The RINJ Foundation Monitoring the Quality of Care Provided

We have developed a program to monitor the patient satisfaction of care provided in these measures.

Effectiveness

Do patients get the expected results from their procedure/ treatments; ask for their opinion by filling out a questionnaire after their treatment/surgery, or ask them to write
their review while at the clinic.

Efficiency

Patient's medical records are accessible and readable, filed in accordance to the procedure or corresponding doctor. Records includes all the necessary documentations such as consultation notes, medical history, consent forms, laboratory test results, pre and post operative notes and photos. Scheduling of patients for their procedures is designed to decrease the wait and increase efficiency of processing the patients which is also geared towards customer satisfaction.

Continuity of care

Explanation of realistic expectations as to the desired procedure and aftercare is done prior to the procedure. Aside from the initial consultation, then the pre-operative evaluation with the doctor, the clinic also provides patients relevant literature about the procedure(s). Post-operative care is scheduled as directed by the attending doctor. Our registered nurse is available for post operative care/advise 24hours a day. An answering service was also implemented after the hours of operation.

Equitable and Safe Care

Our policy is to provide care to all patients equally. Patient's ethnicity, gender, religion, sexual orientation or socioeconomic status does not alter the quality of care provided. The safety of care delivered is also in high regard by our health care providers.

Patient's Privacy

We value and protect our patient's privacy. No information about them will be released or given to anyone without the verbal and written consent (with signature) from the patient.

Non-Medical Staff

Assuring the highest quality of patient care, means putting our non-medical staff through a CPR training. Non medical staff often does the prescription drop off and pick up for our patients to alleviate the burden of waiting and walking after the surgery. They also handles all the billing and filling of applicable information that is kept in an orderly system.

The RINJ Foundation Quality Assurance Program
On Monitoring Adverse Events

In the event that the clinic has encountered a patient having an Adverse Reaction, the guidelines of the CPSO on Monitoring and Reporting Adverse Events will be followed.

The Adverse Drug Reaction Form is available at the clinic, which was downloaded from the Health Canada website. Please see the attached.

8.1.2 Monitoring and Reporting Adverse Events

1. All OHP staff should monitor adverse events. Indicators of adverse events generally include complications related to the use of anesthesia or the procedure, and specifically include, but are not limited to:
a) unplanned hospital admission within 10 days of the OHP procedure
b) unscheduled return to the procedure room for a complication of a procedure
c) complications such as infection, bleeding or injury to other body structure
d) cardiac or respiratory problems during the patient's stay at the OHP or within 48 hours of the stay
e) allergic reactions
f) wrong site, medication or dose
g) death occurring within the OHP

2. All OHP staff should report adverse events as follows:
2.1 Adverse events should be reported immediately to the Medical Director, and submitted in writing to the Medical Director within 24 hours of the event.
2.2 The written report should include the following:
a) name, age, and sex of the person(s) involved in the incident; includes staff and patients
b) name of witness(es) to the event (if applicable)
c) time, date, and location of event
d) description of the incident and treatment rendered
e) date and type of procedure (if applicable)
f) analysis of reasons for the incident
g) outcome
2.3 Death occurring within the OHP should be reported to the coroner.

8.1.3 Review of Adverse events and other QA Monitoring

The Medical Director should:
1) review all adverse events reports and QA monitoring findings occurring over a 12-month period
2) document the review and any relevant corrective actions and quality improvement initiatives taken
3) provide feedback to all staff.