October 2019

EDMONTON ZONE

LEDUC COMMUNITY HOSPITAL

Alberta Health Services

ACCREDITATION AGRÉMENT CANADA

Table of Contents

About this Accreditation Report

Alberta Health Services (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 October 21 – 25, 2019. 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.

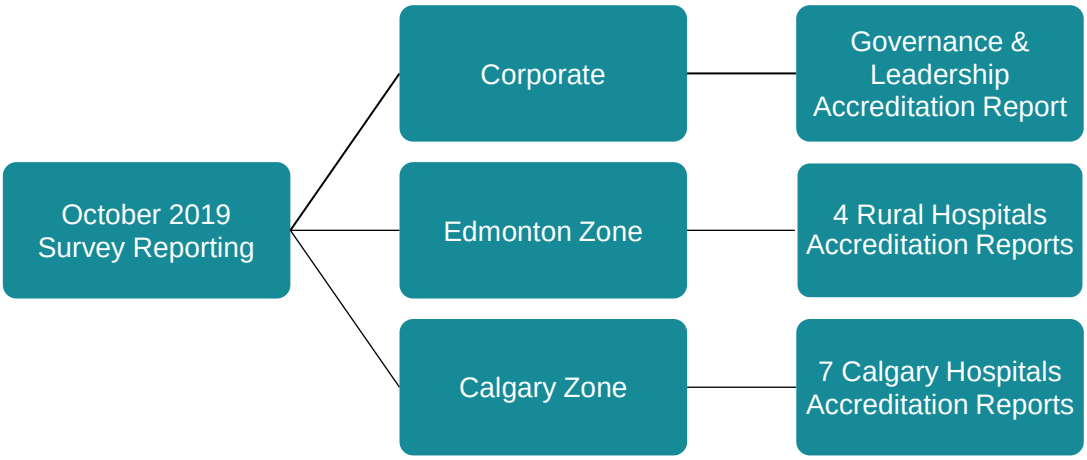
In 2019, Accreditation Canada and AHS co-designed an accreditation cycle that further enhances a sequential accreditation model. Under this new approach, Accreditation Canada will conduct two accreditation visits per year for the duration of the cycle (2019-2022). Accreditation visits are helping AHS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

Site-based assessments for rural hospitals will 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 whereby specialized 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 holistic 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, interim reports will be issued to AHS to support their quality improvement journey. At the end of the four-year accreditation cycle in 2022, a final report will be issued that includes the province’s overall accreditation award.

The accreditation reports for the October 2019 survey are organized as follows:



Edmonton Zone Suburban Hospital Assessment – Sites Visited

Devon General Hospital

Fort Saskatchewan Community Hospital

Leduc Community Hospital

Westview 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.

Section I – Edmonton Zone Report

1. Edmonton Zone Executive Summary

Surveyor Observations

The Edmonton Zone suburban hospital leadership team is commended for their work for its work that has promoted patient-centred care. It was evident at the sites that staff worked closely with patients and families to provide individualized care. Patients and families are very pleased with the care they receive. They described the staff as caring, compassionate, and kind.

Advisory Councils and Networks include patients and family members, and these groups are effective in providing input into Edmonton zone suburban hospital initiatives.

The Infection Prevention and Control (IPC) program in the Edmonton zone supporting the suburban hospitals provides a comprehensive set of tools to support local teams. The entire tool kit, as well as audit results, are available to the public on the AHS website, demonstrating an excellent model of transparency and public accountability. IPC audit results demonstrate good hand hygiene compliance.

Key Opportunities and Areas of Excellence

The Accreditation Canada survey team identified the following key opportunities and areas of excellence for the Edmonton zone suburban hospitals:

KEY OPPORTUNITIES
1. Performance appraisals and professional development were not completed consistently, and staff indicated that they would like to formally hear about their performance.
2. Continue to build upon the good practices related to patient-centred care at the organizational level.
3. Work with Edmonton zone suburban hospitals to align performance indicators with site goals, objectives and initiatives.

AREAS OF EXCELLENCE
1. Advisory Councils are effective and include patients as part the team.
2. Patients and families describe staff as caring, compassionate and kind.

3. The CoACT program promotes collaborative teams which was evident at all sites.

4. The IPC program demonstrates transparency and public accountability by making all IPC policies, procedures and audit results publicly available on the AHS website.

5. The antimicrobial stewardship program throughout AHS is comprehensive and provides extensive support, information, and feedback to practitioners.

2. Results at a Glance

This section provides a high-level summary of the results of the Edmonton zone suburban hospital assessment by standards, priority processes, and quality dimensions.

Compliance Overall[1]

% of criteria

Attested	On Site	Overall
100% met	87% met	91% met

# of attested criteria

Attested	Audited
16 criteria	0 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

Fig. I.1 Compliance by Standard

STANDARD	MET	UNMET	N/A	NOT RATED
Infection Prevention and Control	14			
Service Excellence	29	4		
Total	**43**	**4**		

