ACCREDITATION
AGRÉMENT
CANADA
Qmentum

Accreditation Report

Yukon Hospital Corporation

Whitehorse, YT

On-site survey dates: May 28, 2018 - June 1, 2018

Report issued: July 10, 2018

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 2018. Information from the on-site survey as well as other data obtained from the organization were used to produce this Accreditation Report.

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

Confidentiality

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

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

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

A Message from Accreditation Canada

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

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

Your Client Engagement 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, 2018 to June 1, 2018**

- **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. Perioperative Services and Invasive Procedures - Service Excellence Standards
  12. Reprocessing of Reusable Medical Devices - Service Excellence Standards
  13. Transfusion Services - Service Excellence Standards

- **Instruments**

  The organization administered:

  1. Governance Functioning Tool (2016)
  2. Canadian Patient Safety Culture Survey Tool
  3. Worklife Pulse
  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)	40	4	0	44
 Accessibility (Give me timely and equitable services)	65	3	3	71
 Safety (Keep me safe)	498	45	53	596
 Worklife (Take care of those who take care of me)	101	7	1	109
 Client-centred Services (Partner with me and my family in our care)	227	25	7	259
 Continuity (Coordinate my care across the continuum)	56	0	2	58
 Appropriateness (Do the right thing to achieve the best results)	715	77	18	810
 Efficiency (Make the best use of resources)	50	6	3	59
Total	**1752**	**167**	**87**	**2006**

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	49 (98.0%)	1 (2.0%)	0	34 (94.4%)	2 (5.6%)	0	83 (96.5%)	3 (3.5%)	0
Leadership	50 (100.0%)	0 (0.0%)	0	88 (91.7%)	8 (8.3%)	0	138 (94.5%)	8 (5.5%)	0
Infection Prevention and Control Standards	39 (97.5%)	1 (2.5%)	0	27 (93.1%)	2 (6.9%)	2	66 (95.7%)	3 (4.3%)	2
Medication Management Standards	72 (98.6%)	1 (1.4%)	5	50 (94.3%)	3 (5.7%)	11	122 (96.8%)	4 (3.2%)	16
Biomedical Laboratory Services	70 (98.6%)	1 (1.4%)	0	102 (97.1%)	3 (2.9%)	0	172 (97.7%)	4 (2.3%)	0
Cancer Care	77 (97.5%)	2 (2.5%)	22	110 (98.2%)	2 (1.8%)	16	187 (97.9%)	4 (2.1%)	38
Diagnostic Imaging Services	59 (92.2%)	5 (7.8%)	3	67 (98.5%)	1 (1.5%)	1	126 (95.5%)	6 (4.5%)	4
Emergency Department	60 (85.7%)	10 (14.3%)	1	88 (82.2%)	19 (17.8%)	0	148 (83.6%)	29 (16.4%)	1

Standards Set	High Priority Criteria *			Other Criteria			Total Criteria (High Priority + Other)		
	Met	Unmet	N/A	Met	Unmet	N/A	Met	Unmet	N/A
	# (%)	# (%)	#	# (%)	# (%)	#	# (%)	# (%)	#
Inpatient Services	52 (88.1%)	7 (11.9%)	1	69 (85.2%)	12 (14.8%)	4	121 (86.4%)	19 (13.6%)	5
Mental Health Services	42 (85.7%)	7 (14.3%)	1	76 (83.5%)	15 (16.5%)	1	118 (84.3%)	22 (15.7%)	2
Perioperative Services and Invasive Procedures	102 (90.3%)	11 (9.7%)	2	97 (89.0%)	12 (11.0%)	0	199 (89.6%)	23 (10.4%)	2
Reprocessing of Reusable Medical Devices	80 (95.2%)	4 (4.8%)	4	37 (94.9%)	2 (5.1%)	1	117 (95.1%)	6 (4.9%)	5
Transfusion Services	55 (79.7%)	14 (20.3%)	6	55 (82.1%)	12 (17.9%)	2	110 (80.9%)	26 (19.1%)	8
Total	**807 (92.7%)**	64 (7.3%)	45	900 (90.6%)	93 (9.4%)	38	1707 (91.6%)	157 (8.4%)	83

* Does not includes ROP (Required Organizational Practices)

Overview by Required Organizational Practices

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

This table shows the ratings of the applicable ROPs.

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Safety Culture			
Accountability for Quality (Governance)	Met	4 of 4	2 of 2
Patient safety incident disclosure (Leadership)	Met	4 of 4	2 of 2
Patient safety incident management (Leadership)	Met	6 of 6	1 of 1
Patient safety quarterly reports (Leadership)	Met	1 of 1	2 of 2
Patient Safety Goal Area: Communication			
Client Identification (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)	Met	1 of 1	0 of 0

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Communication			
Client Identification (Mental Health Services)	Met	1 of 1	0 of 0
Client Identification (Perioperative Services and Invasive Procedures)	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)	Unmet	4 of 4	0 of 1
Information transfer at care transitions (Mental Health Services)	Unmet	4 of 4	0 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	4 of 4	2 of 2
Medication reconciliation at care transitions (Cancer Care)	Met	7 of 7	0 of 0
Medication reconciliation at care transitions (Emergency Department)	Met	4 of 4	0 of 0

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Communication			
Medication reconciliation at care transitions (Inpatient Services)	Unmet	4 of 5	0 of 0
Medication reconciliation at care transitions (Mental Health Services)	Unmet	4 of 5	0 of 0
Medication reconciliation at care transitions (Perioperative Services and Invasive Procedures)	Met	8 of 8	0 of 0
Safe Surgery Checklist (Perioperative Services and Invasive Procedures)	Met	3 of 3	2 of 2
The “Do Not Use” list of abbreviations (Medication Management Standards)	Met	4 of 4	3 of 3
Patient Safety Goal Area: Medication Use			
Antimicrobial Stewardship (Medication Management Standards)	Met	4 of 4	1 of 1
Concentrated Electrolytes (Medication Management Standards)	Met	3 of 3	0 of 0
Heparin Safety (Medication Management Standards)	Met	4 of 4	0 of 0
High-Alert Medications (Medication Management Standards)	Unmet	4 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

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

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Infection Control			
Infection Rates (Infection Prevention and Control Standards)	Met	1 of 1	2 of 2
Patient Safety Goal Area: Risk Assessment			
Falls Prevention Strategy (Cancer Care)	Unmet	3 of 3	1 of 2
Falls Prevention Strategy (Diagnostic Imaging Services)	Unmet	3 of 3	1 of 2
Falls Prevention Strategy (Emergency Department)	Unmet	3 of 3	1 of 2
Falls Prevention Strategy (Inpatient Services)	Met	3 of 3	2 of 2
Falls Prevention Strategy (Mental Health Services)	Met	3 of 3	2 of 2
Falls Prevention Strategy (Perioperative Services and Invasive Procedures)	Met	3 of 3	2 of 2
Pressure Ulcer Prevention (Inpatient Services)	Met	3 of 3	2 of 2
Pressure Ulcer Prevention (Perioperative Services and Invasive Procedures)	Met	3 of 3	2 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

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Risk Assessment			
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 members of the board are appointed by the Ministry of Health and Social Services and the Chair is appointed by the Minister of health and Social Services. The Hospital Act requires the Minister of Health and Social services to consult with the municipalities of Dawson City, Watson Lake and Whitehorse regarding the appointments and report that consultation to the Commissioner of the Executive Council who makes recommendation to the Minister.

The community partners focus group had representatives from Health and Social Services, Yukon Emergency Medical Services, Emergency Management Services, Public Health and Adult Protection. The consensus among all groups was that the Yukon Hospital corporation was a collaborative partner in the delivery of services in all areas of the territory. There is good collaboration and sharing with community partners along with strong partnership with government. The hospital does an excellent job leveraging community partnerships for Emergency Preparedness.

The leadership team is strong and the Executive Team has been restructured. They are focused on creating an environment of passionate and engaged people with strong clinical and management leads in place. They have effectively integrated the two new hospitals into the current hospital corporation. They have established a culture of patient safety. Redevelopment and expansion of the emergency department and the operating room demonstrates their commitment to enhancing service delivery.

Staffing and worklife are very robust with a strong sense of teamwork. Staff are dedicated and committed to exceptional patient care and physician engagement and responsiveness is also exceptional.

The Yukon Hospital Corporation provides a full array of acute care services to the territory with plans to continue expansion of services for mental health,outpatients and elder care.Staff are patient and family focused with emphasis on efficient and safe patient care.

Surveyors received very positive feedback from patients and families encountered during this accreditation visit. First Nation Health Programs provide a patient and family focused approach while incorporating traditional practices. As stated by a patient "I feel safe and they treat me like family".

Detailed Required Organizational Practices

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

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

Unmet Required Organizational Practice	Standards Set
Patient Safety Goal Area: Communication	
Information transfer at care transitions Information relevant to the care of the client is communicated effectively during care transitions.	· Inpatient Services 10.16 · Perioperative Services and Invasive Procedures 12.11 · Emergency Department 12.16 · Mental Health Services 9.18
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.	· Mental Health Services 8.6 · Inpatient Services 9.7
Patient Safety Goal Area: Medication Use	
High-Alert Medications A documented and coordinated approach to safely manage high-alert medications is implemented.	· Medication Management Standards 2.5
Patient Safety Goal Area: Risk Assessment	
Falls Prevention Strategy To minimize injury from falls, a documented and coordinated approach for falls prevention is implemented and evaluated.	· Emergency Department 10.6 · Diagnostic Imaging Services 15.6 · Cancer Care 15.7

Detailed On-site Survey Results

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

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

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

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

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

See Appendix B for a list of priority processes.

