



COURSE OUTLINE: HCL102 - PATIENT SAFETY

Prepared: Rebecca Keown, BA(Hons), MBHL

Approved: Sherri Smith, Chair, Natural Environment, Business, Design and Culinary

Course Code: Title	HCL102: PATIENT SAFETY
Program Number: Name	2187: HEALTH CARE LEADER 5985: HEALTH CARE LEADER.
Department:	BUSINESS/ACCOUNTING PROGRAMS
Academic Year:	2023-2024
Course Description:	Ensuring patient safety and health care quality is critical to everyone in health care practice. This course provides health care professionals with the knowledge, skill and systems thinking needed to lead the implementation of effective quality and patient safety programs within a Canadian health care organization. Learners will examine evidence-informed, best practices and elements needed to create a culture of safety and one that engages patients in patient safety and quality improvement. Topics also focus on concepts of human factors, technology, medical errors, and the standards and organizational practices which govern quality, safety and risk management in Canadian health care today.
Total Credits:	3
Hours/Week:	3
Total Hours:	42
Prerequisites:	There are no pre-requisites for this course.
Corequisites:	There are no co-requisites for this course.
Vocational Learning Outcomes (VLO's) addressed in this course: Please refer to program web page for a complete listing of program outcomes where applicable.	2187 - HEALTH CARE LEADER VLO 1 Communicate effectively and appropriately with patients, families, and members of both the health care and administrative teams to maintain a wholly interactive environment. VLO 2 Practice and support evidence informed decision making, using critical thinking skills and best leadership practices to lead sustainable health care operations. VLO 3 Practice within the legal, ethical and professional scope of practice of a leader in Ontario's health care system to maintain the integrity of the health care organization. VLO 4 Address the needs of a diverse patient population using best practices to ensure progressive and positive processes within a health care facility. VLO 7 Utilize health care technology and informatics for the benefit of the patients and support of the institution. VLO 8 Outline strategies to manage risks in the business activities of a health care organization to obtain a sustainable organization. VLO 10 Apply patient and family quality care theories and core concepts of patient safety into current practices to achieve enhanced patient outcomes and positive experiences in the health care setting. VLO 11 Apply principles of operational planning, project management, and quality management to support health care operations.



	5985 - HEALTH CARE LEADER.					
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	VLO 11	Apply principles of operational planning, project management, and quality management to support health care operations.				
Essential Employability Skills (EES) addressed in this course:	EES 1	Communicate clearly, concisely and correctly in the written, spoken, and visual form that fulfills the purpose and meets the needs of the audience.				
	EES 2	Respond to written, spoken, or visual messages in a manner that ensures effective communication.				
	EES 4	Apply a systematic approach to solve problems.				
	EES 5	Use a variety of thinking skills to anticipate and solve problems.				
	EES 6	Locate, select, organize, and document information using appropriate technology and information systems.				
	EES 7	Analyze, evaluate, and apply relevant information from a variety of sources.				
	EES 8	Show respect for the diverse opinions, values, belief systems, and contributions of others.				
	EES 9	Interact with others in groups or teams that contribute to effective working relationships and the achievement of goals.				
	EES 11	Take responsibility for ones own actions, decisions, and consequences.				
Course Evaluation:	Passing Grade: 50%, D					
	A minimum program GPA of 2.0 or higher where program specific standards exist is required for graduation.					
Course Outcomes and Learning Objectives:	<table><tr><th>Course Outcome 1</th><th>Learning Objectives for Course Outcome 1</th></tr><tr><td>Define fundamental terms and explain core concepts related to patient safety in a health care environment.</td><td>1.1. Discuss the meaning of `patient safety`, `quality`, `culture of safety`, `systems thinking`, `risk management` and `high reliability organization` and understand critical quality and safety issues facing Canadian health care today.</td></tr></table>	Course Outcome 1	Learning Objectives for Course Outcome 1	Define fundamental terms and explain core concepts related to patient safety in a health care environment.	1.1. Discuss the meaning of `patient safety`, `quality`, `culture of safety`, `systems thinking`, `risk management` and `high reliability organization` and understand critical quality and safety issues facing Canadian health care today.	
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	<p>1.2. Describe the key dimensions of quality and the central principles of a high reliability organization and understand the role of patient safety within these models.</p> <p>1.3. Explore key milestones and initiatives in the history of patient safety and quality improvement in health care including high profile cases and seminal studies.</p> <p>1.4. Identify and appreciate the role of key organizations in Canada that contribute to improving patient safety including Health Quality Ontario, Canadian Patient Safety Institute, Health Canada, and Canadian Institute for Health Information.</p>
Course Outcome 2	Learning Objectives for Course Outcome 2
Identify best practice patient safety, quality and risk management models and approaches, and understand the patient safety context in Ontario.	<p>2.1. Explore the legislative, regulatory and policy frameworks that support patient safety in Ontario including the Public Hospitals Act, Excellent Care for All Act, Apology Act, Health Care Consent Act.</p> <p>2.2. Understand the mandate and activities of the Coroner's office, professional colleges and regulatory bodies, and Accreditation Canada in advancing health care quality and safety.</p> <p>2.3. Identify and assess the range of clinical and non-clinical risks within a health care organization.</p> <p>2.4. Recognize the linkage between risk management, quality improvement and patient safety functions and understand how they can be effectively integrated within an organization.</p> <p>2.5. Identify reporting and other requirements in relation to patient safety including annual Quality Improvement Plan development, and national medication error and adverse reaction reporting.</p> <p>2.6. Outline the rationale, principles and practices for disclosure of adverse events to patients.</p> <p>2.7. Describe the process and challenges associated with identifying and managing critical incidents and outline the elements of successful investigation and follow-up.</p>
Course Outcome 3	Learning Objectives for Course Outcome 3
Choose and apply strategies, methods and tools to identify, analyze and address patient safety issues.	<p>3.1. Describe the history and evolution of quality improvement science as it pertains to a health care environment.</p> <p>3.2. Explore multiple sources of patient safety and risk data including patient complaints, engagement surveys and advisory council feedback, incident reports, critical incident investigations, Morbidity & Mortality (M & M) reviews, and medico-legal claims to identify and analyze trends and inform quality and safety initiatives.</p> <p>3.3. Undertake root cause analysis, apply an evidence-based approach to common health care safety problems, and understand the role of human factors in health care safety.</p> <p>3.4. Describe and apply the principles of Lean methodology and distinguish the conditions under which Lean, Six Sigma and the Model for Improvement are most applicable.</p> <p>3.5. Distinguish the most appropriate methods and tools to include in quality initiative design, based on the specific</p>

