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Accreditation Report

Qmentum Global™ for Canadian Accreditation Program

Wainwright Health Centre
Alberta Health Services

Report Issued: June 19, 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

Wainwright Health Centre is a small rural site that is committed to providing patient-centred care. Surveyors observed positive interactions between staff, physicians, patients, and families, with care delivered in a respectful, compassionate, and supportive manner. Patients interviewed during the survey reported a high level of satisfaction with the care and services provided at the site and expressed appreciation for the commitment and responsiveness of staff.

The site has experienced significant leadership turnover in recent years; however, a new site leader has recently started in the role with significant overlap and transition support provided by the outgoing site leader. The site also experienced a vacancy rate of approximately 40% in the past. Site leadership undertook a workplace assessment process and implemented many of the resulting recommendations, contributing to a significant reduction in vacancy rates. Staff described improved stability within the workforce and demonstrated commitment to supporting one another and maintaining continuity of care within a challenging rural environment.

The site experiences some challenges related to structure and reporting relationships. Some staff report directly to on-site leadership while others report to off-site leaders, and it appeared that operational priorities are not always aligned. This can create challenges in addressing issues in a timely, efficient, and coordinated manner at the local level. The organization and site leadership are encouraged to explore opportunities to strengthen collaboration, communication, and alignment across leadership structures to ensure that the best possible patient-centred care can be delivered at the site.

Key Opportunities and Areas of Excellence

Area of Excellence

- Site completed a workplace assessment approximately two years ago and using this assessment strengthened its on-site management, increased supports for staff including strengthening its onboarding process, and has achieved a significant reduction in its vacancies over the past few years.
- Over the past year, the site has increased its focus on improving its quality oversight processes, including engagement with frontline staff. The initial focus was within acute care, obstetrics, emergency department, and operating rooms. Dashboards are now being posted on the units or sent to staff by email.
- The site has a good group of physicians with a well-aligned range of general practice specializations (Anesthesia, Surgeon/Endoscopist, Obstetrics) working well together to serve the community.
- The site appears to have strong community support, particularly through investments in equipment and resources that support local care delivery and help maintain services closer to home.
- Staff and patients reported feeling safe at the site, and the surveyor observed a strong security presence on-site.

Key Opportunities

- Several provincial policies and procedures are outdated. AHS is encouraged to update provincial policies and procedures, with priority given to the highest-risk outdated documents. The site is encouraged to implement a process to ensure that, if required, paper versions are of the most up-to-date documents.
- The space where surgical services are provided is very tight, resulting in dirty equipment being transported out of the operating room/endo suite in the opposite direction of the reprocessing suite and then back to the reprocessing suite. There is a single operating room/endo suite resulting in the need to squeeze emergency C-sections between scopes without thorough cleaning of the room, with nursing staff completing a wipe down while often also managing urgent or emergent situations. With the anticipated growth of the town, demand for both endoscopy and obstetrics services is expected to increase. The site is encouraged to consider opportunities to optimize the flow of clean and dirty equipment/supplies within the existing space and plan for increased demand.
- Although quality improvement work was strengthened in the past year, the site is encouraged to continue this work and develop both goals and objectives by service area, as well as a site integrated quality improvement plan, engaging frontline staff, medical staff, and a Patient and Family Advisory Council in developing, implementing, and evaluating the plan. The plan should include auditing, learnings, and continuous quality improvement activities related to the required organizational practices and should leverage corridor and provincial resources.
- The site is encouraged to engage community partners in emergency and disaster preparedness training and collaboratively plan and conduct a mass casualty simulation exercise to strengthen local readiness and coordination across responding agencies and partners.

People-Centred Care

Patients and families interviewed during the onsite survey expressed appreciation for the staff and the services provided. The community appears to be strongly invested in the facility and its ongoing success, which is commendable. This support is evident through active engagement and the presence of a well-established volunteer program that contributes to the overall patient and resident experience.

To further strengthen patient and family engagement, the site is encouraged to establish a Patient and Family Advisory Committee (PFAC). This should include clear education for members regarding the role of the PFAC, defined terms of reference, and a structured work plan for the coming year.

Incoming leadership is encouraged to partner with the PFAC following its establishment to co-design and conduct a communications audit, involving staff, patients, and families. This work would help identify effective strategies for engagement and determine the most appropriate ways to share information and results, ensuring transparency and fostering meaningful collaboration.

