Team Name: Quality, Planning & Performance Team Lead: Regional Lead, Quality, Planning & Performance Approved by: Regional Lead – Corporate Services and Chief Financial Officer	Reference Number: ORG.1810.PL.009 Program Area: Quality, Planning & Performance Policy Section: General
Issue Date: October 12, 2023 Review Date: Revision Date:	Subject: Prospective Analysis

Use of pre-printed documents: Uses are to refer to the electronic document located on the Southern Health-Santé Sud health provider site to ensure the most current document is consulted.

POLICY SUBJECT:
Prospective Analysis

PURPOSE:
The purpose of this policy is to assist/guide leaders in the organization to conduct a prospective analysis utilizing a standard methodology. The Canadian Incident Analysis Framework (CIAF) is a method used in Southern Health Santé Sud for conducting retrospective reviews i.e.) critical incident reviews. The CIAF can also be used when conducting prospective reviews (looking forward) by a particular identified theme looking at opportunities for system improvement i.e.) Falls prevention, Medication events etc.

BOARD POLICY REFERENCE:
Executive Limitation (EL-02) Treatment of Clients
Executive Limitation (EL-03) Treatment of Staff
Executive Limitation (EL-01) Global Executive Restraint Risk Management
Executive Limitation (EL-07) Corporate Risk

POLICY:
To foster a just culture of safety and to comply with Accreditation Canada's Standards, at least one patient safety-related prospective analysis be conducted annually and appropriate system improvements are made as a result.

DEFINTIONS:
Canadian Incident Analysis Framework: is a structured process for identifying what happened, how and why it happened, what can be done to reduce the risk of recurrence and make care safer, and what was learned. It is an integral activity in the incident management continuum, which represents the activities and processes that surround a patient safety incident.

Just Culture of Safety: is about creating an environment where staff feel safe to disclose and discuss potential or actual events while maintaining professional accountability. People are actively involved in the creation of a better system to work in and recognize the complexity of systems and processes of care that contribute to safety events. The culture is fair and supportive, rather than blaming.

Key Stakeholders: include and not limited to patients/residents/clients/family/caregivers; clinicians; healthcare providers; employees; employers; government agencies; insurance companies; investors; local communities and pharmaceutical firms.

Prospective Analysis: is used as an analytical tool to assess and mitigate the occurrence of loss by analyzing a situation or process that carries with it some inherent risk.

IMPORTANT POINTS TO CONSIDER:

Organizational risks that have been identified from insurance claims provided by HIROC on an annual basis may be considered for a prospective analysis.

Critical Incident reviews that have the same identifiable trends or patterns of contributing factors that were not previously perceptible may also reveal recommended actions that were or were not effective. A high-level systems review of multiple critical incidents may be considered.

On an annual basis the regional database is analyzed for all types of safety events per fiscal year by an Analyst. An annual report is created and shared within the organization summarizing all safety events based on trends and themes. The Annual Safety Event Report may be considered.

When conducting a Prospective Analysis include all applicable key stakeholders as team members in the process. Include patients/residents/clients as applicable.

PROCEDURE:

1. The Patient Safety Coordinator(s) identify a topic/area of focus to conduct a prospective analysis on an annual basis.
    - **Note:** Any organizational program/service lead that has identified a specific topic for a prospective analysis is to contact a Patient Safety Coordinator for further discussion and assistance.

2. The prospective analysis is based on information obtained from the following sources e.g.) identified organizational risks, multiple critical incidents &/or trends and themes identified in the annual report of all types of safety events entered into the regional database &/or data received from programs/services within SH-SS.

3. The Patient Safety Coordinator(s) notifies the appropriate Regional Lead(s) that a prospective analysis will be conducted on a chosen "topic" that pertains to their portfolio.

4. The Patient Safety Coordinator(s) works in collaboration with the Regional Lead(s) to identify key stakeholders to be included as team members for the prospective analysis. An

invitation is then distributed to all stakeholders utilizing the "*Prospective Analysis Invitation" ORG.1810.PL.009.FORM.01.*

5. The Patient Safety Coordinator(s) then proceeds to follow the *"Prospective Analysis Checklist"- ORG.1810.PL.009.SD.01* and captures the review process on the *"Prospective Analysis Template" ORG.1810.PL.009.FORM.02.*

6. Following the completion of a Prospective Analysis the Patient Safety Coordinator(s) creates an Executive Summary. The "*Prospective Analysis Executive Summary" ORG.1810.PL.009.FORM.03* is shared within the organization for additional learnings and communication of system improvements being made.

SUPPORTING DOCUMENTS:

ORG.1810.PL.009.FORM.01- Prospective Analysis Invitation
ORG.1810.PL.009.FORM.02- Prospective Analysis Template
ORG.1810.PL.009.FORM.03- Prospective Analysis Executive Summary
ORG.1810.PL.009.SD.01- Prospective Analysis Checklist

REFERENCES:

Accreditation Canada (2019)-November 22, 2021. Ver. 14 *Leadership Standard - Patient safety is monitored and improved on an ongoing basis* (15.0; 15.8)

Health Care Excellence Canada-Patient Safety Incident Analysis accessed on December 23, 2022