

While improving patient safety remains a high priority in Canadian healthcare, organizations today face the new challenge of advancing patient safety and quality of care in an environment where budgets are flat or declining. Investments in patient safety thus compete with other efforts to improve services and to maintain operations. Both strategically and operationally, healthcare organizations need to assess their patient safety efforts through a critical lens and ask two related questions: How will these efforts reduce the risks of injury for patients in our care? What is their likely impact compared with other programs that may improve care and patient outcomes?

The articles in this fifth issue of Patient Safety Papers reflect on this challenge in differing ways. Here's a sample of what lies in this issue.

Better information on risks is a vital first step in comprehending where care needs to be safer. In an innovative analysis of influenza vaccine information on the Internet, Neil Seeman and his colleagues illustrate the value of understanding public perceptions of healthcare issues as a critical step in designing preventive health programs. Effective flu prevention cannot be achieved when a sizable population hold sceptical views on the safety of vaccines. Counter-marketing strategies are needed to provide assurances to those who shrug off the advice of public health leaders. Better information needs to guide action, an insight pursued by Roger Cheng and his coauthors in an assessment of medication safety indicators for acute care hospitals, and by Liudmila Husak and colleagues at the Canadian Institute for Health Information, who analyze the problems of sepsis and its impact on in-patient mortality in Canadian hospitals.

Safer care results only from the effective implementation of a safety solution. Karyn Popovich and her colleagues at North York General Hospital (NYGH) outline their approach to the prevention of pressure ulcers. Despite a growing evidence base of best practices, many organizations struggle to address this problem. By creating a comprehensive program, enlisting front-line staff and building competencies in wound care, NYGH reduced the incidence of skin pressure ulcers by 60%, allowing nursing resources to redirect their attention to other priorities. Investments in information systems have been a major lever for improving patient safety, but they can also introduce new sources of error. Elizabeth Borycki and Elizabeth Keay review the evidence on how healthcare information systems can contribute to increased errors, and these authors provide advice on a range of methods for improving the performance of these systems: strengthening procurement processes, guiding implementation and identifying technology-induced errors. Implementing safety solutions at the front line is rarely feasible if clinicians do not champion their use. Chris Hayes and colleagues from several Toronto area hospitals outline their experiences in creating physician leader positions for patient safety and building organizational support for this key role.

Organizations across Canada are engaged in patient safety projects. But undertakings can be insufficient in scale and often have only limited impact. Scaling up patient safety initiatives requires integrated approaches that link learning and practice changes across programs. Two leading examples from The Hospital for Sick Children (SickKids) and Hamilton Health Sciences offer organizational approaches that systematically address risks and identify improvements. Polly Stevens and her colleagues from SickKids review nine years of learning from critical occurrence reviews, while Rosanne Zimmerman and colleagues from Hamilton Health Sciences identify how they used death reviews to drill down on hospital standardized mortality ratio results in the pursuit of an audacious goal: reducing preventable deaths to zero.

Patient safety solutions are sustained when teamwork thrives and communication is effective. Anne Kearney and her colleagues at Memorial University of Newfoundland describe their implementation of inter-professional education on patient safety, building competencies across medical, nursing and pharmacy students. Angie Andreoli and a team at the Toronto Rehabilitation Institute used the Situation-Background-Assessment-Recommendation (SBAR) tool to strengthen team communication as part of a falls prevention and management initiative. They discovered that SBAR supports improved communication even in non-urgent situations. Physician handover is an important transition. Niraj Mistry et al. describe the development and implementation of a standardized protocol that improves the reliability of handovers at The Hospital for Sick Children.

Assessing and improving patient safety culture create a supportive context for change for the better. Madelyn Law et al. describe a new tool for patient safety culture and discuss how its results help leaders to address underlying issues. Michael Gardam and his co-authors illustrate how effective strategies often rest on both scientific evidence and local adaptations. Their insights on "positive deviance" approaches suggest that complex problems such as infection control need to be understood as behaviour changes that can only be effective if we understand what tactics work in specific settings.

The rich array of experiences and insights detailed in these articles and the others in this collection provide ongoing testimony to the continued efforts across Canada to improve patient safety. I welcome your feedback on these findings.

My thanks go to our editorial advisory board for their continuing guidance. In addition, this year we asked a number of patient safety experts to serve as associate editors of the journal, to review manuscripts and provide feedback in selecting the articles for this special issue. My thanks to all of them for their excellent work and support.

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