



## PATIENT SAFETY PLAN

### PURPOSE

In the long and proud tradition derived from the values of the hospital and focused on the dignity of persons we serve, the Norfolk General Hospital Patient Safety Plan is designed to improve patient safety, reduce risk and respect the dignity of those we serve by assuring a safe environment. Recognizing that medical/health care error reduction requires an integrated and coordinated approach, the following plan relates specifically to a systematic hospital-wide program to minimize physical injury, accidents and undue psychological stress during hospitalization. The organization-wide safety program will include all activities contributing to the maintenance and improvement of patient safety.

Leadership assumes a role in establishing a culture of safety that minimizes hazards and patient harm by focusing on processes of care. The leaders of the organization are responsible for fostering an environment through their personal example; emphasizing patient safety as an organizational priority; providing education to medical and hospital staff regarding the commitment to reduction of medical errors; supporting proactive reduction in medical/health care errors; and integrating patient safety priorities into the new design and redesign of all relevant organization processes, equipment, functions and services.

The Safety Plan was driven from a process external to our hospital which included the Institute of Medicine's 1999 report, "To Err is Human: Building a Safer Health System", the Canadian Patient Safety Institute 2003 "Safer Health Care Now", the Canadian Adverse Event Study "The Baker Norton Report" 2004, and the Accreditation Canada's Patient Safety Goal and Required Organizational Practices.

### VISION

Vision is evidence of intention and commitment. While Mission describes our calling, what it is we are about, or how we participate in the health care ministry; our Vision Statement describes what we want to become.

The vision for Norfolk General Hospital is **to partner with our patients, their families, our staff, our volunteers and our healthcare partners to achieve a healthier community.**

The Vision of Norfolk General Hospital is to focus on patient health outcomes with changes, improvements and continuous monitoring of activities to ensure that the organization's mission is consistently supported, assessed, reviewed and revised as necessary over time. To carry on our Mission and to follow through with our Vision, it is necessary we work together as a team.

## **MISSION**

The Mission of Norfolk General Hospital is **to assist those we serve to achieve the best possible health outcomes.**

## **VALUES**

From the mission and vision flow the following values, which permeate all our endeavors:

### **Innovation**

- We actively seek out and evaluate new evidence based practices and technologies

### **Compassion**

- We demonstrate in our works and actions, empathy for our patients and families treating them in a caring, gentle, courteous and respectful way

### **Accountability**

- We are accountable to each other, the people we serve, our community and the Ministry of Health and Long Term Care for our actions.
- We measure the outcomes of our actions and report them
- We are stewards of the resources entrusted to us and deliver safe, effective and efficient health care

### **Respect**

- We recognize that each individual member of the healthcare team, our partners, patients and their families can improve the quality of our future
- We listen to each other and work together with dignity and consideration to achieve our vision (a healthier community)

### **Empowerment**

- We support and foster environments that enable patients and their families to be involved in care planning and decision making
- We value all members of the hospital team and encourage you to provide input into the decision making process and take initiative to make things better

### **Partnership**

- We are committed to working with our partners to build on each other's skills and expertise maximizing the utilization of resources, and improving communication to ensure an integrated response to patients and community health needs.

## **Improvement**

- We learn from our successes and failures, strive to exceed benchmarks/standards and pursue ongoing education and development

## **OBJECTIVES**

The objectives of the Patient Safety Plan:

Promote involvement and partnering with each patient and family for their safety

Involve patients in decisions about their health care and promote open communication about adverse events

Ensure a safe patient environment throughout the organization: report safety concerns, participate in daily unit huddles, post safety indicators

Incorporate accountability for patient safety at every level of the organization and build initiatives for patient safety into every service

Incorporate patient safety as a standing agenda item on all departmental/service committees

Include patient safety in the orientation process

Encourage organizational learning through audits, review and investigation of adverse events

Incorporate recognition of patient safety as an integral job responsibility and include in performance reviews, job postings and position descriptions

Provide education of patient safety into job specific competencies

Encourage recognition and reporting of adverse events and risks to patient safety without judgment or placement of blame

Collect and analyze data, evaluate care processes for opportunities to reduce risk and initiate actions

Report internally the outcome of adverse event reviews and the actions taken with a focus on processes and systems to reduce risk

Support sharing of knowledge to effect behavioral changes within Norfolk General Hospital by sharing of information through committees, safety reports, Quality Improvement Plan, and organization indicator reports.

