St.Thomas Elgin General Hospital

Quality & Safety Plan

Introduction

At St. Thomas Elgin General Hospital (STEGH), patient and staff safety, and continuous quality improvement are key strategic priorities. The importance of safety is reflected in our Vision and Strategic Priorities, and is embedded into the job descriptions of everyone employed by the hospital. Our Quality and Safety Program is designed to align and support our Mission, Vision and Values, and our philosophy of patient and family-centred care.

STEGH has adopted quality improvement initiatives through Health Quality Ontario, the Patient Safety Institute, The Institute for Safe Medication Practices, Accreditation Canada's Required Organizational Practices (ROP's), and the Canadian Patient Safety Institute's Safety Compliances as key drivers for patient safety in the organization.

STEGH has adopted and delivered staff improvement initiatives as key drivers for staff safety in the hospital. These have been adopted through the Ministry of Labour, Immigration, Training and Skills Development (MLITSD), the Occupational Health and Safety Act, Public Services Health and Safety Association, Transport Canada, Southwestern Public Health, Accreditation Canada's Required Organizational Practices (ROPs), STEGH's Risk Management System (RL6), and our Employee Engagement Survey.

Educating healthcare providers about safety and enabling them to use tools and knowledge to build and maintain a safe system is fundamental to creating a culture of safety across the spectrum of care. Appropriate policies and procedures have been developed, implemented, and evaluated to meet these requirements. The primary focus of this plan is to focus on creating a systematic hospital-wide program to prevent harm, and promote the safety of all patients, visitors, volunteers, and health care workers.

STEGH's Quality and Safety Plan is based upon the Canadian Patient Safety Institute's six safety competencies. The Safety Competencies Framework (SCF) is a framework designed to support the development of a safety program and ongoing professional development. These domains assist with embedding safety evidence into organizational activities, to strengthen advancements in collective knowledge where patient/family partnership, leadership, quality improvement, and cultural competency concepts improve system-wide outcomes (Canadian Patient Safety institute, 2020). While the framework is designed to support patient safety specifically, we view these domains as equally supporting safety safety.

The Safety Competencies

Patient Safety Culture - involves recognizing the importance of ongoing collaboration and the commitment to advocate for change.

Definition: Patient safety culture is an integrated pattern of individual and organizational actions and behaviour based on shared beliefs and values that enables individuals and organizations to continuously seek to minimize the potential for patient harm which may result from the processes of care delivery. Patient safety culture is characterized by authentic leadership, broad, timely and responsive communication, transparency of information, as well as the engagement of patients and families.

Key Enablers where healthcare providers, staff & volunteers are able to:

- Contribute to the establishment and maintenance of a just culture
- Advocate for an improved staff safety culture
- Contribute to the continuous improvement of a safety culture

Teamwork - High-performing interprofessional teams demonstrate capabilities and competencies that are essential to efficient, effective, and safe collaborative practice.

Definition: Optimizing teamwork within and across teams to maximize safety, quality of care, and health outcomes.

Key Enablers where healthcare providers, staff & volunteers are able to:

- Meaningfully partner with patients and families, enabling them to be a key members of their interprofessional teams
- Respect the professional, patient and family roles and responsibilities within the interprofessional team and integrate this delivery seamlessly into service delivery
- Be vigilant of interprofessional team dynamics to optimize safety, quality of care, and health outcomes
- Demonstrate shared authority, leadership and decision making
- Communicate in a respectful and responsive manner
- Work effectively with all members of the interprofessional team and promote understanding, manage differences and resolve conflict

Communication - Effective communication is beneficial to patients and healthcare providers, builds trust, and is a precondition of obtaining patient consent.

Definition: Healthcare professionals engage patients and family members in an open dialogue to promote safety, and to prevent and respond to safety incidents.

Key Enablers where healthcare providers, staff & volunteers are able to:

- Demonstrate effective verbal and non-verbal communication skills to promote quality and patient safety
- Demonstrate effective documentation for patient and staff safety
- Communicate to prevent high risk patient and staff safety threats
- Employ health care technology to provide safe patient care and a safe work environment.