Compliance by Quality Dimension

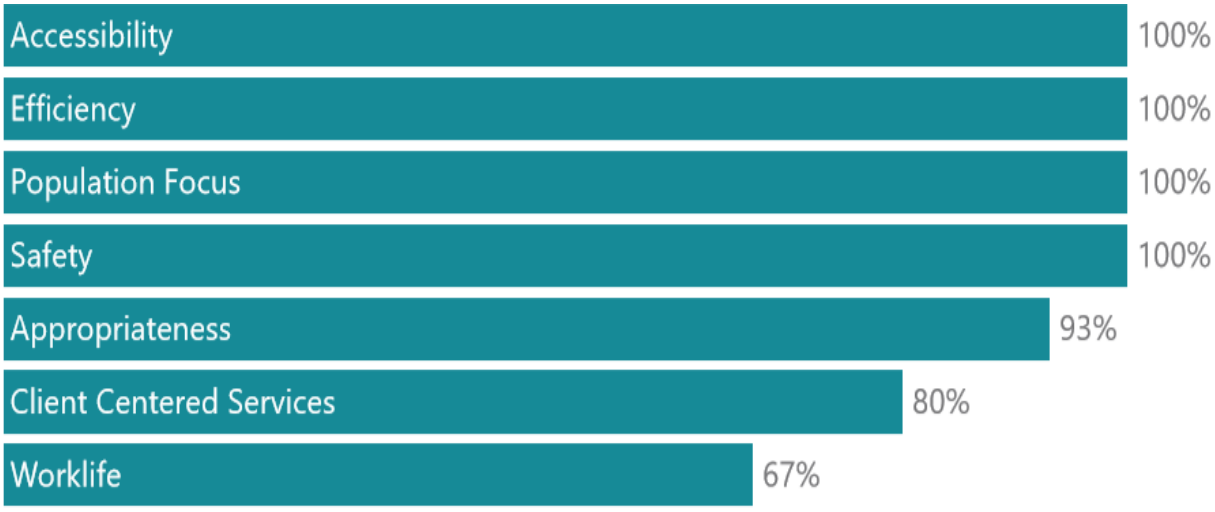


Fig. I.2 Compliance by Quality Dimension

QUALITY DIMENSION	MET	UNMET	N/A	NOT RATED
Accessibility	2			
Efficiency	1			
Population Focus	3			
Safety	4			
Worklife	2	1		
Appropriateness	27	2		
Client Centered Services	4	1		
Total	**43**	**4**		

3. Detailed Results: By Standard

Infection Prevention and Control

All the criteria are met for this Priority Process.

Priority Process Description:

Measures practiced by healthcare personnel in healthcare facilities to decrease transmission and acquisition of infectious diseases.

The Infection Prevention and Control team are to be commended for their commitment to a quality Infection Prevention and Control (IPC) program. There is a strong inter-professional team supporting and guiding IPC, including the involvement of physician leaders. The team is encouraged to continue to explore the input of clients, families, and communities in the infection prevention and control program.

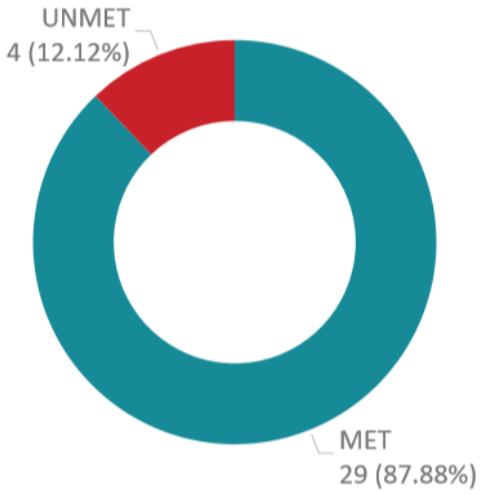
The IPC leadership team has established linkages and communication processes to the sites and created tools to translate standard procedures into locally relevant tool kits. The team is encouraged to establish more formalized structures related to communication to ensure consistency in messaging to all rural sites.

The Westech Audit system ensures that daily audits are completed at all rural sites by environmental staff. Feedback is provided on the audit results.

The implementation of the hand hygiene program has been effective. Hand hygiene audits occur, and the results are posted on the Quality Boards. The team is exploring innovative ways to audit hand hygiene including self-auditing.

The entire IPC toolkit of policies, procedures and audit results are publicly available on the AHS website. This degree of transparency and public accountability is to be commended. The team is encouraged to continue with the auditing process and to share results with clients, families, and the community.

Service Excellence



Description of the Standard:

Addresses team management, human resources and worklife, information management, and quality improvement.

STANDARD	UNMET CRITERIA	CRITERIA
Service Excellence	5.2	Work and job design, roles and responsibilities, and assignments are determined with input from team members, and from clients and families where appropriate.
Service Excellence	10.1	Information and feedback are collected about the quality of services to guide quality improvement initiatives, with input from clients and families, team members, and partners.
Service Excellence	10.4	Indicator(s) that monitor progress for each quality improvement objective are identified, with input from clients and families.
Service Excellence	10.11	Quality improvement initiatives are regularly evaluated for feasibility, relevance, and usefulness, with input from clients and families.

The Edmonton zone suburban hospitals are challenged by the competing priorities that have impacted the sites to achieve many performance improvement targets. The Edmonton zone suburban hospital leadership team is encouraged to determine priorities and set realistic targets for improvement.

The Edmonton zone suburban hospital leadership team is encouraged to provide support to the sites to develop local specific goals and objectives aligned with the AHS strategic direction and quality improvement. This could include education, a framework, and tools to support staff, physicians, patients, and families to embrace quality improvement and patient safety initiatives.

Section II – Leduc Community Hospital Report

1. Leduc Community Hospital Executive Summary

Surveyor Observations

The current survey focused on seven system-wide priority processes (People-Centred Care, Medication Management, Infection Prevention and Control, Physical Environment, Medical Devices and Equipment, Emergency Preparedness, and Patient Flow) as well as five service-level priority processes (Emergency Department, Inpatient Services, Obstetrics Services, Perioperative Services and Invasive Procedures, and Service Excellence). The survey took place October 21-22, 2019 and was conducted by two surveyors from outside of the province.

The Leduc Community Hospital is a well-established hospital with deep community roots. It participates with other Edmonton Zone hospitals to provide a daycare surgical program.

There is a strong culture of team-based collaboration in patient care. The acute care units are aligned with community medical practices to ensure patient follow up on discharge from the hospital.

