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CANADA

Accreditation Report

Qmentum Global™ for Canadian Accreditation Program

Rocky Mountain House Health Centre
Alberta Health Services

Report Issued: June 17, 2026

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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.

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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.

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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.

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Surveyor Overview of Team Observations

Rocky Mountain House Health Centre (RMHHC) is a small but very busy hospital. In addition to adjusting to the recent Alberta Health Services structural reorganization, RMHHC is also one of the 10 provincial pilot sites for hospital-based leadership, an initiative to promote site-level accountability and improved patient outcomes. As this initiative is in its early stages, there have been no major changes implemented in hospital operations at this time. There has been recent leadership turnover, although this is now settling, and staff report better structure and support as a result.

The leadership team at RMHHC works collaboratively to foster an environment where staff, patients, and families are treated like family. Person-centred care is evident throughout all aspects of the healthcare environment and is reflected in the positive culture observed across the site. Despite being a busy hospital, the facility continues to demonstrate strong leadership practices.

Staffing and work-life balance at the site appear to be well managed, with team members consistently supporting one another to ensure both staff and patient needs are met. A strong sense of teamwork and mutual respect contributes to a supportive workplace culture and enhances the delivery of care and services throughout the facility.

Patient satisfaction at the site is exceptionally high and RMHHC should be commended. Patients and their families consistently speak positively about the care they receive and express appreciation for the professionalism and compassion demonstrated by staff. The services that are offered are delivered with a level of expertise and quality comparable to that of a larger centre.

Key Opportunities and Areas of Excellence

Areas of Excellence

- The healthcare team consistently demonstrates strong collaboration, professionalism, and commitment to delivering safe and effective care.
- The team provides high quality care by maintaining strong clinical standards.
- Patients' values, preferences, and individual needs are respected and integrated into services provided.

Key Opportunities

- Introduce and embed quality improvement.
- Introduce daily safety huddles on the inpatient unit and, if feasible, in the emergency department.
- Explore ways to increase staff recruitment and retention for both nursing and medical staff.
- Strengthen working relationships and communication with all community partners.

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People-Centred Care

RMHHC exemplifies people-centered care. Each person's unique circumstances and preferences are reviewed to provide the most appropriate care possible.

Patients and families are aware that their specific care needs related to management of high-risk pregnancies, difficult surgeries, inpatient neonatal and pediatric care, as examples, may not always be available at the site.

Patients who can be safely provided with services at RMHHC receive exemplary care. The site promotes collaboration between patients and healthcare providers, creating a supportive environment where patients can make informed decisions about their treatment and well-being. Shared decision-making helps keep patients informed and actively involved in their care. Stronger communication between the site and community partners would further enhance the patient-centred care already in place.

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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*

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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%
	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%

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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%
	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%
	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%

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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%
	Obstetrics Services	Not rated	Not rated
	Perioperative Services and Invasive Procedures	6 / 6	100.0%
Preventing Falls and Reducing Injuries from Falls	Emergency Department	7 / 7	100.0%
	Inpatient 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	6 / 6	100.0%
	Obstetrics Services	Not rated	Not rated
	Perioperative Services and Invasive Procedures	6 / 6	100.0%
Safe Surgery Checklist	Obstetrics Services	5 / 5	100.0%
	Perioperative Services and Invasive Procedures	5 / 5	100.0%

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Table 1: Summary of the Organization's ROPs

ROP Name	Standard(s)	# TFC Rating Met	% TFC Met
Suicide Prevention Program	Service Excellence	5 / 5	100.0%

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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: 92.9% Met Criteria

7.1% of criteria were unmet. For further details please review the table at the end of this section.

Assessment Results

The team works well with partners and the community. Drills are regularly conducted (e.g., fire drill, code white) and a mass casualty exercise is planned for this month. Results of drills and exercises are shared with staff through committee members. Resource binders are all current and staff know where to find them.

Fire alarms are very audible throughout the site, however announcements over the public announcement system are difficult to hear in some areas of the hospital. Staff, patients and visitors may be unable to hear codes over the system or cannot hear the location of a fire when it is announced. Improving this would be of obvious benefit.

Relationships with the community and local first responders can be strengthened. There have been informal meetings previously, but bilateral communication can be improved. Local first responders are not included on the emergency and disaster management committee and currently do not receive regular communications from RMHHC, and vice versa. The community has not had a community emergency preparedness exercise for several years. The local RCMP and fire and wildlife services have been involved, but RMHHC has not been. The site manager is working to contact these community organizations to re-establish relationships and foster better communication and collaboration to support planning and response.

