MUSKOKA ALGONQUIN HEALTHCARE

2021-2023
Quality and Patient Safety Plan

Muskoka Algonquin Healthcare is a community of providers dedicated to delivering best patient outcomes with high standards and compassion. To ensure a continuous journey of safe, quality patient care while maintaining and improving upon prior successes, a roadmap utilizing the Canadian Quality & Patient Safety Framework, Health Quality Ontario Quality Improvement Framework and Accreditation Canada has been created with input from staff, credentialed staff, Patient and Family Advisory Council (PFAC), Quality & Patient Safety Committee of the Board, Quality Council, Medical Advisory Committee and the Occupational Health & Safety Committee.

Overview

Muskoka Algonquin Healthcare (MAHC) provides emergency health care services and inpatient care at two hospital sites in Huntsville and Bracebridge. Patient care is also supported through a number of outpatient programs at both hospital sites and at the Almaguin Highlands Health Centre in Burk's Falls. As well, MAHC is a rural teaching hospital and is affiliated with several academic institutions; including the Northern Ontario School of Medicine (NOSM) and more than two dozen colleges and universities.
With a budget over $86 million, employing nearly 700 people, over 300 volunteers and approximately 85 active physicians, MAHC services more than 60,000 Muskoka residents and a portion of the East Parry Sound population. In the summer months, the population more than doubles with seasonal residents in cottage country who also rely on the hospital sites.

The privilege and responsibility of addressing the health care needs of MAHC's communities is taken very seriously. The work performed and how it is delivered is not just about numbers or other outcome measurements. Our staff, physicians and volunteers are the most valuable part of the organization.

Mission: Working together to provide outstanding integrated health care to our communities, delivering best patient outcomes with exemplary standards and compassion

Vision: As a trusted partner, we strive to improve the delivery of health care to our communities and to be known as an outstanding place to work, learn and live and be cared for.

Values: Our primary aim is to ensure the individuals we serve are provided with exceptional care and the best experience possible. Our values of accountability, respect, optimism, leadership, and engagement underpin our commitment to this aim.

MAHC is part of a healthcare system that includes the Muskoka and Area Ontario Health Team (MAOHT) the North Simcoe Muskoka Home and Community Care, the Cottage Country Family Health Team, the Algonquin Family Health Team, and Community Mental Health (CMHA) who have worked collaboratively to improve the quality of care for the people of Muskoka and have a history of some shared Quality Improvement Plan (QIP) initiatives. As a collaborative, we are working to improve safe, integrated, effective, people centered access to care throughout the entire continuum of health care.

Ontario Health Team:
Muskoka and Area Ontario Health Team (MAOHT), of which MAHC is a key partner, will be developing and implementing a new model of organizing and delivering health care that better connects patients and providers in their communities to improve patient outcomes. Working together as partners, the MAOHT will build a quality/patient safety focused, equity-driven and outcomes-based system of care provision and services. The MAOHT will begin implementing some of their proposed programs and services in 2021. As part of the delivery of those services, how performance will be measured will be determined. As such, MAHC expects to take an important role in the development of these quality/safety performance indicators.

MAHC's definition of Quality:
"Quality at MAHC results in shared decision-making between the patient, family and the healthcare care team, to achieve a patient identified desired health outcome. MAHC will deliver safe, effective, people-centered services, efficiently and in a timely fashion, resulting in optimal health status for our patients."

Quality and safe care is MAHC's promise to our people and patients. Taking care of people (staff, physicians and volunteers) results in patients and their families receiving the care they expect and deserve.

In addition to providing a safe, quality of care environment to our patients, MAHC is dedicated to providing a safe quality work environment for our people. Therefore, in addition to patient focused elements of quality and safety, this program outlines how MAHC works toward providing a safe quality work environment for care providers.

Everyone in the organization plays an important role in patient safety. Roles and responsibilities for patient safety are defined in position profiles, performance appraisals, handbooks, and orientation material.

The prevention of patient injury is the first consideration in all actions performed and is the responsibility of each employee and physician who practices in this hospital.
Rules and procedures to minimize the possibility of patient injury are essential parts of the patient safety initiative. All staff have accountability for providing safe patient care and shall abide by the principles below.

Guiding Principles of Safe, Quality Care at MAHC

a. **Patient outcomes are improved when we** provide care based on scientific knowledge/best practice to all who could benefit, and refrain from providing services to those not likely to benefit.

b. **Patient access is improved when we** reduce waiting, as sometimes delays are harmful for those who require care.

c. **Patient centeredness is improved when we** provide care that is respectful of and responsive to individual patient and family preferences, patient and staff needs and values.

d. **Patient care is equitable when we** provide care that does not vary in quality or timeliness because of personal characteristics such as gender, ethnicity, geographic location, socioeconomic status, etc.

e. **Patient care is efficient when we** avoid waste, including equipment, supplies, ideas and energy.

f. **Patient care is safe when we take care of the staff that provide the care**- avoid potential injury to patients and staff by focusing on safety first.

Our 2021-2023 Quality and Patient Safety Plan is designed to leverage the forward momentum of our overarching quality and safety culture by ensuring we are proactive in anticipating and responding to patient and staff needs, and, by improving care transitions from our hospital to the community in collaboration with MAOHT and other partners.

Our ongoing quality and patient improvement journey continues to be informed by our patients and their families, our staff, physicians, Board of Directors and health care partners. Our collaborative work in the development of the plan helps to ensure our patients receive comprehensive quality and safe care.

The plan encompasses a number of quality initiatives including: at least one quality/safety initiative and performance indicator from each of the hospital's departments and clinics. Additionally, the plan forms part of MAHC's balanced scorecard.

Operational oversight of the development and implementation of the Quality and Patient Safety Plan rests with Senior Leadership Team, Medical Quality Assurance Committee and Quality Council. To assist in this oversight, a dashboard of results of key performance indicators is provided quarterly to Quality Council, the Quality & Patient Safety Committee of the Board and the Leadership Team.

