JUNE 2021

Viking Health Centre

Central Zone

Alberta Health Services

Spring Survey

June 14 - 25, 2021

ACCREDITATION
AGRÉMENT
CANADA

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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 June 14, 2021 – June 25, 2021. 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 regarding sites and services provided by the organization. Accreditation Canada relies on the accuracy of this information to plan and conduct the on-site survey and produce the Accreditation Report.

About the AHS Accreditation Cycle

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

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

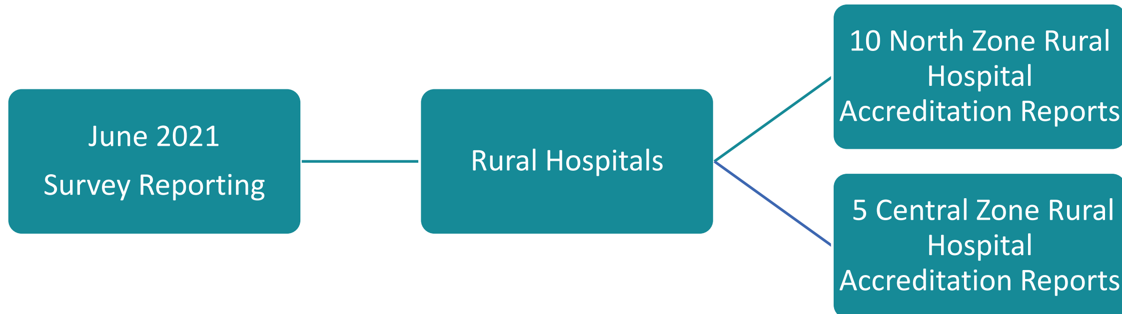
Focused assessment for the foundational standards of Governance, Leadership, Infection Prevention, and Control, Medication Management and Reprocessing of Reusable Medical Devices occurred in the first year of the cycle (Spring and Fall surveys for 2019).

During the cycle (2019-2022), site-based assessments for rural hospitals use a holistic approach and integrate assessments for all clinical service standards applicable at the site, as well as the foundational standards of Medication Management, Infection Prevention and Control, Reprocessing of Reusable Medical Devices, Service Excellence and Leadership. 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 new assessment methods offered by Accreditation Canada. Pre-survey attestation requires sites/teams to conduct a self-assessment against specified criteria within the standards and provide a declaration that the self-assessment is both accurate and reliable to the best of the organization's knowledge. These ratings are validated by Accreditation Canada during the on-site survey and are used to inform an accreditation decision at the end of the four-year accreditation cycle. The second assessment method is unannounced on-site surveys. This method requires all sites and services to participate in pre-survey attestation and engage in the accreditation process to ensure the standards have been implemented and they are *accreditation ready* at all times.

After each accreditation visit, reports are issued to AHS to support their quality improvement journey. AHS's accreditation award will be granted at the end of the accreditation cycle.

The accreditation reports for the Spring 2021 Survey are organized as follows:



North Zone Rural Hospital Assessment – Sites Visited for Unannounced On-site Survey

- Boyle Healthcare Centre
- Edson Healthcare Centre
- Elk Point Healthcare Centre
- George McDougall - Smoky Lake Healthcare Centre
- Hinton Healthcare Centre
- Slave Lake Healthcare Centre
- St. Therese - St. Paul Healthcare Centre
- Wabasca/Desmarais Healthcare Centre
- Whitecourt Healthcare Centre
- William J. Cadzow - Lac La Biche Healthcare Centre

Central Zone Rural Hospital Assessment – Sites Visited for Unannounced On-site Survey

- Coronation Hospital and Care Centre
- Daysland Health Centre
- Vermilion Health Centre
- Viking Health Centre
- Wainwright 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

The team members and leaders at the Viking Health Centre are acknowledged for preparing for and participating in the Qmentum accreditation program, using unannounced visits and attestation as the methodology. Staff were supportive of the accreditation process. A leader described accreditation as "supporting patient safety and care," and "reinforces what we are doing right and provides suggestions to improve." It was further seen as an opportunity to "learn and grow." There were strong interdisciplinary teams supporting quality client care. They were enthusiastic about sharing their work-life with the surveyors. A team member stated, "I love working here. The teams. The people." There is a strong focus on quality, patient safety, and rural access for clients and families. The team members are proud to work at the Viking Health Centre. A team member shared their thoughts on patient safety and stated, "Safety is a must." Strong linkages and communications are demonstrated between Central Zone and the Viking Health Centre particularly, in pharmacy, infection prevention and control, and medical device reprocessing programs.

The Viking Health Centre was built in 1982. The facility is clean and well maintained. There is minimal clutter in patient areas. Wide corridors and large windows provide natural light. There are gardens and a gazebo for clients, families, and team members. The gazebo was funded and designed by the Ladies Auxiliary Group. There are private spaces for client interaction, including a large dining room with reading resources. The environmental services team is acknowledged for their work in ensuring an exceptionally clean facility. There are sufficient spaces for storage. There are hand hygiene stations throughout the site, however, dedicated hand-washing sinks are not widely available for team members and volunteers. The aging infrastructure presents some challenges. This includes small, shared washrooms without showers, that are unable to accommodate a standard wheelchair. There are limited sightlines from the team communication centre to client rooms. In future infrastructure planning, the leaders are encouraged to consider accessibility, workflow, and infection prevention and control priorities in any redesign. Furthermore, they are encouraged to seek the input of clients, families, and team members in infrastructure planning and design.

The team members and leaders are committed to ensuring effective emergency preparedness. Robust emergency preparedness processes are implemented and evaluated. This includes monthly testing of codes and regular fire drills. The Emergency Response Manuals are updated yearly, or as required. The team and leaders are proud of the site's response to the COVID-19 pandemic. This includes the procurement of appropriate supplies and personal protective equipment (PPE), the establishment of screeners at the entrances, hand hygiene, enhanced cleaning, and communication with clients, families, and the community. The team members and leaders were nimble and quickly responded to this challenging event.

