ACCREDITATION
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CANADA

Accreditation Report

Qmentum Global™ for Canadian Accreditation Program

Two Hills 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

At Two Hills Health Centre, there is a strong multi-disciplinary team working collaboratively to provide patient-focused, quality health care that is accessible to their community in a compassionate and respectful way. Discharge and transition planning occurs weekly with a team approach to ensure patients have wraparound comprehensive care for success. The team continually looks for ways to ensure they are providing access to care in innovative ways such as the implementation of the virtual care physician in the emergency department.

There is a small but dynamic leadership team that works collaboratively on improving delivery of safe, quality care by ensuring staff have the resources and education they need to feel confident and competent. Services are reviewed to ensure they meet the needs of the surrounding community. The team is commended for their focus on people-centred care. Through the establishment of numerous partnerships, they facilitate seamless navigation of services across the care continuum. Their commitment is demonstrated by ongoing work with physicians and local communities.

The team is motivated to implement a strategy for process improvement to support quality and safety for patient care. The team would benefit from a focused approach for continuous quality improvement with training for all staff. There is an abundance of data available to teams to help identify and drive improvements and decision making.

Patients receiving care reported a high level of satisfaction with the care they received. They were very complimentary of their care team, describing them as caring, compassionate, kind and hard-working.

Key Opportunities and Areas of Excellence

Areas of Excellence

- Community partnerships and collaboration
- Site leadership
- Education for staff
- Patient and resident engagement
- Virtual Emergency Physician program

Key Opportunities

- Safety and risk assessment for site
- Key staff recruitment (physicians, pharmacist and physiotherapist)
- Advance quality improvement journey
- More education on best possible medication history (BPMH) for accuracy
- Redesign of medication of room in the emergency department to meet standards

People-Centred Care

Within the traditional central zone there are two committees that are established to have patient and family input into service delivery. There are the Patient and Family Care Committee and a Corridor Complex Quality Assurance Committee. At the site level, patient and family feedback is received through leadership rounding, surveys and complaints/concerns received. Additionally, the team meets with members in the community to aid in service design and planning. They have strong relationships with the local medical clinic, family community services, primary care, and local and municipal councils.

Patients, families, and providers benefit from an environment that encourages respect, support, teamwork, and overall wellness. Patients interviewed expressed appreciation for the team's compassion, dedication, strong work ethic, and enthusiasm. The team creates a culturally sensitive environment ensuring they are meeting the needs of the entire community including the Hutterite, Mexican Mennonite and Indigenous communities. They have established relationships within these communities to foster a partnership model where patients, families and healthcare providers work together to make decisions, focusing on respect, dignity and individual needs.

Resident and family councils in the long-term care (LTC) area are established groups consisting of residents and their families, who convene regularly to identify strategies for enhancing the quality of life for residents. There is an opportunity to spread awareness as several families were not aware of the resident and family council. Comprehensive care plans are evident in LTC and they are developed with patients and families to ensure they are meeting the needs of the resident.

Conversations with staff, patients, and families showed a common belief that all care plans in acute care were co-created, explained in detail, and updated as conditions changed. Discharge and transition planning are conducted in partnership with patients and families. Patients that were interviewed knew why they were receiving care, what they could expect as next steps, and what role they could play in advancing a return to better health. Consistent use of whiteboards was noted on the unit in patient rooms and was appreciated by the patient.

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%
Improving Hand Hygiene Practices	Infection Prevention and Control	5 / 5	100.0%
Infection Rates	Infection Prevention and Control	3 / 3	100.0%
Information Transfer at Care Transitions	Emergency Department	5 / 5	100.0%
	Inpatient Services	5 / 5	100.0%
	Long-Term Care Services	5 / 5	100.0%
Infusion Pump Safety	Service Excellence	6 / 6	100.0%