## **PATIENT SAFETY PLAN**

The patient Safety Plan was developed by the Safety Team and is referred to as the "Safety Hexagon". The Safety Hexagon has six fundamental components including safety culture, communication, medication use, worklife/workforce, infection control and risk assessment. The hexagon framework is our commitment to "Excellence in Patient Safety".

### **Components of the Safety Hexagon**

#### **Culture**

The organization has defined the responsibilities for patient safety in the Accident Prevention and Safety Policy (# II-b-1) and adopts patient safety as a strategic goal. The Patient Safety Team will oversee the safety related processes and systems that effect patients, employees and visitors. Our culture includes a non-punitive reporting process while supporting a 'just approach' for reviewing and recommending strategies for improving patient safety. A policy for disclosure of adverse events when harm has occurred is implemented and directors have been in-serviced as to the process for disclosure. Staff will be supported by their leaders to understand and participate in disclosure of adverse events. Reports related to patient safety are provided quarterly to committees at all levels of responsibility within the organization. We support a climate of honesty, trust and openness and therefore have established a disclosure process to support both staff and patients/families. We are committed to prospective reviews for identifying patient safety concerns.

#### **Communication**

We will inform and educate our staff, patients and care partners about their role in patient safety. We are committed to employ effective mechanisms for the transfer of information at interface points of the patient experience in our organization. We have process for verification and other checking systems for high risk services and for reconciling patient medications upon admission, transfer and discharge. Safety is an agenda item for organization committees and staff meetings. Meetings between the organization leaders and staff, departmental meetings, are held on a regular basis to address any staff concerns including safety. Incident reports and accompanying opportunities for improvement are reported quarterly with the organization indicator report. Medication reconciliation is part of the transfer of accountability between units and is completed on admission and discharge for all inpatients. Patients are identified using two identifiers prior to any interventions. The identifiers include: patient full name, date of birth, hospital ID number, and current photo. Dangerous abbreviations have been posted and brought to the attention of all clinical staff including our physician partners. These abbreviations are posted in all clinical areas. The surgical program has embraced the practice of utilizing a Safe Surgery Checklist for all cases and is included in our Quality Improvement Plan.

#### **Medication Use**

Norfolk General Hospital meets the safety standards set by Accreditation Canada in that all concentrated electrolytes are removed from the patient care areas. We provide ongoing training for our staff related to infusion pumps and include staff in any purchase of new infusion pumps. Staff are provided with all alerts from the Institute for Safe

Medication Practices. Clinical leaders and pharmacy partners work together to ensure the safest administration of high risk medications and ongoing audits of the Pac Med system.

### **Worklife/Workforce**

Education about safety is delivered to staff on a regular basis. We report safety occurrences, both actual and potential, quarterly at organization committees and unit specific committees so that opportunities for improvement can be addressed at all levels of responsibility. Safety is addressed in staff orientation materials, patient handbooks, performance reviews, newsletters and job descriptions/postings. Any purchase of equipment includes staff participation in reviewing the products available and choosing the best equipment for our patient population and work flow. Preventative maintenance is planned by the Director of Plant Operations and requisitions for any repairs can be tracked so that units are aware of the progress of any repairs.

### **Infection Control**

We participate in all provincially developed programs that track infection control issues. We adhere to all provincially developed guidelines and monitor infection rates throughout the organization. This information is shared on the hospital web site as well as at organization committees. We participate in a “Just Wash Your Hands” campaign and train all staff/volunteers in proper hand washing/hygiene. We participate in regular audits and provide outcome evidence to staff. Our processes for sterilization of equipment are examined and improved as required.

