PATIENT SAFETY PLAN
2016-2017

William Osler Health System
Patient Safety...It is our Core Business

2013-2018

OUR VISION
Patient-inspired healthcare without boundaries

OUR MISSION
Innovative healthcare delivered with compassion

OUR VALUES
Respect, Excellence, Accountability, Diversity, Innovation

STRATEGIC DIRECTION 1
Create health services with an unwavering commitment to patient-inspired care

STRATEGIC DIRECTION 2
Continue to deliver exemplary care in the eyes of our patients and peers

STRATEGIC DIRECTION 3
Foster bold, innovative partnerships to create a unified health system

STRATEGIC DIRECTION 4
Create impact beyond our immediate community through education and innovation

Patient Safety is Embedded in Everything We do!

William Osler Health System
Introduction to our Patient Safety Plan

Patient safety is a discipline in the healthcare sector that applies safety science methods toward the goal of achieving a trustworthy system of healthcare delivery. Patient safety is also an attribute of healthcare systems; it minimizes the incidence and impact of, and maximizes recovery from adverse events. (Emanuel, Berwick et al, 2008).

A health system with a culture of quality is safe, effective, patient centred, efficient, timely and equitable and commits to ongoing quality improvement (HQO, 2015). At William Osler Health System (Osler) we believe that quality and patient safety is the foundation for every aspect of the services that we provide to our users and community at large. The patient safety plan is a collaboration of our “Clinical Priorities Plan (CPP)”, Quality Improvement Plan (QIP) and our Strategic Plan.

This is illustrated through our joint regional Quality Improvement Plan (Headwaters, Central West Community Care Access Centre and Osler) which is in its second year, and demonstrates our commitment to enhancing **access to safe, effective, equitable, integrated** and **patient-centred care** across the region. We have an expectation that everyone receiving care at any of our sites will receive exceptional care each time every time and that their safety will remain our top priority.

The Quality and Patient Safety department at Osler has undergone a recent shift in its service delivery model which has provided an exciting opportunity to build a transformational program reflective of a high-reliability organization. It aligns and assists with translating the corporate mission, vision and values of Osler, and focuses on patient safety strategies that assist in achieving a superior patient experience. It establishes a patient safety culture that is transparent and ‘just’ which in turn improves quality of worklife. The following plan outlines the steps needed to develop and maintain such a program.
What Informs our Patient Safety Plan?

We are informed by the Central West LHIN IHSP 2016-2019
Our Patient Safety Plan is informed by:

The Central West LHIN Integrated health Service Plan (IHSP) 4 has the following strategic directions: 1) Build Integrated Networks of Care, 2) Drive Quality and Value, 3) Connect and Inform, 4) Demonstrate System Leadership. To advance the priorities outlined in IHSP 4, the Central West LHIN will continue to focus on partnerships among patients, caregivers, providers, cross-sector partners and the community at large. The IHSP 4 reaffirms the Central West LHIN’s commitment to put people and patients at the centre of their local health care system... to improve their health care outcomes and experiences.

Osler’s five year Strategic Plan (2013-2018) with five pillars and four strategic directions ground our Annual Business Plan

Osler’s Annual Business Plan informs the patient safety plan as it allows for integrated planning of activities, ensures that the organization has capacity to undertake proposed initiatives, aids in streamlining high impact activities which will not deplete resources both capital and human.

Osler’s three year Clinical Priorities Plan (CPP) helps propel health system transformation and garners Osler the flexibility to recalibrate and respond to new developments and changes in the environment. The 2013-16 CPP was well positioned for Going Beyond Exemplary with a primary focus on Strategic Direction (SD) 2, to continue to deliver exemplary care in the eyes of our patients and peers. The 2016-19 CPP harnesses the work and achievements of the last three years to propel Osler forward and while a focus on SD 2 will remain at the core of clinical service delivery at Osler, growth and success has evolved the CPP focus to an unwavering commitment to patient inspired care (SD 1) and bold innovative partnerships to create a unified health system (SD 3).

