Policy

Policy Title:	Quality Review	
Applies To:	All Nova Scotia Health Team Members	
Related Procedure(s):	Quality Review - Procedure - AD-QR-005.01	
Approved:	**Effective:**	**Next Review:**
July 21, 2022	August 9, 2022	July 21, 2026
Sponsor:	Senior Director, Quality Improvement and Patient Safety	
Approval Authority:	VP Medicine Executive Leadership Team	
Number: AD-QR-005	**Manual:** Administrative	

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PURPOSE

This policy is part of Nova Scotia Health's system to address Patient Safety Incidents, including Disclosure of Patient Safety Incidents - Policy and Procedure - NSHA AD-QR-010 and Patient Safety Incident Management - Policy and Procedure - NSHA AD-QR-015.

This policy and its accompanying procedure provide coordinated processes for Quality Review with a goal to learn from Quality Reviews to make systematic improvements in the provision of health care and services and to educate stakeholders as to how to monitor and address system data, performance, and specific incidents to enhance Patient outcomes and experiences in the future.

This policy and procedure support the establishment of Quality Oversight structures, processes, and accountabilities which serve to uphold our Patients' and citizens' trust as recipients of care and service and are in accordance with the *Quality-improvement Information Protection Act*.

DEFINITIONS

Contributing Factor	A circumstance, action, or influence which is thought to have played a part in the origin or development of an incident, or to increase the risk of an incident. Examples of Contributing Factors include Patient characteristics, care team, equipment, task, work environment, organizational, bias-related, and equity.
E-Messaging	Messages exchanged between individuals using electronic devices. This includes email, texting/instant messaging, and messages sent between individuals through online messaging services/applications, including video conferencing applications.
Failure Modes & Effects Analysis (FMEA)	A prospective analysis technique or a proactive process improvement tool that serves to prevent high risk incidents from happening. FMEA evaluates an existing process to identify where and how it might fail and to assess the relative impact to determine which parts of the process are most in need of change.
Health Care Provider	Team Members who are engaged in providing health care and services.
Incident Analysis	A structured process that aims to identify what happened, how and why it happened, what can be done to reduce the risk of recurrence, make care safer, and what was learned through the review.
Nova Scotia Health Quality Improvement & Safety (QIS) Council	An interdisciplinary standing Nova Scotia Health Quality Improvement & Safety (QIS) Council to which Zone QIS Councils and Nova Scotia Health Program QIS Councils report in relation to recommendations reached and for issues/findings or Reviewable

	Matters which have application to or implications beyond the Zone/Program served by the QIS Council.
Patient(s)	All individuals including clients, residents, and members of the public who receive or have requested health care or services from Nova Scotia Health and its Health Care Providers.
Patient Safety Incident	An event or circumstance which could have resulted, or did result in unnecessary harm to a Patient, (see Appendix A for severity levels).
Program Quality Improvement & Safety (QIS) Council	An interdisciplinary standing Program Council for each of Nova Scotia Health's programs, as applicable. Where Program QIS Teams exist, they will report to the Nova Scotia Health Program QIS Council in relation to recommendations reached and for issues/findings or Reviewable Matters which have application to or implications beyond the Program QIS Team.
Quality Improvement Activity	An activity of a QIS Team/Council or any other activity that is part of a program or plan: • Approved by a health authority, the Minister, or an entity referred to in Section 3(1)(c) of the *Quality-improvement Information Protection Act* (QIIPA) (i.e., an entity prescribed by the regulations that has terms of reference and membership as mandated by the person or entity creating the committee to carry out quality-improvement activities) and; • Implemented for the purpose of assessing, investigating, evaluating, or making recommendations respecting the provision of health services by a health authority, the Minister or an entity referred to in Section 3(1)(c) of QIIPA, with a view to maintaining or improving the quality of health services.
Quality Improvement & Safety (QIS) Committee of the Board	A subcommittee of the Nova Scotia Health Board of Directors which is established pursuant to Section 39 of the Nova Scotia Health Authorities Act and Nova Scotia Health's corporate by-laws to support the Board in fulfilling its mandate to provide governance oversight for Quality Improvement and Safety.
Quality Improvement & Safety (QIS) Team	An interdisciplinary standing QIS Department, Service, or Facility Team which reports to the Zone QIS Council. QIS Teams for designated programs, as described in the Quality Oversight Structure (Appendix B), report to Program QIS Councils.
Quality Improvement & Safety (QIS) Teams/Councils	Collectively refers to: • Nova Scotia Health QIS Council • Zone QIS Councils

