ACCREDITATION
AGRÉMENT
CANADA
Qmentum

Accreditation Report

Yukon Hospital Corporation

Whitehorse, YT

On-site survey dates: May 28, 2023 - June 1, 2023

Report issued: June 27, 2023

About the Accreditation Report

Yukon Hospital Corporation (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 May 2023. Information from the on-site survey as well as other data obtained from the organization were used to produce this Accreditation Report.

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

Confidentiality

This report is confidential and will be treated in confidence by Accreditation Canada in accordance with the terms and conditions as agreed between your organization and Accreditation Canada for the Assessment Program.

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

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

A Message from Accreditation Canada

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

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

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

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

We look forward to our continued partnership.

Sincerely,

Leslee Thompson
Chief Executive Officer

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Executive Summary

Yukon Hospital Corporation (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

Yukon Hospital Corporation'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: May 28, 2023 to June 1, 2023**

- **Locations**

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

  1. Dawson City Hospital
  2. Watson Lake Hospital
  3. Whitehorse General Hospital

- **Standards**

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

  System-Wide Standards

  1. Governance
  2. Infection Prevention and Control Standards
  3. Leadership
  4. Medication Management Standards

  Service Excellence Standards

  5. Biomedical Laboratory Services - Service Excellence Standards
  6. Cancer Care - Service Excellence Standards
  7. Diagnostic Imaging Services - Service Excellence Standards
  8. Emergency Department - Service Excellence Standards
  9. Inpatient Services - Service Excellence Standards
  10. Mental Health Services - Service Excellence Standards
  11. Obstetrics Services - Service Excellence Standards
  12. Perioperative Services and Invasive Procedures - Service Excellence Standards
  13. Point-of-Care Testing - Service Excellence Standards
  14. Reprocessing of Reusable Medical Devices - Service Excellence Standards
  15. Transfusion Services - Service Excellence Standards

- **Instruments**

  The organization administered:

  1. Worklife Pulse
  2. Canadian Patient Safety Culture Survey Tool
  3. Governance Functioning Tool (2016)
  4. Client Experience Tool

Overview by Quality Dimensions

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

Quality Dimension	Met	Unmet	N/A	Total
Population Focus (Work with my community to anticipate and meet our needs)	38	8	0	46
Accessibility (Give me timely and equitable services)	75	7	0	82
Safety (Keep me safe)	577	46	16	639
Worklife (Take care of those who take care of me)	107	9	1	117
Client-centred Services (Partner with me and my family in our care)	271	23	5	299
Continuity (Coordinate my care across the continuum)	61	1	3	65
Appropriateness (Do the right thing to achieve the best results)	799	109	11	919
Efficiency (Make the best use of resources)	53	5	0	58
Total	**1981**	**208**	**36**	**2225**

Overview by Standards

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

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

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

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

Standards Set	High Priority Criteria *			Other Criteria			Total Criteria (High Priority + Other)		
	Met	Unmet	N/A	Met	Unmet	N/A	Met	Unmet	N/A
	# (%)	# (%)	#	# (%)	# (%)	#	# (%)	# (%)	#
Governance	48 (96.0%)	2 (4.0%)	0	34 (97.1%)	1 (2.9%)	1	82 (96.5%)	3 (3.5%)	1
Leadership	42 (84.0%)	8 (16.0%)	0	83 (86.5%)	13 (13.5%)	0	125 (85.6%)	21 (14.4%)	0
Infection Prevention and Control Standards	33 (84.6%)	6 (15.4%)	1	18 (62.1%)	11 (37.9%)	2	51 (75.0%)	17 (25.0%)	3
Medication Management Standards	71 (91.0%)	7 (9.0%)	0	60 (100.0%)	0 (0.0%)	4	131 (94.9%)	7 (5.1%)	4
Biomedical Laboratory Services	67 (94.4%)	4 (5.6%)	1	101 (96.2%)	4 (3.8%)	0	168 (95.5%)	8 (4.5%)	1
Cancer Care	71 (93.4%)	5 (6.6%)	5	106 (94.6%)	6 (5.4%)	2	177 (94.1%)	11 (5.9%)	7
Diagnostic Imaging Services	64 (97.0%)	2 (3.0%)	2	65 (95.6%)	3 (4.4%)	1	129 (96.3%)	5 (3.7%)	3
Emergency Department	56 (77.8%)	16 (22.2%)	0	83 (77.6%)	24 (22.4%)	0	139 (77.7%)	40 (22.3%)	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
	# (%)	# (%)	#	# (%)	# (%)	#	# (%)	# (%)	#
Inpatient Services	53 (88.3%)	7 (11.7%)	0	73 (86.9%)	11 (13.1%)	1	126 (87.5%)	18 (12.5%)	1
Mental Health Services	43 (86.0%)	7 (14.0%)	0	81 (88.0%)	11 (12.0%)	0	124 (87.3%)	18 (12.7%)	0
Obstetrics Services	72 (98.6%)	1 (1.4%)	0	86 (98.9%)	1 (1.1%)	1	158 (98.8%)	2 (1.3%)	1
Perioperative Services and Invasive Procedures	107 (93.0%)	8 (7.0%)	0	103 (94.5%)	6 (5.5%)	0	210 (93.8%)	14 (6.3%)	0
Point-of-Care Testing	35 (92.1%)	3 (7.9%)	0	31 (68.9%)	14 (31.1%)	3	66 (79.5%)	17 (20.5%)	3
Reprocessing of Reusable Medical Devices	84 (96.6%)	3 (3.4%)	1	38 (95.0%)	2 (5.0%)	0	122 (96.1%)	5 (3.9%)	1
Transfusion Services	71 (100.0%)	0 (0.0%)	5	62 (95.4%)	3 (4.6%)	4	133 (97.8%)	3 (2.2%)	9
Total	**917 (92.1%)**	79 (7.9%)	15	1024 (90.3%)	110 (9.7%)	19	1941 (91.1%)	189 (8.9%)	34

* Does not includes ROP (Required Organizational Practices)

Overview by Required Organizational Practices

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

This table shows the ratings of the applicable ROPs.

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

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Communication			
Client Identification (Mental Health Services)	Met	1 of 1	0 of 0
Client Identification (Obstetrics Services)	Met	1 of 1	0 of 0
Client Identification (Perioperative Services and Invasive Procedures)	Met	1 of 1	0 of 0
Client Identification (Point-of-Care Testing)	Met	1 of 1	0 of 0
Client Identification (Transfusion Services)	Met	1 of 1	0 of 0
Information transfer at care transitions (Cancer Care)	Met	4 of 4	1 of 1
Information transfer at care transitions (Emergency Department)	Unmet	4 of 4	0 of 1
Information transfer at care transitions (Inpatient Services)	Met	4 of 4	1 of 1
Information transfer at care transitions (Mental Health Services)	Unmet	4 of 4	0 of 1
Information transfer at care transitions (Obstetrics Services)	Met	4 of 4	1 of 1
Information transfer at care transitions (Perioperative Services and Invasive Procedures)	Unmet	4 of 4	0 of 1
Medication reconciliation as a strategic priority (Leadership)	Met	3 of 3	2 of 2

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Communication			
Medication reconciliation at care transitions (Emergency Department)	Met	1 of 1	0 of 0
Medication reconciliation at care transitions (Inpatient Services)	Unmet	1 of 4	0 of 0
Medication reconciliation at care transitions (Mental Health Services)	Met	4 of 4	0 of 0
Medication reconciliation at care transitions (Obstetrics Services)	Met	4 of 4	0 of 0
Medication reconciliation at care transitions (Perioperative Services and Invasive Procedures)	Met	4 of 4	0 of 0
Safe Surgery Checklist (Obstetrics Services)	Unmet	3 of 3	0 of 2
Safe Surgery Checklist (Perioperative Services and Invasive Procedures)	Unmet	3 of 3	0 of 2
The “Do Not Use” list of abbreviations (Medication Management Standards)	Met	4 of 4	3 of 3
Patient Safety Goal Area: Medication Use			
Antimicrobial Stewardship (Medication Management Standards)	Unmet	3 of 4	0 of 1
Concentrated Electrolytes (Medication Management Standards)	Met	3 of 3	0 of 0

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

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Worklife/Workforce			
Preventive Maintenance Program (Leadership)	Met	3 of 3	1 of 1
Workplace Violence Prevention (Leadership)	Unmet	2 of 5	3 of 3
Patient Safety Goal Area: Infection Control			
Hand-Hygiene Compliance (Infection Prevention and Control Standards)	Unmet	0 of 1	0 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 (Cancer Care)	Unmet	0 of 2	0 of 1
Falls Prevention Strategy (Inpatient Services)	Unmet	2 of 2	0 of 1
Falls Prevention Strategy (Mental Health Services)	Met	2 of 2	1 of 1
Falls Prevention Strategy (Obstetrics Services)	Unmet	1 of 2	0 of 1
Falls Prevention Strategy (Perioperative Services and Invasive Procedures)	Unmet	1 of 2	0 of 1

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Risk Assessment			
Pressure Ulcer Prevention (Inpatient Services)	Unmet	3 of 3	1 of 2
Pressure Ulcer Prevention (Perioperative Services and Invasive Procedures)	Unmet	0 of 3	0 of 2
Suicide Prevention (Emergency Department)	Met	5 of 5	0 of 0
Suicide Prevention (Mental Health Services)	Met	5 of 5	0 of 0
Venous Thromboembolism Prophylaxis (Inpatient Services)	Met	3 of 3	2 of 2
Venous Thromboembolism Prophylaxis (Perioperative Services and Invasive Procedures)	Met	3 of 3	2 of 2

Summary of Surveyor Team Observations

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

The Yukon Hospital Corporation was established in 1993 pursuant to the Hospital Act. The Act designates that there will be a Board of Directors that is representative of the geographic locations served and the Indigenous populations of Yukon Territory. There is an active and engage Board of Directors supported by a robust committee structure where Administration provides resources and information to support decision making and the setting of strategic priorities.

The Corporation has received feedback from stakeholders that there are concerns about the experience of clients and other stakeholders about siloed healthcare and the lived experience of Indigenous and LGBTQ2 clients in particular and the general public when accessing services. Community partners confirm that there are challenges for clients who might receive more appropriate care in community settings if there were stronger pathways to the right service in the right place at the right time. The organization has addressed the feedback from the public very directly in its new strategic plan by acknowledging the issues and committing to corrective actions.

There is a robust Indigenous Health program that is already operational in the facility. The program operates alongside hospital programs but is not always fully integrated. The organization has committed to some new actions that are designed to improve organizational culture to be safer and culturally competent for Indigenous people.

There is a dedicated and engaged leadership team at all levels of the organization. Staff and community partners did tell surveyors that it would be desirable for leaders to have more of a physical presence in clinical areas and for leaders to be more responsive to inquiries and requests for support from the point of care.

There is a well organized approach to human resource management and an attractive compensation package, however the Yukon Hospitals is experiencing similar recruitment and retention challenges to healthcare systems across the country. There is attention to people strategies in an effort to improve recruitment and retention.

The Accreditation team found engaged and enthusiastic point of care staff who spoke favourably about their employment experience and the opportunity to work in this naturally beautiful part of Canada.

Patient and Family Centred Care would be well served with a more formal approach focused on engaging patients and families in decision-making for the Hospital. Currently there is heavy reliance on satisfaction surveys to hear about client experience retrospectively whereas clients have clearly indicated in those surveys that they want more of a say in how services and facilities are designed.

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 incident disclosure A documented and coordinated approach to disclosing patient safety incidents to clients and families, that promotes communication and a supportive response, is implemented.	· Leadership 15.6
Patient Safety Goal Area: Communication	
Information transfer at care transitions Information relevant to the care of the client is communicated effectively during care transitions.	· Perioperative Services and Invasive Procedures 12.11 · Emergency Department 12.16 · Mental Health Services 9.18
Client Identification Working in partnership with clients and families, at least two person-specific identifiers are used to confirm that clients receive the service or procedure intended for them.	· Inpatient Services 10.2
Safe Surgery Checklist A safe surgery checklist is used to confirm that safety steps are completed for a surgical procedure performed in the operating room.	· Obstetrics Services 10.6 · Perioperative Services and Invasive Procedures 14.3
Medication reconciliation at care transitions Medication reconciliation is conducted in partnership with clients and families to communicate accurate and complete information about medications across care transitions.	· Inpatient Services 9.7

Unmet Required Organizational Practice	Standards Set
Patient Safety Goal Area: Medication Use	
Antimicrobial Stewardship There is an antimicrobial stewardship program to optimize antimicrobial use. NOTE: This ROP applies to organizations providing the following services: inpatient acute care, inpatient cancer, inpatient rehabilitation, and complex continuing care.	· Medication Management Standards 2.3
Patient Safety Goal Area: Worklife/Workforce	
Patient safety: education and training Patient safety training and education that addresses specific patient safety focus areas are provided at least annually to leaders, team members, and volunteers.	· Leadership 10.9
Workplace Violence Prevention A documented and coordinated approach to prevent workplace violence is implemented.	· Leadership 2.12
Client Flow Client flow is improved throughout the organization and emergency department overcrowding is mitigated by working proactively with internal teams and teams from other sectors.NOTE: This ROP only applies to organizations with an emergency department that can admit clients.	· Leadership 13.4
Patient Safety Goal Area: Infection Control	
Hand-Hygiene Compliance Compliance with accepted hand-hygiene practices is measured.	· Infection Prevention and Control Standards 8.6
Patient Safety Goal Area: Risk Assessment	
Falls Prevention Strategy To prevent falls and reduce the risk of injuries from falling, universal precautions are implemented, education and information are provided, and activities are evaluated.	· Perioperative Services and Invasive Procedures 11.11 · Cancer Care 15.7 · Obstetrics Services 8.6 · Inpatient Services 9.8

Unmet Required Organizational Practice	Standards Set
Pressure Ulcer Prevention Each client's risk for developing a pressure ulcer is assessed and interventions to prevent pressure ulcers are implemented.NOTE: This ROP does not apply for outpatient settings, including day surgery, given the lack of validated risk assessment tools for outpatient settings.	· Perioperative Services and Invasive Procedures 11.10 · Inpatient Services 9.9

Detailed On-site Survey Results

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

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

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

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

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

See Appendix B for a list of priority processes.

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

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

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

Priority Process Results for System-wide Standards

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

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

Priority Process: Governance

Meeting the demands for excellence in governance practice.

The organization has met all criteria for this priority process.
Surveyor comments on the priority process(es)

The Board of Directors is appointed by the Minister of Health, Yukon Government. The structure of the Board is defined in legislation. The intent is to ensure representation from the population across the Yukon, with attention to a desired competency matrix. There are nine members, three of whom represent Yukon First Nations. The Minister appoints the Chair.

The Board meets at least quarterly and has a committee structure in place to work with the CEO and Leadership team for specific areas of focus such as Finance, Medical Staff privileges, Governance, Pension Plan, and Quality.

