Accreditation Report

Qmentum Global™ for Canadian Accreditation Program

Whitecourt Healthcare 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

The Whitecourt Healthcare Centre has provided vital healthcare services to the community and surrounding areas for many years and is an integral part of the fabric of the community. It is supported by an active foundation that has provided significant support and acquired needed equipment for the facility.

The site has developed capacities in emergency and disaster management that have served its community well in times of unusual events such as evacuations and, of course, the COVID-19 pandemic.

Staff, physicians, and management refer to a sense of pride and family at the site. Surveyors noticed a distinct sense of commitment to the success of the site and the populations they serve.

Patients and families interviewed expressed satisfaction with the care and services they received. They felt they were invited to be involved and make decisions about their care and well-being. They also expressed their gratitude for access to an array of healthcare services close to home and for the caring, professional attitude of staff and physicians.

The implementation of the Connect Care clinical information system has been a welcome addition, despite some initial learning challenges. Most staff and physicians agree it has changed the way they work and the care provided in many positive ways.

While carefully considering significant space constraints, particularly in the perioperative and reprocessing areas, the site is encouraged to continue its pursuit of clinical and support programs to enhance accessibility to quality care as close to home as possible and continue its collaboration with other facilities, agencies, and partners to best meet the needs of the people served at Whitecourt Healthcare Centre.

Key Opportunities and Areas of Excellence

Areas of Excellence:

- Mix of services provided including emergency services, inpatient services, medical detoxification, and the capacity to address medical concerns and manage withdrawal simultaneously
- A team that demonstrated commitment to compassionate patient-centred care
- Pride in work - sense of family among staff
- Emergency preparedness - fire drills, documented meetings
- Patients pleased with access and approach of staff

Key Opportunities:

- Consistent use of the two person-identifier process even when staff are familiar with the patient
- Evaluation of effectiveness of efforts
- Inadequate medication room for services provided at the site – consider remedies for the deficiencies of the medication room or finding an alternative location for it
- Engagement of staff and patients in localized quality improvement and ongoing monitoring of key performance indicators that are shared widely
- Performance reviews / development conversations completed in a timely manner
- Greater IPC presence on-site to address risks (e.g., hand-hygiene audits not being completed, risk of cross contamination with flow of endoscopes being cleaned, porous surfaces in clinical areas, etc.)
- Establish a process of regularly checking for updated provincial policies if keeping paper versions in binders

People-Centred Care

Staff at Whitecourt Healthcare Centre report a shift in the population served. There is now a greater proportion of senior patients.

In addition to benefiting from the people-centered care structures and processes at the zone and provincial level, the site utilizes an AHS Patient Experience Survey. The survey is left in each room at room turnover for the new patient to complete prior to discharge. It does not appear that this information is communicated back to the staff or used for quality improvement. Although site leadership and staff describe the process used to investigate and follow-up on patient complaints, surveyors found no evidence of easy-to-access proactive communication advising patients on how to initiate a complaint. Site leadership is encouraged to use both posters in the patient areas as well as pamphlets in the patient waiting rooms providing information on how a complaint can be made.

Leadership and staff were able to provide little evidence of co-design or involvement of patients and families in improvement at the local level. Site leadership is encouraged to leverage local structures such as a women's auxiliary, community group, or volunteer to bring this perspective to a health center working group focused on addressing a quality or patient safety issue. As an example, surveyors observed that patient volumes varied significantly during the workday, resulting in staff stress. A working group of staff, a mix of current/former patients/family members, facilitated by site leadership could

consider options for smoothing volumes across the workday. A co-design process, when thoughtfully planned and executed, is likely to result in more creative options with less resistance.

Finally, surveyors observed a staff member bringing in a cat for an elderly patient. This may present an opportunity to co-design a volunteer pet therapy program providing more structure, greater therapeutic benefit, and decreasing the risk to the organization.

Accreditation Decision

Alberta Health Services' accreditation decision continues to be:

Accredited

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

Required Organizational Practices

Required Organizational Practices (ROPs) are essential practices that an organization must have in place to enhance client safety and minimize risk. ROPs contain multiple criteria, which are called Tests for Compliance (TFC).

Table 1: Summary of the Organization's ROPs

ROP Name	Standard(s)	# TFC Rating Met	% TFC Met
Antimicrobial Stewardship	Medication Management	4 / 5	80.0%
Client Identification	Emergency Department	1 / 1	100.0%
	Inpatient Services	1 / 1	100.0%
	Obstetrics Services	Not Rated	Not Rated
	Perioperative Services and Invasive Procedures	0 / 1	0.0%
Concentrated Electrolytes	Medication Management	3 / 3	100.0%
Falls Prevention and Injury Reduction - Inpatient Services	Inpatient Services	2 / 3	66.7%
	Obstetrics Services	3 / 3	100.0%
	Perioperative Services and Invasive Procedures	3 / 3	100.0%
Hand-hygiene Compliance	Infection Prevention and Control	1 / 3	33.3%
Hand-hygiene Education and Training	Infection Prevention and Control	1 / 1	100.0%
Heparin Safety	Medication Management	4 / 4	100.0%