Table 1: Summary of the Organization's ROPs

ROP Name	Standard(s)	# TFC Rating Met	% TFC Met
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%
Managing High-Alert Medications	Medication Management	5 / 5	100.0%
Optimizing Skin Integrity	Emergency Department	6 / 6	100.0%
	Inpatient Services	6 / 6	100.0%
	Long-Term Care Services	6 / 6	100.0%
Preventing Falls and Reducing Injuries from Falls	Emergency Department	7 / 7	100.0%
	Inpatient Services	7 / 7	100.0%
	Long-Term Care Services	7 / 7	100.0%
Preventing Venous Thromboembolism	Emergency Department	6 / 6	100.0%
	Inpatient Services	6 / 6	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

The organization has built a strong foundation in emergency preparedness and demonstrates a genuine commitment to operational readiness through regular monthly drills. There are mock codes followed by debriefings to test response capabilities across a range of scenarios. Fire drills have occurred regularly.

Simulations can be valuable for enhancing staff education and training in emergency procedures, while also strengthening teamwork. Reviews of drills and protocols provide targeted insights that support policy clarification and other quality improvement initiatives. The use of tabletop exercises is encouraged.

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

There is currently not an infection prevention and control (IPC) physician for the central corridor; however, the infection control practitioners (ICP) work with physicians from Calgary for managing current IPC issues. The ICP is not on site daily but visits monthly, conducting a walkthrough during each visit. They check equipment and assess the overall cleanliness of the site. During these visits, discussions are held with nursing staff and physicians regarding IPC-related issues.

IPC policies and procedures are easily accessible to healthcare providers. Compliance with these policies and procedures is monitored.

A comprehensive hand hygiene strategy was evident throughout the organization, with alcohol-based hand rubs available in many locations, particularly at the point of care. Compliance with hand hygiene practices is encouraged and monitored. Reminders are posted throughout the organization, and educational sessions, pamphlets, and videos are used to increase awareness and adherence. Staff are required to attend an IPC education program during orientation.

The housekeeping staff follow specific cleaning processes for cleaning rooms and hallways according to the protocol.

Health care infection rates are monitored. The data is obtained through Connect Care and then put through ProvSurv, this data is then analyzed and IPC reports on infection rates are generated and shared. These reports are discussed with site leadership and presented to site leadership meetings to share learnings and identify improvement opportunities.

Table 3: Unmet Criteria for Infection Prevention and Control

There are no unmet criteria for this section.

Leadership

Standard Rating: 80.0% Met Criteria

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

Assessment Results

Two Hills Health Centre leadership is highly engaged and knowledgeable about the community and the resources available. Information from the various audits and service needs of the communities help to guide the design and provision of services. Numerous partnerships between the health center, the community and external non-health groups have developed, and they work together for the benefit of the community.

There has been an increase in physical and verbal workplace violence. The organization is encouraged to develop a safety strategy to keep staff and patients safe. Potential measures could include installing additional security cameras, providing emergency alert devices or communication devices to staff, implementing controlled-access doors, and ensuring the presence of on-site security during hours when staffing levels are reduced.

Table 4: Unmet Criteria for Leadership

Criteria Number	Criteria Text	Criteria Type
4.2.5	The organization regularly undertakes safety risk assessments, shares the results with staff, and ensures improvement plans are developed to address root causes.	HIGH

Medication Management

Standard Rating: 97.2% Met Criteria

2.8% of criteria were unmet. For further details please review the table at the end of this section.

Assessment Results

Pharmacy services provide oversight for medication delivery and management at the site level. The department consists of a pharmacist, a pharmacy technician and a pharmacy assistant with after-hours access to an on-call pharmacist through the central zone. The pharmacy team receives ongoing education to ensure they are both competent and confident in their roles. This team reports into the central zone pharmacy. The Provincial Medication Management Committee (PMMC) is committed to promoting and advocating for high-quality medication management and safety practices across AHS. Their responsibilities encompass developing medication policies, implementing system practice changes, evaluating system practice processes, providing recommendations for ongoing safety improvements and disseminating information on safe medication practices.

