

QUARTERLY UPDATE

MISE À JOUR TRIMESTRIELLE

Building a safer health system • Accroître la sécurité du système de santé

January to April 2010

Message from Hugh MacLeod, CEO:

It's a challenging time for the healthcare system in Canada. Issues of patient safety and quality of health service delivery must be balanced with fiscal and other day-to-day pressures which makes a decision-making process focused on patient safety difficult.

I understand the struggles. Before arriving at the Canadian Patient Safety Institute both my career and personal experiences showed me how difficult it is to build the case for patient safety as a number one priority and get sustained buy-in from management, executives and health care providers. As a former senior healthcare operational leader, former ADM of Health and, recently, a patient of the system, I believe that in order to build a safer health system we need to act collectively, to come together not to manage the change or to cope with it but to use it to create sustainable improvements in patient safety .

Our goal is to become the Canadian “integrator” of patient safety best practices through: mobilizing leaders, peer-to-peer learning, building awareness of best practice patient safety products, advocating for good public policy on patient safety and building networks of national and international learning partners.

This Quarterly Update can be one of the tools to help us build that meaningful partnership. In this inaugural issue, we focus on three inter-related activities that support the advancement of patient safety, cost reduction and provide a foundation for meeting accreditation standards:

1. A new program for CEO's and Boards -A toolkit with insights and recommendations on how to integrate **patient safety governance**.
2. Current efforts in implementing the **Safe Surgery Checklist** and available resources.
3. The pulse of **Safer Healthcare Now!**

While the **Canadian Patient Safety Institute (CPSI)** is doing the reporting, this is really an update on the work of the Canadian health system.

At CPSI, we get to hear about and see pockets of patient safety excellence delivered through passionate care providers and leaders who truly want to make a difference. With this in mind, CPSI is exploring new approaches to capture patient safety best practices and design knowledge transfer points.

1. Effective Governance for Quality and Patient Safety

The findings of the Canadian Adverse Event Study (Baker Norton et al) as well as reports from the Canadian Institute of Health Information (CIHI) and others highlighted problems in the quality of healthcare services. By the numbers between 9,000 and 24,000 Canadians die every year as a result of preventable adverse events; something goes wrong in one of 13 hospital stays; or to say it differently, CIHI reports suggest 185,000 preventable adverse events happen in Canada every year.

The extent of variations in the delivery of quality, safe healthcare in Canada has prompted a continuing and increasing interest in understanding the strategies, tactics and tools through which healthcare boards can establish quality and safety goals and in stimulating improvement in healthcare organizations. Governing boards of healthcare organizations are legally responsible for the performance of their organizations. There is a growing effort in Canada, especially in Ontario, to establish explicit accountabilities, using performance measures to hold CEOs and boards responsible for performance on quality and safety.

The Canadian Health Services Research Foundation (CHSRF) and the Canadian Patient Safety Institute have partnered to support boards in their efforts to improve governance for quality and patient safety by commissioning research and developing a toolkit and education program.

Coming this Fall, the *Effective Governance for Quality and Patient Safety* education program and toolkit will be available to help boards understand and implement effective governance practices. This initiative, designed for board members, CEOs and healthcare executives focuses on improving quality, performance, and patient safety through the use of evidence. To date, CHSRF and the CPSI have delivered two extremely successful pilot education sessions in Winnipeg and the Hamilton Niagara Haldimand Brant Region LHIN.

The learning program and toolkit are intended to:

- Support boards to understand and integrate core governance functions related to quality and patient safety;
- Provide relevant information to boards regarding approaches for incorporating a focus on quality and patient safety;
- Identify and apply relevant and appropriate tools for creating and sustaining an effective board quality and patient safety plan;
- Enable board members' understanding of how a culture of quality and patient safety within an organization can be led, supported and sustained by the board.

I have been waiting to see such a program and resource developed exclusively for senior decision-makers for some time. Both our pilot courses have clearly demonstrated the appetite for this material and gaps in the knowledge of quality and patient safety matters. There is a state of readiness for this program that will guarantee its success when it rolls out this Fall.

For more information on the content and schedule, please contact Abbie Hain, Project Manager at CPSI at ahain@cpsi-icsp.ca.

Information on the Effective Governance for Quality and Patient Safety education program and toolkit will also be available at www.patientsafetyinstitute.ca starting at the end of May.

2. Surgical Safety

The interest in improving surgical safety through the use of a verbal Checklist is very high across the country at the moment and there are multiple reasons for that. First, research shows that a surgical checklist significantly reduces surgical complications and deaths. Second, operating room teams already know that improved communication is beneficial for patient safety and for teamwork. Finally, and most importantly, pressure from provincial governments and national health organizations to implement, or report if the Checklist is used, together with the launch of the new surgical safety Required Organizational Practice (ROP) by Accreditation Canada in 2010 are very strong determining factors.

