October 2019

EDMONTON ZONE

DEVON GENERAL HOSPITAL

Alberta Health Services

ACCREDITATION AGRÉMENT CANADA

Table of Contents

About this 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 on October 21 – 25, 2019. Information from the 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.

About the AHS Accreditation Cycle

Since 2010, Alberta Health Services (AHS) has embraced a sequential model of accreditation. This model supports a more continuous approach to quality improvement by providing additional opportunities to assess and improve year-over-year, relative to a traditional accreditation approach that adopts one assessment per accreditation cycle.

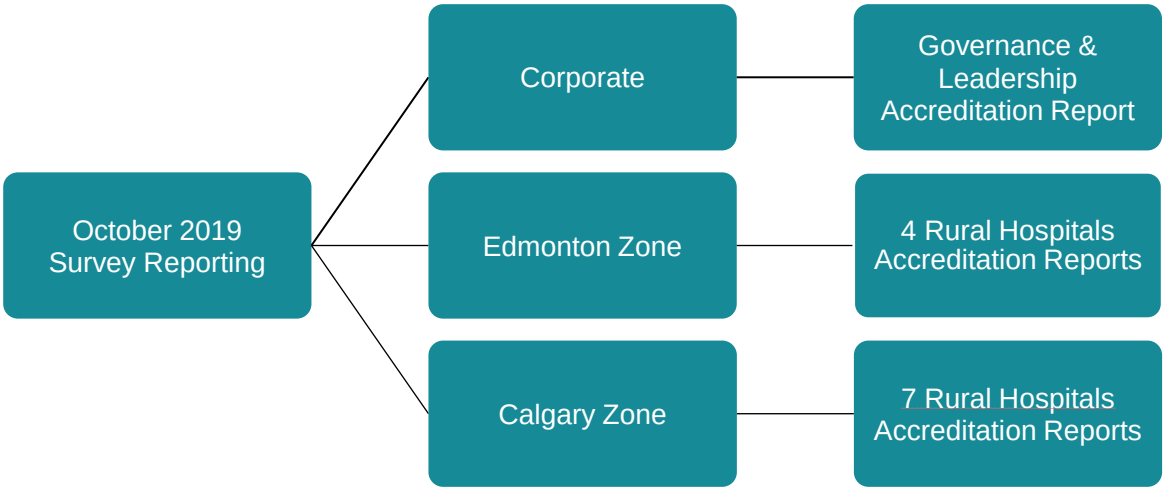
In 2019, Accreditation Canada and AHS co-designed an accreditation cycle that further enhances a sequential accreditation model. Under this new approach, Accreditation Canada will conduct two accreditation visits per year for the duration of the cycle (2019-2022). Accreditation visits are helping AHS achieve their goal of being #AHSAccreditation*Ready* every day by inspiring teams to work with standards as part of their day-to-day quality improvement activities.

Site-based assessments for rural hospitals will integrate assessments for all clinical service standards applicable at the site, as well as the foundational standards of Medication Management, Infection Prevention and Control, Reprocessing of Reusable Medical Devices and Service Excellence. Program-based assessments are applied to large urban hospitals whereby specialized clinical services are assessed against the respective clinical service standard along with the foundational standards. This integrated assessment approach for both small rural hospitals and large urban hospitals provides a more holistic assessment.

To further promote continuous improvement, AHS has adopted a new assessment method referred to as Attestation. Attestation requires teams from different sites throughout the province to conduct a self-assessment against specified criteria and provide a declaration that the self-assessment is both accurate and reliable to the best of the organization’s knowledge. These ratings are used to inform an accreditation decision at the end of the four-year accreditation cycle.

After each accreditation visit, interim reports will be issued to AHS to support their quality improvement journey. At the end of the four-year accreditation cycle in 2022, a final report will be issued that includes the province’s overall accreditation award.

The accreditation reports for the October 2019 survey are organized as follows:



Edmonton Zone Suburban Hospital Assessment – Sites Visited

Devon General Hospital

Fort Saskatchewan Community Hospital

Leduc Community Hospital

Westview Health Centre

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.

Section I – Edmonton Zone Report

1. Edmonton Zone Executive Summary

Surveyor Observations

The Edmonton Zone suburban hospital leadership team is commended for their work for its work that has promoted patient-centred care. It was evident at the sites that staff worked closely with patients and families to provide individualized care. Patients and families are very pleased with the care they receive. They described the staff as caring, compassionate, and kind.

Advisory Councils and Networks include patients and family members, and these groups are effective in providing input into Edmonton zone suburban hospital initiatives.

The Infection Prevention and Control (IPC) program in the Edmonton zone supporting the suburban hospitals provides a comprehensive set of tools to support local teams. The entire tool kit, as well as audit results, are available to the public on the AHS website, demonstrating an excellent model of transparency and public accountability. IPC audit results demonstrate good hand hygiene compliance.

Key Opportunities and Areas of Excellence

The Accreditation Canada survey team identified the following key opportunities and areas of excellence for the Edmonton zone suburban hospitals:

KEY OPPORTUNITIES
1. Performance appraisals and professional development were not completed consistently, and staff indicated that they would like to formally hear about their performance.
2. Continue to build upon the good practices related to patient-centred care at the organizational level.
3. Align Edmonton zone suburban hospital performance indicators with site goals, objectives and initiatives.
AREAS OF EXCELLENCE
1. Advisory Councils are effective and include patients as part the team.

2. Patients and families describe staff as caring, compassionate and kind.

3. The CoACT program promotes collaborative teams which was evident at all sites.

4. The IPC program demonstrates transparency and public accountability by making all IPC policies, procedures and audit results publicly available on the AHS website.