While the hospital provides visibility of quality indicators through unit level 'quality boards' there is an opportunity to better align these quality indicators with unit level quality goals and to embed the quality initiatives into day to day practice for all staff. Local initiatives, such as the 'End PJ Paralysis' initiative are excellent examples of locally lead quality and patient safety improvements.

The staff are challenged to sustain focus on specific quality initiatives due to the sheer volume of initiatives underway within AHS and the Edmonton Zone. Staff are well supported with materials, education and decision support but find it hard to prioritize their focus on specific initiatives.

The hospital is clean, bright, and well maintained. There is a strong community feel expressed by staff and patients. Patients are pleased to be able to access services locally and feel well cared for in a friendly, patient focused environment.

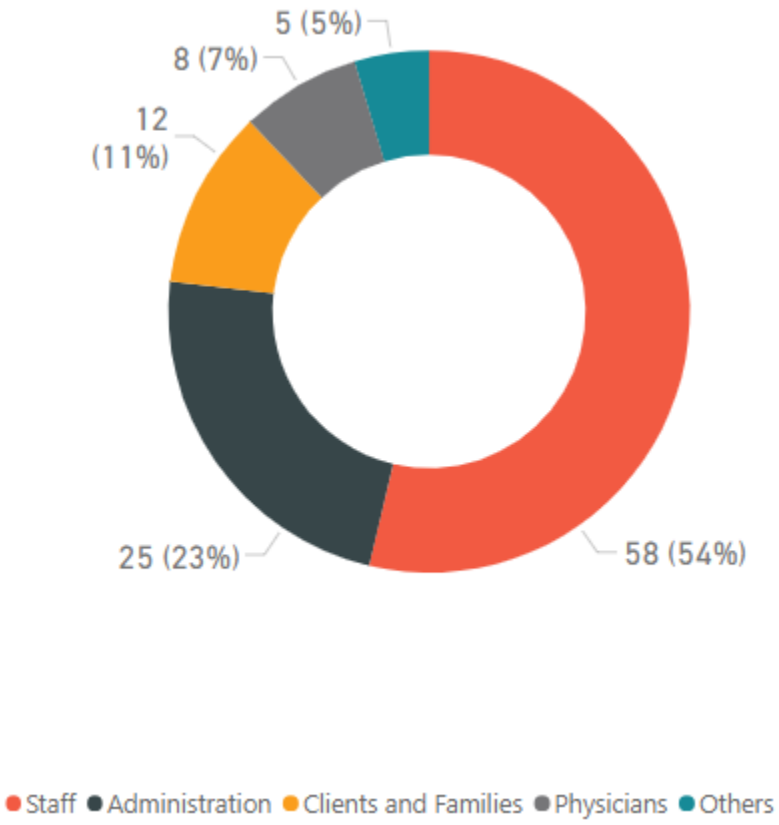
Although there are standardized processes for identified patient safety initiatives such as medication reconciliation (BPMH) and VTE risk assessment and prophylaxis, staff and medical staff continue to use variable processes and workarounds to complete these. The degree of unnecessary variation in these processes may potentially invalidate the safety improvements these standard processes are designed for. Staff and medical staff need to follow standard processes for these initiatives.

Survey Methodology

The Accreditation Canada survey team spent two days at Leduc Community Hospital.

Surveyors conducted 108 interviews during the survey

To conduct their assessment, the survey team gathered information from the following groups[2]:



[2] '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:

AREAS OF EXCELLENCE	
1.	Teamwork and collaborative practice were evident throughout the organization that resulted in integrated care. Physicians work well within the team and follow-up with patients on discharge.
2.	Discharge planning rounds are comprehensive, and the interdisciplinary team takes a holistic approach.
3.	The patient information package related to their roles and responsibilities in patient safety was developed with patient feedback. The material is easy to read and informative.
4.	Patients and families described staff as compassionate and caring. They felt that staff were responsive to their needs and requests.
5.	Patient flow throughout the hospital is well organized and effective.

KEY OPPORTUNITIES	
1.	Although there are standardized processes for identified patient safety initiatives such as medication reconciliation (BPMH) and VTE risk assessment and prophylaxis, staff and medical staff continue to use variable processes. Staff and medical staff need to follow standard processes for these initiatives.
2.	There is limited external signage directing patients to the emergency room (ER). The ER entrance sign is not visible until patients are directly in front of it.
3.	Within the hospital, signage for patients to follow is sparse and there are no floor level indicators for wayfinding.
4.	Staff are encouraged to review quality indicators provided to them by AHS through routine audits and set their own local goals and objectives for improvement from the range of indicators. Staff are also encouraged to set goals and objectives at the unit/hospital level for quality improvement initiatives that may not be audited by AHS.
5.	AHS Zone and hospital management are encouraged to provide consistent feedback to staff on the findings from and outcomes of, safety and critical incident reviews.

