Accreditation Report

Qmentum Global™ for Canadian Accreditation Program

Fairview Health Complex
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

Fairview Health Complex is considered to be the hub of the community. Patients and families expressed comfort and confidence in the hospital, where care is accessible, and physicians and staff are present to attend to their care needs.

Physicians and staff acknowledged the strong site, zone and provincial partnerships that enable optimal patient flow. The hospital has established relevant partnerships with community agencies to respond to emergency situations such as wildfires and measles. Key system partners such as public health are co-located on site.

Key Opportunities and Areas of Excellence

Areas of Excellence:

- Dedicated and committed site and unit leaders who have worked to stabilize health human resources, including physicians and nursing. Nursing agency utilization has recently been reduced to zero.
- The site is well maintained and clean, including patient rooms, common areas and support staff areas.
- Patients and families expressed satisfaction with the exemplary care provided by staff and physicians. There is continuity of care for hospitalized patients where family physicians are the most responsible physician.
- There is clear evidence of a team-based approach to care planning and delivery.

Key Opportunities:

- Patient and family engagement and partnerships in care planning and service design could be made more systematic.
- More frequent quality and safety huddles and safety rounding could be scheduled
- Ensure data and audit information (from Tableau) flow to the zones and sites to enable quality improvement (QI) efforts at the local level
- Build capacity of leaders, physicians and staff in QI methodology

People-Centred Care

Patients and families are appreciative of their local hospital and are satisfied with the care they receive from dedicated caring teams.

While there is evidence of patient and family engagement and input at provincial and zone levels, there is a need for engagement at the site level. The site is encouraged to include patients and family members in the co-design of its services and to engage patients and families in QI initiatives at the local level.

Regular information is gathered from team members at safety huddles and team meetings for which the site has plans to create a regular schedule. There is no systematic process to gather input from patients, families and volunteers and this could be a great area to consider developing such a process.

Leadership, patients and the community expressed concerns around the shortage of Emergency Medical Services for safe patient transport.

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	4 / 5	80.0%
Client Identification	Emergency Department	0 / 1	0.0%
	Inpatient Services	1 / 1	100.0%
	Long-Term Care Services	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%
Hand-hygiene Compliance	Infection Prevention and Control	3 / 3	100.0%
Hand-hygiene Education and Training	Infection Prevention and Control	1 / 1	100.0%
Heparin Safety	Medication Management	4 / 4	100.0%
High-alert Medications	Medication Management	8 / 8	100.0%

ROP Name	Standard(s)	# TFC Rating Met	% TFC Met
Infection Rates	Infection Prevention and Control	3 / 3	100.0%
Information Transfer at Care Transitions	Emergency Department	5 / 5	100.0%
	Inpatient Services	5 / 5	100.0%
	Long-Term Care Services	5 / 5	100.0%
Infusion Pump Safety	Service Excellence	6 / 6	100.0%
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	4 / 4	100.0%
Narcotics Safety	Medication Management	3 / 3	100.0%
Pressure Ulcer Prevention	Inpatient Services	5 / 5	100.0%
	Long-Term Care Services	5 / 5	100.0%
Reprocessing	Infection Prevention and Control	2 / 2	100.0%
Skin and Wound Care	Long-Term Care Services	8 / 8	100.0%

ROP Name	Standard(s)	# TFC Rating Met	% TFC Met
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	4 / 4	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

The site has a well-established emergency and disaster preparedness program that follows the AHS program. These protocols have been tested in recent emergencies, including a recent heating, ventilation and air conditioning (HVAC) system issue that was managed without the need to evacuate patients.

Appropriate emergency disaster response plans and procedures are in place and accessible on Insite and in an emergency response manual (yellow binders) in all relevant areas; however, the policies are outdated, with the oldest policy from 2007 and the newest from 2017. Roles and responsibilities of the emergency response team are clearly outlined and tested.

Learnings are documented after each emergency situation and debriefs are conducted. Findings are shared with team members, and lessons are applied to future situations. Actions are taken to close the loop on identified risks, such as staff not being aware of where to evacuate patients during the HVAC incident, leading to a process improvement.