The Viking Health Centre is supported by the community. The Viking Health Foundation was established in 1997 with a vision of "taking a lead role to enhance health care in our community," and provides financial support to enhance health-related activities. Additionally, the Ladies Auxiliary Group funded and designed a palliative care room.

An engaged interdisciplinary team supports quality care for clients at the Viking Health Centre. The team has been acknowledged for the quality processes in the endoscopy unit and received the Quality Endoscopy Recognition Award in 2019. Additionally, the Influenza Immunization Award was received in 2018-2019, acknowledging the highest rate of staff influenza vaccinations in a rural community hospital.

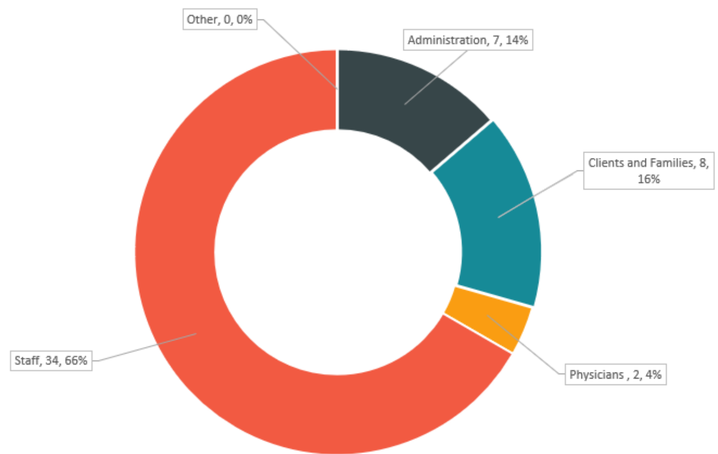
A Zone Infection Control Practitioner supports the team both virtually and through monthly on-site visits. The leaders and team members are proud of their work in implementing CoACT. This initiative is used to create an environment in which care providers work together to provide timely information to patients and families, perform regular check-ins, and help patients and families understand the roles of care providers. There are quality processes implemented including whiteboards at the bedside, interdisciplinary rounds, robust auditing, huddles, and quality improvement boards. The leaders are encouraged to continue to embed quality processes throughout all programs and services and to seek the input of clients, families, and team members in quality improvement initiatives.

The team members and leaders are acknowledged for their commitment to ensuring appropriate patient flow. There are strong patient flow processes implemented with protocols identified to address overcapacity. Appropriate discharge planning is a priority for the leaders and team. Clients and families are an integral part of transition planning. There are initiatives to support appropriate patient flow including family conferences, linkages with community services, interdisciplinary rounds, and the support of an interdisciplinary team. There are opportunities to enhance patient flow. One such action is the documentation of the expected date of discharge on the client's whiteboards.

Survey Methodology

The Accreditation Canada Surveyors spent two days at Viking Health Centre.

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



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

Key Opportunities and Areas of Excellence

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

Key Opportunities

1. Streamline documentation to reduce duplication of information and enhance client safety
2. Cascade quality improvement initiatives to the front lines
3. Separate look-alike/sound-alike high-alert medications in client services and pharmacy areas
4. Assign a medication room for use by the Emergency Department
5. Continue to promote client and family involvement

Areas of Excellence

1. Caring and committed team members, leaders, and physicians
2. Solid communication and linkages with the Central Zone resources
3. The facility is clean and well-maintained
4. There are several resources and equipment to support client care and safety
5. Safety checklists and auditing are detailed and thorough

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 100% met	On-Site 98% met	Overall 98% met	
Number of attested criteria			
Attested 110 criteria	Audited 15 Criteria		

Attestation:

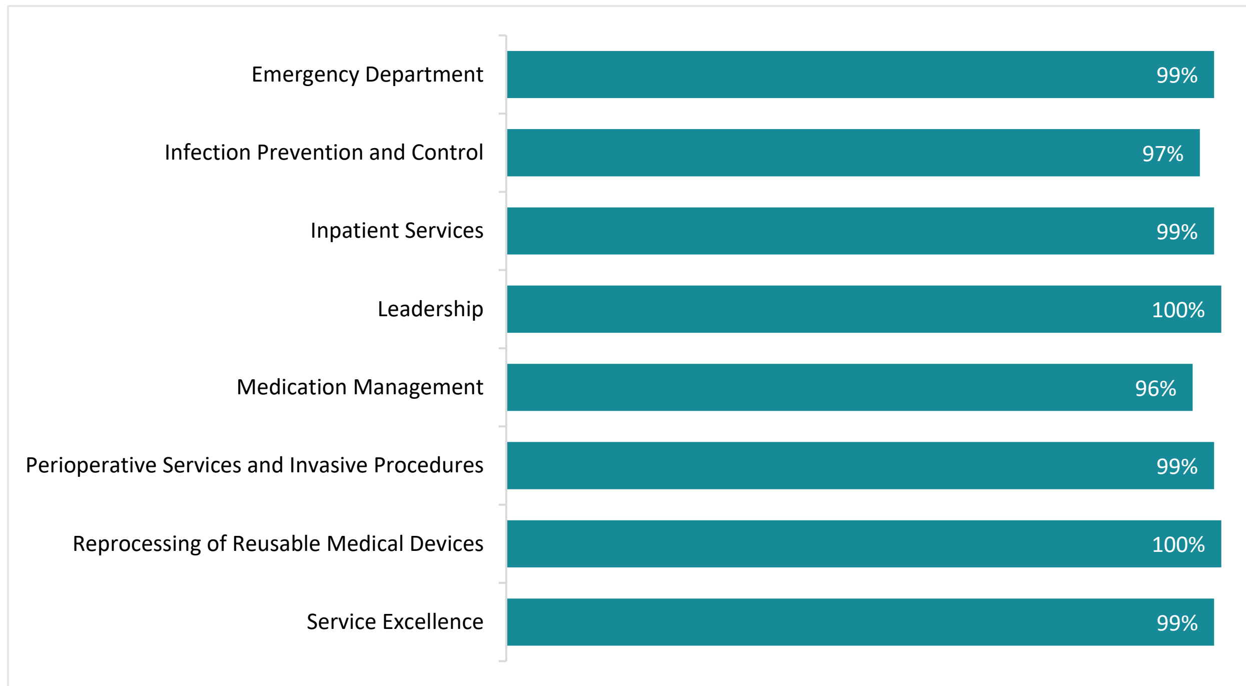
A form of conformity assessment that requires organizations to conduct a self-assessment on specified criteria and provide a declaration that the assessment is accurate to the best of the organization's knowledge. This data is used to inform an accreditation award.

