LONDON HEALTH SCIENCES CENTRE

2022 2026

PATIENT SAFETY PLAN

February 2022

Prepared by the Patient Safety Team

Purpose

The London Health Sciences Centre's (LHSC) 2022-2026 Patient Safety Plan represents a new direction and a significant shift in patient safety culture throughout the organization. This plan will drive forward LHSC's strategic direction to *Deliver Exceptional Quality and Safety,* through the implementation of a proactive and resilient system of patient safety management. This comprehensive multi-year plan integrates best practices from patient safety throughout Canada and across the world.

Background

A positive organizational culture of patient safety is well documented in the literature as a key strategy for improving patient safety within the health care system. The patient safety culture of an organization reflects the perceptions of processes, norms and attitudes relating to a culture of preventable safety incidents which is shared by the organization's healthcare professionals (Okuyama, Galvao, & Silva, 2018). The overarching organizational culture of a healthcare organization influences patient safety culture directly through policies and procedures and by outlining what is acceptable practice for all staff members, physicians, and affiliates.

Many efforts to improve safety have focused on reducing specific harms and incidents instead of focusing on system-based approaches. As such, improving the safety of a healthcare organization requires a shift from a reactive approach to a proactive one, where risks are anticipated and identified in advance to allow for systemwide safety processes to be applied across the organization. This shift requires coordination at all levels of the health care organization in collaboration with key stakeholders and leadership support (NSCPS, 2020).

A Paradigm Shift: Patient Safety Thinking

There is a tendency for healthcare organizations to place the emphasis upon the avoidance of things that go wrong (i.e., patient safety incidents) with the goal of keeping the occurrence of these incidents as low as possible (Hollnagel, 2014). The assumption with this approach is that things go wrong due to failures or malfunctions in specific components of the system, viewing human error in the same light as issues with technology (Hollnagel, et al., 2015). Furthermore, this system is reactive in nature, and an effort to make system improvements is initiated only after the incident has occurred and the patient has experienced harm. This reactive approach to patient safety is referred to as *Safety 1*. Despite being a widely used approach to patient safety, *Safety 1* has limitations including the assumption that healthcare is a linear system and that the risk of a continual focus on what goes wrong can increase staff burnout and decrease morale (Smaggus, 2019).

Due to the increasing demands and complexity of healthcare, it is necessary to find new ways to manage and improve patient safety. As such, healthcare is undergoing a paradigm shift and more healthcare organizations are moving towards a proactive approach to patient safety management referred to as *Safety 2* (Hollnagel, 2015). In this approach there is an appreciation for a system's ability to succeed under varying conditions and that everyday performance variability provides the skills and resources needed to adapt to changing conditions. With *Safety 2*, there is an emphasis on how and why things usually go right which allows for adjustments to be made before something goes wrong (Hollnagel et al., 2015). See Appendix A for a comparison of *Safety 1* and *Safety 2*.

Although the adoption of a *Safety 2* approach is a large undertaking, it is necessary for healthcare organizations to make this shift in preparation for facing the ever-evolving complexities that they will encounter. The result of this shift to *Safety 2* is a resilient healthcare organization poised to manage future safety challenges (Hollnagel et al, 2015).

Considerations

The development of the 2022-2026 Patient Safety Plan was informed by current literature, an environmental scan, internal data and stakeholder feedback. The results of the Canadian Patient Safety Culture Survey (Can-PSCS), completed in September 2020 as part of LHSC's four-year Accreditation cycle, indicated that attention is needed to strengthen the safety culture within the organization. Positive safety culture is an essential component of improving patient safety within an organization (Leape, 2021).

The results of the Can-PSCS 2020 combined with the evolving complexity of the current healthcare system only reinforce the need for LHSC to find ways to strengthen the current culture. On the Can-PSCS, respondents gave LHSC a less than favorable score on overall perceptions of the organization's patient safety culture and 50% of respondents gave LHSC a failing grade on overall patient safety. Questions regarding enabling open communication were scored particularly low with results indicating that staff do not feel the environment at LHSC is judgement-free, indicating that they feel they will experience job repercussions, including loss of their position and limitation of career opportunities, if errors are made (London Health Sciences Centre, 2020). In 2019, LHSC adopted the use of a formal Just Culture approach and algorithm. Despite the initial uptake of this approach, the Can-PSCS results demonstrated that further efforts are needed to build trust and develop communication with respect to patient safety. The shift in patient safety culture, which is the focus of this Patient Safety Plan, supports ongoing work to implement the Just Culture framework and will help improve staff perceptions of outcomes associated with the occurrence of patient safety incidents within the organization.

