September 2020

# Fort Macleod Health Centre

## South Zone

## Alberta Health Services

ACCREDITATION AGRÉMENT CANADA

# Table of Contents

# About this Accreditation Report

AHS (referred to in this report as "the organization") is participating in Accreditation Canada's Qmentum accreditation program. As part of this ongoing process of quality improvement, an on-site survey was conducted September 27, 2020 - October 02, 2020. Information from the survey, as well as other data obtained from the organization, were used to produce this Accreditation Report.

Accreditation results are based on information provided by the organization. Accreditation Canada relies on the accuracy of this information to plan and conduct the on-site survey and produce the Accreditation Report.

## About the AHS Accreditation Cycle

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

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

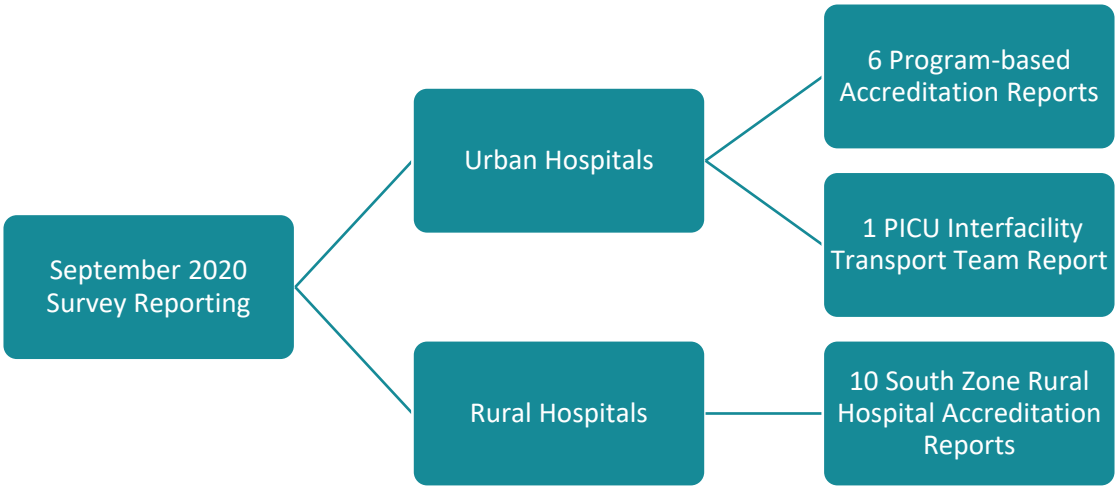
Focused assessment for the foundational standards of Governance, Leadership, Infection Prevention, and Control, Medication Management and Reprocessing of Reusable Medical Devices occurred in the first year of the cycle (Spring and Fall surveys for 2019).

During the cycle (2019-2022), site-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 Medication Management, Infection Prevention and Control, Reprocessing of Reusable Medical Devices and Service Excellence. Program-based assessments are applied to large urban hospitals where clinical services are assessed against the respective clinical service standard along with the foundational standards. This integrated assessment approach for both small rural hospitals and large urban hospitals provides a more comprehensive assessment.

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

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

The accreditation reports for the 2020 Survey are organized as follows:




## South Zone Rural Hospital Assessment – Sites Visited

- Bassano Health Centre
- Big Country Hospital
- Bow Island Health Centre
- Brooks Health Centre
- Cardston Health Centre
- Crowsnest Pass Health Centre
- Fort Macleod Health Centre
- Pincher Creek Health Centre
- Raymond Health Centre
- Taber Health Centre

## Confidentiality

This report is confidential and is provided by Accreditation Canada to the organization only.

Accreditation Canada does not release the report to any other parties.

In the interests of transparency and accountability, Accreditation Canada encourages the organization to disseminate its Accreditation Report to staff, board members, clients, the community, and other stakeholders.

Any alteration of this Accreditation Report compromises the integrity of the accreditation process and is strictly prohibited.

# Executive Summary

## Surveyor Observations

All leaders and staff encountered during the onsite survey visit demonstrated commitment to meeting the needs of their patients and families and expressed a passion for their work and for being a part of the Fort Macleod Health Centre.

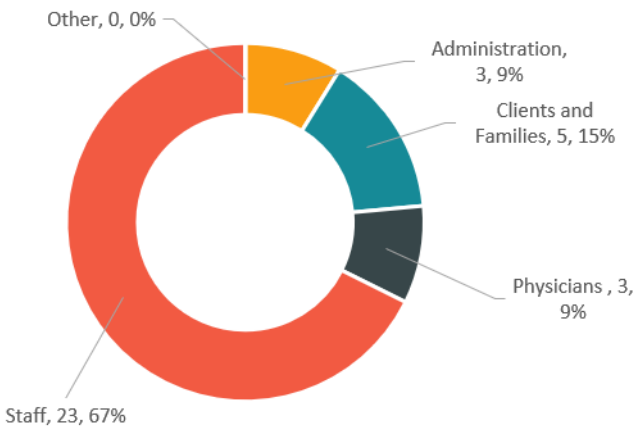
The patient/clinician interactions observed demonstrated compassion and respect and the patients and/or families interviewed reported being engaged and active participants in decision-making regarding their care, demonstrating a commitment by staff to provide compassionate people-centred care. Patients described staff as caring and expressed satisfaction with the services they received.

