ACCREDITATION AGRÉMENT CANADA

Accreditation Report

Qmentum Global™ Program

Bow Island Health Centre

Alberta Health Services

Report Issued: June 18, 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 May 6 to May 10, 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 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 (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 occur 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, Reprocessing of Reusable Medical Devices 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

Bow Island Health Centre provides an intimate and diverse learning environment for student placements. The presence of nursing and Emergency Medical Services (EMS) students enriches the learning environment, providing valuable hands-on experience and fostering a culture of continuous learning. Despite the additional responsibilities placed on existing staff, the opportunity to mentor and guide future healthcare professionals contributes to staff development and the cultivation of a supportive learning community and a recruitment pool.

The dedication and compassion exhibited by staff members across the organization ensures that patients and residents receive high-quality care. Despite challenges, many staff remain committed to delivering personalized care, reflecting a strong sense of empathy and professionalism.

Commitment to continuous improvement is palpable. Despite limited resources and temporary leadership status, the organization's leadership team demonstrates a proactive approach to addressing challenges and driving improvements. Efforts to enhance staff engagement and implement improvements reflect a culture of innovation and adaptability, positioning the organization for long-term success. Incorporating external stakeholders, clients, residents, and families in quality improvement fosters trust and advances relationships, leading to improved outcomes and long-term relationship building.

Prioritizing and enhancing staff competencies and education is an area of leadership focus. Recognizing the importance of ongoing education and skill development, there is an opportunity to invest in dedicated zone resources to support staff training and development onsite. By ensuring compliance with AHS requirements and providing additional training in areas such as trauma, mental health, pediatrics, and palliative care, staff can further enhance their competencies and deliver care that is aligned with the latest evidence and leading practices.

Key Opportunities and Areas of Excellence

Areas of excellence:

At Bow Island Health Center, the Resident and Family Advisory Council (RFAC) is highly engaged and pivotal for resident empowerment and input. This provides a venue for residents to identify priorities and convenes monthly events that are well attended and appreciated. To broaden its impact, consider involving the RFAC in decision-making processes, like service enhancements or facility improvements, alongside staff. Recognize their contributions through annual awards or appreciation events.

The organization has initiated the evaluation of two practices, including recent audits of venous thromboembolism (VTE) prophylaxis using Connect Care data and patient experience assessments via a newly implemented survey using REDCap. This proactive approach demonstrates a commitment to evidence-based decision-making and quality improvement. While early efforts are in place, establishing regular review cycles and integrating feedback mechanisms can enhance the effectiveness of quality improvement initiatives over time.

The Bow Island & District Health Foundation collaboration with staff, patients, residents, and families ensures that funding priorities align with the needs of the community. Recent investments in equipment and facility upgrades, as well as staff recognition initiatives, showcase a commitment to enhancing the overall healthcare environment.

Key Opportunities:

There is a lack of support for new leaders in temporary roles which hinders their effectiveness and integration into the organization. Providing permanent roles, adequate mentorship, resources, and guidance can help these leaders navigate their roles more effectively and contribute to organizational success.

Addressing unresolved human resource issues is crucial for fostering a healthy workplace culture and ensuring safe patient care. This includes tackling behavioral issues, addressing staffing shortages, and implementing performance management reviews to provide feedback and support for staff development.

The limited availability of educational support poses significant challenges to patients, residents, and workforce safety. Ensuring that staff receive regular training, especially in essential areas such as infusion pump usage and emergency disaster management, is essential for maintaining high standards of care.

Addressing the gap in rural health education, delivered at the organization, through consistent training initiatives is vital for staff competency and preparedness.

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.

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 1: Summary of the Organization's ROPs

ROP Name	Standard(s)	# TFC Rating Met	% TFC Met
Medication Reconciliation at Care Transitions - Emergency Department	Emergency Department	1 / 1	100.0%
Suicide Prevention	Emergency Department	5 / 5	100.0%
	Long-Term Care Services	5 / 5	100.0%
Client Identification	Emergency Department	1 / 1	100.0%
	Inpatient Services	1 / 1	100.0%
	Long-Term Care Services	1 / 1	100.0%
Information Transfer at Care Transitions	Emergency Department	4 / 5	80.0%
	Inpatient Services	5 / 5	100.0%
	Long-Term Care Services	1 / 5	20.0%
Hand-hygiene Education and Training	Infection Prevention and Control	1 / 1	100.0%
Hand-hygiene Compliance	Infection Prevention and Control	3 / 3	100.0%
Reprocessing	Infection Prevention and Control	2 / 2	100.0%