Back-up processes are in place and documented for downtime or failure of the electronic medical record (Connect Care) system. Back-up generators are in place, and fan-out lists are updated and kept in the emergency response manuals.

Code training of staff happens at orientation and on an ongoing basis, although the schedule for the training could be more standardized. Training logs are documented and maintained.

Evacuation procedures are adapted to the situation. The site would benefit from standardizing the procedure for typical situations (e.g., in the case of a fire on a unit, evacuate first to...; second to...). The site follows the AHS policy for evacuating patients to AHS sites only, with no agreements in place with community partners for patient evacuations.

Daily bed huddles and surge protocols are in place, ensuring patients are triaged to the right facility where bed capacity is available.

The site is encouraged to develop a regular schedule for testing emergencies and to establish at least one agreement with a community partner as a backup location for patient evacuations. Policies and procedures need to be updated both online and in the physical binders.

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
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: 98.1% Met Criteria

1.9% of criteria were unmet. For further details please review the table at the end of this section.

Assessment Results

Fairview Health Complex follows AHS policies and procedures for infection control, adapting site practices to address emergent issues such as the measles outbreak in the north zone.

One infection control professional (ICP) provides support to multiple sites, being on site one day a week, and as required, and is present at monthly quality meetings.

There is no central reprocessing/sterilization area on-site. Patient-use equipment (e.g., IV poles) is cleaned by staff on the unit following a posted cleaning procedure in a dedicated room. Green tags are placed on the equipment after cleaning. Sterile equipment (e.g., scissors, scalpels) is washed and placed in cleaning solutions and transfer containers on the unit before being sent to the central cleaning area. The equipment is further cleaned in the central cleaning area by a knowledgeable staff member who is on-site three days a week. The equipment is sent out for sterilization to Grande Prairie Regional Hospital while the Peace River Community Health Centre medical device reprocessing department is being renovated.

Surveillance for healthcare associated infections is conducted on admission and during the patient stay as needed. Infection control protocols are followed based on AHS policies and procedures. Rates are reported from board to bedside, and a concise surveillance report is created and provided to the site quarterly. The report is posted on the quality board and discussed with team members.

Fairview Health Complex and north zone hospitals are commended for their hand-hygiene audit results. At the site, one trained staff member conducts hand-hygiene audits of staff and reports the findings. A second leader is completing their training. Aggregate reports are sent back to the site, shared with team members in quality meetings, and posted on quality boards.

Public health staff are on-site, and community partners are involved in responding to infection control incidents (e.g., COVID-19, measles).

While there is a robust infection prevention and control program, the site can further enhance this program by actively involving patients and families in its refinement. More systematic processes to share feedback from audits, outbreaks, etc., would elevate the program.

Plastic-covered furniture that is cracked or torn should be replaced (e.g., stools in the pharmacy department).

Table 3: Unmet Criteria for Infection Prevention and Control

Criteria Number	Criteria Text	Criteria Type
3.3.3	Input is gathered from team members, volunteers, and clients and families on components of the infection prevention and control program.	NORMAL

Leadership

Standard Rating: 100.0% Met Criteria

0.0% of criteria were unmet.

Assessment Results

Fairview Health Complex has new site leadership in place. The site leader and emergency/unit manager have a good handle on the site and are bringing rigor to safe practices and stability of physicians and staffing. They are to be commended for reducing emergency department closures to zero since their arrival, recruiting five physicians, reducing reliance on locum physicians, and eliminating agency use for registered nurses.

The new leaders have systematically prioritized safety protocols. In a short period of time, they have replaced old medication delivery carts and addressed the after-hours medication management system. They are to be commended for their aspirations to establish regular processes for quality huddles and leader rounding.

There is a formalized process for receiving and following up on complaints at the site level. Patient experience surveys are conducted at discharge, with results aggregated and reported back to the site.