An organizational shift of this magnitude requires support by a robust Change Management strategy and plan. In alignment with LHSC Organizational Learning and Development, and the Continuous Improvement of Care (CIC) team, *Kotter's Eight Step Process* for change management will underpin the adoption of this plan (Kotter, 2012).

Patient Safety Plan: Priority Areas

The 2022-2026 Patient Safety Plan will focus on six priority areas to strengthen the patient safety culture through facilitation of the shift to proactive safety management within the organization. These six areas are considered foundational as they will provide the necessary structure to build future safety initiatives that are grounded in *Safety 2* thinking. The priority areas identified are based upon best practice, current literature and internal survey results. The six priority areas are in alignment with Healthcare Excellence Canada's 2021-2026 strategic plan, *Shaping the Future of Quality and Safety: Together* (HEC, 2022). The priority areas are interconnected and advancing in one area is not possible without advancing in all of them. These six priority areas are:

- Teamwork and Communication
- Continuous Learning and Improvement
- Building Reliability
- Leadership
- Psychological Safety and Resilience Engineering
- Responding to Safety Events

*A description of the priority areas is provided in Appendix B

Patient advisors, and key organizational stakeholders, including select physicians with interest and/or training in patient safety, were invited to provide their input and feedback both electronically and through virtual meetings. Across all engagement, stakeholders were supportive of the identified priority areas and specific points of feedback were incorporated within the year one action plan, where applicable. To note, the 2022-2026 LHSC Patient Safety Plan has been developed during the COVID-19 Global Pandemic. Once pandemic pressures ease, there will be additional stakeholder involvement in development of the annul action items. A summary of stakeholder engagement is included in Appendix C.

The six priority areas are further supported by three foundational principles which influence the areas of focus. These principles will be considered in all aspects of the plan and will help to shape the final state of each priority area. The foundational principles are *Just Culture*, *Patient and Family Partnership* and *Health Equity* as depicted in the center of the graphic below. These three foundational principles were specifically identified due to their permanence and importance as organizational priorities.

Figure 1: Visual Depiction of the priority areas within the Patient Safety Plan

LHSC 2022-2026 Patient Safety Plan: Year 1

The 2022-2026 Patient Safety Plan is a four-year plan, with annual actions items identified and added to it on a yearly basis. This decision was made in acknowledgement and appreciation for the everchanging nature of health care in Ontario due to the COVID-19 pandemic. This approach builds flexibility into the plan, allowing a nimbleness to respond to the changing needs of the larger health care system, LHSC staff and physicians and patients and their families. The Patient Safety Plan will ensure yearly alignment with both COVID-19 Pandemic operational priorities, and future Pandemic Recovery plans. As such, the action items for Year 1 are listed in the following chart. In addition, the year one plan will focus on, leveraging existing and ongoing work within LHSC including Just Culture, the Health Equity Framework development, and Continuous Improvement in Care (CIC).

Focus Area	Description	Year 1 Goals	Year 1 Tasks	Metrics/ Evaluation	Key Stakeholders
Teamwork and Communication 	Open, respectful and transparent communication and teamwork, both within and between areas, is essential to developing a culture of patient safety within an organization (Hollnagel, 2015). A leading cause of safety incidents is the breakdown in teamwork and communication (Panesar, 2014).	Create an environment of open and transparent communication within and between teams, patients and families.	Develop a process, in partnership with the Quality and Patient Safety Council (QPSC), to share patient safety learning opportunities across the organization.	☐ Complete ☐ In Progress ☐ Initiation The percentage of safety issues identified that were escalated to QPSC where change initiatives/learnings were implemented and shared	Patient Experience Accreditation Continuous Improvement of Care Quality and Patient Safety Committee
			Leaders to include a question related to patient safety during Purposeful Rounding. Leverage the ongoing Gemba Walks to ensure patient safety topics are discussed.	☐ Complete ☐ In Progress ☐ Initiation	
			Utilize people centered care principles to ensure all patients and families, staff, and health care providers are treated as equal members of the care team in order to enhance communication.	☐ Complete ☐ In Progress ☐ Initiation Results of the People Centered Care Priority Process assessment (conducted by Patient Experience Team)	

