer documents to be scanned or faxed, and have a robust monitoring system to ensure timely and effective transfer of care responsibility, discharge medication and prompt follow-up.

Priority Process: Decision Support

The organization uses the Wolf EMR provided by Telus. Standardized documentation fields are utilized and the patient record is accessible to all in the circle of care and privacy expectations are met. Norman Wells is paper free. However, there is a move to search for another more intuitive and user friendly EMR. One of the concerns is all diagnostic reports are sent to the Nurse in Charge, who then reviews them and forwards them to the ordering provider. Multiple files can be open at once and documentation is done on a Word document: this could lead to documentation errors in the wrong chart.
Paper charts are still located at the Rosie Ovayuak Community Health Centre but locked away and there are plans to further secure them.

Priority Process: Impact on Outcomes

At the Rosie Ovayuak Community Health Centre, policies are complied with; to include all that relate to high-risk processes. Patient safety incidents are reported in the RL6 system and follow up takes place. The team does not observe a cadence of standardized quality improvement practices, such as regular facilitated huddles. That said, improvement discussions do occur.

The team at Norman Wells uses standard disease-specific protocols for care developed in NWT and maintained up to date. While quality improvement objectives are identified, the team at Norman Wells has not developed these objectives to the point of identifying indicators or deliverables. There are currently no formal quality improvement activities at the Norman Wells Remote/isolated Health Centre.

Key performance indicators include but are not limited to; compliance with Information Transfer, Best Possible Medication History and IV Pump training. Audits are conducted for reporting and improvement purposes but there is an overall lack of lack of locally determined goals in some areas. The organization has an opportunity to use these data to inform targeted quality improvement efforts in partnership with staff and clients at the local level.

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.	
25.11	The team shares information about its quality improvement activities, results, and learnings with clients, families, staff, service providers, organization leaders, and other organizations, as appropriate.	
25.12	The team regularly reviews and evaluates its quality improvement initiatives for feasibility, relevance and usefulness.	
Surveyor comments on the priority process(es)		
Priority Process: Episode of Care		

Universal Fall Precautions are in place to ensure a safe environment is in place that prevents falls and reduces the risk of injuries from falling.

Priority Process: Transfusion Services

In 2022, there was a significant restructuring of laboratory and diagnostic imaging services. The aim of this restructuring was to eliminate service variability across the territory, thereby enhancing the quality of service. The subsequent steps should involve gathering information to bolster the transfusion medicine service. The NTHSSA does not have transfusion medicine expertise therefore it operates under a contractual agreement. This expert consulting is in place to align with standards and Accreditation requirements. Within the new structure, the Technical Supervisors and Technical Specialists are working

to standardize Standard Operating Procedures across NTHSSA as well as document control. This is a self identified area of opportunity.
After hours emergency call back is in place to offer transfusion medicine service. All staff have met competency requirements including education for safety, risks, Infection Prevention and Control and hand hygiene.
Pre-transfusion testing, which includes blood typing, crossmatching, and antibody screening is performed to ensure correct blood components match the client. All clients are monitored for adverse reactions.
The physical environment is clean, uncluttered and there is no eating or drinking in the space. All biologic safety procedures are in place. Storage of Blood products meets standard, and this is monitored and documented.
Home Transfusion services are not available.
The team is encouraged to share results of all Quality Improvement initiatives that are occurring. Results are shared within teams however the organizations are encouraged to share with clients and families to celebrate successes.

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: February 1, 2022 to March 18, 2022**
- **Number of responses: 7**

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.	0	14	86	93
2. Governance policies and procedures that define our role and responsibilities are well documented and consistently followed.	14	0	86	94
3. Subcommittees need better defined roles and responsibilities.	43	43	14	69
4. As a governing body, we do not become directly involved in management issues.	0	0	100	85
5. Disagreements are viewed as a search for solutions rather than a “win/lose”.	0	0	100	94

