HURON PERTH HEALTHCARE ALLIANCE

Patient Safety Plan

Quality is never an accident; it is always the result of high intention, sincere effort, intelligent direction and skillful execution; It represents the wise choice of many alternatives.

- W. A. Foster

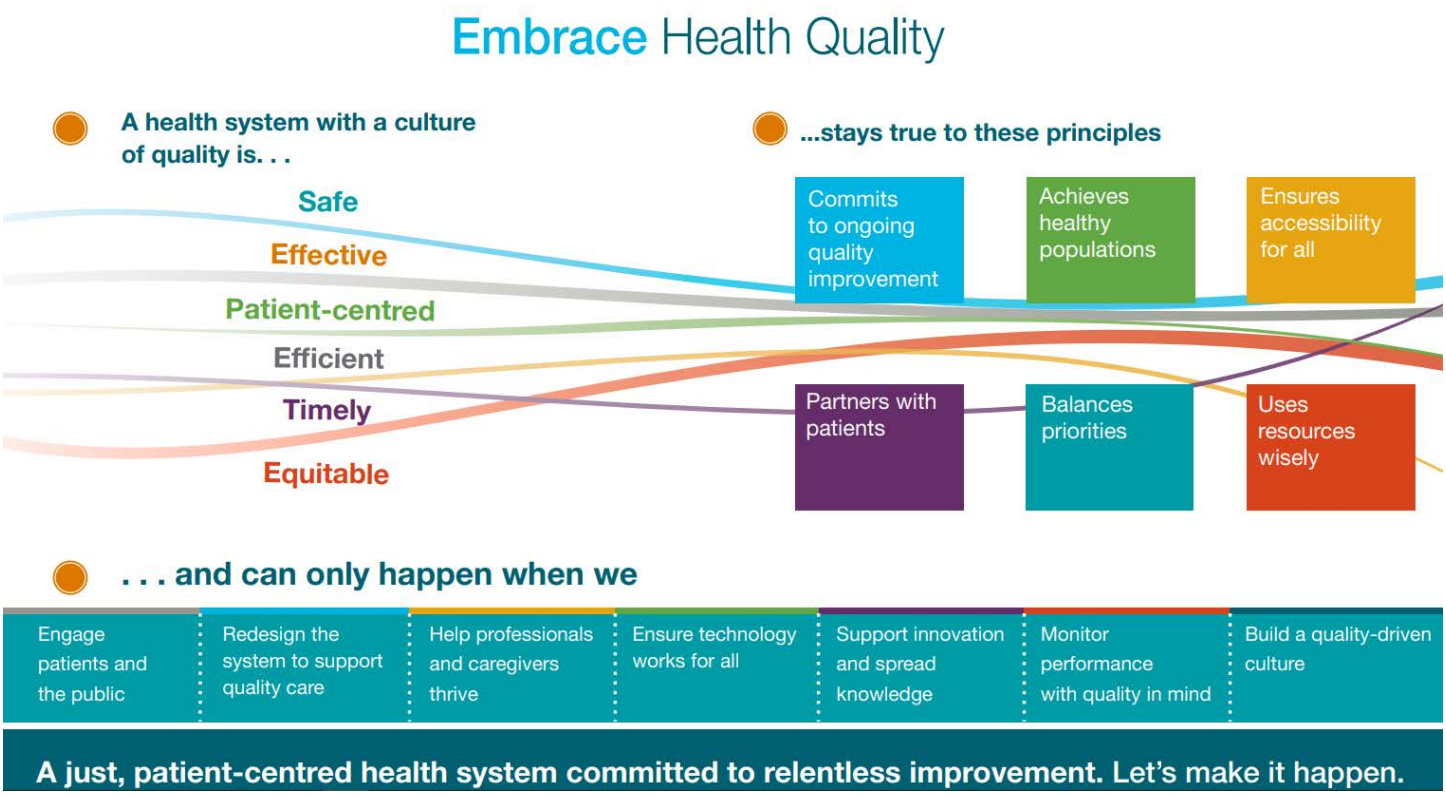
February 2024

Huron Perth Healthcare Alliance

Patient Safety Plan

At Huron Perth Healthcare Alliance (HPHA) we believe that patient safety and quality are the foundation for all services provided within our healthcare system. We envision that everyone accessing care will receive an exceptional patient experience delivered by staff who consistently demonstrate our values of compassion, accountability and integrity.

