ACCREDITATION AGRÉMENT CANADA

Accreditation Report

Qmentum Global™ Program

Alberta Health Services

Urban Hospital Inpatient and Perioperative Services Program

Report Issued: November 20, 2024

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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

The inpatient program covers a variety of patient populations with unique needs, and teams provide excellent care to meet patient needs.

Sites face ongoing bed capacity challenges which require the need to use overcapacity spaces on the units. With the rise in alternate level of care (ALC) patients and challenges with repatriation, leaders continuously work with both internal and external partners to find ways to support patient flow and create capacity. Daily bed meetings and rapid rounds are some ways to address these challenges.

The organization has a team of strong and knowledgeable leaders. The leadership team is action-oriented in addressing challenges and supporting staff. Leaders communicate with their staff through weekly emails, manager huddles, and leadership rounds. At one of the units visited, staff commented on the support of their unit manager, which attracts staff to that unit. Patient flow and capacity challenges remain an ongoing issue for leaders; however, they are committed to addressing this issue and supporting their patients and staff as their priority.

Teams work closely with the internal and external partners in designing and planning service delivery to mitigate risks associated with emergency and disaster planning.

The organization faces challenges with staff recruitment and retention. Some sites follow a collaborative care model (CoACT) with registered nurses (RNs), licensed practical nurse (LPNs) and care aides working together to take care of patients. The organization has adopted several strategies to address staffing shortages. Leaders are recruiting internationally educated nurses and adopting a new graduate mentorship pathway to address some of the challenges with health human resources. The extensive orientation program and incremental increase in the patient load are attractive to new nurses as reported by a new nurse on the unit.

The organization has a strong focus on supporting staff with professional development. Professional developmental opportunities are offered through online learning, in person classes, in-services, simulation training, and conferences, to mention a few. Staff reported to be well supported by the leadership team. As there are new leaders in the organization, they would also benefit from having extra support and guidance as they begin their new roles. Teams receive the support of the ethicist for dealing with complex and challenging patient family situations.

All units conduct huddles with the interdisciplinary team and discuss the patient care plan, barriers to discharge, and patient flow issues. Some programs adopt a quality improvement approach to improving practices with the support of the quality team. They shared required organizational practices (ROP) audit data from Tableau and Connect Care on their quality boards, placed in visible areas (e.g., falls rate, pressure ulcer rate, venous thromboembolism [VTE] rate, hand-hygiene rate, Do Not Use list of abbreviations data). However, a standardized approach to the quality board contents and process is recommended.

Some units provide comprehensive orientation packages to patients and families which includes a patient survey, next steps, shared commitments, and teaching materials. This information could be made available in different languages as well. While many sites have added resources as part of the COVID-19 recovery efforts, some sites have struggled to restart functions such as the rapid response team.

Key Opportunities and Areas of Excellence

Areas of Excellence:

Inpatient Services
- Strong leadership support
- Culture of patient safety
- Teamwork and collaboration

Perioperative Services
- Consistent use of handover notes for information transfer
- Omnicell use for medication safety
- Utilization of Surgical Site Infection (SSI) bundle to decrease SSI rates
- Attention to reducing surgical wait times

Palliative Services
- Dedication to patient and family-centred care
- Culturally and spiritually sensitive care
- Education resources and opportunities for staff/volunteers
- Emotional support for patients, families, caregivers, and staff

Opportunities:

Inpatient Services
- Continue to address capacity challenges and flow
- Focused attention on unmet required organization practices (ROPs) – infusion pump training, pressure ulcer risk assessment, venous thromboembolism (VTE) audits
- Infrastructure - cluttered rooms and hallways
- Patient and family advisors at the site or program level
- Leadership development

Perioperative Services
- Monitoring of SSIs – plan for the future
- ERAS (Enhanced Recovery After Surgery)
- Addition of health care aides to additional sites

Palliative Services
- Enhanced support for home palliative care
- Expand volunteer involvement at some sites
- Evaluate effectiveness of communication at transitions

People-Centred Care

There was a strong people-centered culture palpable on all units. Patients and family members reported they felt respected and received good care from everyone. They were aware of their daily treatment goals and plan of care. One patient shared how much they appreciated staff making the arrangements for them to visit their spouse who was in another facility nearby.