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	4 / 5	80.0%
Cleaning and Low-Level Disinfecting Medical Equipment	Infection Prevention and Control	5 / 5	100.0%
Client Identification	Emergency Department	1 / 1	100.0%
	Inpatient Services	1 / 1	100.0%
	Long-Term Care Services	1 / 1	100.0%
	Obstetrics Services	0 / 1	0.0%
	Perioperative Services and Invasive Procedures	1 / 1	100.0%
Improving Hand Hygiene Practices	Infection Prevention and Control	5 / 5	100.0%
Infection Rates	Infection Prevention and Control	3 / 3	100.0%

Table 1: Summary of the Organization's ROPs

ROP Name	Standard(s)	# TFC Rating Met	% TFC Met
Information Transfer at Care Transitions	Emergency Department	5 / 5	100.0%
	Inpatient Services	5 / 5	100.0%
	Long-Term Care Services	5 / 5	100.0%
	Obstetrics Services	5 / 5	100.0%
	Perioperative Services and Invasive Procedures	4 / 5	80.0%
Infusion Pump Safety	Service Excellence	6 / 6	100.0%
Limiting High-Concentration and High-Total-Dose Opioid Formulations	Medication Management	4 / 5	80.0%
Maintaining an Accurate List of Medications during Care Transitions	Emergency Department	5 / 5	100.0%
	Inpatient Services	5 / 5	100.0%
	Long-Term Care Services	5 / 5	100.0%
	Obstetrics Services	5 / 5	100.0%
	Perioperative Services and Invasive Procedures	3 / 5	60.0%
Managing High-Alert Medications	Medication Management	5 / 5	100.0%

Table 1: Summary of the Organization's ROPs

ROP Name	Standard(s)	# TFC Rating Met	% TFC Met
Optimizing Skin Integrity	Emergency Department	6 / 6	100.0%
	Inpatient Services	6 / 6	100.0%
	Long-Term Care Services	6 / 6	100.0%
	Obstetrics Services	6 / 6	100.0%
	Perioperative Services and Invasive Procedures	6 / 6	100.0%
Preventing Falls and Reducing Injuries from Falls	Emergency Department	4 / 7	57.1%
	Inpatient Services	7 / 7	100.0%
	Long-Term Care Services	7 / 7	100.0%
	Obstetrics Services	4 / 7	57.1%
	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	4 / 6	66.7%
	Perioperative Services and Invasive Procedures	5 / 6	83.3%

Table 1: Summary of the Organization's ROPs

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

Assessment Results by Standard

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

Core Standards

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

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

Emergency and Disaster Management

Standard Rating: 57.1% Met Criteria

42.9% of criteria were unmet. For further details please review the table at the end of this section.

Assessment Results

At Wainwright Health Centre (WHC), emergency and disaster management (EDM) is overseen by the site leadership and managers of all the departments. A regular segment of their leadership meeting agenda is dedicated to EDM issues. The site is supported by a corridor leader shared with other sites, who provides expert advice and monitors a variety of EDM matters. There are electronic and paper copies of the emergency and disaster response manual. An administrative assistant is tasked with ensuring site binders are up to date and aligned with approved and updated plans. The manual for linen and environmental services (LES) was not readily available when asked and when it was presented, many policies were outdated. LES are encouraged to work with the site leadership group to ensure their manual is updated and aligned with other manuals on site.

The site coordinates code of the month activities and a yearly calendar has been created. Fire drills are consistently held and results recorded by the site fire marshal. A fire inspection report is also completed by the facility maintenance lead. Frontline staff interviewed during the survey stated that they participate in fire drills, but results are not shared with them. It is suggested a debrief be held involving all staff to share successes and opportunities for improving drill performance. It was not clear how other codes are tracked and reported. An external fire threat risk assessment is completed annually, although it was not clear who this assessment is shared with.

Site management reported that no mass casualty simulations have been conducted at the site for several years. In addition, there have been no formal efforts to establish partnerships with key community partners, such as local police, fire services, the municipality, or the nearby Canadian Forces Base. New site leadership has identified this as a priority and is encouraged to proactively advance this work without delay to strengthen overall preparedness, community integration, and build collaborative relationships with these partners to establish and coordinate a local emergency and disaster preparedness network to support joint planning, communication, and coordinated response to emergencies.

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
3.7.4	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: 96.0% Met Criteria

4.0% of criteria were unmet. For further details please review the table at the end of this section.

Assessment Results

Wainwright Health Centre is a clean and well-maintained facility. LES staff use checklists based on patient volume and risk level to guide their cleaning practices. The site is supported by a central corridor infection control practitioner (ICP), who conducts monthly visits. These visits include staff engagement and audits of routine practices.

Healthcare-associated infections are monitored through patient records in Connect Care and reported at the national level. When infection rates reach a defined threshold, the ICP initiates a response by convening a working group. Meetings are then held with site leadership and public health officials to assess the situation, implement interventions, and monitor outcomes.

Staff reported having access to regular training on infection prevention and control (IPC). Hand hygiene audits are undertaken and results shared with staff. At times, the site is challenged to obtain a requisite number of audits and the site is encouraged to recruit and train additional auditors for this important safety activity.