The CEO is the only employee of the Board. The Board has processes in place to monitor CEO performance and determine appropriate compensation. The current CEO is a long standing employee so recruitment functions have not been exercised by most of the current members but there are processes in place that mirror good practices for recruitment and retention from a Human Resource Management perspective.

The Board defines itself as a Policy/Governance Board that works closely with the CEO and the leadership team to receive regular reports supporting the fulfilling of their fiduciary duties. The committee structure and regular Board meetings are the mechanisms to get the information Board members need to clarify governance vs operational roles.

The Board is responsible for and approves the strategic planning and views ownership of the strategic plan as shared with all stakeholders. There is a new strategic plan that is currently being operationalized. The Board is proud of the work done to seek community input and openly develop strategies in response to what they heard.

Physician credentialing is delegated to Medical Affairs with recommendations coming to the Board annually through the Medical Staff Committee for approval and renewal. Evidence that QI is an aspect of

this process includes a recent focus on vetting requests for privileges to ensure that bringing on new specialties accounts for costs associated with setting up facilities and equipment to support practice.

There is a conflict of interest policy/bylaws in place. This is one aspect of the orientation and training that is provided to all Board members. Board members state that they are supported with adequate orientation and training and that the committee structure, preparation, and timely availability of Board packages are robust and adequate to support well-informed decision-making.

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		
1.3	Client- and family-centred care is identified as a guiding principle for the organization.	!
1.5	Policies addressing the rights and responsibilities of clients are developed and implemented with input from clients and families.	
1.6	Input is sought from clients and families during the organization's key decision-making processes.	
6.5	Formal strategies or processes are used to manage change.	

Surveyor comments on the priority process(es)

There is a new strategic plan in place for 2022-2027. The plan largely indicates new strategic priorities related to feedback from the community about patient experience, particularly for groups such as Indigenous people and the LBGTQ2 community.

The plan and the discussions with leaders at every level of the organization acknowledges the harm done to Indigenous people and initiatives that will be taken to align with the recommendations of the Truth and Reconciliation Commission. The Hospital has invested time and resources into developing and advancing the Indigenous Health program and changing the organizational culture.

There is an operational plan with component plans from each unit. Each program selects key performance indicators that are monitored quarterly and rolled up into the CEO report to the Board.

The leadership team was transparent about the need to have a more well-defined approach to Patient and Family Centred Care. The main evidence provided during the on-site survey is patient satisfaction surveys. There was no evidence of efforts to engage patients in decision-making processes except in the Indigenous Health Program.

It is evident in many areas of direct care and leadership that there has been significant human resource turnover in all of the hospitals, especially during the pandemic. There is a discussion about covid and change management fatigue. There is also discussion about working in silos and the eventuality that government will create a Territorial Health Authority whereby the Hospital Corp may no longer be the employer. Community partners and patients use the term "working in silos" to describe the current

structure when referencing patient flow from hospital to community and vice versa. These transitional issues may require a more proactive approach to change management. If people don't have answers to their questions, they tend to make assumptions that have no basis in fact. It may be prudent to consider a communication strategy around change management.

Priority Process: Resource Management

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

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

The Yukon Hospitals Corporation is designated under the Hospital Act of the Yukon Government. The Hospital works in very close proximity to the government to prepare, manage, and report on capital and operating budgets. There is a Board of Directors that vets and monitors the budget through its Executive Committee. Approximately 80% of revenue comes from the Territorial Government and 20% for reciprocal agreements with other Provinces and Territories.

The Hospitals Corporation follows the financial cycle of its major funder, which is the Government of the Yukon. The Territorial Government Financial Administration Act provides guidance. Budget prep begins in the fall of the prior fiscal year with the goal of having approval for the fiscal year April 1 to March 31.

Monthly reports are provided to all managers with spending authority, expecting that explanations of variance, decisions for expenditures, and corrective actions are taken with cost drivers in mind. There is a small financial services unit with one business analyst who is available to cost centre managers for consultation.

Annual audits are conducted by the Office of the Auditor General for Canada with reports tabled in the Legislative Assembly.

Priority Process: Human Capital

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

Unmet Criteria			High Priority Criteria
Standards Set: Leadership			
2.12	A documented and coordinated approach to prevent workplace violence is implemented.		ROP
	2.12.1	There is a written workplace violence prevention policy.	**MAJOR**
	2.12.2	The policy is developed in consultation with team members and volunteers as appropriate.	**MAJOR**
	2.12.3	The policy names the individual(s) or position responsible for implementing and monitoring adherence to the policy.	**MAJOR**
10.9	Patient safety training and education that addresses specific patient safety focus areas are provided at least annually to leaders, team members, and volunteers.		ROP
	10.9.1	There is annual patient safety training tailored to the organization's needs and specific patient safety focus areas.	**MAJOR**
Surveyor comments on the priority process(es)			

The organization has a well resourced Human Resources Team with HR Generalists assigned to various hospital units and programs. Recruitment, onboarding, and ongoing HR supports are in place. References and criminal records checks are completed on all new employees. There is some inconsistency in completing regular performance appraisals for in-scope staff but discussions are underway about system improvements such as self-assessment and performance conversations are ongoing.

There are challenges in producing useful management reports to support decision making because the department has been working with a manual system to date. The HR team will welcome plans to implement an automated Human Resource system in the fall of 2023.

Staff turnover and vacancy rates are a challenge, particularly in the facilities outside of Whitehorse. The number of hours contracted to agency nurses is costly and impactful in terms of continuity of care. The organization is looking at strategies to address recruitment and retention challenges.

The organization is particularly proud of its efforts to bring on Indigenous employees to reflect the population of the Territory. A position of Indigenous HR Business Partner has recently been created and filled. Evidence of initiatives is underway to promote work-life balance and a positive work environment. Amongst other things this includes a Working on Wellness committee that explores and initiates activities targeted at creating a healthier workplace.

There is no specific workplace violence strategy or policy. It is recommended that work be initiated to ensure that a policy or suite of policies and a communication strategy around the prevention of workplace violence be put into place. There are examples of leading practices on workplace violence prevention is health systems across the country that could be accessed as references. Typically Occupational Health and Safety and Unions have a role to play in this work.

There is no onboarding and annual patient safety training provided. During the onsite survey there were discussions about how to address this matter via a module that can be added to the organization's learning management system. There are examples of simple basic training modules designed to raise and sustain awareness.

Priority Process: Integrated Quality Management

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

Unmet Criteria			High Priority Criteria
Standards Set: Leadership			
12.4	The risk management approach and contingency plans are disseminated throughout the organization.		!
15.3	A strategy to prevent the abuse of clients is developed and implemented.		!
15.6	A documented and coordinated approach to disclosing patient safety incidents to clients and families, that promotes communication and a supportive response, is implemented.		ROP
	15.6.1	There is a documented and coordinated process to disclose patient safety incidents to clients and families that identifies: • Which patient safety incidents require disclosure • Who is responsible for guiding and supporting the disclosure process • What can be communicated and to whom about the incident • When and how to disclose • Where to document the disclosure.	**MAJOR**
	15.6.2	The disclosure process is reviewed and updated, if necessary, once per accreditation cycle, with input from clients, families, and team members.	**MINOR**
	15.6.3	Those responsible for guiding and supporting the disclosure process are provided with training on disclosure.	**MAJOR**
	15.6.4	Communication occurs throughout the disclosure process with clients, families, and team members involved in the patient safety incident. Communication is documented and based on their individual needs.	**MAJOR**
	15.6.5	As part of the disclosure process, practical and emotional/psychological support is offered to clients, families, and team members involved in the patient safety incident.	**MAJOR**

15.6.6	Feedback is sought from clients, families, and team members about their experience with disclosure and this information is used to make improvements, when needed, to the disclosure process.	**MINOR**
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.	!
16.7	The organization's leaders verify that the quality improvement plans and related changes are implemented.	!
16.9	Reports about the organization's performance and quality of services are shared with the team, clients, families, the community served, and other partners and stakeholders.	
16.10	The results of the organization's quality improvement activities are communicated broadly, as appropriate.	!

Surveyor comments on the priority process(es)

There are elements of quality present in the organization. It is evident that past strategies to be pro-active about Quality Improvement included the expectation that individual units would have QI plans. This system appears to be failing somewhat for various reasons, including staff and leader movement and turnover. Currently some services are more focused on quality assurance and improvement than others. This appears to be related to human resource capacity and the requirements of specific services to meet their own standards. For example, laboratory services have strict standards for reporting critical results.

The organization's leaders told surveyors that they are either early on or in reset mode regarding the quality improvement framework and plans. With the organization embarking on a new strategic plan that makes bold promises to address issues that stakeholders have identified this is an ideal time to refresh the organization's over all approach to quality by developing a QI plan that can be cascaded to the units with some expectations around uniformity. For example, the initiative to create a visibility board with selected metrics to support staff huddles in the medical unit appears to be a mechanism that could be standardized across the organization.

The same principles around developing and communicating an organization wide QI Plan would apply to Risk Management. The HIROC approach that leadership says it is adopting does provide specific tools that are relatively easy for all to understand - heat map, risk register, etc.

There are specific policies that should be created and communicated broadly. These include the prevention of patient abuse and disclosure.

Priority Process: Principle-based Care and Decision Making

Identifying and making decisions about ethical dilemmas and problems.

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

There are dedicated resources from the policy world to support the organization's ethics committee and the ethical lens on policy development. Like many small organizations the organization does not have a high volume of ethical issues that come to the committee for vetting, although occasionally items come forward for discussion and advice. The focus of the committee should therefore be education and awareness. The committee is already aligned with the same portfolio as communication so this is an ideal partnership in this regard.

The organization has a code of conduct and uses a "4-box approach" for ethical decision-making. This involves identifying the issue, validating moral distress, considering remedies, and discussing possible pathways to resolution. The committee recognizes that most ethical issues are resolved prior to being escalated to a committee. This reinforces the notion that building capacity and providing education and awareness to all is worthwhile in a healthcare setting.

As needed the organization looks to outside consultation for consultation with an Ethicist. One example of an issue about conflict of interest was provided.

The organization reports on its activities to the Board on a quarterly basis. The Board supports and is interested in putting an ethical lens on its own activities and those of the organization's operations.

Promotional activities associated with "ethics month" etc and a mandatory training module in the learning management system provide evidence of the organization's efforts to help the workforce, physicians, and leaders when they identify an issue that is not easily resolved at the point of care.

Priority Process: Communication

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

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

The organization has designated an individual to be responsible for communication strategies as part of his portfolio. The communication plan is described as having four areas of focus:

-Internal communications
-External communications
-Brand promotion
-Alignment with strategy

Basic routine communications include newsletters, community publications such as the year in review report (tabled in the Legislative Assembly of the Yukon Government), and social media presence. In addition there are a variety of meetings that include community partners. The organization operates three stand alone hospitals so it has to go the extra mile to connect with community partners who are also publicly funded and delivering community based primary care. Strategically there is awareness that at some point the government might go in the direction of a Territorial Health Authority to strengthen the continuum of community and acute care programs. In the meantime, the organization attempts to proactively nurture partnerships that promote seamless care for individuals who may access services that are related but not operated by the Hospital Corporation.

Privacy officers are in place to ensure that mechanisms are in place to comply with legislation and policy around privacy and access to information. The officers provide information, orientation, education, and support to staff patients, and other stakeholders so that clients and others have timely and appropriate access to information if a request is received.

Some data is collected and stored manually and some is collected through e-health records. There has been some progress in the ability to mine for data, produce reports, and communicate information to support evidence based decision-making and support quality improvement. For example, there is a relatively recently introduced EMR (Meditech) and there is a plan to introduce a Human Resource Information System in the fall of 2023.

Priority Process: Physical Environment

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

Unmet Criteria	High Priority Criteria
Standards Set: Perioperative Services and Invasive Procedures	
3.7 Rooms where surgical and invasive procedures are performed have at least 20 complete air exchanges per hour.	!

Surveyor comments on the priority process(es)

Whitehorse General Hospital (WGH) is the largest hospital in the Yukon that provides a full range of care, including 24/7 emergency care, inpatient and ambulatory care, surgical services, cancer care, visiting specialists' clinics, therapy and lab services, and advanced diagnostic imaging.

The physical space meets applicable laws, regulations, and codes. Access to areas or services are controlled and security camaras are installed throughout the facilities.

Facilities Management and Engineering personnel keep the buildings and mechanicals well maintained.

The physical environment is designed to allow for easy access for an ambulance and stretcher for the transfer of emergency cases to the hospital. Some clinical areas of the hospital are cluttered with stretchers in the corridors. In the Inpatient ward, the safety rails on both sides of the corridors were inaccessible due to the quantity of clutter. This represents a significant hazard to evacuate clients and staff during emergency situations.

Hospital wayfinding signs and graphics are installed to facilitate clients, families, and visitors' navigation throughout the building.
Medical gas pipeline systems are certified and checked at least annually. Airflow and air quality is monitored and maintained in the operating room(s) according to standards applicable for the type of surgical procedures performed. There is an opportunity to begin monitoring the OR air change rate.

Emergency back-up power generators can be used during power outages. It is suggested to add the expected values (ranges) for each of the parameters checked during maintenance. Critical equipment is connected to UPS.

The monthly inspection of the fire extinguishers is not consistently done (e.g., monthly inspection of the extinguisher in the Energy Center has not been performed since July 2022). It was also observed that several reagents used for the testing of the boiled water are expired.

The hospital has a strong policy prohibiting smoking and monitors its compliance. There are signs posted

at the entrance doors to remind people that smoking is prohibited within 5 meters of the hospital premises. There are smoking designated areas for employees and others for clients, families, and visitors.

It is recommended to revise the existing storage and disposal of flammables and ensure meets guidelines and regulations. WGH is commended for its commitments to minimize the organization's operations' impact on the environment (e.g., recycling plastic and cans, replacing regular light bulbs for LED ones). Other actions that are about to be implemented are the "heat recovery chillers".

While Physical Environment was not a Priority Process assigned at Watson Lake and Dawson hospital, it is noted that both sites were clean, bright, spacious and with no cluttering issues.

At Watson Lake, during the surveyor visit, the HVAC system was being repaired and this led to some increased heat in the IT equipment room, but this was quickly solved. Storage of Oxygen tanks in a disused laminar flow room near the in-patient ward was not satisfactory as the smaller tanks were standing alone, not in cradles and not restrained, also some were on their sides on the floor in the way of the cart that held the large oxygen tank, posing a serious hazard risk.

Priority Process: Emergency Preparedness

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

Unmet Criteria		High Priority Criteria
Standards Set: Leadership		
14.9	A business continuity plan is developed and implemented in order to continue critical operations during and following a disaster or emergency.	
14.10	The business continuity plan addresses back-up systems for essential utilities and systems during and following emergency situations.	!
Surveyor comments on the priority process(es)		

The organization works closely With The Territorial Government to ensure it is part of a network of emergency response plans that would align in the event of an emergency. There is awareness of the most likely emergencies to impact people in the Yukon. The Hospital focuses on being at municipal and provincial tables to play a role within their responsibility. There are Hospitals in Whitehorse, Dawson City, and Watson Lake. Each community has risks that are specific to geographical location, population demographics, etc. Plans for fire, flood, power and internet outage, and Mass casualty are typical for tabletop and other exercises. The Hospitals themselves have not done a recent full on mock disaster exercise but have done some table top exercises. The organization considers its response to the pandemic as the most pertinent learning opportunity, awareness raising exercise, and success in promoting readiness and updating of plans. In the near future the Yukon Hospital Corporation will be a partner in a command post exercise that will be conducted in partnership with the Canadian Armed Forces.

