ACCREDITATION
AGRÉMENT
CANADA

Accreditation Report

Qmentum Global™ Program

Urban Hospital Critical Care
Services Program

Alberta Health Services

Report Issued: November 20, 2024

Table of Contents

About Accreditation Canada

Accreditation Canada (AC) is a global, not-for-profit organization with a vision of safer care and a healthier world. Together with our affiliate, Health Standards Organization (HSO), our people-centred programs and services have been setting the bar for quality across the health ecosystem for more than 60 years, and we continue to grow in our reach and impact. HSO develops standards, assessment programs and quality improvement solutions that have been adopted in over 12,000 locations across five continents. It is the only Standards Development Organization dedicated to health and social services. AC empowers and enables organizations to meet national and global standards with innovative programs that are customized to local needs. Our assessment programs and services support the delivery of safe, high-quality care across the health ecosystem.

About the Accreditation Report

The Organization identified in this Accreditation Report is participating in Accreditation Canada's Qmentum Global™ accreditation program.

As part of this ongoing process of quality improvement, the organization participated in continuous quality improvement activities and assessments, including an on-site survey from October 7 – 11, 2024.

Information from the cycle assessments, as well as other data obtained from the Organization, was used to produce this Report. Accreditation Canada is reliant on the correctness and accuracy of the information provided by the Organization to plan and conduct the on-site assessment and produce this Report. It is the Organization's responsibility to promptly disclose any and all incidents to Accreditation Canada that could impact its accreditation decision for the Organization.

Confidentiality

Executive Summary

About the Organization

Since 2010, Alberta Health Services (AHS) has embraced a sequential model of accreditation. This model supports a 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 (2023-2027). Accreditation visits are helping AHS achieve its goal of being Accreditation Ready every day by enabling and empowering teams to work with standards as part of their day-to-day quality improvement activities to support safe care.

Focused assessment for the foundational standards of Governance, Leadership, Infection Prevention, and Control, Medication Management and Reprocessing of Reusable Medical Devices occurred in the first survey of the cycle (Fall 2023).

During the cycle, location-based assessments for rural hospitals use a holistic approach and integrate assessments for all clinical service standards applicable at the site, as well as the foundational standards of Emergency and Disaster Management, Infection Prevention and Control, Leadership, Medication Management and Service Excellence. Program-based assessments are applied to large urban hospitals, provincial, and community-based programs where clinical services are assessed against the respective clinical service standard along with the foundational standards. This integrated assessment approach provides a more comprehensive assessment and aligns with different levels of accountability.

To further promote continuous improvement, AHS has adopted the 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 survey, reports are issued to AHS to support their quality improvement journey. At the end of the accreditation cycle, in Spring 2027, an overall decision will be issued that includes the organizations' accreditation award.

Surveyor Overview of Team Observations

In the fall of 2024, ten critical care units were visited (eight adult and two pediatric units) across the province. The surveyors were warmly welcomed by staff, physicians and leaders for these unannounced visits. The intention of this type of visit reinforces the importance of always being accreditation ready since quality, safety and risk activities must be in place for safe patient care.

The patient care delivered in the critical care units is high quality and based on best practices. The teams have implemented important quality and safety bundles to reduce hospital acquired conditions. These align with the priorities of the Program Improvement and Integration Network in addition to existing best practices. Audits are generally performed to ensure that appropriate assessments and interventions are consistently implemented. Most required organizational practices (ROPs) are in place, but attention to auditing procedures is encouraged as it is easy to be redirected to other activities. Several critical care units have identified opportunities for improvement based on reviewing data or in team discussions. Some of these projects resulted in spread across the province with changes to order sets (eye care). These teams are commended for their expertise and teamwork resulting in quality and safe care for their patients and families.

Staff and physicians report high levels of satisfaction and identified their teams as the major strength of their units. Collaboration and respect are not role dependent but engrained in the culture of the teams. Effective resources have been put in place to support staff and physicians following incidents and general feelings of being overwhelmed.

