2024-2026 AHI/TDMH Patient Safety Plan

Draft: January 2024

Item Number	Goal	Measure/ Indicator	Performance Target	Responsibility	Projected Timeline	Current Status	Comment
Strategic Direction: With our partners, serve our communities exceptionally well by creating an integrated care system							
1	**Transition to Accreditation Canada's continuous assessment cycle following Jan/Feb 2023 Accreditation Survey**	Participation in new cycle	Achieve Accreditation with Exemplary Standing status at next opportunity	Accreditation Canada Lead	Ongoing	Not Started	AC has not initiated this strategy as of January 2024. We will follow AC lead on this item.
2	**Conduct Leadership Safety Walk-abouts led by CEO. Board members, PFCC and Patient/Staff Safety leaders invited to attend.**	Number of rounds completed	Visit each department at both sites at least once annually	CEO/President	Ongoing	Ongoing	Ongoing, across all teams and departments. Annual for each area.
3	**Create a Policy to guide policy development and future policy creation and review to ensure safety policies are reviewed annually and by appropriate stakeholders**	Approval of Policy	Adherence to policy on policies when developing new policies, brinigng for approval, and regular review schedule	Chief Quality Officer, VP HR and Risk	Q1 2024/25	Not Started	Focus for Q1 2024/25. WIll be adopting the Oman's Evidence based model for Policy Adoption and approval. Process to be led by the Quality Team
	Strategic Direction: Proud of our rural roots, as small, vital hospitals, advance our service delivery model						
4	**Implement volunteer led patient experience rounding, inclusive of a volunteer feedback loop to leadership of observed patient safety/ experience feedback.**	Monthly patient experience rounding target met	10 per month	Volunteer coordinators and CNE/VP Clinical Services	Q3: 2023/24	Ongoing	
5	**Involve patients and families in critical incident reviews; involve PFAC in the process as well**	Create a process to involve patients and families in review of recommendations and also bring critical incident reviews/ debriefs to the PFAC	Process created and implemented for both	CNE/VP Clinical Services and Chief Quality Officer/VP HR and Risk	Q2: 2023/24	In Progress	Refreshed critical incident policy completed in F2024. Quality review recommendations are now shared with PFAC as needed.
6	**Educate and engage our team members on ways to provide a culturally safe environment for our patients and their families**	Culturally Safe Patient Experience focused response rate, and percentage of leaders and team members education completion	Training developed and implemented to all leaders and team members	Chief Quality Officer/ VP HR & Risk Manager, Quality & Patient Safety	Q4: 2024/25	In Progress	“Cultural Sensitivity Training” for LMS focused on Indigenous and Mennonite priority populations. Training is currently mandatory for all leaders and educators to start, and then will move out to all team members (i.e. staff, volunteers, professional staff). Further training, such as San' yas course will be offered as resources permit. In F2024, the Patient Experience surveys had a Diversity, Equity and Inclusivity question incorporated.
7.1	**Implement alternate level of care (ALC) Leading Practices and Older Adults Living with Frailty Guidelines**	ALC Leading Practice Self Assessment Tool	All elements of the Leading Practice Self Assessment Tool will be met.	CNE/VP Clinical Services	Q4 2024/25	In Progress	Hired a Clinical Intern Coordinator who will be leading implementation with support of the Inpatient Clinical Managers and Clinical Educators.
7.2	**Refresh falls prevention program in all inpatient clinical areas and standardize program policy and process between sites**	Falls Prevention Program Approved	Falls Prevention Program Approved	CNE/VP Clinical Services	Q2: 2023/24	Completed	Hourly Comfort Rounding has been implemented on all clinical areas.
	Strategic Direction: We are powered by our people, and commit to supporting them to be at their best						
8	**Commit to continuous learning to support development and knowledge of safe practices. Provide patient safety education during orientation and refresh education annually.**	Percentage of team members who attended patient safety education session(s)	At least 85% of team members complete the education sessions	CNE/VP Clinical Services	Annually	Completed, and Ongoing	Patient Safety education is ongoing in different programs. Orientation includes education on patient lifts, med sled, IV pumps, medication admininstration, high alert medications. Annual Nursing Skills fair includes education on lifts, IV pumps, pain pumps, Zoll education. Clinical educator documents staff learning (with sign off on completion). Nursing Skills Fair held at TDMH May 2023, AHI November 2022.
9	**Mandatory Violence Prevention training for clinical facing areas to learn how to interact with patients exhibiting violent behaviours and de-escalate violent situations**	Completion of training	100%	CNE/VP Clinical Services	Annually	Completed and Ongoing	Rolling completion of courses based on recertification requirements. Prioritized for all new staff within 6 months of starting.
	Together, pursue fulsome organizational integration toward better patient care and best use of our resources						
10	**Increase development of consistent practices across sites to prevent the occurance of safety incidents and faciliate access and flow of patients to ensure right place, right time for care.**	All recommendations completed	100% of Access and Flow Streamlining Project Recommendations completed	Director, Clinical Services	Q2: 2024/25	In Progress	Access and Flow streamlining project completed in 2023 with 75% of recommendations completed and the remaining are in progress. Examples include Gridlock Policy, Surge Escalation protocol, Charge Nurse position on inpatient, policy for Left Without Being Seen (LWBS).
11	**Standardize Huddle Boards in all inpatient clinical areas and implement their use in daily huddles**	Percentage of areas with Huddle Boards	100%	Inpatient Clinical Leaders	Q3: 2023/24	Completed	Huddle Boards in place, regular huddles happening with focus on Safety and Quality Improvement.

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12	**Establish and uses mechanisms for timely and accurate transfer of information at transition points (i.e. transfer forms, checklists)**	Pefcentage of transfers of accountability (TOA) forms being accessed	100%	Inpatient Clinical Leaders	Q3: 2023/24	Completed	Audit processes are now in place for TOA in all clinical areas. Bed Report Form and TOA form inter-departmental.
		Percentage of patients being engaged in bedside TOA	Greater than 90%			In Progress	Bedside verbal report with patient engagment implemented Q3 2023/24 with auditing in place at TMDH. To be implemented at AHI in Q4 2023/24
13	**Implement revised Discharge Planning Policy for all inpatient areas inclusive of Patient Education Handout.**	Patient Experience Survey question (Quality Improvement Plan (QIP) question) - Re discharge ("Did you recieve enough information upon discharge from hospital?")	30%	CNE/VP Clinical Services	Q4: 2024/25	Done	Discharge Planning Policy has been revamped. Discharge medication reconciliation has been a focus over the past 2 quarters. Patient Experience Survey implemented, inclusive of QIP question regarding discharge.
14	**Standardize use of white boards at bedside with patient name, nurse/Most Responsible Provider (MRP) name, anticipated date of discharge (ADD), and destination.**	Percentage of white boards completed during audit	100%	CNE/VP Clinical Services	Q4: 2024/25	In Progress	Whiteboards are in place in patient rooms. This is aligned with ALC Leading practices and Older Adults with Frailty guidelines (see above) - focus on completion and auditing.
15	**Suggest Establish a robust Clinical Auditing program to support ROP compliance**						