Accreditation Report

Qmentum Global™ Program

Westview Health Centre

Alberta Health Services

Report Issued: June 18, 2024

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About Accreditation Canada

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

About the Accreditation Report

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

As part of this ongoing process of quality improvement, the organization participated in continuous quality improvement activities and assessments, including an on-site survey from May 6 to May 10, 2024.

Information from the cycle assessments, as well as other data obtained from the Organization, was used to produce this Report. Accreditation Canada is reliant on the correctness and accuracy of the information provided by the Organization to plan and conduct the on-site assessment and produce this Report. It is the Organization's responsibility to promptly disclose any and all incidents to Accreditation Canada that could impact its accreditation decision for the Organization.

Confidentiality

Executive Summary

About the Organization

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

In 2019, Accreditation Canada and AHS co-designed an accreditation cycle that further enhances a sequential accreditation model. Under this new approach, Accreditation Canada will conduct two accreditation visits per year for the duration of the cycle (2023-2027). Accreditation visits are helping AHS achieve its goal of being Accreditation Ready every day by enabling and empowering teams to work with standards as part of their day-to-day quality improvement activities to support safe care.

Focused assessment for the foundational standards of Governance, Leadership, Infection Prevention, and Control, Medication Management and Reprocessing of Reusable Medical Devices occur in the first survey of the cycle (Fall 2023).

During the cycle, location-based assessments for rural hospitals use a holistic approach and integrate assessments for all clinical service standards applicable at the site, as well as the foundational standards of Emergency and Disaster Management, Infection Prevention and Control, Leadership, Medication Management, Reprocessing of Reusable Medical Devices and Service Excellence. Program-based assessments are applied to large urban hospitals, provincial, and community-based programs where clinical services are assessed against the respective clinical service standard along with the foundational standards. This integrated assessment approach provides a more comprehensive assessment and aligns with different levels of accountability.

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

After each accreditation survey, reports are issued to AHS to support their quality improvement journey. At the end of the accreditation cycle, in Spring 2027, an overall decision will be issued that includes the organizations’ accreditation award.

Surveyor Overview of Team Observations

The Westview Health Center provides a variety of inpatient and outpatient services to approximately 97,000 residents. At Westview Health Center the team is their greatest asset. Collaboratively they provide patient-focused, quality health care that is accessible to their community while they strive to be their best and give their best in a compassionate and respectful way. The leadership team is “small but mighty” and focused on improving delivery of safe, quality care despite many being new to their individual leadership roles.

Westview Health Centre is aligned with AHS priorities and direction but does have support to adjust and adapt practice based on the needs of the population. The team has implemented some tools and practices (such as the precursor to the Communication Access Box, and barcode scanning for long-term care residents) that have been or are being considered for provincial rollout.

Quality initiatives are abundant; they are often small and impactful but are not evident on quality boards in units and could be shared more widely for staff, patients, and visitors to highlight successes. The teams are encouraged to develop formal processes to partner with patient and family advisors for input into quality improvement initiatives and inform decision making at the unit level.

Physical space is a challenge given the increasing volume and acuity of the patients presenting to the organization for care. The team continues to be innovative in their approach to delivery of safe, patient-focused care despite the ongoing pressures.

Key Opportunities and Areas of Excellence

Areas of Excellence

1. Highly engaged, committed, and dedicated team. Staff enjoy working at Westview Health Centre.
2. Collaborative leadership team.
3. Strong relationships with community partners.
4. Innovative practice – for example, improved management of *Staphylococcus. aureus* bacteremia; long-term care barcode scanning for medication administration; Communication Access Box.

Key Opportunities:

1. Inclusion of community, patients, and family members as patient/family advisors.
2. Re-establish unit-based Quality Councils or committees.
3. Conduct an environmental scan to assess opportunities to declutter, improve the environment and further reduce safety and infection risks.
4. Consider methods for reducing Alternate Level of Care occupancy; this will also improve patient flow and access to inpatient beds.
5. Growth and development of new leaders, and succession planning strategies.

