ACCREDITATION
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CANADA

Accreditation Report

Qmentum Global™ for Canadian Accreditation Program

Vermilion 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 Vermilion Health Centre, there is a 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.

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. Additional operating room services and specialties were identified and being opened to allow access for care closer to home.

There are challenges with an aging infrastructure and surrounding outdoor space (parking lot). The facility is clean, bright and well maintained by the linen and environmental services staff. There are gardens and patios for patients, residents and families to enjoy.

A strategy for continuous quality improvement is needed 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 nursing team describing them as caring, compassionate, kind and hard-working.

Key Opportunities and Areas of Excellence

Areas of Excellence

- Leadership visibility
- Patients feel well cared for
- Collaborative approach to team-based care
- Staff and physician recruitment and retention

Key Opportunities

- Safety and security
- More focused approach to education
- Recruitment of physiotherapist
- Quality improvement initiatives and training
- Improved utilization of the operating room

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 is a Patient and Family Care Committee and a Corridor Complex Quality Assurance Committee. At the site level patient and family feedback is received through leader rounding and complaints/concerns received. There is an opportunity to formalize the feedback to ensure that you receive necessary information to improve the patient experience in Vermilion Health Centre. Consider patient surveys, or standardizing rounding questions to target those things that the team would find important to improve processes.

Patients, families, and providers benefit from an environment that encourages respect, support, teamwork, and overall wellness. Patients expressed appreciation for the team's compassion, dedication, strong work ethic, and enthusiasm. Patients interviewed felt involved in their care and were very complimentary of the care received. Staff always introduced themselves and were kind and caring.

Resident and family councils in the long-term care (LTC) are established groups consisting of residents and their families, who convene regularly to identify strategies for enhancing the quality of life for residents. 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 were co-created, explained in detail, and updated as conditions changed. 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%
	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	3 / 5	60.0%
	Inpatient Services	5 / 5	100.0%
	Long-Term Care Services	5 / 5	100.0%
	Perioperative Services and Invasive Procedures	5 / 5	100.0%
Infusion Pump Safety	Service Excellence	5 / 5	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%
	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%
	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%
	Long-Term Care 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	5 / 6	83.3%
	Perioperative Services and Invasive Procedures	6 / 6	100.0%
Safe Surgery Checklist	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 strong culture of preparedness for emergencies and disasters, supported by collaboration with police and fire services. Extensive outreach to key communities within the catchment area was evident, and there is access to community groups. The site's emergency and disaster plan is well integrated with broader community plans, and the organization actively consults with community leaders to ensure coordinated planning and response.

A recent shooting in the community demonstrated the effectiveness of this approach, prompting activation of the emergency plan. Appropriate communication occurred with healthcare providers, staff, and security, and fan-out lists were initiated. A debriefing was conducted following the event. A recent electrical failure and delayed generator startup also tested the plan's effectiveness, resulting in the purchase of a new generator. These events have led to several learnings and resulting in improvements to emergency preparedness.

The clinical teams are encouraged to conduct additional simulation exercises for code responses to further strengthen readiness.

Table 2: Unmet Criteria for Emergency and Disaster Management

There are no unmet criteria for this section.

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

There is committed and engaged infection prevention and control (IPC) leadership at Vermilion Health Centre. There has been extensive investment and resources for IPC including staff education and numerous IPC learning modules online.

IPC policies and procedures are easily accessible to healthcare providers. Compliance with hand hygiene practices for staff is encouraged and monitored. There are dedicated handwashing facilities and alcohol-based hand rubs close to the point of care.

Acute care, emergency and long-term care infection control indicators are reviewed with the site lead and action plans are put in place for areas with less than 100% compliance. Hand hygiene audits are conducted through direct observation, supported by a hand hygiene quality improvement plan. There may be an opportunity to also consider electronic monitoring to enhance hand hygiene auditing.

Medical equipment is cleaned and low level disinfected to minimize cross-contamination. Emphasis on low level disinfection is on high touch areas (e.g., door handles, call bells, and railings). Linen and environmental services (LES) staff receive training and follow policies and procedures and manufacturers' recommendations.

