ACCREDITATION
AGRÉMENT
CANADA
Qmentum

Accreditation Report

Alberta Health Services

Edmonton, AB

3rd Component (2014-17 Cycle)

On-site survey dates: May 1, 2016 - May 6, 2016

Report issued: June 7, 2016

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 May 2016. 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 Accreditation Specialist 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 leadership, governance, clinical programs and services against Accreditation Canada requirements for quality and safety. These requirements include national standards of excellence; required safety practices to reduce potential harm; and questionnaires to assess the work environment, patient safety culture, governance functioning and client experience. Results from all of these components are included in this report and were considered in the accreditation decision.

This report shows the results to date and is provided to guide the organization as it continues to incorporate the principles of accreditation and quality improvement into its programs, policies, and practices.

The organization is commended on its commitment to using accreditation to improve the quality and safety of the services it offers to its clients and its community.

Accreditation Decision

Alberta Health Services's accreditation decision is:

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

About the On-site Survey

- **On-site survey dates: May 1, 2016 to May 6, 2016**

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. Aberhart Centre
2. Addiction Recovery Centre
3. Addiction Services Edmonton
4. Alberta Children's Hospital
5. Alberta Hospital Edmonton
6. Athabasca Community Health Services
7. Barrhead Community Cancer Centre
8. Barrhead Healthcare Centre
9. Bonnyville Community Cancer Centre
10. Bonnyville New Park Place
11. Bridgeland Seniors Health Centre
12. Brooks Health Centre
13. Calgary Youth Addiction Services
14. Camrose Community Cancer Centre
15. Carewest - Sarcee
16. Centennial Centre for Mental Health & Brain Injury
17. Central Alberta Cancer Centre
18. Centre Hope Building
19. Chestermere Community Health Centre
20. Chinook Regional Hospital
21. Claresholm Centre for Mental Health and Addictions
22. Cochrane Community Health Centre
23. Cross Cancer Institute
24. Drayton Valley Community Cancer Centre
25. Drayton Valley Community Health Centre
26. Drumheller Health Centre
27. East Calgary Health Centre

28. East Edmonton Health Centre
29. Edmonton General Continuing Care Centre
30. Foothills Medical Centre
31. Forensic Assessment and Community Services
32. Fort Macleod Health Centre
33. Fort McMurray Community Cancer Centre
34. Fort McMurray Provincial Building
35. Glenrose Rehabilitation Hospital
36. Grande Prairie Cancer Centre
37. Grande Prairie Virene Building
38. Henwood Treatment Centre
39. High River Community Cancer Centre
40. Jack Ady Cancer Centre
41. Kaye Edmonton Clinic
42. Kentwood Place
43. Kingsway Professional Building
44. Lander Treatment Centre
45. Lethbridge Centre
46. Lethbridge Provincial Building
47. Lethbridge Youth Residential Treatment Centre
48. Lloydminster Community Cancer Centre
49. Lois Hole Hospital for Women
50. Margery E. Yuill Cancer Centre
51. Mazankowski Alberta Heart Institute
52. Medicine Hat Regional Hospital
53. Mother Rosalie Health Services Centre
54. Northeast Community Health Centre
55. Northern Addictions Centre
56. Northern Lights Regional Health Centre
57. Northgate Centre
58. Olds Provincial Building
59. Peter Lougheed Centre
60. Queen Elizabeth II Hospital
61. Red Deer 49th Street Community Health Centre
62. Red Deer Bremner Avenue Community Health Centre
63. Red Deer Provincial Building
64. Red Deer Regional Hospital Centre

65. Regional Resource Centre
66. Renfrew Recovery Centre
67. Rocky Mountain House Health Centre
68. Rockyview General Hospital
69. Royal Alexandra Hospital
70. Sheldon M. Chumir Health Centre
71. South Calgary Health Centre
72. South Health Campus
73. Southern Alberta Forensic Psychiatric Centre
74. St. Albert Provincial Building
75. St. Therese - St. Paul Healthcare Centre
76. Stettler Addictions Office
77. Stollery Children's Hospital
78. Strathcona Community Hospital
79. Sturgeon Community Hospital
80. Sunridge Mall - 2580
81. Sylvan Lake Community Health Centre
82. Taber Health Centre
83. Tom Baker Cancer Centre
84. Two Hills Health Centre
85. University of Alberta Hospital
86. Vegreville Community Health Centre
87. Vermilion Provincial Building
88. Wetaskiwin Provincial Building
89. Youth Residential Addiction Services

- **Standards**

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

Service Excellence Standards

1. Acquired Brain Injury Services - Service Excellence Standards
2. Ambulatory Care Services - Service Excellence Standards
3. Ambulatory Systemic Cancer Therapy Services - Service Excellence Standards
4. Cancer Care and Oncology Services - Service Excellence Standards
5. Community-Based Mental Health Services and Supports - Service Excellence Standards
6. Home Care Services - Service Excellence Standards

7. Medicine Services - Service Excellence Standards
8. Mental Health Services - Service Excellence Standards
9. Perioperative Services and Invasive Procedures - Service Excellence Standards
10. Rehabilitation Services - Service Excellence Standards
11. Spinal Cord Injury Acute Services - Service Excellence Standards
12. Spinal Cord Injury Rehabilitation Services - Service Excellence Standards
13. Substance Abuse and Problem Gambling - Service Excellence Standards

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)	31	4	0	35
Accessibility (Give me timely and equitable services)	103	3	0	106
Safety (Keep me safe)	325	40	1	366
Worklife (Take care of those who take care of me)	96	10	0	106
Client-centred Services (Partner with me and my family in our care)	461	32	0	493
Continuity of Services (Coordinate my care across the continuum)	105	1	0	106
Appropriateness (Do the right thing to achieve the best results)	587	87	0	674
Efficiency (Make the best use of resources)	11	5	1	17
Total	**1719**	**182**	**2**	**1903**

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
	# (%)	# (%)	#	# (%)	# (%)	#	# (%)	# (%)	#
Acquired Brain Injury Services	40 (87.0%)	6 (13.0%)	0	84 (95.5%)	4 (4.5%)	0	124 (92.5%)	10 (7.5%)	0
Ambulatory Care Services	43 (93.5%)	3 (6.5%)	0	71 (92.2%)	6 (7.8%)	1	114 (92.7%)	9 (7.3%)	1
Ambulatory Systemic Cancer Therapy Services	63 (95.5%)	3 (4.5%)	0	89 (96.7%)	3 (3.3%)	0	152 (96.2%)	6 (3.8%)	0
Cancer Care and Oncology Services	46 (100.0%)	0 (0.0%)	0	84 (100.0%)	0 (0.0%)	0	130 (100.0%)	0 (0.0%)	0
Community-Based Mental Health Services and Supports	29 (65.9%)	15 (34.1%)	0	79 (84.0%)	15 (16.0%)	0	108 (78.3%)	30 (21.7%)	0
Home Care Services	48 (98.0%)	1 (2.0%)	0	76 (100.0%)	0 (0.0%)	0	124 (99.2%)	1 (0.8%)	0
Medicine Services	40 (88.9%)	5 (11.1%)	0	74 (96.1%)	3 (3.9%)	0	114 (93.4%)	8 (6.6%)	0
Mental Health Services	38 (76.0%)	12 (24.0%)	0	81 (88.0%)	11 (12.0%)	0	119 (83.8%)	23 (16.2%)	0

Standards Set	High Priority Criteria *			Other Criteria			Total Criteria (High Priority + Other)		
	Met	Unmet	N/A	Met	Unmet	N/A	Met	Unmet	N/A
	# (%)	# (%)	#	# (%)	# (%)	#	# (%)	# (%)	#
Perioperative Services and Invasive Procedures	93 (80.9%)	22 (19.1%)	0	92 (84.4%)	17 (15.6%)	0	185 (82.6%)	39 (17.4%)	0
Rehabilitation Services	38 (84.4%)	7 (15.6%)	0	73 (91.3%)	7 (8.8%)	0	111 (88.8%)	14 (11.2%)	0
Spinal Cord Injury Acute Services	49 (98.0%)	1 (2.0%)	0	89 (95.7%)	4 (4.3%)	0	138 (96.5%)	5 (3.5%)	0
Spinal Cord Injury Rehabilitation Services	46 (97.9%)	1 (2.1%)	0	86 (98.9%)	1 (1.1%)	0	132 (98.5%)	2 (1.5%)	0
Substance Abuse and Problem Gambling	38 (84.4%)	7 (15.6%)	0	72 (87.8%)	10 (12.2%)	0	110 (86.6%)	17 (13.4%)	0
Total	**611 (88.0%)**	83 (12.0%)	0	1050 (92.8%)	81 (7.2%)	1	1661 (91.0%)	164 (9.0%)	1

* Does not includes ROP (Required Organizational Practices)

Overview by Required Organizational Practices

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

This table shows the ratings of the applicable ROPs.

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Communication			
Client Identification (Acquired Brain Injury Services)	Met	1 of 1	0 of 0
Client Identification (Ambulatory Care Services)	Met	1 of 1	0 of 0
Client Identification (Ambulatory Systemic Cancer Therapy Services)	Met	1 of 1	0 of 0
Client Identification (Cancer Care and Oncology Services)	Met	1 of 1	0 of 0
Client Identification (Home Care Services)	Met	1 of 1	0 of 0
Client Identification (Medicine Services)	Met	1 of 1	0 of 0
Client Identification (Mental Health Services)	Met	1 of 1	0 of 0
Client Identification (Perioperative Services and Invasive Procedures)	Unmet	0 of 1	0 of 0
Client Identification (Rehabilitation Services)	Met	1 of 1	0 of 0

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Communication			
Client Identification (Spinal Cord Injury Acute Services)	Met	1 of 1	0 of 0
Client Identification (Spinal Cord Injury Rehabilitation Services)	Met	1 of 1	0 of 0
Client Identification (Substance Abuse and Problem Gambling)	Met	1 of 1	0 of 0
Information transfer at care transitions (Acquired Brain Injury Services)	Met	4 of 4	1 of 1
Information transfer at care transitions (Ambulatory Care Services)	Met	4 of 4	1 of 1
Information transfer at care transitions (Ambulatory Systemic Cancer Therapy Services)	Unmet	4 of 4	0 of 1
Information transfer at care transitions (Cancer Care and Oncology Services)	Met	4 of 4	1 of 1
Information transfer at care transitions (Community-Based Mental Health Services and Supports)	Unmet	3 of 4	0 of 1
Information transfer at care transitions (Home Care Services)	Unmet	2 of 4	0 of 1
Information transfer at care transitions (Medicine Services)	Unmet	2 of 4	0 of 1
Information transfer at care transitions (Mental Health Services)	Met	4 of 4	1 of 1

