London Health Sciences Centre

Patient Safety Plan 2018-2022

At London Health Sciences Centre, we **"Speak Up for Safety!"** We know that it is the responsibility of each and every person (board members, staff members, physicians, volunteers, patients and family members) to keep our patients safe, every single day. We are committed to delivering a focused, relentless and standardized approach to improving the quality, safety and consistency of care and the patient experience across the organization.

The Patient Safety Plan is a roadmap for safe patient care that designates specific mitigation strategies to address high priority patient risks at London Health Sciences Centre (LHSC). Every 4 years the Safety Plan is reviewed and revised demonstrating LHSC's ongoing commitment to patient safety.

It is an expectation that LHSC Leaders engage in consultation, collaboration and/or co-design with patients and families in accordance with the LHSC Patient and Family Engagement Leader Guide to ensure that each element of the Patient Safety Plan contributes positively to each patient's experience (LHSC Patient Experience Team, 2018).

A Commitment to Safe Patient Care

The LHSC Patient Safety Plan is designed to maintain ongoing vigilance around foundational patient safety activities and to ensure focused attention and resources are dedicated to key priorities that require urgent action and improvement. The plan requires collaboration between staff members, physicians and other affiliates, volunteers, patients, families and the greater community.

As the region's largest acute care teaching hospital, LHSC is uniquely positioned to lead safe patient care in Southwestern Ontario in collaboration with health system partners. LHSC is reaffirming its commitment to keeping patients safe by identifying patient safety as a key pillar of the 2018-2022 LHSC Strategic Plan.

Developing the LHSC Patient Safety Plan

The LHSC Patient Safety Plan is a living document. It is regularly reviewed in order to remain nimble to the complex, changing landscape of acute care. Every four years a formal review of the Patient Safety Plan is conducted, as follows:

- Current patient safety initiatives and activities are reviewed and renewed to ensure ongoing effectiveness.
- Key patient safety priorities are determined through patient safety incident reports, Senior Leader walk rounds and staff and patient feedback.
- The Chief Quality and Patient Safety Officer determines the objectives, measurement plan, timelines and accountabilities for each key patient safety priority in consultation with other Leaders, staff members, affiliates and patient advisors, as appropriate. Objectives and planned initiatives for key patient safety priorities are aligned with the LHSC Strategic Plan and Quality Improvement Plan to ensure alignment with organizational priorities (Accreditation, 2016). Guidelines and standards from external organizations including Accreditation Canada, Safer Healthcare Now, Canadian Patient Safety Institute, Institute for Safe Medication Practices, professional practice standards and applicable legislation are consulted to ensure initiatives are informed by the best available evidence and best practice recommendations.
- The Board of Directors approves the LHSC Patient Safety Plan.
- Once approved, the Patient Safety Plan is communicated throughout the organization and available for review on the Patient Safety website.
- Resources are allocated to support implementation of the Patient Safety Plan, as required.

- Designated Leaders are responsible for implementing planned initiatives and achieving outcomes and ensuring ongoing engagement with patients and families.
- Progress on the plan is shared with the Board of Directors and within the organization quarterly.

Foundational Patient Safety Activities

Activities that form the foundation for safe patient care at LHSC include patient safety incident reporting and analysis and ongoing patient safety education and training.

Patient Safety Incident Reporting

Incident reporting is the cornerstone of patient safety culture at LHSC. It is the responsibility of all staff and affiliates, who observe, are involved in, or made aware of an adverse event or near miss to ensure it is reported. The Adverse Event and Management System (AEMS) is the LHSC software application that supports documentation and tracking of patient safety incidents, findings, recommendations and actions.

Patient Safety Incident Analysis

Patient safety incident analysis is conducted to mitigate future risk to patients. Incident analysis is intended to have a focus on learning and improving the quality of patient care, not punishment. Patient safety incidents are reviewed using the Canadian Incident Analysis Framework (Incident Analysis Collaborating Parties, 2012). While individual accountability is integrated into all professional activities, this approach ensures a focus on process and system design issues that contribute to patient safety incidents. A clear focus on learning and growth in analysis of patient safety incidents from the Board of Directors, all levels of leadership and frontline staff and affiliates contributes to a positive patient safety culture at LHSC.

Area Leaders complete reviews of patient safety incidents reported in AEMS and collaborate with appropriate stakeholders to address any patient safety gaps in the care system. In accordance with the Reporting and Investigation of Adverse Events and Near Misses (Patient, Visitor, Affiliate and Property Events) Corporate Policy, Leaders are expected to share patient safety incident reports and trends with front line staff to ensure ongoing learning.