The integrated joint Quality Improvement Plan (QIP) is a regional cross-sectorial one that illustrates Osler’s desire to continuously improve the quality of care we provide by focusing on areas for improvements which directly impact patient safety in collaboration with our regional partners, CW CCAC and Headwaters Health Care Centre.

Our Enterprise risk management framework may inform key opportunities for improvement through quality of care reviews, data trends from incident reporting system, risk assessment checklist information.

Results from other organizational surveys for e.g. worklife pulse survey, patient safety culture survey and patient experience data are also used to inform this plan.

Patient and Family advisory council, patient voices also captured through the call centre surveys facilitated by the patient experience department.
Patient Safety Guiding Principles

**Patient / Family Centered**
- Engagement of the patients/families at every juncture of care
- Encourages patients/families to take an active role in their own safety
- Collaborates with patient/family to promote their safety
- Patient inspired healthcare without boundaries
- Built through the lens of cultural competency and diversity

**Quality Improvement**
- Utilizes the best available evidence to inform practice
- A prioritized approach which is pragmatic yet committed to relentless improvement

**Culture of Safety**
- Utilizes a system focused and team based approach to patient and staff safety
- Recognizes that the responsibility for patient safety lies with everyone in the health care system including the patient
- Reflects our accountability and responsibility to provide a safe environment for our patients, staff, physician and volunteers

**Integrated Health System**
- Collaboration with internal and external stakeholders to ensure seamless transitions that offer superior patient experience whilst being highly efficient and effective
Patient Safety Overview

We envision a health system at Osler whereby patient safety is a key strategic priority and collaborative practice ensures that together we consistently deliver exemplary care in the eyes of our patients and community.

The goal of the Patient Safety Plan is to enhance and sustain a Culture of Safety at Osler.
Patient Safety Roles and Responsibilities

**Program Level**

The **Clinical Services Director** ensures that the strategic objectives and operational plans are carried out to provide efficient and effective delivery of health care services, priorities are addressed and the service goals are in keeping with the strategic direction of the organization and provides leadership for quality initiatives and risk issues, including patient safety.

The **Clinical Services Manager** is responsible for ensuring the delivery of safe, efficient and patient centered care. This position oversees the management of a multidisciplinary team focused on enhancing the patient experience.

At Osler, all **Staff, Volunteers and Students** are committed to providing professional, evidence informed patient-centred care in a compassionate and caring manner within a diverse cultural environment, spotting risks before they happen, reporting an incident or risk, and learning how to prevent future incidents.

At Osler, all **Physicians** are committed to providing professional, evidence informed patient-centred care in a compassionate and caring manner within a diverse cultural environment. Physicians are leaders in their areas of service participating in regional, provincial, national, and global programs aimed at improving care and measuring our performance against national standards.

**Patients & Families** partners with the health care team to ensure their holistic care needs are appropriately addressed in a safe manner. Patients and families are encouraged to contribute to their own or family member's care plans, be involved in their care, ask questions and talk to their health care providers.
Patient Safety Roles and Responsibilities

**Corporate Level**

**Corporate Medical Director for Quality and Patient Safety**—The Corporate Medical Director for Quality & Patient Safety works in collaboration with all programs and interprofessional teams, leading several corporate wide quality initiatives at Osler. This role chairs the Clinical Quality of Care Committee, the QBP Steering Committee, leads the QBP expert panels in medicine and surgery and oversees a standardized process for the development and evaluation of clinical decision tools including orders sets, clinical protocols, pathways and medical directives.

The **Director Clinical Practice and Quality** is responsible for the resources, strategic goals and objectives, results, decision-making and impact of services for the portfolio which consists of Nursing and Professional Practice, Infection Prevention and Control, Quality and Patient Safety, the Clinical Resource Team and Staffing Office. The Director ensures alignment of strategic directions for the portfolio with corporate and clinical directions and priorities and guides the organization to continually improve quality of care and patient safety.

