

National Perspectives on Patient Safety: Ten Years Later

In early 2014, *Healthcare Quarterly* convened a roundtable discussion on the subject of patient safety. The meeting's main goal was to get the perspectives of some of the leading healthcare organizations across Canada on what has been accomplished during the past 10 years, what has been learned and what remains to be done. The participants were:

RB = G. Ross Baker (moderator), Professor, Institute of Health Policy, Management and Evaluation, University of Toronto

BG = Bruce Gamage, President, Infection Prevention and Control Canada

SJ = Shelly Jamieson, CEO, Canadian Partnership Against Cancer

HM = Hugh McLeod, CEO, Canadian Patient Safety Institute

WN = Wendy Nicklin, CEO, Accreditation Canada

JW = John Wright, CEO, Canadian Institute for Health Information

JZ = Jennifer Zelmer, Executive Vice-President, Canada Health Infoway

The following text is not a verbatim transcript of the meeting. Rather, it distills the main content while, we hope, preserving the energy, enthusiasm and insights each person brought to the discussion.

RB: Ten years after the founding of the Canadian Patient Safety Institute (CPSI) and the Adverse Events Study, what do you think have been the major achievements in Canada in terms of improving patient safety?

HM: The first thing we've achieved is elevating awareness of the importance of patient safety. That has translated into the development of specific patient safety agendas, usually driven by health quality councils or associations.

The second piece has been the combining of disparate parts that didn't connect before. Now, the research community, the education community and the experts in quality improvement have come together to build an array of tools. The CPSI was the quarterback, but the tools – such as the GSKs and the starter kits – were built, delivered and owned by the system, and that basically came out of Safer Healthcare Now!

There is also today endorsement across the country of the importance and the power of the patient and family voice.

WN: There's also recognition – including by governments – that poor quality costs money, and that if you want an efficient and effective healthcare system, you need to focus on quality.

We've also seen progress with transparency. Today, there's a clear recognition of the importance of transparency and that it needs to be monitored with indicators and embedded in communications.

Accreditation Canada is pleased with the impact of our Safe Surgery Checklist Required Organization Practices (ROP) and the evolution of the ROPs. There's still work to be done, yet there have been some marked improvements.

BG: The infection control world has been helped by some scary organisms that came down the pipe, such as SARS, the *C. difficile* outbreaks and the newer multi-drug-resistant organisms. Those brought infection control and systemic gaps to a heightened level of public awareness. Healthcare leaders

realized we needed to get more bodies in place, more funding and to stop paying lip service.

SJ: In the cancer world, the last decade has seen more reporting by agencies, institutions and provinces. There's also less tolerance in the public, among funders and by government, for those of us in healthcare not co-operating on patient safety.

Those of us working in cancer realized there wasn't enough oversight from place to place in terms of putting patients at the centre and making sure the care they receive is the right quality and being done properly. Two examples of how we have addressed these issues are, first, our exploration (with Accreditation Canada) of ambulatory systemic cancer therapy service standards launched in 2011. And last year we started looking at quality radio therapy with the Canadian Organization of Medical Physicists (we've released the first set of technical quality standards).

JW: One important development has been the establishment of a national system for incident reporting. We have five Canadian jurisdictions involved in this, with almost 300 facilities (in the next 12 months we'll hopefully have another two provinces join).

We've also made tremendous strides in medication reconciliation and associated problems. And there's been progress in performance benchmarking and transparency; for example, using indicators to compare hospital deaths and other safety-related items. Finally, there's a lot of analysis that's come out of the data, which have led to better benchmarking.

JZ: I'll start by circling back to something Hugh began with: awareness. We recently consulted with 500 people across Canada, and one of the top five opportunities for action was digital healthcare. There have also been many advances in medication safety and our ability to detect and understand

Canadian Institute for Health Information

A list of highlights of patient safety activities on-going at the Canadian Institute for Health Information (CIHI):

National System for Incident Reporting (NSIR)

- Web application to share, analyze and discuss medication incidents
- Exploring use of NSIR for reporting of radiation oncology incidents

