

Category: BOARD POLICY – ADMINISTRATIVE PARAMETERS	
Title: Commitment to a Culture of Patient Safety	Reference Number: AS 100
Approved by: PHSA Board of Directors	Last Approved: June 22, 2011 Last Reviewed: June 22, 2011

1. PURPOSE

To assist the Provincial Health Services Authority (“PHSA”) and its personnel in understanding organizational and individual responsibilities in optimizing the safety of patient care provided in PHSA agencies.

To promote and maintain a working environment in which all personnel associated with healthcare in the PHSA agencies are treated justly and are expected to report hazards, adverse events and near misses using the BC Patient Safety Learning System (“PSLS”), and to engage in patient safety initiatives that optimize patient care outcomes.

2. POLICY

The PHSA is committed to patient safety and to ensuring that all personnel understand their individual responsibility in this regard.

The PHSA is committed to ensuring that all personnel are aware of the expectation that patient safety issues, such as hazard, adverse event and near miss reports, will be addressed within a non-punitive system.

Individuals are not held accountable for system flaws over which they had no control.

3. SCOPE

The standards of behavior set forth in the policy are intended to apply to all PHSA employees, contractors, medical staff, and students within all PHSA agencies/programmes, as well as employees of academic institutions with whom the PHSA is partnered.

4. ACCOUNTABILITY

The PHSA will demonstrate its commitment to a fair and just culture and will support every individual to deliver the safest possible patient care by:

- Establishing this Policy defining culture of safety, differentiating between system and individual accountability, and describing related processes.
- Informing all persons about a culture of safety and how it is promoted within the PHSA and its Agencies.

- Establishing the context in which errors and misunderstandings are addressed. All personnel associated with healthcare in the PHSA agencies are accountable for their own performance as established by job performance requirements and, if applicable, professional practice standards. Individuals are expected to contribute to patient safety improvements by reporting hazards, adverse events and near misses, and participating in review, follow-up and planning initiatives. Individuals are not held accountable for system flaws over which they had no control. Refer to Appendix A.
- Promoting open reporting of adverse events and potential harm, providing clear information regarding the reporting process, and protecting individuals who report events.
- Promoting open, interdisciplinary discussion of events, and unbiased analysis of these events to determine the relative contributions of system and individual factors.
- Implementing changes based on event analysis.
- Informing patients and families, personnel, organizational leaders, our partners, and the Board about the implemented changes.
- Assessing success in fostering a fair and just culture by evaluating the openness of our communication, and by the achieved improvements in patient safety.

Employees, Contractors, Medical Staff, Students, Employees of Academic Institutions in Partnership with the PHSA

Employees, Contractors, Medical Staff, Students, Employees of Academic Institutions in Partnership with the PHSA are accountable to provide the safest possible care by:

- Conducting themselves within the spirit of this Policy and for contributing towards enhanced patient safety and a culture of safety in the workplace.
- Being aware of performance expectations of their specific roles.
- Adhering to professional practice standards, as applicable.
- Accepting an ethical commitment to patient care.
- Understanding that individual responsibility may be assessed by the manager/Department Head during the initial review, and that investigation through separate professional performance review/discipline mechanisms is required if individual responsibility is determined. Refer to Appendix B.
- Adhering to PHSA policies governing workplace dignity and respect.
- Adhering to PHSA policies governing workplace dignity and human rights.

5. REFERENCES

- Respectful Workplace Policy #HR.004
- Human Rights Policy #HR .002
- Whistleblower Policy #AB620
- Code of Ethics Policy #AB600
- Standards of Business Conduct Policy #AB610

Appendix A: Individual Responsibility and Accountability

All exploratory interviews will be conducted in a respectful fashion reflecting the PHSA's commitment to a fair and just culture, and should include opportunities for the interviewee to provide insights and suggestions for system improvement.

Although all factors associated with an adverse event must be explored within a systems context, individual responsibility may be assessed by the manager/Department Head during the initial review.

Investigation through separate professional performance review/discipline mechanisms is required when an individual has acted:

- a) with intent to harm,
- b) recklessly, without regard for patient's welfare,
- c) impaired under the influence of drugs or alcohol, and
- d) with willful deviation from established policies, procedures, standards or guidelines.