There is a strong focus on quality and safety for patients. Although a patient and family advisory group functions at the provincial level, many sites do not have a local patient family advisory group with lived experience to exert advocacy at the local level. Their input would be invaluable in co-designing the service delivery with the leadership team.

Patient experience is being measured using a survey by hard copy or QR code. The use of a QR code helps leaders to check for real time data. Some senior and frontline leaders do leader rounds approaching patients and seeking their feedback. It is noteworthy that the patient and family advisory group at the provincial level helped to design the patient experience survey. In addition, patient and family advisors helped to design the violent assessment signage tool (VAST).

Additionally, there is a strong commitment to Indigenous health. All staff take a mandatory course on Indigenous culture. Many sites have spiritual space dedicated to Indigenous peoples and for patients with other cultural backgrounds. The Indigenous liaison is available to support Indigenous patients, and the organization is very supportive of cultural practices such as smudging and having sweet grass in the rooms or cultural space.

The organization would benefit from the use of technology for translation and interpretation services. In addition, having an entertainment system available to all patients in their rooms would go a long way in demonstrating the organization’s focus on patients and families.

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, required organizational practices results and conclusively a Quality Improvement Overview.

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
Chinook Regional Hospital	☑
Foothills Medical Centre	☑
Northern Lights Regional Health Centre	☑
Red Deer Regional Hospital Centre	☑
Rockyview General Hospital	☑
Rotary Flames House	☑
South Health Campus	☑
University of Alberta Hospital	☑
Wetaskiwin Hospital and Care Centre	☑

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	Inpatient Services	1 / 1	100.0%
	Perioperative Services and Invasive Procedures	1 / 1	100.0%
Concentrated Electrolytes	Medication Management	3 / 3	100.0%
Falls Prevention and Injury Reduction - Inpatient Services	Inpatient Services	3 / 3	100.0%
	Perioperative Services and Invasive Procedures	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	Inpatient Services	4 / 5	80.0%
	Perioperative Services and Invasive Procedures	5 / 5	100.0%
Infusion Pump Safety	Service Excellence for Inpatient Services	5 / 6	83.3%
	Service Excellence for Perioperative Services and Invasive Procedures	6 / 6	100.0%

Table 2: Summary of the Organization's ROPs

ROP Name	Standard(s)	# TFC Rating Met	% TFC Met
Medication Reconciliation at Care Transitions Acute Care Services (Inpatient)	Inpatient Services	4 / 4	100.0%
	Perioperative Services and Invasive Procedures	4 / 4	100.0%
Narcotics Safety	Medication Management	3 / 3	100.0%
Pressure Ulcer Prevention	Inpatient Services	2 / 5	40.0%
	Perioperative Services and Invasive Procedures	5 / 5	100.0%
Safe Surgery Checklist	Perioperative Services and Invasive Procedures	5 / 5	100.0%
The 'Do Not Use' List of Abbreviations	Medication Management	7 / 7	100.0%
Venous Thromboembolism (VTE) Prophylaxis	Inpatient Services	4 / 5	80.0%
	Perioperative Services and Invasive Procedures	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: 71.4% Met Criteria

28.6% of criteria were unmet. For further details please review the table at the end of this section.

Assessment Results

The emergency and disaster procedures at some sites are outdated (2017). Disaster plans are available to all staff both in electronic and paper formats on the units. Unit-specific risk assessments are completed by the leadership team and results are shared with the staff including the action taken to mitigate the risks identified in the assessment. Regular drills on various codes are conducted and debriefing is done post-drill and results are shared both internally and externally.

A site-specific emergency and disaster plan has not yet been finalized at Rotary Flames House. Emergency and Disaster Management staff and site staff are aware and have plans to address these issues.

Teams work closely with internal and external partners (e.g., RCMP, municipalities, Protective Services, Emergency Medical Services, Public Health, Athabasca Tribal Council, and other organizations in AHS) in designing and planning service delivery specifically to mitigate the risks associated with emergency and disaster planning. At Red Deer Regional Hospital Centre, patients and families are involved in the facility's redevelopment plan and associated risk assessment work.

Table 3: Unmet Criteria for Emergency and Disaster Management

Criteria Number	Criteria Text	Criteria Type
3.1.3	The organization maintains an up-to-date version of its emergency and disaster plan in locations that are known and accessible to all staff, to ensure the plan can be easily accessed during an event.	HIGH
3.1.23	The organization ensures that each site, department, or unit establishes and maintains its own emergency and disaster plan that is aligned and coordinated with the organizational emergency and disaster plan.	HIGH

Infection Prevention and Control

Standard Rating: 94.7% Met Criteria

5.3% of criteria were unmet. For further details please review the table at the end of this section.