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Communication			
Information transfer at care transitions (Perioperative Services and Invasive Procedures)	Unmet	1 of 4	0 of 1
Information transfer at care transitions (Rehabilitation Services)	Met	4 of 4	1 of 1
Information transfer at care transitions (Spinal Cord Injury Acute Services)	Met	4 of 4	1 of 1
Information transfer at care transitions (Spinal Cord Injury Rehabilitation Services)	Met	4 of 4	1 of 1
Information transfer at care transitions (Substance Abuse and Problem Gambling)	Met	4 of 4	1 of 1
Medication reconciliation at care transitions (Acquired Brain Injury Services)	Met	5 of 5	0 of 0
Medication reconciliation at care transitions (Ambulatory Care Services)	Met	7 of 7	0 of 0
Medication reconciliation at care transitions (Ambulatory Systemic Cancer Therapy Services)	Met	7 of 7	0 of 0
Medication reconciliation at care transitions (Cancer Care and Oncology Services)	Met	5 of 5	0 of 0
Medication reconciliation at care transitions (Community-Based Mental Health Services and Supports)	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			
Medication reconciliation at care transitions (Medicine Services)	Met	5 of 5	0 of 0
Medication reconciliation at care transitions (Mental Health Services)	Met	5 of 5	0 of 0
Medication reconciliation at care transitions (Perioperative Services and Invasive Procedures)	Unmet	5 of 8	0 of 0
Medication reconciliation at care transitions (Rehabilitation Services)	Met	5 of 5	0 of 0
Medication reconciliation at care transitions (Spinal Cord Injury Acute Services)	Met	5 of 5	0 of 0
Medication reconciliation at care transitions (Spinal Cord Injury Rehabilitation Services)	Met	5 of 5	0 of 0
Medication reconciliation at care transitions (Substance Abuse and Problem Gambling)	Met	3 of 3	2 of 2
Safe surgery checklist (Perioperative Services and Invasive Procedures)	Unmet	2 of 3	2 of 2
Patient Safety Goal Area: Medication Use			
Infusion pump safety (Ambulatory Care Services)	Met	4 of 4	2 of 2

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Medication Use			
Infusion pump safety (Ambulatory Systemic Cancer Therapy Services)	Met	4 of 4	2 of 2
Infusion pump safety (Cancer Care and Oncology Services)	Met	4 of 4	2 of 2
Infusion pump safety (Home Care Services)	Met	4 of 4	2 of 2
Infusion pump safety (Medicine Services)	Met	4 of 4	2 of 2
Infusion pump safety (Mental Health Services)	Met	4 of 4	2 of 2
Infusion pump safety (Perioperative Services and Invasive Procedures)	Met	4 of 4	2 of 2
Infusion pump safety (Rehabilitation Services)	Met	4 of 4	2 of 2
Infusion pump safety (Spinal Cord Injury Acute Services)	Met	4 of 4	2 of 2
Infusion pump safety (Spinal Cord Injury Rehabilitation Services)	Met	4 of 4	2 of 2
Patient Safety Goal Area: Risk Assessment			
Falls prevention (Acquired Brain Injury Services)	Met	3 of 3	2 of 2
Falls prevention (Ambulatory Care Services)	Unmet	0 of 3	0 of 2

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Risk Assessment			
Falls prevention (Ambulatory Systemic Cancer Therapy Services)	Unmet	3 of 3	0 of 2
Falls prevention (Cancer Care and Oncology Services)	Met	3 of 3	2 of 2
Falls prevention (Home Care Services)	Met	3 of 3	2 of 2
Falls prevention (Medicine Services)	Met	3 of 3	2 of 2
Falls prevention (Mental Health Services)	Unmet	3 of 3	0 of 2
Falls prevention (Perioperative Services and Invasive Procedures)	Unmet	0 of 3	0 of 2
Falls prevention (Rehabilitation Services)	Unmet	0 of 3	0 of 2
Falls prevention (Spinal Cord Injury Acute Services)	Met	3 of 3	2 of 2
Falls prevention (Spinal Cord Injury Rehabilitation Services)	Met	3 of 3	2 of 2
Home safety risk assessment (Home Care Services)	Met	3 of 3	2 of 2
Pressure ulcer prevention (Cancer Care and Oncology Services)	Unmet	3 of 3	1 of 2
Pressure ulcer prevention (Medicine Services)	Unmet	3 of 3	1 of 2

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Risk Assessment			
Pressure ulcer prevention (Perioperative Services and Invasive Procedures)	Unmet	3 of 3	1 of 2
Pressure ulcer prevention (Rehabilitation Services)	Met	3 of 3	2 of 2
Pressure ulcer prevention (Spinal Cord Injury Acute Services)	Met	3 of 3	2 of 2
Pressure ulcer prevention (Spinal Cord Injury Rehabilitation Services)	Met	3 of 3	2 of 2
Skin and wound care (Home Care Services)	Met	7 of 7	1 of 1
Suicide prevention (Community-Based Mental Health Services and Supports)	Met	5 of 5	0 of 0
Suicide prevention (Mental Health Services)	Met	5 of 5	0 of 0
Suicide prevention (Substance Abuse and Problem Gambling)	Met	5 of 5	0 of 0
Venous thromboembolism prophylaxis (Cancer Care and Oncology Services)	Met	3 of 3	2 of 2
Venous thromboembolism prophylaxis (Medicine Services)	Unmet	2 of 3	1 of 2
Venous thromboembolism prophylaxis (Perioperative Services and Invasive Procedures)	Unmet	2 of 3	0 of 2

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Risk Assessment			
Venous thromboembolism prophylaxis (Spinal Cord Injury Acute Services)	Met	3 of 3	2 of 2
Venous thromboembolism prophylaxis (Spinal Cord Injury Rehabilitation Services)	Met	3 of 3	2 of 2

Summary of Surveyor Team Observations

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

Alberta Health Services (AHS) is the largest health system in Canada and continues to evolve as an integrated system providing comprehensive services to Albertans and, in many cases, other parts of Canada. Since the last accreditation on-site survey, a new seven-person board was established and a new acting president and chief executive officer was appointed. The organization has had to adapt to a changing economic environment while remaining focused on its mission to provide a patient-focused, quality health system that is accessible for all Albertans and sustainable for the province. Developed through extensive engagement sessions with staff, the new AHS vision statement is "Healthy Albertans. Healthy Communities. Together."

The accreditation on-site survey process continues to be an integral part of the organization's commitment to quality. An important part of this survey cycle was the incorporation of new standards related to patient- and family-centred care. One of the foundational strategies for AHS is its Patient First Strategy, which was officially launched in June 2015. The strategy is intended to strengthen culture and practices to fully embrace patient- and family-centred care throughout the organization and to empower and enable Albertans to be at the centre of their health care team. A range of activities has been identified to enable patients and families to have a voice and influence not only their personal care but also strategies, policies, and evaluation of AHS.

The organization is at various stages of implementing patient- and family-centred care, with some wonderful examples where input from and partnerships with patients and families are an integral part of how services are planned, delivered, evaluated, and continuously improved. For example, units using the CoACT model are well on their way. In other instances, teams are in the early stages of exploring how to hear the voices of patients and families and enhance their involvement. The organization is encouraged to leverage the many pockets of excellent patient- and family-centred care to expand this culture and practices across the organization. AHS may wish to explore good practices and learnings from other organizations that have experience and well-established practices related to patient- and family-centred care. The accreditation standards and this accreditation report can also serve as resources to inform that important work.

AHS continues to demonstrate its commitment to quality improvement. The organization has established a quality framework and each zone has a quality framework supported by a variety of councils and working groups. The maturity of these strategies and structures varies considerably. The survey team observed examples where quality councils, quality improvement plans, quality improvement initiatives, and performance indicators are well established. In many instances this improvement work is being led and coordinated at the organization, zone, or strategic clinical network level, with implementation at the operational level in different programs, units, and sites. Some teams have well-enunciated quality plans and performance metrics. In some areas and programs, teams are at the early stages of developing and implementing quality plans and will require continued support. These teams can benefit and learn from the experience of their colleagues. The organization is encouraged to build on this foundation to ensure all programs and units have defined quality improvement plans and relevant performance indicators that are analyzed to manage and continuously improve care and services.

Given the scale of AHS, the development, adoption, and spread of best practices and standardization of how things are done are challenging and time consuming. Strong leadership is being provided by the strategic clinical networks, zone councils, and other leadership groups. Progress is being made, although much work remains. Surveyors observed considerable variation in some practices and an opportunity to accelerate the spread of good practices, especially those related to the quality and safety of patient and client care. In some cases, strategic clinical networks and quality committees are new or just being established.

There appears to be some resistance to adopting an organizational approach that requires changes in practices even when accommodation is made to the unique environment of a particular site or program. As well, change fatigue may be a factor, given the many changes experienced across AHS since its inception. Good progress has already been made on implementing many of the Required Organizational Practices (ROPs) across AHS, and the organization has demonstrated the ability to establish many safety processes as standard practice across the organization. The organization is encouraged to consider an accelerated spread strategy for those ROPs that are most critical for safe care and which continue to require broader implementation across the organization.

Another area for improvement and more consistency is in the development of care plans, which are done well in some programs and sites but are not in place or insufficiently completed in other instances.

The Alberta Improvement Way (AIW) has been used by various teams to improve services. However, there has been limited adoption of this methodology in many sites and programs. The organization may wish to consider ways to facilitate learning and broader adoption of the AIW methodology.

In some cases, challenges to ensure coordinated, sustainable services are impacted by the need for supportive infrastructure. The recently announced approval and funding for a comprehensive clinical information system (CIS) is welcomed by the organization and will enable AHS to address many risks and inefficiencies associated with disconnected electronic information systems and paper-based documentation throughout the system. Although full implementation of the new CIS will take many years, it is anticipated to have tangible benefits for patients and care providers. This and other enablers will assist AHS in fulfilling its mandates for excellence in care, teaching, and research.

The AHS structure is intended to enable and enhance continuity of care across the continuum. Many partnerships have been created with other organizations and community agencies. The ability of the organization to work effectively as a large provincial system in collaboration with others was powerfully demonstrated during the on-site survey, which coincided with the horrific forest fire that required evacuation of Fort McMurray. AHS staff, physicians, and volunteers rallied with many other people and agencies to respond to this crisis, demonstrating their compassion and dedication to serving the people of Alberta. AHS is congratulated for the efficiency, effectiveness, and compassion it demonstrated and continues to demonstrate related to the Fort McMurray fire.

Throughout the on-site survey, the dedication and enthusiasm of AHS staff, physicians, and volunteers impressed the survey team. Staff expressed a high level of satisfaction and pride in being part of the AHS team and appreciated the support from their leaders. Staff expressed appreciation for the many learning opportunities within AHS, confirming the organization's commitment to be a learning organization that values its people. AHS has identified collaboration and respect as core values, which many staff indicated were important and appreciated aspects of being part of AHS.

Surveyors also had many opportunities to hear directly from clients, patients, and families about their care experience. They heard a high level of satisfaction from clients, patients, and families and appreciation for the hard work and dedication of the many people and teams providing care and services. It is apparent that the culture of quality improvement and commitment to high-quality care throughout AHS is having a tangible, positive impact on the experience of clients, patients, and families.