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

Accreditation Decision

Alberta Health Services' accreditation decision continues to be:

Accredited

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

Required Organizational Practices

ROPs contain multiple criteria, which are called Tests for Compliance (TFC). Accreditation Canada's Accreditation Decision Committee guidelines require 80% and above of ROP's TFC to be met.

Table 1: Summary of the Organization's ROPs

ROP Name	Standard(s)	# TFC Rating Met	% TFC Met
Medication Reconciliation at Care Transitions - Emergency Department	Emergency Department	1 / 1	100.0%
Suicide Prevention	Emergency Department	5 / 5	100.0%
	Long-Term Care Services	5 / 5	100.0%
Client Identification	Emergency Department	1 / 1	100.0%
	Inpatient Services	1 / 1	100.0%
	Long-Term Care Services	1 / 1	100.0%
	Perioperative Services and Invasive Procedures	1 / 1	100.0%
Information Transfer at Care Transitions	Emergency Department	5 / 5	100.0%
	Inpatient Services	5 / 5	100.0%
	Long-Term Care Services	5 / 5	100.0%
	Perioperative Services and Invasive Procedures	5 / 5	100.0%
Hand-hygiene Education and Training	Infection Prevention and Control	1 / 1	100.0%

Table 1: Summary of the Organization's ROPs

ROP Name	Standard(s)	# TFC Rating Met	% TFC Met
Hand-hygiene Compliance	Infection Prevention and Control	3 / 3	100.0%
Infection Rates	Infection Prevention and Control	3 / 3	100.0%
Medication Reconciliation at Care Transitions Acute Care Services (Inpatient)	Inpatient Services	4 / 4	100.0%
	Perioperative Services and Invasive Procedures	4 / 4	100.0%
Falls Prevention and Injury Reduction - Inpatient Services	Inpatient Services	3 / 3	100.0%
	Perioperative Services and Invasive Procedures	3 / 3	100.0%
Pressure Ulcer Prevention	Inpatient Services	5 / 5	100.0%
	Long-Term Care Services	5 / 5	100.0%
	Perioperative Services and Invasive Procedures	N/A	N/A
Venous Thromboembolism (VTE) Prophylaxis	Inpatient Services	4 / 4	100.0%
	Perioperative Services and Invasive Procedures	N/A	N/A
Medication Reconciliation at Care Transitions - Long-Term Care Services	Long-Term Care Services	4 / 4	100.0%
Fall Prevention and Injury Reduction - Long-Term Care Services	Long-Term Care Services	6 / 6	100.0%
Skin and Wound Care	Long-Term Care Services	8 / 8	100.0%

Table 1: Summary of the Organization's ROPs

ROP Name	Standard(s)	# TFC Rating Met	% TFC Met
Antimicrobial Stewardship	Medication Management	3 / 5	60.0%
High-alert Medications	Medication Management	8 / 8	100.0%
Heparin Safety	Medication Management	4 / 4	100.0%
Narcotics Safety	Medication Management	3 / 3	100.0%
Concentrated Electrolytes	Medication Management	3 / 3	100.0%
The 'Do Not Use' List of Abbreviations	Medication Management	7 / 7	100.0%
Safe Surgery Checklist	Perioperative Services and Invasive Procedures	5 / 5	100.0%
Infusion Pump Safety	Service Excellence	6 / 6	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.

Emergency and Disaster Management

Standard Rating: 100.0% Met Criteria

0.0% of criteria were unmet.

Assessment Results

The organization establishes and maintains a holistic culture of emergency and disaster preparedness that integrates emergency and disaster planning throughout its operations in alignment with AHS guidelines.

As part of its planning process, the organization consults with leaders and governing bodies in the community to determine whether community emergency plans have been developed, and how the organization may integrate its emergency and disaster plan with the community's plans. The team has strong relationships with Emergency Medical Services (EMS), police and fire departments.