At the site level, the pharmacy team is an integral part of the multi-disciplinary team on the units and physicians, nursing and patients see them as a valuable resource. Unfortunately, there is a vacancy with an onsite pharmacist. There is only partial onsite coverage two days a week, while the team actively recruits to fill the gap. They participate in interprofessional rounds when they are available. This helps to provide expertise with prescribing and monitoring medication therapy and providing education about medications to patients and staff. The pharmacist continues to monitor prescribing practices and patients' medication when off-site to support the team.

There is a voluntary Reporting and Learning System for Patient Safety (RLS) to report adverse events, close calls and hazards to help make patient care safer by sharing learnings and improvements made. There is oversight for medication-related events that are reviewed by the Medication Quality and Safety Team (MQST) for further investigation. This team is a valuable resource to help identify and coordinate system-based approaches for improving safe medication processes. Recent reports have identified medication errors involving administration of drugs to patients who no longer required them. Accuracy of BPMHs can be improved; staff should avoid relying solely on auto-populated information for verification, as it may not be current. Education for staff completing the BPMH with continued auditing for improvement is encouraged.

The pharmacy area has a controlled access and the area is clean, bright and well organized to meet the needs of the team and appropriate according to legislation and pharmacy standards. Countertops would benefit from an infection control review to ensure that standards are being met. There is a night cupboard available outside the pharmacy that staff can access after-hours. The pharmacy team stocks and monitors the cupboard to ensure that wards have appropriate stock. Sterile compounding and unit dose packaging is completed at the Wetaskiwin Hospital and Care Centre. Medication is delivered daily Monday-Friday with an electronic reordering system in place based on minimum and maximum levels set by the site with adjustments made based on needs.

Nurses use medication carts stocked with unit dose medications, which are scanned to enhance safety and efficiency. It was noted that since implementing closed loop medication administration that medication errors have significantly decreased. The team leader monitors scanning rates and addresses areas needing improvement. Scanning rates remain high, and action is taken when needed. There is also ward stock available in locked control access medication rooms on the units. The medication rooms are clean, well-lit, and uncluttered. However, the emergency department medication room doubles as the physician's workspace due to limited space, and efforts are underway to resolve this and should be a priority.

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

Service Excellence

Standard Rating: 98.8% Met Criteria

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

Assessment Results

The team works collaboratively to ensure they are meeting the diverse needs of patients and their community. Through the establishment of numerous partnerships, they facilitate seamless navigation of services across the care continuum. Their commitment is demonstrated by ongoing work with physicians and local communities to deliver culturally sensitive care and create individualized care plans that comprehensively meet patient requirements.

The team is encouraged to develop and document service-specific goals and objectives that are clear, have measurable outcomes and success factors, and are realistic and time-specific. Team goals and objectives need to be meaningful to the team and reviewed regularly to ensure there is progress toward achieving them.

Team leadership diligently oversees the monitoring and maintenance of designations, credentials, competency assessments, and training to promote safe and effective service delivery. Professional requirements are regularly updated in alignment with both jurisdictional and organizational policies. Annual performance evaluations are conducted, and opportunities for ongoing professional development are systematically identified.

The current approach to quality improvement demonstrates some sharing of performance metrics; however, there is an opportunity to enhance this process by standardizing how and which quality indicators are communicated and important for care delivery, with frontline staff. Leadership receives a lot of data to help in decision making to drive quality improvement on the units. Leadership is encouraged to review the data to understand which metrics are important to the individual unit and align work with the organizational and corporate goals. Consistently sharing these indicators can help engage staff in ongoing quality improvement efforts.

Several key roles are vacant; only two of five Physician positions are filled. Locum and virtual physicians are providing coverage to keep the emergency room operational but recruiting efforts face difficulties. The Stroke and Geriatric Empowerment Unit (SAGE) is closed due to insufficient physiotherapy staff, affecting adults needing intensive rehabilitation. Leadership is encouraged to continue with recruiting efforts and look to external support to aid in recruitment efforts if needed. Leadership works closely with Portage College to recruit nursing students, which has contributed to low nursing vacancy rates.

The organization emphasizes thorough orientation to ensure staff can deliver safe care across diverse services. Employees note numerous educational options, both online and in person. Investments focus on building staff skills and competencies. A part-time educator now offers a range of certification courses internally, simplifying staff certification and recertification.

