ACCREDITATION
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CANADA

Accreditation Report

Qmentum Global™ for Canadian Accreditation Program

Westlock Healthcare Centre

Alberta Health Services

Report Issued: June 11, 2025

Confidentiality

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About Accreditation Canada

Accreditation Canada is a global, not-for-profit organization with a vision for safer care and a healthier world. Our people-centred programs and services have been setting the bar for quality across the health ecosystem for more than 60 years. We continue to grow in our reach and impact. Accreditation Canada empowers and enables organizations to meet national and global standards with innovative programs that are customized to local needs. Accreditation Canada's assessment programs and services support the delivery of safe, high-quality care in health systems, hospitals, laboratories and diagnostic centres, long-term care, rehabilitation centres, primary care, home, and community settings. Our specialized accreditation and certification programs support safe, high-quality care for specific populations, health conditions, and health professions.

About the Accreditation Report

The Organization identified in this Accreditation Report (the "**Organization**") has participated in Accreditation Canada's Qmentum Global™ for Canadian Accreditation program.

As part of this program, the Organization has partaken in continuous quality improvement activities and assessments, including an on-site survey from April 28 to May 2, 2025. This Accreditation Report reflects the Organization's information and data, and Accreditation Canada's assessments, as of those dates.

Information from the assessments, as well as other information and data obtained from the Organization, was used to produce this Report. Accreditation Canada relied on the accuracy and completeness of the information provided by the Organization to plan and conduct its on-site assessments and to produce this Report. It is the Organization's responsibility to promptly disclose any and all incidents to Accreditation Canada that could impact its accreditation decision for the Organization.

Program Overview

The Qmentum Global Program enables your organization to continuously improve quality of care through the sustainable delivery of high-quality care experiences and health outcomes. The program provides your organization with standards, survey instruments, assessment methods and an action planning feature that were designed to promote continuous learning and improvement, and a client support model for on-going support and advice from dedicated advisors.

Your organization participates in a four-year accreditation cycle that spreads accreditation activities over four years supporting the shift from a one-time assessment while helping your organization maintain its focus on planning, implementing, and assessing quality and improvements. It encourages your organization to adopt accreditation activities in everyday practices.

Each year of the accreditation cycle includes activities that your organization will complete. Accreditation Canada provides ongoing support to your organization throughout the accreditation cycle. When your organization completes year 4 of the accreditation cycle, Accreditation Canada's Accreditation Decision Committee determines your organization's accreditation status based on the program's accreditation decision guidelines. The assessment results and accreditation decision are documented in a final report stating the accreditation status of your organization. After an accreditation decision is made, your organization enters year 1 of a new cycle, building on the actions and learnings of past accreditation cycles, in keeping with quality improvement principles.

The assessment manual (Accreditation Canada Manual) which supports all assessment methods (self-assessment, attestation, and on-site assessment), is organized into applicable Standards and ROPs. To promote alignment with the assessment manual (Accreditation Canada Manual), assessment results and

surveyor findings are organized by Standard, within this report. Additional report contents include a comprehensive executive summary, the organization’s accreditation decision, locations assessed during the on-site assessment, required organizational practices results, and conclusively, People-Centered Care and Quality Improvement Overviews.

Executive Summary

About the Accreditation Cycle

Since 2010, Alberta Health Services (AHS) has embraced a sequential model of accreditation. This model supports a continuous approach to quality by providing additional opportunities to assess and improve year-over-year, relative to a traditional accreditation approach that adopts one assessment per accreditation cycle.

As part of government restructuring, AHS is being divided into four distinct health agencies. Once the change is complete, AHS will serve as a Service Delivery Organization, with a focused mandate on delivering acute care services within hospitals operated by AHS. Current agencies include: Recovery Alberta, Acute Care Alberta and Primary Care Alberta. Recovery Alberta, established in 2024 as the first of Alberta's new provincial health agencies, is responsible for providing comprehensive and accessible recovery-oriented mental health and addiction services and correctional health services across the province. Acute Care Alberta is the new provincial health agency, established in 2025, that oversees the governance and coordination of acute care services (including AHS), emergency medical services and cancer services across Alberta. Primary Care Alberta is the provincial health agency, established in 2025, responsible for primary care, including public health, across the province to support day-to-day health needs through every stage of life.