The healthcare team meets monthly and has a mandate to review all code policies and procedures to ensure they are applicable to the site and aligned with the province. The team has a mechanism in place to debrief following a code to understand any learnings and communicate to all stakeholders any improvement opportunities identified.

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

Unmet Criteria for Emergency and Disaster Management

There are no unmet criteria for this section.

Infection Prevention and Control

Standard Rating: 100.0% Met Criteria

0.0% of criteria were unmet.

Assessment Results

One infection control professional (ICP) provides support to multiple sites, including Westview Health Centre and is on-site at least one day per week and as required. There are good relationships with Environmental Services (ES) and reprocessing department, unit staff and leadership. The ICP is present at monthly site quality meetings and is consulted as needed by clinical and support teams. Westview Health Centre follows AHS policies and procedures and can adapt some of these based on the patient population that it serves (for example, starting blood stream infection surveillance as the population here is not at risk for central line bloodstream infections). The ICP is well connected with the Edmonton zone ICP and is also well supported by the zone medical director for IPC.

Hand-hygiene (HH) auditing and reporting are performed by trained auditors; results are available by zone and by hospital/unit. The HH program here is strong, with good compliance rates. Staff are aware of their performance, as units (emergency department, inpatient) had these posted on their quality boards. The hospital is commended for being one of several receiving a HH Excellence Edmonton Zone award for high compliance with HH. Heathcare associated infection (HAI) rates and environmental cleaning audits are also reported regularly and available to staff.

Unmet Criteria for Infection Prevention and Control

There are no unmet criteria for this section.

Leadership

Standard Rating: 80.0% Met Criteria

20.0% of criteria were unmet. For further details please review the table at the end of this section.

Assessment Results

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

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

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

The physical environment appears clean in all areas visited although storage areas are very limited, leading to clutter in hallways. Carpeted handrails that are difficult to clean, present throughout the facility, were noted on the last survey and are still present; it is recommended that these be removed.

Table 2: 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

Medication Management

Standard Rating: 95.9% Met Criteria

4.1% of criteria were unmet. For further details please review the table at the end of this section.

Assessment Results

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

There are regular reviews of adverse events and trends conducted by the management team to identify, promote, educate, and recommend improvements to assure safe medication processes are in place. Safety incidents are reported using the safety event reporting system and the reviews are rigorous, generating recommendations for improvement and risk mitigation.

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

AHS has a policy/process for allowing multi-dose vials to be permitted in clinical areas, however more work could go into understanding where multi-dose vials can be removed and replaced where appropriate, with unit dose specific medications.

There is an antimicrobial stewardship program in place to support coordinated interventions designed to improve and measure the appropriate use of antimicrobials including selection, dosing, duration of therapy and route of administration. This is the foundation for this work, but there is an opportunity to improve auditing and feedback mechanisms, thereby making a more robust wholesome program.

The team is encouraged to review safe storage of anesthetic agents to ensure they are in an area with adequate ventilation, as per the manufacturer’s instructions.

Required organization practices are embedded in practice, including an up to date “Do Not Use” abbreviation list, high-alert medications, concentrated electrolytes, narcotics safety, heparin safety, and venous thromboembolism (VTE) prophylaxis. Audits are completed at expected frequencies and continuous learning supports improvement. The electronic health record system has care pathways with standard order sets to help guide practice and physicians use computerized prescriber order entry (CPOE) to help prevent errors at the medication ordering and dispensing stages. However, the organization is encouraged to develop and implement a policy on when and how to override the CPOE alert system to ensure the safe ordering of medication.

The pharmacy spaces on the units are well organized and functional. Visual inspection of several medication rooms revealed well organized, clean and clutter free spaces having appropriate access controls and stable environmental conditions. Workstations on wheels support the nursing team with administration of medications and nurses were fluent in articulating and demonstrating safe medication administration practices. ADCs support medication administration in most care areas. The team has expressed a need to include ADCs on the long-term care (LTC) and palliative units to

support the safe delivery and storage of medication.