Team leaders have varying lengths of tenure across the critical care units that were visited. There is respect and trust for these leaders. Medical leadership and clinical unit managers have been innovative and responsive to building effective and just cultures in their units. Good relationships exist between critical care units and the other areas of the hospitals.

The critical care units have developed effective relationships with referring organizations. Collaboration with various clinical services and departments within their own hospitals was identified as a strength ensuring that the patient and family was the common focus of the partnerships. The teams have also established good connections with community agencies, particularly for those patients who are discharged directly to their homes.

Some critical units have been newly constructed while others are older and are challenged to manage space restrictions and find private space for family communications. The organization is encouraged to look at how space might be redesigned to improve patient and staff safety, experience and support infection control practices.

Key Opportunities and Areas of Excellence

Areas of Excellence:

- Outstanding teamwork and collaboration: "just do it" culture
- Strong commitment to excellent patient care with by interdisciplinary teams and patient and family engagement
- Excellent rapid response teams
- Patient assessments and implementation of protocols
- Extensive orientation and ongoing education opportunities (provincial critical care nursing program)
- Recruitment initiatives and supports (hiring new grads)
- Culture of safety and quality improvements at the frontlines

Opportunities:

- Organ and tissue donation policy updates
- Ongoing ethics case studies and education
- Recruitment of critical care team patient advisors
- Optimize patient flow
- Attend to performance/career conversations
- Ensure patients/families are aware of rights and responsibilities and how to initiate complaints/compliments
- Standardized tool for documenting information transfer from the ICU to the ward across sites

People-Centred Care

The importance of patient and family centred care is evident in the critical care units that were visited. There is recognition and appreciation that the involvement of patients and families in all aspects of care and decision-making contributes to a more comprehensive and appropriate level of patient care. There are resources and mandatory education is provided to staff to increase knowledge of Indigenous traditions and practices.

As a result of the global pandemic, most hospitals lost some ground when it comes to having patient advisors involved in their units. Efforts are ongoing to recruit patient advisors to the critical care unit teams in addition to being able to engage their hospital advisors. All teams would benefit from a formalized provincial patient advisor recruitment initiative. Some sites, such as the Chinook Regional Hospital, have been able to secure a patient advisor to become a member of their Quality Care Committee.

Patient information pamphlets are not consistently distributed to patients and families. Where they are offered, they are generally only available in English. There is opportunity for pamphlets to be developed in other languages and leverage patient advisors to provide feedback on content and formatting.

Locally, there are many examples of outstanding patient and family practices. The pediatric cardiac intensive care unit at Stollery Children's Hospital supports families to access accommodations and their individual patient rooms allow for rooming in by family. Ronald McDonald House is also available for Stollery Children's Hospital and Alberta Children's Hospital families. Some of the older hospitals' critical care rooms are smaller and there is no space for families to sleep except for making chairs accessible (recliners where available). The Rockyview General Hospital intensive care unit (ICU)/cardiac care unit (CCU) will include a patient advisor in their planning and co-design of their new space. It is notable that the Foothills Medical Centre critical care unit has posted a quality board in the family waiting room and they have a patient and family advisor involved in many unit activities including revising their ICU welcome package. The Peter Lougheed Centre collects feedback that is used to make improvements such as putting lockers in their family room.

Regular interprofessional rounds occur at least daily (if not twice daily) and families and patients are encouraged to participate as important team members. Patients and families reported that they have opportunities to provide input into the plan of care and major decisions. They are encouraged to participate and feel that they are being heard. Patient and family satisfaction reported during the tracers was extremely high.

Patient and family feedback is welcomed and has resulted in several quality improvements. Some teams have feedback posters in waiting areas and patient rooms to encourage patients and families to share their experiences. The teams are encouraged to conduct a review of how patients and families learn how to provide all types of feedback (part of orientation to the unit, signage).

.

