ACCREDITATION
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CANADA

Accreditation Report

Qmentum Global™ for Canadian Accreditation Program

Provost Health Centre
Alberta Health Services

Report Issued: June 17, 2026

Confidentiality

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About Accreditation Canada

Accreditation Canada is a global, not-for-profit organization with a vision for safer care and a healthier world. Our people-centred programs and services have been setting the bar for quality across the health ecosystem for more than 60 years. We continue to grow in our reach and impact. Accreditation Canada empowers and enables organizations to meet national and global standards with innovative programs that are customized to local needs. Accreditation Canada's assessment programs and services support the delivery of safe, high-quality care in health systems, hospitals, laboratories and diagnostic centres, long-term care, rehabilitation centres, primary care, home, and community settings. Our specialized accreditation and certification programs support safe, high-quality care for specific populations, health conditions, and health professions.

About the Accreditation Report

The Organization identified in this Accreditation Report (the "**Organization**") has participated in Accreditation Canada's Qmentum Global™ for Canadian Accreditation program.

As part of this program, the Organization has partaken in continuous quality improvement activities and assessments, including an on-site survey from May 4, 2026 to May 8, 2026. This Accreditation Report reflects the Organization's information and data, and Accreditation Canada's assessments, as of those dates.

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

Program Overview

The Qmentum Global Program enables your organization to continuously improve quality of care through the sustainable delivery of high-quality care experiences and health outcomes. The program provides your organization with standards, survey instruments, assessment methods and an action planning feature that were designed to promote continuous learning and improvement, and a client support model for on-going support and advice from dedicated advisors.

Your organization participates in a four-year accreditation cycle that spreads accreditation activities over four years supporting the shift from a one-time assessment while helping your organization maintain its focus on planning, implementing, and assessing quality and improvements. It encourages your organization to adopt accreditation activities in everyday practices.

Each year of the accreditation cycle includes activities that your organization will complete. Accreditation Canada provides ongoing support to your organization throughout the accreditation cycle. When your organization completes year 4 of the accreditation cycle, Accreditation Canada's Accreditation Decision Committee determines your organization's accreditation status based on the program's accreditation decision guidelines. The assessment results and accreditation decision are documented in a final report stating the accreditation status of your organization. After an accreditation decision is made, your organization enters year 1 of a new cycle, building on the actions and learnings of past accreditation cycles, in keeping with quality improvement principles.

The assessment manual (Accreditation Canada Manual) which supports all assessment methods (self-assessment, attestation, and on-site assessment), is organized into applicable Standards and ROPs/RSPs. To promote alignment with the assessment manual (Accreditation Canada Manual), assessment results and surveyor findings are organized by Standard, within this report.

Additional report contents include a comprehensive executive summary, the organization's accreditation decision, locations assessed during the on-site assessment, required organizational practices results, and conclusively, People-Centered Care and Quality Improvement Overviews.

Executive Summary

About the Organization

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

As part of government restructuring, AHS has been divided into four distinct provincial health agencies. Once the transition is complete, AHS will serve as a Service Delivery Organization, with a focused mandate on delivering acute care services within hospitals operated by AHS. Current agencies include: Acute Care Alberta, Assisted Living Alberta, Recovery Alberta, and Primary Care Alberta. Acute Care Alberta, established in 2025, oversees the governance and coordination of acute care services (including AHS), and the new provincial health corporations of Emergency Health Services Alberta and Cancer Care Alberta. Assisted Living Alberta, established in 2025, will provide Albertans with a comprehensive, holistic system of continuing care with a full range of wrap-around services including medical and non-medical supports, home care, community care and social services. Recovery Alberta, established in 2024 provides comprehensive and accessible recovery-oriented mental health and addiction services and correctional health services across the province. Primary Care Alberta, established in 2025, is responsible for primary care, including public health, across the province to support day-to-day health needs through every stage of life. Health Shared Services, established December 2025, supports Alberta's provincial health agencies and corporations by delivering shared expertise, systems and resources across finance, data and technology, human resources and governance to enable timely, high-quality care for patients and families.

Accreditation Canada conducts two accreditation visits per year for the duration of the cycle (2023-2027). Accreditation visits help organizations achieve the goal of being Accreditation Ready every day by enabling and empowering teams to work with standards as part of their day-to-day quality improvement activities to support safe care.

Focused assessment for the foundational standards of Governance, Leadership, Infection Prevention, and Control, Medication Management and Reprocessing of Reusable Medical Devices (where applicable) occur at tertiary, regional and urban acute, rehabilitation and psychiatric hospitals, as well as cancer centers in the first survey of the cycle (Fall 2023).

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

To further promote continuous improvement, organizations have adopted the assessment method referred to as attestation. Attestation requires teams 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.

Following each accreditation survey, reports are issued to support the organizations' quality improvement journey. At the end of the accreditation cycle, in Spring 2027, an overall decision will be issued that includes the organization's accreditation award.

Surveyor Overview of Team Observations

Strong and engaged physician support is evident at the Provost Health Centre. Currently, seven physicians provide coverage across all services at the site. A high level of collegiality was observed among the physicians, as well as between physicians and nursing staff. Interactions were respectful and inclusive, with all voices valued. Staff and physicians consistently demonstrated a strong commitment to the patients and residents they serve, as well as to the broader Provost community.

The primary challenges at the site relate to staff recruitment and retention, the coordination of patient transport back to their home province of Saskatchewan, and, at times, availability of Emergency Medical Services (EMS). While interprovincial transport is a provincial issue beyond the site's control, staff and physicians make concerted efforts to mitigate delays and work closely with Referral, Access, Advice, Placement, Information and Destination (RAAPID) to manage transitions. Alberta Health Services' recruitment and retention strategies have had a positive impact; however, many staff are hired into casual or part-time roles and may leave when full-time opportunities become available elsewhere.