Safety, Risk and Quality Improvement - Healthcare providers collect and monitor performance data to assess risk and improve outcomes.

Definition: Acting on safety risks is a broad concept that encompasses identifying, assessing, reducing, and mitigating safety risks to both patients and healthcare providers. This is accomplished by engaging patients and their families and other members of the care team in implementing evidence-informed principles of system design and quality improvement.

Key Enablers where healthcare providers, staff & volunteers are able to:

- Anticipate, identify, reduce and mitigate hazardous and routine situations and settings in which safety problems may arise
- Systematically identify, implement and evaluate quality improvement interventions for patient safety
- Sustain quality improvement and safety practices at a local and system level

Optimize Human and System Factors - Optimizing the human and environmental factors that support the achievement of best human performance is an essential safety competency for all healthcare providers.

Definition: Managing the interaction between people (individuals, healthcare providers, patients, family members and teams) and other system factors (tasks, tools/technologies, organizational, environmental) to optimize safety.

Key Enablers where healthcare providers, staff & volunteers are able to:

- Describe the individual and the environmental factors that affect human performances
- Apply critical thinking techniques to enhance safe decisions and outcomes
- Discuss the impact of the human/technology interface on patient and staff safety
- Recognize that human factors are a diverse set of system elements that must be considered in an integrated manner to improve patient and staff safety and prevent and mitigate hazards

Recognize, Respond and Disclose Patient Safety Incidents - Open, honest, and empathetic disclosure and appropriate apologies benefit patients and families, health providers, and their organizations.

Definition: Recognize and report safety incidents, respond appropriately and effectively to mitigate harm, ensure disclosure, and prevent recurrences.

Key Enablers where healthcare providers, staff & volunteers are able to:

- Recognize patient and staff safety incidents
- Engage with patients and families affected by patient safety incidents to meet their needs
- Disclose patient safety incidents
- Learn from patient and staff safety incidents
- Professionally and constructively cope with the emotional stress of being involved in a safety incident
- Leadership roles support patients, families, healthcare providers involved in a safety incident

Our Commitment to Quality & Safety

Structures that Support Patient Safety

Safety and continuous quality improvement are strategic priorities at STEGH. The importance of patient and staff safety is reflected in our vision and strategic plan, and is embedded into the job descriptions of every staff and volunteer role at STEGH. There are a number of integral components that support the STEGH Quality and Safety Plan.

Board of Directors

STEGH's Board of Directors is accountable for ensuring processes are in place to support patient and staff safety and the provision of quality care. The Excellent Care for All Act (ECFAA), mandates the establishment of a Quality Committee of the Board that ensures all requirements noted within the Act are met. This includes, but is not limited to, establishing a Quality of Care Committee.

Quality and Safety Committee of the Board

The purpose of the Quality of Care Committee, as outlined in the Quality of Care Information Protection Act (QCIPA) of 2016, is to review all critical incidents and ensure recommendations and learnings from the reviews undergo follow up with learnings shared.

The committee may also review non-critical incidents for the purpose of assessing or evaluating the provision of health care with a view to improving or maintaining the safety and quality of health care, or the level of skill, knowledge, and competence of the persons who provide health care.

The Quality Committee of the Board is accountable but not limited to:

- Ensures the quality of patient care delivered is consistent with the Mission, Vision and Values of STEGH.
- Monitors and reports quality issues and the overall quality of services provided across the organization to the Board of Directors.
- Monitors performance indicators; identifies priorities for improvement and tracks progress towards achievement.
- Monitors compliance with accountability requirements related to quality, or patient or staff safety.
- Considers and makes recommendations regarding quality improvement initiatives, patient safety improvements, and policies to the Board of Directors.
- Ensures evidence based practices are provided to staff and health care providers within the organization, and monitors metrics to ensure quality standards are met.

Executive Team

The members of STEGH's Executive Team are stewards of quality and safety across the organization and are delegated this responsibility by the Board of Directors. This commitment and support enhances a culture of safety, excellent care, and continuous quality improvement.