Detailed Required Organizational Practices

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

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

Unmet Required Organizational Practice	Standards Set
Patient Safety Goal Area: Communication	
Information transfer at care transitions Information relevant to the care of the client is communicated effectively during care transitions.	· Community-Based Mental Health Services and Supports 10.9 · Ambulatory Systemic Cancer Therapy Services 12.11 · Perioperative Services and Invasive Procedures 12.11 · Home Care Services 9.10 · Medicine Services 9.11
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.	· Perioperative Services and Invasive Procedures 12.3
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.	· Perioperative Services and Invasive Procedures 14.3
Medication reconciliation at care transitions INPATIENT CARE ONLY: A Best Possible Medication History (BPMH) is generated in partnership with clients, families, or caregivers (as appropriate) and used to reconcile client medications at care transitions.	· Perioperative Services and Invasive Procedures 11.6

Unmet Required Organizational Practice	Standards Set
Patient Safety Goal Area: Risk Assessment	
Falls prevention To minimize injury from falls, a documented and coordinated approach for falls prevention is implemented and evaluated.	· Perioperative Services and Invasive Procedures 11.11 · Ambulatory Systemic Cancer Therapy Services 11.6 · Ambulatory Care Services 8.6 · Rehabilitation Services 8.6 · Mental Health 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 for outpatient settings, including day surgery, given the lack of validated risk assessment tools for outpatient settings.	· Perioperative Services and Invasive Procedures 11.12 · Medicine Services 8.7 · Cancer Care and Oncology Services 8.7
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 · Medicine 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		
3.1	The physical layout of the operating and/or procedure room(s) and equipment are designed to consider client flow, traffic patterns, the types of procedures performed, ergonomics, and equipment movement logistics.	
3.10	There is a regular and comprehensive cleaning schedule for the operating/procedure room and supporting areas posted in a place that is accessible to all team members.	!

Surveyor comments on the priority process(es)

The criteria reviewed for the system priority process of physical environment focused on perioperative services and invasive procedures.

The Alberta Children's Hospital, a relatively new facility, and has operating and procedure rooms that are spacious and well designed to support client flow.

The Lois Hole Hospital for Women is relatively new, only 6 years old, and is well laid out, easily accessible for patients and families. The operating room suites for women's health are uncluttered and spacious.

Although there is a policy on terminal, weekly, and monthly cleaning of the operating rooms, there is no documentation to confirm that terminal, weekly, and monthly cleaning is done at the Stollery Children's Hospital.

There is a garbage room a short distance from where the procedure room is located in the basement of the Tom Baker Cancer Centre. Unfortunately, this means flies have a tendency to migrate to the

operating room suite. The leaders have been made aware of the situation and are addressing it.

At the Tom Baker Cancer Centre the pre-operative area to receive patients and prepare them for surgery is in the main hospital and the patient is then transported on a stretcher to the Tom Baker Cancer Centre for induction of anesthesia and to perform the procedure (brachytherapy). Additionally, there are renovations occurring in the corridor of the operating room suite where the procedure is performed which adds to the inconvenience of the flow and efficiency. The leaders are aware this is not the best set up and are working to improve the process for the benefit of staff and patients.

Space in the cardiac catheterization lab and endoscopy suites at Foothills Medical Centre is very tight. There is no rest space for staff. Patient privacy and confidentiality is at risk in both these areas. The waiting area for the endoscopy suite is in a long hallway, resulting in potential obstruction to stretcher movement.

Nursing space in the daycare unit at Foothills Medical Centre allows little work space for nurses attempting to complete the charting.

At Rockyview General Hospital, the operating suites and the bronchoscopy/gastroscopy day unit both suffer from cramped space in an aging facility. The operating room suites lack appropriate space for privacy for patients and the theatres are extremely cramped, creating ergonomic risks for staff. The bronchoscopy/gastroscopy day unit is a high volume program, operating in an extremely cramped area. This creates privacy and ergonomic risks.

Priority Process: Patient Flow

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

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

The criteria reviewed for the system priority process of physical environment focused on perioperative services and invasive procedures.

There are a number of processes at AHS to improve the efficient use of operating rooms, procedure rooms, and outpatient clinics. There have been issues related to surgical delays that are outside appropriate wait times, particularly in the operating rooms. This problem appears to be greater in Edmonton than in Calgary but is significant at sites in both cities. A number of initiatives are in place to attempt to correct this problem. Alberta's population is among the youngest in Canada and growth of the population may not be the sole cause for excessive demand for surgical services. Members of the Strategic Clinical Network are aware of this and are investigating other potential causes for delays. Some of these may be a concentration of all services in Calgary and Edmonton when some lower risk services could easily be increased in smaller sites.

There is a very high demand for endoscopy services in Alberta and these are provided very efficiently at a number of sites. Some consideration of site renovations might be appropriate to ensure patient privacy and confidentiality. The hallway "waiting room" at the Foothills Medical Centre should be redesigned and enlarged. The scope reprocessing area at Foothills Medical Centre is poorly designed and there is a risk of contamination between clean and dirty areas. The scope reprocessing unit at the Red Deer Regional Hospital Centre is spectacular with two large rooms (dirty and clean), and a pass through between the two rooms via the scope sterilizers. The separation between clean and dirty is absolute.

The cardiac catheterization program at Foothills Medical Centre provides very sophisticated services without undue delays. STEMI (ST segment elevation myocardial infarction) success in Calgary is among the best in Canada. There is an excellent bronchoscopy program for lung cancer screening at Foothills Medical Centre. It is underused and could increase its workload significantly without cost increases.

At the South Health Campus adult Coding Access Targets for Surgery (aCATS) are used to monitor patients who are not meeting targets. This data is used by the scheduling clerks and is provided regularly to each surgeon's office. One challenge encountered is difficulty in closing the loop back to the scheduling clerk from the surgeon's office when patients are not ready to take a surgical date.

South Health Campus uses a block booking system and significant efforts are underway to ensure maximum utilization of blocks. There is a well-developed process to communicate open time to other sites. It has taken time to develop the surgical program fully, due to changes in the services on the site that occurred from the original plan.

The aCATS system developed within AHS is being used to monitor wait times against targets that have been developed based on diagnosis and level of urgency.

At Rockyview General Hospital, each surgeon has their own wait list. The aCATS information is used to select patients for surgery. There are challenges with access for patients awaiting cancer surgery in the areas of urology and colon cancer. Strategies to provide additional operating room time for these services have been focused on.

At the Royal Alexandra Hospital, wait times are monitored through the aCATS system and reported to individual surgeons and surgical section heads. Surgeons are responsible for notifying patients about the anticipated date of surgery and adjusting this as required if the patient's status changes.

It is apparent that different hospitals have adopted different ways of assessing wait times for surgery. The Strategic Clinical Network should consider a province-wide process to identify patients' places on wait lists and minimize excessive wait times.

Wait times for endoscopy at Sturgeon Community Hospital are long. Plans are underway to expand the space, add an additional gastroenterologist, and do 1,248 more cases per year.

Priority Process: Medical Devices and Equipment

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

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

The criteria reviewed for the system priority process of physical environment focused on perioperative services and invasive procedures.

The review of medical devices and equipment focused on the surgical, perioperative, and outpatient procedure areas.

Equipment is well supported by biomedical engineering on the sites. The e-facilities system is in place province wide. Some concerns were heard about the system being labour intensive for end users.

There has been excellent progress in the area of ensuring appropriate, safe reprocessing. There are solid, standardized processes across the sites in the operating rooms and procedure areas. The reprocessing staff are ensuring safe practices, with the use of personal protective equipment at all times.

The reprocessing staff are dedicated and highly skilled. All staff have completed a certificate. They are highly appreciated by the clinical teams in the operating rooms and the outpatient procedure areas. There are a variety of reporting relationship models for the reprocessing staff. There is an opportunity for AHS to evaluate the models to determine if adjustments are needed.

There are physical plant constraints in a number of the older facilities that create difficult working environments. Additional space for these facilities has been requested.

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

Standards Set: Acquired Brain Injury 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.	!
2.4	Space is co-designed with input from clients and families to ensure safety and permit confidential and private interactions with clients and families.	
Priority Process: Competency		
3.1	Required credentials, training, and education are defined for all team members with input from clients and families.	!

3.12	Team member performance is regularly evaluated and documented in an objective, interactive, and constructive way.	!
Priority Process: Episode of Care		
8.11	Diagnostic and laboratory testing and expert consultation are available in a timely way to support a comprehensive assessment.	
10.9	The effectiveness of transitions is evaluated and the information is used to improve transition planning, with input from clients and families.	
Priority Process: Decision Support		
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.	!
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.	!
13.5	Guidelines and protocols are regularly reviewed, with input from clients and families, to ensure they reflect current research and best practice information.	!
Surveyor comments on the priority process(es)		
Priority Process: Clinical Leadership		

Goals and objectives are primarily at the zone and corporate levels. Individual teams and units are encouraged to further develop service-specific goals, with client and family input.

Discharge from inpatient programs requires multiple partners in community services. Staff have developed excellent relationships with educational, vocational, and housing partners to meet the needs of the population they serve.

Staff are commended on their ability to explore options for their clients. Many cases are complex and require collaboration among many players.

In general, the space was designed many years ago and may not meet today's requirements. Motorized wheelchairs and other assistive technology require more space. The organization is encouraged to include client and family input for future renovations and new space design.

Priority Process: Competency

Families and clients interviewed had been oriented to services and the service unit. When admission is known in advance the program provides families and clients with written materials and often a face-to-face visit from the receiving service.

Interdisciplinary collaboration and collegiality was observed at all locations. Disciplines understand their unique roles and responsibilities but are flexible within the team to best serve the client and family.

The organization supports a strong learning environment. Students from all disciplines and medicine were present and welcomed on the care teams.

Priority Process: Episode of Care

Openness and transparency with clients and families is a strength of these programs. Families expressed feeling part of the care team and always involved in care planning.

The care teams are to be congratulated on their attention and vigilance in medication reconciliation and falls prevention. It was evident at all sites that a considerable effort has been made to meet these standards.

The organization is encouraged to include patients and families in quality improvement initiatives and evaluation projects.

Access to beds was raised as a challenge. Patient flow is affected in rehabilitation programs when community placements cannot be found. Similarly access to acute neuroscience beds is impacted when there are no rehabilitation beds. There was no evidence of a centralized intake across the province for acquired brain injury patients.

The organization is encouraged to establish an acquired brain injury clinical network and a collaborative that includes linkages to spinal cord injury and rehabilitation.

Priority Process: Decision Support

Documentation in charts was complete and organized at all locations. The organization is encouraged to continue to reduce variability in forms and electronic platforms.

The use of white boards in patient rooms is viewed very positively by patients, families, and staff. It is hoped that this will spread across all sites.

There was evidence of education and awareness of privacy issues and legislation. Clients and families interviewed had no concerns regarding confidentiality of their personal information.

Priority Process: Impact on Outcomes

The surveyors were impressed with the overall achievement of functional goals by individuals in care. This is a result of true interdisciplinary team function.

The sites reviewed have made progress in using data and outcomes to evaluate their services. The attention to high-risk areas has resulted in better outcomes for some processes such as medication management, falls prevention, and pressure ulcer prevention. The input of families and clients into these and other quality improvement initiatives has been informal and inconsistent. The organization is encouraged to develop a client and family engagement strategy to support families, clients, and teams in this important work.

Standards Set: Ambulatory Care Services - Direct Service Provision

Unmet Criteria			High Priority Criteria
Priority Process: Clinical Leadership			
2.4	Space is co-designed with input from clients and families to ensure safety and permit confidential and private interactions with clients and families.		
2.6	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.		
Priority Process: Competency			
3.1	Required credentials, training, and education are defined for all team members with input from clients and families.		!
Priority Process: Episode of Care			
8.2	The assessment process is designed with input from clients and families.		
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**
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.		!
Priority Process: Impact on Outcomes			
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.	
15.11	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 clinical leadership has dedicated support from senior management to ensure there are sufficient financial and human resources to provide a consistent high standard of care.

