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Accreditation Report

Qmentum Global™ Program

Fort Saskatchewan Community Hospital

Alberta Health Services

Draft 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

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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.

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Surveyor Overview of Team Observations

The Fort Saskatchewan Community Hospital opened in 2012 and provides inpatient and outpatient services to about 27,000 residents. At Fort Saskatchewan Community Hospital, there is a multi-disciplinary team working collaboratively to provide patient-focused, quality health care that is accessible to their community in a compassionate and respectful way. The leadership team is “small but mighty” and work collaboratively on improving delivery of safe, quality care by ensuring staff have the resources and education they need. The facility is clean, bright, and well maintained.

Quality initiatives are abundant, and the team has developed quality boards to display and share metrics. The team uses data to help drive improvements and decision making. The teams are encouraged to develop formal processes to partner with patient and family advisors for input into quality improvement initiatives and inform decision making at the unit level.

Patients receiving care here reported a high level of trust and satisfaction with the care they received. Patients reported a shared sentiment in the community for confidence in the care they would receive when coming to Fort Saskatchewan Community Hospital.

Key Opportunities and Areas of Excellence

Areas of Excellence:

- Commitment to education for staff. A simulation lab on site provides an opportunity for more realistic education and patient care scenarios.
- Availability of data to enable data-driven decision making.
- Collaborative leadership team and engaged staff.
- Patients have great trust in Fort Saskatchewan Community Hospital and applaud the caring staff and environment.

Key Opportunities:

- Inclusion of community patients and their family members as patient and family advisors
- Consider methods for reducing alternate level of care (ALC) occupancy; this will also improve patient flow and access to inpatient beds.
- Address the health human resources to ensure the obstetrical program's sustainability and minimize bypasses to other facilities.
- Address the required organizational practice (ROP) for Medication Management (specifically antimicrobial stewardship).

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Program Overview

The Qmentum Global^{TM} 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^{TM} 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^{TM} 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.

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Accreditation Decision

Alberta Health Services' accreditation decision continues to be:

Accredited

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

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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%
Client Identification	Emergency Department	1 / 1	100.0%
	Inpatient Services	1 / 1	100.0%
	Obstetrics Services	1 / 1	100.0%
	Perioperative Services and Invasive Procedures	1 / 1	100.0%
Information Transfer at Care Transitions	Emergency Department	5 / 5	100.0%
	Inpatient Services	5 / 5	100.0%
	Obstetrics Services	5 / 5	100.0%
	Perioperative Services and Invasive Procedures	5 / 5	100.0%
Hand-hygiene Education and Training	Infection Prevention and Control	1 / 1	100.0%
Hand-hygiene Compliance	Infection Prevention and Control	3 / 3	100.0%

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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%
	Obstetrics Services	4 / 4	100.0%
	Perioperative Services and Invasive Procedures	4 / 4	100.0%
Falls Prevention and Injury Reduction - Inpatient Services	Inpatient Services	3 / 3	100.0%
	Obstetrics Services	3 / 3	100.0%
	Perioperative Services and Invasive Procedures	3 / 3	100.0%
Pressure Ulcer Prevention	Inpatient Services	5 / 5	100.0%
	Perioperative Services and Invasive Procedures	5 / 5	100.0%
Venous Thromboembolism (VTE) Prophylaxis	Inpatient Services	5 / 5	100.0%
	Perioperative Services and Invasive Procedures	4 / 4	100.0%
Antimicrobial Stewardship	Medication Management	3 / 5	60.0%
High-alert Medications	Medication Management	8 / 8	100.0%
Heparin Safety	Medication Management	4 / 4	100.0%

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Table 1: Summary of the Organization's ROPs

ROP Name	Standard(s)	# TFC Rating Met	% TFC Met
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%
Safe Surgery Checklist	Obstetrics Services	5 / 5	100.0%
	Perioperative Services and Invasive Procedures	5 / 5	100.0%
Infusion Pump Safety	Service Excellence	6 / 6	100.0%

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Assessment Results by Standard

Core Standards

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

Emergency and Disaster Management

Standard Rating: 100.0% Met Criteria

0.0% of criteria were unmet.

