ACCREDITATION
AGRÉMENT
CANADA
Qmentum

Accreditation Report

Alberta Health Services

Edmonton, AB

4th Component (2014-17 Cycle)

On-site survey dates: April 30, 2017 - May 5, 2017

Report issued: June 15, 2017

About the Accreditation Report

Alberta Health Services (referred to in this report as “the organization”) is participating in Accreditation Canada's Qmentum accreditation program. As part of this ongoing process of quality improvement, an on-site survey was conducted in April 2017. Information from the on-site survey as well as other data obtained from the organization were used to produce this Accreditation Report.

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

Confidentiality

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

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

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

A Message from Accreditation Canada

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

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

Your Program Manager 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

Alberta Health Services (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 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. 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

Alberta Health Services's accreditation decision is:

Accredited (Report)

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

About the On-site Survey

- **On-site survey dates: April 30, 2017 to May 5, 2017**

This on-site survey is part of a series of sequential surveys for this organization. Collectively, these are used to assess the full scope of the organization's services and programs.

- **Locations**

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

1. Alberta Children's Hospital
2. Anderson Hall - Royal Alexandra Hospital
3. Aspen House
4. Athabasca Community Health Services
5. Athabasca Healthcare Centre
6. Barrhead Healthcare Centre
7. Beaverlodge Community Health Services
8. Big Country Hospital
9. Bow Island Health Centre
10. Bow Island Provincial Building
11. Breton Health Centre
12. Brooks Health Centre
13. Canmore General Hospital
14. CapitalCare - Grandview
15. CapitalCare - Norwood
16. CapitalCare - Strathcona Care Centre
17. Carewest - George Boyack
18. Carewest - Signal Pointe
19. Chinook Regional Hospital
20. Claresholm General Hospital
21. Coaldale Health Centre
22. Cold Lake Community Health Services

23. Cold Lake Healthcare Centre
24. Consort Hospital and Care Centre
25. Coronation Plaza
26. Crowsnest Pass Health Centre
27. Devon General Hospital
28. Didsbury District Health Services
29. Dr. W.R. Keir Building Continuing Care Centre
30. Drayton Valley Community Health Centre
31. Drayton Valley Hospital and Care Centre
32. Drumheller Health Centre
33. East Calgary Health Centre
34. East Edmonton Health Centre
35. East Lake Centre
36. Edmonton General Hospital
37. Edmonton Provincial Laboratory
38. Elbow River Healing Lodge - Sheldon M. Chumir Health Centre
39. Elk Point Healthcare Centre
40. Evansburg Health Centre
41. Foothills Medical Centre
42. Fort McMurray Community Health Centre
43. Fort Saskatchewan Community Hospital
44. George McDougall - Smoky Lake Healthcare Centre
45. Grande Prairie Provincial Building
46. Grande Prairie Virene Building
47. Grimshaw/Berwyn Community Health Complex
48. High Prairie Health Complex
49. High River General Hospital
50. Horse Lake Community Health Station
51. HSBC Building
52. Hythe Continuing Care Centre
53. Innisfail Health Centre

54. J.B. Wood Continuing Care Centre
55. La Crete Community Health Centre
56. Lac La Biche Provincial Building
57. Leduc Community Hospital
58. Leduc Public Health Centre
59. Lethbridge Centre Tower
60. Lethbridge Community Health Centre
61. Lois Hole Hospital for Women
62. Manning Community Health Centre
63. Mannville Care Centre
64. Mayerthorpe Healthcare Centre
65. Medicine Hat Community Health Services
66. Medicine Hat Home Care
67. Medicine Hat Regional Hospital
68. Milk River Health Centre
69. Mother Rosalie Health Services Centre
70. Northern Lights Regional Health Centre
71. Northwest 1 - Home Care Office
72. Northwest Health Centre
73. Oilfields General Hospital
74. Okotoks Health and Wellness Centre
75. Olds Hospital and Care Centre
76. Olds Provincial Building
77. Oyen Community Health Services
78. Peace River Community Health Centre
79. Peter Lougheed Centre
80. Pincher Creek Health Centre
81. Ponoka Community Health Centre
82. Ponoka Hospital and Care Centre
83. Provost Health Centre
84. Queen Elizabeth II Hospital

85. Radway Continuing Care Centre
86. Raymond Health Centre
87. Red Deer Johnstone Crossing Community Health Centre
88. Red Deer Regional Hospital Centre
89. Redwater Health Centre
90. Rimbey Hospital and Care Centre
91. River Heights Professional Centre
92. Rocky Mountain House Health Centre
93. Rockyview General Hospital
94. Rotary Flames House (Alberta Hospital)
95. Royal Alexandra Hospital
96. Sheldon Kennedy Child Advocacy Centre
97. Sheldon M. Chumir Health Centre
98. Slave Lake Healthcare Centre
99. Smoky Lake Continuing Care Centre
100. South Health Campus
101. Southport Tower
102. St. Albert Home Care Office
103. St. Marguerite Health Services Centre
104. St. Theresa General Hospital
105. St. Therese - St. Paul Healthcare Centre
106. Stettler Community Health Centre
107. Stettler Hospital and Care Centre
108. Stollery Children's Hospital
109. Strathcona County Health Centre
110. Strathmore District Health Services
111. Sturgeon Community Hospital
112. Sundre Community Health Centre
113. Sundre Hospital and Care Centre
114. Sutherland Place Continuing Care Centre
115. Taber Health Centre

116. Three Hills Health Centre
117. Tofield Health Centre
118. Two Hills Health Centre
119. Vegreville Care Centre
120. Viking Community Health Centre
121. Vulcan Community Health Centre
122. West Jasper Place Public Health Centre
123. Westlock Continuing Care Centre
124. Westlock Healthcare Centre
125. Westview Health Centre
126. Wetaskiwin Hospital and Care Centre
127. William J. Cadzow - Lac La Biche Healthcare Centre
128. Willow Creek Continuing Care Centre
129. Winfield Community Health Centre

- **Standards**

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

Population-specific Standards

1. Population Health and Wellness

Service Excellence Standards

2. Aboriginal Integrated Primary Care
3. Critical Care
4. Home Care Services
5. Hospice, Palliative, End-of-Life Services
6. Long-Term Care Services
7. Medicine Services
8. Obstetrics Services
9. Perioperative Services and Invasive Procedures
10. Primary Care Services
11. Public Health Services

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)	61	5	0	66
 Accessibility (Give me timely and equitable services)	82	7	0	89
 Safety (Keep me safe)	269	48	6	323
 Worklife (Take care of those who take care of me)	61	25	0	86
 Client-centred Services (Partner with me and my family in our care)	333	44	7	384
 Continuity (Coordinate my care across the continuum)	89	1	0	90
 Appropriateness (Do the right thing to achieve the best results)	439	115	20	574
 Efficiency (Make the best use of resources)	15	3	1	19
Total	**1349**	**248**	**34**	**1631**

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
	# (%)	# (%)	#	# (%)	# (%)	#	# (%)	# (%)	#
Population Health and Wellness	4 (100.0%)	0 (0.0%)	0	35 (100.0%)	0 (0.0%)	0	39 (100.0%)	0 (0.0%)	0
Aboriginal Integrated Primary Care	54 (100.0%)	0 (0.0%)	8	107 (100.0%)	0 (0.0%)	0	161 (100.0%)	0 (0.0%)	8
Critical Care	48 (96.0%)	2 (4.0%)	0	89 (96.7%)	3 (3.3%)	23	137 (96.5%)	5 (3.5%)	23
Home Care Services	37 (75.5%)	12 (24.5%)	0	55 (72.4%)	21 (27.6%)	0	92 (73.6%)	33 (26.4%)	0
Hospice, Palliative, End-of-Life Services	41 (91.1%)	4 (8.9%)	0	103 (95.4%)	5 (4.6%)	0	144 (94.1%)	9 (5.9%)	0
Long-Term Care Services	39 (70.9%)	16 (29.1%)	0	78 (78.8%)	21 (21.2%)	0	117 (76.0%)	37 (24.0%)	0
Medicine Services	22 (48.9%)	23 (51.1%)	0	50 (64.9%)	27 (35.1%)	0	72 (59.0%)	50 (41.0%)	0
Obstetrics Services	60 (84.5%)	11 (15.5%)	2	83 (94.3%)	5 (5.7%)	0	143 (89.9%)	16 (10.1%)	2

Standards Set	High Priority Criteria *			Other Criteria			Total Criteria (High Priority + Other)		
	Met	Unmet	N/A	Met	Unmet	N/A	Met	Unmet	N/A
	# (%)	# (%)	#	# (%)	# (%)	#	# (%)	# (%)	#
Perioperative Services and Invasive Procedures	85 (73.9%)	30 (26.1%)	0	83 (76.1%)	26 (23.9%)	0	168 (75.0%)	56 (25.0%)	0
Primary Care Services	54 (93.1%)	4 (6.9%)	0	90 (98.9%)	1 (1.1%)	0	144 (96.6%)	5 (3.4%)	0
Public Health Services	41 (87.2%)	6 (12.8%)	0	58 (84.1%)	11 (15.9%)	0	99 (85.3%)	17 (14.7%)	0
Total	**485 (81.8%)**	108 (18.2%)	10	831 (87.4%)	120 (12.6%)	23	1316 (85.2%)	228 (14.8%)	33

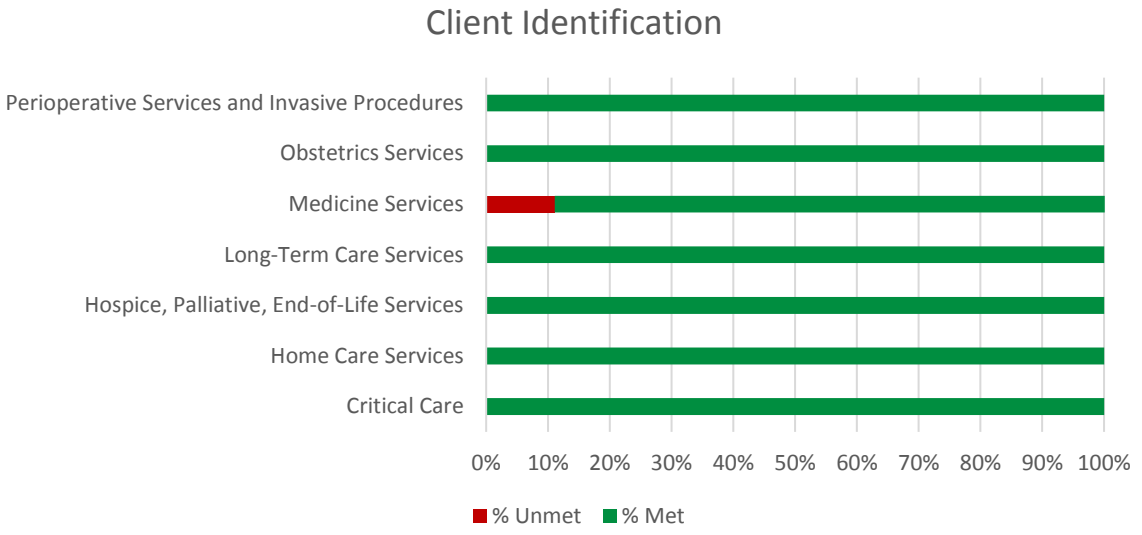
* Does not includes ROP (Required Organizational Practices)

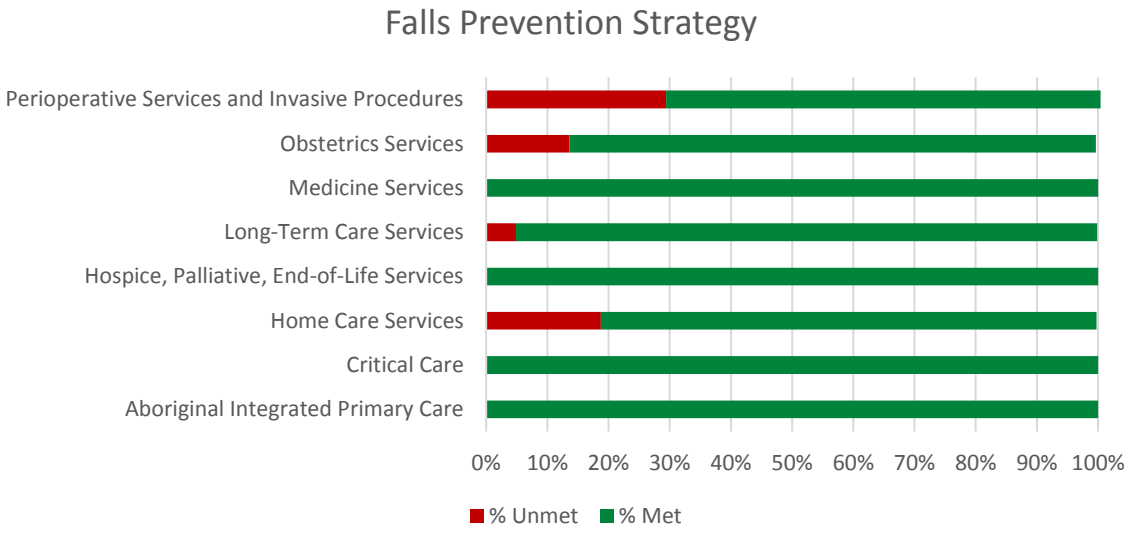
Overview by Required Organizational Practices

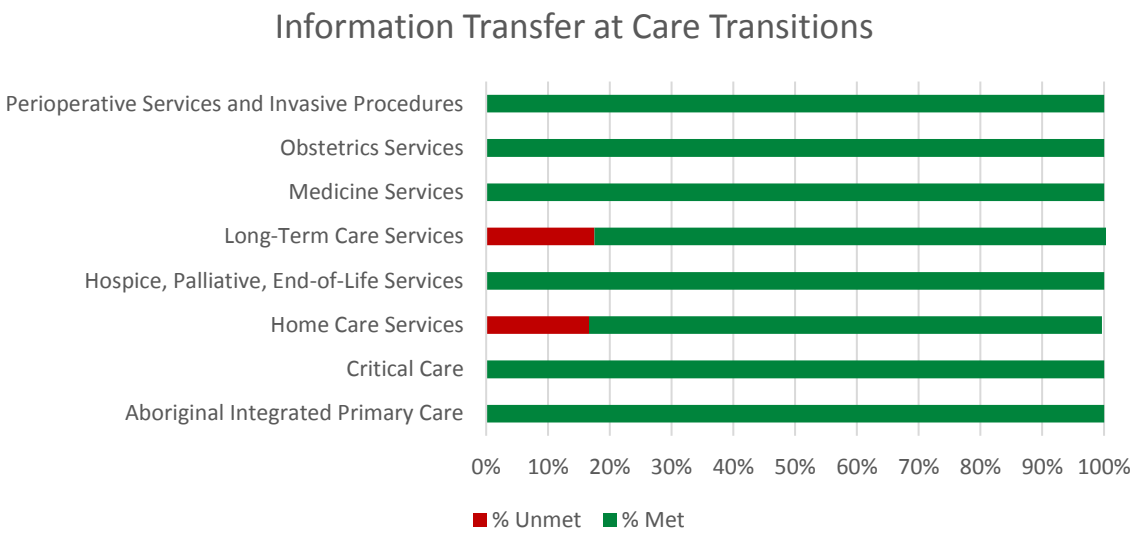
A Required Organizational Practice (ROP) is an essential practice that an organization must have in place to enhance client safety and minimize risk. Each ROP has associated tests for compliance, categorized as major and minor. All tests for compliance must be met for the ROP as a whole to be rated as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

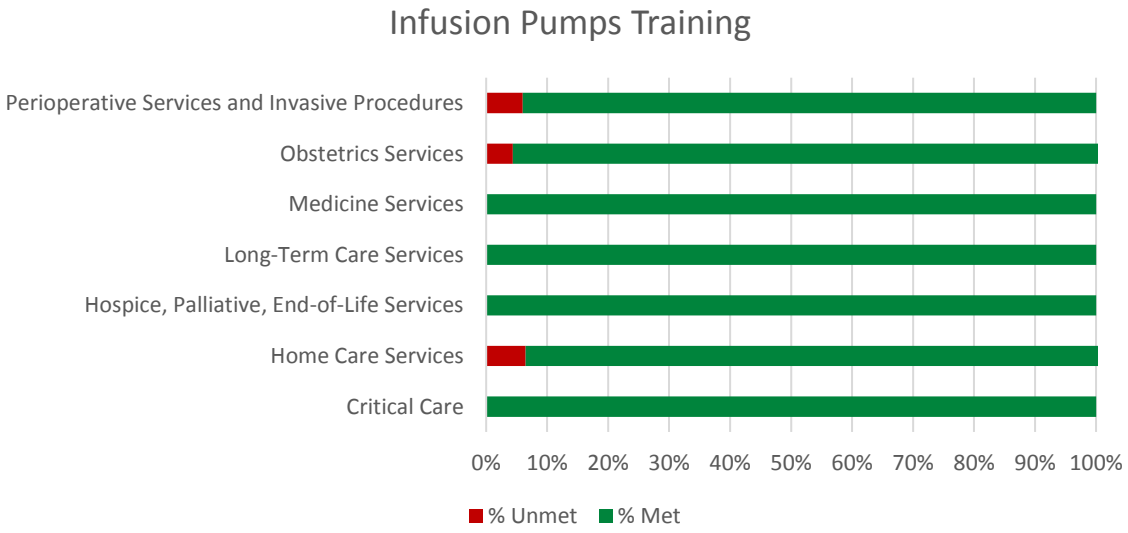
The graphics below show the percentage of locations* evaluated that complied with the ROP requirements.

