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.

- William A. Foster

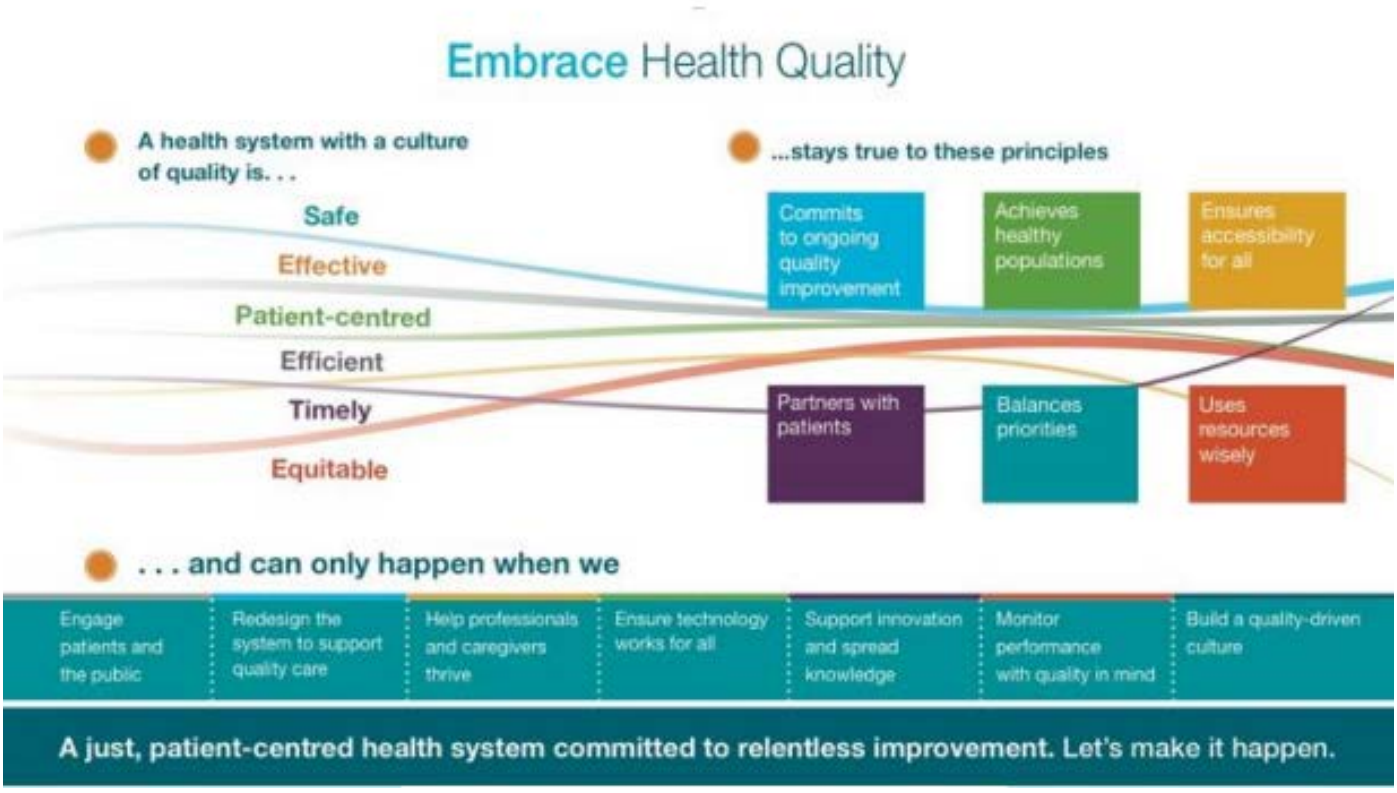
Approved by HPHA Board February 4, 2021

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 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 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. It 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. At HPHA our 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 and to 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 Ontario College of Pharmacists Accreditation Program.

The Objectives of the Patient Safety Plan are to:

1. Deliver high quality, safe care all the time
2. Engage staff and patients in safe practices at work 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, physicians, volunteers, patients, caregivers and the public in 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 is everyone's business: from the Board of Directors to frontline staff to volunteers
- We approach patient safety most effectively when working alongside our Patient 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 for Innovating for Exceptional Health.
- We will foster a culture within HPHA and within 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 in the commitment descriptions of volunteers of the HPHA. 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,* the Board must establish a Quality Committee of the Board that ensures that requirements of the Hospital Management Regulation as it relates to quality are met. This committee meets on average eight to nine times per year, and reviews patient safety related indicators and issues as well as oversees 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 Ethics Committee ensures that ethical issues are considered through the HPHA Framework Supporting Ethical Practice. HPHA engages a clinical ethicist to promote reflective practice, examine ethical principles, advise regarding policies and procedures and provide guidance on ethically challenging situations. HPHA includes Patient Partners in the work of the Ethics Committee to ensure the perspective of the patient is captured.

d. Patient, Family and Staff Experience Framework

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

HPHA is committed to seeking feedback from patients, family members/caregivers, and staff that contributes to a culture of exceptional patient, family and staff experiences. The HPHA views observations, compliments, personal experiences, complaints and/or 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. Staff feedback helps us focus on processes 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 to develop a comprehensive Ontario Health Team that is capable of addressing patient

safety and improving the quality of care. HPHA will continue to explore opportunities to address system-level patient safety concerns through collaborative Accreditation Canada and Quality Improvement Plan initiatives. HPHA demonstrates the prioritization of patient safety by supporting our 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) in response to mandatory Hospital indicators and additional initiatives to advance our patient safety and quality improvement efforts. The development and implement of the QIP involves the active participation of patient partners and front-line staff. The QIP complies with and meet the expectations for health care organizations as defined by the provincial *Excellent Care for All Act* (ECFAA). The QIP is endorsed across the organization including; Quality Committee of the Board, Medical Advisory Council, Patient and Family Partnership Council, and Senior Leadership Team and is approved by the HPHA Board of Directors. The resulting QIP is submitted to the Ontario Health Quality Council.