Metrics/Evaluation Legend
- ☑ Complete
- ◪ In Progress
- ☒ Initiation

Teamwork and Communication 		Utilize existing and upcoming CIC training to help encourage communication and teamwork focused on developing safety strategies and staff led safety initiatives.	Incorporate a safety question (patient or staff) into status exchanges or staff huddles/meetings with the goal of increasing open communication with respect to safety concerns	☐ Complete ☐ In Progress ☐ Initiation	Patient Experience Accreditation Continuous Improvement of Care Quality and Patient Safety Committee
		Ensure patients and families are involved in critical incident reviews.	Create process to ensure patients and families involvement in the Critical Incident Review process	☐ Complete ☐ In Progress ☐ Initiation	

Focus Area	Description	Year 1 Goals	Year 1 Tasks	Metrics/ Evaluation	Key Stakeholders
Continuous Learning and Improvement 	Continuous learning and improvement are essential for organizational growth and resiliency (Hollnagel, 2015). Partnering with the Center for Organizational Learning and Development team, staff development opportunities will be identified and existing programs re-designed to support staff and leaders from a perspective of learning from safety incidents. Healthcare systems must continuously adapt to the rapidly changing demands of the internal and external landscape. Resources must be used effectively in order to maintain the capacity to continuously improve; leading to better quality and safety for staff, patients and families.	Develop an education plan and resources to build capacity and competencies to create an environment that supports the implementation of the Safety 2 culture.	Incorporate principles of Safety 2 into existing learning programs including corporate and unit level orientation, staff and leader education. Inclusion of Safety 2 resources on the Learning Hub.	☐ Complete ☐ In Progress ☐ Initiation	Patient Learning and Development Continuous Improvement of Care Health Equity
			Perform an analysis of the results from the 2023 Accreditation Survey so that areas for improvement can be identified in addition to successes.	☐ Complete ☐ In Progress ☐ Initiation	
			Support clinical teams in the ongoing development of safety initiatives based on available data, clinical observations, successes, and expertise.	☐ Complete ☐ In Progress ☐ Initiation	
		Implement and align strategies for continuous learning, building on the Continuous Improvement of Care initiatives, to enhance the capacity and competency of staff and affiliates, and improvement of patient safety within the organization.	*Collaborate with the CIC team to incorporate Safety 2 principles into CIC training and daily management systems.*	☐ Complete ☐ In Progress ☐ Initiation	

Focus Area	Description	Year 1 Goals	Year 1 Tasks	Metrics/ Evaluation	Key Stakeholders
Building Reliability 	System reliability in health care is essential to ensuring patients receive safe, high-quality care. The use of evidence-based systems, reduction in variation and development of systems to maximize strengths are essential in ensuring reliability in care practices (Frankel, 2017). Maintaining accreditation status and participating in Accreditation Canada's on-site survey process as well as maintaining key partnerships to enable ongoing research are essential in maintaining and improving reliability of care.	Ensure that leaders, staff and physicians have the capacity to participate in organization wide preparation and completion of Accreditation Survey receiving Exemplary Standing.	Ensure ongoing adherence to Accreditation Canada's Required Organizational Procedures, priority processes, and standards of care.	☐ Complete ☐ In Progress ☐ Initiation Mock Survey Results (Q1) Self-Reported Compliance Documents Tracers	Policy Professional Practice Medical Affairs Accreditation Continuous Improvement of Care
		Increase development of consistent practices to prevent the occurrence of safety incidents.	Identify and educate leaders on Always Events (preventative actions) that correspond to the prevention of Never Events. This should include reviewing the effectiveness and adherence to Always Events following the Occurrence of a Never Event.	☐ Complete ☐ In Progress ☐ Initiation 100% of all Never Event reviews will include commentary on the adherence and effectiveness of identified Always Events	
		Ensure organizational policies and procedures are reviewed and developed, and they are in alignment with a *Safety 2* culture.	Develop and initiate a process to ensure all policy reviews include a change to *Safety 2* language and processes.	☐ Complete ☐ In Progress ☐ Initiation	
		Support the use of evidence-based practice and research to help further develop reliability in care practices.	Ensure ongoing endorsement of staff and physicians regarding research endeavors that support the development of evidence based best practices and improved reliability of care.	☐ Complete ☐ In Progress ☐ Initiation	