ROP Name	Standard(s)	# TFC Rating Met	% TFC Met
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%
	Inpatient Services	5 / 5	100.0%
	Obstetrics Services	5 / 5	100.0%
	Perioperative Services and Invasive Procedures	5 / 5	100.0%
Infusion Pump Safety	Service Excellence	4 / 6	66.7%
Medication Reconciliation at Care Transitions - Emergency Department	Emergency Department	1 / 1	100.0%
Medication Reconciliation at Care Transitions Acute Care Services (Inpatient)	Inpatient Services	4 / 4	100.0%
	Obstetrics 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	4 / 5	80.0%
	Perioperative Services and Invasive Procedures	N/A	N/A
Reprocessing	Infection Prevention and Control	Not Rated	Not Rated

ROP Name	Standard(s)	# TFC Rating Met	% TFC Met
Safe Surgery Checklist	Obstetrics Services	3 / 5	60.0%
	Perioperative Services and Invasive Procedures	3 / 5	60.0%
Suicide Prevention	Emergency Department	5 / 5	100.0%
The 'Do Not Use' List of Abbreviations	Medication Management	7 / 7	100.0%
Venous Thromboembolism (VTE) Prophylaxis	Inpatient Services	3 / 4	75.0%
	Perioperative Services and Invasive Procedures	N/A	N/A

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

Monthly fire drills are planned, executed, observed, debriefed, and recorded with feedback provided to participants. A site-based fire marshal is in place and active throughout the facility. An Emergency Disaster Management (E/DM) Committee is also active, meeting regularly, and the minutes are up to date and accessible. Quarterly inspections of the facility are completed. A call-back list is updated regularly, or as specific needs arise. Zone leaders receive regular reports of E/DM activities and results. Fire extinguishers are maintained by an external contractor and were found to be up to date. Workplace health and safety inspections are undertaken and recorded. It is recommended that the site supervisor sign each of the reports. Emergency response plans have been developed for common disruptions, and a business continuity management plan exists.

While it appears the latest policies for E/DM are maintained provincially and updated electronically on Insite, the individual site binders, readily identifiable by their bright yellow color, contain many policies that have not been updated for some time. Response plans for most codes range in vintage from 2008 (mass casualty) to 2024 (bomb threat). Zone representatives indicated that codes and plans are reviewed every three years based on literature reviews and past incidents. Templates for updated plans/codes are sent to sites, and local details can be added. A *Code Orange* response template was sent in 2025, and sites are in the process of updating this plan. It is recommended that all site personnel be made aware that response plans and codes come from a provincial AHS plan. It is further recommended that site binders contain updated plans and accountability be established for ensuring new versions are completed and older versions of response plans are purged from binders at all units and areas in the site. It was also noted that a *Pandemic Guide* dated 2009 was also in a binder.

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

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Infection Prevention and Control

Standard Rating: 90.2% Met Criteria

9.8% of criteria were unmet. For further details please review the table at the end of this section.

Assessment Results

Infection prevention and control (IPC) at the Whitecourt Healthcare Centre is supported by a north zone IPC team who appear quite knowledgeable and enthusiastic about their roles. Information is shared from the zone and provincial IPC team using a “trickle down” effect that often involves emails as well as IPC meetings involving the site manager and heads of the departments. Consultation with related agencies and partners occurs as needed. IPC site visits currently focus on acute care; however, there is hope that this will be expanded to include the entire site and services. Equipment purchases are evaluated by zone IPC to ensure acquisitions align with policies. IPC policies are being reviewed, and completion of this work by IPC is encouraged.

Healthcare associated infections are tracked, analyzed, and shared with leadership. Site staff are aware of challenges with bacteria such as Methicillin-resistant *Staphylococcus aureus*, and contact precautions are quickly initiated and communicated appropriately.

Concern is noted that in the small room, near obstetrical delivery, that is used to test urine, an older model pan cleaning sink is next to the urinalysis testing machine, posing a risk to the accuracy of testing and the safety of employees from splashing if the sink is used to discard samples.

Site practice reviews have occurred. During the survey, significant clutter was observed throughout the site. In addition, there are porous surfaces in a number of clinical and support areas that are not in line with IPC best practices.

Also of concern is the flow of soiled equipment (endoscopes) through the medical device reprocessing space at the site. The area is quite small, and soiled scopes pass by the clean staging area. In addition, the new sink has been installed at the end of the narrow room next to the area for cleaning scopes. The layout of the room presents a risk, and it is recommended this be highlighted and addressed. This should be considered in light of the challenges for IPC posed by the expansion of surgery that will have implications for staff, space, and storage. IPC will need to be fully engaged in all plans to minimize the significant risk of cross-contamination and flow between sterile and soiled areas that such services pose.

