



<p>Team Name: Quality, Planning & Performance</p> <p>Team Lead: Regional Lead - Quality, Planning & Performance</p> <p>Approved by: Regional Lead – Corporate Services & Chief Financial Officer</p>	<p>Reference Number: ORG.1810.PL.011</p> <p>Program Area: Quality, Planning & Performance</p> <p>Policy Section: General</p>
<p>Issue Date: December 1, 2022</p> <p>Review Date:</p> <p>Revision Date:</p>	<p>Subject: Patient Safety Learning Advisory (PSLA)</p>

Use of pre-printed documents: Users are to refer to the electronic version of this document located on the Southern Health-Santé Sud Health Provider Site to ensure the most current document is consulted.

POLICY SUBJECT:

Patient Safety Learning Advisory (PSLA)

PURPOSE:

Each service delivery organization (SDO) is expected by Manitoba Health to share learnings following a critical incident review. Sharing of learnings are placed into the provincial template- Patient Safety Learning Advisory (PSLA) which is a de-identified summary of an event including findings and recommendations. Enough information is provided to stimulate learning across the region while respecting the duty of confidentiality and legislation. To enhance broader system learnings, PSLAs are also shared external to the organization through Manitoba Health for public posting.

BOARD POLICY REFERENCE:

- Executive Limitation (EL-1) Global Executive Restraint & Risk Management
- Executive Limitation (EL-2) Treatment of Clients
- Executive Limitation (EL-3) Treatment of Staff
- Executive Limitation (EL-7) Corporate Risk
- Executive Limitation (EL-9) Communication and Support to the Board

POLICY:

Southern Health-Santé Sud promotes a culture of safety with emphasis on process improvement, rather than casting blame. Our core values of integrity, excellence, respect, compassion and innovation reflect our ethical obligation to be honest and forthcoming about critical incidents within the healthcare system which supports a non-punitive, transparent, and learning environment.

DEFINITIONS:

Critical Incident (CI): An unintended event that occurs when health services are provided to an individual and result in a consequence to him or her that:

- is serious and undesired such as death, disability, injury or harm, unplanned admission to hospital or unusual extension of a hospital stay, and does not result from the individual's underlying health condition or from a risk inherent in providing the health services.

IMPORTANT POINTS TO CONSIDER:

Staff and physicians across Southern Health-Santé Sud are encouraged to review PSLAs and engage in meaningful discussions with colleagues to facilitate broader system learning that promotes a culture of safety.

PROCEDURE:

1. PSLAs are created by a Patient Safety Coordinator following a critical incident review utilizing the provincial template.
2. The Patient Safety Coordinator summarizes the event, and ensures that the event is identifiable. The findings and recommendations from the critical incident review are also added to the provincial template.
3. The Patient Safety Coordinator calls a meeting with the appropriate Senior Lead(s)/ Responsible people/Clinical Team under the program in which the critical incident occurred (e.g.) Acute Care, LTC, Home Care etc...
4. The PSLA recommendations are reviewed/discussed at the meeting from a patient safety lens, operational lens and strategies for implementation. The approved recommendations are then assigned to a responsible person/lead in the organization with a target date.
5. The PSLA then is submitted to Senior Leadership Team for final endorsement and shared with the Board of Directors.
6. The PSLA is submitted to Manitoba Health for external sharing outside of the organization.
7. The PSLA is then shared via an ADMIN. UPDATE and posted to the health care provider site for staff learning under STATS and FACTS.
8. All programs/services leads are to have Patient Safety as a standing agenda item at clinical team meetings.
9. PSLA's applicable to a program/service are to be discussed at team meetings utilizing the "*Tool for Guided Learning and Discussion*".

SUPPORTING DOCUMENTS:

[ORG.1810.PL.011.FORM.01](#) - Tool for Guided Learning and Discussion

REFERENCES:

Accreditation Canada Leadership Standard 15.5 Version 14 November 22, 2021

Manitoba Health, Healthy Living & Seniors (2014). *Patient Safety Learning Advisories (PSLA) Development & Submission Guidelines*. Manitoba, Canada.