Program Overview

The Qmentum Global™ program was derived from an intensive cross-country co-design process, involving over 700 healthcare and social services providers, patients and family members, policy makers, surveyors, clinical, subject matters experts, Health Standards Organization and Accreditation Canada. The program is an embodiment of People Powered Health™ that guides and supports the organization's continuous quality improvement journey to deliver safe, high-quality, and reliable care.

Key features of this program include new and revised evidence based, and outcomes focused assessment standards, which form the foundation of the organization's quality improvement journey; new assessment methods, and a new digital platform OnboardQi to support the organization's assessment activities.

The organization will action the new Qmentum Global™ program through the four-year accreditation cycle the organization is familiar with.

To promote alignment with our standards, assessments results have been organized by core and specific service standards within this report. Additional report contents include, the comprehensive executive summary, the organization's accreditation decision, locations assessed during the on-site assessment and required organizational practices results.

Accreditation Decision

Alberta Health Services' accreditation decision continues to be:

Accredited

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

Locations Assessed in Accreditation Cycle

The following table provides a summary of locations[1] assessed during the organization's on-site assessment.

Table 1: Locations Assessed During On-Site Assessment

Site	On-Site
Alberta Children's Hospital	☑
Chinook Regional Hospital	☑
Foothills Medical Centre	☑
Grande Prairie Regional Hospital	☑
Peter Lougheed Centre	☑
Red Deer Regional Hospital Centre	☑
Rockyview General Hospital	☑
Royal Alexandra Hospital	☑
Stollery Children's Hospital	☑
Sturgeon Community Hospital	☑

Required Organizational Practices

ROPs contain multiple criteria, which are called Tests for Compliance (TFC). Accreditation Canada's Accreditation Decision Committee guidelines require 80% and above of ROP's TFC to be met.

Table 2: Summary of the Organization's ROPs

ROP Name	Standard(s)	# TFC Rating Met	% TFC Met
Client Identification	Critical Care Services	1 / 1	100.0%
Concentrated Electrolytes	Medication Management	3 / 3	100.0%
Falls Prevention and Injury Reduction - Inpatient Services	Critical Care Services	3 / 3	100.0%
Hand-hygiene Education and Training	Infection Prevention and Control	1 / 1	100.0%
Heparin Safety	Medication Management	4 / 4	100.0%
Information Transfer at Care Transitions	Critical Care Services	1 / 5	20.0%
Infusion Pump Safety	Service Excellence for Critical Care Services	6 / 6	100.0%
Medication Reconciliation at Care Transitions Acute Care Services (Inpatient)	Critical Care Services	4 / 4	100.0%
Narcotics Safety	Medication Management	3 / 3	100.0%
Pressure Ulcer Prevention	Critical Care Services	4 / 5	80.0%
The 'Do Not Use' List of Abbreviations	Medication Management	7 / 7	100.0%
Venous Thromboembolism (VTE) Prophylaxis	Critical Care Services	5 / 5	100.0%

Assessment Results by Standard

Core Standards

The Qmentum Global™ program has a set of core assessment standards that are foundational to the program and are required for the organization undergoing accreditation. The core assessment standards are critical given the foundational functions they cover in achieving safe and quality care and services.
The core standards are always part of the assessment, except in specific circumstances where they are not applicable.

Emergency and Disaster Management

Standard Rating: 100.0% Met Criteria

0.0% of criteria were unmet.

Assessment Results

Leaders are involved in local and regional Emergency and Disaster Management meetings that keep them current and familiar with issues. Risks related to potential hazards and safety risks are proactively identified as much as possible and information is shared with team members. In the event of disasters, there is an effective cascading of information from provincial committees to zonal and local meetings. Mock code reviews occur monthly and many critical care areas have this information posted on their quality boards. Tabletop exercises have also taken place and fire drills occur regularly. Debriefs are conducted following incidents.

