Welcome & Bienvenue

May 11-12-2011
Thank-you
Francine Bordage, NB Government
Nova Scotia
Quality and Patient Safety Advisory Committee
Purpose

• Provide advice and make recommendations on matters related to patient safety and quality of care across the continuum of Nova Scotia’s health care system; and

• To bring health system stakeholders together in a collaborative partnership to promote and inform a provincially coordinated, innovative, and patient-centered approach to patient safety and quality improvement in Nova Scotia.
Safety initiatives
Communication networks
Expert groups

Receive input/info.
Provide advice
Take action
Provide progress reports

Request advice
Receive advice
Provide feedback
Assign or assume action

Minister of Health

Quality & Patient Safety Advisory Committee

Agency
Program
Existing committee

N
Y
Develop strategic plan for Committee
Three modes of activity

Reactive
Current
Prospective
Areas of interest

- Addictions
- Blood products
- Diagnostic Safety
- Electronic adverse events monitoring system
- Emergency Department wait times
- EMR
- Handoffs of Care
- Infection control
- Long Term Care
- Medication safety
- Obstetrics (L&D and perinatal care)
- Psychiatry
- Safer Healthcare Now
- Safe Surgery Checklist implementation
- Sleep and Fatigue
- Workplace Issues: Ergonomics/Design
Newfoundland and Labrador Vice Presidents of Quality Committee
Mrs. Peggy Deane
May 22, 2007
Government to Undertake Judicial Commission of Inquiry on Estrogen and Progesterone Receptor Testing for Breast Cancer Patients
Cancer Misdiagnosed
Anatomy of Newfoundland's cancer-testing scandal
Last Updated April 28, 2008
By Vik Adhopia

Avalanche of errors
Culture of secrecy
Who was in charge?
The Past Two Years

Recommendations
Standardization
Automation
Audit
What’s Next?

- Broaden the opportunities for standardization.
- Creating a greater integrated network of focus on Quality.
- Awareness, Education and Training
- Health, Healing and Hope
Patient Safety Provincial Frameworks, Structures & Priorities

Keith Dewar
CEO Health PEI
PEI Patient Safety Strategy 2009-2012

• Goal 1: To have an organizational culture of safety in our healthcare system
• Goal 2: To meet or exceed Safer Healthcare Now (SHN) and Accreditation standards
• Goal 3: To collect, monitor, report and use evidence to improve patient safety
Legislative Framework

• Quality Improvement and Apology Legislation in the *Health Services Act, 2010*
Provincial Policy Framework

- Incident Reporting Policy
- Disclosure of Adverse Events Policy
- Public Compliments/Complaints Policy
- Quality Improvement Activity Policy
Reporting Framework

- New electronic Provincial Safety Management System is rolling out
- Regular reporting to the Health PEI Board, Quality & Safety Committee of the Board and Executive Leadership Team
Quality Structure

• Quality & Patient Safety Council (QPSC)
• 18 Provincial quality teams organized by service area
• Annual reporting of quality teams to QPSC
• Currently under review
Patient Safety Priorities

- Provincial priorities approved by Executive Leadership Team and supported by SHN
  Atlantic Node: medication reconciliation, falls, and transitions
- Accreditation Canada required organizational practices (ROPs)
- SHN initiatives
Resources

- Quality/Risk Manager
- 6 Quality/Risk Coordinators
- Patient Safety Coordinator
- Risk Advisor
- Provide support, advice and assistance related to patient safety, quality and risk activities
Working Well?

- Provincial structure and quality/risk/patient safety resources in place
- Defined quality review process and legislation
- Quality teams defined (TOR, reporting timelines, indicators & work plans)
- Disclosure and monitoring of adverse events is occurring on a regular basis
Challenges?

• Defining the quality structure
• Competing priorities: “urgent crowding out the important”
• Staff shortages/workload
• Engaging with physicians in the quality agenda
• Communication of progress / results to the Front line
• Quality perceived as “Add on”
Questions
The Healing of Hurts:
  ◦ Dale Nixon & Dr Rick Singleton
● Disclaimer on Confidentiality

● Dale’s story

● Rick’s observations
My “Precious Child”
A trauma is an event that shatters the things you take for granted.

Rabbi Earl Grollman

Why?

- Facts
- Feelings
- Future

Avoidable or unavoidable?
Consider the sprawl of endings, losses, trauma … and the persistent WHY?

What feelings are generated …
  guilt, anger, resentment, worry, frustration, embarrassment …

Disclosure is so important so one can move on with feelings.

The only way to get past a feeling is to focus on it!
Feelings survive explanation. Feelings survive compensation.

Grief is

- The journey from the old normal to the new normal.
- Love’s unwillingness to let go.

Acceptance is completed in reinvestment.
Lessons learned

Hurt people hurt people.

Understand and appreciate the depth of the hurt.

Reduce the adversarial climate.

Do the right thing, and do the thing right.
Lessons learned

The best way to care for others is to care for yourself.

This is not about me, nor Dale. It is about this person ... Joshua.
Now ...

A moment to ponder

A couple of minutes to discuss

Some time for questions, comments, and observations.
THANK YOU!!!
Atlantic Learning Exchange
Prince Edward Island, May 2011

Marie Owen & Margaret Colquhoun
Medication Reconciliation Co-Leads

Reducing Harm | Improving Healthcare | Protecting Canadians

www.ismp-canada.org www.saferhealthcarenow.ca
Today’s Objectives

To provide an overview of medication reconciliation in Canada:

– Current State
– Where we are going

www.ismp-canada.org

www.saferhealthcarenow.ca
Outside Canada

• High Five’s - Canada acts as medication reconciliation lead for 4 other countries

• U.S. initiatives -
  – $1 billion Obama patient safety effort
  – The AMA and others in organized medicine have joined the HHS Partnership for Patients, which focuses on reducing hospital-acquired illnesses and readmissions.

www.ismp-canada.org  www.saferhealthcarenow.ca
The Partnership for Patients aims to save lives by preventing hospital-acquired conditions and lowering readmission rates.

- Drug errors are the most common reason for adverse events after hospital patients are discharged.
- Federal initiative has stated goal of decreasing preventable hospital readmissions within 30 days of discharge.
- One of the strategies is: Improving medication reconciliation and safe medication practices.

www.ismp-canada.org

www.saferhealthcarenow.ca
Outside Canada - Jeffrey Schnipper - $1.5 M

- Jeffrey Schnipper, MD, MPH, FHM, Brigham and Women’s Hospital, Assistant Prof. at Harvard

- Prior research revealed a potential reduction of serious medical errors per patient to 0.3 from 1.4 in the past four years.
- “I think those are achievable results across the country,”
- 3 year multi-site project
- Dr. Schnipper will work to bring similar results to hospitals across America The project also will include a package of materials and tools adaptable for any hospital, as well as an implementation guide with the mentored implementation model. “It really should be everything a site needs to improve its MR process,”

www.ismp-canada.org

www.saferhealthcarenow.ca
Safer Healthcare Now

• 500+ MedRec teams - largely acute care
• There is progress!
  – about 25% moving to acute care discharge
  – Med Rec to Go webinar series, national calls, ambulatory clinics models
• Incredible opportunities to move across the system:
  – Provincial Pharmacists Medication Management Services: E.g NB Pharmacheck, NS Medication Review Services
• Addressing barriers:
  – National summit and recommendations
Canadian Success

“MedRec, although difficult, is working to improve patient safety as none of these discussions would have taken place if medication reconciliation had not been undertaken.

Meds were stopped, restarted in error, and medication reconciliation discussions resulted in appropriate decisions to re-stop them.”

Consultant Pharmacist

www.ismp-canada.org
www.saferhealthcarenow.ca
Issues for Canadian Teams

- Seen as additional work with insufficient resources
- Underestimated need for changes in process to create reliable new processes
- Physician and intra-professional engagement
- Patients not included in early communications
- Inadequate supporting technology
Med Rec Is the Right Thing to Do
National Summit A Call to Action

- CPSI, ISMP Canada, Canada Health Infoway
  Feb. 10, 2011
- 70 invited CEO’s, MD’s, national organizations
- To inspire national high level support for medication reconciliation
  – Denison, Schnipper, CEO’s, SHN story, national organizations, group work

www.ismp-canada.org  www.saferhealthcarenow.ca
National Summit: Themes to Address Barriers in Canada

- Inter-Professional Engagement
- Leadership Accountability
- Public/consumer/caregiver engagement
- Physician Roles
- Culture and Human Systems
- Education and Training
- Information Systems and Technology
- Tools and Resources (Enablers)

www.ismp-canada.org

www.saferhealthcarenow.ca
Addressing the Barriers

Inter-Professional Engagement

• Establishing a coalition of leaders across the country including national pharmacy, medical and nursing orgs

• Defining key messages and expectation around inter-professional engagement

www.ismp-canada.org

safer healthcare now!

www.saferhealthcarenow.ca
Addressing the Barriers

Leadership Accountability

• Provide leaders with value proposition
• Gain support for Med Rec as strategic priority
Addressing The Barriers

Public Engagement
• Identify roles for individuals and informal caregivers
• Develop tools to support role of public
• Create plans to include expectation that everyone carries their information
Addressing the Barriers

Education and Training

• Working with academic institutions
• Include role and responsibilities of consumer
• Accreditation Canada Surveyor education
• Safer Healthcare Now
Addressing the Barriers

Information Systems and Technology

- Working with Canada Health Infoway and provinces

www.ismp-canada.org

www.saferhealthcarenow.ca
“I don’t recall when we got permission to stop taking (medication) histories. So we have to be specific and blunt to do this. You will not find a board member or CEO that will tell you it is not important. But they will tell you they think it is being done. There is an assumption that this is occurring as part of the treatment plan.”