Quality & Patient Safety Plan

MAHC is committed to using best practices ensuring optimal patient outcomes. To assist us in fulfilling this commitment, MAHC has adopted the Health Quality Ontario's (HQO) definition of a high-quality health system and uses the Canadian & Patient Safety Framework and the ultimate aims are:

- Improving key quality and safety areas
- Reducing unwarranted care variation
- Strengthening the delivery of high-quality health services that improve patient experiences and outcomes

This people-centred quality and patient safety plan defines five goal areas designed to drive improvement and to align Canadian legislation, regulations, standards, organizational policies and public engagement on patient safety and quality improvement.

Goal 1 | People-Centred Care

People using health services are equal partners in planning, developing, and monitoring care to make sure it meets their needs and to achieve the best outcomes.

Providing care that is respectful of and responsive to individual patient preferences, needs and values, and ensuring that patient values guide all clinical decisions and create a culturally safe environment

Goal 2 | Safe Care

Health services are safe and free from preventable harm.

Avoiding injury.

Ensuring there's a presence of a safety culture across the hospital. Preventable harm is actively monitored and eliminated

Goal 3 | Accessible/Timely/Equitable Care

People have timely and equitable access to quality health services.

Reducing waits and unfavorable delays for both those who receive and those who give care.

Providing care that does not vary in quality because of personal characteristics such as gender, ethnicity, geographic location and socio-economic status.

Goal 4 | Appropriate/Effective/Efficient Care

Care is evidence-based and people-centred.

Providing services based on scientific knowledge to all who could benefit and refraining from providing services to those not likely to benefit (avoiding underuse and overuse). Doing the right thing for the right person at the right time.

Avoiding waste, in particular waste of equipment, supplies, ideas and energy. We continue to avoid waste through participation in the Choosing Wisely program.

Goal 5 | Integrated Care

Health services are continuous and well-coordinated, promoting smooth transitions.

Goal 1 | People-Centred Care

People using health services are equal partners in planning, developing, and monitoring care to make sure it meets their needs and to achieve the best outcomes.
Providing care that is respectful of and responsive to individual patient preferences, needs and values, and ensuring that patient values guide all clinical decisions and create a culturally safe environment

When we help patients make informed decisions about their care, we improve patient outcomes. Health leaders create a people-centred safety culture for patients so patients can make informed contributions on their care and treatment decisions.

When MAHC puts people at the centre and helps patients make informed decisions about their health services and care, patient outcomes improve. The team's role is to ensure patients have the information they need to contribute to these decisions. By reviewing patient-reported experiences and outcome measures we will know if our services are making a positive impact and are responsive to their needs.

Formal and informal partnerships with patients are key to improving health services. MAHC strives to partner with patients in designing and delivering services by establishing and supporting patient partnerships at all levels within the organization.

Diverse peoples, including Indigenous, Black, LGBTQ2S+, immigrant, and people in rural and remote communities, have the right to receive care that is culturally safe. Demonstrating respect for the patient's culture and beliefs and considering diverse values when developing MAHC's organizational vision, mission, values, strategic plan, and allocation of resources ensures delivery of culturally safe care for all.

People-centred care is a guiding principle, at MAHC. Activities include, co-designing services with health care providers and clients, including client and family representatives on advisory and planning groups, including clients and families as part of a collaborative care team, partnering with clients in planning, assessing, and delivering their care and monitoring and evaluating services and quality with input from clients and families.

LEVELS OF ENGAGEMENT	CONSULTATION	INVOLVEMENT	PARTNERSHIP AND SHARED LEADERSHIP
Direct Care	Patients receive information about the diagnosis	Patients are asked about their preferences in treatment plan	Treatment decisions are made based on patients' preferences, medical evidence, and clinical judgement
Organizational design and governance	Organization surveys patients about their care experiences	Organization involves patients as advisers or advisory council members	Patients co-lead safety and quality improvement committees

Performance Metric Status Summary as of Q3:

Completed	Started But Not Complete	Not Started
48	7	3

Performance Metric Details:

Goal 1 | People-Centred Care

OBJECTIVE 1.1: Health services are provided with humility in a holistic, dignified, and respectful manner.

Indicator: Patients' ratings of the extent to which care was provided with respect.

OUTCOMES:

1.1.1 Patients make informed contributions and decisions related to their care and treatment

2.1.1 Diverse peoples, including First Nations, Inuit, metis, Black, LGBTQ2S+, immigrant receive care that is culturally safe

1.1.1 Patients make informed contributions and decisions related to their care and treatment

Actions	Activity/Responsibility	Performance Metrics	Status
Ensure people-centred care is an organizational guiding principle 1.1	Year 1: ▪ Board and Senior Team to review to ensure People-Centred Care is an organizational guiding principle. Review the policy and education to identify any gaps.	Year 1: ▪ Review of People-Centered Care policy completed Year 2: ▪ SR. Team Review of People-Centred Care policy and education is completed and any gaps identified	
Support health teams and patients by providing information and decision-aid tools that promote patient engagement and joint decision-making on treatment plans. 1.1 ▪ Promote the involvement of patients in their own care and use their advice in care-planning processes and evaluations.1.1	(Quality Council/Quality of Care Committee): ▪ Review Goals of Care policy and procedure to ensure patient preferences are included. ▪ Review educational brochure content for patient involvement as part of their care team. ▪ Vetting and input of the PFAC ▪ Develop guidelines to ensure patient	Year 1: ▪ Goals of Care policy review completed with vetting and input of the PFAC Year 2: ▪ PFAC review of educational 'Goals of Care' brochure content and all other material used to communicate to patients/family of their involvement in their own care plan.	