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

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

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

Priority Process Results for System-wide Standards

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

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

Priority Process: Governance

Meeting the demands for excellence in governance practice.

Unmet Criteria	High Priority Criteria
Standards Set: Governance	
12.7 The governing body demonstrates a commitment to recognizing team members for their quality improvement work.	

Surveyor comments on the priority process(es)

The YHC board is currently in a transition period with 4 of the 9 member board remaining and 5 new members being appointed by the Yukon government. The board members represent the various areas of the Yukon and are the voice of their communities while working together to provide a safe and accountable health care system for all Yukoners.

All members of the board are appointed by the Ministry of Health and Social Services and the Chair is appointed by the Minister. The Hospital Act requires the Minister of Health and Social services to consult with the municipalities of Dawson City, Watson Lake and Whitehorse regarding the appointments of residents and report upon the consultations to the Commissioner of the Executive Council.

In respect to the operations of the board and the activities and programs of YHC, the Commissioner is required by the act to take into consideration suitable criteria which includes knowledge, experience and competence.

The board members all receive letters of expectations from the department of health outlining expectations, role and length of term.

The three main responsibilities under performance management for the board include Accreditation guidelines, performance reports and the year in review.

Currently there has been a change to the Hospital Act and to the corporate bylaws and a total review is being conducted leaving the boards roles and responsibilities in a development stage. The board is able to review and provide input during this time.

The Chair of the board meets with the Minister and Deputy Minister on a quarterly basis to discuss capital objectives, new innovation and additional challenges of the organization.

The board was very engaged in the development of the Strategic Plan 2018-2022 and worked with stakeholders and Leadership during the 9 months of development of the plan. They continue to provide input for adoption of the new plan.

Standing items on the board's agenda include but are not limited to: Patient Experience Moment, Quality Report, Medication Incidents, Falls program, Occupancy and Financial report.

The board has been very involved over the last term with the amendment of the Medical Staff Bylaws, under the direction of the Minister, as to allow Nurse Practitioners (NP) to practice within Yukon's hospital under the direction of the Medical Bylaws. The final approval of the amendments is from the Minister.

CEO performance is reviewed Quarterly with an annual performance review by the board of trustees. The individual trustees are assessed by the Chair and the Chair's performance is assessed.

The structure for granting privileges is carried out by the Medical Advisory Committee and the Chief Medical Officer who reviews credentials and training as well as the mandate and scope of services. They recommend individuals to the board of trustees who in turn grants privileges. The process for termination of privileges would follow the same process as an investigation and recommendation to the board of trustees for removal.

Priority Process: Planning and Service Design

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

Unmet Criteria	High Priority Criteria
Standards Set: Leadership	
4.12 Policies and procedures for all of the organization's primary functions, operations, and systems are documented, authorized, implemented, and up to date.	

Surveyor comments on the priority process(es)

The values are communicated orally and in the form of handouts, pamphlets, or posters and are visible throughout the facility. The behaviour of the organization's leaders aligns with the organization's values. The organization's leaders consider the values in decision-making and other processes.

The 90 day business plan is being used for quality improvement purposes and provides direction for the corporation.
It is suggested going forward, to align the service objectives with the strategic plan and to define indicators that will evaluate their objectives. This will support future planning and direction for services.

The process to develop or update the mission statement with input from team members, clients, families, and key stakeholders is conducted through patient and client surveys and face to face with external stakeholders (ie: EMS, DHS and Senior Advocate groups)

Management systems and tools are selected to support coordination, assessment, and evaluation of organizational processes and services, including decision making processes.

The information gathered regarding the community is used to understand how the organization's mandate and services contribute to meeting the community's needs, and to identify service gaps.The information is provided through Yukon Bureau of Stats(age trends, growth patterns), Public Health as well as data from Health Social Services.

Partnerships are developed with other organizations in the community to efficiently and effectively deliver and coordinate services to meet client's needs.

A structured process is used to identify and analyze actual and potential risks or challenges in all areas of the organization.

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 financial policies include generally accepted accounting principles (GAAP), and board or government guidelines. Operating and capital budgets demonstrate that resources are appropriately allocated throughout the organization.

The operating budget tracks the organization's variances within different departments/units supplies as well as the costs of services. When preparing the annual operating and capital budgets, the organization's strategic goals/priorities are considered, and input is sought from team members.

There is a process to have annual operating and capital budgets approved by the governing body.

Budgets are monitored and regular reports are generated on the organization's financial performance into their reporting structure on a monthly bases or as needed.

The organization's leaders verify that the organization meets legal requirements for managing financial resources and financial reporting, e.g., audit, running a deficit.

Priority Process: Human Capital

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

Unmet Criteria	High Priority Criteria
Standards Set: Leadership	
2.11 Team members' fatigue and stress levels are monitored and work is done to reduce safety risks associated with fatigue and stress.	

Surveyor comments on the priority process(es)

A policy regarding reporting, investigating, and resolving behaviour that contravenes the code of conduct is developed and implemented.

Continuing professional development and learning is supported. Part of individual work plans are assessed through performance evaluations.

An immunization policy and associated procedures, which include recommending specific immunizations for team members is in place.

The quality of the organization's work life culture is monitored using an adapted Work Life Pulse Tool, approved by Accreditation Canada. The individual unit/departments managers are required to follow up with staff to discuss areas of improvement that were identified in their specific area of work.

A well being program is in place to support staff in healthy living. There are policies which apply to all care providers in Yukon's Hospitals to ensure safe patient handling procedures to minimize the risk of injury to staff and ensure safe, quality of care for patients.

Priority Process: Integrated Quality Management

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

Unmet Criteria	High Priority Criteria
Standards Set: Leadership	
3.11 Team members, clients, and families who participate in quality improvement initiatives are recognized for their work.	

Surveyor comments on the priority process(es)

The Safety Reporting System is well detailed and meets AC standards in regards to reporting on harmful, no-harm, and near misses. The safety reporting system is simple (few steps), clear (what needs to be reported, how to report, and to whom), confidential, and focused on system improvement.The reporting system is easy to access and is on the desktop of computers in the unit/department throughout the facilities.

The responsibility for the patient safety plan is assigned to the Quality Management Council whose mandate includes organization-wide patient safety; they have a designated team member with responsibility for patient safety whose mandate is to facilitate and improve patient safety throughout the organization.

The Global Trigger Tool is utilized to notify leaders of safety issues as it is an objective measure of harm. The safety incidents are reported to executive leadership monthly (or as appropriate) and is a standing agenda item on the Board of Trustees monthly meetings.

Disclosure policies are in place for areas that are identified by criteria for disclosure to family and clients with support services if needed.

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)

An ethics framework to support ethical practice is developed or adopted, and implemented.

The 5 step process that defined in the ethics framework encourages anyone involved with the organization to raise ethical issues and concerns, confidentially if necessary.

The process includes criteria to guide discussions and decision making about ethical issues.Training in the ethics framework has been provided to staff (ethics learning lunch) as well as to the board of trustees.

Code of conduct policy is in place and is part of the orientation and mandatory education.

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's leaders work with the governing body to identify and collaborate with external stakeholders.

A communication plan is in place with key messages in the areas of: results of safety audits, recognition for audit completion, statistics on employee incidents, clarity of work procedures, shared actions required and taken to improve safety, improvements of the employee role in assuring personal safety and contributing to corporate safety.

Corporate communication tools include the current newsletter, e-memo, digital media, intra-web, special publication and bulletin board (permanent or temporary/event-specific).

The CEO report is a standing item on the boards agenda. Standing items on the board's agenda include but are not limited to: Patient Experience Moment, Quality Report, Medication Incidents, Falls program, Occupancy and Financial report.

The Leaders of the organization elevate the quality and usefulness of the organizations' data and information regularly and the elevation results are used to improve the information systems.

Priority Process: Physical Environment

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

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

The physical space meets applicable laws, regulations, and codes.

Initiatives are undertaken to minimize the impact of the organization's operations on the environment.; for example in the areas of Heat Recovery systems, LED Light replacement and motion sensor lighting.

Heating, ventilation and medical gas systems all meet standards in the areas of preventative maintenance, annual inspections by appropriate regulators and certifications if required.

Infection Prevention and Control representaitives are involved in planning for renovations to ensure compliance to IPC procedures and in maintaining a safe environment for staff and clients.

Priority Process: Emergency Preparedness

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

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

IPC work with other stakeholders in developing Pandemic Plan and Ebola plans. For example they contract out to an Infectious disease specialist who shares best practices and evidence based ressearch as well as conduct a gap analysis and provide advice on surgical infections, hospital acquire infections (HAI).

There are policies and procedures for identifying and responding to outbreaks in line with applicable regulations.

Team members and volunteers are provided with access to policies and procedures for identifying and managing outbreaks. Cheat sheets are available for the Infection Control Practitioner.