Focus Area	Description	Year 1 Goals	Year 1 Tasks	Metrics/ Evaluation	Key Stakeholders
Leadership 	Developing and sustaining a strong patient safety culture requires strong leadership at all levels (WHO, 2021). Ensuring all leaders have the skills and understanding to conduct themselves in alignment with a *Safety 2* culture in daily management and in response to safety incidents.	*Safety 2* competencies for all leaders will be created and endorsed by the senior leadership and physician leadership teams.	Senior Leadership will establish roles and competencies for leaders regarding *Safety 2* by June 30, 2022.	☐ Complete ☐ In Progress ☐ Initiation	Senior leadership Physician leadership Organizational Learning and Development Patient Safety Just Culture
		Develop resources and education strategies to ensure that leaders have the competencies needed to be knowledgeable on the principles and practical application of *Safety 2* theory.	Develop training on the principles and tools regarding *Safety 2* that includes a refresher on existing Change Management education to reflect these principles. This training is to be rolled out to all formal leaders. Consideration to be given to providing the education to Board members as well.	☐ Complete ☐ In Progress ☐ Initiation	
		Ensure all leaders have completed training in Just Culture.	Continue to provide mandatory training and ongoing support in use of the Just culture framework to ensure all leaders are competent in its application.	☐ Complete ☐ In Progress ☐ Initiation Percentage of formal leaders that have completed Just Culture Training with a target of 85%	

Focus Area	Description	Year 1 Goals	Year 1 Tasks	Metrics/ Evaluation	Key Stakeholders
Psychological Safety and Resilience Engineering 	The wellbeing and psychological safety of the workforce is essential for patient safety (NSCPS, 2020). In a psychologically safe culture, staff feel supported to "speak up" and report safety incidents, knowing that they will be managed fairly, without judgement.	Ensure the Just Culture Framework is applied consistently and appropriately in follow-up to safety incidents. During follow up to safety incidents leaders will conduct themselves in a manner congruent with the Just Culture Framework and principles of *Safety 2*.	Ensure ongoing and regular communication to leaders and physicians of available support for Just Culture. Communication should highlight available resources including the 6 online learning modules for Just Culture.	☐ Complete ☐ In Progress ☐ Initiation	Employee Health and Wellness Patient Safety Learning and Development People & Culture Professional Practice
			Explore the feasibility of incorporating Just Culture training into orientation for new staff, leaders and physicians, in collaboration with People and Culture and key stakeholders	☐ Complete ☐ In Progress ☐ Initiation	
			Provide leaders with the competencies, capacity, and education to identify system factors and support staff in accordance with the Just Culture model; including the initiation of quarterly "*Just Culture Hot Topics*" where case studies will be discussed. Effective application of the Just Culture model, and education on Just Culture tools and resources will also be covered.	☐ Complete ☐ In Progress ☐ Initiation	

Psychological Safety and Resilience Engineering 		Review and mitigate system factors contributing to identified safety concerns in order to ensure staff are consistently in an environment to provide safe, quality patient care.	Leverage pre-existing CIC mechanisms, such as status-exchanges, through which staff are able to share safety concerns openly.	☐ Complete ☐ In Progress ☐ Initiation	Employee Health and Wellness Patient Safety Learning and Development Team People & Culture Professional Practice
		Ensure ongoing support is available for all staff, physicians and leaders with a specific focus on response following serious safety incidents.	Leverage pre-existing staff support programs, and opportunities for debrief, through which all staff are able to access help following the occurrence of a significant safety incident. Ensure that these programs are communicated to all staff, leaders, physicians and union partners.	☐ Complete ☐ In Progress ☐ Initiation	

Focus Area	Description	Year 1 Goals	Year 1 Tasks	Metrics/ Evaluation	Key Stakeholders
Responding to Safety Events 	Learning from patient safety incidents when they occur is essential for system improvements. As such, organizations must be made aware of incidents when they occur. These systems also allow for monitoring of underlying trends and patterns to allow for proactive identification of system vulnerabilities (HQO, 2015).	Reconceptualize the adverse event management system (AEMS) as a non-punitive learning system that is used to identify gaps and system vulnerabilities and prioritize system improvements.	Change the name of AEMS to reflect its purpose as a learning system, i.e., Safety Learning System [ii]	☐ Complete ☐ In Progress ☐ Initiation	Risk Management Policy Information Technology Services Patient Experience Occupational Health (Staff Safety) Patient Safety and Accreditation Professional Practice Medical Affairs
			Convene a working group to address shifts in policies, procedures, corporate education from referencing the AEMS System to the new system name.	☐ Complete ☐ In Progress ☐ Initiation	
			Optimize the use of the system by identifying barriers to recording patient safety incidents and develop a plan to address barriers (HQO, 2017).	☐ Complete ☐ In Progress ☐ Initiation	
		Development of processes to formally identify safety trends and respond to them across the organization.	Develop a process for identification and monitoring of trends that include reporting of near misses and no harm events.	☐ Complete ☐ In Progress ☐ Initiation	

