ACCREDITATION
AGRÉMENT
CANADA

Accreditation Report

Qmentum Global™ for Canadian Accreditation Program

Redwater Health 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

Redwater Health Centre is a small 21-bed site with 24-hour emergency room access. The manager oversees multiple sites, creating an environment of competing priorities. Currently, she is the only manager on site. Overall, the staff is committed to delivering safe, high-quality patient care and service at every level of the organization.

One of the strengths of the Redwater Health Centre is the engaged and supportive team. Team members are recognized for their contributions verbally, although formal performance/development conversations are not completed consistently. Leadership assigns and reviews the workload of staff in a manner that ensures patient and staff safety and well-being.

AHS has a very robust and comprehensive orientation and education plan. Leadership encourages staff to participate in opportunities for professional development on a regular basis. The team highlighted the need for a clinical educator to assist with new staff onboarding, education and hands-on skills such as mandatory infusion pump annual retraining.

Several patients, residents and family members shared they received exceptional care. They describe staff as caring, kind, and respectful. AHS is encouraged to seek patient and family advisors to support local site quality initiatives.

Key Opportunities and Areas of Excellence

Areas of Excellence:

- Caring & compassionate staff
- Positive patient feedback
- Environmental services staff

Key Opportunities:

- Alignment with required organizational practices (ROPs) for infusion pump training, medication reconciliation in long-term care
- Safe storage of medication and compliance with narcotics management (open cupboard stocked with high alert medication)
- Consider local patient and family advisors
- Staffing challenges (high turnover rate, recruitment of medical staff)

People-Centred Care

Patients, residents and family members spoke of active participation in the development of care plans and expressed great appreciation for respectful, responsive and compassionate care.

Residents and families share their feedback during Resident and Family Council meetings. Residents and their families expressed high levels of satisfaction with the care and respect they receive. The team is encouraged to maintain and enhance engagement with patients, residents and families in ongoing quality improvement efforts.

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%
	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%
Infection Rates	Infection Prevention and Control	3 / 3	100.0%

ROP Name	Standard(s)	# TFC Rating Met	% TFC Met
Information Transfer at Care Transitions	Emergency Department	5 / 5	100.0%
	Inpatient Services	5 / 5	100.0%
	Long-Term Care Services	5 / 5	100.0%
Infusion Pump Safety	Service Excellence	3 / 6	50.0%
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	1 / 4	25.0%
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%
Suicide Prevention	Emergency Department	5 / 5	100.0%
	Long-Term Care Services	5 / 5	100.0%

ROP Name	Standard(s)	# TFC Rating Met	% TFC Met
The ‘Do Not Use’ List of Abbreviations	Medication Management	7 / 7	100.0%
Venous Thromboembolism (VTE) Prophylaxis	Inpatient Services	5 / 5	100.0%

Assessment Results by Standard

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

Core Standards

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

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

Emergency and Disaster Management

Standard Rating: 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

A dedicated Emergency Disaster Management committee meets monthly, supported by a zone emergency management officer. Monthly code reviews, led by different departments, are conducted, and the practice of rotating the lead department has been positively received, enhancing staff engagement in emergency management. After each drill and incident, hotwash debrief records are completed, providing assessments of events and recommendations for improvement. Staff have reported that these drill exercises are beneficial. The team's commitment was also recognized in a newsletter highlighting their participation in the Hazmat First training program.

The team maintains an updated database for emergency and disaster notifications and is encouraged to conduct drills to evaluate the system and identify areas for improvement.

Policies are developed and reviewed at the provincial level before being adapted for local implementation. The team has established an effective process for updating policies locally. However, some emergency and disaster policies, such as *Code Brown* and *Code Grey*, have not been updated centrally in the past four years. The organization is encouraged to implement a process to ensure these policies are regularly reviewed and updated.

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: 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 organization maintains a clean environment, with waiting room furniture that is generally easy to clean with some requiring repair. Environmental staff are knowledgeable and adhere to protocols that contribute to infection prevention.