There is a continuous review of policies and procedures in regards to IPC with internal and external stakeholders

Earthquake drills occur every Oct, fire drills and Code Blues occur monthly

Code whites and code yellow debriefs are done following each incident to review and look for lessons learnt

Mock exercises with external stakeholders and other first responders and government organizations are planned for Oct, 2018.

The organization worked with external partners to complete a HRVA for the area.

Contingency Plans are currently being reviewed, developed and updated as appropriate.

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: Governance		
2.3	The governing body includes clients as members, where possible.	
10.5	The governing body regularly hears about quality and safety incidents from the clients and families that experience them.	!
Standards Set: Inpatient Services		
1.1	Services are co-designed with clients and families, partners, and the community.	!
1.9	Barriers that may limit clients, families, service providers, and referring organizations from accessing services are identified and removed where possible, with input from clients and families.	
2.5	Space is co-designed with clients and families to ensure safety and permit confidential and private interactions with clients and families.	
3.3	A comprehensive orientation is provided to new team members and client and family representatives.	
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.	
15.9	Patient safety incidents are analyzed to help prevent recurrence and make improvements, with input from clients and families.	!
16.3	Measurable objectives with specific timeframes for completion are identified for quality improvement initiatives, with input from clients and families.	!
Standards Set: Leadership		
1.4	Teams are supported in their efforts to partner with clients and families in all aspects of their care.	
3.3	Teams, clients, and families are supported to develop the knowledge and skills necessary to be involved in quality improvement activities.	

3.6	There are regular dialogues between the organization's leaders and clients and families to solicit and use client and family perspectives and knowledge on opportunities for improvement.	
6.2	When developing the operational plans, input is sought from team members, clients and families, and other stakeholders, and the plans are communicated throughout the organization.	
10.4	Education and training are provided throughout the organization to promote and enhance a culture of client- and family-centred care.	
Standards Set: Mental Health Services		
1.1	Services are co-designed with clients and families, partners, and the community.	!
1.10	Barriers that may limit clients, families, service providers, and referring organizations from accessing services are identified and removed where possible, with input from clients and families.	
2.4	Space is co-designed with clients and families to ensure safety and permit confidential and private interactions with clients and families.	
3.3	A comprehensive orientation is provided to new team members and client and family representatives.	
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.	
15.3	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.	!
1.7	Barriers that may limit clients, families, service providers, and referring organizations from accessing services are identified and removed where possible, with input from clients and families.	
2.4	Space is co-designed with clients and families to ensure safety and permit confidential and private interactions with clients and families.	
6.3	A comprehensive orientation is provided to new team members and client and family representatives.	

6.12	Client and family representatives are regularly engaged to provide input and feedback on their roles and responsibilities, role design, processes, and role satisfaction, where applicable.	
24.7	Patient safety incidents are analyzed to help prevent recurrence and make improvements, with input from clients and families.	!
25.3	Measurable objectives with specific timeframes for completion are identified for quality improvement initiatives, with input from clients and families.	!

Surveyor comments on the priority process(es)

There has been significant emphasis on patient and family engagement at Yukon Hospital Corporation (YHC) since the last survey. The new strategic plan was developed with input from patients and families and this is evident in the new mission, vision, and values for YHC. The First Nations Health Programs demonstrate a commitment to involving patients and families throughout their hospitalization while promoting Indigenous Health Equity. These principles could be followed to further advance patient and family centred care throughout the organization.

Although clearly evident in individual patient and family interactions in Yukon Health Corporation (YHC) family centred care as a strategic approach could be further advanced at the hospital.

The addition of the volunteer program at YHC has enhanced the patient experience in a variety of ways and all volunteers receive extensive cultural awareness training to provide appropriate support. Volunteers facilitate completion of patient surveys by someone who is not a direct care provider at the organization. There are numerous other examples at the unit level of initiatives that could be adopted throughout the hospital.There is a process with community partners to identify, report, and remove barriers to access for clients and families already in place.

Collaboration with clients, partners, and the community in service design was achieved through client tour groups, community focus groups, volunteer services and client experience surveys in the Whitehorse ER.

The organization has facilitated important changes to improve the patient and family experience such as posters for patients who require interpretation, use of whiteboards in patient rooms and the involvement of patients and families from the design phase of the newly renovated areas.

The organization is encouraged to build on the successes to date to further advance patient and family involvement moving forward. Formal frameworks, policies, and processes have been established to facilitate this work to continue.

Priority Process: Patient Flow

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

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

The new 'discharge planning rounds' process implemented last Fall has improved transition and flow of patients through the system. Internal and external partners include nursing, physiotherapy, social work and external home care partners. Daily meetings are attended to provide input.

This is a dedicated patient flow team with participation from staff at all levels of the organization. Rounds are held on a daily basis and barriers to discharge are handled using a case management approach. The information is recorded electronically in the meeting and additions can be made by all team members in attendance. Criteria focuses on barriers to discharge and resolution.The interdisciplinary team approach ensures that barriers to discharge are addressed in a timely manner using a priority system for tracking.

An over capacity policy is in place that addresses the overcapacity issues faced by Whitehorse General Hospital (WGH) through the involvement and collaborative response of all healthcare partners in addressing acute care needs across the Yukon Territory. This strategy leverages internal and external partners to provide the right clinical care and non-clinical supports using the right providers, at the right location and at the right time.
Overcapacity protocols for Dawson City Community Hospital and Watson Lake Community Hospital are aligned with the WGH policy.

Wait times for service are monitored and targets are being set that align with services and ability to provide services (specialist visits).

Priority Process: Medical Devices and Equipment

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

Unmet Criteria		High Priority Criteria
Standards Set: Diagnostic Imaging Services		
8.7	All diagnostic imaging reprocessing areas are equipped with separate clean and decontamination work areas as well as separate clean storage, dedicated plumbing and drains, and proper air ventilation and humidity levels.	!
Standards Set: Reprocessing of Reusable Medical Devices		
3.1	The layout of the MDR department is designed based on service volumes, range of reprocessing services, and one way flow of medical devices.	
3.2	The MDR department is designed to prevent cross-contamination of medical devices, isolate incompatible activities, and clearly separate work areas.	!
3.4	The MDR department has an area for decontamination that is physically separate from other reprocessing areas and the rest of the facility.	!
11.3	All flexible endoscopic reprocessing areas are equipped with separate clean and contaminated/dirty work areas as well as storage, dedicated plumbing and drains, and proper air ventilation.	
11.8	Flexible endoscopic devices are appropriately stored following manufacturers' instructions in a manner that minimizes contamination and damage.	!
12.1	The MDR department has an appropriate storage area for sterilized medical devices and equipment.	!

Surveyor comments on the priority process(es)

The medical device reprocessing unit (MDRD) at Whitehorse Hospital Corporation (WHC) now services both Watson Lake and Dawson Creek sites for MDRD needs. This model ensures there is the expertise for sterilization of all equipment that is required. All staff are certified or were in the process of completing their certification at the time of the visit.

Staff in the medical device reprocessing unit (MDRD) take pride in their work and have a strong cohesive team. Staff feel the leadership for this area is engaged, knowledgeable and approachable and listen to their concerns and perspectives.

Flash sterilization has been removed from all sites.

The physical environment is clean however very cluttered. There is a renovation underway to improve the scope cleaning area and ensure separation of the clean, dirty and storage areas. This is a much needed renovation as the current space and storage areas need to be changed and improved to ensure compliance with Accreditation and Canadian Standards Association standards. Following the important renovation the hospital is encouraged to re-evaluate the storage requirements with the new surgical services that have been added.

The standard operating procedures are available but need to be reviewed and updated to ensure easy access for the staff working in this unit.

Service Excellence Standards Results

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

Priority processes specific to service excellence standards are:

Clinical Leadership

- Providing leadership and direction to teams providing services.

Competency

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

Episode of Care

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

Decision Support

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

Impact on Outcomes

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

Medication Management

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

Organ and Tissue Donation

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

Infection Prevention and Control

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

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: Diagnostic Services: Laboratory		
9.4	The team ensures critical equipment such as refrigerators is protected with an uninterruptible power supply.	!
11.3	The team updates its SOPs every two years or more often if required.	
11.6	The team regularly evaluates compliance with its SOPs and makes changes as needed.	
29.16	The team shares information about its quality improvement activities, results, and learnings with clients, families, staff, service providers, organization leaders, and other organizations, as appropriate.	
Surveyor comments on the priority process(es)		
Priority Process: Diagnostic Services: Laboratory		

Yukon Hospital Corporation ensures the availability of quality laboratory services to assist medical professionals in diagnosing and monitoring health conditions.

The laboratory collects information about service volumes and wait times and information from service providers to inform the laboratory services provided. Planning is done for the types of equipment, devices and supplies required for service provision. Physical space needed is provided and when possible modified to better serve patient and staff needs.

Standardized request forms are utilized. Samples are collected in a safe manner and client's identity is verified before collecting the sample. Samples are appropriately labelled, stored and transported.

Standardized operating procedures are utilized, the standardized operating procedures are up to date, accessible and utilized. Processes exist to evaluate the quality of the analysis and this includes a repeat/reject analysis.

Standardized report formats are utilized consistently. Good processes are utilized to deal with critical or alert values.

A well established quality management system is utilized to evaluate and improve the safety and quality of services. The laboratory's team demonstrates a culture supportive of delivering high quality services. Team members work to their full scope of practice.