The intention of the HPHA Patient Safety Plan is to communicate and support our focus and commitment to providing care that is safe and compassionate while achieving optimal patient outcomes. The Plan is designed to improve patient safety, reduce risk and respect the dignity of our patients by assuring a safe environment. Our Patient Safety Plan aligns with the Ontario Health Quality model that views quality through various dimensions as shown below:



HPHA's Patient Safety Plan

Patient safety is our top priority at HPHA. We promote a culture of safety that protects patients from harm. The Patient Safety Plan outlines a comprehensive program that will ensure our people, policies and procedures, and performance are aligned. Our Patient Safety Plan is designed to support and align with our Commitments to Our Communities Strategic Plan priorities, our Quality Improvement Plans and ongoing quality and patient safety initiatives. The HPHA Patient Safety Plan is also guided in large part by compliance with and adherence to Accreditation Canada's Required Organizational Practices by focusing on their six patient safety domains as well as the principles espoused by Safer Healthcare Now, the Canadian Patient Safety Institute and the Institute for Safe Medication Practices. We also recognize the work of other accreditation bodies informing work in the HPHA such as: Institute for Quality Management in Healthcare (IQMH) focused on Laboratory Accreditation and the Ontario College of Pharmacists Accreditation Program.

The Objectives of the Patient Safety Plan are to:

1. Deliver high quality, safe care at all times
2. Engage staff and patients in safe practices at all levels of the organization
3. Promote a culture of patient safety
4. Build processes that improve our capacity to identify and address patient safety issues
5. Educate staff, patients and caregivers about the Patient Safety program and initiatives that are aimed at improving patient safety and preventing harm

Guiding Principles

HPHA Guiding Principles:

People: Engaging with Passion
Partnerships: Collaborating with Purpose
Performance: Exceeding Expectations

- We believe that patient safety is at the core of a quality healthcare system.
- We value the perspectives, experiences and contributions of all staff, providers, volunteers, patients, caregivers and the public regarding their role in patient safety.
- Patient safety is a continuous pursuit and is embedded in how we do all of our work.
- Accountability for patient safety rest with all parties: from the Board of Directors to frontline staff to volunteers.
- We approach patient safety most effectively when working alongside our Patient and Caregiver Partners.
- We promote a safety culture in which staff feel safe reporting adverse events, errors and near misses. These reports inform our improvements to care.
- We honour our core Values of Compassion, Integrity and Accountability. We will stay true to our Mission of Collaborating for Exceptional Care and our Vision of Innovating for Exceptional Health.
- We will foster a culture within HPHA and with our partners that respects diversity and inclusivity as a shared responsibility promoting access and equity for staff and patients.
- We will strive to remove barriers to services for patients and staff with respect to language and accessibility.

HPHA's Commitment to Quality and Patient Safety

1. Structures that Support Patient Safety

At HPHA, patient safety and quality improvements are key strategic priorities. The importance of patient safety is reflected in our Vision and Strategic Plan and is embedded into the job descriptions of every employee and the commitment descriptions of HPHA volunteers. There are a number of integral and connected structures at HPHA that address patient safety.

a. Board of Directors and the Quality Committee of the Board

The HPHA Board of Directors is legislated to be responsible for patient safety and protection, and the quality of care. As mandated by the *Excellent Care for All Act, 2010,* the Board must establish a Quality Committee of the Board that ensures that the quality related requirements of the Hospital Management Regulation are met. This Committee meets eight to nine times per year, and reviews patient safety related indicators, issues and critical incidents as well as overseeing the preparation of our annual Quality Improvement Plan (QIP). HPHA includes and involves our Patient Partners on the Board of Directors and Quality Committee of the Board to ensure we capture the Voice of the Patient.