Vickie Kaminski
President and CEO Eastern Health, Newfoundland and Labrador
Medication Reconciliation Panel
- Measurement

Alexandru Titeu
SHN – Central Measurement Team
My Med Rec Experience

• Project coordinator for CMT
  – Receive and process all Med Rec data submitted to SHN
  – “Go To” person for non-clinical measurement questions
Issues

• Burden of measurement in MedRec
• Not everyone interprets the MedRec process the same way
  – Staff turnover
  – Hospital mergers
  – Integrating processes
  – Staff training
Best Possible Medication History

RETROACTIVE MEDICATION RECONCILIATION MODEL

STEP 1: Primary Medication History
STEP 2: Admission Orders
STEP 3: BPMH
STEP 4: Compare BPMH with AMOs and resolve any discrepancies

MEASURE: Independent observer measures at a time point after teams usual medication reconciliation process.

PROACTIVE MEDICATION RECONCILIATION MODEL

STEP 1: BPMH
STEP 2: Admission Orders
STEP 3: Verify every medication in BPMH has been assessed by prescriber.

MEASURE: Independent observer measures at a time point after teams usual medication reconciliation process.
What Needs to be Done

• Review the GSK together and come to an agreement with your team about the process you will use
• Develop a measurement strategy that can become part of your work routine
• Orient new staff to established process
Atlantic Region

Undocumented Intentional

Unintentional Discrepancies

Mean Medication Discrepancies by Year

<table>
<thead>
<tr>
<th></th>
<th>2006-2007</th>
<th>2010-2011</th>
<th>Percent Improvement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Undocumented Intentional</td>
<td>0.64</td>
<td>0.13</td>
<td>79.7%</td>
</tr>
<tr>
<td>Unintentional discrepancies</td>
<td>0.77</td>
<td>0.26</td>
<td>66.2%</td>
</tr>
</tbody>
</table>
What Needs to be Done

• Start by measuring (monthly):
  1. Mean # of undocumented discrepancies
  2. Mean # of unintentional discrepancies
  3. Percent reconciled

• After you demonstrate improvement by reaching goal and holding it x 3 months:
  - stop measuring 1 and 2.

• Continue to measure #3 quarterly

• Revisit #1 and #2 every 6-12 months
Atlantic Learning Exchange
Medication Reconciliation Panel Discussion
May 11, 2011
My experience....

- Medication Reconciliation at Admission
- Medication Reconciliation at Discharge
- The role of Pharmacy Technicians
- Horizon Medication Reconciliation Strategy
The issues...

• Benefits of medication reconciliation

• Partial implementation

• Limited technology

• Competing priorities

• Care coordination lacking
What needs to be done...

1. Leadership and Accountability

- Committed leadership to support a culture of patient safety
- Awareness of roles and responsibilities
- Engage in continuous quality improvement
- Sense of ownership and teamwork
What needs to be done…

2. Measurement

• Key Performance Indicators
  • Patient care experience

• Dissemination of results

• Learn from adverse events reported and quality audits

• Use a system approach
3. Building Capacity

- Establish shared commitment
- Systematic proactive planning
- \( \uparrow \) efficiencies and \( \downarrow \) waste
- Maximize the use of technology
- \( \uparrow \) delegation of roles
- Build on current initiatives to avoid duplications
Med Rec: An Academic Perspective

Neil J. MacKinnon, Ph.D., FCSHP
President, Canadian Society of Hospital Pharmacists
Professor, Dalhousie University
The safest place in Canada?

Picture of your organization here.
The safest place in Canada?
The safest place in Canada?
How widely has med rec been implemented in Canada?

- **No discussion or activity**
- **Formally discussed/ considered, not yet implemented**
- **Partially implemented**
- **Fully implemented throughout**


n= 149
### Ranking of priorities

<table>
<thead>
<tr>
<th>Objective</th>
<th>High</th>
<th>Medium</th>
<th>Low</th>
<th>Total</th>
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<td>1.1a Medication reconciliation occurs for INPATIENTS on ADMISSION</td>
<td>89</td>
<td>33</td>
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<td>129</td>
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<tr>
<td><strong>69.0%</strong></td>
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<td></td>
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<tr>
<td>1.1b Medication reconciliation occurs for INPATIENTS on TRANSFER</td>
<td>64</td>
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<td>17</td>
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<td><strong>50.4%</strong></td>
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<tr>
<td>1.1a Medication reconciliation occurs for INPATIENTS on DISCHARGE</td>
<td>68</td>
<td>50</td>
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<td>131</td>
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<tr>
<td><strong>51.9%</strong></td>
<td></td>
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</tbody>
</table>

Source: CSHP 2015 Self-assessment survey, fall 2009. n= 149
Is there a process to obtain a medication history?

<table>
<thead>
<tr>
<th>Standard of Care</th>
<th>Bed Size</th>
<th>Teaching Status</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>All</td>
<td>50 - 200</td>
</tr>
</tbody>
</table>

There is a formal process to obtain a complete and accurate list of the patient's current medications.

<table>
<thead>
<tr>
<th>Standard of Care</th>
<th>Bed Size</th>
<th>Teaching Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>When a patient visits the ER</td>
<td>(n=159)</td>
<td>(34)</td>
</tr>
<tr>
<td>Yes, for all patients</td>
<td>(43)</td>
<td>(8)</td>
</tr>
<tr>
<td>Yes, but for selected patient groups only</td>
<td>(78)</td>
<td>(14)</td>
</tr>
<tr>
<td>When a patient is admitted</td>
<td>(n=160)</td>
<td>(34)</td>
</tr>
<tr>
<td>Yes, for all patients</td>
<td>(91)</td>
<td>(24)</td>
</tr>
<tr>
<td>Yes, but for selected patient groups only</td>
<td>(50)</td>
<td>(5)</td>
</tr>
<tr>
<td>When a patient is transferred</td>
<td>(n=159)</td>
<td>(34)</td>
</tr>
<tr>
<td>Yes, for all patients</td>
<td>(49)</td>
<td>(10)</td>
</tr>
<tr>
<td>Yes, but for selected patient groups only</td>
<td>(60)</td>
<td>(10)</td>
</tr>
<tr>
<td>When a patient is discharged</td>
<td>(n=160)</td>
<td>(34)</td>
</tr>
<tr>
<td>Yes, for all patients</td>
<td>(32)</td>
<td>(7)</td>
</tr>
<tr>
<td>Yes, but for selected patient groups only</td>
<td>(82)</td>
<td>(14)</td>
</tr>
</tbody>
</table>

Base: All respondents

Source: Hospital Pharmacy Survey in Canada, 2009/10.
Who performs med rec?

The health professional responsible for reconciling the patient's medication is:

<table>
<thead>
<tr>
<th>When a patient visits the ER</th>
<th>(n= )</th>
<th>50 - 200</th>
<th>201 - 500</th>
<th>&gt;500</th>
<th>Teach</th>
<th>Non-Teaching</th>
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<td>(19)</td>
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<td>18</td>
<td>6</td>
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<td>5%</td>
<td>11%</td>
<td>11%</td>
<td>9%</td>
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<tr>
<td>Physician</td>
<td>38%</td>
<td>25%</td>
<td>7</td>
<td>8</td>
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<td>43%</td>
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<tr>
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<td>25</td>
<td>8</td>
<td>13</td>
<td>4</td>
<td>8</td>
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<tr>
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<td>26%</td>
<td>40%</td>
<td>22%</td>
<td>21%</td>
<td>29%</td>
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<td>45%</td>
<td>38%</td>
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<td>40%</td>
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<td>1%</td>
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Base: All respondents

Source: Hospital Pharmacy Survey in Canada, 2009/10.
Med Rec Issues from an Academic Perspective

- Evidence of the impact of med rec?
- Not all hospitals are participating in SHN med rec (81%) and, of those who are participating, only 68% are submitting data (Hospital Pharmacy Survey in Canada)
- Application to the non-institutional setting (SafetyNET-Rx)
- The ultimate frontier: linkage to personal health records
Table Questions

- What are some opportunities and ideas for moving ahead to facilitate medication reconciliation across the system?
- What are some next steps which would help?
- How can we (CPSI/SHN/ISMP Canada) provide support?
Atlantic Health Quality and Patient Safety Collaborative
Welcome & Bienvenue

May 11-12-2011
Thank-you
Kneedless Harm: When Things Go Wrong

- Dave McCormack
- Laurel Taylor
- Joan Dawe
- Catherine Gaulton
- Wayne Miller
- Theresa Fillatre
- Donna Murnaghan
Atlantic Learning Exchange
May 2011
Table Top Exercise “KNEEDLESS HARM”
TTX “KNEELESS HARM”

- TTX Overview
- Scenario (x3)/Associated Questions
- Reporting/Panel Discussion
Reasons to Exercise

- Assess the adequacy of current procedures and policies
- Increase general awareness of proficiencies and deficiencies
- Assess allocation of resources and staff
- Clarify roles and responsibilities
- Improve individual performance/Motivate employees/Build confidence
- Evaluate Communication/Coordination
Reasons to Exercise (cont’d)

- Determine redundancies and gaps in planning
- Fill a valuable teaching function
- Identify issues/problems/gaps without any human cost (eliminate problems before the event occurs and before some gets hurt)
- Allow experimental problem solving in a safe environment
• Designate a Scribe
• Designate a Reporter
• Scenarios as presented take a macro level view – please refer to your own organizations/jurisdictions to confirm policies, procedures, accountabilities, roles and responsibilities
• Not necessarily “right” or “wrong” answers – but may show “better” ways to respond to situations
• Reporting of the event
• Disclosing the event
• Investigating the event
• Communicating the event
• Report writing (including contributory factors, root causes and recommendations)
• Improvements in service delivery
• Sharing lessons learned
“.........a plan that is never exercised is like a paperweight – instead of giving you guidance, it instead can weigh you down!”