	% 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.	0	0	100	97
7. Individual members understand and carry out their legal duties, roles, and responsibilities, including subcommittee work (as applicable).	0	0	100	93
8. Members come to meetings prepared to engage in meaningful discussion and thoughtful decision making.	0	29	71	95
9. Our governance processes need to better ensure that everyone participates in decision making.	71	0	29	63
10. The composition of our governing body contributes to strong governance and leadership performance.	0	29	71	94
11. Individual members ask for and listen to one another's ideas and input.	0	0	100	96
12. Our ongoing education and professional development is encouraged.	0	71	29	82
13. Working relationships among individual members are positive.	0	0	100	96
14. We have a process to set bylaws and corporate policies.	0	0	100	96
15. Our bylaws and corporate policies cover confidentiality and conflict of interest.	0	14	86	98
16. We benchmark our performance against other similar organizations and/or national standards.	0	14	86	76
17. Contributions of individual members are reviewed regularly.	29	43	29	63
18. As a team, we regularly review how we function together and how our governance processes could be improved.	0	29	71	79
19. There is a process for improving individual effectiveness when non-performance is an issue.	14	29	57	57

	% Strongly Disagree / Disagree	% Neutral	% Agree / Strongly Agree	%Agree * Canadian Average
	Organization	Organization	Organization	
20. As a governing body, we regularly identify areas for improvement and engage in our own quality improvement activities.	14	43	43	79
21. As individual members, we need better feedback about our contribution to the governing body.	0	29	71	40
22. We receive ongoing education on how to interpret information on quality and patient safety performance.	14	14	71	76
23. As a governing body, we oversee the development of the organization's strategic plan.	0	14	86	96
24. As a governing body, we hear stories about clients who experienced harm during care.	29	14	57	74
25. The performance measures we track as a governing body give us a good understanding of organizational performance.	14	14	71	87
26. We actively recruit, recommend, and/or select new members based on needs for particular skills, background, and experience.	33	33	33	90
27. We lack explicit criteria to recruit and select new members.	67	17	17	79
28. Our renewal cycle is appropriately managed to ensure the continuity of the governing body.	0	29	71	90
29. The composition of our governing body allows us to meet stakeholder and community needs.	14	0	86	89
30. Clear, written policies define term lengths and limits for individual members, as well as compensation.	0	0	100	94
31. We review our own structure, including size and subcommittee structure.	14	29	57	90
32. We have a process to elect or appoint our chair.	0	33	67	93

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	29	14	57	82
34. Quality of care	29	14	57	83

*Canadian average: Percentage of Accreditation Canada client organizations that completed the instrument from January to June, 2022 and agreed with the instrument items.

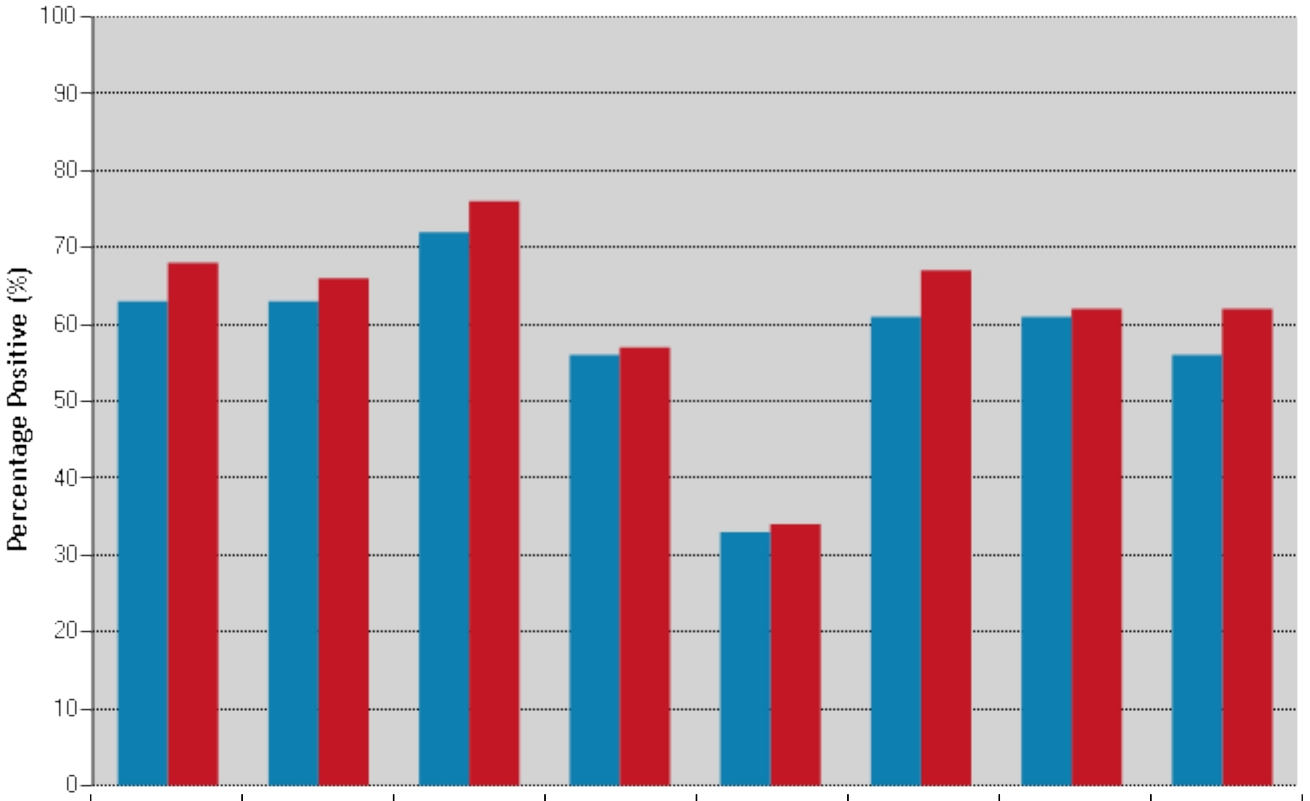
Canadian Patient Safety Culture Survey Tool