Nutrition services understand the importance of their work and were complimentary of training and education opportunities provided. There are regular visits and reports from public health and any areas of non-compliance are addressed immediately. The nutrition services area has considerable clutter. Some of the extra equipment is no longer in service. It is recommended that the team undertake a ‘5S’ project to ensure best use of space for operational efficiency and IPC practices. Although there is consistent tracking and recording of required temperatures, during the on-site survey, it was noted that recording of dishwasher temperatures was inconsistent and needed management attention.

Bio-hazardous waste is disposed of by a third party and handled by staff as per the policy. Medical equipment cleaning is a shared responsibility by LES and clinical staff.

The inpatient unit does not have space for a dedicated sterile clean storage area and utilizes a curtain for separation.

The organization is commended for hosting its policies electronically, however there are legacy paper copies of policies in several areas that are outdated. The site is encouraged to work with IPC to ensure standards for electronic and paper policies are aligned, understood, and enforced. It is apparent that management and staff take IPC seriously and appreciate the zone support they receive. Based on a recommendation of the previous accreditation report, a dedicated hand-washing sink was installed in the medical device reprocessing area.

Table 3: Unmet Criteria for Infection Prevention and Control

Criteria Number	Criteria Text	Criteria Type
2.1.6	Compliance with infection prevention and control policies and procedures is monitored and improvements are made to the policies and procedures based on the results.	NORMAL
2.6.4	There are policies and procedures for cleaning and disinfecting the physical environment and documenting this information.	HIGH

Leadership

Standard Rating: 100.0% Met Criteria

0.0% of criteria were unmet.

Assessment Results

Wainwright Health Centre has undergone significant changes in leadership. At the time of the survey, a new leader was being onboarded with the support of the outgoing site leader. The previous leadership is commended for its efforts to identify and address workplace concerns. This was a major quality improvement undertaking that appears to be having a positive impact.

Leadership at the site tracks a variety of performance indicators that have potential safety risks and share the information; however, it is encouraged to evaluate whether the sharing of performance measures is resonating with frontline staff and the broader community. When questioned during the on-site survey, staff's ability to articulate performance measures and results achieved was mixed. For example, staff in obstetrics informed the surveyor about the email communication and their performance on key indicators, however staff in other areas of the site could not.

The site and the broader corridor of which it is a member, has not established goals/objectives by service area nor does it have a quality improvement plan. Although there were some examples of basic quality improvement initiatives, the site is encouraged to engage quality improvement supports within Alberta Health Services to review the key components of a comprehensive approach to continuous quality improvement, and with staff and patients/families, develop a comprehensive quality improvement plan. Leaders would then be encouraged to set expectations for all units and programs to undertake quality improvement projects within their respective areas.

Although the site has been very well-supported in equipment procurement, funded by its community, there is still a need for ongoing equipment replacements and upgrades. Leadership is encouraged to continue its efforts to articulate medical devices and equipment needs for the site.

The surveyors noted opportunity to strengthen cohesion and consistency across staff that report to on-site management versus those who report to off-site management. At the site and corridor level, leadership is encouraged to consider strategies to support collaboration across teams to deliver the best client focused and safest care possible.

The physical environment is well maintained and safe. There is a visual presence of security staff who round the facility regularly. Staff and patients stated they feel safe and well-supported by their leaders. The site appears to struggle with outdated infrastructure, especially considering increased patient volumes.

Table 4: Unmet Criteria for Leadership

There are no unmet criteria for this section.

Medication Management

Standard Rating: 93.0% Met Criteria

7.0% of criteria were unmet. For further details please review the table at the end of this section.

Assessment Results

The site has a well-organized, clean central pharmacy staffed with an on-site pharmacist, a couple of pharmacy technicians, and, at the time of the survey site visit, two pharmacy students. The site appears to collaborate effectively with its regional hub and provides services to Hardisty Health Centre.

Pharmacy resources are appropriately focused on their stated priority of supporting seniors with complex medication regimens. Pharmacy staff effectively contribute to the interdisciplinary team, a finding that was consistently supported by feedback from both staff and physicians.

As part of developing a quality improvement plan, it is recommended that a medication-related component be included. This could address relevant required organizational practices (ROPs), including improving safety related to the availability and access of high-concentration and high–total-dose opioid formulations, as well as strengthening antimicrobial stewardship. While antimicrobial use audit and feedback processes have not yet been implemented, they are planned for inclusion in future audit and quality improvement activities.

The site is encouraged to provide patients with clear, accessible information on how they can actively participate in medication safety, including steps they can take to reduce the risk of medication-related incidents.

Patients receive a welcome package on admission, which is intended to include guidance on preventing medication-related safety incidents. However, when staff and patients were asked about this package, there appeared to be limited awareness of its content or availability. This suggests an opportunity to strengthen communication and ensure that this information is consistently provided, clearly explained, and understood by both staff and patients.