Although staff expressed a desire to evaluate and continually improve the effectiveness of interventions for each patient and to improve the effectiveness of the services offered by the Fort Macleod Health Centre, a concern was expressed about staffing shortages that preclude the ability to focus beyond day-to-day routines and pressures. This has been aggravated by the additional requirements for COVID-19 such as screening, cleaning, disinfecting and visitor restrictions.

## Survey Methodology

The Accreditation Canada Surveyors spent two days at Fort Macleod Health Centre.

To conduct their assessment, the survey team gathered information from the following groups[1]




[1] "Other" interviewees refer to individuals such as students or volunteers

## Key Opportunities and Areas of Excellence

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

### Key Opportunities

1. Access to dedicated hand-washing sinks in inpatient areas; Alcohol-Based Hand Rub (ABHR) at point of care and ensure dispensers are filled
2. Hand hygiene compliance auditing
3. Medication storage of high-alert medication
4. Emergency preparedness and regular emergency response testing

### Areas of Excellence

1. Client and family-centred care
2. Teamwork
3. Commitment to ongoing staff education
4. High completion rates for Indigenous Awareness and Sensitivity Certificate Program

# Results at a Glance

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

## Compliance Overall[1]

| Percentage of criteria | | |
|---|---|---|
| Attested<br>93% met | On-Site<br>92% met | Overall<br>92% met |
| **Number of attested criteria** | | |
| Attested<br>81 Criteria | Audited<br>14 Criteria | |

### Attestation:

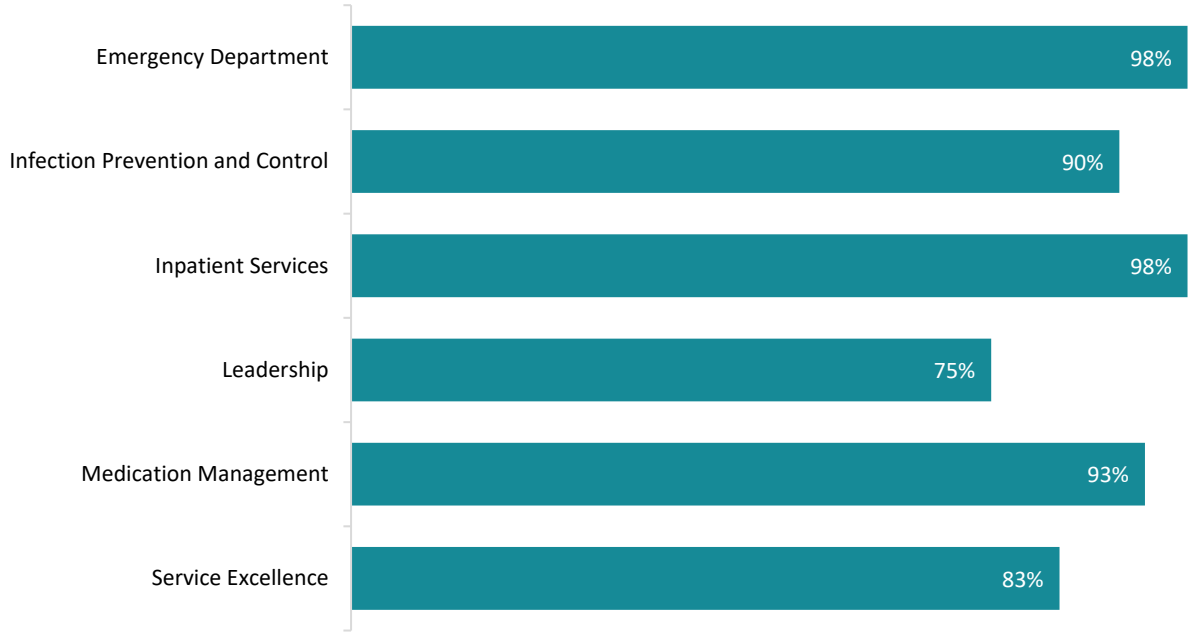
A form of conformity assessment that requires organizations to conduct a self-assessment on specified criteria and provide a declaration that the assessment is accurate to the best of the organization's knowledge. This data is used to inform an accreditation award.