5. The antimicrobial stewardship program throughout AHS is comprehensive and provides extensive support, information, and feedback to practitioners.

2. Results at a Glance

This section provides a high-level summary of the results of the Edmonton zone suburban hospital assessment by standards, priority processes, and quality dimensions.

Compliance Overall[1]

% of criteria

Attested	On Site	Overall
100% met	90% met	94% met

# of attested criteria

Attested	Audited
16 criteria	1 criterion

Attestation:

A form of conformity assessment that requires organizations to conduct a self-assessment on specified criteria and provide a declaration that the assessment is accurate to the best of the organization's knowledge. This data is used to inform an accreditation award.

On-site Assessment:

Peer Surveyors from Accreditation Canada visit one or more facilities to assess compliance against applicable standards.

[1] In calculating percentage compliance rates throughout this report, criteria rated as 'N/A' and criteria 'NOT RATED' were excluded. Data at the 'Tests for Compliance' level were also excluded from percentage compliance calculations.

Compliance by Standard

Fig. I.1 Compliance by Standard

STANDARD	MET	UNMET	N/A	NOT RATED
Infection Prevention and Control	14			
Service Excellence	29	4		
Total	**43**	**4**		

Compliance with ROPs and their associated 'Tests for Compliance' are detailed in the section titled *Detailed Results: Required Organizational Practices (ROPs).*

Compliance by Quality Dimension

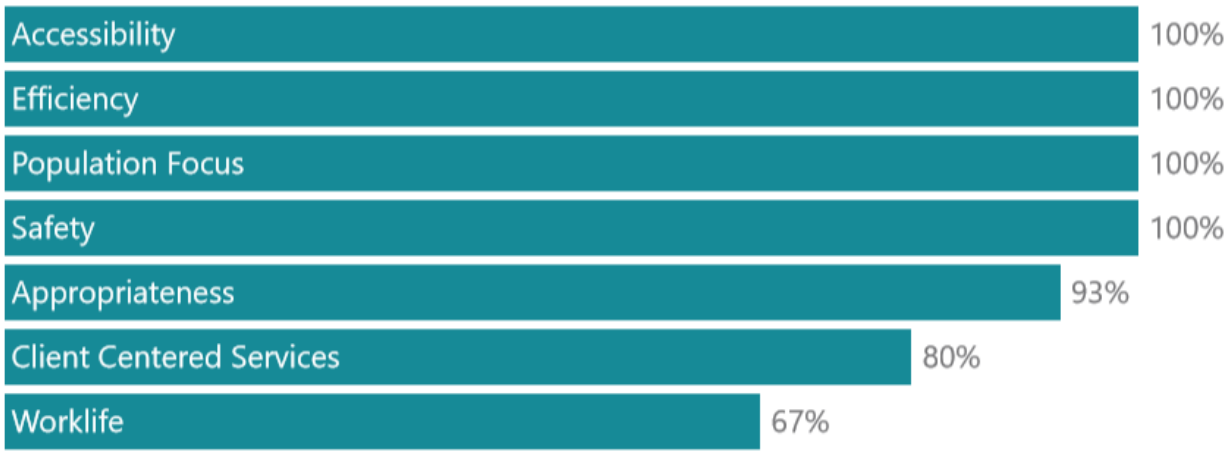


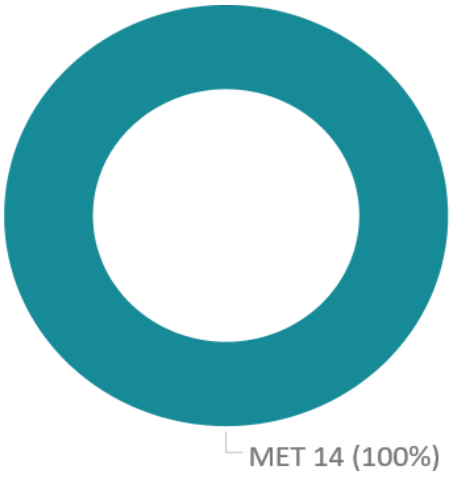
Fig. I.2 Compliance by Quality Dimension

QUALITY DIMENSION	MET	UNMET	N/A	NOT RATED
Accessibility	2			
Efficiency	1			
Population Focus	3			
Safety	4			
Worklife	2	1		
Appropriateness	27	2		
Client Centered Services	4	1		
Total	**43**	**4**		

3. Detailed Results: By Standard

Infection Prevention and Control

All the criteria are met for this Priority Process.



Priority Process Description:

Measures practiced by healthcare personnel in healthcare facilities to decrease transmission and acquisition of infectious diseases.

The Infection Prevention and Control team are to be commended for their commitment to a quality Infection Prevention and Control (IPC) program. There is a strong inter-professional team supporting and guiding IPC, including the involvement of physician leaders. The team is encouraged to continue to explore the input of clients, families, and communities in the infection prevention and control program.

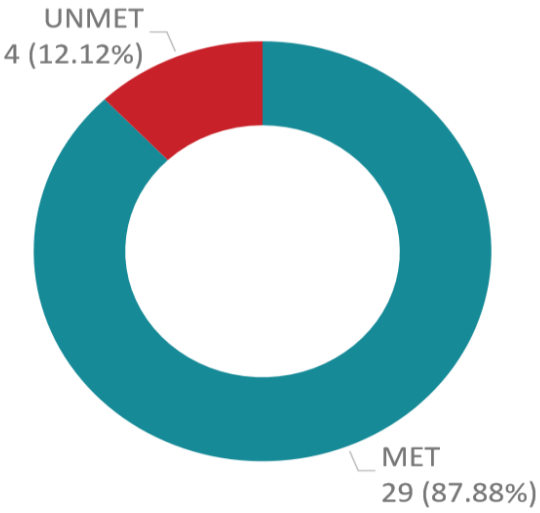
The IPC leadership team has established linkages and communication processes to the sites and created tools to translate standard procedures into locally relevant tool kits. The team is encouraged to establish more formalized structures related to communication to ensure consistency in messaging to all rural sites.