Table 1: Summary of the Organization's ROPs

ROP Name	Standard(s)	# TFC Rating Met	% TFC Met
Infection Rates	Infection Prevention and Control	3 / 3	100.0%
Medication Reconciliation at Care Transitions Acute Care Services (Inpatient)	Inpatient Services	4 / 4	100.0%
Falls Prevention and Injury Reduction - Inpatient Services	Inpatient Services	2 / 3	66.7%
Pressure Ulcer Prevention	Inpatient Services	4 / 5	80.0%
	Long-Term Care Services	4 / 5	80.0%
Venous Thromboembolism (VTE) Prophylaxis	Inpatient Services	5 / 5	100.0%
Medication Reconciliation at Care Transitions - Long-Term Care Services	Long-Term Care Services	4 / 4	100.0%
Fall Prevention and Injury Reduction - Long-Term Care Services	Long-Term Care Services	5 / 6	83.3%
Skin and Wound Care	Long-Term Care Services	8 / 8	100.0%
High-alert Medications	Medication Management	8 / 8	100.0%
Heparin Safety	Medication Management	4 / 4	100.0%
Narcotics Safety	Medication Management	3 / 3	100.0%
Concentrated Electrolytes	Medication Management	3 / 3	100.0%
The 'Do Not Use' List of Abbreviations	Medication Management	7 / 7	100.0%

Table 1: Summary of the Organization's ROPs

ROP Name	Standard(s)	# TFC Rating Met	% TFC Met
Infusion Pump Safety	Service Excellence	1 / 5	20.0%

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: 85.7% Met Criteria

14.3% of criteria were unmet. For further details please review the table at the end of this section.

Assessment Results

The Bow Island Health Centre leadership and key staff have embraced a focus on emergency disaster management. The emergency management officer, who supports the site, indicated that there has been a strong commitment from Bow Island Health Centre staff to put in place the necessary actions to support an emergency disaster response. The facility completed a mock code yellow last week and holds monthly fire drills which are coordinated through the maintenance staff. The fan-out list to notify staff is not up to date, but plans are in place to update it soon.

Emergency disaster manuals are up-to-date and found in each department. Staff interviewed indicate they are familiar with it and how to find the information they require in various emergency situations.

The facility has experienced several utility issues in the past few years, and most recently a partial water loss occurred. The response was well coordinated for the recent event and mitigating strategies have been put in place. Informal debriefs are held following all fire drills and mock code exercises.

The facility is encouraged to contact the local community to share their emergency disaster management plans and enhance the coordination of emergency disaster response planning. In addition, it is recommended that the facility provide further information to the community regarding steps that they may take for their own health needs in an emergency.

Table 2: Unmet Criteria for Emergency and Disaster Management

Criteria Number	Criteria Text	Criteria Type
3.1.2	The organization integrates its emergency and disaster plan with community emergency and disaster plans, to ensure a coordinated response to and recovery from an event.	NORMAL

Criteria Number	Criteria Text	Criteria Type
3.4.10	The organization maintains an accurate and up-to-date database of contact information for all staff, to be able to notify them in case of an emergency or disaster.	HIGH

Infection Prevention and Control

Standard Rating: 100.0% Met Criteria

0.0% of criteria were unmet.

Assessment Results

The Infection Prevention and Control (IPC) program at Bow Island Health Centre is supported by an Infection Control Practitioner from Medicine Hat Regional Hospital. The individual strives to contact Bow Island Health Centre daily throughout the week and is available by phone for consultation at other times. Staff at Bow Island Health Centre are aware of this support and are comfortable accessing it.

Food services, in-house laundry and waste management are conducted in concert with appropriate IPC precautions. The facility is encouraged to address some areas including the missing ceiling panel in the kitchen area, carpet in some lounge areas, wooden furniture, and the use of cardboard in storage areas.

Reprocessing and sterilization of medical equipment for Bow Island Health Centre is carried out in Medicine Hat Regional Hospital. The Bow Island Health Centre is responsible for cleaning and packaging this equipment prior to shipping. The cleaning and disinfecting of other patient equipment at Bow Island Health Centre is carried out primarily by nursing staff as the environmental services staff are only certified to clean high touch surfaces and not any equipment that has had patient contact. The facility is encouraged to review this and look to have environmental staff's certification expanded and free up nurses' time for direct patient care. Also, the facility is encouraged to implement an audit system to ensure cleaning procedures occur.

