Accreditation Report

Qmentum Global™ for Canadian Accreditation Program

Cold Lake Healthcare Centre
Alberta Health Services

Report Issued: June 11, 2025

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 April 28 to May 2, 2025. 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. 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 Accreditation Cycle

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 is being divided into four distinct health agencies. Once the change 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: Recovery Alberta, Acute Care Alberta and Primary Care Alberta. Recovery Alberta, established in 2024 as the first of Alberta's new provincial health agencies, is responsible for providing comprehensive and accessible recovery-oriented mental health and addiction services and correctional health services across the province. Acute Care Alberta is the new provincial health agency, established in 2025, that oversees the governance and coordination of acute care services (including AHS), emergency medical services and cancer services across Alberta. Primary Care Alberta is the provincial health agency, established in 2025, responsible for primary care, including public health, across the province to support day-to-day health needs through every stage of life.

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 standard along with the foundational standards. This integrated assessment approach provides a more 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

Genuine optimism and pride in work was observed amongst staff, physicians and leaders at the Cold Lake Healthcare Centre. They demonstrated curiosity about process improvement and a thirst for feedback.

Several new leaders at the site need support to grow and thrive. Consideration should be given to a mentorship program for leaders (physician and non-physician) within the zone. It was identified by all leaders that they did not feel fully prepared to assume leadership roles and that they would benefit from more training and preparation.

Recent changes to the physician leadership structure within the north zone has occurred. Physician leadership is essential to achieve excellence in patient care provision. However, intentionality and investment are necessary to ensure that physicians are equipped to lead administratively. There must be clarity for both the physician leader and their administrative partners regarding roles and responsibilities, which was noted to be lacking by administrative and physician leaders alike.

While the dyad model of leadership is firmly established at the higher levels of leadership within AHS, it is less ingrained the closer the leader is to the point of care. Education and learning about the dyad model of leadership in health care should be provided and made available to all leaders within the system. A resource could be created to ensure consistent application of the model and consistent understanding as leaders establish working relationships. This could be similar in concept to the Connect Care resources on specific concepts that were created for staff.

Key Opportunities and Areas of Excellence

Areas of Excellence:

- Transition Unit for alternate level of care (ALC) patients
- Hospitalist Model for Inpatient Care
- Trauma Room Quality Improvement Initiative
- Brand new MDR department

Key Opportunities:

- Implementation of regular unit huddles and optimization of quality boards
- Multidisciplinary team-based rounding for inpatients
    - VTE prophylaxis
    - Medication reconciliation
    - Opportunity to co-design with patients/families
- Physician human resource planning with increased physician accountability
    - Role coverage expectations and clarity
    - After-hours primary care provision
- Innovate to cross-train nursing staff across units to increase capacity
- Establishing a local learning culture
    - Infusion pump competency
    - Required courses for nursing and physicians (e.g., Advanced Cardiac Life Support [ACLS], Pediatric Advanced Life Support [PALS], Advanced Trauma Life Support [ATLS])

People-Centred Care

Including patients and their families in service design has occurred at the provincial and zonal levels, but it is not as ingrained locally. There is an opportunity to engage local patients and family partners who reflect the community of patients served at the Cold Lake Healthcare Centre. It is encouraged that local partners participate in quality improvement (QI) initiatives to co-design services alongside frontline staff and physicians. QI project ideas that would benefit from including patient and family partners on the design team were discussed with care teams and local leaders.

The contact information for patient relations and the process to provide compliments and complaints could be made more visible within the emergency department waiting room. The Shared Commitments between staff and patients/families outline the respective commitments to each other.

In the inpatient services there is opportunity to consistently and clearly articulate the goals of care for all patients. There is an increased effort to normalize conversations around end-of-life care amongst patients and families and that is a positive development that will help inform the efforts to partner with patients and families on defining the goals and expected results for care.

Accreditation Decision

Alberta Health Services' accreditation decision continues to be:

Accredited

The organization has succeeded in meeting the fundamental requirements of the accreditation program.