Accreditation Canada conducts two accreditation visits per year for the duration of the cycle (2023-2027). Accreditation visits help organizations achieve the goal of being Accreditation Ready every day by enabling and empowering teams to work with standards as part of their day-to-day quality improvement activities to support safe care.

Focused assessment for the foundational standards of Governance, Leadership, Infection Prevention, and Control, Medication Management and Reprocessing of Reusable Medical Devices (where applicable) occur at tertiary, regional and urban acute, rehabilitation and psychiatric hospitals, as well as cancer centers in the first survey of the cycle (Fall 2023).

During the cycle, location-based assessments for rural hospitals use a holistic approach and integrate assessments for all clinical service standards applicable at the site, as well as the foundational standards of Emergency and Disaster Management, Infection Prevention and Control, Leadership, Medication Management, Reprocessing of Reusable Medical Devices and Service Excellence. Program-based assessments are applied to large urban hospitals, provincial, and community-based programs where clinical services are assessed against the respective clinical service standard along with the foundational standards. This integrated assessment approach provides a more comprehensive assessment and aligns with different levels of accountability.

To further promote continuous improvement, organizations have adopted the assessment method referred to as attestation. Attestation requires teams to conduct a self-assessment against specified criteria and provide a declaration that the self-assessment is both accurate and reliable to the best of the organization’s knowledge. These ratings are used to inform an accreditation decision at the end of the four-year accreditation cycle.

Following each accreditation survey, reports are issued to support the organizations’ quality improvement journey. At the end of the accreditation cycle, in Spring 2027, an overall decision will be issued that includes the organization’s accreditation award.

Surveyor Overview of Team Observations

The organization has fostered strong relationships with community partners, including public health and Royal Canadian Mounted Police services, who noted that leadership is receptive to their feedback and promotes collaboration.

There is a solid partnership between the hospital and long-term care (LTC) unit. Leadership is dedicated to ongoing improvements in quality and patient safety, and they actively support succession planning, with several managers advancing into leadership roles. Staff expressed a desire for more frequent visits from zone leaders, such as their pharmacy leader. 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 Westlock Healthcare Centre is the cohesive, engaged and supportive team. Team members are recognized for their contributions verbally. Formal performance appraisals and development conversations are completed consistently in the inpatient unit but vary across the other clinical areas and departments. Leadership is encouraged to ensure that performance/development conversations occur regularly. Leadership assigns and reviews the workload of staff in a manner that ensures patient and staff safety and well-being. Resources at the site are adequate with current services and demands. This will need to be regularly reviewed as demands increase (e.g., emergency room, operating room, pharmacy). Staff are most proud of their just-culture environment and the focus by their leadership team in ensuring that staff have robust and comprehensive orientation, education and training plans. Leadership encourages staff to participate in opportunities for professional development on a regular basis.

Staff verbalized comfort with bringing forward complaints and concerns. Most staff spoke very highly of team collaboration, adaptability of colleagues, ability to provide quality care in a supportive caring environment, and teamwork.

Several patients, residents, and family members indicated that they received exceptional care, and staff are caring, kind, and respectful. The team works with the organization to ensure its physical spaces are safe and meet patient and resident needs to the greatest extent possible including dignity, respect, privacy and confidentiality. A patient experience survey was completed for inpatients in 2024/25 with the site receiving a score of 78.9%. There is an opportunity to further evaluate the results in areas of pain control, emotional support and coordination of tests and procedures for patients. Site leadership is encouraged to share patient and resident satisfaction results on a quality board, develop a quality process improvement initiative involving patients/residents and their families, and seek further input and feedback. The organization is encouraged to seek patient advisors to support local site quality initiatives.