### On-site Assessment:

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

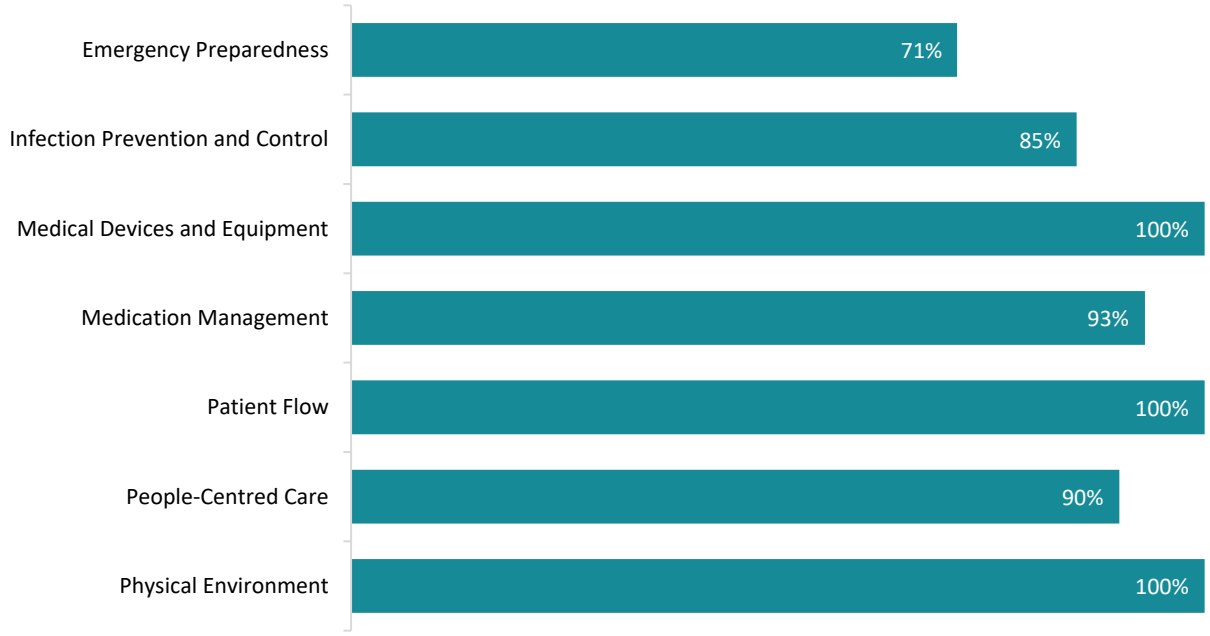
[1] In calculating percentage compliance rates throughout this report, criteria rated as 'N/A' and criteria 'NOT RATED' were excluded. Data at the 'Tests for Compliance' level were also excluded from percentage compliance calculations. Compliance with ROPs and their associated 'Tests for Compliance'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

## Compliance by Standard




| STANDARD | MET | UNMET | N/A | NOT RATED |
|---|---|---|---|---|
| Emergency Department | 92 | 2 | 9 | 0 |
| Infection Prevention and Control | 43 | 5 | 16 | 0 |
| Inpatient Services | 64 | 1 | 4 | 0 |
| Leadership | 6 | 2 | 1 | 0 |
| Medication Management | 71 | 5 | 11 | 0 |
| Service Excellence | 63 | 13 | 0 | 0 |
| Total | 339 | 28 | 41 | 0 |

## Compliance By System Level Priority Process




| PRIORITY PROCESS | MET | UNMET | N/A | NOT RATED |
|---|---|---|---|---|
| Emergency Preparedness | 5 | 2 | 0 | 0 |
| Infection Prevention and Control | 29 | 5 | 0 | 0 |
| Medical Devices and Equipment | 11 | 0 | 16 | 0 |
| Medication Management | 71 | 5 | 11 | 0 |
| Patient Flow | 14 | 0 | 0 | 0 |
| People-Centred Care | 26 | 3 | 0 | 0 |
| Physical Environment | 3 | 0 | 1 | 0 |
| Total | 159 | 15 | 28 | 0 |

## Compliance by Quality Dimension


| DIMENSION | MET | UNMET | N/A | NOT RATED |
|---|---|---|---|---|
| Accessibility | 24 | 1 | 1 | 0 |
| Appropriateness | 111 | 13 | 17 | 0 |
| Client Centered Services | 75 | 4 | 1 | 0 |
| Continuity of Services | 12 | 0 | 0 | 0 |
| Efficiency | 3 | 0 | 4 | 0 |
| Population Focus | 3 | 1 | 0 | 0 |
| Safety | 100 | 7 | 17 | 0 |
| Worklife | 11 | 2 | 1 | 0 |
| Total | 339 | 28 | 41 | 0 |

## Compliance by Required Organizational Practice (ROP)

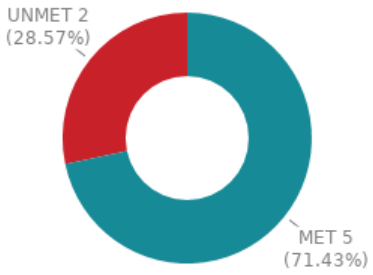
| ROP | STANDARD | RATING |
|---|---|---|
| COMMUNICATION | | |
| Client Identification | Emergency Department | MET |
| | Inpatient Services | MET |
| The 'Do Not Use' list of Abbreviations | Medication Management | UNMET |
| Medical Reconciliation at Care Transitions | Emergency Department | MET |
| | Inpatient Services | MET |
| Information Transfer at Care Transitions | Emergency Department | UNMET |
| | Inpatient Services | UNMET |
| MEDICATION USE | | |
| Antimicrobial Stewardship | Medication Management | UNMET |
| Concentrated Electrolytes | Medication Management | MET |
| Heparin Safety | Medication Management | MET |
| High-alert Medications | Medication Management | MET |
| Narcotics Safety | Medication Management | MET |
| Infusion Pump Safety | Service Excellence | MET |
| INFECTION CONTROL | | |
| Hand-hygiene Compliance | Infection Prevention and Control | UNMET |
| Hand hygiene Education and Training | Infection Prevention and Control | MET |
| Infection Rates | Infection Prevention and Control | MET |
| Reprocessing | Infection Prevention and Control | MET |
| RISK ASSESSMENT | | |
| Falls prevention and injury reduction | Inpatient Services | MET |
| Pressure ulcer prevention | Inpatient Services | MET |
| Suicide prevention | Emergency Department | UNMET |
| Venous thromboembolism prophylaxis | Inpatient Services | MET |

