ACCREDITATION
AGRÉMENT
CANADA

Accreditation Report

Qmentum Global™ for Canadian Accreditation Program

Viking 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

Viking Health Centre stands out as a vital health hub for its region, anchored by a leadership team that pragmatically prioritizes safe, high-quality care. Leaders have fostered excellent community partnerships, working hand in hand with local foundations and retention committees to secure clinical equipment, manage essential clinic infrastructure, and support staff housing. With strong operational foundations and excellent regional support, such as highly responsive biomedical engineering, leadership is now well positioned to formalize overarching service goals for the site. Actively integrating input from patients and community partners into these goals will ensure the site's strategic direction remains aligned with the evolving needs of the local population.

The delivery of clinical services is characterized by impressive agility and a strong embrace of technology. The adoption of Connect Care, the electronic medical record, has successfully hardwired critical safety practices, from medication reconciliation to pediatric assessments and automated sepsis screening, directly into daily workflows. Care transitions between the emergency department and the integrated acute care unit are highly efficient, driven by an adaptable, cross-trained nursing team. Further supporting safe care is the Medical Device Reprocessing Department (MDRD), which maintains rigorous sterilization standards and well-organized physical layouts. To mature these operational strengths, the site is encouraged to implement controlled access for the rear elevator entering the operating room and MDRD's clean space and to partner with the perioperative program to establish formal, measurable quality improvement indicators.

Staffing and work life are anchored by a dedicated, tight knit clinical team that benefits from highly visible, hands-on mentorship from unit leadership. To overcome persistent rural recruitment hurdles, the site has successfully integrated long term agency nurses who function as core team members, stabilizing the schedule without sacrificing continuity of care. However, to fully support this workforce, the organization must address administrative gaps caused by stretched leadership capacity. Reestablishing regular performance evaluations and formalizing professional development plans are critical next steps for staff retention. Furthermore, shifting the site's quality improvement culture from a reactive approach to a proactive, data driven model, utilizing daily safety huddles and visual tracking dashboards, will empower frontline staff to actively lead system improvements.

The physical work environment is meticulously maintained, supported by a highly collaborative infection prevention and control culture where staff take immense pride in their surroundings. However, the organization is encouraged to review its physical plant and emerging security vulnerabilities to ensure a consistently safe environment. This includes addressing environmental controls by ensuring operating room air exchanges meet required standards and implementing controlled access for the rear elevator entering the clean and restricted spaces of the operating room and MDRD. Furthermore, to protect the workforce from rising patient acuity and aggressive encounters, coupled with potential delays in security and external law enforcement response, the site is encouraged to assess the need for targeted physical security upgrades and to formalize a localized response plan for behavioral incidents. Additionally, while educational information is provided and some foundational emergency drills are completed, overarching disaster protocols would benefit from modernization. To move beyond standard educational briefings, the organization is encouraged to update historical mass casualty surge plans and implement regular, escalating tabletop exercises paired with structured debriefings to ensure the team remains genuinely prepared for major regional threats.

Ultimately, client satisfaction and people centred care remain clear strengths of the facility. Patients consistently report feeling well cared for, actively engaged in their treatment, and grateful to receive comprehensive services, close to home. Staff naturally excel at proactive communication, frequently checking on waiting patients to alleviate anxiety and build trust. Moving forward, the facility has an excellent opportunity to elevate this culture from simply informing patients to formally partnering with them. By co-designing resources with patient and family advisors, such as public facing disaster readiness materials, the organization can ensure the community remains an informed and empowered partner in its own healthcare journey.

Key Opportunities and Areas of Excellence

Areas of Excellence

- The organization demonstrates highly effective community partnerships. Leadership collaborates successfully with local foundations and retention committees to secure clinical equipment, support staff housing, and sustain essential primary care infrastructure.
- The facility maintains adaptable clinical operations through a cross trained nursing team. This shared staffing model ensures reliable service continuity and supports seamless care transitions between the emergency department and the acute care unit.
- The transition to the electronic medical record has successfully embedded critical safety assessments, such as medication reconciliation and automated sepsis screening, directly into standard clinical workflows.
- The acute care unit is purposefully designed to meet community needs, featuring a dedicated palliative suite and a flexible obstetrical bed that enable patients to receive appropriate, compassionate care close to home.
- Linen and environmental services and facilities maintenance and engineering personnel maintain a clean and safe physical space. The team demonstrates strong adherence to infection control protocols, effectively managing complex infrastructure upgrades without compromising patient safety.