REGINA PHELPS, RN, BSN, MPA, CEM
President, Emergency Management & Safety Solutions
“When Things Go Wrong”

Does the Board of Directors add value to Quality and Patient Safety?
Outline

• Quality and Patient Safety - the Canadian Context

• What is effective governance for Quality and Patient Safety?

• Role of the Board in assessing and enhancing a Quality and Safety Culture

• Increasing the patient’s voice

• Excellent Care For All Act------ Ontario June 2010
Findings:
• 3,745 charts reviewed
• ~7.5% of hospital admissions involve adverse event; 37% of adverse events considered preventable

Extrapolation:
• Of ~ 2.5 million hospital admissions in Canada in 2000
  Ø 185,000 experienced 1 or more adverse events
  Ø 70,000 of the 185,000 were determined to be preventable
  Ø between 9,000 and 24,000 deaths due to adverse events could have been prevented.

One in ten adults contract infection in hospital

One in ten patients receive wrong medication or wrong dose

More deaths after experiencing adverse events in hospital than deaths from breast cancer, motor vehicle and HIV combined
## How Common Are Adverse Events?

<table>
<thead>
<tr>
<th>Location</th>
<th>Year</th>
<th>AE Rate (%)</th>
<th>Preventable (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>New York</td>
<td>1984</td>
<td>3.7</td>
<td>n/a</td>
</tr>
<tr>
<td>Utah/Colorado</td>
<td>1992</td>
<td>2.9</td>
<td>n/a</td>
</tr>
<tr>
<td>Australia</td>
<td>1992</td>
<td>16.6</td>
<td>51</td>
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<tr>
<td>New Zealand</td>
<td>1998</td>
<td>13.1</td>
<td>37</td>
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<tr>
<td>United Kingdom</td>
<td>1999</td>
<td>10.8</td>
<td>48</td>
</tr>
<tr>
<td>Denmark</td>
<td>2000</td>
<td>9.0</td>
<td>40</td>
</tr>
<tr>
<td>Canada</td>
<td>2001</td>
<td>7.5</td>
<td>37</td>
</tr>
<tr>
<td>Netherlands</td>
<td>2004</td>
<td>5.6</td>
<td>40</td>
</tr>
<tr>
<td>Sweden</td>
<td>2003/4</td>
<td>12.3</td>
<td>70</td>
</tr>
</tbody>
</table>
Adverse Events: the tip of the iceberg

- 300 near misses for every adverse event
Quality and Patient Safety

• The quality and safety in healthcare is not as good as we would like it: there is growing pressure to improve.

• The Board of Directors is ultimately accountable for the performance of the organization.

• Current governance performance in most organizations is unlikely to sustain expectations of government, regulators or the public.
What is effective governance for Quality and Patient Safety?

• Efforts to improve governance practices for quality and safety are in early stages in Canadian healthcare organizations.

• Current and emerging initiatives are focused on:
  - improving skills and knowledge of Board members,
  - improving and expanding current governance practices,
  - assessing and enhancing a quality and safety culture,
  - creating more effective relationships between the Board and senior leadership and the medical staff,
  - enhancing information and measures of performance.
The Drivers of Effective Governance for Quality and Safety

Modified for printing with permission from Dr. G. Ross Baker.
Culture

(From the Ward to the Board)

• The Board has a key role to play in fostering and supporting a culture of quality and patient safety.
Culture

• *Culture* is a combination of:

-an organization’s structure, systems, rules, regulations and practices designed to enhance quality and patient safety

-the values it professes

-its values in practice

  “the way we do things around here”
  “the way people behave when no one is looking”
  “behaviours that are condoned / rewarded”
Culture of Quality and Patient Safety

Increasingly Informed

- GENERATIVE
  Safety is how we do business around here

- PROACTIVE
  We work on the problems that we still find

- CALCULATIVE
  We have systems in place to manage all hazards

- REACTIVE
  Safety is important, we do a lot every time we have an accident

- PATHOLOGIC
  Who cares as long as we do not get caught

Increasing Trust
"In our country, patients are the most under-utilized resource, and yet they have the most at stake. They want to be involved and they can be involved. Their participation will lead to better medical outcomes at lower costs with dramatically higher patient / customer satisfaction."
* Bring a patient to the Board Quality meeting,
  * Bring a family member of a harmed patient to the Board Quality meeting,
  * Start every Board meeting with a patient harm story, (Guidelines for telling “Patient Stories” with Boards—www.delnor.com)
  * Place a Board member on the Patient Advisory Council,
  * Introduce patient and family advisors in the development of action plans to improve the experience of care,
  * Introduce patient relations process (C.A.R.E)
Excellent Care For All Act
(Ontario June 2010 )

- Requires health care organizations (beginning with hospitals) to:
  - Establish Board Quality Committee,
  - Develop and make publicly available annual quality improvement plans (beginning April 1, 2011),
  - Ensure that executive compensation is tied to success of quality improvement plan,
  - Carry out patient / client satisfaction surveys,
  - Carry out employee / care provider surveys,
  - Have a patient relations process,
  - Have a patient declaration of values.
What does the evidence tell us?

• Outcomes are better in hospitals where:
  - The Board spends >25% of its time on quality and safety,
  - The Board receives a formal quality measurement report,
  - There is a high level of interaction between the Board and clinical staff on quality strategy,
  - Senior executive compensation is based in part on quality and safety performance,
  - The CEO is identified as the person with the greatest impact on quality improvement.
Summary
Effective Governance for Quality & Patient Safety

Laurel Taylor
Canadian Patient Safety Institute
Rationale for the project

- Initiated in 2008 with creation of commissioned research and toolkit; followed by development of educational sessions
- Need for framework, methodology and tools identified
- Audience: Primary – board members; Secondary – senior executives, clinical and patient safety leaders
The Goal of the Project
/Strategy

• Provide a national framework and supporting tools to assist boards in their efforts to improve quality and patient safety.

• Identify inhibitors and enablers of change for boards to provide effective leadership in advancing the quality and patient safety agenda.
Measures

• Pre/Post Test knowledge acquisition questionnaire

• Qualitative feedback obtained in six month post session interview

• Evaluation to assess program impact
• Education as an effective means to empower Boards to drive Q & PS agenda

• Patient focus important to generate desired outcomes

• Boards (Stakeholders) will commit time if value evident
Challenges: Tips & Tools for Others

- Perseverance and importance of partnerships and relationship building to create impact with valuable programs
- Peer to peer learning requires coaching
- Flexibility with scheduling/early planning needed to allow participation
- “Going to them”
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Organization: Canadian Patient Safety Institute
Email: jbarre@cpsi-icsp.ca
Phone Number: 613-730-7322
Patient Safety Education Project - Canada

Marie Owen
Canadian Patient Safety Institute
Rationale for the project

- Create a tipping point on frontline delivery of healthcare to inspire and drive a culture of quality and safe care
- PSEP-Canada Patient Safety Trainers teach others core skills in patient safety.
- Emphasis on an interprofessional team approach and peer to peer education
The Goal of the Project /Strategy

- Deliver a high-impact, comprehensive patient safety curriculum
- Utilize effective teaching approaches based on adult education methods
- Promote effective fundamental patient safety practices in their organization
- Foster a culture of patient safety.
Measures

- Pre/Post test knowledge acquisition questionnaire
- Evaluation to assess program impact
Key Insights & Lessons Learned

- Organizational support required
  - Funding/time/resources
- Executive sponsorship essential
- Team approach sustains momentum
- Peer-to-peer learning effective
Challenges: Tips & Tools for Others

- Provide many tools and resources
- Allow customization for organizational context
- Emphasis on Action Plan and alignment with organizational priorities
- Create network of trainers
- Still learning!
Name: Abigail Hain

Organization: CPSI

Email: ahain@cpsi-icsp.ca

Phone Number: 613-730-7322
PEI DIAGNOSTIC IMAGING WAIT TIMES STRATEGY

Gailyne MacPherson
Rationale for the project

• In 2006 PEI began to develop a strategy to improve access to health care.
• There were concerns expressed by physicians and patients regarding the delay in their diagnosis and treatment waiting for exams.
• What can we do to improve?
The Goal of the Project /Strategy

Standardize the length of time patients wait for exams irrespective of their location.