Required Organizational Practices

Required Organizational Practices (ROPs) 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
Antimicrobial Stewardship	Medication Management	0 / 5	0.0%
Client Identification	Emergency Department	1 / 1	100.0%
	Inpatient Services	1 / 1	100.0%
	Long-Term Care Services	1 / 1	100.0%
	Obstetrics Services	1 / 1	100.0%
	Perioperative Services and Invasive Procedures	1 / 1	100.0%
Concentrated Electrolytes	Medication Management	3 / 3	100.0%
Fall Prevention and Injury Reduction – Long-Term Care Services	Long-Term Care Services	6 / 6	100.0%
Falls Prevention and Injury Reduction - Inpatient Services	Inpatient Services	3 / 3	100.0%
	Obstetrics Services	3 / 3	100.0%
	Perioperative Services and Invasive Procedures	3 / 3	100.0%
Hand-hygiene Compliance	Infection Prevention and Control	3 / 3	100.0%
Hand-hygiene Education and Training	Infection Prevention and Control	1 / 1	100.0%

ROP Name	Standard(s)	# TFC Rating Met	% TFC Met
Heparin Safety	Medication Management	4 / 4	100.0%
High-alert Medications	Medication Management	8 / 8	100.0%
Infection Rates	Infection Prevention and Control	2 / 3	66.7%
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	5 / 5	100.0%
Infusion Pump Safety	Service Excellence	4 / 6	66.7%
Medication Reconciliation at Care Transitions - Emergency Department	Emergency Department	1 / 1	100.0%
Medication Reconciliation at Care Transitions – Long-Term Care Services	Long-Term Care Services	4 / 4	100.0%
Medication Reconciliation at Care Transitions Acute Care Services (Inpatient)	Inpatient Services	2 / 4	50.0%
	Obstetrics Services	4 / 4	100.0%
	Perioperative Services and Invasive Procedures	4 / 4	100.0%
Narcotics Safety	Medication Management	3 / 3	100.0%

ROP Name	Standard(s)	# TFC Rating Met	% TFC Met
Pressure Ulcer Prevention	Inpatient Services	5 / 5	100.0%
	Long-Term Care Services	5 / 5	100.0%
	Perioperative Services and Invasive Procedures	5 / 5	100.0%
Safe Surgery Checklist	Obstetrics Services	5 / 5	100.0%
	Perioperative Services and Invasive Procedures	5 / 5	100.0%
Skin and Wound Care	Long-Term Care Services	8 / 8	100.0%
Suicide Prevention	Emergency Department	5 / 5	100.0%
	Long-Term Care Services	5 / 5	100.0%
The 'Do Not Use' List of Abbreviations	Medication Management	7 / 7	100.0%
Venous Thromboembolism (VTE) Prophylaxis	Inpatient Services	3 / 4	75.0%
	Perioperative Services and Invasive Procedures	5 / 5	100.0%

Assessment Results by Standard

The following section includes the outcomes from the attestation 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: 78.6% Met Criteria

21.4% of criteria were unmet. For further details please review the table at the end of this section. .

Assessment Results

Emergency and disaster management (E/DM) is a division within Provincial Population and Public Health. The north zone team responds to floods, fires, telecommunication failures, evacuations and other emergency situations in Cold Lake and the surrounding area. Cold Lake Healthcare Centre has not experienced any disasters in the past few years.

Emergency codes are tested monthly, run by peace officers with assistance from housekeeping. "Be Ready" is the common theme used by the E/DM team. Action plans for each code are routinely updated and documented. The zone lead for E/DM is involved, and policies and procedures are online and current, but binders in the departments are outdated. It is recommended that all binders be updated with the current policies and procedures.

The hospital is well integrated with its community partners including other hospitals in the north zone, fire, and police. With regards to evaluations of mock codes, not all staff stated the results have been shared within the site. Action plans from lessons learned should be shared with all the teams.

