

A Sabbatical Journey of Discovery: Patient Safety

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This is the second in a series of reports to share key learnings from my sabbatical. In spring and summer of 2005, I took a three-month journey through Scandinavia, Europe, Ireland and the United Kingdom to observe innovation in nursing service delivery, in particular, nursing-led services; to explore outcome measurement as it relates to nursing services; to look at patient satisfaction and improving patients' experience as a form of outcome measurement; to learn about palliative care; and to examine ways in which organizations, professional associations and policy makers are attempting to move nursing and healthcare services delivery into the future. I met with leaders in nursing and other health professions, policy makers, faculty and research units. During site visits, I spent time observing nurses at work. I visited teaching hospitals, district or community hospitals, community services, hospices and telehealth facilities. Our international colleagues extended a

warm welcome, helped me gain exposure to things that might be of interest and were eager to learn about our practices in Canada.

The focus of this report is patient safety, especially infection control and patient-centred care.

Infection Control

In all the countries that I visited, hospitals provided uniforms and change areas for nursing staff as an infection-control measure, a practice that also added a look of professionalism to the work environment. In Denmark, infection rates have been reduced by cutting off the sleeves of lab coats and eliminating neckties.

In the Netherlands, I visited infection-free hospitals where staff use the one-hour test for MRSA that was designed at McGill University in Quebec. Their proactive approach to infection control, which has resulted in a cost reduction of 50% in infection management, involves screen-

ing patients and healthcare workers, contact tracing by public health, containment and treatment. All professional staff are screened and must be clear of infection to work with patients. All elective patients are screened. If found to be positive for infection, they are treated before admission; their contacts are traced in the community, screened and treated until negative. In the case of emergency admissions or transfers from organizations known to have gram-negative infections, patients are automatically isolated at the point of entry. They are then screened and isolated until cleared of infection, and all their contacts are traced. When a case of MRSA, VRE or *C. difficile* is found, it must be reported in the next day's newspaper. As a result of these measures, the Netherlands has significantly reduced the number of gram-negative infections in its health-care system. For example, a 650-bed hospital that I visited had only six cases of gram-negative infections in the past year. This same approach could easily be applied in Canada to improve patient safety and reduce the cost of infection management.

In Ireland, nurses take a leadership role in infection control in various nursing-led clinics. For example, clinics in sexual health trace sexually transmitted diseases. Similarly, hospitals retain an infectious disease liaison nurse to manage infections across the continuum of service. The NHS University in England has developed learning modules on infection control that would be a useful resource for us in Canada.

Patient Safety

Patient safety practices in Sweden include a two-hour shift overlap. This time is utilized for communication, interdisciplinary case discussions and staff education. Interdisciplinary rounds involve patients and families. The nursing and pharmacy departments participate together in patient safety chart reviews. A large teaching hospital that I visited in Copenhagen, Denmark, had a quality structure and coordinator in place for the organization, each site and each program.

Interdisciplinary quality education based on action learning has been introduced in Ireland. In England, Acute Life-Threatening Events Recognition and Treatment courses are in place for the entire multidisciplinary team, and Critical Care Outreach teams are well established. Assessment and decision-support software is being tested in England. The Map of Medicine Assessment Decision Tree software is being used in NHS call-in centres. This is a step-wise assessment and decision process that can support registered nurses' assessment of patients and doubles as a patient education tool. The Easy Care Assessment Support software and Electronic Pen are also being tested in England. I loved this one! An electronic pen, which is identified to the nurse, is used to maintain a paper record for the patient at the bedside. When the nurse returns to the nursing station, she puts the pen into a docking station and her notes are automatically recorded in the electronic health record.

Patient-Centred Care

In Norway, hospitals focus on the health and ability of individuals throughout the services continuum. Hospitals are attractively designed as healing environments. In Denmark, patient involvement is supported through open-phone programs to the board of directors and open meetings with patients.

Ireland has organizational awards for listening to patients. Patient involvement is advanced through patient advocacy committees and patient participation on all interdisciplinary quality teams. A cultural diversity officer is available for patients, and the mental health sector has developed quality-of-life outcome measures. In Scotland, Web-based systems support informed patient decision-making

and choice. England has reinstated the matron's role in hospitals to improve patients' experience through visible leadership in the practice environment and the promotion of patient-centred care.

Conclusion

As you can see, our colleagues abroad are advancing patient safety through innovative approaches to infection management, information systems and patient-centred care. Clearly, there are opportunities for nurse leaders in Canada to expand nursing roles to advance patient safety and to increase patient and family involvement in decision-making related to their care. Such changes could improve efficiency and also reduce costs.

Stay tuned for future reports!



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