Assessment Results

Staff and volunteers as well as patients and families received education on hand-hygiene and personal protective equipment (PPE). There is access to alcohol-based hand rubs and hand-wash sinks at the point of care. Hand-hygiene signage is noted around the patient care areas as well. Hand-hygiene results are posted on most units and where the compliance is low, leaders are committed to improving hand-hygiene practices. On some units, the PPE cart in the hallways remains open; it is recommended to keep these carts closed to reduce the risk of contamination.

Infection control practitioners (ICPs) collaborate with site leaders in enforcing best practices related to infection prevention and control. ICPs have good knowledge of outbreak investigation including methodology, data collection, analysis and reporting requirements. While some units are very spacious, others are extremely cluttered in the patient rooms and with equipment and supplies in the hallways. Some buildings are old and have furniture, such as wooden desks, which are a potential source of bacteria and other organisms. Some sites still have four bedded wards.

Some units have a cleaning schedule available on the unit with the responsibilities and frequency delineated; however, there is no checklist or way of letting others know if cleaning has been done or not. The cleaning checklist is usually kept with the housekeeping staff. The program is encouraged to evaluate procedures to communicate cleaning and disinfecting status.

Table 4: Unmet Criteria for Infection Prevention and Control

Criteria Number	Criteria Text	Criteria Type
2.4.6	There are policies and procedures for disposing of sharps at the point of use in appropriate puncture-, spill-, and tamper-resistant sharps containers.	HIGH

Leadership

Standard Rating: 100.0% Met Criteria

0.0% of criteria were unmet.

Assessment Results

Generally, spaces are clean and tidy. At Red Deer Regional Hospital Centre, patient rooms are crowded with equipment and discharged patient belongings are stored with the clean equipment. It is recommended that patient's belongings be removed from this space.

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

The Provincial Medication Management Committee provides leadership and supports various medication management related functions across the organization. The pharmacy is served by pharmacists, pharmacy technicians and pharmacy assistants and supported by a director and managers. The Provincial Pharmacy and Therapeutics Committee oversees the formulary and provides leadership by consulting with the site leadership in making various decisions related to medication management.

Clinical pharmacists are integrated into the clinical programs and assist in the various medication management needs of the programs. Pharmacy leaders attend the site's operational meetings and pharmacists attend rapid rounds, patient care rounds, provide education, and are available for consultations when needed.

Annual audits are completed at the site-level on heparin concentrations, narcotics, concentrated electrolytes, and Do Not Use abbreviations list, to name a few. With the use of the Omnicell automated dispensing units and the safety features of the system, there is less chance for errors with stocking and dispensing. Teams follow robust medication incident reporting systems with which staff are very familiar. The pharmacy team will review the incident reports related to medication management and work with the clinical teams to address any issues.

The pharmacy provides support 24-hours a day by providing access to an on-call pharmacist. High alert medications and look-alike and sound-alike medications are distinctively labelled to prevent errors. The pharmacy department is kept clean and has restricted entry. Members of the pharmacy team take part in various training and orientation required to be competent in supporting the organization.

At Northern Lights Regional Health Centre, construction is underway in the pharmacy and the new area is expected to be operational in 2025. In the interim the site has taken steps to mitigate risk in the current sterile compounding area.

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.

Inpatient Services

Standard Rating: 92.4% Met Criteria

7.6% of criteria were unmet. For further details please review the table at the end of this section.

Assessment Results

During this survey, inpatient programs were visited at nine (9) sites. Many of these programs stood out as model units where excellent collaboration and team functioning was noted.

Despite the heavy workload, staff remain patient-centered and committed to supporting each other. Teams take part in bed meetings and daily rapid rounds to discuss patient flow, discharge planning, and to identify and remove barriers to discharge which help the organization to create capacity. Some programs have proactively identified the expected day of discharge on the white board to communicate with patients and families to keep them in the loop with their expected discharge date. The leaders are encouraged to standardize this practice to create capacity and improve efficiencies in the system.