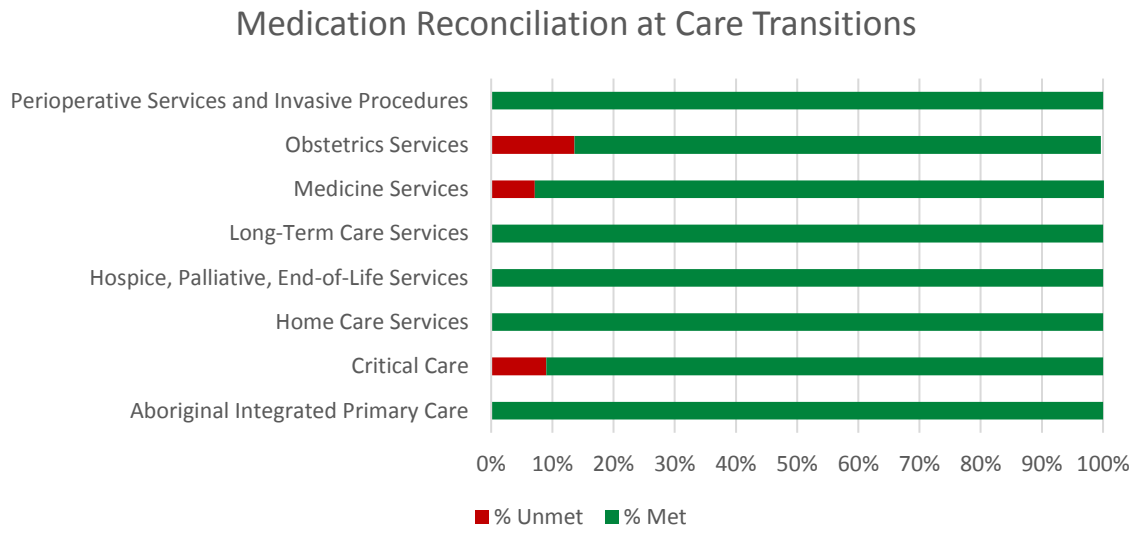
*Number of locations: NICU-Critical Care Services (11 locations), Home Care Services (32 locations), Hospice, Palliative, End of Life (8 locations), Long Term Care Services (41 locations), Medicine Services (28 rural locations), Obstetrics Services (22 locations), Perioperative Services and Invasive Procedure (17 rural locations), Aboriginal Integrated Primary Care (2 locations).

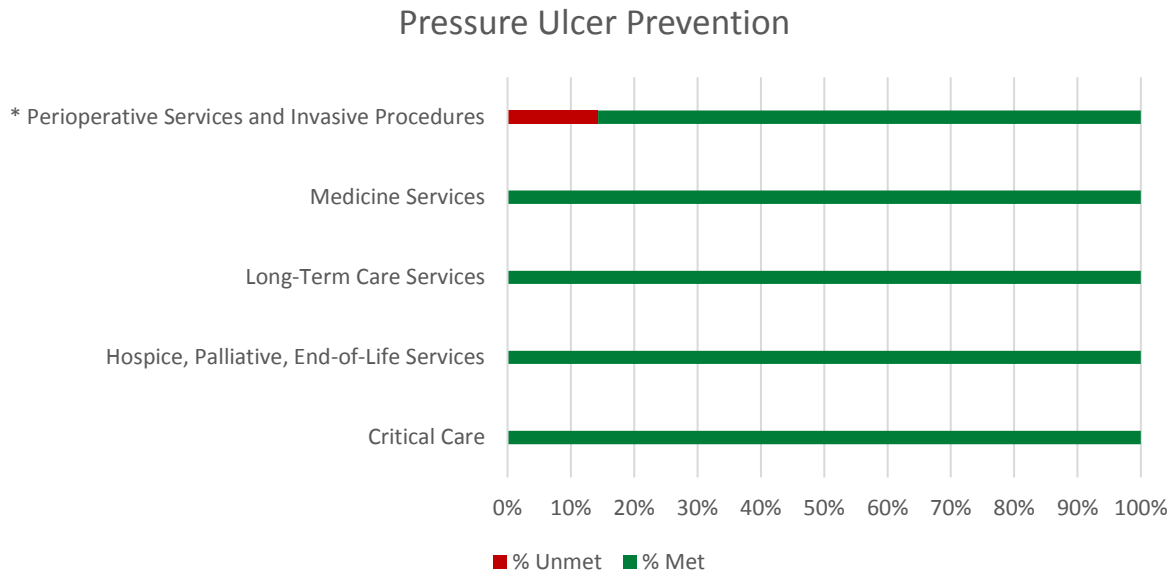




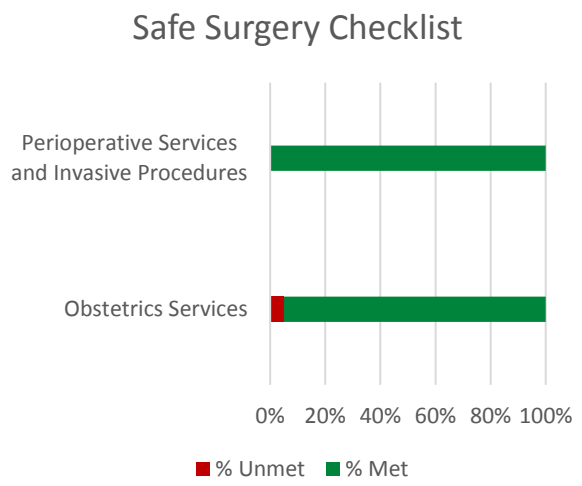

Information Transfer at Care Transitions
Perioperative Services and Invasive Procedures
Obstetrics Services
Medicine Services
Long-Term Care Services
Hospice, Palliative, End-of-Life Services
Home Care Services
Critical Care
Aboriginal Integrated Primary Care
0%
10%
20%
30%
40%
50%
60%
70%
80%
90%
100%
% Unmet
% Met

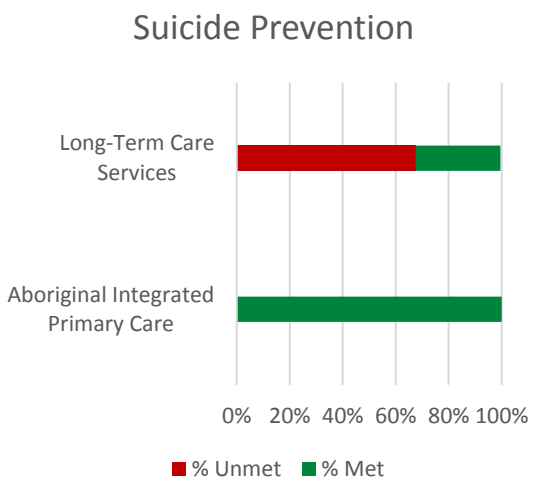

Infusion Pumps Training
Perioperative Services and Invasive Procedures
Obstetrics Services
Medicine Services
Long-Term Care Services
Hospice, Palliative, End-of-Life Services
Home Care Services
Critical Care
0%
10%
20%
30%
40%
50%
60%
70%
80%
90%
100%
% Unmet
% Met

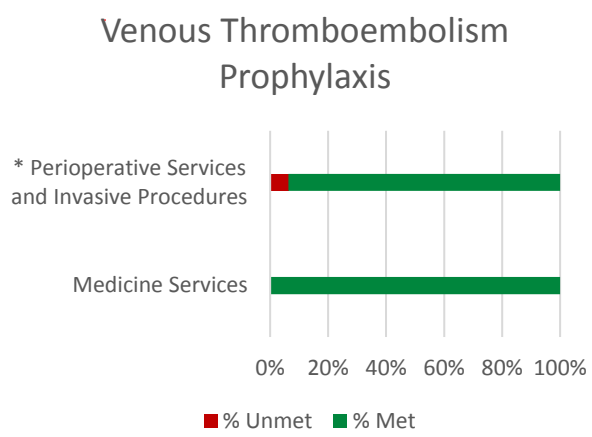


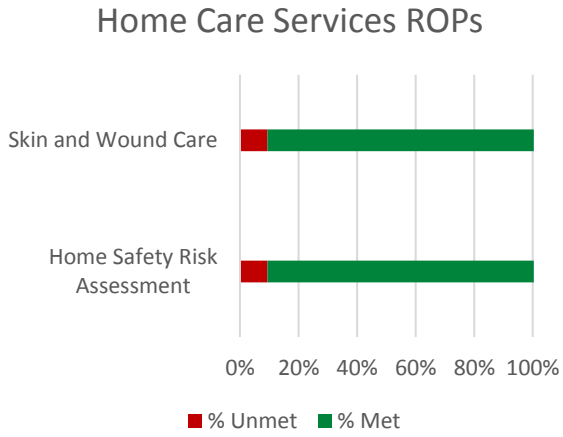


** This ROP in Perioperative and Invasive Procedures does not apply for outpatient settings, including day surgery*









** This ROP in Perioperative and Invasive Procedures does not apply to day procedures or procedures with only an overnight stay*

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: Communication			
Client Identification (Aboriginal Integrated Primary Care)	Met	1 of 1	0 of 0
Client Identification (Critical Care)	Met	1 of 1	0 of 0
Client Identification (Home Care Services)	Met	1 of 1	0 of 0
Client Identification (Hospice, Palliative, End-of-Life Services)	Met	1 of 1	0 of 0
Client Identification (Long-Term Care Services)	Met	1 of 1	0 of 0
Client Identification (Medicine Services)	Unmet	0 of 1	0 of 0
Client Identification (Obstetrics Services)	Met	1 of 1	0 of 0
Client Identification (Perioperative Services and Invasive Procedures)	Met	1 of 1	0 of 0
Information transfer at care transitions (Aboriginal Integrated Primary Care)	Met	4 of 4	1 of 1
Information transfer at care transitions (Critical Care)	Met	4 of 4	1 of 1

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Communication			
Information transfer at care transitions (Home Care Services)	Unmet	2 of 4	0 of 1
Information transfer at care transitions (Hospice, Palliative, End-of-Life Services)	Met	4 of 4	1 of 1
Information transfer at care transitions (Long-Term Care Services)	Unmet	1 of 4	0 of 1
Information transfer at care transitions (Medicine Services)	Met	4 of 4	1 of 1
Information transfer at care transitions (Obstetrics Services)	Met	4 of 4	1 of 1
Information transfer at care transitions (Perioperative Services and Invasive Procedures)	Met	4 of 4	1 of 1
Medication reconciliation at care transitions (Aboriginal Integrated Primary Care)	Met	7 of 7	0 of 0
Medication reconciliation at care transitions (Critical Care)	Unmet	4 of 5	0 of 0
Medication reconciliation at care transitions (Home Care Services)	Met	4 of 4	1 of 1
Medication reconciliation at care transitions (Hospice, Palliative, End-of-Life Services)	Met	5 of 5	0 of 0
Medication reconciliation at care transitions (Long-Term Care 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: Communication			
Medication reconciliation at care transitions (Medicine Services)	Unmet	4 of 5	0 of 0
Medication reconciliation at care transitions (Obstetrics Services)	Unmet	2 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 (Obstetrics Services)	Unmet	2 of 3	2 of 2
Safe Surgery Checklist (Perioperative Services and Invasive Procedures)	Met	3 of 3	2 of 2
Patient Safety Goal Area: Medication Use			
Infusion Pumps Training (Critical Care)	Met	4 of 4	2 of 2
Infusion Pumps Training (Home Care Services)	Unmet	3 of 4	2 of 2
Infusion Pumps Training (Hospice, Palliative, End-of-Life Services)	Met	4 of 4	2 of 2
Infusion Pumps Training (Long-Term Care Services)	Met	4 of 4	2 of 2
Infusion Pumps Training (Medicine Services)	Met	4 of 4	2 of 2
Infusion Pumps Training (Obstetrics Services)	Unmet	2 of 4	0 of 2

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Medication Use			
Infusion Pumps Training (Perioperative Services and Invasive Procedures)	Unmet	2 of 4	0 of 2
Patient Safety Goal Area: Risk Assessment			
Falls Prevention Strategy (Aboriginal Integrated Primary Care)	Met	3 of 3	2 of 2
Falls Prevention Strategy (Critical Care)	Met	3 of 3	2 of 2
Falls Prevention Strategy (Home Care Services)	Unmet	3 of 3	0 of 2
Falls Prevention Strategy (Hospice, Palliative, End-of-Life Services)	Met	3 of 3	2 of 2
Falls Prevention Strategy (Long-Term Care Services)	Unmet	2 of 3	0 of 2
Falls Prevention Strategy (Medicine Services)	Unmet	3 of 3	1 of 2
Falls Prevention Strategy (Obstetrics Services)	Unmet	0 of 3	0 of 2
Falls Prevention Strategy (Perioperative Services and Invasive Procedures)	Unmet	0 of 3	0 of 2
Home Safety Risk Assessment (Home Care Services)	Unmet	2 of 3	2 of 2
Pressure Ulcer Prevention (Critical Care)	Met	3 of 3	2 of 2
Pressure Ulcer Prevention (Hospice, Palliative, End-of-Life Services)	Met	3 of 3	2 of 2

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Risk Assessment			
Pressure Ulcer Prevention (Long-Term Care Services)	Met	3 of 3	2 of 2
Pressure Ulcer Prevention (Medicine Services)	Met	3 of 3	2 of 2
Pressure Ulcer Prevention (Perioperative Services and Invasive Procedures)	Unmet	0 of 3	0 of 2
Skin and Wound Care (Home Care Services)	Unmet	6 of 7	0 of 1
Suicide Prevention (Aboriginal Integrated Primary Care)	Met	5 of 5	0 of 0
Suicide Prevention (Long-Term Care Services)	Unmet	0 of 5	0 of 0
Venous Thromboembolism Prophylaxis (Medicine Services)	Met	3 of 3	2 of 2
Venous Thromboembolism Prophylaxis (Perioperative Services and Invasive Procedures)	Unmet	0 of 0	0 of 1

Summary of Surveyor Team Observations

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

This is the final year in the accreditation cycle (2014 to 2017) for Alberta Health Services (AHS). The organization is commended for its commitment to the accreditation process and its flexibility and creativity in adapting the accreditation process to its large and complex operations. AHS has led the way in developing a variety of strategies to review services across the organization while maintaining a systems approach.

This on-site survey involved 30 surveyors plus a patient advisor observer across 129 sites. There were 198 tracers conducted, with a focus on medicine and perioperative and invasive procedures in rural sites, continuing care, primary care, aboriginal integrated primary care, obstetrics, neonatal intensive care, and public health.

Under the leadership of the new AHS board, the president and CEO, and the leadership team, and in consultation with more than 13,000 staff, AHS has developed a new vision, mission, and values. These serve as a strong foundation to inform and drive planning, policy, and service delivery. A variety of mechanisms has been established to guide this work, including health advisory councils, the Wisdom Council, provincial advisory councils for cancer, addictions, and mental health, and 14 strategic clinical networks (SCNs).

A commitment to more patient- and family-centred care is an important future direction and priority for AHS. The voices of patients and families are informing plans and decisions. There are some wonderful examples of partnerships with patients and families. Staff are trained on the principles of patient engagement and patient- and family-centred care. In many cases, the organization is beginning to move beyond consulting with patients and families to identify and understand their needs (e.g., through satisfaction surveys) to a more genuine partnership that views patients and families as members of the care team and as valued partners in planning, policy development, and evaluation of services. Much of the input from patients and families occurs at the higher-organizational levels, including the SCNs, and, with some exceptions, has not yet been established at the local site and service levels. This represents a significant culture change that will continue to require vision, persistence, and creativity. The organization is encouraged to build on the existing good work and continue to learn from good practices that exist both internally and in other high-performing patient- and family-centred organizations and systems.