The leadership has developed and encouraged a culture of quality, safety, and client-focused care that has cascaded through the organization.

The leadership has created a positive atmosphere of mutual respect, resulting in strong internal and external partnerships within all disciplines.

Priority Process: Competency

All staff have the necessary credentials and competencies to ensure clients receive the highest level of evidence-based care.

Staff are highly motivated, energetic, and dedicated to a culture of client- and family-centred care. This positive momentum is the result of promotion and education.

Continuing professional development is mandatory for all staff, and ongoing education is encouraged and supported by senior management.

Priority Process: Episode of Care

The Medicine units, Ambulatory Care units and Home Care areas all appear to have close links to each other. The Respiratory Therapy group communicates effectively through their Professional Practice Committee and are collaborative in dealing with issues facing the profession and their clients.

The inter-professional dynamics between Respiratory and the other health care professions are mutually respectful, and all groups work well together as a coordinated team . The continuum of services for their clients were shown to be seamless and well coordinated between all three areas.

Client surveys indicate a high degree of satisfaction for the care they receive. Clients and families are encouraged and supported to be actively engaged in their care.

A major concern for clients is the difficulty navigating through the ambulatory care areas at the Foothills

Medical Centre and Peter Lougheed Centre. There is high reliance on volunteers to guide clients and families to their designated location.

Parking and a confusing layout of the building are the main areas causing problems. Investigation into more efficient use of signs and client instructions is indicated, with client and family input into improvements.

The organization is encouraged to address parking issues with the parking authority, and include input from clients and families.

Priority Process: Decision Support

Client records are well organized and updated on a consistent basis. Client records that are maintained in a paper format are currently being accessed by a number of disciplines in the client care team. This has resulted in frustrations in accessing client information and potentially increases the risk of charts being lost, and information duplicated or inadvertently being used for the wrong client.

It is strongly suggested that a move to electronic charting be investigated.

Priority Process: Impact on Outcomes

The foundation of providing quality and safe care is the consistent use of evidence-based guidelines and policies. Safety and quality improvement projects initiated by the Respiratory Health Strategic Clinical Network (RHSCN) are commended.

The Provincial Respiratory Professional Practice Council is encouraged to identify new opportunities for quality improvement to continue this momentum and support the RHSCN.

Standards Set: Ambulatory Systemic Cancer Therapy Services - Direct Service Provision

Unmet Criteria			High Priority Criteria
Priority Process: Clinical Leadership			
1.4	Services are reviewed and monitored for appropriateness, with input from clients and families.		
2.4	Space is co-designed with input from clients and families to ensure safety and permit confidential and private interactions with clients and families.		
Priority Process: Competency			
6.15	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			
10.9	The client's informed consent is obtained and documented before providing services.		!
11.6	To minimize injury from falls, a documented and coordinated approach for falls prevention is implemented and evaluated.		ROP
	11.6.4	The effectiveness of the approach is evaluated regularly.	**MINOR**
	11.6.5	Results from the evaluation are used to make improvements to the approach when needed.	**MINOR**
12.11	Information relevant to the care of the client is communicated effectively during care transitions.		ROP
	12.11.5	The effectiveness of communication is evaluated and improvements are made based on feedback received. Evaluation mechanisms may include: • Using an audit tool (direct observation or review of client records) to measure compliance with standardized processes and the quality of information transfer • Asking clients, families, and service providers if they received the information they needed • Evaluating safety incidents related to information transfer (e.g., from the patient safety incident management system).	**MINOR**
Priority Process: Decision Support			

The organization has met all criteria for this priority process.

Priority Process: Impact on Outcomes		
18.6	There is a policy on ethical research practices that outlines when to seek approval, developed with input from clients and families.	!
Priority Process: Medication Management		
4.2	Computerized physician order entry (CPOE) or Pre Printed Orders (PPO) are used when ordering systemic cancer therapy medications.	!
Surveyor comments on the priority process(es)		
Priority Process: Clinical Leadership		

Across the province it was evident that a high level of care is provided at all centres. All teams demonstrated a significant level of commitment to the provision of quality cancer services and the highest level of patient care. There was evidence of strong partnerships and supportive leadership. Team members were loud in their praise of leadership and felt supported by their managers.

Patient and family center care is a priority for the organization. At some of the centres, however, there is a need of increase patient and family engagement. The engagement of patients and families was described as "consultative" rather than "engagement." A much more concerted and comprehensive plan of true engagement needs to be developed. Senior leaders need to be available to attend patient and family advisory meetings and demonstrate that it is a priority. Patient representatives reported their distress at witnessing disharmony between leaders and also reported "not feeling engaged." Innovative methods need to be employed to enable patients and families to fully engage.

Patient and family representatives also reported a wide variation in the understanding by physicians of the true nature of patient engagement at the site level. The organization is encouraged to work to eliminate such variation.

Some facilities have no patient representatives on committees. It is important that patients are represented on all hospital and facility committees. The concept of "nothing about me, without me" was clearly articulated by patient representatives and needs to be adopted at all sites.

The introduction of the Green Sleeve package is applauded.

A senior staff member expressed concern that the introduction of standardized outpatient time slots is impeding patient-centred care as not all patients have the same needs that can be addressed in a standard time slot. The organization is encouraged to review this practice.

The surveyors were impressed with the wide availability of telehealth facilities across the province, but singularly unimpressed with the lack of regular telehealth usage.

While CancerControl Alberta is a world-class program, many facilities across the province are reaching and in some cases exceeding capacity. With likely additional patient volumes, these facilities will be stretched beyond their ability to cope. Attention needs to be paid to altered service hours to maximize capacity and create more patient-friendly options for access to services. The new Community Cancer Centre in High River and the newly designed space of the Bonnyville Community Cancer Centre are exceptional additions. AHS is encouraged to continue to plan facilities with close engagement of patients and families.

Staff at High River Community Cancer Centre are especially commended for their initiative and the redevelopment of the facility. Their engagement with the local community is exemplary.

Priority Process: Competency

Patients in Alberta are taken care of by a team of superb professional staff with a wide range of experience and knowledge. All staff have relevant credentials and training.

Opportunities for further training are widely available. There was strong evidence of comprehensive orientation and training programs. Clients spoke highly of the professionalism and training of the staff at all sites.

There was broad, but not universal, knowledge of the AHS ethics framework. This led to variation in application.

Consistent with what was seen in other areas, there are significant practice variations across the various sites.

Many staff commented on the implementation of the Strategic Clinical Network. Reaction to the network ranged from dubious optimism to outright opposition. If the network is to be successful, careful attention to broader engagement will be necessary.

Priority Process: Episode of Care

Enthusiastic, empathetic, compassionate staff, dedicated to living the values of AHS in their worklife and committed to providing exceptional care to patients, were encountered across the province.

Staff are clearly committed to eliminating barriers to access to care for patients and their families. A team member commented that no one should have to choose not to have treatment because of barriers.

Patients and families are well engaged in care decisions and all patients were well aware of the range of resources available.

The organization relies heavily on volunteers. All patients and staff were loud in their praise of the

volunteer group.

Staff go to extraordinary lengths to ensure patients are able to access the needed services. However, variation in accessibility exists across the province whether due to over-crowded facilities or other operational reasons. Complaints were heard from patients about lack of flexibility in patient scheduling at some facilities. New and larger facilities are clearly some years away so alternate models of care need to be introduced urgently.

The lack of use of the extraordinary availability of telehealth resources is lamented.

Despite the presence of provincial tumour groups, there is still considerable variation in their application, with individual physician preferences overriding guidelines. No formal assessment of the prevalence of such practices has been conducted but the variation presents challenges for staff and patients. More focused work needs to be done in this area.

A concern was identified related to the lack of a consistent process for obtaining informed consent to administer chemotherapy to both adults and children. There was wide variation in the documentation related to informed consent. This requires attention and the organization is encouraged to develop a more comprehensive informed consent process as quickly as possible.

Transitions between services are still presenting challenges but the transition class initiated at the Camrose Community Cancer Centre is an excellent example of an exemplary practice. The class would benefit from the presence of a leading oncologist, even if this was by means of a recorded video message.

AHS is encouraged to continue implementing and evaluating the falls prevention strategy at some of the sites.

Priority Process: Decision Support

AHS has made considerable progress in the introduction of an electronic health record in cancer care.

Processes for the retention and disposal of patient records are at an advanced level and well adopted and supported.

Patient records were for the most part complete and documentation adequate.

Much work still needs to be done to further province-wide introduction of an electronic medical record.

Quality boards were present in many sites across the province, but were highly variable in their completeness and content. Greater uniformity of quality boards and their content is encouraged.

Priority Process: Impact on Outcomes

AHS is to be commended for its commitment to implementing evidence-based treatment guidelines, as well as a consistent guideline review process. The provincial tumour teams are interdisciplinary and meet regularly to review guidelines.

Nevertheless, despite the presence of guidelines, wide practice variation does occur. Special note is made of the variation in practice in the management of prostate cancer and especially the lack of a clear pathway for patients.

Not all patients receive interdisciplinary consultation and it was not always clear how these decisions are made.

More use of the C-MORE database, analysis of toxicity data, and generating more evidence about outcomes is encouraged.

The organization is encouraged to analyze morbidity and mortality data.

When planning to request charts for a research project, it is recommended researchers seek ethical approval prior to collecting the charts, and always ensure timely access to the charts.

Greater engagement of patients and families in all tumour groups as well as in the development, implementation, and evaluation of quality improvement initiatives is strongly encouraged.

Priority Process: Medication Management

There is a significant culture of safety in the management of cytotoxic chemotherapy. There is strong support and engagement from all pharmacists and pharmacy staff.

The systems do not always support the safety culture of staff. The teams are encouraged to undertake true multi-disciplinary discussion about approaches to patient care, and where safety concerns are raised, someone is identified as responsible for responding to the concerns.

Infusion pump training is well established at all sites.

Incidents are reported on RLS, investigated appropriately, and necessary changes are implemented.

Medication reconciliation is being implemented. Continuing the focused efforts in this area is encouraged to further complement outcomes and attention to patient safety, e.g. it is suggested to explore how the process at Camrose Community Cancer Centre and Cross Cancer Institute could be strengthened to have medication reconciliation completed sooner in the patient experience rather than at the second visit, as is currently being done.

There is widespread use of computerized physician order entry (CPOE) for chemotherapy. The team is encouraged to review the current practice of faxed paper with orders for dose reduction from the Cross Cancer Institute to Camrose Community Cancer Centre. The faxes are often illegible and could create confusion.

The organization is encouraged to implement CPOE for chemotherapy at the Stollery Children's Hospital as soon as possible and to eliminate the current practice of paper orders. The latest versions of the electronic ordering systems permit intersystem communication.

Standards Set: Cancer Care and Oncology Services - Direct Service Provision

Unmet Criteria	High Priority Criteria
Priority Process: Clinical Leadership	
The organization has met all criteria for this priority process.	
Priority Process: Competency	
The organization has met all criteria for this priority process.	
Priority Process: Episode of Care	
8.7 Each client's risk for developing a pressure ulcer is assessed and interventions to prevent pressure ulcers are implemented. NOTE: This ROP does not apply for outpatient settings, including day surgery, given the lack of validated risk assessment tools for outpatient settings.	ROP
8.7.5 The effectiveness of pressure ulcer prevention is evaluated, and results are used to make improvements when needed.	**MINOR**
Priority Process: Decision Support	
The organization has met all criteria for this priority process.	
Priority Process: Impact on Outcomes	
The organization has met all criteria for this priority process.	

