Accreditation Report

Qmentum Global™ Program

Alberta Health Services

Urban Foundational Report

Report Issued: November 29, 2023

Table of Contents

About Accreditation Canada

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

About the Accreditation Report

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

As part of this ongoing process of quality improvement, the organization participated in continuous quality improvement activities and assessments, including an on-site survey from October 16-20, 2023.

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 Medication Management, Infection Prevention and Control, 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

AHS has a team of strong professionals who work collaboratively to provide safe quality care. Sites visited were proud to show the surveyor team how they provide care and services. There is a high degree of variability in the functionality and the age of the facilities that were visited. Despite the aging infrastructure, the environment is well maintained. Some sites were noted to be crowded with overcapacity and they are encouraged to follow protocols in place. There is a strong commitment to environmental stewardship with initiatives to support energy efficiency and cost savings. AHS has a highly structured, integrated, and formalized system of managing medical devices and equipment. At all sites, Infection Prevention and Control (IPC) is led and supported by a strong team. Medication management is supported by an interprofessional team who are working towards standardization to support safe care.

Key Opportunities and Areas of Excellence

Medication Management

Areas of Excellence:

- Provincial standardization in Pharmacy
- Enhanced safety and communication in Connect Care for Medication
- Clinical Pharmacists on inpatient units

Key Opportunities:

- Antimicrobial Stewardship
- Align with NAPRA Standards for sterile compounding
- Use of Automatic Dispensing Cabinets
- Management of Alert Fatigue

Infection and Prevention

Areas of Excellence:

- Medical Leadership is engaged & active in IPC
- Useful information for public on AHS website
- IPC dashboard providing an overview of patients in facility
- Strong partnerships with provincial & organizational partners

Key Opportunities:

- Hand hygiene education & audits
- Decluttering clinical areas
- Opportunity to cascade provincial strategic plan for IPC down to the local level

Reprocessing of Reusable Medical Devices

Areas of Excellence:

- Collaboration at Provincial level with IPC
- Sterile Processing Microsystem tracking system
- Consolidation of reprocessing under oversight of MDRD
- Cross trained MDRD staff

Key Opportunities:

- Infrastructure & equipment rejuvenation
- Impact of surgical volumes
- Endoscopy reprocessing
- Sterile Processing Microsystem expansion

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/foundational and specific service standards within this report. Additional report contents include, the comprehensive executive summary, the organization's accreditation decision, locations assessed during the on-site assessment, required organizational practices results and conclusively a Quality Improvement Overview.

Accreditation Decision

Alberta Health Services accreditation decision continues to be:

Accredited

The organization has met the fundamental requirements of the accreditation program.

Locations Assessed in Accreditation Cycle

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

Table 1: Locations Assessed During On-Site Assessment

Site	On-Site
Alberta Children's Hospital	☑
Alberta Hospital Edmonton	☑
Centennial Centre for Mental Health and Brain Injury	☑
Central Alberta Cancer Centre	☑
Central Production Pharmacy	☑
Chinook Regional Hospital	☑
Cross Cancer Institute	☑
Foothills Medical Centre	☑
Glenrose Rehabilitation Hospital	☑
Grande Prairie Cancer Centre	☑
Grande Prairie Regional Hospital	☑
Jack Ady Cancer Centre	☑
Margery E. Yuill Cancer Centre	☑
Mazankowski Heart Institute	☑
Medicine Hat Regional Hospital	☑
Peter Lougheed Centre	☑
Red Deer Regional Hospital Centre	☑

Rockyview General Hospital	☑
Royal Alexandra Hospital	☑
South Health Campus	☑
Southern Alberta Forensic Psychiatric Centre	☑
Stollery Children's Hospital	☑
Sturgeon Community Hospital	☑
Tom Baker Cancer Centre	☑
University of Alberta Hospital	☑
Wetaskiwin Hospital and Care Centre	☑

[1]Location sampling was applied to multi-site single-service and multi-location multi-service organizations.

Required Organizational Practices

ROPs contain multiple criteria, which are called Tests for Compliance (TFC). ADC guidelines require 75% and above of ROP's TFC to be met.