There is a strong approach to emergency preparedness and infection prevention and control. The site is encouraged to build on its strengths and further enhance its approaches by proactively engaging patients and families in the development of programs, policies, and procedures, and by sharing feedback with patients and families in a systematic way.

There are clear processes for capital acquisition and upgrades. However, there are issues with timelines from requests for urgent equipment that breaks down to the time the equipment arrives at the hospital. AHS is encouraged to evaluate its timelines for processing urgent equipment requests from hospitals and care delivery sites.

The physical environment is clean and uncluttered, and the building appears to be well maintained. Some areas are undergoing construction and renovation.

The site is encouraged to follow up on its plans to implement regular quality huddles with patients, families, and staff, and to conduct regular leader rounding with patients and staff.

Table 4: Unmet Criteria for Leadership

There are no unmet criteria for this section.

Medication Management

Standard Rating: 97.4% Met Criteria

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

Assessment Results

AHS is responsible for developing corporate policies and procedures for medication management, overseen by the provincial Medication Quality and Safety Team.

Required organizational practices (ROPs) are embedded into practice, including an up to date “Do Not Use” abbreviation list, narcotic and heparin safety, venous thromboembolism (VTE) prophylaxis, high alert medications, concentrated electrolytes, etc. These ROPs are integrated into the electronic patient record and a patient education pamphlet used for all admitted patients.

Medication errors and near misses are reported regularly and trended, with action plans developed based on the trends.

The pharmacy and medication rooms are secured, well-organized, and well-lit. There are no automatic dispensing units (ADUs) at this site, but new medication cabinets with locking capabilities were recently purchased. The site is encouraged to prioritize the purchase and adoption of ADUs to enhance patient safety and reduce risk.

There is evidence of an antimicrobial stewardship program clinically, although the program is new, and feedback and audit loops have not been implemented yet. The site is encouraged to proceed with its plan to develop feedback and audit loops for this program.

The site can enhance the engagement of patients and families in systematic ways to improve medication management processes. Linkages between central and site-specific activities can be enhanced through policy development and updates.

It is suggested that old documents (CPS books, medication charts) be removed from the medication room.

Table 5: Unmet Criteria for Medication Management

Criteria Number	Criteria Text	Criteria Type
1.2.3	Antimicrobial Stewardship 1.2.3.5 The program is evaluated on an ongoing basis and results are shared with stakeholders in the organization.	ROP

5.1.7	Separate storage in client service areas and in the pharmacy is used for look-alike medications, sound-alike medications, different concentrations of the same medication, and high-alert medications.	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

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

Fairview Health Complex provides a range of healthcare services, including a 24/7 emergency department, acute care, continuing care, community care, public health, laboratory and x-ray services.

Many members of the Fairview Health Complex clinical leadership team, frontline staff, and physicians are new to their positions and the organization. It is encouraging and commendable to observe their positive engagement, collaboration, and commitment to providing high-quality care to the community they serve. Site clinical leadership addresses risk and safety in an informal manner and is encouraged to work with broader AHS partners to align with a robust Enterprise Risk Management process, developing a site safety culture. There is a risk assessment matrix for the north zone linked to respiratory virus outbreaks that is in use.

There is evidence of strong partnerships within the community and broader provincial system, with a shared focus on working with partners to ensure the best care for patients and families. There is a medical clinic proximal to the site, and public health is on-site daily, serving both patients and staff (e.g., vaccines). Patients and families can access psychiatric care, victim services, pharmacy, dietitian, occupational therapy, and physiotherapy services. Leadership is linked as partners across Area 2, including Fairview Health Complex, Manning Community Health Centre, Grimshaw/Berwyn and District Community Health Centre, and Peace River Community Health Centre, often with shared responsibilities at another site. Patients requiring more acute care are triaged to Peace River or Grande Prairie, and for urgent care, via STARS to Edmonton.

While patient and family advisors provide input at the north zone level, leadership is encouraged to consider more formally engaging patient and family advisors as partners at the site level to better inform quality improvement initiatives, unit and site service design, and decision-making. For example, patients and families could be engaged in co-designing an accessible environment with site partners and the community.