The team is involved in several process improvement projects. They are proud of the work in LTC and palliative care to initiate barcode scanning on these units to support the delivery of safe medication practices. They have also started a new process to support *Staphylococcus aureus* Bacteremia Management (OPTIMUS-SAB) on the inpatient unit. *Staphylococcus aureus* bacteremia (SAB) is associated with high morbidity and mortality. Based on local data, only 29% of SAB patients are managed optimally, resulting in high mortality rates in Alberta (30%) compared to other jurisdictions. Through OPTIMUS-SAB, the intent is to provide support to all acute care physicians caring for adult patients regardless of acute care site. Another initiative was to introduce standardized anesthetic trays in the operating room (OR) to improve delivery and availability of medication. An ADC was also installed in the OR to promote storage, delivery, and traceability of medication.

Table 3: Unmet Criteria for Medication Management

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

Service Excellence

Standard Rating: 98.8% Met Criteria

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

Assessment Results

Most of the leadership team at Westview Health Centre are new to their positions and the organization, but the team is engaged and collaborative, and committed to providing high quality care to the community they serve. The team is aware of the patient flow and capacity pressures that exist; despite surge capacity protocols (EZ STEP), the organization is generally at full capacity. The leadership team is encouraged to continue to find creative, safe solutions to address capacity challenges, though Westview Health Centre is already recognized as a high-priority site for physical growth.

Staffing has generally not been a challenge at Westview Health Centre, and many new staff have been onboarded recently. Staff are overall happy to work here and feel a part of the team, and work to their full scope. The leadership team is aware of the need to provide formal performance conversations regularly as these have not been performed for some staff for many years. Leadership is encouraged to develop future leaders and consider plans for succession planning.

Westview Health Centre has strong partnerships within the community and continues to work with its partners to ensure the best care for patients. While patient and family advisors provide input at the zone level, Westview Health Centre should consider formally engaging patient and family advisors at the site to better inform quality improvement (QI) initiatives, and unit and service decision making.

There is a multidisciplinary site Quality Committee that meets monthly, with unit quality committees just starting to regroup. Although many small and impactful QI processes have been implemented at the site, some have been implemented more broadly (e.g. Communication Access Box), successes could be shared more broadly with staff, patients and families, and the community. The team and organization are commended for their recent HH Excellence award.

Table 4: Unmet Criteria for Service Excellence

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

Service Specific Assessment Standards

The Qmentum Global™ program has a set of service specific assessment standards that are tailored to the organization undergoing accreditation. Accreditation Canada works with the organization to identify the service specific assessment standards and criteria that are relevant to the organization's service delivery.

Emergency Department

Standard Rating: 97.4% Met Criteria

2.6% of criteria were unmet. For further details please review the table at the end of this section.

Assessment Results

The Westview Health Centre emergency department (ED) continues to engage with community partners to optimize care. There is an extensive catalogue of community resources that staff refer patients to regularly. The on-site Indigenous Navigator continues to offer invaluable support to both patients and staff. There is no formal patient or family advisor involved in this unit.

Patient volumes and acuity have continued to increase since the last survey. Patient flow continues to be impacted by several factors, including patients waiting for transfer for off-site computed tomography (CT) scans, high occupancy on the inpatient unit including a high proportion of alternate level of care (ALC) patients, leading to admitted patients in the ED. Management of some sicker patients is limited by resource issues (respiratory therapist support is not available around the clock, and the high flow oxygen, continuous positive airway pressure [CPAP] and ventilators are not available) There is no dedicated seclusion room and no safe private room that could be used in its place.

A quality board was updated with March 2024 HH rates but does not show results of QI initiatives. A regular (weekly) newsletter that is emailed to staff contains ED performance data. The team should consider displaying these, and QI projects, on the quality board. The ED team has restarted efforts to assemble a unit Quality Committee.

A number of new nurses (recent graduates) have been onboarded since the last survey. Nursing staff including licensed practical nurses feel well supported by their colleagues and work to their full scope. Excellent support and training is provided by the clinical educator. Recent physician recruitment efforts (for three physicians) were unsuccessful, although this has not impacted care delivery to date.

