2022

Rocky Mountain House Health Centre

Central Zone

Alberta Health Services

Spring Survey

April 25 – May 6, 2022

ACCREDITATION AGRÉMENT CANADA

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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 April 25 – May 6, 2022. 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 (2019-2023). Accreditation visits are helping AHS achieve its goal of being *Accreditation Ready* every day by inspiring teams to work with standards as part of their day-to-day quality improvement activities.

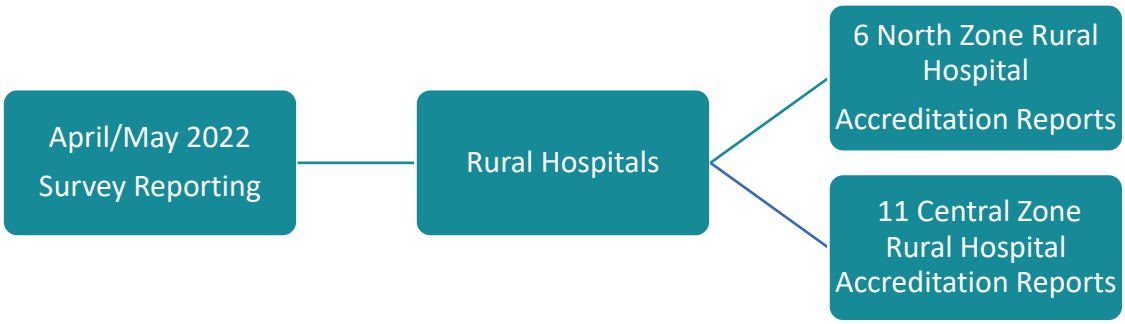
Focused assessment for the foundational standards of Governance, Leadership, Infection Prevention, and Control, Medication Management and Reprocessing of Reusable Medical Devices occurred in the first year of the cycle (Spring and Fall surveys for 2019).

During the cycle (2019-2023), 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 accreditation cycle, in Spring 2023, an overall report will be issued that includes the province's overall accreditation award.

The accreditation reports for the Spring 2022 Survey are organized as follows:



North Zone Rural Hospital Assessment – Sites Visited

- Beaverlodge Municipal Hospital
- Fox Creek Healthcare Centre
- Grande Cache Community Health Complex
- Northwest Health Centre
- St. Theresa General Hospital
- Valleyview Health Centre

Central Zone Rural Hospital Assessment – Sites Visited

- Drayton Valley Hospital and Care Centre
- Drumheller Health Centre
- Hanna Health Centre
- Innisfail Health Centre
- Olds Hospital and Care Centre
- Ponoka Hospital and Care Centre
- Rimbey Hospital and Care Centre
- Rocky Mountain House Health Centre
- Stettler Hospital and Care Centre
- Myron Thompson Health Centre
- Three Hills 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

Rocky Mountain House Health Centre is a busy site working with Red Deer Regional Hospital to assist with decanting of surgical patients from the Regional Hospital.

The leadership team in this site is new. The team is energetic and eager to develop their site into one of excellence. It is highly encouraged that AHS provide some onsite mentoring and support for the new leaders. There are other rural hospitals within the Central Zone that have established leadership teams. It is suggested that linking the new site leadership with more experienced site leadership would be beneficial and may lead to increased retention.

Health Human Resource challenges have resulted in the closure of ten beds at the Rocky Mountain House Health Centre with some agency nurses working in the emergency department and the inpatient units.

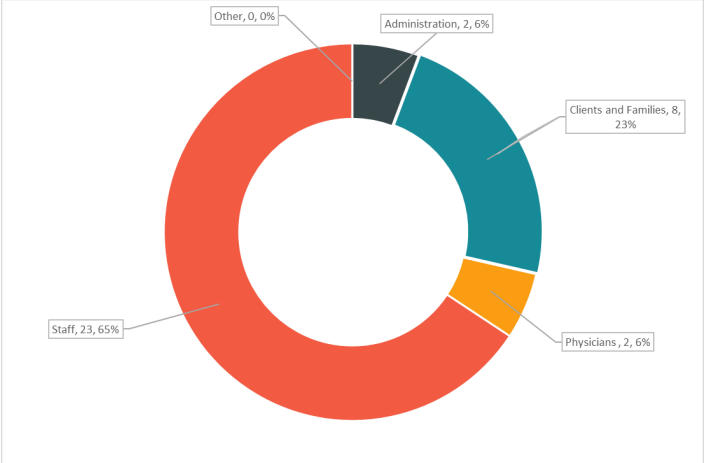
The site could use some assistance in space planning. There is an opportunity to review current space and identify areas that could improve flow and working conditions.

