Are systems reviews including QARs, PSRs and ABCs confusing? Not anymore!

Amir Ginzburg, MD FRCPC
Paula Beard, MA, ACP
Carroll Thorowsky, BSCN, MSA
Dr. Amir Ginzburg, Carroll Thorowsky and Paula Beard have no disclosures.
Learning Objectives

• Outline the principals of incident analysis and steps in immediate management

• Describe the analysis process and range of methods / tools, including the importance of patient/family interviews

• Explore the intersection between individual and system accountability
https://www.youtube.com/watch?v=bfzAfZZ8JHg
• Reflections

• What do providers want?

• What does the public want?
How Hazardous is Health Care?

- **DANGEROUS** (>1/1000)
  - Mountain Climbing
  - Bungee Jumping

- **REGULATED**
  - Chartered Flights
  - Chemical Manufacturing
  - Driving

- **ULTRA-SAFE** (<1/100K)
  - Scheduled Airlines
  - European Railroads
  - Nuclear Power

Diagram Credit: R. Amalberti, L. Leape
### The Canadian Experience

#### Likelihood of an adverse event (CIHI, 2007)

<table>
<thead>
<tr>
<th>Event</th>
<th>Adults</th>
<th>Children</th>
</tr>
</thead>
<tbody>
<tr>
<td>Contracting hospital acquired infection</td>
<td>1 in 10</td>
<td>1 in 12</td>
</tr>
<tr>
<td>Receive wrong medication or dose</td>
<td>1 in 10</td>
<td></td>
</tr>
<tr>
<td>Acute care hospital medical / surgical patient experiencing an adverse event</td>
<td>Non-fatal: 1 in 13</td>
<td>Fatal (Preventable): 1 in 150</td>
</tr>
<tr>
<td>Obstetrical trauma (vaginal delivery)</td>
<td>1 in 21</td>
<td></td>
</tr>
<tr>
<td>Retained foreign body after procedure</td>
<td>1 in 3,000</td>
<td></td>
</tr>
</tbody>
</table>
Blame and Accountability

https://www.youtube.com/watch?v=RZWf2_2L2v8
“The single greatest impediment to error prevention in the medical industry is that we punish people for making mistakes”

Prof. Lucian Leape, Harvard School of Public Health
**Patient Safety Incident:**
An event of circumstance which could have resulted, or did result, in unnecessary harm to a patient.
Clinical Adverse Event

An event that could or does result in an unintended injury or complications arising from healthcare management, with outcomes that may range from (but are not limited to) deaths or disability to dissatisfaction or require a change in patient care.
Safeguards and Latent Hazards

Adapted from James Reason’s Swiss Cheese Model (2000)
<table>
<thead>
<tr>
<th>Theme</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient Fall</td>
<td>17</td>
</tr>
<tr>
<td>Retained Foreign Object</td>
<td>19</td>
</tr>
<tr>
<td>Wrong Site / Side / Procedure Surgery</td>
<td>20</td>
</tr>
<tr>
<td>Diagnosis Delayed - Specimen Related</td>
<td>21</td>
</tr>
<tr>
<td>Incorrect Dx &amp; Tx - Specimen Mix Up</td>
<td>23</td>
</tr>
<tr>
<td>Elopement While in Care</td>
<td>26</td>
</tr>
<tr>
<td>Inpatient Suicide</td>
<td>54</td>
</tr>
<tr>
<td>Communication Amongst Care Providers &amp; Patients &amp; Families</td>
<td>62</td>
</tr>
<tr>
<td>Operational / Governance</td>
<td>62</td>
</tr>
<tr>
<td>Environment / Equipment</td>
<td>75</td>
</tr>
<tr>
<td>Clinical Decision Making</td>
<td>100</td>
</tr>
<tr>
<td>Other</td>
<td>109</td>
</tr>
<tr>
<td>Medication / Fluid Error</td>
<td>118</td>
</tr>
<tr>
<td>Communication Amongst Care Providers</td>
<td>125</td>
</tr>
<tr>
<td>Suicide in Community (Outpatient / Within 30 Days of Discharge)</td>
<td>161</td>
</tr>
<tr>
<td>Delayed Reaction to Clinical Deterioriation</td>
<td>211</td>
</tr>
</tbody>
</table>
Incident Analysis – Why?