Key Opportunities and Areas of Excellence

Areas of Excellence:

- Robust education program
- Caring, compassionate and patient/resident focused staff
- Just culture
- Emergency disaster management and evaluation

Key Opportunities:

- Involvement of patients and families in co-design and input
- Infection prevention and control concerns within the physical environment e.g., wood, carpet, limited hand sanitizers
- Lack of storage space, cluttered spaces and hallways
- Enhancement of quality and risk management with staff and patients

People-Centred Care

At the provincial and zone level, patient and family representatives are regularly engaged to provide input, feedback and provide a consistent patient voice. AHS has developed an active Patient and Family Advisor Network and are involved in an array of activities. AHS is encouraged to recruit patient advisors at the local level and have them involved in site initiatives and education development. Advisors have a strong desire to be relevant and add value to the organization through their engagement. Patient and family advisors are huge assets to healthcare and can speak about their involvement in terms of bringing the patient voice to the planning of programs and service design.

At the site, patient and family members spoke of active participation in the development of care plans, discharge plans and expressed great appreciation for respectful, responsive and compassionate care. There are concerted efforts to increase flexibility in approaches to care and to adapt programs and processes considering the wishes and preferences of the patient and family members.

There are numerous examples of carefully developed processes and programs to respond to the unique needs of patients and their families. Patient and family members spoke about the deeply compassionate care they received and the confidence that they would get the care they needed.

Residents actively participate in their care plans within the LTC unit. Regular interdisciplinary rounds are conducted to address resident concerns. Additionally, residents share their feedback during quarterly Resident Council meetings. Residents and their families shared high levels of satisfaction with the care and respect they receive. The team is encouraged to maintain and enhance engagement with 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

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%
	Perioperative Services and Invasive Procedures	1 / 1	100.0%
Concentrated Electrolytes	Medication Management	3 / 3	100.0%
Fall Prevention and Injury Reduction – Long-Term Care Services	Long-Term Care Services	6 / 6	100.0%
Falls Prevention and Injury Reduction - Inpatient Services	Inpatient Services	3 / 3	100.0%
	Perioperative Services and Invasive Procedures	3 / 3	100.0%
Hand-hygiene Compliance	Infection Prevention and Control	3 / 3	100.0%
Hand-hygiene Education and Training	Infection Prevention and Control	1 / 1	100.0%
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%
	Perioperative Services and Invasive Procedures	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%
	Perioperative Services and Invasive Procedures	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%
	Perioperative Services and Invasive Procedures	5 / 5	100.0%
Safe Surgery Checklist	Perioperative Services and Invasive Procedures	5 / 5	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	5 / 5	100.0%
	Perioperative Services and Invasive Procedures	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

The Emergency Disaster Management Interdisciplinary Committee convenes monthly to address emergency and disaster-related issues. This dedicated committee is focused on enhancing staff and patient safety. Monthly code reviews are conducted at both the departmental and committee levels, with staff finding these reviews beneficial in understanding their roles during a code. 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. Hotwash debrief records, completed after incidents and drills, offer valuable insights into successes and opportunities for enhancement. The team is encouraged to document timelines, responsible individuals, and completion dates for recommendations.

Policies are developed and reviewed centrally before being adapted for local implementation. 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 should establish 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: 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

A variety of online resources and educational materials for infection prevention and control (IPC) are readily accessible, and staff have found them beneficial for managing and preventing infections. Staff are knowledgeable about proper hand-hygiene practices, and hand-hygiene audits are conducted, with results shared throughout the facility. The team is encouraged to share departmental-specific results and actively involve staff and physicians in improvement efforts.

Staff indicated that they had designated sinks for staff use only in patient rooms; however, patients do use these at times. Patient sinks should be considered contaminated and, whenever possible, should not be used for health care worker handwashing. If there are no other sinks for patient use in the room, the team is encouraged to consider convenient access to designated sinks in an area outside of the patient room for health care worker handwashing not shared with patients.

Hand sanitizers are provided inside and outside patient rooms, but some departments lack hand sanitizers at exits before closed doors. The team should consider installing hand sanitizing dispensers near exits. In long-term care (LTC), hand sanitizers are available in patient rooms but are sporadically placed in hallways. The team should evaluate the need for additional hand sanitizing dispensers in the corridors between rooms.