Assessment Results

The AHS Emergency Preparedness and All Hazard Plan is in place at Fort Saskatchewan Community Hospital and the organization establishes and maintains a holistic culture of emergency and disaster preparedness that integrates emergency and disaster planning throughout its operations in alignment with AHS guidelines. Plans are updated regularly to improve emergency response as the situations and environment changes. There is an effort to simplify the information needed to respond to situations effectively for some of the codes. When codes are updated or changed the team has a process for notifying all stakeholders internally and externally to ensure everyone is aware. Plans are placed in yellow binders on the individual units for reference and are kept up to date as changes occur.

As part of its planning process, the organization consults with leaders and governing bodies in the community to determine whether community emergency plans have been developed, and how the organization may integrate its emergency and disaster plan with the community's plans. The team has strong relationships with Emergency Medical Services (EMS), police, corrections facility, and fire departments. The team has partnered with corrections facilities that are nearby because they may have offenders receiving care in the organization. Plans were developed to address issues to improve communication when inmates are transferred to the organization to alert security staff and team members.

The Emergency Preparedness Committee meets bi-monthly and has a mandate to review all code policies and procedures to ensure they are applicable to the site and aligned with the province. When there has been an update, the changes are reviewed with Occupational Health and Safety for site approval changes. The team has a mechanism in place to debrief following a code to understand any learnings and communicate to all stakeholders any improvement opportunities identified.

There is education for each of the codes identified within the organization for staff during onboarding. Provincially there is a "Be Ready Program" that is reviewed with staff. The team participates in mock code blue, code red and code yellow exercises to assist staff with response in emergency situations. The team is encouraged to continue this work to include complex code responses and involve community stakeholders. Consider a code orange or other codes that would require external community partner support and bring them on site for a tabletop or staged code response.

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Unmet Criteria for Emergency and Disaster Management

There are no unmet criteria for this section.

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Infection Prevention and Control

Standard Rating: 100.0% Met Criteria

0.0% of criteria were unmet.

Assessment Results

One Infection Control Professional (ICP) provides support to multiple locations, including Fort Saskatchewan Community Hospital, and is on-site one day per week, or as required. The individual has good relationships with Environmental Services (ES), medical device reprocessing, unit staff, and leadership. They are also involved in meetings related to upcoming expansion plans for the perioperative spaces. The ICP is present at monthly quality meetings and is consulted as needed by clinical and support teams. Fort Saskatchewan Community Hospital follows AHS policies and procedures. Additionally, based on the patient population, the organization adapts policies and procedures with other suburban facilities in the Edmonton zone.

The physical environment is relatively new, spacious and appears very clean in all areas. There are some storage challenges, particularly in the perioperative area, which will hopefully be addressed in future plans. The team is encouraged to review all areas with an eye for improving access to hand sanitizer stations.

Hand-hygiene (HH) auditing and reporting are performed by trained auditors; results are available by zone and by hospital/unit. HH rates are shared and are also posted prominently on quality boards, along with healthcare associated infections (HAI) rates on the inpatient unit.

Environmental auditing is conducted by ES using the Westech Audit system at all rural sites and feedback provided to ES staff for improvement opportunities when needed.

Unmet Criteria for Infection Prevention and Control

There are no unmet criteria for this section.

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Leadership

Standard Rating: 100.0% Met Criteria

0.0% of criteria were unmet.

Assessment Results

The leadership team at Fort Saskatchewan Community Hospital is highly engaged and enthusiastic. They describe themselves as “small but mighty”, working collaboratively to ensure smooth operations of the organization. There is a clear focus on quality and safety through ensuring staff have the tools and education to be able to provide care competently and confidently. Site priorities are aligned with AHS strategic and operational priorities. There is evidence of strong and productive partnerships with key community partners and agencies to support achieving organizational priorities and safe transitions for patients and family members.

The organization reviews, investigates, and resolves complaints in a timely and transparent manner, and analyzes complaints to identify areas for improvement. Complaints are directed to the patient relations advisor who reviews the complaint prior to passing on the concerns to the site director and leadership involved in the complaint. The team will investigate the complaint to understand where there are opportunities to action improvements. The patient relations advisor connects with the patient to close the communication loop with improvements or findings from the investigation.