b. Senior Leadership Team

The HPHA Senior Leadership Team are stewards of quality and patient safety across the organization and are delegated this responsibility by the Board. This deep commitment, coupled with their endorsement and support, enhances a culture of excellent care and quality improvement.

c. Ethics Committee

The mandate of the Ethics Committee is to support awareness and understanding of ethical issues in the healthcare environment; promote awareness, application and advancement of the HPHA Framework to Support Ethical Practice; facilitate and inform quality improvement related to ethical healthcare practice; review information regarding trends in ethics issues as they pertain to the healthcare industry and specifically to the organization; and promote optimal ethical practices. HPHA engages a clinical ethicist to promote reflective practice, examine ethical principles and their application, advise regarding policies and procedures, and provide guidance on ethically challenging situations. Patient Partners participate as Committee members in the work of the Ethics Committee to capture the perspective of the patient.

d. People-Centred Care Framework

The patient's experience of care is integral to how HPHA approaches the provision of safe and people-centred healthcare. HPHA endeavours to incorporate the voice of the patient by including Patient and Caregiver Partners in our committees and improvement teams. This partnership is important through all stages of work, from planning through to evaluation.

HPHA is committed to seeking feedback from patients, caregivers, families and staff that contributes to a culture of exceptional people-centred care. HPHA views observations, compliments, personal experiences, and concerns from patients, families, caregivers and visitors as valued sources of information regarding the perception of the Alliance environment and the quality of the services and care provided. Feedback from our staff helps us focus on processes and issues that will improve quality of work life.

e. External Partnerships

HPHA is committed to addressing patient safety at the system level, including working with our regional healthcare partners as a member of a comprehensive Ontario Health Team directed at addressing patient safety and improving the quality of care. HPHA continues to explore opportunities to address system-level patient

safety concerns through Accreditation Canada surveys, annual Quality Improvement Plans and HPHA Commitments to Our Communities initiatives. Specifically, HPHA is a participant in two collaborative Accreditation Canada surveys, the first sub-region survey with 6 partners and the first multi-board survey with nine partners of the Huron Perth and Area Ontario Health Team (HPA-OHT). Additionally HPHA demonstrates the prioritization of patient safety by supporting external partners in times of need such as outbreaks and when critical demands outstrip available resources, and in supporting the more vulnerable populations in our communities.

2. HPHA's Internal and External Mechanisms to Drive Patient Safety

a. Internal: Annual Quality Improvement Plans

HPHA prepares and implements an annual Quality Improvement Plan (QIP) informed by hospital indicators, initiatives to advance our patient safety and quality improvement efforts, critical incidents and patient feedback. The development and implementation of the QIP involves the active participation of patient partners and front-line staff. The QIP complies with and meets the expectations for health care organizations as defined by the provincial *Excellent Care for All Act, 2010* (ECFAA). The QIP is endorsed by the Senior Leadership Team, Quality Committee of the Board, Medical Advisory Council, and Patient and Family Partnership Council, , and is approved by the HPHA Board of Directors before submission to the Ontario Health Quality Council.

The Plan is available on HPHA's website and addresses designated priority issues, safety targets, safety improvements, and operational efficiencies in safety in a patient-centered approach to providing hospital care. QIP initiatives are included as annual objectives of HPHA's Strategic Plan with performance reported quarterly in corporate dashboards to all levels of the organization.

b. Internal: Commitments to Our Communities

HPHA's Strategic Plan "Commitments to Our Communities" and annual objectives are developed to address key priorities within our Guiding Principles of People, Performance and Partnerships; annual objectives are often change ideas identified in the annual QIP. A defined action plan that includes indicators, milestones and regular status updates is developed for each objective. In recent years, priorities have focused on Patient Experience, Healthcare Worker Recruitment and Retention, and Strengthening Partnerships, including ongoing development of the Huron Perth & Area Ontario Health Team model.

c. Internal: Integrated Risk Management

Risk Management is an integral component of a strong and credible patient safety system. HPHA's management of risk promotes a culture of continuous quality improvement as risk control processes in place are challenged and enhanced to assure identified risks, as well as new and emerging risks that may arise, are effectively addressed. Central to our risk management efforts are two key platforms to assess and mitigate risk – the Healthcare Insurance Reciprocal of Canada (HIROC) Risk Assessment Checklist Program, and HPHA's Workplace Violence Risk Assessment Tool.

