Emergency Medical Services and Interfacility Transport

(Standard Set Version 13.1)

Alberta Health Services

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About this Accreditation Report

AHS (referred to in this report as "the organization") is participating in Accreditation Canada's Qmentum accreditation program. As part of this ongoing process of quality improvement, an on-site survey was conducted September 27, 2020 - October 02, 2020. Information from the survey, as well as other data obtained from the organization, were used to produce this Accreditation Report.

Accreditation results are based on information provided by the organization. Accreditation Canada relies on the accuracy of this information to plan and conduct the on-site survey and produce the Accreditation Report.

About the AHS Accreditation Cycle

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

In 2019, Accreditation Canada and AHS co-designed an accreditation cycle that further enhances a sequential accreditation model. Under this new approach, Accreditation Canada will conduct two accreditation visits per year for the duration of the cycle (2019-2022). Accreditation visits are helping AHS achieve its goal of being #AHS*AccreditationReady* every day by inspiring teams to work with standards as part of their day-to-day quality improvement activities.
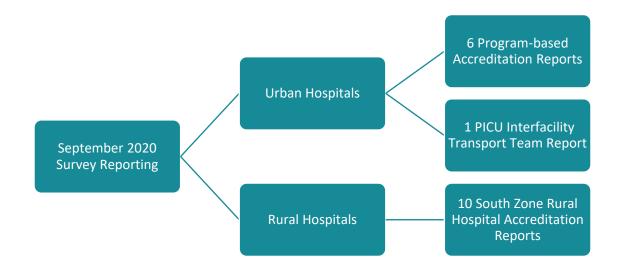
Focused assessment for the foundational standards of Governance, Leadership, Infection Prevention, and Control, Medication Management and Reprocessing of Reusable Medical Devices occurred in the first year of the cycle (Spring and Fall surveys for 2019).

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 and Service Excellence. Program-based assessments are applied to large urban hospitals where clinical services are assessed against the respective clinical service standard along with the foundational standards. This integrated assessment approach for both small rural hospitals and large urban hospitals provides a more comprehensive assessment.

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

After each accreditation visit, reports are issued to AHS to support their quality improvement journey. At the end of the four-year accreditation cycle, in 2022, an overall report will be issued that includes the province's overall accreditation award.

The accreditation reports for the 2020 Survey are organized as follows:

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                         ┌──────────────┐ │ Accreditation Reports    │
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│ September    │         └──────────────┘ │ Transport Team Report    │
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└──────────────┘         │ Hospitals    │ │ Hospital Accreditation   │
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EMS and Interfacility Transport Assessment – 29 Sites Visited

- CALG-300
- EMS - Southgate IFT
- EMS - Edmonton - Station 32
- EMS - Edmonton - Station 39
- EMS - Edmonton IFT-MIH-ATR HQ - Station 400
- EMS - Macleod - Station 41
- EMS -Vegreville
- EMS- Calgary Air
- EMS- Medicine Hat Air
- EMS-Airdrie Station 2
- EMS-Beaverlodge
- EMS-Camrose
- EMS-Coaldale
- EMS-Edmonton Station 27
- EMS-Fairview

- EMS-Fort Macleod
- EMS-Gibbons
- EMS-Grande Prairie (Headquarters)
- EMS-Kananaskis
- EMS-Lacombe
- EMS-Linden
- EMS-Milk River
- EMS-Medicine Hat Sub Station (Headquarters)
- EMS-Olds
- EMS-Peace River
- EMS-Raymond Health Centre
- EMS-Redwater
- EMS-Southern Communication Centre (Headquarters)
- EMS-Spirit River

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 Emergency Medical Services (EMS) program survey took place from September 27 to October 8, 2020. It focused on six system-wide priority processes (People-Centred Care, Infection Prevention and Control, Emergency Preparedness, Medical Devices and Equipment, Physical Environment, and Patient Flow), and five service-level priority processes (Clinical Leadership; Competency; Decision Support; Episode of Care; Impact on Outcomes) from the following standard: Emergency Medical Services and Interfacility Transport (Version 13.1).