Each year, AHS continues to mature as a system. This was evident throughout the on-site survey. The stability of the leadership has facilitated the organization’s ability to focus on the benefits of standardization and best practice deployment. Across the organization there is evidence of increased standardization of practices and application of evidence-informed practices, tools, and decision making. In some cases these have been customized to meet the needs of patients, residents, and clients in particular care settings. Numerous staff expressed appreciation for the support of the SCNs and the zone leadership, as well as the organization’s commitment to continuous quality improvement, staff education, access to data, and support for programs such as the Managing Obstetrical Risk Efficiently (MORE-OB) program. In some locations, staff expressed

some frustration about delays and the perceived inability to move forward independently because of zone-based rules and requirements.

AHS has made a strong commitment to quality and safety. Although some Required Organizational Practices (ROPs) are still unmet, considerable progress has been made. Some ROPs have been widely adopted but are not yet in place in one or a small number of sites, for a variety of reasons including high manager turnover. These sites will require additional support to meet these standards. In some cases, only the evaluation component is missing but plans are underway to do this. Some new safety processes such as suicide prevention have been developed at the AHS level and are just beginning to be deployed at local sites.

Some sites demonstrate an exceptional commitment to quality and proudly display quality boards to educate staff, patients, and visitors about the improvement work underway and the results. At some sites, the maturity of the safety processes and quality improvement initiatives appears to be correlated with the effectiveness and/or stability of management in the respective areas. The organization is encouraged to continue promoting the capacity for and commitment to quality improvement across all sites.

By design, the structure of AHS brings together many previously fragmented facilities, sites, agencies, and services into a single regional system. AHS has many partners and this is evident across the organization. Partners include those involved in care delivery, such as primary care networks, as well as community agencies and corporate sponsors. Some service providers reflect a combination of AHS owned and operated and contracted services such as ambulance services. Concerns were expressed at some rural sites regarding access to and timeliness of ambulance services, significantly impacting patient care. It is important for AHS to continue to manage service contracts with third parties to ensure accountability for quality services.

The 2016 on-site survey occurred during the Fort McMurray fires, at which time AHS and many individuals and agencies came together to respond capably and compassionately to this disaster. Teams continue to exemplify the patient- and family-centred care they demonstrated when they ensured the safe transfer of their patients. Equally commendable is the return of team members to Fort McMurray and the Herculean work, supported by teams from across AHS, to restore health care services in the community. Teams across AHS, in collaboration with many partner organizations, continue to provide support to displaced clients and families and are responding to new challenges. This is a fine example of patient- and family-centred care and the commendable resilience of staff and community.

Throughout the on-site survey, enhanced integration of services among sites and programs was observed. Considerable progress has been made in reducing silos and creating a more system-wide approach to services. The structure of AHS reflects a matrix model, with corporate services reporting through the zones but supporting individual sites. In many cases this works well, but not always. Some rural sites described a sense of isolation and lack of connection to AHS, communications issues and/or a lack of sufficient support by some corporate services, resulting in a negative impact on patient and staff safety. This will continue to be a challenge given the reality of geography and the need to ensure safe environments and practices across all settings and sites. The planned development of a comprehensive, integrated electronic health record will positively impact integration, communication, and coordination across sites and care providers.

The ultimate test of the success of any health system is how it is experienced by patients, clients, residents, families, and communities. In conducting this on-site survey, hundreds of patients, clients, residents, and family members were spoken with, and they generally expressed a high level of satisfaction and praised the dedication and hard work of the individuals and teams who provide care and services. Although opportunities for improvement were identified, there appears to be an increased level of public confidence in the organization and a belief that it is working hard to improve services while being accountable for sustainability and stewardship of public resources.

Similarly, staff throughout the organization generally express a high level of satisfaction with their work and workplace. They show great pride in the work they do, are very engaged in quality improvement, and generally feel supported by the organization. They have identified additional resource and support needs and this will remain an ongoing challenge for the organization.

Compassion, accountability, respect, excellence, and safety are the core values that have been selected to define who AHS is, reflecting that AHS CARES. The results of this on-site survey, while identifying areas for improvement, confirm that AHS does care and is well on its way to being the high-performing organization it aspires to be.

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 resident is communicated effectively during care transitions.	· Home Care Services 9.10 · Long-Term Care Services 9.19
Client Identification Working in partnership with clients and families, at least two person-specific identifiers are used to confirm that clients receive the service or procedure intended for them.	· Medicine Services 9.2
Safe Surgery Checklist A safe surgery checklist is used to confirm that safety steps are completed for a surgical procedure performed in the operating room.	· Obstetrics Services 10.6
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.	· Medicine Services 8.5 · Obstetrics Services 8.5 · Critical Care 8.6
Patient Safety Goal Area: Medication Use	
Infusion Pumps Training A documented and coordinated approach for infusion pump safety that includes training, evaluation of competence, and a process to report problems with infusion pump use is implemented.	· Home Care Services 3.8 · Obstetrics Services 3.9 · Perioperative Services and Invasive Procedures 6.9

Unmet Required Organizational Practice	Standards Set
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.	· Perioperative Services and Invasive Procedures 11.11 · Long-Term Care Services 8.6 · Medicine Services 8.6 · Obstetrics Services 8.6 · Home Care Services 8.7
Pressure Ulcer Prevention Each client's risk for developing a pressure ulcer is assessed and interventions to prevent pressure ulcers are implemented. NOTE: This ROP does not apply to outpatient settings, including day surgery, given the lack of validated risk assessment tools for outpatient settings.	· Perioperative Services and Invasive Procedures 11.12
Suicide Prevention Clients are assessed and monitored for risk of suicide.	· Long-Term Care Services 8.8
Home Safety Risk Assessment A safety risk assessment is conducted for clients receiving services in their homes.	· Home Care Services 14.2
Venous Thromboembolism Prophylaxis Medical and surgical clients at risk of venous thromboembolism (deep vein thrombosis and pulmonary embolism) are identified and provided with appropriate thromboprophylaxis.NOTE: This ROP does not apply for pediatric hospitals; it only applies to clients 18 years of age or older. This ROP does not apply to day procedures or procedures with only an overnight stay.	· Perioperative Services and Invasive Procedures 11.13
Skin and Wound Care An interprofessional and collaborative approach is used to assess clients who need skin and wound care and provide evidence-informed care that promotes healing and reduces morbidity and mortality.	· Home Care Services 8.8

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: Physical Environment

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

Unmet Criteria		High Priority Criteria
Standards Set: Perioperative Services and Invasive Procedures		
3.6	Airflow and quality in the area(s) where surgical and invasive procedures are performed are monitored and maintained according to standards applicable for the type of procedures performed.	!
3.7	Rooms where surgical and invasive procedures are performed have at least 20 complete air exchanges per hour.	!
Surveyor comments on the priority process(es)		

The rural perioperative and medicine service team has developed effective processes to manage supplies and patient flow, despite challenging physical layouts. Rural sites have been innovative in developing practices to deal with space challenges while mitigating patient risk. At smaller sites, opportunities to leverage common spaces have been optimized without compromising care or privacy.

Although there is sharing of some space, areas conform to the three levels of restricted access. Staff are attentive to patient and visitor flow and are commended for developing protocols to restrict access to perioperative spaces.

Extensive logs are kept by location to ensure environmental standards are met. AHS is encouraged to have a central reporting system for these types of data sets.

Processes are in place for environment inspections but are not consistent. Sites are encouraged to have a coordinated approach for certification, monitoring, and reporting across AHS.

Air quality records are kept but were difficult to locate. There is not a consistent protocol to monitor and report on this requirement. A standardized monitoring and reporting approach through a centralized facility database would benefit AHS. This is a critical requirement to ensure patient safety.

All operating rooms and procedure rooms have systems to ensure gas piping and connectors cannot be interchanged.

Effective measures and protocols are in place to maintain segregated flows for the sterility of supplies and equipment. Each location has found local solutions to deal with space and layout challenges. Staff and leadership are commended for their adaptive approaches without needing expensive redesign of physical space. As locations make layout changes, they are encouraged to re-evaluate clean and contaminated supply and instrumentation flow, such as in the endoscopy suites.

AHS is commended for the extensive training and monitoring that is in place for cleaning of perioperative spaces. Housekeeping staff are supported by leadership and understand the significance of their work and its impact on patient safety.

Priority Process: Emergency Preparedness

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

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

The emergency/disaster preparedness team is a diverse group of professionals with varying backgrounds and expertise whose goal is to ensure AHS is well positioned to respond to and recover from any emergency situations. AHS and this team are commended for their success in responding to numerous large scale emergencies such as the floods that occurred in 2013 and the Fort McMurray fire in 2016. AHS has used these very challenging occurrences to refine and enhance its emergency response plans and strategies to react to future events.

There is very good coordination and collaboration with local and provincial bodies responsible for emergency plans. The team talked about participating in numerous mock disaster exercises, and planning for future ones, with partners across the province. These exercises are encouraged, as they are an excellent way to “stress test” the team’s plans in coordination with community partners.

The organization is encouraged to continue to provide ongoing education to staff, service providers, and clients and families related to emergency preparedness. Given the size of the organization and the number of sites, there are challenges in trying to provide a consistent approach in the uptake and readiness for events. This can lead to some variability. Drills of emergency response plans are delivered at the local, site, and zone levels which can result in some inconsistency in terms of readiness and understanding of the plans. AHS is encouraged to continue with its strategies to enhance the education of staff regarding emergency response plans and to continue to promote drills and debriefings as appropriate.

Public health has a very strong leadership presence in emergency preparedness that contributes to good communication and response on issues related to outbreaks and pandemics. As well, there is prompt detection of, response to, and containment of any disease outbreak.

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)

There are 80 rural hospital sites in AHS and 55 of these provide some form of surgical services. AHS is using the Alberta Coding Access Targets for Surgery (ACATS) tool to collect data on diagnosis-based coding for scheduled surgeries. The tool is used for coding booked cases and to help identify wait times for elective surgeries. The timeline for implementing this tool at all sites is by September 2017. Endoscopy cases will be included in the near future.

The ACATS data are collected monthly and results are provided to each zone. The accountability for dealing with those wait time cases that fall outside the acceptable wait window lies with each zone. Physicians are encouraged to work together to develop solutions to their wait time issues. Cancer cases in every zone currently fall outside the window. Alberta residents may use the My Health Alberta website to view wait times for specific surgical cases such as joints and cataracts.

AHS is aware that operating room capacity could be increased by using all operating rooms five days per week in the rural sites. Processes have started to decant some volumes from the larger sites to the smaller sites (e.g., Red Deer to Stettler and Innisfail). Patient safety and staff skill sets and competency are always a top consideration for AHS when moving services. The Rural Resource Survey is helping emergency medical services (EMS) and RAAPID (referral, access, advice, placement, information and destination) identify what kind of services are provided at each rural site.

AHS is in the process of purchasing a clinical information system that will include a standardized operating room scheduling system for the province.

Priority Process: Medical Devices and Equipment

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

Unmet Criteria	High Priority Criteria
Standards Set: Perioperative Services and Invasive Procedures	
4.13 Clean and sterile surgical equipment, medical devices, and supplies are stored separately from soiled equipment and waste, and according to manufacturers' instructions.	!

Surveyor comments on the priority process(es)

Flash sterilization is not done at any site.

All staff are certified in reprocessing.

Broken equipment is returned to use only after being repaired and fully evaluated for safety and effectiveness. Contaminated equipment is kept separately from clean equipment and is transported in covered bins. All clean equipment can be traced back to its sterilization cycle and forward to the patient on which it was used.

Some reprocessing departments are small and crowded and need to be renovated, but the overall process of disinfection and sterilization is still carried out in a professional fashion.

Priority Process Results for Population-specific Standards

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

Priority processes specific to population-specific standards are:

Population Health and Wellness

- Promoting and protecting the health of the populations and communities served through leadership, partnership, and innovation.

Standards Set: Population Health and Wellness - Horizontal Integration of Care

Unmet Criteria	High Priority Criteria
Priority Process: Population Health and Wellness	
The organization has met all criteria for this priority process.	

Surveyor comments on the priority process(es)
Priority Process: Population Health and Wellness

Population health and wellness is a strategic priority. The organization has allocated additional resources to support a shift from an illness focus to a wellness focus. Key administrative and clinical leadership roles are in place to lead initiatives.

The organization uses information from a variety of population health assessments, which include, Canadian Health Measures Survey, Health Status Assessment Dashboard, and clinical information from across the organization to identify priority target populations, gaps, and high-risk areas. Since the data show seniors to be the fastest growing population, the Seniors Health Strategic Clinical Network (SCN) was created. The Seniors Health SCN facilitates connection with key leadership roles across the system, sharing clinical expertise, research, data analysis, and learnings. It also engages residents, patients, caregivers, and families to find better ways to deliver care to improve the health of seniors. The Seniors Health SCN has developed a transformation roadmap that identifies three key areas of focus including dementia, delirium, and frailty.

The organization sets goals for its services and priority populations. There is a process to identify and approve initiatives based on criteria that include available research and evidence, risk to the population, potential to reduce costs and improve quality, and health status. A good example of an initiative to reduce harm and improve the health of seniors was the appropriate use of antipsychotics (AUA) project in the seniors' population. Evidence showed that seniors on long-term antipsychotics were at risk of harm. The data from AHS were above the national average. Through the AUA project the team

demonstrated key components leading to the success of that initiative. These included the engagement of clinicians and family and expert advisory groups; involving partners at provider, community, volunteer, and provincial levels; the use of education to change the practice, inform, and get buy in; and using data to show progress via a balanced scorecard. The initiative resulted in a reduction in antipsychotic prescriptions from 35 percent to 20 percent with an objective to further lower this rate. The residents' and families' experience with the improved quality of life was demonstrated in a video which is a powerful communications tool. The team is sharing its tools and learnings with other jurisdictions and is recognized nationally by the Canadian Institute for Health Information, the Canadian Foundation for Healthcare Improvement, and Choosing Wisely Canada. The organization is commended for its approach and success.

The organization is actively involved in developing and advocating for public policies to improve population health. The team has undertaken a project to implement daily mouth care in Long Term Care (LTC) in response to Alberta's Continuing Care Health Service Standards that require long-term care facilities to provide oral care to residents twice a day. A pilot project was initiated at three sites with a plan to implement a train-the-trainer model. The team is working with the various clinicians and partners to develop a strategy to implement this across all Continuing Care. A toolkit has been developed and is available to all staff (AHS & Contracted) on the Continuing Care Desktop. Information has been developed for residents and families. The educational resources and tool kit for providing oral care in continuing care focus on enabling residents to self-manage their oral care to the degree possible.

There is a strong analytics team in the organization. Information from Tableau, the data analysis system, is used to identify priority areas, monitor improvements, and inform a balanced scorecard approach.

There is evidence of a strong focus on education and training facilitated by clinical educators. Education adapted to the various target groups is integrated into initiatives. This was critical to the success of the AUA project.

Strong community partnerships are evident across the organization. The organization has a well-established relationship with the research community and participates in many research initiatives. The relationship with the primary care physicians in the organization is key to influencing practice at the community level and spreading best practices into primary care within AHS. The organization is encouraged to continue to expand the participation of primary care physicians outside AHS.

Self-management programs are offered for clients with chronic conditions and the organization is encouraged to continue to support these programs.

The team is encouraged to continue to identify initiatives that improve health and can be linked to reduced costs and improved efficiencies. The organization needs to continue to integrate the social determinants of health into program development. Partnerships need to be nurtured across the various sectors. Strategies and partnerships to meet the needs of the indigenous population are encouraged.

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.

Public Health

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

Standards Set: Aboriginal Integrated Primary Care - Direct Service Provision

Unmet Criteria	High Priority Criteria
Priority Process: Clinical Leadership	

The organization has met all criteria for this priority process.

Priority Process: Competency

The organization has met all criteria for this priority process.

Priority Process: Episode of Care

The organization has met all criteria for this priority process.

Priority Process: Decision Support

The organization has met all criteria for this priority process.

Priority Process: Impact on Outcomes

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

The team involves the Wisdom Council in program development and setting goals and objectives.

The team has processes to access the resources and support to achieve its goals and objectives.

The team is skilled and competent in developing and coordinating partnerships with other teams, providers, and organizations.

Priority Process: Competency

The team is a well functioning interdisciplinary team that regularly shares information among members and other teams across the organization.

There are good processes are in place to ensure that each provider has the appropriate license or credentials from the relevant college or association. The team is exploring options for classification of traditional care providers and spiritual healers.