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: November 1, 2021 to December 17, 2021**
- **Minimum responses rate (based on the number of eligible employees): 246**
- **Number of responses: 374**

Canadian Patient Safety Culture Survey Tool: Results by Patient Safety Culture Dimension



	Organizational (senior) leadership support for safety	Supervisory leadership for safety	Unit learning culture	Enabling Open Communication I: judgment-free environment	Enabling Open Communication II: job repercussions of error	Incident follow up	Stand-alone items	Overall Perceptions of Client Safety
	63%	63%	72%	56%	33%	61%	61%	56%
	68%	66%	76%	57%	34%	67%	62%	62%

Legend

Northwest Territories Health and Social Services Authority

* Canadian Average

*Canadian average: Percentage of Accreditation Canada client organizations that completed the instrument from July to December, 2023 and agreed with the instrument items.

Worklife Pulse

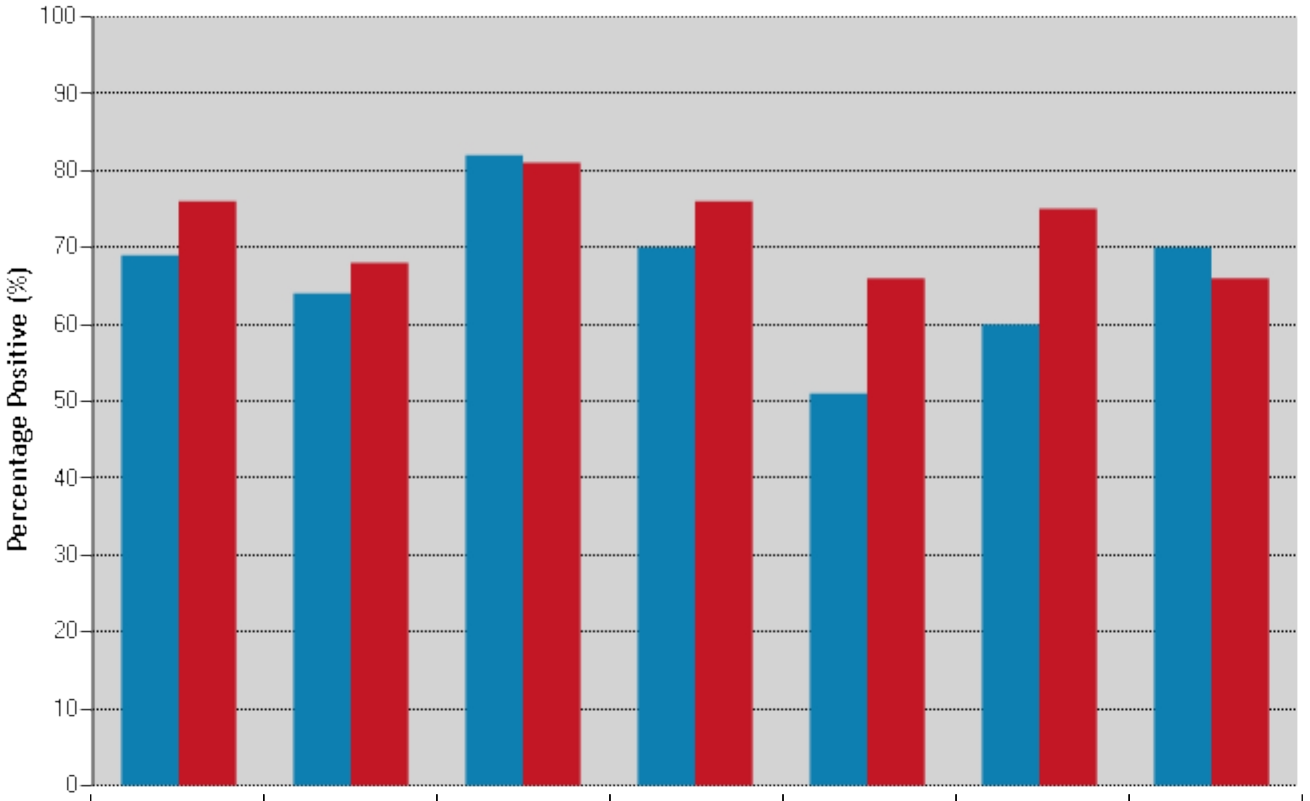
Accreditation Canada helps organizations create high quality workplaces that support workforce wellbeing and performance. This is why Accreditation Canada provides organizations with the Worklife Pulse Tool, an evidence-informed questionnaire that takes a snapshot of the quality of worklife.

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: November 1, 2021 to December 17, 2021**
- **Minimum responses rate (based on the number of eligible employees): 284**
- **Number of responses: 356**

Worklife Pulse: Results of Work Environment



	Job	Training and Development	Coworkers	Immediate Supervisor	Senior Management	Safety and Health	Overall Experience
	69%	64%	82%	70%	51%	60%	70%
	76%	68%	81%	76%	66%	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 July to December, 2023 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	Unmet
Provided a client experience survey report(s) to Accreditation Canada	Met

Organization's Commentary

After the on-site survey, the organization was invited provide comments to be included in this report about its experience with Qmentum and the accreditation process.