While there is an informal process for sharing evaluations and lessons learned during and after outbreaks, the team is encouraged to formalize this process to ensure that insights for preventing future outbreaks are widely communicated to staff and patients.

Environmental services staff are well-trained and understand their role in maintaining a safe environment.

In LTC, it was noted that food service sinks used for rinsing dirty dishes are located adjacent to food preparation areas. The site is encouraged to consider installing a splash barrier between the clean food area and the dirty dishes. In the main kitchen's clean area, sinks used for rinsing pots can cause splashing onto surfaces where clean food wrappings were found. The team should review and clarify the appropriate use of this area.

The linen area is well organized, and staff are knowledgeable about proper separation and the use of personal protective equipment (PPE). The team is encouraged to add hand-hygiene sanitizers to enhance ease of use in this area.

Table 3: Unmet Criteria for Infection Prevention and Control

Criteria Number	Criteria Text	Criteria Type
1.2.10	Applicable standards for food safety are followed to prevent food-borne illnesses.	HIGH
3.3.5	Results of evaluations are shared with team members, volunteers, clients, and families.	NORMAL

Leadership

Standard Rating: 100.0% Met Criteria

0.0% of criteria were unmet.

Assessment Results

The physical environment is aging while the demand for services is increasing. The organization has maximized its current space and will need to expand space to meet future demands/patient volumes. There is limited space for storage which has resulted in clutter and equipment stored in the hall. There is also a significant amount of equipment stored around the perioperative area and in the recovery room.

Several environmental improvement opportunities were identified. For instance, cardboard boxes filled with supplies were found on the floor in the MRI department, and wooden handrails with carpeting were present in all departments. Additionally, paper posters and flyers cluttered the walls, and laminated surfaces on counters and desks were in poor condition, making them difficult to clean and increasing the risk of cross contamination. The team is encouraged to assess high-risk areas in the environment and develop a plan to address these concerns.

During the accreditation survey visit, several visitors and patients were having issues with wayfinding. Signage is small and difficult to read. The team should consider improving wayfinding, and engaging patients and families in the co-design.

Several patient safety and quality indicators are collected and generated through Connect Care and Tableau. Some of these are posted and reviewed with staff at the site level. The creation of program specific indicators that include action plans and targets so that all staff understand their role in achieving specific targets is encouraged. The team may want to consider creating quality teams for each department to facilitate the engagement of staff in quality improvement (QI).

Table 4: Unmet Criteria for Leadership

There are no unmet criteria for this section.

Medication Management

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

All medications are verified electronically by an off-site pharmacist 24 hours a day, seven days per week. A clinical pharmacist is available to meet with patients and consult with physicians. Physicians and nurses commented that they feel supported by the clinical pharmacist.

The site is staffed with one pharmacist, two pharmacy technicians and one pharmacy assistant. The team is well respected by staff. Recruitment and retention of staff in the pharmacy department was identified as a concern, leaving less time for the pharmacist to complete clinical work. Previously pharmacy technicians were able to complete medication reconciliation and adjust within order entry. The pharmacy technicians would like to work to their full scope of practice again, thereby freeing up time for the pharmacist to complete more clinical work.

The pharmacy is clean, well-organized and well lit. One exception is the lighting within the “rolling shelves” area, making it difficult to read medication labels. The team is encouraged to improve the lighting in this area to increase visibility of medication labels.

The team is working on the implementation of automated dispensing units which will improve patient safety and workload. The organization has benefited from the implementation of Connect Care as it has removed many of the previous challenges such as transcription errors, use of “Do Not Use” abbreviations, and provides improved consistency with medication orders and standards. Staff shared they were provided with good education and training related to medication management.

Several audits and indicators are created related to medication management. The leaders are encouraged to share these with their teams on a regular basis to assist in the identification of areas for QI.

Table 5: Unmet Criteria for Medication Management

Criteria Number	Criteria Text	Criteria Type
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: 97.5% Met Criteria

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

Assessment Results

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.