# Detailed Results: System-level Priority Processes

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

## Emergency Preparedness

**Priority Process Description: Planning for and managing emergencies, disasters, or other aspects of public safety. This system-level priority process refers to criteria that are tagged to one of the following standards: Infection Prevention and Control; Leadership.**




During the onsite survey, the Acting Site Lead at Fort Macleod Health Centre indicated that an Emergency Response Team based in Lethbridge supports the specific plans for the rural sites and conducts tabletop exercises.

Staff expressed concern about the internal response protocols and the internal capacity to respond to a patient or visitor exhibiting aggressive or disruptive behaviours. Security personnel are onsite only at night from 7 pm to 7 am, and there are a limited number of staff on all shifts. Staff reported that more clarity is needed regarding the protocols for people who present with mental distress or responsive behaviours. Given the high rate of mental and behavioural disorders presented at Fort Macleod's emergency department, it will be very important to review and train staff in the Code White protocols. In the event of a Code Blue, staff indicated that they had been instructed to call 9-1-1; however, some staff stated that currently, they are not following this process.

The leadership is strongly encouraged to put in place regular testing for both, Code White and Code Blue to address the concerns from frontline staff. It is also recommended to review the policies and procedures and engage front-line staff in this review and the codes' testing. Given the high degree of casual staff, more frequent exercises would be warranted with as many team members as possible participating.

COVID-19 screening protocols for all staff and visitors were found to be in place, noting that staff reported they are being deployed from already short-staffed clinical areas.

| STANDARD | UNMET CRITERIA | CRITERIA |
|---|---|---|
| Leadership | 14.5 | The organization's all-hazard disaster and emergency response plans are regularly tested with drills and exercises to evaluate the state of response preparedness. |
| Leadership | 14.6 | The results from post-drill analysis and debriefings are used to review and revise the all-hazard disaster and emergency response plans and procedures as necessary. |

## Infection Prevention and Control

**Priority Process Description: Providing a framework to plan, implement, and evaluate an effective IPC program based on evidence and best practices in the field. This system-level priority process refers to criteria that are tagged to one of the following standards: Infection Prevention and Control.**


There is no onsite infection control practitioner (ICP) at the Fort McLeod Health Centre. Also, the Site Manager's position has been vacant for several weeks. At the time of the onsite survey, the Emergency Department Registered Nurse (RN) was the "Charge Nurse" for the Health Centre.

There is one ICP that has oversight for the functions of the Infection Prevention and Control Program (IPC) for all sites on the West South Zone. Due to travel restrictions, the ICP can visit sites once every three months. This is a change from the monthly visits that took place before January of this year. However, the ICP is available by telephone for consultations as required by the staff. Daily surveillance is performed electronically. The ICP attends virtual monthly Workplace Health and Safety meetings.

The hospital reports low infection rates. General IPC education is delivered to staff at the Chinook Regional Hospital. Online education is done annually via "My Learning Link." Education is provided to environmental services staff on the type of cleaning to be done in each area. Training is provided using a buddy system; the staff member provides feedback and more training is provided if required.

Greater attention is provided to high-risk areas. All areas surveyed were clean and orderly. The Housekeeping Lead performs five environmental audits per month: two done via microbes/ Glo Germ Gel and three are visual inspections. The results are entered electronically into a database. However, the reports were not easily retrieved. The site will benefit from having easy access to those reports therefore be able to post, track results and trended over time.

Staff wear personal protective equipment when delivering care or handling contaminated material. There was the occasional sighting of staff either not wearing a mask or wearing it below their nose.

Sharps containers are available where required. Safety engineered devices are in use.
Hand hygiene compliance audits were on hold because of COVID-19, except for the dialysis unit where there is a trained reviewer. The hand hygiene coordinator reported that "it has been a struggle to get site-based reviewers at Fort McLeod Health Centre, and as a result, audits are not being done regularly". The organization is encouraged to conduct the audits and communicate results to staff.

There is a shortage of the Alcohol-based hand rubs (ABHR) for the dispensers, and there are no dispensers or sinks in the inpatient units. Staff do have access to bottles of ABHR at their workstations, but this would require the staff member to go outside of the room, go to the workstation, clean their hands, and then attend to the second patient in the room, which was not observed to have occurred. Since there are no sinks in the patient rooms, staff are using the sinks at their shared workstation/kitchenette for hand washing when required. This sink is used for many other different purposes, mainly related to food and snack preparation. The organization is encouraged to review how hand hygiene is being performed in the inpatient units.