The Accreditation survey process serves as a critical mechanism for evaluating and improving healthcare standards for the NTHSSA. By undergoing accreditation, we demonstrate our commitment to quality, which enhances public trust and confidence in our programs and services. Implementing standardized policies and procedures is essential for ensuring consistency and quality across all areas of the organization. By adhering to established standards provided by Accreditation Canada, the NTHSSA has enhanced information to the staff and patients, clients, and families about how programs and services are delivered.
The NTHSSA included three new program standards to the Qmentum cycle for 2019-2023: Ambulatory Care, Home Support Services, and Medication Management for Remote and Isolated Services, reflecting organization’s adaptability to evolve and expand its focus on specific areas of care delivery, and enhancing service quality.

The NTHSSA’s Qmentum cycle for 2019-2023 was completed amidst considerable challenges for staff and clients that included the COVID-19 pandemic, several community floods, and wildfires, that included full evacuations of healthcare facilities, including the Territorial Hospital - Stanton. Advancing through accreditation amongst these challenges highlights the organization's resilience and commitment to service excellence. This resilience also underscored the importance of proactive risk management and contingency planning.

Further emphasizing the importance of client and family collaboration in action plans and program design will demonstrate a culture of continuous improvement, where organizational processes evolve in response to patient and client needs and preferences.

The NTHSSA's approach to accreditation and quality improvement enhances a comprehensive strategy aimed at improving patient outcomes and organizational resilience. By prioritizing standardized policies, program standards, feedback mechanisms, and risk management practices, the NTHSSA demonstrates its commitment to excellence in health and social services delivery.

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 20 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
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

Priority Process	Description
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
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