The laboratory services are challenged with maintaining sample integrity during transport due to the harsh northern environment.

The walk-in freezer used to store reagents and other supplies is not serviced by a backup power system.

Many Standardized Operating Procedures are outdated, lab staff are aware and are working to correct this deficiency.

Standards Set: Cancer Care - Direct Service Provision

Unmet Criteria	High Priority Criteria
Priority Process: Clinical Leadership	
2.3 An appropriate mix of skill level and experience within the team is determined, with input from clients and families.	
Priority Process: Competency	
The organization has met all criteria for this priority process.	
Priority Process: Episode of Care	
15.7 To minimize injury from falls, a documented and coordinated approach for falls prevention is implemented and evaluated. 15.7.5 Results from the evaluation are used to make improvements to the approach when needed.	ROP **MINOR**
20.3 Systemic therapy only: Independent double checks for dose and rate of administration are conducted on infusion pumps prior to administration.	!
Priority Process: Decision Support	
2.2 Technology and information systems requirements and gaps are identified and communicated to the organization's leaders.	
Priority Process: Impact on Outcomes	
The organization has met all criteria for this priority process.	
Priority Process: Medication Management	
6.2 Systemic therapy only: Computerized physician order entry (CPOE) or Pre-Printed Orders (PPO) are used when ordering systemic cancer therapy medications.	!
Surveyor comments on the priority process(es)	
Priority Process: Clinical Leadership	

The cancer care unit at Yukon Hospital Corporation (YHC) has an interdisciplinary team including registered nurses, pharmacists and general practitioners in Oncology (GPO). This model is the same as models created for satellites by the British Columbia Care agency. Patients are under the care of the GPO and the team while receiving systemic therapy treatment.

Hospital overall goals and objectives are in place. The unit is encouraged to develop service specific goals and objectives at the unit level and including the patient and family in this process. The team meets monthly and now includes a patient representative at each meeting. This a model that is unique for the organization and could be used in other areas of the hospital as they advance patient and family centred care.

The cancer care unit at Yukon Hospital Corporation conducts interdisciplinary daily rounds to discuss patients and ensure all appropriate clinical investigations have been completed prior to treatment.

The purchase of new pumps allowed for new opportunities for training and education. Staff indicated the new pumps are easy to use and have improved safety for this patient group.

Priority Process: Competency

Comprehensive education takes place for new staff during orientation and ongoing through skills day and mandatory education sessions. The learning management system ensures that mandatory education can be monitored and reviewed regularly. The team participates in education provided by the British Columbia Cancer Agency and they are encouraged to continue to advocate for opportunities for education from this agency.

Staff and the manager of the area have the appropriate oncology certifications to provide care to this specialized group of patients.

Priority Process: Episode of Care

A comprehensive admission and assessment process is completed for every patient visit to the cancer care unit. Standardized assessment tools have been developed to ensure that assessments and treatments are evidence based and align with the British Columbia Cancer Care Agency. Members of the interdisciplinary team explain what to expect with systemic therapy, possible adverse reactions and potential adjustments to other areas of care.

The general practitioner oncologists are available for patients while receiving treatment in the cancer care unit. There are four family physicians specially trained to oversee this patient group. They are available on a rotating basis on Monday to Thursday. They provide extensive information to the emergency department and family physician for each patient. There is a list of the patients in the emergency department with information and patients are provided education about when to present to the emergency department.

Patients and families are very involved in their care. A patient representative attends the monthly team meetings and provides the patient perspective on changes and this has been a very positive addition to the team. Patients express satisfaction with their care and very much appreciate the staff for their compassionate care. Treatments are very well explained and one patient reported that they are well informed and involved in all decisions related to care.

The stabilization of the cancer care coordinator role has been invaluable to both patients and families in the unit. The role allows for system navigation, seamless transitions between the British Columbia Cancer Agency and facilitates travel with innovative opportunities to fund this transportation. The team has access to the palliative care team within the hospital to support patients with important decisions related to treatment and care when palliative care is required.

The team is encouraged to continue to work with the British Columbia Cancer Agency to advocate for improvements in care and best practice for patients at Whitehorse Hospital Corporation (WHC).

Independent double checks are not performed as there is only one RN on duty. The program is encouraged to look at creative options to ensure double checks for medication and pump settings take place for all patients.

Priority Process: Decision Support

Standard clinical assessments are completed on arrival to the cancer care unit. Patients are assessed for safety risks and comprehensive reviews are conducted related to blood work prior to initiation of systemic therapy treatment.

British Columbia Cancer Agency protocols are followed for all medications administered in this unit. The team is strongly encouraged to further explore opportunities to put a Computerized Physician Order Entry (CPOE) in place for this unit.

Other charting is currently paper based and the hospital is encouraged to explore opportunities to expand electronic documentation involving front line care providers.

Priority Process: Impact on Outcomes

There are many quality improvement initiatives that have been implemented in the cancer care unit. The team has opportunity to receive information and statistics from the British Columbia Cancer Agency related to the outcome of patients receiving treatment in this unit.

The staff members are regularly trained on the handling of cytotoxic drugs and appropriate use of PPE. The physical environment creates challenges for privacy and infection control with chairs physically located so close together. The team is hopeful the potential expansion opportunities will take place in the near future to also accommodate the growing demand for service closer to home for cancer patients.

A standard order set, process for admissions and care plans has been developed that is comprehensive and completed at each visit.

Quality based metrics are visible on the unit and discussed at monthly team meetings. The team is encouraged to find ways to use this data to facilitate meaningful dialogue with staff providing care on this unit.

Priority Process: Medication Management

The physical location of systemic therapy preparation areas are appropriate with recent renovations that have been completed. A very robust system is in place to ensure that orders are processed and double checked for accuracy within the pharmacy department.

The cancer care unit only has one RN on duty and as a result the process to double check orders needs to reviewed and altered for the safety of the patients receiving treatment.

Standards Set: Diagnostic Imaging Services - Direct Service Provision

Unmet Criteria		High Priority Criteria
Priority Process: Diagnostic Services: Imaging		
6.7	The team annually reviews and updates the Policy and Procedure Manual.	
15.3	The team has policies and procedures to deal with medical emergencies.	!
15.4	The team prepares for medical emergencies by participating in simulation exercises.	!
15.6	The team implements and evaluates a falls prevention strategy to minimize client injury from falls.	ROP
15.6.5	The team uses the evaluation information to make improvements to its falls prevention strategy.	**MINOR**
17.3	The team identifies measurable objectives for its quality improvement initiatives and specifies the timeframe in which they will be reached.	!
17.9	The team designs and tests quality improvement activities to meet its objectives.	!
Surveyor comments on the priority process(es)		
Priority Process: Diagnostic Services: Imaging		

Diagnostic services includes general radiology, CT scan, mammography, ultrasound, MRI, and computed tomography. Some services are offered at all three hospital sites: Whitehorse, Dawson City and Watson Lake.
The rural areas provide combined laboratory and imaging technician model. The rural sites offer general radiology and portable ultrasound in the emergency dept..
The team has submitted a request to purchase bone density equipment as they have identified that as a need. At present clients have to go out for the testing.
Photo archiving system (PAC's) is well established across the system.

There is a medical director responsible from Mayfair/RCA Diagnostics, through which they receive coverage by the radiologists.
They use a rotating schedule and a radiologist comes up every month for a week. There is a contract in place for this service.

There is good space available for the services with high level equipment. They have a five year plan for equipment replacement. Preventative maintenance is provided externally by the vendors. Equipment logs are kept, both for equipment identification as well as for preventative maintenance.

There are separate change rooms and bathrooms. Some design changes have occurred to provide more privacy for patients awaiting service and to align some services more closely to the emergency dept.

The staff are knowledgeable and committed to the service. They have regular onsite or online education, but most have have not had the opportunity to go out for professional development. The team developed and updated their training and review booklet for nurses and physicians working in community hospitals across rural areas to guide them when they do diagnostic imaging. They find it to be very helpful. The community hospital staff in rural sites would benefit from regular education and updates, Telehealth could be a useful tool to support education and training. The team is encouraged to participate in simulation exercices around dealing with medical emergencies.

The service is patient focused and a wonderful example of that is the Breast Health Program. The care provider is very knowledgeable and an advocate for the clients. The space for mammography is impressive, leading to an area that promotes communication between the care provider and the patient, as well as provides a warm and less intrusive environment for this procedure. There is also much collaboration with the community regarding this program, such as awareness events and fundraising which improves patient outcomes overall.

Already mentioned, the 90 day business plan is being used for quality improvement purposes and is the direction of the corporation. I would suggest going forward, to align the service objectives with the strategic plan and to define indicators that will evaluate these objectives. This will support future planning and direction for the service, and enhance quality improvement.

The team implements a falls approach, however they need to formalise the falls strategy and implement regular indicator measurements and reporting processes, to evaluate the falls prevention improvements.