The organization is encouraged to continue with collaboration between IPC, LES and dietary and food services regarding IPC processes.

The housekeeping staff follow specific cleaning processes for cleaning rooms and hallways according to the protocol. The hallways and patient rooms were clean and tidy. The leaders are encouraged to support evaluation of cleaning practices by conducting regular audits of the physical environment.

Table 3: Unmet Criteria for Infection Prevention and Control

Criteria Number	Criteria Text	Criteria Type
2.6.6	Compliance with policies and procedures for cleaning and disinfecting the physical environment is regularly evaluated, with input from clients and families, and improvements are made as needed.	NORMAL

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

Visible leadership and easy accessibility to senior leadership is evident at this site. Staff can reach out and discuss any issue with site leadership.

The current site manager wears many different hats. The organization is encouraged to review the workload of the site manager with a focus on appropriate distribution of responsibilities to ensure sustainability. The organization is also encouraged to determine how to redistribute tasks or add resources to support this leadership role.

Site leadership regularly receives and reviews unit-specific information, responds to identified concerns, and implements action plans as needed. Site leadership, in partnership with senior corridor leadership and patients, is encouraged to build structures and systems and embed processes to allow the staff and physicians to achieve high quality care through continuous learning.

Team leadership has access to data and is encouraged to continue analysis of such to drive quality improvement and safety at the site. Prioritizing a clear and sustained strategy for quality improvement is encouraged.

The building has aging infrastructure, and the organization is encouraged to implement safety and security systems to support staff and patients. Staff have reported feeling unsafe due to the lack of on-site security. Response times from the off-site private security company are often lengthy when assistance is requested. As a result, the RCMP serves as a backup; however, their response can take several hours, as they may be occupied elsewhere.

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: 96.5% Met Criteria

3.5% 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-hour access to an on-call pharmacist. The pharmacy team receives ongoing education to ensure they are both competent and confident in their roles. This team reports into the central corridor pharmacy. The Provincial Medication Management Committee (PMMC) functions as AHS' interdisciplinary 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 multidisciplinary team on the units and physicians, nursing and patients see them as a valuable resource. They participate in interprofessional care rounds, help to provide expertise with prescribing and monitoring medication therapy and providing education about medications to patients and staff. The pharmacy team helps to facilitate seamless care with transitions including providing medication reconciliation. 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.

The pharmacy area is clean, bright and well organized to meet the needs of the team and is compliant with legislation and pharmacy standards. There is controlled access with a locked night cupboard available outside of the pharmacy that is maintained by the team. The team does not do any sterile compounding on site and unit dose packaging is completed at the Wetaskiwin Hospital and Care Centre. There is a process in place to stock the units with the necessary medication required for each patient. There is set ward stock on the units in medication rooms that are bright, clean and able to be locked.

The site is encouraged to review their medication storage practices to support safety. While appropriate security measures are in place, medication room doors in multiple areas were observed to be unlocked or propped open. Nurses on the units deliver medications using a cart system stocked with individual patient medication in unit dose packaging by pharmacy. Nursing is expected to scan medication to enhance patient safety and improve efficiency. Scanning rates are tracked and areas for improvement are identified and followed up on.

The team is commended for making improvements based on previous recommendations made for managing the surgical services medication. They have implemented a tray exchange system to ensure medication is available as needed with appropriate expiration dates.

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: 91.5% Met Criteria

8.5% of criteria were unmet. For further details please review the table at the end of this section.

Assessment Results

There is extensive collaboration with many partners including advocacy groups and committees and patients in the community. Patients are engaged in the processes. This collaboration helps to inform service design. The site is encouraged to develop service-specific goals and objectives.

Currently nurse practitioners only work in the community or long-term care and there is little integration of the service delivery with physicians. There is an opportunity to improve communication between nurse practitioners and physicians to optimize the delivery of care to patients in both the community and hospital.

There is a full complement of physician and nursing coverage. The organization has made significant efforts to recruit for these positions and orientation processes are in place. Efforts are ongoing to recruit physiotherapists. The organization is also encouraged to consider the addition of an on-site clinical nurse educator.