Actions	Activity/Responsibility	Performance Metrics	Status
	participation is apparent when determining their care plan.	▪ Develop practice guidelines to ensure patient participates in determining their care plan ▪ Launch of involving patient in their safety, staff asking: o What makes you feel safe? o What would make you feel safer?	
▪ Support and engage the patient, family, or designated representative in decision making. 1.1 ▪ Support the health teams in using standardized care plans with input from patients. 1.1	(Quality Council/Quality of Care Committee): ▪ Review patient satisfaction survey results to obtain 70 % of positives score to patient response that they had participated in their care plan development	Year 2 ▪ Review Patient Satisfaction Survey Results. Target 70% positive score to question 'Did you participate in your care plan development?' ▪ Add as an inpatient rounding question	
Ensure patient experience surveys are distributed and the collected information is analyzed.1.1	Quality Council: Year 1,2,3: ▪ Review, analyze results, quarterly. ▪ Distribution of patient experience survey results, quarterly	Year 1 ▪ Patient satisfaction survey results are reviewed and distributed Year 2 ▪ Patient satisfaction survey results are reviewed and distributed	
Transitions from Hospital to Home- improve quantity and quality of information provided to the patient for successful discharge (QIP 2021/22)	Quality Council: ▪ Continued work to ensure successful patient discharge. ▪ ED is also working on some brochure updating	Year 1: ▪ Med Rec on admission, transfer and discharge ▪ % positive responses to survey question 'Did you receive enough information from hospital staff at time of discharge" Year 2: ▪ Med Rec on admission, transfer and discharge	 Work continues to ensure Med Rec is completed and accurate med list prints to the patient's discharge instructions

Actions	Activity/Responsibility	Performance Metrics	Status
		▪ 70% positive responses to survey question 'Did you receive enough information from hospital staff at time of discharge"	

1.1.2 Diverse peoples, including First Nations, Inuit, metis, Black, LGBTQ2S+, immigrant receive care that is culturally safe

Actions	Activity/Responsibility	Performance Metrics	Status
Use standardized patient tools (e.g. decision aids) and materials (e.g. patient education handouts) written in simple language and ensure availability of interpretation services as required.	Communications: ▪ Review patient tools, aids and education handouts to ensure simple and inclusive language is used. Review and input by PFAC.	Year 1: ▪ Patient tools, aids and education handouts use simple and inclusive language Year 2: ▪ Review patient tools, aids and education handouts to ensure they use simple and inclusive language. Review of the material used by PFAC	
Support the development of a Diversity, Equity and Inclusion Framework that will set the direction for MAHC's continued focus on reducing barriers for racialized and marginalized people who access our services. Develop a communication plan that recognizes and celebrates diversity at MAHC. Continue to support education for staff, leaders and Board related to Diversity, Equity and Inclusion that will support culturally safe health care for our patients and families.	Year 1: ▪ MAHC Diversity, Equity and Inclusion (DEI) Working Group to develop Framework. ▪ Annual communication plan will be developed Year 2: ▪ Year two activities will be determined by the approved strategic framework developed by the Board DEI Working Group. Year 3: ▪ Year three activities will be determined by the approved strategic framework developed by the Board DEI Working Group.	Year 1: ▪ Board Approval of DEI Framework ▪ Senior Team approval of MAHC Communication Plan Year 2: • Gather information around staff and patient experience related to Diversity, Equity & Inclusion. • Gather population information, and experience information to inform actions to support MAHC's IDEA Framework.	

Actions	Activity/Responsibility	Performance Metrics	Status
Train and deploy Patient Experience Partners (QIP)	Quality Council and PFAC: ▪ Recruit Patient Experience Partners	Year 1: ▪ Recruit, train and deploy Patient Experience Partner. Where applicable, ensure policies are updated to include this new service Year 2: ▪ Recruit, train and deploy (5) new 'Patient Experience Partners' to ensure that we always have at least (10) active members on the Patient and Family Advisory Council. When applicable, ensure policies are updated to include PFAC services	

OBJECTIVE 1.2: All aspects of care are co-designed with patients and providers.

Indicator: Patient and provider involvement in care planning, governance, and evaluations (e.g. patient advisors)

OUTCOMES:
1.2.1: Formal and informal patient partnerships are established

Actions	Activity/Responsibility	Performance Metrics	Status
Involve patients and families in planning treatment and improving health services 1.2	Quality Council and PFAC: ▪ Assign Patient Experience Partners (PEP) to appropriate committees	Year 1: ▪ PFAC representation on all appropriate committees Year 2: ▪ Ensure PFAC representation remains on all appropriate committees/councils/collaboratives ▪ PFAC determining.	
Use patient experience and patient outcome tools for improving services.1.2	Quality Council - Year 1,2,3: ▪ Review and analyze patient satisfaction survey results	Year 1: ▪ Patient satisfaction survey results are reviewed and used to identify improvements Year 2: ▪ Patient satisfaction survey results are reviewed and used to identify improvements	
Encourage regular dialogue with patients and families so their perspectives and knowledge can be used to inform initiatives for improvement.1.2	Quality Council - Year 1,2,3: ▪ Review and analyze patient rounding results	Year 1: ▪ Patient rounding results are reviewed and used to identify improvements Year 2: ▪ Patient rounding results are reviewed and used to identify improvements	

OBJECTIVE 1.3: Patients and providers have positive health service experiences.

Indicator: Patients' overall ratings of health service experiences

1.3.1: Patient-reported experience measures and patient-reported outcome measures are collected and reported and demonstrated improvements in experiences and outcomes
1.3.2: Patients, regardless of background and circumstance, are engaged and report health service experiences.
1.3.3: Providers are engaged, report and learn from health service experiences

Actions	Activity/Responsibility	Performance Metrics	Status
▪ Encourage patients to speak up about their concerns 1.3 ▪ Ensure staff are engaged and that they report and learn from patient experiences 1.3	Quality Council: ▪ Implement patient rounding	Year 1: ▪ Implement Patient Rounding and educate staff to respond to input Indicator: Patients' overall ratings of health service experiences Year 2: ▪ Patient Rounding and educate staff to respond to input Indicator: Patients' overall ratings of health service experiences	
Assist patient care departments to identify and prioritize improvements ideas, initiate changes and implement process improvements 1.3	Quality of Care Committee Reviews - Quality Council: ▪ Incident Reporting can we add medication incident reports being reviewed at P&T Committee Patient Ombudsman/ Managers/Leaders: ▪ Receive and respond to complaints, report concerns to quality council along with improvement strategies Medical Quality Assurance Committees: ▪ Staff/Physician Surveying Huddles	Year 1: ▪ Quality & Patient Safety Reporting - Complaints/compliments ▪ Incident Reporting ▪ Quality of Care Review-outcome sharing ▪ Medical Rounds ▪ Survey Results Year 2: ▪ Quality & Patient Safety Reporting - Complaints/compliments ▪ Incident Reporting ▪ Quality of Care Review-outcome sharing ▪ Medical Rounds ▪ Debriefs and Quality of Care Review outcomes ▪ Survey Results	