Many staff commented on the outstanding leadership for their presence, support, and teamwork in their areas. Unfilled vacancies and staffing shortages are of concern for the leadership team. Some units follow team nursing which allows a team of RNs, LPNs and care aides to care for a group of patients and this might be helpful during staffing shortages as demonstrated in the literature.

Many units demonstrated having a strong focus on quality and safety for patients and staff. Many programs have embraced quality improvement initiatives with or without the support of the quality team such as the overdose management beds protocol, PJ paralysis program, and noise meter monitor. Whiteboards in patient rooms are valued and appreciated by patients and families. Leaders and staff are encouraged to ensure that these boards are consistently updated as it is a communication tool for the staff, patients and families. Additionally, having the whiteboard in front of the patient would be recommended to support patient engagement in this communication tool rather than placing it behind the patient.

Transfer of information at various care transitions seems to be standardized, however shift handover communication is unstructured in some areas. Leaders are encouraged to ensure the effectiveness of communication is evaluated and standardize the process for better communication and patient safety. Some units implemented some aspects of CoACT where information placemats (e.g., with tips for a better stay, how to file a complaint) are available in English to patients. There is opportunity for this to be implemented across sites, along with this information being available in other languages. The organization is encouraged to leverage technology to meet the translation and interpretation needs of patients. The current system of booking an interpreter delays the process and could potentially delay discharge as well.

Some sites reported challenges with essential resources in their facilities. Lack of full-time coverage by respiratory therapists (RT), weekend coverage of allied health, and overnight coverage of housekeeping staff all contributes to challenges with patient care and patient flow.

At the University of Alberta Hospital and Wetaskiwin Hospital and Care Centre, pressure injury risk assessment is not carried out consistently. It is important to conduct the risk assessment on admission, at regular intervals and as the patient's condition changes. Physician compliance with the VTE order set needs more attention as compliance was as low as 16% on some units. Although data can be harvested from Connect Care, it is not being shared with staff on a regular basis to make improvements.

At most of the sites visited, patients and families reported that they had received information on rights and responsibilities (shared commitments). It is recommended that Foothills Medical Center and South Health Campus ensure that patients and families are aware of their rights and responsibilities upon admission to their units.

Table 7: Unmet Criteria for Inpatient Services

Criteria Number	Criteria Text	Criteria Type
3.2.13	Clients and families are provided with information about their rights and responsibilities.	HIGH
3.3.9	Pressure Ulcer Prevention 3.3.9.1 An initial pressure ulcer risk assessment is conducted for clients upon admission, using a validated, standardized risk assessment tool. 3.3.9.2 The risk of developing pressure ulcers is assessed for each client at regular intervals and when there is a significant change in the client's status. 3.3.9.5 The effectiveness of pressure ulcer prevention is evaluated, and results are used to make improvements when needed.	ROP
3.3.10	Venous Thromboembolism (VTE) Prophylaxis 3.3.10.3 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.	ROP

Criteria Number	Criteria Text	Criteria Type
3.4.14	Access to spiritual space and care is provided to meet clients' needs.	NORMAL
3.4.18	Information Transfer at Care Transitions 3.4.18.5 The effectiveness of communication is evaluated and improvements are made based on feedback received. Evaluation mechanisms may include: • Using an audit tool (direct observation or review of client records) to measure compliance with standardized processes and the quality of information transfer • Asking clients, families, and service providers if they received the information they needed • Evaluating safety incidents related to information transfer (e.g., from the patient safety incident management system	ROP

Palliative Care Services

Standard Rating: 94.8% Met Criteria

5.2% of criteria were unmet. For further details please review the table at the end of this section.

Assessment Results

Comprehensive, relevant, and easy-to-understand information is available on the AHS site for patients, families, and staff. This includes the scope of palliative and end-of-life services, information on how to access services across the province, as well as information on advance care planning, grief and bereavement. Medical Assistance in Dying (MAID) is specifically addressed, including information on how patients can access the service. A comprehensive MAID policy exists (scheduled review date March 24, 2024) which supports the provision of equitable, autonomous access for patients, while also respecting the needs and wishes of families and providers.

Patient assessment and care delivery is standardized at the sites, and several palliative care tools are in use including the Palliative Performance Scale (PPS), Edmonton Symptom Assessment System (ESAS), and Palliative Prognostic Index (PPI), to name a few. The teams work with patients and families to provide culturally appropriate palliative and end-of-life care. Advance care planning is supported, and patient wishes are documented and incorporated into the care plan. Patients, families, and staff are supported before, during, and after death. Resources are available to support families in grief and bereavement as needed, and the teams follow up with families after death has occurred. A number of opportunities for staff learning are available such as Learning Essential Approaches to Palliative Care (LEAP) Core training, conferences, grand rounds, lunch-and-learn sessions, and weekly rounds to review challenging cases.