Table 2: Summary of the Organization's ROPs

ROP Name	Standard(s)	# TFC Rating Met	% TFC Met
Hand-hygiene Education and Training	Infection Prevention and Control	1 / 1	100.0%
Hand-hygiene Compliance	Infection Prevention and Control	0 / 3	0.0%
Reprocessing	Infection Prevention and Control	2 / 2	100.0%
Infection Rates	Infection Prevention and Control	3 / 3	100.0%
Antimicrobial Stewardship	Medication Management	0 / 5	0.0%
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%

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.

Infection Prevention and Control

Standard Rating: 81.4% Met Criteria

18.6% of criteria were unmet. For further details please review the table at the end of this section.

Assessment Results

Twenty-one sites were visited during the on-site assessment of the IPC standards. Leadership, teamwork, collaboration, and passion were all evident here. At all sites, IPC is ably led and supported by capable individuals who are exceptionally well versed in IPC issues and processes. They are a model of teamwork and functionality. There is a commitment to education, training, knowledge transfer, communication, and partnerships. The ICP practitioners are passionate about their work and their ability to collaborate during trying times to ensure practices and policies are followed, monitored, and communicated.

Since the last Accreditation Canada survey, Connect Care is now in place at most sites. It serves as the information hub for epidemiological review of the client population in conjunction with microbiological reports received from diagnostic laboratories. There is evidence of effective surveillance processes to identify, communicate, track, and analyze infections. This multifaceted team has a laser focus on data mining and analysis and uses this to ensure transmission of germs are minimized.

There are clear processes for educating staff, patients, families, and volunteers on the importance of hand-hygiene to prevent the spread of germs in the hospital. There is opportunity for AHS to expand hand-hygiene education to contractors who may be working on outbreak units.

In some of the sites that were visited, hand-hygiene audits were routinely completed in all areas of the hospitals, and the outcomes of these audits were posted on the units and made visible to the public. However, at other sites, hand-hygiene audit results were not posted as these have not taken place more recently. To ensure the effectiveness of hand-hygiene, high levels of compliance are necessary. Therefore, AHS is encouraged to prioritize hand-hygiene compliance audits. Even if the staff are aware of the importance of hand-hygiene, changing behaviour requires sustained and ongoing efforts.

Access to alcohol-based hand rubs (ABHR) is ubiquitous throughout many of the sites visited. However, for the sites providing mental health and addictions services, it was observed that ABHR was not positioned near entrance ways to rooms, let alone at the point of care. AHS is encouraged to explore ABHR dispensers designed to prevent patient harm from the use or ingestion of ABHR.

Several units in various sites were in outbreak due to COVID-19 transmission and “The Use of Masks to Prevent Transmission of COVID-19 Directive” came into effect during the on-site survey. In all sites, outbreak management was extremely well done, usually under trying conditions. Collaboration and decisive action with early intervention enabled the team to contain the outbreak.

The auditing processes in the environmental services department are exemplary. Significant work has been undertaken to establish auditing tools, support training, and sustaining a high level of service. Standard work practices support staff in understanding and meeting expectations followed up by auditing to embed practice into daily routine through feedback to staff. Some sites have contracted services with Aramark or Sodexo with laundry services primarily a contracted service with K Bro.

AHS continues to undergo many major construction and redevelopment projects. There is significant IPC support for new facility construction and ongoing renovations at existing facilities. Part of AHS’ response to the COVID-19 pandemic was to increase bed capacity in acute care settings, particularly in critical care. The expansion of bed capacity often involved repurposing existing areas within healthcare facilities. Notably, there is the 200-bed Pandemic Response Unit in Edmonton and another in Calgary, which are completely outfitted and ready for use, should the need present. The IPC team is consulted throughout these projects to ensure patient and staff safety both in the physical designs as well as during the renovation work. To ensure that the IPC was consulted early on in construction/renovations, IPC and Capital Management created the IPC Healthcare Facility Design Requirements checklist and the Infection Control Risk Assessment & Preventative Measures Toolkit for Constructions, Renovation & Maintenance documents.