Care teams are encouraged to share patient safety incident reviews and recommendations across the organization to ensure that safe strategies and care models are adopted broadly.

Patient Safety Incident Trends – Surveillance and Action

LHSC is committed to learning from patient safety incidents. Individual reports and trends from actual events and near misses are reviewed quarterly by the Quality and Patient Safety Committee (QPSC) as well as the Quality and Patient Safety Monitoring Committee (QPMC) of the Board.

Patient safety incident surveillance by QPSC and QPMC ensures that additional focus is applied to identified patient safety risks. QPSC and QPMC direct completion of comprehensive patient safety reviews by Patient Safety, Quality and/or Risk teams to address designated patient safety incidents and trends. Recommendations from patient safety reviews are vetted by the appropriate corporate

committee(s) or Leadership team(s) and accepted actions determined by QPSC or QPMC, as appropriate. Actions resulting from patient safety reviews are implemented by designated staff and Leaders.

Celebrating and Learning about Patient Safety at LHSC

Monthly Patient Safety and Quality Rounds provide regular opportunity for patient safety education to leaders, staff, physicians and other affiliates.

The Patient Safety Awards celebrate excellence in patient safety activities at LHSC. Near misses and patient safety initiatives and actions are celebrated through these annual awards. Recipients are from a field of nominees and awards are celebrated during Canadian Patient Safety Week.

Published quarterly by the Patient Safety team, the Patient Safety Newsletter ensures sharing and learning about high priority patient safety topics across the organization.

The LHSC Patient Safety team coordinates an annual regional LHSC Patient Safety Conference which is open to healthcare workers as well as patients and families. The conference is scheduled during Canadian Patient Safety Week and provides participants with practical patient safety content that can be applied in daily work.

Patient Safety Education and Training

Staff and physicians receive foundational patient safety education during their orientation to the institution and at regular intervals. Each department has unit-specific training modules to ensure specialized orientation to patient safety topics. The following corporate education modules are provided to ensure staff, physicians and other affiliates have current understanding of their role in patient safety priorities. (**Denotes physician requirements)

All Staff:

- Accessibility for Ontarians with Disabilities Act Accessibility Regulations (3 years)**
- Behaviour Safety Alert eLearning for Non-Patient Contact (1 year)**
- Code Gridlock (1 year)
- Critical Injuries (one time)
- Cybersecurity (1 year)**
- Emergency Response Codes (2 years)**
- Excelling at Customer Service (one time)**
- Fire Response and Evacuation (1 year)**
- Internal Responsibility System Survey**
- Hallway Transfer Protocol (1 year)
- Hand Hygiene (2 years)**
- Health and Safety Awareness – Worker (one time)**
- Influenza 2017-2018 (1 year)
- Making LHSC Smoke-Free (one time)
- Musculoskeletal Disorders and Ergonomic Hazards (1 year)
- Privacy and Confidentiality - Non-Patient Contact (1 year)**
- Safe Handling and Management of Cytotoxic Drugs (1 year)**
- Sharps Awareness (3 years)**
- WHMIS (3 years)**

- Workplace Harassment Prevention (in-class) (one time)
- Workplace Violence Prevention eLearning (2 years)

Patient Contact (in additional All Staff modules):

- Additional Precautions (2 years)**
- Behaviour Safety Alert eLearning for Patient Contact (switched out for Non-Patient Contact version) (1 year)
- Cytotoxic Safe Handing (1 year)
- Panic Alarm Training (1 year)
- Privacy and Confidentiality - Patient Contact (switched out for Non-Patient Contact version) (1 year)**
- Respiratory Fit Testing (in-class) (2 years)
- Routine Practices (2 years)**
- Workplace Violence Prevention (Medium or High Risk) (in-class) (1 or 2 years)**

Physician Only:

- Sepsis The Golden Hour**

In June 2018, LHSC launched Annual Patient Safety Education (APSE), designed to ensure that staff receive directed, standardized patient safety education. Clinical staff received standardized education on priority topics as determined through a comprehensive review of LHSC patient safety issues, with a focus on Accreditation Canada Required Organizational Practices.

A comprehensive review of feedback from the F2019 APSE will inform planning for future years. Key patient safety education and training priorities will be determined based on AEMS data and through stakeholder feedback. Delivery of APSE is planned for Q1 each year.