Hand-hygiene audits are conducted and reviewed during staff meetings; the most recent six months of data show an impressive 99% compliance rate. Real-time improvements are implemented during the audits, and outbreaks are effectively tracked and managed. Formalizing and sharing the lessons learned from these experiences would be beneficial.

The team is supported by an infection control professional, who assists with outbreaks and the development of recommendations. The team is encouraged to review trends and implement improvements as needed. Monthly Infection Prevention and Control (IPC) committee meetings are held with other organizations to discuss IPC issues.

Hand-hygiene stations are appropriately located throughout the organization, but the team should consider adding more at the entrances of departments, such as the kitchen and long-term care (LTC) area. There are no designated sinks for staff that are easily accessed. The sinks in the room are used for patients and staff. To reduce infection risk, the team should find alternatives to this practice so that staff and patients are not sharing sinks.

Table 3: Unmet Criteria for Infection Prevention and Control

Criteria Number	Criteria Text	Criteria Type
2.5.4	Team members, and volunteers have access to dedicated hand-washing sinks.	NORMAL

Leadership

Standard Rating: 100.0% Met Criteria

0.0% of criteria were unmet. For further details please review the table at the end of this section.

Assessment Results

There are some concerns with the physical environment presenting risks to IPC. Most surfaces where bulletins are posted are washable; however, there is a large blue cloth board at the entrance that should be replaced with a washable alternative. The team is also encouraged to consider laminating papers where residents and patients have access. Additionally, exposed wood on the counter edge at the main nurse's station needs repair to ensure proper cleaning. Addressing these issues support a safe and healthy environment for both patients and staff.

The physical environment is bright and welcoming. During the accreditation survey visit, equipment was present in the halls due to floor replacement; however, the team indicated that typically there is no equipment in the hallways. The outcome of the ongoing floor replacement project has been positively received by several staff members, who appreciate the new flooring. Despite the challenges posed by the construction process, leadership and staff effectively managed the situation. A comprehensive planning process was implemented and modified as needed by the construction project team, ensuring IPC and patient safety were considered.

Medical devices and equipment are available to deliver care. Maintenance and biomedical staff respond promptly to the team's requests. The inpatient unit and other patient areas throughout the facility were noted to be somewhat cluttered with equipment and supplies.

The site and seniors' health manager oversees the facility plus another site and home care services. The manager is dedicated and committed to supporting staff in providing safe, quality care. Quality and patient safety indicators are readily accessible through Tableau and Connect Care and are prominently displayed. Several indicators, such as falls, use of computerized physician order entry (CPOE), and hand-hygiene, are reviewed with staff. However, quality improvement (QI) initiatives are not formalized. Leaders are encouraged to involve staff in identifying and implementing QI initiatives.

Table 4: Unmet Criteria for Leadership

There are no unmet criteria for this section.

Medication Management

Standard Rating: 96.6% Met Criteria

3.4% of criteria were unmet. For further details please review the table at the end of this section.

Assessment Results

An interdisciplinary Provincial Drugs and Therapeutics Committee oversees medication management practices at AHS. The committee works collaboratively with the Medication Quality and Safety Team, policy committee and the newly formed Antimicrobial Stewardship committee to develop, review and approve policies, medical directives, order sets, education, standards of practice and training.

Redwater Health Centre has 14 inpatient beds, seven long-term care beds and 24-hour emergency department (ED) access. The organization is encouraged to complete an assessment of medication accessibility at the site. There is a medication room with fully stocked Pyxis automated dispensing cabinets (ADCs) to support the inpatient unit. The pharmacy is adjacent to the ED with three crash carts fully stocked and a large, locked cabinet of medications in the resuscitation room. The assessment should focus on unnecessary redundancy, overstocking and safety risk. The cabinet in the resuscitation room has high-alert medication stocked within it and was witnessed to be unlocked during the accreditation survey visit with verification from a staff member that it is a concern.