Additionally, the increase in respiratory illness and measles poses significant risk and is resulting in increased personal protective equipment usage. It is suggested the site undertake a “Lean 5S” event to move clutter and ensure there is adequate storage space for equipment for potential outbreaks. Morale is also enhanced when staff do not have to face a cluttered work environment.

There is a provincial quality improvement (QI) plan; however, there is no such plan for the site.

Patient and family advisors are engaged at the provincial and zone level. Recruitment and training of patient and family members is suggested for the site. Training would be overseen by IPC. Hand-hygiene audits have lapsed at the site, and the site is encouraged to work with IPC to recommence these audits. Patients and family members could be utilized in these audits and reporting.

The regular on-site support provided by an IPC expert cannot be understated in today's environment. Increased visibility and engagement at the site by the zone IPC team and support to site management and staff is recommended.

Table 3: Unmet Criteria for Infection Prevention and Control

Criteria Number	Criteria Text	Criteria Type
2.1.6	Compliance with infection prevention and control policies and procedures is monitored and improvements are made to the policies and procedures based on the results.	NORMAL
2.5.6	Hand-hygiene Compliance 2.5.6.1 Compliance with accepted hand-hygiene practices is measured using direct observation (audit). For organizations that provide services in clients' homes, a combination of two or more alternative methods may be used, for example: • Team members recording their own compliance with accepted hand-hygiene practices (self-audit). • Measuring product use. • Questions on client satisfaction surveys that ask about team members' hand-hygiene compliance. • Measuring the quality of hand-hygiene techniques (e.g., through the use of ultraviolet gels or lotions). 2.5.6.3 Hand-hygiene compliance results are used to make improvements to hand-hygiene practices.	ROP
3.3.1	There is a quality improvement plan for the infection prevention and control program.	HIGH

Leadership

Standard Rating: 100.0% Met Criteria

0.0% of criteria were unmet.

Assessment Results

Whitecourt Healthcare Centre has a relatively new site leader. This can be a daunting task, particularly trying to navigate the challenges of a rural site within the north zone. Several departments within the site may report to different program leaders who are not on-site and/or shared among other facilities in other communities.

Whitecourt Healthcare Centre is an active and busy site. Staff are most proud of the sense of pride and family that exists and this is quite commendable. Also, performance metrics in several key areas are above the AHS average.

The foundation has been a big supporter of the facility and has worked to acquire the equipment needed.

The site houses a myriad of health services. It is important that best use be made of the limited space, and the site is free from clutter and storage of equipment and supplies no longer used. It is suggested a “Lean 5S” initiative be undertaken to ensure maximum use of space. As well, the site is encouraged to explore opportunities to involve patients and families in more of the operations and initiatives of the centre. Such support will be particularly beneficial if the site chooses to move forward withQI projects and creating a culture of QI embedded in all of its departments and services. Support from AHS may be available to help facilitate a start.

Medical device reprocessing space and flow of endoscopic equipment for cleaning poses a risk. In addition, the movement of people and equipment and the potential for cross-contamination and breach of sterile space is a concern. The site is encouraged to work with IPC supports and Facilities, Maintenance and Engineering to review current state and implement measures to for better cleaning and sterilization practices in key areas throughout the site. In addition, increased IPC support is suggested to restart hand-hygiene audits and further IPC education.

Another major challenge for leadership will be to develop the capacity to evaluate the effectiveness of its services.

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

Whitecourt Healthcare Centre has an on-site pharmacy that is well-organized with a pharmacist (shared with another site), a pharmacy technician, and a pharmacy assistant. There is no compounding done on-site, and the site does not provide chemotherapy. There is an interdisciplinary approach to medication management, with the pharmacist collaborating with the physicians and nursing staff during daily rounds.

Staff reported that patient self-administration does occur at this site and that patient medications are sometimes kept at the bedside, but the site does not have a process for the safe storage of patient medications at the bedside. Although the patient population served by the site includes patients at increased risk for medication-related complications, the team does not have a process for developing medication plans for these patient groups.

Comprehensive auditing of high-alert medications is maintained. Antimicrobial stewardship is done at this site and is also audited. However, staff reported that they are unaware of the results of the audits, and the results are not used for QI. Leaders are encouraged to share the results of audits with staff and use the results for QI.

As the AHS *Medication Orders* policy (PS-93) has not been updated since 2018, the organization is encouraged to do so.

Table 5: Unmet Criteria for Medication Management

Criteria Number	Criteria Text	Criteria Type
1.2.3	Antimicrobial Stewardship 1.2.3.5 The program is evaluated on an ongoing basis and results are shared with stakeholders in the organization.	ROP
1.3.3	The organization has developed local implementation action plans that include prioritizing which high-risk client populations or units receive the evidence-informed care activities from pharmacists.	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

Criteria Number	Criteria Text	Criteria Type
10.2.4	Medications that are self-administered by clients are stored and labelled safely and appropriately.	NORMAL

Service Excellence

Standard Rating: 88.5% Met Criteria

11.5% of criteria were unmet. For further details please review the table at the end of this section.