Provincial policies are in place to ensure proper storage, preparation, and handling of food to prevent food-borne illness. Any illness that is tracked back to food safety, it is reported to Public Health. Food storage, preparation, and handling are monitored, and AHS only uses accredited suppliers. Food Services have safeguards in place such as temperature checks for fridges/freezers, checklists, and rotation of stock. Patient Food Services is regularly inspected by Environmental Public Health.

While there are two patients on the Provincial IPCC, none participated on Zone level or site level committees. Although they conduct a Patient Satisfaction Survey every 24 months, it does not include questions related to IPC. Input from clients and families is not sought regarding compliance with policies and procedures for cleaning and disinfecting the physical environment and when developing the approach for IPC. The team is encouraged to involve clients and families in their planning around IPC at the Zone and local/site level.

Some of the acute care sites are cluttered, not only with equipment and supplies but also with patients occupying overcapacity spaces. AHS is encouraged to minimize obstructions that impede the flow of people or equipment, especially in the inpatient areas. Additionally, it is recommended that AHS adhere to their Best Practice Recommendation for the Spatial Separation of Patients, as evidenced by the practice of placing a third patient between patients in semi-private accommodations.

Table 3: Unmet Criteria for Infection Prevention and Control

Criteria Number	Criteria Text	Criteria Type
2.2.2	Team members, clients and families, and volunteers are engaged when developing the multi-faceted approach for infection prevention and control.	NORMAL
2.5.3	Team members, client, families, and volunteers have access to alcohol-based hand rubs at the point of care.	HIGH
2.5.4	Team members, and volunteers have access to dedicated hand-washing sinks.	NORMAL
2.5.6	Hand-hygiene Compliance 2.5.6.1 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 (e.g., through the use of ultraviolet gels or lotions). 2.5.6.2 Hand-hygiene compliance results are shared with team members and volunteers. 2.5.6.3 Hand-hygiene compliance results are used to make improvements to hand-hygiene practices.	ROP
2.6.5	Compliance with policies and procedures for cleaning and disinfecting the physical environment is regularly evaluated, with input from clients and families, and improvements are made as needed.	NORMAL

Criteria Number	Criteria Text	Criteria Type
2.7.10	When an organization cleans, disinfects, and/or sterilizes devices and equipment in-house, there are designated and appropriate area(s) where these activities are done.	HIGH
2.7.11	The area where cleaning, disinfection, and/or sterilization of medical devices and equipment are done is equipped with hand hygiene facilities.	HIGH
2.7.13	Items that require cleaning, disinfection, and/or sterilization are safely contained and transported to the appropriate area(s).	HIGH
2.8.2	Areas for reprocessing flexible endoscopes are physically separate from client care areas.	HIGH
2.8.3	Endoscope reprocessing areas are equipped with separate cleaning and decontamination work areas as well as storage, dedicated plumbing and drains, and proper air ventilation.	NORMAL
3.3.3	Input is gathered from team members, volunteers, and clients and families on components of the infection prevention and control program.	NORMAL

Leadership

Standard Rating: 60.0% Met Criteria

40.0% of criteria were unmet. For further details please review the table at the end of this section.

Assessment Results

Physical Environment

Two criteria from the leadership standards regarding safety of physical spaces and client and staff health and safety, were assessed at several sites.

There is a high degree of variability in the functionality and age of facilities that were visited. Despite the aging infrastructure at some of the sites, overall, the physical environment is well maintained, and environmental services provide very clean and inviting atmospheres.

An enthusiastic and multi-skilled team oversees the physical environments of AHS demonstrating collaborative teamwork. The team is committed to keeping the aging facilities in safe working order to meet the needs of clients and staff. Frequent meetings between facilities staff and clinical staff allow for the timely identification of required repairs.

Managing the physical environment at some of the sites was a challenge, especially where the building represents multiple phases of aged infrastructure. This not only presents a challenge for patients and families in terms of wayfinding but also for maintenance and monitoring. Many areas with limited capacity are very congested and teams are encouraged to ensure that clutter is removed where possible.

Some of the original facilities were built over 70 years ago. With time and population growth, the current spaces and environment require investments and upgrades to meet the demand for services and care. There are daily overcapacity challenges present in the emergency rooms with no bed admits exceeding the stretcher capacity.