Redwater Health Centre does not perform compounding; required compounded medications are prepared at Barrhead Healthcare Centre and sent to Redwater Health Centre. A full-time pharmacy technician supports the site Monday to Friday and a pharmacist is assigned remotely Monday to Friday, with on-call pharmacists available after-hours and on weekends.

Audits include monitoring of narcotics, concentrated electrolytes and select heparin products. The site is encouraged to regularly audit compliance with required narcotic counts on change of shift, which is not being completed consistently. The team is encouraged to ensure audit results are regularly shared with site leadership to share at staff meetings and on quality boards. Results on compliance with establishing the best possible medication history (BPMH) are shared and posted on the quality board.

Annual audits are completed on the “do not use” list of abbreviations. Signage was noted throughout medication areas and staff are very familiar with the list.

There is attention given to drug shortages with clear direction/clarity provided when this occurs. Pharmacy monitors all backorders with impact to clinical service, creates medication alerts for practitioners and works with the pharmacy technicians to coordinate sharing of medications across hospitals in the north zone. The organization has a single medical record (Connect Care) with CPOE, fully integrated ADCs, and electronic medication administration record which enhances safe patient care.

Incident reporting is encouraged across the organization and is a culture embedded at the site. Medication related incidents are tracked, trended and reviewed. Such data could be shared with site leadership and staff at the site level to allow for any QI initiatives as necessary.

Table 5: Unmet Criteria for Medication Management

Criteria Number	Criteria Text	Criteria Type
5.1.1	Access to medication storage areas is limited to authorized team members.	HIGH
5.1.6	Medication storage areas meet legislated requirements and regulations for controlled substances.	HIGH
5.1.11	Medication storage areas are regularly inspected, and improvements are made if needed.	NORMAL
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

The clinical and administrative leadership dyad is visibly collaborative and effective in the design and delivery of emergency and inpatient services. Information is collected from patients and families, community partners, and internal partners to inform service design and delivery at the zone level. The organization is encouraged to engage patient advisors at the local level.

Indicators are selected by the team to monitor their success in achieving their goals and findings are shared broadly via their quality board. Teams have developed strategic partnerships to meet the needs of their patients and community. Information on palliative and end-of-life care includes information for patients and families as well as resources for the team, referral and access.

Multidisciplinary team members are appropriately credentialed and maintain competency to ensure safe and effective service delivery. Education and training are provided by the organization to support staff in care delivery within the organization. A documented and coordinated approach for infusion pump safety is not implemented. Staff have not received infusion pump education and training since the clinical educator left the unit. The site is encouraged to recruit another educator for the unit to ensure consistent initial training for new hires, refresher training on the safe use of infusion pumps, and educational support as new skills and procedures are introduced is provided to all team members.

Leadership assigns and reviews workload in a consistent manner and advocates for additional resources. The site has a significant number of new graduates and locum registered nurses on the unit and in the ED. Leadership ensures that staff are provided with education and training on how to identify, reduce and manage safety risks.

Performance/development conversations are to be completed on an annual basis as per organization policy. Staff reported having not received performance appraisals in several years.

Policies and procedures are currently being updated provincially. Staff indicated that they access policies electronically when needed but navigating the online platform to access is challenging. Evidence-informed guidelines are selected for use by the team and are reviewed on a regular basis.

Standardized communication tools are regularly used by the team and compliance is monitored. Comprehensive, standardized assessments are conducted on each patient and documented well in the medical record. Compliance with organizational documentation standards is audited and results are shared with staff. Chart audits are completed to validate compliance with documentation requirements.

Staff are comfortable using the incident reporting and learning system and processes are in place for review of incidents by appropriate clinical leaders. Team leadership follows an organizational policy for disclosure. The team has undertaken a number of initiatives, identifying opportunities for improvement and implementing actions to support change. The organization is strongly encouraged to focus on continuous quality improvements at the unit level.