There is a strong emphasis on designing 'senior friendly' services to meet the needs of older adults served by this program. Service-specific goals are developed by some teams, selected to align with corporate goals and objectives. Indicators are selected by the team to monitor their success in achieving their goals, but findings are not shared broadly via their quality board.

Information on palliative and end-of-life care includes information for patients and families as well as resources for the team, referral and access. The inpatient unit and other patient areas throughout Westlock Healthcare Centre were noted to be somewhat cluttered with space constraints, sometimes obscuring education boards, patient information, and signage. Quality initiatives were highlighted, and staff were aware of them but unable to provide specific detail or evaluation results.

The team has undertaken several initiatives, identifying opportunities for improvement and implementing actions to support change (e.g., alternate level of care [ALC] rates, comprehensive admission package including rights and responsibility pamphlets for admitted patients). The organization is strongly encouraged to focus on continuous QI at the unit level. Patient-focused quality boards are not present on the units; however, there is one in a hallway outside of the inpatient unit. A staff education board exists in the medicine inpatient unit, but audit results, trending or interventions are not consistently posted.

Teams have developed strategic partnerships to meet the needs of their patients and community. A multidisciplinary team including (but not limited to) occupational therapist, physiotherapist, speech language pathologist, social work, clinical pharmacist and dietitian as well as medical and nursing staff provides comprehensive care to patients.

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 implemented. Leadership assigns and reviews workload in a consistent manner and advocates for additional resources and demand continues to grow for services at the site. Staff morale is excellent and proud of the "Just Culture" that has developed throughout Westlock Healthcare Center.

Performance appraisals are to be completed on an annual basis as per organization policy. They are often completed in a timely manner according to staff on the inpatient medicine unit. However, LTC staff have not received performance appraisals/development conversations in several years. All other areas experience variability. Through these conversations there is an opportunity to follow up on issues and opportunities for growth.

Policies and procedures are currently being updated provincially and staff indicated that they access policies electronically when needed but navigating the online platform to access is challenging. The organization is encouraged to revisit and review policies that are identified as not requiring review or revision to ensure best practice is reflected in the policy. Standardized communication tools are regularly used by the team and compliance is monitored. Leadership ensures that staff are provided with education

and training on how to identify, reduce and manage safety risks.

Connect Care implementation took place almost two years ago enabling comprehensive, standardized assessments are conducted on each patient and documented 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.

Leadership and physicians met during the survey could speak to organizational policies regarding privacy and disclosure of health information.

Evidence-informed guidelines are selected for use by the team and are reviewed on a regular basis. 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 the organizational policy for disclosure.

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

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 emergency department (ED) features a prominent sign for identification; however, the directional signage leading to the entrance is small and fading. Inside the department, numerous paper signs clutter the walls, making it challenging for patients to navigate to the registration desk. The team is encouraged to assess the signage and seek patient input for potential improvements.

In recent years, the ED has experienced growth and an increase in patient complexity. It serves a diverse patient population of all ages and is designated as a stroke center utilizing TeleStroke technology. Recent staffing increases have positively impacted workload and staff morale.

The ED has 11 patient spaces, including three resuscitation bays, two private rooms, and multi-stretcher and lounge chair areas. However, there is no negative pressure room available, necessitating the use of a regular private room for patients with airborne illnesses. This creates space challenges, as the room cannot be used for hours following discharge. The team is encouraged to consider establishing a negative pressure area to better accommodate patients with airborne infections.

Patient registration occurs in an open area, raising privacy concerns due to the lack of barriers between the registration desk and the waiting room. The team, in collaboration with patients, is encouraged to explore options to enhance privacy in this space.

While access to spiritual care is available, patients and families currently lack a designated area for spiritual practices. It is suggested that the team investigate opportunities to create a dedicated space for this purpose within the organization.

Staff have access to various training opportunities, including non-violent crisis intervention. Although there is no dedicated seclusion room, a private room is utilized for this purpose. Some staff have expressed concerns about increasing violence in the ED and the limited availability of security or peace officers, a concern echoed by a Royal Canadian Mounted Police officer interviewed during the accreditation survey visit.

