Client Safety Committee

Annual Report

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Submitted by:

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History, Mandate and Responsibilities

The Client Safety committee (previously known as the Patient Safety committee) was struck in November 2008. The committee's mandate is to review issues related to medication errors, client incidents and accidents, client falls, Pro Re Nata (PRN) medications, adverse events, quality improvement, organizational culture, root cause analysis, ensure compliance with the standards and required organizational practices (ROP's) identified by Accreditation Canada, and, generally, advise the Chief Executive Officer (CEO) on matters related to patient safety within the agency. The committee meets, at a minimum, quarterly to discuss and review all issues related to patient safety and make recommendations, where appropriate, to the CEO for remedial action.

Committee Composition

The committee is comprised of:

Permanent members:

Chair – Director behavioural residential services
Chief Executive Officer or designate
Director, rehabilitative services
One Safe Management advanced instructor
One behavioural therapist
One medication coordinator

Members with a two year terms and the option of extending for two years:

A minimum of one direct care staff from each residential service
A minimum of one direct care staff from group/outreach services

Committee Activities and Goals

During the past year the committee was involved in a number of activities to enhance and improve patient safety within the agency.

Culture

Committee members continue to focus on enhancing the culture of client safety in the organization. Root cause analysis (RCA) was introduced for any fall resulting in injury and for any medication administration error that resulted in increased client monitoring. RCAs have provided an important tool to assist in identifying areas for change to reduce errors from occurring in the future.

Due to the added value and success of the RCA process it was determined that RCAs would also be conducted for any fall exceeding an identified “threshold” for the client with or without injury, and for PRN administration which exceeded the client’s personal “threshold”.

The committee also added information about RCAs to the client safety orientation and training package. On hire new staff are informed of the RCA process and the benefit to the client and staff.

During National Patient Safety Week, October 24 - October 31, 2015, the client safety committee scheduled activities to raise awareness and knowledge of client safety. Client safety word searches and games were distributed daily to services. Services submitted their answers to the games and were awarded prizes during the December joint staff meeting as a wrap up to client safety week.

Good Catch Identification

Over the course of the year awards were presented to the staff that identified near misses and hazards within the agency that had the potential to cause harm. There were a total of 73 good catches identified by staff with the annual target being 75.

Good Catch of the Year

Annually a good catch of the year award and plaque is presented to the good catch which was determined to have the most impact.

Kathryn Price, Elmhurst Place, was awarded the Good Catch of the Year. Kathryn, while doing room checks, found that a client while using his headphone had managed to wrap the cord around his neck. It appeared that the cord could have easily tightened if the client had fallen asleep and slumped down on the pillow. Measures were enacted to ensure safe use of headphones and any other “corded” devise.

Client No Harm Incident /Harmful Incident (Formerly Incident/Accident)

In 2015 a change was made in the language used to classify incidents and accidents. This change was made to align with Accreditation Canada’s language. What was previously an incident is now referred to as a ‘No Harm incident” and what was an

accident is a “Harmful Incident” During the 2015-16 fiscal, the data collected on client no harm incidents and harmful accidents indicated that the majority of accidents were due to client physical aggression and environmental aggression. The majority of incidents or near misses were related to client verbal aggression and environmental aggression. This was consistent with the findings from previous years.

Client Safety Incident Event – (formerly Adverse Events)

The same change in language related to client safety incidents resulted in the discontinuation of the term “Adverse Event” replacing it with client safety incident event. This required a change to the client safety incident event levels to better align with best practices in client safety event identification. Managers continued to identify client safety incident events and evaluate the incident to determine and recommend remedial action. The information was then analyzed regularly by the client safety committee and brought to the management team for action where necessary. There was a decrease in adverse events in comparison from 2014-15 to 2015 – 2016.

Medication Management

Over the course of the year the committee tracked and reviewed medication errors and the reasons for errors by both clients and staff. The most prevalent client errors were refusals, while the majority of staff errors were documentation errors. Education with respect to medication administration occurred throughout the year. With these efforts there has been a decrease in documentation errors. The committee also committed to identifying the reason for missed doses as the most prevalent staff error. The investigation is ongoing and will be reported on at a later date.

This finding is consistent with the findings from previous years.

Prospective Risk Analysis – (PRA)

In the month of September client safety committee members and the chair of the committee attended individual service meeting and presented the prospective risk analysis to the service teams. The risk analysis is completed jointly by the joint occupational health and safety committee and the client safety committee. This year’s analysis concentrated on risk related to a one to one community outing at a park festival with a wheelchair bound client.

The prospective analysis involved:

- Conducting a thorough task analysis of the activity
- Evaluating the risk of each step in the task analysis based on the frequency with which an error could occur and the severity of the error
- Developing plans to deal with the risk

Several policies, procedures and training were in place to address the above; however, after completing this process the committee identified actions to be completed. They included:

- Development of a pre outing checklist
- OT/PT assessment of equipment used on varying terrain,
- Review of the client handling training to include more varied scenarios.

Client Safety Committee Goals

The following provides a summary of the committee's goals and performance for 2015-16 as well as the goals and indicators for the 2016-17 fiscal.

Client Safety Committee Goals for 2014-2015

Goal	Indicator	Result
Create a culture of client safety in the organization	90% score on the Accreditation Canada Client Safety Culture Tool	92%
	Implement Root Cause Analysis process for medication administration errors that result in a level 2 adverse event June 2015	Complete
	Implement Root Cause Analysis process for falls resulting in medical treatment where staff are involved. June 2015	Complete
	Add Root Cause Analysis training into O&T at Medication training session – Nov 2015	Complete
	Promote Prospective Risk Analysis within the agency and at services – Sept 2015	Complete

Client Safety Committee Goals for 2016-2017

Goal	Indicator
Create a culture of client safety in the organization	90% score on the agency Client Safety Culture Survey – Feb 2017
	Threshold developed for frequent users of Emergency Departments – October 2016
	90% of Clients will participate in H&S bedroom checks by March 2017
	90% of residential clients have 30 min of physical activity on their daily activity schedule – March 2017
	Clients will submit 30 client good catch forms annually

Other goals related to patient safety are articulated in the organization's Quality Improvement Plan.