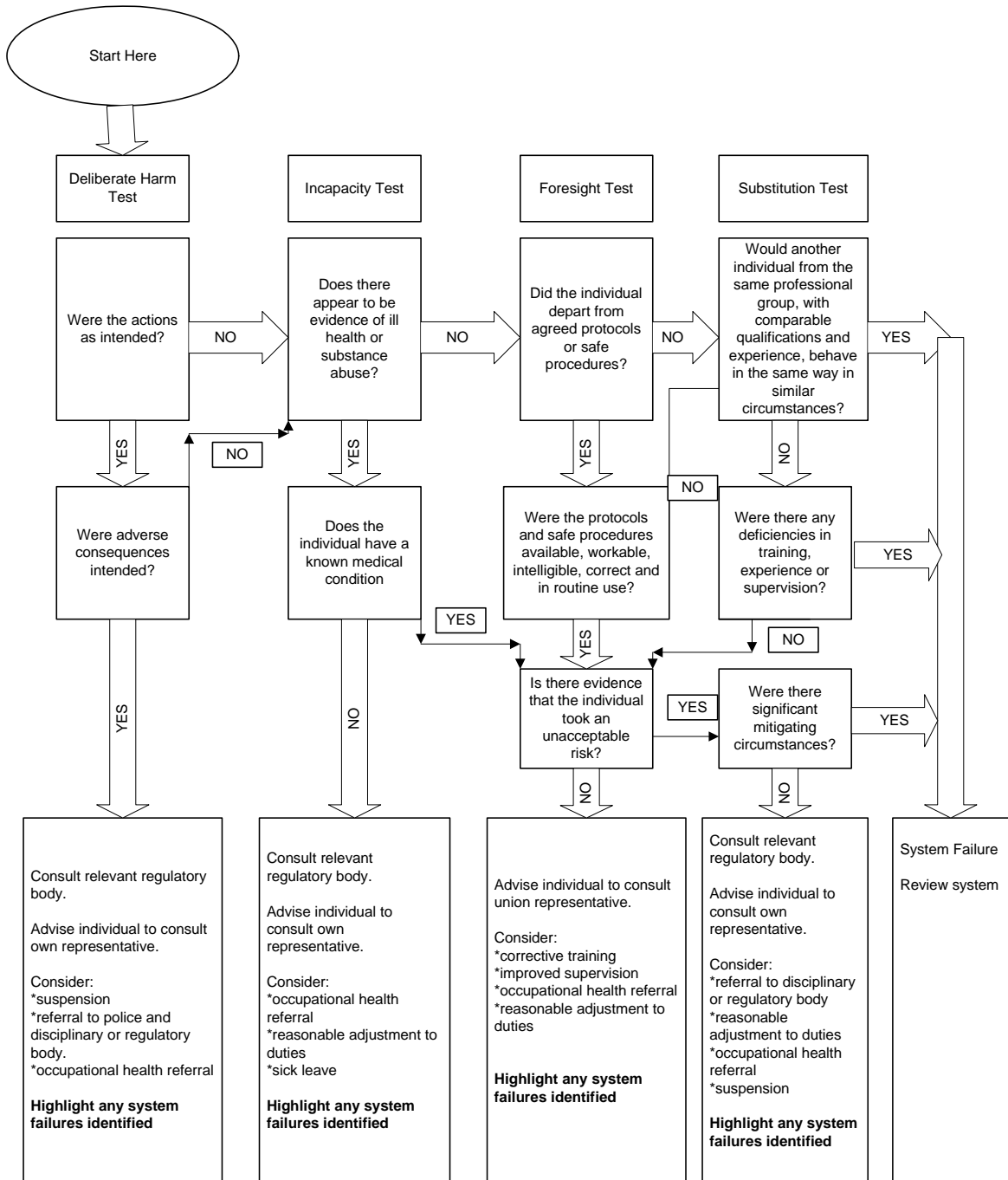
In addition to internal investigation of an event, the PHSA is obligated to report the event to the involved individual's regulatory organization when individual culpability is determined to be a factor.