EMS works closely with the team and is dispatched through RAAPID. Discussions with EMS personnel indicated that they are primarily Basic Life Support (BLS) paramedics. When a higher level of clinical support is required for patient transport, this can occasionally affect EMS availability.

Staff at the site are closely connected and often serve as informal peer support for one another. While staff satisfaction survey results were requested, none were available for review. It is recommended that the team periodically conduct staff and physician satisfaction surveys to better understand workplace experiences. The piloting of Leadership Rounds and REDCap (Research Electronic Data Capture) surveys may also provide valuable opportunities to gather staff and physician perspectives on the work environment and organizational culture.

Key Opportunities and Areas of Excellence

Areas of Excellence

- Collaborative team approach to care
- Patient centered approach – respecting wishes of patients
- Discharge planning, community partnership and seamless transitions into the community
- Spacious, bright and clean environment

Key Opportunities

Even with the high standard of care consistently delivered, there are several opportunities for further strengthening practice and team effectiveness.These include:

- Development of site-specific goals and objectives to provide clear direction and alignment with quality priorities.
- Evaluation of team functioning, which could be supported through leadership rounds and the use of REDCap surveys to gather structured feedback.
- Enhanced education and training in quality improvement (QI) methodologies, including support to develop and apply SMART objectives.
- Improved data and indicator literacy to support meaningful analysis, trend identification, and the use of data to inform and prioritize quality improvement initiatives.
- Consistent performance appraisals for all staff to support accountability, growth, and professional development.
- Introduction of daily huddles, 10–15 minutes in length, held at the quality board and open to all team members. These huddles would focus on quality and safety and provide an opportunity to highlight a single indicator or ROP audit result, discuss current performance, and identify actions to improve outcomes. This approach would support shared awareness, engagement, and continuous improvement across the team.

People-Centred Care

There is no question that staff and physicians are deeply patient-focused and consistently provide care with compassion and respect. Patients spoke highly of the care they received, expressing strong appreciation for both the clinical and interpersonal aspects of their experience. They reported feeling included in decision-making and indicated that information was communicated clearly and in an easy-to-understand manner.

An opportunity exists to further strengthen practice by deepening the team's understanding of person-centred care and expanding meaningful engagement with patients and families. For example, site-specific patient satisfaction survey results are compiled and shared for review and action. While these results are beginning to be interpreted and addressed, there is an opportunity to more actively involve patients and families in developing action plans to address identified gaps. This could occur informally or through small focus groups to test proposed actions for relevance and effectiveness from the patient perspective.

Additional engagement opportunities may include inviting patients and families to review draft educational materials. Feedback could be gathered through simple questions such as, "Does this make sense to you?", "Are there different words we should use?", or "What information would be most important to you?" These approaches would further support meaningful partnerships with patients and families and enhance the delivery of person-centred care across the site.

Accreditation Decision

Alberta Health Services' accreditation decision continues to be:

Accredited

The organization has succeeded in meeting the fundamental requirements of the accreditation program. The current accreditation decision covers all locations that were previously part of Alberta Health Services, and that continue to operate within the same Accreditation Program-related governance and accountability framework. A new accreditation decision will be awarded at the end of the cycle to include locations owned by:

- *Alberta Health Services*
- *Assisted Living Alberta (Home and Community Care, Continuing Care)*
- *Recovery Alberta*
- *Primary Care Alberta (Public Health Services)*
- *Cancer Care Provincial Health Corporation*
- *Emergency Health Services Provincial Health Corporation*
- *Organ and Tissue Donation and Transplantation Provincial Health Corporation*

Required Organizational Practices

Required Organization Practices (ROP) are essential practices that an organization must have in place to enhance client safety and minimize risk. ROPs contain multiple criteria, which are called Tests for Compliance (TFC).

Table 1: Summary of the Organization's ROPs

ROP Name	Standard(s)	# TFC Rating Met	% TFC Met
Adhering to a Do-Not-Use List of Abbreviations, Symbols, and Dose Designations	Medication Management	5 / 5	100.0%
Antimicrobial Stewardship	Medication Management	5 / 5	100.0%
Cleaning and Low-Level Disinfecting Medical Equipment	Infection Prevention and Control	5 / 5	100.0%
Client Identification	Emergency Department	1 / 1	100.0%
	Inpatient Services	1 / 1	100.0%
	Long-Term Care Services	1 / 1	100.0%
	Obstetrics Services	1 / 1	100.0%
	Perioperative Services and Invasive Procedures	1 / 1	100.0%
Improving Hand Hygiene Practices	Infection Prevention and Control	5 / 5	100.0%
Infection Rates	Infection Prevention and Control	3 / 3	100.0%

Table 1: Summary of the Organization's ROPs

ROP Name	Standard(s)	# TFC Rating Met	% TFC Met
Information Transfer at Care Transitions	Emergency Department	5 / 5	100.0%
	Inpatient Services	5 / 5	100.0%
	Long-Term Care Services	5 / 5	100.0%
	Obstetrics Services	5 / 5	100.0%
	Perioperative Services and Invasive Procedures	5 / 5	100.0%
Infusion Pump Safety	Service Excellence	6 / 6	100.0%
Limiting High-Concentration and High-Total-Dose Opioid Formulations	Medication Management	5 / 5	100.0%
Maintaining an Accurate List of Medications during Care Transitions	Emergency Department	5 / 5	100.0%
	Inpatient Services	5 / 5	100.0%
	Long-Term Care Services	5 / 5	100.0%
	Obstetrics Services	5 / 5	100.0%
	Perioperative Services and Invasive Procedures	5 / 5	100.0%
Managing High-Alert Medications	Medication Management	5 / 5	100.0%