With input from stakeholders and endorsement from the Board of Directors, the Executive

Team develops annual priorities that support the advancement of STEGH's strategic plan. Each of the four pillars include strategies goals and timelines aligned with the Strategic Plan.

- Partnering with patients to enhance their care experiences
- Achieving operational excellence to ensure quality and sustainability
- Creating Collaborative Networks to connect patients to the services they need
- Empowering our team to reach their full potential

Ethics Committee

The Ethics Committee ensures that ethical issues are evaluated using STEGH's Framework Supporting Ethical Practice. The committee supports the provision of ethical practice and may engage a clinical ethicist to engage in reflective practice, examine ethical principles, and provide advice regarding policy and procedure development/revision or to provide guidance in relation to ethically challenging situations. Patient partners are included in the work of the Ethics Committee to ensure the voice of the patient is present.

Staff and Physician Engagement

STEGH has implemented evidence-based leadership practices such as dedicated leader-to-staff rounding across the organization. This gives dedicated time for staff and leaders to identify areas for improvement, recognize a colleague for living our values, and strengthen leader/staff relationships that influence the delivery of high quality patient care. Our staff engagement practices are supported by the Huron Model model and cultivate a work environment where staff feel valued.

Local councils and committees across the organization have work plans that focus on specific safety indicators that drive our corporate patient and staff safety indicators.

STEGH has also invested in education and training to support leadership and staff in effectively engaging with colleagues and hardwiring best practices and processes leading to a culture of safety. For example, all leaders and staff attend Crucial Conversations training and learn essential skills to improving safety, quality of care or service, and quality of work life.

STEGH conducts an annual Employee Engagement Survey to help better understand how employees feel about their role, team, safety, leader, and the hospital. Responses are used to co-create action plans with staff/physicians to increase psychological and physical safety throughout the hospital.

Patient and Family Engagement

The patient experience is integral to how STEGH approaches the provision of safe healthcare. STEGH includes the voice of the patient by inviting Patient Partners to be part of committees and improvement teams. Patient partnership is important through all stages of work, and we measure the level of patient engagement using the Spectrum of Engagement; from **informing** and **consulting** through to **involving**, **collaborating** and **co-designing**. AT STEGH, we use an experience-based co-design (EBCD) approach that enables staff and patients to co-design services and/or care pathways, together in partnership.

STEGH seeks to understand feedback from patients, family members and caregivers through an established patient relations process, Patient Experience Council, Patient Experience Surveys, and Patient Experience Dashboards.

AT STEGH, complaints and compliments allow us to track the quality of our patients' experience and identify opportunities for process and system improvements that meet the needs and expectations of patients. As part of our patient relations process, we acknowledge patient and family members/caregivers' complaints and compliments within two business days of receipt. We seek feedback and work with the patient and/or family member/caregiver to bring forward a resolution that is best for them. We then ensure that all concerns are brought forward and investigated by hospital leadership. Lastly, we provide the patient and/or family members/caregivers with a timeframe of receiving follow-up to their resolution within five business days, as per the Excellent Care for All Act (2010). Complaint themes and improvements are reviewed on a quarterly basis by Patient Experience and the Executive Team. Complaint themes help STEGH drive improvements and consider where we can have the greatest impact.

The Patient Experience Council at STEGH is an additional avenue of achieving our shared vision of delivering excellent patient care to our community. Founded in 2012, STEGH's Patient Experience Council has eight active members who are former patients and family caregivers. Patient Partners meet on a monthly basis to share experiences related to the healthcare system to improve services, provide input and feedback and create patient-focused activities, and review materials, policies and practices from the lens of a patient and/or family caregiver.

STEGH measures the patient experience through our own internally developed patient experience surveys. Our internal surveys provide monthly qualitative and quantitative data. Results are shared as dashboards with clinical leaders across all units on a monthly basis to review metrics and determine how to improve our services. Teams meet to review and discuss monthly metrics at huddle boards. At STEGH, we set high targets for our survey questions, as we are constantly striving for continuous improvement.