Table 3: Unmet Criteria for Emergency and Disaster Management

There are no unmet criteria for this section.

Infection Prevention and Control

Standard Rating: 89.5% Met Criteria

10.5% of criteria were unmet. For further details please review the table at the end of this section.

Assessment Results

Staff report feeling comfortable to contact the infection control practitioner when they have questions and concerns. There is a collaborative approach to proactively addressing and managing infection-related issues. Outbreak management strategies are effective and comprehensive.

The critical care units, both adult and pediatric, were well stocked with personal protective equipment (PPE). Hand hygiene stations were appropriately located in the critical care areas. Hand hygiene practices were observed to be performed well, and some patients and families confirmed that hand hygiene is performed "all the time". Hand hygiene education is available at orientation and ongoing education is provided to staff and volunteers (at sites where there are volunteers). The infection control team collaborates with the critical care teams to monitor hospital acquired infections. When patients require isolation, appropriate signage is posted at the entrance to the patient care rooms. Most patients and families reported that they were informed about the rationale for the isolation and their role in observing these safety practices. Signage regarding donning and doffing PPE was observed in most areas. Some units provide patients and families with more formal education. The teams would benefit from a discussion at provincial critical care meetings regarding a consistent approach to patient and family education.

Negative pressure and isolation rooms are available when patients require this additional isolation precaution. The Stollery Children's Hospital pediatric cardiovascular ICU was built approximately six years ago, and some rooms are outfitted with the ability to introduce laminar flow which redirects air from the patient with the control located in the hallway.

The critical care teams have implemented care bundles based on the provincial priorities to keep patients safe and free of infections. Infection rates are posted on most quality boards. The teams are also encouraged to continue to monitor for the provincial co-developed guidelines preventing central line acquired blood stream infections and the bundles related to the Solutions for Patient Safety Network in the pediatric critical care units, specifically central line and surgical site infections.

The policy regarding biowaste hazards needs to be updated as the review/renewal date has passed. It was noted that some staff need to renew the hand hygiene learning module as their review date has expired. Ensure that all staff are aware that despite their frequent practice of hand hygiene, it is expected that regular training updates are required.

At the Chinook Regional Hospital, the nursing station in A-Pod is a wooden structure with many nicks and pieces of wood missing. This is a high risk to harbor bacteria and other organisms and cannot be properly cleaned/disinfected. The organization is encouraged to review and address this structure.

Table 4: Unmet Criteria for Infection Prevention and Control

Criteria Number	Criteria Text	Criteria Type
2.4.5	Policies, procedures, and legal requirements are followed when handling bio-hazardous materials.	HIGH
2.6.1	The areas in the physical environment are categorized based on the risk of infection to determine the necessary frequency of cleaning, the level of disinfection, and the number of environmental services team members required.	HIGH

Leadership

Standard Rating: 100.0% Met Criteria

0.0% of criteria were unmet.

Assessment Results

Building services ensure that requirements related to building codes and legislative standards are met. Staff know who to contact if there are environmental or structural issues.

The infection control teams, and facilities services work together during periods of construction or renovations to keep patients and staff safe according to standards and requirements. At Royal Alexandra Hospital a renovation was in progress to create a locked entrance to the critical care unit and appropriate hoarding and signage was in place. The team confirmed that infection control was collaborating on this construction activity.

Table 5: Unmet Criteria for Leadership

There are no unmet criteria for this section.

Medication Management

Standard Rating: 100.0% Met Criteria

0.0% of criteria were unmet.

Assessment Results

AHS is commended for investing in a variety of safety initiatives regarding the administration of medications in the critical care units. Automated drug dispensing units are an important strategy to prevent medication errors and staff reported that they appreciate and welcome this technology. The implementation of medication barcode scanning has added another layer of safety to the administration of medications. Medication scanning rates are audited and improvements have been made when the target has not been met. Many teams reported that there are times when staff have implemented workarounds if scanning is not going smoothly. These issues are constantly being investigated and when appropriate, education is provided to staff. A patient at Royal Alexandra Hospital reported that her armband was scanned prior to the administration of a medication, and the nurse discovered she was not the intended patient. The patient stated that this process increased her trust in the safety systems in use.