Key Priorities for Patient Safety 2018-2022

Between September 2017 and January 2018, LHSC Leadership undertook a detailed analysis of patient safety risks. Based on patient safety incident reports, staff and physician engagement, seven key priorities were identified for 2018-2022 to form the LHSC Patient Safety Plan. The priorities, required actions, accountabilities and timelines for completion are detailed in the Table below.

Led by the Director of Patient Safety, Experience and Relations, the LHSC Patient Safety Plan Key Priorities will be reviewed quarterly. Progress will be communicated to the Board of Directors and the organization.

References

Accreditation Canada. Plans and Framework Guide. Ottawa, ON: Accreditation Canada; 2016.

Incident Analysis Collaborating Parties. Canadian Incident Analysis Framework. Edmonton, AB: Canadian Patient Safety Institute; 2012.

LHSC Patient Experience Team. LHSC Patient and Family Engagement Leader Guide. London, ON: London Health Sciences Centre; 2018.

Key Patient Safety Priority/ Required Organizational Practices (ROP)	Objective	Planned Initiatives	Measures, Targets and Timeframe	Current Status	Q1	Q2	Accountability
Minimize the occurrence of and injuries from patient falls across all areas of LHSC **ROP: Falls Prevention** **Executive Lead: C. Young Ritchie**	Implement a documented and coordinated approach to identify and address the needs for patients at increased risk for falls across LHSC. Evaluate the effectiveness of the approach and use the results from the evaluation to make improvements.	Year 1: Develop a Corporate Falls prevention policy Year 1: Implement and Evaluate an Ambulatory Care Falls Prevention Strategy Year 1: Update Corporate Falls Prevention Committee Terms of Reference and Accountability Structure Year 1: Complete a corporate wide review of Falls Risk Assessment Tools used in the organization Year 1-4: Provide quarterly reports to the Quality and Patient Safety Committee (QPSC) from Corporate Falls Prevention Committee Year 4: Review effectiveness of the LHSC falls prevention strategy	Policy completion – Q2 F19	Completed			Patients and families: recognize their role in preventing falls Staff: complete Falls risk assessment and implement prevention strategies. Reporting of all patient safety incidents and good catches in the Patient safety incident management system (AEMS) Coordinator/Manager: investigating, monitoring, reporting and sharing of patient safety data reports Director: patient safety report data analysis and mitigation strategies; cross corporate reporting Vice President: Model and promote a culture of safety
			Establish Ambulatory falls prevention strategy – Q1 F19	Completed			
			All areas implementation – Q2 F19	In Progress			
			Falls risk assessment tool assessment completed – Q2 F19	Completed			
			Updates to QPSC – quarterly F19- F23	In Progress			
			Target rate of falls reported per 1000 patient days – 3.5 or lower (progress updated quarterly)	In Progress			
Minimize suicide events for patients in the Emergency Departments (ED), Mental Health areas and patients admitted after a suicide attempt **ROP: Suicide Prevention** **Executive Lead: J. Trpkovski**	Implement a standardized tool for suicide risk assessment in Mental Health and Emergency Services (adults and paediatrics). Implement a standardized tool for suicide risk assessment of inpatients receiving care after a suicide attempt on any clinical unit.	Year 1: Implement an electronic suicide screen to be implemented in the VH and UH EDs (adult and paediatric), inpatient and outpatient Mental Health areas (include adult and paediatric areas) and all units who are providing care to an individual with injuries sustained by their suicide attempt Implement intervention strategies to ensure the immediate safety of patients identified as being at high risk for suicide	Screening tool identified– Q1 F19	Completed			Patients and families: Understand the validity of the Columbia suicide screen, destigmatize mental health illness Staff: complete Columbia suicide tool and implement prevention strategies, destigmatize mental health illness Coordinator/Manager: investigating, monitoring, reporting and sharing of patient safety data reports, destigmatize mental health illness Director: patient safety report data analysis and mitigation strategies; cross corporate reporting, destigmatize
			Patient Safety and Quality Education days completed – Q1 F19	Completed F19			
			Electronic documentation tool completed– Q3 F19				
			Superusers trained – Q3 F19	In Progress			
			Full implementation of assessment tool – Q3 F19	In Progress			
			Monitoring and assessment of implementation plan – Quarterly once implemented F19- F23	In Progress			