Table 2: Unmet Criteria for Emergency and Disaster Management

Criteria Number	Criteria Text	Criteria Type
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

Criteria Number	Criteria Text	Criteria Type
3.4.8	The organization establishes, regularly reviews, and updates as needed policies and procedures to communicate patient and client information in a manner that is safe and facilitates care during an emergency or disaster.	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: 95.0% Met Criteria

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

Assessment Results

The infection prevention and control (IPC) team at Cold Lake Healthcare Centre is commended for their strong commitment to a high-quality IPC program. The staff at Cold Lake Healthcare Centre are dedicated to improving the health and quality of life of the people of Cold Lake and reducing the risk of associated infections. They work closely with the IPC nurse, who is off-site but available as required and visits quarterly. Recently, a complete IPC audit was conducted at this site, and recommendations were made and shared with the appropriate groups for follow-up.

Cold Lake Healthcare Centre is clean and free from floor clutter. Environmental services take pride in their work, following cleaning schedules and completing monthly audits. IPC works closely with environmental services, and laundry is sent off-site.

The teams are committed to the goals of IPC and support each other. Although there is no formal committee for IPC at the local level, it is recommended to set up monthly meetings with the appropriate team members to focus on quality improvement (QI) initiatives. Priorities should be identified, and the team should work collaboratively to ensure safe, quality care for patients, families, communities, and each other.

Outbreaks are managed and tracked, including health associated infections (HAI). However, HAI information has not been shared throughout the site, and it is recommended to include this information on the quality board for discussion during rounding.

Hand-hygiene is practiced by staff at the appropriate moments of contact. Monthly hand-hygiene audits are conducted and shared with staff, patients, and families.

Table 3: Unmet Criteria for Infection Prevention and Control

Criteria Number	Criteria Text	Criteria Type
3.1.2	Infection Rates 3.1.2.3 Information about relevant health care-associated infections and recommendations from outbreak reviews are shared with team members, senior leadership, and the governing body.	ROP
3.3.5	Results of evaluations are shared with team members, volunteers, clients, and families.	NORMAL

Leadership

Standard Rating: 100.0% Met Criteria

0.0% of criteria were unmet.

Assessment Results

The physical environment was clean, uncluttered and kept safe for the patients, family, visitors and staff. During construction, Canadian Standards Association standards are followed closely to keep all people safe.

Staff ensure patients and families are aware of their rights and responsibilities. There are complaint boxes throughout the site by the elevators. Patients and families are encouraged to fill out the complaint form if they have any concerns. The complaints are logged and are addressed in a timely manner with areas for improvement addressed quickly.

All equipment in the medical device reprocessing department are under contract with Steris, which includes repairs and preventive maintenance. The department was recently remodeled, and the equipment is only a few years old.

Table 4: Unmet Criteria for Leadership

There are no unmet criteria for this section.

Medication Management

Standard Rating: 91.4% Met Criteria

8.6% of criteria were unmet. For further details please review the table at the end of this section.

Assessment Results

The pharmacy department at Cold Lake Healthcare Centre consists of one pharmacist, two technicians, and one aide. The site is very busy, with the pharmacy open Monday to Friday during daytime hours. After hours, staff need to obtain medications from the night cupboard if required. There is always a pharmacist on call after hours, although they are often in areas not close to Cold Lake. A second part-time pharmacist would be beneficial at the site with staggered hours, as this would reduce the risk of medication errors and ensure medication reconciliation is completed for patients.

A robust medication reconciliation program is in place, typically completed on admission or within 24 hours, but often missed on weekends or after hours due to workload. It is a shared responsibility between pharmacy and nursing to ensure this is completed, although nursing staff often miss it due to their workload. Monthly audits are conducted to identify gaps.

Antimicrobial stewardship is in the early phases of development, with a committee formed to oversee the program. The site is encouraged to continue growing this program to ensure its success.

The pharmacist attends the Provincial Drugs and Therapeutics committee and Resident Council care conferences (LTC) monthly, and any other requested meetings.

There are no compound drugs or chemotherapy drugs given at this site, so there is no need for a hood or negative pressure room.

It was noted that in the emergency department, narcotics are not placed under a double lock system. It is recommended to review this process to ensure the safety of patients and their families. The medication area in the emergency department is small and compact, and staff have voiced difficulties in working with such limited counter space and a small narcotic cupboard.