2. Results at a Glance

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

Compliance Overall[3]

% of criteria		
Attested	On Site	Overall
99% met	98% met	98% met

# of attested criteria	
Attested	Audited
122 criteria	18 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.

[3] 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

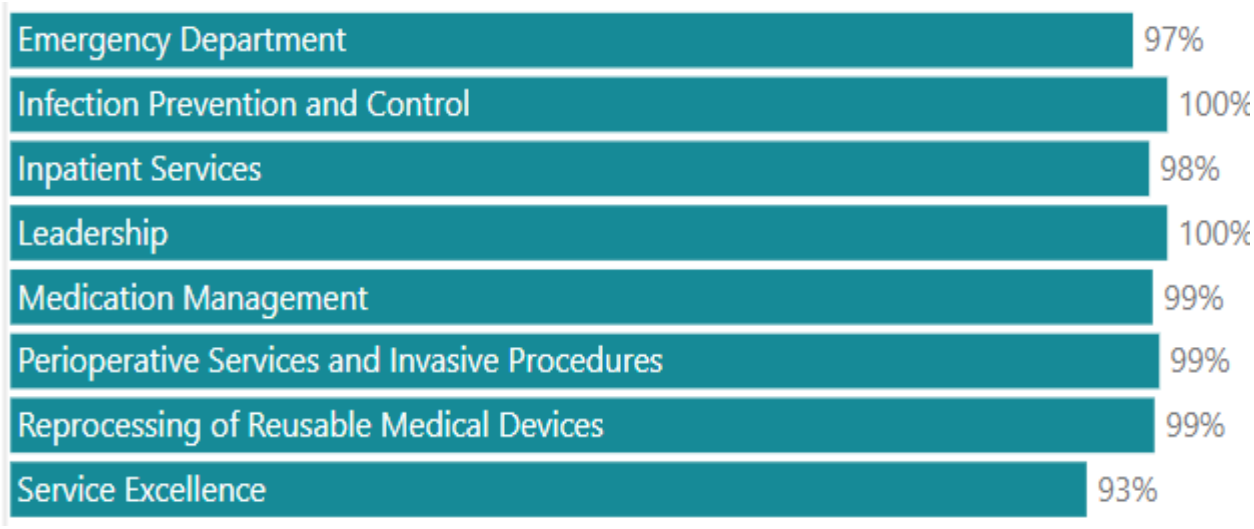


Fig. I.3 Compliance by Standard

STANDARD	MET	UNMET	N/A	NOT RATED
Emergency Department	98	3	2	-
Infection Prevention and Control	30			-
Inpatient Services	61	3	5	-
Leadership	9			-
Medication Management	78	1	12	-
Perioperative Services and Invasive Procedures	145	1	3	-
Reprocessing of Reusable Medical Devices	89	1	1	-
Service Excellence	40	3		-
Total	550	**12**	**23**	**-**

Compliance by System-level Priority Process

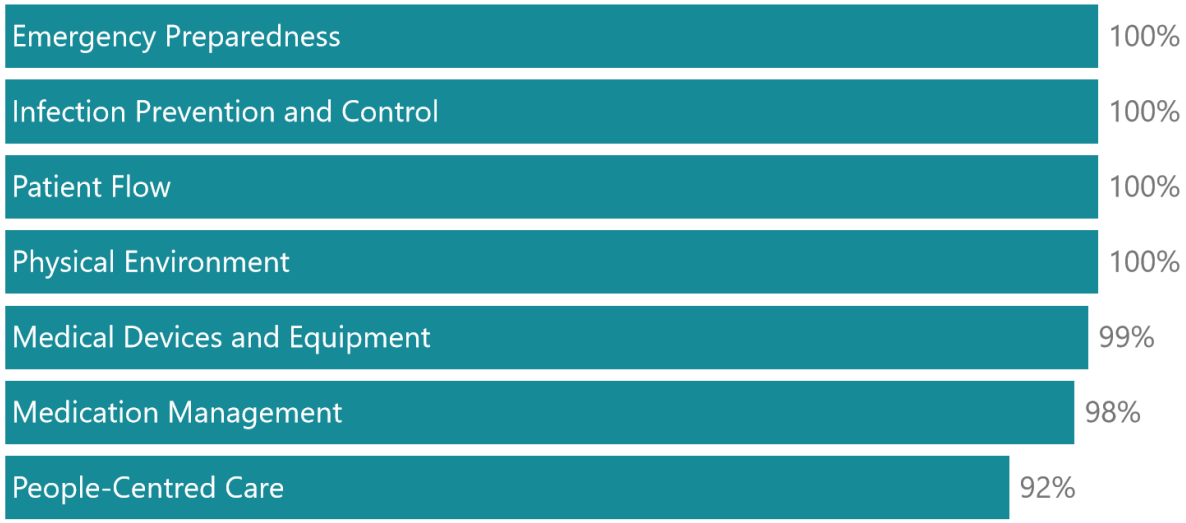


Fig. I.4 Compliance by System-level Priority Process

PRIORITY PROCESS	MET	UNMET	N/A	NOT RATED
Emergency Preparedness	5			-
Infection Prevention and Control	22			-
Patient Flow	19			-
Physical Environment	14			-
Medical Devices and Equipment	114	1	3	-
Medication Management	92	2	12	-
People-Centred Care	34	3		-
Total	**300**	**6**	**15**	**-**

Compliance by Quality Dimension

Fig. I.5 Compliance by Quality Dimension

STANDARD	MET	UNMET	N/A	NOT RATED
Accessibility	32	1	1	-
Appropriateness	164	7	4	-
Client Centred Services	99		2	-
Continuity of Services	20			-
Efficiency	8		1	-
Population Focus	1			-
Safety	207	4	15	-
Worklife	19			-
Total	**550**	**12**	**23**	**-**

Compliance by Required Organizational Practice (ROP)

ROP	STANDARD	RATING
COMMUNICATION		
Client Identification	Emergency Department	Met
	Inpatient Services	Met
	Perioperative Services and Invasive Procedures	Met
The 'Do Not Use' List of Abbreviations	Medication Management	Unmet
Medical Reconciliation at Care Transitions	Perioperative Services and Invasive Procedures	Met
	Emergency Department	Met
	Inpatient Services	Met
Safe Surgery Checklist	Perioperative Services and Invasive Procedures	Met
Information Transfer at Care Transitions	Emergency Department	Met
	Perioperative Services and Invasive Procedures	Met
	Inpatient Services	Unmet
MEDICATION USE		
Antimicrobial Stewardship	Medication Management	Met
Concentrated Electrolytes	Medication Management	Met
Heparin Safety	Medication Management	Met
High-alert Medications	Medication Management	Met
Infusion Pump Safety	Service Excellence	lUnmet
Narcotics Safety	Medication Management	Met
Infection Prevention and Control		
Hand-hygiene Compliance	Infection Prevention and Control	Met