Key Opportunities

- The organization is encouraged to shift its quality improvement framework from a reactive process to a proactive, data driven model. Implementing daily safety huddles and utilizing visual tracking boards will assist the frontline team in setting measurable targets and monitoring progress over time.
- The site is encouraged to address identified environmental and security vulnerabilities. Priorities include ensuring operating room air exchanges meet standards, controlling access to restricted areas of the Medical Device Reprocessing Department and OR, and assessing the need for physical security upgrades to manage behavioral incidents effectively.
- While foundational fire drills and educational sessions are completed, overarching disaster protocols require modernization. The organization is encouraged to update historical mass casualty surge plans and implement regular tabletop exercises paired with structured debriefings.
- To address administrative gaps linked to stretched leadership capacity, the organization is encouraged to reestablish a consistent, objective performance review process and create formal professional development plans to support staff retention.
- Staff would benefit from targeted, practical education regarding organ and tissue donation. Clarifying clinical referral triggers and providing guidance on culturally respectful end of life conversations will enhance bedside confidence and compliance.

People-Centred Care

The organization demonstrates a deep, foundational commitment to people-centred care, consistently ensuring that patients and their families feel respected, informed, and actively involved in their healthcare journey. In the Emergency Department, staff maintain excellent, proactive communication, frequently checking on waiting patients to provide updates on their clinical status and physician availability. This transparency effectively builds trust and alleviates the anxiety of waiting. Similarly, the acute care unit is thoughtfully designed around the specific needs of the local population, featuring a designated palliative suite and a flexible obstetrical bed. Patients consistently report feeling exceptionally well cared for, actively engaged in their daily treatment decisions, and profoundly grateful to receive high-quality care within their own community alongside their personal support networks.

Beyond direct clinical care, the facility's people-centred approach is bolstered by strong, mutually beneficial community partnerships. Leadership actively collaborates with local foundations and retention committees to sustain the primary care network and secure essential equipment. By keeping the hospital deeply integrated as the true health hub of the region, the organization ensures that the broader, holistic needs of the community are met, allowing rural patients to maintain their independence and access care close to home.

To further elevate this strong people-centred culture, there is a distinct opportunity to transition from simply informing patients to formally co-designing care experiences alongside them. For example, the organization is encouraged to collaborate directly with patient and family advisors to develop accessible disaster readiness materials. Empowering the community to understand their options during a severe service interruption makes them active, informed partners in their own safety. Additionally, implementing targeted education for frontline staff on culturally respectful communication during sensitive end-of-life and organ donation conversations will ensure grieving families consistently receive the highest standard of compassionate support.

Finally, the site should look to formalize the integration of the patient and family voice into its broader strategic and quality improvement frameworks. While the team is doing excellent continuous improvement work on the floor, there is an opportunity to systematically share these activities, results, and learnings with clients and community partners to foster deeper transparency. By actively seeking and incorporating client and family input into the development of the site's overarching service goals, leadership can ensure that the facility's future growth remains perfectly aligned with the people it serves.

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%
	Obstetrics Services	1 / 1	100.0%
	Perioperative Services and Invasive Procedures	1 / 1	100.0%
Improving Hand Hygiene Practices	Infection Prevention and Control	5 / 5	100.0%
Infection Rates	Infection Prevention and Control	3 / 3	100.0%

Table 1: Summary of the Organization's ROPs

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

Table 1: Summary of the Organization's ROPs

ROP Name	Standard(s)	# TFC Rating Met	% TFC Met
Optimizing Skin Integrity	Emergency Department	6 / 6	100.0%
	Inpatient Services	6 / 6	100.0%
	Obstetrics Services	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%
	Obstetrics Services	7 / 7	100.0%
	Perioperative Services and Invasive Procedures	7 / 7	100.0%
Preventing Venous Thromboembolism	Emergency Department	6 / 6	100.0%
	Inpatient Services	6 / 6	100.0%
	Obstetrics Services	6 / 6	100.0%
	Perioperative Services and Invasive Procedures	6 / 6	100.0%
Safe Surgery Checklist	Obstetrics Services	2 / 5	40.0%
	Perioperative Services and Invasive Procedures	1 / 5	20.0%

Table 1: Summary of the Organization's ROPs

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

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: 42.9% Met Criteria

57.1% of criteria were unmet. For further details please review the table at the end of this section.