At some of the sites, there are overcapacity issues in the inpatient areas, where three patients occupy a room designed for semi-private use. This practice does not align with the AHS Best practice recommendation for spatial separation. In addition, hallways are cluttered with supplies and equipment on both sides of the halls, impeding the safe movement of people throughout the units.

Entrance ways do not comply with the Alberta Building Code as it relates to barrier free design at one site.

One hospital has almost all wooden rails throughout the building, posing a safety risk due to the potential for chipping and degradation. This makes it difficult to properly sanitize and ensure railings do not become a source of infection. The site is strongly encouraged to move forward with replacement when possible.

Despite the need for site expansion at some of the buildings, the corporate teams are working hand in hand with the clinical teams to ensure the hospitals are operating at a level of efficiency to manage and balance the patient pressures. The housekeeping staff, IPC and clinical teams are well linked and engaged to ensure the daily operations of the hospital, focusing on timely admissions, transfers, and discharges of patients.

At all sites that were visited, it was noted that any area under construction or renovation had implemented safety measures regarding client and staff safety. These measures included infection prevention and control, restricting access to areas under construction, controlling dangerous substances or equipment, and isolating construction and renovation activities to minimize the impact on service delivery.

Medical Devices and Equipment

Leadership criterion regarding the maintenance, upgrading and replacement of medical devices, equipment, and technology to ensure safety was assessed at several sites.

AHS has established a formal process for the planning, acquiring, and replacing medical devices and equipment. A procurement process is in place that outlines the spending authorities and purchasing process. The organization carefully considers information from team members including IPC and bioengineering in the purchasing selection. Introduction of new equipment is accompanied with user training modules, often done in partnership with the vendor. Instructions on how to use the equipment are clearly displayed, and additional information including the operating manuals can be found in the resource binder for each piece of equipment. The organization also maintains a well-established preventative maintenance program throughout the life cycle of its medical devices and equipment. Regular inspections are conducted for the major pieces of equipment, and preventative management inspections are logged in a centralized database. The organization monitors and mitigates risks associated with the use of medical devices and equipment on a regular basis.

All staff are trained on new equipment and the orientation programs cover the use of equipment and technology. Regular retraining and education is provided both in house and by the vendors.

All equipment checked during the onsite visit were found to have visible asset tags and current inspection tags. The Biomedical team and Facilities Maintenance and Engineering (FME) have a customer-centric approach which is commendable. Staff members reported that both Biomedical and FME are responsive to requests and needs.

Table 4: 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
4.3.7	The organization maintains, upgrades, and replaces medical devices, equipment, and technology as needed, to ensure they are safe.	HIGH

Medication Management

Standard Rating: 88.2% Met Criteria

11.8% of criteria were unmet. For further details please review the table at the end of this section.

Assessment Results

Nineteen sites were visited during the on-site assessment of the Medication Management standards. A significant amount of standardization in care processes such parenteral therapy, order set development and bar coding of products has been achieved to support the implementation of Connect Care which began in 2019 and is expected to be completed by 2024. The Connect Care system can provide metrics on various processes within the medication management system in real time such as BCMA scanning rates. However, many medication safety processes are not yet tracked. AHS would benefit from regular auditing of SMART pump compliance usage with the drug libraries.

Strong interprofessional teams collaborate as they work to provide safe and effective patient care. The implementation of Connect Care throughout the province has enhanced communication flow and opportunities to monitor quality and patient safety. Staff engagement is excellent through ongoing team huddles, quality boards, recognition, and face to face communications.

Aging infrastructure in some locations creates extremely cramped pharmacy spaces which has been further compressed with the barcoding of medications and changes in dispensing workflow requiring additional scanners, printers, and computers. Some buildings do not have locked medication rooms to store the ward stock and patient specific medications.

The Alberta College of Pharmacy has adopted the National Association of Pharmacy Regulatory Authorities (NAPRA) standards for sterile and non-sterile compounding and most locations are not compliant with the sterile compounding standards. Recently, the provincial government approved funding for these infrastructure changes and AHS is working toward a new Edmonton Production Centre. The facility will house sterile compounding, non-sterile compounding, packaging, and 24-hour cart exchange. This project is well underway and once implemented will free up much needed space in all the pharmacy departments. An assessment has been completed to determine which acute hospitals will still require NAPRA compliant sterile compounding clean rooms to support initial doses along with just in time compounding of hazardous sterile products, particularly in the Cancer centres.