The leadership team uses data, accessed via Tableau, and Connect Care to review progress on organizational initiatives and process improvement. Data is reviewed at operational and quality meetings and shared with staff via email/newsletters, staff meetings and is displayed on quality boards for discussion. There is a high level of using data to make decisions for program operations and planning.

The team regularly undertakes safety risk assessments, shares the results with staff, and ensures improvement plans are developed to address root causes. Occupational health and safety audits are performed on the units monthly to look for any potential safety risks with action plans put in place to correct any identified issues. Yearly, an organization wide audit is completed.

The organization maintains, upgrades, and replaces medical devices, equipment, and technology as needed, to ensure they are safe. Facility Maintenance and Engineering has a preventive maintenance process for facility equipment. Biomedical Engineering completes monitoring and maintenance with clinical equipment.

Unmet Criteria for Leadership

There are no unmet criteria for this section.

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Medication Management

Standard Rating: 96.0% Met Criteria

4.0% of criteria were unmet. For further details please review the table at the end of this section.

Assessment Results

The pharmacy department at Fort Saskatchewan Community Hospital has oversight for medication delivery and management at the site and has responsibility for providing medication for two other sites within the Edmonton zone three (3) times per week. There is an engaged group of professionals providing this service. Pharmacists are an integral part of the multidisciplinary team on the units and are seen as a valuable resource for physicians, nursing, and patients on the units. Their clinical activities include preventing and resolving issues with medication therapy, providing education about medications, actively participating in interprofessional care rounds, and facilitating seamless care with transitions, including medication reconciliation. The team uses the National Association of Pharmacy Regulatory Authorities (NAPRA) standards to guide practice.

AHS is responsible for developing governance documents such as corporate bylaws, principles, policies, and procedures related to medication management. The provincial Medication Quality and Safety Team (MQST) is a team of dedicated pharmacists, nurses, and pharmacy technicians that serves as a valuable resource for health care professionals. Their expertise lies in identifying and coordinating system-based approaches to improving medication safety to mitigate patient harm.

There are regular reviews of adverse events and trends conducted by the Provincial Patient Safety team to identify, promote, educate, and recommend improvements to assure safe medication processes are in place. Safety incidents are reported using the safety event reporting system and the reviews are rigorous, generating recommendations for improvement and risk mitigation. Recently, an incident reporting trend summary identified an increase in error reporting with HYDROmorphone. There were risk mitigation strategies identified and shared with staff, as well as a reminder of policies associated with safe medication administration. There was an emphasis on barcode scanning and scanning rates were shared to promote increasing compliance with scanning as an important safety strategy.

Various metrics are monitored and/or audited at regular intervals, including barcode scanning rates, night cart dispensing practice, overrides in the automated dispensing cabinet, medication usage and ward stock, to name a few. Hot spots are identified, and the pharmacy team can follow up to support teams for process improvement. It is important that audits and information is shared regularly with the team and leadership to promote compliance and improvements with key metrics such as barcode scanning to improve the safe delivery of medication.

AHS has a policy/process for allowing multi-dose vials to be permitted in clinical areas, however the organization is encouraged to explore options where multi-dose vials can be removed and replaced with unit dose specific medications.

The team recognizes the need for a policy for when and how to override the computerized prescriber order entry (CPOE) alerts to improve this process. Relevant stakeholders are in the early stages of determining suitable content and options for the development of a CPOE policy for AHS.

There is an antimicrobial stewardship program in place to support coordinated interventions designed to improve and measure the appropriate use of antimicrobials including selection, dosing, duration of therapy and route of administration. This is just the foundation for this work, however there is an

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opportunity to improve auditing and feedback mechanisms to improve this program thereby making a more robust wholesome program.

Required organizational practices (ROPs) are embedded in practice, including antimicrobial stewardship principals, an up-to-date “Do Not Use” abbreviations list, high-alert medications, concentrated electrolytes, narcotics safety, heparin safety, and VTE prophylaxis. Audits are completed at expected frequencies and continuous learning supports improvement. The electronic health record has care pathways with standard order sets to help guide practice and physicians use CPOE to prevent errors at the medication ordering and dispensing stages.