There are numerous educational opportunities that staff may avail themselves of including MyLearningLink. However, there is a need for adequate follow-up, documentation and evaluation of the educational and training activities that healthcare providers undertake. In a rural center physicians are generalists and they are encouraged to take Basic Life Support (BLS) and Advanced Cardiovascular Life Support (ACLS) training to ensure optimum safe care for code blue patients.

The organization is encouraged to consider strengthening quality infrastructure in this rural site. A standardized quality improvement approach supported by education and training in quality improvement to build capacity is recommended as well as evaluation of the effectiveness of quality improvement activities.

Although the site manager interacts with staff regularly, there was variable evaluation and no visible documentation identified on the performance of staff.

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

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
4.3.8	The team leadership works with staff to regularly analyze indicator data to evaluate the effectiveness of its quality improvement activities.	HIGH
4.3.9	The team leadership works with staff to implement throughout their services the quality improvement activities that were shown to be effective in the testing phase.	HIGH
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: 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 site provides 24/7 emergency services. There are five beds in the Emergency Department (ED) with two trauma beds and is equipped with appropriate equipment and personnel. Hallways are kept clear and uncluttered. Physicians, managers, and nurses demonstrate a strong interdisciplinary approach to quality, safety, and the delivery of care. The department also supports training, welcoming healthcare paramedics and medical students.

Patients prefer to visit this department for emergency care over others due to the shorter waiting times compared to other sites. Patients indicated that they receive compassionate care from staff and are actively involved in decision-making about their care.

Discharge and transition planning is done on a regular basis with a team approach to ensure comprehensive care. However, there are delays in transporting patients to a higher level of care or service to tertiary hospitals using RAAPID North. There is an opportunity to improve the timeliness and coordination of patient transport to support seamless transitions of care.

There is a lack of privacy at the triage area of the ED. The area is wide open and information being collected by a healthcare provider about a patient can be easily heard and seen. The organization is encouraged to review the triage space at the entrance to ensure patient privacy and safety of staff. Headsets for the unit clerks at the registration desk may aid in ensuring privacy.

The registration desk area at the entrance to the hospital is cluttered and congested. The clerks do not face the front door as the public enter the building. Patients must go through a narrow area to get to registration. Unfortunately, the ambulance offload is in the same area so this area can get quite congested. Unit clerks have expressed concerns about personal safety and patient privacy in that area. Furthermore, there are no panic buttons for staff to access in time of need. The site is encouraged to involve staff and patients in the design of the space around the registration desk.

The mental health observation room is located opposite the main nursing desk. The main nursing desk is not infection control friendly and may require replacement.

The site has lots of data in Tableau and the team may want to consider quality improvement activities with indicators such as ambulance offload times, average length of stay, door to ECG time, turnaround time to specialist consultation, and turnaround time from emergency department to inpatient units. The site may wish to consider using time series run charts and Shewhart charts to demonstrate the variation in processes.

There is a lack of consistency in the delivery of care by physicians. Variability in physician rounding practices and inconsistent use of clinical guidelines can lead to gaps in service. Physician accountability is essential and the organization is encouraged to continue working with physicians to establish clear expectations for service delivery.

IDRAW communication tool is used to communicate patient information. However, there is variation in the use of this tool. The organization is encouraged to audit and analyze use of it.

Table 7: Unmet Criteria for Emergency Department

Criteria Number	Criteria Text	Criteria Type
2.1.3	Timely access for clients is coordinated with other services and teams within the organization.	HIGH
2.7.3	Client privacy is respected during registration.	NORMAL
2.7.17	Information Transfer at Care Transitions 2.7.17.2 Documentation tools and communication strategies are used to standardize information transfer at care transitions. 2.7.17.5 The effectiveness of communication is evaluated and improvements are made based on feedback received. Evaluation mechanisms may include: • Using an audit tool (direct observation or review of client records) to measure compliance with standardized processes and the quality of information transfer • Asking clients, families, and service providers if they received the information they needed • Evaluating safety incidents related to information transfer (e.g., from the patient safety incident management system).	ROP

Inpatient Services

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 inpatient care unit has 25 beds with two additional overcapacity beds. There is a dedicated team committed to ensuring safe delivery of care to the patients admitted to their service. The team cares for a wide range of patients requiring medical services including palliative care. Paediatric patients can also be admitted to the unit and staff are able to provide specialized care to the paediatric population with the appropriate equipment and medication. The medical unit has a fluctuating occupancy rate like many rural organizations, however, because they have challenges placing Alternate Level of Care (ALC) patients, the census remains high.

