Deep River and District Hospital
Patient Safety Plan 2018-2021

Note: Although patient safety goals have been established in the broader patient safety plan, objectives, initiatives, measures, targets etc. are to be determined by relevant accountable committee/individual(s).

Deep River and District Hospital has developed a three-year Patient Safety Plan to ensure we can continue to deliver safe quality care to the people in our care. Our objective is to encourage and promote a culture of patient safety at all levels of the organization. Our plan outlines our priorities and the ways we will respond to patient safety concerns while making system-wide improvements.

Deep River and District Hospital is fully accredited through Accreditation Canada - a not-for-profit, independent organization accredited by the International Society for Quality in Health Care. Accreditation is a voluntary process, which takes place every three years. It gives us an external peer review process to assess and improve our services, based on standards of excellence.

The Patient Safety Plan helps us to ensure we provide safe, excellent care. The plan identifies ongoing strategies so we can meet and exceed Accreditation Canada's required organizational practices and patient safety goals.

Patient Safety Goal	Objective	Priority level	Planned initiatives	Measure(s)	Target	Time-frame	Responsibility
1. Improve Medication Safety	a) Implement improved medication reconciliation process	1	Update policy and protocol for patient centric, medication reconciliation at admission discharge and/or transfer of care.	Medication reconcillation occurring at all transfers of care	100% patients have medication reconcillation occur at all points of care transfer	2019	Pharmacy & Therapeutics Committee
	b) Initiate medication incident reporting to MAC (through P&T) and to Board of Directors		Implement new medication incident reporting system and structure	New Medication incident reporting system in place	100% of medication incidents following revised reporting and review process to MAC	2018	

	c) Implement administration risk mitigation strategies for high risk medications		Adopt standardized dosing and monitoring guidelines for opioids and high risk medications targeting high risk populations including: neonatal, paediatric, critically ill and frail elderly patients;	Guidelines identified for all high risk medications, including initial and maximum dose reccomendatin os, and automatic stop dates	100% of high risk medications administred have stanadarized dosing and monitoring guidelines in place	2020	
2. Identify and mitigate inherent safety risks in specific patient populations	a) Improve the identification, prevention and management of pressure ulcers	2	Adopt evidenced based assessment and management strategies to identify, prevent and treat skin integrity risk and alterations.	RNAO Best Practice Guideline (BPG) interventions implemented	All skin and wound care policies to be updated to reflect evidenced based care and management (RNAO BPGs)	2019	Clinical Team – *Medical and LTC*
	b) Reduce incidence of inpatient falls and reduce severity of harm from falls		Adopt evidenced based assessment and management strategies to identify, prevent and mitigate harm in falls	RNAO Best Practice Guideline (BPG) interventions implemented	All fall prevention, assessment and intervention care policies to be updated to reflect evidenced based care and management (RNAO BPGs)	2018	
	c) Provide support and services in both French and English		Develop and implement a plan to address the needs of the local Francophone community	Francophone service plan developed and implemented	Francophone support program developed and implemented	2019	CNO and Communication s Director
3. Promote effective information transfer with patients and team members across the continuum of care	a) Provide adequate discharge/follow -up instructions	3	Implement Patient Orientated Discharge Summary (PODS)	% patients with PODS completed on medical inpatient unit with discharge	75% of patients will indiciate satisfaction with discharge support provided on Canadian Patient Experience Survey (CPES)	2019	Clinical Team – *Medical*

	b) Establish procedure for performing and communicating therapeutic drug monitoring (TDM)		Collaborate with Laboratory and Primary Care to develop effective communication strategies to support notification of inpatient and discharged patients TDM	Process developed for communication of TDM for discharged patients to Primary care	FHT will receive notification and pertinent care information (including TDM) of 100% of discharged FHT patients	2018	
	c) Ensure patients are receiving care in the most appropriate setting		Initiate reporting and tracking of ALC days on monthly dashboard; Initiation of discharge planning on admission with Estimated Discharge Date (EDD) identified within 24hrs of admission	% of admitted patients for which EDD is identified within 24hours of admission	Inpatient ALC days will be tracked monthly on dashboard; 100% of admitted patients will have EDD identified within 24hrs of admission to inpatient unit	2020	
4. Improve Triage Assessment and Re-assessment process	Implement evidence based triage policies and procedure, and monitor adherence	4	Implement evidenced based triage assessment and re-assessment practices	Best practices reviewed against current processes;	Gaps in practice to best practice will be identified and resolved	2019	Emergency Department Committee
			Formalize chart/e-record audits, analysis of reported incidents/events, learning from medico-legal matters	Audit/review process determined and implemented	Audits and analysis of outcomes/incidents monitored quarterly at Emergency Department Committee	2019	
5. Reduce the Incidence of Healthcare Acquired Infections	a) Implement Hand Hygiene Program	5	Hand Hygiene Program developed, training provided and implemented across all departments	% departments following established hand hygiene program	Targets for hand hygiene audits met on all departmental dashboards	2018	Infection Control Committee
	b) Review and audit adherence to routine practices		Education and Auditing Program developed for routine practices; training provided and implemented across all departments	Process outlined and education provided	Outcomes of audits tracked on dashabord monthly and reviewed by IPAC Committee	2020	

	c) Track and report the incidence of healthcare acquired infections and outbreaks, by organism to IPAC Committee		Communication and collection processes developed for identification, notification and reporting of Healthcare Acquired Infections across all areas of care	Process for tracking and notification to be developed and implemented	Tracking of incidences of Healthcare Aquired Infections will occur on monthly departmental dashboard	2019	
6. Create and Foster a Culture of Safety	a) Support and engage Board of Directors in promoting a culture of Safety	6	Review and refine the accountability structure for quality and safety at the Governance level	% of time at Board meeting focused on patient safety	>15% Board time in meetings spent on quality/patient safety	2019	CEO and Communications Director
	b) Support and engage staff and physicians in developing a culture of patient safety and quality improvement		Education plan developed annually and implemented to provide ongoing education on patient safety and quality improvement	Education provided to staff on patient safety	Annual education provided to all staff on patient safety and quality improvement	2018	CNO
	c) Support and engage patients, residents and families in developing a culture of patient safety and quality improvement		PFAC goals developed annually and collaborative patient education and safety material developed (patient safety brochure)	PFAC goals established each year; Patient education and safety materials developed	PFAC will establish goals each year to improve engagement and promotion of culture of patient safety and quality improvement	2021	Patient and Family Advisory Committee (PFAC)

Reference Documents	• The Joint Commission Journal on Quality and Patient Safety 2018; 44:23–32, “Promising Practices for Improving Hospital Patient Safety Culture” • Accreditation Canada, Canadian Patient Safety Institute, • Governance Centre of Excellence: Quality and Patient Safety, Understanding the Role of the Board • Royal College of Physicians and Surgeons of Ontario: A Culture of Patient Safety • Canadian Patient Safety Institute (2016): Measuring patient harm in Canadian hospitals.
Acknowledgements	• The Scarborough hospital 2016-2017 Quality and Patient Safety Plan, • Muskoka Algonquin Healthcare Patient Safety Plan 2011-2014
Review Process	• Resident Coucil - February 2018 • Patient Family Advisory Committee - February 2018 • Executive Leadership Team - February 2018 • Quality Patient Safety Committee - March 2018 • Board of Directors - March 2018