Staff and service providers work to their full scope of practice.

Team members report a comprehensive orientation process and support for both continuing education and in-service training.

There are processes to support student placement on the team.

Priority Process: Episode of Care

Standardized processes are used for client assessment and the client's individual needs and preferences are included. This assessment is documented and shared.

A Best Possible Medication History is generated and used.

The assessment leads to a care planning process and clients are involved. Clients are assessed and monitored for risk of suicide.

Supports are provided for clients to understand service information and participate in service delivery.

Services are delivered consistent with the care plan and are well documented.

Priority Process: Decision Support

Processes are in place to provide staff with access to research-based evidence and best practice information.

The team also accesses traditional care and spiritual practice information. This information is shared within the team and communicated to other interested practitioners.

There is a culture of organizational learning and evidence-based decision-making coupled with traditional practices.

Priority Process: Impact on Outcomes

The team identifies measures of performance and targets for success and analyzes performance data.

The team is encouraged to review and enhance identification and monitoring of processes and outcome measures to evaluate and improve service quality and client outcomes.

Standards Set: Critical Care - Direct Service Provision

Unmet Criteria		High Priority Criteria
Priority Process: Clinical Leadership		
2.5	Space is co-designed with clients and families to ensure safety and permit confidential and private interactions with clients and families.	
2.8	A universally-accessible environment is created with input from clients and families.	
Priority Process: Competency		
3.11	Team member performance is regularly evaluated and documented in an objective, interactive, and constructive way.	!
4.6	Position profiles with defined roles, responsibilities, and scope of employment or practice exist for all positions.	
Priority Process: Episode of Care		
8.6	Medication reconciliation is conducted in partnership with clients and families to communicate accurate and complete information about medications across care transitions.	ROP
8.6.4	The prescriber uses the BPMH and the current medication orders to generate transfer or discharge medication orders.	**MAJOR**
9.15	The Safer Healthcare Now! Central Line (CLI) bundle is implemented for all clients requiring a central line, in partnership with the client and family.	!
Priority Process: Decision Support		
The organization has met all criteria for this priority process.		
Priority Process: Impact on Outcomes		
The organization has met all criteria for this priority process.		
Priority Process: Organ and Tissue Donation		
The organization has met all criteria for this priority process.		
Surveyor comments on the priority process(es)		
Priority Process: Clinical Leadership		

At a regional level, the Critical Care Strategic Clinical Network (SCN) provides system-level leadership through quality improvement, priority setting, and variation reduction. The Critical Care SCN has only been in place for approximately two years. Membership on the SCN committees cover all geographical zones, with a variety of operational staff and physician leaders. They have embraced patient and family engagement in a very significant way. A transformation roadmap has been developed that identifies priorities for the next three years.

There are many partners involved in the delivery of comprehensive neonatal care. At the strategic level, there are clear partnerships with the practice improvement networks, provincial program, research, and academia. At the local level, there are partnerships with community organizations, foundations, public health, etc.

Neonatal transport teams provide outreach services to all neonatal units in the province. A new telehealth service is being introduced this year, providing video conferencing between level 3 and level 2 centres. The transport team is highly skilled and highly respected. The telehealth program has not yet reached full implementation and there are mixed reactions at this early stage. The team is encouraged to closely monitor this service to ensure it can reach its potential.

There are space concerns in some of the neonatal intensive care units (NICUs). The newer units have been able to introduce spaces that more adequately support family involvement and promote developmental care. However, some units are significantly challenged by congestion. The Critical Care SCN is encouraged to inform the organization of specific needs and assist the organization when priorities for redevelopment are established.

Priority Process: Competency

Units have defined orientation, training, education, and certification plans. Family input is gathered through a variety of means, including surveys, membership on Quality Iimprovement and patient advisory committees.

Most units provide specific training and education on specialty equipment such as infusion pumps, monitoring equipment, and glucometers. Most units run annual skills refresher sessions to maintain competency.

The educators organize annual skills education days. Staff certifications appear to be up to date. Infusion pump training is particularly well done.

The organization is encouraged to review its approach to reducing workplace violence and consider approaches to proactive risk screening, risk reduction, and response training. No obvious incidents were reported. However, given the nature of the unit and the population it serves, there is potential for workplace violence incidents. The organization is encouraged to support staff in their efforts to address workplace violence.

Priority Process: Episode of Care

This is an outstanding group of teams who have recently been included in the Maternal, Newborn, Child, and Youth SCN. Without exception they are high-performing teams that truly understand the concept of patient- and family-centred care. Family involvement in care is clearly supported at the bedside and at the senior leadership levels of the SCN. Family members are on many of the SCN leadership committees and working groups. Many of the local sites have Family Advisory Committees as well. Peer-to-peer support programs are in place in some of the NICUs. This team provides many examples of meaningful family involvement.

All NICUs are classified by the level of care provided. Infants are assessed and the decision to admit is based on infant condition and the capability of the unit. If the local NICU is unable to provide the required care, the child is transferred to an appropriate level of care. The levels of care are well understood by the team members. Very few concerns were expressed regarding level 3 units being willing/able to accept transfers. There have been capacity issues in certain units, but the team seems to work well together to resolve over-capacity situations. The transport team and the telehealth program are important elements of the program, supporting the collaborative approach to care.

From admission to transfer, there are standardized processes to ensure families understand the treatment options and are able to provide informed consent for treatment. Team rounds are an essential practice in the unit. They are truly interdisciplinary, respectful, and effective. Families are encouraged and supported to be active participants in rounds. Team members actively inquire to ensure parent questions are asked and answered. Parent assessments are part of the overall assessment. Parent preferences for care are identified and respected. The team does an excellent job documenting care and treatment plans.

Parents are advised of their rights and responsibilities, primarily through verbal communication. The team is encouraged to prepare written materials to support the discussion regarding rights and responsibilities and also to outline how to raise a concern or a complaint.

This team makes extensive and appropriate use of standardized tools and processes for communication during transitions, such as shift-to-shift report and transfers. The team uses plan, do, study, act (PDSA) cycles to regularly modify and improve its tools.

Patient safety practices are very evident in the NICUs. Parents are aware of these practices and are active participants in practices such as two patient-specific identifiers.

Certain safety practices that have been well developed in adult medicine require modification to support the delivery of neonatal care. For example, medication reconciliation, falls prevention, and pressure ulcer prevention protocols are important practices that were modified to adjust to the neonatal care. Excellent approaches to medication documentation and skin care were observed. The organization is encouraged to formalize and document expected practices to reduce unwarranted variation in approach and permit the evaluation of the practices.

Preparing families for transition out of the NICU is a well-established practice. There are documented pathways and formalized education plans to support the gradual transition to independent care. There is some variation in approach throughout the region.

Priority Process: Decision Support

There are a multitude of approaches to clinical documentation tools and methods, ranging from paper-based systems to various electronic systems. The organization has properly identified the need to adopt a more standardized approach and to reduce the number of systems in use.

The clinical team is aware of the organization's work to select a Clinical Information System. The team has expressed concern that the specific information requirements of their clinical specialty will not be addressed by a generic product. They have communicated their concerns to the organization. It will be important for the organization to ensure there is a process to address critical concerns.

Although there are many different approaches to clinical documentation, in all cases records are well organized and comprehensive. Forms are well designed and easy to interpret.

The teams are commended for their use of standardized tools to support the transfer of information. In most cases, the site teams have embraced this approach to reducing risk.

Priority Process: Impact on Outcomes

The Critical Care SCN has a process to identify and prioritize the need to adopt specific protocols and guidelines. An essential element of the SCN mandate is to reduce unwarranted variation in practice. The process is informed by clinical experts, national networks, and others. This team is very engaged with the work of the Canadian Neonatal Network. The SCN is not able to address all protocol development work in a timely manner. As a result, local teams have continued to develop site-specific protocols to meet local priorities. Although this may be unavoidable, the SCN might consider if there are opportunities to accelerate the process of protocol development to better support the local sites.

There is extensive research activity in this program area, with well-established processes and resources to support staff, physicians, and investigators in ethical research activities.

This team, in all sites, makes extensive use of standardized verification processes to reduce risk and improve safety. Many of these verification processes are successfully supported by documented checklists and documentation policies.

There are many levels of Quality Improvement work underway in this program, ranging from provincial initiatives to local PDSA cycles. There is extensive use of indicator data and staff and patient feedback. Much of the quality improvement work is developed and conducted in partnership with the Canadian Neonatal Network, the Alberta Perinatal Health Program, and academic partners.

Priority Process: Organ and Tissue Donation

This priority process is considered to be not applicable for this critical care population as most NICU patients are too small to qualify as donors.

Standards Set: Home Care Services - 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.	
2.4	Space is co-designed with clients and families to ensure safety and permit confidential and private interactions with clients and families.	
2.5	The effectiveness of resources, space, and staffing is evaluated with input from clients and families, the team, and stakeholders.	
5.2	Work and job design, roles and responsibilities, and assignments are determined with input from team members, and from clients and families where appropriate.	
Priority Process: Competency		
3.8	A documented and coordinated approach for infusion pump safety that includes training, evaluation of competence, and a process to report problems with infusion pump use is implemented.	ROP
3.8.4	The competence of team members to use infusion pumps safely is evaluated and documented at least every two years. When infusion pumps are used very infrequently, a just-in-time evaluation of competence is performed.	**MAJOR**
3.10	Team member performance is regularly evaluated and documented in an objective, interactive, and constructive way.	!
3.11	Client and family representatives are regularly engaged to provide input and feedback on their roles and responsibilities, role design, processes, and role satisfaction, where applicable.	
3.12	Team members are supported by team leaders to follow up on issues and opportunities for growth identified through performance evaluations.	!
4.5	Standardized communication tools are used to share information about a client's care within and between teams.	!

4.6	The effectiveness of team collaboration and functioning is evaluated and opportunities for improvement are identified.	
5.4	Team members are recognized for their contributions.	
Priority Process: Episode of Care		
8.2	The assessment process is designed with input from clients and families.	
8.7	To minimize injury from falls, a documented and coordinated approach for falls prevention is implemented and evaluated.	ROP
8.7.4	The effectiveness of the approach is evaluated regularly.	**MINOR**
8.7.5	Results from the evaluation are used to make improvements to the approach when needed.	**MINOR**
8.8	An interprofessional and collaborative approach is used to assess clients who need skin and wound care and provide evidence-informed care that promotes healing and reduces morbidity and mortality.	ROP
8.8.5	Standardized skin and wound care that optimizes skin health and promotes healing is delivered.	**MAJOR**
8.8.8	The effectiveness of the skin and wound care program is monitored by measuring care processes (e.g., accurate diagnosis, appropriate treatment, etc.) and outcomes (e.g., healing time, pain, etc.) and this information is used to make improvements.	**MINOR**
9.1	The client's individualized care plan is followed when services are provided.	
9.10	Information relevant to the care of the client is communicated effectively during care transitions.	ROP
9.10.1	The information that is required to be shared at care transitions is defined and standardized for care transitions where clients experience a change in team membership or location: admission, handover, transfer, and discharge.	**MAJOR**
9.10.2	Documentation tools and communication strategies are used to standardize information transfer at care transitions.	**MAJOR**

9.10.5	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**
10.7	The effectiveness of transitions is evaluated and the information is used to improve transition planning, with input from clients and families.	
14.2	A safety risk assessment is conducted for clients receiving services in their homes.	ROP
14.2.1	A home safety risk assessment is conducted for each client at the beginning of service.	**MAJOR**
Priority Process: Decision Support		
11.8	There is a process to monitor and evaluate record-keeping practices, designed with input from clients and families, and the information is used to make improvements.	!
12.2	Policies on the use of electronic communications and technologies are developed and followed, with input from clients and families.	
Priority Process: Impact on Outcomes		
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.	!
13.4	Protocols and procedures for reducing unnecessary variation in service delivery are developed, with input from clients and families.	!
13.5	Guidelines and protocols are regularly reviewed, with input from clients and families.	!
13.6	There is a policy on ethical research practices that outlines when to seek approval, developed with input from clients and families.	!

15.1	Information and feedback is collected about the quality of services to guide quality improvement initiatives, with input from clients and families, team members, and partners.	
15.2	The information and feedback gathered is used to identify opportunities for quality improvement initiatives and set priorities, with input from clients and families.	
15.3	Measurable objectives with specific timeframes for completion are identified for quality improvement initiatives, 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.	
15.5	Quality improvement activities are designed and tested to meet objectives.	!
15.6	New or existing indicator data are used to establish a baseline for each indicator.	
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.	!
15.9	Quality improvement activities that were shown to be effective in the testing phase are implemented broadly throughout the organization.	!
15.10	Information about quality improvement activities, results, and learnings is shared with clients, families, teams, organization leaders, and other organizations, as appropriate.	
15.11	Quality improvement initiatives are regularly evaluated for feasibility, relevance, and usefulness, with input from clients and families.	

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

Team members are committed to providing safe, compassionate, high-quality care. There are strong partnerships with individual clients to develop and deliver individualized care and service. Engaging clients in service planning, quality improvement activities, policy development, and evaluation at program, zone, and local levels is the next step in the ongoing implementation of a Patient First Strategy. Clients and families report a high degree of satisfaction with home care services.

The home care program benefits from strong, local community partnerships. Teams are encouraged to continue to work collaboratively with partners such as the EMS palliative care program and the primary

care networks. In addition, they are encouraged to routinely evaluate joint initiatives to ensure the partnership and outcomes meet expectations.

As AHS moves toward its vision of enhanced care in the community, the home care teams will need to identify the enablers for this transformation, including human resources. Numerous areas were noted as experiencing increased volumes and complexity in addition to recruitment and retention challenges. Instability in leadership and clinical staff may be a potential barrier and innovative strategies will be required.

The development of a core set of meaningful goals, objectives, and performance indicators is encouraged to guide the quality improvement initiatives at local level. Local teams had varying levels of understanding of quality improvement and performance indicator development and monitoring.

Priority Process: Competency

One of the greatest strengths of the home care program is the team of highly skilled, resourceful, and committed staff. Staff new to home care benefit from a comprehensive orientation program that includes online and site-specific components. Excellent opportunities are available for staff to participate in continuing education, including annual mandatory training programs and client safety education focused on the required organizational practices. Local, zone, and provincial education programs are available for staff including case management, non-violent crisis intervention, and wound management.

My Learning Link is the electronic system that enables staff and leaders to readily track and access education opportunities. The system also enables staff to include non-AHS education in their learning inventory. Staffing resources and workload in some areas create challenges for staff to meet their learning and professional development needs.

Clinical staff emphasize client and family teaching and provide ongoing monitoring with the focus being to improve and/or maintain the highest degree of independence and client satisfaction.

Teams benefit from the availability of expertise within the organization in areas such as ethics, palliative care, and wound management. Access to educators and practice specialists varies across sites. There are opportunities to explore how to improve access based on need.

Performance evaluations were inconsistently completed across locations. There are many factors contributing to this variability such as high levels of manager turnover and different manager/leader/staff ratios and expectations. The sites are encouraged to complete performance evaluations and to ensure individual team member goals and objectives are included in the process.

Evidence of ongoing evaluation of competency related to infusion pumps was not consistently found.

There are strong interdisciplinary care teams that show a high degree of collaboration at the front-line levels and with partners and agencies.

Priority Process: Episode of Care

A coordinated, consistent intake and assessment process is in place for all clients requesting home care. A case management model is in place at all sites; however, sites report varying challenges with ensuring assessment and care planning timelines are met. InterRAI Home Care is used at all sites for home care and home living programs. Standard assessments are in place including home risk assessment, Braden pressure ulcer risk assessment, interRAI Home Care, and falls risk assessment. Variability was noted in compliance with standards for completion of the home risk assessment and the falls risk assessment.

Families and clients appreciate the open communication with staff. An emphasis on client and family involvement in care is evident in all client interactions and in discussions with various team members. Client choice is respected and highly valued by all team members. Clients express that they are treated with respect and kindness.

Strong interdisciplinary teams deliver home care. Access to occupational therapy, physiotherapy, and social work varies between communities. In some locations, wait times for occupational therapy and physiotherapy can range from one to two months. As the expectations to deliver more care in the community are realized, a redistribution of work will occur and resources will need to be adjusted.

Linkages vary across the continuum to support clients transitioning between acute care and home care. Consistently, strong linkages were noted with supportive living home operators to support clients residing in a variety of supportive living models.

Audits have started in home care services to identify key areas for improvement related to communication at transition points. The organization is encouraged to continue this approach.