d. Internal: RL6 Patient Safety Incident Management System

Incident reporting and management is the cornerstone of patient safety at HPHA. It is the responsibility of all staff and affiliates, who observe, are involved in, or are made aware of an adverse event or near miss to ensure the incident is reported. Our RL6 incident management system supports the documentation and tracking of patient safety incidents, findings, recommendations and actions/improvements. The RL6 Feedback module allows the reporting of and follow through on feedback from staff, patients and caregivers. Our Patient Experience Office manages the Feedback reports to ensure timely response and follow-up, as well as to track and trend feedback themes to identify patent safety and quality improvement opportunities.

e. Internal: Ongoing Patient Safety Initiatives

Ongoing Patient Safety programs and initiatives at HPHA include:

• Huddles • Discharge Rounds • Quality Safety Metrics Boards • Patient Oriented Discharge (PODS) (select diagnosis and procedures) • National Early Warning Score (NEWS) • Choosing Wisely Canada Recommendations • Hand Hygiene Audits • Patient and Caregiver Partners Council • Reporting of Severe Adverse Drug Reactions and Medical Device Incidents under Vanessa's Law • Critical Care Indicators for Antibiotic Resistant Organisms, Special Care Plans, High Risk Exposures, History of Violence • Routine Safety Audits • Policies and Procedures, Standard Work	• Leadership Safety Rounds • Bedside Transfer of Accountability (TOA) and Standardized Shift Report • Program Councils • Orientation – Corporate and Departmental • Patient Coping Kits – Autism Kits • Patient Experience Dashboard • Rounding – staff and patient • Scheduled and Just-in-Time clinical education by HPHA Clinical Educators and Clinical Coaches/ Scholars to reinforce professional practice and reduce patient harm • Bedside Medication Verification • Product Recalls • Drug Recalls
Quality Indicators of Patient Safety:	
• RL6 Incident Reporting (Medication Safety, Falls) • Medication Reconciliation at Care Transitions • Healthcare Associated Infections • Surgical Site Infections • Surgical Safety Checklist • Infection Control Checklist for construction projects • Critical Incident Summary Report (provided quarterly to Quality Committee, Medical Advisory Committee and Board)	• Pressure Injuries • Transfusion reactions/blood/blood product administration • Use of Restraints • Employee Safety • Venous Thromboembolic Prophylaxis (VTE)
Safety Programs:	
• Immunization Programs • Emergency Preparedness Committee • Infection Prevention and Control Program (including Hand Hygiene and PPE support)	• Antimicrobial Stewardship Program • Accreditation Canada • Preventative Maintenance Program
Data from Environmental Safety Issues:	
• Product Recalls • Drug Recalls • Product/equipment malfunction	• Air Quality • Security incidents (RL6) • Workplace Violence (RL6)

Never Events are patient safety incidents that result in serious patient harm or death and that are preventable using organizational checks and balances. Effective 2024, HPHA will participate in the Never Events Hospital Reporting Initiative through Ontario Health with the goal to reduce the occurrence of these events, change the culture surrounding never events, and promote a culture of learning and improvement. As part of this initiative, HPHA will report the number of Never Events that occurred, their associated level of harm, approaches used to assess Never Events, and actions taken to prevent recurrence. This report is be included in the quarterly report to the Quality Committee and Medical Advisory Committee.

f. Internal: Ongoing Staff Safety Initiatives

The Critical Care Indicator Flagging Program is designed to flag, monitor, and mitigate patient behaviours that meet criteria for potential or actual violence in the workplace. The Violence Assessment Tool determines the risk of potential or actual violent behaviour. The flagging is visible in the patient care environment and within key care documents, both electronically and in hard copy, and serves to protect the individual patient, HPHA staff and other patients. Staff are equipped with training such as Nonviolent Crisis Intervention (NVCI) and Gentle Persuasive Approaches (GPA); tools that address why and how to apply safety interventions, and techniques for escalating risk behaviours.

