ACCREDITATION
AGRÉMENT
CANADA

Accreditation Report

Qmentum Global™ for Canadian Accreditation Program

Grimshaw/Berwyn and District Community Health Centre
Alberta Health Services

Report Issued: June 11, 2025

Confidentiality

Table of Contents

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

Grimshaw/Berwyn and District Community Health Centre (Grimshaw/Berwyn) was built in 1985 and provides care to the residents of Grimshaw, Berwyn and its surrounding communities. The facility includes an emergency department (ED), a 20-bed long-term care (LTC) unit (including 1 palliative care bed), diagnostic imaging department and laboratory. Public health and home care share the space and support the clinical services. The facility has been well-maintained and clean.

The current design and layout of the ED poses several challenges, such as the lack of a dedicated medication room and limited visibility of patients in the waiting area from the nursing station. These issues were identified during the last accreditation survey, but improvements have not been made. Several years ago, the ED reduced its hours from 24/7 to 12 hours daily (9am-9pm). Since there is no acute care inpatient unit, any patient who requires admission is transferred to Peace River Community Health Centre. Diagnostic imaging provides x-ray services only. Patients are transferred to nearby hospitals when they require more sophisticated imaging. The leadership is encouraged to assess the operations of the ED in light of patient demands and in partnership with patients and families.

The staff at Grimshaw/Berwyn take pride in the various care improvements that have been implemented and are committed to delivering high-quality healthcare to the community. Clinical management is shared between Peace River Community Health Centre and Grimshaw/Berwyn, and a site manager supports day-to-day functioning of the clinical units and services. The site manager has been successful at recruitment initiatives, but there are still several outstanding vacancies.

Patient and family engagement occurs significantly at the zone and provincial levels. At the site level, frontline staff verbalized that patients are at the centre of all that they do, ensuring their involvement in decisions regarding their care. A proactive Resident Council in the LTC unit facilitates ongoing community involvement. The site is encouraged to explore more ways to integrate patient and family input into service and facility design.

The main area of the hospital prominently features a variety of Indigenous resources. The leadership has actively collaborated with local Indigenous supports, significantly enhancing staff comprehension of practices designed to support this community.

Connect Care has enhanced the standardization of clinical assessments and guidelines. This information system offers numerous reference resources, along with capabilities for electronic medication ordering, verification, and administration practices. The intranet (Insite) site provides staff with a variety of educational programs. Virtual presentations are also available for staff addressing a variety of topics such as palliative care education.

The pharmacy is centrally located within the Grimshaw/Berwyn building. A pharmacy technician is on-site part-time, and there is access to a clinical pharmacist located at Peace River Community Health Centre. The hospital would benefit from reviewing the current card swipe access into the pharmacy for after-hours medication access rather than having a night cupboard. There continue to be challenges related to medication storage in the ED, and site leadership, along with pharmacy, should collaborate to ensure that all medications are securely stored.

Several quality boards are posted across the hospital, including a large and well-organized board in the waiting area. The LTC unit is actively engaged in routine audits of required organizational practices, including screenings for fall risks and suicide risks. Medication reconciliation processes are in place, and improvements are being implemented based on the analysis of audits. Routine post-fall huddles and behavioural care planning strategies are utilized to minimize restraint use. There is an opportunity for the ED and LTC to continue their efforts to identify quality improvement projects at the local level that include goals and objectives, metrics/indicators, and targets. Once this has been accomplished, post the results so that staff, patients and families can be informed about these quality improvements.

Key Opportunities and Areas of Excellence

Areas of Excellence:

- Compassionate and patient-family centred approach to patient/resident care.
- Patients and families report high satisfaction with the care teams.
- Supportive leadership with good collaboration with community partners.
- Hand-hygiene audits with good outcomes.
- Palliative care resources.
- Quality boards are located throughout the facility, facilitating information sharing with the patients, residents, families, and the community.