Assessment Results

The site has established a solid foundation for emergency preparedness by integrating it directly into the joint workplace health and safety committee. Having the regional emergency management officer (EMO) attend these meetings to present updates ensure that department leads can review current plans and cascade vital operational information back to their teams. Furthermore, routine legislative fire drills are consistently completed, and visual aids like "Code of the Month" posters effectively keep emergency protocols visible in nursing stations and break rooms.

However, the detailed, site-specific disaster protocols require modernization. A review of the command center binders revealed that the mass casualty surge plan and its associated operational checklists have not been officially updated since 2015. While overarching zone manuals exist, the specific role assignment tools detailing exactly who does what during a major surge must be aligned with current organizational standards. Furthermore, leadership should consider formalizing the integration of these plans with the broader municipal disaster framework (such as the Beaver Emergency Services Commission) to prevent crossed wires and role duplication during a true community crisis.

It is recommended that leadership formalizes how internal risk assessment results are shared with external stakeholders to keep community partners fully informed.

To better validate the operational readiness of emergency response plans, the site is encouraged to move beyond standard fire drills and “Code of the Month” briefings. Instead, the team is encouraged to regularly conduct tabletop exercises or functional drills for other critical codes, such as Code Orange and Code Green. Combining these exercises with a structured, non-judgmental debriefing process will enable the team to critically evaluate their performance, identify actionable improvements, and strengthen a resilient culture of safety.

Table 2: Unmet Criteria for Emergency and Disaster Management

Criteria Number	Criteria Text	Criteria Type
2.1.3	The organization shares the results of its emergency and disaster risk assessment with internal and external stakeholders, to keep them informed.	HIGH
3.1.2	The organization integrates its emergency and disaster plan with community emergency and disaster plans, to ensure a coordinated response to and recovery from an event.	NORMAL
3.1.3	The organization maintains an up-to-date version of its emergency and disaster plan in locations that are known and accessible to all staff, to ensure the plan can be easily accessed during an event.	HIGH
3.1.23	The organization ensures that each site, department, or unit establishes and maintains its own emergency and disaster plan that is aligned and coordinated with the organizational emergency and disaster plan.	HIGH
3.7.1	The organization conducts regular exercises to validate the effectiveness of its emergency and disaster plan and processes and ensure they meet expectations and objectives.	HIGH
3.7.2	The organization conducts an operational debriefing after each emergency and disaster exercise, to make recommendations for improvement.	HIGH
3.7.3	The organization regularly evaluates the effectiveness of its emergency and disaster planning based on the outcomes of completed exercises and past events, and uses the results to make improvements.	NORMAL
3.7.4	The organization shares evaluation results with internal and external stakeholders including staff, patients, clients, families, and the community, to promote transparency and learning.	NORMAL

Infection Prevention and Control

Standard Rating: 100.0% Met Criteria

0.0% of criteria were unmet.

Assessment Results

Infection prevention and control (IPC) is well integrated into the site's daily operations, functioning as a genuinely collaborative effort rather than a siloed department. The strong partnership between the central IPC team, linen and environmental services (LES), and facilities maintenance and engineering is a notable strength. This was particularly evident during the recent and highly disruptive infrastructure upgrades (roof repairs), where the facility team diligently conducted point-of-care risk assessments and implemented appropriate particulate control measures. These efforts ensured that patient care could continue safely despite the overhead construction.

LES staff demonstrate a high level of pride in maintaining the facility's cleanliness. Long-tenured team members actively mentor new hires, reinforcing rigorous daily cleaning practices and high-touch surface protocols as the standard baseline. Staff effectively align cleaning solutions with specific infection risks, using accelerated hydrogen peroxide for high-touch areas and reserving stronger agents for situations where they are strictly required. They also consistently follow isolation signage and use the appropriate personal protective equipment with ease.