Actions	Activity/Responsibility	Performance Metrics	Status
▪ Encourage staff involvement in quality-improvement projects 1.3 ▪ Staff are involved in identifying and determining quality/safety improvement by initiating or providing feedback on performance improvement metrics. Managers will guide this education on quality/metrics and results interpretation and remediation.	Quality Council and Department Leaders: ▪	Year 1: ▪ All managers with their teams identify a performance improvement each fiscal for monitoring on the Balanced Scorecard ▪ Performance monitoring via the Quality & Patient Safety Report Year 2: ▪ All managers with their teams identify a performance improvement initiative each fiscal for monitoring on the Balanced Scorecard Performance monitoring via the Quality & Patient Safety Report	 
Require staff to participate in patient safety huddles to discuss quality outcomes and improvement activities 1.3	Quality Council: ▪ Staff Huddles Year 1: ▪ All staff huddle boards include the following on the agenda as triggers for discussion: 1) Safety and quality concerns and successes in the past day • Patients • Staff • Physicians 2) Safety and quality issues for patients on today's schedule 3) Review of tracked issues 4) Inputs on other safety and quality issues Announcements and information to share	Year 1: ▪ Agenda is displayed on all huddle boards. Huddles are conducted regularly Year 2: • Conduct staff focus group sessions with staff to bring forward and quality/safety issues • Enhance IMRS to create a 'Quality Safety' form 'RISKY BUSINESS' for reporting	 This work continues and its anticipated will be completed in Q4

Goal 2 | Safe Care

Health services are safe and free from preventable harm. Health services are safe and free from preventable harm.
Avoiding injury.
Ensuring there's a presence of a safety culture across the hospital
Preventable harm is actively monitored and eliminated

MAHC has responsibility for the safe care of patients; creating a safe and supportive environment for patients.

Patients have an expectation to receive safe, quality of care and our staff play an active role in creating a safe and supportive environment for patients to report their experience.
MAHC ensures providers work in psychologically and physically safe environments and have access to psychological support programs.

MAHC is aware of the psychological factors affecting providers' mental health, and promotes psychological health and well-being in the workplace.

MAHC encourages and supports interdisciplinary health teams (including patients and families) to improve patient safety.

MAHC implements evidence-based practices and reports outcome trends to proactively drive safe practices.

Staff play an important role in ensuring our hospital is accredited. Staff participate in the accreditation process and have access to information and indications that reflect organizational safety, such as the rate of patient harm events. Staff ensure patients who are harmed in safety incidents have access to psychological support program (EAP) MAHC reviews and publicly report rates of patient harm and other organizational safety indicators. Do we want to include reference to disclosure?

Staff have knowledge of MAHC's organization's workplace violence policy and prevention programs and report incidents accordingly, participate in training on workplace violence and harassment.

OBJECTIVE 2.1: Safety culture is evident across the continuum of health services.

Indicators: Assessment of organizational efforts to monitor, review, and address patient safety incidents-Staff survey results
Indicator: Training on quality improvement and patient safety provided at all organizational levels

OUTCOMES:
2.1.1: Patients, providers and leaders are encouraged and supported to report and act on patient safety concerns and incidents
2.1.2: Patient harm events are disclosed to the patient and/ or family as soon as known and documented according to organizational policies

2.1.3: Patient safety events are analyzed and acted upon by interdisciplinary teams which include patients.
2.1.4: Patients who are harmed have access to psychological support programs (via EAP).
2.1.5: Providers work in psychologically and physically safe environments, with access to psychological support programs.

Actions	Activity	Performance Metrics	Status
▪ Mandate timely and ongoing communication and reporting by staff (including patients and families) of safety risks. ▪ Support an audit and feedback system to ensure that recommendations to improve patient safety are implemented 2.1	Quality/Risk - Year 1,2,3: ▪ Annual review of Incident Reporting and Disclosure Policies ▪ Provide education on disclosure process and ensure appropriate supports are in place including guidance. ▪ Leader rounding ▪ Staff Huddles ▪ Patient rounding ▪ Incident Reporting ▪ Complaints/Concerns ▪ Care Reviews	Year 1: ▪ Annual review of Incident Reporting and Disclosure Policies completed ▪ Monitoring of recommendation completion and sharing resolution outcome Year 2: ▪ Annual review of Incident Reporting and Disclosure Policies completed ▪ Monitoring of recommendation completion and sharing resolution outcome, via Quality Council ▪ Acting on and sharing outcome from leader & patient rounding, staff huddles, complaints and care reviews.	
Create organizational policies and confidential reporting methods for health teams (including patients and families) to report safety concerns and incidents 2.1. ▪ Establish practices that support the sharing of information and open discussion about patient safety with health teams (e.g. rounding) 2.1	Quality/Risk - Year 1,2,3: Incident Management and Reporting System provides ability for reporter/staff to input and receive resolution comment • Accessibility Feedback • Whistleblower • Opportunity for Improvement (OFIs) • Ombudsman concerns • MAHC's website complaints/concerns • Accessibility Feedback form	Year 1: ▪ Review input from all reporting mechanisms for improvement Year 2: Review input from all reporting mechanisms for improvement	

Actions	Activity	Performance Metrics	Status
▪ Set structures and processes to facilitate collective dialogue and actions for safe care (e.g. safety huddles to empower staff to proactively deliver safe care 2.1 ▪ Ensure that information on action plans and changes for improvements are shared with appropriate stakeholders 2.1 ▪ Report, learn from and act on patient safety concerns and incidents according to policies 2.1 ▪ Leader Rounding	Quality Council/Quality of Care Committee: ▪ staff huddles ▪ memorandums ▪ Quality Matters! Newsletter ▪ Quality of Care recommendations are implemented ▪ Incidents are reviewed and analyzed to identify process improvements ▪ Leader rounding is implemented and information used to identify improvement opportunities	Year 1: ▪ Implement Leader Rounding by September 2021. ▪ Collect and analyze information obtained Year 2: ▪ Quality Council review of incidents ▪ Quality of Care Committee debriefs ▪ Staff Huddles ▪ MAHC Matters! newsletter contributions Year 2: ▪ Collect and analyze information obtained from leader/patent rounding ▪ Quality Council review of incidents ▪ Quality of Care Committee debriefs ▪ Staff Huddles ▪ MAHC Matters! newsletter contributions	
Use mandated Health Canada reporting tools to report interventions related to harm events 2.1	Pharmacy & Therapeutics Committee and Safe Medication Practices Committee: ▪ Mandatory reporting	Year 1: ▪ Mandatory reporting of Serious Adverse Drug Reactions (SADR)- Share learning Year 2: ▪ Mandatory reporting of Serious Adverse Drug Reactions (SADR)- Share learning	