Hand hygiene Education and Training	Infection Prevention and Control	Met
Infection Rates	Infection Prevention and Control	Met
Risk Assessment		
Falls Prevention and Injury Reduction	Inpatient Services	Unmet
	Perioperative Services and Invasive Procedures	Met
Suicide prevention	Emergency Department	Unmet
Pressure Ulcer Prevention	Inpatient Services	Unmet
Venous thromboembolism prophylaxis	Inpatient Services	Met
	Perioperative Services and Invasive Procedures	Met

3. 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

This system-level priority process refers to criteria that are tagged to one of the following standards: Leadership and Infection Prevention and Control.

All the criteria are met for this Priority Process.

Priority Process Description:

Planning for and managing emergencies, disasters, or other aspects of public safety.

A quick reference guide for all codes is available. Code Red is reviewed with staff on a monthly basis. Each month, one of the other codes is reviewed on-line and at staff meetings.

There is a robust user-friendly program to prepare staff, physicians, and volunteers in an event of an infection outbreak. It includes strategies to prevent flu outbreaks. The training program is comprehensive and includes online and in-person training.

Infection Prevention and Control

This system-level priority process refers to criteria that are tagged to the Infection Prevention and Control Standard.

All the criteria are met for this Priority Process.

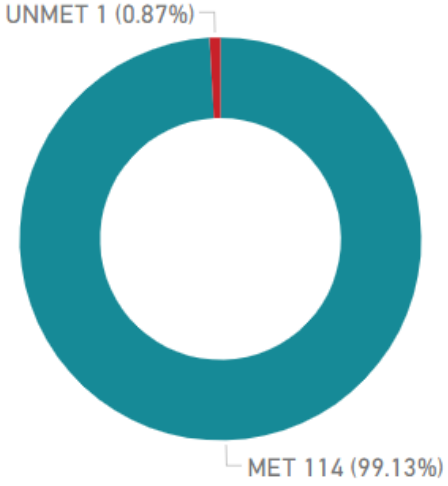
Priority Process Description:

Providing a framework to plan, implement, and evaluate an effective IPC program based on evidence and best practices in the field.

The Leduc Community Hospital infection prevention and control team is supported by extensive educational and support materials. The infection control lead has developed excellent unit level support materials that translate the general information into useful 'just in time' material for local clinical staff. Hand hygiene compliance rates are routinely monitored and are high.

Medical Devices and Equipment

This system-level priority process refers to criteria that are tagged to one of the following standards: Infection Prevention and Control, Perioperative Services and Invasive Procedures, and Reprocessing of Reusable Medical Devices.



Priority Process Description:

Obtaining and maintaining machinery and technologies used to diagnose and treat health problems.

STANDARD	UNMET CRITERIA	CRITERIA
Reusable Medical Reprocessing of Devices	3.3	Access to Medical Device Reprocessing (MDR) department is controlled by restricting access to authorized team members only and being identified with clear signage.

The Leduc Community Hospital provides medical device reprocessing for both the Leduc and Devon Hospitals. There is a solid team of appropriately trained medical device reprocessing MDR technicians working in the MDR unit. There were no identified issues pertaining to the sterilization and reprocessing processes followed by the MDR staff.

Endoscopy scopes are cleaned and reprocessed in a separate unit adjacent to the endoscopy suite. Staff are appropriately trained and follow all manufacturer's instructions in reprocessing and maintaining the endoscopes. There is a good one-way flow of scopes from the 'dirty' to the 'clean' sides of the unit.

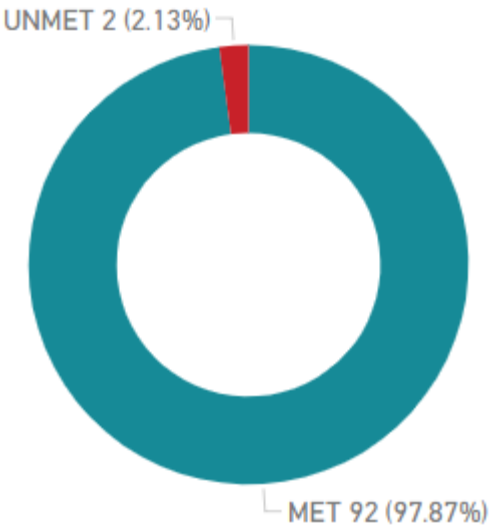
Soiled equipment from the Devon Hospital is shipped in a combination of closed plastic containers and clearly marked plastic bags. It is important that any transport method be sufficiently covered and protected to avoid accidental exposure or contamination. Sealed containers for all soiled equipment are preferred. The same is true for the transport of soiled equipment from the Leduc operating room (OR). Although there is a dedicated dumb waiter directly from the OR to the MDR area, equipment is transported in open basins covered only with a folded cloth. Covered and sealed containers would be more appropriate to avoid the potential for equipment to fall out if a basin is accidentally dropped or spilled.

The MDR is effectively designed as a one-way flow of equipment and materials. There are designated areas dirty, clean and sterile equipment. Although the areas for clean and sterilized equipment are understood by MDR staff, they are not indicated by signs. There is one crossover spot where unsterilized equipment is stored as sterilized equipment is transported past for storage that the MDR may wish to relocate.