	• Program QIS Councils • QIS Teams
Quality Improvement Information	Information in any form that is communicated for the purpose of, or created in the course of, carrying out a Quality Improvement Activity. This does **not** include: • Information contained in a record, including a health record, that is maintained for the purpose of providing and documenting health services to an individual • The fact that a QIS Team/Council met or conducted a Quality Improvement Activity • Information disclosed to a person or, in the event of the person's incapacity, to the person's Substitute Decision-Maker, regarding any quality-related event in which the person is directly affected • The terms of reference of a QIS Team/Council • An accreditation report issued by Accreditation Canada
Quality Review	The systematic analysis and evaluation of health service structures, practices, and/or results that focus on the entire continuum of care and services; including, but not limited to, • Patient Safety Incidents and individual cases which are reviewed based on predetermined criteria for the purposes of education and/or improvement in and increased safety of health care/service or practice, • Review of team/organization/system data and indicators to proactively improve quality and Patient safety in specific areas of service and the system, • Analysis of health consumer needs with a view to improve performance, quality, safety, and experience. Quality Review includes analysis of Contributing Factors to inform opportunities for improvement.
Quality, Safety & Performance Framework	Nova Scotia Health's Quality, Safety and Performance Framework serves to build a common understanding of the provincial approach to quality and focuses organizational attention, action, and resources on promoting quality and safety while improving Patient experience and outcomes.
Reviewable Matters	Includes: • All Patient Safety Incidents. • Performance, safety, quality, utilization, flow & efficiency, and efficacy of service data and other reports and data

	deemed relevant to Nova Scotia Health or to specific areas of service as represented by a Quality Improvement & Safety Team or Council. • Issues identified through Accreditation Canada's Accreditation process, including but not limited to, issues related to compliance with Accreditation Canada's Required Organizational Practices (ROP).
Risk Analysis	Involves identifying sources of potential risk, assessing the likelihood that the risk will cause harm, the consequences if harm does occur and risk mitigation strategies.
Safety Improvement & Management System (SIMS)	The Nova Scotia Health province-wide reporting and management information system used to enhance the capability of Health Care Providers to improve safety. The electronic Patient Safety Incident reporting system was developed with processes to report, analyze, recommend actions, and monitor improvements.
Serious Reportable Events (SRE)	A subset of Patient Safety Incidents as identified in the Nova Scotia Health & Wellness Serious Reportable Event Reporting Policy.
Substitute Decision Maker (SDM)	A person who is given the authority to make admission, care, or treatment decisions on behalf of a Patient under the Hospitals Act.
Team Members	Refers to all employees, physicians, learners, volunteers, board members, contractors, contract workers, franchise employees, and those with affiliated appointments and other individuals performing activities within Nova Scotia Health.
Zone Quality Improvement & Safety (QIS) Council	An interdisciplinary standing zone-wide council with the mandate and responsibility to address zone-wide quality, Patient safety, and standards of health service. Quality Improvement & Safety (QIS) Teams report to the Zone QIS Council in relation to recommendations reached and for an issue/finding or Reviewable Matters which has application to or implications beyond the area/ /department/facility/service served by the QIS Team.

PRINCIPLES AND VALUES

1. Quality Review is an important component of quality, safety, and system performance and aids in maintaining and improving care and health services by promoting, monitoring, evaluating, and improving the system of care for those served by Nova Scotia Health.
2. **Improvement and Learning:** Quality Reviews provide benefit from the application of critical analysis and interdisciplinary lenses. Nova Scotia Health's goal in enacting this policy is to learn from Quality Reviews in order to:
   - Make systemic improvements in the provision of health care and services

- Direct Team Members as to how to monitor and address the impact to Patients or consequences of failure to meet standards or benchmarks in relation to other Reviewable Matters
- Monitor and address system data, performance, and specific incidents to enhance outcomes and the Patient experience in the future