On-site Assessment:

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

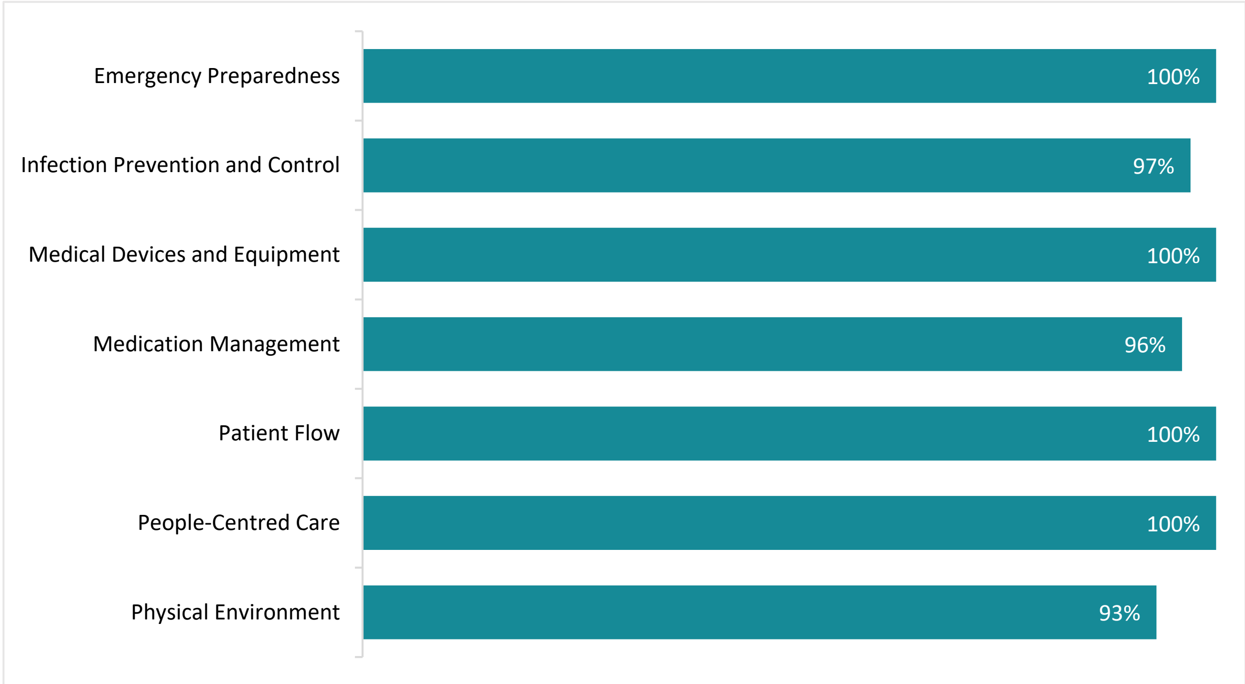
[1] In calculating percentage compliance rates throughout this report, criteria rated as 'N/A' and criteria 'NOT RATED' were excluded. Data at the 'Tests for Compliance' level were also excluded from percentage compliance calculations. Compliance with ROPs and their associated 'Tests for Compliance'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

Compliance by Standard



STANDARD	MET	UNMET	N/A	NOT RATED
Emergency Department	93	1	1	0
Infection Prevention and Control	36	1	0	0
Inpatient Services	66	1	2	0
Leadership	9	0	0	0
Medication Management	76	3	8	0
Perioperative Services and Invasive Procedures	144	2	3	0
Reprocessing of Reusable Medical Devices	91	0	0	0
Service Excellence	75	1	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	33	1	0	0
Medical Devices and Equipment	109	0	3	0
Medication Management	90	4	8	0
Patient Flow	19	0	0	0
People-Centred Care	40	0	0	0
Physical Environment	13	1	0	0

Compliance by Quality Dimension

DIMENSION	MET	UNMET	N/A	NOT RATED
Accessibility	35	1	0	0
Appropriateness	190	2	4	0
Client Centered Services	105	0	1	0
Continuity of Services	20	0	0	0
Efficiency	6	0	0	0
Population Focus	4	0	0	0
Safety	209	6	8	0
Worklife	21	0	1	0

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	MET
Medication Reconciliation at Care Transitions	Emergency Department	MET
	Inpatient Services	MET
	Perioperative Services and Invasive Procedures	MET
Safe Surgery Checklist	Perioperative Services and Invasive Procedures	MET
Information Transfer at Care Transitions	Emergency Department	MET
	Inpatient Services	MET
	Perioperative Services and Invasive Procedures	MET
MEDICATION USE		
Antimicrobial Stewardship	Medication Management	UNMET
Concentrated Electrolytes	Medication Management	MET
Heparin Safety	Medication Management	MET
High-alert Medications	Medication Management	MET
Narcotics Safety	Medication Management	MET
Infusion Pump Safety	Service Excellence	MET
INFECTION CONTROL		
Hand-hygiene Compliance	Infection Prevention and Control	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	MET
	Perioperative Services and Invasive Procedures	MET
Pressure Ulcer Prevention	Inpatient Services	MET
	Perioperative Services and Invasive Procedures	MET
Suicide Prevention	Emergency Department	MET
Venous Thromboembolism Prophylaxis	Inpatient Services	MET
	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 no unmet criteria for this Priority Process.