Despite the high interest and obvious value backed by evidence, teams struggle to implement this simple and inexpensive tool. While the tool is simple, implementation is not so straight forward. As you know, culture can eat strategy for lunch! Understanding ones local culture is key to any introduction of innovation. We are asking operating room (OR) teams to shift thinking on a number of levels:

- Shifting from a *surgeon* focused process to a *patient* - focused process; and
- Shifting from “a group of individuals who each do their part” to a “team who manages the interactions between the parts.”

If we can help people understand that this is not a simple “just do it” (similar to hand hygiene) then we have done every clinician a huge service. CPSI offers a multitude of resources for frontline teams on our website, www.safesurgerysaveslives.ca, the Checklist Action Series being one of the most valued.

One wave of eight webinars has just finished, the second one started in April, and our staff is now preparing the third wave to start in the fall.

To sustain the implementation of the surgical Checklist, frontline teams need significant support from management at all levels, and boards. Executives need to demonstrate with actions that surgical safety is important on their agenda and that they are willing to engage in the change. Messages from across the country show that teams have two key concerns: engaging physicians and the legal liability associated with documenting use of the checklist. CPSI is addressing this by having physician and legal counselors available on webinars, but this must also be addressed at local levels.

CPSI is currently rolling out a national evaluation where trained interviewers will call every operating room manager in Canada! We need to know:

- If the checklist is implemented, how, and in which specialties;
- Its impact on communication, teamwork, workflow and patient safety;
- Implementation barriers and facilitators.

3. *Safer Healthcare Now!* Teams

Reducing harm, improving healthcare and protecting Canadians is the focus of 1158 *Safer Healthcare Now!* teams from some 334 healthcare organizations.

Started as a grassroots campaign over five years ago, *Safer Healthcare Now!* has been extremely effective in helping to jump-start the patient safety movement in Canada. Despite the impact that *Safer Healthcare Now!* has had across the country, there is a tremendous amount of work still to be done.

We know that many organizations encounter significant barriers and challenges to adopting the *Safer Healthcare Now!* interventions as standard practices. Some of the most effective and safest healthcare organizations in the world are those who have gone beyond placing patient safety in their strategic plans, to actively implementing a patient safety plan. Here is a snapshot of qualities that best practice organizations possess:

1. *The identification of common goals:* Aligning local strategies to national priorities makes it easier for the organizations to do the right thing and help ensure that “we are all singing from the same song sheet.”
2. *The identification of patient safety priorities that are meaningful to frontline clinicians:* In order to lead to sustainable change, frontline engagement is required.
3. *Measuring:* Measurement is necessary to evaluate the progress an organization is making in achieving their patient safety goals.

In the past year the *Safer Healthcare Now!* measurement methodology has undergone an important redesign evolving from a Microsoft Excel based format to a web-based electronic platform. The new Patient Safety Metrics System offers two major enhancements to the *Safer Healthcare Now!* measurement process.

First, the process of data entry has been streamlined and simplified. It is believed, this improvement will increase the number of sites submitting data to *Safer Healthcare Now!*, which will lead to an even richer source of patient safety data for Canada. Second, the Patient Safety Metric System provides enhanced access and transparency to Canadian patient safety data and reports. The system will be able to pull both the historical *Safer Healthcare Now!* data and current data from a central data source and provide easy access to real-time performance reports. The reports will allow for analysis and benchmarking of data across time, sites, organizations and provinces/territories.

Safer Healthcare Now! Teams have made a commitment to continue to support clinicians in their patient safety work.

safer healthcare
now!

A virtual learning improvement plan is available covering the following topics:

- New Approach to Controlling Superbugs;
- Improving AMI Care;
- Medication Reconciliation in Home Care;
- Falls Prevention;
- Reducing Central Line Infections;
- Safe Surgery;
- Surgical Checklists;
- Improving Safety for the Critically Ill.

For more information, please visit
www.saferhealthcarenow.ca

What's upcoming in our August Update?

- 1) Research About the Cost of Patient Safety (The Economics of Patient Safety)
- 2) Patient Safety Education for the Frontline (our Patient Safety Education Project-Canada!)
- 3) *Safer Healthcare Now!* online data system (Provincial Results)

In closing, I especially want to acknowledge the **1,000 people who have registered to date for the Hand Hygiene Challenge**, and successfully completed the newly revised online education “Clean Your Hands!” module. This participation level suggests that healthcare professionals across Canada are committed to reducing the spread of infection through optimal hand hygiene.

In addition I also want to thank Accreditation Canada and CHICA-Canada for partnering with the Canadian Patient Safety Institute in hosting Canada's first national **STOP! Clean Your Hands Day** on **Wednesday, May 5, 2010**, in conjunction with the World Health Organization's global initiative.

For more information on our Hand Hygiene Challenge, please visit www.handhygiene.ca



I'll be happy to hear about successes and challenges in patient safety, explore the “whys” and discuss how to build synergy. Contact me at hmacleod@cpsi-icsp.ca or 1-866-421-6933.