Focus Area	Description	Year 1 Goals	Year 1 Tasks	Metrics/ Evaluation	Key Stakeholders
Responding to Safety Events 			Establishment of a process for the Quality and Patient Safety Council (QPSC) to review emerging issues and trends from frontline staff, leaders, providers and safety incident data for ongoing monitoring and prioritization of corporate quality and patient safety activities.	☐ Complete ☐ In Progress ☐ Initiation	Risk Management Policy Department Information Technology System Patient Experience Occupational Health (Staff Safety) Patient Safety and Accreditation Professional Practice Medical Affairs

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Appendix A: Comparison of Safety 1 and Safety 2

	Safety 1	Safety 2
Definition of safety	That as few things as possible go wrong	That as many things as possible go right
Safety Management Principle	Reactive, respond when something happens or is categorized as an unacceptable risk.	Proactive, continuously trying to anticipate developments and events.
View of human factors in safety management	Humans are predominantly seen as a liability or hazard. They are a problem to be fixed.	Humans are seen as a resource necessary for system flexibility and resilience. They provide flexible solutions to many potential problems.
Accident investigation	Accidents are caused by failures and malfunctions. The purpose of an investigation is to identify the causes.	Things basically happen in the same way, regardless of the outcome. The purpose of an investigation is to understand how things usually go right as a basis for explaining how things occasionally go wrong.
Risk assessment	Accidents are caused by failures and malfunctions. The purpose of an investigation is to identify causes and contributory factors.	To understand the conditions where performance variability can become difficult or impossible to monitor and control

Adopted from Hollnagel, et al., 2015.

Appendix B – Glossary of Terms

Foundational Principles Definitions

These definitions were chosen by the Patient Safety Team based on current knowledge and LHSC priorities. The Patient Safety Plan will align with the ongoing work of content expert departments; as their definitions evolve so will the definitions within the Patient Safety Plan.

Just Culture

Just Culture is a values-supportive system of shared accountability where organizations are accountable for the systems they have designed and for responding to the conduct of their employees in a fair and just manner. It focuses on proactive management of both system design and individual conduct. A Just Culture organization is one that holds itself accountable, holds staff and providers accountable, and has staff and providers who hold themselves accountable. In a Just Culture organization, staff and providers are treated with respect and feel supported when things go wrong or almost go wrong (LHSC, 2022).

Health Equity

Health equity is created when individuals have a fair opportunity to reach their fullest health potential. Achieving health equity requires reducing unnecessary and avoidable differences that are unfair and unjust. Many causes of health inequities relate to social and environmental factors including: income, social status, race, gender, education and physical environment. (Public Health Ontario, 2020).

Patient and Family Partnership

An approach to care where patients and families and healthcare professionals' partner to give patients a voice in the design and delivery of the care and services they receive. This allows patients to be proactive in their healthcare journey for better health outcome; and improve the experience of patients and families (CPSI – PEAT, 2021).

Priority Areas Definitions

Teamwork and Communication

- Appropriate conduct of all staff, leaders, and physicians through open, respectful and transparent communication and teamwork, both within and between areas, is essential to developing a culture of patient safety within an organization (Hollnagel, 2015). A leading cause of safety incidents is the breakdown in teamwork and communication (Panesar, 2014).

Continuous Learning and Improvement

- Continuous learning and improvement are essential for organizational growth and resiliency (Hollnagel, 2015).
- Partnering with Organizational Learning and Development, opportunities will be identified and existing programs re-designed to support staff and leaders to develop the competency to utilize safety incidents as learning opportunities.
- Healthcare systems must continuously adapt to the rapidly changing demands of the internal and external landscape. Resources must be used effectively in order to ensure there is capacity to continuously improve, leading to better quality and safety for staff, patients and families.

Building Reliability

- System reliability in healthcare is essential to ensuring patients receive safe, high-quality care. The use of evidence-based processes, reduction in variation, and the development of systems to maximize strengths are all essential in ensuring reliability in care practices (Frankel, 2017).
- Maintaining Accreditation status and participating in Accreditation Canada's on-site survey process as well as well as maintaining key partnerships to enable and support ongoing research are essential in maintaining and improving the capacity to provide reliable care.