Standards Set: Emergency Department - Direct Service Provision

Unmet Criteria		High Priority Criteria
Priority Process: Clinical Leadership		
1.3	Specific goals and objectives regarding wait times, length of stay (LOS) in the emergency department, client diversion to other facilities, and number of clients who leave without being seen are established, with input from clients and families.	
2.4	An appropriate mix of skill level and experience within the team is determined, with input from clients and families.	
2.9	The effectiveness of resources, space, and staffing is evaluated with input from clients and families, the team, and stakeholders.	
6.2	Work and job design, roles and responsibilities, and assignments are determined with input from team members, and from clients and families where appropriate.	
Priority Process: Competency		
4.1	Required training and education are defined for all team members with input from clients and families.	!
4.14	Team member performance is regularly evaluated and documented in an objective, interactive, and constructive way.	!
4.16	Team members are supported by team leaders to follow up on issues and opportunities for growth identified through performance evaluations.	!
Priority Process: Episode of Care		
10.6	To minimize injury from falls, a documented and coordinated approach for falls prevention is implemented and evaluated. 10.6.5 Results from the evaluation are used to make improvements to the approach when needed.	ROP **MINOR**
12.16	Information relevant to the care of the client is communicated effectively during care transitions.	ROP

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).	**MINOR**
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		
15.2	Policies on the use of electronic communications and technologies are developed and followed, with input from clients and families.	
Priority Process: Impact on Outcomes		
16.2	The procedure to select evidence-informed guidelines is reviewed, with input from clients and families, teams, and partners.	
16.3	There is a standardized process, developed with input from clients and families, to decide among conflicting evidence-informed guidelines.	!
16.4	Protocols and procedures for reducing unnecessary variation in service delivery are developed, with input from clients and families.	!
16.5	Guidelines and protocols are regularly reviewed, with input from clients and families.	!
17.1	A proactive, predictive approach is used to identify risks to client and team safety, with input from clients and families.	!
17.2	Strategies are developed and implemented to address identified safety risks, with input from clients and families.	!
17.3	Verification processes are used to mitigate high-risk activities, with input from clients and families.	!
17.4	Safety improvement strategies are evaluated with input from clients and families.	!
18.1	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.	

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.	
18.13	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		

There are good partnerships with other teams, providers and organizations.
A high level of collaboration and interdependence between medical and nursing leadership is evident in the emergency department (ED). The Emergency Department has interdisciplinary team members including, physicians, registered nurses, physiotherapists and pharmacists when required. Staff feel that medical and nursing leadership are approachable and highly invested and engaged in the unit.

The new Emergency department at Whitehorse enhances and promotes optimal patient flow and safety for both patients. The department spent extensive time getting patient and family input into the physical design and care changes for this new area.

The interdisciplinary team meets monthly. They review quality metrics, make decisions on changes required and brainstorm ideas for consideration.

The purchase of new pumps allowed for new opportunities for training and education. Staff indicated the new pumps are easy to use and have improved safety for this patient group.

Priority Process: Competency

There is a skilled knowledgeable interdisciplinary team that can manage and deliver effective programs and services in the emergency department.
Team members communicate effectively and recognize there respective roles and contributions to client care.

The purchase of new pumps allowed for new opportunities for training and education. Hard and soft limits have been set up including the pediatric population seen in the emergency department.

Comprehensive education takes place for new staff during orientation and ongoing through skills day and mandatory education sessions. This is followed by unit orientation and mentorship opportunities available in the emergency department setting. The learning management system ensures that mandatory education can be monitored and reviewed regularly.

The Dawson staff would welcome opportunities to provide further training and education. This might include clinical placements/exchanges with inpatient staff in Whitehorse if feasible.

Performance reviews are completed however processes need to be put in place to ensure that they are up to date and reflect hospital policies.

Priority Process: Episode of Care

The Emergency Department staff take great pride in delivering a very high standard of care. A high degree of trust and willingness to try new ideas to improve care permeates the department.This team partners well with clients and families to provide client centered services throughout their healthcare encounter.

Access is through a formal intake and triage process that feeds to the nursing and physician assessment. The assessment is well documented. Attention is paid to a best possible medication history. The triage process is electronic and the new electronic tracking board allows for good visualization of the patients in the department and their status.

Patients and families were very involved in the development of the new emergency department and patients are involved in their care and care is delivered in a safe and effective manner.

Essential information is communicated effectively during transfers however standardized tools are not in place creating challenges to audit this important practice.

Suicide risk assessment is completed however a standardized tool is not used. The team has access to mental health services at the unit level and this has provided excellent support to this patient population with seamless transition back to the community.

Fall prevention strategies are in place however a more formal approach needs to be created to ensure evaluation and improvements can be initiated.

Significant work has been done to ensure infusion pump training on the new pumps has been completed for the organization along with standardization of pumps. The Learning Management System allows for tracking of education along with skills and education days for all nursing staff. Pump training is covered in hospital orientation. Hard and soft limits have been set and drug libraries are available at the service level including pediatrics for the emergency department.

During transitions a verbal report is completed. The staff is encouraged to create a more formalized transfer of accountability process to ensure seamless transitions between units. The medicine unit is encouraged to continue to find ways to involve the patient and family in changes made at the unit level.

Priority Process: Decision Support

The Canadian Triage Acuity Scale (CTAS)is completed electronically at Whitehorse on all patients. This facilitates appropriate assignment of CTAS level for all patients.Standardized clinical assessments are completed at all sites. Client information is maintained in a secure and efficient manner. An electronic tracking board is generated from the CTAS assessment allowing for real time information for the care team.

Other charting is currently paper based and the hospital is encouraged to explore opportunities to expand electronic documentation involving front line care providers.

Priority Process: Impact on Outcomes

Overall organizational goals and objectives are available however more work needs to be done on unit goals and objectives at the program level to engage patients and families.

There is a clear commitment to Quality and the emergency department is aligned with corporate quality initiatives. Some clear examples include medical directives, electronic triage assessments and a state of the art new emergency department that was built with input from stakeholders, staff and patients.

The addition of the fast track unit in the emergency department along with consistent hours for the charge nurses has led to improved patient flow and improved care for all patients.

Quality based metrics are discussed at monthly meetings and electronic triage has provided opportunity for more accurate acuity levels to be assigned to all patients presenting to the emergency department.

Verbal reports are completed for all transitions with a face to face report. This is well done and provides all information in a concise format. A standardized format to follow needs to be developed to ensure audits of this practice can be done.

Priority Process: Organ and Tissue Donation

The emergency department at the time of the accreditation visit did not have clear policies, procedures and protocols to identify potential organ donors.The team is encouraged to explore opportunities to identify potential organ and tissue donors moving forward.

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

Unmet Criteria		High Priority Criteria
Priority Process: Infection Prevention and Control		
4.2	There are policies and procedures that are in line with applicable regulations, evidence and best practices, and organizational priorities.	!
5.2	Team members, clients and families, and volunteers are engaged when developing the multi-faceted approach for IPC.	
14.3	Input is gathered from team members, volunteers, and clients and families on components of the IPC program.	

Surveyor comments on the priority process(es)

Priority Process: Infection Prevention and Control

An interdisciplinary IPC team includes has wide representation. It includes representation from Watson Lake, Dawson City and from Public Health (ad hoc).

There is an Infection and Prevention and Control Practitioner at the Whitehorse Hospital who is available for consultation to the Dawson and Watson sites. The hospital has also contracted the IPAC Medical Director and Antimicrobial Lead at St Paul's Hospital.

Resources include a qualified contracted IPC physician, an IPC professional, and an interdisciplinary committee to promote the IPC program, as well as access to a microbiology laboratory that can assist with surveillance information. Finding innovative ways to engage others in IPAC data collection and auditing would further support the IPC program.

The hospital has made a number of quality improvements in infection prevention and control including the establishment of an antibiotic stewardship program, the construction of the emergency departments, and the enhancement of the physical environment to promote best practices for patient isolation. A number of improvements have been made in particular in the areas of patient isolation in Emergency and Maternity, and in antibiotic stewardship. IPC work with other stakeholders in developing Pandemic Plan and Ebola plans. They contract out an Infectious disease specialist who provides best practices and evidence base recommendations as well evidence was seen of a gap analysis and advice on surgical infections, hospital acquire infections (HAI).

In alignment with the Patient and Family Centred Care strategy being recommended, the team is encouraged to engage clients and families when developing approaches to IPC including educational materials for families and visitors and to undertake an evaluation of its services including gathering input from clients and families as outlined in the standards.

The IPC team is consulted when planning and designing for construction and renovations. Ongoing attention to infection control best practices during reconstruction is encouraged. It is important that the standards are adhered to in order to ensure patient safety. Refer to current CSA Standards Z8000 and Z317.13, and PHAC's Construction-related nosocomial infections in patients in health care facilities: Decreasing the risk of Aspergillus, Legionella.

Standard Operating Procedures are available for most equipment but need to be reviewed regularly with the volume of new surgical procedures added to the organization.

Personal Protective Equipment and hand sanitizers are easily accessible throughout the hospital and in the patient care areas.

Hand hygiene education is provided with lots of hand washing stations as well as hand sanitizers. Visitors have a good understanding around the process.
The housekeeping staff is committed to the highest level of cleanliness and are very aware of the importance of cleaning and disinfecting the environment to ensure patient safety.

Team members and volunteers are provided with access to policies and procedures for identifying and managing outbreaks. Cheat sheets are available for the Infection Control practitioner.