The interdisciplinary inpatient care team notes that while educational opportunities exist for staff, they would appreciate the return of an educator to better support staff development. Currently, individuals are responsible for enrolling in courses to maintain their competencies. Specialized care training such as emergency care, advanced cardiovascular life support (ACLS), and paediatric advanced life support (PALS) courses are tracked by staff in a binder on the unit with note of completion and renewal dates. A more coordinated approach to education could be beneficial, including the possibility of sharing an educator to ensure consistent support. Since staffing is shared with the emergency department and can be adjusted to support both areas, a review of staffing levels and roles in both units is recommended to ensure appropriate resourcing and workload distribution.

Timely access to laboratory testing and diagnostic services is available. However, MRI and CT scans are not offered at this site. The organization is encouraged to consider expanding medical imaging services, as ultrasound is currently available only four days per week.

The team is encouraged to look at new ways to reduce the length of stay related to the increase in ALC patients occupying acute beds. Looking at opportunities to begin discharge planning starting in ED, linking patients and family to the services that they require and having support in place to assess and begin care planning and treatment strategies early. Staff identified the need for easier access to geriatric assessments and support to meet the needs of older adults who are living with complex and chronic health conditions. Additionally, it was noted that discharges of medical patients can be delayed because of inconsistent practices with physician rounding. The team is encouraged to review the discharge planning process to look for areas for improvement.

The team uses whiteboards at the patient's bedside as a means of communication with the patient and family. The whiteboards were consistently filled out and patients and family found them helpful. Patients were extremely complementary of the care they received and described their nursing team as caring, compassionate, kind and hard-working. They also stated that the team consistently introduced themselves, performed hand hygiene and followed proper identification procedures. It was noted that during transition in care between shifts, the team utilize a handover in the electronic medical record as well as a taped report to ensure appropriate information in communicated. Consider if there is an opportunity to embed bedside shift report into practice on the unit to involve patients and families in care delivery. Bedside shift report has been proven to increase patient safety and satisfaction. It aids in preventing adverse events, improving communication while involving patients in their care.

The team raised safety concerns, noting incidents where staff felt unsafe due to aggressive patient behavior. With no on-site security, staff have depended on local police, which is challenging at night

because of limited availability. A risk assessment is recommended to identify ways to enhance staff safety, such as locking doors, installing more cameras, providing emergency alert devices, or employing security personnel during certain hours.

There is a falls risk screening tool built into Connect Care that is completed on admission and as required. Universal fall precautions are implemented where appropriate to ensure a safe environment that prevents falls and reduces the risk of injuries from falling, supported by policies, procedures and processes. If a fall occurs the incident is recorded in RLS allowing the team to review the processes to make improvements as needed. Consider how to share metrics like this with the team and patients on the unit to continue to look for ways to improve by visual displays tracking and trending data. Although a least restraint policy is followed, staff still experience challenges with patients who wander, partly because the unit is open and located near the ED. It may be beneficial to review the area for potential issues and assess whether technological solutions could enhance patient safety. For example, implementing radiofrequency identification (RFID) technology may help prevent patient elopement.

Upon admission a best possible medication history (BPMH) is generated, verified and documented for each patient. Pharmacy and nursing generally complete this first step. Pharmacy monitors compliance and quality of the BPMH and helps to ensure accuracy. Data is available to understand compliance rate. The team is encouraged to review the current process to look for ways to improve compliance rates to meet established targets.

Pharmacy also plays an important role in ensuring patients are on the appropriate thromboprophylaxis. There is a VTE policy in place to guide practice and admission order sets include appropriate VTE prophylaxis. VTE prophylaxis is audited but it is unclear who is following up on missed opportunities and advancing practice.

