ACCREDITATION
AGRÉMENT
CANADA
Qmentum

# Accreditation Report

## Hay River Health and Social Services Authority

Hay River, NT

On-site survey dates: December 1, 2019 - December 6, 2019

Report issued: January 14, 2020

# About the Accreditation Report

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

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

# Confidentiality

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

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

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

# A Message from Accreditation Canada

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

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

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

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

We look forward to our continued partnership.

Sincerely,

Leslee Thompson
Chief Executive Officer

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# Executive Summary

Hay River 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

Hay River 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: December 1, 2019 to December 6, 2019**

- **Locations**

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

  1. Gensen Building
  2. H.H. Williams Memorial Hospital
  3. Hay River Regional Health Centre
  4. Supportive Living Campus
  5. Woodland Manor

- **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. Infection Prevention and Control Standards
  2. Leadership
  3. Medication Management Standards

  ***Service Excellence Standards***

  4. Child, Youth, and Family Services - Service Excellence Standards
  5. Community-Based Mental Health Services and Supports - Service Excellence Standards
  6. Emergency Department - Service Excellence Standards
  7. Inpatient Services - Service Excellence Standards
  8. Long-Term Care Services - Service Excellence Standards
  9. Perioperative Services and Invasive Procedures - Service Excellence Standards
  10. Primary Care Services - Service Excellence Standards
  11. Reprocessing of Reusable Medical Devices - Service Excellence Standards

- **Instruments**

  The organization administered:

  1. Worklife Pulse
  2. Canadian Patient Safety Culture Survey Tool
  3. 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) | 30 | 10 | 0 | 40 |
| Accessibility (Give me timely and equitable services) | 77 | 5 | 6 | 88 |
| Safety (Keep me safe) | 398 | 29 | 26 | 453 |
| Worklife (Take care of those who take care of me) | 101 | 8 | 1 | 110 |
| Client-centred Services (Partner with me and my family in our care) | 280 | 25 | 2 | 307 |
| Continuity (Coordinate my care across the continuum) | 66 | 0 | 0 | 66 |
| Appropriateness (Do the right thing to achieve the best results) | 486 | 106 | 28 | 620 |
| Efficiency (Make the best use of resources) | 18 | 6 | 4 | 28 |
| **Total** | **1456** | **189** | **67** | **1712** |

## 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 |
| | # (%) | # (%) | # | # (%) | # (%) | # | # (%) | # (%) | # |
| Leadership | 38 (77.6%) | 11 (22.4%) | 1 | 76 (83.5%) | 15 (16.5%) | 5 | 114 (81.4%) | 26 (18.6%) | 6 |
| Infection Prevention and Control Standards | 35 (87.5%) | 5 (12.5%) | 0 | 25 (86.2%) | 4 (13.8%) | 2 | 60 (87.0%) | 9 (13.0%) | 2 |
| Medication Management Standards | 62 (100.0%) | 0 (0.0%) | 16 | 57 (100.0%) | 0 (0.0%) | 7 | 119 (100.0%) | 0 (0.0%) | 23 |
| Child, Youth, and Family Services | 75 (89.3%) | 9 (10.7%) | 0 | 95 (96.9%) | 3 (3.1%) | 1 | 170 (93.4%) | 12 (6.6%) | 1 |
| Community-Based Mental Health Services and Supports | 32 (71.1%) | 13 (28.9%) | 0 | 72 (76.6%) | 22 (23.4%) | 0 | 104 (74.8%) | 35 (25.2%) | 0 |
| Emergency Department | 60 (85.7%) | 10 (14.3%) | 2 | 81 (87.1%) | 12 (12.9%) | 14 | 141 (86.5%) | 22 (13.5%) | 16 |
| Inpatient Services | 48 (81.4%) | 11 (18.6%) | 1 | 70 (84.3%) | 13 (15.7%) | 2 | 118 (83.1%) | 24 (16.9%) | 3 |
| Long-Term Care Services | 55 (98.2%) | 1 (1.8%) | 0 | 99 (100.0%) | 0 (0.0%) | 0 | 154 (99.4%) | 1 (0.6%) | 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 |
| | # (%) | # (%) | # | # (%) | # (%) | # | # (%) | # (%) | # |
| Perioperative Services and Invasive Procedures | 100 (89.3%) | 12 (10.7%) | 3 | 95 (88.0%) | 13 (12.0%) | 1 | 195 (88.6%) | 25 (11.4%) | 4 |
| Primary Care Services | 50 (86.2%) | 8 (13.8%) | 1 | 77 (85.6%) | 13 (14.4%) | 1 | 127 (85.8%) | 21 (14.2%) | 2 |
| Reprocessing of Reusable Medical Devices | 79 (95.2%) | 4 (4.8%) | 5 | 34 (85.0%) | 6 (15.0%) | 0 | 113 (91.9%) | 10 (8.1%) | 5 |
| **Total** | **634 (88.3%)** | 84 (11.7%) | 29 | 781 (88.5%) | 101 (11.5%) | 33 | 1415 (88.4%) | 185 (11.6%) | 62 |

* 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** | | | |
| Patient safety incident disclosure (Leadership) | Met | 4 of 4 | 2 of 2 |
| Patient safety incident management (Leadership) | Unmet | 4 of 6 | 0 of 1 |
| Patient safety quarterly reports (Leadership) | Unmet | 0 of 1 | 0 of 2 |
| **Patient Safety Goal Area: Communication** | | | |
| Client Identification (Emergency Department) | 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 (Perioperative Services and Invasive Procedures) | Met | 1 of 1 | 0 of 0 |
| Information transfer at care transitions (Community-Based Mental Health Services and Supports) | Met | 4 of 4 | 1 of 1 |
| Information transfer at care transitions (Emergency Department) | 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 (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 (Perioperative Services and Invasive Procedures) | Met | 4 of 4 | 1 of 1 |
| Medication reconciliation as a strategic priority (Leadership) | Met | 3 of 3 | 2 of 2 |
| Medication reconciliation at care transitions (Community-Based Mental Health Services and Supports) | Met | 3 of 3 | 1 of 1 |
| Medication reconciliation at care transitions (Emergency Department) | Met | 1 of 1 | 0 of 0 |
| 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 |
| Safe Surgery Checklist (Perioperative Services and Invasive Procedures) | Unmet | 0 of 3 | 0 of 2 |
| The “Do Not Use” list of abbreviations (Medication Management Standards) | Met | 4 of 4 | 3 of 3 |

| Required Organizational Practice | Overall rating | Test for Compliance Rating | |
|---|---|---|---|
| | | Major Met | Minor Met |
| **Patient Safety Goal Area: Medication Use** | | | |
| Antimicrobial Stewardship (Medication Management Standards) | Met | 4 of 4 | 1 of 1 |
| Concentrated Electrolytes (Medication Management Standards) | Met | 3 of 3 | 0 of 0 |
| Heparin Safety (Medication Management Standards) | Met | 4 of 4 | 0 of 0 |
| High-Alert Medications (Medication Management Standards) | Met | 5 of 5 | 3 of 3 |
| Infusion Pumps Training (Emergency Department) | Met | 4 of 4 | 2 of 2 |
| Infusion Pumps Training (Inpatient Services) | Met | 4 of 4 | 2 of 2 |
| Infusion Pumps Training (Perioperative Services and Invasive Procedures) | Met | 4 of 4 | 2 of 2 |
| Narcotics Safety (Medication Management Standards) | Met | 3 of 3 | 0 of 0 |
| **Patient Safety Goal Area: Worklife/Workforce** | | | |
| Client Flow (Leadership) | Met | 7 of 7 | 1 of 1 |
| Patient safety plan (Leadership) | Unmet | 1 of 2 | 1 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 |

| Required Organizational Practice | Overall rating | Test for Compliance Rating | |
|---|---|---|---|
| | | Major Met | Minor Met |
| **Patient Safety Goal Area: Worklife/Workforce** | | | |
| 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 |
| Infection Rates (Infection Prevention and Control Standards) | Met | 1 of 1 | 2 of 2 |
| **Patient Safety Goal Area: Risk Assessment** | | | |
| 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 (Perioperative Services and Invasive Procedures) | Met | 2 of 2 | 1 of 1 |
| 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 |
| Suicide Prevention (Child, Youth, and Family Services) | Met | 5 of 5 | 0 of 0 |

| Required Organizational Practice | Overall rating | Test for Compliance Rating | |
|---|---|---|---|
| | | Major Met | Minor Met |
| **Patient Safety Goal Area: Risk Assessment** | | | |
| 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 |
| Venous Thromboembolism Prophylaxis (Inpatient Services) | 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.**

Phase 1 of Hay River Health and Social Services Authority
September 30th - October 1st, 2019
Sites Surveyed: Woodlawn Manor, Hay River Regional Health Centre, H&H William and Genzen buildings.

Infection Prevention Control
There is a lack of signage throughout the Health Centre/Hospital relating to hand washing, many sinks do not have posters or any directions on how to properly wash hands. Audits are done monthly and posted on SharePoint, but there is nothing posted for the public and/or staff to see except if they log into SharePoint. The manual is out of date (2012) and the links in the manual are still operational. This is a territorial manual and apparently is being worked on.

Community Based Mental Health
There has been a high turnover of staff, leadership and many changes, some mandated and others related to an external review. There were mandated changes to Mental Health Therapist credentials; territorial-wide changes to policies and procedures for community counseling services staff. Consequently, there has been less attention paid to other standards. Leadership needs to monitor/support quality improvement and focus on some of the other standards.

Primary Care
The health centre is a new space, and this is a very positive thing for the community/staff. There are significant challenges with access that has led to low satisfaction by the patients and providers. The front desk staff are struggling as they are the face of the organization. The constant flow of locums leads to lack of continuity, another struggle for the patients.

Child & Family Services
There have been some improvements in this area from the last survey. They have taken on a new model of care that is successful to date. There is some work to do with partners/public yet in understanding the new model, but the team is on it. There are some standards not met, particularly around involving the voice of the customer. They do not solicit the input of their clients despite some opportunities to do so (e.g. planning new build).

People Centred Care
Across all the areas there was a lack of input by patients/families. We spent some time reviewing this with the leadership and providing examples of how they could incorporate the voice of their customers in a more formal way. For example: Child & Family Services interpret regular complaints with “input from clients/families”. The organization arranged a session with 12 members of the public to attend a focus group on People Centred Care and only one person attended. None of the other 11 called to cancel.

There are many positive things happening; however, there is a lack of visibility and formalization of quality initiatives. There are no quality boards, no visible signs indicating there are projects underway.

Phase 2 Hay River Health and Social Services Authority
December 3rd - December 5th, 2019
Sites Surveyed: Hay River Regional Health Centre

Board of Directors
The Board of Management of the Authority was removed in 2006/7 and replaced with a Public Administrator to who the Authority Chief Executive Officer (CEO) reports directly. This individual is appointed by the government and assumes all the responsibilities and accountabilities of the Board. Through conversations with the CEO, they are very supportive of the organization, particularly in the area of external communications with the community. It is felt, based on the information and reporting if there are opportunities to strengthen information flow through the development of dashboards, particularly articulating patient safety and quality/risk indicators.

Community and Community Partners
Meetings were held during the survey visit with the RCMP, Ambulance, the Municipality and Women and Children's Shelter. All participants were very complimentary of the organization and felt that they had the appropriate opportunities to engage around issues of shared accountability. Mental Health was a key point of discussion, particularly with the RCMP, where relationships with staff were seen to be positive and very much aligned around the needs of the clients.