There is strong collaboration between staff and physicians. Grand rounds are held weekly with all disciplines and there is an extensive review of all patients. New ideas of managing or provision of clinical service are shared and may be acted upon.

The organization takes many opportunities to celebrate staff and their contributions to quality care. Some examples include shout out boards, years of service recognition, personal e-cards from leadership, Nurses Week celebration and implementation of “Rock & Roll”, a peer recognition strategy.

The team has a risk and reporting system as a strategy to address identified safety risks to help identify potential solutions and risk mitigation strategies. Leadership reviews events, investigates and follows up with staff looking for ways to improve processes.

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

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: 99.2% Met Criteria

0.8% of criteria were unmet. For further details please review the table at end of this section.

Assessment Results

The emergency department is space challenged. It has six beds with one trauma bay. Physicians are highly motivated and are hardworking. The physician group is stretched to the limit with only two physicians covering the entire community including acute care, emergency department, long term care, and walk-in clinic. The organization is encouraged to continue recruitment efforts to increase the physician pool.

The emergency department is open from 8:00 am to 5:00 pm on Monday to Thursday with a physician on site, then between 8:00 pm to 8:00 am, the virtual physician is on call. On Fridays, the site physician is on call from 8:00 am to 5:00 pm and the rest of the weekend locums are on call until Monday at 8:00 am.

The virtual emergency physician program (VEP) relies upon an experienced emergency department physician to remotely support the facility temporarily when on-site physician support is not available. In these instances, site clinical staff can connect with an AHS physician by telephone or videoconference for emergency department patients with non-life-threatening issues. This off-site virtual physician collaborates with local staff, speaks with patients, orders tests and medications, and transfers or discharges patients.

The VEP program helps bridge gaps by connecting physicians to temporary support facilities without available on-site emergency department physicians. Most physicians in the pilot program had experience working in rural, resource-challenged emergency departments and had existing privileges in the zone, which greatly supported the program's launch. While the program is not a replacement for recruitment or a long-term substitute for in-person physician coverage, it is a temporary solution to help manage less acute cases.

With regards to the space and layout of the emergency department, the physician's dictation area is currently located within the medication room. The organization is encouraged to redesign this space to provide a suitable area for dictation and teleconferencing. Additionally, a makeshift triage area is used at the entrance during periods of patient overflow; however, this area lacks adequate privacy and should be reviewed. The organization is also encouraged to designate a seclusion or private secure room in the emergency department if this is required to support patient or staff safety.

Table 7: Unmet Criteria for Emergency Department

Criteria Number	Criteria Text	Criteria Type
2.4.8	Seclusion rooms and/or private and secure areas are available for clients.	HIGH

Inpatient Services

Standard Rating: 100.0% Met Criteria

0.0% of criteria were unmet.

Assessment Results

There is an enthusiastic, engaged leadership team, committed to ensuring safe delivery of care to patients admitted to the Two Hills Health Centre. The inpatient unit consists of 15 beds with 4 overflow beds to increase capacity to 19 when appropriate resources are available. The average census hovers around 78% but can easily fluctuate above 100%. Like many organizations they have challenges with placing Alternate Level of Care (ALC) patients. They work closely with the transitional care coordinator to place patients and have, on average, 30% ALC patients in acute care beds.

Staff receive training for both emergency department and inpatient services. The team cares for medical, palliative, and paediatric/newborn patients, which requires a diverse set of skills and can make it challenging for staff to maintain confidence and competence. To support ongoing learning and development, a part-time educator and team lead provide education and practical guidance throughout the program. The team has created efficient methods to provide education, track staff competencies, and monitor course completion rates.

The team prioritizes quality care and understands the population they serve. They collaborate with physicians and local communities, including Mennonite, Hutterite, and Indigenous groups, to provide culturally sensitive care. Individualized care plans ensure all patient needs are addressed.