The Westech Audit system ensures that daily audits are completed at all rural sites by environmental staff. Feedback is provided on the audit results.

The implementation of the hand hygiene program has been effective. Hand hygiene audits occur, and the results are posted on the Quality Boards. The team is exploring innovative ways to audit hand hygiene including self-auditing.

The entire IPC toolkit of policies, procedures and audit results are publicly available on the AHS website. This degree of transparency and public accountability is to be commended. The team is encouraged to continue with the auditing process and to share results with clients, families, and the community.

Service Excellence



Description of the Standard:

Addresses team management, human resources and worklife, information management, and quality improvement.

STANDARD	UNMET CRITERIA	CRITERIA
Service Excellence	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.
Service Excellence	10.1	Information and feedback are collected about the quality of services to guide quality improvement initiatives, with input from clients and families, team members, and partners.
Service Excellence	10.4	Indicator(s) that monitor progress for each quality improvement objective are identified, with input from clients and families.
Service Excellence	10.11	Quality improvement initiatives are regularly evaluated for feasibility, relevance, and usefulness, with input from clients and families.

The Edmonton zone suburban hospitals are challenged by the competing priorities that have impacted the sites to achieve many performance improvement targets. The Edmonton zone suburban hospital leadership team is encouraged to determine priorities and set realistic targets for improvement.

The Edmonton zone suburban hospital leadership team is encouraged to provide support to the sites to develop local specific goals and objectives aligned with the AHS strategic direction and quality improvement. This could include education, a framework, and tools to support staff, physicians, patients, and families to embrace quality improvement and patient safety initiatives.

Section II – Devon General Hospital Report

1. Devon General Hospital Executive Summary

Surveyor Observations

The current survey focused on seven system-wide priority processes (People-Centred Care, Medication Management, Infection Prevention, and Control, Physical Environment, Medical Devices and Equipment, Emergency Preparedness, and Patient Flow) as well as five service-level priority processes (Emergency Department, Inpatient Services, Long Term Care Services, and Service Excellence).

The survey took place October 23 - 24, 2019 and was conducted by two surveyors from outside of the province.

Devon General Hospital is well respected by the community. Patients and families feel that they receive excellent compassionate care and Devon General Hospital is one of the best hospitals in the province. Staff is described as caring, kind and compassionate. Staff have embraced patient/resident centred care and involve patients and families in their plan of care.

The site faces challenges related to the many competing priorities with limited capacity to complete all corporate priorities. Several major initiatives are being rolled out that will require significant change management at the bedside at the same time as delivering care. The organization is encouraged to develop a process to focus on a few manageable initiatives at a time involving staff and patients in the development of goals and quality improvement initiatives.

Generally, excellent patient/resident care is being provided with high satisfaction rates. There is some variation in the implementation and evaluation of the Required Organizational Practices (ROPs) between the services. It was noted that there is heavy reliance for Connect Care to improve the standardization of clinical processes. The organization is encouraged to continue to identify and address change management processes required for compliance of ROPs.

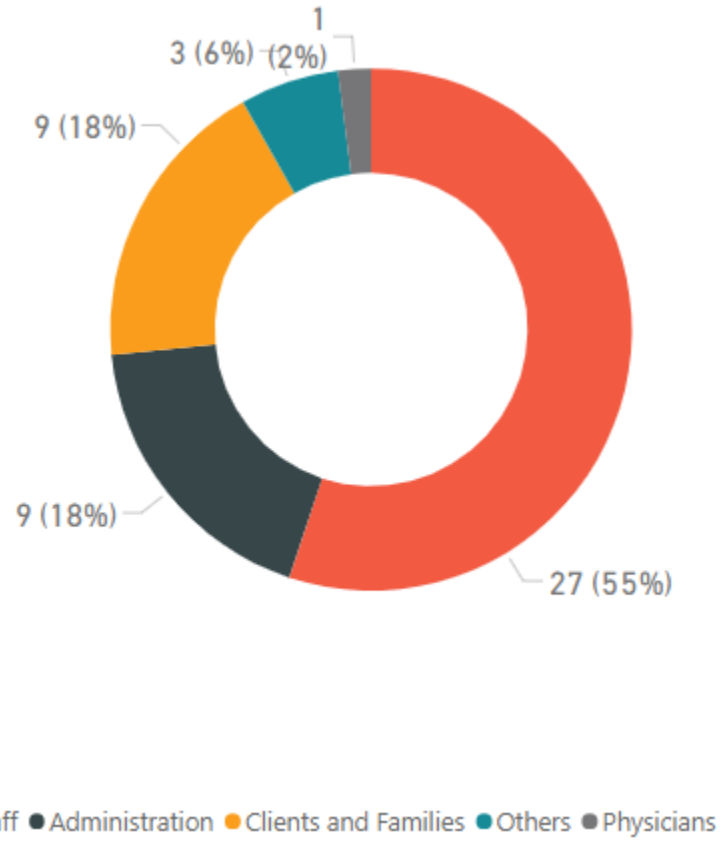
Leadership and the teams are commended for their excellent work and their ongoing commitment to patient/resident centred care, patient/resident safety and quality improvement.

Survey Methodology

The Accreditation Canada survey team spent two days at Devon General Hospital.

To conduct their assessment, the survey team gathered information from the following groups[2]:

Surveyors conducted 48 interviews during the assessment of programs and services.