The Ambulance Team had very good relations, particularly with emergency room (ER) staff and, while not initially enamored with the physical changes made within the organization to co-locate the ER and Inpatients, appreciated the processes put in place to address the situation.

The Municipality is very supportive of the efforts of the organization to strengthen care in the region, and communication between the two (2) are strong. The Authority regularly engages with the Municipality around issues of mutual importance and both are aligned around the health priorities for the region.

The Shelter received strong support from the organization, with clinical relationships as required being readily available. The Shelter is looking to redevelop and there may be opportunities with the ongoing planning to expand long-term care within the Authority to co-locate/develop for efficiencies moving forward.

A wonderful example of how seriously the Authority takes its relationship with the community was how it responded to the high-rise fire in Hay River, a response that justifiably resulted in the awarding of a Premiers Excellence Award.

The final point with respect to the community relates to the ongoing shortage of physicians and, specifically some of the negative feedback directed at the Authority. From all information reviewed, the Authority is doing all it can in this area, including ensuring physician access on a 24 hour/day basis through the Emergency Department.

Physician recruitment is a major issue right across the Country, with all regions being short and recruiting against one-another. As such, it is remarkably competitive and all potential candidates do their due diligence as they make decisions, including reviewing community social media and media. While the "silent majority" in the community are likely understanding of the situation, in so much as there is negative coverage, this does nothing to help the situation.

If not already in place, the Authority could consider establishing a Community Recruitment Committee to help support efforts in this area and to continue to focus on strengthening partnerships and relationships with other providers and education partners.

Leadership

The Authority is led by a very dedicated team, with good representation across all areas. There are several very strong programs and initiatives underway and the Strategic and Operational Plans developed by the Authority are noted. Unfortunately, the previously mentioned physician shortage has consumed significant time and energy from the leadership team which could be impacting its ability to focus on other organizational priorities, notably advancing the five (5) strategic priorities developed by the organization.

Initiatives such as the zero-based budgeting process, the planned expansion of dialysis and long-term care, the clinical re-organization, the enhanced emphasis on Mental Health and the ongoing dialogue with the NTHSSA to partner around key areas of program and service delivery are all noted with approval.

The recently introduced Leadership "Lean" Training is noted with approval. While all training of this nature is beneficial, one for the key outcomes could be the introduction of more structure to internal efforts in areas such as quality improvement and risk mitigation. Developing frameworks, assessing priorities and implementing dashboards that engage the organization, including front line staff in areas such as this will be important moving forward.

Ongoing efforts to strengthen communication are also noted. Despite some negative feedback through Worklife Opinion Surveys, the Survey Team felt that several good communication channels existed and that perhaps the crux of the issue is site visibility of the Senior Team.

Staff and Worklife

Recently completed Worklife Surveys highlight an engaged work force that are comfortable raising suggestions to strengthen the culture of the organization. Efforts within the Human Resources Team are impressive as they focus on strengthening overall engagement in the organization. The fact that the organization is now having to turn away applicants is a strong reflection of the organization having all the right pieces in place to advance the vision and mission of the Authority.

Team members felt safe within the organization and were very positive about the training and education opportunities provided. Orientation was specifically raised as a strength and staff felt that leaders listened to their concerns, as evidenced by the relocation of the emergency department. The staff felt supported through their respective teams and there was a very strong alignment to the organization.

Delivery of Care and Service
The facility was very clean and well cared for, and from discussions there was a significant pride in this fact, with the housekeeping staff being specifically noted as a key part of the team. There is a very committed staff resulting in strong frontline care. This is supported by strong training efforts in areas such as hand hygiene, Infection Prevention and Control, medication reconciliation, and infusion pumps.

Education and auditing were noted with approval, with the addition of a nurse educator who received advanced education resulting in the organization being able to directly offer PALS, ALS, BLS on site. Chart reviews to ensure completion of initiatives such as Braden Scale and Medication Reconciliation were impressive.

Except for the ED, there is paper-based charting, which is an opportunity for the organization moving forward with technology.

Strong partnerships were noted by staff in areas such as with First Responders, Med-Response and Public Health. This reflects the overall commitment of the organization to ensure strong working relationships across the system. In this area, there was a lack of supportive housing flagged as an issue, something that was exacerbated with the high-rise fire locally.

Two important areas to focus on moving forward include bringing quality improvement alive at the front lines, and strategically engaging patients, family member and caregivers in the decision making of the organization.

Overall, a very impressive model of care delivery with a great team.

Client Satisfaction
Clients commented positively on the care provided and noted that they were treated with dignity and respect. Families felt welcome on the inpatient unit and all spoken with felt that they were a part of their follow up care plan and knew what to expect when they were discharged.

Some comments were made around wait times however, in context of the broader healthcare system, the Surveyors were impressed with the access to care across the Authority. There were also comments raised around physician recruitment, with all hoping that the ongoing, immediate challenges could be rectified.

It was a pleasure to survey the Hay River Health and Social Services Authority and the organization, and more importantly its team members are commended for the dedication and commitment they bring to improving the health and well-being of the population served.

# Detailed Required Organizational Practices

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

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

| Unmet Required Organizational Practice | Standards Set |
|---|---|
| **Patient Safety Goal Area: Safety Culture** | |
| **Patient safety quarterly reports**<br>The governing body is provided with quarterly reports on patient safety that include recommended actions arising out of patient safety incident analysis, as well as improvements that were made. | · Leadership 15.10 |
| **Patient safety incident management**<br>A patient safety incident management system that supports reporting and learning is implemented. | · Leadership 15.4 |
| **Patient Safety Goal Area: Communication** | |
| **Safe Surgery Checklist**<br>A safe surgery checklist is used to confirm that safety steps are completed for a surgical procedure performed in the operating room. | · Perioperative Services and Invasive Procedures 14.3 |
| **Patient Safety Goal Area: Worklife/Workforce** | |
| **Patient safety plan**<br>A patient safety plan is developed and implemented for the organization. | · Leadership 15.1 |

# 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: Planning and Service Design

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

| Unmet Criteria | | High Priority Criteria |
|---|---|---|
| **Standards Set: Leadership** | | |
| 1.6 | Input is sought from clients and families during the organization's key decision-making processes. | |
| 6.5 | Formal strategies or processes are used to manage change. | |
| 6.6 | Management systems and tools are used to monitor and report on the implementation of operational plans. | ! |

**Surveyor comments on the priority process(es)**

With the overall territorial structure of healthcare across the Northwest Territories, several the items contemplated in the Planning and Service Design Priority Process are not under the pursue of the HRHSSA.

A Strategic Plan is in place for the Authority, developed in partnership with the GNWT. The local input in its development does not match that that would occur if the process were exclusively locally driven. There are however good ongoing efforts to bring the Plan alive within the organization, notably through the development of an Operational Plan that identifies strategies to advance the organizations 5 strategic Priorities noted in the Plan. These include: Mental Health and Addictions Services to Meet the Continuum of Care; Primary Care including Improving Access, Integration of Interdisciplinary Teams, Disease Prevention and Health Promotion; Dialysis Closer to Home; Improve Quality of Services to Protect Children including Enhanced Supports for Vulnerable Families in a Culturally Safe and Respectful Way; and Foundational Support of Operations.

The way the organization is tracking progress is noted with approval. The 50+ Activities identified to support the Plan will go a long way towards ensuring the expectations in the Plan are met. Introducing

formalized project management tools into the organization i.e. automated decision support systems, will enhance the organizations capacity to meet and exceed expectations.

The process being followed in developing the Business Plan for the Dialysis Expansion is comprehensive, and the work ongoing in the Mental Health Program is noted. This latter initiative is a good reflection of the efforts made by the organization to understand the needs of the community that are not being addressed locally, when there is the capacity and expertise to do so.

The organization has several opportunities in this priority process to further strengthen efforts, including: increasing engagement of staff in the development of and implementation of specific goals and objectives; ensuring change management supports are embedded into the organization, as well as acquiring automated tools to generate the data necessary to plan and advance goals. Finally, the organization needs to develop a plan to formally introduce clients/patients into the planning infrastructure of the organization.

## Priority Process: Resource Management

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

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

**Surveyor comments on the priority process(es)**

A meeting with the Director of Finance and Administration and the Manager of Facilities provided a good overview of the process followed in resource planning and allocation.

The annual cycle begins when the government issues the annual budget call to publicly funded organizations, with the organization preparing the subsequent submission. Efforts typically begin with in-year actuals, with know adjustments factored in to the process. One of the key challenges faced by the organization in the budget process is the governments' commitment to fund FTEs at level 4 of respective pay grids, while the majority of HRHSSA staff being on levels 7/8 of the grids. This puts immediate pressure on the organization and can be a major contributing factor to in-year variances. This also highlights the importance of ensuring that, as much as is practical salaries and benefits mirror those in the NWTHSSA.

The Authority is commended for its efforts in introducing a zero-based budgeting process. This will help engage all managers in the budget cycle by forcing a detailed awareness of spending and involving the organization from the ground up in determining spending priorities. This initiative will also provide an opportunity to engage front line staff in the budget process and, more importantly in fiscal oversight throughout the year.

Capital planning is a combination of the "Evergreen" program through the government, and local equipment and facilities investments. With the new building, certain ongoing investments will also be overseen by the Government of the Northwest Territories. This results in the organization needing clear documentation on accountabilities around building maintenance and refreshing. While clear with the new hospital, as time passes and maintenance and investments become required, ensuring clarity will be important.

The Foundation is commended for the support it provides to the Authority with capital investments. Efforts to address the old hospital and to move forward with planning a new, expanded long term care facility are noted. From a fiscal perspective, consolidating to fewer sites will become more important moving forward.

The greatest financial "threat" to the HRHSSA appears to be the fact that it operates outside the Government of the Northwest Territories, including administering its own Pension Plan. It is understood that detailed analyses are ongoing around this and that to date, remaining separate is the decision of record. That said, the organization is urged to continue to pursue these discussions with the relevant authorities for the mid and long-term benefits that would accrue to the HRHSSA, and the NWT.

Continuing discussions with the NWTHSSA around access to decision support software are encouraged, and greater emphasis on financial, operational and clinical indicators will pay dividends.

The team and organization are commended for their focus on fiscal integrity and have good plans in place to further stabilize the financial position of the organization.

## Priority Process: Human Capital

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

| Unmet Criteria | High Priority Criteria |
|---|---|
| **Standards Set: Leadership** | |
| 10.5 There is a talent management plan that includes strategies for developing leadership capacity and capabilities within the organization. | |

**Surveyor comments on the priority process(es)**

A very insightful meeting was held with members of the Human Resources Team, with the Team able to provide context to several the areas reviewed by the survey team.

Kudos from the beginning on the success of ongoing recruitment and retention efforts. Except for a small number of remarkably hard positions to fill, the HRHSSA is now in the position of having to turn away applicants to the positions. One of the key drivers in this uptick in applications is that the Authority is now seeing friends of employees put their name forward as a result of the positive feedback shared from working with the organization. The organization also goes to great efforts to ensure that new employees have the resources they need to do their respective jobs. The Orientation Program is very strong, including the follow up that occurs after employees have been with the organization for 6 months. The Team is encouraged to continue with discussions with the GNWT and NTHSSA around sharing and integrating resources as appropriate.

Turnover is very low, which is testament to the efforts made in supporting and retaining staff once having joined the Authority. The most recent worklife survey reviewed highlighted further opportunities to engage staff and impact satisfaction overall however this is layered onto a staff group already quite satisfied and engaged. That said, communication with Senior Leaders was flagged as an area that could be strengthened, with the notion of greater visibility across the organization noted by some. Formally introducing "Rounding" could strengthen here, as could increasing other communication lines i.e. direct messaging.

