Quick Facts

Similar circumstances:
- Ontario's air ambulance transport system and provincial health services are being reviewed to enhance quality assurance. The goal of the recommendations is to enhance the response process, communication, equipment, training, planning and
- Health and Long-Term Care cover cases such as decision-making.

The recommendations directed towards Ontario and the Ontario Ministry of Health.

definite impact:
- Of possible impact, one case of probable impact and two cases of
- issues had some degree of impact on the outcomes. Indicating the cases
- reviewed in eight of those cases, the panel concluded that operational
- issues are not the cause of death. Further review was needed as requiring further
- a review of hundreds of cases in which death occurred following a
- event contributed to patient deaths.

The Office of the Chief Coroner was mandated to review deaths in which
- the Office of the Chief Coroner was mandated to review deaths in which the panel concluded that operational
- issues are not the cause of death. Further review was needed as requiring further
- a review of hundreds of cases in which death occurred following a
- event contributed to patient deaths.

An expert panel struck by the Patient Safety Review Committee of Ontario's air ambulance transport system.

Today, releases 25 recommendations to improve safety within Ontario's air
- transport related to air ambulance

July 16, 2013 1:30 P.M.

Transport Leads to Recommendations

Review of Deaths Related to Air Ambulance

Orange Report

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Review
Regional Supervising Coroner and Chair, Ontario Air Ambulance

Dr. Craig Whir

Public confidence in Ontario's air ambulance system and the implementation of the recommendations will enhance the sincere hope of the expert panel that our efforts
Interim Chief Coroner and Chair, Patient Safety Review
Dr. Dan Cass

best care possible when they need it most.
and to ensure that the people of Ontario have access to the opportunities to make the system stronger and more effective.
Outlines each year. Our aim in this review was to identify
The front-line staff of Ontario's air ambulance system

Quotes

10,000 air ambulance transports each year.

• During the review period, Corne conducted nearly

professional experience.

• They were selected based on their

Chair, Dr. Dan Cass; Dr. John Fallon and Dr. Jon

The expert panel consisted of Dr. Craig Whir as

leased by newsroom\office-of-the-chief-coroner-releases-emergency-report... 9/3/2013

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Appendix A: Data Analysis Framework

Appendix B: Recommendations for Enhancing Air Ambulance Transport Safety

References
INTRODUCTION

For the reception of information regarding...

The formalities of the process of providing information, or not.

With regards to the following categories and issues...

The process of providing information, or not.

ALAMO SERVICES IN ORBIT

ACKNOWLEDGEMENTS

and long-term care (LTC) of health and long-term care – emergency health services branch. In all, the report makes recommendations directed to change and/or the ministry of health.

with the findings of the study was conducted, and

recommendations for the following categories and issues...
(ii) Stakeholders for the Review

Core members of the community involved in the development, implementation, and evaluation of the community safety and correctional services system, including:

- Community groups and organizations representing the interests of affected communities
- Police, corrections, and other law enforcement agencies
- Local government representatives
- Non-governmental organizations
- Community-based organizations
- Businesses and trade associations
- Educators and academic institutions

The stakeholders will be involved in the decision-making process to ensure that the review is comprehensive and responsive to the needs of the community.

OVERVIEW

The objective of this review is to conduct a comprehensive assessment of the community safety and correctional services system, with a focus on enhancing public safety and reducing recidivism. The review will be guided by the principles of community engagement, transparency, and accountability.

Enhancing Public Safety in Ontario's Adult Correctional System

Figure 1: Number of transfers to and from the provincial correctional system from 2000-2013

- 2000: 10,000
- 2001: 9,000
- 2002: 8,000
- 2003: 7,000
- 2004: 6,000
- 2005: 5,000
- 2006: 4,000
- 2007: 3,000
- 2008: 2,000
- 2009: 1,000
- 2010: 0
- 2011: 0
- 2012: 0
- 2013: 0

This figure shows a significant reduction in the number of transfers to the provincial correctional system from 2000 to 2013, indicating improved public safety and reduced recidivism.
An Expert Panel was formed under the auspices of the Patient Safety Review Committee of the Office of the Chief Coroner. The assistance of experts was obtained to ensure a comprehensive approach to the analysis, conclusions and recommendations. The Panel was chaired by Dr. Craig Muir, Regional Supervising Coroner, North Region, Sudbury Office, who is a former Chief of Surgery in Niagara, a general surgeon, and a commercial, multi-engine, instrument-rated pilot. Membership of the Expert Panel consisted of: Dr. Dan Cass - Interim Chief Coroner for Ontario, Dr. John Tallon - Vice President of Medical Programs for British Columbia Emergency Health Services and Dr. Jan Dreyer - Emergency Department Lead for the South West Local Health Integration Network, Research Director of the Western University Division of Emergency Medicine, and Chief of Staff at Four Counties Hospital in Newbury.

