Practice Improvement Record Example

Practice Monitoring | Safety Project

1. What Self-Selected Activity did you do and why?

In your response include at a minimum: (a) name of activity, (b) description of activity, (c) date(s) of activity, (d) reason for choosing the activity (e) how the activity fits with your practice (current or future). Mandatory.

November to August

As a Unit Manager I was tasked to complete a Patient Safety Culture Survey action plan for our rehabilitation department. Our patient population includes adults and seniors in acute care.

The goal of this project was to select actionable item(s) that would strengthen our departments patient safety culture. This is turn will improve our patient outcomes and patient experience while in hospital.

This project took place over nine months and involved:

- *Bringing team members together to review site survey results.*
- *Identifying item(s) that need improvement*
- *Agreeing on at least one item where we could make an actionable improvement (SMART goal)*
- *Develop a plan and timeline*
- *Report back to the team*

2. What did you learn and how did you grow professionally?

In your response include, at a minimum, specific examples of: (a) what you learned, (b) how your personal competence improved, (c) how what you learned benefited patients or the physiotherapy/health care system, (d) include resources to show current information was used to improve your practice (name, source, topic). In drafting your response, consider the **guiding questions**.

Reviewing the site survey, I was surprised on the percentage of staff who feel that they will be judged and that there will be job repercussions as a result of a patient incident. It made me reflect that I need to always be mindful to create a safe, positive environment when I am meeting with team members to get more information on an incident. That I need to place the focus on learning from the incident versus the formal term of investigation.

I also felt that we could do a better job in recognizing team members who are doing an excellent job of role modelling patient safety standards. Although we did not set a specific department action item, I did meet with all of the Team Leads and tasked them to work with their individual teams to develop a way to enhance this culture. Some decided to do a monthly staff recognition; others made more of an effort to give that feedback in the 1:1 meetings with team members.

The biggest learning for me is that I do a good job at gathering more information from team members after an incident and collaboratively coming up with lessons learned and actions so that a similar incident does not happen again, but I was never reporting those lessons learned beyond the team member involved in the incident and the team lead. At our department monthly meetings I have a standing agenda item under OH&S to report on staff workplace incidents, but I did not have a standing agenda item to report on lessons learned from patient incidents. Going through this process taught me to think broader when reviewing patient incidents, and how the learnings could be applied to multiple areas in our

department. It also taught me that the department needs to hear that action is being taken when I receive a Reporting and Learning System (RLS) report.

Once we identified the survey item we could improve upon the following actions were taken:

- *Review of site survey results and action plan at monthly department meeting.*
- *Adding review of RLS reports (avoiding staff or patient identifiers) to department meeting agenda; allowing time for discussion and questions.*
- *Based on focus group results:*
- *Team members appreciated learning from department patient safety incidents. Examples included: not rushing, taking more time to explain the treatment plan to patients before proceeding, and ensuring all appropriate health care providers are informed after incident.*
- *Team members appreciated the opportunity to provide suggestions for improvement – either specifically related to the incident, or applying the lessons learned to other areas for improvement. For example, re-organizing/de-cluttering treatments spaces to allow for safer movement for patients in the treatment space.*
- *Team members appreciated hearing that action was taken when RLS reports were submitted.*

Completing a focus group six months after implementation with the initial working group team members to determine if there has been a positive impact to their practice by having an increased awareness of patient safety incidents and actions taken/recommendations

We did not have the opportunity to collect patient feedback, but I will provide feedback to the organization that it would be great to combine the next Patient Safety Culture Survey with a site wide patient safety hospital experience survey.

Campione, J., and Famolaro, T. Promising Practices for Improving Hospital Patient Safety Culture. The Joint Commission Journal on Quality and Patient Safety. 2018; 44: 23–32.

http://www.patientsafetyinstitute.ca/en/toolsResources/PatientSafetyIncidentManagementToolkit/PatientSafetyManagement/pages/patient-safety-culture.aspx

3. Looking back, which Standard of Practice or Ethical Conduct Responsibility was addressed by participating in this activity.

Quality Improvement
Risk Management
Safety

4. Your evidence of participation.