Patients interviewed were very satisfied with the care provided and the communication from staff; they were not aware of their patient rights although Shared Commitments posters are visible in the ED.

Table 5: Unmet Criteria for Emergency Department

Criteria Number	Criteria Text	Criteria Type
2.4.8	Seclusion rooms and/or private and secure areas are available for clients.	HIGH
2.4.15	Clients and families are provided with information about their rights and responsibilities.	HIGH
2.4.16	Clients and families are provided with information about how to file a complaint or report violations of their rights.	HIGH

Inpatient Services

Standard Rating: 100.0% Met Criteria

0.0% of criteria were unmet.

Assessment Results

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

The team has implemented bedside shift report to improve communication at transitions in care between shifts to improve delivery of safe patient care. There are white boards in patient rooms to aid as a communication tool with patients and families but were noted to not be filled out with all relevant information for the patient. Consider how to standardize this important communication tool to provide patients and families with the plan of care and most responsible members of the team on a day-to-day basis.

Staff report feeling well prepared and supported to work on the unit through educational offerings and learnings available to them. Staff performance appraisals were noted as a gap with many staff reporting that they have never had an appraisal during their many years of service. Consider ways to improve delivery of performance appraisals. The staff interviewed expressed their satisfaction with working on the unit and for the organization as evidenced by the low turn-over rate and with a large presence of experienced staff. There is a strong sense of team reported by the staff as the reason they want to work on the unit.

The patients and families interviewed were very satisfied with the care they received and felt they could be actively involved in their care plans. They described the staff as knowledgeable, caring, and compassionate. Patients and families can provide valuable input regarding care and service delivery that could benefit team members and enhance services. Consider the best approach to gathering additional feedback and utilizing the information for improvement opportunities.

There is a quality board on the unit for staff, patients, and families to understand some of the key metrics on the unit. Ensure that staff are engaged in understanding the metrics and how they impact care delivery and patient outcomes as the team is a valuable resource to engage in problem solving to improve metrics.

The inpatient unit is clean and bright. However, the area needs to be reviewed to understand how to remove clutter and maximize existing space. The team is encouraged to review their space to ensure it is compliant with current infection control standards. Some examples of things to review include the carpeting on handrails and paper posted on walls. All surfaces in patient areas must be properly cleaned between patients.

Unmet Criteria for Inpatient Services

There are no unmet criteria for this section.

Long-Term Care Services

Standard Rating: 100.0% Met Criteria

0.0% of criteria were unmet.

Assessment Results

The Government of Alberta sets provincial expectations for quality in continuing care through the province's accommodation and health service standards. The organization has recently had an audit using the Continuing Care Health Service Standards (CCHSS) that establish the minimum standards in the provision of high quality, individualized health care services, which are based on the assessed needs of each resident. The audit is also designed to support a safe and comfortable environment for residents and set expectations for the quality of accommodation services such as meals, housekeeping, and maintenance. Audit findings were shared with staff and actions taken to improve delivery of care. Some recommendations highlighted with improvements noted included enhanced cleaning schedules for aero-chambers, intravenous pumps and other equipment, increased staff training with CCHSS education, improved medication management, and improved post fall protocol compliance.

The team is commended for their work to implement barcode scanning of medications in response to medication errors reported in the safety reporting system. The team is continuing to work to improve the documentation tools used in both LTC and palliative as they work with stakeholders to improve the connect care system for compliance monitoring. A further step would be to advance the safety of medication administration and storage by adding ADCs to the units to improve the safety of delivery and tracking of medications.

The organization uses evidence-informed protocols and defined criteria to identify potential residents, such as those with a progressive life-limiting illness, those who have experienced a significant decline in health, and those who are in transition. The beds are a regional resource and as such residents are assigned rooms by the regional bed allocation team.