Responsibility for the coordination of Emergency Response has recently been assigned to the manager of security services. Plans are described as "a little bit dusty" as a result of the pandemic and staff turnover. Emergency Response planning and a broader plan to update and refresh the Hospitals' committee structure have been considered. The organization uses the Incident Command System as their structure for Emergency Response Planning.

The current approach appears to be somewhat ad hoc. It is recommended that the organization ensure that efforts to update communication strategies, policies, procedures, and committees continue and that there be clear designation of roles and responsibilities for all involved in Emergency Preparedness according to the ICS model so that everyone knows their role and so that responsibilities in the command centre are practiced and understood.

Priority Process: People-Centred Care

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

Unmet Criteria		High Priority Criteria
Standards Set: Cancer Care		
8.3	A comprehensive orientation is provided to new team members and client and family representatives.	
8.12	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.	
27.3	Measurable objectives with specific timeframes for completion are identified for quality improvement initiatives, with input from clients and families.	!
Standards Set: Emergency Department		
1.1	Services are co-designed with clients and families, partners, and the community.	!
3.5	Barriers within the emergency department that impede clients, families, providers, and referring organizations from accessing services are identified and addressed, with input from clients and families.	
4.15	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: Governance		
2.2	There are established mechanisms for the governing body to hear from and incorporate the voice and opinion of clients and families.	
5.3	The governing body provides oversight of the organization's efforts to build meaningful partnerships with clients and families.	!
5.4	The governing body monitors and evaluates the organization's initiatives to build and maintain a culture of client- and family-centred care.	!

Standards Set: Inpatient Services		
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		
3.6	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.	
9.2	There are mechanisms to gather input from clients and families in co-designing new space and determining optimal use of current space to best support comfort and recovery.	
10.4	Education and training are provided throughout the organization to promote and enhance a culture of client- and family-centred care.	
Standards Set: Mental Health Services		
3.15	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: Obstetrics Services		
3.13	Client and family representatives are regularly engaged to provide input and feedback on their roles and responsibilities, role design, processes, and role satisfaction, where applicable.	
18.3	Measurable objectives with specific timeframes for completion are identified for quality improvement initiatives, with input from clients and families.	!
Standards Set: Perioperative Services and Invasive Procedures		
1.1	Services are co-designed with clients and families, partners, and the community.	!
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.	
25.3	Measurable objectives with specific timeframes for completion are identified for quality improvement initiatives, with input from clients and families.	!

Surveyor comments on the priority process(es)

There is evidence of efforts to hear about the experience of patients and families retrospectively via evaluations and surveys. There are also some excellent ways of engaging with patients and families about their care plans and roles in self-care in places like medicine, surgery, obstetrics, and cancer care.

The standards for patient and family centred care aim to pro-actively engage patients and families in decision-making at every level of the organization. This often looks like a patient and Family Advisory Council with patient advisors who have a defined role in the organization's operations, committee structures, etc.

It is recommended that the organization undertake a Quality Improvement initiative to formalize its approach to Patient and Family Centred Care in a way that works in this culture. The existing Indigenous Health Program and the plans to improve Indigenous Health in clinical operations represent great efforts to engage clients and families in defining what the program should look like. This approach could also work well for the general population's engagement in program and facility design.

Priority Process: Patient Flow

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

Unmet Criteria		High Priority Criteria
Standards Set: Emergency Department		
3.1	Client flow throughout the organization is addressed and managed in collaboration with organizational leaders, and with input from clients and families.	!
3.2	A proactive approach is taken to prevent and manage overcrowding in the emergency department, in collaboration with organizational leaders, and with input from clients and families.	!
3.11	Protocols to move clients elsewhere within the organization during times of overcrowding are followed by the team.	!
3.12	Protocols are followed to manage clients when access to inpatient beds is blocked.	
Standards Set: Leadership		
13.1	Client flow information is collected and analyzed in order to identify barriers to optimal client flow, their causes, and the impact on client experience and safety.	
13.2	Information about barriers to client flow is used to develop a strategy to build the organization's capacity to meet the demand for service and improve client flow throughout the organization.	
13.3	The organization's leaders collaborate with other service providers and partners to improve and optimize client flow.	
13.4	Client flow is improved throughout the organization and emergency department overcrowding is mitigated by working proactively with internal teams and teams from other sectors. NOTE: This ROP only applies to organizations with an emergency department that can admit clients.	ROP
13.4.1	The organization's leaders, including physicians, are held accountable for working proactively to improve client flow and mitigate emergency department overcrowding.	**MAJOR**

13.4.3	There is a documented and coordinated approach to improve client flow and address emergency department overcrowding.	**MAJOR**
13.4.8	Client flow data is used to measure whether the interventions prevent or reduce overcrowding in the emergency department, and improvements are made when needed.	**MINOR**
13.5	The effectiveness and impact of the client flow strategy is evaluated.	

Surveyor comments on the priority process(es)

Patient flow is a significant concern for the Yukon Hospital Corporation (YHC), particularly at the Whitehorse General Hospital site. High patient volumes and the ability to safely discharge patients remain issues the YHC has little control over. The organization is encouraged to continue their efforts to engage with governmental healthcare and community partners to identify opportunities to increase long- term care access and home-care support. Successes have been achieved with the implementation of the Transition Care Coordinator, supported by Clinical Nurse Leads and the multidisciplinary approach, to facilitate discharge planning early in the inpatient journey.

Identifying and addressing policy limitations that impact quality care for the patient should be addressed to help facilitate the safe discharge of patients to their homes. Expanding access to in-home care in general, and IV antibiotic support in particular, would better facilitate discharge planning and improve the ability to provide care for the right patients in the right place at the right time. If existing community home-care supports cannot provide home care to support discharged patients, then the YHC leadership is encouraged to engage with the government to negotiate the equipment and personnel resources to provide these services and patient-centered care.

Within the emergency department, limited mental health resources are available and ideally would be available through a partnership with the Mental Wellness and Substance Use Service to provide clinical support in the emergency department, continuity of care and to identify resources to support a safe discharge. With the development of the expanded inpatient Mental Wellness Unit, there may be further opportunities to provide programs in collaboration with this team to prevent interruptions for existing clients and to develop relationships to help support the patient through discharge.

The leadership is encouraged to address client flow throughout the organization in collaboration with the Yukon government and other governmental healthcare agencies to identify redundancies and gaps within the healthcare system. Development of a "no wrong door" approach for individuals to enter the healthcare system and then engage with the hospital, care services and community partners in a seamless manner would be ideal. Human and material resources are limited and there are potential efficiencies to removing barriers and promoting care across the continuum. Engaging with patients and families is essential to fully identify gaps and the needs of the community.

Community partners that provide shelter and remote community support are also critical to support safe discharge from the hospital and preventing a return to the emergency department and/or readmission. Working in collaboration with these community partners may further identify opportunities for YHC relationships to support their shared clients.

The organization does have an emergency department overcrowding plan and an inpatient surge policy. Both policies would benefit from clarity and detail in where patients would be decanted, which spaces would be utilized and how these additional beds and patients would be clinically managed. Detailing these contingencies within the plan is recommended to support staff when confronted with these urgent situations. Engaging patients and families in this process is also recommended to gain their insight and feedback.

Meditech has greatly improved flow with continuous charting and visibility between departments and sites within Yukon Hospital Corporation. There are opportunities to utilize the electronic health record to identify further opportunities to optimize client flow. Identifying and quantifying potential admission avoidance opportunities and the cause of discharge delays (missing results, late discharge orders, social limitations, transportation, etc.) are examples of potential analysis to support the team in removing associated barriers.

Collaboration with partners to improve and optimize client flow continues to develop and improve partnerships and relationships. Inter-governmental department collaboration between the Yukon Hospital Corporation and Care Services, which includes both Long Term Care and Home Care, is a critical partnership that needs to coordinate and streamline discharge services for the benefit of patients and families. YHC strongly supports the "Home First" philosophy but the gaps in resources to support this concept directly impact client flow throughout the hospitals. Mental Wellness and Substance Use is another department with whom stronger partnerships are required to support patient safety and continuity of care.

The perioperative team has improved the efficiency of operating room utilization through the use of block times, central booking and standardized scheduling processes. The physical layout of the registration, perioperative, operating room and recovery areas facilitate flow. As the team moves forward, reviewing surgeon, anesthesia and nursing staff scheduling and utilization may be considered to further maximize flow and improve capacity.

There is an opportunity to further investigate and review client flow processes as part of a quality initiative. Raw client flow data is collected and monitored but a deeper dive into the processes may identify areas of opportunity to prevent emergency room presentation, decrease unnecessary admissions and mitigate delays in discharge.

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		
5.4	The team involved in reprocessing medical devices is prepared for the functions it performs through education and training in a formal medical device reprocessing training program recognized by the health care setting.	!
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.	!
15.9	Indicator data is regularly analyzed to determine the effectiveness of the quality improvement activities.	!
15.12	Quality improvement initiatives are regularly evaluated for feasibility, relevance, and usefulness, with input from stakeholders.	

Surveyor comments on the priority process(es)

This busy and vital service supports Yukon Hospital services, Government services and Indigenous community needs.

Positive steps have occurred since the last survey. This includes work done to resolve unmet and outstanding criteria at that time and the completion of renovations to the MDR area. The team is to be commended for bringing in external expertise and support for the area as they continue the work to meet and maintain expected standards. Efforts should continue to meet this area's current and future needs.

Attention to performance and competency is thoughtful and successful, as all staff members are trained in all duties/stations and rotate through the work areas on a set rotation to maximize skills and share workload. Well done!

The department often responds with real time quality improvement activities as soon as issues of interest or concern arise. Some are raised internally; others arise with key partners like the OR team. Steps are then taken to resolve or improve as needed in the area without formal documentation. For example, this includes work such as the addition of bumpers and testing to resolve tear issues with heavier case packs; and the overall space organization efforts. This is a great team which should consider having a member

train with QI to champion efforts in this important department.

Given the turnover in OR leadership, it is fortunate that a staff member has championed a leadersip collaboration within MDR. With the current CCM this effort has grown steadily and they are a great team.

In addition, consider supporting any education that supports the informal leader, and formalizes the role of a working Lead for this department, reporting up to the CCM or some model of this. There is risk associated with the loss of CCM and if the informal MDS leader steps back from this role.

The steps taken and work done since the last survey are to be commended. The project to add space and the push to organize the area as required has significantly improved the space, function, and separation as needed.

The MDR team is welcoming, committed and efficient as work is done. It was a pleasure to see all that has been accomplished,

Service Excellence Standards Results

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

Priority processes specific to service excellence standards are:

Point-of-care Testing Services

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

Clinical Leadership

- Providing leadership and direction to teams providing services.

Competency

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

Episode of Care

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

Decision Support

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

Impact on Outcomes

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

Medication Management

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

Organ and Tissue Donation

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

Infection Prevention and Control

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

Diagnostic Services: Imaging

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

Diagnostic Services: Laboratory

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

Transfusion Services

- Transfusion Services

Standards Set: Biomedical Laboratory Services - Direct Service Provision

Unmet Criteria		High Priority Criteria
Priority Process: Episode of Care		
The organization has met all criteria for this priority process.		
Priority Process: Diagnostic Services: Laboratory		
8.2	The layout of the laboratory prevents cross-contamination by separating incompatible activities.	!
11.2	The team has access to SOPs that are applicable to the activities it carries out.	
11.3	The team updates its SOPs every two years or more often if required.	
20.4	The team accepts or rejects each sample according to established criteria.	
22.2	The team identifies possible uncertain results and determines their importance in how it might affect interpretation.	
27.4	The team uses safety practices when handling, examining, or disposing of biological and chemical materials.	!
29.1	The team has a comprehensive quality management system.	!
29.4	The team identifies measurable objectives for its quality improvement initiatives and specifies the timeframe in which they will be reached.	!
Surveyor comments on the priority process(es)		
Priority Process: Episode of Care		

The team follows universal precautions to ensure a safe environment that prevents falls and reduces the risk of injuries from falling.

Priority Process: Diagnostic Services: Laboratory

The laboratory service at Whitehorse General Hospital (WGH) is well organized with a highly competent, good mix of committed staff, management, and scientific staff. There is a designated and enthusiastic coordinator responsible for the quality and safety of the department. The department will benefit from integrating the quality management system of the labs and ensure all the quality system essentials are addressed in one document for all. Management meetings are held on a regular basis; however, a formal laboratory quality committee has not been established.

The labs are located on the ground floor of the hospital. Testing is done in the areas of hematology, coagulation, routine and immune-chemistry, urinalysis, semen analysis, molecular biology, and some basic bacteriological procedures such as gram stain. There are over 40 staff members, including lab technologists, assistants, and clerical/support staff. Recruitment and retention challenges of lab staff were reported.

Orientation and initial training and competency assessment is well done. Access to continuing education was also reported. Compliance to the hospital performance appraisal expectation is challenging, mainly for casual staff.

Collection of blood samples for outpatients is performed from 8:00AM till 4:00PM in a separate area at any of the four phlebotomy stations. A curtain is used to offer privacy and confidentiality to patients. Two identifiers were verified before performing venipuncture. Blood is collected with gloves and after performing handwashing procedures. Proper techniques for collecting blood, including the correct order of drawing blood were noted. A gel sanitizer is installed at each station. Interviewed patients reported wait times of over 60 minutes from arrival till procedure is done. This can be reduced by having a floater or a person responsible of taking the specimens back to the lab for processing.

Access to the lab is restricted and employees use their ID badge to
unlock the door. A biohazard sign is posted outside the main entrance to the lab; however, the PPE expectations are not detailed. A laboratory coat is available for visitors. The temperature of the lab has been monitored and documented. It was noted that just recently (since middle of May 2023), the lab started monitoring humidity as well which complies with international guidelines.

Document control challenges such as obsolete documents, abridge instructions and standard use of templates were identified in all lab disciplines. In addition, several SOPs have not been reviewed for years (up to 10 years in some cases). Other documents/procedures, such as risk management have not been implemented. Three different versions of critical results were observed. This issue do not guarantee that staff have access to new guidelines or protocols for lab policies and procedures. An immediate effort should be placed to correct this deficiency.

Validation records of the DxH 800s were incomplete. Adding a front page with the summary of the validation studies and having management to review will be beneficial. The expire date of the reagents and consumables is not always documented.
Most instruments are interfaced to the LIS. Results from the osmometer are manually transcribed in the system. This could result in transcription errors. Results from referral labs are scanned into the system.