Access to the MDR unit is clearly marked with appropriate signage for the use of personal protective equipment. Once inside the outer foyer, however, there are several doors that are not pass protected or signed that allow direct access to the clean equipment and sterile storage areas. The multiple points of access could allow cross contamination by staff. The MDR unit is encouraged to clearly sign the appropriate entry doors and ensure that they cannot be accessed by unauthorized staff.

Medication Management

This system-level priority process refers to criteria that are tagged to the Medication Management Standard and Perioperative Services and Invasive Procedures.



Priority Process Description:

Using interdisciplinary teams to manage the provision of medication to clients.

STANDARD	UNMET CRITERIA	CRITERIA
Medication Management	23.6	Lot numbers and expiry dates for vaccines are recorded in the client record following administration.
Perioperative Services and Invasive Procedures	3.4	Use of multi-dose vials is minimized.

The pharmacy team is high functioning and committed to patient safety. New learners are welcomed into the program.

They have embraced the Good Catch program by being aware of potential errors and being diligent in reporting these. There is an excellent practice in which reports are themed and potential actions are developed at the corporate level and shared with all the pharmacy departments.

There is a good standard high-level alert labeling protocol that is followed. Medication packages are labelled as high alert as per the protocol; however, there is not a distinguishing colour on the actual medication packaging. The organization is encouraged to explore options for distinguishing packaging for high alert medications.

Abbreviation “Do Not Use List” protocols are followed. Some physicians continue to use unacceptable abbreviations. Staff reported that audits of compliance are not completed which is a requirement.

During observation of a medication pass, it was noted that staff had a difficult time washing their hands before entering a room as they are carrying the medication and the Medication

Administration Record. The team is encouraged to explore strategies that will facilitate good hand hygiene during medication administration.

Lot numbers and expiry dates for vaccines are recorded in the client record following administration.

Patient Flow

This system-level priority process refers to criteria that are tagged to one of the following standards: Leadership, Emergency Department, and Perioperative Services and Invasive Procedures.

All the criteria are met for this Priority Process.

Priority Process Description:

Assessing the smooth and timely movement of clients and families through service settings.

Patient flow within the Leduc Community Hospital is well organized and efficient. Transfer times for admitted patients from the ER to inpatient units consistently meet target times.

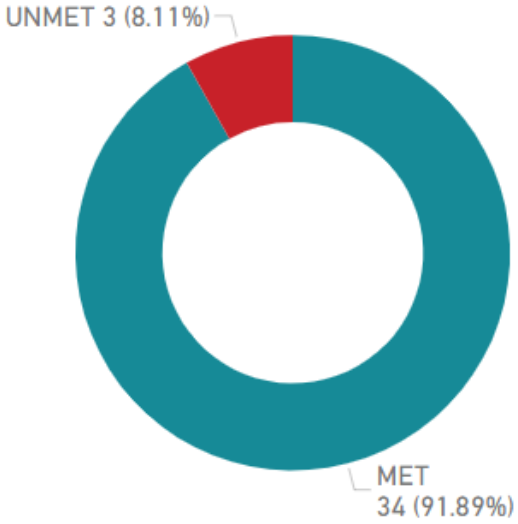
Patient flow to the OR follows a one-way flow through surgical daycare, preop holding, OR, and post-operation units.

Wayfinding for patients within the hospital could be improved by using floor level directional indicators to specific clinical units. Currently, ceiling level signs may not be easily visible to patients.

Patient transfers to higher levels of care are effectively managed and the ER participates in a Zone level EMS triage and ER bypass policy and protocol to ensure that patients are transported to an appropriate level of care expeditiously.

People-Centred Care

This system-level priority process refers to criteria that are tagged to one of the following standards: Emergency Department, Inpatient Services, Perioperative Services and Invasive Procedures, and Service Excellence.



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.

STANDARD	UNMET CRITERIA	CRITERIA
People-Centred Care	5.1	Each client's physical and psychosocial health is assessed and documented using a holistic approach, in partnership with the client and family.
People-Centred Care	1.3	Service-specific goals and objectives are developed, with input from clients and families.
People-Centred Care	10.3	Measurable objectives with specific timeframes for completion are identified for quality improvement initiatives, with input from clients and families.

The organization has embraced patient-centred care at the bedside. Teams are committed to providing individualized patient-centred care. Patients indicated that they are involved in the development of their care plans and goal setting. Patients understood and were engaged in promoting their own safety; for example, getting out of bed with assistance and using good hand hygiene practices. The whiteboards in the room are being used and patients/families interviewed found the information on these boards helpful when these were updated.

The organization continues to work on enhancing patient-centred care. Leadership rounding is completed on a regular basis. Patient and family feedback is collected along with patient relations feedback that facilitates the identification of improvement areas. Several examples of improvements related to patient feedback were shared including: improvement of the whiteboards, addition of room numbers, improved signage, open visiting and food services improvements.

The organization is encouraged to formally involve patients and families in the development of measurable objectives related it quality improvement at the unit level.

Patients and families described staff as knowledgeable, caring and compassionate. They indicated they receive good individualized care and are proud of the community hospital.

Physical Environment

This system-level priority process refers to criteria that are tagged to one of the following standards: Leadership and Perioperative Services and Invasive Procedures.

All the criteria are met for this Priority Process.

Priority Process Description:

Providing appropriate and safe structures and facilities to achieve the organization's mission, vision, and goals.

This team is committed to ensuring a good service that supports safe patient care.

The organization is challenged with issues related to an aging building. There are several requests for maintenance and the team sets priorities considering the impact on patients. Accessibility issues related to bariatric patients entering the emergency department was noted. The organization is encouraged to develop plans to ensure all patients have equal access.

Preventative maintenance contracts are secured for major building operations such as boilers, elevators and MDRD equipment. A hand-written logbook is kept. The team is encouraged to explore and implement an electronic system that is proactive in ensuring that preventative maintenance is completed on time by the contracted service providers.