Following the completion of the Edmonton Zone Production Centre, a further expansion of the Calgary Zone Production Centre, which is now extremely cramped, will be completed.

Antimicrobial Stewardship programs were temporarily paused or no longer expanded during the COVID-19 pandemic. There is no provincial wide data available from Connect Care and AHS is encouraged to develop these reports as well as a strategy to provide Antimicrobial Stewardship programs in the Acute Care hospitals and Cancer centres.

Table 5: Unmet Criteria for Medication Management

Criteria Number	Criteria Text	Criteria Type
1.2.3	Antimicrobial Stewardship 1.2.3.1 An antimicrobial stewardship program has been implemented. 1.2.3.2 The program specifies who is accountable for implementing the program. 1.2.3.3 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. 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
5.1.1	Access to medication storage areas is limited to authorized team members.	HIGH
5.1.2	Medication storage areas are clean and organized.	HIGH
5.1.6	Medication storage areas meet legislated requirements and regulations for controlled substances.	HIGH

Criteria Number	Criteria Text	Criteria Type
5.2.3	Chemotherapy medications are stored in a separate negative pressure room with adequate ventilation and are segregated from other supplies where possible.	HIGH
7.2.1	Medication preparation areas are clean and organized.	HIGH
7.2.3	There is a separate negative pressure area for preparing hazardous medications, with a 100 percent externally vented biological safety cabinet.	HIGH
7.2.4	Sterile products are prepared in a separate area that meets standards for aseptic compounding.	HIGH
9.1.5	Automated dispensing cabinets in client service areas interface with the medication order entry management system.	NORMAL
9.3.1	Medications are delivered securely from the pharmacy to client service areas.	HIGH

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.

Reprocessing of Reusable Medical Devices

Standard Rating: 83.8% Met Criteria

16.2% of criteria were unmet. For further details please review the table at the end of this section.

Assessment Results

Eleven sites were visited during the on-site assessment of the Reprocessing of Reusable Medical Devices standards. AHS has consolidated Certified Medical Device Reprocessing (MDR) Technicians to work within the three key areas of MDRD. Staff have been cross trained creating flexibility in their workload and the ability to provide assistance when particular areas are busy. Staff rotations ensure that competencies are maintained, and all areas can be appropriately staffed, ensuring there is someone on site to reprocess endoscopes. Some sites have introduced Service Aides who can be assigned tasks that do not require a Certified MDRD technician's expertise. Sites with staffing challenges may want to consider work that could be readily assigned to a Service Aide rather than an MDRD technician. For example, at one site a considerable number of consumable supply returns from the Operating Room are reshelved daily using a MDRD technician.

While competency assessments are completed annually, performance reviews are not consistently completed. As such opportunities for growth are not identified. There have been numerous vacancies and staff are backfilling manager positions. This provides an opportunity for staff to try out the role and gain experience to apply for Manager positions. A dedicated Educator is instrumental in supporting new staff, conducting orientation, and ensuring that ongoing education is provided to all staff. When an Educator is not in place, these responsibilities fall to the senior staff and take them away from their work. An educator in the department would ensure new staff receive consistent orientation and training and existing staff would have a resource to assist in training for any new equipment, standards, and policies. It is recognized that not all sites have a full time Educator, and some are shared between sites. The organization in encouraged to review this support.

The Sterile Processing Microsystem tracking system (SPM) has been implemented in 13 sites across AHS. A review of the SPM implementation will take place, and the information gathered will help inform planning for further implementation of the tracking system. Feedback on the usefulness of the SPM and the reports that can be generated was positive. The organization is encouraged to continue the implementation of the system at those sites where it would be beneficial.

A positive workplace culture was evident in many of the MDRDs, and the staff are passionate and pride themselves on their work. Positive relationships with IPC and the operating room were noted. Many staff described the department as an "excellent" place to work, feeling supported in education and training. Student Practicums take place, and many of the students have gone on to be hired within the site.