The pharmacy is well organized and meets all regulations applicable to the space. The team has identified that there is not a need for sterile compounding due to low usage and the equipment used for this will be removed. The spaces on the units are well organized and functional. Visual inspection of several medication rooms revealed well organized, clean and clutter free spaces having appropriate access controls and stable environmental conditions. Workstations on wheels support the nursing team with administration of medications and nurses were fluent in articulating and demonstrating safe medication administration practices.

Table 2: Unmet Criteria for Medication Management

Criteria Number	Criteria Text	Criteria Type
1.2.3	Antimicrobial Stewardship 1.2.3.4 The program includes interventions to optimize antimicrobial use, such as audit and feedback, a formulary of targeted antimicrobials and approved indications, education, antimicrobial order forms, guidelines and clinical pathways for antimicrobial utilization, strategies for streamlining or de-escalation of therapy, dose optimization, and parenteral to oral conversion of antimicrobials (where appropriate). 1.2.3.5 The program is evaluated on an ongoing basis and results are shared with stakeholders in the organization.	ROP
3.3.2	A policy is developed and implemented on when and how to override the CPOE system alerts.	HIGH
5.1.9	Multi-dose vials are used only for a single client in client service areas.	HIGH
9.1.5	Automated dispensing cabinets in client service areas interface with the medication order entry management system.	NORMAL

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Service Excellence

Standard Rating: 98.8% Met Criteria

1.2% of criteria were unmet. For further details please review the table at the end of this section.

Assessment Results

The leadership team at Fort Saskatchewan Community Hospital is highly collaborative and committed to providing high quality care. The team is aware of the patient flow and capacity pressures and the typically high proportion of ALC clients on the inpatient unit. This creates significant flow challenges, and the team is encouraged to continue to explore solutions. The addition of four flex beds for the ED (within the Diagnostic Imaging department) has helped to alleviate pressures in the ED; ongoing funding for these beds should be considered.

Most nursing staff positions at the organization are filled. Many new staff have been recruited recently; 70% of nursing positions in the ED are held by new recruits. Staff are overall happy to work here and feel a part of the team, feel well supported, and work to their full scope. Licensed practical nurses feel fully integrated into their teams. The leadership team is aware of the need to provide formal performance evaluations on a regular basis.

Fort Saskatchewan Community Hospital works with the community to improve the health of the community. A recent partnership through the Fort Saskatchewan Policing Committee will see Fort Saskatchewan Community Hospital working with community partners (RCMP, Families First, the city and ministerial groups) to provide services for unhoused and acute mental health patients. The organization has also partnered with the Primary Care Network (PCN) to identify primary care providers for discharged inpatients in need and hopes to expand this to other areas (e.g., emergency department) in the future. Formal engagement of patient and family advisors who could help inform care and decision making is currently being discussed.

Each unit/program has a quality committee. The organization has a leadership team meeting every two months at which quality issues are discussed. Quality improvement initiatives could be formalized, and results shared more broadly.

Table 3: Unmet Criteria for Service Excellence

Criteria Number	Criteria Text	Criteria Type
2.1.10	The team leadership regularly evaluates and documents each staff member's performance in an objective, interactive, and constructive way.	HIGH

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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: 99.1% Met Criteria

0.9% of criteria were unmet. For further details please review the table at the end of this section.

Assessment Results

The Fort Saskatchewan Community Hospital ED is fortunate to be part of a newly built facility. The area is bright, clean, and relatively uncluttered. All rooms are private; there is an electronically monitored airborne infection isolation room as well as a well-placed seclusion room. Recent changes in placement of monitored beds to congregate these in one area has facilitated workflow and nursing assignments. Changes to the triage/registration area are encouraged to improve patient privacy. A review of alcohol-based hand rub dispenser placement should be conducted with Infection Prevention and Control to ensure point of care access for all rooms.

Approximately 70% of nursing staff are new hires within the past two years. The manager is relatively new to the role however, over time has been able to coach the team and improve team dynamics as well as workplace culture to the point that all staff shared they felt well supported and happy at work. There has been considerable effort with improving orientation and buddy shifts, offering additional orientation and education sessions, developing an essential skills list, and ensuring training to these skills, and the 0.5 FTE educator is a valuable resource to the team.

