OBJECTIVES

- To promote the use of the Patient Safety Learning Summary (PSLS) process as a means to share lessons learned from system reviews completed to improve patient safety.

- To outline the steps to initiate, develop, and distribute a PSLS.

APPLICABILITY

Compliance with this document is required by all Alberta Health Services employees, members of the medical and midwifery staffs, students, volunteers, and other persons acting on behalf of Alberta Health Services (including contracted service providers as necessary).

ELEMENTS

1. Purpose of a PSLS

   1.1 A PSLS allows clinical leaders and/or accountable leaders within AHS to share lessons learned from analysis of clinical adverse events (CAEs) and effective ways to manage these risks and prevent future patient harm.

   1.2 A PSLS may be shared with:

      a) AHS health care providers who may benefit from lessons learned; and

      b) patients affected by a CAE. When shared as part of the follow-up disclosure meeting, a PSLS provides a summary of facts and results of
the review. It is not intended to replace open discussion between a patient and health care provider(s) about the events leading to harm. Refer to AHS Disclosure of Harm Procedure.

2. Initiation of a PSLS

2.1 Upon completion of a patient safety-related review or initiative, the Patient Safety representative, in consultation with the clinical leader and/or accountable leader, may initiate the creation of a PSLS outlining lessons to be learned from any of the following types of reviews:

a) Quality Assurance Review (QAR);

b) Patient Safety Review (PSR);

c) quality improvement initiative; and/or

d) Patient Safety initiative.

2.2 A PSLS is appropriate to develop when:

a) the review identified system issues and recommendations; and/or

b) lessons learned apply to a broad patient population.

3. Development of Content for a PSLS

3.1 Using the approved PSLS template, the Patient Safety representative shall develop the PSLS in collaboration with a member of the applicable review team.

3.2 The information contained within the PSLS shall:

a) be limited to the agreed upon facts about the scenario, identified hazards, and lessons learned;

b) be written with language supporting just culture;

c) not include individually identifying information to protect the privacy of patients and the health care providers involved, in accordance with the Health Information Act (Alberta);

d) for Quality Assurance Reviews:

(i) a draft PSLS should be developed concurrently with the corresponding QAR summary and presented to the Quality Assurance Committee for review; and

(ii) the PSLS is not considered final or ready for distribution until the Provincial Patient Safety team has reviewed and approved it.
e) for PSR and Quality Improvement/Patient Safety initiatives:

(i) a draft PLS should be developed and reviewed by the appropriate accountable leader; and

(ii) the PLS is not considered final or ready for distribution until reviewed and approved by the provincial Patient Safety team.

f) The provincial Patient Safety representative shall seek answers for the following when developing the PLS:

(i) Is there any current litigation underway?

(ii) Are there any concerns for future litigation?

(iii) Did any of the staff/medical staff involved in the review express any concerns for the process or the fact that some of the key learnings might be shared?

(iv) Are there plans to share the PLS with the patient?

(v) Are there anticipated concerns when shared with the patient?

(vi) Is this a high profile case, or is there potential for media exposure?

(vii) Are there other review or investigation processes underway or planned (e.g., patient concerns, fatality inquiry)?

(viii) Does the PLS speak to changing known professional practice guidelines?

g) Once the draft version of the PLS is reviewed by the appropriate committee or accountable leader, the corresponding review summary document (including answers questions above) shall be emailed to provincial Patient Safety team at Quality.Assurance@ahs.ca.

h) The provincial Patient Safety team shall review the document to ensure the content is appropriate for sharing.

(i) The provincial Patient Safety team may consult with Health Law for review of the content of the PLS based on the answers to the questions above.

4. Final Review of PLS

4.1 An appropriate accountable leader approves the draft PLS prior to final review by the Provincial Patient Safety team.
a) The Provincial Patient Safety representative shall review and provide suggestions to ensure the PSLS meets Health Law and organizational requirements for sharing the PSLS.

b) The final draft version of the PSLS shall be forwarded to the Provincial Patient Safety team for final review.

c) The final version of the PSLS does not require Quality Assurance Committee approval.

4.2 Once the PSLS has been reviewed and updated, the provincial Patient Safety representative shall upload the final version of the PSLS to the recommendation tracker.