The survey was conducted by five surveyors from outside of the province. The surveyors visited 29 locations across the province, including two EMS Air locations. The EMS team conducted the attestation process in advance of the survey. This assessment method helped them to prepare for the onsite visit and create quality improvement plans. Program leadership and staff have embraced the accreditation journey and the new methodologies.

Across all EMS sites, the survey team found an EMS team that conducts themselves in a professional and courteous manner. The EMS stations visited during the survey included a variety of facilities and arrangements, from "mega" stations where multiple trucks start and end their shift each day, to shared stations with fire resources to small rural, single truck stations that lack the comfortable crew quarters of some of the larger, urban stations. However, when responding to calls the EMS team has access to well-maintained trucks and equipment necessary to do their job in every station.

With the COVID-19 pandemic in full swing, Accreditation Canada chose to eliminate ride alongs for all EMS surveyors. Consequently, the observations and findings that would normally be evaluated during a surveyor ride along did not occur during this on-site visit. Instead, surveyors relied on other strategies such as crew interviews, scenario discussions and demonstrations from EMS team members to evaluate the episode of care.

Considering COVID-19, the EMS team has adjusted their service delivery with appropriate AHS infection prevention and control protocols to protect both the provider and the patient against transmission.

In addition to the health care pressures caused by COVID-19, another significant challenge for AHS EMS is the municipal resistance against the planned consolidation of contracted communication centres into AHS owned and operated Communication Centres. This move is being done to recognize anticipated annual savings and will see medical emergency calls transferred to AHS owned and operated Communication Centres instead of being processed and dispatched by contracted services.

The priority for the EMS team going forward is to find ways to incorporate people-centred care into their service. Including the perspective of the client and family from the service planning and design level down. This will serve to enhance the patient experience across the organization.

The EMS team is supported by an engaged senior leadership that considers innovative solutions to manage service demands such as the Mobile Integrated Health (MIH) program as an alternative to transporting patients to emergency departments and providing care in the community to address patient flow issues. The ATRCC (Assess Treat and Refer Coordination Centre) staffed by Advanced Care
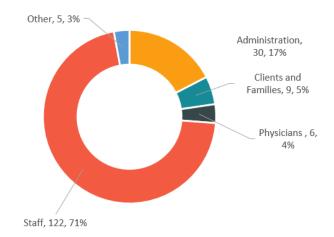
Paramedics, who rotate between the ATRCC and front line Mobile Integrated Health work to review and schedule patient contacts.

With the introduction of strategies to manage demand and impact patient flow, a definite area for focus for this team needs to be optimizing the utilization of EMS Interfacility Transport (IFT) resources more appropriately. The implementation of system status management software specific to IFTs in October 2020 will be beneficial, however, collaboration and communication with referral sources will be imperative and consideration must be given to alternate, non-traditional EMS IFT resources like virtual health for some patient populations. AHS should also consider the financial and resource impact of the current state of IFTs and create a quality improvement strategy to address these issues.

Survey Methodology

The Accreditation Canada Surveyors visited 29 EMS locations.

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

Other, 5, 3%

Administration, 30, 17%

Clients and Families, 9, 5%

Physicians, 6, 4%

Staff, 122, 71%

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[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. Patient and family input and engagement in quality improvement and performance improvement initiatives

2. Strategic initiatives to decrease offload delays which result in inefficient use of time and resources. These initiatives should focus on Interfacility Transfers and with continued efforts with alternative care for EMS transports. Solutions to address bottlenecks across the system from admission to discharge should be considered.

3. Key performance indicators (KPIs) that are extracted from performance data to inform opportunities for improvement and help set priorities for the team.

4. Improved utilization and sharing of data and analytics. A great deal of data is collected however it is not always shared in a meaningful way for quality improvement purposes.

Areas of Excellence

1. The implementation of system status management software (Optima) to manage and support access and flow across the entire province. The ability of each communication centre to serve as a back up for each other ensures a level of redundancy and that calls are processed in a seamless manner.

2. The Mobile Integrated Healthcare (MIH) program and the Assess Treat and Refer Coordination Centre (ATRCC) bring care to the patient in the community, pre-empting emergency department visits and possible hospital admissions.

3. Fleet Management program and their dedication to safety and standardization.

4. EMS staff are very dedicated and committed to the communities they serve regardless of their location across the province.