The team takes pride in its ability to provide quality care. The availability of respiratory therapist support 24-hours per day, non-invasive ventilation and a ventilator would improve care for critically ill patients awaiting transfer. Capacity issues are frequently limited by the numbers of ALC patients in the inpatient area, and admitted patients to the ED. There is a telemedicine link to the stroke team and pediatric ICU in Edmonton which provides additional support to staff. Patients were highly satisfied with the care they were receiving.

Selected outcomes are measured and shared with staff largely by email. Changes based on family feedback, mainly through the Reporting and Learning System (RLS) and Patient Relations, are incorporated into practice when possible. There is no dedicated patient or family advisor for the ED; their input could help inform further improvements in the delivery of care.

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Table 4: Unmet Criteria for Emergency Department

Criteria Number	Criteria Text	Criteria Type
2.7.3	Client privacy is respected during registration.	NORMAL

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Inpatient Services

Standard Rating: 100.0% Met Criteria

0.0% of criteria were unmet.

Assessment Results

The inpatient unit has 38 beds with a mixture of 28 medical beds, five surgical beds, three labour delivery recovery beds, one flex bed and an overflow bed. This mix of services provides a challenge for service delivery for the staff working on the unit as they need to be competent across the program. Focused education is provided in each of the areas as staff become confident in the area which can create challenges for recruitment and retention. There is a clinical nurse educator (CNE) and an assistant head nurse that help guide nursing practice on the unit. Providing education across the program can be challenging given the wide variety of skills needed to work within the program. The team is encouraged to continue to look at innovative ways to deliver education while ensuring there is the ability to consistently deliver the necessary education and monitor progress of staff from novice to expert to support safe patient care.

The interdisciplinary team works collaboratively to provide care working closely with patients and families. There are multidisciplinary rounds daily to discuss patient care to determine the best possible treatment plan to help coordinate care and discharge planning. Bottle necks in patient flow occur as ALC patients waiting for a bed continues to remain consistently high. The team is encouraged to continue working towards reducing the average length of stay and to continue to creatively look at ways externally and internally to improve patient flow.

The team has adopted CoACT Collaborative Care, a model of care that facilitates interprofessional teams working together in partnership with patients and families to achieve optimal health outcomes. The team has implemented bedside shift report to improve communication at transitions in care between shifts to improve delivery of safe patient care. There are white boards in patient rooms to aid as a communication tool with patients and families and were consistently filled out. Comfort rounds are also in place to promote a proactive approach to direct patient care needs and to support communication and improved patient satisfaction and outcomes.

There is a quality board posted on the unit for staff and patients to view key metrics important to improving quality, safety, and patient outcomes. Data posted on the board is shared with the team during huddles, at staff meetings, by email and in newsletters sent to the team. There was data posted on hand-hygiene, antibiotic resistance (organization rate) and patient safety reports (by type and volume).
The site is encouraged to ensure that staff are engaged in understanding of the metrics and how they impact care delivery and patient outcomes given that the team is a valuable resource to engage in problem solving to improve metrics. Metrics/indicators could align with organizational and corporate goals and objectives.

The team has recognized the importance of implementing pressure ulcer prevention strategies. The team has a standardized approach to education on pressure ulcer prevention with a standardized approach to risk assessments. The team conducts the Pressure Ulcer/Injury Prevalence Audit annually to assess the number and severity of pressure ulcers occurring on the unit. This validated process provides a summary report to help determine baseline prevalence and measure intervention outcomes to help drive improvement in patient safety and reduce avoidable injuries.

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The team has a people-centered care approach through ongoing work to treat their patients with dignity and respect and involving them in all decisions about their health. This is demonstrated through their family conferences to help guide planning and care for patients that are consistent with the patient's goals. The team engages patient and families at the point of care to understand how they can inform care delivery on the unit as well as through paper-based surveys and leader rounds to better understand experiences. There is opportunity to enhance engagement of patients in the planning and delivery of care. The manager has plans to recruit a family advisor to support the team on committees and change initiatives.