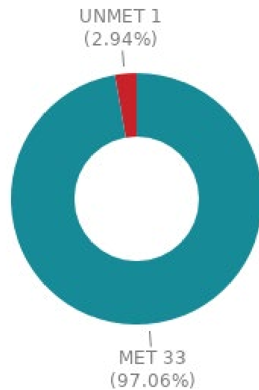
The team members and leaders of the Viking Health Centre are committed to ensuring effective emergency preparedness processes which are implemented and evaluated regularly. This includes monthly testing of codes and regular fire drills. The emergency response plans are tested with tabletop exercises completed. The Emergency Response Manuals are updated yearly, or as required, and are located in client service areas. The team members receive education to support the all-hazard disaster and emergency response plans. The team and leaders are proud of the site's response to the COVID-19 pandemic. The team members and leaders are encouraged to continue to test the emergency preparedness plan and to make changes accordingly.

The Zone Infection Control Practitioner (ICP) works closely with the team members and leaders. There is access to infection prevention and control policies. The leaders and team members stated that they have access to infection prevention and control resources. Communication with clients, families, and communities during outbreak situations occurs. The team members and leaders are encouraged to continue to collaborate with ICPs to ensure the proactive management of outbreaks.

The leaders and team members communicate and collaborate with community partners to support emergency preparedness including the police, fire departments, municipalities, and community organizations. There are partnerships with the towns of Viking and Beaver County to ensure an effective community and site-based emergency response. The leaders and team members meet with their partners to discuss roles, responsibilities, and emergency response. Joint emergency planning exercises are held. The leaders and team members are encouraged to continue to meet with partners to ensure comprehensive emergency preparedness and to participate in joint emergency response testing. The team members and leaders embraced the lessons learned from the simulations and incorporated the changes as appropriate.

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.



Infection prevention and control (IPC) is a priority for the team members and leaders of the Viking Health Centre. They are proud of their work in implementing the IPC program.

The leaders and team members stated that they have access to IPC resources. A Zone Infection Control Practitioner (ICP) supports the team both virtually and through monthly on-site visits. An infection prevention and control quality board provides information for team members and highlights quality processes for the program. Infection prevention and control is involved in the planning and construction of the physical environment. The hospital-acquired infection rates are tracked, and the information is shared. There have been no hospital-acquired infections in the last year. The leaders are encouraged to continue to assess the workload of the ICP in keeping with emerging infection prevention issues and trends.

The team members and leaders are proud of their work in responding to the COVID-19 pandemic. There was a strong commitment to ensuring client and staff safety during this unprecedented event. The team members and leaders were nimble and responsive in their response to COVID-19. There is COVID-19 symptom screening at the hospital entrance, masks are provided, and hand hygiene is completed. The COVID-19 screener stated that she felt safe at work and that education and training have been provided. There are robust standardized IPC processes implemented. The team members stated that they have received education and training on hand hygiene, the use of personal protective equipment, and IPC processes. They also stated that they feel safe and protected at work.

Hand hygiene audits are completed, and the results are posted. There are hand hygiene stations located throughout the facility. However, dedicated hand-washing sinks are not available for team members and volunteers and are used for other purposes. The site is encouraged to ensure access to dedicated hand-washing sinks for team members and volunteers.

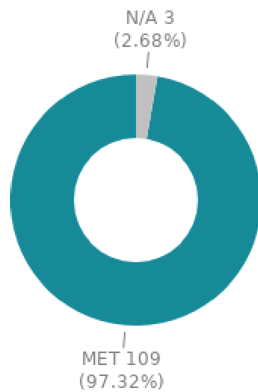
The Viking Health Centre is clean and well maintained. The environmental services team provides exceptional cleaning throughout the facility. They were constantly and proactively cleaning client and staff areas. A team member described her commitment to ensuring a clean environment for clients and staff saying, “safety is a must.” The environmental services team has access to current policies and procedures and has used checklists to confirm that the cleaning has been completed. Environmental services, laundry, and dietary team members stated that they have received education on hand hygiene, personal protective equipment, and the use of hazardous products. Furthermore, they are aware of the process to follow if they have issues or concerns. They noted that they felt that their safety is supported by Alberta Health Services. Biomedical waste is transported in keeping with policies and procedures. The laundry service is located off-site. The team members follow policies and procedures to ensure the safe transportation of both dirty and clean laundry. The storage areas for both the clean and dirty linens

are well organized and maintained. There is no clutter. The dietary department is clean and well organized. The fridge and freezer temperatures are monitored and recorded. The team members have received education on food safety and there have been no incidents of food-borne illness reported.

STANDARD	UNMET CRITERIA	CRITERIA
Infection Prevention and Control	8.4	Team members, and volunteers have access to dedicated hand-washing sinks.

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.



There are no unmet criteria for this Priority Process

At the Viking Health Centre, the medical device and reprocessing department (MDRD) is clean and well-appointed with easily maintained stainless steel surfaces. Access to the service area is appropriately restricted.

From a functional perspective, there is a clear separation of clean from dirty activities. There is a one-way flow of medical equipment from dirty to clean across a range of reprocessing services.

The MDRD is open two to four days a week and both MDR technicians are certified medical device reprocessing technicians (CMDRT). There is a robust orientation program for new employees.