Assessment Results

Patients interviewed at Whitecourt Healthcare Centre stated that they were pleased with the timely access to services and care they received from staff and physicians. Site management, staff and physicians at the site have a sound knowledge and awareness of the populations served by their facility – geriatric, mental health and addiction needs are increasing.

Staff at the site report receiving appropriate orientation and completing their yearly required training on MyLearningLink. Performance reviews/development conversations appear to be inconsistent, and in several employees' cases, non-existent despite long years of service. The site is encouraged to work with Human Resources to undertake a current state assessment and develop an ambitious plan to ensure development conversations are up to date.

There is evidence of medical leadership at the site and an episode of emergency care witnessed by a surveyor, was of a high degree of professionalism and compassion displayed by staff and physician. There was excellent collaboration among the team and the patient felt very well served and respected.

The electronic health information system, Connect Care, recently implemented has been an excellent addition to care. Assessments, screenings, and care are documented. Care plans, clinical pathways and medication reconciliations are utilized. Continuity of care and transfer of information among site providers as well as with referred specialists is facilitated. Connect Care has enhanced record keeping. Patient records were complete and up-to-date. Evaluation of record keeping occurs across the system and follow-ups are made as needed.

The AHS "Shared Commitment" literature is visible at the site; however, it is suggested posters and opportunities to provide feedback be more visible in patient waiting areas.

Performance at the site is tracked and reported openly. Although considerable indicators of performance exist and are accessible, it is suggested that greater effort be placed on sharing this information at the site level (with frontline staff, providers, and the general community). The current "pull" system from Tableau, rather than a "push" system, is suboptimal given the heavy workloads of frontline staff. QI activities are not readily evident at the site, and staff interviewed indicated they have not participated in, or been aware of, any QI projects. The site is encouraged to pursue AHS resources for help in initiating several short-term quality projects that could form the foundations of a QI culture. Patients and families are encouraged to be part of any such efforts. Although there are patient and family advisory activities at the provincial and zone levels, no such groups have been developed at the site. The site is encouraged to build capacity in people-centered care and engage local people in support of the healthcare facility and its operations.

Palliative care services are available and supports are provided for families suffering a loss.

Although components of many required organizational practices are in place, the site has not been compliant with the requirements to evaluate the effectiveness of its safety programs and approaches in areas such as hand-hygiene, falls prevention, venous thromboembolism (VTE) prophylaxis, and pressure ulcer prevention. Use of two client identifications was also not consistent at the site.

A review of training records indicates only one staff member had training in 2024 or later and it appears the remainder of staff are not up to date. Site management indicated that correcting this is a priority for themselves and the clinical nurse educator (CNE). This is a high risk for the site, and they are encouraged to ensure all staff are evaluated and current with infusion pump training.

The site will suggest chaplains if requested; however, there is no designated space for spiritual care. At times, a patient lounge may be used, or at other times, spiritual care is provided in patients' rooms. The site is encouraged to identify space for spiritual care.

Performance reviews/development conversations have not been consistently done. Some staff interviewed stated it has been longer than four years since they have had one done. The site manager also indicated the challenges of keeping up on development conversations. The site is encouraged to review its approach and set expectations to catch up and monitor/share results.

Table 6: Unmet Criteria for Service Excellence

Criteria Number	Criteria Text	Criteria Type
2.1.7	Infusion Pump Safety 2.1.7.4 The competence of team members to use infusion pumps safely is evaluated and documented at least every two years. When infusion pumps are used very infrequently, a just- in-time evaluation of competence is performed. 2.1.7.5 The effectiveness of the approach is evaluated. Evaluation mechanisms may include: • Investigating patient safety incidents related to infusion pump use • Reviewing data from smart pumps • Monitoring evaluations of competence • Seeking feedback from clients, families, and team members	ROP
2.1.10	The team leadership regularly evaluates and documents each staff member's performance in an objective, interactive, and constructive way.	HIGH
2.1.12	The team leadership supports staff to follow up on issues and opportunities for growth identified through performance evaluations.	HIGH
4.3.3	The team identifies measurable objectives for its quality improvement initiatives including specific timeframes for their completion.	HIGH

Criteria Number	Criteria Text	Criteria Type
4.3.4	The team identifies indicators to monitor progress for each quality improvement objective.	NORMAL
4.3.7	The team leadership works with staff to regularly collect indicator data and track progress towards quality improvement objectives.	NORMAL
4.3.10	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: 97.2% Met Criteria

2.8% of criteria were unmet. For further details please review the table at the end of this section.

Assessment Results

Patients interviewed expressed their satisfaction with their care and treatment at the Whitecourt Healthcare Centre. They felt the service was highly accessible and had short wait times to be seen. During the survey, several interactions with nurses and physicians were observed. Staff and physicians were found to be highly competent and professional. Explanations were given and patients had opportunities to be involved in their care and treatment. Triage was very close to initial registration. It was a thorough process guided by Connect Care to ensure all assessments were completed.