External Partnerships

STEGH is committed to continually improving patient and staff safety at a system level, including collaborating with regional healthcare partners such as the Elgin Ontario Health Team, SOHAC, St. Thomas Police Services, and CMHA to assist in improving quality of care, supporting a safe environment, and improving patient outcomes.

STEGH Internal and External Mechanisms to Drive Patient Safety

Annual Quality Improvement Plans (Internal)

Corporately, on an annual basis, the Quality and Safety Committee of the Board leads a process to develop the annual Quality Improvement Plan (QIP). The QIP is a formal, documented set of quality commitments aligned with system and provincial priorities that a health care organization makes to its patients, family caregivers, staff and community to improve quality through focused targets and actions. The QIP is recommended to the Board of Directors by the Quality and Safety Committee of the Board for approval. The annual QIP contains the key patient safety goals for the upcoming year and is found on STEGH's website.

Quality, Risk and Safety Scorecard (Internal)

STEGH maintains a Corporate Patient Safety & Quality Scorecard that contains a set of mandatory patient safety indicators, patient experience and feedback indicators and other locally identified indicators and targets that drives continuous quality improvement, enhanced patient and staff safety, advancements in clinical practice and process improvements. Scorecard progress is reviewed monthly by the Board of Directors and Patient Safety & Quality Committee and weekly during leadership huddles.

Integrated Risk Management (Internal)

Integrated Risk Management (IRM) 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. IRM assists leaders in identifying risks, tracking and monitoring risks within the organization, and within specific departments, determines the probability of a risk occurring multiplied by the impact should that risk occur. Risk scores are evaluated and used to inform priorities for action.

RL6 Safety Incident Reporting and Management (Internal)

RL6 is the software used at STEGH to document patient and/or staff safety incidents. It is the responsibility of all staff and affiliates, who observe, are involved in, or are made aware of a safety incident to ensure the incident is reported. The system allows for documentation and tracking of safety incidents, findings, recommendations, root cause analysis, and actions/improvements. RL6 incident data is used as a tool to promote learning throughout the organization.

STEGH has embedded learning from incidents at multiple levels of leadership and we utilize LEAN methodology when reviewing incidents to conduct root cause analysis and identifying trending opportunities.

Ongoing Patient Safety Initiatives (Internal)

Ongoing safety programs and initiatives at STEGH include:

Safety Strategies

- Patient risk assessments (CAM, MORSE, BRADEN, BSA, Columbia, etc.)
- Bullet (Discharge) Rounds
- Hourly Rounding
- Regional Bed Board
- KPI Boards
- Performance Boards
- Patient Oriented Discharge (PODS)

Safety Strategies - Continued..

- Choosing Wisely Initiatives
- Hand Hygiene Observations
- Patient Experience Council
- Co-designed patient resources
- Reporting of Severe Adverse Drug Reactions and Medical Device Incidents under Vanessa's Law
- Critical Care Indicators for Antibiotics Resistant Organisms
- Tier 1 Huddles
- Weekly Tier 2 Leadership Huddle
- Bi-weekly Tier 3 Huddle
- Bedside Transfer of Information and Accountability (TOIA)
- Program Councils
- Physician Orientation
- Staff Orientation
- Rounding – Staff and Patient
- Just-in-time clinical education to reinforce professional practice and reduce patient harm
- Post fall huddles
- M+M Rounds
- Safety incident reporting
- Incident Debrief
- JUST culture
- Better Outcomes Registry & Network (BORN)
- PSHSA safety risk assessments
- Ongoing education/learning for staff:
    - San-yas training
    - Crucial Conversations: Mastering Dialogue in Healthcare
    - Gentle Persuasion Approach
    - Non-violet Crisis Intervention Training
    - PINEL Restraint training
    - PSHSA Supervisor training
    - Hand-held Metal Detector training

Safety Strategies - Continued..