3. **Just Culture**: The importance of fairly balancing an understanding of system failure with professional accountability. A just culture promotes safe care through a consistent, fair culture of accountability, where Patient Safety Incidents and Near Misses are freely reported, reviewed, and learned from. In a just culture, the reasons for unexpected clinical outcomes and Patient Safety Incidents are not pre-judged and the rights of all individuals, including Patients, are protected. All are aware of Patient Safety Incident reporting expectations, and when analyzing Patient Safety Incident reports, professional accountability of Health Service Providers is determined fairly. Without a just culture, individuals would not feel safe to report Patient Safety Incidents and they would go unreported. This would directly impact our ability to prevent Patient safety issues from recurring in the future.
4. **Confidentiality**: Quality Review is most effectively undertaken in a confidential environment where participants can safely report, participate, and freely discuss the underlying Contributing Factors to the Patient Safety Incident, and thus enhancing the best process for learning from Patient Safety Incidents. Quality Improvement Information must be kept confidential in compliance with the *Quality-improvement Information Protection Act* (QIIPA) which prohibits disclosure and access to Quality-improvement Information except as expressly permitted under QIIPA.
5. **People-Centred Care:** As a foundation of Nova Scotia Health, we are working to place the dignity and respect of Patients, families, and communities at the heart of every decision. Through processes such as Quality Review, we seek to build trust-based relationships to achieve more genuine partnerships with those we serve. This policy, in conjunction with others such as NSHA-AD-QR-020 Family Presence, demonstrate Nova Scotia Health's commitment to people-centred care.

POLICY STATEMENTS

1. Quality Reviews are supported through the development of Nova Scotia Health's Quality Oversight Structure (see Appendix B), the Quality, Safety, & Performance Framework, and are conducted in compliance with the Nova Scotia *Quality-improvement Information Protection Act (QIIPA)*.
    1.1. In keeping with QIIPA, all of the Quality-Improvement Teams/Councils are established or designated by Nova Scotia Health, with the terms of reference and membership as mandated by Nova Scotia Health, to carry out Quality-Improvement Activities.
2. Nova Scotia Health has a Nova Scotia Health-wide Quality Improvement & Safety (QIS) Council.
3. Each Nova Scotia Health zone has a Zone QIS Council.

4. Each Nova Scotia Health program, where applicable, may have a Program QIS Council.
5. Nova Scotia Health has established Quality Improvement and Safety Teams to further support Nova Scotia Health's Quality Oversight Structure (see Appendix B).
    5.1. One or more service areas, departments, or full sites may combine to form one QIS Team depending on the size of the service or site.
6. Nova Scotia Health has a mechanism to monitor all Quality Reviews of Reviewable Matters conducted, including recommended actions that result from the Quality Reviews and the progress toward implementation of the recommendations.
7. Nova Scotia Health's monitoring, review, and management of all Reviewable Matters is conducted via Nova Scotia Health's Quality Oversight Structure (Appendix B), supported by a just culture, and applicable policies and procedures which establish:
    7.1. Expectations and guidance for all Team Members in the delivery of safe, responsible, and supportive health care and services for Patients
    7.2. Expectations in relation to the analysis of Reviewable Matters with the goals of:
        7.2.1. Improving quality, safety, and performance by learning from Quality Reviews
        7.2.2. Implementing system changes to prevent or minimize the recurrence of Patient Safety Incidents and other Patient safety issues
        7.2.3. Addressing the failure to meet standards or benchmarks in relation to other Reviewable Matters through a Quality Review process
8. QIS Teams, Program QIS Councils, Zone QIS Councils, and Nova Scotia Health QIS Council (collectively referred to as "QIS Teams/Councils") are responsible to operate, monitor, review, and address Reviewable Matters as per their terms of reference. The QIS Committee of the Board provides Nova Scotia Health-wide governance oversight for the Quality Improvement and Safety program.
9. Quality Review by QIS Teams/Councils, or any other structure specified in Appendix B, may be carried out through the use of various Quality Review tools including, but not limited to:
    - Incident Analysis (may include concise, comprehensive, and multi-Incident analysis)
    - Morbidity and Mortality (M&M) review
    - Failure Modes and Effects Analysis (FMEA)
    - Risk Analysis or process improvement analysis (e.g., Lean Six Sigma)
    - Any other appropriate review tools
10. All Team Members are expected to participate fully in the Quality Review process when required and are accountable to understand the nature and intent of the process, their role, and their obligations, including but not limited to, maintaining confidentiality.
11. E-Messaging and voicemail outside the Nova Scotia Health network are not considered secure systems and must not be used to communicate Quality Improvement Information, or information in relation to specific Patient Safety Incidents or Quality Review

proceedings. Refer to NSHA AD-AO-045 Electronic Messaging of Personal Health Information.