Unmet Criteria for Inpatient Services

There are no unmet criteria for this section.

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Obstetrics Services

Standard Rating: 100.0% Met Criteria

0.0% of criteria were unmet.

Assessment Results

The obstetrical program is within the inpatient program with approximately 250-300 deliveries annually. The team recently conducted a review of the services they offer to understand the challenges and needs, to support increasing this service to improve care for obstetrical and gynecological patients. Identified was the need for Human Resources to maintain the ongoing support for this program by looking at innovative ways to provide on call coverage for the obstetrician group of two. There is an identified need and desire to assist the rest of the zone to deliver low risk obstetrical care for women in the community. There are three labour, delivery, and recovery beds available for patients to deliver in Fort Saskatchewan Community Hospital with gynecology beds available within the mix on the unit. The team consists of Obstetricians, Midwives and Nursing trained to provide this care. They are linked through RAAPID (Referral, Access, Advice, Placement, Information & Destination) North to access consultation and advice and/or transfer of patients to a higher level of care facility.

There are challenges with maintaining access to this program due to the human and space resources, at times this has led to closures, causing patients to travel outside of the community for care. The team is encouraged to continue to look for ways to avoid closures if this is to be a sustainable program.

The nursing staff are trained to work across the inpatient, surgical and obstetrics service. This can be a challenge to ensure staff are competent and confident in all areas given the low number of births at the site. The team is provided with the necessary education to provide the skills and knowledge needed to work in this complex environment. Departmental leadership monitors staffing levels and skill levels regularly to ensure there is an appropriate skill mix of novice and experienced staff to ensure an appropriate mix of skill and knowledge. There has been an investment in education through managing obstetrical risk efficiently (MoreOB) and acute care of at-risk newborns (ACoRN).

The team has embraced the MoreOB program to help address potential risk and patient safety issues through standardized education. This continuous patient safety program is used to build confidence and competency to improve the quality of care delivered. The CNE plays an important role in ensuring the team has the necessary skills to care for the patients including fetal health surveillance, neonatal resuscitation, and emergency responses. The CNE helps to elevate practice through mock codes and simulation exercises in a simulation lab to keep staff knowledge current. To address an identified need the team created a postpartum hemorrhage cart and education to standardize equipment, supplies, and response to ensure delivery of safe care during an emergency. The team is encouraged to continue with the MoreOB program to further create a culture of patient safety and promotion of best practices. Consider debriefing every delivery to continuously learn and transfer knowledge to new staff. ACoRN training for staff focuses on a systematic approach to the identification and management of babies who are at risk and/or become unwell in the first few hours or days after birth. As well, 12 staff have just completed the Maternal Newborn Nursing Orientation with the Edmonton zone.

The labour rooms are spacious and well designed to provide everything needed to support mother and newborn during delivery and initially at birth. After delivery mothers are moved to a postpartum room and provided support for 24-hour rooming in private, comfortable rooms where the dad can also stay overnight.

Since the last report there was the introduction of an electronic health record that helps to standardize assessments. There are clinical pathways that guide practice, falls risk assessment, medication reconciliation, standardized triage assessment (Obstetrical Triage Assessment Scale [OTAS]) and

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handover tools built into the record. Both Modified Early Warning Scores (MEWS) for adults and Pediatric Early Warning Scores (PEWS) for pediatric are built into the documentation system to help identify patients that are at increased risk of deterioration to help guide practice and improve patient outcomes.

The leadership on the unit has oversight for all the services provided on the unit and has a large span of control. Leadership regularly rounds on staff and patients to understand challenges and celebrate successes. There is not a formal process for completing performance appraisals currently, and leadership uses the rounding to monitor and support staff. As well there are conversations with patients occurring to understand how to best meet the patient's needs. There is an Inpatient/Woman's Team that meets bi-monthly to review operations and quality on the unit. It is a multidisciplinary team that would benefit from having a patient advisor as part of the team. The unit leadership has plans to recruit into this position.

Unmet Criteria for Obstetrics Services

There are no unmet criteria for this section.