5. Standardized ground resources.

Results at a Glance

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

Compliance Overall[1]

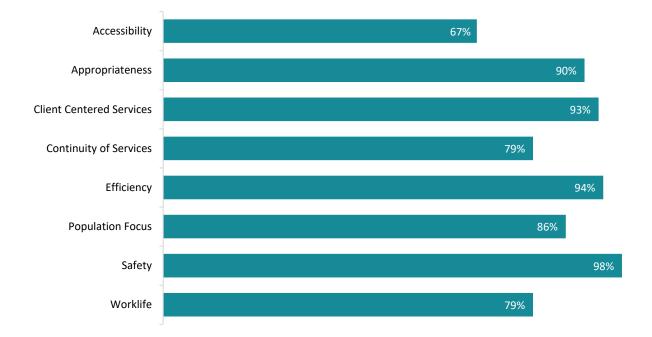| Percentage of criteria			Attestation:
Attested	**On-Site**	**Overall**	A form of conformity assessment that requires organizations to conduct a self-assessment on specified criteria and provide a declaration that the assessment is accurate to the best of the organization's knowledge. This data is used to inform an accreditation award.
97% met	90% met	92% met	
Number of attested criteria			**On-site Assessment:**
Attested	**Audited**		Peer Surveyors from Accreditation Canada visit one or more facilities to assess compliance against applicable standards.
66 Criteria	7 Criteria		

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[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

Emergency Medial Services (EMS) and Interfacility Transport

	92%

STANDARD	MET	UNMET	N/A	NOT RATED
Emergency Medical Services (EMS) and Interfacility Transport	220	19	1	0

Compliance by Quality Dimension

Dimension	Percentage
Accessibility	67%
Appropriateness	90%
Client Centered Services	93%
Continuity of Services	79%
Efficiency	94%
Population Focus	86%
Safety	98%
Worklife	79%

DIMENSION	MET	UNMET	N/A	NOT RATED
Accessibility	2	1	0	0
Appropriateness	47	5	0	0
Client Centered Services	25	2	0	0
Continuity of Services	11	3	0	0
Efficiency	16	1	0	0
Population Focus	6	1	0	0
Safety	98	2	1	0
Worklife	15	4	0	0
Total	220	19	1	0

Compliance by Required Organizational Practice (ROP)

ROP	STANDARD	RATING
COMMUNICATION		
Client Identification	Emergency Medical Services (EMS) and Interfacility Transport	MET
Information Transfer at Care Transitions	Emergency Medical Services (EMS) and Interfacility Transport	MET
MEDICATION USE		
High-alert Medications	Emergency Medical Services (EMS) and Interfacility Transport	MET
Narcotics Safety	Emergency Medical Services (EMS) and Interfacility Transport	MET
Infusion Pump Safety	Emergency Medical Services (EMS) and Interfacility Transport	MET
INFECTION CONTROL		
Hand-hygiene Compliance	Emergency Medical Services (EMS) and Interfacility Transport	UNMET
Hand hygiene Education and Training	Emergency Medical Services (EMS) and Interfacility Transport	MET
Reprocessing	Emergency Medical Services (EMS) and Interfacility Transport	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.

MET 11
(100%)

EMS has been an active participant in many disasters throughout Alberta, including local, regional and provincial responses. These occur in collaboration with other first response and healthcare agencies. EMS services have demonstrated their ability to be prepared for and react to all emergencies. Mass Casualty Incident kits are in the EMS trucks however there is inconsistency with these and at times with some kits, not able to be found. The organization may consider including this and other non-medically required kits on the monthly ambulance checklist to confirm that availability.

Infection Prevention and Control

Priority Process Description: Providing a framework to plan, implement, and evaluate an effective IPC program based on evidence and best practices in the field. This system-level priority process refers to criteria that are tagged to one of the following standards: Infection Prevention and Control.

There are no unmet criteria for this Priority Process.

MET 15
(100%)

EMS has two dedicated infection prevention and control (IPC) staff, but do not have a dedicated IPC committee. The IPC staff do sit on numerous other IPC committees and bring the information back to EMS through the Quality, Safety and Patient Management committee. In the absence of dedicated IPC meetings, the IPC coordinators need to confirm that IPC remains a standing item on other committees with the opportunity to fully address IPC education, initiatives and issues.