Patient flow remains a challenge, particularly with an increasing number of patients designated as ALC awaitingLTC beds. The team employs a phased approach to manage patient flow and reduce overcrowding, participating in daily huddles with north zone and Edmonton hospitals. Excellent dashboards providing capacity data assist in effective bed management.

Staff are trained in organ donation and are committed to improving referral rates as appropriate.

Patients and families interviewed expressed high satisfaction with the care they receive, describing the team as efficient, compassionate, and competent. Many patients noted that they choose to drive past other hospitals to receive care at Westlock Healthcare Centre. The survey highlighted the caring and collaborative nature of the staff and physicians.

Numerous quality indicators, including ambulance offload times, are collected and reviewed with staff. The next step is to analyze these indicators to identify areas for QI.

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

0.0% 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. The inpatient unit has a clinical pharmacist who assists with completion. Leadership at the site are encouraged to engage physicians to ensure compliance with medication reconciliation on admission.

On admission, standardized information as well as service-specific information is provided to patients. They are written in plain language and were developed with input from patients and families. 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.

The team has put considerable effort into standardizing practices across the region to improve care and reduce risk. A number of evidence-informed clinical guidelines have been developed or adopted by the interdisciplinary team and incorporated into practice (e.g., deep vein thrombosis/pulmonary embolism).

The team has timely access to diagnostic testing and specialist consultation. Palliative and end-of-life care is available to patients and supported by the team as indicated/requested. Spiritual care services are always available as needed for patients/residents. There is no dedicated spiritual space in acute care but a family/quiet room is accessible if needed.

At Westlock Healthcare Centre, workflow was described as challenging and a number of barriers to patient flow were identified. Significantly high ALC patients on the inpatient unit (range 30-50%) was identified as the biggest barrier, limiting access to beds for more acute patients. The site has currently developed a quality initiative to engage key partners, analyze and trend the data, and explore options for consideration and recommendation which will increase patient flow and decrease ALC rate. The presence of quality boards vary with little focus on patient-centric quality boards throughout the site. Consideration should be given to the deployment of standardized quality boards, located in public areas. Key performance indicators related to quality, safety and efficiency need to be consistently tracked, shared with frontline staff and displayed.

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 LTC home is welcoming, clean and bright. There is a designated bathing room; however, it did not appear welcoming, and the tub and resident lift appeared dated. It is suggested that renovations and equipment be considered for future replacement to ensure resident comfort.

Staff indicated that 24/7 access for designated family/support was not the norm unless an exception was made e.g., for palliative reasons. Ensuring staff are aware of AHS policies regarding family presence, including open visiting for designated family/support persons, could make the process smoother and more consistent, rather than relying on exceptions.

The Resident Council meets quarterly, and families are invited, but attendance is low. The team is encouraged to reach out to families to determine if there is interest in creating a Family Council meeting virtually to facilitate input from families.

Interdisciplinary rounds are held weekly where the team reviews the residents' needs, goals and care in detail. Residents and families are involved in care planning. It was noted that a number of residents had an indwelling catheter which increases the risk of urinary tract infections. The team should review the criteria for indwelling catheters utilizing best practices and ensure that these are followed.

Several indicators are collected, posted and reviewed. The team is encouraged to analyze and determine areas for QI initiatives and implement strategies for improvement.

The LTC team is commended for their commitment to providing good care and creating a home-like environment for residents and their families.

Table 9: Unmet Criteria for Long-Term Care Services

There are no unmet criteria for this section.

Perioperative Services and Invasive Procedures

Standard Rating: 100.0% Met Criteria

0.0% of criteria were unmet.

Assessment Results

The perioperative leadership and staff are to be commended on their commitment to providing quality and safe care for their patients. There is a strong level of compassion and engagement evident in the care that they provide consisting of collaborative interdisciplinary teams. Consideration of future growth and demands will need to be at the forefront of planning for the organization.