The site benefits from a centralized infection control practitioner conducting regular rounds, offering an objective perspective on the care environment. The infection control practitioner reviews microbiology reports weekly to monitor healthcare-associated infections and supports the local team in quickly implementing contact tracing or outbreak management protocols when community-acquired infectious diseases impact the facility. IPC data transparency is strong, with hand hygiene compliance results actively shared during staff meetings and displayed on quality boards.

To further strengthen this culture of safety, the site is encouraged to empower hand hygiene auditors to provide real-time coaching across all clinical disciplines. In a close-knit rural hospital setting, there can be hesitation to address practices in the moment such as a nurse correcting a physician or a housekeeper reminding a nurse. Fostering an environment where peer-to-peer accountability is encouraged and supported will help improve compliance and reduce transmission risks.

Finally, the team demonstrates commendable adaptability in managing IPC protocols within an aging physical environment. Shared patient bathrooms and the need to position isolation carts in hallways present ongoing logistical challenges. Staff manage these constraints effectively by establishing clear physical boundaries and maintaining vigilance. The team is encouraged to sustain these strong interim practices while opportunities for capital improvements to modernize patient care spaces are explored.

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

The leadership team are strong advocates for patient safety and demonstrate a deep, pragmatic understanding of the realities of their rural, clinical environment. They consistently show a clear prioritization of high quality, safe clinical care over the desire to simply maintain the status quo when resources are stretched. This type of courageous leadership is exactly what ensures long term patient safety in rural settings.

The site also benefits from stellar regional support systems, particularly biomedical engineering out of Red Deer. The biomed team provides excellent, highly responsive preventive maintenance and rapid troubleshooting, keeping critical medical devices safe, functional, and up to date. With these strong operational foundations in place, the organization is encouraged to formalize and pursue its overarching service goals, ensuring they are measurable, time specific, and actively incorporate input from patients and community partners.

Operational safety is tracked well via the electronic incident reporting system, with good integration of workplace health and safety advisors who help close the loop on reported hazards. However, the site is facing new security vulnerabilities due to rising patient acuity and a transient population, particularly regarding concern related to aggressive encounters in the emergency department. Relying heavily on off-site security and RCMP, who may be hours away responding to calls, creates a potential response delay. The organization is encouraged to continue to monitor health and safety indicators and assess whether further interventions are required at the site.

The organization is further encouraged to consider pursuing physical security upgrades to protect the workforce. Enhancing surveillance systems with improved lines of sight to main entrances and staff doors may be beneficial. Additionally, the site is encouraged to formalize its internal response to behavioral incidents. Given the realities of a smaller rural facility where designating a dedicated response team may not be feasible, the site should develop a pragmatic approach tailored to its limited staffing footprint. Clarifying role expectations during aggression codes, such as ensuring minimum coverage remains for other patients, and establishing firm triggers for when to immediately disengage and rely on external law enforcement will ensure a safer and more coordinated approach.

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: 97.3% Met Criteria

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

Assessment Results

The organization demonstrates generally safe and well-structured medication management practices aligned with accreditation standards. The pharmacy is secured with controlled access, and clear processes are in place for use of the night cupboard and after-hours pharmacy access.

Antimicrobial stewardship activities are supported and monitored at both the provincial and zone levels. When on site, the pharmacist actively participates in patient rounds and collaborates with prescribers, including communicating through Connect Care to recommend appropriate conversion from intravenous to oral therapy. Pharmacy services are further supported through staff orientation, where a pharmacy technician provides education on available services and after-hours procedures.

There is no hazardous compounding or handling of hazardous materials at this site. While verbal and telephone medication orders are infrequent, the current policy guiding these practices is outdated and requires review to ensure alignment with current standards. The site does not utilize automated dispensing units.

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: 89.4% Met Criteria

10.6% of criteria were unmet. For further details please review the table at the end of this section.