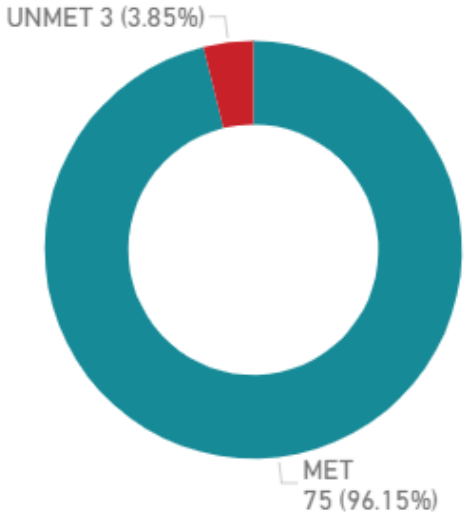
There is an effective interdisciplinary team that plans for and manages safety during periods of renovation and construction projects. Infection control and health safety protocols are followed.

The team is committed to ensuring building systems are functioning appropriately. They take ownership of problems, learn from incidents and make improvements in the back-up systems to reduce the impact of utility failures.

4. 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.[4]

Emergency Department



Episode of Care Bundle Description:

Partnering with clients and families to provide client-centred services throughout the health care encounter.

STANDARD	UNMET CRITERIA	CRITERIA
Emergency Department	5.8	Seclusion rooms and/or private and secure areas are available for clients.
Emergency Department	9.9	The effectiveness of transitions is evaluated, and the information is used to improve transition planning, with input from clients and families.
Emergency Department	10.1	Specific goals and objectives regarding wait times, length of stay (LOS) in the emergency department, client diversion to other facilities, and number of clients who leave without being seen are established, with input from clients and families.

The ER at Leduc Community Hospital is easily accessible from the front entrance of the hospital. Staff recently implemented a revised flow pattern for triaging and registering patients that ensures that all patients presenting to the ER are initially triaged using the standard CTAS criteria and then can be directly observed while in the waiting room.

There is limited external signage directing patients to the emergency entrance which is accessed from a residential street parallel to the main thoroughfare. The main sign over the door of the ER is only visible after approaching the front entrance. This may not be enough to

[4] Note that the calculations in this section sum all of the Service-level priority processes in an *Episode of Care* bundle. These calculations exclude Required Organizational Practices.

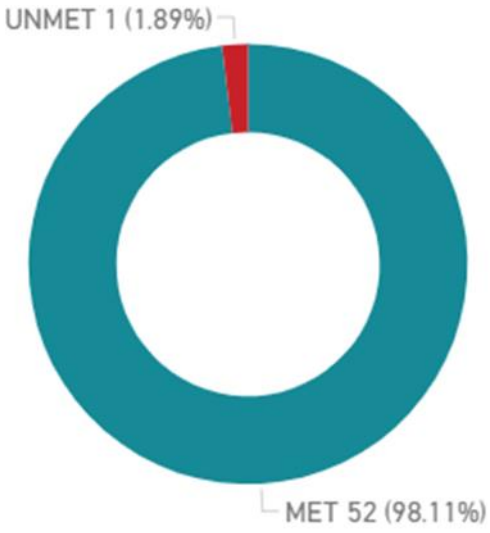
allow a patient unfamiliar with the hospital to quickly find the ER. Enhanced exterior signage from the main thoroughfare to the ER would be helpful.

Standardization of processes for patient safety initiatives such as medication reconciliation (BPMH) and VTE risk assessment and prophylaxis. Currently, staff and medical staff use different processes to complete these and the resulting safety improvements are not realized.

The Leduc ER is aligned with other Zone ERs in an EMS triage and bypass transfer system that focuses on getting patients to the appropriate care in an efficient manner. Patients identified by EMS staff as having acute mental health concerns are transferred directly to Edmonton. Nonetheless, Leduc ER staff need to be competent to identify, assess, and initially manage patients presenting to the ER with varying mental health issues. All staff could complete the appropriate mental health and addictions training modules offered by AHS. Similarly, a standardized suicide risk assessment could be incorporated into all patient assessments. There is no 'secure room' for aggressive or unstable psychiatric patients and there is limited ability to keep these patients safe from self-harm.

The ER along with other areas of the hospital has adopted safety needles as part of its safety sharps initiatives. However, the ER has not started using safety scalpels and non-safety needles are still available.

Inpatient Services



Episode of Care Bundle Description:

Partnering with clients and families to provide client-centred services throughout the health care encounter.

STANDARD	UNMET CRITERIA	CRITERIA
Inpatient Services	4.12	Ethics-related issues are proactively identified, managed, and addressed.
Inpatient Services	6.11	There is a process of when to use restraints and education does occur. There is no evaluation/assessment of trending of the use as a last resort.

This team is collaborative, integrated, and high functioning. Patients indicated that staff are caring and provide compassionate care.

The admission assessments that were reviewed did not include a standardized approach for a psycho-social assessment. However, weekly rounds are very thorough and include discussion about the patients' psycho-social needs. The organization is encouraged to include psycho-social assessments on admission.

Quality Boards that post AHS objectives were evident on the units. However, generally, performance indicators were not aligned with the objectives at the unit level. The team is aware of AHS's focus in areas such as hand hygiene, and prevention of falls and pressure ulcers; however, clear targets were not identified except for hand hygiene. Staff was not aware of specific improvement initiatives that they were working on. Staff indicated that they would like to see the Quality Council that included staff, start up again. They felt that this would assist in ensuring that the teams were working together to make improvements. The team is encouraged to work with staff and patients/families to set realistic targets and actions to achieve and monitor progress towards these key performance indicators.