Staff receive comprehensive education and training on medications administered for their specific patient populations at orientation. Additionally, training is ongoing regarding automated drug dispensing cabinets and barcode scanning. The clinical pharmacists are valuable resources for these teams as are the pharmacy technicians. Best practice requirements related to high alert medications are well established and engrained in the team's everyday practices. Medication rooms are secure, clean and well organized; however, some have more space than in others depending on the newness of the unit.

Policies and procedure related to managing medications are easily accessible to staff. The electronic health record (Connect Care) provides staff with information related to medication information "often using only one or two clicks", in the words of a staff member. Medication incidents are investigated, and discussions occur at the site level and local level when system issues have been identified.

Audits of medication-related required organizational practices are performed and reported. The data is available, however further education and training is recommended to support managers with extracting and using this information.

Table 6: Unmet Criteria for Medication Management

There are no unmet criteria for this section.

Service Specific Assessment Standards

The Qmentum Global™ program has a set of service specific assessment standards that are tailored to the organization undergoing accreditation. Accreditation Canada works with the organization to identify the service specific assessment standards and criteria that are relevant to the organization's service delivery.

Critical Care Services

Standard Rating: 90.3% Met Criteria

9.7% of criteria were unmet. For further details please review the table at the end of this section.

Assessment Results

The critical care teams visited during this accreditation survey demonstrated high employee satisfaction and commitment to quality and safe patient and family centred care. Staff and physicians reported they are motivated to improve the health status of their patients and provide the safest evidence-based care possible. There is evidence of collaboration between team members, patients and families, and internal and external partners. Local, zonal, and regional critical care committees help support the identification and implementation of evidence-based practices.

The culture of these critical care units was generally reported to be the main reason why staff come to work every day. Staff feel supported by their leaders and colleagues. Teamwork and collaboration are embedded in the culture. The staffs' professionalism and attention to all aspects of quality assessments and interventions was remarkable. Their teamwork was noted to be highly sophisticated and exemplary. In the event of staff feeling overwhelmed or experiencing burnout, they identified a myriad of resources that are available to them. The focus on quality care bundles to reduce preventable safety incidents is impressive. Patient assessment protocols for skin injuries, delirium, violence, sepsis, falls risk, central line infections are consistently performed and documented. The Peter Lougheed Centre is encouraged to complete audits for some of the safety bundles such as central line associated blood stream infections (CLABSI) and catheter-associated urinary tract infection (CAUTI) in concert with implementing the sepsis protocol. Additionally, this team is encouraged to evaluate the effectiveness of the pressure ulcer prevention strategies. Connect Care is a tremendous support that serves not only as a documentation tool but also as a quality guide to ensure all appropriate interventions are implemented and communicated throughout the team.

Medical emergency teams (MET) or rapid response teams are in place and support clinical teams in the hospitals. These teams are commended for responding to patients outside of critical care areas who are experiencing a decline in their health status. At the Royal Alexandra Hospital, the team follows up with patients four hours and 24 hours after patients have been discharged from their unit. At Sturgeon Community Hospital, MET follows up with patients who have been assessed by their team but did not require transfer to the critical care unit.

Patient flow challenges exist at many sites and the ability to transfer patients once they are ready for transfer out of critical care, was reported as being delayed at times.

At the Peter Lougheed Centre, staff reported that transfer of information from the critical care unit to the ward is only done verbally. It is not documented nor standardized. As "hand-offs" are one of the most vulnerable times in a patient's journey, it is highly recommended that standardized tools be utilized for transferring information about the critical care patient as they are being moved elsewhere.