Table 1: Summary of the Organization's ROPs

ROP Name	Standard(s)	# TFC Rating Met	% TFC Met
Optimizing Skin Integrity	Emergency Department	6 / 6	100.0%
	Inpatient Services	6 / 6	100.0%
	Long-Term Care Services	6 / 6	100.0%
	Obstetrics Services	6 / 6	100.0%
	Perioperative Services and Invasive Procedures	6 / 6	100.0%
Preventing Falls and Reducing Injuries from Falls	Emergency Department	6 / 7	85.7%
	Inpatient Services	7 / 7	100.0%
	Long-Term Care Services	7 / 7	100.0%
	Obstetrics Services	7 / 7	100.0%
	Perioperative Services and Invasive Procedures	7 / 7	100.0%
Preventing Venous Thromboembolism	Emergency Department	6 / 6	100.0%
	Inpatient Services	4 / 6	66.7%
	Obstetrics Services	3 / 6	50.0%
	Perioperative Services and Invasive Procedures	3 / 6	50.0%

Table 1: Summary of the Organization's ROPs

ROP Name	Standard(s)	# TFC Rating Met	% TFC Met
Safe Surgery Checklist	Obstetrics Services	5 / 5	100.0%
	Perioperative Services and Invasive Procedures	5 / 5	100.0%
Suicide Prevention Program	Service Excellence	5 / 5	100.0%

Assessment Results by Standard

The following section includes the outcomes from the attestation (if applicable) and on-site assessments, at the conclusion of the on-site assessment.

Core Standards

Qmentum Global™ for Canadian Accreditation has a set of core assessment standards that are foundational to the program and are required for the organization undergoing accreditation. The core assessment standards are critical given the foundational areas of high quality and safe care they cover.

The core standards are always part of the assessment, except in specific circumstances where they are not applicable.

Emergency and Disaster Management

Standard Rating: 100.0% Met Criteria

0.0% of criteria were unmet.

Assessment Results

There is a site-specific emergency and disaster management (EDM) plan that aligns with the overall AHS EDM plan. The site plan supports staff readiness and patient safety. Regular drills, education, and accessible resources contribute to staff awareness of roles and responsibilities during emergency events.

Monthly fire drills are conducted by on-site facilities maintenance and engineering (FM&E) staff. Drills are typically scheduled during the day, Monday to Friday, at the beginning of each month. Each drill includes direct observation, completion of drill reports, post-drill debriefing, and targeted education as required. This structured approach supports continuous learning and reinforces fire safety expectations across the organization. Introducing after-hours fire drills on a periodic basis (e.g., quarterly) would better test readiness across all shifts and ensure staff availability and response capacity during evenings, nights, and weekends.

“Be Ready” emergency code drills are conducted on a monthly schedule that is circulated to all areas. Managers and supervisors are expected to review the drills with their teams and discuss staff roles and responsibilities. While this expectation is clearly communicated, there is currently no formal mechanism in place to verify or audit that these discussions are consistently occurring. Strengthening this feedback and validation process would enhance quality assurance and staff preparedness. This could include brief attestations, manager signoffs, or targeted staff feedback to assess understanding of individual roles during emergency situations.

The site-specific EDM plan is accessible in both paper and electronic formats, providing redundancy in the event of power or system outages. The site-specific emergency response manuals are located throughout the facility (five binders on site). These binders are organized with coloured tabs to support navigation; however, they do not currently include a table of contents. Some handwritten updates were noted in at least one binder, indicating a need for more standardized document control to ensure consistency, currency, and version accuracy across all formats.

The organization would benefit from strengthening document control by ensuring a clearly identified “source of truth” for emergency preparedness resources. Enhancements may include adding a table of contents to all paper binders, eliminating handwritten changes, and ensuring all updates are formally approved and version controlled. This would help maintain consistency between paper-based and electronic emergency planning resources.

It is recommended that the organization conduct a major disaster or mass casualty drill (e.g., wildfire or other external disaster scenario). The last large-scale exercise (code white) occurred in 2021. Conducting a comprehensive, scenario-based drill would support system-level testing, interdepartmental coordination, and the identification of gaps in preparedness.

Finally, participation in a mass casualty simulation is strongly encouraged. The most recent exercise was a tabletop simulation conducted in 2021. Conducting an in-person or functional simulation would enhance readiness, staff confidence, and system-level coordination in the event of a major incident. Involving community partners such as Emergency Medical Services, fire services, and police, as well as students acting as simulated patients, could foster engagement and build community awareness of emergency and disaster response efforts.

Table 2: Unmet Criteria for Emergency and Disaster Management

There are no unmet criteria for this section.

Infection Prevention and Control

Standard Rating: 100.0% Met Criteria

0.0% of criteria were unmet.

Assessment Results

The Infection Prevention and Control (IPC) program is well established and demonstrates alignment with Accreditation Canada standards. The infection control professional (ICP) is on site at least once per month, and more frequently as required, providing leadership, oversight, and support to staff. The ICP also participates in monthly department head meetings and provides reports as needed to ensure risks, trends, and compliance issues are communicated and addressed at the leadership level.

Staff across the organization demonstrated strong knowledge of IPC protocols, including routine practices, outbreak management, and hand hygiene expectations. Ongoing communication and education are supported through IPC newsletters, which are developed for the site and posted to ensure staff have access to timely, relevant information.