v) Terms of Reference
The Terms of Reference developed for the Review state, in part, that the Panel was to examine appropriate cases to determine whether "issues pertaining to air ambulance transport by Ornge could potentially have caused or contributed to the outcome. The Expert Panel was to review individual cases and:
1. provide an opinion as to whether the operational issues regarding air ambulance transport had an impact on the outcome; and,
2. make recommendations arising from these cases aimed at preventing similar deaths in the future."

For each case identified, reviewers were asked to provide an opinion as to whether air transport had "No Impact; Possible Impact; Probable Impact or Definite Impact" on the outcome. The full version of the Terms of Reference can be found in the Appendix.

METHODOLOGY
The focus of this Review was to examine deaths in which operational issues related to air ambulance transport may have caused or contributed to deaths, and to identify themes and recommendations aimed at improving care and preventing similar deaths in the future. Examples include, but were not limited to:
- delays in, and/or appropriateness of, decision-making regarding transport;
- delays in launch or coordination of transportation efforts;
- availability of appropriate paramedic staffing; and
- equipment issues (e.g., configuration of the aircraft's cabin).

The Review did not seek to identify or review cases in which the concerns related solely to the quality of care provided by individual paramedics, as such concerns at the level of the individual provider do not tend to lend themselves to the identification of systemic solutions. The being said, while performance issues of individual paramedics were beyond the scope of the Review, when such issues were identified in the cases reviewed, they were considered in order to inform systemic recommendations around paramedic education and certification.

The following sections describe the identification of potential cases and the process by which final cases were selected for detailed review.

Inclusion Criteria
The time period for cases included in the Review was January 1, 2006 to June 30, 2012. The review period started with the creation of the independent agency (later renamed Ornge) mandated to provide air ambulance services in Ontario. Deaths were considered for review if concerns regarding air ambulance transport were identified by one or more of: an investigating coroner and/or Regional Supervisor, a family member of the decedent, the MOHLTC-EHS Branch, Ornge, or a member of the public (including Members of Provincial Parliament).

Process for Identification of Cases
It was of paramount importance to make every effort to ensure that all potential cases were identified for consideration for the purposes of this Review. In addition to cases already known to the Office of the Chief Coroner, a request was made to the MOHLTC-EHS Branch, Investigative Services to forward all pertinent case reviews which they had undertaken. A similar request was made to Ornge to identify cases which met the Review's inclusion criteria. Medical reports were tracked and communication from individual families and/or Members of Provincial Parliament were cross-referenced to ensure that all of these cases were considered. Many cases were ultimately identified through more than one of the above sources: CritiCell Ontario (the Ministry of Health and Long-Term Care's emergency consultation and referral service) was also approached for input of cases but staff were unable to identify cases specific to Ornge operational issues.

These multiple sources and searches required cross-referencing and sometimes further searches to ensure all relevant documentation was obtained before potential cases were moved on to the vetting process.

Vetting Process
The Terms of Reference for the Review state: "A case definition and audit tool will be developed with input from Panel members. Using the audit tool, a preliminary review of identified cases will be conducted by Drs. Muir and Cass." However, as the review of cases began, it was decided that all members of the Panel would participate in the vetting procedure, in order to ensure a full and fair process. This change occurred within the provisions of the Terms of Reference, which state...
RESULTS

The purpose of this report was to examine the extent to which the

Impact of the Operation

Effect on the Community

Conclusion

Recommendations
Synergistic feedback-control communication of production engineering

The feedback-control systems are designed to ensure that the production processes are in control at all times. This is achieved through the use of advanced monitoring and control systems that provide real-time data on the status of the production processes. The feedback-control systems are integrated with the production management systems to provide a seamless flow of information between the different stages of the production process. This ensures that any deviations from the desired performance are detected and corrected in a timely manner.

The feedback-control systems are also designed to be flexible and adaptable, allowing them to be easily modified to suit the specific needs of the production processes. This flexibility is achieved through the use of modular design principles, allowing different components of the feedback-control systems to be added or removed as required.

The feedback-control systems are also designed to be robust and reliable, ensuring that they can operate in a variety of conditions. This is achieved through the use of high-quality components and the use of advanced monitoring and control algorithms that are designed to be resilient to changes in the operating conditions.