Planned 2014-2015 Projects

- Comparison of weekend/weekday mortality
 - Do weekend admitted patients have a higher death rate, and if so, possible explanations
- Harmful incidents in hospitals
 - Number and types of hospital safety incidents, associated costs, patient groups impacted, most common safety incidents
- Drug use among seniors on public drug programs
 - Number and types of drugs used by seniors, focusing on inappropriate use (Beers' drugs list)
- In-hospital infection indicators
 - In-hospital sepsis rate, sepsis mortality rate
 - Surgical site infection rate
 - In-hospital infection rate – Clostridium difficile, methicillin-resistant Staphylococcus aureus and vancomycin-resistant Enterococcus
- Harmful incident indicator (new safety measure)
 - Harm that occurs and treated in the same acute inpatient admission

- Obstetric trauma measure
 - Updates trauma measures such as lacerations or tears
- Falls prevention
 - Partnership project regarding data on falls across care settings and profiles prevention initiatives and tools

Recent Analytical Products

- OurHealthSystem.ca
 - Public website features patient safety measures: hospital death rates, use of antipsychotic drugs without diagnosis, compromised wounds
- International comparisons
 - Using Organisation for Economic Co-operation and Development data compares Canada's to other countries with focus on care quality and patient safety
- Compromised wounds
 - Prevalence of wounds across different health settings, and patient characteristics associated with high wound rates
- Hospitalization for adverse drug reactions
 - Prevalence of adverse drug reaction-related hospitalizations in seniors, the types of drugs and reactions and the risk factors
- Medication reconciliation
 - Status of medication reconciliation implementation and benefits of more widespread implementation

For more go to www.cihi.ca

medication conflicts and other issues. There has also been a variety of system-level changes; for example, in surveillance and education.

RB: The next question is about surprises. What has surprised you in these efforts over the last decade to improve patient safety? What have been the unanticipated developments?

HM: My biggest surprise is the gap between assumptions and expectations. I assumed political figures, governments and senior health-system leaders got the importance of patient safety. On paper, patient safety is often a priority; however, it frequently gets sidelined in practice.

In *Crossing the Quality Chasm* (2001), the authors said, “The science and technologies involved in healthcare, the knowledge skills, care intervention, devices and drugs have advanced more rapidly than our ability to deliver them safely, effectively and efficiently.” That’s a powerful statement, and I see its truth every day.

These challenges have forced us to think and act differently, and to collaborate at a level I haven’t seen before. We now know that the patient safety agenda is beyond any single organization and the only way to move forward is to value what each partner brings.

BG: I am reminded of the saying “Culture eats strategy for lunch.” We talk a lot about the fact that we’re trying to move to patient-centred care, but I’ve been surprised by the amount of resistance to that change. So much care today is staff-centred

and, unfortunately, physician-centred. We run up against this a lot when we try to implement big changes. Healthcare workers, especially physicians, often resist change.

WN: I am more disappointed than surprised. Why aren’t we seeing some measurable change? The healthcare system is still very unsafe. How do we really get at meaningful initiatives that will make a measurable difference?

Transitions are a huge issue. Many adverse events occur when patients transition between organizations, care providers and units, as well as when they’re discharged to home.

JZ: One of the surprises for me has been the number of people I’ve talked to recently who have had friends, relatives or are themselves involved with the health system and who are also interested in quality. It’s so challenging, though, especially for patients and families, to be active and engaged participants in safety.

JW: The push-back from the healthcare community on the adoption of flu shots or hand hygiene continually surprises me.

But, on the upside, I must say many jurisdictions are becoming and wanting to be more transparent around safety. There’s a lot more interest in better comparative data, and that’s been a positive surprise.

SJ: I’m surprised by the repetition of mistakes across different jurisdictions. Something bad happens in one province and is all over national papers and watched daily for months and examined through standing committees. And then 24 months

Canada Health Infoway

Supporting safer care through the use of innovative digital health solutions was identified as a key opportunity for action in stakeholder consultations that inform Canada Health Infoway’s plans and priorities. For example, Infoway co-invests with provinces, territories and others in solutions at the point of care (e.g., electronic medical records and clinical synoptic reporting); mechanisms to share core health information (e.g., medication profiles, test results and discharge summaries) with authorized clinicians through electronic health records; consumer health solutions; and other digital health solutions that have been shown to improve safety, such as computerized provider order entry. Infoway also works with partners – such as Accreditation Canada, CPSI, ISMP Canada and COACH – to improve understanding of how digital health can influence safety, share those learnings with the healthcare community and

encourage adoption of best practices. One mechanism for doing so is the by-clinicians-for-clinicians Knowing Is Better campaign. In addition, Infoway encourages and incents healthcare providers to grow the use of digital health solutions that enable safer care and share their experiences with others through the ImagineNation Challenges. The recently completed Outcomes Challenge series focused on areas such as medication reconciliation and clinical synoptic reporting. The current eConnect Impact Challenge series is focusing on communication among healthcare providers and between providers and patients.