Key Opportunities:

- Consider conducting an operational review of the ED to identify opportunities to better support the community (Urgent Care/Ambulatory Care)
- Formalize quality improvement activities based on goals and objectives with indicators and involvement of staff and other stakeholders.
- Monitor and evaluate ED-related wait time indicators and share with staff and other partners.
- Review the current layout of the ED/triage area to ensure proper monitoring of ED patients in the waiting room.
- Relocate the ED medication cart and consider constructing a proper medication room.
- Evaluate the feasibility of creating a pharmacy night cabinet.

People-Centred Care

Patient and family-centred care was evident throughout the survey experience at Grimshaw/Berwyn. Staff reported that the reason they come to work every day is because of their patients/residents and families. Patients/residents are included in decision-making and care planning activities. Patients and families report a high level of satisfaction with the compassionate care they receive. In particular, given the limited availability of physicians in the community, patients stated they were very grateful to be able to visit the ED when they had no other access to a family physician. The staff are commended for their dedication, resilience, and commitment to their teams, patients/residents and families.

There has been significant involvement at the provincial and north zone level by patient care advisors in various clinical processes and practices such as infection control, quality improvements, and emergency preparedness. There are opportunities for patients and families to provide feedback to the organization at a more local level. Staff are responsive to this feedback and enable input to influence both clinical and non-clinical activities. The teams can enhance these opportunities for feedback by posting specific information for patients/residents and families about the complaints process. Posting the Shared Commitments statements (rights and responsibilities) would also enhance their patient-centred care activities.

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	5 / 5	100.0%
Client Identification	Emergency Department	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%
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%
Infection Rates	Infection Prevention and Control	3 / 3	100.0%
Information Transfer at Care Transitions	Emergency Department	5 / 5	100.0%

ROP Name	Standard(s)	# TFC Rating Met	% TFC Met
	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%
Narcotics Safety	Medication Management	3 / 3	100.0%
Pressure Ulcer Prevention	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%
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%

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: 85.7% Met Criteria

14.3% of criteria were unmet. For further details please review the table at the end of this section.

Assessment Results

Emergency and disaster response plans are found on Insite and in yellow binders located in each department. Most plans have a current review date; however, several are out of date. The site manager has updated these policies and is waiting for AHS review and approval. The leadership attends regular emergency and disaster meetings.

Staff receive education on the code of the month. This is information is posted on their quality boards. Regular drills are conducted, assessed for effectiveness, and reports are submitted to AHS consistently. Some hospital staff have participated in local community mock casualty/emergencies.

Information about various emergencies that would affect patients and visitors is shared with them. The leaders use the patient evaluation tracker to coordinate the need for information with patients/families.

Personal protective equipment is available for staff, visitors and volunteers. Decontamination equipment is located in the ambulance bay.

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

Infection Prevention and Control

Standard Rating: 100.0% Met Criteria

0.0% of criteria were unmet.

Assessment Results

The Infection Prevention and Control (IPC) program is supported by an offsite infection control practitioner (ICP) and a provincial on-call team. This practitioner participates in the local IPC committee and is a valuable resource for staff. The ICP offers guidance on isolation precautions, outbreak management, and healthcare-associated infection investigations. Additionally, IPC is consulted for construction projects and plays a role in environmental services and waste management programming.

Annual hand-hygiene education is mandatory for all staff, supplemented by ongoing training as needed during quarterly compliance audits conducted by the onsite hand-hygiene champion/clinical leader. Audit results are shared with staff on quality boards throughout the facility, ensuring visibility for patients, families, and staff alike. IPC manuals are readily accessible in clinical areas and on Insite.

The organization is encouraged to involve the IPC team to review the appropriateness of wooden handrails in hallways, boardrooms, and in the long-term care (LTC) unit. as this material cannot be cleaned effectively.

Table 3: Unmet Criteria for Infection Prevention and Control

There are no unmet criteria for this section.

Leadership

Standard Rating: 100.0% Met Criteria

0.0% of criteria were unmet.

