Patient Safety Alerts & Safer Practice Notices

Frequently Asked Questions (FAQ)

Identification Phase

Staff, medical staff or leaders who become aware of a patient safety hazard that should be shared to minimize further harm shall contact their site, program or zone Patient Safety/Quality Improvement Staff. They in turn will contact the stewards of the process, the Provincial Patient Safety Department

What is a Patient Safety Alert (PSA)

This notification is used when the patient safety hazard requires an alert, specific action to mitigate the hazard and an evaluation to determine if the action was completed.

What is a Safer Practice Notice (SPN)

This notification is used when the patient safety hazard requires reminders of safer and improved patient care practices.

Intake and evidence gathering phase

1) Patient Safety/Quality Improvement Staff shall assist the requestor to complete a *PSA or SPN Intake Request* using the suggested template (see Appendix A).

2) Patient Safety/Quality Improvement Staff shall review reporting and learning system (RLS) for patient safety to determine the frequency of voluntary reports submitted for similar adverse events and close calls. They will also complete a search of the Recommendation Tracker Database, the Global Patient Safety Alerts website, the Patient Concerns FACT Database and ISMP website.

3) Patient Safety/Quality Improvement Staff shall consult with the following departments to determine if other incidents or issues exist that were not reported in RLS, and to determine if related equipment or medication advisories or notifications are underway or planned:

- Pharmacy Services
- Contracting, Procurement & Supply Management (CPSM)
- Workplace Health and Safety (WHS)
- Patient Concerns
- Health Professions Strategy & Practice (HPSP)

4) The Requestor will find an executive sponsor to agree to approve the preliminary content and distribute the SPN

Content development phase (see Appendix B for Content Creation Tips)

1) Patient Safety/Quality Improvement Staff will use a consultative process to develop the *Patient Safety Alert* or *Safer Practice Notice* and include, as appropriate:

- Health Professions Strategy & Practice (HPSP);
- Contracting, Procurement & Supply Management (CPSM);
- Pharmacy Services;
- Clinical Educators;
- Human Factors Department
- Other subject matter expert(s) like Facilities Maintenance and Engineering, Clinical Policy, and Strategic Clinical Networks

2) The Provincial Patient Department Staff will access the locked templates and insert the draft content developed.

3) The Provincial Patient Department Staff will make any necessary edits and create a final draft for approval.

Approval Phase

1) Content approval of a PSA or SPN shall be required of the executive sponsor responsible for the operational area(s) involved (or delegate).

2) Final approval of a PSA or SPN shall be required of the Vice-President Quality & Chief Medical Officer (or delegate)

Distribution Phase

1) A provincial or Zone distribution list shall be developed in consultation with identified stakeholders and Patient Safety/Quality Improvement Staff during development of the PSA or SPN.

2) The SPN shall be disseminated via email from the sponsoring senior leader's office to the identified appropriate/impacted areas through the Zone leadership. Once a Safer Practice Notice is received by email, the recipients shall review and further disseminate it within their areas of responsibility, as appropriate.

3) The PSA shall be disseminated via email from the sponsoring senior leader's office to the identified appropriate/impacted areas through the Zone leadership. Once a Patient Safety Alert is received by email, the recipients shall review and further disseminate it as a high priority item within their areas of responsibility, as appropriate. They should also be prepared to participate in the follow-up survey process.

Posting Phase

1) The Provincial Patient Safety Department shall ensure the *Patient Safety Alert* or *Safer Practice Notice* is available on the Insite Patient Safety Department web page under “Our Teams/Patient Safety/Patient Safety Alerts/Safer Practice Notices”.

2) The Provincial Patient Safety Department shall ensure the *Patient Safety Alerts* or *Safer Practice Notices* are available on the Alberta Health Services external (public) website under “Information for Health Professionals/Our Teams/Departments/Patient Safety”.

3) The Provincial Patient Safety Department may share relevant *PSA or SPN* content with reciprocal, external patient safety partners, such as Institute for Safe Medication Practices Canada (ISMP), Global Patient Safety Alerts, Health Canada, etc.

Follow-up Phase

1) All *Patient Safety Alerts* require designated individuals to provide feedback to the Provincial Patient Safety Department via a specified response mechanism (Appendix H *Safety Alert Feedback Process*). Reports shall be summarized and distributed to Zone leadership by the Patient Safety Department.

2) The Provincial Patient Safety Department will monitor RLS for minimum of six (6) months or, if a recurrence is reported, until a period of three (3) months has passed with no new reports.

3) Applicable Zone leadership shall be notified if any new reporting and learning system reports are identified, with the expectation that they follow up to ensure the *Patient Safety Alert* was circulated, reviewed and acted upon.