While an opportunity exists to develop a Corporate Talent Management Program, the HR Team is aware of the make up of the staff group and has a good hand on needs the organization can anticipate moving forward. They have also developed some very strong programs to support staff in their day-to-day activities, including Return to Work and Attendance Management Programs.

The organizations Violence Prevention Program is noted with approval and great strides are taken to ensure that staff have the tools available to them to deal with this issue. Training in de-escalation techniques as well as Non-Crisis Intervention are very well received, and the Union engagement around areas such as Domestic Violence prevention go a long way towards creating a culture based on mutual

respect.

The focus on mental health and employee wellness/well-being was noted with approval. Specific training opportunities in this area, the Fitness Centre, and the Mental Health in the Workplace Sub-Committee of the Occupational Health and Safety Committee are good examples of this commitment.

The HR Downloads subscription has been very helpful in the Department staying on top of the latest in Human Resources developments. In addition, the programs ability to generate HR Reports through the Crystal Program ensure that the right data is being generated to support overall HR decision-making.

The commitment to develop staff group specific "Action Plans" is noted with approval. The initial RN Action Plan is a tremendous effort to identify issues and create plans to address. The intention is to roll these plans out across the organization, and it is expected that they will help address some of the work place concerns raised in areas such the Long-Term Care Home.

The HR Team should be proud of the work they are doing on behalf of the HRHSSA. There are several innovative programs in place, with lots of enthusiasm to move the program forward. Clearly, there are pressures on the team, including the administration of the Pension Plan however these are not taking the team off their focus.

## 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** | | |
| 3.1 | Quality improvement is identified as a strategic priority. | ! |
| 3.5 | Opportunities are provided for leaders throughout the organization to participate in collaborative quality improvement initiatives. | |
| 3.8 | The spread and sustainability of quality improvement results is promoted and supported. | |
| 3.9 | The organization's leaders promote learning from quality improvement results, and making decisions informed by research and evidence, client experience, and ongoing quality improvement. | |
| 3.10 | The organization's leaders promote and support the consistent use of standardized processes, decision-support tools, or best practice guidelines to reduce variation in and between services, where appropriate. | |
| 3.11 | Team members, clients, and families who participate in quality improvement initiatives are recognized for their work. | |
| 12.2 | The organization's leaders implement an integrated risk management approach to mitigate and manage risk. | ! |
| 12.3 | As part of the integrated risk management approach, the organization's leaders develop risk mitigation plans. | ! |
| 12.4 | The risk management approach and contingency plans are disseminated throughout the organization. | ! |
| 12.5 | The effectiveness of the integrated risk management approach is regularly evaluated and improvements are made as necessary. | |
| 15.1 | A patient safety plan is developed and implemented for the organization. | ROP |
| 15.1.2 | There is a plan and process in place to address identified patient safety issues. | **MINOR** |
| 15.1.3 | The plan includes patient safety as a written strategic priority or goal. | **MAJOR** |

| | | |
|---|---|---|
| 15.4 | A patient safety incident management system that supports reporting and learning is implemented. | ROP |
| 15.4.5 | All recommended actions resulting from the analysis of patient safety incidents are reviewed and the rationale to accept, reject, or delay implementation is documented. | **MAJOR** |
| 15.4.6 | Information about recommended actions and improvements made following incident analysis is shared with clients, families, and team members. | **MAJOR** |
| 15.4.7 | The effectiveness of the patient safety incident management system is evaluated and improvements are made based on feedback received. Evaluation mechanisms may include:<br>• Gathering feedback from clients, families, and team members about the system<br>• Monitoring patient safety incident reports by type and severity<br>• Examining whether improvements are implemented and sustained<br>• Determining whether team members feel comfortable reporting patient safety incidents (e.g., based on results from the Canadian Patient Safety Culture Survey Tool). | **MINOR** |
| 15.10 | The governing body is provided with quarterly reports on patient safety that include recommended actions arising out of patient safety incident analysis, as well as improvements that were made. | ROP |
| 15.10.1 | Quarterly patient safety reports are provided to the governing body. | **MAJOR** |
| 15.10.2 | The quarterly patient safety reports outline specific organizational activities and accomplishments in support of the organization's patient safety goals and objectives. | **MINOR** |
| 15.10.3 | The governing body supports the patient safety activities and accomplishments and acts on the recommended actions in the quarterly patient safety reports. | **MINOR** |
| 16.1 | An integrated quality improvement plan is developed and implemented. | ! |
| 16.2 | A defined process is followed to select and monitor system-level process and outcome measures to evaluate the organization's performance at a strategic level. | ! |

| | | |
|---|---|---|
| 16.6 | Opportunities for quality improvement are identified based on trends in patient safety incidents, performance data, patient experience data, feedback from Client and Family advisory councils and other sources, and plans are developed to prioritize and address those opportunities. | ! |
| 16.7 | The organization's leaders verify that the quality improvement plans and related changes are implemented. | ! |

**Surveyor comments on the priority process(es)**

Of all the programs overseen by the HRHSSA, the one with the greatest opportunity to influence the direction of the organization in the coming years is the Quality Program. While several the component pieces of a strong quality program are in place, the organization needs to develop a clearer strategy in the area of Quality Improvement/Risk Mitigation.

There are very appropriate protocols and systems in place around disclosure and the organizations commitment to medication reconciliation is very strong. The new RL6 Incident Management System is noted with approval and once the organization begins utilizing the data generated through the system to inform its quality program, it will start to fully benefit from this tool.

The Leadership Team is keen to ramp up its focus on safety, and has completed a Risk Inventory, with the next step to move to a full plan that clearly ranks the safety issues facing the organization that allows it to begin to address risk issues in order of priority. The same vision is in place to develop a Plan that focuses directly on Patient Safety issues. As this Plan evolves, the organization will be able to develop a clear approach to engaging patients, clients and families.

The current Leadership Training underway will provide some very good insight into the requirements of developing a more robust quality program. In addition, discussions with other partners, notably the NTHSSA will help focus the needs.

The bottom line is that a clear strategy needs to be developed, that engages patients and staff in its formation, the setting of priorities, as well as the reporting and evaluation of same. The pieces are there, and the resources have been identified and are appropriate to begin moving the focus on quality and safety to the next level.

## Priority Process: Principle-based Care and Decision Making

Identifying and making decisions about ethical dilemmas and problems.

| Unmet Criteria | High Priority Criteria |
|---|---|
| **Standards Set: Leadership** | |
| 1.11 There is a process for gathering and reviewing information about trends in the organization's ethics issues, challenges, and situations. | |
| 1.12 Information about trends in ethics issues, challenges, and situations is used to improve the quality of services. | |

**Surveyor comments on the priority process(es)**

It is recognized that the organization is in the process of migrating its Ethics Program to a partnership with the NTHSSA, a decision that is very much supported moving forward. The tools and framework included in the materials shared with the surveyors were comprehensive and well developed.

The process of record however is the 2015/16 Ethics Plan, a Plan that is very comprehensive, and reflects a great approach and framework for ethical decision-making. The structure and composition of the Ethics Committee is noted with approval however it was unclear as to how active the Committee was in ongoing deliberations. Tools available i.e. the Ethics Consultation Form are appropriate and supported.

As the organization transitions, determining the renewed priority areas of focus will be important. Ensuring a strong education plan is developed will be key, to ensure that staff understand the importance of a strong ethical decision-making framework and process to their day-to-day functioning. Having both immediate support for ethical situations, as well as a framework through which the organization can review other issues will be important.

A great example of a decision very much informed by a strong ethics program was the introduction and implementation of Medical Assistance in Dying. In this area, arguably one of the most ethically charged issues that has faced hospitals in recent memory, the organization has handled its introduction extremely well. Of note, the compassion and caring exhibited when these decisions have been made has been outstanding. One of the most poignant reminders of the focus on patient and family focused care that exists across the organization.

Congratulations on the efforts in this important area.

## Priority Process: Communication

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

| Unmet Criteria | High Priority Criteria |
|---|---|
| **Standards Set: Leadership** | |
| 11.6 Teams are provided with timely access to research-based evidence and leading and best practice information. | ! |

**Surveyor comments on the priority process(es)**

The Authority is commended for the emphasis it is currently placing on communications, both internally and externally.

Circumstances beyond the organization's control, specifically the recruitment of physicians has resulted in some negative push-back from the community over the past couple of years, publicly and on social media. The approach taken in responding has been positive, with a very clear plan on getting out to groups across the Authorities catchment area to present facts and to hear feedback. Attending meetings with the local Municipal Council, Wellness Council, Councils and hosting open community meetings have all helped re-frame the communication narrative around the organization.

Being proactive with messaging will continue to be important and the recent efforts in publishing good news stories is noted with approval. Researching creative ways of getting these messages in front of community members is important, particularly considering the challenges in getting the local newspaper to publish.

Efforts to specifically engage individuals in the community who are negative are noted and should continue regardless of results to date. Engaging others in external messaging, including physicians is noted and should be expanded.

Dialogue with specific external partners to the Authority revealed a high level of confidence in the organization. All felt that the were consulted on issues pertinent to their respective organizations, and all reinforced how transparent the organization was with communication efforts.

Internally, the organization has several effective tools in place. Information shared with the Survey Team revealed some communication gaps from the perspective of certain staff however no specific solutions had been presented. It appears there are comprehensive tools in place, including the monthly newsletter, open forums, staff meetings, one-on-one engagement, and on-line. New approaches to engage the organization can be considered, including rounding on staff and holding huddles in patient care areas to disseminate information. Ensuring continued, consistent visibility of the Senior Leadership Team throughout the organization will also be important moving forward.

All engaged in the communication portfolio are to be commended.

## 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)**

Hay River Health and Social Services Authority provides appropriate and safe structures and facilities to achieve the organization’s mission, vision, and goals.

The recently constructed hospital provides a safe physical environment that ensures safety, security, comfort and confidentiality. Some teams noted that the new space did not well support their team functioning so HRHSSA has been innovative in renovating or repurposing some space to enhance the care processes.

The design facilitates staff and patient and family security, comfort and access. Restricted access and high-risk areas are clearly labelled with doors and access points appropriate to the level of care or population served,

Safe procedures are utilized in the operation and monitoring of the buildings for quality and safety. Airflow and quality are monitored and ensured. There are designated physically separate spaces according to function. Procedure rooms have appropriate equipment and cleaning schedules. Back-up systems are adequate and maintained and impacts of failures are mitigated.

Some services are still being delivered from the former hospital site which does present operational and maintenance issues. Other services are delivered from leased office space.

New long-term care facilities are being planned.

## Priority Process: Emergency Preparedness

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

The organization has met all criteria for this priority process.

**Surveyor comments on the priority process(es)**

The team and leaders of Hay River Health and Social Services Health Authority (HRHSSA) are acknowledged for the strong commitment to emergency planning. The HRHSSA received the Premier's Excellence Award for the response to the High-Rise fire in March 2019. The team members and leaders participate on the Health Emergency Management Advisory Group, the Town of Hay River's Community Emergency Response Committee and South Slave Lake Region Emergency Response Committee. Emergency planning is a priority for the team and leaders. This includes radio and communication testing, code testing and simulation exercises. Incident command training has been held. Simulation and drills have tested the emergency plans and used to make improvements. Fire drills occur on a regular basis.