The palliative care service at Northern Lights Regional Health Centre (NLRHC) consists of two nurses and a social worker on site and is integrated with the multidisciplinary North Zone Palliative Care team. They support palliative care in the community and at NLRHC, including three designated palliative care beds on the inpatient medical ward. At NLRHC, patients, families, and/or caregivers do not have the opportunity to visit the palliative care unit, either in person or virtually, prior to initiating care. The team is encouraged to provide this opportunity, to familiarize the patient, family, and/or caregivers with the philosophy of care, physical layout, and to orient them to the services. This practice is supported at Rotary Flames House and at Wetaskiwin Hospital and Care Centre.

Rotary Flames House (RFH) is a comparatively well-resourced service supporting pediatric palliative and respite care in seven funded beds with expansion to eleven if necessary. A diverse and dedicated multidisciplinary team delivers comprehensive care in a home-like setting and has a very robust volunteer program. There is opportunity at other sites to develop a more proactive approach to involving volunteers in supporting palliative care patients and their families.

At the Wetaskiwin Hospital and Care Centre, there is opportunity to collect outcome measurements or patient satisfaction from the palliative patients and families to support quality improvement. The team receives kudos cards from families who receive care in the palliative suites which is reflective of the good care provided to them.

Delivering high quality palliative care in the home is a challenge for all sites. With current resources, teams feel that this necessary service is successful only when the family is engaged and able to contribute in a significant way to the care delivery in the home. It is felt that this is not sustainable nor equitable. Teams shared additional support would be optimal to help patients and families in the home to develop and sustain a comprehensive home palliative care program.

Table 8: Unmet Criteria for Palliative Care Services

Criteria Number	Criteria Text	Criteria Type
2.1.7	The organization has a standardized process to collect outcome information about the clients', families', and/or caregivers' perceptions and experiences of care for quality improvement purposes.	HIGH
3.3.3	The organization provides clients, families, and/or caregivers with the opportunity to become familiar with the team's services and the physical environment before starting care.	NORMAL
4.1.9	As part of the assessment, the team determines the client's need and desire for the services of a volunteer.	NORMAL

Perioperative Services and Invasive Procedures

Standard Rating: 95.5% Met Criteria

4.5% of criteria were unmet. For further details please review the table at the end of this section.

Assessment Results

The physical layout of the perioperative areas at the two sites visited (Northern Lights Regional Health Centre [NLRHC] and Chinook Regional Hospital [CRH]) has appropriately restricted access and facilitates safe movement of patients and equipment. Temperature and humidity are monitored locally by the operating room staff and centrally by Facility Maintenance and Engineering (FME) staff with central alarm capability for out-of-range readings. High humidity has been a problem in the recent past and is monitored closely by the team.

FME staff at NLRHC state that pressure sensors servicing the operating rooms are unable to properly measure airflow. They are unable to confirm that the operating rooms are under positive pressure. FME staff also state that the current air handler is not functioning properly such that the facility is noncompliant with air exchange requirements in the operating rooms (ten exchanges per hour reported on the day of the visit).

A regular and comprehensive cleaning schedule for the operating room and supporting areas was not found posted in a place that is accessible to all team members. Surgical equipment and devices are calibrated and maintained as per manufacturers' instructions. There is a process in place to manage equipment recalls which includes a communication plan and removing affected items from use.

Any reprocessing done in the perioperative area is performed by qualified personnel with Medical Device Reprocessing Department (MDRD) oversight. There is clear separation of clean and contaminated materials, and contaminated items are transported appropriately in covered carts. At NLRHC, immediate-use ('flash') sterilization is not done in the perioperative area. Also at this site, when equipment is returned to the operating room following repair, there is opportunity to clearly mark equipment with the date of return instead of an email sent notifying staff of the return including a description of the maintenance performed.

Clinical pharmacists are integrated into the multidisciplinary care teams providing evidence-informed pharmaceutical care and acting as a valuable resource to the team. Omnicell automated dispensing cabinets are used in the operating room and on the inpatient unit. Medication rooms are clean, secure, and well organized.