Table 5: Unmet Criteria for Medication Management

Criteria Number	Criteria Text	Criteria Type
1.2.3	Antimicrobial Stewardship 1.2.3.1 An antimicrobial stewardship program has been implemented. 1.2.3.2 The program specifies who is accountable for implementing the program. 1.2.3.3 The program is interdisciplinary, involving pharmacists, infectious diseases physicians, infection control specialists, physicians, microbiology staff, nursing staff, hospital administrators, and information system specialists, as available and appropriate. 1.2.3.4 The program includes interventions to optimize antimicrobial use, such as audit and feedback, a formulary of targeted antimicrobials and approved indications, education, antimicrobial order forms, guidelines and clinical pathways for antimicrobial utilization, strategies for streamlining or de-escalation of therapy, dose optimization, and parenteral to oral conversion of antimicrobials (where appropriate). 1.2.3.5 The program is evaluated on an ongoing basis and results are shared with stakeholders in the organization.	ROP
5.1.1	Access to medication storage areas is limited to authorized team members.	HIGH
5.1.2	Medication storage areas are clean and organized.	HIGH
5.1.6	Medication storage areas meet legislated requirements and regulations for controlled substances.	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
7.1.1	The pharmacist reviews each medication order prior to the first dose being administered.	HIGH

Service Excellence

Standard Rating: 93.7% Met Criteria

6.3% of criteria were unmet. For further details please review the table at the end of this section.

Assessment Results

It is evident that staff at Cold Lake Healthcare Centre strive to achieve clinical excellence and are proud of the care they provide to patients, working in service to their community. Several leaders are new to their roles and are eager to improve the workplace and care provision. However, competing priorities for these new leaders have meant that staff members have not had recent performance reviews/ development conversations. For teams to be successful, they must be supported, mentored, and provided growth opportunities.

There is an opportunity to grow and foster a local learning culture. There was inconsistency in competency with using smart pumps and in the completion of courses that should be mandatory for working in specific units. Ensuring competencies are demonstrated on a consistent timeframe, mandating specific courses for nurses and physicians (such as ACLS, ATLS, PALS, etc.), and then holding them accountable to complete the courses is a necessary starting point to build a culture that embraces and promotes learning within the organization. One way to ensure competencies are verified may be to hold regular skills days and staff education sessions. Building capacity among staff to provide courses such as ACLS and PALS locally, where feasible, is encouraged.

It is also encouraged that a comprehensive physician human resource plan be established for Cold Lake Healthcare Centre that accounts for the multiple roles fulfilled by physicians practicing in the community. The population's needs should be considered when recruiting physicians with particular skill sets and expertise. Physician human resource planning must consider that physicians cannot simultaneously be on call for multiple services and that the safe provision of obstetrical services requires that four physicians be available for emergency caesarean sections: surgeon, surgical assist, anesthetist, and infant attendant. As the physician group expands, serious consideration should be given to expanding primary care access within the community by providing advanced access clinic bookings, evening booked clinics, and evening walk-in availability to ensure the community has access to primary care, which will reduce the burden on the emergency department. There is also an opportunity to recruit and onboard local patient and family partners from the community who can actively engage in co-designing services.

AHS is encouraged to invest in leadership professional development opportunities to set up their leaders for success. There is an opportunity to better support all leaders, including physician leaders, to feel confident and competent when leading their people, giving special attention to formally educate those leading in a dyad relationship on how to be successful as a high-performing dyad.

Table 6: Unmet Criteria for Service Excellence

Criteria Number	Criteria Text	Criteria Type
2.1.7	Infusion Pump Safety 2.1.7.4 The competence of team members to use infusion pumps safely is evaluated and documented at least every two years. When infusion pumps are used very infrequently, a just-in-time evaluation of competence is performed. 2.1.7.5 The effectiveness of the approach is evaluated. Evaluation mechanisms may include: • Investigating patient safety incidents related to infusion pump use • Reviewing data from smart pumps • Monitoring evaluations of competence • Seeking feedback from clients, families, and team members	ROP
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
4.3.10	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

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: 98.2% Met Criteria

1.8% of criteria were unmet. For further details please review the table at the end of this section.