### **Risk Assessment**

All incidents related to falls are reported and reviewed quarterly with various committees across the organization. Improvement initiatives are submitted and reported quarterly to hospital committees and staff. All staff are in-serviced to recognize and respond to concerns around patient falls. The organization has partnered with organizations in the Hamilton Niagara Haldimand Brant Local Health Integration Network to introduce electronic capture of adverse events. Staff have been provided with an electronic teaching package and organization leaders are expected to ensure that their staff have participated in all educational opportunities. Posters for patients/families are available on all in-patient units and across the organization so that our partners in care will be aware of our commitment to patient safety and understand their role in preventing falls. NGH will continue to be an active participant with the LHIN in developing a LHIN-wide strategy to reduce the risk of falls in all sites and sectors.

## **ORGANIZATION AND FUNCTIONS OF TEAM**

The Patient Safety Team is a standing interdisciplinary group that coordinates the organization’s Patient Safety Plan through a systematic, coordinated, continuous approach. The inaugural meeting was January 30, 2008. The meeting commenced with completing a Patient Safety survey. The survey will be repeated in one year and will be utilized as a tool to measure the success and sensitivity to the promotion of a safety culture. Following this, the survey will be extended to the entire staff at Norfolk General Hospital. The Patient Safety Team meets quarterly and promotes, monitors and enhances patient safety. All Patient Safety reports will be brought to the committee for review and approval before posting for the general staff. The Patient Safety Team’s first mandate was to highlight awareness of their role. This was accomplished by hosting a

Patient Safety Logo contest and by the promotion of the Committee during Patient Safety Week. Each year the committee takes the opportunity to promote the committee and patient safety initiatives during Patient Safety Week. The team has developed safety indicators that are reported regularly to the team and posted for all staff.

Each member of the Patient Safety Team has a responsibility to be a Patient Safety Resource to his/her particular service as well as to the hospital as a whole.

A. The Patient Safety Team will be chaired by the Vice President of Patient Care.

- The team will receive ongoing education related to patient safety.
- Team membership includes services involved in providing patient care, i.e., Pharmacy, Laboratory, Surgical Services, Quality Management, Infection Control, Medical Imaging, Nursing, Occupational Health and Safety, Clinical Education, Respiratory Therapy, Rehabilitation

B. The scope of the Patient Safety Team includes review of statistics related to adverse events involving the patient population of all ages, visitors, and volunteers. Aggregate data will be used for review and analysis in the prioritization of improvement efforts, implementation of action steps and follow-up monitoring for effectiveness. The severity categories of adverse events are standardized across the LHIN and reflect the severity levels recommended by the World Health Organization and include:

- Near Miss: an event which did not reach the patient
- No Harm: an event which reached the patient but no discernible harm resulted. No follow up required
- Harmful Incident, mild harm: an event resulting in an outcome that is symptomatic, mild. May require non invasive intervention. Additional follow up may be required.
- Harmful Incident, moderate: an event resulting in an outcome that is symptomatic, requires intervention, additional monitoring, increased LOS and follow up
- Harmful Incident, serious (Critical Event): an event resulting in an outcome that is symptomatic requiring invasive intervention and or major surgery. Extensive follow up required. Reported to Senior Team, Quality Committee, and MAC
- Harmful Incident, death (Critical Event): extensive follow up and investigation required. Reported to Senior Team, Quality Committee and MAC

C. The mechanism to insure all components of the organization are integrated into the program is through a collaborative effort of multiple disciplines. This is accomplished by:

- Reporting of potential or actual occurrences through the Electronic Incident Reporting system by any employee.
- Communication between the Patient Safety Resources and the Patient Safety Team leader to assure a comprehensive knowledge of not only clinical, but also environmental factors involved in providing an overall safe environment.

- Reporting of patient safety and operational safety measurements/activity to Quality Assurance Committee.
  - All committee meetings will include "Safety" as a standing agenda item
  - Reporting of Critical Events to the Medical Advisory Committee
- D. The mechanism for identification and reporting a Sentinel Event/Adverse Events will be as indicated in organizational policies # I-a-9 (Sentinel Events for patients and visitors) and policy # II-b-2 (Incident Reporting) respectively. Any root cause analysis of hospital processes conducted for Critical or Sentinel Events will be submitted for review/recommendations to the Patient Safety Team, Quality Assurance Committee and Medical Advisory Committee.
- E. As this organization supports the concept that errors occur due to a breakdown in systems and processes, staff involved in an event with an adverse outcome will be supported by:
- A non-punitive approach and without fear of reprisal, as evidenced by the incident reporting policy. To undertake periodic evaluations of the extent to which such a culture has been achieved
  - Voluntary participation in the root cause analysis for educational purposes and prevention of further occurrences.
  - Resources such as Pastoral Care, Social Services, or EAP should the need exist to counsel the staff
- F. A proactive component of the program includes an annual selection of a potentially high risk or error prone process for concentrated activity, ongoing measurement and periodic analysis. The selected process and approach to be taken will be communicated to the Quality Assurance Committee.