Partnerships have been established with external agencies such as the police, municipalities, private corporations, emergency services and the fire department. The strong involvement of the partners has enabled interagency testing of the emergency plans. The leaders are encouraged to continue with the plans to further test emergency preparedness. This includes working with Public Safety Canada's Regional Resilience Assessment Program to review and test the integrity and resilience of the cyber infrastructure, IT security, IT operations and ability for business continuity and disaster recovery.

The team is to be commended for the robust testing of the codes. This includes testing of Code's Orange, White, Yellow, Red, Grey, Purple, and Blue. A "Code of the Month," educational program is offered to the team members by the nurse educator. Furthermore, simulations and table top testing of emergency preparedness is completed and documented. One such table top exercise was the testing of the Hay River Health and Social Services Health Authority community evacuation plan with broad representation from community partners. Debriefings occur and lessons learned from such exercises are documented.

The team and leaders have worked hard to ensure continuity of services in the event of an emergency or disaster. This includes ensuring back-up systems for essential utilities. Back-up systems are maintained and impacts of failures are mitigated. Business continuity plans are developed. The leaders are encouraged to continue to test the business continuity plans and makes changes accordingly.

The infection prevention and control team work closely with the emergency preparedness team. This includes involving the emergency preparedness leaders to attend infection prevention and control meetings. Policies and procedures are available to the team members who are involved in identifying and preventing outbreaks. There is a strong partnership with public health.

## 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: Child, Youth, and Family Services** | | |
| 2.4 | Space is co-designed with clients and families to ensure safety and permit confidential and private interactions with clients and families. | |
| **Standards Set: Community-Based Mental Health Services and Supports** | | |
| 1.2 | Services are co-designed with clients and families, partners, and the community. | ! |
| 1.11 | 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. | |
| 4.10 | Client and family representatives are regularly engaged to provide input and feedback on their roles and responsibilities, role design, processes, and role satisfaction, where applicable. | |
| **Standards Set: Emergency Department** | | |
| 1.1 | Services are co-designed with clients and families, partners, and the community. | ! |
| 2.5 | Space is co-designed with clients and families to ensure safety and permit confidential and private interactions with clients and families. | |
| 18.3 | Measurable objectives with specific timeframes for completion are identified for quality improvement initiatives, with input from clients and families. | ! |
| **Standards Set: Inpatient Services** | | |
| 1.1 | Services are co-designed with clients and families, partners, and the community. | ! |
| 2.5 | Space is co-designed with clients and families to ensure safety and permit confidential and private interactions with clients and families. | |
| 3.12 | Client and family representatives are regularly engaged to provide input and feedback on their roles and responsibilities, role design, processes, and role satisfaction, where applicable. | |

| | | |
|---|---|---|
| 16.3 | Measurable objectives with specific timeframes for completion are identified for quality improvement initiatives, with input from clients and families. | ! |
| **Standards Set: Leadership** | | |
| 3.3 | Teams, clients, and families are supported to develop the knowledge and skills necessary to be involved in quality improvement activities. | |
| 3.6 | There are regular dialogues between the organization's leaders and clients and families to solicit and use client and family perspectives and knowledge on opportunities for improvement. | |
| 6.2 | When developing the operational plans, input is sought from team members, clients and families, and other stakeholders, and the plans are communicated throughout the organization. | |
| 10.4 | Education and training are provided throughout the organization to promote and enhance a culture of client- and family-centred care. | |
| **Standards Set: Long-Term Care Services** | | |
| 17.3 | Measurable objectives with specific timeframes for completion are identified for quality improvement initiatives, with input from residents and families. | ! |
| **Standards Set: Perioperative Services and Invasive Procedures** | | |
| 1.1 | Services are co-designed with clients and families, partners, and the community. | ! |
| 1.7 | Barriers that may limit clients, families, service providers, and referring organizations from accessing services are identified and removed where possible, with input from clients and families. | |
| 2.4 | Space is co-designed with clients and families to ensure safety and permit confidential and private interactions with clients and families. | |
| 6.3 | A comprehensive orientation is provided to new team members and client and family representatives. | |
| 6.12 | Client and family representatives are regularly engaged to provide input and feedback on their roles and responsibilities, role design, processes, and role satisfaction, where applicable. | |
| 24.7 | Patient safety incidents are analyzed to help prevent recurrence and make improvements, with input from clients and families. | ! |

| | | |
|---|---|---|
| 25.3 | Measurable objectives with specific timeframes for completion are identified for quality improvement initiatives, with input from clients and families. | ! |
| **Standards Set: Primary Care Services** | | |
| 2.5 | Space is co-designed with clients and families to ensure safety and permit confidential and private interactions with clients and families. | |
| 3.11 | Client and family representatives are regularly engaged to provide input and feedback on their roles and responsibilities, role design, processes, and role satisfaction, where applicable. | |

**Surveyor comments on the priority process(es)**

Hay River Health and Social Services authority is on a journey to enhance its approach to Client and Family Centered Care (CFCC). The HRHSSA works collaboratively with clients and families to provide care that is respectful, compassionate, culturally safe and competent, while being responsive of needs, values, cultural backgrounds and beliefs, and preferences.

Clients and families are included and acknowledged as active participants in the collaborative care team. They are empowered to make informed decisions. They are involved in care and assessments, identifying goals and results of care, and monitoring the progress toward achieving the goals.

Hay River Health and Social Services Authority is encouraged to further review and, as appropriate, enhance its approach to Client and Family Centered Care. It is recommended this include a focus on organizational culture and safety, leadership and communication, service level engagement and development and integration of Client advisors.

## Priority Process: Patient Flow

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

The organization has met all criteria for this priority process.

**Surveyor comments on the priority process(es)**

The patient flow throughout the Hay River Health and Social Services Authority provides seamless transfer of clients requiring admission from the emergency department to an inpatient bed. Inpatient beds are available. There is no overcrowding in the emergency department. From January 1, 2019 to December 3, 2019 there were at total of 6439 clients seen in the emergency department. The CTAS levels were as follows: CTAS1- 11 clients, CTAS 2-427 clients, CTAS 3- 1457 clients, CTAS 4-1975 clients and CTAS5- 2049 clients. The outpatient clinics are used to provide services to clients who are CTAS level 4 and 5. Additionally, some clients who are CTAS level 3 are also seen in the clinic.

The team has initiated processes to continue to support patient flow. This includes ensuring appropriate discharge and working with partners to support discharge planning and care across the continuum. The transfer of high-risk clients requiring transfer to another facility is provided by Med-Response. The team members and leaders also work closely with first responders.

Emergency department (ED) overcrowding is not system-wide challenge for the emergency department at the Hay River Health and Social Services Authority. Inpatient beds are available and timely access to diagnostic services are available. The Northwest Territories Health and Social Authority is developing an overcrowding protocol. The team members and leaders are encouraged to continue to ensure appropriate patient flow and the efficient use of inpatient beds and resources.

## 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: Reprocessing of Reusable Medical Devices** | | |
| 15.1 | There is a quality improvement program for reprocessing services that integrates the principles of quality control, risk management, and ongoing improvements. | |
| 15.4 | Measurable objectives with specific timeframes for completion are identified for quality improvement initiatives with input from stakeholders. | ! |
| 15.5 | Indicator(s) that monitor progress for each quality improvement objective are identified, with input from stakeholders. | |
| 15.6 | Quality improvement activities are designed and tested to meet objectives. | ! |
| 15.7 | New or existing indicator data are used to establish a baseline for each indicator. | |
| 15.8 | There is a process to regularly collect indicator data and track progress. | |
| 15.9 | Indicator data is regularly analyzed to determine the effectiveness of the quality improvement activities. | ! |
| 15.10 | Quality improvement activities that were shown to be effective in the testing phase are implemented broadly throughout the organization. | ! |
| 15.11 | Information about quality improvement activities, results, and learnings is shared with stakeholders, teams, organization leaders, and other organizations, as appropriate. | |
| 15.12 | Quality improvement initiatives are regularly evaluated for feasibility, relevance, and usefulness, with input from stakeholders. | |

**Surveyor comments on the priority process(es)**

HRHSSA has good processes in place for obtaining and maintaining machinery and technologies to diagnose and treat health problems.

Planning processes are utilized for selecting, upgrading and replacing medical devices and equipment. Preventative maintenance occurs and is documented. The preventive maintenance process is linked to

risk management.

Good processes are utilized to clean, sterilize and reprocess medical devices. Staff are well educated, trained, knowledgeable and skilled. They work collaboratively with other teams. Medical devices and equipment are readily available and accessible, and work reliably. Reprocessed devices are clean and functional.

The team is encouraged to review and enhance the use of evidence and quality improvement measures to evaluate and improve safety and quality of service.

# 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:

**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

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

| Unmet Criteria | High Priority Criteria |
|---|---|
| **Priority Process: Clinical Leadership** | |
| 12.1 The physical environment for service delivery is safe, culturally inclusive, comfortable, and designed with input from clients and families. | |

| | | |
|---|---|---|
| **Priority Process: Competency** | | |
| | The organization has met all criteria for this priority process. | |
| **Priority Process: Episode of Care** | | |
| 18.3 | At the beginning of service, medication reconciliation is conducted for clients identified as requiring it, in partnership with the client, family, and service providers . | ! |
| 18.4 | Medication discrepancies are resolved in partnership with clients and families or communicated to the client's most responsible prescriber and actions that are taken to resolve medication discrepancies are documented. | ! |
| 18.5 | When medication discrepancies are resolved, the medication list is updated and provided to the client or family (or primary care provider, as appropriate) along with information about the changes. | ! |
| 19.7 | A policy and procedure for the use of seclusion and restraints is established in partnership with clients and families, and is followed by the team. | ! |
| 19.8 | A least-restraint policy is followed by the team. | ! |
| 19.9 | A procedure is followed to appropriately implement restraints, monitor a client in restraint, and document the use of restraints in the client record. | ! |
| 19.10 | A process to monitor the use of restraints is established, and this information is used to improve the policy, procedures, and process. | ! |
| **Priority Process: Decision Support** | | |
| | The organization has met all criteria for this priority process. | |
| **Priority Process: Impact on Outcomes** | | |
| 8.2 | The procedure to select evidence-informed guidelines is reviewed, with input from clients and families, teams, and partners. | |
| 8.3 | There is a standardized process, developed with input from clients and families, to decide among conflicting evidence-informed guidelines. | ! |
| 8.4 | Protocols and procedures for reducing unnecessary variation in service delivery are developed, with input from clients and families. | ! |

## Surveyor comments on the priority process(es)

### Priority Process: Clinical Leadership

The Child, Youth, and Family Services Team has a standardized, comprehensive intake process. They collaborate with many partners (Justice, RCMP, Restorative Justice Committee, Out of Territory Liaison, Legal Aid, Probation, Corrections, Home Care, Acute Care, Primary Care, Day Cares, Foster Families etc.) to provide a "wrap around" service to their clients/families. The team identify their clients (many are from low socio-economic status and are indigenous) and they are creative and innovative in the ways they help their children, youth and families cope with their difficult realities. Even within these vulnerable groups there are some clients who present even higher risk: homeless men, children with disabilities/high needs, single parents and children from at risk families. The team works tirelessly to support these high-risk populations.

The team uses a strengths-based approach that includes a philosophy of harm reduction. They are much more proactive, working hard to prevent bigger issues. This is a change of philosophy over the last several years, which would have seen the team be more reactive.

The leadership works hard to ensure partners know about their services. Having moved to a newer model of care (Structured Decision-Making or SDM) over the last few years, they have provided presentations/information sessions to their major partners (e.g. RCMP). They are sensing it is time to refresh the information. The change to the SDM model has been transformational and required a great deal of education/change management. In the SMD model, every effort is made to keep the child safely in their own home or environment. In the previous model of care the child would more quickly be removed from the environment, sometimes to their detriment. The new SDM model may be interpreted by the public as the team not doing their job or responding to reports when the child is not immediately removed.