The facility does not do endoscopy.

Bow Island Health Centre has trained two staff as hand-hygiene auditors and data collected from these audits demonstrates very good compliance in both the long-term care area and the inpatient unit whose recent scores of 100% and 98% respectively.

The facility is commended for its work on preparing for a potential measles outbreak in the area as there is a low vaccination rate in the community served.

Unmet Criteria for Infection Prevention and Control

There are no unmet criteria for this section.

Leadership

Standard Rating: 80.0% Met Criteria

20.0% of criteria were unmet. For further details please review the table at the end of this section.

Assessment Results

Day-to-day leadership at the Bow Island Health Centre is provided by an interim site manager and an assistant head nurse. There are considerable challenges within the organization including staffing shortages, a lack of education support and strife amongst the nursing staff due to the request to function as one unit versus the distinct areas of emergency, inpatients and long-term care. AHS is encouraged to revisit the resources available to Bow Island Health Centre and better support the leaders in their work of ensuring safe, quality care to patients and their families.

Most patient concerns are raised directly to the interim site manager who works to resolve these as quickly as possible. Some concerns are forwarded directly to Patient Relations and then communicated back to the site manager for review and handling.

A major risk identified by the leadership is the lack of staffing, particularly in the emergency department (ED) and at night when only one registered nurse is covering the ED. Safety rounds with leadership and Joint Health and Safety committee members have been reinstated and will be occurring regularly.

The facility is relatively large and somewhat disjointed due to the number of short corridors and what appear to be additions to the building. Some areas contain wooden furniture and carpeting, and the facility is encouraged to address these to reduce the potential for infections. Several rooms are being used for storage of equipment that is no longer used and the facility is encouraged to remove this equipment and reduce clutter. Oxygen tanks were seen unsecured against the wall of a busy hallway, it is recommended that these be placed in a larger stand that is secure and cannot be knocked over.

The facility has undergone renovations, and Infection Prevention and Control staff were fully engaged in planning and monitoring the environment during the renovations. Through the financial support of the Bow Island & District Health Foundation, the Bow Island Health Centre is well equipped for the services provided.

Equipment is also well maintained through a preventive maintenance program carried out by the in-house maintenance staff.

Table 3: Unmet Criteria for Leadership

Criteria Number	Criteria Text	Criteria Type
4.3.1	The organization ensures its physical spaces are safe and meet relevant laws and regulations.	HIGH

Medication Management

Standard Rating: 96.1% Met Criteria

3.9% of criteria were unmet. For further details please review the table at the end of this section.

Assessment Results

Medication management at Bow Island Health Centre is supported by access to a main medication room and the close attention of an on-site pharmacy assistant who orders the medications and monitors inventory in the main medication storage room, as well as the medication rooms in each of the three clinical areas across the health centre. Off-site pharmacist support is available to staff and physicians on a 24/7 basis. The pharmacy assistant carries out a weekly audit of the medication rooms on the clinical areas and a full hazardous medications and narcotic audit is conducted annually.

Registered staff administering medication can access the main medication room if there is a need after hours or on the weekend. By exception, high concentration of Heparin is kept, in limited supply, within the ED medication room.

One bin is being used with partitions for high-alert medications versus being in separate bins. This is likely due to the lack of space within medication rooms. However, the organization is encouraged to separate all high-alert medications to reduce the potential risk that the wrong drug is used.

The medication room on the long-term care unit is very small and is located within the resident's dining/living room area where residents are gathered and often watch TV. The room is not large enough to comfortably have two people in it at once and it would have very poor ventilation if the door was kept shut during the process of preparing medications for administration. The facility is encouraged to review the location of this medication room.

Table 4: Unmet Criteria for Medication Management

Criteria Number	Criteria Text	Criteria Type
5.1.7	Separate storage in client service areas and in the pharmacy is used for look-alike medications, sound-alike medications, different concentrations of the same medication, and high-alert medications.	HIGH
6.1.8	Steps are taken to reduce distractions, interruptions, and noise when team members are prescribing medications or transcribing and verifying medication orders.	NORMAL

Criteria Number	Criteria Text	Criteria Type
7.2.2	Appropriate ventilation, temperature, and lighting are maintained in the medication preparation areas.	HIGH

Service Excellence

Standard Rating: 87.2% Met Criteria

12.8% of criteria were unmet. For further details please review the table at the end of this section.