A comprehensive, standardized assessment is conducted for each patient and documented in the medical record. Patient assessments, as well as laboratory and radiology results, are readily available to all team members prior to and at the time of surgery. The operative record is comprehensive and those reviewed during the onsite survey were noted to be complete. Standardized criteria are in place to determine whether a patient is fit for discharge from the recovery unit.

Health care aides (HCAs) are available at some, but not all sites. Staff at NLRHC state that nursing staff on the surgical unit have less time to devote to "nursing practice" as they spend much of their time completing tasks done by HCAs at comparative sites. There may be opportunity to expand the HCA role equitably across sites to optimize patient care.

Information transfer at transitions is in place; however, information transfer from the operating room to the recovery unit is verbal, not standardized, and not documented. This introduces unnecessary risk in terms of incomplete reporting. It is suggested that the information shared at this transition be standardized to mitigate this risk.

Staff at NLRHC were aware of the organizational resources available to them to assist with managing ethics-related issues and were able to speak to the issue citing specific patient examples, but staff at CRH were unaware. It is encouraged that staff across all sites receive training and education on where and how to access the resources available.

Staff at NLRHC report that patients and families are not consistently provided with information about their rights and responsibilities and patients and family spoken with during the onsite survey confirm that they did not receive such information.

Block times are used to optimize patient flow. Wait lists are monitored and patients whose condition deteriorates on the wait list are able to contact the surgeon's office for reassessment and reassignment on the wait list if necessary. Surgical wait times are monitored and benchmarked against the Alberta Coding Access Targets for Surgery (ACATS). The furthest 'out of window' cases are prioritized for scheduling.

Table 9: Unmet Criteria for Perioperative Services and Invasive Procedures

Criteria Number	Criteria Text	Criteria Type
1.1.6	Airflow and quality in the area(s) where surgical and invasive procedures are performed are monitored and maintained according to standards applicable for the type of procedures performed.	HIGH
1.1.7	Rooms where surgical and invasive procedures are performed have at least 20 complete air exchanges per hour.	HIGH
1.1.10	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.	HIGH
1.2.3	Surgical equipment or medical devices returned to the operating/procedure room following repair or replacement are clearly marked with the date of their return/arrival and a signed notice describing the maintenance or purchase.	HIGH

Criteria Number	Criteria Text	Criteria Type
1.3.2	Medications in the surgical area are stored in a locked area or similarly secured, as per the organization's policies regarding medication storage.	HIGH
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
2.4.8	Access to spiritual space and care is provided to meet clients' needs.	NORMAL

Service Excellence for Inpatient Services

Standard Rating: 95.0% Met Criteria

5.0% of criteria were unmet. For further details please review the table at the end of this section.

Assessment Results

The organization has a strong supportive leadership team. The leaders are invested in supporting staff to have a safe place to work and patients to receive safe and quality care. Leadership rounds seeking the feedback of staff and patients are conducted regularly.

The organization has a good process in place for supporting staff with continuing education. MyLearningLink (online learning platform) is used for reminding staff to do required courses in the recommended timelines. Managers are required to track the completion and follow up with staff as needed. Many managers are doing their best to have performance/career discussions with their staff however, many sites are falling behind in completing this annually. This is attributed to the workload of the managers and their turnover. The organization is encouraged to come up with ways to support staff performance/career conversations/evaluation consistently as it supports staff with their professional development.

At Chinook Regional Hospital, not all staff have had infusion pump training within the last two years. The program is encouraged to review training standards across sites for consistency in supporting safe care.

The organization uses Connect Care for electronic charting. Both staff and leaders are getting acquainted to the system. Leaders and staff point out the need for more education to be comfortable with the system and for the ongoing changes that are added. Currently, metrics are available to leaders in Tableau and Connect Care. Some leaders reported that they lacked knowledge on how to extract metrics from Connect Care. Leaders need education and guidance in pulling these reports from the system. Leaders are encouraged to explore ways in which quality and safety information is shared with staff. Competing priorities and a shortage of leaders pose challenges for sharing information with the staff and providers consistently and in a timely manner. Being able to create reports and share the reports with staff will empower leaders and help the teams build quality improvement actions using real time data.

The organization has good security features in place and access to patient information is monitored. Staff will be flagged if they access information that is not relevant to provide care for their patients.