Hand-hygiene was evident in most MRDRs, with hand-hygiene audits being completed and posted in many

departments. Quality boards were visible in most sites and in many areas, staff spoke of the quality improvement (QI) Initiatives that have been completed or are underway. However, there are some sites where QI at the local level does not take place. Leaders are encouraged to work with the teams to identify and address recurring incidents that could benefit from improvement, helping the staff to be engaged in the improvement process.

Standard Operating Procedures (SOPs) are available to staff, either electronically through their shared drive or in binders in the department. Some sites have provided SOPs at workstations to facilitate access for staff. Leaders are encouraged to ensure the SOPs at the workstations are kept up to date. New staff spoke positively about their onboarding and orientation.

Staff spoke positively about the support received from their managers. Supervisors appreciated being included in discussion relating to the increase in surgical volumes and the impact on their departments. Staff were aware of critical policies such as recalls, and flash sterilization is rarely used with a defined process to follow when used.

Capital equipment replacement is ongoing and the needs of the MDRD will need to be considered given the surgical targets and expansions. The physical infrastructure poses challenges at some sites. In some endoscopy reprocessing areas, there is no separation between the clean and dirty areas. While some sites have approved renovation plans, they are encouraged to put processes in place to mitigate any potential of cross decontamination until the renovations can be completed. Areas are encouraged to ensure that access is restricted and well-marked to allow only authorized staff to enter. Sites are encouraged to ensure that dirty items returned to MDRD are transported in appropriate covered bins.

Table 6: Unmet Criteria for Reprocessing of Reusable Medical Devices

Criteria Number	Criteria Text	Criteria Type
1.3.1	The layout of the Medical Device Reprocessing (MDR) department is designed based on service volumes, range of reprocessing services, and one way flow of medical devices.	NORMAL
1.3.3	Access to the Medical Device Reprocessing (MDR) department is controlled by restricting access to authorized team members only and being identified with clear signage.	HIGH
1.3.5	Appropriate environmental conditions are maintained within the Medical Device Reprocessing (MDR) department and storage areas.	HIGH

Criteria Number	Criteria Text	Criteria Type
1.3.6	The Medical Device Reprocessing (MDR) department has floors, walls, ceilings, fixtures, pipes, and work surfaces that are easy to clean, non-absorbent, and will not shed particles or fibres.	HIGH
1.4.6	Preventive maintenance is documented for reprocessing equipment.	HIGH
2.1.11	Team member performance is regularly evaluated and documented in an objective, interactive, and constructive way.	HIGH
2.1.12	Team members are supported by team leaders to follow up on issues and opportunities for growth identified through performance evaluations.	HIGH
3.2.1	The reprocessing area is equipped with hand hygiene facilities at entrances to and exits from the reprocessing areas, including personnel support areas.	HIGH
3.2.2	The reprocessing area's designated hand-washing sinks are equipped with faucets supplied with foot-, wrist-, or knee-operated handles, electric eye controls, automated soap dispenser and single-use towels.	NORMAL
3.2.5	Hand hygiene is performed before beginning and after completing work activities, as well as at other key points, to prevent infection.	HIGH
4.3.3	All flexible endoscopic reprocessing areas are equipped with separate clean and contaminated/dirty work areas as well as storage, dedicated plumbing and drains, and proper air ventilation.	NORMAL
4.3.8	Flexible endoscopic devices are appropriately stored following manufacturers' instructions in a manner that minimizes contamination and damage.	HIGH

Criteria Number	Criteria Text	Criteria Type
4.4.5	Standard operating procedures (SOPs) are followed for handling, distributing, and transporting sterile medical devices and equipment.	HIGH
4.4.6	Sterile medical devices are distributed and transported using clean, enclosed, or covered carts and bins, or plastic bags.	NORMAL
5.2.3	All sterilized items in storage, or transported to patient service areas or other organizations, can be tracked.	HIGH
5.3.2	Information and feedback is collected about the quality of services to guide quality improvement initiatives with input from stakeholders and team members.	NORMAL
5.3.11	Information about quality improvement activities, results, and learnings is shared with stakeholders, teams, organization leaders, and other organizations, as appropriate.	NORMAL