Leadership

- Enabling leaders to have the competencies, capacities and tools to "walk the talk" for a *Safety 2* mindset at all levels of leadership.
- Developing and sustaining a strong patient safety culture requires strong leadership at all levels (WHO, 2021).
- Ensuring all leaders conduct themselves in a manner that supports a Safety 2 culture during daily management and in response to safety incidents.

Psychological Safety and Resilience Engineering

- The wellbeing and psychological safety of the workforce is essential for patient safety (NSCPS, 2020). In a psychologically safe culture, the conduct within the organization of leaders and colleagues ensures staff feel supported in raising concerns and reporting safety incidents, knowing that they will be managed fairly, without judgement.

Responding to Safety Events

- Learning from patient safety incidents when they occur is essential for system improvements. As such, organizations must have systems in place to be made aware of incidents when they occur. These systems also allow for monitoring of underlying trends and patterns to allow for proactive identification of system vulnerabilities (HQO, 2015)

Appendix C - Summary of Stakeholder Engagement

Stakeholder engagement was completed with patient advisors and identified stakeholders at LHSC. Due to pressures related to the COVID-19 pandemic the decision was made to not ask Clinical Leaders for their input on the year 1 action plan. The lack of feedback from this stakeholder group is identified as a limitation of this plan, one that will be rectified when the year 2 action items are developed.

An email was sent to stakeholders and stakeholder groups (see below) offering them the opportunity to provide their input on the six priority areas. In addition, multiple meetings were held with key stakeholders to allow for open discussion. All stakeholder-provided feedback was reviewed and discussed by the Patient Safety Team.
The comments and feedback received were consolidated and saved to inform action items for subsequent years action items.

Patient Safety Plan - Key Stakeholders

Department/Role	Stakeholder Contacted	Meeting Date	Email	
			Date Sent	Replies Recieved
Patient & Family Advisors	Patient Advisor #1		1/21/2022	☑
	Patient Advisor #2		1/21/2022	☑
	Bill Gerbert, Patient Advisor		1/21/2022	☑
Physicians	Dr. Mason Curtis, Physician	1/28/2022	1/21/2022	☑
	Dr. Jennifer Lam, Physician		1/21/2022	☑
Patient Experience department	Manuella Giuliano, Manager		1/17/2022	☑
Nursing Council	Lori O'Brien, Co-Chair	1/19/2022	1/21/2022	☑
Clinical Educators	Sarah Smith, Manager	1/25/2022	1/21/2022	☑
	Anne McVety, Clinical Educator		1/21/2022	☑
	Lidia Yanchuk, Clinical Educator		1/21/2022	☑
MAC Chair	Dr. Scott McKay, MAC Chair		1/21/2022	☑
Ethics & Health Equity	Jill Sangha, Specialist	2/1/2022	1/21/2022	☑
	Robert Sibbald, Director		1/21/2022	☑
Patient Relations	Alicia Cooper, Manager		1/21/2022	☑
Privacy & Risk Management	Krista Muncaster, Manager		1/21/2022	☑
	Andrea McInerney, Director	12/21/2022	1/21/2022	☑
Just Culture	Nancy Lawrence, Manager		1/21/2022	☑
Children's Hospital	Jatinder Bains, Vice President		1/21/2022	☑
Communications	Gehna Singh Kareckas, Director	1/28/2022	1/21/2022	☑
Organizational Learning and Development	Lorinda Hallam, Director	12/21/2022	1/21/2022	☑
	Maureen Doherty Neilson, Manager	12/21/2022	1/21/2022	☑
	Kyle Cameron, Manager		1/21/2022	☑
Quality & Performance	Maurice Williams, Manager	1/27/2022	1/21/2022	☑
Support Services	Andy Rombouts, Director		1/21/2022	☑
Volunteer Services	Meghan Innes, Manager		1/21/2022	☑
Manager's Council	Allison Armstrong, Co-Chair	2/2/2022		
Occupational Health and Safety Services	Cathy Stark, Director	1/24/2022	1/21/2022	☑

[i] 85% is the identified target due to turnover in Leadership.
[ii] A patient safety learning system is structured reporting, collation and analysis of patient safety incidents (adverse events). (Health Quality Ontario, 2017)