Assessment Results

The emergency department (ED) at Cold Lake Healthcare Centre is staffed by a high-functioning team of highly skilled nurses and physicians who take pride in their work and support each other. They are dedicated to providing excellent patient care for the community they serve. Patients report being treated with kindness and respect, and they trust their care providers.

An exciting quality improvement initiative has recently been launched, involving a core team of nurses from the ED to reorganize and optimize supplies and equipment within the trauma room. This initiative is driven by engaged frontline staff and supported by the north zone quality improvement (QI) staff. It has great potential to serve as a model for other rural hospitals to prepare their sites for high-acuity low-occurrence events.

There is an opportunity to expand the number of QI activities in the ED, as an engaged group of nurses genuinely desire to improve the department. Once they have gained experience through the trauma room project, they will have greater knowledge and confidence to initiate further projects, which should be supported. Ideally, these projects should include physicians and patient/family partners as team members, offering an opportunity for physician engagement, team building, and co-design with patients and families.

Optimizing the flow of patients within the department to better utilize assessment spaces and reduce wait times is another opportunity. A Kaizen philosophy using Lean and Six Sigma methodologies could provide structure and rigor to this work. Again, this work should involve nursing, physicians, and local patient/family partners.

The quality boards in the department are not currently utilized. Local leadership is encouraged to implement regular huddles involving all team members to discuss issues that matter to those in the department. This forum should raise issues and concerns, identify opportunities for improvement, share performance data, and provide quick organizational updates. ED data collected in terms of time to physician initial assessment, low acuity non-admit length of stay, high acuity non-admit length of stay, admitted patient length of stay, and time to inpatient bed following the decision to accept the patient should be the basis for understanding ED flow performance. The team must first understand their performance to see improvements.

The ED sees a high level of acuity, yet due to the lower volume of overall presentations inherent to rural sites, nurses and physicians may sometimes go long periods without managing very acute patients. Acute Cardiac Life Support (ACLS) and Pediatric Acute Life Support (PALS) courses should be mandatory for nurses and physicians in the ED.

Table 7: Unmet Criteria for Emergency Department

Criteria Number	Criteria Text	Criteria Type
2.4.8	Seclusion rooms and/or private and secure areas are available for clients.	HIGH
2.5.6	Universal fall precautions, applicable to the setting, are identified and implemented to ensure a safe environment that prevents falls and reduces the risk of injuries from falling.	HIGH

Inpatient Services

Standard Rating: 92.3% Met Criteria

7.7% of criteria were unmet. For further details please review the table at the end of this section.

Assessment Results

There is excitement among nurses and physicians about the upcoming launch of a hospitalist model of inpatient care in June 2025 at the Cold Lake Healthcare Centre. In this model, each physician will be responsible for inpatient care for all patients admitted for a period of one week in rotation. This model holds promise for improved patient care for several reasons, including decreasing variation in practice, improving physician availability, facilitating team-based interdisciplinary care, and enabling predictable discharge planning.

Currently, variation in physician rounding practices has resulted in some physicians rounding at unpredictable hours of the day and, oftentimes, not at all. Patients report being unaware of when or if they will see their physician and feeling in the dark about the plan for their care. Nursing and allied health professionals are challenged to formulate discharge and care plans, resulting in prolonged lengths of stay.

Venous thromboembolism (VTE) prophylaxis is not consistently ordered by physicians for eligible patients. Audits show that this occurs roughly half the time. This is likely a product of inconsistent practice and a siloed approach to care. Similarly, medication reconciliation is not consistently completed for inpatients within 24 hours of admission. Goals of care discussions often do not occur.

Implementing a hospitalist model must be viewed as an enabler for an improved way to deliver inpatient care and not the end game. It will allow for the implementation of structured interdisciplinary bedside rounding (SIBR). Through this structured model, patient-centered care is paramount, and standardized ordering of best practice inpatient care protocols, such as VTE prophylaxis, can be easily facilitated.