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
1.2.5	Limiting High-Concentration and High-Total-Dose Opioid Formulations 1.2.5.5 The organizational leaders ensure the organization's medication management quality improvement plan includes activities to improve safety practices related to the availability of and access to high-concentration and high-total-dose opioid formulations.	ROP
1.2.6	Antimicrobial Stewardship 1.2.6.5 The program is evaluated on an ongoing basis and results are shared with stakeholders in the organization.	ROP
4.3.2	A policy that specifies when and how to override smart infusion pump alerts is developed and implemented.	HIGH
5.1.3	The organization has implemented comprehensive procedures for the safe use of medications stored in automated dispensing cabinets (ADCs).	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
9.1.5	Automated dispensing cabinets in client service areas interface with the medication order entry management system.	NORMAL
10.1.2	At the time of admission, information on how to prevent patient safety incidents involving medications is provided to and discussed with clients and families.	HIGH

Service Excellence

Standard Rating: 98.8% Met Criteria

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

Assessment Results

Leadership and staff have a good understanding of the needs and expectations of the populations they serve. A trusting relationship has been nurtured, and the community has responded with significant financial support that has afforded the site access to significant medical devices and equipment. Staff are well trained and indicated they had access to a variety of training programs and learning opportunities which is tracked. Patients' charts reviewed were generally complete and up to date with care plans in place. Whiteboards in patients' room were updated daily. Staff felt Connect Care has been an asset and they are encouraged to fully optimize the capacity of this system. A range of performance measures are collected and tracked by leadership.

Safety incidents, complaints, and risks are responded to. Staff are encouraged to report incidents and near misses. There was some concern raised that staff still feel there is a "summative" or punitive culture versus a "formative" culture that recognizes the value of learning from errors and near misses.

There was a large discrepancy in the frequency of development conversations. Many staff shared they had not had development conversations, others recalled having one several years ago, and others had had a review within the past year. Leadership is encouraged to review its approach to, and expectations for, these conversations for all staff.

Table 6: Unmet Criteria for Service Excellence

Criteria Number	Criteria Text	Criteria Type
2.1.10	The team leadership regularly evaluates and documents each staff member's performance in an objective, interactive, and constructive way.	HIGH

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: 93.8% Met Criteria

6.2% of criteria were unmet. For further details please review the table at the end of this section.

Assessment Results

The emergency department consists of six designated beds and provides 24/7 coverage. There is access to laboratory and diagnostic imaging services (including a CT scanner). The department responds to over 1300 emergency visits per year, averaging approximately 35 visits per day.

The site is supported by a rotation of community physicians, who spoke highly of the nursing staff. No issues were reported in obtaining specialist consultations. Nursing staff interviewed were well trained and felt they had training opportunities to keep them current in their roles. Care providers receive orientation to the service and many have received training in the care of pediatric patients. Although there is appropriate equipment for adults and pediatric patients, transfers to advanced pediatric care in larger centres is facilitated when deemed necessary.

Patients shared that the department was clean and well-kept and wait times were appropriate. They were appreciative of the access to emergency care and felt staff and physicians provided a personal touch with their service.

Emergency medical services staff advised that the site was highly cooperative, knowledgeable and there were no issues regarding delays in offloading. Staff collaborate to manage patient flow within the facility and with other sites nearby.

Registration for emergency department services takes place upon entry and patients are directed to waiting areas for triage. A Connect Care record is utilized and includes standard assessment tools. During the on-site visit, a patient triage interview was observed that was generally well-done, however an obviously needed screening for risk of falls was not asked or documented in Connect Care. The site is encouraged to review expectations for screening and recording these assessments as per its policy. Regular review and auditing of charts is encouraged, and results should be shared with staff to emphasize the importance of adherence to assessment expectations in triage.

The department receives support from the pharmacy. The entrance to the medication room was locked as was the narcotic cabinet, however other medication cabinets inside the room were unlocked. Recording of wasted medications takes place, however greater rigor in this process is encouraged to ensure that wasted medications are not left on top of the cart awaiting a second signature.

Waiting areas are separated and less than ideal for monitoring waiting patients. The staff informally designate a room as a “seclusion room” however this room has glass doors, no camera and is adjacent to an exit hallway. The site is encouraged to review its seclusion protocol and space designation to ensure a safe and effective seclusion space exists.

Staff advised they were unaware of any formal process to evaluate the effectiveness of transitions that could be used to improve planning in this realm. There may be some informal mechanisms, however these were not identified. The site is encouraged to engage patients and families to undertake these evaluations and consider the results as improvement opportunities.