Staff and physicians spoke of a sense of belonging and “family” at the site that was highly valued.

Connect Care has been a significant enhancement at the site, despite some ongoing learning challenges to fully utilize the tool. Performance indicators exist and are tracked at zone and provincial levels. Sites in the north zone appear to outperform the provincial scores in several areas of performance. Unfortunately, these results are seldom shared at the site level with staff, and it is recommended these indicators be highly publicized within the site and with partners.

Access to diagnostic imaging (CT scan) off-site was a challenge shared with surveyors by physicians, staff and patients.

Emergency Medical Services(EMS) are responsive and off-load issues are a rarity.

Patient privacy and confidentiality at registration is suboptimal. A lockable storage cabinet in the treatment room containing high alert medications was found to be unlocked and easily accessible to patients and family members. It is recommended that efforts be made to ensure all storage areas designated to be locked are maintained and monitored.

The site manager shared a number of examples of site improvement efforts and of requests for human factors from AHS support for other projects being denied. Despite this, there is limited evidence of ongoing QI within the site. A “culture of busyness” prevails and although staffing issues pose challenges, QI activities hold potential to address a variety of the issues that impact work-life and patient safety and satisfaction. A physician champion appears available to help. The emergency department (ED) services are encouraged to develop a culture of QI that includes limited time projects that can address problems. These projects should involve frontline staff, physicians, patients and family members. They should identify, track, and report key performance indicators and targets within the service and site.

There was very limited awareness among staff of the ethics framework and tools to help in ethical dilemmas and decision-making. Training is encouraged and wider promotion of the framework and related materials is suggested.

Components of the required organizational practices (ROPs) are in place, however full compliance with ROPs was not achieved, as the effectiveness of efforts have not been evaluated. For example, hand-hygiene audits have not been completed; infusion pump training is not up to date. Site management and the CNE are aware of these gaps and have begun to address them. It is suggested aggressive targets be established, shared, and promoted among the staff.

Two patients interviewed remarked that the biggest issue was knowing where to park and go into the ED. The site is encouraged to form a project group comprised of staff and patients to review signage for parking and entrance and make recommendations for potential improvement.

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
2.4.13	Ethics-related issues are proactively identified, managed, and addressed.	HIGH
2.7.3	Client privacy is respected during registration.	NORMAL

Inpatient Services

Standard Rating: 94.4% Met Criteria

5.6% of criteria were unmet. For further details please review the table at the end of this section.

Assessment Results

The inpatient services is an integral component of Whitecourt Healthcare Centre. Staff have a sound knowledge of the populations they serve and display empathy and compassion to patients and visiting family members. Yearly required training modules are completed, and staff feel there are other training opportunities available. Training and updating competencies on infusion pumps is recommended without delay. When questioned, nursing staff were not aware of an ethics framework and displayed limited knowledge of what constitutes an ethical issue. The site is encouraged to organize and deliver ethics training to staff and ensure prompts and supports for ethical decision-making are highlighted on units.

Patients and family members interviewed were highly satisfied with the service and felt staff were professional, diligent, and caring. One patient identified how they felt staff went above and beyond to ensure they were comfortable during their stay. Inpatient care is impacted by the limited access to diagnostic imaging services and required EMS transport to other sites.

The inpatient unit and surrounding areas had a large amount of soiled linen bags in carts awaiting transport for eventual cleaning off-site. The unit is not the most appropriate area for these amounts. Storage in other areas or in an outside area could be explored along with the possibility of more frequent pick-up by the contractor.

Housekeeping staff appear highly motivated and spoke of taking pride in their work. Regular audits of cleaning are undertaken, and follow-up is initiated when results warrant.

As with other clinical services at the site, components of the ROPs were being met, there was no evidence of evaluation of the effectiveness of these practices. The site is encouraged to review the tests for compliance for the ROPs to develop strategies to achieve full compliance as soon as possible. In addition, the inpatient team is encouraged to collaborate with other services at the site to develop a QI plan that will identify key issues, risks, and problems and bring together other staff, physicians, patients, and families to undertake QI projects. These projects should be communicated on quality boards and include key performance indicators that have targets and are highly visible to staff and patients.

Nursing staff advised they were unaware of efforts to evaluate the effectiveness of the program. They were unaware of falls rates at the site. The site is encouraged to evaluate the effectiveness of their falls prevention, pressure ulcer prevention, and VTE prophylaxis programs and share the results on an ongoing basis as a means of accountability as well as for making improvements.

Patient records were up to date and complete. Nursing staff interviewed were aware of the policy on restraints, and examples of compliance were observed.

Access to spiritual care is facilitated by staff; however, there is no specific space designated for spiritual care. It is suggested a review of existing space be undertaken and potential modifications and some acquisition of furnishings be made to an area that could enhance spiritual care experiences for the populations served.