Survey Methodology

The Accreditation Canada Surveyors spent 1.5 days at Rocky Mountain Health Centre.

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

Groups	# of interviews
Administration	2
Client & Families	8
Physician	2
Staff	23
Other	0



[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. Further develop team goals and objectives
2. Audit Required Organizational Practices (ROPs) and follow up
3. Perform a structured orientation for clinical staff
4. Find ways to mitigate the Health Human Resource challenges

Areas of Excellence

1. Building capacity for additional OR cases
2. Assisting the Red Deer Regional Hospital by taking on their Day Surgery Cases
3. Energetic and eager leadership team
4. Hospitalist Program with excellent transfer of information at transitions
5. Caring and committed staff

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 97% met	On-Site 94% met	Overall 94% met
Number of attested criteria		
Attested 106 criteria	Audited 18 Criteria	

Attestation:

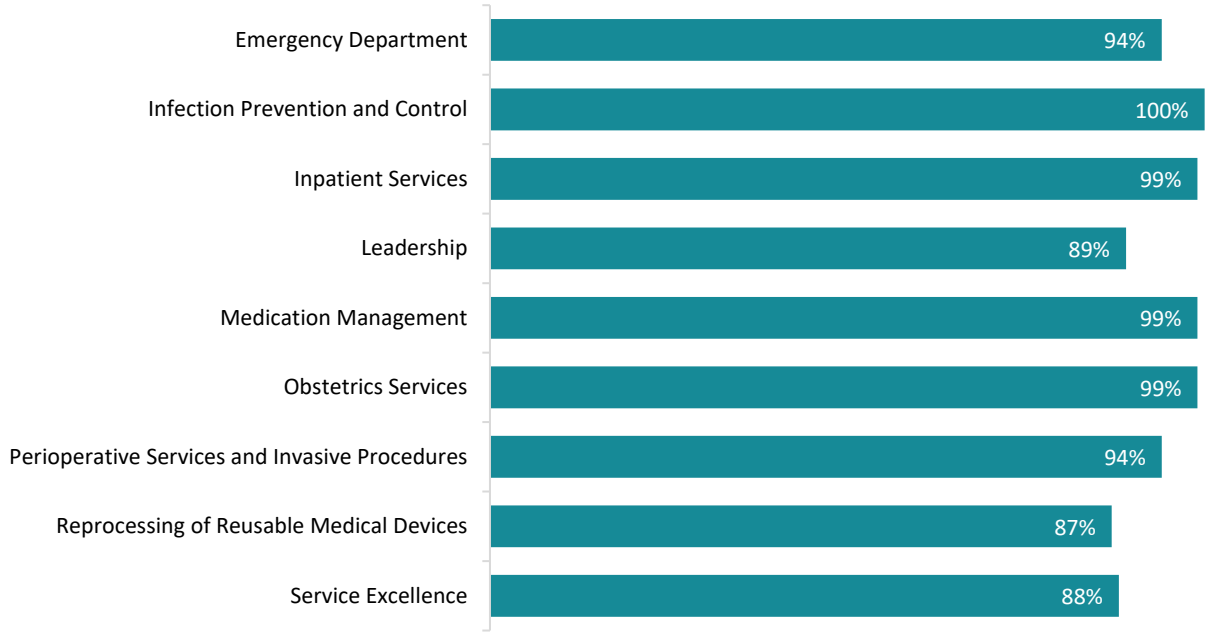
A form of conformity assessment that requires organizations to conduct a self-assessment on specified criteria and provide a declaration that the assessment is accurate to the best of the organization's knowledge. This data is used to inform an accreditation award.