The **Manager Quality and Patient Safety** develops and supports systems across the organization, which ensures that risks to patient safety are identified and solutions are implemented to prevent and /or reduce harm. The Manager works collaboratively with all programs and services in facilitating, educating and consulting on patient safety and quality improvement activities.

The **Quality Improvement Specialists** work to ensure that patient safety is embedded in the operational activities of the organization. They operate under a program based delivery model i.e. each are attached to a specific program. They support quality improvement activities across their respective areas and acts as agents of change and role models for quality practice.
Key Elements of our Patient Safety Plan

Assessment of Patient Safety Culture
- Patient Safety culture survey completed in June 2015 results have been analysed in conjunction with the results of the employee engagement survey.
- Action items have been identified to address improvement opportunities both at a local unit level and an organizational level through program based patient safety delivery model and executive workarounds.

Raising Awareness about a Culture of Safety
- We have utilized materials from the Canadian Patient Safety Institute’s Trainer Program, to deliver patient safety modules to staff across the organization via safety huddles, rounds, meetings, presentations, case studies.
- With the introduction of a new incident reporting system in May 2015 staff were reoriented to the incident reporting system and the importance of incident reporting.
- Storytelling continues to be used as a means of communicating patient safety information to staff and physicians.
- Knowledge transfer of patient safety awareness and improvement through case study presentations at Grand Rounds.
- Organizational recommendations for improvements arising from Quality of Care reviews are shared with the patient and family.

Promoting Change in a Culture of Safety
- Culture of accountability is clearly articulated during discussions and presentations about patient safety.
- The organization recognizes the crucial role of the patient’s perspective in establishing a culture of safety as such we have prioritized engaging patient representatives in the design and nurturing of safety efforts.
- Patient safety activities occur throughout the year and during dedicated weeks such as Patient Safety week, Infection Prevention and Control Week.
- The organization has a defined corporate patient engagement strategy.
- There are outlined guidelines to manage code of conduct and other human resources related activities.
- There are corporate mechanisms in place to provide feedback and follow up in relation to patient safety incidents and near misses.

Data Management and System Design
- Patient safety data is collected and analysed.
- Engagement of direct care providers and their utilization of generated reports needs to continue.
- Decision makers are provided with written results.
- Osler’s Performance Management System houses patient safety indicator data for the QIP, Corporate Scorecard, Program Scorecards, Executive Operating Summary, Quarterly Quality Report, Integrated Quality Based Procedure Report and a number of other clinical and assessment.

Assessment of Patient Safety Culture

- Raising Awareness about a Culture of Safety
- Promoting Change in a Culture of Safety
- Data Management and System Design

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Key Elements of our Patient Safety Plan

Risk Identification and Analysis

- There currently exists a number of policies/processes that ensure that we are identifying and analyzing our risks.
- The organization has a robust urgent alerts and recalls process which centralizes the receipt, monitoring, distribution and documentation of all urgent alerts and recalls.
- Risk related reports are disseminated to members of the executive team and the board.
- Work continues in regards to “creating an organization with a memory” how are we sharing recommendations and lessons learned across the organization so that past incidents are not repeated.
- We will also continue to utilize the HIROC Risk Assessment Checklist program in order to help clinical and non-clinical areas assess their risks and to implement mitigation strategies that are based on best-practice and expert review. The results of these checklists will also be shared widely within the organization to improve patient safety and reduce risk.

Mitigate Risks Through System Thinking & Design & Human factors Analysis

- The quality and patient safety department operates on the principles of system thinking. Process improvement activities are also governed by these principles.
- Improvements can be made however to ensure that new processes are analysed through the lens of Human Factors (HF) (example, embedded HF components to medical devices, RFPs).