Reviews of IPC practices and audits for Antibiotic-Resistant Organisms (ARO) screening, or informal shadowing need to be conducted according to policy. The team is encouraged to educate staff on these areas and develop quality improvement initiatives as a result of these reviews/audits/shadowing.

| STANDARD | UNMET CRITERIA | CRITERIA |
|---|---|---|
| Infection Prevention and Control | 8.3 | Team members, client, families, and volunteers have access to alcohol-based hand rubs at the point of care. |
| Infection Prevention and Control | 8.4 | Team members, and volunteers have access to dedicated hand-washing sinks. |
| Infection Prevention and Control | 14.3 | Input is gathered from team members, volunteers, and clients and families on components of the infection prevention and control program. |
| Infection Prevention and Control | 14.4 | The information collected about the infection prevention and control program is used to identify successes and opportunities for improvement, and to make improvements in a timely way. |
| Infection Prevention and Control | 14.5 | Results of evaluations are shared with team members, volunteers, clients, and families. |

## Medical Devices and Equipment

**Priority Process Description: Obtaining and maintaining machinery and technologies used to diagnose and treat health problems. This system-level priority process refers to criteria that are tagged to one of the following standards: Infection Prevention and Control.**


**There are no unmet criteria for this Priority Process.**

Medical Devices and Equipment are not sterilized at this location. Cleaning and disinfecting of medical devices and equipment is the responsibility of both Housekeeping staff and Heath Care Aides.

The Maintenance and Engineering Department is a key aspect of the organization and the department consists of three individuals (of which one is seasonal) who provide services throughout the hospital. The organization has a preventative maintenance software program that enables staff to enter devices that need repairs or attention. Clinical equipment is listed by area/location with make/model/serial number and preventative maintenance frequency checks and due dates.

Preventative maintenance is done on all equipment that the team deems necessary and there are contracts done with vendors on specialized equipment. Corrective maintenance service requests are tracked and trended.

Equipment safety alert management issued by manufacturers is adhered to. The Department attends regular virtual safety meetings with the South Zone Safety Officer, where rural issues are addressed regionally. The team is proud of the work they do and recognize that their work directly impacts the patient experience.

## Medication Management

**Priority Process Description: Using interdisciplinary teams to manage the provision of medication to clients. This system-level priority process refers to criteria that are tagged to one of the following standards: Medication Management.**


There is no onsite pharmacy or pharmacy personnel at Fort McLeod Health Centre. All medication is prepared and distributed from Chinook Regional Hospital. A pharmacy assistant comes onsite once a week and does a review of medication used from the night cupboard and the Emergency room. There is a pharmacist that is available 24/7 from Chinook Regional Hospital should the need arise.

Auditing of some medication is done by the pharmacy staff from Chinook Regional Hospital. Since travel restrictions have been put in place and due to COVID-19, the site was not able to conduct some audits. The site is

encouraged to restate this practice as soon as possible. It was unclear as to whether audits on the "Do Not Use" list of abbreviations are being done as those results were not available at the time of the survey.

In the night medication cupboard and Emergency department medication area, medications of various strengths of the same drug were stored in the same bin. This included high-alert medications. It is recommended that the organization review how medications are stored in these two areas.
Staff in the Community Support Beds program reported a concern regarding the unsafe medication practice of administering medication to pediatric clients after hours when there is only one Registered Nurse (RN) for the inpatient beds. Independent double checks for high-risk medications are not being done as the only other RN is in the Emergency department, where they may be busy attending to emergency clients.

| STANDARD | UNMET CRITERIA | CRITERIA |
|---|---|---|
| Medication Management | 6.5 | Teams can access an on-site or on-call pharmacist at all times to answer questions about medications or medication management. |
| Medication Management | 12.6 | Look-alike, sound-alike medications; different concentrations of the same medication; and high-alert medications are stored separately, both in the pharmacy and client service areas. |
| Medication Management | 19.2 | A pharmacist or other qualified team member verifies, as soon as possible, that the correct medications were dispensed after hours. |
| Medication Management | 19.3 | The system for dispensing medications when the pharmacy is closed is regularly evaluated and improvements made as needed. |
| Medication Management | 23.3 | An independent double check is conducted at the point of care before administering high-alert medications. |

## Patient Flow

**Priority Process Description: Assessing the smooth and timely movement of clients and families through service settings. This system-level priority process refers to criteria that are tagged to one of the following standards: Emergency Department; Leadership.**


**There are no unmet criteria for this Priority Process.**

Patient flow has not been identified as a priority for the organization at this time, due to the smaller emergency visits and low rates of admission to an inpatient bed (Community Support or Special Disabilities). On an average day, there are no bottlenecks for service and care.

For Community Support Beds, weekly interdisciplinary rounds with home care nurses and dietary staff highlight the need for admission. There is an informal process to manage overcrowding in the emergency department. This is usually accomplished by calling in staff. The emergency department staff were not aware of wait times and response times for clients accessing services. The team should develop a formal mechanism for reporting whether there is a wait time for the beds.