IPC coordinators do not have a dedicated Infectious Disease consultant for this team. While they have not had issues accessing this expertise on an ad hoc basis, a dedicated advisor who is familiar with the unique issues of the EMS environment would be beneficial.
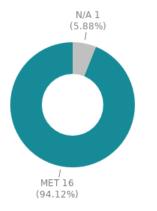
Hand-Hygiene audits are not consistently being completed within the EMS and there is significant zonal variability. The EMS teams are aware of hand-hygiene audits within the hospital environment, but most have not experienced this in the EMS environment. Staff shared that they are unclear as to how audits are to be completed and have not been provided with the tools on how to proceed with an audit. Further education as to how audits are to be completed and identifying a champion at each station may help in furthering education and compliance.

The EMS teams demonstrate good cleaning techniques of the ambulance and equipment and describe best practices. However, documentation of deep cleaning completion is inconsistent in some stations. Supervisors and team members state that direct observation audits are completed but these are not documented. No audits have been completed utilizing a secondary verification system.

It was observed during the visit that the canvas bags being taken into patient homes may be difficult to clean properly. The organization may consider using leather bags such as the ones for head restraint devices that are carried on the ambulance for emergency services.

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: Infection Prevention and Control.

N/A 1
(5.88%)

MET 16
(94.12%)

There are no unmet criteria for this Priority Process.

The AHS EMS fleet maintenance program is very impressive and is consistent across the province. EMS vehicles are serviced on a regular basis with an electronic tracking system that documents the service history of each vehicle. To ensure crews do not experience downtime as a result of a vehicle taken out for service, another vehicle is always provided.

Protocols exist for cleaning and disinfecting EMS vehicles regularly and when additional deep cleaning is required.

These standardized processes have been developed in consultation with the IPC team; however, there is currently no audit process in place. AHS and EMS would benefit from the establishment of an audit process to ensure standards for cleaning the inside of EMS vehicles are maintained.

Documentation, storage and administration of medications and controlled substances are consistent with policies and procedures adhered to. Each EMS station maintains its own supply of medications; however, it was noted that some stations have supplies that are more than required and are at risk of waste due to upcoming expiry dates.

Medical Directors are easily accessible for advice and consultation to EMS crews supporting them in the field, this includes medication administration outside of documented protocols. Safe medication

practices were evident across EMS regarding labelling and storage of high-alert and look-alike medications. As well, regular audits were conducted to support safe medication practices and ensure patient safety. It was noted that two different systems still exist as all stations are converting to retinal scanners.

Noted in Medicine Hat Air Ambulance and ground EMS, there is not a standardized pump system across the province. This leads to delays in time to air due to the transfer of Alaris pumps to Baxter pumps used in the Calgary sites. A consistent pump standard would save not only time but supplies from being wasted.

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.

UNMET 1
(100%)

Ambulance crews have inconsistent access to patient health information. As the EMS system is not yet connected to Connect Care, they have no access to the patient's health record unless they engage the Online Medical Consultation (OMC) physician through dispatch.

Ideally, the handover to the EMS would include all pertinent health information, but this was found to be inconsistent between facilities, departments and individuals. Engaging EMS and nursing representatives to standardize the flow of required information would be beneficial to guide handover information flow. It is noted that there are four different communication tools described on the AHS website (SBAR, iCHAT, iDRAW and ISoBAR) and teams are urged to familiarize themselves with the one used at their facility. EMS go to a variety of facilities. To streamline communication between sites as well as within, one format throughout AHS may help improve information flow.

The organization will benefit with a complete evaluation of the Interfacility Transport (IFT) service. The utilization currently is a detriment to the EMS teams and their primary mandate, the patients, patient flow throughout the organization and the financial bottom line. While OPTIMA and LOGIS will help mitigate some of these issues, others will require alternate solutions. Some issues may be improved with education to hospital and urgent care physicians and staff to ensure they are aware that the ambulance is not mandatory for transport. Education on EMS capabilities and Advanced Care Paramedic and Primary Care Paramedic scope of practice may also limit requests for a higher level of transport than is required to support the patient. Additionally, in-hospital teams need to confirm that the patient is ready for transport before the IFT request.