Surveillance activities are conducted through regular monitoring of laboratory reports and trend analysis, supplemented by direct communication with frontline staff. This approach supports early identification of potential infections and enables prompt intervention when required.

Low-level disinfection practices are supported by standardized checklists for shared equipment, such as medication carts and wheelchairs. These checklists are readily available on the units, and cleaning is generally completed during the night shift. Observations confirmed that staff were performing hand hygiene appropriately and were able to clearly describe outbreak protocols.

Hand hygiene compliance is actively monitored through regular audits. Audit results are posted on unit quality boards and discussed at staff meetings, promoting transparency, accountability, and continuous improvement.

In addition to acute care areas, the kitchen, cafeteria, laundry, and housekeeping departments were visited. Staff in all areas were knowledgeable and demonstrated a strong understanding of their roles and responsibilities in preventing the spread of infection and maintaining a safe, healthy environment.

Laundry Services
Linen flow is well organized, supporting the separation of clean and soiled processes. Appropriate personal protective equipment (PPE) is used during the sorting of soiled linen. Linen carts are covered during transport, with appropriate cart exchange on the units. Only long-term care (LTC) laundry is processed on site; all acute care linens are sent to an external linen service and are transported appropriately.

Housekeeping
Standard operating procedures (SOPs) and cleaning checklists are in place and up to date. Daily cleaning checks are consistently documented. Hazardous materials safety data sheets (SDS) are accessible. Cleaning supplies are stored appropriately and are readily available.

Dietary Services
The dietary area is spacious, clean, and well lit. Refrigeration units are appropriate and monitored with alarm systems to ensure food safety. There is currently an interim supervisor working off site; a new supervisor has been hired and is expected to be on site in the coming weeks to provide direct oversight.

At present, there is only one entrance/exit to the kitchen. Clean and soiled food carts use the same entry and exit point. Ideally, separate entrances should be designated to reduce the risk of cross-contamination. Where the addition of a second entrance is not feasible, the team is encouraged to continue implementing and strengthening mitigation strategies to minimize this risk. These may include clear scheduling, signage, defined workflow controls, and enhanced cleaning practices.

Table 3: Unmet Criteria for Infection Prevention and Control

There are no unmet criteria for this section.

Leadership

Standard Rating: 100.0% Met Criteria

0.0% of criteria were unmet.

Assessment Results

Several new managers have been appointed during a period of broader system restructuring. The acute care manager is an experienced and capable nurse who has held her management role for four years. She is well supported by a highly knowledgeable and seasoned clinical resource nurse (CRN), who fulfills multiple roles and demonstrates strong awareness of organizational priorities and operations. An administrative assistant provides additional support for both roles, contributing to the effective functioning of the leadership team.

The long-term care (LTC) nurse manager is relatively new and brings extensive experience as a licensed practical nurse, with a strong background in LTC settings. The manager has already initiated several quality improvement efforts aimed at enhancing resident care and quality of life.

The physical environment is actively maintained to support the safety of both patients and staff. Local leadership works directly with FM&E and linen and environmental services to adapt spaces for optimal use.

There is a comprehensive scheduled preventive maintenance (PM) program for all equipment. Depending on the equipment, PM is handled by the FM&E, biomedical staff, or IT vendors.

Table 4: Unmet Criteria for Leadership

There are no unmet criteria for this section.

Medication Management

Standard Rating: 96.2% Met Criteria

3.8% of criteria were unmet. For further details please review the table at the end of this section.

Assessment Results

Medications are securely stored and readily accessible in key clinical areas, including the emergency department, acute care, and a designated night cupboard. This supports timely access to medications while maintaining safety and control. Long-term care (LTC) areas also maintain a limited and appropriate supply of medications to meet resident needs.

The clinical pharmacist participates in interprofessional patient care by rounding with physicians and contributing to medication management discussions. Medication orders are reviewed and updated during rounds, with physicians verifying orders at the conclusion, supporting accuracy and shared accountability in prescribing practices.

Strong processes are in place for the dispensing and administration of medications through the main pharmacy. These processes are supported by a highly skilled and experienced pharmacy team, including an on-site pharmacist available five days per week, with after-hours on-call consultation as required. The team is further strengthened by a knowledgeable pharmacy technician and assistant. Each team member clearly understands their roles and responsibilities, contributing to safe and efficient medication practices.Multiple checks and balances are embedded throughout pharmacy workflows to ensure that the right medication is provided to the right patient at the right time. Patient safety is further supported with electronic unit-dose scanning and robust inventory control systems, reducing the risk of medication errors and enhancing accountability.

An opportunity for improvement was identified in the discharge medication reconciliation process within Connect Care. At the time of discharge, the system requires a manual “refresh” to ensure the most recent Best Possible Medication History (BPMH) and Medication Reconciliation are accurately reflected in the After Visit Summary (AVS). Strengthening this step would help ensure clinicians and patients are consistently working from the most current medication record.

In addition, continued reinforcement of keeping the medication room door closed, the acute care unit is encouraged to further support medication security, environmental control, and compliance with best practices for safe medication storage.

No areas of concern were identified in the LTC setting. Medication administration for two residents was observed. Medications were provided in unit-dose packaging, and two-patient identification was consistently applied, including the use of resident photographs on medication drawers and within the electronic Medication Administration Record (eMAR) in Connect Care. The medication room was observed to be secure, with doors always closed, supporting safe medication storage and access.

The organization is encouraged to review and update its policies and procedures related to smart pump alert overrides, as well as medication orders, including telephone and verbal orders.