[2] 'Other' interviewees refer to individuals such as students or volunteers.

Key Opportunities and Areas of Excellence

The Accreditation Canada survey team identified the following key opportunities and areas of excellence for this site:

AREAS OF EXCELLENCE	
1.	There is an excellent collaborative team culture. Team members demonstrate trust in, and respect for, their co-workers and other team members.
2.	There is a high level of patient and family engagement. This is demonstrated by active family involvement in the daily care of patients and residents, an active patient advisory council, and patient representation on quality committees. There is also strong community involvement in support for the hospital and in the activities provided to long term care residents.
3.	Staff demonstrates commitment to providing personalized care for patients and residents. There is a palpable feeling of community and care for patients and residents as “friends and neighbours.”
4.	The hospital is a clean, bright and welcoming facility. Customized artwork and murals bring a feeling of community to the facility
5.	Hand hygiene rates, as evidenced both by audit results and by surveyor observation, are excellent. In the latest audit, physicians exceeded all other staff in hand hygiene compliance rates.

KEY OPPORTUNITIES

1. There are good processes and standards in place to promote patient safety. However, there is variability in the implementation of the ROPs between the services. The hospital is encouraged to standardize the processes across the services.
2. The organization is encouraged to work with physicians to determine a process that ensures all orders are verified.
3. Key performance indicators are developed at the corporate level and shared locally; however, the teams do not fully understand their role in quality improvements. The site is encouraged to involve staff and patients in the identification of areas of focus and the development of goals and initiatives for quality improvement and sustainability.
4. Performance evaluations are not completed formally, and staff indicated they would like to have a performance appraisal completed. Leadership is encouraged to determine an appropriate method to ensure formal appraisals are completed.
5. Internal and external Emergency Department way-finding could be improved. For people not familiar with the hospital way-finding may create a challenge during stressful times or in less than ideal lighting conditions. The site is encouraged to explore solutions with patients and families to improve visibility of the Emergency Department.

2. Results at a Glance

This section provides a high-level summary of results by standards, priority processes and quality dimensions.

Compliance Overall[3]

% of criteria		
Attested	On Site	Overall
99% met	98% met	98% met

# of attested criteria	
Attested	Audited
88 criteria	13 criteria

Attestation:

A form of conformity assessment that requires organizations to conduct a self-assessment on specified criteria and provide a declaration that the assessment is accurate to the best of the organization's knowledge. This data is used to inform an accreditation award.

On-site Assessment:

Peer Surveyors from Accreditation Canada visit one or more facilities to assess compliance against applicable standards.

[3] In calculating percentage compliance rates throughout this report, criteria rated as 'N/A' and criteria 'NOT RATED' were excluded. Data at the 'Tests for Compliance' level were also excluded from percentage compliance calculations. Compliance with ROPs and their associated 'Tests for Compliance' are detailed in the section titled *Detailed Results: Required Organizational Practices (ROPs).*

Compliance by Standard

Fig. I.3 Compliance by Standard

STANDARD	MET	UNMET	N/A	NOT RATED
Emergency Department	100	1	2	
Infection Prevention and Control	29		21	
Inpatient Services	63	1	5	
Leadership	9			
Medication Management	76	2		
Long Term Care	76	1	1	
Service Excellence	40	3	13	
Total	**396**	**8**	**42**	

Compliance by System-level Priority Process

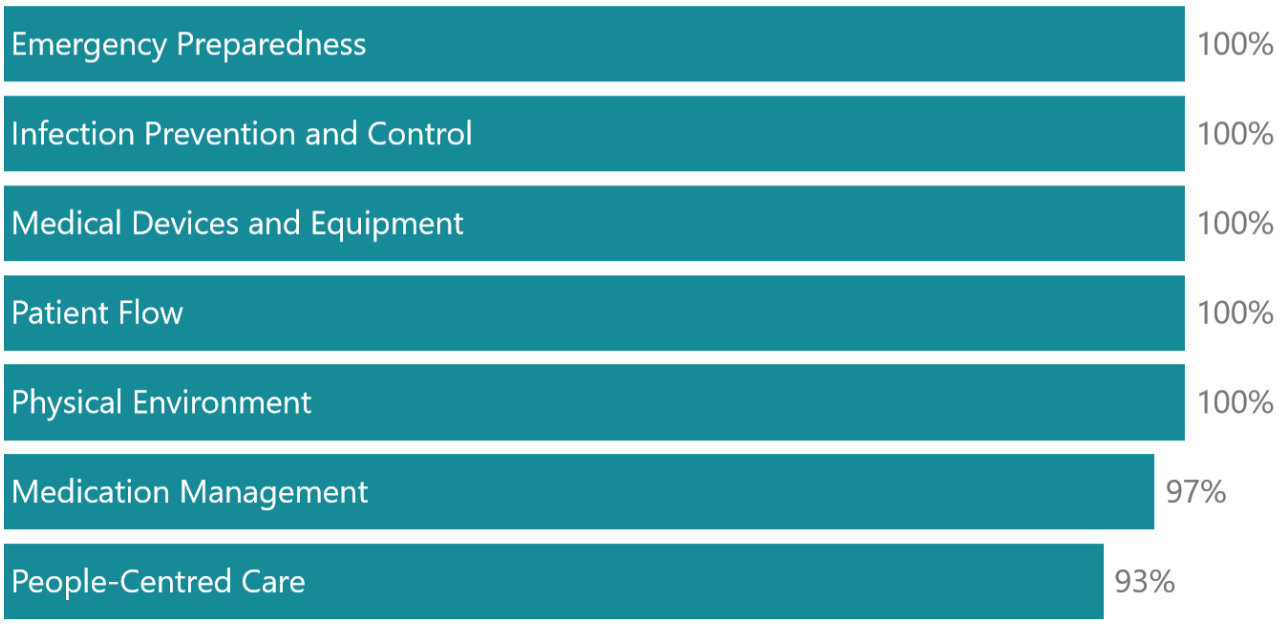


Fig. I.4 Compliance by System-level Priority Process

PRIORITY PROCESS	MET	UNMET	N/A	NOT RATED
Emergency Preparedness	5			
Infection Prevention and Control	22			
Medical Devices and Equipment	6		21	
Patient Flow	14			
Physical Environment	4			
Medication Management	76	2	13	
People-Centred Care	27	2		
Total	**154**	**4**	**44**	