Table 8: Unmet Criteria for Inpatient Services

Criteria Number	Criteria Text	Criteria Type
3.3.3	The inpatient services team works with the emergency department team to initiate the geriatric needs assessment, where appropriate, for clients who enter into the organization through the emergency department.	HIGH
3.3.9	Preventing Venous Thromboembolism 3.3.9.6 The team participates in activities to improve the program to prevent venous thromboembolism as part of the organization's integrated quality improvement plan.	ROP
3.3.14	Diagnostic and laboratory testing and expert consultation are available in a timely way to support a comprehensive assessment.	NORMAL

Long-Term Care Services

Standard Rating: 100.0% Met Criteria

0.0% of criteria were unmet.

Assessment Results

The interdisciplinary team meets every Thursday to review resident care plans. In addition, monthly conferences are held with families and caregivers. Strong collaboration among staff, along with weekly physician rounds on Sundays, has improved communication with residents and their families. Individual care plans are well developed in partnership with residents and families and are documented.

Feedback is actively sought from team members and the residents. A resident quality survey has been used to identify priorities for implementation. The organization has strengthened the quality council, leading to updates in many long-term care processes and increased collaboration with infection prevention and control activities.

Residents and their families are informed of their rights and responsibilities. Residents consistently report receiving excellent care from compassionate staff. Both residents and families feel heard and their voices are valued.

The physical environment is spacious and well designed, with wide, uncluttered corridors and accessible doorways. Care aides are cross-trained and prepare meals for residents. The organization is caring for an increasingly medically complex population, including a growing number of residents living with dementia.

Quality improvement (QI) activities have supported rapid learning and measurable progress. The organization is to be commended for its QI activities in reducing falls. A comprehensive QI plan has been created and is being implemented.

Table 9: Unmet Criteria for Long-Term Care Services

There are no unmet criteria for this section.

Perioperative Services and Invasive Procedures

Standard Rating: 100.0% Met Criteria

0.0% of criteria were unmet.

Assessment Results

There is a dynamic team focused on ensuring patients receive quality care. They have achieved success with recruiting and retaining competent, skilled, engaged staff. The surgical program provides safe, quality care through predominantly day surgery care, however inpatient beds are available as needed.
The team performs approximately 830 procedures per year and has capacity to increase the number of procedures performed. Specialties include general surgery, urology, endoscopy, orthopedics and podiatry. The team is actively looking to provide additional services based on the needs of the population they serve, such as gynaecology and ears, nose and throat (ENT).

The team receives the appropriate education to be able to deliver consistent, evidence-based care using the Operating Room Nurses Association of Canada (ORNAC) standards. Designations, credentials, competency assessments, and training are monitored and maintained to ensure safe and effective delivery of services. Professional requirements are kept up to date in accordance with provincial and organizational policies. Staff have post-diploma certification from MacEwan University to prepare them to work in this challenging, fast-paced, and team-oriented environment. There are both registered nurses and licensed practical nurses working in the operating room providing service within accepted scopes of practice. Staff receive training on new procedures, equipment, devices and supplies to ensure they have the knowledge skills and ability to provide the necessary care and support.

Care of patients undergoing surgery begins with preoperative phone assessments by members of the team. The patient is assessed for any needs for further assessment either in person or virtually by anaesthesia to ensure they are optimized for surgery, appropriate for the level of care provided at the Vermilion Health Centre and avoid last minute cancelation. Detailed instructions are given to the patient to prepare them for their procedures. On the day of the surgery patients are received in the preoperative area to prepare them for surgery. Staff complete a detailed assessment in Connect Care, the electronic medical record, and patients are transferred to the operating room following a standard process to ensure correct, complete information is shared within and between teams. Connect Care has many standard fields to support accurate and complete documentation and transfer of knowledge within and between teams. Following the procedure patients are transferred to the recovery area by the surgical team where a full report is verbally given ensuring that information pertinent to the patient care is communicated.

The team provides patients with comprehensive pre- and post-op instructions to ensure the patients have the information they require. Patients are also aware of follow up plans and how to access care if required. There is not a formalized way to receive feedback from patients about their care to look for opportunities for improvement.

There is an opportunity to use data to drive process improvement. The team currently does not monitor any indicators to understand how they are performing. They receive feedback from visiting surgeons that their room turnovers are very fast compared to other sites. The team should look to identify metrics that are meaningful to the work they do. After gathering baseline data, they can compare it to peer benchmarks. Using this information can then drive process improvement where indicated.