On-site Assessment:

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

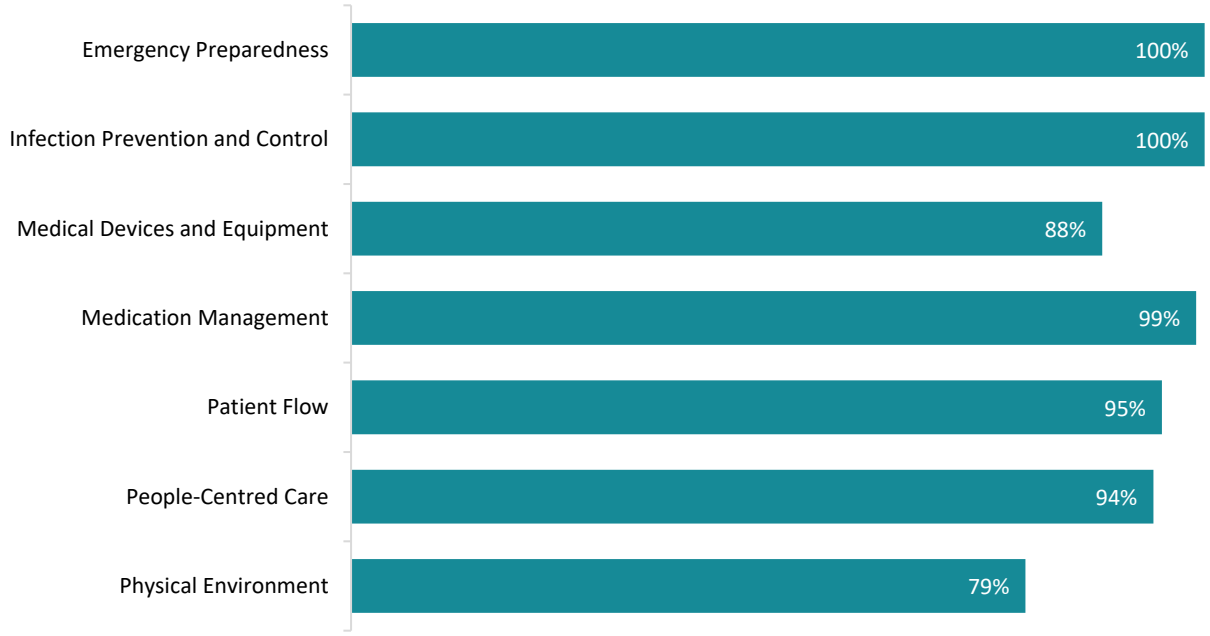
[1] In calculating percentage compliance rates throughout this report, criteria rated as 'N/A' and criteria 'NOT RATED' were excluded. Data at the 'Tests for Compliance' level were also excluded from percentage compliance calculations. Compliance with ROPs and their associated 'Tests for Compliance'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

Compliance by Standard



STANDARD	MET	UNMET	N/A	NOT RATED
Emergency Department	89	6	0	0
Infection Prevention and Control	37	0	0	0
Inpatient Services	67	1	1	0
Leadership	8	1	0	0
Medication Management	75	1	11	2
Obstetrics Services	81	1	1	0
Perioperative Services and Invasive Procedures	137	8	4	0
Reprocessing of Reusable Medical Devices	78	12	1	0
Service Excellence	67	9	0	0

Compliance By System Level Priority Process



PRIORITY PROCESS	MET	UNMET	N/A	NOT RATED
Emergency Preparedness	7	0	0	0
Infection Prevention and Control	34	0	0	0
Medical Devices and Equipment	95	13	4	0
Medication Management	90	1	11	2
Patient Flow	18	1	0	0
People-Centred Care	47	3	0	0
Physical Environment	11	3	0	0

Compliance by Quality Dimension

DIMENSION	MET	UNMET	N/A	NOT RATED
Accessibility	42	2	0	0
Appropriateness	199	18	5	1
Client Centered Services	128	3	2	0
Continuity of Services	25	0	0	0
Efficiency	5	1	0	0
Population Focus	4	0	0	0
Safety	219	11	10	1
Worklife	17	4	1	0
Total	639	39	18	2

Compliance by Required Organizational Practice (ROP)

ROP	STANDARD	RATING
COMMUNICATION		
Client Identification	Emergency Department	MET
	Inpatient Services	MET
	Obstetrics Services	MET
	Perioperative Services and Invasive Procedures	MET
The 'Do Not Use' list of Abbreviations	Medication Management	UNMET
Medical Reconciliation at Care Transitions	Emergency Department	MET
	Inpatient Services	MET
	Obstetrics Services	MET
	Perioperative Services and Invasive Procedures	MET
Information Transfer at Care Transitions	Emergency Department	UNMET
	Inpatient Services	UNMET
	Obstetrics Services	UNMET
	Perioperative Services and Invasive Procedures	UNMET
Safe Surgery Checklist	Obstetrics Services	UNMET
	Perioperative Services and Invasive Procedures	UNMET
MEDICATION USE		
Antimicrobial Stewardship	Medication Management	MET
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	UNMET

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
RISK ASSESSMENT		
Falls prevention and injury reduction	Inpatient Services	UNMET
	Obstetrics Services	UNMET
	Perioperative Services and Invasive Procedures	UNMET
Pressure ulcer prevention	Inpatient Services	UNMET
	Perioperative Services and Invasive Procedures	UNMET
Suicide prevention	Emergency Department	MET
Venous thromboembolism prophylaxis	Inpatient Services	UNMET
	Perioperative Services and Invasive Procedures	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.