Standards Set: Inpatient 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.		
Priority Process: Competency			
3.1	Required training and education are defined for all team members with input from clients and families.		!
Priority Process: Episode of Care			
9.4	The assessment process is designed with input from clients and families.		
9.7	Medication reconciliation is conducted in partnership with clients and families to communicate accurate and complete information about medications across care transitions.		ROP
	9.7.5	The client, community-based health care provider, and community pharmacy (as appropriate) are provided with a complete list of medications the client should be taking following discharge.	**MAJOR**
10.16	Information relevant to the care of the client is communicated effectively during care transitions.		ROP
	10.16.5	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).	**MINOR**
11.9	The effectiveness of transitions is evaluated and the information is used to improve transition planning, with input from clients and families.		

Priority Process: Decision Support		
2.2	Technology and information systems requirements and gaps are identified and communicated to the organization's leaders.	
Priority Process: Impact on Outcomes		
14.2	The procedure to select evidence-informed guidelines is reviewed, with input from clients and families, teams, and partners.	
14.3	There is a standardized process, developed with input from clients and families, to decide among conflicting evidence-informed guidelines.	!
14.5	Guidelines and protocols are regularly reviewed, with input from clients and families.	!
16.4	Indicator(s) that monitor progress for each quality improvement objective are identified, with input from clients and families.	
16.8	Indicator data is regularly analyzed to determine the effectiveness of the quality improvement activities.	!
16.11	Information about quality improvement activities, results, and learnings is shared with clients, families, teams, organization leaders, and other organizations, as appropriate.	
16.12	Quality improvement initiatives are regularly evaluated for feasibility, relevance, and usefulness, with input from clients and families.	
Surveyor comments on the priority process(es)		
Priority Process: Clinical Leadership		

The medical unit in Whitehorse has medical beds and interdisciplinary team members including registered nurses and licensed practical nurses along with other allied health care providers that include physiotherapists ,pharmacists and dieticians. Patients are admitted under a family physician and there is a process in place for patients who do not have a family physician.

A newly appointed site Administrator begins in Dawson in June ending an 18 month vacancy which has been ably managed in the interim by the Watson Lake Administrator and the Dawson clinical lead. The new administrator will provide on site leadership which will provide an opportunity to build on current strengths and to establish annual quality improvement goals for patient care.

Hospital overall goals and objectives are in place and the units at all sites are encouraged to develop service specific goals and objectives at the unit level including the patient and family in this process.

The hospital is encouraged to continue the work on advancing the licensed practical nurse's role to full scope of practice as well as including the patient and family in this change.

Priority Process: Competency

The medicine unit in Whitehorse is part of interdisciplinary daily rounds to discuss clinical status and discharge rounds. Team members communicate effectively and recognize their respective roles and contributions to client care.

The purchase of new pumps allowed for new opportunities for training and education.

Comprehensive education takes place for new staff during orientation and is ongoing through skills day and mandatory education sessions. The learning management system ensures that mandatory education can be monitored and reviewed regularly.

The Dawson staff would welcome opportunities to provide further training and education would be welcomed. These may include clinical placements/exchanges with inpatient staff in Whitehorse if feasible.

Performance reviews are completed however processes need to be put in place to ensure that they are up to date and reflect hospital policies.

Priority Process: Episode of Care

The majority of patients admitted to the medicine program have pre-printed admission orders that are utilized. During the admission process patients and families receive information on patient safety and support services available. Medicine staff members complete comprehensive assessments in a timely manner and communicate their findings on the care plan available to all members of the interdisciplinary team.

Fall prevention, ulcer prevention, venous thromboemebolism and other programs are well engrained into the daily practice on the medical unit. The teams documentation for these programs is well done and extensive.

Significant work has been done to ensure infusion pump training on the new pumps has been completed for the organization along with standardization of pumps. The Learning Management System allows for tracking of education along with skills and education days for all nursing staff. Pump training is covered in hospital orientation. Hard and soft limits have been set and drug libraries are available at the service level.

Patients and families are encouraged to be involved in their care. Whiteboards in each room have information on patient safety, discharge and care providers. The medicine unit is encouraged to continue ensuring the boards are completed for all patients on this unit.

Patients express satisfaction with their care and very much appreciate the staff for their kind care. Treatments are very well explained and one patient reported feeling very safe and having great trust in the care they receive in their hospital. Although clearly evident in individual patient and family interactions in Dawson, patient and family centred care as a strategic approach could be further advanced at the hospital.

The addition of a volunteer program has been an extremely positive change to support patient and family centred care at the unit level.Volunteers are oriented centrally by the organization as well as locally on the unit and facilitate the completion of patient satisfaction surveys at the unit level.

During transitions a verbal report is completed. The staff is encouraged to create a more formalized transfer of accountability process to ensure seamless transitions between units. The medicine unit is encouraged to continue to find ways to involve the patient and family in changes made at the unit level.

Medication Reconciliation is completed on admission and at discharge for complex patients. This needs to be consistently done for all patients at the point of discharge.

Priority Process: Decision Support

Standard clinical assessments are completed on arrival to the medical unit. Patients are assessed for safety risks: in addition to risk for falls, pressure ulcers, and deep vein thrombosis, they are also assessed for pain and aggressive behavior when applicable.

Charting is currently paper based and the hospital is encouraged to explore opportunities to expand electronic documentation involving front line care providers.

Priority Process: Impact on Outcomes

There is a clear commitment to quality and inpatient services are aligned with corporate quality initiatives. Some clear examples include pre-printed orders for conditions such as unstable angina, venous thromboembolism and prophylaxis and alcohol withdrawal. A standard admission order set is available for general medical admissions. Order sets are well used and facilitate evidence based care for all patients. The "4 P" rounding initiative is fully implemented and audits show good compliance over time.

Quality based metrics are visible on the unit and the team is encouraged to find ways to use this data to facilitate meaningful dialogue to improve quality at the unit level. An example relevant to Dawson for example is food delivery and other areas related to patient satisfaction.

Standards Set: Medication Management Standards - Direct Service Provision

Unmet Criteria		High Priority Criteria
Priority Process: Medication Management		
1.3	The roles and responsibilities of the interdisciplinary committee are regularly evaluated and improvements are made as needed.	
2.5	A documented and coordinated approach to safely manage high-alert medications is implemented.	ROP
2.5.4	The policy includes procedures for storing, prescribing, preparing, administering, dispensing, and documenting each identified high-alert medication.	**MAJOR**
15.5	There is a procedure to address disagreements among the team regarding medication orders.	
21.1	Information about medications is discussed and documented prior to the initial dose and when the dose is adjusted, in partnership with the client and family.	!
26.1	Teams are informed of the value of, and their role in, reporting adverse drug reactions to Health Canada; specifically unexpected or serious reactions to recently marketed medications.	

Surveyor comments on the priority process(es)

Priority Process: Medication Management

The Pharmacy and Therapeutics committee is well established and agenda items are relevant to accreditation standards and best practice. There is active participation from disciplines and minutes are brought forward to the Medical Advisory Committee. These include changes made to allow for pharmacists to be at the unit level and to assist with medication reconciliation, reviews of complex patients and support for the clinical teams.

The physical renovations to the pharmacy area have facilitated the creation of a separate negative pressure area for preparing chemotherapy medications along with a secondary separate room for sterile products and intravenous admixtures. The team is encouraged to continue to review the ventilation in these new areas.

The pharmacy department has led numerous changes and process improvements related to medication administration. The pharmacy department at Yukon Hospital Corporation (YHC) provides oversight to Dawson and Watson alike to ensure 24/7 pharmacy support. The pharmacy has led the implementation of

automated dispensing cabinets in some key areas of the hospital and is encouraged to continue to move this plan forward. The addition of automated dispensing cabinets to replace night cupboards has allowed for better control over all medications and trending of data for individual unit requirements.

The antimicrobial Stewardship committee is well established and has made changes and improvements. The admission screening for Antibiotic Resistant Organisms (AROS) and Intravenous to Oral Antimicrobial Step-Down Guidelines ensure ongoing improvements are in place. The team has made significant progress to optimize antimicrobial use.The antimicrobial stewardship committee has been in place since 2015. Risk factors are determined on admission through and admission screening process. Intravenous to Oral Antimicrobial step down guidelines have been developed and encompass a pharmacist review. Audits are conducted and information related to audits is brought back to the Pharmacy and Therapeutics committee for dissemination as appropriate.

The pharmacy department is encouraged to continue their work to review and audit the practices that have been put in place and put forward more formal mechanisms to share this data with appropriate care providers. Changes have been made to streamline the formulary and this work needs to continue to further streamline the medications available in the organization. Polices for the high alert medications need to be reviewed and updated by the Pharmacy and Therapeutics Team.