Assessment Results

The organization demonstrates a strong commitment to community centered care, reinforced by highly effective and mutually beneficial local partnerships. Leadership has effectively engaged attraction and retention committees led by the community to assist with staff housing and integration into the local area. Furthermore, the hospital works closely with a highly supportive local foundation that not only secures key clinical equipment, like infant warmers, but also plays a direct role in sustaining the primary care network by managing the clinic building. This symbiotic relationship is critical to retaining physicians and ensuring the hospital remains the health hub of the community.

In the face of persistent rural recruitment challenges and a demographic wave of frequent maternity leaves, the site has had to be creative to maintain service continuity. Integrating long-term agency nurses has been a successful strategy to stabilize the core acute and emergency schedules. Because these agency nurses are embedded for long durations, they function as true members of the team, maintaining high standards of care without the constant disruption of short-term parachute staffing.

To mature the site's service delivery, the quality improvement framework needs to shift from a reactive posture to a formal, proactive model. While staff are clearly putting effort into process changes following clinical incidents, these initiatives currently lack defined, measurable targets. Establishing baseline data before making a change, setting SMART (Specific, Measurable, Achievable, Relevant, Time bound) goals, and utilizing specific tracking metrics will allow the team to truly measure whether their adjustments are leading to sustained improvement.

As part of this quality improvement evolution, establishing a brief, daily safety huddle with a visual management tool, like a ticket board or a daily tracking dashboard, would be transformative. This structure would empower frontline staff to raise real time safety concerns, track intervention progress daily, and foster a deeper culture of transparency. Formalizing a strategy to share these quality improvement activities, results, and learnings with staff, clients, and community partners will ensure everyone is pulling in the same direction.

On the human resources front, supporting staff development is crucial. High turnover and the capacity stretch on site leadership have led to significant gaps in formal performance evaluations, leaving some long tenured staff without documented reviews for several years. The organization needs to reestablish an interactive, objective performance review process. Creating formal professional development plans and systematically tracking growth opportunities will go a long way in supporting, mentoring, and retaining this incredibly dedicated workforce.

Table 6: Unmet Criteria for Service Excellence

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

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: 100.0% Met Criteria

0.0% of criteria were unmet.

Assessment Results

The emergency department operates with an impressive degree of agility, which is essential for a rural facility. The clinical team is extensively cross-trained across multiple areas, including acute care and obstetrics, providing the hospital with the operational flexibility needed to maintain services despite staffing challenges. During patient intake, staff make excellent use of electronic documentation to support thorough, holistic assessments. Clinical workflows are thoughtfully designed to automate sepsis screening based on vital signs and to prompt domestic violence or suicide risk assessments whenever clinical concerns arise.

Pediatric care stands out as a practical, well-executed strength. The nursing team intuitively adapts to younger patients, capturing weights immediately and relying on specific, age-appropriate assessment tools like the Pediatric Respiratory Assessment Measure (PRAM) score for respiratory presentations. This tailored approach ensures that even in a generalized emergency setting, pediatric patients receive specialized, evidence-based evaluations. Staff demonstrate a clear comfort level with pediatric workflows, frequently collaborating to ensure children and their parents are put at ease during triage and treatment.

Patient flow is managed exceptionally well, aided by manageable daily volumes of approximately ten visits. Staff keep a vigilant eye on the waiting room, frequently checking on patients (often every thirty minutes) to catch any signs of deterioration early. This proactive communication keeps patients informed about physician availability and builds trust. Furthermore, internal handovers to the acute care unit are seamless, specifically because the cross-trained nurses often follow the patient to the acute care unit, ensuring that critical clinical context is never lost in translation.

When dealing with higher-acuity presentations, the team is consistently prepared. Trauma rooms are proactively set up the moment notifications are received from Emergency Medical Services. Because physicians are frequently working at the adjacent clinic rather than directly on the floor, the nursing staff have developed strong, reliable communication channels to provide rapid clinical updates and secure verbal orders, ensuring that treatment is never delayed while waiting for a physician to physically arrive in the department.

Table 7: Unmet Criteria for Emergency Department

There are no unmet criteria for this section.

Inpatient Services

Standard Rating: 100.0% Met Criteria

0.0% of criteria were unmet.