There are regular tabletop drills for various scenarios as well as monthly fire drills. Consideration should be given to more frequent practice of other drills and conducting fire drills and code blue situations outside of day shift hours. Results from drills are reviewed with site leads and staff. Emergency Response Manuals are available and accessible on all units. Some areas of the manual such as Code Green and Facility Evacuation Plan have not been updated in several years. Consideration should be given to review and ensure they remain applicable.

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 a Zone representative for infection prevention and control (IPC) at Rocky Mountain House Health Centre. The Zone Infection Control Practitioner (ICP) visits the site at least once weekly but was not onsite during the accreditation visit. This resource is appreciated by the staff and is easy to reach for questions.

At the time of the site visit there was no evidence of hand hygiene rates and audits have not been conducted. Due to health human resource challenges the site has been unable to recruit a staff member to conduct audits and provide feedback. Staff in all areas of the hospital receive education during orientation and with the high turnover in leadership, the annual education on hand hygiene has not been consistently completed.

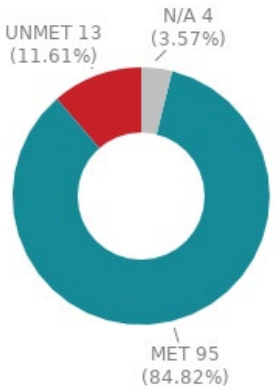
Staff in areas visited were knowledgeable about infection control practices. There was a COVID outbreak at this site in the past six months. The outbreak was identified early, and steps were taken to ensure the outbreak was resolved in a timely way.

The COVID pandemic has focused on IPC practices and the multiple changes in knowledge about the virus has led to a robust multi-disciplinary team serving the province, with input at all levels to deliver client friendly messages to the public, staff and patients and clients in healthcare facilities.

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: Perioperative Services and Invasive Procedures; Reprocessing of Reusable Medical Devices.

The MDR area is small, cramped, and is being replaced soon with a new build including an operating theatre. The decontamination area is a small room with a table dividing one side of the room between clean and dirty items. The clean side, or where the sterilizer is has no hand wash sink. There is a separate room where the bundles are wrapped but it is in with an office space.



There is no restricted access to the clean or dirty areas. The staff are diligent with quality control and monitor their own sterile supply room for temperature and humidity.

Currently the Operating Room (OR) leaves the contaminated items in a box outside the OR and the MDR staff pick them up and take them to the decontamination area.

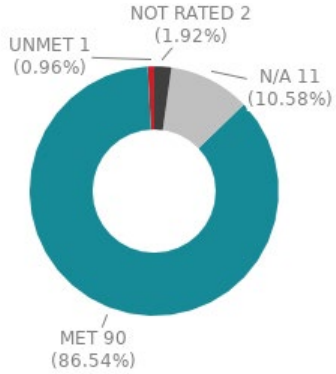
In the new build coming, staff are concerned with the flow of endoscopy. The endoscopy reprocessing area will be quite distant from the procedure room where the endoscopy will be taking place. It would be beneficial to have input from staff i.e., someone familiar with nursing flow and MDR flow to review plans prior to starting construction.

Biomed and facility staff work together to ensure all equipment is functioning properly. There is a capital equipment process that allows for leadership to solicit feedback from staff and physicians and then put forward their desired equipment list.