Individualized care plans are developed for each resident based on the results of the initial assessment completed and the resident's goals and preferences. It includes pertinent information about the resident's history, assessments and diagnostic results, allergies, and medication, including any medication or adverse drug reactions. The care team reassesses the health status of the resident in a timely manner and updates the residents individualized care plans accordingly. There is a nurse practitioner associated with the program to help facilitate care and is supported by family physicians. The residents have access to physiotherapy, occupational therapy, and recreational therapy to enhance resident care and additional support services for personal care and comfort.

The team currently does not have an active family and resident council but continue to try to recruit to revive this valuable resource to help inform resident care. Continue to actively pursue recruitment efforts.

The team has a patient-centered care approach through ongoing work to treat their patients with dignity and respect while involving them in all decisions about their health. This is demonstrated through their family conferences held on admission to the unit and yearly, or as needed, to help guide planning and care for patients that are consistent with the patient's goals. Another example is the addition of an Indigenous navigator to provide support and advocacy for First Nations, Metis and urban Indigenous patients and families by facilitating and coordinating access to services while helping residents and families navigate the healthcare system. The navigator also supports the team to gain a better understanding of how to provide holistic care for the residents they care for by promoting traditional, cultural, spiritual medicines in harmony with western medicine practices. Smudging is encouraged and supported when/where appropriate.

Unmet Criteria for Long-Term Care Services

There are no unmet criteria for this section.

Palliative Care Services

Standard Rating: 100.0% Met Criteria

0.0% of criteria were unmet.

Assessment Results

The organization has policies and resources to help team members implement a palliative approach to care using evidence-based protocols and criteria. The Edmonton Zone Palliative Care Team helps to facilitate and support access to palliative care services for those with a progressive life-limiting illness experiencing a decline in health.

The organization recognizes the importance of the physical environment and helps patients, families, and/or caregivers to select an appropriate service setting given the choices and resources available. The team works collaboratively with the patient and family to maximize the safety of the physical environment while making every effort to provide privacy, solitude, and quiet in their place of care. The unit is warm and welcoming, and patients interviewed expressed a high level of satisfaction with both the environment and the care they receive.

The team is commended for their work to implement barcode scanning of medications in response to medication errors reported in the safety reporting system. The team is continuing to work to improve the documentation tools used in both LTC and palliative as they work with stakeholders to improve the Connect Care system for compliance monitoring. A further step would be to advance the safety of medication administration by adding ADCs to the units and improve the safety of delivery and tracking of medications.

The team knows which partners to connect to in its network to ensure patients, families, and/or caregivers always have access to palliative care expertise or essential service. The team meets with patients and families and/or caregivers to collaboratively plan and manage care. Patients and family interviewed felt part of the care planning. They can discuss and document the patients' advance care plans, including those that address resuscitation and the use of potentially life- sustaining treatments in accordance with the patient's wishes, organization's policy and relevant legislation.

Policies and procedures to respond to requests for medical assistance in dying (MAID) comply with applicable ethical, legal, and regulatory frameworks. Team members know how to respond to requests for MAID and follow the organization's policies and procedures to manage these requests. This includes an objective assessment of patients, families, and/or caregivers' understanding of various options to relieve suffering. The team can accommodate community requests as well as the internal organizations requests for MAID.

The team has access to specialized training to help health care providers with the knowledge, attitudes, and skills to help provide palliative care to patients and families facing life-limiting illnesses. The team is encouraged to continue this training for all staff that are providing care for these patients. Also look for ways to ensure team members have additional resources to help them cope with dying, grief and bereavement and the cumulative effects of patient death.

Unmet Criteria for Palliative Care Services

There are no unmet criteria for this section.

Perioperative Services and Invasive Procedures

Standard Rating: 99.4% Met Criteria

0.6% of criteria were unmet. For further details please review the table at the end of this section.