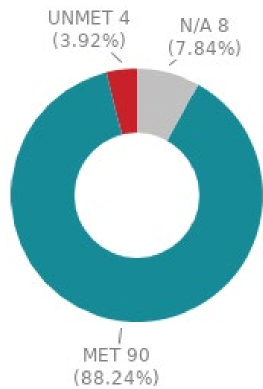
All MDR equipment is reprocessed centrally. Single-use medical devices are occasionally used in the outpatient unit. To ensure that the devices are not reused they are returned to the MDRD after their usage where they are verified and discarded. Flash sterilization does not occur at this site.

All cleaning and sterilization processes meet the required standards of care allowing tracking and recall when necessary. The recall process includes producing a written report and notifying the affected area.

Specific equipment is contracted out and contracts are monitored to ensure the quality of services that are provided. Manufacturer recommendations, as well as infection prevention and control best practices, are incorporated into policy and procedure development. A recent infection prevention and control inspection resulted in the MDRD successfully complying with the required quality standards.

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.



The medication management team at the Viking Health Centre includes a pharmacist on-site for three days a week, virtual coverage by a pharmacist for two days a week, and a pharmacy technician. There is an on-call pharmacist for the team members to access after-hours.

The intent of the pharmacy service is pharmacist-supported patient care and safe drug production and distribution. This includes the following: pharmacists monitoring drug therapy to ensure it is appropriate for the patient and making therapy recommendations, providing direct patient care by reviewing patient clinical status and drug therapy, identifying drug-related problems, and working with the healthcare team to resolve them, and the pharmacy department providing a safe, accurate, and timely drug distribution system.

The pharmacy team is proud of their work in providing quality medication management processes. Furthermore, team members commented on the value of working as part of an interdisciplinary team. A team member stated, "I am proud of the wonderful pharmacy department. The remote coverage is great. We are doing well as members of a multi-disciplinary team." There are strong working relationships with physicians and other members of the healthcare team. The pharmacy team is actively engaged with supporting client care. This includes bedside rounding, medication reviews, and participating in interdisciplinary rounds. They are a resource to the healthcare team and are available for consultation on medication issues. The team members are proud of working to their full scope of practice including the pharmacist and the pharmacy technician. They stated that they feel safe at work and have received education on hand hygiene, personal protective equipment, and hazardous products.

The pharmacy has controlled access. There is one room in which medication distribution, storage, and preparation occur. The pharmacy area is quiet, clean, well-organized, and has good lighting. Three computer stations are available, however, there is an opportunity to declutter the pharmacy area as there are some outdated resource materials. Medications are safely transported to the patient units in keeping with protocol. There was a recent review of the medications contained in the night cupboard with an expanded medication menu. Audits are completed. There is limited compounding completed at the site, however, the compounding occurs on a counter that is porous and thus unable to be appropriately cleaned in the event of a medication spill. The team members and leaders are encouraged to review the process for compounding to ensure it is completed in an appropriate space and to make changes accordingly.

Conditions appropriate to protect medication stability are maintained in medication storage areas. Appropriate storage conditions have considered the temperature and light sensitivity, packaging, and delivery containers. In the pharmacy, medications are stored in fridges with temperature controls which are checked and recorded on a regular basis. The medication fridge has an alarm that pharmacy team members check on during working hours, including checking the temperature strips indicating when the temperatures have varied beyond the approved measures. However, after hours the temperature alarm is not sent to team members outside of the pharmacy area. This may result in a break in the cold chain and potential loss of medication. The leaders are encouraged to identify a process to ensure that the medication fridge alarms are appropriately responded to after hours.

Expired, discontinued, recalled, damaged, and contaminated medications are stored separately from medications in current use in a locked cupboard in the pharmacy. However, there were some expired medications located in the client service areas. The team members and leaders are encouraged to review and ensure that expired, discontinued, recalled, damaged and contaminated medications, in both areas, are removed and stored separately from medications in current use.

Anesthetic gases and volatile liquid anesthetic agents are not stored in an area with adequate ventilation, as per the manufacturer's instructions. The anesthetic gases and volatile liquid anesthetic agents are stored on a shelf with the other medication stock. The leaders are encouraged to move these gases and agents to an area with adequate ventilation, as per the manufacturer's instructions. Adequate ventilation minimizes the exposure of team members to harmful gases in case one or more bottles break.

Look-alike/sound-alike medications and high-alert medications need to be stored separately, both in the pharmacy and client service areas. They are stored in red bins with a high alert label on the bin. However, some of the medications are stored in a yellow bin with a piece of red plastic denoting that it is a red bin. The team is encouraged to consistently follow the policy regarding separating these types of medications in the medication storage areas to prevent confusion and promote safety.

An Antimicrobial Stewardship Manual has been developed (provincial/zone collaboration) and the Antimicrobial Stewardship Program has been implemented. The pharmacist attends patient rounds and interdisciplinary meetings. Medications are reviewed and in keeping with the antimicrobial stewardship program as well as with the input of the physician and clinical team, changes as appropriate are made. The Antimicrobial Stewardship Program is not evaluated on an ongoing basis. The leaders are encouraged to evaluate the program on a regular basis and share the results with stakeholders.

STANDARD	UNMET CRITERIA	CRITERIA
Medication Management	12.6	Look-alike, sound-alike medications; different concentrations of the same medication; and high-alert medications are stored separately, both in the pharmacy and client service areas.
Medication Management	12.7	Expired, discontinued, recalled, damaged, and contaminated medications, are stored separately from medications in current use, both in the pharmacy and client service areas, pending removal.
Medication Management	13.4	Anesthetic gases and volatile liquid anesthetic agents are stored in an area with adequate ventilation, as per the manufacturer's instructions.
Perioperative Services and Invasive Procedures	3.2	Medications in the surgical area are stored in a locked area or similarly secured, as per the organization's policies regarding medication storage.

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.

There are no unmet criteria for this Priority Process.

At the Viking Health Centre, there are no lengthy waitlists for acute care, rehab, the Emergency Department (ED), or the operating room. The importance of streamlining flow processes within each department is essential for the hospital to serve its patients in a timely fashion.