Assessment Results

The facility is clean and accessible for patients and visitors. The building has a significant amount of wooden railings that are challenging to properly clean according to infection control standards. Poor site lines from the emergency department (ED) to the waiting room create challenges in monitoring patients waiting for service.

The leaders at Grimshaw/Berwyn are visible and approachable, managing patient/resident and family issues and concerns in a responsive manner. Frontline staff play a significant role in addressing issues before they escalate into larger complaints.

Medical devices and technology are well maintained, and staff report they have the proper equipment to perform their roles. The ED physicians indicated they would benefit from having a bedside ultrasound machine to reduce the need to transfer patients out of the ED to larger hospitals.

Table 4: Unmet Criteria for Leadership

There are no unmet criteria for this section.

Medication Management

Standard Rating: 96.5% Met Criteria

3.5% of criteria were unmet. For further details please review the table at the end of this section.

Assessment Results

Medications are prepared at Peace River Community Health Centre and are transported to Grimshaw/Berwyn. Staffing in the pharmacy includes a part-time pharmacy technician and remote coverage by a clinical pharmacist from Peace River Community Health Centre. The Connect Care electronic system is a significant enabler of this process. The pharmacy would benefit from reorganizing and co-locating high-risk medications within the space.

There is no pharmacy night cabinet when medications are required after-hours. The current process involves staff gaining access to the pharmacy using a swipe card. This creates risks from the time a medication is obtained until the pharmacy technician reviews the accessed drugs since the entire pharmacy's drugs are available, except the locked narcotics drawer. Staff document the medication they have taken, and then the pharmacy technician reviews the medication that was accessed. However, the pharmacy technician does not work every day, and there could be delays in this reconciliation process. The team is encouraged to consider an alternate strategy, such as creating a night cupboard that limits access to certain medications.

In the ED, the medication cart is located in the small nursing station. At the time of the accreditation visit, the cart was not locked, although the narcotics drawer was locked. The current location does not allow for reducing interruptions and noise. The medication preparation area in the ED was observed to be cluttered with an open vial on the counter (no date documented relating to date/time it was opened). The team is encouraged to review medication administration practices, including location of the medication cart, and consider advocating for a proper medication room with an automated dispensing unit. This suggestion was provided in a previous accreditation survey.

Table 5: Unmet Criteria for Medication Management

Criteria Number	Criteria Text	Criteria Type
5.1.2	Medication storage areas are clean and organized.	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
7.2.1	Medication preparation areas are clean and organized.	HIGH

Criteria Number	Criteria Text	Criteria Type
9.2.1	When the pharmacy is closed, there is controlled access to a night cabinet or to automated dispensing cabinet for a limited selection of urgently required medications.	HIGH

Service Excellence

Standard Rating: 87.5% Met Criteria

12.5% of criteria were unmet. For further details please review the table at the end of this section.

Assessment Results

The staff are commended for their dedication, resilience, and commitment to their teams, patients/residents and families.

Quality improvement (QI) objectives with indicators were not evident. While there were discussions about monitoring activities such as bar code scanning, specific objectives with indicators were not shared. The team would benefit from working with the quality team to formalize QI projects, including goals, objectives and targets to monitor progress. Leaders have access to various indicators related to provincial and zone quality activities, but there is very little information about QI activities and resulting indicators shared with staff to obtain their input. The teams are encouraged to collaborate with the quality team to develop a way to engage frontline staff with QI activities.

The teams are encouraged to share outcomes of QI activities with all partners including patients/residents, families, and community partners. Some information about audits is posted on quality boards for staff to review, but this should occur in a more fulsome way.