For more information, please visit www.infoway-inforoute.ca

goes by and the same thing happens in another jurisdiction.

I think what happens is you solve one crisis and you just move on to the next one, without fixing the systemic problem or learning the lesson from another jurisdiction.

RB: I would like us now to think about where we should go next. What should we be doing, and what are the strategies and investments we need to be making to continue to push this agenda forward?

SJ: At the core of the solution is who does what. I talk inside of our cancer world about the sweet spot for our organization, about stepping into the spot where no one else is. Any time we're duplicating something that someone else is doing we really have to ask ourselves if that's what the taxpayer expects from us.

BG: We need to look at how to deal with low hand-hygiene and flu vaccine rates – to get people to take ownership of those issues. We need people to recognize that not making those changes is putting lives at risk.

One of the ways this is being moved forward is the use of measures as performance indicators, including pay-for-performance indicators. But that's a dangerous, slippery slope because of rate-gaming and surveillance biases. We need to be careful about messaging so that people take ownership of the rates, as opposed to looking at them in a punitive light.

JW: One of the main challenges is communication, not only with the public and CEOs, but at the frontline. It's about education and ethics.

Bruce is right that one indicator isn't the be all and end all. But pushing indicators down to the shop floor or the nursing unit is a major challenge.

JZ: I'm a big believer in making the right thing to do the easy thing to do. So, how can we build in the opportunity for systemic change? By focusing on leadership and culture we can make change happen, and not just with particularly enthusiastic individuals.

We also need the right tools at the frontline and throughout the system. That's where digital health comes in. It's how, for instance, you make it easier for somebody to do medication reconciliation and ensure that surgical checklists are completed.

WN: Building on Shelley's point, each of our organizations has a niche, and it comes down to how we optimize contributions. Accreditation is a vehicle to help move this agenda forward.

Picking up on Jennifer's comments, leadership must come from all levels of the organization. How we align goals among leaders is key. In terms of the national agenda, however, the system is fragmented with varying priorities. While those of us in this discussion are doing our best to align, the reality is

Accreditation Canada

Patients, clients and residents are central to patient safety and to the accreditation program. Guided by the Accreditation Canada 2012–2014 patient safety strategy, *Achieving Safe Care*, work continues to enhance the Qmentum accreditation program to respond to emerging safety risks both nationally and internationally. Strengthening the focus on client- and family-centred care will be a focus for standards enhancements planned for release in 2015.

Through analysis and reporting of accreditation data, Accreditation Canada is uniquely positioned to contribute to improved healthcare system performance. The 2013 Canadian Health Accreditation Report: *Safety in Canadian Healthcare Organizations* highlighted care transitions as a critical opportunity for system improvement. Collaborative reports with national patient safety partners offer important insights related to the health system. *Making Care Safer: From Hospital to Home Care* was released earlier this year, co-authored by the Canadian Patient Safety Institute. A report on falls prevention in partnership with the Canadian Institute for Health Information and the Canadian Patient Safety Institute will be released in October 2014. Moving

forward, collaborative reports will continue to be increased.

The Accreditation Canada required organizational practices (ROPs) are evidence-based practices that mitigate risk and contribute to improving the quality and safety of health services. As part of the Accreditation Canada ROP life cycle, five ROPs were transitioned to the standards in 2013. This transition will assist healthcare organizations in balancing the implementation of existing ROPs with the introduction of new ROPs, while at the same time retaining important safety principles in the standards. Three new ROPs were introduced in January 2014 for assessment during on-site surveys beginning in 2015: the Client Flow ROP, the Accountability for Quality ROP that applies to the governing body and the Skin and Wound Care ROP (for home care services, reflecting a direction to widen the scope of the ROPs across the continuum of care to specific sectors).