Table 5: Unmet Criteria for Medication Management

Criteria Number	Criteria Text	Criteria Type
4.3.2	A policy that specifies when and how to override smart infusion pump alerts is developed and implemented.	HIGH
5.1.1	Access to medication storage areas is limited to authorized team members.	HIGH
6.1.5	There is a policy for acceptable medication orders, with criteria being developed or revised, implemented, and regularly evaluated, and the policy is revised as necessary.	HIGH
6.1.8	There is a policy on telephone and verbal orders for medications that specifies when such orders are acceptable, how they are to be documented, and when they are to be co-signed by the prescriber.	HIGH

Service Excellence

Standard Rating: 88.0% Met Criteria

12.0% of criteria were unmet. For further details please review the table at end of this section.

Assessment Results

Staff and volunteers have access to a comprehensive suite of online education and training resources that support role competency and ongoing professional development. Required education modules, including those completed annually or at defined intervals, are clearly articulated and well understood by staff. An electronic learning management system tracks attendance and completion, enabling managers to monitor compliance and address gaps in a timely manner. This approach supports accreditation expectations related to staff competence, safety, and readiness to provide quality care.

While examples of quality improvement activities are evident within both acute and long-term care services, a formalized, site-level quality improvement framework has not yet been established. There is currently no standardized process for the identification, prioritization, approval, or evaluation of quality improvement initiatives at the site level. As a result, improvement efforts that do occur are not consistently structured, nor are they routinely assessed for feasibility, relevance, sustainability, or impact on patient outcomes.

To align more fully with accreditation standards, education and training in quality improvement methodology would be beneficial. This should include an emphasis on developing SMART Goals (Specific, Measurable, Achievable, Relevant, and Time-bound) clearly defined objectives, and the use of measurable pre- and post-implementation indicators. Establishing a consistent process for evaluating quality improvement initiatives would strengthen accountability and support evidence-informed decision-making. The creation of a site-specific quality council to review, vet, and monitor quality initiatives would further enhance alignment with organizational priorities and compliance with quality and safety standards.

Performance conversations are not completed consistently within either acute care or long-term care services. Site and senior leaders are aware of this gap and acknowledge the need for improvement. Addressing this gap will strengthen leadership practices and support a culture of quality, safety, and continuous learning.

There is a process in place for filing patient complaints; however, patients were not aware of it. They indicated they would raise concerns directly with a staff member. While information about the complaint process is available on the website, no patient information pamphlets or posters were observed on-site to inform patients during their stay.

Table 6: Unmet Criteria for Service Excellence

Criteria Number	Criteria Text	Criteria Type
1.1.3	The team develops its service-specific goals and objectives.	NORMAL
2.1.10	The team leadership regularly evaluates and documents each staff member's performance in an objective, interactive, and constructive way.	HIGH
2.1.12	The team leadership supports staff to follow up on issues and opportunities for growth identified through performance evaluations.	HIGH
2.2.4	The team evaluates the effectiveness of its collaboration and functioning, and identifies opportunities for improvement.	NORMAL
4.3.3	The team identifies measurable objectives for its quality improvement initiatives including specific timeframes for their completion.	HIGH
4.3.4	The team identifies indicators to monitor progress for each quality improvement objective.	NORMAL
4.3.5	The team leadership works with staff to design and test quality improvement activities to meet objectives.	HIGH
4.3.6	The team leadership works with staff to use new or existing indicator data to establish a baseline for each indicator.	NORMAL
4.3.10	The team leadership ensures that information about quality improvement activities, results and learnings are shared with staff, clients and families, organizational leaders, and partners, as appropriate.	NORMAL

Criteria Number	Criteria Text	Criteria Type
4.3.11	The team regularly evaluates quality improvement initiatives for feasibility, relevance, and usefulness.	NORMAL

Service Specific Assessment Standards

The Qmentum Global™ for Canadian Accreditation program has a set of service specific assessment standards that are included in the accreditation program based on the services delivered by different organizations. Service standards are critical to the management and delivery of high-quality and safe care in specific service areas.

Emergency Department

Standard Rating: 96.9% Met Criteria

3.1% of criteria were unmet. For further details please review the table at the end of this section.

Assessment Results

The service provides 24/7 care to both adult and pediatric populations, with most patients being adults. Pediatric specific equipment is readily available, including a dedicated pediatric code cart, supporting safe and timely care for children. Care areas are bright, spacious, and well lit, supporting patient privacy, dignity, and confidentiality.

Nursing and medical staff demonstrated a high level of knowledge, skill, and experience. Collegial and respectful interactions were observed among team members, reflecting a positive interprofessional practice environment.

Patients spoken with expressed high levels of satisfaction with the care received. They reported that staff communicated clearly and explained their condition, investigations, and care plans in a way that was understandable and reassuring.

While existing Alberta Health Services policy allows provider discretion regarding triage screening, there is an opportunity to strengthen consistency by establishing minimal screening expectations for rural sites. Standardizing core elements of screening at triage would support equitable, timely, and consistent assessment of patients especially as it relates to the potential for falls and venous thromboembolism assessments.

There is an opportunity to further formalize multidisciplinary case review processes by establishing routine reviews on a defined schedule (monthly or quarterly), supporting continuous quality improvement and shared learning. There is also opportunity to measure, monitor and share data on EMS off load times and length of stay in the emergency department. The only data presented was wait times to see the physician.

Table 7: Unmet Criteria for Emergency Department

Criteria Number	Criteria Text	Criteria Type
2.4.16	Clients and families are provided with information about how to file a complaint or report violations of their rights.	HIGH
2.5.5	Preventing Falls and Reducing Injuries from Falls 2.5.5.2 The team follows the organization's procedure to conduct screening for risk of falls and injuries from falls.	ROP
3.1.2	Ambulance offload response times are measured and used to set target times for clients brought to the emergency department by Emergency Medical Services.	NORMAL
3.1.3	Data on wait times for services, the length of stay in the emergency department, and the number of clients who leave without being seen is tracked and benchmarked.	NORMAL

Inpatient Services

Standard Rating: 95.9% Met Criteria

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

Assessment Results

The inpatient unit has fifteen (15) inpatient beds, including two designated for palliative care and two for obstetrics.