Table 7: Unmet Criteria for Emergency Department

Criteria Number	Criteria Text	Criteria Type
2.3.6	After the initial triage assessment, clients who are waiting for service are advised which team member to contact if their condition changes.	HIGH
2.4.8	Seclusion rooms and/or private and secure areas are available for clients.	HIGH
2.5.5	Preventing Falls and Reducing Injuries from Falls 2.5.5.1 The team follows the organization's procedures for providing a safe physical environment to prevent falls and reduce injuries from falls. 2.5.5.2 The team follows the organization's procedure to conduct screening for risk of falls and injuries from falls. 2.5.5.3 The team follows the organization's procedure to ensure a comprehensive assessment is conducted for a client who screens positive for risk of falls or injuries from falls.	ROP
2.8.9	The effectiveness of transitions is evaluated and the information is used to improve transition planning, with input from clients and families.	NORMAL
3.1.1	Specific goals and objectives regarding wait times, length of stay (LOS) in the emergency department, client diversion to other facilities, and number of clients who leave without being seen are established, with input from clients and families.	NORMAL
3.1.2	Ambulance offload response times are measured and used to set target times for clients brought to the emergency department by Emergency Medical Services.	NORMAL

Inpatient Services

Standard Rating: 100.0% Met Criteria

0.0% of criteria were unmet.

Assessment Results

Inpatient service consists of 25 inpatient beds as part of a combined unit for inpatient, perioperative, and obstetrical services as well as an infusion clinic. Staff have a sound knowledge of the population served.

The staff interviewed were pleased with the opportunities to maintain their competencies. Orientations were found to be thorough and helped prepare staff for work on the unit. Several staff indicated they have not had a development conversation and others indicated it had been several years since their last one. Site leadership is encouraged to ensure all staff receive regular feedback on their work.

There is a combination of single- and double-bed rooms. The unit is very well maintained by linen and environmental service (LES) staff who receive training and audits of their work. Storage space is limited and clean supplies are stored in an area that has curtains separating the area from a busy ward. A pharmacist services the unit and ensures medications are appropriately stocked. Controlled medications are appropriately stored. Pharmacists make every effort to accompany physicians on their rounds and follow-up when necessary.

Patients expressed they were informed and engaged in their care. Whiteboards in patient rooms were updated by staff daily. Patients and family members were appreciative of staff and of having a facility in their community. They appreciated the “personal” touch they received from staff.

Records reviewed during the on-site tracer were complete and up to date. Nursing staff felt the information shared on admission was very good. Consents were obtained and documented.

Table 8: Unmet Criteria for Inpatient Services

There are no unmet criteria for this section.

Long-Term Care Services

Standard Rating: 100.0% Met Criteria

0.0% of criteria were unmet.

Assessment Results

Wainwright Continuing Care Home is co-located with the Wainwright Health Centre. The home offers 24/7 residential care for people with complex medical needs. There are 59 residential beds (in single and double rooms) cared for by a full range of healthcare providers and support staff. There is also an active volunteer group which includes palliative care volunteers and a group of community physicians supporting residents in the facility.

There is a well-organized and active recreation program. Staff and management at the site work with residents and their families to ensure residents are placed in the most appropriate environment. There is also a comfortable palliative care area that provides access to a palliative care nurse which is shared with other sites.

The site tracks several performance measures through a dashboard that is shared. Hand hygiene audits are conducted and results shared. An interdisciplinary team undertakes a monthly review of performance in key areas related to safe care and quality. A recent increase in pressure ulcers has been noticed, and the site is encouraged to undertake a quality improvement project to address the matter. It is suggested that another area of focus is the inconsistency in developmental conversations. The site management is commended for initiating the “Rock Star” recognition program.

The site has been well-supported by the community and is hoping to secure more ceiling lifts. The facility is well maintained by LES staff who are trained and audited in their efforts. The staff indicated they felt great pride in their work.

Resident charts were reviewed and found to be complete and up to date. A policy of least restraint is practiced. Residents and family members interviewed during the on-site survey felt they were informed and able to influence care.

A Resident Council meets monthly and is usually well attended. Minutes are recorded. The site is commended for undertaking a survey of resident and family satisfaction as a quality improvement project. The results were summarized and are being shared. The survey found that respondents felt staff were caring and respectful; residents felt safe and comfortable and appreciated activities and social events.

Areas identified for improvement in the survey included food and dining; laundry and clothes; staffing and wait times; and more meaningful Resident Council meetings. The site is encouraged to engage residents and family in co-designing a refreshed approach to Resident Council meetings.

Table 9: Unmet Criteria for Long-Term Care Services

There are no unmet criteria for this section.

Obstetrics Services

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

Staff reported that the team delivers between 300-400 births a year. The team is made up of seven committed registered nurses (RNs), a general practitioner (GP) for obstetrics/surgery (with capacity to perform cesarean sections [C-sections]), and GP anesthesia. The four-bed unit is located at the end of the acute care unit, offering privacy and a quiet atmosphere.