Scheduling may assist with other IFT issues. It is not uncommon for IFT crews to wait extended periods for tests or consultations. This wait is extended if the IFT is requested hours in advance of the scheduled appointment to ensure that the patient is there on-time. For some consultants, having patients arrive an hour ahead of the appointment is standard procedure, but this should be waived for IFT appointments.

Confirming consultant availability (not in the operating room or working in off-site clinic) prior to sending the patient for consultation would also mitigate this issue.

AHS would benefit by creating a quality improvement strategy to improve patient flow across the system. The utilization of data and analytics from the Integrated Operations Center would be of great benefit. Data could include reasons for time delays such as consultations, or lack of inpatient beds. Creating a large quality improvement strategy with a single focus and identified outcomes will engage and focus all programs, zones and levels as well as improve efficiency and decrease waste and cost.

Other issues will require more innovative approaches. For example, some concerns were identified related to patient admissions for the purpose of transport to a scheduled medical appointment for consultations that could be conducted virtually.

There seems to be a conflict between the dispatch and some of the EMS teams. The teams will call for back up from fire or police, and there is a lag of time for the help to arrive. It is imperative that dispatch and the EMS teams work together to respond to a risk or critical situation. This is not the time for disagreement. There can always be a case review later that can be used in teaching and quality improvement initiatives.

STANDARD	UNMET CRITERIA	CRITERIA
Emergency Medical Services (EMS) and Interfacility Transport	23.10	The team has timely access to the patient's health information.

People-Centred Care

Priority Process Description: Working with clients and their families to plan and provide care that is respectful, compassionate, culturally safe, and competent, and to see that this care is continuously improved upon. This system-level priority process refers to criteria that are tagged to one of the following standards: Emergency Department; Inpatient Services; Long-Term Care Services; Service Excellence.

There are no unmet criteria for this Priority Process.

Within the context of people-centred care (PCC) and the EMS standards, there was minimal evidence that the engagement of patients and families has been rolled out to the stations and front-line staff level. The PCC engagement and work within EMS is being demonstrated currently at the corporate and zone levels.

MET 4
(100%)

The PCC approach is still within the infancy stages and the EMS and the organization is strongly encouraged to educate their teams at all levels on this concept and the importance or relevance of the people-centred care philosophy within the context of their work and roles in the organization. The patient and or family

member provides an important voice to future health service delivery. Rather than relying retrospectively on feedback from patients/families via satisfaction surveys, engaging patients and/or family members from the design and planning stages, ensures their needs are considered from the outset.

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

There are no unmet criteria for this Priority Process.

MET 12
(100%)

AHS EMS has many strengths when it comes to the physical environment of their EMS fleet and stations. EMS Business Standards and Operational Support (BSOS) team is well organized and thorough in their provincial approach. Supervisors in the respective zones all commented on the exemplary service provided by BSOS and the difference that this team has made in their day to day work. Although each station is varying in age, the stations reviewed during the survey were all well maintained, clean, tidy, and well organized.

Within the vehicles and stations, medication and equipment are stowed properly, and thoroughly and complete preventative maintenance records exist. Each station, including the storage bay/garage, was also equipped with good ventilation systems.

Extensive work has been done within AHS EMS over the past couple of years with rollout of power stretchers and power load to assist in the mitigation of musculoskeletal injuries. Most of the fleet except for the dual cot vehicles are all configured to meet safe and effective medical care; however, there are some issues with the dual cot vehicles which should not be overlooked. Although they are currently not being used with two patients due to COVID-19 restrictions. The vehicles present ergonomic challenges and staff do not feel safe to put them into practice. The teams are not able to resuscitate or intubate with a stretcher pushed against a wall. In some places, the teams choose to stop the car and intubate on the side of the road to mitigate risks to the patient and staff. Although EMS has implemented power stretchers to reduce back and lifting injuries as noted above, in the double cars, they cannot use the power load, so the stretcher is now 50lbs heavier to get into the vehicle. This now is a bigger risk to the staff. The stretchers also have a higher tipping ratio as they need to be put into the car on an angle. There have been patients who have been put into tipping situations and have fallen. They cannot move bariatric patients as the weight to side turn ratio is too high. The teams interviewed were told the cars were rolled out to assist with IFT congestion by putting two patients into the car when needed or to support mass casualty events. COVID-19 has temporarily stopped the practice of doubling up on transfers, the vehicles themselves are noted to be a challenge to work in and at times unsafe to practice emergency resuscitative care. The organization is encouraged to investigate the safety of the dual cot vehicles to mitigate and eliminate safety risks for both patients and staff.