Develop the Key Performance Indicators necessary to compare ourselves with other jurisdictions and to report to the Canadian Institute for Health Information.
Measures

- CT wait times improved from 48% of U3 exams within benchmark in Q2 08/09 to over 90% within benchmark in last 6 quarters.
- MR wait times improved from 41% of U3 within benchmark from Q2 08/09 to 78% within benchmark in last quarter and we are still improving.
Key Insights & Lessons Learned

• Ask for input from the schedulers (they know the issues and it will help with buy in).
• Exclude any exams that are date requested (please do in three months, they are not actually waiting).
• Be prepared to validate your data and revisit the process and participants regularly.
Challenges: Tips & Tools for Others

• The data is hard evidence for support of other initiatives.
• Importance of data entry can not be overstated – garbage in garbage out.
• Frequent analysis of the data, early on to pick up any issues or gaps.
• Share the successes of how the initiative is going with those involved.
Name: Gailyne MacPherson

Organization: Health PEI

Email: tgmacpherson@ihis.org

Phone Number: 902-894-0297
Door to Triage Times
A Prospective Analysis

Lisa Sampson
Patient Safety Coordinator
South Shore Health
Rationale for the project

• In the Fall 2010 Patient and staff reports of prolonged wait times in ER from door to triage
• This became an opportunity to do a Prospective Analysis with a team consisting of ER/Ambulatory Care Nurses, Ward Clerk, and Manager, Drs and their office staff, Registration Staff, Decision Support Analyst, Industrial Engineer, Quality, Risk and Patient Safety
The Goal of the Project / Strategy

To identify failure points in the process of an ED/ Ambulatory Care visit that contribute to prolonged wait times.

To include the staff in identifying and implementing improvements in Emergency/Ambulatory Care Services that reduce wait times.

To evaluate the success of the changes.
Measures

- Data collection as a baseline to evaluate improvements eg. CTAS, patient #s, ER vs Amb Care, time in triage, # and type of phone calls
- Booked patient lists from physician offices vs walk-ins for Ambulatory Care
- Registration codes pilot-ED vs. booked
- Booked clinics
- Wait time audits
- Phone calls
Key Insights & Lessons Learned

- Document the issue and the current process
- Useful tools - Process map following the flow of the patient
- Share with everyone involved for their input on failure points
Challenges: Tips & Tools for Others

- Utilize the data
- Get input from everyone involved
- Keep the process simple and realistic
Name: Lisa Sampson, Patient Safety Coordinator
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Phone Number: (902) 543-4604 ext 2804
Cell: (902)521-7584
Home Phototherapy Program

Angela Wickett
The Obstetrical/Genealogical Service at Dr. Everett Chalmers in Fredericton noticed an increasing trend in re-admission rates for newborns. Data was collected on the reason for the re-admission and hyperbilirubinemia was identified as a common cause.
Home Phototherapy

- Recent literature was demonstrating a shift in hyperbilirubinemia treatment.
- Phototherapy can be delivered safely and effectively at home via a portable “bili bed”.
- The program purchased one bed and began to shift their practice from admitting patients for treatment to managing them in the home setting.
The impact of this improvement can be measured by:

- Reduction in the re-admission rates for hyperbilirubinemia
- Decrease in total Length of Stay (LOS) for mother and newborn
- Associated cost saving with decrease LOS
- Promotion of bonding between newborn and family
Measures

Readmissions for Neonatal Jaundice

- Introduction of the Home Phototherapy Program

Timeline:
- 1996-1997
- 1997-1998
- 1998-1999
- 1999-2000
- 2000-2001
- 2001-2002
- 2002-2003
- 2003-2004
- 2004-2005
- 2005-2006
- 2006-2007
- 2007-2008
- 2008-2009
- 2009-2010
Measures

Cost Based on LOS 2 days

Introduction of the Home Phototherapy Program

$212,510.00 in 6 years
$56,490 in 9 years

Year

Key Insights & Lessons Learned

- Changing practice takes time
- Shifting of responsibility may meet resistance
- Once you have demonstrated results… keep going
Challenges: Tips & Tools for Others

- Have an effective champion or lead
- The Pediatrician for this project was passionate and the major driving force behind it
Name: Angela Wickett

Organization: Horizon Health Network

Email: Angela.Wickett@Horizonnb.ca

Phone Number: (506) 474-4608
Improvement of Reperfusion times for STEMI’s

Catherine Little, RN BN
Rationale for the project

• In 2008, the Saint John Regional Hospital (SJRH) Emergency Department (ED) and the New Brunswick Heart Center (NBHC) implemented the SHN AMI bundle with great success.

• In October 2010 an audit was performed to evaluate time to thrombolytics and PCI.

• The outcome of that audit showed that further improvement of triage to needle times in treatment of STEMI’s was needed.
The Goal of the Project /Strategy

That all patients presenting to the SJRH ED with a STEMI receive treatment of thrombolytics or PCI within the recommended times as outlined by the Safer Healthcare Now! initiative.
Cath Lab Checklist

All STEMI’S should be considered for possible transfer to the Cardiac Catheterization Lab for Intervention. The following should be done before the Interventional Cardiologist arrives to assess the patient:

- Patient should be on portable ECG monitor
- Connect O2 tubing to portable tank
- Make sure all clothing is off, Johnny shirt only!!!
- Shave Prep to Right wrist, both groins
- If at all possible IV access should be in the Left arm
- Were Plavix/ASA ordered, given and charted
TNK checklist For Emergency Department

- □ 2 Peripheral IV line with 0.9% NaCl, 1 with a stopcock
  - Left arm if possible
- □ Continuous Cardiac monitoring: may perform additional ECG's at any time if Patient becomes pain free or shows significant ECG changes
  - Baseline ECG
  - 30 min post TNK
  - 60 min post TNK
- □ Initial set of Cardiac bloods including type and screen, PT/PTT, INR
- □ Chart patient weight
- □ Portable Chest X-Ray PRN
- □ Vital Signs: BP in both arms initially; **NO AUTOCUFF**
  - Post TNK: Q 15 min x 4
  - Q 30 min x 2
  - Q 1 hour x 4
- With each set of V/S assess and **document** the effect of treatment and general patient condition including pain scale
- □ Neuro VS prior to TNK
  - Q1h x 4 hours
  - Q4h x 24 hour
  - and PRN Subject to patient condition
- □ Check all potential bleeding sites q1h x 4, then q2h x 6
  - Place pressure drsg on any puncture sites
- □ 1:1 Nursing for at least 90 minutes...longer if conditions warrants.
  - **Patients Can be transferred 30 minutes post TNK**
- □ Check with Physician re ordering of Plavix, ASA and Anticoagulants
  - Lovenox OR Heparin is given post TNK
- **If lovenox is given there is 1 dose IV, followed by 1 dose SC**
- **LOVENOX SHOULD BE AVOIDED:** age >75, weight > 102 kg.
- Creat > 200mmol/L. These are precursors for increased bleeding and renal failure
- **HEPARIN is used following the Cardiac Weight based protocol**
- Reference:

---

1 Nurse should be directed as primary caregiver.
Measures - Thrombolytics

AMI 4AC - Thrombolytic Agent Received Within 30 Minutes of Hospital Arrival (Concurrent)

<table>
<thead>
<tr>
<th>Month</th>
<th>Actual</th>
<th>Goal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nov 2007</td>
<td>7%</td>
<td>90%</td>
</tr>
<tr>
<td>Nov 2008</td>
<td>44%</td>
<td>90%</td>
</tr>
<tr>
<td>Nov 2009</td>
<td>0%</td>
<td>90%</td>
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<tr>
<td>Nov 2010</td>
<td>0%</td>
<td>90%</td>
</tr>
<tr>
<td>Nov 2011</td>
<td>0%</td>
<td>90%</td>
</tr>
<tr>
<td>Nov 2012</td>
<td>0%</td>
<td>90%</td>
</tr>
</tbody>
</table>

- Actual: Percentage of patients receiving the thrombolytic agent within 30 minutes of hospital arrival.
- Goal: 90% for all months.
Measures - PCI

AMI 4BC - Percutaneous Coronary Intervention (PCI)
Received Within 90 Minutes of Hospital Arrival (Concurrent)

Percentage

Month


0%  10%  20%  30%  40%  50%  60%  70%  80%  90%  100%

Actual  Goal

100%  83%  33%
Key Insights & Lessons Learned

- Ongoing auditing after implementation of evidence based practices is vital to ensuring quality and safe patient care.

- Continuous education relating to components of AMI bundle is important for consistent patient care.

- Development of checklists is very helpful for success, for example, use of thrombolytics, and Cath Lab preparation.