Three of the rooms can be used as Labour–Delivery–Recovery-Postpartum (LDRP) suites, while one room is better suited for postpartum care only. The team's interactions with the patient and their partner were observed to be warm, respectful, and supportive. Staff also demonstrated strong teamwork, with positive and collaborative interactions among team members.

The site is encouraged to formalize its quality improvement plan and include key obstetrical priorities such as falls prevention, venous thromboembolism (VTE) prevention, and consistent use of two-person identifiers, ensuring that all required tests of compliance are addressed. The site is also encouraged to reinstate the patient welcome package, including the Shared Commitments and information on how patients and families can file a complaint. In addition, strengthening collaboration with community providers to support the development and communication of comprehensive, individualized care plans is recommended.

The site is encouraged to continue building staff proficiency and confidence in using Connect Care so the system is used effectively throughout the patient journey from initial assessment, through care and treatment, to discharge planning. The team should ensure that patient preferences, including the birth or delivery plan, are clearly documented in the plan of care within Connect Care so that all team members have consistent access to this information.

C-sections are performed in a shared operating/endoscopy room. While planned C-sections are scheduled for early mornings, emergency procedures are interspersed between endoscopy cases during the day. Nursing staff complete a rapid wipe-down of the OR between cases, often while also managing urgent or emergent clinical situations. This raises concerns about whether adequate cleaning is consistently achieved to support safe patient care. A clearly posted cleaning schedule visible to all staff outside the OR was not observed, and staff appeared unaware of this requirement. The site is encouraged to strengthen coordination among LES, perioperative services, and obstetrics to ensure that appropriate and consistent cleaning protocols are followed between endoscopy procedures and C-sections.

Table 10: Unmet Criteria for Obstetrics Services

Criteria Number	Criteria Text	Criteria Type
1.2.14	Clients and families are provided with information about their rights and responsibilities.	HIGH
1.2.16	Clients and families are provided with information about how to file a complaint or report violations of their rights.	HIGH
1.3.5	Preventing Falls and Reducing Injuries from Falls 1.3.5.2 The team follows the organization's procedure to conduct screening for risk of falls and injuries from falls. 1.3.5.3 The team follows the organization's procedure to ensure a comprehensive assessment is conducted for a client who screens positive for risk of falls or injuries from falls. 1.3.5.7 The team participates in activities to improve the program to prevent falls and reduce injuries from falls as part of the organization's integrated quality improvement plan.	ROP
1.3.7	Preventing Venous Thromboembolism 1.3.7.3 The team implements interventions to prevent venous thromboembolism as part of the client's individualized care plan. 1.3.7.5 The team participates in continuous learning activities about the program to prevent venous thromboembolism.	ROP
1.3.18	A comprehensive and individualized care plan is developed and documented in partnership with the client and family.	HIGH
1.4.1	The client's individualized care plan is followed when services are provided.	NORMAL

Criteria Number	Criteria Text	Criteria Type
1.4.2	Client Identification 1.4.2.1 At least two person-specific identifiers are used to confirm that clients receive the service or procedure intended for them, in partnership with clients and families.	ROP

Perioperative Services and Invasive Procedures

Standard Rating: 93.0% Met Criteria

7.0% of criteria were unmet. For further details please review the table at the end of this section.

Assessment Results

Wainwright Health Centre provides a limited range of preoperative and procedural services focused primarily on endoscopy and low-acuity surgical procedures. Services are delivered through a small but committed interdisciplinary team that works collaboratively to support safe, efficient patient flow and timely access to care for the local community. Staff demonstrated a strong understanding of patient needs in a rural setting and appeared to work closely together to coordinate scheduling, patient preparation, procedural support, and discharge planning. The surveyor observed positive interactions between staff and patients, with care delivered in a respectful, supportive, and patient-centred manner.

Processes are in place to support patient assessment, preparation, monitoring, and recovery; however, the shared use of procedural space between perioperative services and planned and urgent/emergent C-sections requires careful coordination to maintain workflow, infection prevention and control practices, and environmental cleaning standards. The perioperative team demonstrated commitment to maintaining patient safety and continuity of care despite operational pressures and competing demands that can occur in a small rural site.

In collaboration with the perioperative team, the site is encouraged to formalize annual goals and objectives and develop a comprehensive quality improvement plan. This plan should identify key priorities, including fall prevention and reducing injuries from falls, optimizing skin integrity, preventing venous thromboembolism (VTE), improving medication reconciliation processes to ensure accurate medication lists across care transitions, and evaluating the effectiveness of communication during transitions of care.