- Uphold our commitment to value safety for patients, families and healthcare providers.
- To learn, improve care, and share our learning
- Minimize risk of future similar harm
Canadian Incident Management Continuum

CLOSE THE LOOP
Share what was learned (internally and externally)

BEFORE THE INCIDENT
- Ensure leadership support
- Cultivate a safe and just culture
- Develop a plan including resources

IMMEDIATE RESPONSE
- Care for and support patient/family/providers/others
- Report incident
- Secure items
- Begin disclosure process
- Reduce risk of imminent recurrence

PREPARE FOR ANALYSIS
- Preliminary investigation
- Select an analysis method
- Identify the team
- Coordinate meetings
- Plan for/conduct interviews

ANALYSIS PROCESS
- Understand what happened
- Determine how and why it happened
- Develop and manage recommended actions

FOLLOW THROUGH
- Implement recommended actions
- Monitor and assess the effectiveness of actions

Source: CPSI
Before an Incident

- Cultivate a safe and just culture
- Leadership support
- Develop a plan including resources
Systems Analysis Methodology (AHS, 2017)

Adverse Event/Close Call → Immediate Management → Ongoing Management → Recommend, Evaluate & Share

- Respond
- Environment
- Secure
- Protect
- Offer Support
- Notify
- Disclose/Document

Initial Assessment: Systems Thinking

Accountability Decision Tool

AHS Leader: Determine Response(s) Required

- Quality Assurance Review (s.9 protected)
- Patient Safety Review (not s.9 protected)
- Human Factors Evaluation
- Educational Case Review
- Administrative Review
- Patient Concerns Resolution Process
- Simulation
- Quality Improvement Initiative
- Safety Alert/Safer Practice Notice
Table Exercise:

You are a patient safety / QI practitioner and the ICU manager call you to assist in the immediate management of this incident

• Provide guidance to the ICU team on next steps
Immediate Response

CLOSE THE LOOP
- Share what we learned (internally and externally)

FOLLOW THROUGH
- Promote recommended actions
- Monitor and measure the effectiveness of actions

ANALYSIS PROCESS
- Understand what happened
- Objectives: how and why it happened
- Evaluate and recommend recommended actions

PREPARE FOR ANALYSIS
- Preliminary investigation
- Select an analysis method
- Identify the team
- Coordinate meetings for immediate reviews

IMMEDIATE RESPONSE
- Can be non-reportable events
- Notify appropriate person
- Report incident
- Enforce trend
- Begin investigation process
- Reduce risk of similar incident

Immediate Management

Quality Assurance Reviews

Quality Assurance Reviews (QARs) are one way in which we can learn from adverse events (or close calls) in healthcare. The primary objective of these reviews is to identify system issues that contributed to the event and to generate recommendations to prevent similar adverse events from occurring in the future.

The review team consists of individuals who are knowledgeable about the care processes relevant to the incident and does not evaluate the performance of individuals. The focus is on how to improve systems of care, not the actions of individuals. If you are a community physician participating in this review, this is disclosing information to you under section 36 of the Health Information Act. Your obligations to maintain the confidentiality of this information remain in place. Should you receive a request for this information, we can assist you as this QAR is protected from disclosure.