### Priority Process: Competency

The team has the appropriate credentials to do their role. The social workers must provide their license annually, provide annual Criminal Records Checks, take Child Protection Training (3 weeks) and take other mandatory training (e.g. Aboriginal Awareness). In addition, Non-violent Crisis Intervention Training, ASIST (Suicide Prevention), Mental Health First Aid, Adoption Training and Interview Training are all encouraged. The organization provides a Professional Development Fund of up to $2,000 annually for each employee as well as seven (7) paid days to take additional training.

There is an extensive on-boarding process and the employees report the orientation meets their needs. The supervisor provides ongoing mentoring and coaching. Employees receive both informal and formal feedback on a regular basis. Performance appraisals are up to date and are used to assist with professional development planning.

The team huddles every Monday morning; there is good teamwork and collaboration within the team and with partners. The team has added a position as gaps were identified and hope to have an additional position in the next year to be a liaison with the Acute Care sector.

**Priority Process: Episode of Care**

In 2017 the team implemented SDM (Structured Decision-Making) as their model of care. This has been a huge quality improvement project for the team. The model encourages more accountability on the part of the staff resulting in less children in care, more utilization of family strengths and a less intrusive process for clients/families. The team feels good about the work they are doing and the culture in the team is very positive. The team report they feel supported and are given the freedom to be creative in how they do their work. One of the ways this is manifested is in “meeting the client where it makes sense”. Recognizing that the office may be intimidating, staff may meet the client at the local pool or in a park.

With the SDM model, timelines match up with the legislation. There are structured steps in the process that are logical and methodical. The team conducts comprehensive safety assessments that result in one of three conclusions: client is safe, safe with a plan, or unsafe. Based on the safety assessment, the team develops an appropriate safety plan.

While there is regular and ongoing feedback from individual clients (mostly with complaints), the team may wish to consider implementing a family council or committee to formalize the feedback mechanism. There is going to be a new build in the next year and this would provide an excellent opportunity to incorporate the voice of the customer into planning. Currently the team have no formal feedback mechanisms for obtaining input from their clients/families into planning for services.

**Priority Process: Decision Support**

The team transitioned to a new electronic record (Matrix) over the last several years. This system includes comprehensive tools to collect appropriate information in a systematic way. The records are complete and up to date. Staff use government issued mobile devices that are properly encrypted for safety purposes with appropriate policies to guide use.

**Priority Process: Impact on Outcomes**

As noted earlier, comprehensive safety assessments and development of safety plans are conducted. As a result of the Auditor General Reports (2014, 2017) the team has implemented Audits of Foster Families. While some of the work has been getting completed, there had not been any documentation. The team has implemented quarterly Foster Home Audits and they are reported to the authority.

The implementation of the electronic documentation system has been another quality improvement which has helped the team track progress, provide information on access for example. The team has begun to apply a quality improvement lens to their work, developing indicators that they are reporting on monthly and quarterly.

Finally, the team needs to work to formalize the input from clients and families into their service planning/delivery. This will strengthen the great work of the team even further.

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

| Unmet Criteria | | High Priority Criteria |
|---|---|---|
| **Priority Process: Clinical Leadership** | | |
| 1.1 | A person-centred, strengths-based, and client-directed approach to services and supports is taken with input from clients and families. | |
| 1.3 | Information is collected from clients and families, partners, and the community to inform service design. | |
| 1.4 | Service-specific goals and objectives are developed, with input from clients and families. | |
| 1.7 | Processes and policies are established to meet the diverse needs of the community, with input from clients and families. | |
| 1.8 | Services are reviewed and monitored for appropriateness, with input from clients and families. | |
| 2.1 | A strategy is developed to promote optimal mental health and reduce the stigma of mental illness and concurrent disorders, with input from clients and families. | |
| 2.2 | The strategy includes working with other services, groups, programs, and organizations in the community (e.g. social services, justice, etc.) to raise awareness of the resources and supports available to clients and families. | |
| 2.3 | Mental health promotion sessions are delivered in the community in partnership with other organizations, and with input from clients and families. | |
| 3.3 | An appropriate mix of skill level and experience within the team is determined, with input from clients and families. | |
| 3.5 | The effectiveness of resources, space, and staffing is evaluated with input from clients and families, the team, and stakeholders. | |
| 3.6 | A universally-accessible environment is created with input from clients and families. | |
| 6.2 | Work and job design, roles and responsibilities, and assignments are determined with input from team members, and from clients and families where appropriate. | |

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| **Priority Process: Competency** | | |
| 4.1 | Required training and education are defined for all team members with input from clients and families. | ! |
| **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** | | |
| 15.1 | There is a standardized procedure to select evidence-informed guidelines that are appropriate for the services offered. | ! |
| 15.2 | The procedure to select evidence-informed guidelines is reviewed, with input from clients and families, teams, and partners. | |
| 15.3 | There is a standardized process, developed with input from clients and families, to decide among conflicting evidence-informed guidelines. | ! |
| 15.4 | Protocols and procedures for reducing unnecessary variation in service delivery are developed, with input from clients and families. | ! |
| 15.5 | Guidelines and protocols are regularly reviewed, with input from clients and families. | ! |
| 16.1 | A proactive, predictive approach is used to identify risks to client and team safety, with input from clients and families. | ! |
| 16.2 | Strategies are developed and implemented to address identified safety risks, with input from clients and families. | ! |
| 16.3 | Verification processes are used to mitigate high-risk activities, with input from clients and families. | ! |
| 16.4 | Safety improvement strategies are evaluated with input from clients and families. | ! |
| 17.1 | 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. | |
| 17.2 | The information and feedback gathered is used to identify opportunities for quality improvement initiatives and set priorities, with input from clients and families. | |
| 17.4 | Indicator(s) that monitor progress for each quality improvement objective are identified, with input from clients and families. | |

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| 17.5 | Quality improvement activities are designed and tested to meet objectives. | ! |
| 17.6 | New or existing indicator data are used to establish a baseline for each indicator. | |
| 17.7 | There is a process to regularly collect indicator data and track progress. | |
| 17.8 | Indicator data is regularly analyzed to determine the effectiveness of the quality improvement activities. | ! |
| 17.9 | Quality improvement activities that were shown to be effective in the testing phase are implemented broadly throughout the organization. | ! |
| 17.10 | Information about quality improvement activities, results, and learnings is shared with clients, families, teams, organization leaders, and other organizations, as appropriate. | |
| 17.11 | 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 HRHSSA Community-Based Mental Health and Supports team has had many recent challenges. These include mandated changes in credentials of mental health therapists, territorial wide changes to the policies and procedures for community counseling and significant staff turnover. HRHSSA leadership is aware of these challenges. Leadership has acted to address these challenges and concerns and has had an external review of the program completed. Recommendations are being implemented.

It was noted by the accreditation surveyors that the team has been focused on these challenges and provision of care and less so on the other accreditation standards.

It is recommended that HRHSSA leadership monitor and support the team's quality improvement process with a true focus on patient and family safety and care.

**Priority Process: Competency**

The HRHSSA Community-Based Mental Health and Supports team has new leadership and many new members. It is in the process of building a collaborative, patient and family focused, knowledgeable and interdisciplinary team that manages and delivers effective programs and services.

Good processes ensure that each team member has the appropriate license or credential from the relevant college or association and these processes are ongoing. Team members have some input into their work and job design. There are clear roles and responsibilities. Team members are encouraged to

work to their full scope of practice. Team members described a robust orientation process. There is good support for continuing education and training. Team members are aware of organization policies. Ongoing competency evaluation and performance appraisal occurs and is seen as positive by staff.

The team is encouraged to formalize the processes utilized to evaluate and improve team functioning.

**Priority Process: Episode of Care**

The HRHSSA Community-Based Mental Health and Supports team partners with clients and families to provide client-centered services throughout the health care encounter.

The team has a formal intake process. The client assessment is standardized and considers clients' individual needs and preferences. The assessment is documented and shared. It includes a Best Possible Medication History and appropriate risk assessment for suicide. The assessment leads to a care and service planning process, with clients directly involved in their own care planning process. Progress is monitored with the client and adjusted as needed. Supports and education are provided for clients and families to understand service information and participate in service delivery. Positive relationships are maintained and there is a high level of engagement of clients and families.

The team delivers safe and effective services that are consistent with the clients care plan. Informed consent is obtained, and the clients identify is verified prior to receiving care and services.

Transitions are planned with clients and families; well documented and essential information is communicated.

**Priority Process: Decision Support**

The HRHSSA Community-Based Mental Health and Supports team maintains efficient and secure information systems to support effective service delivery. Complete client records are maintained and documented in a standardized way. These records are secure and confidential.

**Priority Process: Impact on Outcomes**

The HRHSSA Community-Based Mental Health and Supports team utilizes evidence informed guidelines. Safety risks are identified and addressed. Safety incidents are monitored, analyzed and information used to make improvements. Indicators are utilized for quality improvement. Some sharing of quality improvement results occurs. There is some support for a culture of organizational learning and evidence informed decision making.

The team is encouraged to build upon and strengthen its processes for using evidence and quality improvement measures to evaluate and improve safety and quality of services.

## Standards Set: Emergency Department - Direct Service Provision

| Unmet Criteria | | High Priority Criteria |
|---|---|---|
| **Priority Process: Clinical Leadership** | | |
| 1.3 | Specific goals and objectives regarding wait times, length of stay (LOS) in the emergency department, client diversion to other facilities, and number of clients who leave without being seen are established, with input from clients and families. | |
| 1.4 | Services are reviewed and monitored for appropriateness, with input from clients and families. | |
| **Priority Process: Competency** | | |
| The organization has met all criteria for this priority process. | | |
| **Priority Process: Episode of Care** | | |
| 12.4 | An established procedure, such as the use of armbands, is used to identify clients in the emergency department. | |
| 13.9 | 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** | | |
| 16.2 | The procedure to select evidence-informed guidelines is reviewed, with input from clients and families, teams, and partners. | |
| 16.3 | There is a standardized process, developed with input from clients and families, to decide among conflicting evidence-informed guidelines. | ! |
| 16.4 | Protocols and procedures for reducing unnecessary variation in service delivery are developed, with input from clients and families. | ! |
| 16.5 | Guidelines and protocols are regularly reviewed, with input from clients and families. | ! |
| 17.2 | Strategies are developed and implemented to address identified safety risks, with input from clients and families. | ! |
| 17.4 | Safety improvement strategies are evaluated with input from clients and families. | ! |

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| 18.2 | The information and feedback gathered is used to identify opportunities for quality improvement initiatives and set priorities, with input from clients and families. | |
| 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. | ! |
| 18.8 | New or existing indicator data are used to establish a baseline for each indicator. | |
| 18.9 | There is a process to regularly collect indicator data and track progress. | |
| 18.10 | Indicator data is regularly analyzed to determine the effectiveness of the quality improvement activities. | ! |
| 18.11 | Quality improvement activities that were shown to be effective in the testing phase are implemented broadly throughout the organization. | ! |
| 18.12 | Information about quality improvement activities, results, and learnings is shared with clients, families, teams, organization leaders, and other organizations, as appropriate. | |
| 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 emergency departments at the Hay River Health and Social Services Authority was recently relocated adjacent to the inpatient unit. The nursing staff is shared between the emergency department and inpatient unit. The leaders and team members are committed to providing quality emergency care to clients and families. The team noted that they have the appropriate resources to do their work. However, they noted that the recruitment and retention of physicians is important in providing emergency care to clients. Partnerships and relationships have been formed with other health care organizations to support the appropriate transfer of clients. This includes local First Responders and Med-Response transfer team.