Standards Set: Mental Health Services - Direct Service Provision

Unmet Criteria		High Priority Criteria
Priority Process: Clinical Leadership		
1.3	Clinical services and supports are recovery-oriented and focused on well-being.	
1.5	Service-specific goals and objectives are developed, with input from clients and families.	
3.12	A strategy to reduce stigma of mental illness among the team is developed with input from clients and families.	
Priority Process: Competency		
3.1	Required training and education are defined for all team members with input from clients and families.	!
3.5	Education and training are provided on the organization's care delivery model.	
Priority Process: Episode of Care		
2.7	The physical environment is safe, comfortable, and promotes client recovery.	
7.14	Clients and families are provided with information about their rights and responsibilities.	!
8.6	Medication reconciliation is conducted in partnership with clients and families to communicate accurate and complete information about medications across care transitions.	ROP
8.6.5	The client, community-based health care provider, and community pharmacy (as appropriate) are provided with a complete list of medications the client should be taking following discharge.	**MAJOR**
9.10	The client's physical activity needs are supported as part of comprehensive service delivery.	!
9.18	Information relevant to the care of the client is communicated effectively during care transitions.	ROP

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).	**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		
13.2	The procedure to select evidence-informed guidelines is reviewed, with input from clients and families, teams, and partners.	
13.3	There is a standardized process, developed with input from clients and families, to decide among conflicting evidence-informed guidelines.	!
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.	
15.4	Indicator(s) that monitor progress for each quality improvement objective are identified, with input from clients and families.	
15.7	There is a process to regularly collect indicator data and track progress.	
15.8	Indicator data is regularly analyzed to determine the effectiveness of the quality improvement activities.	!
15.10	Information about quality improvement activities, results, and learnings is shared with clients, families, teams, organization leaders, and other organizations, as appropriate.	
Surveyor comments on the priority process(es)		
Priority Process: Clinical Leadership		

The Secure Medical Unit is a 5 bed medical stabilization unit which serves the mental health population through a capable and committed interdisciplinary team. The organization is planning to develop mental

health services and establish an expanded Secure Medical Unit in future. The hospital is encouraged to include a recovery-oriented and trauma-informed approach focused on harm reduction, fostering hope, enabling choice, encouraging responsibility, and promoting dignity and respect in their upcoming program planning for the new unit.

Priority Process: Competency

The Secure Medical Unit serves the mental health population and consists of a committed inter-disciplinary team of competent professionals who understand one another's roles and demonstrate mutual respect in their collaborative efforts to serve patients and families.

Priority Process: Episode of Care

Staff are doing a great job in the current environment to enhance the patient's experience but there are limitations which could be addressed as the planning for the new secure unit gets underway.

As the hospital begins planning the new Secure Medical Unit, an opportunity exists to engage patients and families in the planning process. Collaboration with clients, partners, and the community can be achieved through client reps, client advocacy groups, community advisory committees, and client experience surveys.

Medication reconciliation is an identified challenge on admission since it is difficult to gather the information for the Best Possible Medication History. Med rec on discharge could be enhanced to ensure that community pharmacies receive a medication update on all discharges. As well, an opportunity exists to evaluate discharge transitions in a formal way by regularly reviewing with partners the effectiveness of communication on discharge.

Priority Process: Decision Support

Client records are accessible and up-to-date. Information is easy to find and identify, and is organized for ease of use. Changes in the patient's condition are noted and communicated effectively. Staff are very aware of the importance of protecting patient privacy and work collaboratively with the patient on disclosure of health information.

Priority Process: Impact on Outcomes

There is a clear commitment to quality outcomes and there is alignment with corporate quality initiatives however no evdidence was seen of any specific program based quality improvement activities underway.

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

Unmet Criteria	High Priority Criteria
Priority Process: Clinical Leadership	
1.3 Service-specific goals and objectives are developed, with input from clients and families.	
1.4 Services are reviewed and monitored for appropriateness, with input from clients and families.	
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	
The organization has met all criteria for this priority process.	
Priority Process: Episode of Care	
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**
Priority Process: Decision Support	
The organization has met all criteria for this priority process.	

Priority Process: Impact on Outcomes		
23.2	The procedure to select evidence-informed guidelines is reviewed, with input from clients and families, teams, and partners.	
23.3	There is a standardized process, developed with input from clients and families, to decide among conflicting evidence-informed guidelines.	!
23.4	Protocols and procedures for reducing unnecessary variation in service delivery are developed, with input from clients and families.	!
23.5	Guidelines and protocols are regularly reviewed, with input from clients and families.	!
23.6	There is a policy on ethical research practices that outlines when to seek approval, developed with input from clients and families.	!
24.1	A proactive, predictive approach is used to identify risks to client and team safety, with input from clients and families.	!
24.2	Strategies are developed and implemented to address identified safety risks, with input from clients and families.	!
24.3	Verification processes are used to mitigate high-risk activities, with input from clients and families.	!
24.4	Safety improvement strategies are evaluated with input from clients and families.	!
25.2	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.	
25.11	Quality improvement initiatives are regularly evaluated for feasibility, relevance, and usefulness, with input from clients and families.	

Priority Process: Medication Management

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

The team is well led. Service specific goals and objectives have not been developed with input from clients and families. The team identifies the resources and supports to achieve the team's goals and objectives and works to obtain them. Good partnerships are established with other teams, providers and organizations.
The team has a culture to deliver high quality services.

Priority Process: Competency

The perioperative team is a skilled, knowledgeable and interdisciplinary team that manages and delivers effective programs and services. The team works collaboratively. Good processes exist to ensure that each team member has the appropriate license or credential from the relevant college or association. These processes are ongoing. Clear roles and responsibilities exist, orientation is provided as well as some ongoing education and training. Efforts are underway to ensure ongoing competency evaluation and performance appraisal.

Priority Process: Episode of Care

The perioperative team partners well with clients and families to provide client centered services throughout the healthcare encounter.
A formal booking or intake process is performed and this feeds to an assessment. The assessment, and care and service plan is formulated with input from the patient and family. Services are delivered in a safe and effective manner. Transition planning and information transfer occur.

Priority Process: Decision Support

Records are maintained and secured in a manner to support effective service delivery.

Priority Process: Impact on Outcomes

The perioperative team uses evidence and quality improvement measures to evaluate and improve the safety and quality of services.
The team is encouraged to enchance client and family input to their quality improvement processes.

Priority Process: Medication Management

The perioperative team manages and administers medication in an effective and safe manner.

Standards Set: Transfusion Services - Direct Service Provision

Unmet Criteria		High Priority Criteria
Priority Process: Transfusion Services		
1.3	When transfusion services are contracted to or from external organizations, the team establishes and maintains an agreement with each organization that outlines the requirements and respective responsibilities.	
4.3	The team has a formal program to maintain team members' competence that includes evaluating their theoretical and practical knowledge on transfusion services using a variety of techniques.	
4.5	Team managers document the results of competency assessments and reassessments.	
4.6	The team participates in a proficiency testing program that includes taking remedial actions when sufficient proficiency testing performance is not attained.	
4.7	The team has a system to regularly evaluate the effectiveness of their training and competency assessment activities.	
5.1	The team develops and follows clear and concise SOPs for its transfusion activities.	
5.3	The team reviews and updates the SOPs every two years or more often if required.	
5.6	The team regularly evaluates compliance with its SOPs and makes changes as needed.	
8.1	The team has the equipment needed to maintain appropriate environmental conditions in refrigerators and other equipment used to store blood components and blood products.	
8.3	The team maintains and regularly tests an alarm system to alert staff to changes in conditions or malfunctions.	!
8.4	The team regularly monitors and records that a functioning emergency backup system is available for equipment used for storing blood components and blood products.	!
14.1	The team follows SOPs for preparing blood components and blood products.	

14.3	The team verifies that specific precautions have been followed for red blood cells prepared for recipients with anti-IgA.	!
15.3	For recipients at risk of transfusion-associated graft versus host disease (TA-GVHD), the team verifies that all cellular components have been irradiated.	!
16.4	The organization stores platelets and pooled platelets and apheresis platelets at 20-24 degrees Celsius with gentle agitation for up to five days.	
18.4	When tested blood components are not available, the organization has a policy for releasing untested blood components in emergency situations that requires the inclusion of a comprehensive release voucher, documented client informed consent, and documented approval of the recipient's attending physician.	!
18.5	When untested blood is released, the team immediately communicates the results to the appropriate team members when they are received from the appropriate organization.	!
18.6	The team maintains a record of each case where blood is released prior to completion of testing.	!
20.7	Before transfusing red cells, the team follows SOPs for cross-matching the donor's and recipient's blood to verify compatibility.	!
20.9	The team follows specific SOPs for selecting and handling components for infants.	!
21.3	There is a procedure for notifying recipients about the blood product(s) they received that includes documenting the notification in the client record.	!
24.6	The team follows SOPs for retaining records.	!
25.1	The team collects information and feedback from clients, families, staff, service providers, organization leaders, and other organizations about the quality of its services to guide its quality improvement initiatives.	
25.10	The team implements effective quality improvement activities broadly.	!
27.1	The team follows SOPs for quarantining and destroying unsafe blood components and blood products.	!
27.4	The team follows SOPs and a control system that allows for the complete and timely recall of any released blood components and blood products.	!

Surveyor comments on the priority process(es)

Priority Process: Transfusion Services

Blood transfusion services are offered at Whitehorse Hospital only. Transfusion services are discouraged at the rural sites however in exceptional circumstances, ie palliative care, blood may be transfused with as much direction and support as is possible from a distance.
The team is considering developing a framework to guide requests for remote transfusion in those very rare situations.

There is a multidisciplinary, Transfusion Services Committee with representatives from lab, leadership, administration, medical consultant from St Pauls Hospital in Vancouver, clinical nurse educators, quality coordinator, medical day care nurse, Whitehorse Hospital medical director and a physician rep. This committee meet quarterly. Their goal is to move to IQMH accreditation for laboratory services.