Table 6: Unmet Criteria for Service Excellence

Criteria Number	Criteria Text	Criteria Type
1.1.3	The team develops its service-specific goals and objectives.	NORMAL
4.3.3	The team identifies measurable objectives for its quality improvement initiatives including specific timeframes for their completion.	HIGH
4.3.4	The team identifies indicators to monitor progress for each quality improvement objective.	NORMAL

Criteria Number	Criteria Text	Criteria Type
4.3.5	The team leadership works with staff to design and test quality improvement activities to meet objectives.	HIGH
4.3.6	The team leadership works with staff to use new or existing indicator data to establish a baseline for each indicator.	NORMAL
4.3.7	The team leadership works with staff to regularly collect indicator data and track progress towards quality improvement objectives.	NORMAL
4.3.8	The team leadership works with staff to regularly analyze indicator data to evaluate the effectiveness of its quality improvement activities.	HIGH
4.3.9	The team leadership works with staff to implement throughout their services the quality improvement activities that were shown to be effective in the testing phase.	HIGH
4.3.10	The team leadership ensures that information about quality improvement activities, results and learnings are shared with staff, clients and families, organizational leaders, and partners, as appropriate.	NORMAL
4.3.11	The team regularly evaluates quality improvement initiatives for feasibility, relevance, and usefulness.	NORMAL

Service Specific Assessment Standards

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

Emergency Department

Standard Rating: 95.2% Met Criteria

4.8% of criteria were unmet. For further details please review the table at the end of this section.

Assessment Results

The hours of operation of the ED have changed from 24 per day to 12 hours daily (9am-9pm). Signage is posted at the entrance to the hospital denoting this change in hours, along with alternative hospital EDs. The communities that Grimshaw/Berwyn support have limited access to primary care and as such, a significant volume of patients with less urgent and non-urgent (Canadian Triage and Acuity Scale [CTAS] 4 and 5) present to the ED, which creates challenges with continuity of care.

There is no evidence that established timelines for triage assessments are achieved since the metrics are not collected and reviewed. CTAS wait times and left without being seen data (for adults and pediatrics) has not routinely been reviewed and shared with staff. Although staff reported they have a sense that they are meeting these wait times, the manager is encouraged to run reports for these metrics to monitor, evaluate, and share the ED performance with staff, patients, and families.

The team is encouraged to consider ways to improve site lines from the ED/triage area to the waiting room. This may require triage renovations to improve waiting room monitoring procedures.

Patient assessments are thorough and well documented. Nurses can use nurse-initiated protocols if a physician is not immediately available to provide orders. Best practice guidelines have been incorporated into the Connect Care system, supporting safe and quality care.

The team is encouraged to develop service goals and objectives taking feedback from patients and families into consideration. These goals should align with the priorities of the health system's strategic plan.

Patients and families reported that staff and physicians are caring and compassionate. They receive education about their health condition and are included in the care planning process. Several patients stated that they are fortunate to have this hospital as part of their community.

Posters and information about rights and responsibilities or Shared Commitments were not observed in the department. It is an important component of patient-centred care to educate patients on these expectations.

Patients were not able to identify how to file a complaint or to report violations of their rights. They "guessed" that they would speak to their nurse about it. Patients and families would benefit from posters or pamphlets that educate them about how to report these types of concerns.

Table 7: Unmet Criteria for Emergency Department

Criteria Number	Criteria Text	Criteria Type
2.2.1	Entrance(s) to the emergency department are clearly marked and accessible.	HIGH
2.3.3	A triage assessment for each client is completed and documented within established timelines, and in partnership with the client and family.	HIGH
2.3.4	A triage assessment for each pediatric client is conducted within established timelines, and in partnership with the client and family.	HIGH
2.4.15	Clients and families are provided with information about their rights and responsibilities.	HIGH
2.4.16	Clients and families are provided with information about how to file a complaint or report violations of their rights.	HIGH

Long-Term Care Services

Standard Rating: 100.0% Met Criteria

0.0% of criteria were unmet.