Table 8: Unmet Criteria for Inpatient Services

Criteria Number	Criteria Text	Criteria Type
3.2.12	Ethics-related issues are proactively identified, managed, and addressed.	HIGH
3.3.8	Falls Prevention and Injury Reduction - Inpatient Services 3.3.8.3 The effectiveness of fall prevention and injury reduction precautions and education/information are evaluated, and results are used to make improvements when needed.	ROP
3.3.9	Pressure Ulcer Prevention 3.3.9.5 The effectiveness of pressure ulcer prevention is evaluated, and results are used to make improvements when needed.	ROP
3.3.10	Venous Thromboembolism (VTE) Prophylaxis 3.3.10.3 Measures for appropriate VTE prophylaxis are established, the implementation of appropriate VTE prophylaxis is audited, and this information is used to make improvements to services.	ROP
3.3.14	Diagnostic and laboratory testing and expert consultation are available in a timely way to support a comprehensive assessment.	NORMAL

Obstetrics Services

Standard Rating: 97.0% Met Criteria

3.0% of criteria were unmet. For further details please review the table at the end of this section.

Assessment Results

Obstetrics services have only recently been re-initiated at Whitecourt Healthcare Centre, and staff report a slow increase in the number of deliveries. The site benefits from some staff with many years of obstetrical experience. During the visit, there were no obstetrical patients on-site, and thus a mock tracer process was used.

The staff have implemented a number of tactics to support compliance with best practices, policies, and procedures, including laminated algorithms on the cabinet doors and policies/procedures printed off and in a folder on the wall. During the mock tracer process, the staff demonstrated compliance with obstetrical care criteria. Recent patients interviewed also articulated a high degree of satisfaction, although both patients identified the timeliness of anesthesia services as a challenge.

The physical site challenges include the second delivery room being a significant distance from the primary delivery room. There is an anteroom immediately outside of the delivery room used for urine testing, where stale-dated urine samples were found. The supply room attached to the main delivery room had a medication fridge without a record of fridge temperature monitoring and some used and unused multi-dose medication vials on the cart. As this room needs to be ready at all times, the staff are encouraged to regularly check this room for readiness.

The process of starting staff in the inpatient areas and, once demonstrating confidence and competence, expanding them to more specialty areas such as obstetrics appears to be working well. Both patients reported a high degree of collaboration among the nursing staff to support them during their stay.

No evidence was found at the site of information easily accessible or proactively provided to patients and families about how to file a complaint. The site is encouraged to display posters in patient areas and have pamphlets available in waiting rooms. The results of the evaluation of the safe surgery checklist are not shared with the staff nor are they used to plan improvement or expansion initiatives.

Table 9: Unmet Criteria for Obstetrics Services

Criteria Number	Criteria Text	Criteria Type
1.2.16	Clients and families are provided with information about how to file a complaint or report violations of their rights.	HIGH

Criteria Number	Criteria Text	Criteria Type
1.5.6	Safe Surgery Checklist 1.5.6.4 The use of the checklist is evaluated and results are shared with the team. 1.5.6.5 Results of the evaluation are used to improve the implementation and expand the use of the checklist.	ROP

Perioperative Services and Invasive Procedures

Standard Rating: 94.4% Met Criteria

5.6% of criteria were unmet. For further details please review the table at the end of this section.

Assessment Results

Whitecourt Health Centre provides both surgical and endoscopy services and these are scheduled on different days. During the two-day on-site visit, no surgical services were performed and one day of endoscopy was scheduled. The perioperative area has a combined pre-operative and recovery area, an endoscopy room and an operating room.

The perioperative and invasive procedures and medical devices reprocessing areas have significant space constraints with patient and staff movement, clean instrument movement and dirty equipment all competing for the same space.

Although no surgical procedures were done during the on-site visit, a mock safe surgical checklist process was done and suggests good compliance with the process. Audits are also done on the process, but staff report that they are unaware of the results. The results also appear not to be used for QI.

Monitoring is done but the air exchanges in the operating room (19.4) is just below the lower acceptable limit (20). From conversations with the facilities staff, this is the maximum capacity of the antiquated system. The organization is encouraged to take this into consideration when considering the types of procedures done at this site.

While in the endoscopy area, the two person-specific identifier process was observed not being done across several patients and for one patient across multiple points in their care journey. Site leadership is encouraged to reinforce the importance of two person-specific identifiers even when the number of patients served is small.

No evidence was found of patients and families having easy access to or proactively being provided information on how to file a complaint. The site is encouraged to post posters in patient areas and pamphlets in the waiting rooms.

Given the space constraints, the site is encouraged to both evaluate the current procedures as well as using the facility constraints as a consideration for future procedures.