There is an emphasis on safety in the home for clients and providers. Numerous strategies are employed when working with high-risk clients such as care agreements and use of alternate space in the community. Staff members are aware of the work alone policy and their responsibilities regarding this. As service hours expand, there may be a need to enhance current mechanisms that support staff working alone.

The falls prevention work is acknowledged. Teams are at varying stages of completing education related to falls prevention and associated processes. Concerns were expressed regarding the need to contextualize the falls prevention program for home care. The team would benefit from consistent implementation of processes to evaluate the overall effectiveness of its approach to falls prevention.

Demand for home care services is increasing and becoming more complex. The hours of service vary across the sites based on resource availability. Teams are waiting for new funding to expand services. Services can be initiated with minimal wait time, with the exception of services such as occupational and physiotherapy where wait times can be up to one to two months based on resource availability.

Priority Process: Decision Support

Many sites use electronic documentation systems, and several use a combination of paper and electronic systems. The ability to use tablets for documentation in homes is limited due to variations in internet connectivity across the province.

Client records that were reviewed appear comprehensive. The team is encouraged to examine documentation processes to identify and reduce duplication. Consistent, routine audits of documentation do not occur. The team is acknowledged for the recent introduction of audit process for compliance with documentation related to ROPs. Teams are at various stages of implementing and using these audits to drive quality improvement. The team is encouraged to develop a routine which includes a consistent documentation review process in addition to audits focused on the ROPs. This will ensure complete, accurate documentation that meets applicable standards.

There are multiple strategies to support communication among team members. Staff have access to AHS cell phones and GPS devices to support working in the community. A strong sense of connectivity is apparent among team members.

Priority Process: Impact on Outcomes

Client safety is a priority in all environments. Risk assessments are well defined and applied in client settings, followed by interventions being incorporated into the care plan and evaluated.

Incidents are reported and documented in the Reporting and Learning System and are reviewed, tracked, and trended for lessons learned and improvements.

The organization’s disclosure policy is well implemented and supported by staff.

There is an integrated approach to quality, safety, and risk management at the organizational and program levels. However, there is a need to further define this at the local levels.

A continuing care quality management framework has been developed. The continuing care service excellence team has been working on several quality initiatives including falls prevention, appropriate use of antipsychotics, and more.

In local areas, Quality Improvement plans are in very early stages of development at most sites. The local teams would benefit from additional support and expertise for quality improvement activities, and performance measurement development and tracking from the corporate organization.

Each local area is encouraged to develop specific goals and objectives, measurable indicators, tracking and monitoring processes, and evaluations.

Numerous and varied methodologies are used to communicate at transition points, but there are no consistent or standardized mechanisms or documents. The organization is encouraged to develop a communication model whereby consistent methods and tools are used across all programs and sites.

Standards Set: Hospice, Palliative, End-of-Life Services - Direct Service Provision

Unmet Criteria		High Priority Criteria
Priority Process: Clinical Leadership		
2.5	There is a designated person to oversee and lead hospice palliative and end-of-life volunteer services.	
Priority Process: Competency		
3.14	Team member performance is regularly evaluated and documented in an objective, interactive, and constructive way.	!
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.	
Priority Process: Episode of Care		
8.2	The assessment process is designed with input from clients and families.	
Priority Process: Decision Support		
12.8	There is a process to monitor and evaluate record-keeping practices, designed with input from clients and families, and the information is used to make improvements.	!
13.2	Policies on the use of electronic communications and technologies are developed and followed, with input from clients and families.	
Priority Process: Impact on Outcomes		
14.2	The procedure to select evidence-informed guidelines is reviewed, with input from clients and families, teams, and partners.	
14.3	There is a standardized process, developed with input from clients and families, to decide among conflicting evidence-informed guidelines.	!
14.5	Guidelines and protocols are regularly reviewed, with input from clients and families.	!
Surveyor comments on the priority process(es)		
Priority Process: Clinical Leadership		

One of the strengths of the AHS Provincial Palliative and End of Life (PEOL) Care program is the coordinated approach that has been taken for PEOL across the province. The program has been established to ensure equitable access in urban and rural settings a 24 hours a day, seven days a week. The level of coordination has fostered the development of a robust program to meet client and patient needs.

There is a high degree of client, patient, and family involvement in PEOL care. This is based on a strong foundation of client and patient partnership. Strong partnerships among the program, its service components, and the clients, patients, and families are evident. Where there is an opportunity for improvement is for greater involvement of and input from clients, patients, and families in the proactive development of services.

There is a true network of services for PEOL care that spans specialized inpatient units, hospice care, community-based palliative and home care, and consultation and outreach teams. Patients and clients are well served by this network and individual care needs are met through the appropriate matching of the patient and client to the service.

Volunteers are a key component in the provision of PEOL care. Volunteer engagement is a little uneven across the various settings visited. In some settings, a core, small group of volunteers supports the service. In other settings, it is challenging to attract volunteers to support PEOL care. Regardless of the level of use, there are good processes to ensure volunteers are an integral part of the team. They are a tremendous support to clients, patients, and the care team in enhancing PEOL care.

Overall, there is strong leadership for the Provincial PEOL Care program. This is evident at the provincial, zone, and local levels. It is manifested through the development of a comprehensive PEOL program that meets client and patient needs and continually evolves to ensure there is equitable access to good PEOL care across the entire province.

Priority Process: Competency

Comprehensive education and training programs are available to staff and volunteers across the Provincial Palliative and End of Life Care program. Education and training takes place at orientation, on an annual basis for those areas requiring it, and on an as-needed basis to introduce new protocols, guidelines, and equipment. It can span corporate policy and procedure education and training as well as unit- and team-specific competencies. Education and training is not solely focused on staff members but is also designed for volunteers to ensure they are competent in their role of supporting clients and patients.

Infusion pump use is important in PEOL care and there are rigorous training and education programs in place. Training takes place on hire or transfer of staff and is conducted on a regular basis to ensure staff members remain competent on infusion pump use. Training is also provided to patients who are discharged home with pumps to ensure they are comfortable with pump use and can troubleshoot issues with the pump at home.

Regular evaluation of team member performance was uneven across the organization. Staff in some settings said they have regular, routine performance evaluation and review while staff in other settings indicated they have not had a performance review in some time or could not remember the last time they had a performance review.

Team members in the PEOL Care program are competent and their competence is supported through regular education and training that supports their ability to meet the needs of their clients and patients.

Priority Process: Episode of Care

The Provincial Palliative and End of Life (PEOL) Care program has truly created an integrated and comprehensive service model that spans the entire province in both institutional and community settings. There are strong partnerships with patients, clients, and families and teams feel a strong connection to the people they serve.

One of the key achievements is the comprehensiveness of the program. It can provide service 24/7 and referrals can be made by anyone. Teams are highly responsive and tailor care plans to meet the goals of the patient or client. There are criteria in place to assess acceptance into the various components of the PEOL Care program and services are designed so patients and clients can move through the various service offerings based on their evolving care needs.

In the case of most hospices, patients and families are given an opportunity to tour the hospice in advance of the admission. Upon admission, information is provided to patients and families that outlines resources available, patient rights, and key contacts should they have any concerns.

There are true partnerships among patients, clients, families, and their care teams. Goals of care decisions are supported and it is recognized that goals of care will evolve over time. Team members are trained in how to be responsive to changes in goals and how to track and document these changes. Across all settings, the green sleeve was consistently used to store documents related to goals of care. In some electronic systems, the green sleeve is supplemented by identifying the level of intervention in the clinical information system.

AHS has an ethical decision-making framework. Ethical dilemmas are identified by team members and there is a process through which ethical dilemmas can be addressed. Team members are provided with training on the ethics framework.

AHS has effectively addressed the recent federal Medical Assistance in Dying (MAID) legislation. Team members consistently highlighted the proactive approach taken by AHS to develop the provincial policy on MAID. AHS played a significant leadership role in addressing issues related to MAID requests and supporting patients and clients in their choices related to MAID.

Medication reconciliation is effectively carried out across all care settings. There is evidence of a comprehensive falls prevention strategy. A review of client and patient records consistently

demonstrated the adoption of a falls prevention strategy and this is reinforced with signs that are used to identify clients or patients at risk of falling. Strategies to address pressure ulcers are in place and there is documented evidence of the use of a standardized score to assess pressure ulcers and develop a care plan to address a client's or patient's pressure ulcers. There was consistent use of two identifiers to verify the identity of a client or patient and this was verified in conversations with patients and clients. There are good communication processes to share information at transitions. As patients often move between settings in palliative settings across the zone or across the province, it is important to have excellent information transfer between care settings.

Overall, the provision of care and service through the components of the Provincial PEOL Care program is a true partnership among patients, clients, families, and the care team. A holistic approach is taken to identify the care needs of the patient or client and the services provided are responsive to ensure that care needs can be met on a daily basis. Families are very much a part of the care provided to patients or clients and it is evident there is a strong connection with all members of the care team, including volunteers.

Priority Process: Decision Support

A variety of information systems are used across the Provincial PEOL Care program, from acute care systems to community-based information systems. Some are integrated to a greater extent than others. Regardless of the system configuration, the goal is effective and efficient information flow to support care and service and the program strives to meet this goal. With the vision of an integrated clinical information system across AHS, more integration will be achieved in coming years.

In all cases, an accurate and comprehensive record is kept for clients and patients. The record includes a care plan for the client or patient and accurately captures the goals of care. There are consistent definitions of goals of care across AHS and a standardized process to identify goals of care and make them accessible through the use of a green sleeve in the client or patient chart.

In the home setting, there is inconsistency as to whether clients keep a copy of their community-based health record in their home. In some areas, clients have a copy of their record in their home while in others they do not. AHS is encouraged to determine a standard practice regarding clients retaining a copy of their record in their home when receiving community-based palliative services.

Given the scope of the Provincial PEOL Care program to support care across the province, telehealth is used to support care in rural areas where it is important that clients access the services required to support their care needs. The program is encouraged to continue to develop its telehealth system to support the care needs of clients regardless of where they may be located.

Priority Process: Impact on Outcomes

Impact on outcomes is probably the area where the Provincial PEOL Care program has the greatest opportunity for improvement. Inherent in PEOL care is a strong connection among patients, clients,

families, and the care team. In many cases, a true partnership exists. For many criteria, there is a requirement for input from clients, patients, and families. At a program level, this is where there is the greatest opportunity for engagement to advance patient- and family-centred care.

Across the province and zones, routine measures of satisfaction are tracked through families completing satisfaction surveys. There is evidence that survey results are shared at the site level and the sites are very responsive to issues that may be highlighted in satisfaction survey results. The overall response rate is approximately 30 percent. Overwhelmingly, responses tend to be very positive.

At the program level, there are opportunities to engage patients, clients, and families in system design and planning. AHS has embarked on its journey toward patient- and family-centred care. There is significant engagement at the site level. AHS needs to build on this site-level engagement and nurture it at the program and provincial levels to enhance PEOL care.

There seems to be a lack of consistency in the use of information systems across AHS to capture data related to PEOL care. In some cases, there are no electronic information systems, with paper records being maintained and no core data items analyzed to monitor program performance. The AHS Provincial PEOL Care program is encouraged to evaluate the information systems used to capture patient and client information related to care and explore whether there is a minimum data set available to meet its needs for performance monitoring.

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

Unmet Criteria		High Priority Criteria
Priority Process: Clinical Leadership		
1.3	Service-specific goals and objectives are developed, with input from residents and families.	
2.1	Resource requirements and gaps are identified and communicated to the organization's leaders.	
2.4	The physical space is designed with input from residents and families and is safe, comfortable, and reflects a home-like environment.	
2.5	The physical security of residents is protected.	
Priority Process: Competency		
3.15	Team member performance is regularly evaluated and documented in an objective, interactive, and constructive way.	!
3.16	Resident and family representatives are regularly engaged to provide input and feedback on their roles and responsibilities, role design, processes, and role satisfaction, where applicable.	
3.17	Team members are supported by team leaders to follow up on issues and opportunities for growth identified through performance evaluations.	!
4.4	Standardized communication tools are used to share information about a resident's care within and between teams.	!
4.5	The effectiveness of team collaboration and functioning is evaluated and opportunities for improvement are identified.	
5.1	The workload of each team member is assigned and reviewed in a way that ensures resident and team safety and well-being.	
5.3	Team members are recognized for their contributions.	
9.14	Access to spiritual space and care is provided to meet residents' needs.	
Priority Process: Episode of Care		
6.2	There is a process to respond to requests for services in a timely way.	
8.6	To minimize injury from falls, a documented and coordinated approach for falls prevention is implemented and evaluated.	ROP

	8.6.1	A documented and coordinated approach to falls prevention is implemented.	**MAJOR**
	8.6.4	The effectiveness of the approach is evaluated regularly.	**MINOR**
	8.6.5	Results from the evaluation are used to make improvements to the approach when needed.	**MINOR**
8.8	Clients are assessed and monitored for risk of suicide.		ROP
	8.8.1	Clients at risk of suicide are identified.	**MAJOR**
	8.8.2	The risk of suicide for each client is assessed at regular intervals or as needs change.	**MAJOR**
	8.8.3	The immediate safety needs of clients identified as being at risk of suicide are addressed.	**MAJOR**
	8.8.4	Treatment and monitoring strategies are identified for clients assessed as being at risk of suicide.	**MAJOR**
	8.8.5	Implementation of the treatment and monitoring strategies is documented in the client record.	**MAJOR**
9.1	The resident's individualized care plan is followed when services are provided.		
9.3	All services received by the resident, including changes and adjustments to the care plan, are documented in the resident record.		
9.8	A process to monitor the use of restraints is established by the team, and this information is used to make improvements.		!
9.10	Residents' access to dental services is facilitated by the team.		
9.19	Information relevant to the care of the resident is communicated effectively during care transitions.		ROP
	9.19.1	The information that is required to be shared at care transitions is defined and standardized for care transitions where residents experience a change in team membership or location: admission, handover , transfer, and discharge.	**MAJOR**
	9.19.2	Documentation tools and communication strategies are used to standardize information transfer at care transitions.	**MAJOR**
	9.19.4	Information shared at care transitions is documented.	**MAJOR**

9.19.5	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 resident records) to measure compliance with standardized processes and the quality of information transfer • Asking residents, 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**
10.1	Residents and families are provided with an environment that is flexible and meets their needs.	
10.2	Residents and families are provided with opportunities to engage in activities that are meaningful and important to the them.	
10.3	A pleasant dining experience is facilitated for each resident.	
12.7	The effectiveness of transitions is evaluated and the information is used to improve transition planning, with input from residents and families.	
Priority Process: Decision Support		
13.1	An accurate, up-to-date, and complete record is maintained for each resident, in partnership with the resident and family.	!
13.8	There is a process to monitor and evaluate record-keeping practices, designed with input from residents and families, and the information is used to make improvements.	!
Priority Process: Impact on Outcomes		
15.3	There is a standardized process, developed with input from residents and families, to decide among conflicting evidence-informed guidelines.	!
15.4	Protocols and procedures for reducing unnecessary variation in service delivery are developed, with input from residents and families.	!
15.5	Guidelines and protocols are regularly reviewed, with input from residents and families.	!
15.6	There is a policy on ethical research practices that outlines when to seek approval, developed with input from residents and families.	!
16.3	Verification processes are used to mitigate high-risk activities, with input from residents and families.	!

16.7	Patient safety incidents are disclosed to the affected residents and families according to the organization's policy, and support is facilitated if necessary.	!
17.3	Measurable objectives with specific timeframes for completion are identified for quality improvement initiatives, with input from residents and families.	!
17.4	Indicator(s) that monitor progress for each quality improvement objective are identified, with input from residents and families.	
17.5	Quality improvement activities are designed and tested to meet objectives.	!
17.6	New or existing indicator data are used to establish a baseline for each indicator.	
17.7	There is a process to regularly collect indicator data and track progress.	
17.8	Indicator data is regularly analyzed to determine the effectiveness of the quality improvement activities.	!
17.9	Quality improvement activities that were shown to be effective in the testing phase are implemented broadly throughout the organization.	!
17.11	Quality improvement initiatives are regularly evaluated for feasibility, relevance, and usefulness, with input from residents and families.	

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

There are many talented, committed clinical leaders in this program.

The teams have processes to develop goals and objectives with input from residents, families, and community partners. Information about services provided is made available to the community. There are processes to access resources and support needed to achieve the team's goals and objectives.

The teams interviewed have developed many coordinating partnerships with other teams, providers, and organizations.

The teams have developed a culture of care to deliver high-quality services.

A number of the teams interviewed are challenged by leadership turnover, which is hampering quality improvement activities and sapping morale. The organization is encouraged to work on succession planning and leadership development.

Priority Process: Competency

The teams observed were mature, collaborative, interdisciplinary, and displayed great teamwork.