	<p>improvement challenges being addressed.</p> <p>3.6. Understand the importance of, and explore methods to, engage patients and their families in improvement work.</p> <p>3.7. Discuss examples of common evidenced-informed patient safety practices including order sets, electronic health records, checklists and computerized decision support and the role technology and digital health play in improving patient safety.</p> <p>3.8. Describe important features of patient safety measurement and tracking at the departmental, program, organization and systems level and analyse quantitative and qualitative measurement strategies in patient safety.</p>								
	<table> <tr> <th>Course Outcome 4</th><th>Learning Objectives for Course Outcome 4</th></tr> <tr> <td>Evaluate the intersection of an organizational culture of safety and high-quality.</td><td> <p>4.1. Explore the concepts of `culture of safety`, `just culture`, and `no blame` culture as they pertain to patient safety in health care organizations.</p> <p>4.2. Describe key elements of organizations that support safer care and assess organizational culture.</p> <p>4.3. Understand how systems issues, rather than individual health professional errors, are at the root cause of patient safety incidents including communication breakdowns, lack of teamwork, poorly designed care processes and inattention to human factors, and a punitive organizational culture.</p> <p>4.4. Identify and explain the core patient safety and quality improvement competencies for all health care professionals.</p> <p>4.5. Understand the role of leaders, the board of directors, and other governing bodies in fostering a culture of safety in health care organizations.</p> <p>4.6. Explain the impact that engaging patients and their families can have on quality improvement strategies and safety culture, and identify approaches used to meaningfully engage these key stakeholders in supporting effective care outcomes.</p> </td></tr> </table>	Course Outcome 4	Learning Objectives for Course Outcome 4	Evaluate the intersection of an organizational culture of safety and high-quality.	<p>4.1. Explore the concepts of `culture of safety`, `just culture`, and `no blame` culture as they pertain to patient safety in health care organizations.</p> <p>4.2. Describe key elements of organizations that support safer care and assess organizational culture.</p> <p>4.3. Understand how systems issues, rather than individual health professional errors, are at the root cause of patient safety incidents including communication breakdowns, lack of teamwork, poorly designed care processes and inattention to human factors, and a punitive organizational culture.</p> <p>4.4. Identify and explain the core patient safety and quality improvement competencies for all health care professionals.</p> <p>4.5. Understand the role of leaders, the board of directors, and other governing bodies in fostering a culture of safety in health care organizations.</p> <p>4.6. Explain the impact that engaging patients and their families can have on quality improvement strategies and safety culture, and identify approaches used to meaningfully engage these key stakeholders in supporting effective care outcomes.</p>				
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Date:	June 23, 2023								
Addendum:	Please refer to the course outline addendum on the Learning Management System for further information.								