There are position profiles with defined roles, responsibilities, and scope of employment for all positions. Managers and leaders use a recruitment management program software tool, where applicant pre-checks are completed by human resources, and areas of concern or opportunity for follow-up can be flagged (e.g., international applicants who require support and guidance). Managers and leaders strive to balance the workload of nursing staff members in a challenging environment with vacancies, ongoing recruitment challenges, and working with agency and locum nursing staff.

Training and education are provided to staff on an online learning system, with access to required orientation and annual education refresher modules, as well as professional development opportunities. Staff member development conversations have not been regularly completed or documented. Starting in the summer, there is a plan to ensure staff member performance, via development conversations, is evaluated and documented in an objective, interactive, and constructive way. The ongoing plan is to ensure these conversations are completed annually and, with the support of the clinical nurse educator (CNE), to focus on staff in need of learning support or additional skills acquisition. Site leadership is commended for developing a staff recognition program, including a plan for site Nursing Week celebration activities where other health professions will be invited to participate and engage.

There are policies for patient information, privacy and security, and electronic communication at the zone level that teams access. Connect Care is now well established, and there is strong agreement among

staff and leadership on the many positive aspects of the electronic documentation tool. It is commendable that patients and families have access to MyAHS Connect, a patient portal. Patients are provided with a barcode or log-in access and can review their clinical notes, appointments, and test results. Supported by the site quality lead, quality improvement (QI) and safety initiatives are continuing to develop and grow at the site and unit level. The quality lead joins monthly site quality meetings and weekly staff meetings with managers. Key quality indicators, generated at the zone level, are brought forward to staff and discussed, including hand-hygiene, barcode medication administration, and required organizational practices. There is evidence of quality huddles, with a quality board on the inpatient unit. The focus is to broaden quality boards and huddles to other areas and to move to weekly huddles. Leadership engages in rounding in patient areas and brings forward any concerns as well as compliments to the huddles. Patient safety incident reports are completed online using the Reporting and Learning System (RLS), and follow-up with patients is completed by site leadership as they are able. Depending on the nature and severity of the incident, a debrief will be conducted, and reports are shared with the quality lead.

Team leadership does not engage with staff to regularly analyze indicator data to evaluate the effectiveness of its QI activities, nor do they regularly evaluate QI initiatives for feasibility, relevance, and usefulness. The site is encouraged to expand and deepen its QI processes to meet these criteria.

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
2.1.12	The team leadership supports staff to follow up on issues and opportunities for growth identified through performance evaluations.	HIGH
4.3.3	The team identifies measurable objectives for its quality improvement initiatives including specific timeframes for their completion.	HIGH
4.3.8	The team leadership works with staff to regularly analyze indicator data to evaluate the effectiveness of its quality improvement activities.	HIGH
4.3.11	The team regularly evaluates quality improvement initiatives for feasibility, relevance, and usefulness.	NORMAL

Service Specific Assessment Standards

The Qmentum Global™ for Canadian Accreditation program has a set of service specific assessment standards that are included in the accreditation program based on the services delivered by different organizations. Service standards are critical to the management and delivery of high-quality and safe care in specific service areas.

Emergency Department

Standard Rating: 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 Fairview Health Complex has a flexible, community-based model that provides 24/7 emergency services and a walk-in clinic for the local community, open from 0900-1300 seven days a week, including statutory holidays. After the clinic closes, an ED physician is available on call. A variety of clinic services are available by appointment, including Holter monitoring and infusions.

There are nine beds and approximately 8,400 ED visits per year. A physician and registered nursing staff are on site 24/7. Staff speak to the value of the ED team and the strong support they receive from leadership. A committed and dedicated team of clinicians and staff support patient care in the ED. Patients can access a variety of services, including social work, psychiatry, victim services, public health, pharmacy, physiotherapy, and dietitians. Adult and pediatric patients who require more acute or urgent care services travel to Peace River, Grande Prairie, and via STARS to Edmonton.