Extended Influences on Patient Safety

- External agencies such as Accreditation Canada, Institute for Health Care Improvement, World Health Organization, Canadian Patient Safety Institute and Safer HealthCare Now are all examples of agencies which assists with informing Osler’s patient safety strategy. This function is also achieved by having an Enterprise risk management structure at Osler.
- Regular reviews of safety bulletins, alerts and recalls such as Emergency Care Research Institute (ECRI), Institute for Safe Medication Practices (ISMP), Canadian Medical Devices Sentinel Network (CMDSNet)
- Osler’s Patient and Family Advisory Council, Program Advisory Council, Community
Leadership & Governance

Leadership

- Accountability for quality and patient safety is decentralized at Osler i.e. everyone has a responsibility to drive this agenda.
- Patient safety as a priority is clearly articulated in the operational sphere of Osler. It is the foundation for how we conduct business and is an expectation of all care providers. Quality and Patient Safety is articulated in every clinical priority plan within the Clinical Program, Clinical Services and Clinical Practices portfolios.

Governance

- Governance for quality and patient safety at Osler is provided by the Quality Governance Council which is accountable to ensure Osler’s corporate and local quality initiatives support the mission to deliver “patient-inspired health care without boundaries”, the Excellent Care for All Act (ECFAA) and to provide the best patient experience.
- Patient safety and quality improvement are evaluated through activities of the Clinical Quality of Care Committee (CQCC). The purpose of the Clinical Quality of Care Committee is to carry on activities for the purpose of studying, assessing, or evaluating the provision of health care at Osler with a view to improving or maintaining the quality of health care.
- The CQCC is a designated quality of care committee under the Quality of Care Information Protection Act, 2004.
- Members of the executive team are regularly engaged in patient safety walkabouts
- The Medical Advisory Committee (MAC) is the primary body for ensuring the delivery of quality of care to Osler’s patients and provides regular reports to the Board of Directors through the Chief of Staff.
- Members of the board receive quarterly patient safety reports

Aligning Governance Structure

[Diagram showing the organizational structure of governance, including the Board, Health Services Committee, SLT, Quality Governance Council, CSLT, MAC, QIP & Accreditation, Risk & Emergency Preparedness, Patient Experience, QBP, Clinical Quality of Care, with names of individuals in some roles.]
Operational Plan for 2016-2017

Key Deliverables 2016-2017

- Lead corporate Patient Safety and Quality Improvement activities.
- Lead corporate Accreditation related activities.
- Lead and report on corporate Quality Improvement Plan
- Review the effectiveness of team based program delivery model.
- Refine and improve the new incident reporting system in conjunction with the Enterprise risk Management department. This is to ensure that it continues to be user friendly and meets the needs of its users.
- Implement and support educational opportunities for programs and services related to patient safety, Root Cause Analysis (RCA), Failure Mode Effect Analysis (FMEA), and other methodologies. In addition, conduct monthly and quarterly patient safety grand rounds that are interactive, practical, engages staff and advances patient safety within the organization.

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Patient Safety In Action at Osler:
Appendix: Supplementary Document

Patient Safety is lived in action at Osler with many patient safety and quality initiatives. Understanding our roles in patient safety helps translate knowledge into action. This document presents highlights of quality initiatives at Osler that support patient safety in action. It is not an exhaustive list but features examples of how our daily work is grounded in keeping patients safe and how we improve the work that we do through quality improvement initiatives.
Our Patient Safety Plan is Lived by:

**Understanding Effective Governance**

The Governing body i.e. “The Board” is accountable for the quality of care provided by the organization.

Quality and Patient Safety are standing agenda items at all regular meetings of the governing body.

The Board monitors the quality and patient safety performance through the corporate scorecard, quarterly reports and other established processes.

Senior leaders who report to the governing body are held accountable for the quality and patient safety performance of the organization through their performance evaluations.

**Bedside Reporting, Use of White boards**

Demonstrates that we are in partnership with our patients/families in their care and that the care we provide is driven by their expectations and wishes.

Encourages the patients/families to participate in keeping themselves safe and informed about their care.

Demonstrates mutual responsibility for patient safety.

**Transfer of information (Right patient, right care, and right time)**

Standardized approach to information sharing and Transfer of Accountability (TOA) conducted by you during care transitions promotes patient safety (CHAT/SBAR).

Improves the effectiveness of coordination and communication amongst healthcare providers (HCP) at all care transitions (admission, handover, transfer or discharge), within, between or across settings.