## People-Centred Care

**Priority Process Description: Working with clients and their families to plan and provide care that is respectful, compassionate, culturally safe, and competent, and to see that this care is continuously improved upon. This system-level priority process refers to criteria that are tagged to one of the following standards: Emergency Department; Inpatient Services; Long-Term Care Services; Service Excellence.**


There was a traumatic event that occurred when surveyors arrived on site. During all survey activities, the professional manner of all staff was noted, as well as how staff worked effectively to support one another and the families involved. Adjustments to accommodate care during this tragic situation and the pandemic restrictions were made respectfully. The Fort Macleod staff are commended for their compassionate and people-centred response and their professionalism and caring attitude that was expressed in service to the family.

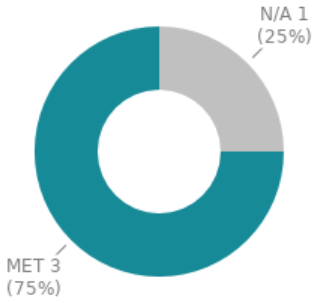
Across all areas of the Fort Macleod Health Centre, the focus by clinicians on patients and families was evident. Patients expressed gratitude for the care received. The most frequent barrier to people-centred care reported by patients is the perception of staff being “too busy.” It may be helpful for the leadership to explore with staff, appropriate messaging for patients and families about their daily challenges.

There is a significant opportunity at the Fort Macleod Health Centre to expand ways to engage patients and families at all levels of clinical and administrative processes.

| STANDARD | UNMET CRITERIA | CRITERIA |
|---|---|---|
| Service Excellence | 1.3 | Service-specific goals and objectives are developed, with input from clients and families. |
| Service Excellence | 3.3 | A comprehensive orientation is provided to new team members and client and family representatives. |
| Service Excellence | 3.12 | Client and family representatives are regularly engaged to provide input and feedback on their roles and responsibilities, role design, processes, and role satisfaction, where applicable. |

## Physical Environment

**Priority Process Description: Providing appropriate and safe structures and facilities to achieve the organization's mission, vision, and goals. This system-level priority process refers to criteria that are tagged to one of the following standards: Leadership.**




**There are no unmet criteria for this Priority Process.**

The physical infrastructure of the Fort Macleod Health Centre is adequate for the range of ambulatory community-based and inpatient services provided. The site provides good lighting and was clean and uncluttered. The flow of patients through the site was changed due to COVID-19 restrictions to ensure adherence to Infection Prevention and Control (IPC) standards.

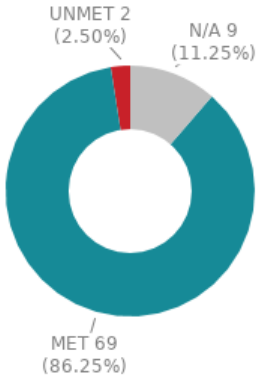
There was visible attention onsite to waste diversion through recycling bins.

# Detailed Results by Service-Level Priority Process

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

## Emergency Department

**Episode of Care Bundle Description: Partnering with clients and families to provide client-centred services throughout the health care encounter.**




The Emergency department is dedicated to serving the needs of the community. Informal assessment of the types of problems coming to the emergency, wait times and transit times have supported the development of several innovative programs. Clients and families are informally and regularly asked about their experience as part of their care interaction, but a more intentional involvement of clients and family in developing how to provide feedback on different aspects of the clinical practice would strengthen any new program development.

The process from febrile illness screening, to triage, to registration is organized and runs smoothly from the point of patient entry into the department. The physical layout of the Emergency department allows for privacy. CTAS scores are assigned. The use of two- patient identifiers was confirmed during the onsite visit. Patients typically spend little time in the waiting room before the initial assessment, and while they are waiting, they are monitored visually and advised to contact a team member should their condition change.

Documentation on the emergency records remains paper-based. Standardized assessment tools are used during the assessment process. The medication reconciliation process is initiated in the Emergency department with a Best Possible Medication History (BPMH). Universal falls prevention precautions are put into place.

There is an opportunity for improvement in the area of assessing clients for the risk of suicide as this is not done consistently. Questions relating to suicide assessment is not part of the standard assessment and treatment in the Emergency department. Education and training are required for the staff.

There was a standardized transfer sheet when clients move out of the Emergency department. Verbal reports are given at shift end. While there is not a standardized tool (checklists) for the transfer of information among team members, based on the size of the department and staffing, it may be enough for verbal reporting. However, the organization needs to evaluate the effectiveness of the communication strategies used.

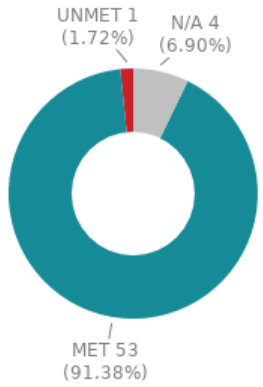
The department staff have priority access to laboratory, and diagnostic imaging, and feel supported by consulting services with no significant gaps identified. Processes are in place to mitigate risk from high-risk activities such as abnormal blood results or discrepancies between initial diagnosis and final diagnostic imaging results. There are resources and processes in place to isolate and manage potentially infectious patients, and this process was observed in action during the COVID-19 pandemic. Adult and pediatric resuscitation equipment and supplies are readily available.