Assessment Results

Inpatient care is performing well, a success largely driven by the adoption of the Connect Care electronic medical record. Transitioning to this robust system has noticeably streamlined daily clinical workflows and drastically improved documentation accuracy. Critical safety practices, such as medication reconciliation, comprehensive skin integrity assessments, and falls risk evaluations, are no longer standalone tasks; they are hardwired directly into the clinical workflow, which has driven high compliance. Care transitions from the emergency department are highly efficient, backed by solid handover notes and an agile, cross trained nursing team that leverages electronic navigators to ensure absolute continuity of care.

The acute care unit functions as a truly integrated, multipurpose service. By blending general inpatient beds with a designated, thoughtfully designed palliative suite and a flexible obstetrical bed, the unit maximizes its utility for the local population. This patient centered layout is highly valued by the community. Patients consistently report feeling well cared for, actively engaged in their treatment decisions, and profoundly grateful to receive high quality care close to home rather than facing long transfers to urban centers.

The physical environment is well maintained, safe, and heavily monitored by an engaged LES team. Despite the obvious spatial challenges of operating in an older building, including shared patient bathrooms that necessitate careful and sometimes creative isolation cart placements, staff successfully keep hallways clear of clutter. Storage rooms are tidy, and lifesaving equipment is organized and instantly accessible, which is vital for safe care delivery.

Unit leadership is highly visible, deeply experienced, and heavily engaged in daily operations. The onsite clinical resource nurse (CRN) provides excellent, direct clinical mentorship, running monthly simulated emergency response education, such as code blue, and facilitating continuous point of care skill development. This localized mentorship is backed by documentation of equipment training on tools like infusion pumps, the completion of mandatory learning modules, and the excellent support of a part time, multisite educator.

Moving forward, the inpatient team has a fantastic opportunity to take its quality improvement work to the next level. While the current quality board successfully tracks key indicators like venous thromboembolism prophylaxis and general patient experience, the unit is encouraged to clearly identify specific priority improvement areas. By pulling baseline data to understand current performance and setting measurable targets with firm deadlines, the team can transition from tracking data to actively driving change. Formalizing these strategies, perhaps through brief daily safety huddles, will empower the frontline team to track intervention progress and demonstrate sustained, data driven improvements over time.

Table 8: Unmet Criteria for Inpatient Services

There are no unmet criteria for this section.

Obstetrics Services

Standard Rating: 97.4% Met Criteria

2.6% of criteria were unmet. For further details please review the table at end of this section.

Assessment Results

At the time of the visit, obstetrical services were experiencing a temporary disruption due to limited anesthesia coverage. As a result, the assessment was conducted as a tabletop tracer. To supplement this review, feedback was gathered through telephone interviews with two patients who had previously delivered at the site.

The program has experienced several service disruptions related to health human resource constraints. These challenges have affected service continuity and contribute to a low annual delivery volume of approximately 60 births. The patient population served is primarily low risk, with deliveries typically occurring at or beyond 36 weeks' gestation. Available clinical services include nitrous oxide, oxytocin administration, and epidural anesthesia when coverage permits. There are currently no midwives affiliated with the program.

The organization has established a maternal–child specific falls prevention policy. The program also participates in the MoreOB initiative, which provides ongoing education and support aimed at improving patient outcomes, particularly valuable in low-volume obstetrical settings. Staff maintain current certification in Fetal Health Surveillance, with recertification required every two years. Neonatal Resuscitation Program (NRP) certification is also mandatory and maintained through regular recertification.

Education and simulation activities are supported by a nurse with a focused interest in obstetrics. This individual leads drills on high-risk scenarios, such as postpartum hemorrhage (PPH), and has collaborated with a zone educator to optimize the accessibility and organization of PPH supplies. An additional quality initiative underway is the transition from estimated blood loss to quantitative blood loss measurement.

The program is in the early stages of formal quality improvement work. There is an opportunity to further leverage data by establishing measurable targets and implementing defined strategies to demonstrate sustained improvement.

As the review was conducted via tabletop tracer, direct confirmation of surgical safety checklist completion was not possible. Compliance is not currently monitored on a case-by-case basis, representing an opportunity to strengthen processes by tracking adherence, identifying barriers, and implementing improvements to ensure consistent completion.