There are good processes to ensure all team members have the appropriate license or credential from relevant colleges. This process is ongoing. Job descriptions support clear roles and responsibilities and team members work to full scope of practice.

There are good orientation processes and support for ongoing in-service education and training.

Ongoing competency evaluation and performance appraisal occurs in many areas but completion could be improved.

An excellent suite of electronic training programs for professional growth is available to all staff.

Priority Process: Episode of Care

A comprehensive intake process is used to gather pertinent information on the resident and family. This assessment leads to a well-documented care plan. The resident and family have input into the care plan. Services are delivered in keeping with the care plan and care is well documented. The care plan is changed as appropriate, with input from the resident and family.

It is evident that residents are well cared for. Particularly commendable is the work around the appropriate use of antipsychotic medications in dementia. There is also a notable effort to reduce the use of physical restraints. However, there is much work to be done to improve dementia care, with a focus on therapeutic recreation and creating environments that move beyond the institutional to those that support thriving with dementia.

Although much good work has been done at many sites regarding the ROPs, such as Falls Prevention, Suicide Prevention and Information Transfer, there are many gaps. It is suggested that focused improvement efforts be made in these key areas.

Priority Process: Decision Support

Resident information is readily available to service providers, residents, and families. Records are maintained in a safe and secure manner and documentation is standardized in the various sites that have electronic and paper charting. Paper charts still exist and the organization is encouraged to move forward with electronic charting throughout.

Priority Process: Impact on Outcomes

Evidence-informed guidelines are selected. Staff use the organization-wide ethical decision framework.

Teams focus on safety and safety risks are identified in a proactive manner. Safety incidents are monitored and analyzed and information is used to make improvements.

All teams are encouraged to build on and enhance existing processes for using quality improvement measures to evaluate and improve the safety and quality of services.

The organization is encouraged to continue its efforts to include the perspectives of residents and families.

Standards Set: Medicine Services - Direct Service Provision

Unmet Criteria		High Priority Criteria
Priority Process: Clinical Leadership		
1.1	Services are co-designed with clients and families, partners, and the community.	!
1.2	Information is collected from clients and families, partners, and the community to inform service design.	
1.3	Service-specific goals and objectives are developed, with input from clients and families.	
1.4	Services are reviewed and monitored for appropriateness, with input from clients and families.	
2.3	An appropriate mix of skill level and experience within the team is determined, 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.	
2.5	The effectiveness of resources, space, and staffing is evaluated with input from clients and families, the team, and stakeholders.	
2.7	A universally-accessible environment is created with input from clients and families.	
5.2	Work and job design, roles and responsibilities, and assignments are determined with input from team members, and from clients and families where appropriate.	
Priority Process: Competency		
3.1	Required training and education are defined for all team members with input from clients and families.	!
3.9	Education and training are provided on information systems and other technology used in service delivery.	
3.11	Team member performance is regularly evaluated and documented in an objective, interactive, and constructive way.	!
3.13	Team members are supported by team leaders to follow up on issues and opportunities for growth identified through performance evaluations.	!

4.1	A collaborative approach is used to deliver services.	!
4.3	Position profiles with defined roles, responsibilities, and scope of employment or practice exist for all positions.	
4.5	The effectiveness of team collaboration and functioning is evaluated and opportunities for improvement are identified.	
9.7	Access to spiritual space and care is provided to meet clients' needs.	
Priority Process: Episode of Care		
6.3	Defined criteria are used to determine when to initiate services with clients.	
6.4	When the team is unable to meet the needs of a potential client, access to other services is facilitated.	
6.5	Clients and families are made aware of the team member who is responsible for coordinating their service, and how to reach that person.	
7.6	The team verifies that the client and family understand information provided about their care.	
7.13	Clients and families are provided with information about their rights and responsibilities.	!
7.14	Clients and families are provided with information about how to file a complaint or report violations of their rights.	!
7.15	A process to investigate and respond to claims that clients' rights have been violated is developed and implemented with input from clients and families.	!
8.2	The assessment process is designed with input from clients and families.	
8.5	Medication reconciliation is conducted in partnership with clients and families to communicate accurate and complete information about medications across care transitions.	ROP
8.5.5	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**
8.6	To minimize injury from falls, a documented and coordinated approach for falls prevention is implemented and evaluated.	ROP
8.6.4	The effectiveness of the approach is evaluated regularly.	**MINOR**

9.2	Working in partnership with clients and families, at least two person-specific identifiers are used to confirm that clients receive the service or procedure intended for them. 9.2.1 At least two person-specific identifiers are used to confirm that clients receive the service or procedure intended for them, in partnership with clients and families.	ROP **MAJOR**
9.8	Clients and families have access to psychosocial and/or supportive care services, as required.	
10.7	The client's risk of readmission is assessed, where applicable, and appropriate follow-up is coordinated.	!
Priority Process: Decision Support		
11.8	There is a process to monitor and evaluate record-keeping practices, designed with input from clients and families, and the information is used to make improvements.	!
12.2	Policies on the use of electronic communications and technologies are developed and followed, with input from clients and families.	
Priority Process: Impact on Outcomes		
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.	!
13.4	Protocols and procedures for reducing unnecessary variation in service delivery are developed, with input from clients and families.	!
13.5	Guidelines and protocols are regularly reviewed, with input from clients and families.	!
13.6	There is a policy on ethical research practices that outlines when to seek approval, developed with input from clients and families.	!
14.1	A proactive, predictive approach is used to identify risks to client and team safety, with input from clients and families.	!
14.2	Strategies are developed and implemented to address identified safety risks, with input from clients and families.	!
14.3	Verification processes are used to mitigate high-risk activities, with input from clients and families.	!
14.4	Safety improvement strategies are evaluated with input from clients and families.	!

14.7	Patient safety incidents are analyzed to help prevent recurrence and make improvements, with input from clients and families.	!
15.1	Information and feedback is collected about the quality of services to guide quality improvement initiatives, with input from clients and families, team members, and partners.	
15.2	The information and feedback gathered is used to identify opportunities for quality improvement initiatives and set priorities, with input from clients and families.	
15.3	Measurable objectives with specific timeframes for completion are identified for quality improvement initiatives, 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.	
15.5	Quality improvement activities are designed and tested to meet objectives.	!
15.6	New or existing indicator data are used to establish a baseline for each indicator.	
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.	!
15.9	Quality improvement activities that were shown to be effective in the testing phase are implemented broadly throughout the organization.	!
15.10	Information about quality improvement activities, results, and learnings is shared with clients, families, teams, organization leaders, and other organizations, as appropriate.	
15.11	Quality improvement initiatives are regularly evaluated for feasibility, relevance, and usefulness, with input from clients and families.	

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

The rural medicine sites visited demonstrated a very high level of engagement and are a well-articulated team. Staff engagement is strong. Clients and families report feeling well treated, respected, and informed. There is a strong commitment to ongoing education and excellent support permitting staff to attend Continuing Medical Education activities. Physicians are highly engaged at the sites visited.

Client- and family-centred care is generally managed at the zone level with patient advisors most frequently involved through the Quality Improvement Committee and the Patient- and Family-Centred Committee. There is no specific SCN for medicine. AHS is currently having internal discussions regarding the need for an additional medicine-specific SCN, with consideration being given to adding a Primary Health Care Integrarion Network that would incorporate many aspects of medicine.

Many of the SCNs incorporate a rural perspective into their committees, and will frequently ask for rural input into guideline and policy development.

With reference to rural medicine, the leadership teams are working to come to an understanding about how patient advisors, clients, and families could have more formal involvement at local rural sites. There is very good engagement between the communities and the local hospitals. Many communities will hold town hall meetings at which time citizens can provide input into local hospital services. There is less opportunity for input into guideline and policy development and the evaluation of quality improvement activities.

A patient- and family-centred approach was seen at some sites. At one site, feedback from clients and families was collated in a one-page newsletter, with questions and comments, that was posted on a quality board. At another site, information about improvement initiatives and services was shared with clients and families using paper tablemats called Plate Update. Patients at another site are invited to share their experiences at staff education meetings. There is considerable interest in recruiting patient and family representatives at many of the sites, but this has not yet occurred.

Input from clients and families appears to be a new idea in some areas. The rural medicine teams are in very early days incorporating patient advisors and families in a proactive fashion, especially in the areas of policy, guideline development, service delivery, job design, roles and responsibilities, clinical assignments, and quality improvement initiatives. There is early recognition of the importance of involving clients and families.

There is a good working relationship between the local leadership teams and the zone leadership teams. The local unit managers are engaged with the staff on their units. They are a key support to the staff.

The recruitment and retention of staff is a concern at many sites, especially the recruitment and retention of casual staff. There are many strategies in place that vary depending on the rural community. The communities are engaged in the recruitment of staff and especially of physicians.

Staff at the Peace River Community Health Centre have developed a unique laminated double-sided placemat with easy-to-read information about the services available to clients and families, and what they should expect of staff.

The patient whiteboards in each room have been designed with thought and care. Families and staff actively use the white boards at many sites. They have become important communication tools for staff, physicians, clients, and families.

The AHS Improvement Way strategy to manage barriers to access is well thought of and is seen to help eliminate barriers to transfer.

Priority Process: Competency

Staff have frequent opportunities for ongoing education, including Advanced Cardiac Life Support, Trauma Nurse Core Course, and non-violent crisis intervention. The medical team works very collaboratively with multiple care providers including pharmacists, licensed practical nurses, health care aides, and non-clinical providers.

Training and education plans are defined and well used by the staff. However, they were developed with minimal input from clients and family members. There is mandatory privacy training for all staff. There was good compliance with training and education programs. Domestic violence screening is being undertaken at some sites and AHS is encouraged to spread this to all acute care sites. At some sites, the management teams have identified the need for additional resources to support staff education. Most units have a part-time or full-time educator.

The organization is encouraged to celebrate its successes widely both internally and externally, with the help of communications and leaders in the organization.

Performance appraisals are challenging for many organizations and this holds true for many of the AHS sites visited. Performance appraisals were noted to be very inconsistently completed primarily due to time constraints for many managers. There was a suggestion that performance appraisals could be combined with annual education days to optimize the use of manager and staff time.

Informal evaluations are done for quality improvement initiatives undertaken. The team is encouraged to move toward enhancing its evaluation processes.

Priority Process: Episode of Care

The ROPs are generally well done at most sites. It is evident great effort has been focused on this important area. Medication reconciliation is well incorporated at all the sites visited.

There are challenges with some ROPs. The challenges tend to be related to identifying and using appropriate indicator data, evaluation of results to make further improvements, and the effectiveness of the approaches used. Overall, the rural medicine program is encouraged to continue to develop, monitor, and evaluate quality indicators.

There were sites where the medicine program did not have clearly defined admission criteria for the inpatient units. Having defined admission criteria may help facilitate and prioritize transfers to and from higher level of care facilities.

Venous thromboembolism prophylaxis is well engrained as part of the admission process. Many of the sites manage post-operative care for patients who have undergone major orthopedic procedures and VTE prophylaxis is appropriately used in these situations.

sites manage post-operative care for patients who have undergone major orthopedic procedures and VTE prophylaxis is appropriately used in these situations.

The falls program is well engrained into the clinical assessment processes at most sites. It is often used to direct future care. However, there are pockets of inconsistency in completing the assessment in a timely manner and managing post-fall analysis. There are incidents where patients have had multiple falls with no evident changes to the care plan or visual aids in the patient's environment. The organization is encouraged to evaluate the causes of patient falls to track preventable trends.

The CoACT program has been piloted at various acute care facilities over the past two years. This is a significant change initiative. It is generally well accepted where it has been piloted. In many sites, there are interdisciplinary rounds and meetings to support the assessment process. Many sites are incorporating aspects of this program, such as rapid rounds, bedside white boards, and bedside shift change rounds.

A significant effort has been made to improve compliance with the use of two person-specific identifiers. Education has been completed and staff have been engaged to provide input into mechanisms for improvement. On several occasions during the on-site surveys, patients were observed to have been given medications with no attempt to verify the identity of the patient.

Transitions are key times in the care of a patient, being inherently high risk and fraught with challenges. Generally, there are good transition processes with staff members using available tools. There does not appear to be a standardized tool to assist staff with patient transitions, or at least staff do not know where to find such transition tools. Transitions from acute care to long-term care and vice versa appear to be well documented. There is greater inconsistency in documentation when patients are transferred between acute care facilities.

Teams are encouraged to develop and implement an effective evaluation of transition programs at the local sites. Some local sites are challenged to evaluate the effectiveness of their processes during transition periods. There have been instances where outpatient clinics closed and they were unable to follow up with patients.

Priority Process: Decision Support

The approach to the admission process is very interactive and patient centred. Initial assessments use valuable input from the patient and/or family members. There is good documentation and good use of standardized assessment tools such as falls prevention assessments, wound assessments where applicable, and medication reconciliation.

Charting often reflects a team-based approach to care.

Priority Process: Impact on Outcomes

The medicine teams at the rural sites visited are highly focused on patient care and clinical outcomes. They are caring and broadly incorporate patients into decision making related to their care.

There was limited information available from the medicine team regarding the role of patient advisors, clients, and family members in a number of clinical areas. There is limited contact with clients and families with regard to which guidelines are reviewed and subsequently incorporated by the team. Clients and families have limited input into the standardized process when conflicting evidence exists during the development of guidelines.

Overall, the team is doing great work in falls prevention, hand hygiene, and wound care management activities; however, it has not used new or existing indicator data to establish a baseline for each indicator at the site level. Although the majority of sites regularly collect indicator data and use the data to track progress, there remain a few sites where this could be improved.

Front-line staff remain engaged with quality improvement. Quality measures are posted on quality boards for staff at many of the sites visited. Performance measures for the North Zone and a combined subset of rural hospitals in the North Zone are included on many of the quality whiteboards. Front-line staff are encouraged to obtain additional education regarding the Quality Improvement process and quality improvement data collection.

No clinical research is being undertaken at the small rural facilities.

Standards Set: Obstetrics Services - 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			
3.1	Required training and education are defined for all team members with input from clients and families.		!
3.9	A documented and coordinated approach for infusion pump safety that includes training, evaluation of competence, and a process to report problems with infusion pump use is implemented.		ROP
	3.9.2	Initial and re-training on the safe use of infusion pumps is provided to team members: • Who are new to the organization or temporary staff new to the service area • Who are returning after an extended leave • When a new type of infusion pump is introduced or when existing infusion pumps are upgraded • When evaluation of competence indicates that re-training is needed When infusion pumps are used very infrequently, just-in-time training is provided.	**MAJOR**
	3.9.4	The competence of team members to use infusion pumps safely is evaluated and documented at least every two years. When infusion pumps are used very infrequently, a just-in-time evaluation of competence is performed.	**MAJOR**
	3.9.5	The effectiveness of the approach is evaluated. Evaluation mechanisms may include: • Investigating patient safety incidents related to infusion pump use • Reviewing data from smart pumps • Monitoring evaluations of competence • Seeking feedback from clients, families, and team members.	**MINOR**
	3.9.6	When evaluations of infusion pump safety indicate improvements are needed, training is improved or adjustments are made to infusion pumps.	**MINOR**

3.12	Team member performance is regularly evaluated and documented in an objective, interactive, and constructive way.	!
3.13	Client and family representatives are regularly engaged to provide input and feedback on their roles and responsibilities, role design, processes, and role satisfaction, where applicable.	
3.14	Team members are supported by team leaders to follow up on issues and opportunities for growth identified through performance evaluations.	!
5.4	There is a policy that guides team members to bring forward complaints, concerns, and grievances.	
Priority Process: Episode of Care		
7.8	The client's capacity to provide informed consent is determined.	
7.11	When clients are incapable of giving informed consent, consent is obtained from a substitute decision maker.	!
7.13	Ethics-related issues are proactively identified, managed, and addressed.	!
7.14	Clients and families are provided with information about their rights and responsibilities.	!
7.16	Clients and families are provided with information about how to file a complaint or report violations of their rights.	!
7.17	A process to investigate and respond to claims that clients' rights have been violated is developed and implemented with input from clients and families.	!
8.5	Medication reconciliation is conducted in partnership with clients and families to communicate accurate and complete information about medications across care transitions.	ROP
8.5.2	The BPMH is used to generate admission medication orders OR the BPMH is compared with current medication orders and any medication discrepancies are identified, resolved, and documented.	**MAJOR**
8.5.4	The prescriber uses the BPMH and the current medication orders to generate transfer or discharge medication orders.	**MAJOR**
8.5.5	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**

8.6	To minimize injury from falls, a documented and coordinated approach for falls prevention is implemented and evaluated.	ROP
8.6.1	A documented and coordinated approach to falls prevention is implemented.	**MAJOR**
8.6.2	The approach identifies the populations at risk for falls.	**MAJOR**
8.6.3	The approach addresses the specific needs of the populations at risk for falls.	**MAJOR**
8.6.4	The effectiveness of the approach is evaluated regularly.	**MINOR**
8.6.5	Results from the evaluation are used to make improvements to the approach when needed.	**MINOR**
10.6	A safe surgery checklist is used to confirm that safety steps are completed for a surgical procedure performed in the operating room.	ROP
10.6.1	The team has agreed on a three-phase safe surgery checklist to be used for surgical procedures performed in the operating room.	**MAJOR**
10.7	There is a policy and procedure for sponge and needle counts both before and after all vaginal births.	!
Priority Process: Decision Support		
14.8	There is a process to monitor and evaluate record-keeping practices, designed with input from clients and families, and the information is used to make improvements.	!
Priority Process: Impact on Outcomes		
16.2	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.	!
Surveyor comments on the priority process(es)		
Priority Process: Clinical Leadership		

Under the guidance of the reorganized AHS and Maternal, Newborn, Child, and Youth SCN, the obstetrical program has become a shining light responding to the needs of over 50,000 families each year. The leadership has been proactive in identifying new standards and protocols that equip the program to respond across the spectrum from small rural settings to large university-based facilities. Drawing on the educational support of MORE-OB and other programs, they have collectively raised the standard of care and capacity of the staff.