- Collaboration of a multidisciplinary team is vital for the success of any initiative.
Challenges: Tips & Tools for Others

- Have an effective champion or lead
- Ensure all stakeholders in initiative are aware of implementation strategies to get buy-in
- Provide education as necessary to healthcare providers
- Data measured by 24 hour clock and healthcare providers sometimes deficient in recording specific times on orders and interventions
Name: Catherine Little, RN BN

Organization: Horizon Health Network

Email: Catherine.Little@HorizonNB.ca

Phone Number: 506 648 6015
New Brunswick (NB) Surgical Access Registry
Margaret Meier
Surgical Access Registry

- Established in 2007
- Involvement by Regional Health Authorities (RHAs) and Surgeons from each surgical specialty from all zones
- Goal: to provide surgical care in a timely manner based on patient need / acuity
- Links to Horizon Health Network’s goal: "to optimize access to services by ensuring the right mix of centralized and distributed services and through the innovative use of technologies within available resources"
- Aligns with the New Brunswick Provincial Health Plan Pillar of "enhancing access"
The Goal of the Project /Strategy

- Standardization of patient assessments
- Standardization provincially enables benchmarking, tracking and trending of each facility’s ability to meet targets.
- Determines where resources can be best utilized
- Public involvement – to assist the public with making informed choices as they evaluate the potential wait-times across the province for specific surgical procedures and services by utilizing the public website that has been created.

http://www1.gnb.ca/0217/SurgicalWaitTimes/Index-e.aspx
Measures

• Reduction in wait times for specific surgeries

• Measurement of median, average and 90th percentile of days waiting by category I – IV
  – Category I – surgery needs to be done within three weeks
  – Category II – within six weeks
  – Category III – within three months
  – Category IV – within one year

• It is the goal of the DOH that all surgeries be completed within one year
Key Insights & Lessons Learned

- Requires leadership support and physician buy-in to utilize the information.
- Champions to jumpstart the initiative
- Communication, communication, communication!
- Provide frequent feedback re: data results
- Data quality is essential and audits of multiple fields are completed daily
- Use the data to make decisions
Challenges: Tips & Tools for Others

- Communication, communication, communication!
- Stakeholder engagement
- Prompt follow-up to feedback
Name: Margaret Meier

Organization: Horizon Health Network

Email: Margaret.Meier@horizonNB.ca

Phone Number: 506-857-5102
Capital Health’s Virtual Bed program

Natasha Kerr

Susan Gray-Marmaroff
Rationale for the project

- Pilot from October 2010 - March 2011
- Virtual Bed program enables hospital patients deemed ‘ALC’ to return home with enhanced health care support services for up to 60 days, while they make a decision about their long term care
- Gives patients a) the option to go home - where they want to be, b) time to recover, and c) the best environment in which to consider long term care
- Reduces the client’s risk of hospital-acquired illness
- Increases quality of care while freeing up costly hospital beds for those who need them most
The Goal of the Project
/Strategy

• Use established home care agencies to provide up to 56 hrs of care/week for 60 days - enhanced beyond Regular Home Support.
• Assign a Virtual Bed Care Coordinator for intensive case management.
• Ensure family can participate in care plan
• Ensure client has applied for long term care
• Use a collaborative team of VON nurses, Occupational Therapists, Physiotherapists, Rehab Assistants, etc.
• Patient outcomes: the change in home care services needed after 60 days and the delay to long term care facilities
• Stakeholder satisfaction (clients, families, caregivers, etc.)
• Increase in the number of appropriate client referrals from acute care
• Increase in the number of clients in the Virtual Bed program
Key Insights & Lessons Learned

• Need to educate acute care teams that LTC is not the optimal/first option, and that clients can get quality care at home
• Having consistent caregivers and family involvement is key
• Using non-CCA workers may meet resistance
• Single home care agency, agency’s staffing levels and understanding of time commitment required
Challenges: Tips & Tools for Others

• Begin using a pilot phase
• Generate support from acute care
• Use pilot data to educate influencers and generate support for the program
• Explore the idea of Virtual Bed with a client/family at an earlier stage in the long term care discussion.
• It can be a challenge identifying eligible clients with family support
Contact Information

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Senior Communications Advisor
Integrated Continuing Care

Organization: Capital Health

Email: candice.hayman@cdha.nshealth.ca

Phone Number: 902-487-0617
Select & Dine
Room Service

Cindy Bigelow P.Dt.
Monica Krauch P.Dt.
Rationale for the project

• When- Rolled out on Sept 23rd, 2010

• Who- Food and Nutrition Services, Colchester Regional Hospital

• Why- To reduce waste, and increase patient satisfaction
• To Increase patient satisfaction by giving patients choice in meal selections, and when they want to receive their meal.

• To reduce food waste, patients will only receive what they want, when they want it.
Measures

• Patient Satisfaction Survey to be completed.
  – We have had an increase in the amount of positive comments received from patients and staff about our service and quality of our food.

• Waste Audit
Key Insights & Lessons Learned

- Communicate as much as possible with all staff and the public
- Organization is key
- Flexibility to continue to make changes to ensure system is operating efficiently.
- Involve frontline staff where ever possible in planning process.
Challenges: Tips & Tools for Others

- Take every opportunity to promote your service.
- Involve Frontline staff where possible in planning.
Name: Cindy Bigelow

Organization: Colchester East Hants Health Authority

Email: cindy.bigelow@cehha.nshealth.ca

Phone Number: (902) 893-5554 ext.2129
Programme diabétique

Alice Hébert
Directrice
de programmes cliniques
Rationale pour le projet

• Le Centre diabétique Joslin fut mis en place en mai 2006. Depuis, le programme diabétique à l’HRC de Bathurst est affilié avec le Centre diabétique Joslin et fut accrédité pendant 5 années consécutives.

• Le Centre diabétique Joslin est reconnu mondialement comme étant le centre d’excellence.
Rationelle pour le projet

- Le coût du diabète au N.-B.
  - On estime que 65 000 personnes au Nouveau-Brunswick ont reçu un diagnostic de diabète de type 1 ou de type 2 en 2010.
    - Environ 8,6 % de la population.
  - Que ce chiffre augmente de 23 000 au cours de la prochaine décennie pour se fixer à 88 000 personnes.
    - soit 10,9 % de la population.
Le but du projet / la stratégie

• Mission:
  Conquérir le diabète sous toutes ses formes.

• Vision:
  Améliorer la vie des gens diabétiques et ses complications par des soins innovateurs, l'enseignement basé sur la recherche qui mène à la prévention et la gestion individuelle de la maladie.
Comparaison de A1Cs chez des patients diabétiques choisis de façon aléatoire à notre Centre affilié

A1C avant
Mean A1C 10.2
Mean A1C 7.8
A1C après
avant après
Joslin
Joslin
**United Kingdom Prospective Diabetes Study**

: diminution du risque de complications concernant le diabète associé à une diminution de 1 % de A1C

---

**L’analyse de l’observation de l’étude des données de l’UKPDS**

<table>
<thead>
<tr>
<th>Percent increase in relative risk corresponding to a 1% rise in HbA1C</th>
<th>Any diabetes-related endpoint</th>
<th>Diabetes-related death</th>
<th>All cause mortality</th>
<th>Myocardial infarction</th>
<th>Stroke</th>
<th>Peripheral vascular disease†</th>
<th>Microvascular disease</th>
<th>Cataract extraction</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>21%</strong></td>
<td><strong>21%</strong></td>
<td><strong>14%</strong></td>
<td><strong>14%</strong></td>
<td><strong>12%</strong></td>
<td></td>
<td></td>
<td><strong>43%</strong></td>
<td><strong>37%</strong></td>
</tr>
</tbody>
</table>

†Lower extremity amputation or fatal peripheral vascular disease

*P = 0.035; **P < 0.0001

Visites de patient à la Clinique diabétique (externes)

• Depuis notre affiliation, nous sommes en croissance continue

![Graphique montrant la croissance des visites de patients avant et après Joslin]
Résultats

Étude de 50 dossiers

- Triglycéride
  - Diminution: 6%
  - Inchangé: 14%
  - Augmentation: 80%

- Cholestérol LDL
  - Diminution: 16%
  - Inchangé: 22%
  - Augmentation: 62%

- Poids
  - Diminution: 18%
  - Inchangé: 28%
  - Augmentation: 54%
• Initiation d’équipe multidisciplinaire dès le début du projet.
• Implication médicale essentielle.
• Le support administratif est essentiel.
• Avoir des réunions structurées régulières afin de conserver le momentum.
Défis : conseils pour les autres

• Être conscient des étapes et des défis reliés aux changements et les adresser objectivement.

• Présenter le projet à différents niveaux, afin d’offrir la plus grande transparence possible.

• Continuer de garder les gens informés de la progression du projet.
Coordonnées

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• Organisation : Hôpital régional Chaleur
• Courriel: alice.hebert@vitalitenb.ca
• Numéro de téléphone : 544-2357
Break
• 2008

• We are a patient led organization

• We are a program of CPSI

• With the support of CPSI we work to make “Every Patient Safe”
The Goal of the Project /Strategy

- “Every Patient Safe”
- “We Champion the Patient Voice to Advance Safe Health Care”
- To provide a forum for patients to speak about their experiences with a focus on sharing learning opportunities for improvement
Support the CPSI business plan by:

• Including the patient voice in the design of patient safety programs and services

• Leveraging the patients voice to achieve extraordinary improvements in patient safety
The work we do

• Participate in conferences on patient safety as keynote speakers, panel members or poster presentations

• Participate in steering groups, task forces and working committees

• Support research activities through PFPSC research working group
Measures of Success

- Evaluate yearly
- Milestone and action plans items accomplished
- PFPSC members engaged and satisfied with their contributions
- Beneficiaries of PFPSC services are satisfied with members performance
- Increased the number of patients engaged in patient safety efforts in Canada
Messages for You

• To err is human, to cover up is unforgivable, to fail to learn is inexcusable. (Sir Liam Donaldson, WHO 2005)

• Long after we remember the words you used, we will remember how you made us feel
  (Deb Prowse, PFPSC)

• You can be a thunderstorm in someone’s day or you can be their rainbow.
  (Donna Davis, PFPSC)

• Although you may never be able to give us acceptable reasons for what has happened – you may be able to make our journeys after the event just a little bit easier.”
  (Dale Nixon, PFPSC)
Contact Information