There is a laboratory biosafety manual available to employees. Handwashing rates exceed 95%. Eyewash and shower stations are checked on a weekly basis. There is an opportunity to add the eye wash station parameters/expectations that shall be confirmed by staff. In addition, the team is encouraged to install a second plumbed station close to biochemistry. Global Harmonized System (GHS) symbols and SDS have been implemented.

Establishing a lab safety committee will add value to the program as it will provide the opportunity to discuss ongoing lab safety issues, promote a safe working environment with respect to chemical and physical hazards and will assist with proper implementation of safe practices.
Lab management is encouraged to seek more proactively physician feedback to improve services and TATs. Developing indicators for the pre-analytical phase will be also beneficial.

A few documents were observed for the retention of lab materials and documents. The team is invited to unify the criteria and define new retention parameters such as abnormal hematology slides in line with national, territorial, or international guidelines.

A great opportunity to alleviate staffing pressures is to review the scope and mix of duties assigned to MLTs and MLAs to optimize the appropriate utilization of staff.

At Dawson, TAT issues/delays for referred out testing and significant rejection of microbiology specimens were reported by clinicians. More details of the site visit are found under POCT.

Standards Set: Cancer Care - Direct Service Provision

Unmet Criteria			High Priority Criteria
Priority Process: Clinical Leadership			
The organization has met all criteria for this priority process.			
Priority Process: Competency			
The organization has met all criteria for this priority process.			
Priority Process: Episode of Care			
15.7	To prevent falls and reduce the risk of injuries from falling, universal precautions are implemented, education and information are provided, and activities are evaluated.		ROP
	15.7.1	Universal fall precautions, applicable to the setting, are identified and implemented to ensure a safe environment that prevents falls and reduces the risk of injuries from falling.	**MAJOR**
	15.7.2	Team members and volunteers are educated, and clients, families, and caregivers are provided with information to prevent falls and reduce injuries from falling.	**MAJOR**
	15.7.3	The effectiveness of fall prevention and injury reduction precautions and education/information are evaluated, and results are used to make improvements when needed.	**MINOR**
Priority Process: Decision Support			
23.9	There is a process to monitor and evaluate record-keeping practices, designed with input from clients and families, and the information is used to make improvements.		!
Priority Process: Impact on Outcomes			
27.4	Indicator(s) that monitor progress for each quality improvement objective are identified, with input from clients and families.		
27.5	Quality improvement activities are designed and tested to meet objectives.		!
27.13	Indicator data are compared to available benchmarks.		
27.14	Indicator data is regularly analyzed to determine the effectiveness of the quality improvement activities.		!

27.15	Quality improvement activities that were shown to be effective in the testing phase are implemented broadly throughout the organization.	!
27.16	Information about quality improvement activities, results, and learnings is shared with clients, families, teams, organization leaders, and other organizations, as appropriate.	
27.17	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

It was a pleasure to visit this conscientious and committed service.

Cancer Care has a new leader who is also responsible for Medical Day Care and Visiting Specialists. She is highly motivated to work with the team on goals, objectives and opportunities for the growing Cancer Care program.

This program is affiliated with the BC Cancer Agency (BCCA) and uses forms, policies and references as appropriate. Staff are well trained and provide clinical care, education and navigation. A new position of Administration Assistant is in place and the interdisciplinary team is appreciative of this role and its support for patient needs and their work.

The team works hard to maintain a well stocked and welcoming area for clients and families.

Priority Process: Competency

The team works hard to maintain a well stocked and welcoming area for clients and families.

Training for all clinical staff is expected and provided. BCCA plays a key role in the clinical and specialty aspects. WGH also ensures standard orientation is provided in organizational requirements.
Medication and infusion pump safety is evident. Pharmacy is a clear partner and the departments work together seamlessly each day on medication prep, delivery, administration and disposal as required.
Attention is needed to ensure ongoing competency for infusion pumps is maintained as required (competency assessment at a minimum every 2 years with follow up as needed).

Priority Process: Episode of Care

The skill and care of all who participate in Cancer Care is clear. Nursing has created roles and schedules to meet the department's needs and delivery of care. GPO’s are now 6 strong and with this, coverage is

ensured, and service hours may soon expand to include Mondays. Patient feedback described Cancer Care by saying “Outstanding, beyond outstanding!”, and the team is “above and beyond”.

Not all Required Organizational Processes are in place, though work to resolve this is not onerous for Cancer Care and some improvements needed are organization wide. For example Falls Prevention needs review and must clearly set out guidelines and expectations for universal falls precautions for non-admitted clients and patients throughout all services.

The team demonstrates person centered care in each encounter, and takes opportunities to check in using a holistic approach on patient needs whenever possible. For example, review and discussion occur upon arrival, during treatment, and before leaving. Education material was evident and relevant.

Priority Process: Decision Support

Cancer Care was not included in the recent 1Health EMR rollout. This presents some challenges to the service and its work with other WGH departments such as Inpatients and Emergency where a need to share information is high. The hard copy (paper-based) Cancer Care charts are kept in the main service area (“Karen's Room”) and as clients end this service, old charts are kept in boxes on the floor in the department. In addition, a binder is kept in the Emergency Department with each patient's condition, MRP (GPO), and plan of care shared. These issues may be resolved with shareable EMR use. Attention should be given to address the dormant health records in this area; the need for Cancer Care to be included in EMR should be planned, prioritized and have a time frame identified.

Priority Process: Impact on Outcomes

This area collects data/stats and shares this upward as required. Unfortunately assessment, impact, and outcomes of this are unknown.

In conversation opportunities for quality improvement were easily seen.

First areas of attention may be the project the team began in response to a medication reaction involving a code, and the problem solving that has occurred; participating in and pursuing the organization on the plan and path for Universal falls protection; or, Collecting Service specific patient feedback,(including feedback on transitions) and setting goals/metrics based on those results and their impact on patient safety and outcomes.

This Service is ideal for recruiting patient or family partners as a team members on any of these efforts. The new Admin Assistant will also benefit, as will a partnership/coach from QI to work with Cancer Care to build a meaningful QI plan for the team and stakeholders yet it is not onerous.

Pick one thing the group sees as a priority, and work with a QI lead to begin what should be a continuous piece of practice.

Priority Process: Medication Management

The work observed with both the Pharmacy and the Cancer Care Team staff on duty for the Survey was very well done. All team members were focused and careful on the Medications and process steps required for safety.

Standards Set: Diagnostic Imaging Services - Direct Service Provision

Unmet Criteria		High Priority Criteria
Priority Process: Diagnostic Services: Imaging		
3.10	The team evaluates and documents each team member's performance in an objective, interactive, and constructive way.	
15.1	The team has a safety program led by a safety officer, a safety committee, or both.	!
17.13	The team implements effective quality improvement activities broadly.	!
17.14	The team shares information about its quality improvement activities, results, and learnings with clients, families, staff, service providers, organization leaders, and other organizations, as appropriate.	
17.15	The team regularly reviews and evaluates its quality improvement initiatives for feasibility, relevance and usefulness.	
Surveyor comments on the priority process(es)		
Priority Process: Diagnostic Services: Imaging		

Whitehorse General Hospital has a comprehensive diagnostic imaging department including X-ray, CT scan, MRI and ultrasound. There is no nuclear medicine imaging department. The management team is well defined and includes expertise from the technical and medical areas.

Wait times for procedures are logged and reported to senior leadership. Efforts are always in place to bring the wait times down to acceptable periods, but little information is reaching the client. There is an opportunity to publish wait times for the various modalities and their priority listings. Staff members report many calls from patients wondering about a referral, when the time could have been spent on other duties. One client was interviewed in the waiting area, who was getting another x-ray taken (more radiation) as she had not been given a wait time estimate for her MRI.

There appears to be a gap in the coordination of services by the administrative team when new programs are considered. When Orthopedics was introduced, DI had not been consulted to prepare for an increase in demand for services.

The department has contracted Rads staff based in British Columbia but there is usually one or 2 Rads present at the hospital, which is greatly appreciated by attending staff at Emergency, Surgery and in-patient wards. There is availability by phone 24 hours a day.

Quality improvement initiatives have included Pre-assessing clients for mammograms to speed up the

mammogram turn-around time; ultrasound guided injections for sport medicine; a pain therapy program. Another excellent initiative has been the introduction of a staff position to coordinate and control the Quality Assurance and Preventative Maintenance programming. This Safety coordinator position is temporary and the organization is encouraged to ensure full funding and permanence for such an important patient safety position.

There are X-ray facilities at Watson Lake Hospital. The technician is qualified and supported by the team in Whitehorse. There is also a portable x-ray machine in the ED and nurses are taught how to use it after hours for basic limbs and CXR's.

Standards Set: Emergency Department - 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.	
1.6	The role of the emergency department in the organization's all-hazard disaster and emergency response plan is clearly defined.	!
2.1	Resource requirements and gaps are identified and communicated to the organization's leaders.	
2.2	There is a process to collaborate with partners to develop resource-sharing arrangements to offer safe and effective services for each client and family.	
2.9	The effectiveness of resources, space, and staffing is evaluated with input from clients and families, the team, and stakeholders.	
Priority Process: Competency		
4.14	Team member performance is regularly evaluated and documented in an objective, interactive, and constructive way.	!
5.5	Standardized communication tools are used to share information about a client's care within and between teams.	!
5.6	The effectiveness of team collaboration and functioning is evaluated and opportunities for improvement are identified.	
6.1	The workload of each team member is assigned and reviewed in a way that ensures client and team safety and well-being.	
Priority Process: Episode of Care		
8.7	There is ongoing communication with clients who are waiting for services.	
8.8	Clients waiting in the emergency department are monitored for possible deterioration of condition and are reassessed as appropriate.	
9.13	There is a policy and process to manage medico-legal issues in the emergency department.	!

10.16	A process is followed to communicate and validate client diagnoses when there is discrepancy between the initial diagnosis and diagnostic imaging or laboratory results.	!
12.16	Information relevant to the care of the client is communicated effectively during care transitions. 12.16.5 The effectiveness of communication is evaluated and improvements are made based on feedback received. Evaluation mechanisms may include: • Using an audit tool (direct observation or review of client records) to measure compliance with standardized processes and the quality of information transfer • Asking clients, families, and service providers if they received the information they needed • Evaluating safety incidents related to information transfer (e.g., from the patient safety incident management system).	ROP **MINOR**
13.2	Clinical guidelines are used to determine whether a client is fit for transfer of care.	!
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		
14.8	There is a process to monitor and evaluate record-keeping practices, designed with input from clients and families, and the information is used to make improvements.	!
Priority Process: Impact on Outcomes		
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.	!
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.	!

18.10	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		
11.1	There are established protocols and policies on organ and tissue donation.	
11.2	There is a policy on neurological determination of death (NDD).	
11.3	There is a policy to transfer potential organ donors to another level of care once they have been identified.	
11.4	There are established clinical referral triggers to identify potential organ and tissue donors.	
11.5	Training and education on organ and tissue donation and the role of the organization and the emergency department is provided to the team.	
11.6	Training and education on how to support and provide information to families of potential organ and tissue donors is provided to the team, with input from clients and families.	
11.7	When death is imminent or established for potential donors, the OPO or tissue centre is notified in a timely manner.	
11.8	All aspects of the donation process are recorded in the client record, including the family's decision about organ and tissue donation.	
Surveyor comments on the priority process(es)		
Priority Process: Clinical Leadership		

The Yukon Hospital Corporation (YHC) emergency departments are encouraged to engage with patients, families and community partners to inform service design. Surveys, focus groups and committee collaboration are opportunities to collect information to identify gaps and improve service. Technology, including QR-code accessible feedback forms and tablets with focused questionnaires, may be considered to facilitate gaining information from patients and families.

Some data is available to identify specific goals and objectives and to support quality improvement initiatives. Managers and front-line staff would benefit from education and support to identify appropriate data and key performance indicators. This information and the initiatives to support quality should be developed and shared with the involvement of physicians, staff, patients and families.

Partnerships have been developed with other services, programs, providers and organizations. There continue to be gaps, particularly between government healthcare agencies, that need to be addressed.

The emergency response plan is dated (2014) and includes information related to the emergency department prior to the rebuild in Whitehorse. The other sites also require a review of emergency plans to ensure they remain relevant to the capability of the emergency department.

Structural resource requirements and gaps are identified and communicated to the organization's leaders but the leadership has been unable to successfully address these issues. An internal example within Yukon Hospital Corporation is the gap in the transfer of accountability between emergency and hospitalist groups. An external gap identified is the challenge of coordinating discharge care Continuing Care homecare services.

The organization has successfully collaborated with some partners to share resources and improve client and family service provision. Unfortunately, there are barriers within the healthcare system that Yukon Hospital Corporation struggles to navigate to coordinate patient-centred care. While this survey focuses on hospital accreditation, as one component of the Yukon Government Health and Wellness program, this higher-level leadership issue requires government involvement to streamline and coordinate resources between government departments to offer safe and effective services for Yukoners.

Priority Process: Competency

Meditech is a relatively new electronic health record for the organization and implementation is ongoing. The program has standardized information-sharing and protocol functions. Nursing has embraced this functionality as many of the communication tools are required within the platform. The physician group would benefit from further education on accessing these communication tools to ensure completion or may choose to modify programming so that these functions are promoted to facilitate utilization. The teams have access to super-users who are accessible to support the physicians and staff with any concerns.

Team collaboration and functioning have not been formally evaluated.

The workload of the nursing staff is assigned to ensure client and team safety. There is a concern that the physician workload requires review as the CTAS time-to-be-seen scores indicate that lower acuity levels are seen more rapidly than higher acuity. This is most concerning for the CTAS 3 group. Validating these statistics and mitigating user documentation errors is recommended. If valid, then a review of the emergency room flow and physician workload should be undertaken to ensure that resources are prioritized for higher acuity patients.

The emergency teams report excellent consultation support from surgical, obstetrical and psychiatric colleagues. External emergency transport services, tertiary care centers and central intake services are also reported to be excellent.

Priority Process: Episode of Care

The emergency department at Whitehorse was rebuilt five years ago with input from physicians and staff. The department has excellent sight lines and flow with private rooms, negative pressure space and a seclusion area. The double trauma room is spacious, well equipped, and designed for its purpose. The only concern regarding the department layout is the location of the triage nurse which does not support the direct observation of the waiting room. During high-volume periods or bed blocking in the emergency department, it is a challenge for the triage nurse to interrupt triage to reassess waiting room patients within the guidelines.

The Dawson City Community Hospital is a well-designed emergency department that facilitates the flow of patients, families, staff and clinicians. Located adjacent to both the primary care clinic and the inpatient unit, accessibility for support and cross-coverage is supported.

There is no policy on managing discrepancies. The ordering physician is responsible for following up on all tests they order. There is no policy to support clinicians when results arrive after the shift is completed and the ordering physician is no longer available. The emergency physician group has not embraced the transfer of care culture but may require consideration for the recruitment and retention of future emergency physicians.

The Meditech system has a checklist to verify that patients have been assessed for transfer of care but this is not consistently utilized. Concerns were expressed that patients are transferred while still unstable and inappropriate for admission. Auditing Meditech on whether transfer tools and checklists are completed, surveying staff on satisfaction with handover procedures and patient and client surveys are potential options to determine the effectiveness of transitions.