STANDARD	UNMET CRITERIA	CRITERIA
Perioperative Services and Invasive Procedures	2.9	Contaminated items are transported separately from clean or sterilized items, and away from client service and high-traffic areas.
Reprocessing of Reusable Medical Devices	2.5	The effectiveness of resources, space, and staffing is evaluated with input from the team, and stakeholders.
Reprocessing of Reusable Medical Devices	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
Reprocessing of Reusable Medical Devices	3.2	The Medical Device Reprocessing (MDR) department is designed to prevent cross-contamination of medical devices, isolate incompatible activities, and clearly separate work areas.
Reprocessing of Reusable Medical Devices	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.
Reprocessing of Reusable Medical Devices	3.4	The Medical Device Reprocessing (MDR) department has an area for decontamination that is physically separate from other reprocessing areas and the rest of the facility.
Reprocessing of Reusable Medical Devices	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.
Reprocessing of Reusable Medical Devices	6.2	Work and job design, roles and responsibilities, and assignments are determined with input from team members, and stakeholders where appropriate
Reprocessing of Reusable Medical Devices	8.2	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.
Reprocessing of Reusable Medical Devices	8.9	Workplace assessments of the Medical Device Reprocessing (MDR) department are regularly conducted for ergonomics and occupational health and safety.
Reprocessing of Reusable Medical Devices	11.3	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.
Reprocessing of Reusable Medical Devices	12.1	The Medical Device Reprocessing (MDR) department has an appropriate storage area for sterilized medical devices and equipment.
Reprocessing of Reusable Medical Devices	12.2	Access to the sterile storage area is limited to authorized team members.

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; Perioperative Services and Invasive Procedures.



There is a pharmacist, pharmacy tech, and a pharmacy assistant onsite giving excellent service to the site. The pharmacist attends Rapid Rounds and does the discharge medication reconciliation. The pharmacy itself is well organized. The pharmacy tech has organized the drugs into oral, integumentary, inhalation and injectable. These medications are in color coded trays, which match the colored trays in the inpatient medication room.

Look alike - sound alike medications are stored side by side, however, with a high alert and sound alike sticker on the drugs. Tall Man lettering is also used to help differentiate the drugs.

The pharmacy team is looking forward to the implementation of Care Connect. The pharmacist believes that there will be fewer errors, and less need to call physicians to confirm prescriptions.

No audits of Do Not Use abbreviations are done in the pharmacy. Audits of high alert drugs, narcotics, and electrolytes are done on a yearly basis.

STANDARD	UNMET CRITERIA	CRITERIA
Medication Management	21.1	Information about medications is discussed and documented prior to the initial dose and when the dose is adjusted, in partnership with the client and family.

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; Perioperative Services and Invasive Procedures.

Patient flow is managed daily. Due to site level human resource challenges ten beds have been closed at this site.

Ambulance wait times for patient transfers, consults, or diagnostic tests can be delayed and patient transport systems are not reliable.

There are times patients will wait in the emergency department for up to two days for admission to Rocky Mountain House Health Centre. The perceived reason is the number of beds that have been closed due to staff shortages along with the pressure to admit Alternate Level of Care (ALC) patients from other sites.

There was no perceived delay in getting higher level of care transfers for patients to a referral centre.

The site is encouraged to set up more formal auditing to measure the wait times, transfer times and time to transfer admitted patients from the emergency department to the inpatient unit.

STANDARD	UNMET CRITERIA	CRITERIA
Leadership	13.1	Client flow information is collected and analyzed in order to identify barriers to optimal client flow, their causes, and the impact on client experience and safety.

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; Obstetrics Services; Perioperative Services and Invasive Procedures; Service Excellence.

A formal Patient and Family Advisory Council is in place at the Central Zone level. The Rocky Mountain House Health Centre has a process for follow up on patient and family concerns. Pamphlets with this information were available in key patient care areas at this site.

At the care team level, the Collaborative Care approach is in its very early stages of implementation. Comfort Rounds and Care Huddles along with use of whiteboards in patient rooms are evident but not consistently completed nor is feedback provided to the units on progress. No formal audits

are in place and the team is encouraged to implement these as part of their quality improvement journey. Patients spoke very positively about their care and involvement in care decisions.

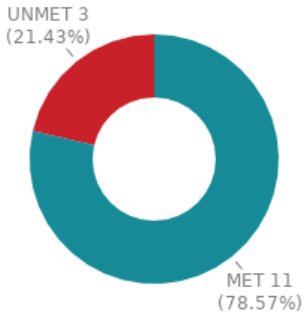
The presence of a mental health nurse onsite has supported the emergency department with appropriate assessment and treatment for this patient group. Mental health patients however do have long waits at times for psychiatric medical consultation and care.

The site is encouraged to consider creative ways to further engage patients in planning and service design at the local site level.