Compliance by Quality Dimension

Fig. I.5 Compliance by Quality Dimension

STANDARD	MET	UNMET	N/A	NOT RATED
Accessibility	28		1	
Appropriateness	119	3	15	
Client Centred Services	107		1	
Continuity of Services	17			
Efficiency	5		1	
Population Focus	1			
Safety	237	5	28	
Worklife	8	2	1	
Total	**522**	**10**	**47**	

Compliance by Required Organizational Practice (ROP)

ROP	STANDARD	RATING
COMMUNICATION		
Client Identification	Emergency Department	Met
	Inpatient Services	Met
	Long Term Care Services	Met
The 'Do Not Use' List of Abbreviations	Medication Management	Unmet
Medication Reconciliation	Emergency Department	Met
	Inpatient Services	Met
	Long Term Care Services	Met
Information Transfer at Care Transitions	Emergency Department	Met
	Inpatient Services	Met
	Long Term Care Services	Met
MEDICATION USE		
Antimicrobial Stewardship	Medication Management	Met
Concentrated Electrolytes	Medication Management	Met
Heparin Safety	Medication Management	Met
High-alert Medications	Medication Management	Met
Infusion Pump Safety	Service Excellence	Met
Narcotics Safety	Medication Management	Met
Infection Prevention and Control		
Hand-hygiene Compliance	Infection Prevention and Control	Met
Hand hygiene Education and Training	Infection Prevention and Control	Met

Infection Rates	Infection Prevention and Control	Met
Risk Assessment		
Falls Prevention and Injury Reduction	Inpatient Services	Met
	Long Term Care Services	Met
Pressure ulcer prevention	Long Term Care	Met
	Inpatient Services	Met
Suicide prevention	Emergency Department	Met
	Long Term Care	Met
Venous thromboembolism prophylaxis	Inpatient Services	Met

3. Detailed Results: System-level Priority Processes

Accreditation Canada defines priority processes as critical areas and systems that have an impact on the quality and safety of care and services. System-level priority processes refer to criteria that are tagged to one of the following priority processes: Emergency Preparedness; Infection Prevention and Control; Medical Devices and Equipment; Medication Management; Patient Flow; People-Centred Care; Physical Environment. Note that the following calculations in this section exclude Required Organizational Practices.

Emergency Preparedness

This system-level priority process refers to criteria that are tagged to one of the following standards: Leadership and Infection Prevention and Control.

All the criteria are met for this Priority Process.

Priority Process Description:

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

Staff felt that they were well prepared for emergency codes. Regular mock codes for fire were held. They commented the sheets summarizing each code were helpful and easy to implement when needed.

The Incident Management System has been exercised and there are scheduled mock exercises.

The team effectively prevents and manages infection outbreaks. There is a robust user-friendly program to prepare staff, physicians, and volunteers in the event of an outbreak. It includes strategies to prevent flu outbreaks. The training program is comprehensive and includes online and in person training.

Infection Prevention and Control

This system-level priority process refers to criteria that are tagged to the Infection Prevention and Control Standard.

All the criteria are met for this Priority Process.

Priority Process Description:

Providing a framework to plan, implement, and evaluate an effective IPC program based on evidence and best practices in the field.

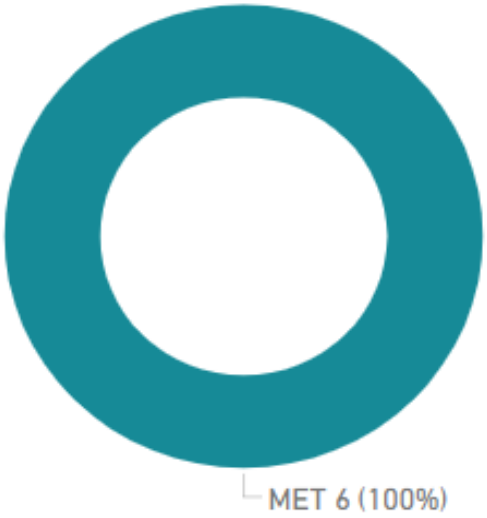
The Devon General Hospital infection prevention and control team is supported by extensive educational and support materials. The infection control lead has developed excellent unit level support materials that translate the general information into useful 'just in time' material for local clinical staff.

The hospital is clean and well maintained. Staff throughout the hospital report a high level of knowledge of infection control processes and standards. Hand hygiene compliance rates are routinely monitored and are high, including among physicians.

Medical Devices and Equipment

This system-level priority process refers to criteria that are tagged to one of the following standards: Infection Prevention and Control.

All the criteria are met for this Priority Process.