The "End PJ Paralysis" initiative is viewed as an excellent practice. The team indicated that they have already seen improved patient outcomes. The organization is implementing this program throughout the entire organization which is viewed positively.

It was noted that the falls assessments were completed; however, the interventions document was not consistently completed. Staff suggested that the interventions should start on the same page as the assessment to make it more visible.

Perioperative Services and Invasive Procedures

All the criteria are met for this Priority Process.

Episode of Care Bundle Description:

Partnering with clients and families to provide client-centred services throughout the health care encounter.

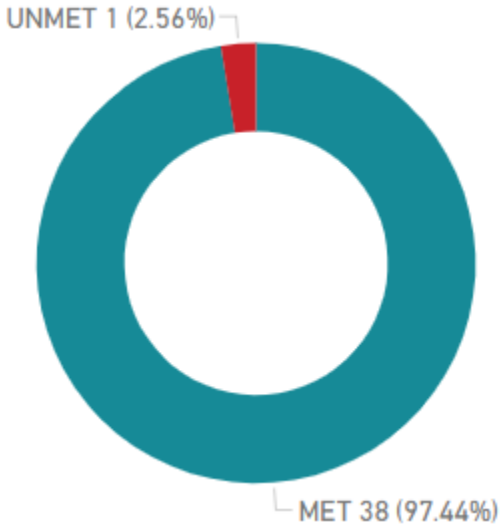
The Leduc Community Hospital surgical program is a day care program, organized in alignment and collaboration with other surgical units across the Edmonton Zone. Although it would not normally be considered routine to have neurosurgery performed in a rural hospital, the decision process to optimize utilization of all OR suites within the Zone to allow access to low-risk daycare surgical procedures has been well thought out. There is a focus on ensuring that patients access surgery within the designated time limits set for each surgical procedure.

The operating suite is a modern, well designed three OR units that are well equipped. Staff follow the Safe Surgery processes with a well-established three phase checklist and appropriate preoperative 'pauses'.

The OR suite has appropriate zones of escalating sterility. The overall OR suite is pass protected to avoid unauthorized access. The zones of sub-sterility and sterility are clearly demarcated by a change in the flooring color. This is understood by staff. However, there is no corresponding signage to indicate the change in zones that would alert a newcomer or visitor to these zones and remind staff visually of the change in zones and access restrictions.

Dirty equipment from the OR is transported directly to MDR via a dedicated dumb waiter. Equipment is transported in uncovered basins wrapped in a folded towel. The OR and MDR are encouraged to adopt the use of closed and sealed containers for the transport of dirty equipment to eliminate the risk of contamination if a basin is dropped or spilled.

Service Excellence



Episode of Care Bundle Description:

Partnering with clients and families to provide client-centred services throughout the health care encounter.

STANDARD	UNMET CRITERIA	CRITERIA
Service Excellence	2.7	A universally-accessible environment is created with input from clients and families.

The teams noted that there were several competing priorities from central which made it difficult to make significant improvements in one area and sustain the results.

Most performance appraisals were completed as per the policy. However, some staff indicated that they had not had a review for some time and would like to have one. The site is encouraged to find a methodology in which all staff have access to performance evaluation.

Staff acknowledged that there were several opportunities for online education. Some staff noted that ongoing external education was no longer supported and in cases where it was, the process to receive support was onerous. They felt that attending external conferences were valuable as they always shared new learnings that improved practice.

Staff indicated that they were recognized by their peers. They suggested that they would like to see more recognition from leadership.

Staff were aware that there was an ethical framework; however, were not knowledgeable about the process. When they have questions, they refer to leadership. The site is encouraged to discuss potential ethical issues and possibly share case studies to increase use of the framework and tools.

5. Criteria for Follow-up

Criteria Identified for Follow-up by the Accreditation Decision Committee

STANDARD	CRITERIA TYPE	CRITERIA	DUE DATE
Emergency Department	Regular	**5.8** Seclusion rooms and/or private and secure areas are available for clients.	June 30, 2020
Emergency Department	ROP	Clients are assessed and monitored for risk of suicide. **6.7.1** Clients at risk of suicide are identified. **6.7.2** The risk of suicide for each client is assessed at regular intervals or as needs change.	June 30, 2020
Inpatient Services	ROP	To prevent falls and reduce the risk of injuries from falling, universal precautions are implemented, education and information are provided, and activities are evaluated. **5.8.3** The effectiveness of fall prevention and injury reduction precautions and education/information are evaluated, and results are used to make improvements when needed.	June 30, 2020
Inpatient Services	ROP	Each client's risk for developing a pressure ulcer is assessed and interventions to prevent pressure ulcers are implemented. **5.9.5** The effectiveness of pressure ulcer prevention is evaluated, and results are used to make improvements when needed.	June 30, 2020
Inpatient Services	ROP	Information relevant to the care of the client is communicated effectively during care transitions. **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	June 30, 2020

		needed Evaluating safety incidents related to information transfer (e.g., from the patient safety incident management system.	
Medication Management	ROP	A list of abbreviations, symbols, and dose designations that are not to be used have been identified and implemented. **14.7.7** Compliance with the organization's 'Do Not Use List' is audited and process changes are implemented based on identified issues.	June 30, 2020
Reprocessing of Reusable Medical Devices	Regular	**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.	June 30, 2020
Service Excellence	ROP	A documented and coordinated approach for infusion pump safety that includes training, evaluation of competence, and a process to report problems with infusion pump use is implemented. **3.8.5** The effectiveness of the approach is evaluated. Evaluation mechanisms may include: Investigating patient safety incidents related to infusion pump use Reviewing data from smart pumps Monitoring evaluations of competence Seeking feedback from residents, families, and team members	June 30, 2020