STANDARD	UNMET CRITERIA	CRITERIA
Service Excellence	1.3	Service-specific goals and objectives are developed, with input from clients and families.
Service Excellence	2.4	Space is co-designed with clients and families to ensure safety and permit confidential and private interactions with clients and families.
Service Excellence	3.3	A comprehensive orientation is provided to new team members and client and family representatives.

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; Perioperative Services and Invasive Procedures.



Rocky Mountain House Health Centre is an older building with a newer addition. The physical site is well maintained with appropriate infrastructure supports in place. Areas are well organized and preventative maintenance is done on all equipment. Online systems contain alerts to ensure follow up and regular preventative maintenance is completed.

Signage for the hospital is appropriate and units are organized, neat, and clean with minimal clutter in hallways.

Capital investments have been made to maintain the site with plans underway for an OR expansion that may result in an additional generator to support this expansion. The team is encouraged to involve patients and families in the review of the layout and design of this building.

STANDARD	UNMET CRITERIA	CRITERIA
Perioperative Services and Invasive Procedures	1.1	The physical layout of the operating and/or procedure room(s) and equipment are designed to consider client flow, traffic patterns, the types of procedures performed, ergonomics, and equipment movement logistics.
Perioperative Services and Invasive Procedures	1.2	The area where invasive procedures are performed has three levels of increasingly restricted access: unrestricted areas, semi-restricted areas, and restricted areas.
Perioperative Services and Invasive Procedures	1.9	The operating/procedure room has a restricted-access area for the sterile storage of supplies.

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.

Emergency Department

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

The Rocky Mountain House Health Centre has a busy emergency department (ED) seeing patients 24/7. The department itself is small, with lots of equipment stored in various areas. The ED is staffed with RNs, LPNs, and one physician. The unit has a designated quiet room for mental health patients; however, the room is currently being used to store equipment to create space in other areas to conduct COVID suspect intubations.

Staff have access in the daytime hours to a mental health nurse that is onsite. This provides support for appropriate assessment and treatment of this patient group.

Pediatric Assessment Guidelines are posted/laminated and available to assist staff with triage assessments. The ED is encouraged to look at reviewing a pediatric triage tool to implement in the department. The tool can be very helpful by providing the norms for each age grouping making it easier for staff to recognise a deterioration in the pediatric patient status.

Staff are also encouraged to review triage guidelines and conduct audits to ensure patient triage meets Canadian Triage and Acuity Care Standards. Audits should also be put in place for other key areas of practice in the ED including reassessments, information transfer, and length of stay for admitted patients to look for areas for improvement in the quality improvement journey.

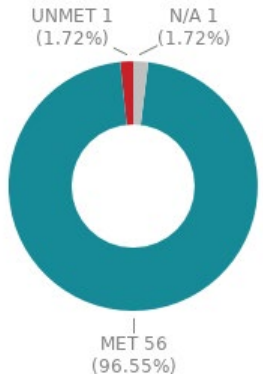
There are poor sight lines within the department to the rooms and the waiting room, however, there are cameras within the department to allow opportunity to view the waiting room. Staff are encouraged to consider patient rounding in the waiting area when the wait times are long.

Staff orientation at the site level is not well organized or standardized. The unit is encouraged to develop orientation checklists to ensure all important aspects of care are covered during this time. Staff indicated that there is a lack of ongoing education available at the site level.

STANDARD	UNMET CRITERIA	CRITERIA
Emergency Department	1.1	Orientation to the unique work environment in the emergency department is provided to new team members.
Emergency Department	4.8	Clients waiting in the emergency department are monitored for possible deterioration of condition and are reassessed as appropriate.
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.
Emergency Department	10.3	Data on wait times for services, the length of stay in the emergency department, and the number of clients who leave without being seen is tracked and benchmarked.

Inpatient Services

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



Inpatient services consist of a variety of medical/surgical admissions with limited order sets available. A very small number of stable pediatric admissions take place each year and order sets are available to ensure safe quality care for this patient group. Education for this low volume care is in place for staff on the inpatient units.

There is minimal orientation provided to staff at this site. The leadership is encouraged to develop a more formalized orientation program and request visible educator presence to support the staff.

Physician care is provided by Hospitalists that rotate on a weekly basis. The physicians are to be commended for the hospitalist home grown electronic summary that they complete for each patient to ensure safe transition each week.