For more information please refer the Accreditation Canada website at: www.accreditation.ca

that Canada has 13 or 14 different health systems (provincial, territorial, national) with variable priorities.

As Bruce mentioned, it's critical to ensure that physicians are involved. In addition, we need focus on the continuum of care. We should identify big dot measures and critical initiatives that will have the biggest impact.

HM: The good news is that everybody is involved in patient safety. The bad news is that because everybody is involved, we trip over each other. We must leverage the root strength that each organization brings and work in partnership.

You would think, after all of the data streams we've created, we'd be much better at dealing with system variances. But that requires rigorous political, governance and senior leadership.

It's also important that we avoid declaring victory too soon. Let's first learn about where we're at and then identify the work still to be done.

I recently heard a great talk by Marian Walsh, the president and CEO of Bridgepoint Active Healthcare. Marian pointed out that the majority of our patient safety and quality tools came from research that was tidy and linear. But patients are messy; they present with multiple chronic conditions. Marian said that disjuncture is creating huge quality and patient safety gaps.

At the CPSI, we've spent a lot of time looking at what Australia, Scotland and the United States are doing. And we've got a big table (chaired by Michael Kirby) set up on January 27th to begin the conversation about what a national, Canadian-made framework would look like – one that could accommodate individual organizational strategies.

RB: Some would argue there is already a lot of effort being put into organizing care and making linkages between people, settings and agencies. So, what kinds of further collaboration do we need?

SJ: Perhaps the CPAC model is applicable to this issue. As an example, our cancerview.ca portal has about 45 different players in the cancer field. The search engine is linked and the materials are all there. We were trying to create one place where the entire cancer control community could go to be directed to anybody who'd done relevant work. The key here is not being the one in charge, but being the one that facilitates.

Similarly, I could get excited about a national framework that others could hang their work on. It would be our collective responsibility to ensure those efforts had a measurable impact and could spread.

JZ: It's absolutely essential that, at the level of national organizations, we are making sure we don't fall over each other and that we're good at communicating what we're doing.

BG: IPAC has 1,700 members across the country, and we have a lot invested in getting the work of infection control front and centre, and really making changes. When there is a major issue that needs to be addressed, we want people to recognize that there is a national association – with a huge amount of expertise and influence – that needs to be at the table.

Infection Prevention and Control – Canada

The Infection Prevention and Control - (IPAC-Canada) continues to work collaboratively with our partners in Canada to promote patient safety. Our work with the Canadian Patient Safety Institute, Accreditation Canada and the Public Health Agency of Canada around 2013 STOP! Clean Your Hands Day is ongoing. A series of webinars were held to coincide with the 2013 WHO Hand Hygiene Day. We are also working with the Canadian Patient Safety Institute (CPSI) on the development of a national patient safety strategy.

Within IPAC we have undertaken many initiatives towards patient safety. A working group has been appointed to develop core competencies for infection prevention and control professionals across Canada. This document will be a roadmap for all infection control professionals as they work towards becoming experts in their field. It will also assure patients that healthcare providers in this field are competent in their practice.

Hand hygiene has been identified as the cornerstone for preventing healthcare-associated infections. It is also well-known that compliance with hand hygiene among healthcare providers is suboptimal. IPAC is developing a series of webinars around adult learning and hand hygiene.

IPAC has developed more than 40 audit tools. The tools can be used in healthcare facilities to ensure appropriate practice is being followed and identify areas where intervention is needed to keep patients safe from acquiring infections.

Finally, IPAC will be developing a Learning Objects Repository (LOR). Member-developed education resources will be posted to our website after review by a group of expert educators.

Further information on these initiatives is available at www.ipac-canada.org

RB: Bruce, do you see linking your work to a broader patient safety strategy as something that would help to deepen commitment or something that might move people away from the issues you see as critical?

BG: It's a double-edged sword. We don't want to lose ownership of our piece, but we also have to acknowledge that we can't do it on our own and that we need to collaborate in order to push the agenda.

WN: I believe we need to be clearer about the steps required for change and sustainability. What would success (a safer system) look like? Appreciating the fact there are variances depending on our areas of focus, we need to understand what success would look like in five years and how to get buy-in from all the collaborating partners (including governments, patients and families).

There may be a place for regulation in advancing patient safety. And I also believe we need the federal government involved.