Ethical dilemmas are commonplace in critical care units and the staff reported that most of the time they can manage these issues with discussions amongst their highly skilled teams. There are ethical resources available to these teams, yet many people were not familiar with the ethical framework and/or how to contact an ethicist. There is an opportunity to increase education for these teams and case studies could be an effective approach for ongoing ethics education. Furthermore, there is an opportunity to educate patients and families on their rights and responsibilities and how to file a complaint or violation of their rights. This information is not provided in a consistent manner across the province.

The introduction of education and focus on the importance of respecting and incorporating Indigenous beliefs and practices into patient care is noted. The respect and dignity of all cultural norms and beliefs is a priority for these teams. Many Indigenous resources have been made available including new roles such as Indigenous wellness coordinators.

Lastly, the clinical teams are familiar with the organ and tissue donation policies however these policies require updating. Private space is used to have discussions related to donation, however some of the older units have less than ideal conditions. Human Organ and Procurement Exchange (HOPE) program has been rebranded to Give Life Alberta and many teams were not familiar with the new name but assumed that the processes would be the same.

Table 7: Unmet Criteria for Critical Care Services

Criteria Number	Criteria Text	Criteria Type
2.2.14	Ethics-related issues are proactively identified, managed, and addressed.	HIGH
2.2.15	Clients and families are provided with information about their rights and responsibilities.	HIGH
2.2.16	Clients and families are provided with information about how to file a complaint or report violations of their rights.	HIGH
2.3.8	Pressure Ulcer Prevention 2.3.8.5 The effectiveness of pressure ulcer prevention is evaluated, and results are used to make improvements when needed.	ROP

Criteria Number	Criteria Text		Criteria Type
2.4.23	Information Transfer at Care Transitions		ROP
	2.4.23.1	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.	
	2.4.23.2	Documentation tools and communication strategies are used to standardize information transfer at care transitions.	
	2.4.23.4	Information shared at care transitions is documented.	
	2.4.23.5	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).	
2.7.1	There are policies and procedures on organ and tissue donation.		NORMAL
2.7.3	There is a policy on donation after cardiovascular death (DCD).		NORMAL
2.7.4	There is a policy on neurological determination of death (NDD).		NORMAL

Service Excellence for Critical Care Services

Standard Rating: 97.5% Met Criteria

2.5% of criteria were unmet. For further details please review the table at the end of this section.

Assessment Results

The Program Improvement and Integration Network (PIN) for critical care services (formerly the Critical Care Strategic Clinical Network) identified several priorities for Alberta's adult and children's critical care community that support the quality work at a provincial, zonal, and local level. These priorities include advancing the knowledge of healthcare professionals and decision-makers to better understand Indigenous peoples' healthcare experiences, optimizing the electronic health record (Connect Care) and supporting staff to obtain and retain their critical care clinical expertise.

Alberta Children's Hospital and Stollery Children's Hospital have joined the Solutions for Patient Safety Network which is a network of children's hospitals across North America that are working together to eliminate serious harm across children's hospitals. The critical care units in these hospitals are employing many of the best practices to reduce hospital acquired conditions. The outcomes of the quality improvements associated with these priorities were evident across the sites the team visited during survey tracers. The electronic health record was pivotal to the standardization of assessments and documentation. The teams are encouraged to continue sharing quality improvement initiative metrics more broadly with staff, physicians and patients and families. Unit-based quality committees discuss these indicators, but all team members would benefit from learning about progress with their priorities.

Newly hired nurses felt very supported and would seek out help when they had questions or assistance was required. Orientation is tailored to meet their experience and learning needs. The Alberta Critical Care Nursing Program is an 8-week, comprehensive orientation to critical care that new staff attend. This program is supplemented by a meaningful local unit orientation. The interprofessional teams are comprised of nurses, physicians, allied health professionals, educators, clinical nurse specialists (CNS), leaders, Indigenous coordinators, and learners. The teams have invested in hiring additional clinical nurse educators in response to the recruitment of new and novice staff. Feedback regarding Connect Care was highly positive with many staff and physicians wondering how they managed with their paper health record.