Actions	Activity	Performance Metrics	Status
Provide education and training for incident reporting, incident management, and disclosure 2.1 Report, learn from and act on patient safety concerns and incidents according to policies 2.1 Inform patients and families about available supports during and after a patient safety incident (e.g. Spiritual Care)	Human Resources: ▪ Incident Management reporting, orientation Quality Council: ▪ Incident Management and Disclosure Policy (IMRS prompts if disclosure was done) Quality of Care Committee members receive alerts for incidents reported with Critical severity. Oversight to ensure all aspects of patient supports are provided.	Year 1: ▪ All new staff are provided incident reporting and response requirements ▪ Incident reporting used to identify performance improvements opportunities ▪ Incident reporting and follow-up to ensure disclosure to the patient/SDM has occurred Year 2: ▪ All new staff are provided incident reporting and response requirements ▪ Incident reporting used to identify performance improvements opportunities ▪ Incident reporting and follow-up to ensure disclosure to the patient/SDM has occurred ▪ Target 95% of all staff will annually complete the Learning Module on Incident Reporting	

Actions	Activity	Performance Metrics	Status
▪ Report, learn from, and act on patient safety concerns and incidents according to organizational policies. ▪ Provide training for incident reporting, incident management, and disclosure. ▪ Staff report patient safety concerns and incidents following reporting process ▪ Disclosure of safety concerns and incidents to patients, families, and the rest of the health team.	Quality Council: ▪ Incidents are collected, analyzed and communicated. ▪ Education of incident reporting and management and disclosure Quality of Care Committee Activity: ▪ Incidents and/or care issues are reviewed as deemed appropriate by members and recommendations tracked	Year 1: ▪ Incident reporting is reviewed in the quarterly Quality & Patient Safety report for use in identifying improvement opportunities. Year 1: ▪ Incidents and/or care issues are reviewed by Quality of Care members, recommendations identified and tracked by Quality Council to completion/resolution Year 2: ▪ Incident reporting is reviewed in the quarterly Quality & Patient Safety report for use in identifying improvement opportunities. Year 2: ▪ Incidents and/or care issues are reviewed by Quality of Care members, recommendations identified and tracked by Quality Council to completion/resolution	
Workplace violence incidents reported by hospital workers (QIP)	Human Resources./ Joint Occupational Health: -workplace violence committee meets regularly ▪ all incidents are reviewed and analyzed to identify prevention strategies by MAHC's Joint Health & Safety Committees ▪ Debriefs of code whites to identify improvements	Year 1: ▪ Workplace violence incidents reported <=54 (QIP) Year 1: ▪ Workplace Violence Policy is reviewed ▪ Workplace Violence Committee prepares a work plan and executes, annually Year 2: ▪ Workplace violence incidents reported <=54 (QIP) Year 2: ▪ Workplace Violence Policy is reviewed ▪ Workplace Violence Committee prepares a work plan and executes, annually	

Actions	Activity	Performance Metrics	Status
Ensure the health team is aware of available support programs, turnover rates, and plans for improvement.2.1	Human Resources:	Year 1: ▪ Report turnover rate and staff exit reasons for analysis and identification of plans for improvement ▪ Educate staff on the availability of psychological support (e.g. EAP) Year 2: ▪ Report turnover rate and staff exit reasons for analysis and identification of plans for improvement ▪ Educate staff on the availability of psychological support (e.g. EAP)	
Develop tool, training and strategies to de-escalate aggressive situations in a nonintrusive manner 2.3	Human Resources/Education:	Year 1 ▪ Provide and monitor attendance at MANDT training Year 2 ▪ Provide and monitor attendance at MANDT training (establish target with Occ. Health)	

OBJECTIVE 2.2: Safe and effective care is provided and monitored.

OUTCOME:

2.2.1: Evidence-based practices are implemented.

2.2.2 Provider practices are reviewed and outcome trends are reported to proactively drive safe practices.

Actions	Activity	Performance Metrics	Status
Staff participate in multidisciplinary patient-safety huddles/rounds and review patient safety incidents to identify ways to improve.2.2	Quality Council, Quality of Care Committee, Medical Quality Assurance	Year 1: ▪ Staff Huddles ▪ Physician Rounds Year 2: ▪ Staff Huddles ▪ Physician Rounds	
Avoidable 'Never Events' are reported and reviewed	Quality of Care Committee	Year 1: ▪ Indicator: Rates of patient harm events Year 2: ▪ Indicator: Rates of patient harm events	
Infection Prevention and Control (IPAC)	IPAC: ▪ Audit and reporting of Hand Hygiene, C. Diff, VRE, MRSA, Surgical Site Infections	Year 1: ▪ Analyze and respond to results of Hand Hygiene, C.Diff, VRE, MRSA, Surgical Site Infections Year 2: ▪ Analyze and respond to results of Hand Hygiene, C.Diff, VRE, MRSA, Surgical Site Infections	
Medication reconciliation is performed on admission, transfer and discharge	Quality Council Pharmacy & Therapeutics Safe medication Practices Family practice	Year 1: ▪ Roll out completion of the Automatic Drug Dispensing units (ADUs). Process changes for Med Rec on admission, transfer and discharge is implemented. Year 2: Process changes for Med Rec on admission, transfer and discharge are implemented (QI initiative is completed)	 Work continues on Med Rec