Key Patient Safety Priority/ Required Organizational Practices (ROP)	Objective	Planned Initiatives	Measures, Targets and Timeframe	Current Status	Q1	Q2	Accountability
	Risk assessment will occur at the time of contact with the hospital and reassessment at regular intervals or as needed.						mental health illness Vice President: Model and promote a culture of safety, destigmatize mental health illness
Minimize patient harm resulting from medication discrepancies at the time of care transitions in Ambulatory Care areas at LHSC **ROP: Medication Reconciliation at Care Transitions - Ambulatory Care** **ROP: Medication Reconciliation as a Strategic Priority** **Executive Lead: N. Johnson**	Implement medication reconciliation in all ambulatory areas assessed as requiring medication reconciliation based on standardized risk assessment.	Year 1: Update Corporate Policy Year 1: Complete risk assessment for all Ambulatory Care areas at LHSC Year 1: For areas assessed as requiring medication reconciliation, determine the frequency with which medication reconciliation will be completed Year 1: Full implementation for areas assessed as requiring medication reconciliation Audit compliance and based on findings, determine strategy to improve compliance	Policy updated complete – Q2 F19	In Progress			Patients and families: recognize their role in medication safety Staff: reporting of patient safety incidents and good catches in the Patient safety incident management system (AEMS) Coordinator/Manager: investigating, monitoring, reporting and sharing of medication safety related data reports Director: patient safety report data analysis and mitigation strategies; cross corporate reporting Vice President: model and promote a culture of safety
			Risk Assessment complete in all areas – Q1 F19	Completed			
			Determine the frequency with which medication reconciliation will be completed in all areas – Q1 F19	Completed			
			Full implementation for areas assessed as requiring medication reconciliation – Q2 F19	In Progress			
			Audit compliance and, based on findings, modify strategy – Following implementation F19	In Progress			
			Data collection for compliance – F19 - F23	In Progress			
			Establish target completion rate for ambulatory medication reconciliation - Q3 F19				
			Continue to monitor, report to, and support applicable units - F19 – F23				

Key Patient Safety Priority/ Required Organizational Practices (ROP)	Objective	Planned Initiatives	Measures, Targets and Timeframe	Current Status	Q1	Q2	Accountability
Minimize the risk of harm from services and procedures due to patient misidentification **ROP: Client Identification** **Executive Lead: C. Young Ritchie**	For all high-risk and selected low-risk services and procedures, at least two person-specific identifiers are used to confirm that patients receive the service or procedure intended for them.	Year 1: Determine appropriate person-specific identifiers that will be acceptable for care areas Year 1: Policy update Year 1: Determine moments for client identification Year 1: Train-the-trainer with specialists and educators (June education days) - ensure staff education is provided on the appropriate use of two person-specific identifiers at appropriate steps in care Year 1 - 4: Audit compliance and, based on findings, determine strategy to improve compliance Year 1: Implement armband scan procedure for ED areas for laboratory samples Year 1: Identify ambulatory areas that have high-risk services that require armband implementation	Define appropriate person-specific identifiers and moments requiring identification – Q1 F19	Completed			Patients and families: recognize the importance of client ID and their role in safety Staff: understand the importance of Client ID and report patient safety incidents and good catches in the Patient safety incident management system (AEMS) Coordinator/Manager: investigating, monitoring, reporting and sharing of scanning and labeling. Director: scanning and labeling data analysis and mitigation strategies; cross corporate reporting Vice President: model and promote a culture of safety, remove perceived or real barriers
			Policy update approval – Q2 F19	Completed			
			Armband implementation in Inpatient and Emergency Departments, including training of superusers and staff – Q1-2 F19	In Progress			
			Auditing of practice in clinical areas – F19 – F23	In Progress			
			Risk assessment and armband implementation high-risk Ambulatory areas – Q3-4 F19 – F23				
			Leader Report development; finalized - Q2 F19	In Progress			
Develop a coordinated reporting structure to support leader review of patient safety incidents **ROP: Patient Safety Incident Management**	Develop a structure to ensure regular review and analysis of patient safety incidents, both corporately and within each Patient Care Area.	Year 1: Develop monthly patient safety incident reports to share with Area Leaders to support regular review within care teams Year 1: Develop quarterly patient incident reviews/reports that identify and investigate corporate patient incident trends Year 1: Determine oversight accountability structure for quarterly	Corporate Report developed; finalized - Q1 F19	In Progress			Patients and families: recognize their role in the promotion of patient safety and are empowered to report patient safety incidents and near misses (good catches) Staff: report patient safety incidents and good catches into the patient safety incident management system (AEMS) Coordinator/Manager: monitoring,
			Oversight/Accountability structure for quarterly patient incident reviews/reports – Q2 F19	In Progress			
			Implement monitoring structure for recommendations that result from patient				