There is an opportunity to engage patients and families in co-design at the local level. The implementation of SIBR rounds could serve as an excellent opportunity to partner with patients and their families to co-design this process. With the support of QI specialists, physicians, nurses, allied health professionals, and patient/family partners, a model can be designed that works for all parties involved in care provision.

The quality boards in the department are not utilized. Local leadership should implement regular huddles around the quality boards, involving all team members, to discuss issues that matter to those on the unit. This forum should raise issues and concerns, identify opportunities for improvement, share performance data, and provide quick organizational updates. Data around quality indicators should be visible so that they are known to staff, physicians, and patients.

Table 8: Unmet Criteria for Inpatient Services

Criteria Number	Criteria Text	Criteria Type
1.1.1	Services are co-designed to meet the needs of an aging population, where applicable.	NORMAL
1.1.2	Services are co-designed to effectively serve pediatric and youth populations, where applicable.	NORMAL
3.3.5	Goals and expected results of the client's care and services are identified in partnership with the client and family.	NORMAL
3.3.7	Medication Reconciliation at Care Transitions Acute Care Services (Inpatient) 3.3.7.1 Upon or prior to admission, a Best Possible Medication History (BPMH) is generated and documented in partnership with clients, families, caregivers, and others, as appropriate. 3.3.7.2 The BPMH is used to generate admission medication orders or the BPMH is compared with current medication orders and any medication discrepancies are identified, resolved, and documented.	ROP
3.3.10	Venous Thromboembolism (VTE) Prophylaxis 3.3.10.2 Clients at risk for VTE are identified and provided with appropriate, evidence-informed VTE prophylaxis.	ROP
3.3.16	A comprehensive and individualized care plan is developed and documented in partnership with the client and family.	HIGH

Long-Term Care Services

Standard Rating: 100.0% Met Criteria

0.0% of criteria were unmet.

Assessment Results

The long-term care services are housed within a dedicated 31-bed facility attached to the Cold Lake Healthcare Centre. The environment is consistently maintained to high standards — clean, well-organized, and free of clutter — promoting both safety and comfort for residents.

The care team comprises health care aides (HCAs), licensed practical nurses (LPNs), and registered nurses (RNs). While staffing challenges have been a recurring issue — particularly in securing HCA replacements — recent recruitment of international healthcare professionals has significantly improved staffing stability and continuity of care.

Ongoing professional development is a cornerstone of the care model. Staff receive continuous training in key areas such as wound care, behavioral management, international nursing practices, safe mobility techniques, minimal restraint protocols, suicide risk assessment, and other essential competencies. This commitment to education ensures that the team remains equipped to meet the evolving needs of residents.

Strong, respectful relationships between staff, residents, and families are a defining feature of the home. Upon admission, families and residents are introduced to Shared Commitments, which outlines mutual expectations and is revisited as needed to reinforce trust and transparency.

Resident engagement is actively encouraged through structured forums. Annual Resident Council meetings provide an opportunity for residents and families to voice feedback and collaborate with the care team. Additionally, monthly care conferences ensure that each resident’s care plan is regularly reviewed and tailored to their individual needs.

Overall, the facility offers a warm, inclusive, and supportive environment where residents and their families feel welcomed and valued.

Table 9: Unmet Criteria for Long-Term Care Services

There are no unmet criteria for this section.

Obstetrics Services

Standard Rating: 99.0% Met Criteria

1.0% of criteria were unmet. For further details please review the table at the end of this section.

Assessment Results

Obstetrical care at the Cold Lake Healthcare Centre is delivered by a dedicated and highly skilled team of physicians and nurses. Despite its small size, the team demonstrates exceptional commitment and resilience, consistently striving to provide high-quality, evidence-based care. Their efforts are supported by the moreOB program, which reinforces best practices in obstetrics and fosters a culture of continuous improvement and patient safety.