Actions	Activity	Performance Metrics	Status
Healthcare-acquired pressure injuries reduction (QIP)	Quality Council	Year 1: ▪ Sustainability of the program. Wound care education -Redirecting the email wound referrals to our team members on shift and covering their team while they do the referrals, and assigning each team member a week to do education with staff (e.g. training of new staff, education projects within inpatient units. Year 2: ▪ Hospital Acquired Pressure Target- 5% reduction, per quarter. TBD when Q4 results are in.	
Safe Surgery Checklist- used to initiate, guide, and formalize communication among the team members conducting a surgical procedure. i. Briefing- before the induction of anesthesia ii. Time out- before skin incision iii. Debriefing- before the patient leaves the operating room	Surgical Services Committee: ▪ Surgical Safety Checklist is completed prior to procedure start 100%	Year 1: ▪ Three- phase surgery checklist is used for all surgical procedures performed in the operating room and for every surgical procedure. Completed 100% of the time prior to procedure start. ▪ Surgical Safety Checklist is monitored, evaluated and results are shared with the team. Results of the evaluation are used for any identified improvements requirements. Year 2: ▪ Three- phase surgery checklist is used for all surgical procedures performed in the operating room and for every surgical procedure. Completed 100% of the time prior to procedure start. ▪ Surgical Safety Checklist is monitored, evaluated and results are shared with the team. Results of the evaluation are used for any identified improvements requirements.	
Risk Management Self-Assessment (RMSAM) (HIROC)	VP/CFO Risk	Year 1: ▪ Self- Assessment is completed Q3 Year 2: ▪ Top 3 priorities have mitigation strategies by Q4	

OBJECTIVE 2.3: Safe care is addressed as a public health concern.

OUTCOME:
2.3.1: Health service organizations actively participate in an accreditation process.
2.3.2: Rates of patient harm and other indicators that reflect organizational safety are reported publicly

Actions	Activity	Performance Metrics	Status
Accreditation (CCHSA) Every four years, as part of the accreditation process, health services organizations take part in a self-evaluation followed by a survey visit. This accreditation process allows the Canadian Council on Health Services Accreditation (CCHSA) and the organization to evaluate the quality of the organization's services by comparing them nationally to accepted standards. Participate in planning for accreditation and making recommended improvements to address any identified deficiencies. Ensure that an accreditation process is implemented with the involvement of all relevant stakeholders. 2.3 Ensure that accreditation results are shared broadly within the organization and with the public, as appropriate. Monitor accreditation Staff participate in planning for accreditation and making recommended improvements. 2.3 Recommendations and data to identify areas for improvement and allocate funding. 2.3	Senior Team/Quality & Patient Safety Committee of the Board Quality Council Senior Team Board: ▪ prepare for accreditation scheduled for October 2022	Year 1: ▪ Accreditation planning ▪ Accreditation Self-Assessment ▪ Required organization practices (GOP) gaps identified and eliminated Year 2: ▪ Accreditation planning ▪ Required organization practices (GOP) gaps identified and eliminated ▪ Tracer training (including 2 PFAC members) and tracers conducted ▪ Survey completed November 2022 achieving accreditation with exemplary status	

Actions	Activity	Performance Metrics	Status
Certification/Accreditations – Pharmacy Ontario pharmacies must meet certain standards to be accredited. These standards include governance and legal compliance, management and employee relations, pharmacy premises, delivering services, equipment and technology, information management, safe medication management system and quality improvement. The standards of operation for pharmacies support the regulation of pharmacies of Ontario under the Drug and Pharmacies Regulation ACT, 1990.	Pharmacy	Year 1: ▪ Pharmacy completes an annual accreditation in the month of May and an annual certification each fall (Sept/Oct). Both are with the Ontario College of Pharmacists Year 2: ▪ Pharmacy completes an annual accreditation in the month of May and an annual certification each fall (Sept./Oct.). Both are with the Ontario College of Pharmacists	
Certification/Accreditation-Laboratory Services The Laboratory is committed to a Quality Management System based on Ontario Accreditation Requirements. MAHC Laboratories are licensed and accredited by IQMH (Institute for Quality Management in Healthcare) every four (4) years. The mandatory laboratory accreditation consists of numerous requirements to ensure the facility meets explicit quality management criteria and is competent to carry out laboratory examinations. A peer (onsite) assessment occurs every 4 years to review compliance to the standards for HDMH, SMMH Laboratories and the Burk's Falls Collection Centre.	Laboratory: ▪ accreditation preparation ▪ close any gaps identified resulting from last accreditation Definition is: Assessment visit to review the quality management system, safety and all areas that collect specimens and perform and support patient testing for purposes of diagnosis, prevention or treatment of patients. Lab accreditation covers the Almaguin Highlands Health Centre Collection Centre and HDMH and SMMH lab.	Year 1: ▪ Lab Accreditation cycle is every 4 years. Year 2: ▪ Lab Accreditation cycle is every 4 years (lab conducting preparation activities)	

Actions	Activity	Performance Metrics	Status
Certification/Accreditation- Diagnostic Imaging Yearly audits are conducted as per Healing Arts and Radiation Protection ACT (HARP) and Internal yearly audits for diagnostic imaging staff on repeat/reject analysis for quality assurance and internal yearly audits are conducted. Accreditation of echocardiography- defined standards are demonstrated performance characteristics that provide evidence of quality service provision. In their entirety standards provide a means of identifying appropriate services and ensuring all patients receive timely, and effective assessment. There is a set of fifty-four (54) standards distributed among six (6) performance indicators	Diagnostic Imaging: ▪ Certification steps undertaken ▪ Conduct audit against standards	Year 1: Abide by certification requirements as follows: ▪ HDMH CT IHF clinic – every 3 years with the Ministry of Health–IHF ▪ Mammography - every 3 years (CAR) ▪ Ontario Breast Screening Program Technologists - annual review ▪ Echo – 3 years with Accreditation Canada (AC) diagnostics ▪ Nuclear Med- every 5 years with CNSC ▪ All Radiology equipment – minimum yearly HARPs Year 2: Abide by certification requirements as follows: ▪ HDMH CT IHF clinic – every 3 years with the Ministry of Health–IHF (due: Jan 2024) ▪ Mammography - every 3 years (CAR) (HDMH due Dec 2023, SMMH due Sept. 2022) ▪ Ontario Breast Screening Program Technologists - annual review ▪ Echo – 3 years with Accreditation Canada (AC) diagnostics (Completed July 2019) Echo was only done once. and then the provincial group was folded into another overarching body. ▪ Nuclear Med- every 5 years with CNSC (Jan 2026) ▪ All Radiology equipment – minimum yearly HARPs	