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Table 2: Unmet Criteria for Emergency and Disaster Management

Criteria Number	Criteria Text	Criteria Type
3.1.2	The organization integrates its emergency and disaster plan with community emergency and disaster plans, to ensure a coordinated response to and recovery from an event.	NORMAL

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Infection Prevention and Control

Standard Rating: 98.0% Met Criteria

2.0% of criteria were unmet. For further details please review the table at the end of this section.

Assessment Results

RMHHC has been part of the traditional central zone infection prevention and control (IPC) program and follows AHS policies and procedures. There is one infection control professional (ICP) who covers multiple sites; they are on-site about once per month but are available during working hours via phone or Connect Care as needed.

Hand hygiene auditing is conducted by trained site auditors; unit-specific compliance rates are available but are not broadly posted. Leadership is aware of results and is invested in maintaining good hand hygiene compliance. Alcohol-based hand rub (ABHR) dispensers and sinks are generally accessible in the emergency department, however on the inpatient unit, ABHR is not at point-of-care. Consideration can be given to repositioning ABHR dispensers, weighing the specific safety risks of having dispensers in patient rooms in this hospital. There are no readily accessible hand hygiene sinks for staff in the inpatient corridors. Patient washrooms are very small and there is only one sink in patient rooms which is used by patients. There are no dedicated hand hygiene sinks in most of the units.

Healthcare-associated infection rates are also available using the AHS reporting template (reporting numbers of cases vs. standardized rates), but some staff were not aware of results. The ICP is involved in current renovation meetings, but the teams would benefit from having this individual on-site more often (e.g., weekly) during renovations so that proper IPC risk assessments and site reviews can be conducted, and any breaches can be corrected.

Education for staff, volunteers and contractors is required at orientation and then every three years. While staff feel supported, the limited on-site presence of the ICP is a potential challenge to enhancing collaborative relationships and quality improvement activities at RMHHC. Support for certification for the ICP should also be considered. While the Certified in Infection Control (CIC) is a recognized standard for demonstrating competency in IPC, it is currently a preferred qualification rather than a requirement within AHS.

Table 3: Unmet Criteria for Infection Prevention and Control

Criteria Number	Criteria Text	Criteria Type
2.5.4	Team members, and volunteers have access to dedicated hand-washing sinks.	NORMAL

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Leadership

Standard Rating: 100.0% Met Criteria

0.0% of criteria were unmet.

Assessment Results

There is relatively new leadership over the past year, with a new manager for acute care and the emergency department and a temporary director (hospital-based leadership). The site manager has been in her role for three years. Now that the leadership team is stable, they are focused on re-establishing quality improvement activities in all areas, sharing hospital and unit-based metrics more transparently, and engaging frontline staff in improvement activities. Also, staff feel more secure with on-site presence of contracted security guards (since August 2025).

Physical space is well maintained and clean. While patient spaces are adequate, some staff areas would benefit from review. For example, the pharmacy is small and it is challenging for staff and trainees to work together in this small space, and there is limited space for change rooms for the operating room staff. It would be beneficial if these areas were also addressed in the designs for the operating room expansion. Having the ICP visit the site regularly (i.e., at least weekly) during this construction would be of great value.

Table 4: Unmet Criteria for Leadership

There are no unmet criteria for this section.

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Medication Management

Standard Rating: 97.3% Met Criteria

2.7% of criteria were unmet. For further details please review the table at the end of this section.

Assessment Results

Medication management is handled well by the small on-site team, which includes a pharmacist, pharmacy technician, and pharmacy assistant. The team makes excellent use of the limited space available. The pharmacy is highly organized, with colour-coded bins based on medication route: yellow for oral medications, green for topical medications, and red for injectables. All bins are arranged alphabetically by generic name. This organization system is also used in the night cupboard and nursing units. Tall Man lettering is used effectively to help distinguish medications, along with high-alert and sound-alike medications warning stickers.

The team works well together and is well respected throughout the facility. Connect Care has helped reduce medication errors and improved documentation of medication use. The team also participates in weekly central corridor team meetings.

The current system works well within the existing environment; however, there are concerns about space limitations if automated dispensing cabinets (ADCs) are introduced throughout the building.