The site ED is linked to key AHS strategic priorities, including reducing Emergency Medical Services (EMS) wait times, decreasing ED wait times, improving patient flow, enhancing access and continuity of care, and addressing ongoing systemic health human resource challenges, including physician and nursing staff shortages and recruitment and retention challenges. A strategic quality initiative focused on facilitating timely access to ED physician care is the ED virtual physician visit. The team expressed the positive impact of five internationally trained physicians on the ED team, enhancing quality, patient safety, and access to timely care, treatment, and intervention.

In the context of systemic nursing staffing shortages, the ED utilizes locum and agency nursing staff to ensure adequate staffing coverage, quality of care, and patient safety. Leadership is commended for reducing the number of agency nursing staff used, focusing on recruitment and retention of nursing staff and the use of locum nursing staff linked to AHS. While helpful in the short term, leaders are encouraged to continue working with AHS and system partners to focus on recruitment and retention efforts to secure permanent nursing staff.

Patient flow and access to care in the ED are episodic challenges, with processes to monitor length of stay, capacity, and surge. There are long waits for patient access to long-term care for alternative level of care patients, a recognized system issue and one of the foci of patient flow efforts. The staff spoke positively of Connect Care as an effective electronic documentation and communication tool where staff and clinicians can access patient information across multiple encounters and sites. One staff member described it as "being able to see the full patient picture at a glance to provide safe, informed care." It is commendable that Connect Care prompts staff to complete and plan care linked to key patient safety screening tools (e.g., suicide risk screening and domestic violence screening).

The physical space in the ED is used efficiently, with good flow and use of space. The team is encouraged to declutter the walls of paper and laminated postings and explore the use of poster boards, quality boards, and electronic signage for communication. The ED does not have a seclusion room, and leadership is encouraged to secure a space for this use and purpose. With no security services on site, it is recognized that the ED team partners with the Royal Canadian Mounted Police for support in select patient situations.

Required organizational practices (ROPs) are mainly in place, except for the consistent use of two person-specific identifiers to confirm that patients receive the service or procedure intended for them. Staff effectively use barcode scanning of the patient's wristband, for example, with medication administration, but do not consistently confirm patient identity with a second person-specific identifier, stating that they often "know the patients well". Leadership is to be commended for focused efforts underway to improve best practices with education and training protocols to strive to meet this ROP.

Leadership and the team continue to be innovative in their approach to the delivery of safe, patient-focused quality care despite system pressures. A focus on quality and patient safety is evident in speaking with the team. The CNE (a shared resource across Area 2) works with ED leadership to focus on tracking and reporting on key quality indicators (e.g., hand-hygiene, falls, patient safety incidents). Regular staff meetings and huddles create a forum for quality-focused sharing and engagement. A key opportunity to deepen QI at the ED unit and staff level would be the development of quality indicators and quality boards, linked to huddling and rounding processes. The inclusion of patients and families in huddling and rounding is an additional opportunity for engagement and partnership.

Patients interviewed were satisfied with the care provided and communication from staff. A number of patients were not aware of their patient rights, although Shared Commitments posters were visible in the area. This is an opportunity for focused engagement with patients and families to ensure an understanding of their rights and responsibilities.

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
2.7.6	Client Identification 2.7.6.1 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

Inpatient Services

Standard Rating: 100.0% Met Criteria

0.0% of criteria were unmet.

Assessment Results

The 18-bed inpatient unit at Fairview Health Complex can adjust the number of beds based on patient needs and census. The unit is well-organized with good lines of sight and cameras in the corridor areas. A new inpatient unit manager is bringing attention to quality and standard practices. The unit primarily serves patients with medical conditions, although occasionally, patients with mental health and pediatric conditions are admitted temporarily before being transferred to Grand Prairie Regional Hospital.