The emergency department is clean and well organized. There are spaces for two clients plus a cast room. The housekeeping staff are proud of their work in providing a safe and clean environment for clients and families. There are two seclusion rooms. The team and leaders are encouraged to continue to involve clients and patients in any future co-design of the emergency departments. Furthermore, the leaders are

encouraged to continue to seek feedback on the effectiveness of resources, space, and staffing with input from clients and families, the team, and stakeholders.

Client satisfaction surveys are completed. However, services are not reviewed and monitored for appropriateness, with input from clients and families. The leaders are encouraged to involve clients and families in the review of services.

The leaders are encouraged to involve clients and families, the team, and community partners in developing team goals and objectives. Goals and objectives should be aligned with the organization's strategic directions. The objectives should be clear, have measurable outcomes and success factors, and be realistic and time-specific. The service specific goals should be reviewed annually or as needed and their achievement evaluated.

**Priority Process: Competency**

The emergency department has a committed team providing emergency services to clients and families. The team members spoke highly of the education and training provided. The team is acknowledged for the strong commitment to infusion pump training. The team members spoke highly of the value of the orientation process. This includes mentorship by an experienced nurse. Required competencies identified for the team members. The team members are supported by a nurse educator. Education and training are provided to team members on how to prevent workplace violence. The team members noted that they felt safe at work. Performance appraisals are completed for team members.

The SBAR tool has recently been implemented. The team members have commented on the benefit of the SBAR in improving the flow of information among other members of the team. The leaders are encouraged to continue to support the implementation of the SBAR tool.

**Priority Process: Episode of Care**

The emergency department team is engaged in providing emergency care to clients and their families. There are effective working relations with First Responders and the Med-Response team. Clients noted that they were treated with care, dignity and respect. A client stated, “I really appreciate the care by the nurses.” Furthermore, the clients stated that they were aware of their follow up care.

The entrances to the emergency department is clearly marked. The physical space is clean and organized. All clients are triaged using the CTAS. The triage areas allow for private conversations. Medication reconciliation is initiated for all clients with a decision to admit. Laboratory and diagnostic imaging resources are available. There is access to inpatient beds. A negative pressure isolation room is available.

The effectiveness of transitions is not evaluated, and the information used to improve transition planning, with input from clients and families. The leaders are encouraged to evaluating transitions to verify that client and family needs were met, and concerns or questions addressed. Additionally, the leaders are encouraged to share the client feedback and the overall results of the evaluation with the organization's

leaders and the governing body and to use this information to improve transitions.

Armbands are not used in the emergency department. Clients receive an armband when they are admitted. The leaders are encouraged to implement armbands for clients presenting to the emergency department.

**Priority Process: Decision Support**

The staff and leaders are committed to using decision support to enable client care. Education and training are provided to the team on the use of technology. Electronic medical records are used in the emergency department.

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

**Priority Process: Impact on Outcomes**

The HRHSSA Community-Based Mental Health and Supports team utilizes evidence informed guidelines. Safety risks are identified and addressed. Safety incidents are monitored, analyzed and information used to make improvements. Indicators are utilized for quality improvement. Some sharing of quality improvement results occurs. There is some support for a culture of organizational learning and evidence informed decision making.

The team is encouraged to build upon and strengthen its processes for using evidence and quality improvement measures to evaluate and improve safety and quality of services.

**Priority Process: Organ and Tissue Donation**

The organization is encouraged to complete the organ and tissue donation services.

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

| Unmet Criteria | | High Priority Criteria |
|---|---|---|
| **Priority Process: Infection Prevention and Control** | | |
| 2.1 | There is an IPC team responsible for planning, developing, implementing and evaluating the IPC program. | ! |
| 4.3 | There are policies and procedures for using aseptic techniques when preparing, handling, and administering sterile substances both within the preparation area and at the point of care. | ! |
| 5.6 | The effectiveness of the multi-faceted approach for promoting IPC is evaluated regularly and improvements are made as needed. | |
| 7.1 | There are OHS policies and procedures to reduce the risk of transmitting microorganisms among team members, and clients. | ! |
| 7.4 | There are work restrictions that are in line with OHS guidelines for team members, and volunteers with transmissible infections. | ! |
| 14.1 | There is a quality improvement plan for the IPC program. | ! |
| 14.2 | IPC performance measures are monitored. | |
| 14.4 | The information collected about the IPC program is used to identify successes and opportunities for improvement, and to make improvements in a timely way. | |
| 14.5 | Results of evaluations are shared with team members, volunteers, clients, and families. | |
| **Surveyor comments on the priority process(es)** | | |
| **Priority Process: Infection Prevention and Control** | | |

HRHSSA utilizes a framework to plan, implement and evaluate infection prevention and control practices.

A dedicated individual supports the program and works with all teams and partners with other organizations to promote infection prevention control. Key areas supported include point of care risk assessment, hand hygiene, aseptic techniques, personal protective equipment, cleaning and disinfection of the physical environment, reprocessing medical devices and equipment and handling waste and linen.

The infection control and prevention team are encouraged to evaluate and enhance using evidence and quality improvement measures to evaluate and improve safety and quality of service.

## Standards Set: Inpatient Services - Direct Service Provision

| Unmet Criteria | | High Priority Criteria |
|---|---|---|
| **Priority Process: Clinical Leadership** | | |
| 1.3 | Services are co-designed to meet the needs of an aging population, where applicable. | |
| 1.5 | Service-specific goals and objectives are developed, with input from clients and families. | |
| 1.6 | Services are reviewed and monitored for appropriateness, with input from clients and families. | |
| **Priority Process: Competency** | | |
| The organization has met all criteria for this priority process. | | |
| **Priority Process: Episode of Care** | | |
| 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** | | |
| 14.2 | The procedure to select evidence-informed guidelines is reviewed, with input from clients and families, teams, and partners. | |
| 14.3 | There is a standardized process, developed with input from clients and families, to decide among conflicting evidence-informed guidelines. | ! |
| 14.4 | Protocols and procedures for reducing unnecessary variation in service delivery are developed, with input from clients and families. | ! |
| 14.5 | Guidelines and protocols are regularly reviewed, with input from clients and families. | ! |
| 15.1 | A proactive, predictive approach is used to identify risks to client and team safety, with input from clients and families. | ! |
| 15.2 | Strategies are developed and implemented to address identified safety risks, with input from clients and families. | ! |
| 15.4 | Safety improvement strategies are evaluated with input from clients and families. | ! |

| | | |
|---|---|---|
| 16.2 | The information and feedback gathered is used to identify opportunities for quality improvement initiatives and set priorities, with input from clients and families. | |
| 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. | ! |
| 16.10 | Quality improvement activities that were shown to be effective in the testing phase are implemented broadly throughout the organization. | ! |
| 16.11 | Information about quality improvement activities, results, and learnings is shared with clients, families, teams, organization leaders, and other organizations, as appropriate. | |
| 16.12 | 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 fourteen bed Inpatient Service is led by committed team members and leaders. The leaders and team members are committed to providing quality care to clients and families. The team noted that they have the appropriate resources to do their work. However, they noted that the recruitment and retention of physicians would assist them in providing care to clients. The team commented on the support received from experienced nurses which was beneficial to them in their work.

The physical environment of the inpatient unit is welcoming, with large windows in client's rooms allowing for natural light. The hallways are free from clutter. The client and service areas are well organized.

The design of the palliative care room received input from clients and families. The leaders are encouraged to continue to seek feedback on the effectiveness of resources, space, and staffing with input from clients and families, the team, and stakeholders. Furthermore, the leaders are encouraged to co-design services and space with the input of clients and families.

Client satisfaction surveys are completed. However, services are not reviewed and monitored for appropriateness, with input from clients and families. The leaders are encouraged to involve clients and families in the review of services and monitoring for appropriateness.

The leaders are encouraged to involve clients and families, the team, and community partners in developing team goals and objectives. Goals and objectives should be aligned with the organization's strategic directions. The objectives should be clear, have measurable outcomes and success factors, and be realistic and time-specific. The service specific goals should be reviewed annually or as needed and their achievement evaluated.

**Priority Process: Competency**

A committed inter-disciplinary team supports the provision of inpatient services. The leaders and team are committed to providing quality services for clients and families. The leaders are acknowledged for their commitment to supporting the education and learning needs of team members. The team members spoke highly of the education and training provided by Hay River Health and Social Services Authority. They felt their education and training needs were supported. The team members valued the contributions of the nurse educator. The leaders and team are to be commended for their commitment to infusion pump safety. Education and training are provided on ethical decision-making.

The team members stated that the orientation process was very beneficial and prepared them to work on the inpatient unit. They also appreciated the support of the experienced nurses. The team stated that they felt safe at work. Performance appraisals are completed for team members.

The SBAR tool has recently been implemented. The team members have commented on the benefit of the SBAR in improving the flow of information among other members of the team. The leaders are encouraged to continue the implementation of the SBAR tool.

**Priority Process: Episode of Care**

An engaged team is committed to providing quality inpatient services. A pharmacist supports the inpatient care team. The clients and families described receiving excellent care. A family member stated, “The nurses are wonderful. They can’t do enough for us.” The clients noted that they were treated with care, dignity and respect. There is a document outlining the rights and responsibilities of clients. The team members and leaders are encouraged to ensure the robust distribution and sharing of this information. There are White Boards at the bedside indicating the name of the nursing staff responsible for client care. The team and leaders are to be commended for their commitment to ensuring patient satisfaction surveys are completed.

The acute medical units are clean with hand hygiene products and hand washing sinks available. There is work space for staff and availability of private spaces to hold meetings and private conversations. There are spaces for clients and families including spiritual spaces. The housekeeping staff take pride in providing a clean comfortable space for clients.

The team is to be commended for their commitment to medication reconciliation, pressure ulcer prevention and falls prevention. Regular auditing occurs.

The effectiveness of transitions is not evaluated, and the information used to improve transition planning, with input from clients and families. The leaders are encouraged to evaluating transitions to verify that client and family needs were met, and concerns or questions addressed. Additionally, the leaders are encouraged to share the client feedback and the overall results of the evaluation with the organization's leaders and the governing body and to use this information to improve transitions.

**Priority Process: Decision Support**

The staff and leaders are committed to using decision support to enable client care. Education and training are provided to the team on the use of technology. Paper charting is used on the inpatient unit. The protection of client information is an important priority for the team members and leaders. Education and training on privacy and protection of client information is provided.

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

**Priority Process: Impact on Outcomes**

The inpatient team is encouraged to review and enhance their approach to using evidence and quality improvement measures to evaluate and improve safety and quality of services. This may include initiatives such as safety huddles, purposeful rounding, leadership rounding, and post-discharge telephone calls used to support safety and quality.

Patient satisfaction surveys are completed. The team members and leaders are encouraged to share the results with the team and clients. Quality improvement boards may provide an opportunity to share quality improvement process with the team members, clients and families.

The leaders and team have established a Clinical Practices Advisory Committee which assists in the selection of evidence-informed guidelines. The leaders and team are encouraged to continue to develop and implement evidence-based guidelines with the input of clients and families.

The inpatient team is encouraged to develop a culture of meaningful client and family engagement. The clients and families will offer important insights into the design of programs, services and quality and safety initiatives.