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

The leadership teams of AHS and CancerControl Alberta appear to be on a path which, if diligently pursued, will successfully establish standardized goals, tools, reporting structures, and feedback to guide oncology objectives for all Albertans. This is having a very beneficial impact on team morale and recognizes the role they play in the overall provision of high-quality care.

The inclusion of clients, families, and partners in creating and establishing these processes is variable. It appears that good progress is being made to expand the processes of the more highly functioning sub-programs across the oncology service to those that have not yet been able to fully realize the valuable role clients and families can play.

Priority Process: Competency

The processes to ensure appropriate hiring, training, and re-certification of professionals involved in all aspects of oncological care are well developed and maintained. Educational opportunities are readily and widely available both for maintenance of professional competency as well as educational support for specific AHS initiatives. These efforts were recognized and lauded by the clients and families interviewed during the on-site survey.

Priority Process: Episode of Care

There was the clear evidence that the dedicated and compassionate efforts of the oncology teams have resulted in a positive impact at the client level, throughout the client's journey. The Green Sleeve package is recognized as an excellent initiative.

As legal and professional expectations become more demanding with respect to informed consent for treatment, the organization may wish to ensure these standards are met consistently across all disciplines.

Priority Process: Decision Support

Oncology has a varied mix of paper charting and different electronic medical records at all levels of care, including tertiary facilities. Despite the challenges this creates to prompt and accurate transfer of information at various transitions of care, the teams have been able to meet this requirement. The organization is in the process of assessing the needs of oncology services as it looks to consolidate its approach to electronic medical record keeping.

Clients and families have access to their information and caregivers are well aware of client rights with respect to their health information.

Priority Process: Impact on Outcomes

The work being done by CancerControl Alberta and hospitals to meet and disseminate consistent standards within their respective services and with each other is well underway, and appears to be reflected at the front-line level. AHS is encouraged to continue to develop these processes throughout all disciplines and to integrate formal input from clients and families into these processes.

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

Unmet Criteria			High Priority Criteria
Priority Process: Clinical Leadership			
1.2	Services are co-designed with clients and families, partners, and the community.		!
2.2	The strategy includes working with other services, groups, programs, and organizations in the community (e.g. social services, justice, etc.) to raise awareness of the resources and supports available to clients and families.		
2.4	Participation in community events to raise awareness about mental health, mental illness, and concurrent disorders is demonstrated.		
3.3	An appropriate mix of skill level and experience within the team is determined, with input from clients and families.		
3.4	Space is co-designed with input from clients and families to ensure safety and permit confidential and private interactions with clients and families.		
Priority Process: Competency			
4.1	Required credentials, training, and education are defined for all team members with input from clients and families.		!
4.6	Education and training are provided on the organization's ethical decision-making framework.		
4.9	Team member performance is regularly evaluated and documented in an objective, interactive, and constructive way.		!
4.10	Client and family representatives are regularly engaged to provide input and feedback on their roles and responsibilities, role design, processes, and role satisfaction, where applicable.		
Priority Process: Episode of Care			
10.9	Information relevant to the care of the client is communicated effectively during care transitions.		ROP
	10.9.1	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**

10.9.5	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**
12.7	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		
3.2	Technology and information systems requirements and gaps are identified and communicated to the organization's leaders.	
13.8	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.	!
14.2	Policies on the use of electronic communications and technologies are developed and followed, with input from clients and families.	
Priority Process: Impact on Outcomes		
15.2	The procedure to select evidence-informed guidelines is reviewed, with input from clients and families, teams, and partners.	
15.3	There is a standardized process, developed with input from clients and families, to decide among conflicting evidence-informed guidelines.	!
15.4	Protocols and procedures for reducing unnecessary variation in service delivery are developed, with input from clients and families.	!
15.5	Guidelines and protocols are regularly reviewed, with input from clients and families, to ensure they reflect current research and best practice information.	!
16.2	Strategies are developed and implemented to address identified safety risks, with input from clients and families.	!
16.3	Verification processes are used to mitigate high-risk activities, with input from clients and families.	!

16.4	Safety improvement strategies are evaluated with input from clients and families.	!
16.7	Patient safety incidents are analyzed to help prevent recurrence and make improvements, with input from clients and families.	!
17.3	Measurable objectives with specific timeframes for completion are identified for quality improvement initiatives, with input from clients and families.	!
17.4	Indicator(s) that monitor progress for each quality improvement objective are identified, with input from clients and families.	
17.5	Quality improvement activities are designed and tested to meet objectives.	!
17.6	New or existing indicator data are used to establish a baseline for each indicator.	
17.7	There is a process to regularly collect indicator data and track progress.	
17.8	Indicator data is regularly analyzed to determine the effectiveness of the quality improvement activities.	!
17.9	Quality improvement activities that were shown to be effective in the testing phase are implemented broadly throughout the organization.	!
17.10	Information about quality improvement activities, results, and learnings is shared with clients, families, teams, organization leaders, and other organizations, as appropriate.	
17.11	Quality improvement initiatives are regularly evaluated for feasibility, relevance, and usefulness, with input from clients and families.	

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

Services are delivered by committed, passionate staff members who are dedicated to improving the mental health of their clients.

The services are indeed recovery oriented. For many of the services, this approach has been embedded in their practice for many years. However, there are staff members who could benefit from further education regarding recovery-oriented practice.

There are a few excellent examples of the integration of community-based mental health and addictions services. There are also examples where the services are really just co-located and are not integrated. There are a number of locations where there are still significant opportunities for real integration and for

new ways of working together for the benefit of clients. The implementation of a common assessment form would advance this integration as would a focus on concurrent disorders.

There is a need to fully implement the client- and family-centred care components of the Accreditation Canada standards at the site level. Discussions within site teams to fully understand the implications and appropriateness of these components may assist with implementation.

Priority Process: Competency

There is a robust online training program which is appreciated by many of the staff members. There are some training programs that have not yet been rolled out to individual sites. Continued rollout of these programs is encouraged.

Staff members primarily use team conversations and consultation with their licencing bodies when dealing with ethical issues. There does not appear to be a consistent awareness of the AHS ethical framework or its use. Further education on the framework is recommended. It would also be useful if site managers facilitated team conversations regarding the use of the framework, applying local case examples.

Priority Process: Episode of Care

There is a strong commitment in all programs to client-centred and recovery-oriented practices. In the programs visited staff were extremely committed to the people they serve.

Staff members and teams participate in principle-based decision making and know how to access professional resources such as an ethicist.

Further training on the ethical framework and its use would help give direct service staff members a more formal process to deal with ethical issues.

All programs and services operated from a team approach and there appeared to be good collaboration among team members.

The effectiveness of communication at the time of care transitions needs to be evaluated, with improvements made based on feedback received.

Priority Process: Decision Support

Documentation methods vary across sites. For example, some Addiction and Mental Health programs use an electronic system while some programs are still using paper records. Some services, particularly those with co-located/integrated mental health and addictions services, have a mixture of both. There is an eagerness to move to electronic record keeping which should be facilitated by the provincial government's recent announcement of funding for an electronic health record.

Priority Process: Impact on Outcomes

There is a solid effort throughout the programs to implement improvement initiatives. There are zone plans for quality improvement with measured indicators.

Priority has been given to the quality improvement initiatives that have been agreed to at a zone level. Quality improvement activities with measurable outcomes are not necessarily linked to local issues. In addition, a process for including clients and families in the setting of priorities has not yet been established.

Standards Set: Home Care Services - Direct Service Provision

Unmet Criteria		High Priority Criteria
Priority Process: Clinical Leadership		
The organization has met all criteria for this priority process.		
Priority Process: Competency		
5.3	Processes for who to contact for advice, support, or to address issues while on duty are known by team members.	!
Priority Process: Episode of Care		
9.10	Information relevant to the care of the client is communicated effectively during care transitions.	ROP
9.10.3	During care transitions, clients and families are given information that they need to make decisions and support their own care.	**MAJOR**
9.10.4	Information shared at care transitions is documented.	**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**
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

Respiratory home care services are one of many services provided in clients' homes. The Respiratory Health home care teams are encouraged to continue their efforts to strengthen the continuity of care from acute to community-based care. It is evident that there are many recent successes in providing respiratory care home services. With the increasing complexity of home care services, teams are encouraged to build a strong base of core quality practices, share knowledge, and promote consistency across respiratory home care services, standardizing service while customizing local care.

The home care services teams are commended for maintaining and strengthening a culture of client and family engagement. Home care service staff seek family engagement in program planning and service improvement. Client and family engagement in projects such as the integrated service delivery project for children with complex airway needs and participation in surveys provide home care teams with valuable information to improve processes and service outcomes.

The home care services teams are applauded on building and strengthening service partnerships to support care for clients across the continuum, as well as for their commitment to identifying and addressing safety risks in homes and at the office.

Strengths of the home care services clinical leadership include dedicating time and resources for regularly scheduled team meetings and providing education opportunities throughout the year.

The home care services teams are encouraged to consistently develop service-specific goals and objectives and include input from clients and families in this process.

Priority Process: Competency

The home care teams are commended for the comprehensive education provided to team members, and for supporting strong linkages with specialist services so clients can remain in their homes.

The teams are encouraging families to provide feedback on their roles, service processes, and service satisfaction. It is evident the teams work closely with families to address areas of dissatisfaction.

The teams are also commended for building collaborative relationships within the team and with specialist and community resources across the health and social services sectors.

The home care teams follow formal guidelines to meet standards related to competency in the use of infusion pumps. The teams are commended for comprehensive tracking of competencies. Manufacturer issues with new infusion pumps in the Calgary zone have resulted in suspension of new pump use. When adjustment parts are available and tested, pumps will be in place. However, due to potential infection risks, families will no longer be able to independently use the pumps. Consideration of opportunities to support clients and families operation of pumps is encouraged.

Priority Process: Episode of Care

Medicine, Ambulatory and Home Care Respiratory services plan and coordinate care to support clients through service transitions. The continuum of care is evident across all three areas.

Home care teams are commended for their efforts to remove service barriers for clients and families. The teams work closely with specialists and families to gather detailed and accurate information. Clients appreciate the responsiveness of the home care staff and the quality of the care provided. They also appreciate the opportunity to provide input on care planning. Home care teams are commended for the interdisciplinary approach to service delivery.

The very comprehensive home care assessment process is notable.

Priority Process: Decision Support

It is evident that in-home client records enable the flow of client information and coordination of care planning among all in-home providers.

A move toward electronic charting is encouraged to enhance client information safety and accessibility.

Home care teams are encouraged to gather client and family input in areas of decision support including policies related to technology.

Priority Process: Impact on Outcomes

AHS and the home care teams are reviewing and modifying policies and procedures on an ongoing basis. Teams are commended for sharing knowledge and tools with others across the region. Home care teams are encouraged to seek opportunities for further collaboration and enhanced standardized practices.

Home care teams are commended for their efforts in anticipating and mitigating risks for clients and staff. Teams consider potential risks and have developed processes to reduce those risks, including education for staff and parents. Information and issues are identified and shared. Feedback is also used to inform quality improvement activities. Teams are encouraged to develop a more formalized process.

The team regularly monitors client, program, team, and community stakeholder information and feedback to identify and prioritize quality improvement initiatives.