Staff credentialing, privileging, education, and competency assessments are documented. All staff receive an orientation that meets their needs. They receive education on workplace violence, just-culture and complaints. There is a strong safety culture in the perioperative setting. Patient safety incidents are reported according to the organization's policy and documented with strategies developed and implemented to address identified safety risks.

The operating room has a focus on safety and quality. Documentation is complete and the surgical safety checklist is performed consistently. The patient journey is patient-centric and seamless. The procedure rooms currently meet waitlist needs for cataract and orthopedic surgery. The site is currently hiring another orthopedic surgeon to ensure patients are receiving care within the identified benchmarks. While this will address the waitlist, the challenge will be inpatient bed availability to meet that demand. The procedure room runs very effectively and efficiently. Patients and families speak very highly of care received in the perioperative setting. Patients described their care as exceptional, timely and by a team that is compassionate and caring.

The organization is encouraged to identify appropriate storage space for equipment that is currently stored in and around the perioperative area and in the recovery room. This limits space and challenges when care is required for more than one post-operative patient. All areas are exceptionally clean, the equipment is well maintained and meeting IPC standards.

There is a code cart located in the perioperative area adjacent to the procedure room. Protocols and guidelines are well established with comprehensive education provided to all staff. All medications are double-checked and prepared by the individual responsible to administer.

The organization has a robust program for its medical devices. Preventive maintenance schedules are developed. Policies are in place for equipment management and repair, cleaning, staff training, critical incident investigations, recalls, disposal and decommissioning. The required organizational learning system is used for tracking reported issues. Cleaning and disinfecting of medical devices and equipment were noted to be performed frequently and consistently at the time of the survey. Manufacturer recommendations are available for all of the medical devices and equipment and confirmation that cleaning and disinfecting is consistently done in accordance with manufacturer recommendations. It is recommended that the organization proceed with the proposed expansion of the medical device reprocessing area and a comprehensive review of resource needs also take place that allows for successful recruitment when the expansion is complete. The expansion will allow for purchase of additional equipment to meet future demands and avoid delays or cancellation of procedures.

Table 10: Unmet Criteria for Perioperative Services and Invasive Procedures

There are no unmet criteria for this section.

Reprocessing of Reusable Medical Devices

Standard Rating: 98.9% Met Criteria

1.1% of criteria were unmet. For further details please review the table at the end of this section.

Assessment Results

The leaders and team members of the medical device reprocessing department (MDRD) are committed to the quality of medical device and equipment reprocessing. Each team member spoke to being proud to contribute to high quality patient care. A comprehensive orientation is provided to new team members. Team performance is regularly evaluated and documented in an objective, interactive and constructive manner. Dress code policy is strictly adhered to as it pertains to clothing, hair covering, footwear, jewelry and PPE. There is strong evidence of team resiliency.

The organization is encouraged to proceed with the recommended renovation and expansion of the MDRD. Current space is maximized with inability to purchase or reprocess additional equipment. The reprocessing areas are clean and well maintained but very limited in space. The washer and sterilizer are maximized to capacity. As well, additional washers and sterilizer are needed for any further growth in service provision at the site. Staff are well trained in standard operating procedures (SOP).

The MDRD has a good relationship with perioperative services to manage volumes, instrumentation purchases and the development of new SOPs. Reprocessing is not contracted out to external providers.

The MDRD allows appropriate separation of contaminated and clean/sterilized items with temperature and humidity monitored regularly, but the separation can be improved. The planned renovations will allow for ideal spacing, design to meet service volumes and better flow through the department.

Table 11: Unmet Criteria for Reprocessing of Reusable Medical Devices

Criteria Number	Criteria Text	Criteria Type
4.4.1	The Medical Device Reprocessing (MDR) department has an appropriate storage area for sterilized medical devices and equipment.	HIGH

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
Infection Prevention and Control	1.2.10 - Applicable standards for food safety are followed to prevent food-borne illnesses.	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
Reprocessing of Reusable Medical Devices	4.4.1 - The Medical Device Reprocessing (MDR) department has an appropriate storage area for sterilized medical devices and equipment.	June 2, 2026