The CoACT collaborative care model has been implemented, and the team works in a collaborative approach to meet patient needs. Individual physicians conduct daily rounds with nursing staff and pharmacy, when available. Following daily rounds, the charge nurse huddles with nursing and interprofessional staff to discuss and update care plans. Some patients had an expected date of discharge (EDD) documented in Connect Care, while others did not. The leadership team is encouraged to work with physicians to establish a consistent approach to the use of EDD, which will support patient flow and discharge planning.

Connect Care has been in use at the site for three years. Nursing staff use standardized tools to complete their documentation. While reviewing inpatient electronic health records with a nurse, the surveyor observed several alerts indicating that the goals of care designation (GCD) had not yet been reviewed and signed off by the most responsible physician (MRP). The leadership team is encouraged to review GCD sign-off responsibilities with MRPs to ensure timely completion.

Required organizational practice (ROP) compliance data were posted on the quality board, highlighting trends and opportunities for improvement, particularly in venous thromboembolism (VTE) prophylaxis and medication reconciliation, among others. For VTE, the data indicated that decision-support tools in Connect Care are not consistently used by the medical team. Physicians are encouraged to increase their use of these best-practice decision-support tools within Connect Care.

Updates on ROP compliance are shared with staff through meetings and email communication. The leadership team is encouraged to establish service-specific goals with the team and consider regular huddles to review key safety and quality priorities, as well as opportunities for improvement.

All patients spoke highly of the individualized care provided by staff and felt well informed about their plan of care. They reported feeling listened to and respected. There is an opportunity to increase awareness of AHS Shared Commitments, which outline patient rights and responsibilities, as well as the process of submitting a complaint.

Table 8: Unmet Criteria for Inpatient Services

Criteria Number	Criteria Text	Criteria Type
3.2.13	Clients and families are provided with information about their rights and responsibilities.	HIGH
3.2.14	Clients and families are provided with information about how to file a complaint or report violations of their rights.	HIGH
3.3.9	Preventing Venous Thromboembolism 3.3.9.2 The team follows the organization's procedure to use clinical decision support tools to determine appropriate interventions for a client who screens positive for risk of venous thromboembolism. 3.3.9.4 The team follows the organization’s procedure to report health care associated venous thromboembolism as a safety incident.	ROP

Long-Term Care Services

Standard Rating: 97.6% Met Criteria

2.4% of criteria were unmet. For further details please review the table at the end of this section.

Assessment Results

The LTC setting is supported by an engaging and enthusiastic site manager who has been in the role for just over one year. As an LPN with a strong background in long-term care and resident-centred practice, she brings relevant clinical experience and leadership to the role.

The unit is staffed by a complement of registered nurses (RNs) and health care aides (HCAs) who consistently demonstrate respectful, compassionate, and professional interactions with residents. Volunteers also support residents in their daily activities. Staff were observed engaging with residents in a caring and dignified manner. Participation in unit rounds was observed as part of the tracer activity, and rounds were strongly resident-focused, with active engagement and collaboration from all staff present.

Staff who were interviewed clearly expressed pride in their work and appreciation for the strong peer support within the team. They demonstrated knowledge, commitment, and a genuine desire to continuously improve the care provided to residents. Staff also spoke positively about the availability of education and training resources through online platforms and expressed a shared commitment to quality and safety for both residents and themselves.

The LTC unit is a large, secure, and well-lit environment that is appropriately equipped to meet resident needs. The space includes designated areas for private conversations, recreational activities, games, and personal services such as a hairdressing salon. A monthly recreation and activities calendar is posted in each resident's room and displayed on large whiteboards in common areas, promoting awareness and participation in meaningful activities.

Numerous quality improvement initiatives were identified that enhance the resident experience and quality of life. Examples include the implementation of resident and family "welcome packages" and planning for a new palliative care comfort kit designed to support young children accompanying families during end-of-life experiences.

While several quality initiatives are underway, there was no evidence of a quality improvement plan with clearly defined and measurable goals and objectives, as expected within accreditation standards for long-term care. The team demonstrates a strong foundation on which to build. In alignment with standards emphasizing resident-centred care and meaningful engagement, it is recommended that the results of the quality-of-life survey be shared with the resident council to solicit their input. This feedback would support the identification of priority actions and inform the development of a structured, data-driven quality improvement plan that demonstrates ongoing monitoring, evaluation, and continuous improvement.

Table 9: Unmet Criteria for Long-Term Care Services

Criteria Number	Criteria Text	Criteria Type
4.1.1	Teams have a quality improvement plan for improving residents' quality of life.	HIGH
4.1.2	Teams have a quality improvement plan for improving residents' quality of care.	HIGH

Obstetrics Services

Standard Rating: 95.7% Met Criteria

4.3% of criteria were unmet. For further details please review the table at the end of this section.

Assessment Results

Provost Health Centre has two (2) obstetrics beds as part of its funded complement of fifteen (15) inpatient beds. There is strong alignment with guidelines for maternal and infant care; however, the number of deliveries at the site has declined in recent years due to decreased physician and anesthesia availability, as well as patients choosing to deliver at other centres. Current annual deliveries range between 25 and 30 cases.