Staff shared that they feel well prepared to work on the inpatient unit due to effective education and orientation. The environment promotes active involvement of patients and families in care decisions. Patient needs, choices, and preferences inform service goals, and patients are educated about their rights and responsibilities during admission, with documentation in the electronic chart.
Staff report they do not always feel safe. The team is encouraged to conduct a risk assessment and implement changes to improve safety. A review of risk events revealed staff are entering into many workplace violence events related to aggressive behaviour.

The team uses handover notes in Connect Care to share key information. Adding a bedside shift report can boost patient safety, satisfaction, prevent adverse events, and improve communication by involving patients in their care.

Universal fall precautions are implemented where appropriate to ensure a safe environment that prevents falls and reduces the risk of injuries from falling and is supported by policies, procedures and processes. Information and education is given to the patient as to how they can help prevent a fall. If a fall occurs the incident is recorded in the risk management system allowing the team to review processes to make improvements when needed. The fall risk assessment is completed on admission, daily, after a fall, or if any change in condition and is documented in the patient’s electronic health record.

A BPMH is generated, verified, and documented for each patient upon admission by the admitting nurse or pharmacy technician. Pharmacy staff review all BPMHs for accuracy and quality. Accuracy of BPMHs can be improved; staff should avoid relying solely on auto-populated information for verification, as it may not be current. Errors have occurred when medications were administered that patients were no longer taking.

The Braden Scale for screening pressure sore risk is completed upon admission and every week on Monday, Wednesday and Friday, and skin assessments are completed daily. Documented protocols and procedures based on best practice guidelines are then implemented to prevent the development of pressure ulcers. The team has implemented the AirTap system. This air-assisted device is designed to safely turn, reposition, and laterally transfer patients while reducing strain of caregivers. This has significantly improved both patient safety and staff well-being within the inpatient unit. By reducing the physical strain associated with repositioning and transferring patients, the system has helped decrease worker injuries related to lifting, pulling, and repetitive movement. Its gentle air-assisted technology also minimizes friction and shear on a patient's skin, lowering the risk of skin breakdown and pressure injuries, particularly for individuals with limited mobility.

Venous thromboembolism (VTE) prophylaxis is included in admission order sets. There is a VTE policy in place to guide practice and pharmacy plays an important role in ensuring patients are on the appropriate thromboprophylaxis.

There is a quality board posted on the unit for staff and patients to view key metrics and share information. Additionally, data and messaging are shared with the team during huddles, at staff meetings, by email and in newsletters sent to the team. The team is encouraged to continue this important work to advance patient safety and review what metrics are important to care delivery that need to be shared with the team and add them to the quality board. Doing so helps everyone understand what's being measured and how they can influence care and patient outcomes by participating in problem-solving efforts to improve these metrics.

Table 8: Unmet Criteria for Inpatient Services

There are no unmet criteria for this section.

Long-Term Care Services

Standard Rating: 100.0% Met Criteria

0.0% of criteria were unmet.

Assessment Results

The long-term care has 56 beds. The environment is spacious, clean and bright with ample natural light from large windows. Strong leadership is evident. Residents are informed of their rights and responsibilities. Some residents may have mild cognitive impairment, however, there are no residents identified as high risk for elopement. A comprehensive needs assessment is performed upon admission to long-term care. There are adequate nursing requirements. However, there is need for further recruitment of healthcare aides.

A recent resident and family survey identified several areas where improvement in care for residents could be made. This was communicated to residents and families. Several activities were identified as important to the residents including food and dining, expansion of recreational activities, and improvement of communication. The organization has formed a quality improvement team that will action those survey results. Terms of reference and objectives have been developed.

The team is also working on a hand hygiene quality improvement project with goals and objectives. There are hand hygiene champions who audit compliance. Other quality improvement activities in progress include work on preventing falls, pressure ulcers and health care infections.

Table 9: Unmet Criteria for Long-Term Care Services

There are no unmet criteria for this section.

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	2.4.8 Seclusion rooms and/or private and secure areas are available for clients.	June 8, 2027
Leadership	4.2.5 The organization regularly undertakes safety risk assessments, shares the results with staff, and ensures improvement plans are developed to address root causes.	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