Actions	Activity	Performance Metrics	Status
Ensure transparent and safe internal and external procedures for reporting on patient safety incidents and actions for improvement that are well communicated to patients and families, highly visible, support safe space for reporting and take a trauma informed care approach. 2.3		Year 1: ▪ Indicator: Rates of patient harm events are reported in the Quality & Patient Safety, quarterly. Year 2: ▪ Indicator: Rates of patient harm events are reported in the Quality & Patient Safety, quarterly.	

Goal 3 | Accessible/Timely/Equitable Care

People have timely and equitable access to quality health services.

Reducing waits and unfavorable delays for both those who receive and those who give care.

Providing care that does not vary in quality because of personal characteristics such as gender, ethnicity, geographic location and socio-economic status.

MAHC endeavors to ensure that diverse peoples, including indigenous, Black, LGBTQ2S+, immigrant, and people from rural and remote communities receive safe equitable and timely care.
MAHC ensures that targets for access to services are measured and publicly reported. Health Leaders identify and address barriers to access related to language, payment, insurance, transportation, prescriptions, as well as other barriers by considering social determinants of health.

Health teams provide care and services within their scope of practice and optimize their skills based on evidence.

All members of the health team follow the legal requirements, guidelines, standards of practice, and recommendations set by their licensing body or regulatory college.

Health leaders determine a needs-based human resource allocation strategy, including an appropriate skill mix for their workforce.

OBJECTIVE 3.1: Care, diagnostics, and services are accessible for all people in an equitable and timely manner.

Indicator: Wait times for locally selected care, treatments, and procedures, analyzed by sociodemographic variables, geographic variables, and/or deprivation indices.

Indicator: Rate of access to primary care provider, analyzed by socio- variables, geographic deprivation indices

OUTCOMES:

3.1.1: Diverse peoples, including First Nations, Inuit, Metis, Black, LGBTQ2S+, immigrant, and people in rural and remote communities, receive safe, equitable, and timely care

3.1.2: Targets for access to services are measured and publicly reported

3.1.3: Alternative options for care delivery are available, including virtual and in- person visits with a provider

Actions	Activity	Performance Metrics	Status
Staff introduce themselves and share information about their role and responsibility with patients and families.	Quality Council: ▪ AIDET education ▪ monitor results of patient satisfaction surveying and patient rounding ▪ LMS	Year 1: ▪ Patient satisfaction survey results are reviewed for performance results for this question Year 2: ▪ Patient satisfaction survey results are reviewed for performance results for the question 'did staff introduce themselves'. Target 90%	
When providing virtual health services, use a protocol for ensuring patient safety, privacy and confidentiality	Director, Quality & Risk: ▪ implement a virtual health service protocol and policy	Year 1: ▪ Develop a protocol and policy for ensuring patient safety to support virtual care Year 2: ▪ Identify opportunities to provide virtual care if appropriate (e.g. virtual ED care 4s, 5s?)	
Ensure wait-time data is captured and standardized targets set by the province in collaboration with patients and providers. 3.1	Quality Council/ Utilization Committee/Surgical Committees: ▪ collect, review, analyze wait-time data to identify improvement strategies	Year 1 ▪ identify wait time improvement initiatives ▪ prepare and execute plan to reduce wait times Year 2 ▪ identify wait time improvement initiatives ▪ prepare and execute plan to reduce wait times ▪ Seamless MD? ▪ Wait time Novari system	
Timely transitions from ED to Inpatient bed (QIP)	Quality Council	Year 1: ▪ 90th percentile- time from ED to Inpatient Bed Year 2: ▪ 90th percentile- time from ED to Inpatient Bed	

OBJECTIVE 3.2: Human resources are effectively matched to population needs.

OUTCOMES:

3.2.1: A needs-based human resources allocation strategy is in place, including an appropriate skills mix for the workforce

3.2.2: The scope of practice of health service providers (both regulated and unregulated, knowledge keepers and Elders) is recognized and optimized based on evidence.

Actions	Activity	Performance Metrics	Status
Ensure evidence-based practices and relevant legal requirements for health human resourcing are being followed 3.2	Human Resources/Chief of Staff	Year 1: ▪ Continuously as required Year 2: ▪ Continuously as required	
Collaborate with labour unions, associations, and regulatory colleges to establish and regularly update provider scope-of-practice and position profiles.3.2	Human Resources Managers Senior Leadership Team	Year 1: ▪ Regular Job Profile Reviews completed and updates on SharePoint in accordance with Accreditation Canada Requirements. Year 2: Regular Job Profile Reviews completed and updates on SharePoint in accordance with Accreditation Canada Requirements.	
Ensure the staffing process appropriately considers candidate skills, education, and knowledge.3.2	Human Resources Managers Senior Team	Year 1: ▪ Recruitment process is legally compliant and assesses knowledge, skill and ability for the position. Year 2: ▪ Recruitment process is legally compliant and assesses knowledge, skill and ability for the position.	

Actions	Activity	Performance Metrics	Status
Succession Planning	Chief of Staff CEO	Year 1: ▪ Clinical Services Resources Plan ▪ Credentialed Staff Recruitment Year 2: ▪ Clinical Services Resources Plan ▪ Credentialed Staff Recruitment ▪ Succession plan for Sr. Team, Directors/Managers	
Ensure the scope of practice of health service providers is recognized and optimized.	Human Resources Nursing Professional Development Advisory Council	Year 1: ▪ Review conducted Year 2: ▪ Review conducted	

Goal 4 | Appropriate/Effective/Efficient Care

Care is evidence-based and people-centred.

Providing services based on scientific knowledge to all who could benefit and refraining from providing services to those not likely to benefit (avoiding underuse and overuse). Doing the right thing for the right person at the right time.