The plan is available on HPHA's website and addresses the designated safety targets, safety improvements, and operational efficiencies in safety in a patient-centered approach to providing hospital care. Initiatives and actions from our Quality Improvement Plan are included as annual objectives of HPHA's Strategic Plan and measured and reported quarterly in the corporate dashboard to disseminate our performance in quality and patient safety achievement at all levels of the organization.

b. Internal: Commitments to Our Communities

Commitments to Our Communities is HPHA's Strategic Plan and annual objectives are developed to address key priorities within our Guiding Principles of People, Performance and Partnerships. Each objective has a defined action plan that includes indicators, milestones and regular status updates. In recent years, priorities have focused on Patient Flow, Workplace Violence Prevention, Wellness and development of the Huron Perth & Area Ontario Health Team model.

c. Internal: Integrated Risk Management – Risk Registry

Integrated risk management promotes continuous, proactive and systematic processes to understand, manage and communicate risk from an organization-wide perspective in a cohesive and consistent manner. Strategic decision-making is supported that contributes to the achievement of the organization's overall objectives.

The Risk Registry identifies, tracks and monitors associated risks in HPHA's operations by determining the probability of a risk occurring multiplied by the impact should that risk occur. The resulting risk scores inform priorities for action to mitigate risk.

d. Internal: RL6 Patient Safety Incident 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 system supports the documentation and tracking of patient safety incidents, findings, recommendations and actions/improvements. The RL6 system also allows for 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, track and trend feedback themes and inform 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) • National Early Warning Score (NEWS) • Choosing Wisely • Hand Hygiene Audits • Patient Partnership 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	• Leadership Safety Rounds • Beside Transfer of Accountability (TOA) and Standardized Shift Report • Program Councils • Orientation • Patient Coping Kits – Autism Kits • Patient Experience Dashboard • Rounding – staff and patient • Scheduled and Just-in-time clinical education by HPHA Clinical Educators to reinforce professional practice and reduce patient harm • Bedside Medication Verification
Quality Indicators of Patient Safety:	
• RL6 Occurrence Reporting (Medication Safety, Falls) • Medication Reconciliation at Care Transitions • Healthcare Associated Infections • Surgical site infections • Surgical Safety Checklist	• 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)

f. Internal: Ongoing Staff Safety Initiatives

The Critical Care Indicator Flagging Program is designed to monitor, flag, and mitigate patient behaviours that meet the criteria of 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.

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	• Measuring quality indicators at different levels throughout the organization • Program Councils focus on quality of care and patient safety • RL6 system to report and track incidents for our patients and staff • Integrated Risk Management system to assess risk in the organization • Surgical Safety Checklist before and after procedures
Communications	• Sustainment of Medication Reconciliation on Admission • Transfer of Accountability (TOA) and Standardized Shift report • Staff and Patient Rounding • National Early Warning System (NEWS) Huddles • Quality Safety Metrics Boards • Secure "My Chart" platform allowing patients access to their medical record • Patient Oriented Discharge Summary (PODS).
Medication Use	• 90 Day medication reviews on long term patients

	• Audits of VTE (Venous Thromboembolism Prophylaxis) • Antibiotics prophylaxis in surgery • Audits of safety reports for medication incidents and Do Not Use abbreviations • Infusion pump training, evaluation of competence, and monitoring of reports.
Infection Prevention and Control	• Ongoing monthly hand hygiene data collection with report mid-month • Orientation and education of staff, patients and families on hand hygiene practices and Personal Protective Equipment (PPE) • Healthcare Associated Infections (HAI) investigation tool used for investigating, monitoring and reporting to staff and patient
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 • Integrated Risk Management program in development • Risk assessments for falls, pressure injuries, and medication reconciliation
Worklife/Workforce	• Our goal is to be the "Safest Hospital in Ontario" • Workplace Violence Prevention: Critical Care Indicators Flagging Program for potential and actual violent patient behaviour • Non-Violent Crisis Intervention Program training for all staff (orientation and ongoing) • Responsive Behaviour education for staff of Accreditation partner organizations.

h. External – Other Accreditation Bodies

Patient safety is enhanced by ensuring our laboratory diagnostic testing and pharmacy standards, policies and procedures are upheld. The HPHA Laboratory is regularly assessed and accredited by the Institute for Quality Management in Hospitals (IQMH). Their 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 has an accrediting arm that is tasked with ensuring the HPHA pharmacy meets the requirements as outlined in the *Drug and Pharmacies Regulation Act* (O.Reg.264/16).

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

- Health Quality Ontario (HQO)
- Canadian Institute for Health Information (CIHI)
- 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)
- 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, reporting of key performance indicators to regional and provincial bodies, and achievement of and adherence to standards and Required Organizational Practices of various accreditation bodies.