The initiatives that support patient flow include daily bed rounds, algorithms, admission criteria, efficient scheduling, online reports, linkages with community services, and interprofessional collaboration. In addition, access to diagnostic tests and diagnostic imaging services are timely because there exists a great collaboration between organizations to support the facility when diagnostic tests that are ordered are not provided at this site (e.g., CT scan, MRI, angiography, interventional radiological imaging, non-routine blood tests).

The site is also working closely with the medical teams to create walk-in clinics in the community to reduce the number of unnecessary visits to the ED. This initiative, coupled with the onset of the COVID-19 pandemic has significantly reduced the number of ED visits.

The site is encouraged to evaluate the impact of patient flow strategies and measures that have been implemented, including patients and families' feedback on changes the hospital is making to improve their access and flow through the facility.

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; Perioperative Services and Invasive Procedures; Service Excellence.

There are no unmet criteria for this Priority Process.

The leaders and team members are committed to providing people-centered care. The programs and services of the Viking Health Centre are held in high regard by clients and families. Additionally, the Viking Health Centre is supported by community partners and there is a strong sense of community pride and ownership.

The Viking Health Foundation provides financial support to enhance health-related activities and was described by a team member as, "An amazing group of people. They supported the operating room program and they pay for education for staff." There is also the Ladies Auxiliary Group who funded and designed a palliative care room. The clients and families spoke highly of the care provided. A client stated, "It is a wonderful hospital. It has been a lifesaver for me. There is a lot of laughter and smiles. You are not a number you are a person." The clients and families described being treated with care, dignity, and

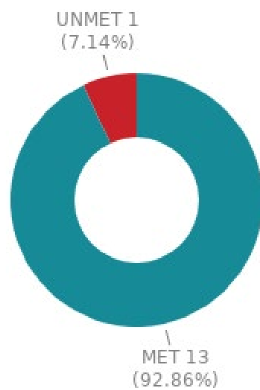
respect. These are foundations upon which the leaders and team members can use to support the people-centered care journey.

The Viking Health Centre serves a senior population and activities are in place to support senior care. The leaders are encouraged to continue to support senior-friendly initiatives and to seek the input of clients, families, and team members in co-design. In future infrastructure planning, the leaders are encouraged to consider accessibility, workflow, and infection prevention and control priorities in any redesign and to obtain input from clients, families, and team members.

There are several initiatives implemented that support people-centered care. CoACT is implemented and has served to guide quality and people-centered care initiatives. There are collaborations with clients, partners, and the community in service design. Additionally, client experience surveys are reviewed and acted upon, leadership rounding occurs, and input is received from the foundation and auxiliary members. The leaders are encouraged to continue to ensure that the programs and services provided at Viking Health Centre meet the needs of their clients and families. The participation and input of clients and families into the development, implementation and evaluation of services and programs will enhance the quality of the care provided.

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.



The Viking Health Centre was built in 1982; it is well maintained, and efforts are made to ensure that the facility is safe. There are several backup systems in place in the event of a systems failure and there is a complete preventative maintenance program. These are tested regularly with minimal or no interruption. All service repairs are tracked, and patient-related equipment failures are prioritized in accordance with the Field Level Risk Assessment (FLRA) tool.

Although temperature controls in the MDRD (medical device and reprocessing department) are regularly monitored during weekdays, the site is encouraged to include temperature monitoring on weekends and during off-shifts.

The site is designed to facilitate patient flow as evidenced by the co-positioning of the Emergency Department, diagnostic imaging, and the inpatient care unit with the perioperative environment.

During a tour of the facility, it was noticed that clinical areas were uncluttered, clean, and bright. The grounds outside are beautifully landscaped and well maintained. The facility has many private and comfortable seating areas for clients and families. In terms of patient satisfaction, clients and families were pleased with wayfinding and with signage. Staff members are pleased with the layout of the rooms which provides ample space to work. Facility management staff are to be commended for their efforts and for being knowledgeable in providing a clean, well-maintained, and welcoming environment.

In terms of patient and staff safety, there are nurse call bells in patients' rooms, and fire exits are well lit with natural light and are free from clutter. The falls prevention program is applied in all areas of patient-related activities. The site is encouraged to install a lock on the door that accesses the operating room. In addition, due to the close proximity of the inpatient unit to the perioperative area, it is suggested that the site put in place visuals (e.g., signage, red tape on the floor) to indicate that once you go beyond a certain point on the inpatient care unit you are entering a restricted area.

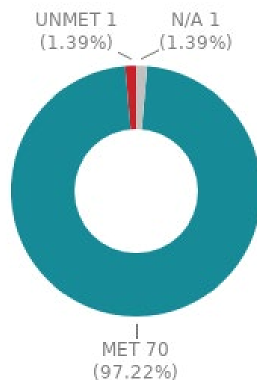
STANDARD	UNMET CRITERIA	CRITERIA
Perioperative Services and Invasive Procedures	1.2	The area where invasive procedures are performed has three levels of increasingly restricted access: unrestricted areas, semi-restricted areas, and restricted areas.

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.



Upon entering the Emergency Department (ED) every patient is screened at the registration desk for COVID-19, and then, patients who require urgent care are directed to the ED to be triaged. The registration desk is adjacent to the ED which ensures rapid access to patients who require urgent interventions. After being triaged, patients may be placed in a bed or requested to stay in the waiting room where they are appropriately monitored.

The department is open 24/7 and consists of six care spaces, including two trauma bays. Acute upper respiratory infections are the most common reason for emergency visits. Four family physicians provide care on a rotating basis, along with a combination of registered nurses, licensed practical nurses, and administrative staff. An ambulance bay adjacent to the ED was recently built. The ED's interprofessional collaboration is palpable.