Best practice guidelines are developed at the provincial level using the current evidence and with the engagement of the patient and family advisors.

Table 10: Unmet Criteria for Service Excellence for Inpatient Services

Criteria Number	Criteria Text	Criteria Type
1.2.7	The team works with the organization to create a universally accessible service environment.	NORMAL
2.1.7	Infusion Pump Safety 2.1.7.4 The competence of team members to use infusion pumps safely is evaluated and documented at least every two years. When infusion pumps are used very infrequently, a just- in-time evaluation of competence is performed.	ROP
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

Service Excellence for Perioperative Services and Invasive Procedures

Standard Rating: 93.8% Met Criteria

6.2% of criteria were unmet. For further details please review the table at the end of this section.

Assessment Results

Team leaders at Northern Lights Regional Health Centre (NLRHC), although relatively new in their roles, have worked to improve their services and introduce relevant changes. They receive information from a variety of sources to inform service design and delivery. Provincial priorities are the main drivers in this regard (e.g., hip and knee arthroplasties, reduction in wait times) but information gleaned from patient surveys and input from patient and family advisors have also served to shape service design and delivery. For example, feedback from Indigenous patient partners led to the creation of an Indigenous wellness space and accommodation of smudging within the facility. Team leaders in both the operating room and surgical inpatient unit have identified resource requirements and service gaps to organizational leaders and work with them to creatively fill these gaps when possible. Although there is access to designated spiritual space for Indigenous services, there is no other designated spiritual space.

Team leaders work with the organization and staff to ensure that credentials, competency assessments, and training are monitored and maintained to ensure safe and effective delivery of services. New staff receive a comprehensive and standardized orientation from the organization including periodic recertification as necessary. Completion of required organizational learning and certifications are tracked and shared with team leaders for follow up. The teams also provide a unit-specific orientation with appropriate mentorship to support new staff. Staff receive training on the use of new devices and equipment when necessary. Infusion pump training is provided and evaluated on a regular basis and patients are trained to safely operate patient-controlled analgesia pumps as required.

For the perioperative and surgical inpatient services teams at NLRHC, performance conversations are not conducted on a regular basis, and many staff reported not receiving one recently. Team leaders meet with staff informally to support them in their professional development. These meetings and any progress in meeting professional development goals are not documented. There is opportunity to conduct regular, formal conversations with staff, documenting strengths and opportunities for growth and professional development which can be supported and followed up on at a subsequent meeting.

A standardized assessment is completed on each patient, supported by Connect Care. Charts are audited by team leaders to evaluate compliance with organizational documentation policies. Staff receive training on confidentiality initially and at regular intervals. Patients are able to conveniently access the information in their health records online.

Provincial practice guidelines, clinical pathways, and order sets are incorporated into the delivery of inpatient and perioperative services, although not consistently. Enhanced Recovery After Surgery (ERAS) protocols, for example, are readily available in Connect Care but they are not regularly used. There are a number of practices in place to identify and mitigate high-risk activities and staff are very familiar with mitigation strategies which were observed repeatedly during the survey (e.g., management of verbal orders, two-person verification for high alert medications). Team members are well versed in the incident reporting systems both for staff incidents (MySafetyNet) and patient incidents (RLS). There is a policy for disclosure of adverse events with which staff and physicians had some familiarity and knew how to seek further detailed information and assistance if necessary. The team actively seeks information from patients and families as well as community partners about the quality of services and uses this information to identify opportunities for improvement. The teams at NLRHC were able to speak to several quality improvement projects undertaken including pressure injury prevention, monitoring patients post narcotic administration, and reduction in surgical site infections.

The surgical services participated in the American College of Surgeons (ACS) National Surgical Quality Improvement Program (NSQIP) until September 2024 when budget constraints led to the elimination of the coordinator position. This person regularly collected and reported on key surgical data utilized to improve the quality of surgical care. Their ongoing work identified an increase in surgical site infections (SSI) and demonstrated a significant reduction after appropriate interventions were put into place. It is not clear to the team if and how these data will continue to be collected and managed, introducing the potential for recurrence of increased rates of surgical site infection and other complications of surgical care.

Although the team does access the services of the Indigenous liaison and have utilized a patient and family advisor to review a patient survey in the past, there is opportunity to significantly increase the role of patient and family advisors in shaping service design and delivery.