Review Cycle

1. All *PSA or SPN* must be current and require review at least once every three (3) years.

2. The Provincial Patient Safety Department will chair a quarterly PSA/SPN Review Committee. Each PSA and SPN will be presented to the Review Committee for examination of the event that lead to the PSA/SPN as well as actions recommended as a result of that event. Following a standardized approach, various data sources will be considered as well as current practice within AHS, to determine next steps for each PSA/SPN

3. Based upon the consensus of the group, a recommendation will be made to either re-issue the updated PSA/SPN or consider the PSA/SPN resolved:

4. Those PSA/SPN where the hazard still exists, but the mitigating strategies require revision shall be labelled “updated”.

5. Any PSA/SPN deemed no longer applicable shall be labelled “resolved”. Resolved means that the equipment is no longer in use across AHS, the identified hazard no longer exists, or has been translated into new policies and procedures.

6. An email will be sent to the identified Executive Sponsor for their review and decision to support or challenge the outcome of the Review Committee deliberations. Depending upon the decision from the Executive Sponsor, the process to re-issue or resolve the PSA or SPN will be initiated.

Appendix A -Patient Safety Alert -Safer Practice Notice Intake Request

Date:

Name and Title of Requestor:

Patient Safety Representative completing Request:

Requested Template:

☐ **Safety Alert** –specific actions are required by identified individuals or departments within designated timelines

- Feedback to Patient Safety required on completion of actions taken

☐ **Safer Practice Notice-** issue has broad scope, actions are recommended

- Feedback to Patient Safety is not required

Reason for Safety Alert (SA) or Safer Practice Notice (SPN):

Issue:

RLS Search Results:

Actions taken thus far to mitigate harm:

Proposed Actions to mitigate future harm:

Scope of Distribution:

Name of Sponsor agreeing to distribute:

Estimated Date of Distribution:

SAC Score from Hazard Assessment (see page 2)

References:

Hazard Assessment

Step 1: Determine probable severity level if hazard did or were to reach a patient

Step 2: Determine likelihood of occurrence

Step 3: Determine SAC score from matrix below and take action

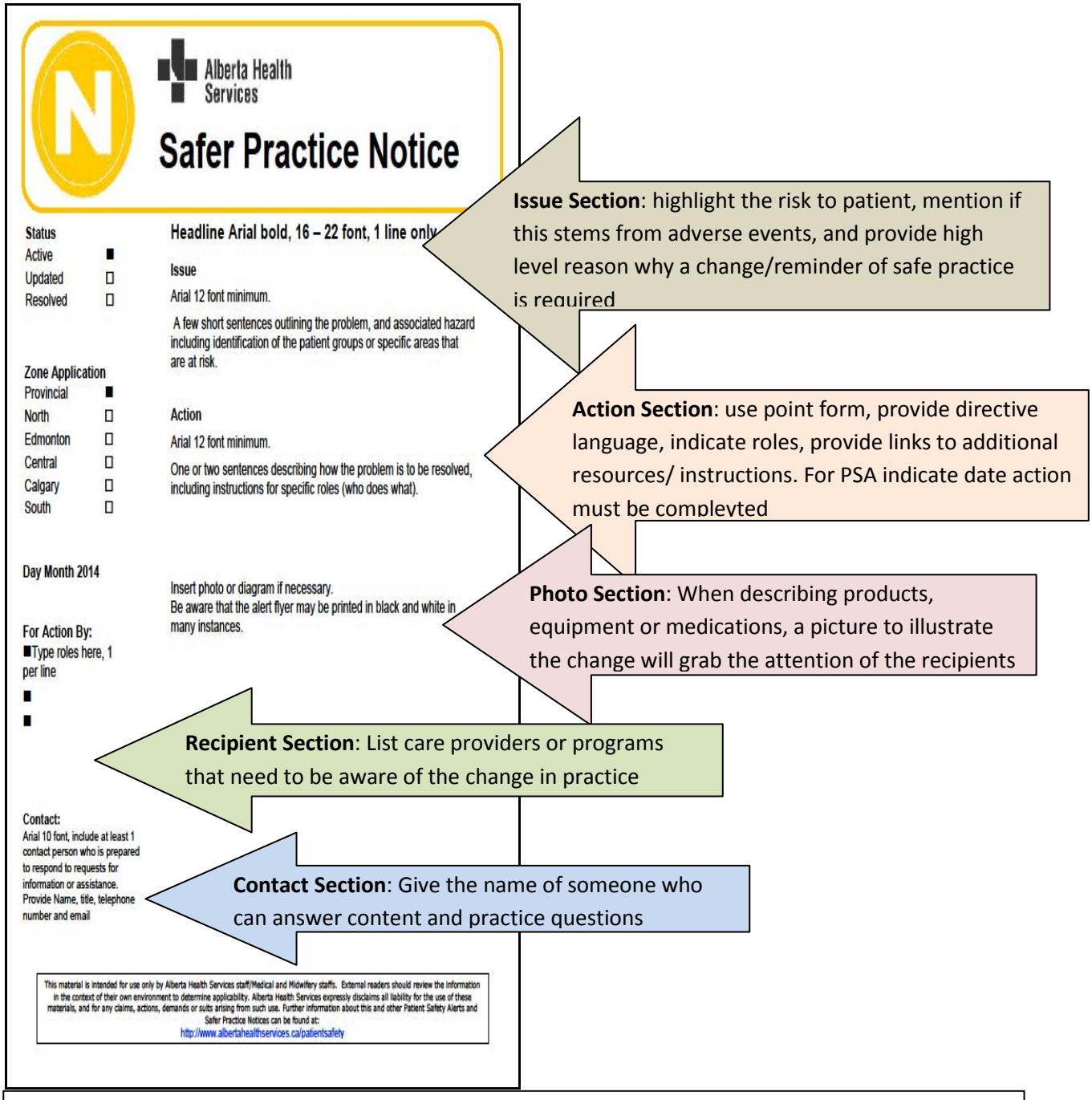
		SEVERITY			
		Severe Harm or Death	Moderate Harm	Minimal Harm	No apparent Harm or Close Call
LIKELIHOOD	Frequent	3	3	2	1
	Occasional	3	2	1	1
	Uncommon	3	2	1	1
	Remote	3	2	1	1