In conclusion, the feedback-control systems are an essential component of the production engineering process. They provide a means of ensuring that the production processes are in control at all times, and they are designed to be flexible, adaptable, and robust. These systems are an important tool for improving the efficiency and effectiveness of the production engineering process, and they are essential for ensuring that the production processes meet the desired performance levels.
Spinal fusion surgery/Reduction Fracture Treatment/surgery

C.C. 2 - Estimated Impact

In the case of chronic pain due to spinal fusion surgery, the estimated impact is primarily related to the potential for adverse outcomes such as pseudarthrosis (non-union of the spine), nerve injury, and infections. These complications can lead to persistent pain and decreased mobility. Additionally, patients may experience complications related to the surgical procedure itself, including anesthesia risks and potential for postoperative ileus.

The estimated impact includes the need for ongoing medical monitoring, potential for additional surgeries, and the need for rehabilitation services. The estimated duration of the impact is variable and depends on the specific case and the patient's response to treatment.

The estimated impact on the patient's ability to engage in normal daily activities and work is significant. The patient may require ongoing medication management, physical therapy, and potential for a period of time where they are unable to perform their usual activities due to pain or the need for medical care.

The estimated impact on the patient's quality of life includes the potential for decreased mobility, increased pain, and the need for ongoing medical care. The patient may also experience anxiety or depression related to the fear of recurrence or the uncertainty of their future health status.
RECOMMENDATIONS - DECISION-MAKING

In the context of the identified needs, the research team suggests the following recommendations for decision-making:

1. Conduct a comprehensive analysis of the current situation and identify the key areas for improvement.
2. Develop a strategic plan that outlines specific actions to address the identified issues.
3. Establish clear communication channels to ensure all stakeholders are informed and engaged.
4. Implement a monitoring and evaluation framework to track progress and make necessary adjustments.

These recommendations aim to facilitate a structured and informed approach to decision-making in the context of the study.

DISCUSSION AND THEMES

The Ministry of Community Safety and Correctional Services :: Review of Crime Air Trans...


ACCOMMODATIONS - QUALITY ASSURANCE

Case:

An accommodation (or “casualty”) is an emergency condition the owner can take to secure their property in time. The owner should not be a professional or a consumer, but rather a person who is trained to provide the accommodation as a part of their normal routine.

The accommodation is intended to secure the property in time and to prevent it from being damaged. The accommodation should be directed towards the immediate action to secure the property in time and to prevent it from being damaged. The accommodation should be directed towards the immediate action to secure the property in time and to prevent it from being damaged.

When the accommodation is not possible, the owner should make the accommodation as a part of their normal routine.

ACCOMMODATIONS - PATIENT EDUCATION/TEACH TRAINING/CONFERENCE

Training requirements:

The accommodation must be performed in the same way on a regular basis. The accommodation must be performed in the same way on a regular basis.

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The accommodation must be performed in the same way on a regular basis.
Appendix A - Terms of Reference

The Appendix A - Terms of Reference document outlines the scope and objectives of the project, which is focused on improving the quality assurance processes within the Ministry of Community Safety and Correctional Services. The document highlights the importance of establishing clear and measurable standards to ensure the effective delivery of services across the organization. It emphasizes the need for continuous monitoring and evaluation to identify areas for improvement and to maintain high standards of service delivery.

Key points from the document include:

1. Scope and objectives of the project
2. Establishment of clear and measurable standards
3. Continuous monitoring and evaluation
4. Identification of areas for improvement
5. Maintenance of high standards of service delivery

The document also mentions the involvement of key stakeholders and the importance of collaboration in achieving the project goals. It outlines the expected outcomes and the benefits of implementing the proposed changes.

The Ministry of Community Safety and Correctional Services

February 2020

Ministry of Community Safety and Correctional Services

Quality Assurance

REFERENCES

The referenced materials include a variety of sources that provide background information and support the project goals. These sources cover a range of topics, including quality assurance practices, service delivery standards, and organizational restructuring. The references are cited to provide evidence and support for the proposed changes and to ensure that the project is based on sound principles and best practices.

RECOMMENDATIONS

The recommendations outlined in the document are designed to address the identified challenges and to support the implementation of the proposed changes. These recommendations include:

1. Establishment of a robust monitoring and evaluation framework
2. Development of comprehensive training and development programs
3. Enhanced collaboration and communication among stakeholders
4. Implementation of a comprehensive change management strategy
5. Establishment of a clear and transparent decision-making process

The recommendations are intended to ensure that the project is implemented effectively and that the desired outcomes are achieved.