Table 6: Unmet Criteria for Service Excellence

Criteria Number	Criteria Text	Criteria Type
2.1.7	Infusion Pump Safety 2.1.7.2 Initial and re-training on the safe use of infusion pumps is provided to team members: • Who are new to the organization or temporary staff new to the service area • Who are returning after an extended leave • When a new type of infusion pump is introduced or when existing infusion pumps are upgraded • When evaluation of competence indicates that re-training is needed • When infusion pumps are used very infrequently, just-in-time training is provided 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. 2.1.7.6 When evaluations of infusion pump safety indicate improvements are needed, training is improved or adjustments are made to infusion pumps.	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

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: 99.1% Met Criteria

0.9% of criteria were unmet. For further details please review the table at the end of this section.

Assessment Results

The ED has a clear external identification sign, but internal directional signage in the entrance needs enhancement. The team is encouraged to engage patients to invite feedback for improvements.

New staff have been recruited, though vacancies remain a challenge. To increase flexibility, the ED team is crossed-trained in the medicine department. Learning and training are supported through educational modules and courses including Advanced Cardiac Life Support, and Pediatric Advanced Life Support. The team highlighted the need for an educator to assist in meeting the increased learning needs of new staff.

The community faces a shortage of family practice physicians, leading to many patients seeking treatment at the ED. Recruitment of medical staff has posed challenges. The ED is typically staffed 24 hours a day, though there is one day a week when no physician is present during the daytime. Night shifts are managed by locum positions. A protocol has been established to guide staff and Emergency Medical Services in managing schedule issues. The team is encouraged to continue its recruitment efforts.

Crash carts are to be checked nightly to ensure these are fully stocked and locked. It was noted that the pediatric cart was left unlocked. To ensure the availability of equipment during an emergency, the team should follow the daily process.

Access to spiritual care services is available; however, patients and families do not have access to a designated space to observe spiritual practice. The team is encouraged to investigate opportunities to create a dedicated space for this purpose within the organization.

Initial registration is completed when the patient enters the department. Patient registration occurs in an open area, raising privacy concerns due to the lack of barriers. It is suggested that the team, in collaboration with patients, explore options to enhance privacy in this space. After patients are triaged, they either wait within the department or in an area outside of the department doors without line of sight. To reduce patient safety risks, the team should formalize and enhance the monitoring of patients while waiting in this area.

Patients and families described staff and physicians as caring and felt they were always received excellent respectful care. They described their experience as positive each time they came to the hospital.

Table 7: Unmet Criteria for Emergency Department

Criteria Number	Criteria Text	Criteria Type
2.7.3	Client privacy is respected during registration.	NORMAL

Inpatient Services

Standard Rating: 100.0% Met Criteria

0% of criteria were unmet.

Assessment Results

Accreditation Canada ROPs were in place and charts reviewed onsite included the required supporting documentation. Medication reconciliation is completed through Connect Care on admission, during transitions of care and on discharge. Leadership at site are encouraged to engage physicians to increase compliance with completion of a BPMH and medication reconciliation on admission.

On admission, standardized information, as well as service-specific information is provided to patients. Information is collected and communicated during care transitions using standardized tools, and the effectiveness of communication is evaluated. The discharge process is also standardized and includes a discharge summary and any medication changes. Evidence-informed clinical guidelines have been developed or adopted by the interdisciplinary team and incorporated into practice.

Palliative and end-of-life care is available to patients and supported by the team as indicated. The 14-bed inpatient unit has a dedicated palliative care room. Spiritual care services are available as needed for patients/residents. Site leadership are encouraged to identify a dedicated spiritual space at the site.

One of the inpatient beds was closed to facilitate renovations. The remaining beds are usually filled with patients requiring subacute care, with a significantly high alternate level of care (ALC) rate of approximately 30%. The site has developed a quality initiative to engage key partners, analyze and trend the data, and explore options to increase patient flow and decrease ALC rate. Family presence is supported and encouraged with no restrictions on visiting hours.

A quality board is located in a high traffic area that includes information on fall rates, IPC surveillance (i.e. methicillin-resistant *Staphylococcus aureus* and *Clostridium difficile* rates), hand-hygiene compliance and other performance indicators related to quality, safety and efficiency.

