Editorial

Responses to the two previous issues of Patient Safety Papers suggest that there is a large audience for descriptions of effective patient safety practices. While few would argue that Canadian healthcare is measurably safer today than it was five years ago, there are important initiatives that have laid the groundwork for improvements. For example, the Safer Healthcare Now! (SHN) campaign has engaged teams across the country in six critical areas where current performance has lagged behind knowledge of what is needed for safer care. Yet, SHN nicely illustrates the continuing challenges to improve safety. Even with evidence-based bundles of changes, useful metrics to assess improvement and well-orchestrated supports for teams, overall progress in SHN is uneven: some teams have been very successful, but others struggle to make and sustain improvements in their performance.

Despite the slow pace of progress, there is a growing awareness of risks, which is the first step in augmenting safety defences. Still, most organizations have a limited understanding of the extent to which care is safe or unsafe. And strategies to share learning, for example, from root-cause analyses, are still in early stages across most of Canada.

Experience in Canada and elsewhere suggests that there are three critical elements for making and sustaining improvement. Measurement is vital for identifying current performance, assessing the impact of improvements and holding the gains. Knowledge of the improvement skills necessary to plan and test changes, learn from results and anchor improvements into ongoing systems of care is essential for reaching higher levels of reliability. And, finally, leadership at all levels – front-line, middle management and senior leadership – is needed to ensure a relentless focus on patient safety. Healthcare is complex, and there are many demands on leaders' time. Only a continued emphasis on the goals of safer care and a strategic investment in safety will ensure that we build on the momentum of effective practices and the experiences of implementing them in Canadian healthcare organizations.

This special issue of *Healthcare Quarterly* provides continuing evidence of work across the country to make healthcare safer. In "Improving Care at the Front Lines," several articles detail efforts to reduce falls, lessen the numbers of infections and institute safer practices to prevent harm. The articles included in "Medication Safety" outline strategies to develop better measures, assess current performance, identify risks and design safer medication practices. The tools used by these authors to assess and improve practice are likely to find uses in many other settings.

Although there are many unique risk factors that threaten patient safety, one common feature of many incidents is a failure in communication and teamwork. In several articles in "Teamwork and Communication," authors outline strategies for improving these practices. Safe practice requires the communication of patient and client needs and agreement across disciplines, shifts and organizations about what care is needed. Efforts to improve teamwork and communication build upon shared values and work habits that support safety.

In "Creating a Patient Safety Culture," authors discuss new tools to assess and shift the culture, helping to create an environment where patient safety practices will flourish. One core aspect of a safe culture is the recognition that safer care must involve patients and their families. Three articles address challenges of "Involving Patients and Families." The authors outline efforts to engage patients, improve communication and reduce the fears that such involvement may expose individual practitioners and organizations to unwanted publicity or legal actions. Much remains to be done in this area.

Finally, in "Broadening the Patient Safety Agenda," several articles describe the initiation of patient safety in long-term care and rehabilitation settings and the use of the balanced scorecard to integrate patient safety into strategy. Acute care remains the area with the greatest experience with patient safety practices. And while the underlying principles of safe practice are consistent across settings, their implementation in settings where clients are residents and have continuing relationships with staff raises new challenges.

The range of issues, settings and ideas provided in this issue reminds us of the complexity of patient safety and the need to keep the challenge of providing safer care at the forefront of the healthcare agenda. We welcome your feedback on the ideas and experiences shared by authors from across the country.

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