Name: Patients for Patient Safety Canada

Organization: CPSI

Email: info@patientsforpatientsafety.ca

Phone Number: 1 866 421-6933
Implementation of BD Nexiva™ Closed IV Catheter System

Susan LeBlanc
Clinical Program Director
Chaleur Regional Hospital
Bathurst, N.B.
In September 2009, as part of our zone’s needle safe initiative, we determined that the BD Nexiva™ System best met patient and employee safety goals for IV catheter systems. We thus began working towards the acquisition and implementation of this system.
The Goal of the Project

Strategy

- To acquire and implement needleless systems throughout Zone 6 of the Vitalité Health Network. This had already been accomplished with our hypodermic (IM, S/C, Insulin, Tuberculin) needles.
- To enhance patient care while reducing clinical complications associated with venipuncture and IV therapy.
- To reduce injuries related to exposure to blood and blood borne pathogens.
- To improve efficiency in care provision.
Measures

• User feedback * June 2010 (6 months post implementation)
  80% of end users satisfied, 17% having usage concerns; concerns addressed – Follow-up survey October 2010 – 95% end user satisfaction rate
• Patient Satisfaction surveys – no complaints r/t IV therapy
• Financial analysis - Corporate rebate from BD Canada to ensure that the initiative was cost neutral in year 1
  - significant reduction in the use of 7 inch extension tubing's (savings of $__________)
• IV dwell times – 72 to 96 hr dwell time
  - decreased rate of dislodgement
• Change management – slow implementation
• Necessity of longer term clinical support, in-servicing, troubleshooting
• Strong nursing leadership – capacity to influence
• Pre-implementation support from Medical personnel
Challenges: Tips & Tools for Others

• Ensure availability of support people during and post implementation (coaching, support, troubleshooting)
• Ongoing assessment of efficiency benefits (nursing time saved, IV dwell times, dislodgement rates) and safer workplace objectives (needle stick injuries, blood contact)
Name: Susan LeBlanc
Organization: Chaleur Regional Hospital
Email: susan.leblanc@vitalitenb.ca
Phone Number: 506-544-2670
Chronic Obstructive Pulmonary Disease (COPD) Demo Project Primary Care

Harbourside Family Health Centre, PEI

Kendra Biggar
Rationale for the Project

- Screening of patients began on May 19, 2010 at Harbourside Family Health Centre. The 1 year reassessment of patients will commence mid-May 2011.
- Clinical team consisted of a LPN, RN, COPD Educator (Respiratory Therapist) and the physician
- COPD is a progressive chronic disease that affects over 5% of the PEI population, compared to 4.6% in Canada
- Number of cases is estimated to rise substantially over the next four years by over 50%
- Complex disease that is left unmanaged results in high and costly utilization of health services and poor quality of life
- Length of stay in acute care for COPD is nearly twice the national average and patients can have several visits to hospital per year
The Goal of the Project /Strategy

- To improve health outcomes and quality of life for patients with COPD
- To research, select and test innovative evidence-based care pathways for COPD using an interdisciplinary team approach
- To emphasize prevention and primary care to avoid complications and exacerbation
- To facilitate education and training of healthcare providers
- To reduce pressures on the acute care system
• Three questionnaires were utilized during the patient’s first visit:
  – Breathing Clinic Questionnaire
  – Patient Health Questionnaire (PHQ-4)
  – St. George’s Respiratory Questionnaire for COPD Patients
• The questionnaires will be repeated at the one year mark to determine if progress has occurred in improving the patient’s quality of life
• Data will be assessed/collection as to the number of ER visits and admissions to acute care for the participants
The pilot was successful at recruiting moderate to high risk patients. Need to explore ways of attracting patients earlier to the program. Patients expressed high satisfaction. Numbers are small, but have seen slight decrease in the # of ED visits to Prince County Hospital for COPD. Evaluation is expected to be completed in Fall 2011.
Challenges: Tips & Tools for Others

- Need ongoing efforts to continue to recruit patients to the program
- Dedicated resources are required to implement the pilot
- Limitations to using medical claims data for identifying COPD patients for the program as a chart audit showed that not all patients had COPD
- Coordination is required to ensure health professionals are available
Contact Information

Name: Kendra Biggar, RRT CRE
Organization: Health PEI, Prince County Hospital
Email: kebiggar@ihis.org
Phone Number: (902) 438-4252
Health PEI
Clinical Information System (CIS) Project

Margaret Duffy
Rationale for the project

- Replacing legacy systems and implementing an integrated electronic patient records (EPR) system in PEI’s hospitals for:
  - Registration, Scheduling, Health Records, Labs, Pharmacy, Nursing Clinical Documentation, Physician Progress Notes, Surgical and Emergency Department solutions, interfaces to diagnostic imaging results, specialist consultations & financials, and CPOE
- Kicked-off in 2006; restructured late 2007; Phased roll-out April 2008 to June 2013;
- Joint PEI/Cerner team of Clinical & IT professionals;
- Foundational implementation towards PEI’s iEHR.
The Goal of the Project /Strategy

• Improved patient safety and better health outcomes through secure access to patient information and decision support tools at point of care;
• Keeping in line with the overall iEHR vision:
  – One patient, One record; Quality & Safety;
  – Effective Information Management; and Meeting evolving healthcare needs.
Measures

• Supporting tool (system enabler) to the Health PEI strategic vision of “Care will be delivered through a single, integrated system of care…”

• Specific measures over time, reductions in…
  – medication errors, duplicate/unnecessary tests, need to repeat medical history, readmissions for same or related diagnosis, lengths of stay;
  – turnaround time from order to collection/exam for stat and urgent diagnostic tests; turnaround time from physician order to administration of first dose medication.
Key Insights & Lessons Learned

- Moving to an EHR is more a “cultural transformation” than an IT innovation;
- Standardization is key and it is hard to achieve;
- Governance Model & Change Management are crucial;
- Rigor must be placed around managing the work and maintaining project scope;
- Hospital & Medical Leadership MUST be Engaged.
Challenges: Tips & Tools for Others

- Steering Committee, Provincial Working Groups and Hospital Implementation Teams, with cross-representation from all professions / facilities;
- Change Management Unit focused on minimizing user resistance; maximizing user engagement;
- Right mix of Clinicians/IT Specialists on Team;
- Establish a good relationship with your vendor;
- Rigorous project management framework;
- Learn from others … but do what’s right for you …
- Make it easier to do the right thing …
Contact Information

Name: Margaret Duffy, CIS Clinical & Business Lead Operations

Organization: Health PEI, Health Information Management Division, E-Health Projects

Email: maduffy@gov.pe.ca

Phone Number: (902) 620-3869
Integration of Continuing Care Services in NS

Continuing Care Considerations

Sandra Bauld
Chair, Health Association Nova Scotia Continuing Care Council
Executive Director, Northwood Homecare Ltd
Rationale

• **When**
  - Discussions ongoing since late 1990’s
  - Reintroduced in 2008

• **Who**
  - Department of Health & Wellness (DHW)
  - District Health Authorities (DHA)
  - Long-term, Home Care Provider Organizations
  - Health Association Nova Scotia, Service Agreement Working Group, Continuing Care Council

• **Why**
  - Better integration of health care services along the continuum
The Goal of the Project / Strategy

- Develop a service agreement that the DHAs and Service Providers find acceptable

- Shift majority of responsibilities for delivery of con’t care services from DHW to the DHAs
  - E.g. Devolve coordination role from DHW to DHAs

- Ultimately: more effective and efficient coordination of services at local level
Measures

• Accountability mechanisms outlined in the service agreement

• Long-term process / service improvements
• Ensure the sector is involved

• It’s good to know your partners
Challenges: Tips & Tools for Others

- Set realistic timelines
- Be aware of everyone who might be influencing outcomes
- Build on the positives to move past sticking points
Contact Information

Name: Sandra Bauld

Organization: Health Association Continuing Care Council

Email: sbauld@nwood.ns.ca

Phone Number: 902 – 421 - 7374
Unsafe Abbreviations

Angela Wickett
The use of unsafe / error prone abbreviations has been recognized as a global safety issue. The removal of such abbreviations has been recommended by several governing bodies; such as ISMP and Accreditation Canada. In order to facilitate safe medication use, as an organization it was / is necessary to assess and change our practice.
Rationale for Project

80% of use
The Goal of the Project /Strategy

- To reduce the overall incidence of adverse events related to the use of unsafe abbreviations / error prone abbreviations.

- To assess the baseline data regarding the number of unsafe abbreviations used; in order to identify and implement strategies to reduce the use of unsafe abbreviations.

- To educate staff regarding the potential harm that can occur from using such unsafe or error prone abbreviations.

- To facilitate a change in practice in order to align with best practice standards / safety recommendations from Accreditation Canada, ISMP, and other industry leaders.
Measures

- Pre printed on orders
- Posters
- Email/Mox
- Pocket cards
- Email/doc fo black/palm
- Sticker by desk

The chart shows the percentage of measures used, with 'Pre printed on orders' having the highest percentage.
Measures

Next steps …
• Through education sessions provided to staff and a post implementation chart audit, we will see:
  – A reduced number in the overall use of unsafe abbreviations.
  – A increased number of clarifying orders that are written when interpreting staff notice unsafe abbreviations.
  – An overall decrease in the number of medication errors / adverse events related to misinterpretation of written orders when unsafe abbreviations are used.
Key Insights & Lessons Learned

– To change a long standing practice takes time.