- Ongoing education/learning for staff continued...
  - eLearn modules:
    - Workplace Violence Prevention
    - Emergency Codes
    - Adverse Event Reporting
    - Point of Care Risk Assessment
    - Personal Protective Equipment (PPE)
    - Slips, Trips, and Falls Prevention
    - Searching of a Patient and their Belongings
    - Diversity, Equity, and Inclusion Training
    - Micro-aggressions in the Workplace
    - Unconscious Bias
  - Patient lift training
  - Emergency Code Mocks
  - Continuous Improvement - Principles and Behaviours (in-person training)
  - Respiratory Protection Program and Training
  - AIDET: Connecting with Staff and Patients training

Quality Indicators of Patient Safety

- Safety Incident Reporting Patient (medication safety, falls)
- Safety Incident Reporting Staff (workplace violence, injury)
- Critical Incident Review (QCIPA)
- Hand Hygiene Compliance
- Medication Reconciliation at Discharge
- Beside Medication Verification
- Discharge summaries
- Time to inpatient bed
- Readmission rates
- Repeat ED visits
- Never Events
- Patient Experience Feedback

Quality Indicators of Patient Safety - Continued..

- Healthcare associated infections
- Surgical Site Infections
- Surgical Safety Checklist
- Pressure injuries
- Venous Thromboembolic Prophylaxis (VTE)
- Quality Improvement Plan

Safety Programs/Committees

- Immunization Programs
- Risk Management Committee (Emergency Preparedness)
- Infection Control Committee
- Outbreak Management Team
- Interprofessional Practice Committee
- Pharmacy and Therapeutics Committee
- Antimicrobial Stewardship Committee
- Workplace Health and Safety Program
- Joint Health & Safety Committee
- Departmental Safety Representatives
- Workplace Violence Prevention Committee
- Musculoskeletal Disorder (MSD) Champions
- Early and Safe Return to Work Policy (with robust accommodation practices)
- Healthy Pregnancy Program
- Fragrance Controlled Workplace
- Hand Care Program
- Individual Staff Safe Work Plans (for domestic and/or workplace violence)

Data from Environmental Safety Issues

- Product Recalls
- Drug Recalls
- Product/Equipment Malfunction
- Air Quality

Data from Environmental Safety Issues continued...

- Environmental audits
- Security Incidents
- Workplace Violence
- Departmental Safety Audits
- Joint Health & Safety Committee Audits

Accreditation Canada (External)

STEGH is Accredited with Exemplary Status by Accreditation Canada.

Institute for Quality Management in Healthcare (IQMH):

Patient safety is enhanced by ensuring our laboratory testing policies and procedures meet IQMH standards. STEGH's Laboratory programs are regularly assessed and accredited by IQMH.

Ontario College of Pharmacists (OCP):

STEGH is Accredited by the Ontario College of Pharmacists (OCP). The OCP evaluates STEGH's pharmacy to ensure it meets the requirements as outlined in the Drug and Pharmacies Regulation Act (O.Reg.264/16).

STEGH utilizes other sources of data and information from the following to inform the Quality and Safety Plan, safety initiatives, and advance performance:

- Ontario Health (OH)
- Canadian Institute for Health Information (CIHI)
- Institute for Safe Medication Practices (ISMP)
- Accreditation Canada Required Organizational Practices (ROPs)
- Occupational Safety and Health Administration (OSHA)
- Public Services Health and Safety Association (PSHSA)
- Institute for Healthcare Improvement (IHI)
- Canadian Foundation for Health Care Improvement (CFHI)
- Provincial Infectious Diseases Advisory Committee (PIDAC)
- Public Health Ontario (PHO)
- Southwestern Public Health Unit (SWPHU)

Continued...

- Workplace Safety and Insurance Board (WSIB)
- Ministry of Labour (MOL)

STEGH holds itself accountable both through internal structures and with external partners. Performance at the unit, program, and corporate levels is reported, monitored, and actioned with internal committees with subsequent reporting to the Board of Directors. Accountability to external partners is demonstrated through such mechanisms as the Strategic Plan, balanced scorecard, 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

The Quality and Safety plan developed by STEGH is directly aligned with the operational Strategic Plan, the Quality and Patient Safety scorecard, and Pay for Performance metrics.

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