Nova Scotia Health (NSH) Patient Safety and Quality Culture Strategy Indicator Dashboard

	Components	Best Practice/ Key Concepts	Data Source	Freq.	Indicator	Yr over Yr Change	Result	NSH overall	Central Zone	Eastern Zone	Northern Zone	Western Zone
Enabling Component	**Organizational priority**	Board educated, engaged, accountable, prioritizes patient safety?	GFT #22	Annual	22. We receive ongoing education on how to interpret information on quality and patient safety performance.							
		Safety/quality vision, strategy, plan, goals (with input from patients, families, staff, physicians)	WLP #17	Annual	17. Senior managers effectively communicate the organization's goals.							
		Safety/quality resources/infrastructure	PSC #3	Annual	3. Senior management provides a climate that promotes patient safety.							
	CEO/senior leadership behaviours	Relentless communication about safety/quality vision, stories, results?	Internal Survey	Annual	Potential: of respondents who have listened to a patient and family story, the % indicating they felt that listening to the story(ies) positively impacted the care/service they provide							
		Leadership regular/daily interaction with units, staff, patients and families?	Internal Survey	Annual	Potential: of respondents who have participated in a LSR, % indicating they felt that improvement actions were taken as a result of the LSR occuring.							
		Model key values (e.g. honesty, fairness transparency, openness, learning, respect, humility, inclusiveness, person-centredness)?	WLP #18	Annual	18. Senior managers are committed to providing high-quality care.							
			WLP# 20	Annual	20. Senior managers are committed to providing a safe and healthy workplace.							
	Human Resources	Leaders/staff/physicians engaged; clear expectations/incentives for safety/quality?	PSC #2	Annual	2. Senior management has a clear picture of the risk associated with patient care.							
			PSC #16	Annual	16. My supervisor/manager says a good word when he/she sees a job done according to established patient safety procedures.							
			PSC #17	Annual	17. My supervisor/manager seriously considers staff suggestions for improving patient safety.							
		"Just culture" program/protocol?	PSC #s5	Annual	5. If I make a serious error my manager will think I am incompetent.							
			PSC #6,	Annual	6. My co-workers will lose respect for me if they know I've made a serious error.							
			PSC #10	Annual	10. Others make you feel like a bit of a failure when you make an error.							
			PSC #8	Annual	8. Making a serious error may cause a staff member to lose his/her job.							
			PSC #13	Annual	13. If I make a serious error I worry that I will face disciplinary action from management.							
			PSC #14	Annual	14. Making a serious error would limit my career opportunities around here.							
		Disruptive behaviour protocol?	WLP #21	Annual	21. My organization takes effective action to prevent violence in the workplace.							
			WLP #22	Annual	22. My organization takes effective action to prevent abuse in the workplace.							
		Staff and physician safety (physical/psychological/ burnout); safe environment program?	WLP #23	Annual	23. My workplace is safe.							
			WLP #24	Annual	24. I am able to balance my family and personal life with work.							
			WLP #25	Annual	25. In the past 12 months, would you say that most days at work were…							
	Health Information/ technology/ devices	E-health records support safety (e.g. decision support, alerts, monitoring)?	HIMM Analytics	Annual	HIMM Analytics EMR Adoption Model Stage number (scale of 7) Target is 5							
		Technology/devices support safety (e.g. human factors, standardized automated identification)?	HIMM Analytics	Annual	HIMM Analytics EMR Adoption Model Stage number (scale of 7) Target is 6							
	Health system alignment	Community/industry-wide collaborations?	Survey	Annual	Select question from survey around community partners							
		Align with nat'l/int'l accreditation, regulatory, professional standards?	GFT #1	Once every 4	1. We regularly review and ensure compliance with applicable laws, legislation, and regulations.							
			GFT #16	Once every 4	16. We benchmark our performance against other similar organizations and/or national standards.							