– With change comes resistance.

– Once results have been demonstrated spread your practice.
Challenges: Tips & Tools for Others

– Ensure the responsibility is spread equally.

– Appoint and utilize clinical champions.

– Advocate and educate at every possible opportunity.
Contact Information

Name: Angela Wickett

Organization: Horizon Health Network

Email: Angela.Wickett@Horizonnb.ca

Phone Number: (506) 474-4608
Patient Safety
Metric System

Alexandru Titeu
SHN – Central Measurement Team
• Where we started

• Where we are now

• Where we think we need to go (time permitting)
The Past

- MS Excel worksheets with run charts
- Monthly, quarterly data, whenever submission
- Quarterly Reports prepared and distributed by CMT
Goals of PS Metrics

• Streamline enrollment and simplify data submission
  – Integrated the SHN enrollment and SHN measurement databases
  – “One-stop-shop” for data submission
Goals of PS Metrics

• Provide real-time access to data and standardized reports
  – 103 indicators across 14 interventions
  – Acute Care, Long-term Care, Home Care
• Data can be rolled up or drilled down for reporting
  – “Team” > Organization > Region > Node > National
Patient Safety Metrics
Patient Safety Metrics: Measuring to Reduce Harm

Users that have completed training
All users that have previously submitted data have been registered into the system, and all data has been transferred from your worksheets. Temporary Passwords have been sent to users that have completed the training sessions.

Users that have NOT completed training
Watch a recorded Patient Safety Metrics Training Session either online or by using Windows Media Player. Then enter your email address and click on Forgot Password to receive your Temporary Password.

Users that are NOT registered or organizations that are NOT enrolled in SHN
We shall post the enrollment form soon.

Note: To access the Patient Safety Metrics system, please use Internet Explorer as your browser, rather than Firefox or Chrome.

Patient Safety Metrics
Please enter your Email and Password in the fields below.

Email

Password

Login

Forgot Password?
Guest Data Entry
Version française

SHN | Training Manual | Privacy Policy
<table>
<thead>
<tr>
<th>Intervention with Data Submitted</th>
<th>Intervention Status</th>
<th>Lastest Data</th>
</tr>
</thead>
<tbody>
<tr>
<td>AMI - Improved Care for Acute Myocardial Infarction</td>
<td>Working To Goal</td>
<td>2011/Mar</td>
</tr>
<tr>
<td>CLI - Central Line-Associated Primary Bloodstream Infections</td>
<td>Working To Goal</td>
<td>2011/Mar</td>
</tr>
<tr>
<td>Falls-Acute - Reducing Falls and Injury from Falls in Acute Care</td>
<td>Working To Goal</td>
<td>2011/Mar</td>
</tr>
<tr>
<td>Falls-LTC - Reducing Falls and Injury from Falls in Long-term Care</td>
<td>Working To Goal</td>
<td>2011/Mar</td>
</tr>
<tr>
<td>MedRec-Acute - Medication Reconciliation in Acute Care</td>
<td>Inactive</td>
<td>2008/May</td>
</tr>
<tr>
<td>SSI - Reducing Surgical Site Infection</td>
<td>Working To Goal</td>
<td>2011/Mar</td>
</tr>
<tr>
<td>VAP - Ventilator-Associated Pneumonia</td>
<td>Working To Goal</td>
<td>2011/Apr</td>
</tr>
</tbody>
</table>

Manage Interventions
2.0 Mean Number of Unintentional Discrepancies per Patient (General Surgery)

Year: 2011  Month: May

An unintentional discrepancy has occurred when the physician has unintentionally changed, added or omitted a medication the patient was taking prior to admission.

**Denominator**
1. Enter the total number of patients in this sample population.
   - 10

**Numerator**
2. Enter the total number of Unintentional (Type 3) Discrepancies identified on the BPHI for the patients in the sample (#1) after the medication reconciliation process has been completed.
   - 5

**Your Result**
3. Numerator/Denominator
   - 0.50

**Goal**
- Decrease the rate of unintentional discrepancies by 75% in one year

**Comments**
<table>
<thead>
<tr>
<th>Report Type</th>
<th>Description</th>
<th>Last Run</th>
<th>Status</th>
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<tbody>
<tr>
<td>Quarterly Report - National and Node (all patient samples)</td>
<td></td>
<td>2011/04/26</td>
<td>Run</td>
</tr>
<tr>
<td>Quarterly Report - National and Region (all patient samples)</td>
<td></td>
<td>2011/04/01</td>
<td>Run</td>
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<td>Quarterly Report - Organization and National (all patient samples)</td>
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<td>Run</td>
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<tr>
<td>Quarterly Report - Organization and Node (all patient samples)</td>
<td></td>
<td>2011/04/26</td>
<td>Run</td>
</tr>
<tr>
<td>Quarterly Report - Organization and Province (all patient samples)</td>
<td></td>
<td>2011/04/26</td>
<td>Run</td>
</tr>
<tr>
<td>Quarterly Report - Organization and Region (all patient samples)</td>
<td></td>
<td>2011/03/01</td>
<td>Run</td>
</tr>
</tbody>
</table>
Patient Safety Metrics Quarterly Report

### Quarterly Report - Organization and National (all patient samples)

**Run Chart**

<table>
<thead>
<tr>
<th>Month</th>
<th>Denominator</th>
<th>Numerator</th>
<th>Your Result</th>
<th>Result-National</th>
<th># Reports-National</th>
<th>Goal</th>
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</thead>
<tbody>
<tr>
<td>2007/Apr</td>
<td>46</td>
<td>51</td>
<td>1.11</td>
<td>0.71</td>
<td>96</td>
<td></td>
</tr>
<tr>
<td>2007/May</td>
<td>42</td>
<td>41</td>
<td>0.77</td>
<td>0.08</td>
<td>104</td>
<td></td>
</tr>
<tr>
<td>2007/Jul</td>
<td>48</td>
<td>61</td>
<td>1.16</td>
<td>0.87</td>
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<tr>
<td>2007/Dec</td>
<td>52</td>
<td>61</td>
<td>1.04</td>
<td>0.89</td>
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<td></td>
</tr>
<tr>
<td>2008/Jan</td>
<td>42</td>
<td>41</td>
<td>0.77</td>
<td>0.08</td>
<td>104</td>
<td></td>
</tr>
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<td>1.15</td>
<td>0.87</td>
<td>106</td>
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<td>1.04</td>
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<td>103</td>
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<td>2009/Oct</td>
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<td>0.08</td>
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<td>2009/Sep</td>
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<td>2009/Jan</td>
<td>42</td>
<td>41</td>
<td>0.77</td>
<td>0.08</td>
<td>104</td>
<td></td>
</tr>
</tbody>
</table>
Patient Safety Metrics

Metrics3D Dashboard

[Image of dashboard showing enrolled and submit count by province, as well as a comparative table for MedRec-Acute 2.0]

<table>
<thead>
<tr>
<th>PROVINCE</th>
<th>Result - MedRec-Acute 2.0</th>
<th>Goal - MedRec-Acute 2.0</th>
</tr>
</thead>
<tbody>
<tr>
<td>New Brunswick</td>
<td>0.06</td>
<td>0.00</td>
</tr>
<tr>
<td>Newfoundland and Labrador</td>
<td>0.02</td>
<td>0.00</td>
</tr>
<tr>
<td>Nova Scotia</td>
<td>0.61</td>
<td>0.99</td>
</tr>
<tr>
<td>Prince Edward Island</td>
<td>0.03</td>
<td>0.50</td>
</tr>
<tr>
<td>National Average</td>
<td>0.55</td>
<td>0.49</td>
</tr>
</tbody>
</table>
Early Feedback

- I have transitioned a number of teams so that they are doing their own data entry and getting their reports from the [PS Metrics] system. That will save me a lot of time. The system is great... I like it a lot and I think it is much better for the teams to be doing this part as I think they are more connected with their own data now.

  Dawn Hollohan,
  Performance Measurement Coordinator
  Cape Breton Regional Health Authority, NS

- I just want to complement you on the new website! It's so easy to enter data and navigate, thanks.

  Dianne Pletz RN, BScN,
  Decision Support Analyst,
  St. Mary's General Hospital, ON
First 6 weeks

<table>
<thead>
<tr>
<th></th>
<th>Feb 24 - April 14, 2011</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Total users trained on PS Metrics</strong></td>
<td>298</td>
</tr>
<tr>
<td><strong>Number of unique users logging in after training</strong></td>
<td>182</td>
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<tr>
<td><strong>Total number of logins</strong></td>
<td>673</td>
</tr>
<tr>
<td><strong>Average number of logins per user</strong></td>
<td>3.70</td>
</tr>
<tr>
<td><strong>Number of unique users submitting data</strong></td>
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<tr>
<td><strong>Data points entered by users onto PS Metrics</strong></td>
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<tr>
<td><strong>Data points entered by CMT from worksheets</strong></td>
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</tr>
<tr>
<td><strong>Total Datapoints entered</strong></td>
<td>5447</td>
</tr>
</tbody>
</table>
Thank You

Alexandru Titeu
Project Coordinator, Central Measurement Team
shn.ea@utoronto.ca
416-946-3103

Virginia Flintoft
Project Manager, Central Measurement Team
virginia.flintoft@utoronto.ca
416-946-8350
Global Patient Safety Alerts

Anne MacLaurin
Canadian Patient Safety Institute
Safe care...accepting no less.