JW: CIHI collaborates at many different levels, be it with ministries or the national system, as well as with practitioners, CPSI, Accreditation Canada and others, to turn data into information and knowledge. For example, we've completed a couple of analytical reports on falls prevention and we have another one forthcoming later this year.

We also work at a third level, which is with a lot of advisory committees that involve people across the country on developing indicators. So, we need to be asking, "What are the safety indicators we should develop nationally? How should they be presented in comparisons?"

HM: We have an opportunity to move the agenda forward by figuring out what each one of us brings to the table individually and then harnessing our collective strengths. Doing so will also bring new credibility and, thereby, make us able to knock on the doors of the federal and provincial governments to influence policy (and perhaps funding), to influence the research and education communities and to influence board governance and senior leadership.

RB: Much of what we've done in the last 10 years has been around awareness-building and engagement. But many of us are still surprised by how difficult the process is and how resilient some of the patient safety challenges have been. Do we have to alter our approaches?

WN: Progress has been slower than we would like. We need to recognize complexity and address the complexity of the healthcare system. What are some of the barriers? What are the ingredients of success? What is their contribution? Who are the key stakeholders? Where are we headed? Do we have collective buy-in to reach those goals?

Canadian Partnership Against Cancer

The Canadian Partnership Against Cancer works with a variety of partners and stakeholders from across Canada to improve cancer control outcomes through the implementation of a coordinated national cancer strategy. Part of that includes looking at how we can implement best practices that improve patient safety. This is happening not only within professional groups or individual organizations, but also crossing geographic boundaries, as people and organizations come together to share and develop standards, and the health systems support these efforts. Two examples of how we're achieving this through the strategy are:

- In partnership with Accreditation Canada and the Canadian Association of Provincial Cancer Agencies, we've developed new standards for healthcare providers delivering systemic chemotherapy treatment. These standards mark an important step in building a comprehensive quality program for the safe delivery of chemotherapy treatment in Canada.

- Led by the Canadian Partnership for Quality Radiotherapy and the Canadian Organization of Medical Physicists, we've developed new technical standards to improve the quality and safety of radiation therapy. We're now developing incident reporting to allow practitioners to openly discuss events or "good catches" to help others learn from these experiences and track them in a coordinated way.

These initiatives are a few examples of how we're fostering the sharing of information, helping jurisdictions to learn from each other and building best practices. We're working with partners to evaluate their ongoing benefits.

For more information go to
www.partnershipagaincancer.ca

JZ: There are places where engagement is really appropriate, and there are other places where enforcement might be appropriate. I also think we haven't taken as much advantage as we might of global examples.

JW: The sharp pointy sticks of enforcement, as well as blame and shame, are effective in the short run. But we're playing in a long-run game. It's about the nudge, it's about the cultural change that Hugh and Bruce spoke to. From where I sit – getting the evidence out, getting the facts, doing the education and so on – an engagement strategy is definitely preferred.

HM: I believe you need both engagement and enforcement, but I'm always cautious about using a sharp stick. I think you need a blunt instrument. I really like the Excellent Care for All Act in Ontario, where the province is already seeding changes in behaviour and mindset through the Quality Improvement Plans (QIPs).

We still have a pile of work to do with behaviour and mindset. We talk a lot about culture, and that resides at the unit level. It even changes between shifts and between nurses.

Another issue to deal with is the unhealthiness of our workplaces. We have more people off on sick leave, long-term disability and workers' compensation than ever before.

WN: Building on Hugh's comments, I believe a patient-safe environment is a staff-safe environment. Initiatives to support healthy work environments must be on the patient-safety agenda.

BG: From an infection-control perspective, I'm invested in engaging frontline folks, patients and the public to make these changes. In British Columbia (BC), one of the big drivers of change has been pay-for-performance around infection control. That gets the attention of senior leaders but, as I mentioned before, it could also lead to gaming and under-reporting.

The other interesting thing happening in BC has been the mandatory flu-vaccine program. There's been a lot of yelling and screaming in response. But it's almost come down to unless you have a pointy stick, change doesn't happen.