A concern was identified with admission procedures from the emergency department that would benefit from higher-level review and interdepartmental collaboration. The decision to admit needs to be a consultation between the emergency and admitting physicians. This conversation should include suitability for admission and inclusion of additional testing if required to support diagnosis and treatment decisions, focused on the needs of the patient.

Within the admission procedures, a concerning gap in care is noted between the time of the decision to admit and the acceptance of accountability by the admitting physician. This gap is unacceptable and leaves nursing staff unsupported for clinical decisions and orders. Emergency physicians and hospitalists need to work together to develop a system of admission acceptance and transfer of accountability that supports and provides appropriate care for the patient.

Meditech does include transfer checklists for admission to support decision-making and ensure that required steps have been completed to support admission. The teams are encouraged to review these checklists for suitability and utilize the appropriate tools to support the emergency department and admitting clinicians.

The emergency department physicians and staff across sites feel well supported by team members and appreciate the physical spaces in which they work. The passion for emergency medicine is evident and there is pride in the quality of care provided.

Priority Process: Decision Support

The recently implemented Meditech system provides a consistent platform across all three sites of the Yukon Hospital Corporation. The system continues to be monitored and updated to improve functionality, identify areas of concern and address identified utilization errors.

This electronic health record includes decision support within the system to prompt appropriate monitoring. These forced functions support patient safety and mitigate risk. The organization may consider involving physicians, frontline staff, clients and families in prioritizing and implementing these functions.

Education on Meditech functionality is ongoing and supported by nursing staff with additional Meditech experience and training. Finding notes was noted to be a challenge which may be mitigated by utilizing the title function and standardizing the labelling of nursing and other notes.

Priority Process: Impact on Outcomes

The YHC has not developed a formal patient and family advisory program to gather input. Involving patients and families in their care and decisions that impact them and their care must be emphasized. The organization is strongly encouraged to look at ways to hear the voices of patients and families through surveys, audits, focus groups and a patient and family advisory board.

There continues to be some variability in service delivery that is clinician dependant. While the nuances of clinical care are expected, the admission, consultation, transfer of care and discharge processes should be standardized so each department has the same expectations at transition.

Many guidelines and protocols on SharePoint are out of date and require revision and review. Involving clients and families in this process in addition to physicians and frontline staff is recommended.

The emergency department team would benefit from education and support to identify opportunities for quality improvement activities. Providing managers with opportunities to learn the fundamentals of quality improvement will support them in working with their team to identify priorities and design activities to improve the identified parameter.

Priority Process: Organ and Tissue Donation

The 2002 organ donation policy references the nonexistent Pacific Organ Retrieval Team (P.O.R.T). This policy should be updated to reflect the relationship with BC Transplant. The policy should also include the organ and tissue donation services that can and cannot be supported within the Yukon Hospital Corporation to make this clear for physicians, staff, patients and families.

The consideration of MAiD clients who desire to be organ donors should also be considered in future policy development.

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

Unmet Criteria		High Priority Criteria
Priority Process: Infection Prevention and Control		
1.1	IPC program components are regularly reviewed based on a risk assessment and organizational priorities.	!
2.5	The interdisciplinary committee regularly evaluates the program's structure and functions and makes improvements as needed.	
3.2	Trends in health care-associated infections and significant findings are shared with other organizations, public health agencies, clients and families, and the community.	
4.1	A risk assessment is completed to identify high-risk activities, and the activities are addressed in policies and procedures.	!
4.6	Compliance with IPC policies and procedures is monitored and improvements are made to the policies and procedures based on the results.	
4.7	IPC policies and procedures are updated regularly based on changes to applicable regulations, evidence, and best practices.	!
5.1	A multi-faceted approach to promoting IPC is used within the organization.	!
5.2	Team members, clients and families, and volunteers are engaged when developing the multi-faceted approach for IPC.	
5.3	The multi-faceted approach to IPC includes an education program tailored to IPC priorities, services, and client populations.	!
5.6	The effectiveness of the multi-faceted approach for promoting IPC is evaluated regularly and improvements are made as needed.	
8.6	Compliance with accepted hand-hygiene practices is measured.	ROP

8.6.1	Compliance with accepted hand-hygiene practices is measured using direct observation (audit). For organizations that provide services in clients' homes, a combination of two or more alternative methods may be used, for example: • Team members recording their own compliance with accepted hand-hygiene practices (self-audit). • Measuring product use. • Questions on client satisfaction surveys that ask about team members' hand-hygiene compliance. • Measuring the quality of hand-hygiene techniques (e.g., through the use of ultraviolet gels or lotions).	**MAJOR**
8.6.2	Hand-hygiene compliance results are shared with team members and volunteers.	**MINOR**
8.6.3	Hand-hygiene compliance results are used to make improvements to hand-hygiene practices.	**MINOR**
9.5	Compliance with policies and procedures for cleaning and disinfecting the physical environment is regularly evaluated, with input from clients and families, and improvements are made as needed.	
12.10	The results of investigations are used to improve programs, policies, or procedures, and to prevent health care-associated infections from recurring.	
14.1	There is a quality improvement plan for the IPC program.	!
14.2	IPC performance measures are monitored.	
14.3	Input is gathered from team members, volunteers, and clients and families on components of the IPC program.	
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		

The Infection Prevention and Control (IPC) program at Yukon Hospitals is transitioning as the organization moves away from the pandemic priority. Through the pandemic, IPC was part of every committee meeting and as the organization shifts, attention needs to be paid to which committees require IPC presence and ensure that they are invited to and not excluded from appropriate meetings.

YHC has excellent IPC support contracted through St Paul's for an infectious disease physician who is involved in committee meetings and advises on policies, procedures and consults as required.

Microbiology capability is also provided by St Paul's and further support is also made available through this service.

The IPC team is appropriately located within the inpatient department, providing direct access for physicians and staff at the Whitehorse site to address questions and concerns. The proximity supports monitoring of precautions and audits on IPC processes including PPE and hand washing. The organization is commended for ensuring that IPC remains prominently placed post-pandemic when complacency risk is highest. Support to Dawson and Watson Lake is provided through annual visits and consultations as required by IPC or the supported site. It was noted that information such as trends in healthcare-associated infections is collected but inconsistently shared with the community sites. The IPC team may consider scheduling regular virtual meetings to ensure that conversations on IPC are facilitated. This may proactively identify areas of concern and facilitate education and comfort on IPC issues.

Watson Lake and Dawson City are served by the IPC representative based at Whitehorse. Admissions and microbiology results are reviewed and communicated to the nursing staff. There have been no hand wash audits or recent training programs due to the rapid changes in the workforce and the unstable leadership. Staff members at both sites are well-qualified and knowledgeable on standard IPC precautions. They do not participate in input surveys, or audits and have not received outcome information. There is no IPC or Quality Board at either hospital.

The Whitehorse General Hospital kitchen provides meals for the hospital, the cafeteria and the long-term centre. Some equipment in the kitchen has been identified as needing maintenance and a potential safety issue with water leaking onto the floor. Ensuring that dates are consistently placed on prepared foods needs to be monitored. The team does an excellent job of maximizing their space and workflow. The laundry service also has a great flow from dirty to clean. This area has been equipped with ergonomic mats and weighted bins. Concerns about staffing levels and the impact on processes and team safety were noted.

Environmental services are to be commended on the high level of cleanliness noted at all three sites. Environmental service staff are well-trained and observed to follow appropriate protocols and procedures. Visual and indicator audits have not been completed recently. The manager recently developed a protocol to support audits moving forward. Leveraging technology to support auditing processes is recommended. Redevelopment and updating of cleaning protocols and procedures for environmental services in different areas of the hospital is in progress and on track to be completed this month. Concerns were noted that staffing limitations do result in some areas, such as the Whitehorse kitchen and cafeteria, not having environmental services coverage over weekends. The organization is encouraged to continue monitoring areas to ensure staffing does not adversely impact the organization.

Infectious disease signage is currently posted with adhesive on inpatient doors which does not consistently hold. The adhesive also leaves a residue which requires removal. The installation of spring-

loaded holders to hold signage on the front and back of patient doors is in progress and addresses this issue.

Clutter was noted in some hospital areas and should be reviewed through the IPC lens to minimize reference books, binders, and paper posted on walls.

The IPC program does not have a quality improvement plan and has not conducted a formal risk assessment across the three sites. The Meditech module to enable access to outcome-based data has not been installed and this is an impediment to collecting data and identifying QI opportunities. Hand hygiene data is collected at the Whitehorse site but not at the other locations. It is recommended that the sites review their audit methodology and determine whether other tools, such as tablets or QR codes with linked audits may assist in involving patients in collecting hand hygiene information. Identifying successes and opportunities for improvement will support the QI program and initiatives to make improvements in processes and impact outcomes. Involving other staff, volunteers, clients and families in IPC program components will further inform IPC priorities and initiatives.

Some hand hygiene audits have been conducted in Whitehorse but not at the community hospital sites. This is being discussed and the team is encouraged to consider auditing methods that leverage technology to minimize the impact on staff. Once audits are completed, the results should be widely shared and the results used to identify opportunities to improve compliance.

The IPC team is encouraged to share audit and QI program results with the front-line staff, patients, families, and community partners.

Standards Set: Inpatient Services - Direct Service Provision

Unmet Criteria			High Priority Criteria
Priority Process: Clinical Leadership			
2.8	A universally-accessible environment is created with input from clients and families.		
Priority Process: Competency			
3.6	Education and training are provided on the organization's ethical decision-making framework.		
3.11	Team member performance is regularly evaluated and documented in an objective, interactive, and constructive way.		!
3.13	Team members are supported by team leaders to follow up on issues and opportunities for growth identified through performance evaluations.		!
5.5	The effectiveness of team collaboration and functioning is evaluated and opportunities for improvement are identified.		
6.5	Education and training on occupational health and safety regulations and organizational policies on workplace safety are provided to team members.		!
10.12	Access to spiritual space and care is provided to meet clients' needs.		
Priority Process: Episode of Care			
9.7	Medication reconciliation is conducted in partnership with clients and families to communicate accurate and complete information about medications across care transitions.		ROP
	9.7.1	Upon or prior to admission, a Best Possible Medication History (BPMH) is generated and documented in partnership with clients, families, caregivers, and others, as appropriate.	**MAJOR**
	9.7.2	The BPMH is used to generate admission medication orders or the BPMH is compared with current medication orders and any medication discrepancies are identified, resolved, and documented.	**MAJOR**
	9.7.3	The prescriber uses the BPMH and the current medication orders to generate transfer or discharge medication orders.	**MAJOR**
9.8	To prevent falls and reduce the risk of injuries from falling, universal precautions are implemented, education and information are provided, and activities are evaluated.		ROP

	9.8.3 The effectiveness of fall prevention and injury reduction precautions and education/information are evaluated, and results are used to make improvements when needed.	**MINOR**
9.9	Each client's risk for developing a pressure ulcer is assessed and interventions to prevent pressure ulcers are implemented. NOTE: This ROP does not apply for outpatient settings, including day surgery, given the lack of validated risk assessment tools for outpatient settings.	ROP
	9.9.5 The effectiveness of pressure ulcer prevention is evaluated, and results are used to make improvements when needed.	**MINOR**
9.12	A comprehensive nutritional assessment is completed when clinically indicated.	
10.2	Working in partnership with clients and families, at least two person-specific identifiers are used to confirm that clients receive the service or procedure intended for them.	ROP
	10.2.1 At least two person-specific identifiers are used to confirm that clients receive the service or procedure intended for them, in partnership with clients and families.	**MAJOR**
10.13	Clients and families have access to psychosocial and/or supportive care services, as required.	
Priority Process: Decision Support		
	The organization has met all criteria for this priority process.	
Priority Process: Impact on Outcomes		
16.4	Indicator(s) that monitor progress for each quality improvement objective are identified, with input from clients and families.	
16.5	Quality improvement activities are designed and tested to meet objectives.	!
16.6	New or existing indicator data are used to establish a baseline for each indicator.	
16.8	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

At Whitehorse, accessibility on the ward is significantly limited by the clutter in the corridors such that the handrails are not accessible on either side of the hallways. A combination of family doctors and Hospitalists provides medical care. The Meditech system does not always capture who the attending is, and daily rounds are performed to ensure there are no 'orphan' patients. Nursing staff feel the pressure of sub-par staffing but generally are a cohesive group. Pharmacy, IPC and Public Health have offices on the ward which greatly helps coordinate team care.

Watson Lake Hospital is a new building, only 10 years old.
The lower level is rented to and occupied by the family practice group, who also provide Emergency and inpatient care for the hospital. The upper level is the hospital, with areas for administration, in-patient care and Emergency. The in-patient unit is 6-beds, currently occupied by one patient. it is not usually very full. Emergency sees up to 8 patients daily. There are 2 RN’s on duty for the hospital.

There are nursing gaps, and these are filled with Agency nurses. An identified gap in service is Mental health, in particular MH resources for children. The physician group are developing a proposal to provide this service at the local elementary school, with support from the local indigenous groups.

Dawson: Physician leadership is present and there is 24/7 coverage. An operations coordinator provides on-site leadership to the team and connects with senior leaders at WGH for direction.
Nurse scheduling and workload is monitored. The team has set up bed occupancy thresholds to identify staff pressures Casual staff is contracted out for short periods to provide additional support and coverage.

Priority Process: Competency

Most of the staff turnover is due to Agency nurses. They get some orientation, but not the full on-boarding provided for full time staff members. Most training is provided by the nurse educator who is located in Whitehorse but visits Watson Lake and Dawson city regularly. Some training modules are on-line. Staff members are aware of ethical decision making but are unaware of the Yukon Hospital Ethics decision framework or where to find it. When a dilemma occurs, be it ethical or with a complaint from a patient, they refer to the manager in Whitehorse. There is an opportunity to have increased sessions, maybe lunch and learns, on recognizing an ethical situation and then dealing with it.

Nursing staff members who were interviewed during the site visits, were very competent and

knowledgeable and had independently sought further training in specific areas. Their performance evaluations are not up to date at Whitehorse nor at Watson Lake, but they are completed at Dawson.

A major gap exists at Watson Lake with the unfilled positions of Operational Lead (CEO) and Clinical Nurse Leader. Without these positions filled there is some oversight from Whitehorse but overall morale is low and there is a lack of vision for the future. Staff are not having performance evaluations.

Dawson: An interdisciplinary team is very engaged, competent, and committed to patient-centred care. Due to the high turnover of nursing casual staff, orientation and training focuses on day to day operations and does not cover corporate protocols such as fire safety.

Performance appraisals are up to date. Staff have access to continuing education.

Priority Process: Episode of Care

The organization collects hospital data on falls, pressure ulcers, and DVT's, but there is inadequate feedback to the individual hospitals or their care teams.
The physician group is encouraged to adopt a written hand-over document such as SBAR, particularly on transfers from ED to In-patients, as the spoken handover may be non-specific on pending tests or results.
There are opportunities at all 3 hospitals to feed back to the floors the pertinent data and information that is gathered and used for analysis by the administrators. Staff members feel left out and not informed of trends or projects.