Table 10: Unmet Criteria for Perioperative Services and Invasive Procedures

Criteria Number	Criteria Text	Criteria Type
1.1.1	The physical layout of the operating and/or procedure room(s) and equipment are designed to consider client flow, traffic patterns, the types of procedures performed, ergonomics, and equipment movement logistics.	NORMAL
1.1.3	Heating, ventilation, temperature, and humidity in the area where surgical and invasive procedures are performed are monitored and maintained according to applicable standards, legislation, and regulations.	NORMAL
1.1.7	Rooms where surgical and invasive procedures are performed have at least 20 complete air exchanges per hour.	HIGH
1.2.1	Surgical equipment and medical devices are regularly calibrated according to the manufacturers' instructions.	HIGH
1.2.9	Contaminated items are transported separately from clean or sterilized items, and away from client service and high-traffic areas.	HIGH
2.2.16	Clients and families are provided with information about how to file a complaint or report violations of their rights.	HIGH
2.4.3	Client Identification 2.4.3.1 At least two person-specific identifiers are used to confirm that clients receive the service or procedure intended for them, in partnership with clients and families.	ROP
2.6.3	Safe Surgery Checklist 2.6.3.4 The use of the checklist is evaluated and results are shared with the team. 2.6.3.5 Results of the evaluation are used to improve the implementation and expand the use of the checklist.	ROP

Reprocessing of Reusable Medical Devices

Standard Rating: 87.2% Met Criteria

12.8% of criteria were unmet. For further details please review the table at the end of this section.

Assessment Results

Whitecourt Healthcare Centre decontaminates surgical instruments and reprocesses scopes. No sterilization is done on-site including flash sterilization. All instruments requiring sterilization are sent off-site.

The organization has a process in place of auditing its sites every two years and this process was co-occurring while the surveyors were on-site. Whitecourt Healthcare Centre has a very seasoned and committed medical devices reprocessing (MDR) core team and as well as causal staff.

The MDR department has significant challenges due to lack of space both within the clean and dirty rooms and in the space immediately adjacent to these two rooms. In the clean room, large unused crates are currently being stored. Site leadership is encouraged to prioritize the removal of these crates for storage elsewhere or for disposal. There are also two pieces of decommissioned equipment that constrain space.

Both decontamination and scope cleaning processes occur in a very small space resulting in contaminated equipment moving over the clean endoscopy space and dirty and clean scopes traversing the same space. Staff employ strategies to decrease the risk of contamination such as staggering timing and cleaning surfaces in-between. The hand washing sink is at the furthest side of the room which is the cleanest end of the room instead of next to the door.

The site is encouraged to investigate options and implement strategies to address the current risk situation.

Table 11: Unmet Criteria for Reprocessing of Reusable Medical Devices

Criteria Number	Criteria Text	Criteria Type
1.3.1	The layout of the Medical Device Reprocessing (MDR) department is designed based on service volumes, range of reprocessing services, and one way flow of medical devices.	NORMAL
1.3.2	The Medical Device Reprocessing (MDR) department is designed to prevent cross-contamination of medical devices, isolate incompatible activities, and clearly separate work areas.	HIGH

Criteria Number	Criteria Text	Criteria Type
1.3.3	Access to the Medical Device Reprocessing (MDR) department is controlled by restricting access to authorized team members only and being identified with clear signage.	HIGH
1.3.4	The Medical Device Reprocessing (MDR) department has an area for decontamination that is physically separate from other reprocessing areas and the rest of the facility.	HIGH
1.3.5	Appropriate environmental conditions are maintained within the Medical Device Reprocessing (MDR) department and storage areas.	HIGH
4.3.2	All flexible endoscopic reprocessing areas are physically separate from patient care areas.	HIGH
4.3.3	All flexible endoscopic reprocessing areas are equipped with separate clean and contaminated/dirty work areas as well as storage, dedicated plumbing and drains, and proper air ventilation.	NORMAL
4.4.1	The Medical Device Reprocessing (MDR) department has an appropriate storage area for sterilized medical devices and equipment.	HIGH
4.4.2	Access to the sterile storage area is limited to authorized team members.	HIGH
5.2.4	Standard operating procedures (SOPs) are used by staff to identify when there may be a problem with sterilization and when a recall is needed.	HIGH
5.2.5	Standard operating procedures (SOPs) are applied to recall sterilized items that may have been compromised.	HIGH
5.3.11	Information about quality improvement activities, results, and learnings is shared with stakeholders, teams, organization leaders, and other organizations, as appropriate.	NORMAL

Criteria for Follow-up

Criteria identified for follow-up by the Accreditation Decision Committee

Follow-up Requirements		
Standard	**Criterion**	**Due Date**
Emergency and Disaster Management	3.1.3 - The organization maintains an up-to-date version of its emergency and disaster plan in locations that are known and accessible to all staff, to ensure the plan can be easily accessed during an event.	June 2, 2026
Emergency and Disaster Management	3.4.8 - The organization establishes, regularly reviews, and updates as needed policies and procedures to communicate patient and client information in a manner that is safe and facilitates care during an emergency or disaster.	June 2, 2026
Emergency Department	2.2.1 - Entrance(s) to the emergency department are clearly marked and accessible.	June 2, 2026
Emergency Department	2.4.13 - Ethics-related issues are proactively identified, managed, and addressed.	June 2, 2026
Infection Prevention and Control	2.5.6.1 - Compliance with accepted hand-hygiene practices is measured using direct observation (audit). For organizations that provide services in clients' homes, a combination of two or more alternative methods may be used, for example: • Team members recording their own compliance with accepted hand-hygiene practices (self-audit). • Measuring product use. • Questions on client satisfaction surveys that ask about team members' hand-hygiene compliance. • Measuring the quality of hand-hygiene techniques (e.g., through the use of ultraviolet gels or lotions).	June 2, 2026
Infection Prevention and Control	2.5.6.3 - Hand-hygiene compliance results are used to make improvements to hand-hygiene practices.	June 2, 2026
Inpatient Services	3.2.12 - Ethics-related issues are proactively identified, managed, and addressed.	June 2, 2026
Inpatient Services	3.3.8.3 - The effectiveness of fall prevention and injury reduction precautions and education/information are evaluated, and results are used to make improvements when needed.	June 2, 2026