Priority Process Description:

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

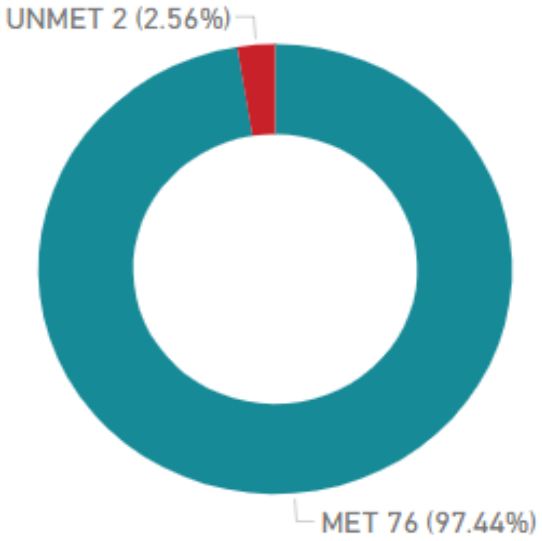
There is no reprocessing of medical devices at the Devon General Hospital. Reusable supplies are sent to the Leduc Community Hospital MDR for reprocessing.

Soiled equipment is transported in a combination of closed plastic basins and plastic bags to avoid spillage and cross contamination. Sterile equipment is stored separately and is clearly labelled with appropriate indicators and labels.

Staff has access to an appropriate range of medical devices and equipment for emergency, inpatient, and long term care.

Medication Management

This system-level priority process refers to criteria that are tagged to the Medication Management Standard.



Priority Process Description:

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

STANDARD	UNMET CRITERIA	CRITERIA
Medication Management	14.6	Steps are taken to reduce distractions, interruptions, and noise when team members are prescribing, writing, and verifying medication orders.
Medication Management	23.6	Lot numbers and expiry dates for vaccines are recorded in the client record following administration.

Pharmacy services are provided to the Devon Hospital by the pharmacy at Leduc Community Hospital. Patient medications are delivered in unit dose packages. There is a limited local medication supply that is securely stored in fingerprint pass protected PYXIS machines.

High alert medications are clearly identified and labelled within the PYXIS machines. However, high alert labels are applied only to the drawer holding the medication and not to the vials, ampoules, or boxes themselves. This raises the possibility that the high alert nature of the medication may not be recognized after it is withdrawn from the PYXIS machine.

There is no consistent identification of 'sound-alike, look-alike' (or SALA) medications. Pharmacy staff may have to take this into account in arranging medication in the PYXIS machines to physically separate them, but the organization should consider clearly labelling SALA medications as an additional alert and safety feature.

While staff follow generally accepted medication handling practices for narcotics, staff acknowledge that due to workload and staffing levels, it may not always be possible to ensure

direct observation of each stage of narcotic withdrawal, dose calibration in syringes, and immediate wastage. Staff, management, and pharmacy need to be alert to the potential for diversion.

Patient Flow

This system-level priority process refers to criteria that are tagged to one of the following standards: Leadership and Emergency Department.

All the criteria are met for this Priority Process.

Priority Process Description:

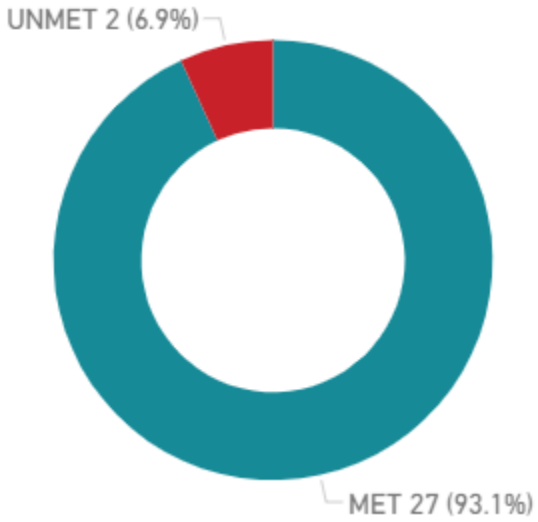
Assessing the smooth and timely movement of clients and families through service settings.

Internal patient flow within the Devon General Hospital is streamlined as the hospital is compact and has a combined acute care and long term care unit. Transfers from the Emergency Department (ED) to the acute care unit are efficient and timely.

The Emergency Department participates with the Emergency Medical Services (EMS) and other hospitals in the Edmonton zone to triage patients and bypass the Devon ED for specific patients to ensure patients obtain the appropriate level of care expeditiously.

People-Centred Care

This system-level priority process refers to criteria that are tagged to one of the following standards: Emergency Department, Inpatient Services, Long Term Care Services, and Service Excellence.



Priority Process Description:

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

STANDARD	UNMET CRITERIA	CRITERIA
Service Excellence	1.3	Service-specific goals and objectives are developed, with input from clients and families.
Service Excellence	10.3	Measurable objectives with specific timeframes for completion are identified for quality improvement initiatives, with input from clients and families.

Devon General Hospital has embedded patient-centred care throughout the site. There is a Quality Council that includes two family members. They are very committed to making improvements and have provided recommendations that have resulted in improvements for example: name tag initiative, white board improvements and implementation of diverse recreational activities. Family members indicated that management is very responsive to their ideas and requests. Patients and families commented that the white boards were consistently updated and were very useful.

Currently unit specific measurable goals and objectives are not developed at a unit level. The organization is encouraged to formally involve staff, patients and families in the development of measurable objectives related it quality improvement at the unit level.