Canadian Patient Safety Institute (CPSI)

The Canadian Patient Safety Institute (CPSI) is a not-for-profit organization that exists to raise awareness and facilitate implementation of ideas and best practices to achieve a transformation in patient safety. We envision safe healthcare for all Canadians and are driven to inspire extraordinary improvement in patient safety and quality. A number of evidence-based tools and resources are currently available:

1. Two research reports published in 2013 with partners: Canadian Paediatric Events Study; and Safe at Home: Pan-Canadian Home Care Study. <www.patientsafetyinstitute.ca/English/toolsResources/patientSafetyPublications>
2. Patient safety education programs delivered by faculty: Advancing Safety for Patients in Residency Educations (ASPIRE) in partnership with the Royal College of Physicians and Surgeons of Canada; Canadian Patient Safety Officer Course; Effective Governance for Quality and Patient Safety; Patient Safety Education Program – Canada; the Canadian Patient Safety Competencies Framework and e-mapping tool. <<http://www.patientsafetyinstitute.ca/English/education>>
3. Safer Healthcare Now! Tools and resources supported by intervention leads and faculty. <www.saferhealthcarenow.ca/en/interventions>
4. A full suite of patient safety incident management tools: incident analysis, disclosure guidelines, media guidelines, teamwork and communications. <www.patientsafetyinstitute.ca/English/tools/Resources/teamworkCommunication>

5. Global patient safety alerts <www.globalpatientsafety-alerts.com>

The 2013–2018 CPSI Business Plan sets out four strategies to move patient safety forward:

1. Provide leadership on the establishment of a national integrated patient safety strategy.
2. Inspire and sustain patient safety knowledge within the system, and through innovation, enable transformational change.
3. Build and influence patient safety capability (knowledge and skills) at organization and system levels.
4. Inspire and engage all audiences across the health system in the national patient safety agenda.

Under Goal 1, CPSI has formed the National Patient Safety Consortium, which is a group of system leaders to develop an action plan for patient safety. CPSI has also committed to working with partners on four initial areas of focus, namely, medication safety, surgical care safety, infection prevention and control and safety in the home care setting, with national summits and roundtables scheduled in 2014 to map actions. We look forward to working with you.

**For more information go to
www.patientsafetyinstitute.ca**

RB: What one or two things do you think we should focus on during the next five years if we're going to advance the patient safety agenda?

JZ: We need to focus on transitions of care. There's growing evidence of serious transition-related safety risks. The second thing is a continued focus on the patient and family voice, and the culture that supports that.

BG: It will be critical to bring together all the groups and to work together with the ministries. We need to continue to push these agendas and get the messages out there; otherwise, it's going to be a huge bursting bubble.

HM: In this era of social media, we'd better pay attention to the patient–family–client mix. If we don't, bad news will spread and that will lead to knee-jerk reactions by the government.

Patients also tell us they're tired of providers orbiting around and not connecting. This is a fundamental issue that needs addressing.

My third wish is for the development of a strategy to build a new kind of resiliency – coping and adapting capacities and skills for frontline workers so they can face all those changing winds we've been talking about.

JW: From the CIHI perspective, it will be important to round out the databases by ensuring all jurisdictions have the opportunity to participate in the development of the patient safety indicators needed at the local, regional and national levels for performance benchmarking.

WN: I would add that we should be cautious to not focus on the narrow wedge of safety, because safety is just a component

of quality. We ought to keep an eye on other measurable aspects of quality – such as appropriateness and population health – as well as what's happening to outcomes. Otherwise an overbalance of focus on safety will lead to other major risks and safety issues arising.

In addition, communication is important. Some of the spread and uptake challenges may be in how we communicate.

In the next five years, we need to see improvement relative to the OECD numbers. Finally, as stated before, we must be clear about our goals and measuring and reporting on progress.

HM: I agree with Wendy, and I believe we need to ensure there's connectivity between patient safety and appropriateness, quality, wait time and other issues. That speaks to the need for a new narrative, one that connects all the pieces.

RB: In many ways the patient safety agenda has become much more complex because it's very difficult just to focus on safety alone and expect, thereby, to get people's attention and make progress. We need to have a much bigger picture than that.

HM: I think back again to the warning the Crossing the Quality Chasm authors gave in 2001. When I reflect on where we're at today, the situation is even more complex. We need more of these kinds of conversation.

RB: Thank you for saying that, Hugh, and thanks everybody for your participation today. This has been a rich, wonderful discussion. HQ