The site leadership at Rocky Mountain House Health Centre are new to their roles and need to be provided guidance and mentorship. The staff and physicians are excited about the new site leadership and the ideas they have for improving quality at the unit level. The atmosphere at the facility is pleasant and bright with a cohesive interdisciplinary team environment.

Daily discharge rounds are conducted and the interdisciplinary team including the physician participates. Huddle boards are visible, however, information on the huddle boards is very outdated. Huddles are

encouraged but not consistently done. There are several local improvement opportunities that could be put in place to ensure alignment with evaluation of Required Organizational Practices. A proactive auditing system should be put in place with results that are shared with the team.

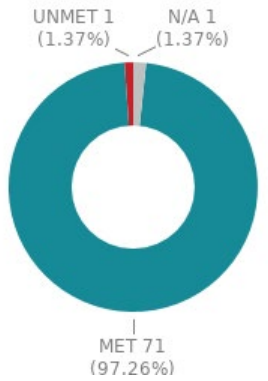
At the care team level this site is in the early phases of Collaborative Care implementation and audits are not completed to ensure follow up and feedback on these initiatives. Comfort Rounds along with whiteboards in patient rooms are evident but not consistently updated or completed. The patients spoke very positively related to their care. The team is encouraged to move forward with bedside shift reports to further engage patients in care decisions.

Paper based charting is in place which results in documents being in different locations on the unit. The upcoming implementation of Connect Care is eagerly anticipated, and preparations are underway.

STANDARD	UNMET CRITERIA	CRITERIA
Inpatient Services	6.11	A process to monitor the use of restraints is established by the team, and this information is used to make improvements.

Obstetrics Services

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



This site previously had approximately 300 births per year but is now down to about 100. This has caused skill maintenance issues and a private midwife practice has set up, without much collaboration between the site or the physicians. Approximately 20% of the midwives' clients must come into hospital to deliver. Rocky Mountain House Health Centre is encouraged to develop a working relationship with the midwives. One patient had to transition to the hospital as she required a c-section and had been labouring for more than 48 hours.

There is minimal orientation for new staff coming to the site. They do participate in MORE OB and have developed a relationship with the Labour & Delivery unit at Red Deer Regional Hospital to analyze fetal heart strips. The staff in Red Deer have told the staff at the site to fax a strip at any time they are worried or just want to confirm what they are seeing. This has made staff more comfortable with understanding the fetal heart monitoring and staff feel supported.

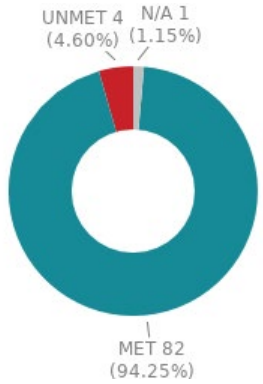
The clients are very appreciative of the service and describe the experience as "great care".

The program could use some dedicated educational time to maintain their skills levels.

STANDARD	UNMET CRITERIA	CRITERIA
Obstetrics Services	8.8	The effectiveness of transitions is evaluated and the information is used to improve transition planning, with input from clients and families.

Perioperative Services and Invasive Procedures

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



The perioperative area is small and cramped. There is a new build occurring, breaking ground was due to occur in March.

There is really only one number lock to access the operating room (OR), but it is easily circumvented by the multiple access points through the hallways.

The preoperative area and recovery area are the same space, and it is situated down two different corridors from the OR.

The Safe Surgical Checklist has been abbreviated and does not meet the standards. Rocky Mountain House Health Centre is encouraged to do a refresh and implement this best practice in the OR.

Booking forms come from the surgeon's office and are then entered into the provincial system that tracks wait times. Patients are booked according to their place on the waitlist, and by urgency, which is determined by the surgeon.

The site is currently rearranging some of their space to assist Red Deer Regional Hospital in decanting some of their outpatient surgeries. Currently the recovery room is also used for wound care on a weekly basis.

STANDARD	UNMET CRITERIA	CRITERIA
Perioperative Services and Invasive Procedures	6.5	The assessment includes a discussion with the client about postoperative pain management options and preferences.
Perioperative Services and Invasive Procedures	14.1	Counts for sponges, sharps, and instruments are documented in the client record.
Perioperative Services and Invasive Procedures	15.16	There is a process to follow up with discharged day surgery clients.
Perioperative Services and Invasive Procedures	15.17	The effectiveness of transitions is evaluated and the information is used to improve transition planning, with input from clients and families.