Assessment Results

The organization has experienced staff and leaders committed to continuous quality improvement.

There is a visible quality board which demonstrates transparency and commitment to improvement. There are newly identified service-specific goals, which show a proactive approach to addressing issues. However, the Organization would benefit from a formal quality improvement framework and plan with specific objectives, timeframes, and evaluation.

The organization is slightly above the AHS average in Patient Experience survey results, which offers a foundation to build upon. The leadership team recognizes staff efforts and is working to instill a culture of appreciation and innovation.

The temporary nature of the only two leadership roles pose challenges to sustained progress and fosters a level of uncertainty in the organization.

To advance service excellence, the site is encouraged to consider the following:

Action stability in leadership roles and accountabilities; advance localized decision making with appropriate supports for rural health care settings.

Implement performance conversations/evaluations to acknowledge staff contributions. Use this opportunity with staff to set clear expectations on training, expected behavior and teamwork and the consequences of noncompliance. Access and receive the support and coaching needed from senior leadership to support the needed organizational culture change.

Develop clear objectives, measures (Key Performance Indicators) and timeframes for improvement in a quality improvement plan that is co-designed with internal and external stakeholders (including patients, residents, staff, physicians, and community partners).

Ensure accountability for monitoring staff credentials and competencies is clear.

While infusion pump orientation for new team members is documented, nearly all other training occurs on an ad-hoc basis, through peers and without documentation. Regular rural health education days, where comprehensive training would typically occur, have been infrequent, with only one session in the last two years. These sessions require staff to travel to Lethbridge. There is no evaluation or documentation of infusion pump competence beyond orientation. Suggestions to address this include implementing a structured training program for all staff, not just new team members, with documentation of completion. Explore alternatives to in-person rural health education days to ensure consistent training opportunities for all staff recognizing the need for 24/7 coverage at the facility. Establish a formal evaluation process for infusion pump competence beyond orientation to ensure ongoing proficiency and safety.

Table 5: Unmet Criteria for Service Excellence

Criteria Number	Criteria Text	Criteria Type
2.1.2	The team leadership ensures that the credentials, qualifications, and competencies of each staff member are verified, documented, and up-to-date.	HIGH
2.1.7	Infusion Pump Safety 2.1.7.2 Initial and re-training on the safe use of infusion pumps is provided to team members: • Who are new to the organization or temporary staff new to the service area • Who are returning after an extended leave • When a new type of infusion pump is introduced or when existing infusion pumps are upgraded • When evaluation of competence indicates that re-training is needed • When infusion pumps are used very infrequently, just-in-time training is provided 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. 2.1.7.5 The effectiveness of the approach is evaluated. Evaluation mechanisms may include: • Investigating patient safety incidents related to infusion pump use • Reviewing data from smart pumps • Monitoring evaluations of competence • Seeking feedback from clients, families, and team members 2.1.7.6 When evaluations of infusion pump safety indicate improvements are needed, training is improved or adjustments are made to infusion pumps.	ROP
2.1.10	The team leadership regularly evaluates and documents each staff member's performance in an objective, interactive, and constructive way.	HIGH

Criteria Number	Criteria Text	Criteria Type
2.1.12	The team leadership supports staff to follow up on issues and opportunities for growth identified through performance evaluations.	HIGH
4.3.3	The team identifies measurable objectives for its quality improvement initiatives including specific timeframes for their completion.	HIGH
4.3.4	The team identifies indicators to monitor progress for each quality improvement objective.	NORMAL
4.3.11	The team regularly evaluates quality improvement initiatives for feasibility, relevance, and usefulness.	NORMAL

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.

Emergency Department

Standard Rating: 97.4% Met Criteria

2.6% of criteria were unmet. For further details please review the table at the end of this section.

Assessment Results

Nurses in the emergency department have high levels of autonomy and work closely with one community physician to deliver care for 6,600 patients annually.

Patients and family members interviewed as part of this survey visit stated their care experience, staff professionalism and involvement in decision making was excellent. They also appreciated the quick triage and ability to receive exceptional care within their community.

While transitions of care are well documented in a standardized manner in Connect Care, there is an opportunity to formally assess their effectiveness, involving clients and families for input. This may inform potential improvements in patient and workforce safety.

Specific goals and objectives regarding wait times, emergency department length of stay (LOS), and clients leaving without being seen are not formalized or tracked. This highlights an opportunity for goal setting, monitoring, and benchmarking.