Table 9: Unmet Criteria for Obstetrics Services

Criteria Number	Criteria Text	Criteria Type
1.5.6	Safe Surgery Checklist 1.5.6.3 There is a process to monitor compliance with the checklist. 1.5.6.4 The use of the checklist is evaluated and results are shared with the team. 1.5.6.5 Results of the evaluation are used to improve the implementation and expand the use of the checklist.	ROP

Perioperative Services and Invasive Procedures

Standard Rating: 95.0% Met Criteria

5.0% of criteria were unmet. For further details please review the table at end of this section.

Assessment Results

At the time of the visit, perioperative services were experiencing service disruptions due to lack of anesthesia coverage, and no surgeries were scheduled. As a result, the assessment was conducted as a tabletop tracer. Preoperative processes are in place to support patient readiness, including a pre-anesthetic clinic for appropriate patients and preoperative phone calls for all patients.

Findings identified gaps in environmental controls within the operating room. While a temperature monitor is present in the operating room (OR) suite, it is not continuously monitored when staff are not in the area and is not connected to an alarm system to notify staff of variances. This does not meet the standard requiring that heating, ventilation, temperature, and humidity be consistently monitored and maintained in accordance with applicable standards, legislation, and regulations. Additionally, the site's air balance report indicates that air exchanges per hour are 10.55, which is below required standards for surgical and invasive procedure areas, representing a further gap in compliance with ventilation requirements.

During the survey, it was identified that the hospital's only elevator has a rear door that opens directly into clean and restricted areas of the OR and Medical Device Reprocessing department, with unrestricted access via a push button. This presents a risk to maintaining the integrity of restricted areas. It is recommended that the rear door be secured with controlled access, ensuring entry is limited to authorized personnel, while maintaining public access through the front elevator door only.

As the review was conducted via tabletop tracer, direct confirmation of surgical safety checklist (SSC) completion was not possible. Compliance is not currently monitored on a case-by-case basis, representing an opportunity to strengthen processes through tracking adherence, identifying barriers, and implementing improvements to ensure consistent completion. Staff also identified that there are occasions when physicians are not present in the operating room during completion of the SSC, as they may be attending consultations outside the OR. This represents an additional area of opportunity to reinforce team participation and adherence to established safety protocols.

Table 10: Unmet Criteria for Perioperative Services and Invasive Procedures

Criteria Number	Criteria Text	Criteria Type
1.1.2	The area where invasive procedures are performed has three levels of increasingly restricted access: unrestricted areas, semi-restricted areas, and restricted areas.	NORMAL

Criteria Number	Criteria Text	Criteria Type
1.1.3	Heating, ventilation, temperature, and humidity in the area where surgical and invasive procedures are performed are monitored and maintained according to applicable standards, legislation, and regulations.	NORMAL
1.1.6	Airflow and quality in the area(s) where surgical and invasive procedures are performed are monitored and maintained according to standards applicable for the type of procedures performed.	HIGH
1.1.7	Rooms where surgical and invasive procedures are performed have at least 20 complete air exchanges per hour.	HIGH
1.1.9	The operating/procedure room has a restricted-access area for the sterile storage of supplies.	HIGH
2.6.3	Safe Surgery Checklist 2.6.3.2 The checklist is used for every surgical procedure. 2.6.3.3 There is a process to monitor compliance with the checklist. 2.6.3.4 The use of the checklist is evaluated and results are shared with the team. 2.6.3.5 Results of the evaluation are used to improve the implementation and expand the use of the checklist.	ROP

Reprocessing of Reusable Medical Devices

Standard Rating: 94.2% Met Criteria

5.8% of criteria were unmet. For further details please review the table at the end of this section.

Assessment Results

This assessment was conducted as a tabletop tracer due to a disruption of services, with no surgical or endoscopy procedures occurring at the time because of limited anesthesia coverage. The Medical Device Reprocessing department (MDRD) demonstrates adherence to key reprocessing standards; with appropriately certified staff whose credentials are monitored at the zone level.