While patient volumes in the obstetrical unit are generally low and unpredictable, the workload can become demanding—particularly for the single nurse often assigned to the unit. To enhance responsiveness and reduce strain during peak periods, it would be advantageous to orient and cross-train additional nursing staff to support the unit as needed. Furthermore, offering Neonatal Resuscitation Program (NRP) certification to operating room nurses would strengthen the team's capacity to manage neonatal emergencies effectively.

A safety concern was identified regarding the medication carts used for epidural administration and postpartum hemorrhage management. Although these carts are appropriately stocked with necessary medications and equipment, they are currently unsecured. In alignment with best practices and medication safety standards, these carts should be locked to prevent unauthorized access and ensure compliance with regulatory guidelines.

Table 10: Unmet Criteria for Obstetrics Services

Criteria Number	Criteria Text	Criteria Type
1.1.1	Clients and families can access essential services 24 hours a day, seven days a week.	NORMAL

Palliative Care Services

Standard Rating: 100.0% Met Criteria

0.0% of criteria were unmet.

Assessment Results

There is a strong commitment to improving palliative care services within Cold Lake Healthcare Centre. The palliative care program, supported by AHS, is based in the community but integrated into the acute care services.

The north zone recently received a substantial grant from Healthcare Excellence Canada to partner with the Cold Lake First Nation to improve palliative care services. This initiative holds great promise for enhancing palliative care services for those involved and is an excellent example of partnership and collaboration.

Within the inpatient unit, two beds are allocated for palliative services. There is a commitment to improving the physical space and the understanding and awareness of palliative care best practices to ensure excellent end-of-life care is provided locally.

Table 11: Unmet Criteria for Palliative Care Services

There are no unmet criteria for this section.

Perioperative Services and Invasive Procedures

Standard Rating: 99.4% Met Criteria

0.6% of criteria were unmet. For further details please review the table at the end of this section.

Assessment Results

Cold Lake Healthcare Centre has two operating rooms and one endoscopy suite. Each room is checked daily for humidity and temperature.

The team operates one to two rooms per day. The booking clerk tracks surgical, and endoscopy wait times, which are within the normal timeframe for some cases and over for others. Emergency cases are prioritized based on urgency.

Medication reconciliation is performed upon admission and transferred if the patient is admitted. The risk of venous thromboembolism (VTE) is assessed pre-surgery to determine if mechanical or chemical VTE prophylaxis is required.

A surgical safety checklist, consisting of three steps, is completed for every patient to confirm that all safety steps are followed for each surgical procedure. Monthly audits are conducted to ensure compliance.

Only a few staff members are certified in the operating room (OR) course. Some staff are trained on the spot, grandfathered in, or given a crash course of one week plus one day of clinical training. It is recommended that all staff obtain the OR course through an approved AHS OR program.

In the post anesthesia care unit (PACU), the team recovering patients from general anesthesia, with or without intubation, has not been certified to work in this area. There is an opportunity for all RNs working in this area to take the PACU course, ACLS, or PALS certification. This OR operates on both children and adults. The site is encouraged to review staffing complement to support safety.

Table 12: Unmet Criteria for Perioperative Services and Invasive Procedures

Criteria Number	Criteria Text	Criteria Type
1.2.14	The education, certification, and competency of team members involved in reprocessing in the operating/procedure room are verified.	HIGH

Reprocessing of Reusable Medical Devices

Standard Rating: 99.0% Met Criteria

1.0% of criteria were unmet. For further details please review the table at the end of this section.

Assessment Results

The team in the medical device reprocessing department (MDRD) should celebrate their successes; renovated department, new equipment and dedicated staff who embrace best practices and standards. The staff are all certified in their training.

This team has a strong work ethic, loyalty and an understanding of excellent patient care. Leadership has been supportive, and staff have been kept up to date on new processes/equipment that have been brought into the operating room. There are currently two full-time staff that rotate on call; a third staff would be recommended to relieve the team lead to do her quality assurance work, ordering and other such duties.

Standard operating procedures are current and up to date. The technician worked hard on updating pick lists, instrument sets, picture books and organizing each service with manufacturer's instructions for reprocessing, cleaning and sterilization. The team may benefit from an instrument management system to track instruments to patients.