Table 6: Unmet Criteria for Emergency Department

Criteria Number	Criteria Text	Criteria Type
2.7.17	Information Transfer at Care Transitions 2.7.17.5 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
3.1.1	Specific goals and objectives regarding wait times, length of stay (LOS) in the emergency department, client diversion to other facilities, and number of clients who leave without being seen are established, with input from clients and families.	NORMAL
3.1.3	Data on wait times for services, the length of stay in the emergency department, and the number of clients who leave without being seen is tracked and benchmarked.	NORMAL

Inpatient Services

Standard Rating: 97.8% Met Criteria

2.2% of criteria were unmet. For further details please review the table at the end of this section.

Assessment Results

Annually, Bow Island Health Centre provides inpatient care for over 230 patients. However, during this survey visit, there were no acute care patients.

Multiple team members were able to consistently explain and demonstrate the processes used to provide care through chart reviews of previous clients that had been recently discharged. Staff are cross trained to work in multiple areas of the organization to support flow and surge activity.

Interpretation and translation is available and used as required. Proactive translation of materials to support the populations served (Mexican Mennonite community) may foster increased engagement and patient and family satisfaction. At present, this is only available for posters that reinforce the symptoms related to COVID and what to do.

Staff are consistently conducting falls assessment on all inpatients as part of admission and during a change in patient status. Implementing ‘falling stars’ signage in patient rooms and on respective doors would serve as a clear visual reminder to patients, families, and staff about the importance of falls prevention.

While Connect Care is routinely used to document patient care transitions, there is an opportunity to periodically evaluate these communications' effectiveness to inform potential patient and workforce safety improvements.

Establishing formal evaluation processes for falls prevention and pressure ulcers would ensure continuous enhancement of care quality and patient safety.

Table 7: Unmet Criteria for Inpatient Services

Criteria Number	Criteria Text	Criteria Type
3.3.8	Falls Prevention and Injury Reduction - Inpatient Services 3.3.8.3 The effectiveness of fall prevention and injury reduction precautions and education/information are evaluated, and results are used to make improvements when needed.	ROP

Criteria Number	Criteria Text	Criteria Type
3.3.9	Pressure Ulcer Prevention 3.3.9.5 The effectiveness of pressure ulcer prevention is evaluated, and results are used to make improvements when needed.	ROP

Long-Term Care Services

Standard Rating: 90.2% Met Criteria

9.8% of criteria were unmet. For further details please review the table at the end of this section.

Assessment Results

Bow Island Health Centre’s long-term care (LTC) setting prioritizes residents' needs and preferences, fostering a supportive and personalized environment. The environment is clean despite areas that are very crowded. The organization is encouraged to implement a 5S lean methodology to ensure a safe and uncluttered environment for residents, families, and staff.

Despite lean staffing and occasional understaffing, employees demonstrate a deep understanding of residents, actively inquiring about preferences (timing for activities of daily living, meals, clothing) and accommodating them.

Overall, communication is good. However, two notable areas for improvement were observed related to resident care. Firstly, the team is encouraged to communicate planned resident departures to appropriate members of the LTC staff in advance. During this site visit, a resident was discharged, and most staff were unaware that a near-term discharge had been planned. Secondly, LTC nursing care transitions are not documented in Connect Care creating a potential resident safety risk since communications on transitions is not standardized. AHS is encouraged to collaborate with LTC staff to co-design an effective and efficient process in Connect Care appropriate for the long-term care setting. While informal audits of transfer of accountability have occurred, the team is encouraged to formalize the process, frequency, and confirm who has accountability. Collaboration with staff in designing efficient processes within Connect Care ensures tailored solutions for the long-term care setting, fostering innovation that can be scaled regionally and provincially.

Fall risk assessment and suicide risk assessments are conducted on every patient. Staff are encouraged to implement and communicate the 'falling stars' signage in patient rooms and on respective doors to serve as a clear visual reminder to patients, families, and staff about the importance of falls prevention. There is a need to periodically evaluate falls prevention and education effectiveness, pressure ulcer prevention effectiveness and communication effectiveness (e.g. transitions of care).