QARs are conducted under section 36 of the Alberta Evidence Act. Section 36 protects the patient to receive a safe environment for sharing opinions, so that the members of the review team can obtain the best possible understanding of the event and contributing factors. The information is confidential and cannot be subpoenaed or entered into evidence in a court of law, and is not subject to a request for information under Alberta’s access to information legislation. Participants in a QAR are not permitted to answer any questions or share any documentation that is produced in this review. It is important to highlight that the files, such as clinical records, are not protected by section 36 and a patient or their authorized representative cannot access these records under the Health Information Act.

What can I expect if asked to participate in an interview or analysis meeting related to the event?

- QARs are a collaborative and consultative process used to understand the limitations of our healthcare system, learn and make recommendations for improvement aimed at preventing this type of event from recurring.
- Participants will be treated with care, compassion, respect, and dignity.
- All discussions within a QAR and documents produced by a QAR are protected by sections 36 and confidential. Any discussions that occur during this review cannot be subpoenaed and you cannot answer any questions as to the discussions before the QAR in a court of law. Your name is not used anywhere in the final report that is submitted to the Quality Assurance Committee for approval.

QARs have two parts:
- Investigation Phase: interviews with staff, physicians, patients, and families understand.
  - What happened?
  - What can be done to prevent a similar situation?
  - What was communicated to the patient?
  - What was done to improve safety for future patients?
  - Analysis Phase: identifyroot cause & develop recommendations:
  - What system issues can be changed to make patients safer?
  - In the conclusion, the only information released is the brief, identified factual case description as well as any recommendations and lessons learned.
- QAR summary is shared with the QAC for operational assignment
- Patient safety learning_summary is shared with staff and physicians who may benefit from lessons learned, and affected patients/families for sharing lessons learned.

If you have questions about the QAR process you are encouraged to call.
# Disclosure

<table>
<thead>
<tr>
<th>Barriers</th>
<th>Facilitators</th>
</tr>
</thead>
<tbody>
<tr>
<td>Culture of minimal discussion of error</td>
<td>Patient safety training (how to identify and disclose incidents)</td>
</tr>
<tr>
<td>Lack of confidence in organizational support</td>
<td>High safety culture</td>
</tr>
<tr>
<td>Social fears</td>
<td>Perceived support</td>
</tr>
<tr>
<td>Fear of litigation</td>
<td>Routine open discussions of incidents</td>
</tr>
<tr>
<td>Hierarchy</td>
<td></td>
</tr>
</tbody>
</table>
Patient Safety Policy Suite: Disclosure

Quick reference guide

What is this procedure?
Despite our best efforts to provide safe care, patients may occasionally experience harm while in our care. When harm occurs to a patient, we must communicate what happened to the patient/family in an empathetic, timely, and transparent manner.

This is called DISCLOSURE OF HARM, and is one of six procedures in the patient safety policy suite.

What you need to know

<table>
<thead>
<tr>
<th>Disclosure</th>
<th>When any harm occurs, a risk of future harm exists or if a change in care or monitoring is made because of something occurring in care we provide, we must disclose to the patient/family.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Close calls</td>
<td>In the event of a close call, disclose if it's in the best interest to the patient/family to know or if they would wish to know. If you aren't sure, disclose the close call to the patient/family.</td>
</tr>
</tbody>
</table>
| How do I disclose?  | 1. Acknowledge that harm has occurred to the patient and apologize on behalf of AHS.  
                            2. Explain the future impact the harm could have on the patient.  
                            3. Explain how the harm occurred. If unsure, don’t speculate, but commit to investigate and follow up with the patient/family to discuss what we learned and why the harm occurred. |
| When is disclosure complete? | Disclosure is complete when the patient receives an accurate understanding of what happened, the impact it will have on them and how AHS will respond. In complex cases, the disclosure process may involve several conversations. |

Source: AHS (2017)
Apology Legislation
• Also known as “second victims”

• Health care providers involved in a patient safety incident often experience emotional and sometimes physical distress

- shame
- helplessness
- fear
- worry
- anger
- distress
- guilt
- depression
- shock
- chaos
- anxiety
Support for Providers

What is needed:

• Professional re-affirmation
• Personal reassurance
Support for Providers (AHS)

Tips for Supporting Staff Involved in Clinically Serious Adverse Events

- The mental wellness of our staff and physicians is a big component of the safety of our environment and it is prudent for the sake of both the staff involved and patients to assess whether staff might need to be replaced on a short term basis to ensure safety while they have a chance to recover.