Table 8: Unmet Criteria for Inpatient Services

There are no unmet criteria for this section.

Long-Term Care Services

Standard Rating: 95.1% Met Criteria

4.9% of criteria were unmet. For further details please review the table at the end of this section.

Assessment Results

The LTC team is cross trained in other areas, providing flexibility in staffing. The team indicated that they have staffing challenges related to having so many new staff and AHS staff that travel within AHS who are temporarily assigned to the hospital. Staff used the term “travel nurse” for these nurses.

During the accreditation survey visit, it was challenging to gather information on new resident admissions, as staff had not yet experienced an admission. Leadership plans to orient nurses to the admission process. An initiative to create a health care aid task checklist was started but was not continued. Staff would like this initiative to continue as they feel it would help establish routines.

The BPMH is collected, but there was no evidence of in the chart that the medications are reconciled. A medication reconciliation completion report was also not available. Staff were unaware of their role in the medication reconciliation process. The team is encouraged to review the medication reconciliation policy, participate in training, and audit effectiveness.

A social worker and psychotherapist are available to meet residents' needs. The team is encouraged to consider holding interdisciplinary case rounds/conferences at least quarterly to discuss each resident and review their care plan. Family members receive regular updates and provide feedback through the Family Council.

Recreational activities are offered for a few days throughout the week. Some staff believe more activities are needed. Residents interviewed expressed that the activities offered met most of their needs. The team is encouraged to continue working with residents to determine preferred activities.

Staff shared there were visiting hours restrictions, but exceptions are made. Further investigation revealed visiting hours are open. Since this is the resident’s home, it is suggested that all staff, residents, and families know that visiting hours for care partners are open.

Resident rooms are adjacent to acute care beds. There is a large dining/activity room that is welcoming, but the hallway to resident rooms does not support a home-like environment. Involving residents and families, the team is encouraged to explore ways to create a more home-like environment for residents.

Residents praised the LTC staff as caring and respectful, which was evident during the accreditation survey visit. Residents were satisfied with their care and food, with no suggestions for improvement.

Table 9: Unmet Criteria for Long-Term Care Services

Criteria Number	Criteria Text	Criteria Type
2.5.1	Medication Reconciliation at Care Transitions – LongTerm Care Services 2.5.1.2 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. 2.5.1.3 Upon or prior to re-admission from another service environment (e.g., acute care), the discharge medication orders are compared with the current medication list and any medication discrepancies are identified, resolved, and documented. 2.5.1.4 Upon transfer out of long-term care, the resident and next care provider (e.g., another long-term care facility or community-based health care provider) are provided with a complete list of medications the resident is taking.	ROP

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
Long-Term Care Services	2.5.1.2 - 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
Long-Term Care Services	2.5.1.3 - Upon or prior to re-admission from another service environment (e.g., acute care), the discharge medication orders are compared with the current medication list and any medication discrepancies are identified, resolved, and documented.	June 2, 2026
Long-Term Care Services	2.5.1.4 - Upon transfer out of long-term care, the resident and next care provider (e.g., another long-term care facility or community-based health care provider) are provided with a complete list of medications the resident is taking.	June 2, 2026
Medication Management	5.1.1 - Access to medication storage areas is limited to authorized team members.	June 2, 2026
Medication Management	5.1.6 - 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

Standard	Criterion	Due Date
Service Excellence	2.1.7.2 - Initial and re-training on the safe use of infusion pumps is provided to team members: • Who are new to the organization or temporary staff new to the service area • Who are returning after an extended leave • When a new type of infusion pump is introduced or when existing infusion pumps are upgraded • When evaluation of competence indicates that re-training is needed • When infusion pumps are used very infrequently, just-in-time training is provided	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	2.1.7.6 - When evaluations of infusion pump safety indicate improvements are needed, training is improved or adjustments are made to infusion pumps.	June 2, 2026