Table 11: Unmet Criteria for Service Excellence for Perioperative Services and Invasive Procedures

Criteria Number	Criteria Text	Criteria Type
1.1.3	The team develops its service-specific goals and objectives.	NORMAL
1.2.8	The team leadership ensures that clients are provided with access to spiritual care and space for spiritual practices to meet their needs.	NORMAL
2.1.10	The team leadership regularly evaluates and documents each staff member’s performance in an objective, interactive, and constructive way.	HIGH
2.1.11	The team leadership regularly engages with client and family representatives to gather input and feedback on their roles and responsibilities as well as role design, processes, and satisfaction.	NORMAL
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**
Emergency and Disaster Management	3.1.3 - The organization maintains an up-to-date version of its emergency and disaster plan in locations that are known and accessible to all staff, to ensure the plan can be easily accessed during an event.	November 28, 2025 • Red Deer Regional Hospital Centre • Rotary Flames House
Emergency and Disaster Management	3.1.23 - The organization ensures that each site, department, or unit establishes and maintains its own emergency and disaster plan that is aligned and coordinated with the organizational emergency and disaster plan.	November 28, 2025 • Rotary Flames House
Infection Prevention and Control	2.4.6 - There are policies and procedures for disposing of sharps at the point of use in appropriate puncture-, spill-, and tamper-resistant sharps containers.	November 28, 2025 • Red Deer Regional Hospital Centre
Inpatient Services	3.2.13 - Clients and families are provided with information about their rights and responsibilities.	November 28, 2025 • Foothills Medical Centre • South Health Campus
Inpatient Services	3.3.9.1 - An initial pressure ulcer risk assessment is conducted for clients upon admission, using a validated, standardized risk assessment tool.	November 28, 2025 • University of Alberta Hospital • Wetaskiwin Hospital and Care Centre
Inpatient Services	3.3.9.2 - The risk of developing pressure ulcers is assessed for each client at regular intervals and when there is a significant change in the client's status.	November 28, 2025 • University of Alberta Hospital • Wetaskiwin Hospital and Care Centre
Inpatient Services	3.3.9.5 - The effectiveness of pressure ulcer prevention is evaluated, and results are used to make improvements when needed.	November 28, 2025 • Wetaskiwin Hospital and Care Centre
Inpatient Services	3.3.10.3 - 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.	November 28, 2025 • University of Alberta Hospital

Follow-up Requirements		
Standard	Criterion	Due dates for sites
Inpatient Services	3.4.18.5 - The effectiveness of communication is evaluated and improvements are made based on feedback received. Evaluation mechanisms may include: • Using an audit tool (direct observation or review of client records) to measure compliance with standardized processes and the quality of information transfer • Asking clients, families, and service providers if they received the information they needed • Evaluating safety incidents related to information transfer (e.g., from the patient safety incident management system	November 28, 2025 • Rotary Flames House
Perioperative Services and Invasive Procedures	1.1.6 - Airflow and quality in the area(s) where surgical and invasive procedures are performed are monitored and maintained according to standards applicable for the type of procedures performed.	November 28, 2025 • Northern Lights Regional Health Centre
Perioperative Services and Invasive Procedures	1.1.7 - Rooms where surgical and invasive procedures are performed have at least 20 complete air exchanges per hour.	November 28, 2025 • Northern Lights Regional Health Centre
Perioperative Services and Invasive Procedures	1.1.10 - 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.	November 28, 2025 • Northern Lights Regional Health Centre
Perioperative Services and Invasive Procedures	1.2.3 - Surgical equipment or medical devices returned to the operating/procedure room following repair or replacement are clearly marked with the date of their return/arrival and a signed notice describing the maintenance or purchase.	November 28, 2025 • Northern Lights Regional Health Centre
Perioperative Services and Invasive Procedures	1.3.2 - Medications in the surgical area are stored in a locked area or similarly secured, as per the organization's policies regarding medication storage.	November 28, 2025 • Chinook Regional Hospital
Perioperative Services and Invasive Procedures	2.2.15 - Clients and families are provided with information about their rights and responsibilities.	November 28, 2025 • Northern Lights Regional Health Centre
Service Excellence for Inpatient Services	2.1.7.4 - The competence of team members to use infusion pumps safely is evaluated and documented at least every two years. When infusion pumps are used very infrequently, a just-in-time evaluation of competence is performed.	November 28, 2025 • Chinook Regional Hospital