## 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** | |
| 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 HRHSSA long-term care team is well led: it has good leadership and direction to the team providing service.<br><br>Goals and objectives for the team are developed in conjunction with the senior leadership, clients, patients, families and community partners. Clients and families are involved in service design and review at many levels and formally thru resident counsel.<br><br>The long-term care team has processes to identify, access, and utilize the resources and supports to achieve the team's goals and objectives.<br><br>The team is skilled at coordinating partnerships with other teams, providers and organizations.<br><br>The team has developed and fosters a culture to deliver high quality services. |
| **Priority Process: Competency** |
| The HRHSSA long-term care team is a mature, skilled, knowledgeable, interdisciplinary team that manages and delivers effective programs and services. |

The team is collaborative and shares information well between members and with other teams across the organization. An informal process is used to evaluate team functioning and to make improvements.

Good processes ensure that each team member has the appropriate license or credential from the relevant college or association and these processes are ongoing. Team members have some input into their work and job design. There are clear roles and responsibilities. Team members work to their full scope of practice. Team members described a robust orientation process. There is good support for continuing education and training.

Team members are aware of and follow organization policies.

Ongoing competency evaluation and performance appraisal occurs and is seen as very positive by staff.

The team is encouraged to formalize the processes utilized to evaluate and improve team functioning.

**Priority Process: Episode of Care**

The HRHSSA long-term care is skilled at partnering with clients and families to provide client-centered services throughout the health care encounter.

The team has a formal intake process. The client assessment is standardized and considers clients' individual needs and preferences. The assessment is documented and shared. It includes a Best Possible Medication History and appropriate risk assessment for falls, suicide and pressure ulcers. The assessment leads to a care and service planning process, with clients directly involved in their own care planning process. Progress is monitored with the client and adjusted as needed. Supports and education are provided for clients and families to understand service information and participate in service delivery. Positive relationships are brain day there is a high level of engagement of clients and families.

The team delivers safe and effective services that are consistent with the clients care plan. Informed consent is obtained, and the clients identify is verified prior to receiving care and services.

Transitions are planned with clients and families; well documented and essential information is communicated.

**Priority Process: Decision Support**

The HRHSSA long-term care team maintains efficient and secure information systems to support effective service delivery. Complete client records are maintained and documented in a standardized way. These records are secure and confidential.

The records are a hybrid of paper and electronic charts. A move to move complete electronic records is in the planning stages.

**Priority Process: Impact on Outcomes**

The HRHSSA long-term care team utilizes evidence informed guidelines. Safety risks are identified and addressed. Safety incidents are monitored, analyzed and information used to make improvements. Indicators are utilized for quality improvement. Some sharing of quality improvement results occurs. There is some support for a culture of organizational learning and evidence informed decision making.

The team is encouraged to build upon and strengthen its processes for using evidence and quality improvement measures to evaluate and improve safety and quality of services.

## Standards Set: Medication Management Standards - Direct Service Provision

| Unmet Criteria | High Priority Criteria |
|---|---|
| **Priority Process: Medication Management** | |

The organization has met all criteria for this priority process.

| Surveyor comments on the priority process(es) |
|---|
| **Priority Process: Medication Management** |

Hay River Health and Social Services Authority promotes a collaborative approach to medication safety.

There is an up-to-date, evidence-based formulary and good processes utilized to approve medication selection for client areas.

Team members have the necessary qualifications and training to safely administer medications. Medications are appropriately selected and stored, with attention to problematic names, packaging and labeling.

Prescribing and ordering medication is done in a safe and consistent manner, with access to up-to-date client information. Prescriptions and medication orders are reviewed for accuracy and appropriateness. Medications are dispensed safely, accurately and in a timely way. Medications are administered safely and with appropriate monitoring. Clients are informed about their medications.

The medication management system is monitored and evaluated.

## 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. | | |
| 1.4 | Services are reviewed and monitored for appropriateness, with input from clients and families. | | |
| **Priority Process: Competency** | | | |
| The organization has met all criteria for this priority process. | | | |
| **Priority Process: Episode of Care** | | | |
| 14.3 | A safe surgery checklist is used to confirm that safety steps are completed for a surgical procedure performed in the operating room. | | ROP |
| | 14.3.1 | The team has agreed on a three-phase safe surgery checklist to be used for surgical procedures performed in the operating room. | **MAJOR** |
| | 14.3.2 | The checklist is used for every surgical procedure. | **MAJOR** |
| | 14.3.3 | There is a process to monitor compliance with the checklist. | **MAJOR** |
| | 14.3.4 | The use of the checklist is evaluated and results are shared with the team. | **MINOR** |
| | 14.3.5 | Results of the evaluation are used to improve the implementation and expand the use of the checklist. | **MINOR** |
| **Priority Process: Decision Support** | | | |
| The organization has met all criteria for this priority process. | | | |
| **Priority Process: Impact on Outcomes** | | | |
| 23.4 | Protocols and procedures for reducing unnecessary variation in service delivery are developed, with input from clients and families. | | ! |
| 23.5 | Guidelines and protocols are regularly reviewed, with input from clients and families. | | ! |
| 24.1 | A proactive, predictive approach is used to identify risks to client and team safety, with input from clients and families. | | ! |

| | | |
|---|---|---|
| 24.2 | Strategies are developed and implemented to address identified safety risks, with input from clients and families. | ! |
| 24.3 | Verification processes are used to mitigate high-risk activities, with input from clients and families. | ! |
| 24.4 | Safety improvement strategies are evaluated with input from clients and families. | ! |
| 25.1 | 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. | |
| 25.2 | The information and feedback gathered is used to identify opportunities for quality improvement initiatives and set priorities, with input from clients and families. | |
| 25.4 | Indicator(s) that monitor progress for each quality improvement objective are identified, with input from clients and families. | |
| 25.5 | Quality improvement activities are designed and tested to meet objectives. | ! |
| 25.6 | New or existing indicator data are used to establish a baseline for each indicator. | |
| 25.7 | There is a process to regularly collect indicator data and track progress. | |
| 25.8 | Indicator data is regularly analyzed to determine the effectiveness of the quality improvement activities. | ! |
| 25.9 | Quality improvement activities that were shown to be effective in the testing phase are implemented broadly throughout the organization. | ! |
| 25.10 | Information about quality improvement activities, results, and learnings is shared with clients, families, teams, organization leaders, and other organizations, as appropriate. | |
| 25.11 | Quality improvement initiatives are regularly evaluated for feasibility, relevance, and usefulness, with input from clients and families. | |

**Priority Process: Medication Management**

The organization has met all criteria for this priority process.

**Surveyor comments on the priority process(es)**

**Priority Process: Clinical Leadership**

The perioperative services are well led and has good direction.

There are processes in place to identify and obtain the resources and supports, equipment and supplies needed to deliver quality services. Good partnerships have been developed with other teams, providers and organizations. The teams culture supports the delivery of high-quality services.

The team is encouraged to review and enhance their approach to foster a culture of meaningful client and family engagement.

**Priority Process: Competency**

The perioperative and invasive procedures team is a skilled, knowledgeable, interdisciplinary team that manages and delivers effective programs and services.

The team utilizes a collaborative approach, with good teamwork and communication. information is shared well between team members and with other teams. each team member has the appropriate license or credential form the relevant college or association, this process is ongoing. the team has an appropriate mix of team members skills and experience. Team members work to their full scope of practice.

there is an orientation process and provision of ongoing education and training. Ongoing competency evaluation and performance appraisal occurs and is seen as positive by the staff.

**Priority Process: Episode of Care**

The perioperative team provides client-centered services throughout the health care encounter.

The team provides dental surgery on a day procedure basis and endoscopy services.

A formal intake assessment is performed well. This intake leads to a care and service plan. Clients and families are engaged in their care. Informed consent is obtained and appropriately documented. Clients identify is verified prior to receiving care and services. Services are delivered in a safe and effective manner.

**Priority Process: Decision Support**

The perioperative services team maintains efficient and secure records to support effective service delivery. Complete client records are maintained, and documentation occurs in a standardized way. Records are secure and confidential.

**Priority Process: Impact on Outcomes**

The perioperative team is encouraged to review and enhance their approach to using evidence and quality improvement measures to evaluate and improve safety and quality of services.

The perioperative team is encouraged to develop a culture of meaningful client and family engagement.

**Priority Process: Medication Management**

The perioperative services promote a collaborative approach to medication safety. Team members have the necessary qualifications and training to safely administer medications.

Medications are prescribed and administered safely, accurately and with appropriate monitoring.

## Standards Set: Primary Care Services - Direct Service Provision

| Unmet Criteria | | High Priority Criteria |
|---|---|---|
| **Priority Process: Clinical Leadership** | | |
| 1.2 | Information is collected from clients and families, partners, and the community to inform service design. | |
| 1.3 | Service-specific goals and objectives are developed, with input from clients and families. | |
| 1.4 | Services are reviewed and monitored for appropriateness, with input from clients and families. | |
| 2.6 | The effectiveness of resources, space, and staffing is evaluated with input from clients and families, the team, and stakeholders. | |
| **Priority Process: Competency** | | |
| 3.1 | Required training and education are defined for all team members with input from clients and families. | ! |
| 4.3 | Position profiles with defined roles, responsibilities, and scope of employment or practice exist for all positions. | |
| **Priority Process: Episode of Care** | | |
| 6.6 | During regular hours, same-day access to primary care services is available to clients and their families, as required. | ! |
| 9.2 | The assessment process is designed with input from clients and families. | |
| 11.13 | 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** | | |
| 12.8 | There is a process to monitor and evaluate record-keeping practices, designed with input from clients and families, and the information is used to make improvements. | ! |
| 13.2 | Policies on the use of electronic communications and technologies are developed and followed, with input from clients and families. | |
| **Priority Process: Impact on Outcomes** | | |
| 14.2 | The procedure to select evidence-informed guidelines is reviewed, with input from clients and families, teams, and partners. | |

| | | |
|---|---|---|
| 14.3 | There is a standardized process, developed with input from clients and families, to decide among conflicting evidence-informed guidelines. | ! |
| 14.5 | Guidelines and protocols are regularly reviewed, with input from clients and families. | ! |
| 14.6 | There is a policy on ethical research practices that outlines when to seek approval, developed with input from clients and families. | ! |
| 15.3 | Verification processes are used to mitigate high-risk activities, with input from clients and families. | ! |
| 15.4 | Safety improvement strategies are evaluated with input from clients and families. | ! |
| 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. | |

**Surveyor comments on the priority process(es)**

**Priority Process: Clinical Leadership**

The Primary Care Team has worked hard to assist their clients/families know about their services. There are brochures about services that are nicely done. There is improved collaboration around the referral process. There appears to be the appropriate mix of skills/staff in the clinic. The clinic is accessible to individuals who have disabilities, live with obesity and other issues.

The website information about the health centre could be expanded to describe the services available. For example: What does well women mean? Does this mean prenatal care or pap testing? Doing some work on the website may help the public choose the right provider/right services?

The organization is planning to undergo Primary Care Renewal and that is a very positive thing. Currently there is very little input garnered from clients and their families into the planning/delivery of services at the health centre. Incorporating the voice of the customer is hard work; however, it pays off by delivery of services that are needed and wanted by those using the services.

**Priority Process: Competency**

The Primary Care Team has conducted training on Non-violent Crises Intervention and Suicide Prevention “in house”. Staff have opportunity for additional ongoing training through the PDI or Professional Development Initiative. This fund (maximum $2,000/year) assists staff to travel out of the area to attend conferences, workshops and training. Staff are appreciative of this funding.