Assessment Results

The perioperative program at Westview Health Centre is supported by a functional healthcare team with many staff who are cross trained to work in different areas. Staff feel part of a cohesive team and enjoy their work. The manager is relatively new; the creation of an assistant head nurse position has given staff a more consistent route to raise concerns and more educational support. The two ORs are booked with lower acuity day surgery patients; no emergency surgical procedures are performed, making scheduling consistent and largely predictable. Patients were very satisfied with their care (“very good”) and that the staff were “helpful and kind”.

The recovery room is used for both pre-operative and post-operative patients. Capacity is limited and when all beds are occupied, this sometimes delays the OR schedule. Locations for point-of-care alcohol-based hand rub (ABHR) dispensers are limited by the physical layout of the bed bays (absence of walls), however ABHR is available throughout the unit. Patients are asked to mark the side of surgery pre-operatively. Permanent Sharpie markers are used as skin markers, and markers are wiped down with alcohol between patients supported based on local research and AHS policy. Use of a spray wand in the patient washroom, though rarely used to clean the hopper there, is not recommended and removal should be considered.

ADCs have been recently introduced to the perioperative area and has been well received. Standardization of medication trays for anesthesia carts has also been introduced recently. The restricted corridor is not well demarcated as it is contiguous with the route of entry to the endoscopy suite; clearer markings and signage are recommended.

Patients were not aware of their rights and responsibilities, however felt comfortable enough with their care providers to inform them directly of their concerns. There is information in the after-visit summary (AVS) about how to contact Patient Relations. The Shared Commitments initiative is still relatively new, and the OR team is in the process of printing pamphlets for patients.

Table 7: Unmet Criteria for Perioperative Services and Invasive Procedures

Criteria Number	Criteria Text	Criteria Type
2.2.15	Clients and families are provided with information about their rights and responsibilities.	HIGH

Reprocessing of Reusable Medical Devices

Standard Rating: 99.0% Met Criteria

1.0% of criteria were unmet. For further details please review the table at the end of this section.

Assessment Results

Medical device reprocessing (MDR) is located within the perioperative area. There are no dedicated hand hygiene sinks, however the clean and soiled areas are proximal to the hands-free surgical scrub sinks. There are five full-time employees and a number of casual staff, all of whom are certified either by Canadian Standards Association (CSA) or Healthcare Sterile Processing Association (HSPA). The area routinely undergoes safety audits to evaluate any improvements required for staff wellness (e.g., stress mats, hearing loss) and occupational risks.

The MDR educator (works at multiple suburban sites) ensures that staff are made aware of any changes in reprocessing procedures and of equipment changes and provides feedback to staff. Staff education and competencies are documented. Staff who were asked have had performance evaluations completed within the past year.

While the MDR department does not have computer-based system for tracking equipment and relies on manual processes, there is a robust system in place should equipment recalls or endoscope tracking be required. Reprocessed equipment is stored appropriately until use or, for endoscopes, seven days after reprocessing (endoscopes are tagged and dated). The team is responsive to any Reporting and Learning System incidents and addresses these as needed.

Table 8: Unmet Criteria for Reprocessing of Reusable Medical Devices

Criteria Number	Criteria Text	Criteria Type
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

Criteria for Follow-up

Criteria Identified for follow-up by the Accreditation Decision Committee

Follow-up Requirements		
Standard	Criterion	Due Date
Emergency Department	2.4.15 - Clients and families are provided with information about their rights and responsibilities.	May 30, 2025
Medication Management	1.2.3.4 - The program includes interventions to optimize antimicrobial use, such as audit and feedback, a formulary of targeted antimicrobials and approved indications, education, antimicrobial order forms, guidelines and clinical pathways for antimicrobial utilization, strategies for streamlining or de-escalation of therapy, dose optimization, and parenteral to oral conversion of antimicrobials (where appropriate).	May 30, 2025
Medication Management	1.2.3.5 - The program is evaluated on an ongoing basis and results are shared with stakeholders in the organization.	May 30, 2025
Perioperative Services and Invasive Procedures	2.2.15 - Clients and families are provided with information about their rights and responsibilities.	May 30, 2025