Watson Lake has no Quality Board and Team members are not aware of any changes in process that may have come about due to the data gathered on the interventions' effectiveness.
The food at Watson Lake is "boring" and the 2-week menu cycle has not changed "in decades". There is an opportunity to review the food services and whether a more novel approach may have cost benefits and be more nutritious. The traditional indigenous meals are appreciated. There should be consistent use of patient armbands and 2 identifiers. Improved orientation of all staff members is needed. Staff members acknowledge a gap in the availability of psycho-social services, although the presence of indigenous services is an asset.

Dawson City hospital: The Dawson site has 6 beds. Due to staff pressures, the target for bed occupancy sits at 50%. However, for most part the occupancy rate is 30%. There is a dedicated nurse for hospitalized patients.

Patients spoke of their satisfaction with the service and the level of expertise of the teams.

Excellent practices with storing of high alert medication were observed. Lack of compliance to document Best Possible Medication History (BPMH) at admission were identified.

Priority Process: Decision Support

The organization has recently switched from paper-based documentation and medical records to electronic, using the Meditech Expanse platform. Staff members are generally pleased with the switch and report a good orientation. Physicians are taking longer to adapt. The system requires repeated mouse clicking and this does slow down record keeping.

The system does have capability to send reports such as discharges, to the primary physician clinics, which use a different EMR.

Dawson: Client information is documented in the hospital EMR. Education and training on legislation to protect client privacy is provided and random checks are conducted to detect issues

Priority Process: Impact on Outcomes

Guidelines and protocols for care have been streamlined with the introduction of the Meditech EMR. The Medical Advisory and P&T Committees have input to the content.
Considerable data is collected for management. Indicator data is collected and excellent quality reports are prepared for management but these are not shared in the clinical areas, and there is no evidence at the clinical level that the data is being used in real time to improve processes or outcomes.

At Whitehorse there are several ideas for Q improvement initiatives, including more wheelchair availability, bedside handover, more longitudinal nursing care. An opportunity exists to increase the number of whiteboard pens (tie one to each whiteboard) so that the patient whiteboards may be updated – none were correct during the tracer. The clutter in the hallways is dangerous and the handrails are not accessible to patients or staff.

There are no defined quality improvement initiatives at Watson Lake Hospital and there is no Leadership on Quality due to staffing vacancies. There are opportunities to develop one or several, as staff members have highlighted some suggestions, and these would follow a documented PDSA cycle. Some suggestions have been: to update the meal menu and ask patients for menu suggestions; develop a standardized handover summary not unlike the paper based SBAR format; improve the “Snapshot” summary in Meditech; consider opening a couple of long term beds at Watson Lake; consider having an addictions centre at Watson; consider a pediatric satellite MH program at the local school.

Dawson: The commitment to quality and patient safety is evident. Patients are satisfied with the level of care and dedication of the physicians, staff and volunteers.

Standards Set: Medication Management Standards - Direct Service Provision

Unmet Criteria			High Priority Criteria
Priority Process: Medication Management			
2.3	There is an antimicrobial stewardship program to optimize antimicrobial use. NOTE: This ROP applies to organizations providing the following services: inpatient acute care, inpatient cancer, inpatient rehabilitation, and complex continuing care.		ROP
	2.3.4	The program includes interventions to optimize antimicrobial use, such as audit and feedback, a formulary of targeted antimicrobials and approved indications, education, antimicrobial order forms, guidelines and clinical pathways for antimicrobial utilization, strategies for streamlining or de-escalation of therapy, dose optimization, and parenteral to oral conversion of antimicrobials (where appropriate).	**MAJOR**
	2.3.5	The program is evaluated on an ongoing basis and results are shared with stakeholders in the organization.	**MINOR**
6.5	Teams can access an on-site or on-call pharmacist at all times to answer questions about medications or medication management.		!
7.2	A policy on when and how to override CPOE alerts is developed and implemented.		!
11.2	A policy that specifies when and how to override smart infusion pump alerts is developed and implemented.		!
12.6	Look-alike, sound-alike medications; different concentrations of the same medication; and high-alert medications are stored separately, both in the pharmacy and client service areas.		!
13.4	Anesthetic gases and volatile liquid anesthetic agents are stored in an area with adequate ventilation, as per the manufacturer's instructions.		!
15.1	The pharmacist reviews all prescription and medication orders within the organization prior to administration of the first dose.		!
16.4	Sterile products and intravenous admixtures are prepared in a separate area with a certified laminar air flow hood.		!

Surveyor comments on the priority process(es)

Priority Process: Medication Management

The organization has centralized Medication Management services in Whitehorse with the Whitehorse pharmacy dispensing for Watson Lake and Dawson City hospitals. The interdisciplinary Pharmacy and Therapeutics team meets about 8 times a year and the agenda includes requests for new drugs on the formulary, removal of some drugs, review of medication dispensing systems. Orders from all 3 hospitals are received at the Whitehorse pharmacy electronically. Orders are filled and shipped weekly to these hospitals. The satellite hospitals have a pharmacy from which to dispense the first few days' worth of prescriptions. If a medication is not immediately available, the Whitehorse pharmacy orders it from the local retail pharmacy to fill the need in the initial days. The Antimicrobial Stewardship Program has not yet implemented interventions for optimizing antimicrobial use, and no audits are available.

Medication shortages have become so widespread that there is a call for country-wide medication procurement processes.

The introduction of the Meditech EMR and its embedded MAR has improved the medication management process. Further patient safety strategies at Whitehorse include the use of Automated dispensing cabinet. Nursing staff use the Vancouver Island Health Authority medication infusion standards.

The medication storage areas at all 3 hospitals are clean and well lit. There is an issue with slanting shelves at Dawson City hospital, which should be remedied. Doors are kept closed/locked at all the client service areas that were reviewed – bravo!

Standards Set: Mental Health Services - Direct Service Provision

Unmet Criteria		High Priority Criteria
Priority Process: Clinical Leadership		
1.5	Service-specific goals and objectives are developed, with input from clients and families.	
2.3	An appropriate mix of skill level and experience within the team is determined, with input from clients and families.	
2.5	The effectiveness of resources, space, and staffing is evaluated with input from clients and families, the team, and stakeholders.	
Priority Process: Competency		
3.10	Education and training on how to prevent and manage violent or aggressive behaviour using de-escalation techniques are regularly provided to the team.	
Priority Process: Episode of Care		
2.8	The physical security of clients, families and staff is protected in the service setting.	!
6.5	Defined criteria are used to determine when to initiate services with clients.	
8.10	A process to assess the client prior to granting off-unit leave and upon return from leave is followed by the team in partnership with the client and family.	!
9.18	Information relevant to the care of the client is communicated effectively during care transitions. 9.18.5 The effectiveness of communication is evaluated and improvements are made based on feedback received. Evaluation mechanisms may include: • Using an audit tool (direct observation or review of client records) to measure compliance with standardized processes and the quality of information transfer • Asking clients, families, and service providers if they received the information they needed • Evaluating safety incidents related to information transfer (e.g., from the patient safety incident management system).	ROP **MINOR**

10.9	The effectiveness of transitions is evaluated and the information is used to improve transition planning, with input from clients and families.	
Priority Process: Decision Support		
	The organization has met all criteria for this priority process.	
Priority Process: Impact on Outcomes		
13.4	Protocols and procedures for reducing unnecessary variation in service delivery are developed, with input from clients and families.	!
14.1	A proactive, predictive approach is used to identify risks to client and team safety, with input from clients and families.	!
15.1	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.	
15.2	The information and feedback gathered is used to identify opportunities for quality improvement initiatives and set priorities, with input from clients and families.	
15.5	Quality improvement activities are designed and tested to meet objectives.	!
15.8	Indicator data is regularly analyzed to determine the effectiveness of the quality improvement activities.	!
15.9	Quality improvement activities that were shown to be effective in the testing phase are implemented broadly throughout the organization.	!
15.10	Information about quality improvement activities, results, and learnings is shared with clients, families, teams, organization leaders, and other organizations, as appropriate.	
15.11	Quality improvement initiatives are regularly evaluated for feasibility, relevance, and usefulness, with input from clients and families.	
Surveyor comments on the priority process(es)		
Priority Process: Clinical Leadership		

The Yukon Hospital Corporation (YHC) has five beds within the Secure Medical Unit (SMU). This is not a psychiatric or mental health unit, an interesting nuance impacting inpatient mental health care. The unit is intended for stabilization and stays of less than 30 days prior to discharge or transfer to a psychiatric bed outside the Yukon. With the development of the Mental Wellness Unit, the bed number will expand to eight (and potentially twelve) and there is an opportunity for the organization to review the mental health needs of the Yukon population, and work with partners to provide these services across the

continuum of care.

The Mental Wellness and Substance Use Service has personnel resources and the YHC is encouraged to continue conversations with this organization and the government to remove barriers and synergize these resources with overlapping mandates. Cooperation could provide expanded capability within the inpatient environment with daytime programming and a more seamless transition to outpatient resources and services upon discharge.

With the expansion, the organization will need to ensure that the staff complement is suitable to support patient medical and psychiatric needs of inpatients and the wider community. One consideration may be including a hospitalist or nurse practitioner with training in mental health to facilitate standardization of inpatient care, prioritize on and off-service patients and facilitate a coordinated discharge plan in consultation with psychiatry and the mental health nursing team.

Yukon's healthcare system requires ongoing effort and communication to navigate. Including outpatient medical services and community partners to support continuity of care following discharge and reduce the risk of readmission is critical to support patient-centered care throughout the territory. The lack of specialized resources, including social work and nursing, necessitates that barriers to partnerships and sharing patient care responsibilities within a multidisciplinary environment need to be removed.

The team has an opportunity to develop service specific goals and objectives to support mental health programs for the Yukon. Involving patients and families and community partners where applicable is recommended.

First Nation involvement in promoting Indigenous health and link supports to access appropriate services and programs within the hospital and following discharge is a priority. Efforts are ongoing to further develop and support this program.

Variability in admission criteria adherence and support impacts mental health and psychiatry providers. With the development of the new Mental Wellness Unit, there is an opportunity to determine and define the services and model within which inpatient mental health services will be provided in the Yukon.

Resource requirements and gaps are identified and communicated to the organization's leaders. The leadership is unable to action many of the required program changes due to governmental barriers and healthcare silos. This is often perceived by front-line staff as unheard, and the leadership is encouraged to be transparent about the challenges and limitations.

A formal evaluation of the effectiveness of resources and staffing with input from clients, families, the team and stakeholders is recommended to review the patient admission process and programming.

Priority Process: Competency

Non-violent crisis intervention, de-escalation and CODE White training are recommended for the Mental Health team as well as other providers including staff from the emergency department, inpatient units and the security team. Exercising all CODES including CODE White on a regular basis in different areas of the hospital is highly recommended so that staff feel more confident in managing these difficult and unpredictable situations.

The team indicated they received regular hospital-wide and generic nursing training but felt they would benefit from opportunities for further education specific to mental health.

Meditech standardized communication tools and a review of handover processes are recommended to streamline this process. Utilizing Meditech to document the transition of care notes with a standardized title identifying the note as such will assist the nursing team to abbreviate and consolidate reports and minimize the requirement to extend the shift to facilitate this handover.

Concerns that incident reporting does not provide follow-up and an organizational attitude that there is no point in submitting the incident report. The leadership recognizes this issue. Closing the loop on incident reporting to report to the individual or unit from where the incident was reported will be included.

Priority Process: Episode of Care

The mental health team is dynamic and passionate about mental health. Although the unit is not defined as a mental health unit, the team is keen to support the patients through their stabilization and while awaiting transition or transfer to another facility.

The psychiatry team is passionate about mental health and is engaged in outpatient and inpatient care, providing continuity for this complex population. The psychiatry team is relatively new in the Yukon and mental health service planning should consider how the addition of this specialty can best support mental health programs.

Admission of mental health patients through the emergency department requires review, inter-departmental communication and cooperation to ensure that admission criteria are met and that the patient is suitable for transfer. Updating and utilizing admission criteria may help to support decision-making in consultation between the referring and admitting physician. Confirmation that Meditech transfer of care checklists are completed is one tool that may help support decision-making.

A review of processes within the SMU should be reviewed and standardized with attention to safety and risk. One example is to review the smoking policy to ensure that patients have a defined destination and time of return. With the new build, security considerations should be paramount.

Training on the practical elements of using restraints and potential pitfalls is also highly recommended to ensure they have been applied appropriately and meet the intended use requirements for all staff who utilize restraints.

Defined criteria are available for admission to the Secure Medical Unit but the checklist is seldom used. Admissions to the unit are frequently completed without confirmation of suitability and acceptance by the admitting physician.

Priority Process: Decision Support

With the implementation of Meditech, the organization has improved the standardization of protocols, especially on the nursing side with forced functions built into the system. There is further opportunity to review areas that would benefit from further standardization, education around Meditech functionality especially around the transition of care and to gain the perspective of patients and families.

Informally, the team identifies risk areas that have not been formally assessed. Including this assessment as a regular part of group huddles, surveying patients, families and staff or an audit of the physical space may be considered to prevent risks to client and team safety.

Priority Process: Impact on Outcomes

Quality improvement activities are ongoing at a high level but are not communicated to the front-line staff, physicians, patients, and families.

Activities specific to the SMU have not been identified and there is an opportunity for the team to develop their own initiatives that are meaningful to the team. Engagement of front-line staff with sharing of collected metrics, inclusion in quality initiative identification and planning and inclusion of patients and families in these processes is recommended.

Standards Set: Obstetrics Services - Direct Service Provision

Unmet Criteria			High Priority Criteria
Priority Process: Clinical Leadership			
The organization has met all criteria for this priority process.			
Priority Process: Competency			
The organization has met all criteria for this priority process.			
Priority Process: Episode of Care			
8.6	To prevent falls and reduce the risk of injuries from falling, universal precautions are implemented, education and information are provided, and activities are evaluated.		ROP
	8.6.2	Team members and volunteers are educated, and clients, families, and caregivers are provided with information to prevent falls and reduce injuries from falling.	**MAJOR**
	8.6.3	The effectiveness of fall prevention and injury reduction precautions and education/information are evaluated, and results are used to make improvements when needed.	**MINOR**
10.6	A safe surgery checklist is used to confirm that safety steps are completed for a surgical procedure performed in the operating room.		ROP
	10.6.4	The use of the checklist is evaluated and results are shared with the team.	**MINOR**
	10.6.5	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			
The organization has met all criteria for this priority process.			
Surveyor comments on the priority process(es)			
Priority Process: Clinical Leadership			

Nurses are well trained and prepared in Obstetrics as is required. Those not currently working in Maternity that have an interest in this area may be supported to begin with Mentorship opportunities and/or the needed Course (ex. BCIT). In this way, interest opens the door, and staffing is found to be

stable with often someone to call when there are needs.