- Consider the need to bring functional teams together (e.g., lab staff who work together in one area) to open the lines of communication. During the meeting general information is shared (e.g., a clinically serious adverse event has occurred and a process is underway to understand what happened and how we can make care safer). This information is provided by the local leader and is intended to open dialogue, avoid secrecy, isolation, and shame. Reaching out to the event during this type of meeting is not recommended and may, in some cases, be harmful.

- During a general information session one or one interactions with staff and physicians send clear messages of support to all staff involved: “We will figure this out together.”

- Provide information about how the organization is going to respond to prevent future harm to patients and better support staff to do their work. Include any relevant policies, procedures, or guidance documents.

- Help staff and physicians understand that it may be helpful to seek support from family, friends, and peers and that is to be encouraged. However, individuals should not provide patient identifying information or specific details about the event. This type of detail is provided within approved organizational processes for learning such as a quality assurance review or a patient safety review.

- Remind staff that if they need additional support they are encouraged to obtain assistance through Employee Assistance Programs (EAP) and other professionals. Managers can also call for advice on the best way to support their teams.

- 24 hour contact number for confidential EAP help for AHS employees is 1-877-273-3134
- 24 hour contact number for confidential support for physicians and residents is the Physicians and Family Support Program of the AMA 1-877-507-4707 (767-4677).

- Occasionally staff want to speak with an individual who has experience with clinically serious adverse events but are not administratively involved in the particular event. Currently there is one such informed and objective individual available to be staffed on an as needed basis:

- Dr. Bruce MacLeod can be contacted at Bruce.macleod@albertahealthservices.ca

The Second Victim

Fatal errors and those that cause harm are known to harm health-care practitioners throughout their lives. The impact of the error is felt in their private lives, interactions with professional colleagues, and in the midst of their social lives.

Immediately after the error is recognized, practitioners typically experience stress-related psychological and physical reactions related to sadness, tear, anger, and shame.

They are immediately panicked, horrified, and appraised, which is manifested by disbelief, shock, an increased blood pressure and heart rate, muscle tension, rapid breathing, extreme sadness, appetite, disturbances, and difficulty concentrating.

While awaiting investigation of the error, the second victim is often plagued with fears of losing a job and the financial consequences of unemployment and lowered lives; being labeled as incompetent or careless by colleagues, their family, and the patient’s family, loss of coworkers’ respect; involvement in a civil or criminal court proceeding; and loss of a professional license.

Heartbreaking photo captures doctor’s grief after loss

KHOU.com  4:49 p.m. EDT March 20, 2015

An EMT worker has shared a photo his coworker took of a doctor grieving over the loss of a 19-year-old patient.

(Photo: Reddit NickMoore911)

"The man pictured was unable to save one of his patients. Though this is a common occurrence in our field of work, the patients we lose are typically old, sick, or some combination of the two. The patient that died was 19 years old, and for him, it was one of those calls we get sometimes that just hits you," wrote redditor NickMoore911.

"Within a few minutes, the doctor stepped back inside, holding his head high again."
Prepare for Analysis

- Ongoing Management
- Initial Assessment: Systems Thinking
- Accountability Decision Tool
- AHS Leader: Determine Response(s) Required
  - Quality Assurance Review (s.9 protected)
  - Patient Safety Review (not s.9 protected)
  - Human Factors Evaluation
  - Educational Case Review
  - Administrative Review
  - Patient Concerns Resolution Process
  - Simulation
  - Quality Improvement Initiative
  - Safety Alert/Safer Practice Notice
Facilitator (with IA knowledge) paired with a leader (with operational accountability)

Determine scope

Apply legislation if applicable

Identify team members (interprofessional!)