Table 8: Unmet Criteria for Long-Term Care Services

Criteria Number	Criteria Text	Criteria Type
2.5.2	Fall Prevention and Injury Reduction - Long-Term Care Services 2.5.2.6 The effectiveness of fall prevention and injury reduction activities (e.g., risk assessment process and tools, protocols and procedures, documentation, education, and information) are evaluated, and results are used to make improvements when needed.	ROP

Criteria Number	Criteria Text	Criteria Type
2.5.4	Pressure Ulcer Prevention 2.5.4.5 The effectiveness of pressure ulcer prevention is evaluated, and results are used to make improvements when needed.	ROP
2.5.7	Information Transfer at Care Transitions 2.5.7.1 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 2.5.7.2 Documentation tools and communication strategies are used to standardize information transfer at care transitions. 2.5.7.4 Information shared at care transitions is documented. 2.5.7.5 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: 100.0% Met Criteria

0.0% of criteria were unmet.

Assessment Results

The organization is meeting expectations for an approved subset of criteria chosen to evaluate palliative care in rural hospitals. Patients and families expressed appreciation for the services provided.

Teams have access to specialized expertise and consultants through telephone and online support channels. However, onsite consultations for palliative care are rarely available, limiting opportunities for learning and mentoring. Training for staff on continuous ambulatory delivery device (CADD) pumps may enhance the care experience for patients and improve their quality of life.

Although multiple spaces are available for palliative care patients and their families, the current location is far removed from the nursing station, posing challenges for safe care delivery. The organization is strongly encouraged to review optimal placement, seeking input from community members, patients, and families. The Bow Island & District Health Foundation has committed to funding enhancements to the space, facilitating improvements in patient care and comfort.

Unmet Criteria for Palliative Care Services

There are no unmet criteria for this section.

Criteria for Follow-up

Criteria Identified for follow-up by the Accreditation Decision Committee

Follow-up Requirements		
Standard	Criterion	Due Date
Emergency and Disaster Management	3.4.10 - The organization maintains an accurate and up-to-date database of contact information for all staff, to be able to notify them in case of an emergency or disaster.	May 30, 2025
Emergency Department	2.7.17.5 - 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).	May 30, 2025
Inpatient Services	3.3.8.3 - The effectiveness of fall prevention and injury reduction precautions and education/information are evaluated, and results are used to make improvements when needed.	May 30, 2025
Inpatient Services	3.3.9.5 - The effectiveness of pressure ulcer prevention is evaluated, and results are used to make improvements when needed.	May 30, 2025
Long-Term Care Services	2.5.2.6 - The effectiveness of fall prevention and injury reduction activities (e.g., risk assessment process and tools, protocols and procedures, documentation, education, and information) are evaluated, and results are used to make improvements when needed.	May 30, 2025
Long-Term Care Services	2.5.4.5 - The effectiveness of pressure ulcer prevention is evaluated, and results are used to make improvements when needed.	May 30, 2025
Long-Term Care Services	2.5.7.1 -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.	May 30, 2025
Long-Term Care Services	2.5.7.2 - Documentation tools and communication strategies are used to standardize information transfer at care transitions.	May 30, 2025
Long-Term Care Services	2.5.7.4 - Information shared at care transitions is documented.	May 30, 2025

Follow-up Requirements		
Standard	Criterion	Due Date
Long-Term Care Services	2.5.7.5 - 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)	May 30, 2025
Medication Management	5.1.7 - Separate storage in client service areas and in the pharmacy is used for look-alike medications, sound-alike medications, different concentrations of the same medication, and high-alert medications.	May 30, 2025
Medication Management	7.2.2 - Appropriate ventilation, temperature, and lighting are maintained in the medication preparation areas.	May 30, 2025
Service Excellence	2.1.2 - The team leadership ensures that the credentials, qualifications, and competencies of each staff member are verified, documented, and up-to-date.	May 30, 2025
Service Excellence	2.1.7.2 - Initial and re-training on the safe use of infusion pumps is provided to team members: • Who are new to the organization or temporary staff new to the service area • Who are returning after an extended leave • When a new type of infusion pump is introduced or when existing infusion pumps are upgraded • When evaluation of competence indicates that re-training is needed • When infusion pumps are used very infrequently, just-in-time training is provided	May 30, 2025
Service Excellence	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.	May 30, 2025
Service Excellence	2.1.7.5 - The effectiveness of the approach is evaluated. Evaluation mechanisms may include: • Investigating patient safety incidents related to infusion pump use • Reviewing data from smart pumps • Monitoring evaluations of competence • Seeking feedback from clients, families, and team members	May 30, 2025

Follow-up Requirements		
Standard	Criterion	Due Date
Service Excellence	2.1.7.6 - When evaluations of infusion pump safety indicate improvements are needed, training is improved or adjustments are made to infusion pumps.	May 30, 2025