12. All documents and other communication created related to Patient Safety Incidents and Quality Review (including Safety Improvement & Management System (SIMS) reports), and the reports that follow are protected from Disclosure pursuant to the *Quality-improvement Information Protection Act* including, but not limited to, Quality Improvement Information and Quality Improvement Activities.
13. Human resource issues, such as discipline (e.g., Medical Staff Bylaw issues, harassment complaints) are separate and are not Reviewable Matters for purposes of this policy and therefore not a part of the Quality Review process. Any such matter, including but not limited to allegations or actions listed below, are managed through administrative performance processes, separately from Quality Review:
    - Serious breach of professional or organizational standards
    - Issues relating to the competence of health professionals
    - Criminal acts
    - Purposeful unsafe acts
    - Intent to cause harm
    - Acts related to substance abuse by providers/staff
    - Suspected Patient abuse of any kind

REFERENCES

Legislative Acts/References

Province of Nova Scotia. (2014). *Fatality Investigations Act* (Chapter 31 of the Acts of 2001). http://nslegislature.ca/legc/statutes/fatality%20investigations.pdf

Province of Nova Scotia. (2015). *Quality-improvement Information Protection Act* (Chapter 8 of the Acts of 2015). https://nslegislature.ca/sites/default/files/legc/statutes/quality-improvement%20information%20protection.pdf

Other

Accreditation Canada. (2020). Required Organizational Practices (ROP's) Handbooks 2020. Accreditation Canada ROP Handbook

Canadian Medical Protective Association (CMPA). *Good Practices Guide. (2022)* https://www.cmpa-acpm.ca/serve/docs/ela/goodpracticesguide/pages/index/index-faculty-e.html

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Healthcare Excellence/ Canadian Patient Safety Institute (2020). *A guide to Patient Safety Improvement. Integrating Knowledge Translation & Quality Improvement Approaches.* https://www.patientsafetyinstitute.ca/en/toolsResources/A-Guide-to-Patient-Safety-Improvement/Pages/default.aspx

Healthcare Excellence/ Canadian Patient Safety Institute (2019). *Engaging Patients in Patient Safety. https://www.patientsafetyinstitute.ca/en/toolsResources/Patient-Engagement-in-Patient-Safety-Guide/Pages/default.aspx*

Healthcare Excellence/ Canadian Patient Safety Institute. (2022). *Patient Safety Culture.* http://www.Patientsafetyinstitute.ca/en/toolsResources/PatientSafetyIncidentManagementToolkit/PatientSafetyManagement/pages/Patient-safety-culture.aspx

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Healthcare Excellence/ Canadian Patient Safety Institute. (2022). *Incident Management* https://www.patientsafetyinstitute.ca/en/toolsResources/PatientSafetyIncidentManagementToolkit/IncidentManagement/Pages/default.aspx

Nova Scotia Health & Wellness (DHW). (2021). *Serious Reportable Event Reporting Policy.* https://novascotia.ca/dhw/hsq/documents/Serious-Reportable-Event-Interim-Reporting-Policy.pdf

World Health Organization. (2022). *Patient Safety Action Plan 2021-2030.* https://www.who.int/multi-media/details/launch-event-global-patient-safety-action-plan-2021-2030

RELATED DOCUMENTS

Policies

NSHA AD-AO-045 Electronic Messaging of Personal Health Information

NSHA AD-QR-010 Disclosure of Patient Safety Incidents

NSHA AD-QR-015 Patient Safety Incident Management

NSHA AD-HR-040 Whistleblower

Relevant Local Policies related to discipline

Procedures

Quality Review - Procedure - AD-QR-005.01

Documents

Additional Quality Review resources may be found here.

Appendices

Appendix A: Safety Improvement & Management System (SIMS) - Patient Safety Incident Severity Levels