The team could benefit from a larger workspace, especially considering the number of students spending extended periods in the pharmacy. Minor improvements to labelling and traffic flow could be made by rewiring and relocating the label makers, allowing the technician to work more efficiently. This change could also create space for an additional desk for temporary staff. An occupational health assessment may also be beneficial.

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
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

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Service Excellence

Standard Rating: 91.8% Met Criteria

8.2% of criteria were unmet. For further details please review the table at the end of this section.

Assessment Results

There is relatively new leadership over the past year, with a new manager for the acute care and emergency department and temporary director. The site manager has been in her role for three years. There have been several organizational changes in the past year, one of which is the implementation of hospital-based leadership for which RMHHC is a pilot site.

Staffing has been challenging. Over half of the nursing staff are considered “new,” either to RMHHC, to nursing overall, or requiring additional training to fulfill their roles at this site. Despite incentives to work in rural settings, nursing retention remains an ongoing challenge. Staff interviewed reported being very happy working at the site and expressed appreciation for the strong teamwork and support among colleagues. Physician retention has also been difficult, with several recent resignations and a slow recruitment process; however, physician coverage has been maintained. Staff roles are well defined, with clear job descriptions and established competencies. The site benefits from the presence of a clinical educator. While development conversations have not been conducted recently, they are in the process of restarting. Support services such as emergency and disaster management, infection prevention and control, and occupational health are not frequently present on-site.

Patients are very satisfied with their care (based on the most recent patient satisfaction survey). Patient and family input and concerns are used to improve service delivery. The addition of three site-specific patient-family advisors who are enthusiastic to help improve connections to the community and improve patient flow is noteworthy. The Indigenous liaison position is currently vacant. The hospital works well with its partners, including the three nearby First Nation communities, although it can enhance and formalize working relationships with the town.

Quality initiatives are not evident at this site; there are plans to restart quality improvement activities and the team is encouraged to do this. Provincial resources could possibly help with this. There is relevant data collected that is not shared with frontline staff, who could be engaged in quality initiatives as well.

Table 6: Unmet Criteria for Service Excellence

Criteria Number	Criteria Text	Criteria Type
2.1.10	The team leadership regularly evaluates and documents each staff member's performance in an objective, interactive, and constructive way.	HIGH
2.1.12	The team leadership supports staff to follow up on issues and opportunities for growth identified through performance evaluations.	HIGH

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Criteria Number	Criteria Text	Criteria Type
4.3.2	The team uses information and feedback about the quality of services to identify opportunities for quality improvement initiatives and set priorities.	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
4.3.10	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
4.3.11	The team regularly evaluates quality improvement initiatives for feasibility, relevance, and usefulness.	NORMAL

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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: 97.0% Met Criteria

3.0% of criteria were unmet. For further details please review the table at the end of this section.

Assessment Results

The emergency department (ED) sees a mix of pediatric and adult cases. The waiting room remains physically removed from the line of sight of clinical staff but is video monitored to the ED desk. Reception clerks notify nurses of obvious concerns, and ED nurses surveil waiting patients when they call patients in from the waiting room. There are plans to convert part of the registration desk to a triage area, with full-time triage nurses during the day and evening shifts who will have direct line of sight over the waiting room. Patient registration occurs in front of the waiting room and may compromise confidentiality.

There is no clear signage for the ED, nor directing patients to the main entrance (there are signs for the ambulance bay and the night entrance only). The area is clean and appears well maintained. There is no airborne infection isolation room, but one room can be mostly emptied to create a seclusion room temporarily, until the patient can be transferred.

Many staff are cross-trained to work in both the ED and inpatient areas. A robust, competency-based orientation program is in place for new staff, including online education, ED familiarization, and buddy shifts. Dedicated linen and environmental services staff are also assigned to the ED.

Staff and physicians report feeling well supported, demonstrate strong teamwork, and appear highly satisfied working in the ED. There is timely access to specialists, primarily in Red Deer, with additional support available through the provincial Referral, Access, Advice, Placement, Information & Destination (RAAPID) system when needed.

Processes exist for managing discrepant or critical results after a patient has left the ED. Critical results are communicated via phone to the ED physician, while other results are sent to the ordering physician or, occasionally, to clinics. However, these processes should be reviewed and standardized, as there is potential for delays in appropriate follow-up and management.