New initiatives such as Obstetrical Triage Acuity Scale (OTAS) scoring, transfer of care via corridors of care, and expanding the use of nurse practitioners have had a positive impact on the delivery of care.

There is a clear recognition of the value of patients and families in the decision-making steps. Both at the bedside and in the meeting room, this new voice is encouraged, supported, and most importantly heard.

All these initiatives and successes track back to effective leadership.

Priority Process: Competency

The focus on education to maintain and acquire new skills is paramount in the organization. In this program, the focus and advocacy around the MORE-OB program has effectively raised the bar in supporting this philosophy. Refreshingly, documentation shows that the organization considers MORE-OB to be the key resource for the program.

Simulation techniques in various settings, supported by mechanical models, have been well received and supported by staff and physicians across the organization.

In some sites, hospitals have digitized a number of their policies for easy access and created a number of small laminated forms that are at the bedside ready to be used if needed.

Teamwork is the mantra of the program. From volunteers to front-line nurses and physicians to allied staff, they collectively believe in the value of teamwork. Even in smaller sites, multi-tasking allows more complex situations to be successfully managed.

Teamwork is not based in one site, it was interesting to observe the support larger sites give to more isolated or northern communities.

Priority Process: Episode of Care

The overall impression of the obstetrical service during the on-site survey is overwhelmingly positive. The focus was to evaluate the need and ensure it is met in the most appropriate site, whether in a small rural setting or a large tertiary site. Without doubt, the system is very patient centric.

There are well-designed processes to meet the needs of the pregnant patient, her newborn, and her family. Site size did not matter; the same passion and caring existed in all the sites.

Programs are consistent across the spectrum from small to large. The use of the MORE-OB program, the use of standard medical guidelines, consistency in language and designations such as OTAS, and skin-to-skin are a few examples of how consistent, high standards of care are ensured.

There is a clear recognition that some patients have unique needs, such as culture, language, and marginalization. The organization has developed approaches to support these patients.

The obstetrics program recognizes it is only one step on the continuum of care. Relationships with family doctors, public health, and children's aid societies have been established and supported. This involves effective information sharing and recognizing its unique needs and supports for the family.

The recent rollout of the falls protocol and medication reconciliation in the obstetrical setting has been inconsistently implemented across the province. Some of the smaller sites are uncertain how to proceed especially when obstetrical patients may be co-located with patients of other services. A review of the impact of this initiative is scheduled to occur at the senior level. The organization is encouraged to review the implementation of this initiative and provide additional education and help where needed.

The Safe Surgery Checklist and Pause is generally completed and well done. There are sites where a formal Pause with key staffs' attention and input does not occur. AHS is encouraged to ensure a formal Pause occurs in the operating room suite prior to administering the anesthetic.

The patients who were interviewed are happy. They feel engaged and supported. They feel the love and have great faith in the program.

Priority Process: Decision Support

In most sites, the patient record is primarily in paper format. Some information is available digitally but often this is externally driven such as the pharmacy information.

Although economic realities may delay implementation of the full electronic record, planning for it is encouraged.

Priority Process: Impact on Outcomes

There is a quality improvement forum to help monitor and identify opportunities to improve. A number of creative improvements have been developed and implementation of these changes is supported.

The close relationship between the academic centres and the program allows a number of research initiatives to be triggered locally, such as the REDUCED trial; that is attempting to reduce the use of C-sections for dystocia. These and other research projects will allow the program to remain ahead of the curve.

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.	
2.1	Resource requirements and gaps are identified and communicated to the organization's leaders.	
2.3	An appropriate mix of skill level and experience within the team is determined, 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.	
2.5	The effectiveness of resources, space, and staffing is evaluated with input from clients and families, the team, and stakeholders.	
8.2	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		
6.1	Required training and education are defined for all team members with input from clients and families.	!
6.2	Credentials, qualifications, and competencies are verified, documented, and up-to-date.	!
6.3	A comprehensive orientation is provided to new team members and client and family representatives.	
6.6	Education and training are provided on the organization's ethical decision-making framework.	
6.9	A documented and coordinated approach for infusion pump safety that includes training, evaluation of competence, and a process to report problems with infusion pump use is implemented.	ROP

	6.9.2	Initial and re-training on the safe use of infusion pumps is provided to team members: • Who are new to the organization or temporary staff new to the service area • Who are returning after an extended leave • When a new type of infusion pump is introduced or when existing infusion pumps are upgraded • When evaluation of competence indicates that re-training is needed When infusion pumps are used very infrequently, just-in-time training is provided.	**MAJOR**
	6.9.4	The competence of team members to use infusion pumps safely is evaluated and documented at least every two years. When infusion pumps are used very infrequently, a just-in-time evaluation of competence is performed.	**MAJOR**
	6.9.5	The effectiveness of the approach is evaluated. Evaluation mechanisms may include: • Investigating patient safety incidents related to infusion pump use • Reviewing data from smart pumps • Monitoring evaluations of competence • Seeking feedback from clients, families, and team members.	**MINOR**
	6.9.6	When evaluations of infusion pump safety indicate improvements are needed, training is improved or adjustments are made to infusion pumps.	**MINOR**
6.11		Team member performance is regularly evaluated and documented in an objective, interactive, and constructive way.	!
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.	
6.13		Team members are supported by team leaders to follow up on issues and opportunities for growth identified through performance evaluations.	!
7.3		Position profiles with defined roles, responsibilities, and scope of employment or practice exist for all positions.	
12.8		Access to spiritual space and care is provided to meet clients' needs.	
Priority Process: Episode of Care			

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.	
10.14	Ethics-related issues are proactively identified, managed, and addressed.	!
10.15	Clients and families are provided with information about their rights and responsibilities.	!
10.16	Clients and families are provided with information about how to file a complaint or report violations of their rights.	!
10.17	A process to investigate and respond to claims that clients' rights have been violated is developed and implemented with input from clients and families.	!
11.2	The assessment process is designed with input from clients and families.	
11.8	The assessment includes processes to evaluate risk of postoperative nausea and vomiting (PONV).	
11.11	To minimize injury from falls, a documented and coordinated approach for falls prevention is implemented and evaluated.	ROP
11.11.1	A documented and coordinated approach to falls prevention is implemented.	**MAJOR**
11.11.2	The approach identifies the populations at risk for falls.	**MAJOR**
11.11.3	The approach addresses the specific needs of the populations at risk for falls.	**MAJOR**
11.11.4	The effectiveness of the approach is evaluated regularly.	**MINOR**
11.11.5	Results from the evaluation are used to make improvements to the approach when needed.	**MINOR**
11.12	Each client's risk for developing a pressure ulcer is assessed and interventions to prevent pressure ulcers are implemented. NOTE: This ROP does not apply to outpatient settings, including day surgery, given the lack of validated risk assessment tools for outpatient settings.	ROP
11.12.1	An initial pressure ulcer risk assessment is conducted for clients upon admission, using a validated, standardized risk assessment tool.	**MAJOR**
11.12.2	The risk of developing pressure ulcers is assessed for each client at regular intervals and when there is a significant change in the client's status.	**MAJOR**

	11.12.3	Documented protocols and procedures based on best practice guidelines are implemented to prevent the development of pressure ulcers. These may include interventions to prevent skin breakdown; minimize pressure, shear, and friction; reposition; manage moisture; optimize nutrition and hydration; and enhance mobility and activity.	**MAJOR**
	11.12.4	Team members, clients, families, and caregivers are provided with education about the risk factors and protocols and procedures to prevent pressure ulcers.	**MINOR**
	11.12.5	The effectiveness of pressure ulcer prevention is evaluated, and results are used to make improvements when needed.	**MINOR**
11.13	Medical and surgical clients at risk of venous thromboembolism (deep vein thrombosis and pulmonary embolism) are identified and provided with appropriate thromboprophylaxis. NOTE: This ROP does not apply for pediatric hospitals; it only applies to clients 18 years of age or older. This ROP does not apply to day procedures or procedures with only an overnight stay.		ROP
	11.13.5	Information is provided to clients and team members about the risks of VTE and how to prevent it.	**MINOR**
11.19	A comprehensive and individualized care plan is developed and documented in partnership with the client and family.		!
14.9	The client's vital signs are monitored and documented by a qualified team member prior to and throughout the procedure.		!
17.1	Routine practices are followed to reduce the risk of infection to clients and team members.		!
17.2	A dress code is followed within the surgical suite.		!
17.4	Prophylactic antibiotics are administered by qualified team members within the appropriate timeframe.		!
17.8	Soiled linen, infectious material, and hazardous waste are handled appropriately.		!
20.3	Clients are continually observed as they recover from anesthesia, and vital signs and other observations are frequently documented.		
20.16	There is a process to follow up with discharged day surgery clients.		

20.17	The effectiveness of transitions is evaluated and the information is used to improve transition planning, with input from clients and families.	
Priority Process: Decision Support		
21.8	There is a process to monitor and evaluate record-keeping practices, designed with input from clients and families, and the information is used to make improvements.	!
22.2	Policies on the use of electronic communications and technologies are developed and followed, with input from clients and families.	
Priority Process: Impact on Outcomes		
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.	!
24.7	Patient safety incidents are analyzed to help prevent recurrence and make improvements, with input from clients and families.	!
25.1	Information and feedback is collected about the quality of services to guide quality improvement initiatives, with input from clients and families, team members, and partners.	

25.2	The information and feedback gathered is used to identify opportunities for quality improvement initiatives and set priorities, with input from clients and families.	
25.3	Measurable objectives with specific timeframes for completion are identified for quality improvement initiatives, 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		
5.2	Medications in the surgical area are stored in a locked area or similarly secured, as per the organization's policies regarding medication storage.	!
5.3	The contents of medication carts for the surgical area are standardized across the organization.	
15.3	Every medication and solution on the sterile field is labeled.	!
16.3	Medications and related supplies stored on anesthesia carts are standardized.	
Surveyor comments on the priority process(es)		
Priority Process: Clinical Leadership		

Managers in the rural sites work closely with the staff. In some hospitals, some management roles are not filled and staff feel the impact of this. Overall, there appear to be good working relationships among managers, staff, local leadership teams, and zone leadership. There are a few central and northern sites where staff feel they do not see enough of their zone leaders and feel isolated.

Recruitment and retention is an issue for most rural sites, particularly those that are not close to the larger centres. New graduates often use the rural site to enter AHS and then leave to move to larger centres or to locations of their choice within AHS. Orientation and training are ongoing.

Educators move between hospital sites and staff feel the services the educators bring are extremely valuable to their work. Some sites receive part-time education hours; however, staff commented that the educators work diligently to meet their learning needs. Staff feel AHS is a good organization for providing learning opportunities and on-going education.

The strategic clinical networks and the Rural Perioperative and Medicine Services SET team are commended for their provincial approach to improving quality for surgical services. Three key projects

are in progress: ACATS, enhanced recovery after surgery, and the safe surgery checklist. The project outcomes will improve patient flow, satisfaction, and safety and enhance the quality of care.

Patient names are called out in the waiting rooms. AHS is encouraged to consider a number system to ensure patient privacy.

Priority Process: Competency

Patient safety, staff skill sets, and maintaining competency are top considerations for AHS when relocating services. There are AHS hospital sites where nurses are expected to have large scopes of practice and may work in the emergency department, inpatient unit, operating room, and maternal child. AHS is encouraged to ensure those staff working in numerous clinical specialties feel supported and have the required certifications and credentials to work competently in clinical areas. Staff expressed concerns in sustaining competence as case volumes and hands-on experience may be minimal. On the reverse side, there are benefits to staff having skill sets for multiple services in that it adds flexibility in the system and makes it easier to move staff to where the needs are.

There appears to be a good working relationship between local leadership teams and zone leadership teams. The local unit managers are engaged with the staff on their units. They are a key support and provide daily guidance to the staff. At some sites the management team has identified the need for additional resources to support staff education. Most units have an educator. The educators, whether part time or full time in the hospital, are a valuable resource to support staff learning needs.

Recruitment and retention of staff is a concern at some rural sites, especially the recruitment and retention of casual staff. Various strategies are in place depending on the community.

There is an identified need for staff to have regularly scheduled performance appraisals, so they can receive feedback and be supported in their learning needs and professional development. Performance appraisals provide an opportunity for managers to give quality time to their staff.

Priority Process: Episode of Care

There are 80 rural facilities in AHS and 55 of these hospitals provide some form of surgical services, including general surgery, endoscopy, ophthalmology, plastics, orthopedics, and women's health.

Numerous operating rooms in rural Alberta are not in use a great deal of the time. AHS is aware that operating room capacity, surgical volumes, and patient flow could be improved by using all operating rooms in the rural sites five days per week. There are examples in the province where decanting surgical services and volumes from the larger hospital sites to the smaller hospital sites has brought successful transition results (e.g., the cataract program in Red Deer was moved to Innisfail Health Centre and the endoscopy program to Stettler). AHS is encouraged to continue its work on developing Centres of Excellence and transitioning appropriate surgical services from large acute centres to rural hospitals. Front-line managers and staff in rural sites expressed the desire to discuss and provide input into what

surgical services could be moved to their sites. The voice of the staff is imperative for success in moving forward together.

AHS may want to consider putting parameters or indicators on surgery and patient case types to ensure there is a comprehensive understanding of what and who is appropriate for surgery in the rural setting.

AHS has approved a safe surgery checklist and supporting policies and this is used. Clinical pathways and order sets are used for specific diagnoses and AHS is encouraged to continue developing them.

Overall the ROPs are implemented and well embedded into the daily practice of front-line staff. There are some areas for improvement for some ROPs.

Falls prevention processes and practices are not standardized across the province, and AHS is encouraged to standardize aspects of this ROP. Examples include using a specific falls icon such as a falling star, slip sign, or yellow bracelet. Currently varying icons and practices are used. While all inpatients are assessed for risk of falls, it is also important to assess all outpatients and this does not currently occur. With AHS's vision of patients travelling to rural sites for surgical services, it is important to provide a standardized approach to the ROPs to ensure the public has a consistent and clear understanding of processes and practices and a continuum of care exists among sites.

Patient names are called out in the waiting rooms at most rural sites. AHS is encouraged to consider a number system to ensure patient privacy.

Priority Process: Decision Support

The majority of patient charts are paper. Diagnostic imaging and laboratory results are obtained on the computer. Unit clerks organize patient charts using a checklist, which facilitates finding information on the chart.

There is an interactive approach to admission and discharge and it may include patient and family members. Initial patient assessments use valuable input from the patient and/or family members. Discharge planning is interactive and interdisciplinary.

Standardized forms, such as the inter-facility patient transfer form, admission and discharge checklist, and the function assessment record are used across the system for admission, transition, and discharge. Staff find these forms valuable.

Medical records departments have secure entry. Patient files are secured and retained according to legislation.

Priority Process: Impact on Outcomes

Patient and family inclusion at the rural hospital site level is in its early phases. Staff have a limited understanding of how the role of the patient and family will evolve into the work of the hospital and how patient and family input may change their practice. AHS is currently using Patient and Family Advisors and it would benefit the staff to have examples of how the patient voice has impacted current projects, policies, and processes, along with an overview of AHS's vision of patient- and family-centred care.