Book interviews (patient/family, staff, physicians, etc), and meetings

Prepare materials
More About Section 9

Alberta Health Services QAC and QAC Subcommittee Structure

- AHS Board appointed
- Authorized to constitute QAC subcommittees
- Authorized to constitute Section 9 protected review teams with a life expectancy of less than one year to review specific events
- Conducts activities across entire scope of AHS regarding serious or potentially serious systemic issues
- Receives Section 9 protected reports and information from any AHS QAC and external reviewers (e.g., HCMA, fatality request)
- Reports quarterly on patient safety activities to the Patient Safety Department
- Reports QA information arising from QA activities to the AHS Executive and Governance Structures as appropriate

Complex Review Zone QA Committees
- AHS Board appointed
- Authorized to constitute QAC subcommittees
- Authorized to constitute Section 9 protected review teams with a life expectancy of less than one year to review specific events
- Supports QAC activities that are complex in nature and/or cannot easily be undertaken by other AHS QACs or QAC subcommittees
- Reports findings of QA reviews to QAR requestor
- Reports QA activities and learnings to the AHS QAC and appropriate administrative leadership
- Reports quarterly on patient safety activities to the Patient Safety Department (including numbers and list of all existing subcommittees)

Provincial Committees
- Authorized to constitute QAC subcommittees
- Authorized to constitute Section 9 protected review teams with a life expectancy of less than one year to review specific events
- Ensures the Zone/Complex Review Committee has an up-to-date list of all established QAC subcommittees
- Reports QA activity quarterly to the Patient Safety Department

QA Committees
- Authorized to constitute QAC subcommittees
- Authorized to constitute Section 9 protected review teams with a life expectancy of less than one year to review specific events

- AHS Board appointed
- Authorized to constitute QAC subcommittees
- Authorized to constitute Section 9 protected review teams with a life expectancy of less than one year to review specific events
- Conducts activities across entire scope of AHS regarding serious or potentially serious systemic issues
- Receives Section 9 protected reports and information from any AHS QAC and external reviewers (e.g., HCMA, fatality request)
- Reports quarterly on patient safety activities to the Patient Safety Department
- Reports QA information arising from QA activities to the AHS Executive and Governance Structures as appropriate

QA Subcommittees
- Authorized by any QAC, as listed above
- Reports quarterly QA activity to the Patient Safety Department
- Reports findings of QA reviews to QAR requestor
- Reports on activities and general learnings related to QA activity to

- North Zone QAC
- South Zone QAC
- Central Zone QAC
- Edmonton Zone QAC
- Calgary Zone QAC
- Provincial QAC

- Patient Safety Department QA
- Corrections Health Services QA
- Laboratory Services Provincial QAC
- Emergency Medical Services QA
- Diagnostic Imaging Services QA
- Population & Public Health QA
- Provincial Perinatal QA

- Queen Elizabeth II Regional Hospital QAC
- Northern Lights Regional Health Centre QAC
- University of Alberta Hospital Regional Hospital Clinic QAC
- Royal Alexandra Hospital QAC
- Glenrose Rehabilitation Hospital QAC
- CHIPS Edmonton Zone QAC (Stollery Children’s Hospital)
- Mazankowski Alberta Heart Institute QAC