Home care teams are encouraged to continue their quality improvement initiatives and continue to identify measurable objectives with specific timeframes, with input from clients and families.

Home care teams are encouraged to continue their efforts in indicator development.

Priority Process: Medication Management

Medication management does not apply to home care services.

Standards Set: Medicine 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.	
2.4	Space is co-designed with input from 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.	
Priority Process: Competency		
3.11	Team member performance is regularly evaluated and documented in an objective, interactive, and constructive way.	!
4.4	Standardized communication tools are used to share information about a client's care within and between teams.	!
Priority Process: Episode of Care		
8.7	Each client's risk for developing a pressure ulcer is assessed and interventions to prevent pressure ulcers are implemented. NOTE: This ROP does not apply for outpatient settings, including day surgery, given the lack of validated risk assessment tools for outpatient settings.	ROP
8.7.5	The effectiveness of pressure ulcer prevention is evaluated, and results are used to make improvements when needed.	**MINOR**
8.8	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
8.8.2	Clients at risk for VTE are identified and provided with appropriate, evidence-informed VTE prophylaxis.	**MAJOR**

	8.8.3	Measures for appropriate VTE prophylaxis are established, the implementation of appropriate VTE prophylaxis is audited, and this information is used to make improvements to services.	**MINOR**
9.4		Treatment protocols are consistently followed to provide the same standard of care in all settings to all clients.	!
9.11		Information relevant to the care of the client is communicated effectively during care transitions.	ROP
	9.11.1	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**
	9.11.4	Information shared at care transitions is documented.	**MAJOR**
	9.11.5	The effectiveness of communication is evaluated and improvements are made based on feedback received. Evaluation mechanisms may include: • Using an audit tool (direct observation or review of client records) to measure compliance with standardized processes and the quality of information transfer • Asking clients, families, and service providers if they received the information they needed • Evaluating safety incidents related to information transfer (e.g., from the patient safety incident management system).	**MINOR**
Priority Process: Decision Support			
		The organization has met all criteria for this priority process.	
Priority Process: Impact on Outcomes			
13.3		There is a standardized process, developed with input from clients and families, to decide among conflicting evidence-informed guidelines.	!
15.3		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			
		Medicine services for respiratory patients appear to be well designed and responsive to the unique needs of this patient population.	

Service delivery is monitored on an ongoing basis and additional support is provided as needed. Staff are well trained with clearly defined roles and scope of service. There is a strong relationship between the staff and the patients they care for.

The concept of involving clients and families in all aspects of their care is supported but needs to be further developed and formalized.

Priority Process: Competency

Staff education and training play a prominent role in the safe delivery of services by the team.

Training is tracked for completeness.The team is encouraged to plan its education and training a little more formally. The development of an education needs assessment for the program might assist clinical leadership in better planning the use of its education and training resources and seeing where there are unmet needs.

The implementation of CoACT is noted with approval.

Priority Process: Episode of Care

There appears to be a good connection between health care providers across the continuum in Respiratory Health. Health care providers knew each other by name and were aware of the nature of client information and general communication that was needed in the other client service areas in Respiratory Health. The continuum of services by the Respiratory Health staff, for their clients, were shown to be seamless and well coordinated between all the areas.

Clients and families have ready access to the patient's health care information and actively participate in the patient's plan of care. Patient confidentiality is respected and access to the health record/health information is controlled.

The process for consent to health care appears to be followed and documented in the health record and the team understands its role in the consent process.

Where possible, clients and their families are actively involved in decisions regarding their care, and where possible, staff respect the personal preferences of their clients. Several areas of care are provided through protocols and care paths that embody the necessary best practices for optimal care delivery.

Priority Process: Decision Support

The team is actively engaged in converting patient health records to an e-chart, with plans to complete the process over the entire organization.

Electronic charting is secure and layered access, depending on the need of the staff, is provided.

Chart audits are regularly done both as a source of improvement data and to validate the construct and completeness of the health record.

Priority Process: Impact on Outcomes

The team has a formal process to identify, document, and review incidents. Disclosure is a part of this process, to keep the patient and family that experience the incident informed.

There appear to be several quality improvement activities being implemented. The team's leadership is encouraged to review opportunities for further training in quality improvement and consider the development of a formal quality improvement plan to better support the improvement work. The development and monitoring of indicators is primarily done through the review of indicator data and not through the use of formal indicators. There is a value in reviewing where the development and monitoring of actual indicators would assist in the review and evaluation process of service performance and improvement activities.

Standards Set: Mental Health Services - Direct Service Provision

Unmet Criteria		High Priority Criteria
Priority Process: Clinical Leadership		
1.7	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 input from 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.	
Priority Process: Competency		
3.1	Required credentials, training, and education are defined for all team members with input from clients and families.	!
3.6	Education and training are provided on the organization's ethical decision-making framework.	
3.14	Team member performance is regularly evaluated and documented in an objective, interactive, and constructive way.	!
Priority Process: Episode of Care		
2.7	The physical environment is safe, comfortable, and promotes client recovery.	
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**
9.1	The client's individualized care plan is followed when services are provided.	
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		
13.3	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, to ensure they reflect current research and best practice information.	!
13.6	There is a policy on ethical research practices that outlines when to seek approval, developed 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.	!
15.3	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.	!
15.11	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		

Fourteen mental health sites were visited. At all sites, staff were dedicated and patient centred in their approach to care. Patients repeatedly identified staff as the major strength of the establishment. Teams

were observed to work in an interdisciplinary way.

Partnerships with other hospitals and community mental health services were strong and enhance continuity of care.

Even though patients and families, when possible, are involved in the care process, and clinical teams encourage their active participation, their role in the design and evaluation of resources, space, and staffing has not yet been established at most sites.

Priority Process: Competency

Orientation for new staff is comprehensive. Staff were satisfied with the ongoing access and availability of training and education. A culture of quality improvement and patient safety is evident.

Performance evaluation is not done regularly and annually at all sites.

Priority Process: Episode of Care

A very comprehensive addiction and mental health assessment is done routinely on admission. The tool is standardized and harmonized across all inpatient teams at all sites. It includes basic patient information, mental health status examination, overall risk of suicide and domestic violence assessments, homicide and aggression/violence assessments, trauma history, concurrent disorders assessment, elopement risk assessment, a safety plan, falls risk, medications, and medical conditions. A post-discharge follow up is done after seven days.

The buildings at some sites are old with numerous physical obstacles. This does not provide a safe environment that promotes patient recovery.

Priority Process: Decision Support

Clinical and management leadership and support are present and dynamic.

The development and evaluation of record-keeping processes and the policies on electronic communications and technologies do not have client and family involvement.

Priority Process: Impact on Outcomes

A culture of quality improvement and patient safety is present. Quality improvement activities are occurring.

Input from patients and families needs to be improved.

The development, implementation, and evaluation of clinical outcome measures is the next step in the evolution of the culture.

Standards Set: Perioperative Services and Invasive Procedures - 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.	
2.5	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.	
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 credentials, training, and education are defined for all team members with input from clients and families.	!
6.11	Team member performance is regularly evaluated and documented in an objective, interactive, and constructive way.	!
6.13	Team members are supported by team leaders to follow up on issues and opportunities for growth identified through performance evaluations.	!
7.4	Standardized communication tools are used to share information about a client's care within and between teams.	!
Priority Process: Episode of Care		

10.1	There is an open, transparent, and respectful relationship with each client.	
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.	!
11.2	The assessment process is designed with input from clients and families.	
11.6	INPATIENT CARE ONLY: A Best Possible Medication History (BPMH) is generated in partnership with clients, families, or caregivers (as appropriate) and used to reconcile client medications at care transitions.	ROP
11.6.1	Upon or prior to admission, a Best Possible Medication History (BPMH) is generated and documented, in partnership with clients, families, caregivers, and others, as appropriate.	**MAJOR**
11.6.2	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**
11.6.5	The client, community-based health care provider, and community pharmacy (as appropriate) are provided with a complete list of medications the client should be taking following discharge.	**MAJOR**
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 for outpatient settings, including day surgery, given the lack of validated risk assessment tools for outpatient settings.		ROP
	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
	11.13.2	Clients at risk for VTE are identified and provided with appropriate, evidence-informed VTE prophylaxis.	**MAJOR**
	11.13.3	Measures for appropriate VTE prophylaxis are established, the implementation of appropriate VTE prophylaxis is audited, and this information is used to make improvements to services.	**MINOR**
	11.13.5	Information is provided to clients and team members about the risks of VTE and how to prevent it.	**MINOR**
12.3	Working in partnership with clients and families, at least two person-specific identifiers are used to confirm that clients receive the service or procedure intended for them.		ROP
	12.3.1	At least two person-specific identifiers are used to confirm that clients receive the service or procedure intended for them, in partnership with clients and families.	**MAJOR**
12.11	Information relevant to the care of the client is communicated effectively during care transitions.		ROP
	12.11.1	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**
	12.11.2	Documentation tools and communication strategies are used to standardize information transfer at care transitions.	**MAJOR**
	12.11.4	Information shared at care transitions is documented.	**MAJOR**

	12.11.5 The effectiveness of communication is evaluated and improvements are made based on feedback received. Evaluation mechanisms may include: • Using an audit tool (direct observation or review of client records) to measure compliance with standardized processes and the quality of information transfer • Asking clients, families, and service providers if they received the information they needed • Evaluating safety incidents related to information transfer (e.g., from the patient safety incident management system).	**MINOR**
14.3	A safe surgery checklist is used to confirm that safety steps are completed for a surgical procedure performed in the operating room.	ROP
	14.3.2 The checklist is used for every surgical procedure.	**MAJOR**
14.6	A process for appropriate skin preparation is conducted prior to surgery.	!
17.2	A dress code is followed within the surgical suite.	!
17.5	Airborne, droplet, and contact precautions are used as appropriate to reduce the risk of infection to clients and team members.	!
18.4	A smoke evacuation system is used when any energy source that produces plume (e.g. electrosurgical unit) is operated.	!
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, to ensure they reflect current research and best practice information.	!
24.1	A proactive, predictive approach is used to identify risks to client and team safety, with input from clients and families.	!
24.2	Strategies are developed and implemented to address identified safety risks, with input from clients and families.	!
24.3	Verification processes are used to mitigate high-risk activities, with input from clients and families.	!
24.4	Safety improvement strategies are evaluated with input from clients and families.	!
25.2	The information and feedback gathered is used to identify opportunities for quality improvement initiatives and set priorities, with input from clients and families.	
25.3	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		
15.3	Every medication and solution on the sterile field is labeled.	!
Surveyor comments on the priority process(es)		
Priority Process: Clinical Leadership		

Written goals and objectives for perioperative services were not often found. Many of the hospitals are planning to get input from patients and families but have not as yet implemented a method to engage them. Engaging patients and families helps align the needs of the community with the services provided by the hospitals.

A number of hospitals visited did not have a process to receive feedback from patients and families on the effectiveness of surgical services, resources, space, or staffing.

Engaging patients and families in planning, delivering, and evaluating health care is new to many of the areas surveyed and better developed in others. AHS is encouraged to continue the journey to engage patient advocates.

Priority Process: Competency

The staff are well trained, have the appropriate credentials, and consistently report annual recertification is done, and it was an important part of providing safe health care in a safe environment.

