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July 9, 2019

Ms. Jennifer Fuchinsky
Fatality Inquiry Coordinator
Justice and Solicitor General
9th Floor Peace Hills Trust Tower
10011 109 Street NW
EDMONTON AB T5J 3S8

Dear Ms. Fuchinsky:

Re: Thelma Eileen Williams, Public Fatality Inquiry - Response to Recommendations

Thank you for providing the Honourable Judge Joyce L. Lester's report. This letter is to provide a response to the three recommendations impacting Alberta Health Services (AHS) at the Royal Alexandra Hospital (RAH). A Patient Safety Learning Summary will be disseminated provincially to support organizational learning and consideration of these recommendations at other sites where similar gaps may exist.

Recommendation 1

A better communication procedure must be in place when hospital physicians "sign out" or transfer patients to the relief physician when their shifts end.

Response

Alberta Health Services (AHS) accepts this recommendation. (In Progress)

Although the fatality inquiry indicates that this recommendation has largely been addressed, all RAH program medical leads have been asked to approach their groups and establish, if not already present, a consistent communication strategy for the handover of patients. Service specific guidelines and/or communication tools regarding patient handover, informed by best practices, will be developed for physicians, medical residents, AHS clinical assistants and clinical associates that are working in the respective services.

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The Medical Advisory Council at the RAH has been engaged and this item will become a standing agenda item for every meeting to ensure support for respective medical leads and to monitor progress of site-wide implementation expected to be complete by March 31, 2020.

Recommendation 2

An adequate communication procedure that addresses communication among hospital staff as well as between families and hospital staff must be in place for the discharge of patients.

Response

Alberta Health Services (AHS) accepts this recommendation. (In Progress)

The verbal handover tool IDRAW was implemented site-wide at the RAH in 2017. The tool is specifically designed to structure the verbal interaction between staff members to include; **I**dentity, **D**iagnosis, **R**ecent Changes, **A**nticipated Changes, and **W**hat should I be worried about? Evaluation and reimplementation of the tool is currently in progress with an increased focus on safety culture and the importance of communication. This continued work and refinement of the IDRAW tool will be completed by March 31, 2020.

Education on IDRAW and an additional communication tool SBAR (**S**ituation, **B**ackground, **A**ssessment, and **R**ecommendation) has been added to the RAH new hire orientation and annual education requirements.

The RAH has also previously implemented in 2016/17 bedside shift reports, which most often include patients and families, on medicine and surgery inpatient units. Including patients and families in shift report greatly improves patient experience, patient safety, and outcomes including recovery and pain management. It has been demonstrated to be integral to patient and family centered care as facilitates information sharing, collaboration and the promotion of patient dignity and respect.

Communication between care providers, patients, and families has been identified as a priority at the RAH. A model called 'Co-Act' was implemented at RAH in 2014. Patients can now designate a primary support person who will advocate and communicate with hospital staff on their behalf. The nursing team and the family member can now voice concerns regarding discharge directly to the physician. This approach in which inter-professional teams work together in partnership with patients and families works to achieve optimal health outcomes. Additionally, whiteboards have been implemented at each patient bedside to provide opportunity for communication. Anticipated date of discharge is information included on the whiteboards to assist in preparing patients and families.

Recommendation 3

A communication procedure regarding the autopsy decision must be in place between family members and ER physicians.

Response

Alberta Health Services (AHS) accepts this recommendation. (In Progress)

The RAH Emergency Department Site Chief has been engaged to develop a communication guideline for the RAH ED physician group with respect to autopsy decisions between family members and ED physicians. Implementation by December 31, 2019 will include change management strategies and a sustainability plan.

Sincerely,

Original signed

Verna Yiu, MD, FRCPC
President and Chief Executive Officer

C: Dr. Francois Belanger, Vice President Quality and Chief Medical Officer AHS
Lorna Rosen, Deputy Minister of Health
Aaron Neumeyer, Assistant Deputy Minister, Financial and Corporate Services, Alberta Health