There is one surgeon and one anesthesiologist available to support cesarean section (C-section) procedures. Some cases are scheduled, while others may occur urgently. If no medical staff are available to perform a C-section, patients are transferred to another facility. The medical team is exploring opportunities to build capacity to strengthen surgical and anesthesia support for C-section cases.

Based on clinical guidelines and available support for C-sections, only low-risk deliveries are performed at the site due to variability in surgical backup. Maternal pre-admission clinics are held, and comprehensive risk assessments are completed. If high-risk factors are identified during the initial assessment, care options are discussed with the patient and family, and plans are made for delivery at another centre.

From a quality and safety perspective, the team actively participates in the Managing Obstetrical Risk Efficiently (moreOB) program. Meetings are held every two months with a representative from Red Deer Regional Hospital Centre, who prepares reports and meets with the team to review results and identify opportunities for improvement. Currently, there is some uncertainty regarding continued support for the moreOB program due to the transition from the Central Zone to the Edmonton Corridor model within the hospital corridor approach. The organization is encouraged to clarify ongoing support for participation in the moreOB program at Provost Health Centre under the new structure.

While reviewing AHS obstetrics policies and procedures, the surveyor noted that several policies have not been updated, with review dates ranging from 2020 to 2023. There was also inconsistent use of screening for the risk of venous thromboembolism (VTE). Although AHS has VTE prophylaxis order sets and decision-support tools embedded within Connect Care, these tools are not consistently used by all members of the medical team. At the same time, there was no evidence of incident reports related to missed or absent VTE prophylaxis orders. Continued reinforcement and standardization of these tools would support best practices in patient safety.

Some variation in physician approaches to the delivery experience was noted by team members. The obstetrics team is encouraged to review current practices and establish a more standardized approach to support both quality of care and the patient experience. The site’s obstetrics medical lead has been conducting simulation scenarios for common obstetrical processes and practices. The organization is encouraged to continue supporting this important initiative to advance learning and maintain clinician competency.

Patients and families spoke highly of the care they had received, highlighting strong communication, compassionate care, and respect for their opinions and choices. Those who had previously been on the unit noted receiving a maternity package prior to previous deliveries and described the transition home as seamless. However, they indicated they had not received information about AHS Shared Commitments (which outline patient rights and responsibilities) or the process for submitting a complaint. The organization is encouraged to consider including this information in the maternity package provided to patients prior to delivery.

Table 10: Unmet Criteria for Obstetrics Services

Criteria Number	Criteria Text	Criteria Type
1.2.14	Clients and families are provided with information about their rights and responsibilities.	HIGH
1.2.16	Clients and families are provided with information about how to file a complaint or report violations of their rights.	HIGH
1.3.7	Preventing Venous Thromboembolism 1.3.7.1 The team follows the organization's procedure to conduct screening for risk of venous thromboembolism. 1.3.7.2 The team follows the organization's procedure to use clinical decision support tools to determine appropriate interventions for a client who screens positive for risk of venous thromboembolism. 1.3.7.4 The team follows the organization's procedure to report health care associated venous thromboembolism as a safety incident.	ROP

Palliative Care Services

Standard Rating: 94.7% Met Criteria

5.3% of criteria were unmet. For further details please review the table at the end of this section.

Assessment Results

The site has two palliative care beds. There is a palliative care nurse who visits patients in both the community and the hospital to conduct palliative care assessments and provide symptom management advice. Staff commented on the responsiveness and value of the palliative care nurse and team to the community and the hospital.

One patient was admitted from the community for palliative care assessment. A family meeting was held with the patient, family, and interprofessional team members including the charge nurse, physician, discharge planner and palliative resource nurse, to determine the best options for placement to meet the patient needs at this time. The patient's family expressed concerns about the plan and were able to openly discuss the approach with the team. The plan was adjusted to support patient and family needs as a transition plan was being put in place.

Several AHS policies, guidelines, and algorithms aligned with palliative and end-of-life care are not current and are encouraged to be reviewed and updated.

Table 11: Unmet Criteria for Palliative Care Services

Criteria Number	Criteria Text	Criteria Type
1.1.1	The organization has policies and resources to help team members implement a palliative approach to care.	HIGH
5.1.1	The organization has policies and procedures to address requests for medical assistance in dying (MAiD).	HIGH

Perioperative Services and Invasive Procedures

Standard Rating: 96.6% Met Criteria

3.4% of criteria were unmet. For further details please review the table at the end of this section.

Assessment Results

The perioperative and invasive procedures program is budgeted for 45 cases per year. The surgical procedures are low risk in nature, with approximately 85–90% performed as day surgeries. Inpatient procedures are generally caesarean section cases.

During the visit the three scheduled surgical cases (dental procedures) were cancelled. The cancellations occurred because the dental instruments were not delivered to the hospital in time to be sterilized by the part-time central service technician in the medical device reprocessing department (MDRD). Surgical cancellations negatively impact both the patient experience and staff utilization. The leadership team is encouraged to develop a process to ensure that the small volume of operating room procedures is communicated to key stakeholders in a timely manner, so that equipment and staffing requirements can be effectively coordinated.

Based on chart review, standardized tools are utilized throughout the surgical experience. Patients are contacted the day prior to surgery to confirm that pre-operative instructions have been understood and are being followed.

The perioperative area was built in the late 1970s. The space does not meet the standards of at least 20 complete air exchanges per hour. Current tracking shows 10 air exchanges per hour. The site leadership and FM&E are exploring upgrades to the perioperative/OR air handling system.

As per the AHS falls risk management policy, programs can determine approach to falls screening. The perioperative team is encouraged to consider falls screening in the preadmission assessment. There is an opportunity for the team to review a consistent approach for documentation of screening for VTE prophylaxis.