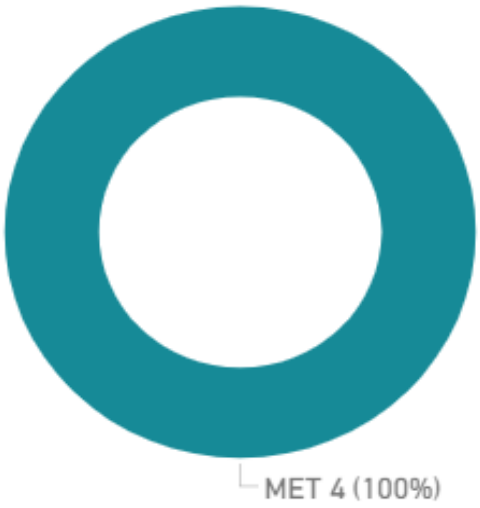
All patients interviewed were very pleased with the care that they receive. They commented that call bells were answered promptly. They describe the staff as caring, compassionate and very kind. Patients commented that staff supported not just them, but also their families. Patients and

families felt that they were listened to and staff were very responsive to their needs. All patient and family members interviewed commented that Devon General was the best hospital and they chose to come to this site over others.

Physical Environment

This system-level priority process refers to criteria that are tagged to one of the following standards: Leadership.

All the criteria are met for this Priority Process.



Priority Process Description:

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

Routine preventative maintenance contracts are secured for major building operations such as boilers, chillers and elevators. There is a sign-in book for contractors that enter the building. Once the maintenance is completed a paper copy is completed. The team is encouraged to explore and implement an electronic system that is proactive in ensuring that the preventive maintenance is completed on time by the contracted service providers along with the record of completion.

The internal testing of the generator is well documented. In response to identified issues, new processes are put into place to mitigate risk of failure.

Ongoing requests for maintenance are sorted with the highest priority being patient safety.

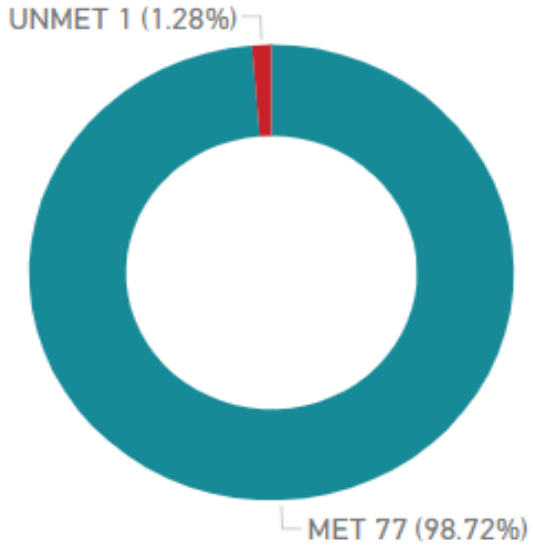
There is an excellent and effective check list for orientating new hires.

Way-finding signage is not clearly marked before and when entering the building. The organization is encouraged to involve patients and families to develop appropriate colour, size and placement of way finding signage. For example, the external Emergency Department signage is not clearly identified. During an emergency it is important for patients to be able to clearly identify where they need to go for emergency services.

4. Detailed Results by Service-Level Priority Process

Accreditation Canada defines priority processes as critical areas and systems that have an impact on the quality and safety of care and services. Service-level priority processes refer to criteria that have been tagged to one of the following priority processes: Clinical Leadership; Competency; Decision Support; Episode of Care; Impact on Outcomes.[4]

Emergency Department



Episode of Care Bundle Description:

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

STANDARD	UNMET CRITERIA	CRITERIA
Emergency Department	5.8	Seclusion rooms and/or private and secure areas are available for clients.

The emergency department is well designed with a dedicated triage area and trauma room. The triage area and nursing desk have incomplete views of the waiting room, although patients in the waiting room can be monitored by camera.

Triage is consistently done prior to patient registration following established CTAS parameters with pediatric specific triage guidelines.

There is very little external signage to direct patients to the Emergency Department from the street although internal signage clearly directs patients to the triage area.

[4] Note that the calculations in this section sum all of the Service-level priority processes in an *Episode of Care* bundle. These calculations exclude Required Organizational Practices.

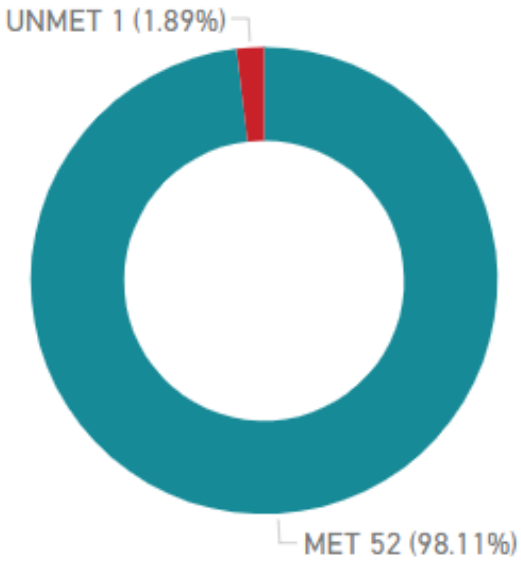
The dirty laundry cart is kept in the middle of the ED with high traffic of staff and patients around it. While this is convenient for staff to access, it presents a high risk of cross contamination. The dirty laundry cart should be moved to a non-traffic area.

The ED utilizes an effective, clear and efficient documentation process for patients receiving outpatient intravenous therapy in the ED.

The ED ambulance entrance is remote from the ED and EMS must transport patients down a long back hallway that is cluttered with stored equipment. EMS bring stretchers into the ED via a back door and staff may not be aware of their pending arrival in order to be ready to receive the patient. The ED staff are encouraged to work with local EMS to develop consistent communication to ensure timely and effective transfer of care from EMS to nursing staff.

Although the ED is not designated to receive acute psychiatric patients, there is a need for staff to be prepared to assess and manage psychiatric patients who may present to the ED. There is no secure room to safely accommodate unstable psychiatric or aggressive patients. The practice of cleaning out an ED exam room does not necessarily meet the functional need of maintaining a safe space for these patients.