The Emergency department staff including the physicians would benefit from a strategic session to prioritize the department's annual objectives which should include clear performance targets. It is recommended to educate and engage staff in the collection of indicator data to use for monitoring, evaluation or quality improvement activities.

| STANDARD | UNMET CRITERIA | CRITERIA |
|---|---|---|
| Emergency Department | 4.2 | A standardized pediatric-specific tool is used to conduct the triage assessment of pediatric clients. |
| Emergency Department | 6.13 | Urgent medications and pharmacy staff can be accessed 24 hours a day, 7 days a week. |

## Inpatient Services

**Episode of Care Bundle Description: Partnering with clients and families to provide client-centred services throughout the health care encounter.**




Consistent with the community profile for the Fort Macleod local geographic area, the focus of inpatient care provided at the Fort Macleod Health Centre is on older adults. Defined criteria are in place for transitions between the Fort Macleod Health Centre and neighbouring sites (Lethbridge and Cardston). Patients admitted to the ten Community Support Beds at the site are designated low acuity, typically older adults and often receiving end of life, palliative care. Direct admissions of patients from the Emergency Department to the Community Support Beds are rare. The Community Support Beds are divided into House 1 with four single rooms and House 2 with six semi-private rooms. During COVID-19, patients are admitted to House 1 and quarantined for fourteen days.

During the onsite accreditation survey, ongoing challenges related to staffing shortages were described and these have been aggravated due to COVID-19 visitor restrictions. The wife of one patient reported she has "helped the nurses because they are so short-staffed". Another patient reported that she waited 45 minutes to be escorted to the unit to visit her husband; due to COVID-19 restrictions, she was unable to access the unit through the usual entrance and must wait for a staff escort.

While the Strategic Clinical Networks support all sites with the selection of evidence-informed guidelines, it is recommended that more attention be paid to the needs of the lower acuity sites, such as Fort Macleod Health Centre, to integrate evidence-informed guidelines and clinical pathways into service delivery. Where instruments have been selected, such as the suicide risk assessment, attention should be paid to ensuring there is an understanding and consistent use of the selected tool. Although the acting Site Lead indicated that clinical care pathways such as chronic obstructive pulmonary disease (COPD) or asthma pathways are in place at some of the rural sites, clinicians indicated these are not used at this site to inform the care plans developed for the Community Support Bed patients. One staff member reported using tools and pathways at other rural sites and welcomed the opportunity to spread the use to the Fort Macleod Health Centre. This reinforces the opportunity to put in place care pathways to ensure both continuity and a consistent standard and quality of care for patients across all rural sites. Ischemic heart disease, pneumonia, and diabetes were the top three main reasons for inpatient admissions noted in the community profile, providing some guidance for areas of focus.

Although the degree of standardization of documentation tools and communication strategies at transition points can vary depending on organizational size and complexity, the significant number of casual staff presents a risk if tools are not used to guide the inclusion of relevant information needed to ensure care transitions occur safely for patients. As tools and forms are not in place to track what is communicated at transition points (both at shift handover and when patients move between sites or departments), the effectiveness of communications cannot be evaluated.

| STANDARD | UNMET CRITERIA | CRITERIA |
|---|---|---|
| Inpatient Services | 5.18 | Where appropriate, clinical care pathways are consistently followed when providing care to clients to achieve the same standard of care in all settings to all clients. |

## Service Excellence

**Episode of Care Bundle Description: Partnering with clients and families to provide client-centred services throughout the health care encounter.**


Clinical care providers were observed during the onsite visit to be working closely with patients and families to define their service goals, monitoring progress and re-evaluating goals as needed. Although goals and objectives were articulated in discussions with leadership, there was no evidence of documented goals and objectives with metrics to assess progress or timelines for achievement. Front line staff did not know the annual or quarterly goal setting as a team, and there was no documentation of goals and objectives.

The recent project in the Community Support Beds, to improve WIFI at the site in alignment with plans for the implementation of Connect Care, is a wonderful example of engagement with patients and families. The leadership is encouraged to build on the foundation of this experience to increase the engagement with patients and families regularly, including gathering input onsite level goals and objectives.

While indicator data is tracked and analyzed at the organization (AHS) and zone level, little evidence of knowledge translation and use of this data to inform local quality improvement at the site was described by any front-line staff during the onsite survey. The leadership is encouraged to educate staff on how to use the data and engage them in quality improvement initiatives.

Although the acting Site Leader indicated she conducts coaching conversations with new staff, she acknowledged that workload precludes conducting regular evaluations with all direct reports. Regular reviews of staff performance provide an opportunity to define personal and professional goals in alignment with organizational and site-level goals and objectives. Many organizations have established a formal process for coaching conversations as an alternative to performance evaluations to monitor and provide support to clinical and non-clinical staff.