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Perioperative Services and Invasive Procedures

Standard Rating: 100.0% Met Criteria

0.0% of criteria were unmet.

Assessment Results

The surgical program at Fort Saskatchewan Community Hospital is in the preliminary stages of planning an expansion, in anticipation of accommodating increased surgical volumes. Present space is usually adequate to accommodate most planned procedures but can become quite busy with occasional short delays in procedures. Most surgeries are day surgeries, but there are planned post-operative admissions and selected emergency surgeries (including those after-hours) are also performed here. High volumes of endoscopies are also performed. The team is congratulated for receiving the 2023 Canadian Association of Gastroenterology's Quality Endoscopy Recognition Award.

The medication room door in day surgery was not secured, but the area has relatively restricted access; medications are secured within the automated dispensing cabinet. Dishes (thermal drink cups) were noted in the medication room in the day surgery area. The site is encouraged to explore alternative storage options.

The team is a collaborative, cohesive group; relationships among nursing, physicians and ancillary staff are excellent, with open communication and respect among team members. They describe the organization as a great place to work – "we love it here". Nursing staff are cross-trained to cover the different areas of this program, work to scope and feel well supported by their educator and their leaders, who are accessible and approachable.

Patient and family feedback from RLS incidents and Patient Relations is used to improve service. The perioperative manager rounds regularly on 2-3 patients daily to obtain additional feedback. A multidisciplinary Perioperative Program Management (Quality) Team meets monthly and addresses safety and quality issues. While there are many quality improvement initiatives implemented (e.g. recent adoption of a closure bundle for abdominal surgeries), successes are not widely shared or posted on the quality board.

Patients were very satisfied with their care, noting the efficiency of the process on day of surgery and the kindness of staff. Communication was clear, and staff were responsive to questions and returned phone calls promptly.

Unmet Criteria for Perioperative Services and Invasive Procedures

There are no unmet criteria for this section.

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Reprocessing of Reusable Medical Devices

Standard Rating: 100.0% Met Criteria

0.0% of criteria were unmet.

Assessment Results

Medical device reprocessing is located within the perioperative area. The area routinely undergoes safety audits to evaluate any improvements required for staff wellness (e.g. stress mats, hearing loss) and occupational risks.

All staff are certified either by Canadian Standards Association (CSA) or Healthcare Sterile Processing Association (HSPA). Staff education and competencies are documented. Staff feel well supported in their roles; there is an educator who works with multiple suburban hospitals. Educational opportunities are encouraged and supported. Staff education and competencies are documented. Performance evaluations have been completed within the past year or so. Changes in reprocessing procedures and equipment are well communicated. Quick access resource materials have been developed for all surgical equipment. Workload is appropriate in the absence of being short staffed (e.g. sick calls). Staff are on-call and are called in for after-hours cases to ensure that equipment cleaning and disinfection (including endoscopes) are not delayed.

The Medical Device Reprocessing Department (MDRD) does not have computer-based system for tracking equipment, but the paper-based system allows for equipment recalls if necessary. New washer disinfectors were just installed this year. There are relatively new automated endoscope re-processors which allow automated tracking of endoscope use.

The endoscope storage cabinet door is currently broken and has been replaced by a heavy-duty plastic sheet; a request has been made to have this repaired. This will likely be replaced in the near future.

Feedback is largely direct from the operating rooms and through RLS reports. These are reviewed with the team and changes made as needed.

Unmet Criteria for Reprocessing of Reusable Medical Devices

There are no unmet criteria for this section.

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Criteria for Follow-up

Criteria Identified for follow-up by the Accreditation Decision Committee

Follow-up Requirements		
Standard	Criterion	Due Date
Medication Management	1.2.3.4 - The program includes interventions to optimize antimicrobial use, such as audit and feedback, a formulary of targeted antimicrobials and approved indications, education, antimicrobial order forms, guidelines and clinical pathways for antimicrobial utilization, strategies for streamlining or de-escalation of therapy, dose optimization, and parenteral to oral conversion of antimicrobials (where appropriate).	May 30, 2025
Medication Management	1.2.3.5 - The program is evaluated on an ongoing basis and results are shared with stakeholders in the organization.	May 30, 2025

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