Frontline healthcare providers and healthcare organizations around the world are looking for and developing solutions to patient safety incidents and challenges.

Global Patient Safety Alerts is an innovative information-sharing resource to help you prevent and mitigate patient safety incidents in your organization and help others succeed.

Here you'll find more than 800 patient safety incident advisories, alerts, and recommendations. Learn what works and share your own insights and solutions with healthcare providers, healthcare organizations, patients, and the public.

You'll also find customizable, evidence-based tools you can start using immediately to help you achieve your goals.

By asking, listening, and talking to one another, we can grow our own patient safety initiatives and help others grow theirs. Join the conversation and get the solutions you need today.
The Goal of the Project /Strategy

- Global Patient Safety Alerts is a cost-free, searchable repository of indexed summaries and links to patient safety incidents in the form of advisories, alerts, and recommendations from around the world.

- Sharing of this information with each other will catalyze learning about patient safety for all.
Sharing for Learning

Alerts & Advisories

Search

Find alerts, advisories, and recommendations from patient safety, quality, and healthcare organizations from around the world.

Sharing our collective knowledge, evidence, and analysis allows us to help ensure that every patient experience is safe. Take action by learning from and sharing with the global patient safety community. Together, we can do big things.

Search

Surgery
Results for: Surgery

2006-03-24
*Delayed diagnosis of a patient’s perforated viscus following hip replacement surgery*
Winnipeg Regional Health Authority (Canada) Canada

Topic: Care Management

Summary: A delayed diagnosis of a patient’s perforated viscus following hip replacement surgery related to staff not being able to reach the attending physician and an alternate not being identified. An additional surgery was eventually performed and the patient was discharged home a number of months later.

2009-09-01
*Cisternal Implant Risk*
National Center for Patient Safety (Department of Veteran’s Affairs - USA) United States of America

Topic: Surgery

Summary: FDA has determined that, over the past 14 years, 52 cases of meningitis after cisternal implant have been reported worldwide, all of which 12 billion deaths have resulted from these cases. It was identified that 24 cases (of the 52 worldwide cases) were in North America. Suggestions for reducing this risk are provided at applicable VA facilities for consideration.

2009-09-01
*Ensuring Correct Surgery and Invasive Procedures*
National Center for Patient Safety (Department of Veteran’s Affairs - USA) United States of America

Topic: Surgery

Summary: The Veterans Health Administration (VHA) Directives provides specific policy on what steps must be taken to ensure that all surgery and invasive procedures are performed in the clinical setting and only performed on the correct patient, at the correct site, and with the correct implant, if applicable. Note: This policy does not apply to vasectomy or intravenous therapy. The five steps for ensuring correct surgery and invasive procedures are performed in the clinical setting. The Directives describe...

2009-03-01
*Elderly patient with new hip pain found to have retained surgical instrument following complex abdominal surgery*
Winnipeg Regional Health Authority (Canada) Canada

Topic: Surgery

Summary: An elderly patient underwent complex abdominal surgery that was performed by three surgeons (one general and two specialty surgeons) and two separate nursing teams. The surgical instrument count performed at the conclusion was indicated as correct on the patient’s medical record. It was verified that the instrument count was correct. A week later the patient developed hip pain. It was determined that the instrument was not removed from the wound. A number of months later, the patient visited a physician with a complaint of...

2006-02-22
*Delayed diagnosis of a patient’s perforated viscus following hip replacement surgery*
Winnipeg Regional Health Authority (Canada) Canada

Topic: Care Management

Summary: A delayed diagnosis of a patient’s perforated viscus following hip replacement surgery related to staff not being able to reach the attending physician and an alternate not being identified. An additional surgery was eventually performed and the patient was discharged home a number of months later.
Alert Summary

Title: Delayed diagnosis of a patient’s perforated viscus following hip replacement surgery

Topic: Care Management

Publication Type: Critical Incident Learning Summary

Single or Multiple Incident: Single

Summary: A delayed diagnosis of a patient’s perforated viscus following hip replacement surgery related to staff not being able to reach the attending physician and an alternate not being identified. An additional surgery was eventually performed and the patient was discharged home a month later.

Department: Orthopedics, Surgery, Geriatrics

Date: 2003/03/21 (YYYY/MM/DD)

Country: Canada

Organization: Winnipeg Regional Health Authority (Canada)

Keywords: rapid response team, medical emergency team, elder care, assessment, physician handover, communication, on call physicians

Actions to reduce risk

1. Reinforce within the facility the importance of an attending surgeon providing coverage when away / unavailable.
2. Reinforce with staff the option of contacting on-call physician or medical manager of surgery if unable to reach attending physician.

Environment / Equipment

Consideration be given to site participation in the Safer Healthcare Now! Initiative with respect to Rapid Response Teams.

View Full Alert

Critical Incident Category: Diagnostic

What happened?
An elderly male patient, five days after surgery for hip fracture, developed abdominal distention and fever. Initial assessment suggested post-op sepsis. The following morning the patient was found to have a perforated viscus. Surgery was performed and the patient was discharged home a number of months later.

What were the review findings?
- An alternate covering physician was not identified.
- Staff were uncertain about how long to continue attempting to reach the attending physician and who to contact as an alternate when unable to reach the attending physician.

What was recommended?
- Consideration be given to site participation in the Safer Healthcare Now! Initiative with respect to rapid response teams.
- The importance of an attending Surgeon providing coverage when away/unavailable be reinforced within the facility.
- The option of contacting the "on call" physician, or the Medical Manager of Surgery, if unable to reach an attending physician be reinforced with staff.

This report has been prepared at the direction of the WRHA Patient Safety and Quality Research Committee and is privileged under Section 9 of the Manitoba Evidence Act. It has been abstracted from an actual Critical Incident Review, but identifying information has been removed or modified in order to circulate to Health Care Providers and Organizations to promote learning from Critical Incidents.
Rationale for the project

• Why
  – Learning from patient safety incidents was trapped within various jurisdictions and needed a place to be centrally shared.

• Who
  – CPSI, with support from the WHO
  – 22 contributing organizations from 5 countries

• When
  – Launched February 15, 2011
  – Over 1200 viewers from 40 countries
Evaluation and Measures

- Web analytics will help us understand how frequently the system is accessed.

- An evaluation is planned for September, 2011 using a logic model to understand the user experience and the applicability of the information contained within the system.
Key Insights

The key to encouraging use of Global Patient Safety Alerts is remove the barrier of resource burden on users and demonstrate value – place the information users need directly at their finger tips and they will cycle their learning back into the system.
• Global Patient Safety Alerts is a simple tool that users can engage with as little or as much as they want - resources available are independent of each other and can be used separately.

• Global Patient Safety Alerts uses a familiar “google-like: search engine that will be expanded over time.
Globalpatientsafetyalerts.ca

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Closing Thoughts

Theresa Fillatre
May 12, 2011
Revisiting our Goals

- Showcase Atlantic initiatives
- Develop adverse event system response skills & capacity
- Review & understand provincial quality & patient safety structures & priorities & implementation challenges
- Highlight first voice experience
- Provide a public education event
- Examine national activities & potential links
- Keep it simple & get maximum dialogue
How Did We Do In Attracting Our Target Audience?

- Frontline staff (70)
- Physicians (10)
- Quality & System Performance Supports (22)
- Governance (6)
- CEOs & Senior Leaders (25)
- Health Departments / Government (12)
- 100-140 participants (150)
- Public (20)
Key Observations

• Every province & org has amazing pockets of excellence & good practices
• Common strategies, priorities & implementation / capacity building challenges across the 4 provinces
• Patient & family centered systems are valued ….not there yet
• Leadership & governance roles are key
• Measurement & data entry duplication
• Adults learn by doing & improvements can be achieved (concern re holding the gains)
• Policy & focused national /Atlantic strategies may leverage system level change
• Amazing enthusiasm & energy pervails
Potential to Change the Ways We Work

- Potential to explicitly align prov priorities, strategies, Accreditation Canada & SHN & CPSI products & services (Deeper dives & focusing resources)
- Potential to draw on patient & family experience & voice in more ways
- Economies of scale are likely possible by working together as 4 provs on a few key areas annually
- R&D (Rob & deploy)
- Merits to focusing explicitly on provider, patients, and governance education & capacity building
Potential Atlantic Collaborative
Mtg Agenda June 22, 2011

- Governance for Patient Safety Program
- Patient Safety Metrics System
- PSEP Canada
- Engaging with Physicians (Royal College & PSEP)
- Advocacy for use of Global Alerts
- Marketing & Use of Improving Care Search Centre
- Other???
Appreciating the Dream Team

- Janet Hodder PEI
- Karen Mc Caffrey PEI
- Mariette Duke NB
- Nancy Roberts NB
- Wayne Miller NL
- Bev Griffiths NL
- Sandy Goodwin NS (E Dunlap & E Gunn)
- MJ MacDonald NS
The Staff Behind the Scenes

- Jason Thompson CPSI
- Dannie Currie SHN Atlantic
- Lynn Riley SHN Atlantic
- Laurie Mc Nally Health PEI
- Marie Owen CPSI
- Anne Mac Laurin CPSI
- Dave Mc Cormack Eastern Health NL
- All of our speakers!
Response to Challenge for Host Province 2013?

Thank You & Safe Travels