Inpatient Services



Episode of Care Bundle Description:

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

STANDARD	UNMET CRITERIA	CRITERIA
Inpatient Services	6.11	A process to monitor the use of restraints is established by the team, and this information is used to make improvements.

The Acute Care team and Long Term Care team are co-located and provide integrated care. They cover for each other and consider all of the patients/residents as “their” patients/residents. The teams provide patient/resident centred care and the individualized care needs are planned

and met with patient and family input. The teams provide the level of care that is needed without having to move residents out of their home when they require some acute care.

The teams are high functioning and take pride in their work. There is a culture and commitment of caring, kindness and providing the best care possible.

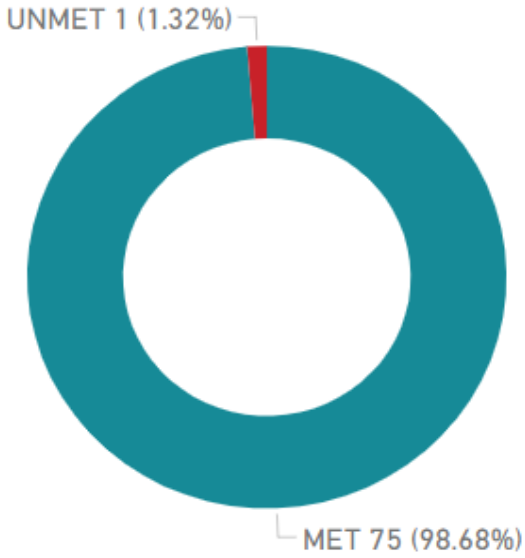
The team has an excellent orientation and preceptor program. New staff feel supported and competent to do their job. Ongoing education is provided via online modules and hands on experience through the clinical educator according to their learning needs.

The admission assessments that were reviewed did not include a standardized approach for a psycho-social assessment. The organization is encouraged to include psycho-social assessments on admission to assist with discharge planning. Staff noted that they start discharge planning on admission, and they do discuss their social situation with patients and families.

The variable process for the acceptance of physician orders related to accepting “all previous orders” during a transfer from another organization needs to be reviewed to ensure consistency across the services.

The teams are commended for their ongoing commitment to provide the best care for their patients and residents.

Long Term Care Services



Episode of Care Bundle Description:

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

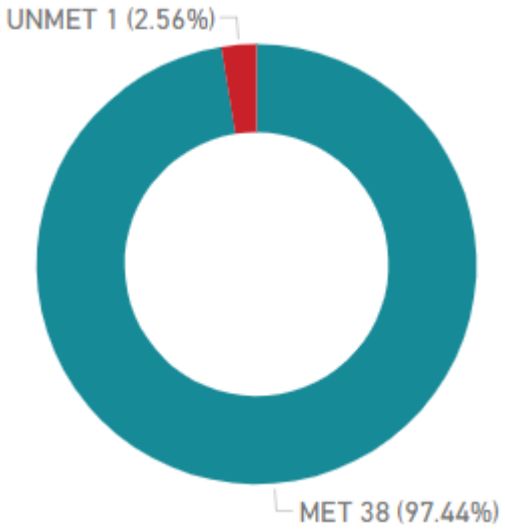
STANDARD	UNMET CRITERIA	CRITERIA
Long-Term Care Services	5.8	A process to monitor the use of restraints is established by the team, and this information is used to make improvements.

Recreational activities are designed with feedback from families and residents. Residents and families feel that the recreational program is excellent. Outings are arranged to ensure that residents still feel part of the community.

Comprehensive care plans are developed with input from families and residents. Monthly rounds are held with the inter-disciplinary team and changes are made as required.

It was noted that a variable process for the acceptance of physician orders related to accepting “all previous orders” during a transfer from another site creates a risk. The organization is encouraged to work with physicians to determine a process that ensures all orders are verified including the standard for medication reconciliation.

Service Excellence



Episode of Care Bundle Description:

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

STANDARD	UNMET CRITERIA	CRITERIA
Service Excellence	3.11	Team member performance is regularly evaluated and documented in an objective, interactive, and constructive way.

Formal performance evaluations are not completed on a regular basis. Staff indicated that they would like to have regular formal “sit downs” with their leader to discuss what they are doing well and what they could improve. It was noted that staff who were accountable to leaders not within Devon General Hospital did have regular evaluations.

There is an opportunity for staff growth and development. Several staff are given the opportunity to try new roles and cross training among the areas. This was viewed positively by staff. Some staff felt that they would like more support to attend conferences to continue their learning.

Staff are responsive when patient incidents occur and review these as a team to discuss specific improvements.

Service specific goals and objectives aligned with quality improvement activities were not evident. Staff was not aware of specific goals or quality improvement initiatives that they were working on. A quality board is visible to all that includes metrics and targets; however, staff indicated that this was more of a senior leadership board and they were not involved in setting goals, targets or action plans. Leadership is encouraged to work with staff and patients/families to determine focused manageable goals with targets and develop action plans that are supported and monitored.

5. Criteria for Follow-up

Criteria Identified for Follow-up by the Accreditation Decision Committee

STANDARD	CRITERIA TYPE	CRITERIA	DUE DATE
Emergency Department	Regular	**5.8** Seclusion rooms and/or private and secure areas are available for clients.	June 30, 2020
Medication Management	ROP	A list of abbreviations, symbols, and dose designations that are not to be used have been identified and implemented. **14.7.7** Compliance with the organization's 'Do Not Use List' is audited and process changes are implemented based on identified issues.	June 30, 2020