- Continuing Care, Edmonton Zone QAC
- Edmonton Zone: Addiction & Mental Health QAC
- Community & Rural Hospitals, Edmonton Zone QAC
- Primary Care, Chronic Disease Management, Public Health QAC
- Centre QAC
- Critical Care (Calgary Zone) QAC
- Emergency (Calgary Zone) QAC
- Alberta Children’s Hospital QAC
- Rockyview General Hospital QAC
- Peter Lougheed Centre QAC
- Community & Rural Health & Facilities (Calgary Zone) QAC
- Integrated Seniors Health (Calgary Zone) QAC
- Women’s Health & Perinatal (Calgary Zone) QAC
- Neonatal (Calgary Zone) QAC
- South Health Campus QAC
- Foothills Medical Centre QAC
- Calgary Zone QAC
- Surgical Services (Calgary Zone) QAC
- Addiction & Mental Health (Calgary Zone) QAC
- Campus Science (Calgary Zone) QAC
- Women’s Health & Perinatal (Calgary Zone) QAC
- Neonatal (Calgary Zone) QAC
- South Health Campus QAC
- Tom Baker Cancer Centre QAC
- Cross Cancer Institute QAC
- Provincial Cancer Council Complex QAC

- Appointed by any QAC, as listed above
- Reports quarterly QA activity to the Patient Safety Department
- Reports findings of QA reviews to QAR requestor
- Reports on activities and general learnings related to QA activity to
Preliminary investigation:

- Memory fades, dominant story tellers emerge
- Pumps, IVs, bottles, packaging, containers, sharps
- Rhythm strips, fetal monitoring tracings, telemetry logs, shift assignments, OR list, paging log, CCTV

Start ASAP

Secure ‘usual’s

Secure ‘unusual’s
Prepare for Analysis

Preliminary investigation:

Documents
- Secure / review health record and incident report
- Are these a good “black box” ???

Come prepared
- Think about themes that require a deeper dive
- E.g., equipment, environment, teamwork, communication, policies / procedures

Probe to ‘blunt end’
- Challenging but mission critical for improvement to occur
Supportive Interviewing

Preparation
- Consider where, when, with whom, by whom

Opening
- Introductions / purpose / confidentiality

Communication
- “Tell their story” and “re-enact”; try not to interrupt
- Open-ended questions and active listening
- Do not make or agree with derogatory comments made regarding others involved in the care
- Record interview in a comfortable way

Closing
- Thank the patient/family member
- What to expect next
Table Exercise – Work in Pairs!

As part of the QAR process, the QAR lead is meeting with Mr. I.O.’s daughter, for an interview.

- **Pick up one ‘A’ and one ‘B’ role description**
- Read your roles and prepare for the sim (5 minutes)
- Conduct the sim (7 minutes)
- Debrief at your tables (8 minutes)
Analysis Process:

- Understand what happened
- Determine how and why it happened
- Develop and manage recommended actions to reduce risk of future similar recurrence
Ishikawa (Cause and Effect) Diagram

Environment

2 patients in adjacent rooms needed blood at the same time
High acuity shift

Fatigue / Scheduling

Blood given at 4 AM
1 nurse sick call

Wrong Blood / Wrong Patient

Policies / Procedures

Order set not used by new resident
No independent double check

Communication

Insufficient orientation for new resident
Blood bank concerned but did not inform ER
**INCIDENT:** Patient elopement

**OUTCOME:** Patient found cold and dehydrated 2 km from hospital

- Caretakers initially worked independently to try and find resident
- Communication lacking between staff members when resident first identified as missing
- Staff unfamiliar with Code Yellow procedures
- Close call charted but not formally reported or investigated
- Process changes not implemented after previous elopement

**ORGANIZATION**
- Lack of clarity around when to call a Code Yellow
- Code Yellow not called when resident not in room
- Assumptions made re: resident's whereabouts
- Lack of standard expectations re: resident status checks
- Electronic bracelet failed to alarm
- Monitoring bracelet was expired
- Electronic bracelet not tested daily per instructions provided with device
- No internal process to ensure device testing and accompanying documentation
- Fire alarm not “heard” or responded to
- Fire alarm sounds frequently staff are “desensitized”
- Routine use of an emergency exit to access the staff parking lot

**PATIENT**
- Cognitively impaired; elopement risk
- Code Yellow not fully implemented when resident first identified as missing