Patients and families feel cared for and express satisfaction with physician and nursing care on the unit. They have positive comments about the new physicians and the compassionate care of the nurses. Locum nurses commented that they feel comfortable practicing in the facility as AHS uses the same EMR, infusion pumps, protocols, etc. The organization is to be commended for the level of standardization it has achieved across its care delivery sites.

There is a structured admission process for each patient, including the best possible medical history (completed by a nurse), Braden Scale Assessment for Pressure Ulcers, Schmid Scale for Falls Risk Assessment, and general screening for respiratory infections. A domestic violence screen is done on each patient admission, which is commendable.

The medication management approach is sound, and two person-specific identifiers were used in all observed instances. Patients are educated about their medications before administration. Hand-held technology (ROVER) enables nurses to scan patient ID bands and medications and complete documentation at the bedside. Observations showed good patient-centered approaches during medication administration. VTE prophylaxis screening is completed by physicians, and appropriate therapies are initiated.

The EMR has structured tools to facilitate patient transitions, and a verbal transfer is also completed for patient transfers. The EMR ensures the seamless flow of information from site to site. Patients and families indicated that their information was transmitted properly between care sites and that receiving teams knew why they were there.

Patient transfers for diagnostic tests or surgeries between sites are done by family members due to EMS shortages and costs. At least one patient interviewed relayed that they were very sick in the ED when their spouse had to transfer them for surgery to Grand Prairie Regional Hospital.

The unit is encouraged to follow up on its plan to implement regular quality and safety huddles. The site is encouraged to develop mechanisms for patient and family engagement to co-design services and processes of care.

Table 8: Unmet Criteria for Inpatient Services

There are no unmet criteria for this section.

Long-Term Care Services

Standard Rating: 100.0% Met Criteria

0.0% of criteria were unmet.

Assessment Results

The long-term care (LTC) service adjoins the main Fairview Health Complex site. There are 66 beds, including one palliative care bed. The leadership model includes an on-site manager and an area seniors manager who oversees LTC centers in Area 2 in the north zone. The LTC physical space is very bright and aesthetically pleasing, with considerable effort to ensure the environment is safe and home-like for residents. The area is to be commended for its resident and family-centered focus, with a robust recreation therapy program and respite program. The service works closely with case managers from the Access team and the Placement team to facilitate respite care. Staff and teams are clearly engaged and committed to providing excellent, safe, and quality-informed care to residents.

Safety and quality are clearly a key focus. There are regular site inspections conducted by the Seniors Quality Improvement and Accessibility Team, including walkabouts, engagement with residents, families, and staff, and a review of resident care plans and safety incidents. Areas for improvement are shared with leadership, and action plans are developed and tracked. In addition, the team follows specific procedures to address any claims of violations of residents' rights, including RLS and, as required, a federal program, ‘Protection of Persons in Care,’ where leadership has a duty to report alleged or observed harm.

Site leadership and team members all expressed the value of the strong model of patient-centered care for residents, underpinned by respect, dignity, and safety. A strong interprofessional team of nurses, allied health professionals, and physicians coordinate and plan care linked to resident care needs and goals of care. Access to needed services is informed by InterRAI assessments (completed quarterly or as needed), Connect Care assessments, care conferences, family meetings, and regular staff and team meetings. The program is proactive in arranging meetings should changes in the resident's health status occur. Physicians, nurses, and teams utilize multiple communication modalities to exchange and transfer information, including SBAR (Situation-Background-Assessment-Recommendation), where staff alert physicians to any resident needs and concerns. Leadership and staff expressed communication as an area for focused improvement, voicing concern around the risk of fragmented communication and the challenges of engaging all key team members for information exchange. The manager has started planning to hold team huddles on a regular basis.

Standard assessment tools are used. Staff express appreciation for the Connect Care information and documentation system, where standardized assessments and care provision planning are facilitated. There is a provincial hotline to report resident abuse and handle complaints. Site follow-up is initiated and investigated. Staff have access to comprehensive mandatory training and professional development modules, both online and in person. Staff receive annual training in senior abuse recognition and prevention.