The physical environment of the perioperative area presents several challenges. Air exchange rates in the perioperative area are slightly below the recommended level (measured at 19 exchanges per hour, where 20 are recommended). Air exchange in the initial decontamination area also appears limited and should be formally tested. The air handling system is reportedly scheduled for an upgrade in the coming months. The current workflow for dirty equipment is suboptimal. Equipment is transported out of the operating room/endoscopy suite in the opposite direction of the reprocessing area for initial decontamination and then returned to the reprocessing suite. This process requires movement through an inpatient care area, increasing the risk of cross-contamination. The site is encouraged to explore opportunities to improve the flow of clean and dirty equipment and supplies within the existing space. Also, the presence of a single shared operating room/endoscopy room creates scheduling and safety challenges. Emergency C-sections must be accommodated between endoscopy procedures, often with only a rapid wipe-down of the room performed by nursing staff. This raises concerns about whether adequate cleaning is consistently achieved. Strengthening collaboration with LES is also recommended to ensure thorough and consistent cleaning of the OR suite to support patient safety. A clearly defined cleaning schedule should be developed and posted in a visible location within the perioperative area.

A recently returned piece of equipment was observed without a visible marked date of return and description of the maintenance. In discussion with Bio Med, the digital system does not allow the sites to view information about maintenance or repairs nor is there a consistent process for communicating this information to the site or unit staff. This was confirmed by the unit’s assistant manager.

Site management reported that patients received a welcome package on admission, however, no evidence of this was found and staff who were asked were not aware of a welcome package. No evidence of communication related to rights and responsibilities/Shared Commitments in the physical environment was seen and staff were unaware of any mechanisms for sharing this information with clients/families. The site is encouraged to consider opportunities for improving visibility of Shared Commitments (rights and responsibilities).

Table 11: Unmet Criteria for Perioperative Services and Invasive Procedures

Criteria Number	Criteria Text	Criteria Type
1.1.1	The physical layout of the operating and/or procedure room(s) and equipment are designed to consider client flow, traffic patterns, the types of procedures performed, ergonomics, and equipment movement logistics.	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
1.1.10	There is a regular and comprehensive cleaning schedule for the operating/procedure room and supporting areas posted in a place that is accessible to all team members.	HIGH
1.2.3	Surgical equipment or medical devices returned to the operating/procedure room following repair or replacement are clearly marked with the date of their return/arrival and a signed notice describing the maintenance or purchase.	HIGH
1.2.9	Contaminated items are transported separately from clean or sterilized items, and away from client service and high-traffic areas.	HIGH
2.2.15	Clients and families are provided with information about their rights and responsibilities.	HIGH

Criteria Number	Criteria Text	Criteria Type
2.3.7	Preventing Venous Thromboembolism 2.3.7.5 The team participates in continuous learning activities about the program to prevent venous thromboembolism.	ROP
2.3.8	Maintaining an Accurate List of Medications during Care Transitions 2.3.8.4 The team participates in continuous learning activities about the medication reconciliation procedure to maintain an accurate list of medications during care transitions. 2.3.8.5 The team participates in activities to improve the medication reconciliation procedure to maintain an accurate list of medications during care transitions as part of the organization's integrated quality improvement plan.	ROP
2.4.11	Information Transfer at Care Transitions 2.4.11.5 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
2.5.2	Operating/procedure rooms contain readily-accessible suction equipment and back-up suction equipment.	NORMAL

Reprocessing of Reusable Medical Devices

Standard Rating: 97.5% Met Criteria

2.5% of criteria were unmet. For further details please review the table at the end of this section.

Assessment Results

Wainwright Health Centre provides medical device reprocessing services primarily in support of endoscopy and low-acuity procedural services. Reprocessing activities are carried out in an environment where staff work closely with the perioperative and obstetrics teams to support timely patient care and maintain continuity of services. Staff demonstrated commitment to infection prevention and control practices and working collaboratively to manage workflow demands associated with a shared procedural environment. Staff appeared knowledgeable regarding the handling, cleaning, and movement of equipment and demonstrated awareness of the importance of reprocessing in supporting safe patient care. The surveyor also observed staff making the best of working within a space-constrained environment, including navigating a less-than-ideal pathway to the reprocessing area and adapting workflow processes to accommodate fixed layout limitations within the reprocessing suite.

Despite these environmental challenges, staff appeared committed to maintaining safe and efficient operations.

At the time of the survey visit, one staff member had been in the role for approximately one week. The surveyor observed effective mentoring and support of the novice staff member by an experienced team member. Interactions between staff reflected a positive learning environment, with staff providing guidance, answering questions, and reinforcing processes in a respectful and supportive manner. The collaborative approach observed appeared to contribute positively to staff development, team functioning, and continuity of safe reprocessing practices within the site.

Air exchange rates in the reprocessing area are slightly below the recommended level (measured at 19 exchanges per hour versus the recommended 20). Air exchange in the initial decontamination area also appears limited and should be formally assessed. The air handling system is reportedly scheduled for upgrade in the coming months.