When products near their expiry date, products are returned to St Pauls Hospital for use, to reduce wastage.

The staff are properly trained and receive ongoing professional development through lunch and learns, CSMLS and Media Lab online education, and regular performance reviews. Staff met on-site shared they receive performance reviews every 2-3 years. There did not seem to be many opportunities for professional development outside the Yukon, albeit some had attended a conference outside the Territory.

The SOPs which guide the work in blood transfusion services need to be reviewed, updated and approved. Many are out of date with last reviews in 2004, 05, 07, 2011 and 2012.
The green binders contain the new SOPs, those procedures that needed to be replaced. These NEW SOPs are well organised with a standardised format for development. The staff are asked to sign off once reviewed. I would encourage that ALL SOPs be reviewed and updated in the very near future. Some HR support for this is required.

The physical environment will be supported with the new outpatient lab however while fairly large, the space is congested and the traffic area thru the lab is busy. The flow needs to be considered so staff can efficiently and safely carry out their work.
The areas needs to be assessed to avoid incidents and/or errors. They are encouraged to apply the LEAN process to the space for efficiency and flow improvement.

Home infusions are not available in the Yukon.

The team has developed a Quality Improvement (QI) Plan to guide the work in addressing the Accreditation Canada standards however they are encouraged to develop their indicators into a QI plan, with timelines and evaluation benchmarks. This will support them in evaluating their work and plan for the future.

Further to this, the team should consider developing a QI plan to define their objectives that are aligned with the overall Yukon Hospital Corp strategic plan, as well as with the indicators. The priorities they identified as (1) attention to the documentation management system (Sharepoint), (2) lab training checklist, and (3) competency assessment checklist for new and existing staff could also be incorporated into the objectives for simplicity.

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: January 4, 2017 to November 11, 2017**
- **Number of responses: 1**

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	94
2. Governance policies and procedures that define our role and responsibilities are well documented and consistently followed.	0	0	100	95
3. Subcommittees need better defined roles and responsibilities.	0	100	0	70
4. As a governing body, we do not become directly involved in management issues.	0	0	100	85
5. Disagreements are viewed as a search for solutions rather than a “win/lose”.	0	0	100	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.	0	0	100	96
7. Individual members understand and carry out their legal duties, roles, and responsibilities, including subcommittee work (as applicable).	0	0	100	96
8. Members come to meetings prepared to engage in meaningful discussion and thoughtful decision making.	0	0	100	94
9. Our governance processes need to better ensure that everyone participates in decision making.	100	0	0	59
10. The composition of our governing body contributes to strong governance and leadership performance.	0	0	100	95
11. Individual members ask for and listen to one another's ideas and input.	0	0	100	97
12. Our ongoing education and professional development is encouraged.	0	100	0	86
13. Working relationships among individual members are positive.	0	0	100	98
14. We have a process to set bylaws and corporate policies.	0	0	100	95
15. Our bylaws and corporate policies cover confidentiality and conflict of interest.	0	0	100	98
16. We benchmark our performance against other similar organizations and/or national standards.	0	100	0	77
17. Contributions of individual members are reviewed regularly.	0	100	0	71
18. As a team, we regularly review how we function together and how our governance processes could be improved.	0	0	100	84
19. There is a process for improving individual effectiveness when non-performance is an issue.	0	100	0	60
20. As a governing body, we regularly identify areas for improvement and engage in our own quality improvement activities.	0	0	100	84

	% Strongly Disagree / Disagree	% Neutral	% Agree / Strongly Agree	%Agree * Canadian Average
	Organization	Organization	Organization	
21. As individual members, we need better feedback about our contribution to the governing body.	0	0	100	44
22. We receive ongoing education on how to interpret information on quality and patient safety performance.	0	0	100	81
23. As a governing body, we oversee the development of the organization's strategic plan.	0	0	100	97
24. As a governing body, we hear stories about clients who experienced harm during care.	0	0	100	86
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.	100	0	0	86
27. We lack explicit criteria to recruit and select new members.	0	0	100	77
28. Our renewal cycle is appropriately managed to ensure the continuity of the governing body.	0	0	0	89
29. The composition of our governing body allows us to meet stakeholder and community needs.	0	0	100	94
30. Clear, written policies define term lengths and limits for individual members, as well as compensation.	0	0	100	93
31. We review our own structure, including size and subcommittee structure.	0	0	0	87
32. We have a process to elect or appoint our chair.	0	0	0	86

*Canadian average: Percentage of Accreditation Canada client organizations that completed the instrument from July to December, 2017 and agreed with the instrument items.

Overall, what is your assessment of the governing body's impact over the past 12 months, in terms of driving improvements to:	% Poor / Fair	% Good	% Very Good / Excellent	%Agree * Canadian Average
	Organization	Organization	Organization	
33. Patient safety	0	0	100	80

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	
34. Quality of care	0	0	100	81

*Canadian average: Percentage of Accreditation Canada client organizations that completed the instrument from July to December, 2017 and agreed with the instrument items.

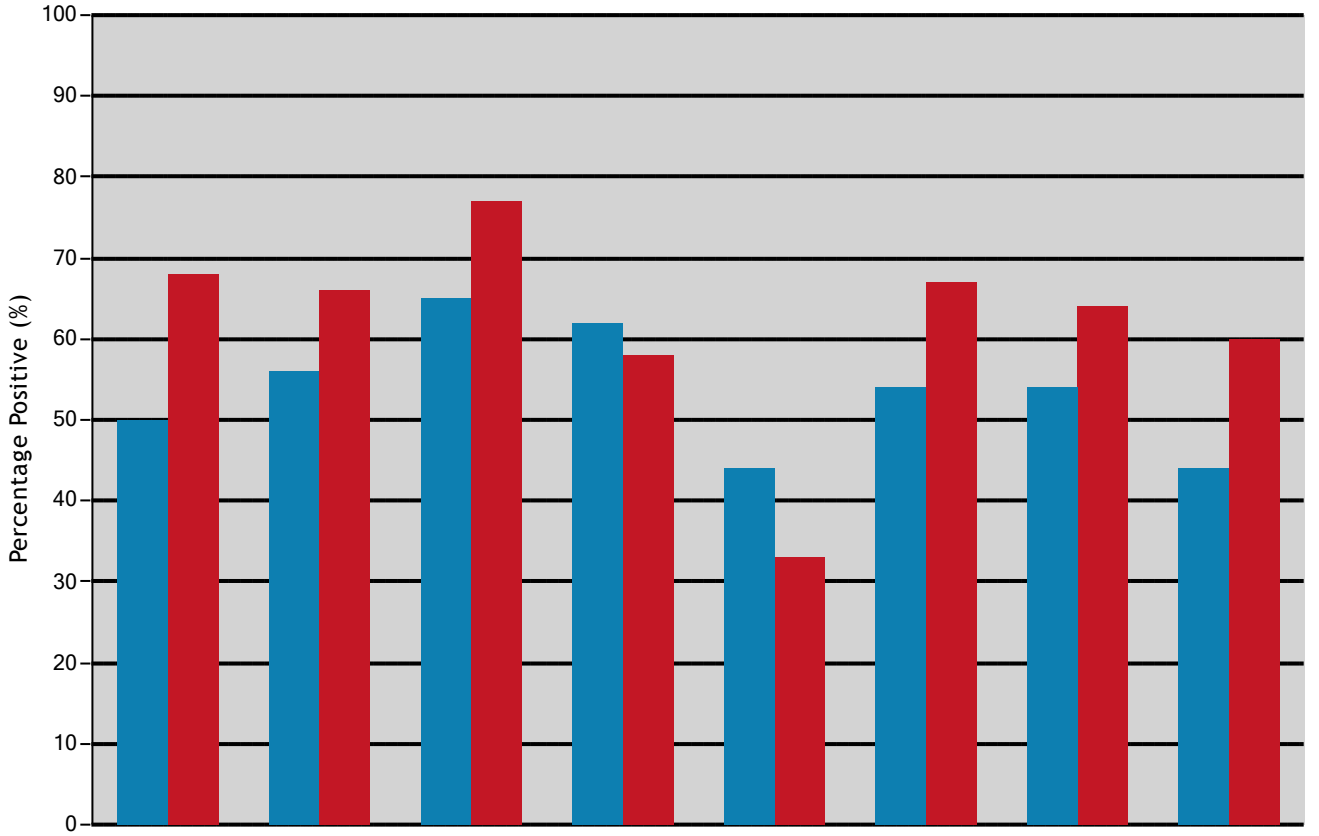
Canadian Patient Safety Culture Survey Tool

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: May 23, 2017 to September 4, 2017**
- **Minimum responses rate (based on the number of eligible employees): 173**
- **Number of responses: 179**

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
	50%	56%	65%	62%	44%	54%	54%	44%
	68%	66%	77%	58%	33%	67%	64%	60%

Legend

Yukon Hospital Corporation

* Canadian Average

*Canadian average: Percentage of Accreditation Canada client organizations that completed the instrument from July to December, 2017 and agreed with the instrument items.

Worklife Pulse

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.

The organization used an approved substitute tool for measuring quality of Worklife. The organization has provided Accreditation Canada with results from its substitute tool and had the opportunity to identify strengths and address areas for improvement. During the on-site survey, surveyors reviewed actions the organization has taken.

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 10 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
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.