All standards related to driving, operating records, and training in vehicles are met, and the EMS leadership should be commended on meeting these standards at such a high level. The compliance of using safety restraints with the new power cots and mattresses is no longer an issue except for the bariatric cots, where a better solution for safety belt extension should be explored.

As some of the older stations and vehicles begin to no longer meet standards, the EMS Business Standards and Operational Support (BSOS) leadership is encouraged to confirm that they have robust short and long term strategic plans that align with AHS to ensure that they have fully functioning EMS services in the community they continue to serve.
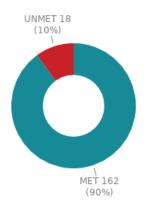
There are no consistent standards for the facilities within the service. Some have lovely televisions, leather furniture, while others are operating out of an old warehouse equipped with old furniture, and on the outside no address, or designation.

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; Organ and Tissue Donation.

Emergency Medical Services (EMS) and Interfacility Transport

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

UNMET 18 (10%)

MET 162 (90%)

While the scope of service for EMS is in line with the strategic plan of AHS, the organization should reevaluate the utilization of this resource. Inappropriate usage of ambulance services for IFTs is undertaken without oversight. This may cause issues for clients that are not getting the right care in the right place. The inappropriate use of the ambulances convolutes the system, and site-based decisions without oversight and direction is reducing efficiency. The EMS team is encouraged to develop their own strategic plan in line with AHS strategic direction; this may help guide future policies for EMS.

The EMS teams provide the transport but are currently excluded from transport planning and advising on most appropriate level of care to meet the patient clinical needs during transport. The referring facilities are not adequately aware of EMS scope of care and it was noted that a higher level of care than required is often requested. Referring sites should request the transport, and the EMS team decide the level of care that will complete the trip based on objective clinical criteria. Further, upon arrival, the EMS teams noted patients and families were often misinformed and advised that the ambulance was required although they were medically stable. This educational disconnect between EMS, physicians, staff, and patients and families results in inappropriate usage within the organization.

Evaluation of trends in service and engaging the frontline providers for recommendations may be of value in realigning EMS transport with the intent of the program. The teams await the introduction of LOGIS to support decisions and to more efficiently track and utilize assets. However, the educational component must be hand in hand with these software solutions, and it must be emphasized to ensure that iRequest information is entered accurately and the IFT request is appropriate.

Communication and exchange of information is always a challenge in large and diverse systems. The teams do receive information via email and from the AHS EMS site. Sometimes, critical information is missed in the flow of information. The organization may want to consider a system where critical information such as changes to clinical pathways or procedures for PPE resupply need to be acknowledged; therefore, supervisors can confirm the frontline teams are receiving critical information. The anticipated inclusion of EMS in the Connect Care system to improve sharing of medical information

with other health providers and access past reports will greatly improve the flow of information within AHS.

Overtime is a significant dissatisfier for EMS crews and they indicate that working overtime is a frequent occurrence. Workload distribution and metrics surrounding utilization should be regularly reviewed to optimize EMS team management.

Performance appraisals are in the process of being completed with frontline staff. While not universally completed; the teams are working towards this goal. All staff interviewed appreciated the new appraisal system and found it beneficial.

While most of the communication functions are provided within AHS, some dispatch services are contracted through external agencies. There was a concern expressed from multiple sites that the external dispatch agencies were disproportionately distributing IFT workload which directly contributed to prolonged crew days for AHS EMS teams. It was noted that the data showing AHS EMS utilization by site did not include contracted EMS providers which will be important in evaluating overall utilization. It is recommended that dispatch services and workloads of contracted providers be reviewed to ensure workload distribution is equitable. If the concerns regarding inequitable tasking are unfounded, this information should be disseminated to alleviate the perceptions of EMS team members. If these concerns are verified, the organization needs to take steps to rectify workload distribution irregularities.