**CARE TEAM**
- No standardized process for “mock” codes

**EQUIPMENT**
- 3 month device used instead of 12 month
- Similar appearance of devices
- Two types of bracelets stocked

**WORK ENVIRONMENT**
- Electronic bracelet was tested daily per instructions provided with device

**TASK**
- Electronic bracelet failed to alarm
- Monitoring bracelet was expired

**OTHER**
- Adapted from: CPSI’s Canadian Incident Analysis Framework
• Address risks/factors identified
  – At appropriate system level
  – Evidence based, long term solution
  – SMART

• Assign responsibility at appropriate level

<table>
<thead>
<tr>
<th>Category</th>
<th>Recommended Action</th>
<th>Accountability</th>
<th>Target Date</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Policy / Procedure</td>
<td>IDC for insulin</td>
<td>CNO</td>
<td>June 1, 2015</td>
<td>Complete</td>
</tr>
<tr>
<td>Equipment</td>
<td>Barcoding pilot</td>
<td>Dir. Pharmacy</td>
<td>Sep 1, 2015</td>
<td>In Progress</td>
</tr>
</tbody>
</table>
Hierarchy of Effectiveness
Table Exercise – your table is the analysis team!

The QAR Lead is leading the analysis team through recommendation development. A member of the analysis team, a senior leader, notes that if the glucose had been tested the patient would not have died. She asks, “who was accountable for testing the glucose?”

- **Who should be disciplined?**

- **What is your approach this question?**
Individual performance vs systems issue?

Source: Canadian IA Framework (Incident Decision Tree, based on James Reason’s Culpability Model)
Follow Through:

- Implement recommended actions
- Monitor and assess the effectiveness of actions

Close the Loop:

- Share what was learned (internally and externally)
• Incident analysis is critical to a safe and just culture
• Burning platform for improvement work
• Opportunity for patient / provider / system healing
• Preparation is key
• Share learning broadly
• Accountability for recommended actions!
Learning Objectives

• Outline the principals of incident analysis and steps in immediate management

• Describe the analysis process and range of methods / tools, including the importance of patient/family interviews

• Explore the intersection between individual and system accountability
### Quality Assurance Committee
- QAC Chair Handbook
- QAC Quick Reference Guide
- AHS QAC Structure
- QAC Terms of Reference Modifications
- Engaging Patient Advisors on AHS QAC
- QAC Meeting Agenda Template
- QAC Meeting Minutes Template
- QAC Chair Contact List
- Appropriate Accountability Decision Support Tool

### Quality Assurance & Patient Safety Review Tools
- SAM Handbook
- The Overview: Learning from Adverse Events in AHS
- QAR Quick Reference Guide

### AHS Patient Safety Learning Summary
- Patient Safety Learning Summary - Tips & Worksheet
- Patient Safety Learning Summary - Template
- Patient Safety Learning Summary - FAQs
- Patient Safety Learning Summary - Process Flowchart

### Resources
- QAR Request & Acceptance Form
- QAR Process Flow Map
- QAR G.O.A.L Tool
- QAR Project Plan
- QAR Ownership Confirmation Reference
- QAR Checklist
- QAR Interview Tracking Form
- QAR Interview Guidelines
- QAR/PSR Reference Card
- QAR Document Control Checklist
- Disclosure Support (external site)

### Templates
- QAR Timeline Template
- QAR Team Membership Template
- QAR Email Templates & Instructions
- Confidentiality Agreement for Non-AHS Employees Participating in a SAM
- QAR Summary Template
- Patient Safety Review Summary Template
- QAR Summary Peer Feedback Checklist
- Recommendation Assessment & Prioritization Tool
Questions?

Amir.Ginzburg@thp.ca
(Amir Ginzburg)

Paula.Beard@albertahealthservices.ca
(Paula Beard)

thorow@shaw.ca
(Carroll Thorowsky)