Most sites have been working on local quality improvements with positive patient outcomes. For example, the team at Red Deer Regional Hospital Centre noticed that their medication reconciliation rate was declining so they implemented a quality improvement project that resulted in improved compliance. The team at Chinook Regional Hospital is commended for including a patient on their Quality Care Committee. The Royal Alexandra Hospital team learned that 60% of their patients experienced ocular damage. They worked with Ophthalmology to create an eye care protocol that led to provincial changes to the ICU admission orders. The Foothills Medical Centre leadership emails their monthly quality report to all staff.

Quality care discussions or huddles occur on most units at their quality boards. There is an opportunity for these boards to be standardized with room for local information. The quality boards in the Sturgeon Community Hospital and Royal Alexandra Hospital ICU/CCUs provided excellent quality information for both staff and patients/families. Quality indicators with targets were displayed and indicated the quality work occurring at the provincial, zonal, and local levels. Several provincial-wide initiatives were spread from the identification of issues at local hospitals.

The teams are commended for focusing on improving the culture of quality and safety with many staff stating that they feel incredibly supported and included in decision-making. Leaders are visible, nimble and approachable. Vacancy rates for registered nursing staff have improved and investments in orientation and ongoing education is commendable. Many patients and/or families stated that they are visited by leadership

on a regular basis. Leaders are on the lookout for signs of burnout given the population that they serve. Support is available for staff and leaders following incidents or difficult patient situations. The results of the Our People Pulse surveys have been evaluated and most units have developed action plans to address concerns. Performance conversations are starting to be conducted, and the team leaders are aware of the importance of providing staff with ongoing feedback and opportunities for further professional growth.

Table 8: Unmet Criteria for Service Excellence for Critical Care Services

Criteria Number	Criteria Text	Criteria Type
2.1.10	The team leadership regularly evaluates and documents each staff member's performance in an objective, interactive, and constructive way.	HIGH
2.1.12	The team leadership supports staff to follow up on issues and opportunities for growth identified through performance evaluations.	HIGH

Criteria for Follow-up

Criteria identified by the Accreditation Decision Committee for follow-up reporting to Accreditation Canada

Follow-up Requirements		
Standard	Criterion	Due dates for sites
Critical Care Services	2.2.15 - Clients and families are provided with information about their rights and responsibilities.	November 28, 2025 • Alberta Children's Hospital • Chinook Regional Hospital
Critical Care Services	2.2.16 - Clients and families are provided with information about how to file a complaint or report violations of their rights.	November 28, 2025 • Chinook Regional Hospital
Critical Care Services	2.3.8.5 - The effectiveness of pressure ulcer prevention is evaluated, and results are used to make improvements when needed.	November 28, 2025 • Peter Lougheed Centre
Critical Care Services	2.4.23.1 - 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.	November 28, 2025 • Peter Lougheed Centre
Critical Care Services	2.4.23.2 - Documentation tools and communication strategies are used to standardize information transfer at care transitions.	November 28, 2025 • Peter Lougheed Centre
Critical Care Services	2.4.23.4 - Information shared at care transitions is documented.	November 28, 2025 • Peter Lougheed Centre
Critical Care Services	2.4.23.5 - 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).	November 28, 2025 • Peter Lougheed Centre

Follow-up Requirements		
Standard	Criterion	Due dates for sites
Infection Prevention and Control	2.4.5 - Policies, procedures, and legal requirements are followed when handling bio-hazardous materials.	November 28, 2025 • Chinook Regional Hospital • Grande Prairie Regional Hospital • Rockyview General Hospital • Sturgeon Community Hospital
Infection Prevention and Control	2.6.1 - The areas in the physical environment are categorized based on the risk of infection to determine the necessary frequency of cleaning, the level of disinfection, and the number of environmental services team members required.	November 28, 2025 • Chinook Regional Hospital