The organization has invested in power lift and load systems for the ambulances which, are greatly appreciated by the EMS staff, and which correlate with a reduced rate of work-related lifting injuries. As it was mentioned above, for bariatric patients, the stretchers cannot be utilized (due to girth, not weight) and thus, the heaviest patients still require the manual lift. While equipping teams with bariatric stretchers compatible with the lift and load system may not be practical, some bariatric patients could be accommodated with the existing power system if a system of longer restraints were available. The team is experienced with removing the restraints for cleaning purposes and longer (bariatric) restraints could be installed and utilized as required. This would also reduce the need to switch stretcher operating systems for bariatric patients with which the teams are no longer familiar.

It was noted that the quantities of seldom used medication is quite high relative to frequency of use, and there may be an opportunity to reduce stock in some areas. Additionally, several medications (seldom used) are due to imminently expire and some teams noted that they are sometimes issued nearly expired medication. The Medication Management team may want to review stocking policies and rotate stock out of low volume stations and into high volume EMS locations and/or hospitals that are more likely to utilize the stock prior to expiration. The refrigerators at EMS stations are regular refrigerators with temperature probes. Temperature record sheets are maintained sporadically in some locations. Reviewing temperature sensitive medication storage procedures and policies should be reviewed.

The retinal scanner to open the narcotics safe is a robust and secure solution. Some team members report that the equipment is installed and needs to be activated in their station.Otherwise, there were no concerns identified with narcotic records and storage, in stations where the process of using two reporting systems exists, procedures should be reviewed.

Currently, the ambulance drug supply is reported via echecks and the counts never change as the supply is replenished immediately following use. The restocking supply at the station is where the counts change and including this in the echecks would provide the Medication Management team with more immediate oversight of narcotic usage.

Sharps and expired medications from EMS are usually disposed of at the local hospital. Some locations no longer have this arrangement, and a new system for disposal needs to be identified.

There is inconsistent staff awareness of the ethics framework. Staff were unaware of training related to ethics and did not identify a significant portion of their daily jobs as being ethically charged. They were not aware of how to obtain help in managing ethics related issues. Utilizing the ethics framework within case studies pertinent to EMS may help to make ethics and the framework real to the front-line staff.

Team members report that feedback is received when something goes wrong; however, they would like to receive more balanced feedback from supervisory staff. Opportunities to conduct performance appraisals or performance conversations need to occur with the frequency defined in the organization's policy. Suggestion from some staff is an annual or semiannual check in with a counsellor to ensure there are no mental health concerns. This would further eliminate the stigma around calling for peer assistance.

Introduction of clinical key performance indicators, with input from the senior medical director and his team, front line providers, and the quality department using a people-centred care approach should be used to identify and drive the training content delivered on an annual basis. EMS team members should receive feedback on patient care reports on a regular and routine basis, not just when cases are flagged for review.

Quality Improvement activities do occur, the next step is to cascade the information to the front-line staff. Some team members recall receiving operational data in the past; however, EMS teams are often unaware of quality improvement activities and the timelines planned for implementation. The leadership is encouraged to orientate team members on how to access quality improvement results.

STANDARD	UNMET CRITERIA	CRITERIA
Emergency Medical Services (EMS) and Interfacility Transport	1.1	The team's scope of service is aligned with the organization's mission or strategic plan.
Emergency Medical Services (EMS) and Interfacility Transport	1.3	The written response and deployment plan includes strategies to manage the demands of emergency medical services and interfacility transport.
Emergency Medical Services (EMS) and Interfacility Transport	1.4	Transport planning is undertaken with input from patients, families, and partners.
Emergency Medical Services (EMS) and Interfacility Transport	5.1	Required training and education are defined for all team members with input from patients and families.
Emergency Medical Services (EMS) and Interfacility Transport	5.20	Team member performance is regularly evaluated and documented in an objective, interactive, and constructive way.
Emergency Medical Services (EMS) and Interfacility Transport	5.21	Patient and family representatives are regularly engaged to provide input and feedback on their roles and responsibilities, role design, processes, and role satisfaction, where applicable.
Emergency Medical Services (EMS) and Interfacility Transport	6.1	A collaborative approach is used to deliver services.
Emergency Medical Services (EMS) and Interfacility Transport	6.5	Position profiles with defined roles, responsibilities, and scope of employment or practice exist for all positions.
Emergency Medical Services (EMS) and Interfacility Transport	7.1	The workload of each team member is assigned and reviewed in a way that ensures patient and team safety and well-being.
Emergency Medical Services (EMS) and Interfacility Transport	7.6	Team members are recognized for their contributions.
Emergency Medical Services (EMS) and Interfacility Transport	14.1	When communication centre functions are provided through an external provider, the organization ensures that service meets requirements for the safety of patients and team members.
Emergency Medical Services (EMS) and Interfacility Transport	14.5	Standardized information for each call is documented.