Table 10: Unmet Criteria for Perioperative Services and Invasive Procedures

There are no unmet criteria for this section.

Reprocessing of Reusable Medical Devices

Standard Rating: 97.1% Met Criteria

2.9% of criteria were unmet. For further details please review the table at end of this section.

Assessment Results

The Medical Devices and Reprocessing Department (MDRD) consistently prioritizes quality, safety, and efficiency, maintaining compliance with relevant standards. The department's vibrant enthusiasm and pride reflect strong staff engagement. MDRD adheres to Canadian Standards Association (CSA) standards when reprocessing medical devices and equipment.

The department is organized, clean, and has a one-way flow of instruments from dirty to clean with distinct zones separated by walls with a pass-through window to facilitate flow. There is appropriate environmental monitoring for temperature and humidity. Work surfaces are made from non-porous cleanable materials. Workstations for assembly of instrument sets are adjustable and have proper lighting. Workplace assessments of the MDRD should be regularly conducted for ergonomics and occupational health and safety.

Manufacturers' recommendations for cleaning and sterilization of medical devices are adopted according to standards. The team has access to paper copies of instrument sets with pictures to aide in the accurate assembly of the sets. SOP's provide consistency in task completion and help decrease the risk of errors.

The team is certified in sterile reprocessing through recognized programs and receives training and support from company representatives for new technologies. Annual audits by zone leads assess individual competency and provide feedback when needed.

The team has placed some of their instrumentation in Genesis Sterilization Containers. The team is encouraged to review their equipment/instruments to understand if there are opportunities to move more equipment to a sterile container system that could increase efficiencies in the operating room and MDRD, reduce costs and waste as well as provide better protection for costly instrumentation.

There was a need identified during the last accreditation cycle and again by an infection control audit that hand hygiene facilities at entrances to and exits from the reprocessing area need to be improved. Specifically, an appropriate sink equipped with faucets supplied with foot, wrist or knee operated handles, electric eye controls, automated soap dispenser and single use towels to help prevent recontamination of hands. Consider consulting staff to understand how this important improvement can be achieved.

The staff are engaged in quality improvement activities within the department to improve processes in an informal way. They are currently not using data or metrics in any meaningful way. A more formalized approach to continuous quality improvement would benefit the team.

Table 11: Unmet Criteria for Reprocessing of Reusable Medical Devices

Criteria Number	Criteria Text	Criteria Type
3.2.1	The reprocessing area is equipped with hand hygiene facilities at entrances to and exits from the reprocessing areas, including personnel support areas.	HIGH
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
3.2.9	Workplace assessments of the Medical Device Reprocessing (MDR) department are regularly conducted for ergonomics and occupational health and safety.	HIGH

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	2.1.3 Timely access for clients is coordinated with other services and teams within the organization.	June 8, 2027
	2.7.17.2 Documentation tools and communication strategies are used to standardize information transfer at care transitions.	June 8, 2027
	2.7.17.5 The effectiveness of communication is evaluated and improvements are made based on feedback received. Evaluation mechanisms may include: • Using an audit tool (direct observation or review of client records) to measure compliance with standardized processes and the quality of information transfer • Asking clients, families, and service providers if they received the information they needed • Evaluating safety incidents related to information transfer (e.g., from the patient safety incident management system)	June 8, 2027
Inpatient Services	3.3.3 The inpatient services team works with the emergency department team to initiate the geriatric needs assessment, where appropriate, for clients who enter into the organization through the emergency department.	June 8, 2027
	3.3.9.6 The team participates in activities to improve the program to prevent venous thromboembolism as part of the organization's integrated quality improvement plan.	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
	5.1.1 Access to medication storage areas is limited to authorized team members.	June 8, 2027

Follow-up Requirements		
Standard	Criterion	Due Date
Medication Management	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
Reprocessing of Reusable Medical Devices	3.2.1 The reprocessing area is equipped with hand hygiene facilities at entrances to and exits from the reprocessing areas, including personnel support areas.	June 8, 2027