g. External – Accreditation Canada Required Organizational Practices (ROPs)
Examples of HPHA's performance related to the six Patient Safety Areas of ROPs include:

Safety Culture	• Measurement of quality indicators at different levels throughout the organization • Program Councils' focus on quality of care and patient safety • RL6 system to report and track patient safety and employee incidents • Integrated Risk Management system to assess and respond to risk in the organization • Surgical Safety Checklist before and after procedures
Communications	• Transfer of Accountability (TOA) and Standardized Shift report • Staff and Patient Rounding • National Early Warning System (NEWS) Huddles • Quality Safety Metrics Boards • Secure platforms allowing patients access to their Medical Imaging records ("PocketHealth") and medical record (ConnectMyHealth) • Patient Oriented Discharge Summary (PODS) (select diagnosis and procedures) • Patient Feedback (RL Feedback, electronic and paper-based surveys)
Medication Use	• 90-Day medication reviews on long stay patients • VTE (Venous Thromboembolism Prophylaxis) audits • Antibiotics prophylaxis in surgery audits • Safety reports generated from medication incidents audits • Dangerous Abbreviations audits • Infusion pump training, evaluation of competence, and monitoring of patient safety reports.
Infection Prevention and Control	• Ongoing monthly hand hygiene data collection with report mid-month • Orientation and ongoing education of staff, patients and families regarding hand hygiene practices and Personal Protective Equipment (PPE) • Healthcare Associated Infections (HAI) investigation tool used for investigating, monitoring and reporting to staff and patients • Outbreak management • Involvement in construction projects • Close working relationship with Huron Perth Public Health
Risk Assessment	• Falls and medication errors reported and tracked in RL6 system • Quality Reviews and Quality of Care reviews (under *Quality of Care Information Protection Act* [QCIPA]) for high risk and critical incidents and as indicated for any incident • Integrated Risk Management program • Risk assessments for suicide, falls, pressure injuries, and medication reconciliation • Assurance that construction projects meet all required organizational and program standards

Worklife/Workforce	• Workplace Violence Prevention: Critical Care Indicators Flagging Program for potential and actual violent patient behaviour • Non-Violent Crisis Intervention Program training • Responsive Behaviour education for staff of HPA-OHT Accreditation partner organizations. • Immunization program

h. External – Other Accreditation Bodies

Patient safety is enhanced by ensuring our laboratory diagnostic testing and pharmacy policies and procedures meet or exceed all applicable standards. The HPHA Laboratory is regularly assessed and accredited by the Institute for Quality Management in Hospitals (IQMH) whose mission is to elevate the integrity of the medical diagnostic testing system by providing rigorous, objective, third-party evaluation according to international standards.

The Ontario College of Pharmacists (OCP) has an accrediting arm that is tasked with ensuring hospital pharmacies meet the requirements as outlined in the *Drug and Pharmacies Regulation Act* (O.Reg.264/16). HPHA receives an annual site visit and communicates with the OCP on a regular basis.

In addition to internal sources of data, HPHA utilizes data and information from external sources to inform our quality and patient safety initiatives and advance our performance that includes the following:

- Ontario Health - Quality (HQO)
- Canadian Institute for Health Information (CIHI)
- Healthcare Excellence Canada (HEC)
- Institute for Safe Medication Practices (ISMP)
- Accreditation Canada Required Organizational Practices (ROPs)
- Occupational Safety and Health Administration (OSHA)
- Institute for Healthcare Improvement (IHI)
- Foundation for Health Care Improvement
- Health Care Management (HCM)
- Infection Prevention and Control (IPAC) resources/accreditation

As an organization, HPHA holds itself accountable both through our internal structures and with our external partners. Performance at the unit and program levels is dually reported and actioned at Program Councils and internal committees with subsequent reporting to the Board. Accountability to our external partners is demonstrated through such mechanisms as collaborative Quality Improvement Plans, joint initiatives, report of key performance indicators to regional and provincial bodies, and achievement of and adherence to standards and the required practices of various accreditation bodies and regulated Colleges.