Endoscopy procedures are done in the perioperative area and reprocessed in the MDRD. Although the staff are certified in the MDRD, yearly re-certification should be done/signed for staff working with endoscopes.

The site has a contract with Steris for preventive maintenance and other equipment issues. A log is kept with dates and concerns.

Table 13: Unmet Criteria for Reprocessing of Reusable Medical Devices

Criteria Number	Criteria Text	Criteria Type
1.2.1	Resource requirements and gaps are identified and communicated to the organization's leaders.	NORMAL

Criteria for Follow-up

Criteria identified for follow-up by the Accreditation Decision Committee

Follow-up Requirements		
Standard	**Criterion**	**Due Date**
Emergency and Disaster Management	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 2, 2026
Emergency and Disaster Management	3.4.8 — The organization establishes, regularly reviews, and updates as needed policies and procedures to communicate patient and client information in a manner that is safe and facilitates care during an emergency or disaster.	June 2, 2026
Emergency Department	2.4.8 — Seclusion rooms and/or private and secure areas are available for clients.	June 2, 2026
Infection Prevention and Control	3.1.2.3 — Information about relevant health care-associated infections and recommendations from outbreak reviews are shared with team members, senior leadership, and the governing body.	June 2, 2026
Inpatient Services	3.3.7.1 — Upon or prior to admission, a Best Possible Medication History (BPMH) is generated and documented in partnership with clients, families, caregivers, and others, as appropriate.	June 2, 2026
Inpatient Services	3.3.7.2 — The BPMH is used to generate admission medication orders or the BPMH is compared with current medication orders and any medication discrepancies are identified, resolved, and documented.	June 2, 2026
Inpatient Services	3.3.10.2 — Clients at risk for VTE are identified and provided with appropriate, evidence-informed VTE prophylaxis.	June 2, 2026
Medication Management	1.2.3.1 — An antimicrobial stewardship program has been implemented.	June 2, 2026
Medication Management	1.2.3.2 — The program specifies who is accountable for implementing the program.	June 2, 2026
Medication Management	1.2.3.3 — The program is interdisciplinary, involving pharmacists, infectious diseases physicians, infection control specialists, physicians, microbiology staff, nursing staff, hospital administrators, and information system specialists, as available and appropriate.	June 2, 2026

Standard	Criterion	Due Date
Medication Management	1.2.3.4 — The program includes interventions to optimize antimicrobial use, such as audit and feedback, a formulary of targeted antimicrobials and approved indications, education, antimicrobial order forms, guidelines and clinical pathways for antimicrobial utilization, strategies for streamlining or de-escalation of therapy, dose optimization, and parenteral to oral conversion of antimicrobials (where appropriate).	June 2, 2026
Medication Management	1.2.3.5 — The program is evaluated on an ongoing basis and results are shared with stakeholders in the organization.	June 2, 2026
Medication Management	5.1.1 — Access to medication storage areas is limited to authorized team members.	June 2, 2026
Medication Management	5.1.2 — Medication storage areas are clean and organized.	June 2, 2026
Medication Management	5.1.6 — Medication storage areas meet legislated requirements and regulations for controlled substances.	June 2, 2026
Medication Management	6.1.5 — There is a policy for acceptable medication orders, with criteria being developed or revised, implemented, and regularly evaluated, and the policy is revised as necessary.	June 2, 2026
Perioperative Services and Invasive Procedures	1.2.14 — The education, certification, and competency of team members involved in reprocessing in the operating/procedure room are verified.	June 2, 2026
Service Excellence	2.1.7.4 — The competence of team members to use infusion pumps safely is evaluated and documented at least every two years. When infusion pumps are used very infrequently, a just-in-time evaluation of competence is performed.	June 2, 2026
Service Excellence	2.1.7.5 — The effectiveness of the approach is evaluated. Evaluation mechanisms may include: • Investigating patient safety incidents related to infusion pump use • Reviewing data from smart pumps • Monitoring evaluations of competence • Seeking feedback from clients, families, and team members	June 2, 2026