Competency efforts are strong and frequently are Interprofessional. For example Instructors within this group are trained and available for NRP and Fetal Surveillance. Consider supporting staff time to take these and other key courses as some are not covered, though have local providers. Ie. Fetal Surveillance.

Work to ensure that the WGH hospital wide modules education are completed Examples include Falls, Ethics, and IV pumps (with reassessment of competency and updating). Also work to ensure Performance Appraisals are completed. As this area sometimes gets redeployed, all assessment modules would be helpful. For example Skin pressure assessment tools are relevant and required even if they are often not needed on Obstetrics beyond the first questions.

There is a push on education planned for the fall as well as performance meetings to follow. This is timely. Policy work is dated in some areas, also known as an area for attention.

Priority Process: Competency

Record keeping is standardized and occurs in a hybrid model where some paper based documents are needed which are later scanned into the EMR. Staff are managing this well.

Priority Process: Episode of Care

The unit is warm and welcoming with efforts to provide what birth plans require evident ie) large shower spaces, a birthing pool and birthing ball.
The area is also prepared for urgent and emergent situations including emergency c-section routines.

Clients and families have access to support at all hours and report being very thankful for coming in for assessment when worried or calling the Unit. - "it helped so much”
The connections to care and support, from pregnancy to post delivery is evident. The Solstice Clinic, the Maternity Unit and later, Public Health or the Indigenous Health Centre are all engaged participants.

It was a pleasure to speak with and see the Obstetrics group. Nursing staff were proud and complementary about the close, collegial relationships in place with the interprofessional team and the impact that this has on work-life and patient care. As many are from this community, they not only ‘are the service’ but they ‘use the service’, giving a lens from both sides.

Priority Process: Decision Support

Clients and families have access to support at all hours and report being very thankful for the ability to come in for assessment when worried or call the Unit. “it helped so much”

The connections to care and support from pregnancy to post delivery is evident. The Solstice Clinic, the Maternity Unit and later Public Health or the Indigenous Health Centre are all engaged participants.

Priority Process: Impact on Outcomes

Examples of quality initiatives are present and tracked on this unit. These can be raised through many channels and the interdisciplinary Maternity Newborn Committee which meets monthly, is often a place to begin this process as issues are raised and problem-solved.

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

Unmet Criteria			High Priority Criteria
Priority Process: Clinical Leadership			
The organization has met all criteria for this priority process.			
Priority Process: Competency			
6.11	Team member performance is regularly evaluated and documented in an objective, interactive, and constructive way.		!
Priority Process: Episode of Care			
11.10	Each client's risk for developing a pressure ulcer is assessed and interventions to prevent pressure ulcers are implemented. NOTE: This ROP does not apply to outpatient settings, including day surgery, given the lack of validated risk assessment tools for outpatient settings.		ROP
	11.10.1	An initial pressure ulcer risk assessment is conducted for clients upon admission, using a validated, standardized risk assessment tool.	**MAJOR**
	11.10.2	The risk of developing pressure ulcers is assessed for each client at regular intervals and when there is a significant change in the client's status.	**MAJOR**
	11.10.3	Documented protocols and procedures based on best practice guidelines are implemented to prevent the development of pressure ulcers. These may include interventions to prevent skin breakdown; minimize pressure, shear, and friction; reposition; manage moisture; optimize nutrition and hydration; and enhance mobility and activity.	**MAJOR**
	11.10.4	Team members, clients, families, and caregivers are provided with education about the risk factors and protocols and procedures to prevent pressure ulcers.	**MINOR**
	11.10.5	The effectiveness of pressure ulcer prevention is evaluated, and results are used to make improvements when needed.	**MINOR**
11.11	To prevent falls and reduce the risk of injuries from falling, universal precautions are implemented, education and information are provided, and activities are evaluated.		ROP

11.11.2	Team members and volunteers are educated, and clients, families, and caregivers are provided with information to prevent falls and reduce injuries from falling.	**MAJOR**
11.11.3	The effectiveness of fall prevention and injury reduction precautions and education/information are evaluated, and results are used to make improvements when needed.	**MINOR**
12.11	Information relevant to the care of the client is communicated effectively during care transitions.	ROP
12.11.5	The effectiveness of communication is evaluated and improvements are made based on feedback received. Evaluation mechanisms may include: • Using an audit tool (direct observation or review of client records) to measure compliance with standardized processes and the quality of information transfer • Asking clients, families, and service providers if they received the information they needed • Evaluating safety incidents related to information transfer (e.g., from the patient safety incident management system).	**MINOR**
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
14.3.4	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**
20.17	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		
24.4	Safety improvement strategies are evaluated with input from clients and families.	!
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.	!
25.9	Quality improvement activities that were shown to be effective in the testing phase are implemented broadly throughout the organization.	!
25.11	Quality improvement initiatives are regularly evaluated for feasibility, relevance, and usefulness, with input from clients and families.	
Priority Process: Medication Management		
15.3	Every medication and solution on the sterile field is labeled.	!

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

This is a hard-working department.The Manager was hired in 2021 after a series of turnovers for this role. It is currently dependent on Travel Nurse staff participation as so many services across the country. This department has done well to achieve coverage in this way, as many cannot. Perioperative Leadership and the steady team are key to continuing to attract permanent and temporary nurses.

This is the primary Service for the Yukon. All operative cases for the Yukon are managed at WGH or transferred to another province as needed. A recent Sustainability Plan was developed to document the needs and gaps in this high use and growing service after a closure in the early spring was necessary due to staffing shortages. OR case numbers surpass expectations and this information and data that has been shared with the Government. Attention and evaluation of efforts should continue and be updated to reflect ongoing current and growing needs, including staffing levels for department(s) (ie) MDR workload. Partnerships,work and efforts of all stakeholders is essential.

Other efforts led by the Manager and Leadership to ensure service now include initiatives such as Booking (case scheduling) processes. These have been altered to more accurately reflect complete case time for the team, versus a focus on ‘cut to close’ time. This should assist with planning, slates, and help to relieve staff pressures. The slate order is also being reviewed for best use of resources including staff and flow. One example is a revised ortho case order.

Tests of change to improve function or resources, should continue as pressures continue.

Priority Process: Competency

The current Manager has revised, clarified, and documented staff roles. Positive steps to address flow and maintain a strong service have included increasing positions and reviewing job roles and duties. (Role 1,2 and 3). This approach is positive and essential to ensure skill sets, workload sharing and increase competencies. Staff are positive about these changes.

Staff shared the support from leadership to take Perioperative or other related courses. This was seen as a real benefit for themselves and the organization. One shared, "I'm still here!", highlighting the value of this support for staff, retention, competency, and patient care.

Priority Process: Episode of Care

The Whitehorse General Hospital (WGH) OR has 2 ORs and 1 flex room. In-house there are 4 General, 2 Orthopedic and 2 Obs/Gyn Surgeons. In addition there are a number of visiting specialists that form a strong service which fully utilizes available OR time.

All areas of the perioperative process showed high teamwork and cooperation. The team performed assigned rolls and looked to assist others whenever available.
Close attention is paid to the slate and needs for the day. A delayed patient arrival was immediately observed, followed up on, and well communicated.

The department collects and submits both data and information on an ongoing basis. Key events and initiatives have taken priority in recent years. It is now time to renew quality improvement efforts in a deliberate way. There are 2 CPL's for this service who may be ideal to lead with this work in partnership with a QI team member. There are many areas to begin with including gaps in Accreditation ROP work. In addition, the team may choose meaningful goals and objectives based on statistics currently collected; and further work to improve flow; slates processes; or staff roles and engagement. Make it meaningful for Periop.

A plan will get things started. Engage QI, leaders, and the team. then they are encouraged to share it and post it.

Intraoperatively teamwork is evident with the interprofessional team working together to facilitate a smooth start, procedure and ending, up to and including patient transfers to the stretcher at case end.

Throughout the phases of care, communication was observed and well done. Highlights include the adoption of the Safe Surgery Checklist with 3 critical stages; and the transition of care handoff from OR to Recovery Room. The patient and OR team was received by a two nurse intake, where one nurse is focused on transition communication and one continuously able to focus on the patient. Safe Surgery and Transitions require evaluation as per best practice with review and implementation of any improvements.

All charts assessed were found to have discharge education present and in a format ready for patient teaching and departure. This is a great approach.

With the new electronic record required information and assessments are prompted in most cases but not all. Leaders and staff are encouraged to identify gaps in the chart for improvement efforts. For example, for inpatients- the required pressure ulcer risk assessment tool was not easily found and not found in use.

Throughout the day, patients were appreciative about care, and the attention to detail regarding their needs that all care providers displayed. Person and family centred care was present at each step.

When staff were asked about the best thing about WGH, they universally stated, “It’s the people” or “the team” that they feel are the best things about work. Well done!

Priority Process: Decision Support

The new Meditech electronic record is in place. This moves the efforts and benefit of one shared and continuous patient care record forward. Gaps and the need for ongoing education were identified, but all are committed to this key step in record keeping.

Parts of the record are completed on a paperbased process and later scanned into the EMR. This presents an opportunity to carry out ongoing assessment evaluation and improvements on this blended process.

Priority Process: Impact on Outcomes

The department collects and submits both data and information on an ongoing basis. Key events and initiatives have taken priority in recent years. It is now time to renew quality improvement efforts in a deliberate way. There are 2 CPL’s for this service who should be ideal to lead with this work in partnership with a QI team member. There are many areas to begin with including gaps in the Accreditation ROP work. In addition, the team may choose meaningful goals and objectives based on statistics currently collected; current and further work to improve flow; slates processes; or staff roles and engagement.

The team is encouraged to make it meaningful for Periop.

A plan will get things started. Engage QI, leaders, and the team. The team is encouraged to share it and post it.

Priority Process: Medication Management

Strong focus with professions showing accountability with their areas of accountability. Medication areas and emergency supplies are monitored and secure.

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

Unmet Criteria		High Priority Criteria
Priority Process: Point-of-care Testing Services		
1.3	The lab director or suitably qualified health care professional works with an interdisciplinary professional committee to define the scope of services and oversee the delivery of POCT. CSA Reference: Z22870:07, 4.1.2.	
1.4	The interdisciplinary committee review POCT quality control data on an annual basis and make improvements as needed. CSA Reference: Z22870:07, 5.6.6.	
3.3	The organization evaluates the performance of health care professionals delivering POCT annually. CSA Reference: Z22870:07, 5.1.5.	
3.4	As part of their performance evaluation, health care professionals delivering POCT must routinely demonstrate their competence. CSA Reference: Z22870:07, 5.1.5.	
4.1	The organization has SOPs for each point-of-care test it performs.	
4.2	Each SOP contains the title and purpose of the SOP, number of pages, unique identification number, date it was implemented or revised, signature of the authorizing person(s) and date of authorization, steps to be followed in the procedure, and the individual responsible for checking, reviewing, and approving the SOP.	
4.4	The organization places the SOPs in areas where health care professionals delivering POCT can easily access them.	
4.6	The lab director or suitably qualified health care professional annually reviews and evaluates the effectiveness of the SOPs and adjusts the SOPs, training activities, or monitoring processes as necessary.	
4.7	The lab director or suitably qualified health care professional reviews the SOPs following a patient safety incident, changes in regulatory or legal requirements, internal or external audits, and other situations as defined in the organization's policies.	
5.6	The organization removes all POCT equipment that are inappropriate, non compliant, deteriorated, and substandard.	!

7.5	Immediately prior to performing the point-of-care test, the health care professional verifies that the POCT equipment is in proper working order by means of a quality control check.	
9.2	Before releasing any test results, health care professionals delivering POCT verify that the results comply with set acceptability criteria.	
10.1	The organization has a POCT quality improvement process. CSA Reference: Z22870:07, 4.2.2, 4.2.4.	!
10.2	The lab director or suitably qualified health care professional develops and maintains a POCT quality improvement manual.	
10.3	The lab director or suitably qualified health care professional communicates the quality improvement policies to health care professionals delivering POCT and verifies that they follow them.	
10.4	The organization regularly monitors a set of POCT quality indicators.	
10.6	Health professionals delivering POCT gather and record quality control data for each point-of-care test.	!

Surveyor comments on the priority process(es)

Priority Process: Point-of-care Testing Services

The Point of Care Testing (POCT) program at Whitehorse General Hospital (WGH) has the overall responsibility for certification, maintenance, and quality assurance of the POCT devices throughout the main hospital and other satellite locations. The POCT lead is commended for her dedication and commitment to improving the program.

At Whitehorse General Hospital (WGH), POCT testing is offered for Glucose, urinalysis, b-HCG and Covid testing. There are over 800 users listed as Glucometer users in the Lab Information System, however an accurate number is accurate to obtained as there is a high turn over rate and the amount of agency nurses that come and goes.

Staff performing POCT must complete initial training and competency assessment on each device they will be operating, before being granted access for testing. Competency assessments are done annually, and re-certification is given to successful staff.

Quality control for urinalysis is performed for laboratory staff and devices are exchanged daily and QC results for the Glucometers are automatically loaded in the middleware. Challenges were reported with correctly performing quality control for pregnancy tests at ED. Team will benefit from implementing HCG testing on the Clinitek Status as this machine offers a lock out feature when QC fails.

Nurses reported that having easy access to SOPs for POCT testing available to the users will be beneficial

for the program and improve compliance to expectations,

There is an External Quality Assurance program for each POCT test.

WGH is encouraged to establish a multidisciplinary POCT Advisory Committee that assists in evaluating, selecting, and implementing POCT devices/tests throughout WGH and satellite sites, as well as reviews the overall performance of the program, discuss non-conformances, POCT requests and opportunities for improvements.

At Dawson City Community Hospital (DCCH), an extensive menu of POCT testing is conducted. In ED and while the central POCT lab is opened, nurses perform testing for urinalysis, b-HCG, and glucose. Additional POCT testing (i.e., CBC, liver function test, routine chemistry, fetal fibronectin, and urine microscopic examinations) is also done by a technologist that conducts lab and imaging procedures and uses a variety of lab devices to perform the testing. After hours and during weekends, nurses have access to the lab POCT equipment, reagents, and supplies.
Due to the high levels of nurse staff turnover, proper orientation and training is difficult to achieve. The team reported numerous issues such as missing results, inadequate QC and QA practices, and potential lab errors. The physician leader commented that the existing lab staffing model is not sustainable to provide timely patient care.

Significant challenges with document control practices were observed, including obsolete documents available to users, posted abridge instructions and proper document template/parameters.

Noncompliance with competency assessments, quality assurance, correlation studies and “EQA testing by the users” practices were noted. Nursing leaders are invited to review and discuss the model with the POCT coordinator/lab management in conjunction with physicians to implement a solid POCT model at all sites that guarantee accurate and reliable results, so the clinicians can treat and manage clients accordingly.

Standards Set: Transfusion Services - Direct Service Provision

Unmet Criteria		High Priority Criteria
Priority Process: Episode of Care		
The organization has met all criteria for this priority process.		
Priority Process: Transfusion Services		
5.2	The team has access to SOPs that apply to the activities they carry out.	
5.3	The team reviews and updates the SOPs every two years or more often if required.	
5.4	The team follows a document control procedure for developing and maintaining SOPs.	