Efforts are made to recognize staff: There are “kudos” put on Sharepoint. This is relatively new but

appreciated by staff. There are long term service awards, performance appraisals, as well as much informal feedback to one another.

Some of the position profiles are out of date and need to be updated. New position profiles remain in draft and need to be completed.

**Priority Process: Episode of Care**

Patients who visit Primary Care in Hay River report being treated with respect and dignity by all staff. The referral process has improved with care being coordinated more efficiently for patients. The process to enter a complaint is available on the website as are the Rights and Responsibilities – these could be more prominent at the centre.

A major issue for the health centre is the lack of physician coverage. Like other parts of rural Canada, the site has struggled to recruit and retain physicians. This has led to access issues (long waits for appointments), lack of continuity and the reception staff unfortunately bear the brunt of the frustration felt by clients and families who vent to the reception staff. The organization is aware and working with the reception staff. The reception staff are to be commended for remaining professional and expressing empathy to clients who they recognize are frustrated with the wait at times.

Another impact of the lack of stability in the physician complement is that the professional development for physicians may not be as stable as it once was. One physician noted that they no longer have educational rounds, local CME or Journal Club. The lack of these things may contribute to the lack of retention of physicians. Patient report they have long waited for appointments; once they get to see someone, they are highly competent, but the wait can be long.

The organization has recently begun a long-term locum arrangement with a nurse practitioner (NP). The NP comes to Hay River for one month and then is gone for a month. On the month they are back “at home”, they access the electronic medical record via VPN and can obtain results on patients. With the use of technology, they can contact patients and follow up with them. While this project is in the very early stages, the NP is proving continuity and follow up that is appreciated by patients.

**Priority Process: Decision Support**

The Primary Care Team uses the Electronic Medical Record (EMR) Wolfe by Telus. The team is finding many efficiencies by using an EMR and patients appreciate that their information is in the same place. There are some improvements that can be made, and some tools turned on (e.g. to capture cancer screening); however, there is a standardized record that records the current and past medications, history and treatments.

The team is monitoring No Show Rates as well as Turn Away Rates and using this data to plan and improve services: e.g. diabetes No Show Rates are high (40%+). The team is going to improve their access in the evenings and expand group appointments.

The Primary Care Services need to include the input of clients and families where possible.

**Priority Process: Impact on Outcomes**

The Primary Care Services have been tracking their No Shows, recognizing these are missed opportunities for care. Diabetes No Show rates are over 40%. The team has been strategizing as to how to improve these rates and will be looking at group appointments as well as expanding the hours into the evening. In addition, they are looking at “turn away rates” and will be planning how to address these.

Primary Care needs to find ways to formalize input from clients/families. Incorporating the “voice of the customer” is important to ensure high quality services that meet the needs of patients. The organization is hoping to improve this through Primary Care Renewal, they are in the early planning stages and looking to the Nuka System in Alaska.

Finally, the organization needs to make their quality work more visible. Having quality boards up where they are visible to clients, families and staff is important.

# 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.

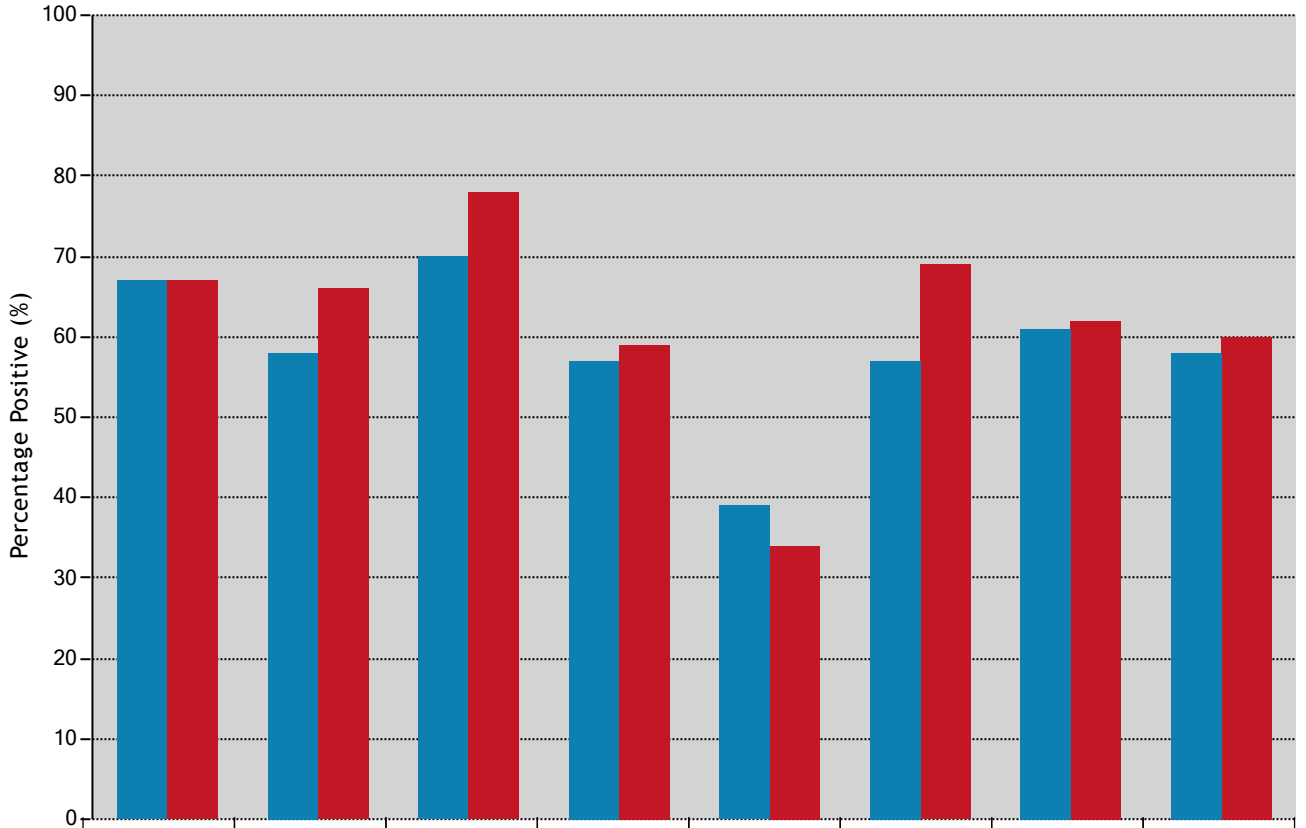
## Canadian Patient Safety Culture Survey Tool

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: August 1, 2018 to September 28, 2019**
- **Minimum responses rate (based on the number of eligible employees): 93**
- **Number of responses: 100**

**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 |
|---|---|---|---|---|---|---|---|---|
| | 67% | 58% | 70% | 57% | 39% | 57% | 61% | 58% |
| | 67% | 66% | 78% | 59% | 34% | 69% | 62% | 60% |

**Legend**

Hay River Health and Social Services Authority

* Canadian Average

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

## Worklife Pulse

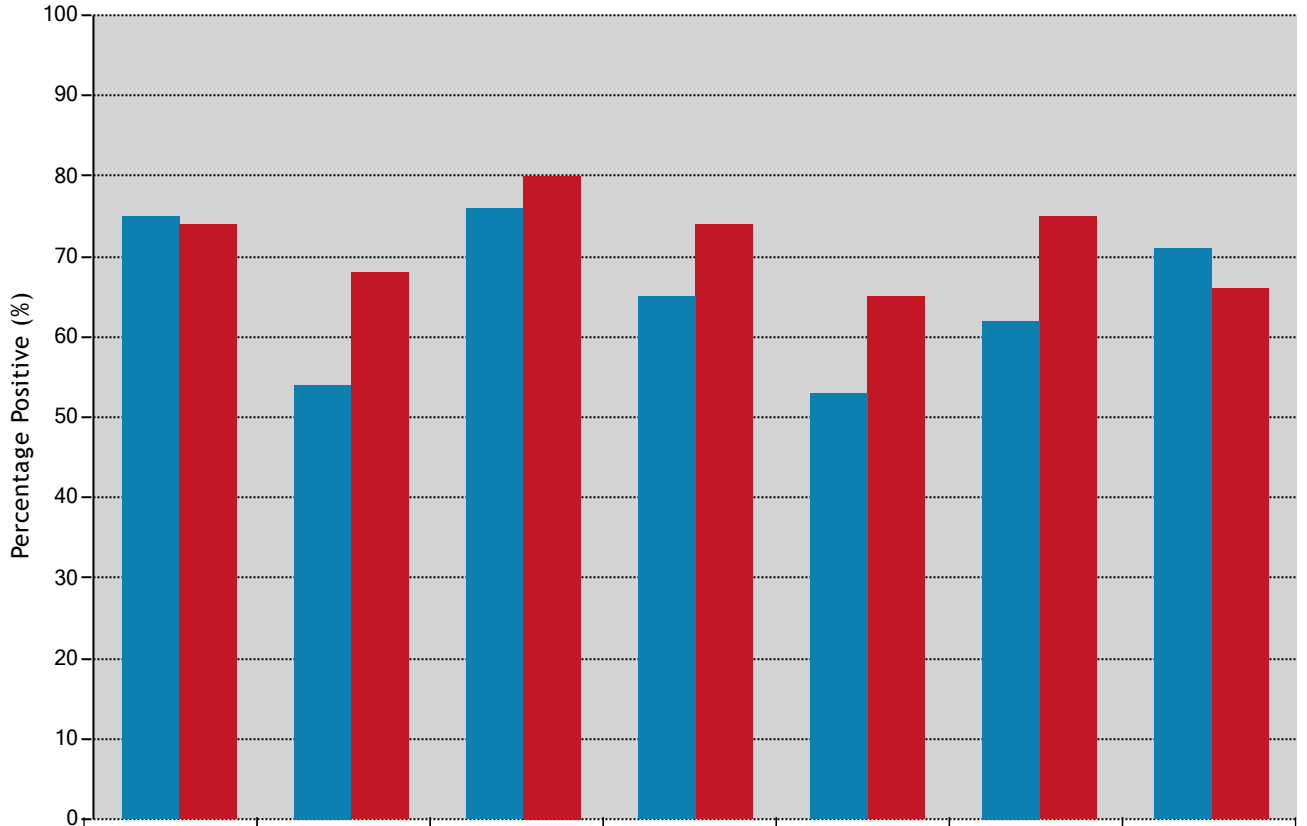
Accreditation Canada helps organizations create high quality workplaces that support workforce wellbeing and performance. This is why Accreditation Canada provides organizations with the Worklife Pulse Tool, an evidence-informed questionnaire that takes a snapshot of the quality of worklife.

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

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

- **Data collection period: August 1, 2018 to September 20, 2018**
- **Minimum responses rate (based on the number of eligible employees): 130**
- **Number of responses: 131**

**Worklife Pulse: Results of Work Environment**




| | Job | Training and Development | Coworkers | Immediate Supervisor | Senior Management | Safety and Health | Overall Experience |
|---|---|---|---|---|---|---|---|
| | 75% | 54% | 76% | 65% | 53% | 62% | 71% |
| | 74% | 68% | 80% | 74% | 65% | 75% | 66% |

**Legend**

Hay River Health and Social Services Authority

* Canadian Average

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

# Client Experience Tool

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

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

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

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

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

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

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

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

# Appendix A - Qmentum

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

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

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

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

## Action Planning

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

# Appendix B - Priority Processes

## Priority processes associated with system-wide standards

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

## Priority processes associated with population-specific standards

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

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

## Priority processes associated with service excellence standards

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

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