Performance reviews were generally done well and consistently across the province. There are, however, opportunities at several sites where advancing performance reviews would benefit the hospitals and the staff. Team members at the Mazankowski Alberta Heart Institute and Stollery Children's Hospital felt supported by team leaders but the lack of performance reviews is a barrier to finding opportunities for growth.

AHS is commended for the training and recertification on infusion pumps. AHS might consider formal training for anaesthesia residents on the use of infusion pumps, as it was consistently reported that they learn to use them "on the job."

Priority Process: Episode of Care

Clients across the perioperative, endoscopy, bronchoscopy, and surgery units were very positive about the care that they received, including the respectful relationships and the open communication with the care teams.

Although there are well designed corporate brochures providing patients with information about their rights and responsibilities, many were not aware of the brochures. AHS hospitals are encouraged to post this information in areas clearly visible to patients and continue to educate patients on their rights and responsibilities. It will be important to develop a formal information tool to outline patients' rights and responsibilities when accessing healthcare services.

There was inconsistency across the hospitals as to how patients file a complaint or report violations of their rights.

A process for increasing the involvement of patients and families is in progress; however, it was not evident that the process for assessing a patient's physical and psychosocial health was consistently designed with input from patients and families.

The surgical safety check list is a standard that all physicians and staff should be expected to abide by. At some sites, not all team members remained in the operating room for the final count or debrief portion of the checklist.

Limited evidence was found at some sites in relation to the availability and use of a formal falls

prevention program that assesses, documents, implements, and evaluates fall prevention activities to minimize the risk of falls. The organization is encouraged to implement fall prevention strategies across all the hospitals.

Evaluation and improvements related to pressure ulcer prevention needs to be developed and implemented in all facilities.

Although the use of two person-specific identifiers was generally closely adhered to, there were occasions when the protocol was noted to have not been followed.

The process for communicating at handover points needs to be standardized and documented across all the sites.

The patient experience is determined by all interactions with staff, whether it be physician, service worker, nurse or allied health. Many patients spoke of the great care they received; however in some cases, it is the one bad experience that they remember. The team is encouraged to continue engaging patients and families in their care and decision making processes.

AHS is well on its way to completing medication reconciliation in perioperative services in a number of its hospitals and is encouraged to continue to roll it out. The Best Possible Medication History (BPMH) is not used consistently in the surgical program across all sites. This could be a useful tool to generate medication orders consistent with the philosophy and goals of medication reconciliation. There are physicians who are less than compliant with the policy on medication reconciliation and who need to be brought on board. In particular, medication reconciliation on discharge is an important safety feature as patients are transferred back to the community.

Priority Process: Decision Support

There is considerable variability in the development of electronic health records across the province, with many hospitals still in a primarily paper environment. AHS is embarking on a journey to develop a provincial health information system and is encouraged to push forward with this challenging endeavour as it will help standardize treatment and make patient care information available to all providers. The addition of patient and family advisors to the planning committees will ensure that issues important to the community are brought forward.

Priority Process: Impact on Outcomes

Standards requiring input from patients and families are new and some hospitals are further ahead than others in adopting the principles of patient- and family-centred care. The Alberta Children's Hospital and Stollery Children's Hospital have a longer history of involving patients and families and often engage them in developing space, policies, and programs. The concept of being patient and family centred often means engaging them in the development and evaluation of guidelines. Patients and families may not have the knowledge or expertise of clinicians but engaging them helps maintain a focus on those who are receiving the care.

Priority Process: Medication Management

All medications on a sterile field in the operating room need to be labelled. One hospital has a policy that when there is only one medication on the field, the medication does not need to be labelled. The organization is encouraged to review this policy as it is not in accordance with the standard. It is suggested that AHS implement a policy to have all medications labelled in endoscopy suites.

Standards Set: Rehabilitation 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.		!
1.3	Service-specific goals and objectives are developed, with input from clients and families.		
1.4	Services are reviewed and monitored for appropriateness, with input from clients and families.		
Priority Process: Competency			
3.12	Client and family representatives are regularly engaged to provide input and feedback on their roles and responsibilities, role design, processes, and role satisfaction, where applicable.		
3.13	Team members are supported by team leaders to follow up on issues and opportunities for growth identified through performance evaluations.		!
Priority Process: Episode of Care			
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.		!
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**
10.8	The effectiveness of transitions is evaluated and the information is used to improve transition planning, with input from clients and families.		

Priority Process: Decision Support		
The organization has met all criteria for this priority process.		
Priority Process: Impact on Outcomes		
13.2	The procedure to select evidence-informed guidelines is reviewed, with input from clients and families, teams, and partners.	
13.3	There is a standardized process, developed with input from clients and families, to decide among conflicting evidence-informed guidelines.	!
13.5	Guidelines and protocols are regularly reviewed, with input from clients and families, to ensure they reflect current research and best practice information.	!
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.	
15.11	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

Clients benefit from the strong clinical leadership, community partnerships, and research evident within the rehabilitation portfolio. The portfolio would benefit from establishing a network to facilitate integrated, evidence-informed service planning and delivery across the continuum within the provincial system.

The development of goals and objectives at the unit/team level was inconsistent across sites visited. Teams are encouraged to continue with planned approaches to achieve such goals and objectives and ensure mechanisms for client/family input are established or enhanced.

The development of a client engagement framework, the introduction of the Patient/Family Resource Centre, and the Ambassadors at the Glenrose Rehabilitation Hospital are noteworthy examples of mechanisms to support clients and families as partners in service planning and delivery.

Staff and clients benefit from the support provided for student placement. The Interprofessional Student Services program is an innovative model that can be applied in all settings to support collaborative practice.

Sites visited were designed several years ago, the focus on creating spaces that promote function and accessibility was evident. As space redesign is considered the team is encouraged to ensure meaningful mechanisms are in place to engage clients and families.

Priority Process: Competency

A key strength of AHS is the skilled, dedicated staff and physicians working in the rehabilitation program. Staff speak highly of the many opportunities afforded to them for professional development including paid leave days, individual education funds, the Emerging Leaders Program, and multiple local and regional in-services, lunch and learns, and webinars. All staff are required to complete annual training in key areas.

The availability of multiple opportunities and mechanisms to support collaborative practice and research is noteworthy.

Although standardized communication tools and processes were used within sites, the rehabilitation program would benefit from a broad program review and introduction of standardized communication tools across the continuum and sites.

Priority Process: Episode of Care

There was strong attention paid to client safety across sites. Medication reconciliation was recently introduced and despite differing systems across sites, there was evidence of compliance with this process. There were varying approaches to falls prevention strategies across the program, and there are opportunities to leverage the good work being done in specific locations.

A strong emphasis on client involvement in care planning was evident throughout the rehabilitation program. Clients and families truly direct the goals of their rehabilitation stay or program. Collaborative interdisciplinary teams provide holistic care and service for clients. Goal attainment is high across ambulatory and inpatient rehabilitation programs. Teams are encouraged to consider engaging clients in team rounds as well as family conferences.

Access to programs and services can be a challenge in some areas. Central intake and triage criteria are in place in some locations to assist with prioritization. AHS staff are working diligently on improving transitions for clients across the lifespan and across the continuum of care. In particular, special attention has been paid to improving the transitions from youth to adult.

The formation of the Ambulatory Community Rehabilitation Advisory Committee is a positive step toward facilitating cross-sector, interprofessional, evidence-based planning. The rehabilitation program is encouraged to consider similar types of collaboration across the continuum.

Priority Process: Decision Support

Work is ongoing on the implementation of the electronic medical record in ambulatory care programs in several locations. Sites are at different stages of implementation. Additionally, in the inpatient areas visited documentation was partially electronic and partially manual. Documentation processes were consistent within sites; however variability in forms and electronic platforms was noticed. The rehabilitation program is encouraged to reduce this variability.

There are numerous examples of the use of technology to support rehabilitation. The Syncrude Centre for Motion and Balance, Retouch, and the Ekso skeleton are just a few examples of technology used to aid in rehabilitation.

Implementation of audit processes at both the local and program levels varied. The program is encouraged to consider mechanisms to evaluate documentation with respect to key priority areas such as falls prevention to ensure compliance with standards and completeness of documentation to guide local and program-specific improvement activities.

Members of the interdisciplinary team were enthusiastic about the recently introduced white boards across the inpatient sites. Clients also reported positive feedback.

Priority Process: Impact on Outcomes

The team is encouraged to identify meaningful ways to engage clients in broad service planning and quality improvement initiatives. There are several positive examples of approaches that can be used to support implementation across the program.

Quality boards were recently introduced at most rehabilitation sites visited. The program is encouraged to develop a consistent set of process and outcome measures in collaboration with families, clients, and staff, to monitor program performance. Client experience surveys were administered inconsistently and sporadically.

Standards Set: Spinal Cord Injury Acute 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 patients and families.	
2.4	Space is co-designed with input from patients and families to ensure safety and permit confidential and private interactions with patients and families.	
2.5	Sufficient space is available to accommodate patients with spinal cord injury and provide safe and effective services, including private space for patients and families.	
2.9	A universally-accessible environment is created with input from patients and families.	
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		
11.8	There is a process to monitor and evaluate record-keeping practices, designed with input from patients and families, and the information is used to make improvements.	!
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
Patients benefit from the strong clinical leadership, community partnerships, and research evident within the spinal cord injury, stroke, and rehabilitation programs. The spinal cord injury service would benefit from participation in a network to facilitate integrated, evidence-informed service planning and delivery across the continuum within the provincial system. The team is encouraged to continue with planned

approaches to achieve this and to ensure mechanisms for client and family input are established or enhanced.

The development of a client engagement framework, the introduction of the Patient Experience Team, and the adoption of the CoACT program are noteworthy examples of mechanisms that support clients and families as partners in service planning and delivery.

The acute spinal cord unit is located in an aging building on a unit not designed for patients with equipment needs, nor are the bathrooms wheelchair accessible. As opportunities for relocation to a more appropriate space become available, the team is encouraged to ensure meaningful mechanisms are in place to engage clients, families, and staff in the design of the unit.

Goals and objectives are set at the zone level. The team is encouraged to develop service specific goals and objectives.

Priority Process: Competency

A key strength of AHS is the skilled, dedicated staff and physicians working in the spinal cord injuries program. Staff speak highly of the many opportunities afforded to them for professional development. All staff are required to complete annual training in key areas.

Patients are engaged in planning and quality improvement initiatives.

The availability of multiple opportunities and mechanisms to support collaborative practice and research is noteworthy.

Although standardized communication tools and processes were used within sites, the program would benefit from a broad program review and introduction of standardized communication tools across the continuum and sites.

Priority Process: Episode of Care

A strong emphasis on patient involvement in care planning was evident as demonstrated by the fact that this unit implemented CoACT even though they were not part of the CoACT cohort. Collaborative interdisciplinary teams provide holistic care and service. The patients expressed confidence in the unit leaders and staff, and goal attainment is high as patients are motivated to transition to the rehabilitation unit. Teams are encouraged to consider engaging patients in team rounds and not just family conferences.

Access to the rehabilitation unit can be a challenge. Triage criteria are in place to assist with prioritization. AHS staff are working diligently to improve transitions for clients across the lifespan and across the continuum of care.

The team is encouraged to consider providing information to clients on how to access records as part of the orientation process.

Priority Process: Decision Support

Documentation in the client record was complete.