Enacting Component	**Care Settings and managers**	Integrated, unit based safety practices (e.g. daily briefings, visual management, local problem solving)?	Survey	Annual	% of respondents that have indicated they are currently engaged in a safety huddle/quick meeting/gathering where safety is a focus Of those that responded, % that indicated huddles significantly or very signficantly helped to prevent a safety incident							
		Managers/physician leaders foster psychological safety (speaking up)?	PSC #3	Annual	3. Senior management provides a climate that promotes patient safety.							
			PSC #16	Annual	16. My supervisor/manager says a good word when he/she sees a job done according to established patient safety procedures.							
			PSC #17	Annual	17. My supervisor/manager seriously considers staff suggestions for improving patient safety.							
	Care Processes	Standardized work/care processes where appropriate?	OPOR?	Annual	% specified care areas using standardized order sets							
		Communication/patient hand-off protocols (e.g. between shifts/units, across care continuum)?	Audit	?	Indicator under development % of transfers utilizing the Provincial Transfer Form between NSHA facilities							
	Patient and Family engagement/ co-production of care	Patients/families partners in all aspects of care (e.g. planning, decision-making, family presence policy, rounds, access to health record/test	Client Experienc	Annual	% patients responding positively to survey questions on being consulted in decision making in their care and health service.							
		Patients/families involved in local safety/quality initiatives?	Internal audit	Annual	% of Quality Teams with patient family advisors							
		Disclosure and apology protocols?	SIMS	Annual	Percentage of SRE patient safety incident disclosure							
	Situational Awareness/ resilience	Processes for real.time/early detection of safety risks and patient deterioration (by staff/ patients/ families)?	PSC #15	Annual	15. Individuals involved in patient safety incidents have a quick and easy way to report what happened.							
		Protocols for escalation of care concerns (by staff/patients /families)?		Annual	Indicator under development							
Learning Component	**Education/ capability building**	Leaders/staff/physicians trained in safety and improvement science, teamwork, communication?	PSC #19	Annual	19. In my area of care, after a serious error has occurred, we think about how it came about and how to prevent the same mistake in the future.							
			PSC #20	Annual	20. On this unit, when a serious error occurs, we analyze it thoroughly.							
			PSC #21	Annual	21. On this unit, after a serious error has occurred, we think long and hard about how to correct it.							
			WLP #12	Annual	12. The people I work with help each other out							
			WLP #9		9. I receive the training I need to do my job well.							
		Team-based training, drills?	Team STEPPS Evaluation	Annual	Average participant % change in pre-post score using the TeamSTEPPS Canada™ Learning Benchmarks tool. This may change as request to look at specific question instead							
	Incident reporting/ management/ analysis	Effective risk/incident reporting system for events related to patients/families and staff/physicians	PSC #15	Annual	15. Individuals involved in patient safety incidents have a quick and easy way to report what happened.							
		Structured processes for responding to and learning from safety events/critical incidents	PSC #18	Annual	18. On this unit, when a serious error occurs, we think about it carefully.							
			PSC #19	Annual	19. In my area of care, after a serious error has occurred, we think about how it came about and how to prevent the same mistake in the future.							
			PSC #20	Annual	20. On this unit, when a serious error occurs, we analyze it thoroughly.							
			PSC #12	Annual	12. Staff are usually given feedback about changes put into place based on incident reports.							
			PSC #21	Annual	21. On this unit, after a serious error has occurred, we think long and hard about how to correct it.							
	Safety/quality measurement/ reporting	Regular measurement of safety culture (unit and organization)?	PSC #22	Annual	22. Please give your unit an overall grade on patient safety.							
			PSC# 23	Annual	23. Please give your organization an overall grade on patient safety.							
		Retrospective/prospective safety and quality process and outcome measures?	SIMS	Annual	% Quality Review Recommendations complete							
		Regular, transparent reporting of safety/quality plan results?	Manual count?	Annual	% targeted programs posting regular Quality & Safety indicator reporting							
	Operational Improvements	Structured methods, infrastructure to improve reliability, streamline operations (e.g. PDSA, lean, human factors engineering, prospective risk analysis)?	PSPI	Annual	LEAN session attendance - Percent total attendance. Each session can hold a specific number of people - report total numerator over denominator							