Appendix B: Quality Oversight Structure

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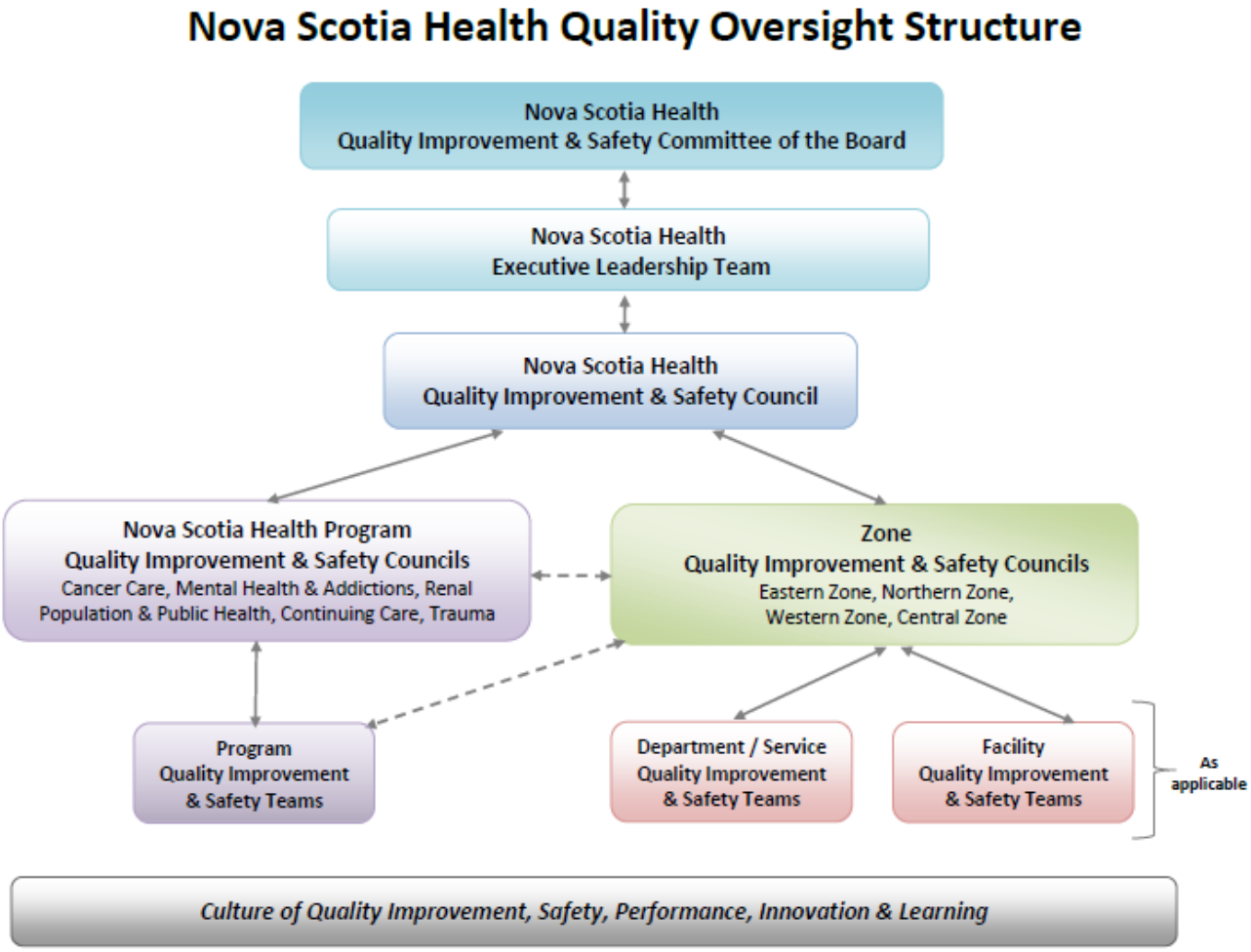
Appendix A: Safety Improvement & Management System (SIMS) - Patient Safety Incident Severity Levels

Severity Level	Definition
Near Miss	An incident that did not reach a person. The incident has potential for harm and is intercepted or corrected prior to reaching a person.
No Harm Incident	An incident that reached a person, but no discernible harm resulted. Outcome is not symptomatic, or no symptoms are detected, and no treatment is required.
Mild Harm Incident	An incident where the outcome is symptomatic, symptoms are mild, loss of function or harm is minimal or intermediate, but short term or minimal intervention is required (for example: extra observation, investigation, review, or minor treatment)
Moderate Harm Incident	An incident where the outcome is symptomatic and requires intervention (for example: additional operative procedure, additional therapeutic treatment) or an increased length of stay; or causing minor permanent, long-term harm or loss of function
Severe Harm Incident	An incident where the outcome is symptomatic, requiring life-saving intervention or major surgical/medical intervention or shortening life expectancy or causing major permanent, long-term harm or loss of function.
Death	Death which may have occurred in association with a patient safety event.

Appendix B: Quality Oversight Structure



VERSION HISTORY

Version:	Effective:	Approved by:	What's changed:
Original	2017-07-13	Executive Leadership Team VP Quality and System Performance	N/A
Major Revision	2022-08-09	VP Medicine Executive Leadership Team	Regular review and updates