5. Distribution of a PSLS

5.1 The final version of a PSLS shall be provided to the accountable leader, for approval and distribution to the:

a) patient affected by the CAE or safety concern;

b) health care providers affected by the CAE or safety concern;

c) program site or affected patient care area or setting; and

d) local program areas where doing so would directly support a patient safety learning or initiative applicable to the area including discussions at team meetings.

5.2 The provincial Patient Safety team shall develop a monthly listing report of recent PSLS that met Health Law and organizational requirements. The report shall be distributed provincially to Zone and program quality and patient safety leaders for further sharing with:

a) Quality Assurance Committees;

b) Quality Councils;

c) Practice Councils;

d) Managers/leaders/educators; and

e) Strategic Clinical Networks.

5.3 A PSLS cannot be shared with stakeholders external to AHS.

a) Exception: A PSLS may be shared with patients affected by a CAE (refer to Section 1.2 b) above).
6. Retaining

6.1 The provincial Patient Safety team shall retain the PSLS as per the AHS Records Retention Schedule.

DEFINITIONS

Accountable leader means the individual who has ultimate accountability to ensure the consideration and completion of the listed steps in the management of the Alberta Health Services Patient Safety Learning Summary Procedure. Responsibility for some or all of the components of management may be delegated to the appropriate level responsible administrative leader, but the accountability remains at the senior level.

Clinical adverse event (CAE) means an event that reasonably could or does result in an unintended injury or complications arising from health care management, with outcomes that may range from (but are not limited to) death or disability to dissatisfaction with health care management, or require a change in patient care.

Disclosure means the formal process involving an open discussion between a patient and staff of Alberta Health Services about the events leading to a serious clinical adverse event, hazard or harm.

Fatality inquiry means an inquiry held before a judge at the Provincial Court that determines the deceased’s identity and the date, time, place and circumstances of their death.

Health care provider means any person who provides goods or services to a patient, inclusive of health care professionals, staff, students, volunteers and other persons acting on behalf of or in conjunction with Alberta Health Services.

Just culture means an environment where everyone feels safe, encouraged, and enabled to discuss quality and safety issues, where reporting and learning are key elements.

Patient means all persons, inclusive of residents and clients, who receive or have requested health care or services from Alberta Health Services and its health care providers. Patient also means, where applicable:

a) a co-decision-maker with the person; or
b) an alternate decision-maker on behalf of the person

Patient Safety Learning Summary (PSLS) means the standard document and collaborative process to ensure that patients, families and health care providers can see the linkage between reporting, managing and analyzing clinical adverse events and other types of initiatives, culminating in the sharing of transparent, respectful, and non-identifying recommendations for improvement and organizational learning.

Patient Safety representative means the staff employed to promote quality patient care and patient safety at a site, program, business area, zone or provincial level.
Patient Safety Review (PSR) means a system analysis to identify opportunities for system improvements. Where the facts are sufficient to understand what happened there is no need to establish review protection as per section 9 of the Alberta Evidence Act.

Quality Assurance Review (QAR) means a quality assurance activity conducted under the terms of section 9 of the Alberta Evidence Act.

Quality improvement initiative means a systematic approach to making changes that leads to better patient outcomes, stronger systems performance, and enhanced professional development. It is supported by the ongoing cooperation between health care professionals, patients, researchers, planners, and educators.

Recommendation tracker means the database that serves as an organizational memory of the assessment, review, and outcome of healthcare system investigations resulting from clinical adverse events, close calls, and hazards.

REFERENCES

- Alberta Health Services Governance Documents:
  - Disclosure of Harm Procedure (#PS-95-01)
  - Immediate and Ongoing Management of Clinical Adverse Events Procedure (#PS-95-02)
  - Non-Identifying Health Information Privacy Standard (#IPO-2013-0004)
  - Patient Safety Alerts, Safer Practice Notices, and Patient Safety Memos Procedure (#PS-95-05)
  - Recognizing, Responding To, and Learning From Clinical Adverse Events, Close Calls, and Hazards Policy (#PS-95)
  - Records Retention Schedule (#1133-01)
  - Reporting of Clinical Adverse Events, Close Calls, and Hazards Procedure (#PS-95-04)

- Non-Alberta Health Services Documents:
  - Alberta Evidence Act
  - Health Information Act (Alberta)