Standard	Criterion	Due Date
Inpatient Services	3.3.9.5 - The effectiveness of pressure ulcer prevention is evaluated, and results are used to make improvements when needed.	June 2, 2026
Inpatient Services	3.3.10.3 - Measures for appropriate VTE prophylaxis are established, the implementation of appropriate VTE prophylaxis is audited, and this information is used to make improvements to services.	June 2, 2026
Medication Management	1.2.3.5 - The program is evaluated on an ongoing basis and results are shared with stakeholders in the organization.	June 2, 2026
Medication Management	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
Obstetrics Services	1.2.16 - Clients and families are provided with information about how to file a complaint or report violations of their rights.	June 2, 2026
Obstetrics Services	1.5.6.4 - The use of the checklist is evaluated and results are shared with the team.	June 2, 2026
Obstetrics Services	1.5.6.5 - Results of the evaluation are used to improve the implementation and expand the use of the checklist.	June 2, 2026
Perioperative Services and Invasive Procedures	1.1.7- Rooms where surgical and invasive procedures are performed have at least 20 complete air exchanges per hour.	June 2, 2026
Perioperative Services and Invasive Procedures	1.2.1 - Surgical equipment and medical devices are regularly calibrated according to the manufacturers' instructions.	June 2, 2026
Perioperative Services and Invasive Procedures	1.2.9 - Contaminated items are transported separately from clean or sterilized items, and away from client service and high-traffic areas.	June 2, 2026
Perioperative Services and Invasive Procedures	2.2.16 - Clients and families are provided with information about how to file a complaint or report violations of their rights.	June 2, 2026
Perioperative Services and Invasive Procedures	2.4.3.1 - At least two person-specific identifiers are used to confirm that clients receive the service or procedure intended for them, in partnership with clients and families.	June 2, 2026

Standard	Criterion	Due Date
Perioperative Services and Invasive Procedures	2.6.3.4 - The use of the checklist is evaluated and results are shared with the team.	June 2, 2026
Perioperative Services and Invasive Procedures	2.6.3.5 - Results of the evaluation are used to improve the implementation and expand the use of the checklist.	June 2, 2026
Reprocessing of Reusable Medical Devices	1.3.2 - The Medical Device Reprocessing (MDR) department is designed to prevent cross-contamination of medical devices, isolate incompatible activities, and clearly separate work areas.	June 2, 2026
Reprocessing of Reusable Medical Devices	1.3.3 - Access to the Medical Device Reprocessing (MDR) department is controlled by restricting access to authorized team members only and being identified with clear signage.	June 2, 2026
Reprocessing of Reusable Medical Devices	1.3.4 - The Medical Device Reprocessing (MDR) department has an area for decontamination that is physically separate from other reprocessing areas and the rest of the facility.	June 2, 2026
Reprocessing of Reusable Medical Devices	1.3.5 - Appropriate environmental conditions are maintained within the Medical Device Reprocessing (MDR) department and storage areas.	June 2, 2026
Reprocessing of Reusable Medical Devices	4.3.2 - All flexible endoscopic reprocessing areas are physically separate from patient care areas.	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
Reprocessing of Reusable Medical Devices	4.4.2 - Access to the sterile storage area is limited to authorized team members.	June 2, 2026
Reprocessing of Reusable Medical Devices	5.2.4 - Standard operating procedures (SOPs) are used by staff to identify when there may be a problem with sterilization and when a recall is needed.	June 2, 2026
Reprocessing of Reusable Medical Devices	5.2.5 - Standard operating procedures (SOPs) are applied to recall sterilized items that may have been compromised.	June 2, 2026

Standard	Criterion	Due Date
Service Excellence	2.1.7.4 - The competence of team members to use infusion pumps safely is evaluated and documented at least every two years. When infusion pumps are used very infrequently, a just-in-time evaluation of competence is performed.	June 2, 2026
Service Excellence	2.1.7.5 - The effectiveness of the approach is evaluated. Evaluation mechanisms may include: • Investigating patient safety incidents related to infusion pump use • Reviewing data from smart pumps • Monitoring evaluations of competence • Seeking feedback from clients, families, and team members	June 2, 2026