Emergency Medical Services (EMS) and Interfacility Transport	19.11	Ethics-related issues are proactively identified, managed, and addressed.
Emergency Medical Services (EMS) and Interfacility Transport	20.4	Established contact precautions are followed when treating patients with possible communicable diseases.
Emergency Medical Services (EMS) and Interfacility Transport	23.9	There is a process to monitor and evaluate record-keeping practices, designed with input from patients and families, and the information is used to make improvements.
Emergency Medical Services (EMS) and Interfacility Transport	26.4	Verification processes are used to mitigate high-risk activities, with input from patients and families.
Emergency Medical Services (EMS) and Interfacility Transport	27.4	Indicator(s) that monitor progress for each quality improvement objective are identified, with input from patients and families.
Emergency Medical Services (EMS) and Interfacility Transport	27.11	Information about quality improvement activities, results, and learnings is shared with patients, families, teams, organization leaders, and other organizations, as appropriate.

Criteria for Follow-up

Criteria Identified for Follow-up by the Accreditation Decision Committee

Follow-up Criteria			
Standard: Emergency Medical Services			
#	Criteria	Site	Due Date
1.3	The written response and deployment plan includes strategies to manage the demands of emergency medical services and interfacility transport.	EMS-Fort Macleod	May 30, 2021
6.1	A collaborative approach is used to deliver services.	EMS-Fort Macleod	May 30, 2021
14.1	When communication centre functions are provided through an external provider, the organization ensures that service meets requirements for the safety of patients and team members.	EMS -Vegreville	May 30, 2021
14.5	Standardized information for each call is documented.	EMS-CALG-300	May 30, 2021
20.4	Established contact precautions are followed when treating patients with possible communicable diseases.	EMS-CALG-300	May 30, 2021
26.4	Verification processes are used to mitigate high-risk activities, with input from patients and families.	EMS-Camrose EMS-Lacombe	May 30, 2021

Follow-up ROPs			
Standard	ROP - Test of Compliance	Site	Due Date
	Hand-hygiene Compliance		
Emergency Medical Services	8.7.1 Compliance with accepted hand-hygiene practices is measured using direct observation (audit). For organizations that provide services in clients' homes, a combination of two or more alternative methods may be used, for example: Team members recording their own compliance with accepted hand-hygiene practices (self-audit). Measuring product use. Questions on client satisfaction surveys that ask about team members' hand-hygiene compliance. Measuring the quality of hand-hygiene techniques.	• EMS-CALG-300 • EMS-Coaldale • EMS-Fairview • EMS-Kananaskis • EMS-Lacombe • EMS-Linden • EMS-Medicine Hat Sub Station (Headquarters) • EMS-Raymond Health Centre	May 30, 2021
	8.7.2 Hand-hygiene compliance results are shared with team members and volunteers.	• EMS -CALG-300 • EMS - Edmonton IFT-MIH-ATR HQ - Station 400	May 30, 2021

			• EMS-Coaldale • EMS-Fairview • EMS-Kananaskis • EMS-Lacombe • EMS-Linden • EMS-Medicine Hat Sub Station (Headquarters) • EMS-Raymond Health Centre	
Emergency Medical Services	8.7.3	Hand-hygiene compliance results are used to make improvements to hand-hygiene practices.	• EMS - Edmonton IFT-MIH-ATR HQ - Station 400 • EMS-Coaldale • EMS-Fairview • EMS-Kananaskis • EMS-Lacombe • EMS-Linden • EMS-Medicine Hat Sub Station (Headquarters) • EMS-Raymond Health Centre	May 30, 2021