Recent challenges include a growing number of patients presenting with mental health and addiction/substance use concerns. Surge capacity on the inpatient unit is limited due to a high volume of alternate level of care (ALC) patients, which frequently results in admitted patients boarding in the ED. RMHHC attempts to follow its surge capacity protocol. Since August 2025, a 24/7 contracted security presence has been in place in the ED, partly in response to staff safety concerns.

Patients reported that they were not informed of their rights and responsibilities, nor were they provided with information on how to file a complaint or report violations of their rights.

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Areas for improvement are communicated with staff and posted in the unit, although staff were not aware of ED metrics. Unit-specific metrics that are collected (e.g., hand hygiene rates, ED specific metrics) would be relevant for staff to know to drive improvement further. Leaders are encouraged to consider implementing more formal quality improvement activities and putting up a quality board in this unit. Consideration should be given to adding an ED quality board.

Table 7: Unmet Criteria for Emergency Department

Criteria Number	Criteria Text	Criteria Type
2.2.1	Entrance(s) to the emergency department are clearly marked and accessible.	HIGH
2.4.15	Clients and families are provided with information about their rights and responsibilities.	HIGH
2.4.16	Clients and families are provided with information about how to file a complaint or report violations of their rights.	HIGH
2.7.3	Client privacy is respected during registration.	NORMAL

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Inpatient Services

Standard Rating: 97.9% Met Criteria

2.1% of criteria were unmet. For further details please review the table at the end of this section.

Assessment Results

The 21-bed inpatient unit is currently almost half occupied with alternate level of care (ALC) patients. This, in conjunction with plans for expanded orthopedic surgeries, has potential to cause additional flow challenges. The unit provides care for obstetrical, post-operative and medical patients. Pediatric and mental health patients are not admitted to this unit.

The unit is clean and feels uncluttered despite having supplies in the hallways. Staff enjoy working here, citing the teamwork and team support on the unit; they work to their full scope based on their competencies. They feel adequately oriented and trained to manage their patient assignments.

Multidisciplinary rounds take place daily, ensuring ancillary healthcare staff, nursing and physicians are up to date.

Alcohol-based hand rub (ABHR) is not located at point-of-care. Consideration can be given to repositioning ABHR dispensers, weighing the specific safety risks of having dispensers in patient rooms vs. the ability of staff (and others) to readily access ABHR.

Staff report some concerns related to the sight lines for visual call bell alerts given the layout of the unit; at times patient call bell lights cannot be seen by the nursing staff assigned to care for them.

Multidisciplinary rounds occur daily, providing recent updates that enhance patient care and improve discharge planning. Patients are satisfied with their care, are treated with respect and feel engaged and well-informed in their care. Patients reported that they were not informed of their rights and responsibilities, nor were they provided with information on how to file a complaint or report violations of their rights.

Quality metrics (hand hygiene and other required organizational practices) are posted on two quality boards. The implementation of huddles on this unit is encouraged to highlight issues and concerns and engage staff more actively in safety and quality initiatives.

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

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Obstetrics Services

Standard Rating: 100.0% Met Criteria

0.0% of criteria were unmet.

Assessment Results

Obstetrical services include two fully equipped labour and delivery rooms located in the inpatient area near the nursing desk. The site typically supports approximately 100 to 150 births each year. When additional space is needed for families, palliative care rooms are used for postpartum care, with refrigeration available for breast milk storage. Nitrous oxide and oxygen are available in both labour rooms as well as in the emergency department. All staff are educated and cross-trained to work in obstetrics, the emergency department, and the inpatient unit. During all staffed hours, at least one core-trained labour and delivery staff member is scheduled.

RMHHC maintains a strong working relationship with Red Deer Regional Hospital Centre for the care of high-risk obstetrical patients. High-risk mothers are referred to Red Deer Regional Hospital Centre for assessment and follow-up care. Staff at Red Deer Regional Hospital Centre collaborate closely with RMHHC and are available at any time to provide support, including assistance with interpreting fetal monitoring strips.

The site also works collaboratively with a well-established community midwifery program, which is particularly important given that obstetricians are available on a two-weeks-on, two-weeks-off schedule. Public Health provides prenatal monitoring and assessment until the third trimester, at which point patient charts are transferred to the inpatient unit for safekeeping in preparation for delivery.