Staff prefer to have paper copies of policies and standard operating procedures available on both the dirty and clean sides of the reprocessing area. While these binders are actively used, some documents were found to be outdated. The team is encouraged to implement a process to ensure that all paper-based policies and procedures are regularly reviewed and kept current.

Table 12: Unmet Criteria for Reprocessing of Reusable Medical Devices

Criteria Number	Criteria Text	Criteria Type
1.3.1	The layout of the Medical Device Reprocessing (MDR) department is designed based on service volumes, range of reprocessing services, and one way flow of medical devices.	NORMAL

Criteria Number	Criteria Text	Criteria Type
1.3.2	The Medical Device Reprocessing (MDR) department is designed to prevent cross-contamination of medical devices, isolate incompatible activities, and clearly separate work areas.	HIGH
1.3.5	Appropriate environmental conditions are maintained within the Medical Device Reprocessing (MDR) department and storage areas.	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 and Disaster	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
Emergency Department	2.4.8 Seclusion rooms and/or private and secure areas are available for clients.	June 8, 2027
	2.5.5.1 The team follows the organization's procedures for providing a safe physical environment to prevent falls and reduce injuries from falls.	June 8, 2027
	2.5.5.2 The team follows the organization's procedure to conduct screening for risk of falls and injuries from falls.	June 8, 2027
	2.5.5.3 The team follows the organization's procedure to ensure a comprehensive assessment is conducted for a client who screens positive for risk of falls or injuries from falls.	June 8, 2027
Infection Prevention and Control	2.6.4 There are policies and procedures for cleaning and disinfecting the physical environment and documenting this information.	June 8, 2027
Medication Management	1.2.5.5 The organizational leaders ensure the organization's medication management quality improvement plan includes activities to improve safety practices related to the availability of and access to high-concentration and high-total-dose opioid formulations.	June 8, 2027
	1.2.6.5 The program is evaluated on an ongoing basis and results are shared with stakeholders in the organization.	June 8, 2027

Follow-up Requirements		
Standard	**Criterion**	**Due Date**
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
	5.1.3 The organization has implemented comprehensive procedures for the safe use of medications stored in automated dispensing cabinets (ADCs).	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
Obstetrics Services	1.2.14 Clients and families are provided with information about their rights and responsibilities.	June 8, 2027
	1.2.16 Clients and families are provided with information about how to file a complaint or report violations of their rights.	June 8, 2027
	1.3.5.2 The team follows the organization's procedure to conduct screening for risk of falls and injuries from falls.	June 8, 2027
	1.3.5.3 The team follows the organization's procedure to ensure a comprehensive assessment is conducted for a client who screens positive for risk of falls or injuries from falls.	June 8, 2027
	1.3.5.7 The team participates in activities to improve the program to prevent falls and reduce injuries from falls as part of the organization's integrated quality improvement plan.	June 8, 2027
	1.3.7.3 The team implements interventions to prevent venous thromboembolism as part of the client's individualized care plan.	June 8, 2027
	1.3.7.5 The team participates in continuous learning activities about the program to prevent venous thromboembolism.	June 8, 2027
	1.4.2.1 At least two person-specific identifiers are used to confirm that clients receive the service or procedure intended for them, in partnership with clients and families.	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

Follow-up Requirements		
Standard	**Criterion**	**Due Date**
Perioperative Services and Invasive Procedures	1.1.7 Rooms where surgical and invasive procedures are performed have at least 20 complete air exchanges per hour.	June 8, 2027
	1.1.10 There is a regular and comprehensive cleaning schedule for the operating/procedure room and supporting areas posted in a place that is accessible to all team members.	June 8, 2027
	1.2.3 Surgical equipment or medical devices returned to the operating/procedure room following repair or replacement are clearly marked with the date of their return/arrival and a signed notice describing the maintenance or purchase.	June 8, 2027
	1.2.9 Contaminated items are transported separately from clean or sterilized items, and away from client service and high-traffic areas.	June 8, 2027
	2.3.7.5 The team participates in continuous learning activities about the program to prevent venous thromboembolism.	June 8, 2027
	2.3.8.4 The team participates in continuous learning activities about the medication reconciliation procedure to maintain an accurate list of medications during care transitions.	June 8, 2027
	2.3.8.5 The team participates in activities to improve the medication reconciliation procedure to maintain an accurate list of medications during care transitions as part of the organization's integrated quality improvement plan.	June 8, 2027
	2.4.11.5 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
Reprocessing of Reusable Medical Devices	1.3.2 The Medical Device Reprocessing (MDR) department is designed to prevent cross-contamination of medical devices, isolate incompatible activities, and clearly separate work areas.	June 8, 2027
	1.3.5 Appropriate environmental conditions are maintained within the Medical Device Reprocessing (MDR) department and storage areas.	June 8, 2027