Key Patient Safety Priority/ Required Organizational Practices (ROP)	Objective	Planned Initiatives	Measures, Targets and Timeframe	Current Status	Q1	Q2	Accountability
Executive Lead: J. Schleifer Taylor		patient incident reviews/reports Year 1-4: Implement monitoring structure for recommendations that result from patient incident reports	incident reports – Q4 F19 – F23				reporting and sharing of patient safety data reports, empower staff to report Director: patient safety report data analysis and mitigation strategies; cross corporate reporting Vice President: Model and promote a culture of safety
			Leader education completed - Q3 F19				
Support patient safety and experience through cultural competency training for staff and affiliates **Embedded in all of the clinical standards** **Executive Lead: J. Schleifer Taylor**	Provide culturally competent care as a fundamental component of safe, quality, and equitable patient and family-centred care at LHSC.	Year 1: Complete Leader education Year 1: Complete Health Equity Impact Assessment Year 1: Identify unit champions to review the Cultural Competence E-Learning Module Series Year 1: Add Google translate to external LHSC website Start Year 1: Corporate Communications to provide feature articles (intranet, thePage) that celebrate diversity Year 1: Cultural Competence E-Learning Module Series to be uploaded to iLearn platform Year 2: Ensure appropriate hospital signs are multilingual or use pictures/photographs to provide information or instructions Year 2-3: Continue to provide cultural competence training for all staff F20 -21	Health Equity Impact Assessment completed – Q3 F19				Patients and families: cultural needs are met and respected Staff: Appreciate and recognize cultural differences and provide culturally compassionate care Coordinator/Manager: monitoring, reporting and sharing of patient demographics Director: understand the cultural needs of the population they serve through data analysis and cross corporate reporting Vice President: Model and promote cultural competence and a culture of safety
			Unit champions identified and e-learning completed – Q3 F19				
			Website update completed – Q4 F19				
			Corporate Communications publish articles with focus on diversity – ongoing F19 – F23				
			Cultural Competence e-learning modules uploaded to iLearn and completed by assigned staff – Q4 F19	In Progress			
			Cultural Competence training for all staff F20 -21				
			Review of existing hospital signs with appropriate modifications completed – Q4 F19	In Progress			

Key Patient Safety Priority/ Required Organizational Practices (ROP)	Objective	Planned Initiatives	Measures, Targets and Timeframe	Current Status	Q1	Q2	Accountability
		Year 1-4: Develop patient resources aligned to cultural needs: interpretive services program, accessibility workplace plan, spiritual services, food services, rights and responsibilities	Designated cultural patient resources completed - Q4 F19	In Progress			
			Complete assessment of June 2018 Patient Safety and Quality Education Days – Q2 F19	Completed			
Establish patient safety education and training strategy **ROP: Patient Safety - Education and Training** **ROP: Patient Safety Plan** **ROP: Patient Safety Quarterly Reports** **Executive Lead: J. Schleifer Taylor**	Develop a structure to ensure staff, affiliates, volunteers and patient advisors receive annual, targeted, standardized patient safety education.	Year 1-4: Annual Patient Safety Education (APSE) to occur for staff. Method of delivery for F2020 will be based on formal review of feedback from June 2018 Patient Safety and Quality Education days. Delivery of APSE planned for Q1 each year. Year 1-4: Patient Safety conference to be hosted during Canadian Patient Safety Week Year 1-4: LHSC Patient Safety Awards Year 1-4: Patient Safety and Quality Rounds to occur monthly Year 1-4: Update and maintain Patient Safety Website with information based on organizational needs Year 1-4: Establish Quarterly Patient Safety Newsletter	Gap analysis - review of AEMS to determine patient safety training priorities for APSE F2020 – Q3 F19 – F23				Patients and families: recognize LHSC's commitment to patient safety, help to identify safety topics Staff: continuously improve safety knowledge, support content creation Coordinator/Manager: Support continued education opportunities for staff Director: Support continued education opportunities for staff Vice President: Model and promote a culture of safety, support continued patient safety educational opportunities
			Complete implementation, evaluation plan for APSE F2020 – Q4 F19 – F23				
			LHSC Patient Safety Conference – Q3 F19 – F23	In Progress			
			Patient Safety and Quality Rounds – monthly (ongoing)	Ongoing			
			Patient Safety Newsletter – Q2 first edition, then monthly F19 – F 23	Completed. Next issue - In Progress			