To optimize patient flow, the site has worked closely with the community and with the medical team to create walk-in clinics. This initiative, coupled with the onset of the COVID-19 pandemic has reduced the number of ED visits by 30% since 2010.

A variety of documentation tools are used in the ED and the same nursing notes and charting can be transcribed in several different places. Patient-related information can be found on the nurses' Kardex, on a clipboard, on the patient profile form, etc. This poses a risk to patient safety and the site is encouraged to pursue its efforts to eliminate duplicate charting.

In terms of staff competency, all ED nurses are Advanced Cardiovascular Life Support (ACLS) and Pediatric Advanced Life Support (PALS) certified, and they comply with regular mandatory online training modules.

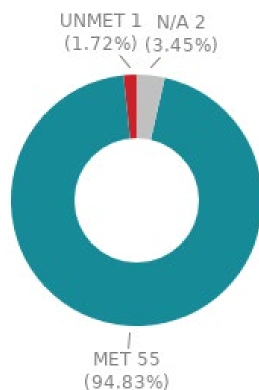
In terms of quality improvement, the clinical teams agree with the value of conducting regular audits. However, few members were able to articulate improvements in clinical practices resulting from auditing. The site is encouraged to promote the added value of auditing patient care practices in the ED by sharing audit results with staff and acquiring their input regarding the results.

In terms of patient safety, it was noted that in the medication room adjacent to the trauma room in the ED there are many expired drugs. In addition, some ED nurses prefer preparing their medications on the inpatient care unit. It is important that the site address these issues soon.

STANDARD	UNMET CRITERIA	CRITERIA
Emergency Department	9.9	Effectiveness of transitions is evaluated, and the information is used to improve transition planning, with input from clients and families.

Inpatient Services

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



The inpatient unit at the Viking Health Centre consists of fourteen acute inpatient beds, with one palliative care bed and one obstetrical bed. There are eight private rooms, one palliative care room, and four semi-private rooms with a shared washroom. There are four ceiling track lifts available. The inpatient unit is clean and bright, with large windows in client rooms that overlook green space. The corridors are wide and have minimal clutter. There are adequate storage spaces that are well organized. There are private spaces for client interaction, including a large dining room with reading resources. There are gardens and a gazebo for clients, families, and team members.

The environmental services staff are exceptional. There is evidence of strong cleaning processes. An environmental services staff commented, “I love working here. Safety is a must.” They are very proud to provide clean and safe spaces for clients. Furthermore, they stated that they follow policies and procedures in completing the cleaning and that they feel safe at work. The aging infrastructure presents some challenges. This includes small, shared washrooms without showers and are unable to accommodate a standard wheelchair, resulting in a lift to a smaller wheelchair. There are limited sightlines from the team communication centre to client rooms. In future infrastructure planning, the leaders are encouraged to consider accessibility, workflow, and infection prevention and control priorities in any redesign. Furthermore, they are encouraged to seek the input of clients, families, and team members in infrastructure planning and design.

The community is supportive of the care provided in the inpatient unit as is evident in the Ladies Auxiliary Group funding and designing a palliative care room. They participated in the re-design and selected colors and furniture for this room. Additionally, a gazebo was funded by this group. The clients and families spoke highly of the care provided. A client stated, “I would recommend this hospital to anyone.” Additionally, the team members were held in high regard by clients and families. A client stated, “Nurses, doctors, the lab staff, they are all wonderful. I can’t complain. I would highly recommend it.” Personalized and holistic care was another reason why clients recommended the Viking Health Center. Client feedback is obtained, and satisfaction surveys are completed. The leaders are encouraged to continue to seek client and family input to further strengthen programs and services.

There is a strong interdisciplinary team committed to providing quality and safe inpatient care. The team members include nurses, a physiotherapist, a mental health worker, an occupational therapist, pharmacist, pharmacy technician, and rehabilitation assistant, to name a few, as well as having access to other team members including a palliative care nurse, dietician, and social worker. The leaders are visible in the client services areas and are very engaged and accessible to the team. The clients and families were complementary regarding the care provided at the Viking Health Centre. They had no suggestions for improvement. The client's rights and responsibilities were shared on admission using a laminated placemat. The team members are encouraged to reinforce the rights and responsibilities with clients upon admission.

The team members valued the education and training provided to assist them to effectively work in inpatient services. The leaders are supportive and encourage the team to participate in education and training. The team members described a strong orientation process with a buddy system implemented. There is a strong commitment to auditing which is completed with the assistance of team members. The team and leaders are encouraged to continue with this important work and to continue to share audit results.

There is a strong commitment to quality care. A dedicated interdisciplinary team is acknowledged for providing a safe environment for clients during the COVID-19 pandemic. The team members and leaders are proud of implementing CoACT and the resulting quality processes that have been implemented. Currently, the shift-to-shift report is taped, and the team will be implementing a new shift-to-shift handoff using bedside reporting. There are whiteboards in client rooms which the clients value as a communication tool. Documenting the expected date of discharge on the client whiteboards would be a tool to enhance patient flow. The implementation of Connect Care has started with a go-live date anticipated in 2022. There is a quality improvement board located in a prominent area in the inpatient unit. The leaders are encouraged to continue to embed the quality processes throughout the program and services.

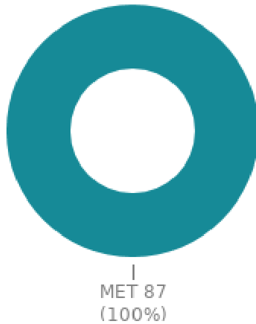
Paper-based charting is used in the client areas with plans to implement Connect Care. The care plans are developed and updated with the input of clients and families. Client records are accessible and up to date. Clients and families are involved in the assessment process. The leaders are encouraged to continue the implementation of Connect Care supporting team members through the change management process.