The selection may be based on information published by Accreditation Canada, Sentinel Event Alerts, and/or other sources of information including risk management, performance improvement, quality assurance, infection control, research, patient/family suggestions/expectations or process outcomes.

- The process will be assessed to determine the steps where there is or may be undesirable variation (failure modes). Information from internal or external sources will be used to minimize risk to patients affected by the new or redesigned process.
  - For each failure mode, possible effects on patients, as well as the seriousness of the effect, will be identified.
  - The process will be redesigned to minimize the risk of failure modes.
  - The redesigned process will be tested and implemented.
  - Measures to determine effectiveness of the redesigned process will be identified and implemented. Strategies to maintain success over time will be identified.
- G. Solicitation of input and participation from patients and families in improving patient safety will be accomplished by:
- Conversations with patients and families during Nursing Director or Charge Nurse rounds

- Comments from Patient Satisfaction surveys
- H. Methods to assure ongoing in-services, education and training programs for maintenance and improvement of staff competence and support to an interdisciplinary approach to patient care is accomplished by:
- Providing information and reporting mechanisms to new staff in the orientation training
  - Providing ongoing education, including reporting mechanisms, through information presented in Skills Days and Patient Safety Week.
  - Evaluating staff knowledge levels and participation of patient safety principles in annual performance appraisals, audits and staff survey.
- I. Internal reporting – To provide a comprehensive view of both the clinical and operational safety activity of the organization:
- The minutes/reports of the Patient Safety Team, as well as Patient Safety Report and Patient Satisfaction report will be submitted through the Director of Quality to the Quality Assurance Committee.
  - These reports will include ongoing activities including data collection presented in statistical process control charts, analysis, actions taken and monitoring for the effectiveness of actions.
- J. The Patient Safety Team will submit a Report to the Norfolk General Hospital staff during patient safety week which includes:
- Definition of the scope of occurrences including sentinel events, near misses and adverse occurrences
  - Detail of activities that demonstrate the patient safety program has a proactive component by identifying the high-risk process selected
  - Results of the high-risk or error-prone processes selected for ongoing measurement and analysis.
  - A description of how the function of process design that incorporates patient safety has been carried out using specific examples of process design or redesign that include patient safety principles.
  - The results of how input is solicited and participation from patients and families in improving patient safety is obtained.
  - A description of the procedures used and examples of communication occurring with families about adverse events or unanticipated outcomes of care.
  - A description of the examples of ongoing in-service, and other education and training programs that are maintaining and improving staff competence and supporting an interdisciplinary approach to patient care.

EVALUATION/APPROVAL

The Patient Safety Plan will be evaluated at least every three years or as changes occur, and revised as necessary at the direction of the Patient Safety Team. Annual evaluation of the plan's effectiveness will be documented in the annual report.

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Bettyann DeRonde, Vice President Patient Care  
Norfolk General Hospital