**Practising Hand hygiene**

Protects everyone and reduces the transmission of healthcare associated infections (HAIs) through effective hand hygiene when performed at the appropriate times.

Prevents your patient from experiencing additional lengths of stay, etc.

Engages the patient/families in infection prevention strategies.
Our Patient Safety Plan is Lived by:

Incident reporting including near misses

Reporting incidents through Osler’s incident reporting system results in timely, factual and comprehensive investigation of incidents.

Promotes organization discussions and learnings and enhances patient safety through the implementation of system improvements.

It helps to minimize and eliminate such incidents in the future.

Teams should be engaged in discussing the top 3 incidents/near misses in their areas and actions taken to prevent reoccurrence of these incidents.

Patient engagement/feedback results in a reduction of patient safety incidents.

Quality Improvement activities, Participation during Quality of Care Reviews, Root Cause Analysis (RCA), Failure Mode Effect Analysis (FMEA)

Each unit should identify an improvement initiative that has been completed within the last year.

Analysis of data should occur to show that it has resulted in patient care improvement/patient engagement. e.g. Quality Based procedures, reducing medication errors, early mobility program, and any accreditation related activity.

Participation in Quality of Care reviews supports the disclosure process, promotes error proofing of clinical processes, results in system improvement and creates an organization with a memory.

FMEA of a high risk process identifies failure points and proactively mitigates risks before they become incidents.

Environmental scan

Your checking of code blue cart, code white buttons, floor stock medications, oxygen cylinders and room sweep for suicidal patients if applicable etc. ensure patient safety.

Using Resources Wisely

Elimination of waste; Fiscal responsibility for e.g. limiting waste of supplies, ordering only what is needed, monitoring inventory par levels, not hoarding supplies; Helps clinicians and patients prevent unnecessary tests, treatments or procedures.
Our Patient Safety Plan is Lived by:

**Timely Completion of Risk Assessments**
Completions of risk assessments (i.e. Falls Risk, Pressure Injury, Suicide Risk) as defined by the hospital’s policies and procedures allows for early and appropriate interventions which helps in the reduction of the patient’s risk for harm.

Serves as a means of engaging and participation by the patient in their care

**Adherence to Policies, Standards of Practice, and Professional code of conduct**
Helps in a standardized, evidence informed approach to patient care
Adherence to professional code of conduct supports exemplary care and creates a respectful environment amongst the team.

**Effective Communication**
Research indicates that 70% of critical incidents are communication related.
The use of accessibility resources such as interpreter services, language lines, American Sign Language interpreters, helps us to meet the needs of the population that we serve.

**Positive Patient Identification**
Positive patient identification ensures that the right patient receives the right treatment, service or procedure intended for them and prevent harmful incidents such as medication errors and wrong person procedures, privacy breaches, allergic reactions, discharge of patients to the wrong families.

**Patient and Family engagement**
Council Participation - Patient & Family Advisory Council (PFAC), unit-based councils, program councils; Project Work/PMO - PFA on project teams
Committee Participation - Way-finding, accessibility
Program Development & Implementation – Patient & Family Advisor (PFA) on program committees
Strategic Planning - Clinical Priority Plan (CPP), Quality Improvement Plan (QIP), Annual Business Plan (ABP)
Policy Review or Co-design - PFAC involvement in policy development
Surveys/Patient Family Feedback - NRC, call centre, comment cards.
William Osler Health System is a hospital system ‘Accredited with Exemplary Standing’ that serves 1.3 million residents of Brampton, Etobicoke, and surrounding communities within the Central West Local Health Integration Network. Osler’s emergency departments are among the busiest in Ontario and its labour and delivery program is one of the largest in Canada. William Osler Health System Foundation builds and fosters relationships in order to raise funds to support William Osler Health System’s capital, education and research priorities at Brampton Civic Hospital, Etobicoke General Hospital and Peel Memorial Centre for Integrated Health & Wellness (targeted for completion in 2015-16), (to open early 2017).