Free births within the community have also been identified. These families work closely with the emergency department and the midwifery program to help ensure the safety of both mother and baby. Skin-to-skin care is supported for both vaginal and caesarean births, and the “Golden Hour” approach is maintained whenever possible.

Although RMHHC offers limited obstetrical services, the quality of care provided is highly regarded by postpartum patients and their families.

Table 9: Unmet Criteria for Obstetrics Services

There are no unmet criteria for this section.

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Perioperative Services and Invasive Procedures

Standard Rating: 100.0% Met Criteria

0.0% of criteria were unmet.

Assessment Results

The perioperative environment is newly constructed and is a modern environment equipped with the latest technology and equipment. The small perioperative team is highly skilled, knowledgeable, and collaborative, working together to ensure the safety of both patients and staff.

Perioperative staff are cross-trained in all areas of care, including pre-operative care, scrubbing, circulating, and the post-anesthesia care unit (PACU). Two registered nurses (RNs) are trained and certified as RN First Assistants (RNFAs). The current staffing complement includes seven RNs (including two RNFAs), two operating room technicians (licensed practical nurses [LPNs]), and one casual RN. Linen and environmental services (LES) staff are only available until 1900 hours, after which perioperative staff are responsible for all cleaning duties. Consideration should be given to providing 24-hour LES coverage to reduce the workload placed on the two on-call RNs.

Physician coverage includes one in-house general surgeon, a gynecologist working on a two-weeks-on/two-weeks-off schedule, plastic surgery services, and an orthopedic program for total knee arthroplasties transferred from Red Deer Regional Hospital Centre. A total of seven orthopedic surgeons use surgical blocks at this facility on Mondays and Wednesdays. Expanding to an additional orthopedic surgery day would help maintain staff proficiency with implants and knee procedures while further reducing wait times for total knee replacements. Completion of the second operating room theatre in the new build will provide additional surgical block opportunities and further enhance orthopedic services at the facility. At present, limited implant storage capacity restricts expansion of the program.

One area of concern is the limited space available for male and female staff change rooms. Currently, patient rooms are being used as staff changing areas, and there are no shower facilities available for staff. There is an opportunity for dedicated changing rooms and showers to be incorporated into the design of the second theatre expansion.

Team leadership is encouraged to proceed with their plans to implement 15-minute morning safety huddles prior to the first surgery. This initiative will further enhance the safety of both patients and staff. The team is highly engaged and motivated to continue building a strong rural perioperative program, and they are clearly progressing in a positive direction.

Table 10: Unmet Criteria for Perioperative Services and Invasive Procedures

There are no unmet criteria for this section.

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Reprocessing of Reusable Medical Devices

Standard Rating: 99.1% Met Criteria

0.9% 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) is a newly built area equipped with advanced technology and designed to support high-quality reprocessing standards. The endoscopy program uses endoscopy medivators with continuous airflow connections to scopes, allowing sterilization and cleaning validation to be extended from weekly to monthly intervals.

All staff are MDRD certified and maintain annual Healthcare Sterile Processing Association (HSPA) education and competency approval, in addition to Canadian Standards Association (CSA) certification renewal every five years. Quality oversight is conducted by management in accordance with CSA standards. Staff are cross-trained across all MDRD areas and participate in a mandatory annual education day. Preventive maintenance for the department is completed annually by Steris.

To support the upcoming expansion associated with the new operating room theatre build, it is recommended that additional staff training be completed in advance. Increasing the number of trained personnel will help ensure seamless integration and support the anticipated rise in MDRD demand once the second operating room begins operating at full block capacity. The team is actively working to increase operating room block utilization and has the capacity to expand sterilization services beyond the facility if needed.

Staff report feeling that their contributions are not consistently recognized or acknowledged. Introducing visible and structured recognition mechanisms such as quality boards that include a dedicated “Kudos” section could help address this gap. These boards would provide a space to highlight staff achievements, celebrate positive patient feedback, and recognize teamwork and individual contributions.

Table 11: Unmet Criteria for Reprocessing of Reusable Medical Devices

Criteria Number	Criteria Text	Criteria Type
2.2.3	Team members are recognized for their contributions.	NORMAL

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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	2.2.1 Entrance(s) to the emergency department are clearly marked and accessible.	June 8, 2027
	2.4.15 Clients and families are provided with information about their rights and responsibilities	June 8, 2027
	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
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
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
	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

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