At many sites, quality indicators and measures are posted on quality boards for staff, patients, and visitors to view. Common indicators across the hospital sites appear to be hand hygiene, methicillin-resistant Staphylococcus aureus, medication reconciliation, and patient experience. Compliance and audit results may be discussed at site quality huddles, patient care councils, staff meetings, and quality improvement meetings. Staff appear to be unaware of how their quality initiatives align with AHS's overall quality improvement plan.

At this time, there appears to be no research occurring in the rural sites.

Priority Process: Medication Management

There is pharmacy support at each rural site. Medications are locked behind double locks and medication carts are stored in locked medication rooms when not in use. Narcotics and high-risk medications require double signatures and this practice is followed. Crash carts are standardized at the sites and checks for outdated medications are assigned to either the nursing or pharmacy staff. Once a medication reaches the out-date, the pharmacy sends the drug to a site that can use it before expiration.

Medication reconciliation for inpatients and outpatients is done well. Regular auditing and ongoing education support the staff in becoming proficient in this task. The NetCare database is very much appreciated and helps staff obtain necessary and current medication information.

Medication rooms are clean and clutter free. Cupboards and shelves are marked and well organized. Refrigerators hold only medications. Staff report that patient medications are available in a timely manner.

Several clinic units have refrigerators to store medications. Refrigerator temperatures are monitored daily, weekly, or not at all, depending on the clinical area. The temperature is documented on a form. Staff are unclear as to what the refrigerator temperature parameters are and to whom to report discrepancies in temperatures. It would be of benefit to provide the policy and processes to staff in an education session.

Standards Set: Primary Care Services - Direct Service Provision

Unmet Criteria		High Priority Criteria
Priority Process: Clinical Leadership		
5.2	Work and job design, roles and responsibilities, and assignments are determined with input from team members, and from clients and families where appropriate.	
Priority Process: Competency		
The organization has met all criteria for this priority process.		
Priority Process: Episode of Care		
8.14	Clients and families are provided with information about their rights and responsibilities.	!
Priority Process: Decision Support		
The organization has met all criteria for this priority process.		
Priority Process: Impact on Outcomes		
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.	!
16.3	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)		
Priority Process: Clinical Leadership		

The team involves clients in program development and setting goals and objectives, and the goals and objectives are linked to the clinic's mission and values.

The team has processes to access the resources and support to achieve its goals and objectives.

The team is skilled and competent in developing and coordinating partnerships with other teams, providers, and organizations.

Priority Process: Competency

The team is a well-functioning interdisciplinary team that regularly shares information among team members and other teams across the organization.

Physicians and staff are hired and developed in keeping with the team's mission, values, goals, and objectives.

Good processes are in place to ensure each provider has the appropriate license or credentials from the relevant college or association. This process is ongoing.

Staff and service providers work to their full scope of practice.

Team members report a comprehensive orientation process and support for both continuing education and in-service training.

There are processes to support student placement on the team.

Priority Process: Episode of Care

Standardized processes are used for client assessment and clients' individual needs and preferences are included. The assessment is documented and shared, and it leads to a care planning process where the client is involved.

A best possible medication history is generated and used.

For more complex and complicated clients a formal case management process is used. Supports are provided to help clients understand service information and participate in service delivery. Services are delivered consistently within the care plan and well documented. Services are well coordinated among different providers. Progress is monitored with the client and adjustments made as needed.

Priority Process: Decision Support

Processes are in place to provide staff with access to research-based evidence and best practice information. This information is shared within the team and communicated to other interested practitioners.

Client records are accurate, up to date, and secure.

There is a culture of organizational learning and evidence-based decision making.

Priority Process: Impact on Outcomes

The team identifies performance measures and targets for success. The team also analyzes performance data and identifies clinical priorities.

There is some benchmarking and the team describes examples of successful quality improvement initiatives.

The team is reviewing and enhancing its identification and monitoring of processes and outcome measures to evaluate and improve service quality and client outcomes.

Standards Set: Public Health Services - Direct Service Provision

Unmet Criteria		High Priority Criteria
Priority Process: Clinical Leadership		
The organization has met all criteria for this priority process.		
Priority Process: Competency		
4.2	Required training and education are defined for all team members with input from clients and families.	!
4.3	Team member performance is regularly evaluated and documented in an objective, interactive, and constructive way.	!
4.4	Ongoing professional development, education, and training opportunities are available to each team member.	
Priority Process: Impact on Outcomes		
16.1	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.	
16.2	The information and feedback gathered is used to identify opportunities for quality improvement initiatives and set priorities, with input from clients and families.	
16.3	Measurable objectives with specific timeframes for completion are identified for quality improvement initiatives, with input from clients and families.	!
16.4	Indicator(s) that monitor progress for each quality improvement objective are identified, with input from clients and families.	
16.5	Quality improvement activities are designed and tested to meet objectives.	!
16.6	New or existing indicator data are used to establish a baseline for each indicator.	
16.7	There is a process to regularly collect indicator data and track progress.	
16.8	Indicator data is regularly analyzed to determine the effectiveness of the quality improvement activities.	!
16.9	Quality improvement activities that were shown to be effective in the testing phase are implemented broadly throughout the organization.	!

16.10	Information about quality improvement activities, results, and learnings is shared with clients, families, teams, organization leaders, and other organizations, as appropriate.	
16.11	Quality improvement initiatives are regularly evaluated for feasibility, relevance, and usefulness, with input from clients and families.	
Priority Process: Public Health		
7.6	The effectiveness of communication strategies is evaluated and improvements are made as a result.	
8.3	Health impact assessments for proposed public policies, programs, and projects are conducted in collaboration with partners and with input from the community.	
9.7	Health promotion activities are regularly evaluated and improvements are made as a result.	

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

The leadership provided by the Population, Public and Indigenous Health Strategic Clinical Network helps maximize resources and support standardization of best and promising practices across the geographically based zones. There is recognition that local needs and partnerships may influence the implementation plan for the standard practices.

The Dyad leadership model further supports and drives quality improvement. AHS has matured to become a unified organization and this strong foundation will help promote continuous innovation.

With the new primary care governance structure, this leadership team has much to offer in terms of creating strategies to address the full continuum of care (population health promotion, health prevention, harm reduction, and primary, secondary, tertiary, and quaternary prevention by dying well, without pain and with dignity). There is also expertise in supporting complex populations and the social determinants of health, and developing targeted programs.

Several teams in the North Zone may require additional support to fully implement the clinical standards. Staff turnover and leadership changes could necessitate a rebuilding of trust in teams and communities and with partners.

Priority Process: Competency

Staff are knowledgeable, passionate, and practice a client-centred approach. The teams that provide decision support services have diverse backgrounds and competencies, and are dedicated to the betterment of population health monitoring, intervention, and evaluation.

The dyad leaders strive for quality improvement and provide support for success to their teams.

Priority Process: Impact on Outcomes

The vast majority of teams are highly motivated to focus on process, along with short- and longer-term outcomes. There are a few locations with smaller teams that are interested, however, they either do not have the capacity or are uncertain where to start.

There is significant and sophisticated health system analytic capacity to support the zones not only in population and public health, but also across the care continuum. There is also evidence of questions and hypotheses from zone leaders and front-line public health teams that require study.

Some teams use data to inform baseline metrics and track many improvement metrics. An overall dashboard of the "critical few" metrics for the Population, Public and Indigenous Health portfolio is encouraged. These would then cascade to the most relevant zone metrics based on population health needs.

Population and public health practice is one part of the health system that has the breadth and depth of understanding to support the quadruple aim and the organization is encouraged to leverage this strength.

Priority Process: Public Health

There is a strong, respectful, and open relationship with the Senior Program Officer who has responsibility for this team. This is a passionate, dedicated team of highly knowledgeable, competent staff who are attentive to confidentiality and feel safe reporting near misses and errors.

The interactive population health dashboard is innovative and there is evidence it is used by teams and decision makers.

There is strong leadership and oversight for emergency/disaster management that is well linked with the public health surveillance function. Other strengths include the Public Health Agency of Canada surveillance officers at the provincial laboratory who bridge public health with the laboratory.

There is strong collaboration with diverse community partners. The partners vary from community to community based on the needs identified. The team is highly credible, enabling it to readily establish new partnerships to address emerging population health needs. Of special note is the opioid crisis response model that was a collaborative response across many sectors inside and outside of health. Also noteworthy is Project Watch, a partnership to address safe housing for the most vulnerable, that includes environmental health officers, the Edmonton Police Service, social agencies, landlords, and tenants. There is evidence of a strong partnership based on respect and coordination of each organization’s unique mandates.

There is a continuous quality improvement focus that includes process and longer-term outcome measures. The quality improvement cycle (AIW) provides a framework to implement continuous quality improvement and the teams are encouraged to make these efforts visible at the sites to further motivate staff. The implementation of quality improvement plans varies among sites. Some have plans that are fully developed, others have a plan that is not yet implemented, and at some smaller sites there is no evidence of a plan. This is an opportunity to learn across the zones, sharing information and starting with where the teams are to build on their strengths and make continuous quality improvement relevant in day-to-day work.

Programs targeting specific populations with greatest need are prioritized. Staff at all levels are readily able to identify ethical dilemmas and have access to ethics consultation services. There is also an AHS bioethicist who has studied client vaccine hesitancy at a Master's level and who does not appear to be connected to the immunization leaders; which is a missed opportunity.

The tobacco reduction program, linking with mental health and addictions and other partners, has promising initial results in targeted populations such as prenatal and new Canadians. There could be further linkages for mental health and well-being promotion as the public health team has experience with building community resiliency.

The team is encouraged to submit some of its innovations as Leading Practices, as they could drive public health practice in Canada and beyond.

The IT/IM infrastructure is ageing and planning is underway to transition to Meditech. There was evidence of this being an inclusive process for all future users.

Other challenges include ongoing work on improving data surveillance for injuries, significant and sustained population growth, changing demographics, population shifts, and ensuring cultural needs are understood and addressed. Supply costs are also increasing. With the enhancement of community-based services there may be a need to explore resource reallocation.

While public health is the primary service provider for childhood immunizations the team is encouraged to consider partnering with primary care to create additional capacity to address gaps in immunization coverage rates. This could be on a trial basis with selected primary care sites, with appropriate supports. The team is acknowledged for taking the step of having licensed practical nurses employed with the school immunization program.

The team is encouraged to continue seeking the guidance of the Wisdom Council and to develop a written plan to address the Truth and Reconciliation calls to action.

Senior executive support for better integration with the primary care networks would also help this team move forward on the goal of population health, including a lens of health equity and the broader social determinants of health. The current connections with the networks are inconsistent and this is a missed

opportunity. There is also a role for Population, Public, and Indigenous Health at the governance level and for a seat at the table with the zone discussions. This would support the World Health Organization goal of “reorienting the health system” to achieve healthier populations.

Organization's Commentary

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

Alberta Health Services (AHS) has reviewed Accreditation Canada's May 2017 on-site survey report. We appreciate the effort and time that the survey team took to visit 129 sites, the majority of which were rural and remote facilities.

It is important to note that any given 'unmet' rating does not necessarily apply to all (or even several) of the sites; nor does it always apply to every service area within a particular site. Rather, for the Required Organizational Practices (ROPs), if one service area at one particular site receives even one unmet rating on just one (of several) tests for compliance, the rating is reflected as being 'unmet' for the entire organization. Improvement to the way ratings are presented is necessary to more accurately reflect the reality that most service areas in the majority of surveyed sites received 'met' ratings.

Accreditation Canada has acknowledged that adjustments are necessary to produce more meaningful reports for large multi-service and multi-site healthcare systems such as AHS. Over the next year, Accreditation Canada and AHS have committed to co-design a new assessment and reporting process that will better suit the needs of a large integrated health system.

AHS looks forward to receiving the detailed ratings for each individual site and service. AHS will approach the detailed survey results within the spirit of our values, holding ourselves accountable where there is need to further improve the quality and safety of services and respectfully working with staff and patients to achieve greater excellence in care.

The following were identified by the survey team during a debriefing presentation to AHS staff:
Major strengths for the organization:
- AHS has made significant, tangible progress towards a fully-integrated health system
- Progress has been made in reducing variation and utilization of common tools in many areas, however more work is needed
- Improvements have been observed in AHS' ability to focus and finish on initiatives before moving onto the next area
- Passionate and caring staff, physicians, and volunteers who show pride in their work and a strong understanding of the AHS values
- The benefit and value in being part of AHS, due to professional development and educational opportunities
- Specialized clinics to serve Alberta's indigenous population
- Strategic Clinical Networks (SCNs)
- Noticeable progress in quality safety culture and initiatives
- Depth and diversity of community partnerships
- Strong collaboration across the entire continuum of care
- Very satisfied patients, residents and families.

Opportunities for improvement:
- Increased input from patients and families in care planning and program design
- Continued development of technology platforms (e.g. the clinical information system)
- Opportunity to optimize capacity of operating rooms in rural areas
- Improve retention of point-of-care leaders and better succession planning in rural areas
- Staff performance reviews completed with more regular frequency
- Better utilization of data to support quality improvement initiatives
- More consistent evidence of quality, safety and person centered care initiatives across sites and in Medicine services

Many of the opportunities for improvement outlined in this report had previously been self-identified by the organization. Multiple initiatives are already underway, all of which are linked to our four foundational strategies:

AHS Patient First Strategy –Foundational to the Patient First Strategy are our patient and family advisors who are increasingly providing input to provincial committees, SCNs and research activities. Our next steps are to further standardize processes for and integrate patient/family input closer to the point of care within local programs and quality committees. The patient/family voice is captured in real time through introduction of bedside shift reports and leader rounding. Processes to meaningfully include patients and families in service planning, quality improvement, policy development and evaluation at program, zone and local levels will be further formalized. Use of telehealth technology will be enhanced to provide care to our patients and families from birth to death regardless of their geographical location in the province. Increased standardization for care transitions as patients move across care settings (e.g., acute to long-term care) and across zones (where different IT platforms are used for patient care records) is underway to improve experience for patients and families.

Our People Strategy - As noted by the survey team, AHS organizational values are well understood and integrated into practice. Overall, we can do better in our completion of performance reviews, performance management, coaching and mentoring, succession planning, leadership development and recognition. Improved communication and engagement with physicians and staff and strong leadership will also help to successfully achieve changes to our practice. Our community stakeholders are an integral part of supporting healthcare in Alberta and we recognize the need to enhance our partnerships with primary care physicians and Primary Care Networks. All solutions and work toward standardization must be informed by the perspectives of those we serve, our patients/residents and their families.

Clinical Health Research, Innovation & Analytics Strategy - Our SCNs continue to engage partners and identify gaps where research and innovation would significantly benefit patients and the health system. Easy, timely and secure access to health information assists application and spread of knowledge and innovation across the system to achieve service excellence. Local levels have access to data to develop meaningful goals and objectives and to identify performance indicators to guide

quality improvement initiatives. Education and support for the analysis and interpretation of data, such as that currently tracked through Tableau, will be provided to make the information meaningful for even our smallest sites.

Information Management/Information Technology Strategy – The main objective is to make the right information available to the right people at the right time across the health system, so that providers have access to complete information at the point of care. Patient access to health information will increase through MyHealth.Alberta.ca. Clinical knowledge content embedded into our new Clinical Information System (CIS) will be very helpful to standardize clinical practice. Development of Clinical Knowledge topics is underway with input from physicians, staff and patients and families (where appropriate). AHS is very close to determining the vendor for our new provincial CIS. Full implementation will span several years, connecting and unifying information that currently exists in more than 1,300 different IT systems across the province. The transition from paper based to electronic health records will enhance patient/resident safety and make their information accessible only to those who are authorized through provider registry.

As we reflect on the results from the hundreds of sites, services and programs surveyed over the 2014-2017 accreditation cycle we have used the information to further develop the patient and family focus within our health system while improving quality and safety of the care we provide. We look forward to our next cycle, anticipating a review process that will better suit the needs of a large integrated health system.

Appendix A - Qmentum

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

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

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

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

Action Planning

Following the on-site survey, the organization uses the information in its Accreditation Report and Quality Performance Roadmap to develop action plans to address areas identified as needing improvement. The organization provides Accreditation Canada with evidence of the actions it has taken to address these required follow ups.

Evidence Review and Ongoing Improvement

Five months after the on-site survey, Accreditation Canada evaluates the evidence submitted by the organization. If the evidence shows that a sufficient percentage of previously unmet criteria are now met, a new accreditation decision that reflects the organization's progress may be issued.

Appendix B - Priority Processes

Priority processes associated with system-wide standards

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

Priority processes associated with population-specific standards

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

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

Priority processes associated with service excellence standards

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

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