The development of quality teams is new in rural sites. There is not yet a Quality Council at Fort Macleod Health Centre. The site leaders are encouraged to move forward with plans to establish a council that engages staff, patients and families to promote a culture of quality improvement, quality initiatives with measures that permit assessment of whether changes lead to improvements.

| STANDARD | UNMET CRITERIA | CRITERIA |
|---|---|---|
| Service Excellence | 3.11 | Team member performance is regularly evaluated and documented in an objective, interactive, and constructive way. |
| Service Excellence | 3.13 | Team members are supported by team leaders to follow up on issues and opportunities for growth identified through performance evaluations. |
| Service Excellence | 8.2 | The procedure to select evidence-informed guidelines is reviewed, with input from clients and families, teams, and partners. |
| Service Excellence | 8.3 | There is a standardized process, developed with input from clients and families, to decide among conflicting evidence-informed guidelines. |
| Service Excellence | 10.1 | Information and feedback is collected about the quality of services to guide quality improvement initiatives, with input from clients and families, team members, and partners. |
| Service Excellence | 10.2 | The information and feedback gathered is used to identify opportunities for quality improvement initiatives and set priorities, with input from clients and families. |

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| Service Excellence | 10.4 | Indicator(s) that monitor progress for each quality improvement objective are identified, with input from clients and families. |
| Service Excellence | 10.6 | New or existing indicator data are used to establish a baseline for each indicator. |
| Service Excellence | 10.10 | Information about quality improvement activities, results, and learnings is shared with clients, families, teams, organization leaders, and other organizations, as appropriate. |
| Service Excellence | 10.11 | Quality improvement initiatives are regularly evaluated for feasibility, relevance, and usefulness, with input from clients and families. |

# Criteria for Follow-up

## Criteria Identified for Follow-up by the Accreditation Decision Committee

| Follow-up Criteria | | | |
|---|---|---|---|
| **Standard** | **Criteria** | | **Due Date** |
| Infection Prevention and Control | 8.3 | Team members, client, families, and volunteers have access to alcohol-based hand rubs at the point of care. | May 30, 2021, |
| Inpatient Services | 5.18 | Where appropriate, clinical care pathways are consistently followed when providing care to clients to achieve the same standard of care in all settings to all clients. | May 30, 2021 |
| Leadership | 14.5 | The organization's all-hazard disaster and emergency response plans are regularly tested with drills and exercises to evaluate the state of response preparedness. | May 30, 2021, |
| Medication Management | 12.6 | Look-alike, sound-alike medications; different concentrations of the same medication; and high-alert medications are stored separately, both in the pharmacy and client service areas. | May 30, 2021, |

| Follow-up ROPs | | | |
|---|---|---|---|
| **Standard** | **ROP - Test of Compliance** | | **Due Date** |
| Emergency Department | **Suicide prevention** | | |
| | 6.7.1 | Clients at risk of suicide are identified. | May 30, 2021, |
| | 6.7.2 | The risk of suicide for each client is assessed at regular intervals or as needs change. | May 30, 2021, |
| | **Information Transfer at Care Transitions** | | |
| | 8.17.5 | 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, 2021 |

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| Infection Prevention and Control | **Hand-hygiene Compliance** | | |
| | 8.6.1 | Compliance with accepted hand-hygiene practices is measured using direct observation (audit). For organizations that provide services in clients' homes, a combination of two or more alternative methods may be used, for example: Team members recording their own compliance with accepted hand-hygiene practices (self-audit). Measuring product use. Questions on client satisfaction surveys that ask about team members' hand-hygiene compliance. Measuring the quality of hand-hygiene techniques. | May 30, 2021, |
| | 8.6.2 | Hand-hygiene compliance results are shared with team members and volunteers. | May 30, 2021, |
| | 8.6.3 | Hand-hygiene compliance results are used to make improvements to hand-hygiene practices. | May 30, 2021, |
| Inpatient Services | **Information Transfer at Care Transitions** | | |
| | 6.18.2 | Documentation tools and communication strategies are used to standardize information transfer at care transitions. | May 30, 2021 |
| | 6.18.5 | 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 | May 30, 2021 |
| Medication Management | **Antimicrobial Stewardship** | | |
| | 2.3.1 | An antimicrobial stewardship program has been implemented. | May 30, 2021 |
| | 2.3.2 | The program specifies who is accountable for implementing the program. | May 30, 2021 |
| | 2.3.3 | The program is interdisciplinary, involving pharmacists, infectious diseases physicians, infection control specialists, physicians, microbiology staff, nursing staff, hospital administrators, and information system specialists, as available and appropriate. | May 30, 2021 |
| | 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 | May 30, 2021 |

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| | | parenteral to oral conversion of antimicrobials (where appropriate). | |
| | 2.3.5 | The program is evaluated on an ongoing basis and results are shared with stakeholders in the organization. | May 30, 2021 |
| | **The 'Do Not Use' list of Abbreviations** | | |
| | 14.7.7 | Compliance with the organization's 'Do Not Use List' is audited and process changes are implemented based on identified issues. | May 30, 2021 |