The transitions of clients and families are not being evaluated in a formal process. The team and leaders are encouraged to regularly contact a sample of clients, families, or referral organizations to determine the effectiveness of the transition or end of service and monitor client perspectives and concerns after the transition. The client feedback and results of the evaluation would then be used to improve transitions.

STANDARD	UNMET CRITERIA	CRITERIA
Inpatient Services	7.9	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.



There are no unmet criteria for this Priority Process

The perioperative environment consists of one operating room (OR) theater that functions two to four days a week from 0700 to 1515. The surgical department provides a wide range of surgeries including dental surgery, podiatry, gynecology, and general surgery. Approximately 354 days of surgery cases and 255 endoscopies are performed annually. Most procedures are elective.

Patients report being treated with respect and with dignity. Some examples of questions and comments that were communicated by the nurses to the patients during the survey were: "Every question is a valid question," or "Can you please repeat what I just said so I can appreciate your understanding of what was explained?" In addition, every patient who undergoes a procedure is ensured that their family will receive a personalized post-op call from the OR nurse to inform them of their loved one's overall status. A surgical tracking system is in the process of being developed conjointly with Connect Care. The system will be displayed in the surgical waiting room and will allow family members who are waiting to be informed in real-time about their loved one's movement throughout the perioperative environment (patients will be identified with a code to protect their identity). The hospital is congratulated for putting in place this initiative!

From a patient safety and quality perspective, all required organizational practices (ROPs) that were assessed were met. The surgical checklist is applied to all procedures and the consent form was reviewed with the treating physician prior to surgery. Strict adherence to side rails being up is followed and two patient identifiers are used for all patients along their surgical journey. The OR is set up functionally with easy access to all supplies. Regular audits are performed. For patients who undergo an endoscopy, a Global Rating Scale (GRS) keeps track of the patient's satisfaction, and all surgical patients are invited to complete a CoACT patient experience survey. When asked about the survey results, the OR staff were unable to comment. The site is encouraged to share patient-related survey results with staff members and to include their feedback when practices to better meet patients and family needs are developed.

Upon surveying the post-anesthesia care unit (PACU) it was noticed that some medication vials in the crash cart were expired. In the pre-admission, and post anesthesia care unit the crash cart was unlocked. These are important safety issues, and the site is encouraged to immediately implement mechanisms to ensure that the crash cart is safe, complete, and ready to use. All medication administration observations were documented and there were double-checks for high alert medication and narcotics.

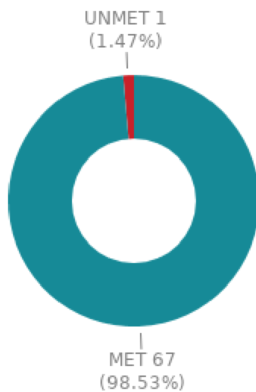
OR cancellation rates are tracked, and the site is encouraged to identify and address the reasons patients cancel their surgery so that cancellations can be minimized. During patient transitions from OR

to PACU and the inpatient unit, verbal reports are given and signed off. The site is encouraged to assess the quality of the verbal reports to ensure that pertinent information is communicated during these susceptible transition moments. Because the pre-admission unit and the PACU are combined, the site is encouraged to decrease human voice levels in the pre-admission unit as speaking loudly can be disturbing to a patient who is recovering from surgery and anesthesia.

All staff members are appropriately credentialed and have expressed their appreciation for the ongoing educational opportunities that are offered.

Service Excellence

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



Service excellence is supported by a committed and dedicated leadership team. They are progressive and committed to ensuring quality and safe client care. Collaborative working relationships with both internal and external partners are fostered with the goal of improving programs and services. There is a leadership mentoring plan for staff. Education and training are provided to the team members on the use of technology.

A strength of the leadership team is its visibility and accessibility for clients, families, and team members. This includes a strong orientation process, providing a buddy system for new staff, and support during daily interactions with the team. Performance appraisals are completed and are viewed as an important tool to support the growth and development of staff. The team members stated that they were appreciative of the support provided by the leaders. There is a strong commitment to both team and client safety. The team members stated that they feel safe at work including the access to Protective Services. Safety resources are available including access to personal protective equipment, education and training, and policies and procedures.

A collaborative interdisciplinary team supports client care. The team members stated that they have the resources to do their work. The site was described as a “great place to work,” and “having a great team.” There is a strong commitment to quality improvement. CoACT has been implemented including quality boards, whiteboards, auditing processes, interdisciplinary rounds, family conferences, and leadership rounds, to name just a few. The input of clients and families is valued and obtained by the team members and leaders including, client satisfaction surveys with the information obtained used to improve client experience. The team and leaders are encouraged to continue to seek opportunities to enhance the input of clients and families into the design of programs and services. The leaders are committed to using decision support to enable quality client care. The leaders and team members have access to evidence-based guidelines to support quality care with the support of the Central Zone.

STANDARD	UNMET CRITERIA	CRITERIA
Service Excellence	2.7	A universally accessible environment is created 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
Medication Management	12.6	Look-alike, sound-alike medications; different concentrations of the same medication; and high-alert medications are stored separately, both in the pharmacy and client service areas.	June 30, 2022
Medication Management	12.7	Expired, discontinued, recalled, damaged, and contaminated medications, are stored separately from medications in current use, both in the pharmacy and client service areas, pending removal.	June 30, 2022
Medication Management	13.4	Anesthetic gases and volatile liquid anesthetic agents are stored in an area with adequate ventilation, as per the manufacturer's instructions.	June 30, 2022
Perioperative Services and Invasive Procedures	3.2	Medications in the surgical area are stored in a locked area or similarly secured, as per the organization's policies regarding medication storage.	June 30, 2022

Follow-up ROPs			
Standard	ROP - Test of Compliance		Due Date
Medication Management	**Antimicrobial Stewardship**		
	2.3.5	The program is evaluated on an ongoing basis and results are shared with stakeholders in the organization.	June 30, 2022