A systematic, unbiased assessment will be completed to determine the presence and extent of individual performance issues contributing to an event. This is done during the initial event review. Refer to the PHSA policy entitled "Hazards, Adverse Events, and Near Misses: Non-punitive Reporting".

The following framework, developed by the National Patient Safety Agency, is helpful in determining if an event is appropriate for system analysis.

Appendix B: Incident Decision Tree

Incident Decision Tree
Work through the tree separately for each individual involved



Based on original framework developed by the National Patient Safety Agency

Appendix C: Definitions¹

Adverse Event: A bad outcome of care. An injury that was caused by health care management rather than the patient's underlying disease, also called harm, injury, or complication. Bad outcomes of care include disability, death, prolonged hospital stay. Health care management refers to all aspects of the health care system, not just the actions or decisions of physicians or nurses.

Unpreventable adverse event: An injury (or complication) that was not due to an error or systems failure and is not always preventable at the current state of scientific knowledge. There are two major categories:

Type 1: Common, well-known hazards of high risk therapy. Patients understand the risks and accept them in order to receive the benefit of the treatment.

Example: complications of chemotherapy

Type 2: Rare but known risks of ordinary treatments. The patient may or may not have been informed of the risk in advance.

Example: side-effects of medications; certain wound infections

Preventable adverse event: An injury (or complication) that results from an error or systems failure. It is useful to distinguish three categories:

Type 1: Error by the attending physician.

Example: technical error during performance of a procedure.

Type 2: Error by anyone else in the healthcare team

Examples: a nurse gives wrong medication to patient; a resident makes a technical or decision error; a radiologist misses a lesion.

Type 3: Systems failure with no individual error.

Examples: IV pump failure that causes drug overdose; Failure of system to communicate abnormal lab results to ordering physician.

Error: The failure of a planned action to be completed as intended or the use of a wrong plan to achieve an aim. A medical error that causes harm results in an adverse event. Errors are classified as follows:

Serious Error: An error that has the potential to cause permanent injury or transient but potentially life threatening harm.

Minor Error: An error that does not cause harm or have the potential to do so.

Near Miss: An event or error that could have caused harm but did not reach the patient because it was intercepted.

Incident: Any unexpected or undesirable event that causes harm, places a patient, visitor or staff member at risk or harm, or results in loss, damage, or theft.

Critical Patient Safety Event (CPSE) : An unexpected occurrence, either immediate or latent, involving death or serious or permanent physical or psychological injury. CPSE affecting patients are by definition adverse events and may be caused by error. CPSE also include product defects

¹ Harvard Hospitals. (2006). When things go wrong: Responding to adverse events. Massachusetts. Author.

and protocol and process failures that potentially or actually result in an adverse outcome to patients, clients or the healthcare system. Within PHSA all CPSEER are formally reviewed.

Near miss: An event or error that could have caused harm but did not reach the patient because it was intercepted

Hazard: A set of circumstances of a situation that could harm a person's interests, such as their health or welfare.

Culture of Safety: An underlying philosophy of the workplace in which a shared and constant commitment to safety permeates the entire organization and is characterized by:

1. An acknowledgement of the high risk, error prone nature of PHSA's health care activities;
2. A non-punitive environment where individuals are able to report incidents or near misses in order to optimize patient care outcomes;
3. The expectation of collaboration across disciplines and sectors to seek solutions to vulnerabilities; and
4. Organizational willingness to direct resources to address safety concerns.

Appendix D: Professional Regulatory Bodies

Below is a non-inclusive list of professional regulatory bodies with a mandate to protect the public interest:

College of Physicians and Surgeons of British Columbia

<https://www.cpsbc.ca/cps>

College of Registered Nurses of British Columbia

<http://www.crnbc.ca/>

College of Pharmacists of British Columbia

<http://www.bcpharmacists.org/>

College of Midwives of British Columbia

<http://www.cmbc.bc.ca/>

College of Physical Therapists of British Columbia

<http://www.cptbc.org/>

College of Occupational Therapists of British Columbia

<http://www.cotbc.org/>

Board of Registration for Social Workers in British Columbia

<http://www.brsw.bc.ca/>

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