All ROPs are in place. Given that LTC residents do not wear wristbands, two person-specific identification is supported by photo face sheets generated by Connect Care. Photos are updated via quarterly InterRAI assessments. Staff can access the services of a wound care nurse for more complex wounds and pressure injuries.

Medication safety is a focus of both the LTC and palliative care service. Medications are scanned, and resident identification is validated using a resident-specific photo face sheet generated by Connect Care. A recommended quality and safety step would be to advance the safety of medication administration by adding automated dispensing cabinets to the units and improving the safety of delivery and tracking of medications. The team is continuing to work to improve the documentation in both LTC and palliative

care, noting that the Connect Care system has been well received by staff.

The site is commended for its focus on resident and family education and training to optimize resident physical and psychological safety. A Resident Handbook is provided to residents and families that includes teaching tools, such as falls safety, skin health, and medication safety. A dedicated recreation therapist hosts a Resident and Family Council where feedback from residents, families, and caregivers is collected to improve service and quality. There is a quality board located in the staff space, and leadership is encouraged to quantify updated and relevant quality indicators from Tableau (via Connect Care) to post on the board and link to staff and team huddles for monitoring, sharing, and celebrating successes. Resident and family experience surveys are provided to patients and families, and results are reviewed by the manager and shared with staff. RLS incidents are reviewed and shared with staff.

Table 9: Unmet Criteria for Long-Term Care Services

There are no unmet criteria for this section.

Palliative Care Services

Standard Rating: 100.0% Met Criteria

0.0% of criteria were unmet.

Assessment Results

There are three palliative beds at Fairview Health Complex, two on the inpatient acute unit and one in LTC. A zone-based palliative care team provides clinical care and support, composed of physicians, nurse practitioners, and registered nurses. There are robust policies, resources, and partnerships to help team members implement a palliative approach to care using evidence-based protocols and criteria. Goals of care are informed by the patient's palliative score. The palliative care team offers monthly staff-focused training and education, linked to the provision of patient-centered palliative care.

The site recognizes the importance of palliative care services, including the physical environment, and assists patients, families, and caregivers in selecting an appropriate service setting given the choices and resources available. The team works collaboratively with the patient, family, and site staff to optimize care planning and support. The physical environment and palliative care spaces provide privacy and solitude, located in a care provision environment. Leadership and teams are commended for creating dedicated palliative care spaces to support comfort, connection, dignity, and peace.

The teams and staff in LTC and acute inpatient care areas have access to and are connected to palliative care expertise and essential services. The palliative care team meets with patients, families, and caregivers to collaboratively plan and manage care. Patients’ advance care plans are discussed and documented, including those that address resuscitation and the use of potentially life-sustaining treatments in accordance with the patient wishes, organization policy, and relevant legislation. Leadership and staff share that patients and families express a high level of satisfaction with both the environment and the care they receive.

There are updated policies and procedures to respond to requests for medical assistance in dying (MAID) which comply with relevant ethical, legal, and regulatory frameworks. Team members respond to requests for MAID, following the organization’s protocol to direct patients and families to a dedicated MAID team based in Peace River. The team can accommodate community requests as well as internal organization requests, noting MAID can be conducted on site at the Fairview Health Complex by the MAID team. Spiritual care needs are assessed in Connect Care, with services available across the site, including chaplaincy and on-site church services. An Indigenous coordinator is available in Peace River to support Indigenous cultural practices, including smudging ceremonies.

The team has access to specialized training on key knowledge, attitudes, and skills to help provide palliative care to patients and families facing life-limiting illnesses. It is commendable that the team offers monthly education sessions for staff and guidance on directing team members to additional palliative care resources. The team is encouraged to continue this training for all staff and clinicians providing care for these patients.

Table 10: Unmet Criteria for Palliative Care Services

There are no unmet criteria for this section.

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
Emergency Department	2.7.6.1 - 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 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	5.1.7 - Separate storage in client service areas and in the pharmacy is used for look-alike medications, sound-alike medications, different concentrations of the same medication, and high-alert medications.	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