Date Approved: \_\_\_\_\_

Revised: September 2011

## Patient Safety Plan Chart

Goal: To establish a formal safety program at Norfolk General Hospital				
Objectives:				
<ul style="list-style-type: none"> <li>▪ To fully implement patient safety strategies over a three year period</li> <li>▪ To educate all staff, healthcare partners, patients/families and volunteers about the patient safety initiatives which are part of the overall safety plan</li> <li>▪ To report indicators of safety to the Patient Safety Team</li> <li>▪ To evaluate the success of the safety strategies annually</li> </ul>				
Improvement Strategies				
<b>Action Step</b>	<b>Source</b>	<b>2008/09</b>	<b>2009/10</b>	<b>2011/12</b>
<i>Perspective: Culture</i>				
Adopt patient safety as a written strategic priority	Goals and Objectives	Completed	Updated	Updated
Educate all staff about the reporting of Adverse Events including appropriate follow up	Quality and Professional Practice	Completed	Electronic incident reporting system	Education for staff during orientation
Carry out one prospective analysis yearly (FMEA)	Management Forum	Completed	Rapid Response Team	Standardization of Crash Carts
Quarterly Reports disseminated across the organization	Quality and Professional Practice	Completed	Completed	Completed MAC included
Policy for Disclosure	Quality and Professional Practice	Completed	Completed	Completed
<i>Perspective: Communication</i>				
Organization awareness of safety initiatives	Patient Safety Team	Completed	Patient Safety Boards	Patient Safety Week
Review organization indicators to ensure that patient safety is appropriately addressed and reported	Quality and Professional Practice	Dashboard Indicators	Dashboard Indicators	Patient Safety Indicators
Patient safety assessment will be included in the admission and discharge process: falls, functional assessment, hand hygiene, etc.	Informatics	Completed	Completed	Updated
Implement verification of all high risk activities	Accreditation Canada	Completed	Policy Updated	Policy Updated
Include patient safety information in the Patient Handbook	Patient Care Portfolio	Completed	Updated	Updated
Update all dangerous abbreviations	ISMP	Completed	Completed	Updated
Patient Identification: use of two patient identifiers prior to any intervention	Accreditation Canada	Completed	Completed and updated to include other services	Updated to include admission assessment
Medication Reconciliation on all inpatient units (admission, transfer, discharge)	Accreditation Canada	Completed in two areas (ED	All units on admission and	Electronic documentation of medication

		and 3E)	discharge	reconciliation
Safe Surgical Checklist	Accreditation Canada		Policy developed and practice implemented	Staff trained to audit practice
<i>Perspective: Medication Use</i>				
Safe storage and dispensing of medications: removal of concentrated electrolytes from units. Standardize and limit drug concentrations Policy/procedure for Heparin and Narcotic safety	Accreditation Canada	Completed	Completed	Completed
Training on the use of Infusion pumps. All clinical staff trained on the use of infusion pumps annually	Accreditation Canada	Completed	Completed	Completed
<i>Perspective: Worklife/Workforce</i>				
Include patient safety in the performance review process, job interview process and all orientation programs for staff and volunteers	Human Resources	Completed	Completed	Completed
Roles and Responsibilities included in all employee handbooks, orientation, policy and performance review	Patient Care Portfolio	Completed	Completed	Completed
Safety Training for all staff. Yearly safety training will be formally introduced into our 'Skills Day'	Education and Occupational Health	Completed	Completed	Completed
Patient Safety Plan developed, approved and disseminated to all staff	Patient Safety Team	Completed	Completed	Revised
Preventative Maintenance: a formal process for preventative maintenance will be in place and information disseminated to the organization. This will be built electronically	Plant Operations	Completed	Completed	Completed
Education for staff related to workplace violence	Human Resources: Occupational Health			Policy: Violence, Harassment and Disruptive behaviour prevention III-C-25. Education for staff (orientation)
<i>Perspective: Infection Control</i>				
Include all required organizational practices related to patient safety in clinical practice and documentation.	Accreditation Canada	Completed	Completed	Completed – included in Patient Safety Team

Hand hygiene, MRSA/VRE/C Diff., Surgical Site infection, Ventilator assisted Pneumonia, Central Line infections and vaccine use				indicators
Sterilization of equipment. Review of present practice	Accreditation Canada	Completed	Completed	Updated service Completed
Infection rates posted and available both to the public, the organization and MOHLTC	MOHLTC	Completed	Completed	Completed
<i>Perspective: Risk Assessment</i>				
Review and update Falls Prevention Strategy to meet the required organizational practice	Accreditation Canada	Completed	Updated and staff educated	LHIN-wide participation in Falls Strategy
Pressure Ulcer Prevention	Accreditation Canada	Risk assessment on admission	Risk assessment on admission	Policy updated Education for staff related to wound management and risk assessment
Venous Thromboembolism prophylaxis	Accreditation Canada			Policy developed Assessment on admission
Suicide Prevention	Accreditation Canada			Form 1 policy updated to include risk assessment and appropriate placement