Assessment Results

The LTC unit at Grimshaw/Berwyn accommodates up to 20 residents, including a designated bed for respite and palliative care. The interprofessional team consists of registered nurses, licensed practical nurses, health care aides, and a recreation therapy assistant who collaborate to deliver exceptional care. The team also has access to an occupational therapist and dietitian if their expertise is required. The north zone palliative care team is a tremendous source of expertise and education for palliation and respite care. Their commitment to fostering a homelike atmosphere for residents is evident in their daily interactions with residents and family members. A family member of one resident commented that “this place just feels warm and welcoming”. The spacious and accessible rooms, washrooms, and hallways are maintained with attention to IPC standards.

The environment within the unit is warm and inviting, designed to resemble a home. Seasonal decorations, a piano, and a large television in the common area contribute to this welcoming ambiance. Residents have the opportunity to choose from two meal options during each dining experience, which takes place in a sociable setting as long as their health permits. A recreation therapy assistant provides a variety of activities and outings to enrich the residents' lives. The team has limited access to a physician given the workload and responsibilities of the local physician group. The physician will contact the team virtually when required. This practice should be reviewed against best practices for LTC residents.

A rights and responsibilities document (expectations and responsibilities) are posted on the quality board within the LTC unit for staff, residents and families to review.

Standardized assessment tools and guidelines are populated in the Connect Care electronic record, enabling the development of personalized care plans and behaviour safety plans. Numerous safety protocols are implemented to mitigate risks of falls and pressure injuries. Residents and family members are educated about special safety needs put in place such as isolation, falls prevention, and choking hazards. Audits of these quality and safety practices are performed and results are shared at staff meetings. The team is encouraged to continue to post these results to generate discussions about potential QI activities. Behaviour support plans are developed in concert with the staff and family to address responsive behaviours.

The team is encouraged to continue to develop unit-specific QI projects based on indicators and outcomes that are tracked and audited, including specific targets.

The team manager is new to her role and her energy and passion for quality and safe residential care are contagious.

Feedback from residents indicates that they feel well-treated and receive commendable care. The team receives information about opportunities for improvement and input from the Resident and Family Council. Based on resident and family discussions during the tracer, staff are proud to provide patient and family-centered care that is based on best practices.

Table 8: 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

The palliative care provided by the staff in the LTC unit works in close collaboration with the north zone palliative care team, leveraging their extensive expertise to enhance the quality of care. This partnership facilitates a comprehensive approach to palliative care, ensuring that all staff members receive ongoing education and support. The north zone team offers valuable insights into best practices and advanced techniques, empowering the LTC staff to deliver more effective and compassionate care tailored to the unique needs of each resident.

In this specialized environment, the nursing staff is committed to providing compassionate and appropriate palliative care that prioritizes the comfort and dignity of residents. With only one designated palliative care bed available on the unit, the staff are dedicated to maximizing the resources and support available to each resident requiring palliative services. This emphasis on personalized care allows the team to focus on pain management, emotional support, and holistic approaches that address not just physical symptoms but also the psychological and spiritual needs of residents and their families.

Respecting the wishes of both residents and their families is a cornerstone of the palliative program, ensuring that care plans reflect individual preferences and values. The staff engages in open and empathetic communication, fostering an environment where residents and families feel heard and supported in their decision-making processes. By prioritizing these values, the palliative care team not only enhances the quality of life for residents but also provides families with the reassurance that their loved ones are receiving care that aligns with their personal wishes during a critical time.

Table 9: 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	2.2.1 - Entrance(s) to the emergency department are clearly marked and accessible.	June 2, 2026
Emergency Department	2.4.15 - Clients and families are provided with information about their rights and responsibilities.	June 2, 2026
Emergency Department	2.4.16 - Clients and families are provided with information about how to file a complaint or report violations of their rights.	June 2, 2026
Medication Management	5.1.2 - Medication storage areas are clean and organized.	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
Medication Management	7.2.1 - Medication preparation areas are clean and organized.	June 2, 2026
Medication Management	9.2.1 - When the pharmacy is closed, there is controlled access to a night cabinet or to automated dispensing cabinet for a limited selection of urgently required medications.	June 2, 2026