Physician Responsibilities with Accreditation Required Organizational Practices (ROPs)

Physician participation is critical for patient safety and to meet accreditation requirements. Please ensure you are aware and follow these ROPs.
Please refer to Accreditation Canada's ROP Handbook for a full ROP details.

ROP	Evidence Base	Physician Responsibility
Patient Safety Incident Management	In a culture of patient safety, everyone is encouraged to report and learn from patient safety incident. A reporting system facilitates monitoring and learning from data to prevent recurrences.	• Report patient safety incidents and near misses in the Safety Improvement & Management System SIMS Quick link (anonymous or confidential) • Promote safety by learning from patient safety incidents and participate in quality review so care processes can be improved. • See NS Health's NS Health's Patient Safety Incident Management Policy and NS Health's Quality Review Policy for full detail
Patient Safety Incident Disclosure	Research shows a positive relationship between patient satisfaction with how a patient safety incident is handled by an organization and formal open disclosure. Disclosing in an open and timely manner may maintain the patient's positive relations with service providers and reduce risk of litigation. Disclosure is required for all patient safety incidents which reach the patient (including where there has been no harm).	• Attend to the patient's safety and clinical care needs • Inform those affected that a patient safety incident has occurred. Only state facts as they are known, do not speculate or assign blame • It is always right however, to say we are sorry for what happened in a compassionate way. An apology is not an expression of liability and are protected under the Nova Scotia Apology Act • Offer support to all involved • Document the disclosure on the health record • Review/implement recommended actions to prevent future incidents • Model/teach learners the physician's role in disclosure • See NS Health's NS Health's Disclosure of Patient Safety Incidents Policy, CMPA's Guidelines; and Canadian Guidelines for additional detail
Hand hygiene	Hand hygiene is considered the single most important way to reduce health care-associated infections. Cost estimates of health care-associated infections significantly exceed those related to hand hygiene.	• Perform the 4 moments of hand hygiene: 1. before initial contact with the patient or their environment 2. before a clean/aseptic procedure 3. after body fluid exposure risk 4. after touching a patient or their environment • Complete required annual hand hygiene education sessions • Model and instruct learners to adhere to proper hand hygiene • See NS Health's Hand Hygiene Policy for full detail
Patient/Client Identification	Using two patient identifiers to confirm that patients receive the service or procedure intended for them can avoid patient safety incidents (e.g., medication errors)	• Use at least 2 patient/client specific identifiers to confirm they receive the service/procedure intended for them • This is done in partnership with patients/families by validating 2 unique identifiers and explaining it is an important safety practice • See NS Health's Client Identification Policy for full detail
Information transfer at care transitions	Information transfer has been identified as critical in improving patient safety, particularly at transition points - ensuring the accurate and timely exchange of information to minimize misunderstanding.	• Ensure safe, timely information handover to other physicians and staff at admission, handover, transfer, and discharge • Ensure patients/families are given the information they need to make decisions and support their care at care transitions • Document information that is transferred to other care team members and the patient/family

*Patient refers to individual receiving care/service and can include residents and clients

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Medication Reconciliation at care transitions	Research suggests that over 50% of patients have at least one discrepancy between the medications they take at home with those ordered upon admission to the hospital. Many of these have the potential to cause medication related patient safety incidents.	• Use established formal process to reconcile patients' medications at admission, transfer and discharge • Step 1: documenting the best possible medication history which can be done by various people at admission, transfer or discharge • Step 2: requires a clinician to order the medications the patient should be on at admission, transfer or discharge.
"Do not Use" List of Dangerous Abbreviations	An average of 5% of medication errors are attributable to dangerous abbreviation use. Medication errors can lead to an increase in the length of stay, more diagnostic tests and changes in drug treatment.	• Apply the ISMP List of Do Not Use Dangerous Abbreviations to all medication-related documentation • Model and teach this to your learners • Know Do Not Use Abbreviation audit results/trends for your service
Safe surgery checklist	Safe surgery checklists play an important role in improving the safety of surgical procedures (e.g., wrong surgery, retained objects) as they can reduce the likelihood of complications following surgery and improve surgical outcomes.	• The surgeon of record must use a 3-phase safe surgery checklist for every surgical procedure in the operating room • Ensure that learners (e.g., residents/fellows) use the checklist • See our Operating Room Team Surgical Safety Checklist Policy for detail
Venous thromboembolism (VTE) prophylaxis	Development of VTE is the most common preventable cause of hospital death. Incidence of VTE can be reduced or prevented by identifying patients at risk and providing appropriate, evidence-informed thromboprophylaxis.	• Identify patients at risk for VTE (deep vein thrombosis & pulmonary embolism) • Ensure appropriate prophylaxis is in place, including post-discharge prophylaxis for major orthopedic surgery patient • If "at risk" patient is not prophylaxed, document reason why
Antimicrobial Stewardship (AMS)	Antimicrobial stewardship programs optimize the use of antimicrobials to improve patient outcomes, reduce the risk of infections including *Clostridium difficile*, reduce or stabilize levels of antibiotic resistance, decrease drug toxicities, and promote patient safety.	• Participate in practices aimed at optimizing antimicrobial use • Ensure antimicrobials are dosed correctly, reassessed regularly, and used for the shortest duration possible • Ensure streamlining or de-escalation of therapy and conversion from parenteral to oral formulation when appropriate. • See NS Health's Antimicrobial Stewardship site for additional information
Infection rates	Physicians who are well informed about infection rates are better equipped to prevent and manage infection rates. Use of infection rates may focus on a particular health care-associated infection, or may be service, program or organization wide.	• Participate in actions to prevent and manage infection. • Know infection rates for your service (see our IPAC site – Infection Rate page) • Review infection rate data to identify areas for improvement
Client Flow	Overcrowding is a system-wide challenge and usually a result of a mismatch between capacity and demand. Evaluating client flow data facilitates development of strategies to meet variations, reduce barriers, and prevent overcrowding.	• Participate in interventions to improve client flow that address the barriers and variations in demand that have been identified through relevant data
Annual patient safety education & training	Educating health care providers about patient safety and enabling them to use this knowledge to build and maintain a safe system is critical to creating the safest health system.	• Complete at least one patient safety training session per year. You can incorporate this annually into existing forums (e.g., Grand Rounds). • Document your patient safety training at group sessions or in the Learning Management System.

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