Surveyor comments on the priority process(es)

Priority Process: Episode of Care

Whitehorse General Hospital (WGH) has implemented several fall precautions to ensure a safe environment that prevents falls and reduces the risk of injuries from falling

Priority Process: Transfusion Services

An experienced technologist leads the Transfusion Medicine service at Whitehorse General Hospital. The service is provided 24/7 by dedicated technologists. Orientation and initial training and competency assessment is well done. Records are available.

Over 550 units of red blood cells (RBC) are transfused annually. The team also prepares and releases Platelets, Fresh Frozen Plasma and Cryoprecipitate. The service is adjacent to core lab areas. The access to the testing area is controlled.

Blood issuing and administration follows a very comprehensive process that includes the proper identification and labelling of the blood product, the record of the person picking up the product and the documentation of the patient identifiers prior to transfusion. In addition, vital signs prior, during and post transfusion are recorded.

A significant number of policies and procedures from blood collection, labelling storing, testing, and releasing and transportation have been developed. However, a systematic process for the reviewing and updating of these documents is yet to be implemented and several documents have not been reviewed in years. Turnaround expectations for urgent, elective, and STAT orders are defined, however they are not tracked in a consistent basis.

Several physicians and other key stakeholders attend the Transfusion Medicine committee. Meetings are held on a quarterly basis. Minutes are available. There is an opportunity to revise the existing model in line with international guidelines.

Red Blood Cells (RBC) units are stored in dedicated blood bank fridges. Fresh Frozen Plasma and Cryoprecipitate are kept in a separate freezer. The temperature of these equipment is monitored. An audible mechanism-alarm have been installed for the fridges and freezer. There is a platelet shaker.

The team performs an ABO typing, DAT, and Antibody Screen. Antibody investigation is referred out to Canadian Blood Services.
It was reported that the team has been unable to implement a criterion for the proper use of O negative blood (e.g., women at childbearing age and young kids) due to limitations with the TM LIS.

O negative is also issued during emergency crossmatching requests until an ABO is performed and blood specific units are issues. Immediately prior to release, the team visually inspects and documents all blood bags for leakage or other abnormalities. Blood is usually picked up and transported by nurses.

The process to follow during massive transfusion protocol (MTP) was discussed. Problems around timely de-activation of the protocol were noted. The team is invited to develop a separate procedure to describe in detail step by step the activities around activation, during the episode and post/deactivation of the MTP and consider the new name massive hemorrhage protocol (MHP).

The configuration of the TM physical space at WGH added to the ongoing staffing pressures presents challenges regarding the installation of new equipment (e.g., MTS gel centrifuge/incubator and plasma thawer).

Physicians at Dawson shared scenarios of chronic anemic patients where RBC units should be transfused without delays or for elder patients that do not wish to travel to WGH. If implemented, the team is encouraged to consider this request, including benefits and risks, and develop proper quality assurance mechanisms.

Instrument Results

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

Governance Functioning Tool (2016)

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

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

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

- **Data collection period: July 14, 2022 to August 10, 2022**
- **Number of responses: 6**

Governance Functioning Tool Results

	% Strongly Disagree / Disagree	% Neutral	% Agree / Strongly Agree	%Agree * Canadian Average
	Organization	Organization	Organization	
1. We regularly review and ensure compliance with applicable laws, legislation, and regulations.	0	0	100	93
2. Governance policies and procedures that define our role and responsibilities are well documented and consistently followed.	0	0	100	94
3. Subcommittees need better defined roles and responsibilities.	80	0	20	70
4. As a governing body, we do not become directly involved in management issues.	0	0	100	87
5. Disagreements are viewed as a search for solutions rather than a “win/lose”.	0	0	100	95

	% Strongly Disagree / Disagree	% Neutral	% Agree / Strongly Agree	%Agree * Canadian Average
	Organization	Organization	Organization	
6. Our meetings are held frequently enough to make sure we are able to make timely decisions.	17	0	83	95
7. Individual members understand and carry out their legal duties, roles, and responsibilities, including subcommittee work (as applicable).	0	0	100	95
8. Members come to meetings prepared to engage in meaningful discussion and thoughtful decision making.	0	0	100	92
9. Our governance processes need to better ensure that everyone participates in decision making.	50	17	33	61
10. The composition of our governing body contributes to strong governance and leadership performance.	17	0	83	92
11. Individual members ask for and listen to one another's ideas and input.	0	17	83	95
12. Our ongoing education and professional development is encouraged.	0	0	100	89
13. Working relationships among individual members are positive.	0	0	100	95
14. We have a process to set bylaws and corporate policies.	0	0	100	93
15. Our bylaws and corporate policies cover confidentiality and conflict of interest.	0	0	100	96
16. We benchmark our performance against other similar organizations and/or national standards.	17	17	67	77
17. Contributions of individual members are reviewed regularly.	20	20	60	71
18. As a team, we regularly review how we function together and how our governance processes could be improved.	17	17	67	77
19. There is a process for improving individual effectiveness when non-performance is an issue.	60	0	40	64

	% Strongly Disagree / Disagree	% Neutral	% Agree / Strongly Agree	%Agree * Canadian Average
	Organization	Organization	Organization	
20. As a governing body, we regularly identify areas for improvement and engage in our own quality improvement activities.	0	0	100	83
21. As individual members, we need better feedback about our contribution to the governing body.	0	0	100	44
22. We receive ongoing education on how to interpret information on quality and patient safety performance.	0	0	100	78
23. As a governing body, we oversee the development of the organization's strategic plan.	0	0	100	94
24. As a governing body, we hear stories about clients who experienced harm during care.	0	20	80	82
25. The performance measures we track as a governing body give us a good understanding of organizational performance.	0	0	100	91
26. We actively recruit, recommend, and/or select new members based on needs for particular skills, background, and experience.	40	20	40	88
27. We lack explicit criteria to recruit and select new members.	67	0	33	79
28. Our renewal cycle is appropriately managed to ensure the continuity of the governing body.	50	17	33	87
29. The composition of our governing body allows us to meet stakeholder and community needs.	17	0	83	87
30. Clear, written policies define term lengths and limits for individual members, as well as compensation.	17	0	83	92
31. We review our own structure, including size and subcommittee structure.	33	17	50	86
32. We have a process to elect or appoint our chair.	20	20	60	87

Overall, what is your assessment of the governing body's impact over the past 12 months, in terms of driving improvements to:	% Poor / Fair	% Good	% Very Good / Excellent	%Agree * Canadian Average
	Organization	Organization	Organization	
33. Patient safety	0	40	60	83
34. Quality of care	0	40	60	82

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

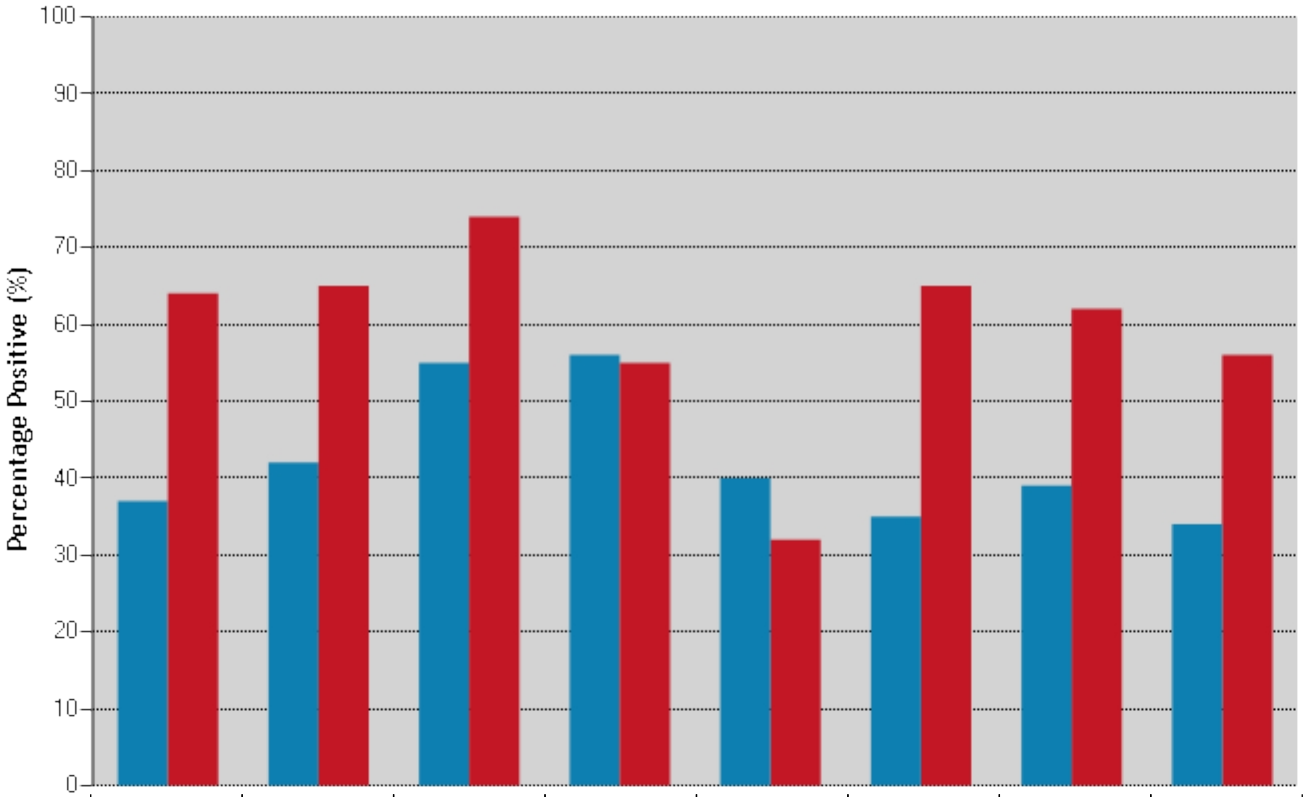
Canadian Patient Safety Culture Survey Tool

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

Results from the Patient Safety Culture Tool allow the organization to identify strengths and areas for improvement in a number of areas related to patient safety and worklife. Accreditation Canada provided the organization with detailed results from its Patient Safety Culture Tool prior to the on-site survey through the client organization portal. The organization then had the opportunity to address areas for improvement. During the on-site survey, surveyors reviewed progress made in those areas.

- **Data collection period: June 1, 2021 to May 31, 2022**
- **Minimum responses rate (based on the number of eligible employees): 160**
- **Number of responses: 164**

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
	37%	42%	55%	56%	40%	35%	39%	34%
	64%	65%	74%	55%	32%	65%	62%	56%

Legend

Yukon Hospital Corporation

* Canadian Average

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

Worklife Pulse

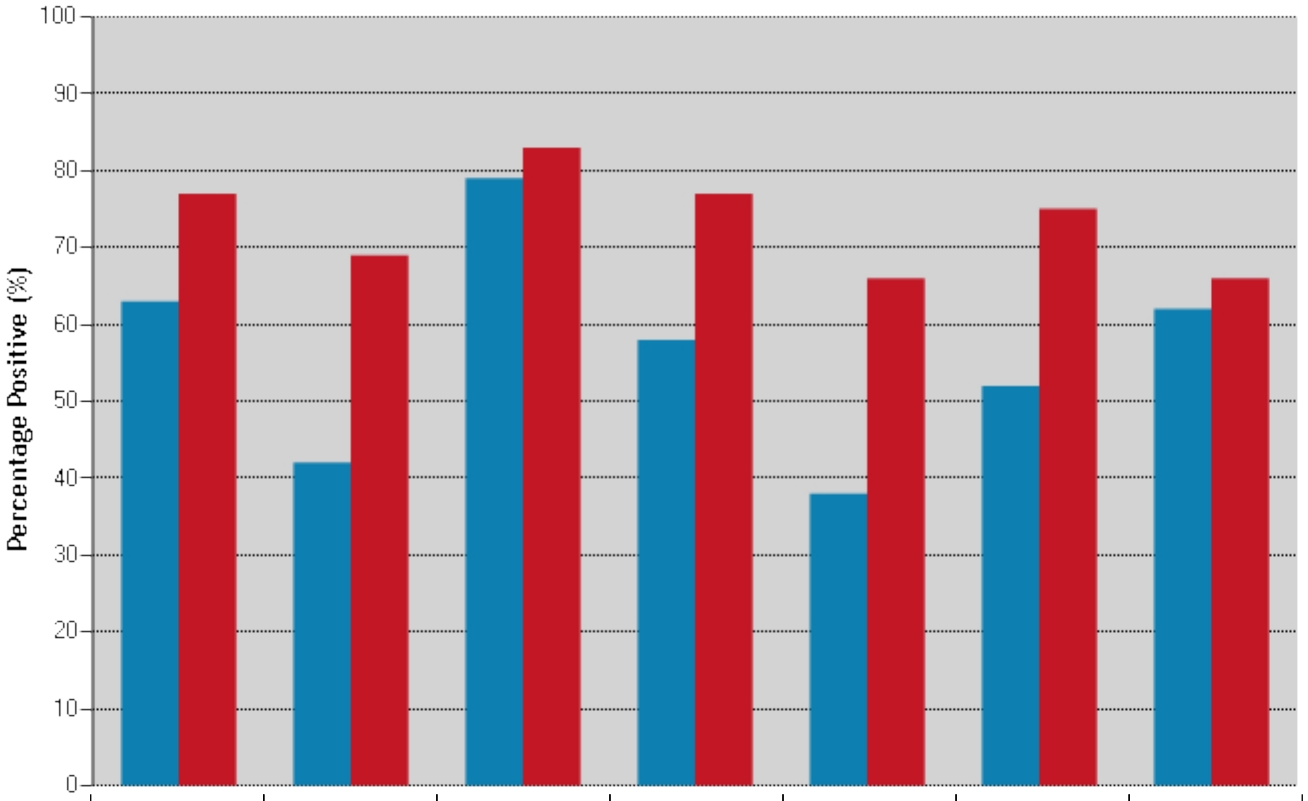
Accreditation Canada helps organizations create high quality workplaces that support workforce wellbeing and performance. This is why Accreditation Canada provides organizations with the Worklife Pulse Tool, an evidence-informed questionnaire that takes a snapshot of the quality of worklife.

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 6, 2021 to June 10, 2022**
- **Minimum responses rate (based on the number of eligible employees): 200**
- **Number of responses: 212**

Worklife Pulse: Results of Work Environment



	Job	Training and Development	Coworkers	Immediate Supervisor	Senior Management	Safety and Health	Overall Experience
	63%	42%	79%	58%	38%	52%	62%
	77%	69%	83%	77%	66%	75%	66%

Legend

Yukon Hospital Corporation

* Canadian Average

*Canadian average: Percentage of Accreditation Canada client organizations that completed the instrument from July to December, 2022 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
Population Health and Wellness	Promoting and protecting the health of the populations and communities served through leadership, partnership, and innovation.

Priority processes associated with service excellence standards

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

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