Service Excellence

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

Some guidelines and order sets are available for common conditions at this site. Incidents are reported and follow up is complete when a risk is identified. The team is encouraged to move forward with auditing best practices and providing feedback to staff as they continue their quality improvement journey. The huddle boards in place at the site should be updated regularly and consistent huddles should be held for staff engagement and learning.

The site is encouraged to regularly conduct performance evaluations and strengthen training opportunities.

STANDARD	UNMET CRITERIA	CRITERIA
Service Excellence	3.1	Required training and education are defined for all team members with input from clients and families.
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	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.
Service Excellence	10.8	Indicator data is regularly analyzed to determine the effectiveness of the quality improvement activities.
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
Emergency Department	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).	June 30, 2023
Infection Prevention and Control	8.6.2	Hand-hygiene compliance results are shared with team members and volunteers.	June 30, 2023
	8.6.3	Hand-hygiene compliance results are used to make improvements to hand-hygiene practices.	June 30, 2023
Inpatient Services	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, 2023
	5.9.5	The effectiveness of pressure ulcer prevention is evaluated, and results are used to make improvements when needed.	June 30, 2023
	5.10.3	Measures for appropriate VTE prophylaxis are established, the implementation of appropriate VTE prophylaxis is audited, and this information is used to make improvements to services.	June 30, 2023
	6.11	A process to monitor the use of restraints is established by the team, and this information is used to make improvements.	June 30, 2023
	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 (e.g., from the patient safety incident management system	June 30, 2023

Medication Management	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, 2023
	21.1	Information about medications is discussed and documented prior to the initial dose and when the dose is adjusted, in partnership with the client and family.	June 30, 2023
Obstetrics Services	3.6.3	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, 2023
	4.16.2	Documentation tools and communication strategies are used to standardize information transfer at care transitions.	June 30, 2023
	4.16.4	Information shared at care transitions is documented.	June 30, 2023
	4.16.5	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)	June 30, 2023
	5.6.1	The team has agreed on a three-phase safe surgery checklist to be used for surgical procedures performed in the operating room.	June 30, 2023
	5.6.2	The checklist is used for every surgical procedure.	June 30, 2023
	5.6.5	Results of the evaluation are used to improve the implementation and expand the use of the checklist.	June 30, 2023
Perioperative Services and Invasive Procedures	1.9	The operating/procedure room has a restricted-access area for the sterile storage of supplies.	June 30, 2023
	2.9	Contaminated items are transported separately from clean or sterilized items, and away from client service and high-traffic areas.	June 30, 2023
	6.10.3	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, 2023
	6.11.5	The effectiveness of pressure ulcer prevention is evaluated, and results are used to make improvements when needed.	June 30, 2023

	7.11.1	The information that is required to be shared at care transitions is defined and standardized for care transitions where clients experience a change in team membership or location: admission, handover, transfer, and discharge.	June 30, 2023
	7.11.2	Documentation tools and communication strategies are used to standardize information transfer at care transitions.	June 30, 2023
	7.11.4	Information shared at care transitions is documented.	June 30, 2023
	7.11.5	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).	June 30, 2023
	9.3.1	The team has agreed on a three-phase safe surgery checklist to be used for surgical procedures performed in the operating room.	June 30, 2023
	9.3.2	The checklist is used for every surgical procedure.	June 30, 2023
	9.3.5	Results of the evaluation are used to improve the implementation and expand the use of the checklist.	June 30, 2023
	14.1	Counts for sponges, sharps, and instruments are documented in the client record.	June 30, 2023
Reprocessing of Reusable Medical Devices	3.2	The Medical Device Reprocessing (MDR) department is designed to prevent cross-contamination of medical devices, isolate incompatible activities, and clearly separate work areas.	June 30, 2023
	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, 2023
	3.4	The Medical Device Reprocessing (MDR) department has an area for decontamination that is physically separate from other reprocessing areas and the rest of the facility.	June 30, 2023
	3.6	The Medical Device Reprocessing (MDR) department has floors, walls, ceilings, fixtures, pipes, and work surfaces that are easy to clean,	June 30, 2023

		non-absorbent, and will not shed particles or fibres.	
	12.2	Access to the sterile storage area is limited to authorized team members.	June 30, 2023
Service Excellence	3.1	Required training and education are defined for all team members with input from clients and families.	June 30, 2023
	3.8.6	When evaluations of infusion pump safety indicate improvements are needed, training is improved or adjustments are made to infusion pumps.	June 30, 2023