The physical layout supports clear separation of clean and dirty areas, and processes are in place to ensure safe practice, including the use of biological and chemical indicators in accordance with policy, proper maintenance and tracking of scopes linked to patient identifiers, and the use of a scope cabinet for storage. Transportation of instruments is managed through separate, closed carts for clean and soiled items, and sterilization records are current, accessible, and well maintained.

However, it was identified that the hospital's only elevator has a rear door that opens directly into clean and restricted areas of MDRD, accessible via an unsecured push button, posing a risk to the integrity of restricted spaces; controlled access is recommended. While the quality of reprocessing practices is not in question, there is an absence of formal quality improvement initiatives within the department. Given limited staffing, with one full-time employee supported by casual staff, there is an opportunity to collaborate with the perioperative program to guide quality improvement initiatives and share learnings.

Table 11: Unmet Criteria for Reprocessing of Reusable Medical Devices

Criteria Number	Criteria Text	Criteria Type
1.3.3	Access to the Medical Device Reprocessing (MDR) department is controlled by restricting access to authorized team members only and being identified with clear signage.	HIGH
2.1.11	Team member performance is regularly evaluated and documented in an objective, interactive, and constructive way.	HIGH
2.1.12	Team members are supported by team leaders to follow up on issues and opportunities for growth identified through performance evaluations.	HIGH

Criteria Number	Criteria Text	Criteria Type
4.4.2	Access to the sterile storage area is limited to authorized team members.	HIGH
5.3.2	Information and feedback is collected about the quality of services to guide quality improvement initiatives with input from stakeholders and team members.	NORMAL
5.3.11	Information about quality improvement activities, results, and learnings is shared with stakeholders, teams, organization leaders, and other organizations, as appropriate.	NORMAL

Criteria for Follow-up

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

Follow-up Requirements		
Standard	**Criterion**	**Due Date**
Emergency and Disaster Management	2.1.3 The organization shares the results of its emergency and disaster risk assessment with internal and external stakeholders, to keep them informed.	June 8, 2027
	3.1.3 The organization maintains an up-to-date version of its emergency and disaster plan in locations that are known and accessible to all staff, to ensure the plan can be easily accessed during an event.	June 8, 2027
	3.1.23 The organization ensures that each site, department, or unit establishes and maintains its own emergency and disaster plan that is aligned and coordinated with the organizational emergency and disaster plan.	June 8, 2027
	3.7.1 The organization conducts regular exercises to validate the effectiveness of its emergency and disaster plan and processes and ensure they meet expectations and objectives.	June 8, 2027
	3.7.2 The organization conducts an operational debriefing after each emergency and disaster exercise, to make recommendations for improvement.	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

Follow-up Requirements		
Standard	**Criterion**	**Due Date**
Obstetrics Services	1.5.6.3 There is a process to monitor compliance with the checklist.	June 8, 2027
	1.5.6.4 The use of the checklist is evaluated and results are shared with the team.	June 8, 2027
	1.5.6.5 Results of the evaluation are used to improve the implementation and expand the use of the checklist.	June 8, 2027
Perioperative Services and Invasive Procedures	1.1.6 Airflow and quality in the area(s) where surgical and invasive procedures are performed are monitored and maintained according to standards applicable for the type of procedures performed.	June 8, 2027
	1.1.7 Rooms where surgical and invasive procedures are performed have at least 20 complete air exchanges per hour.	June 8, 2027
	1.1.9 The operating/procedure room has a restricted-access area for the sterile storage of supplies.	June 8, 2027
	2.6.3.2 The checklist is used for every surgical procedure.	June 8, 2027
	2.6.3.3 There is a process to monitor compliance with the checklist.	June 8, 2027
	2.6.3.4 The use of the checklist is evaluated and results are shared with the team.	June 8, 2027
	2.6.3.5 Results of the evaluation are used to improve the implementation and expand the use of the checklist.	June 8, 2027
Reprocessing of Reusable Medical Devices	1.3.3 Access to the Medical Device Reprocessing (MDR) department is controlled by restricting access to authorized team members only and being identified with clear signage.	June 8, 2027
	4.4.2 Access to the sterile storage area is limited to authorized team members	June 8, 2027