SEVERITY	DEFINITION
Death	An event or circumstance causing death in which the most likely cause is due to an error that occurred in the course of receiving care.
Severe Harm	An event or circumstance where there is severe harm to the patient. Severe adverse effects may include permanent injury or disfigurement, fractures (other than extremities) or a sudden life-threatening change in vital signs. Immediate, life-saving intervention is required and losses may be irreversible. For example, a wrong dose of medication leads to a cardio-pulmonary arrest.
Moderate Harm	An event or circumstance where there is moderate harm to the patient. Moderate adverse effects may include moderate lacerations, fractures of the extremities, burns, unintentional heavy sedation, and partial loss of limb or organ function. Where there is functional loss, function is expected to return to previous levels. For example, a patient falls, sustains a fractured arm. The arm is casted and function returns after a short period of physiotherapy.
Minimal Harm	An event or circumstance where there is minimal harm to the patient. Minimal adverse effects may include abrasions, skin breakdown, pain, minor burns, bruises, scratches, confusion, emotional distress and anxiety. Intervention for minimal harm may include x-rays, sutures, physician examination, blood collection or re-collection and closer observation, even if short-term in nature. For example, a patient received an incorrect dose of insulin. A new order was received and follow-up glucometer check performed.
No Apparent Harm	An event or circumstance where at the time of the event the patient does not appear to suffer any harm, but may suffer harm in the future. For example, a patient falls and hits their head but there is no evidence of bruising, swelling or any change in neurological status.
Close Call	An event in which a patient is exposed to or involved in a situation with the potential for harm. For one or more reasons the danger did not reach the patient. For example, a nurse discovers a patient is allergic to penicillin when checking the name band before hanging the IV penicillin dose.
LIKELIHOOD	
Frequent	Likely to occur immediately or within a short period of time (may happen several times in one month)
Occasional	Probably will occur (may happen several times in 3 to 4 months).
Uncommon	Possible to occur (may happen sometime in six [6] months).
Remote	Unlikely to occur within the next year
SAC Score 3	Actions to eliminate or control identified hazards are urgent and high priority Consider issuing a Patient Safety Alert (PSA) or Safer Practice Notice (SPN) as appropriate
SAC Score 2	Actions to eliminate or control identified hazards are important and moderate priority Consider issuing a Safer Practice Notice
SAC Score 1	Consider managing in local area. (i.e. Memo, Frontline Notifications, newsletter) Publication of PSA or SPN would not be typical; however, there may be exceptions experience.

The matrix provided here was developed by the Department of Veterans Affairs (VA) National Center for Patient Safety (NCPS) Safety Assessment Code (SAC) Matrix1 and modified to utilize the Reporting and Learning System (RLS) definitions of severity.

Appendix B- Tips for the creating PSA & SPN content

The following is a quick overview of the details to be considered when completing the following sections of a PSA or SPN.



General Tips:

- Use point form not full sentences
- Ensure message has synergy with existing guidelines, policies and educational resources
- Dependant on the audience, try to avoid technical language, jargon and acronyms
- For PSA, recipients will be required to complete a follow-up survey, link may be provided in document or in attached email