The use of white boards in patient rooms is viewed very positively by patients, families, and staff. It is noteworthy that the unit is implementing the CoACT program on its own as part of the strong commitment to client- and family-centred care.

Education and awareness of privacy issues and legislation are evident. Clients and families interviewed had no concerns regarding confidentiality of their personal information.

Priority Process: Impact on Outcomes

There are varying levels of engagement of clients in broad service planning and quality improvement initiatives. Quality boards were recently introduced as the team implemented CoACT as part of its commitment to client- and family-centred care.

The program is encouraged to develop a consistent set of process and outcome measures in collaboration with families, clients, and staff, to monitor program performance across the continuum.

Standards Set: Spinal Cord Injury Rehabilitation Services - Direct Service Provision

Unmet Criteria	High Priority Criteria
Priority Process: Clinical Leadership	
The organization has met all criteria for this priority process.	
Priority Process: Competency	
The organization has met all criteria for this priority process.	
Priority Process: Episode of Care	
10.8 The effectiveness of transitions is evaluated and the information is used to improve transition planning, with input from patients and families.	
Priority Process: Decision Support	
11.8 There is a process to monitor and evaluate record-keeping practices, designed with input from patients and families, and the information is used to make improvements.	!
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

Patients benefit from the strong clinical leadership, community partnerships, and research evident within the spinal cord injury, stroke, and rehabilitation programs. The spinal cord injury rehabilitation service would benefit from the establishment of a network to facilitate integrated, evidence-informed service planning and delivery across the continuum within the provincial system.

The development of goals and objectives at the unit/team level was apparent on this unit as part of a robust quality improvement approach.

The development of a patient engagement framework, the Patient Experience Team, and peer supporters are noteworthy examples of mechanisms to support clients and families as partners in service planning and delivery.

The rehabilitation unit at the Foothills Medical Centre was designed several years ago and features spaces that promote function and accessibility. The involvement of patients to enhance the environment was

evident and appreciated by patients and staff.

Priority Process: Competency

A key strength of AHS is the skilled, dedicated staff and physicians working in the spinal cord injury rehabilitation program. Staff speak highly of the many opportunities afforded to them for professional development. All staff are required to complete annual training in key areas.

The availability of multiple opportunities and mechanisms to support collaborative practice and research is noteworthy.

Although standardized communication tools and processes are used within sites, the program would benefit from a broad program review and introduction of standardized communication tools across the continuum and sites.

Priority Process: Episode of Care

Strong attention is paid to patient safety on both units visited. Medication reconciliation was recently introduced and there was evidence of compliance with this process across the continuum.

The service has developed an outstanding pressure ulcer prevention program known as "Under Pressure" which has been well received by staff.

A strong emphasis on patient involvement in care planning is evident. Patients and families truly direct the goals of their rehabilitation stay/program. Collaborative interdisciplinary teams provide holistic care and service for their patients. Goal attainment is high. Teams are encouraged to consider engaging clients in team rounds and not just family conferences.

Access to programs and services can be a challenge. Triage criteria are in place to assist with prioritization. AHS staff are working diligently on improving transitions for clients across the lifespan and across the continuum of care.

Priority Process: Decision Support

Documentation in charts was complete. However, the combination of electronic and paper charting appears to be very cumbersome. The organization is encouraged to continue to reduce variability in forms and electronic platforms.

The use of white boards in patient rooms is viewed very positively by patients, families, and staff.

There was evidence of education and awareness of privacy issues and legislation. Clients and families interviewed had no concerns regarding confidentiality of their personal information.

Priority Process: Impact on Outcomes

There are varying levels of client engagement in broad service planning and quality improvement initiatives. Quality boards were recently introduced as part of the commitment to client- and family-centred care.

The program is encouraged to develop a consistent set of process and outcome measures in collaboration with families, clients, and staff to monitor program performance across the continuum.

Standards Set: Substance Abuse and Problem Gambling - 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.	!
1.3	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 input from clients and families to ensure safety and permit confidential and private interactions with 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 credentials, training, and education are defined for all team members with input from clients and families.	!
3.6	Education and training are provided on the organization's ethical decision-making framework.	
3.12	Ongoing professional development, education, and training opportunities are available to each team member.	
Priority Process: Episode of Care		
8.2	The assessment process is designed with input from clients and families.	
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.	!
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, to ensure they reflect current research and best practice information.	!
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.	

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

The organization has established extensive partnerships within their services and the broader community they serve. Several examples of community outreach exist. The teams demonstrate a willingness to serve as both a provider of information and education to a variety of service providers as well as a recipient of knowledge from clients, families, and other providers to provide individualized client care.

The organization is encouraged to establish formal processes to obtain and incorporate input on service design and organizational processes from clients and families. Evidence of this level of client and family involvement was not consistently observed. Exploring options, for example, through client and family advisory committees, questionnaires, and focus groups will assist the organization to enhance services.

Priority Process: Competency

AHS provides a comprehensive orientation for new staff as well as ongoing specialized clinical education for individual service areas. Staff receive education at orientation and annually on managing violent episodes. The organization has developed several mandatory educational modules including risk assessments, management of aggressive behaviour, documentation, and concurrent disorders.

There are inconsistencies in the education and training of staff on the AHS ethical decision-making framework. Staff monitor and address potential ethical issues as a team and will consult with the clinical ethicist from time to time regarding extremely complex cases.

Interprofessional collaboration between team members was evident. Including clients and families in

their care is a robust practice in the addiction and mental health program. Standardized communication tools and processes exist within and between teams.

Priority Process: Episode of Care

The teams are interested in increasing collaboration between addiction and mental health services to enhance client care. Co-location of these traditionally separate service areas is enhancing the concurrent capabilities of staff and collaboration between the services. Teams use a variety of assessment tools and many have been standardized across services.

The client-centred approach at all levels is a strength across all services. While reflected in diverse ways, attention to the needs of clients was exceedingly consistent. The family is integral to the client's care and recovery and family members felt supported and informed about recovery plans for the clients.

Priority Process: Decision Support

Client records are well organized and updated consistently. The organization is aware that the various information systems do not interface with one another, making it challenging to achieve mental health and addictions service integration. Some sites use paper-based charts while others use a hybrid of paper and electronic charts.

Priority Process: Impact on Outcomes

Teams are encouraged to continue their improvement efforts at the local level. There are also zone plans for quality improvement with measured outcomes. The organization is encouraged to incorporate client and family feedback into quality improvement efforts and the development and review of evidence-based guidelines.

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 2016 on-site survey report and appreciates its findings. They accurately capture the successes and challenges of our province-wide, integrated health system.

In this report, Accreditation Canada surveyors recognized our passionate and caring staff who work collaboratively in strong interdisciplinary teams to meet the needs of patients, both within the organization and with community partners. During survey week, surveyors also acknowledged additional strengths contributing to AHS' ability to provide safe, quality patient care:

- Committed executive leadership and front line managers
- Positive interactions between staff, patients and families at the point of care
- Continued progress and dedication to quality improvement
- Significantly improved medication reconciliation practice from the last survey

AHS recognizes the value of Accreditation Canada's QMentum program to guide ongoing quality improvement. Many of the opportunities for improvement outlined in this report had been self - identified by the organization and as a result, multiple initiatives are already underway to address them. Some examples include:

- Standardization and Spread of Best Practice – AHS is committed to improving standardization and spread of best practice, whether it be the utilization of standard forms to communicate important information when a patient is transferred from one facility to another or communication of new medications prescribed in hospital to providers responsible for care in the community. We also continue work on implementation of standard clinical pathways for target populations. COPD pathways and standard order sets and Alberta Rectal Cancer Clinical Pathway are just a few of many examples.

Achieving standardized practice across a large health system has its challenges, and solutions require a multi-pronged approach. Clinical knowledge content embedded into our new Clinical Information System (CIS) will be very helpful to standardize clinical practice. Improved communication and engagement with physicians and staff and strong leadership will also help to successfully achieve practice change. All solutions and work toward standardization must be informed by the perspectives of those we serve, our patients/residents and their families.

- AHS Patient First Strategy – The Patient First Strategy is about strengthening AHS' culture and practices to fully embrace patient-and family centred care (PFCC). AHS is in the early stages of the Patient First Strategy, with the 2015/16 year focused on the roll out to implementation across the organization. Foundational to the Patient First strategy are our patient and family advisors who are increasingly providing input to provincial committees, Strategic Clinical Networks (SCNs) and research activities. Our next steps will further integrate patient/family input closer to the point of

care, within in local programs and quality committees. We will improve our efforts to capture the patient/family voice in real time, by further spreading many of our current patient centered practices such as bedside shift reports and leader rounding with patients. The Patient First Strategy walks hand-in-hand with Our People Strategy, Strategy for Clinical Health Research, Innovation & Analytics and Information Management/Information Technology Strategy.

- AHS Improvement Way (AIW) - will be utilized to increase efficiency, decrease waste, manage variation, while measuring the change associated with these efforts. In its simplest form, the AHS Improvement Way (AIW) is a common organization-wide approach for solving problems, making improvements and managing change based on LEAN and Six Sigma principles. It is an improvement process designed for all levels of our organization, whether frontline, leadership or administrative roles. While many AHS staff have AIW training, the application of AIW principles to guide day-to-day improvement initiatives will receive greater attention as we further our work to implement operational best practices.

- Greater staff engagement in quality improvement processes – in 2015/16 AHS began implementing Quality Councils at the provincial, zone, site, program and unit levels. Implementation will be ongoing until all clinical service areas are engaged in the work of quality councils. Phase two of CoACT will further enhance quality culture through increased use of quality boards at the point of care and staff huddles to discuss quality issues.

The 2017-2020 AHS Health and Business Plan is transitioning to a balanced scorecard/Quadruple Aim Approach. Using input from patients and families, we will also identify other meaningful quality indicators that translate to enhanced patient safety moving forward.

- Provincial Clinical Information System (CIS) - With the recent funding announcement by Alberta Health, AHS will soon issue a Request for Proposal to select a vendor for our new provincial CIS. Full implementation will span seven years, connecting and unifying information that exists in more than 1,300 different clinical information systems across the province. The CIS will enable care transformation so that Albertans can benefit from the same quality and standards wherever they are in the province. This will be accomplished through clinician access to expert clinical knowledge content reflecting evidence based best practices. The transition from paper based health records to electronic will enhance patient/resident safety and make their information accessible only to those who are authorized through provider registry. Essentially, all care-givers will be working from the same set of standardized best practices to ensure patients, families, care-givers and staff, get the right information, at the right time and place in order to make the best possible health care choices.

Finally, we are proud of our organizational response to assist residents of Fort McMurray due to the wildfires. Accreditation Canada surveyors reviewing AHS services and facilities witnessed firsthand AHS' emergency response in action. One surveyor safely escaped Fort McMurray as the Northern Lights Regional Hospital went into evacuation mode the afternoon of May 3, 2016. A systems response directed by dedicated, compassionate staff resulted in the safe evacuation and transport of 73 acute care patients and 32 continuing care residents within a span of two hours.

AHS stands alongside all people who live and work in the Fort McMurray area; we are committed to meeting your health needs even under the worst of circumstances, and in the coming weeks and months will continue to serve you as the city and surrounding industry work toward full restoration. On behalf of the people of Fort McMurray, we wish to thank Accreditation Canada surveyors for their support, compassion and generous donation to the Red Cross during the survey week.

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