The surveyor observed that several surgical policies were not updated (safe surgery checklist, surgical site verification, and more). The organization is encouraged to update the outdated policies.

Table 12: Unmet Criteria for Perioperative Services and Invasive Procedures

Criteria Number	Criteria Text	Criteria Type
1.1.6	Airflow and quality in the area(s) where surgical and invasive procedures are performed are monitored and maintained according to standards applicable for the type of procedures performed.	HIGH

Criteria Number	Criteria Text	Criteria Type
1.1.7	Rooms where surgical and invasive procedures are performed have at least 20 complete air exchanges per hour.	HIGH
1.1.8	Ducts have microbic filters whenever sterile fields are required.	HIGH
2.3.7	Preventing Venous Thromboembolism 2.3.7.1 The team follows the organization’s procedure to conduct screening for risk of venous thromboembolism. 2.3.7.2 The team follows the organization's procedure to use clinical decision support tools to determine appropriate interventions for a client who screens positive for risk of venous thromboembolism. 2.3.7.4 The team follows the organization’s procedure to report health care associated venous thromboembolism as a safety incident.	ROP

Reprocessing of Reusable Medical Devices

Standard Rating: 96.7% Met Criteria

3.3% of criteria were unmet. For further details please review the table at the end of this section.

Assessment Results

The medical device reprocessing department (MDRD) was renovated several years ago and includes a separate decontamination room, excellent lighting, and appropriate equipment to meet the reprocessing needs of this low-volume, low-complexity perioperative and invasive procedures site. One identified gap is the absence of a handwashing sink in the decontamination area. This gap has been noted in two IPC audits of the MDRD. The organization is encouraged to prioritize the acquisition and installation of a sink in the decontamination area.

Given the low volume of activity, there is a part-time central service technician (CST) who works independently in the department. The CST is highly knowledgeable in reprocessing practices and works at another AHS site. An instrument tracking system is not currently in use, which is appropriate given the type and volume of instruments processed at the site.

The organization maintains a comprehensive medical device reprocessing website that includes links to centralized and decentralized training videos, as well as standard operating procedures (SOPs).

Table 13: Unmet Criteria for Reprocessing of Reusable Medical Devices

Criteria Number	Criteria Text	Criteria Type
3.2.2	The reprocessing area's designated hand-washing sinks are equipped with faucets supplied with foot-, wrist-, or knee-operated handles, electric eye controls, automated soap dispenser and single-use towels.	NORMAL
5.3.11	Information about quality improvement activities, results, and learnings is shared with stakeholders, teams, organization leaders, and other organizations, as appropriate.	NORMAL

Criteria for Follow-up

Criteria identified by the Accreditation Decision Committee for follow-up reporting to Accreditation Canada

Follow-up Requirements		
Standard	**Criterion**	**Due Date**
Emergency Department	2.4.16 Clients and families are provided with information about how to file a complaint or report violations of their rights.	June 8, 2027
	2.5.5.2 The team follows the organization's procedure to conduct screening for risk of falls and injuries from falls.	June 8, 2027
Inpatient Services	3.2.13 Clients and families are provided with information about their rights and responsibilities.	June 8, 2027
	3.2.14 Clients and families are provided with information about how to file a complaint or report violations of their rights.	June 8, 2027
	3.3.9.2 The team follows the organization's procedure to use clinical decision support tools to determine appropriate interventions for a client who screens positive for risk of venous thromboembolism.	June 8, 2027
	3.3.9.4 The team follows the organization's procedure to report health care associated venous thromboembolism as a safety incident.	June 8, 2027
Medication Management	4.3.2 A policy that specifies when and how to override smart infusion pump alerts is developed and implemented.	June 8, 2027
	5.1.1 Access to medication storage areas is limited to authorized team members.	June 8, 2027
	6.1.5 There is a policy for acceptable medication orders, with criteria being developed or revised, implemented, and regularly evaluated, and the policy is revised as necessary.	June 8, 2027
	6.1.8 There is a policy on telephone and verbal orders for medications that specifies when such orders are acceptable, how they are to be documented, and when they are to be co-signed by the prescriber.	June 8, 2027

Follow-up Requirements		
Standard	**Criterion**	**Due Date**
Obstetrics Services	1.2.14 Clients and families are provided with information about their rights and responsibilities.	June 8, 2027
	1.2.16 Clients and families are provided with information about how to file a complaint or report violations of their rights.	June 8, 2027
	1.3.7.1 The team follows the organization's procedure to conduct screening for risk of venous thromboembolism.	June 8, 2027
	1.3.7.2 The team follows the organization's procedure to use clinical decision support tools to determine appropriate interventions for a client who screens positive for risk of venous thromboembolism.	June 8, 2027
	1.3.7.4 The team follows the organization's procedure to report health care associated venous thromboembolism as a safety incident.	June 8, 2027
Perioperative Services and Invasive Procedures	1.1.6 Airflow and quality in the area(s) where surgical and invasive procedures are performed are monitored and maintained according to standards applicable for the type of procedures performed.	June 8, 2027
	1.1.7 Rooms where surgical and invasive procedures are performed have at least 20 complete air exchanges per hour.	June 8, 2027
	1.1.8 Ducts have microbic filters whenever sterile fields are required.	June 8, 2027
	2.3.7.1 The team follows the organization's procedure to conduct screening for risk of venous thromboembolism.	June 8, 2027
	2.3.7.2 The team follows the organization's procedure to use clinical decision support tools to determine appropriate interventions for a client who screens positive for risk of venous thromboembolism	June 8, 2027
	2.3.7.4 The team follows the organization's procedure to report health care associated venous thromboembolism as a safety incident.	June 8, 2027