Avoiding waste, in particular waste of equipment, supplies, ideas and energy. We continue to avoid waste through participation in the Choosing Wisely program.

Health leaders/teams:

- encourage health promotion and disease prevention within their organization
- ensure their teams deliver evidence-based care that incorporates patient preferences.
- prepare their team to use new treatments and technologies
- include health promotion and disease prevention in their treatment plans.
- use evidence-based care to minimize unnecessary care variations throughout a patient's journey while respecting the patient's preferences.
- ensure new treatments, technologies, medical devices, and equipment are evaluated and monitored for appropriate use.
- are prepared to effectively implement, evaluate, and monitor new treatments, technologies, medical devices, and equipment.
- are accountable for reducing unwarranted variations in care.

OBJECTIVE 4.1: Health services are planned and delivered based on the needs of the population.

OUTCOME:
4.1.1: There is evidence that health promotion and disease prevention are addressed

Actions	Activity	Performance Metrics	Status
MAHC is a signatory and active partner of MAOHT	Actively participate in MAOHT activities	Year 1: ▪ Actively participate in MAOHT activities Year 2: ▪ What are the goals and objective on the MAOHT workplan that involve a specific deliverable of MAHC?	

OBJECTIVE 4.2: Appropriate care is actively promoted and monitored, and unwarranted variations are minimized

OUTCOMES:
4.2.1: Evidence-based care is demonstrated throughout the patient journey, reflecting patient preferences
4.2.2: Unwarranted care variations are minimized

Actions	Activity	Performance Metrics	Status
Develop, implement, and evaluate care pathways.4.2	Dr. Abdel-Razek and J. Raine to review and provide input into this section Reminder to include new credentialing software	Year 1: To be determined Year 2: To be determined PPNO? • Choosing Wisely?	
Provide feedback on the use of care pathways and evidence-based standards.4.2 Ensure comprehensive patient participation in developing and implementing care pathways.4.2 Ensure education is provided to health teams on evidence-based care and care pathways 4.2			

Actions	Activity	Performance Metrics	Status
Collect utilization data on care pathways and share it with health teams.4.2 Ensure standardized processes and resources (e.g., decision aids) are available to health teams (including patients and families) to reduce variation in and between services and to support quality improvement and change management.4.2 Allocate resources to collect data on unwarranted care variations and share it with health teams.4.2			
Encourage health teams to involve patients and use data and information to understand care variations and establish protocols and procedures for quality improvement.4.2			

OBJECTIVE 4.3: Emerging treatments and technologies are systematically evaluated and implemented in health services.

OUTCOMES:

4.3.1: Treatments, technologies, medical devices, and equipment are evaluated and monitored for appropriate use.

4.3.2: Health teams are prepared for effective use of new treatments and technologies

Actions	Activity	Performance Metrics	Status
▪ Ensure serious adverse drug reactions and medical device incident rates are tracked (e.g., quality scorecards), shared with health teams, and actioned for positive change.4.3 ▪ Follow mandatory reporting requirements in accordance with the Protecting Canadians from Unsafe Drugs Act.4.3 ▪ Review information on serious adverse drug reactions and the requirements for reporting medical-device incidents 4.3	Quality/Risk Manager Pharmacy & Therapeutic Committee	Year 1: Serious Adverse Drug Reactions and Medical-Device incidents are reviewed and reported to Health Canada Year 2: • Serious Adverse Drug Reactions and Medical-Device incidents are reviewed and reported to Health Canada Year 2: • Safer med and/or Pharmacy & Therapeutics to establish activity	
▪ Provide information related to end-user needs for electronic health record system. 4.3 ▪ Use an audit and feedback process to ensure issues are reported and corrective action is taken. 4.3	Digital Working Group – MAOHT	Year 1: ▪ Perform Assessment and inventory of Digital assets and prioritize needs Year 2: ▪ Determine what will be measured and why and establish a target ▪ My Chart- patient portal	

Actions	Activity	Performance Metrics	Status
▪ Monitor and build awareness about treatments and technologies ▪ Familiarize, investigate technologies and treatments and determine applicability.4.3 ▪ Report the utilization status of new technologies to education providers and researchers.4.3 ▪ Allocate resources and develop a strategy for implementing and evaluating new treatments, technologies, and medical devices. 4.3	Senior Team Quality Council Medical Quality Assurance Committee Medical Advisory Committee IMIT	Year 1: ▪ Establish methods that will be used to identify new treatment and technologies Year 2: To be determined Urology equipment – reducing LOS	 We require a review of the present methods used to identify new treatment and technology. Typically, new treatment and/or technologies are identified via committees, council etc.

Actions	Activity	Performance Metrics	Status
▪ Ensure there is an evaluation process for the adoption and implementation of emerging treatments and technologies. 4.3 ▪ Align the use of new technologies and treatments with the guidelines set out by Choosing Wisely Canada. 4.3 ▪ Ensure health teams have the required education and training to use new treatments and technologies. ▪ Identify gaps in education and the impact on treatment and technology usage. 4.3			

Goal 5 | Integrated Care

Health services are continuous and well-coordinated, promoting smooth transitions.

Health leaders ensure coordinated care across health services and establish the infrastructure and accountability for care transitions, particularly from urban to rural and remote settings.

Health teams are accountable for the quality of service during care transitions and the overall coordination of care across health services, particularly from urban to rural and remote settings.

Health leaders ensure patients and providers have appropriate access to integrated electronic health records.

Health teams and patients require timely access to information in electronic health records.

OBJECTIVE 5.1: Patients experience smooth transitions across health services.

OUTCOME:

5.1.1: The infrastructure and accountability for care transitions are in place.

5.1.2: Providers coordinate care across health services

Actions	Activity	Performance Metrics	Status
▪ Ensure care transition processes are developed in collaboration with patients and families. ▪ Partner with other organizations to efficiently and effectively deliver and coordinate services.	MAOHT: ▪ determine needs and the method to provide access to information required to provide care ▪ Transitions from hospital to home activity	Year 1: ▪ Continue to participate in MAOHT Year 2: ▪ Continue to participate in MAOHT ▪ MAOHT director to determine what and by when