A SURGICAL CARE SAFETY ACTION PLAN

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Introduction

There are many things to think about before heading into surgery: whether you'll get safe care should not be one. And, because Canadians trust their health care providers, it usually isn't. Sadly, however, there are growing numbers of people who know from experience — their own, or a loved one's — that surgical care is not always as safe as it should be. It's time to change that.

In its business plan for 2013-2018, the Canadian Patient Safety Institute made a commitment to advance a national action plan to accelerate patient safety improvement in Canada. The commitment focuses on accelerating safety improvements in four priority areas: medication safety, surgical care, infection prevention and control, and home care. These are not efforts the Canadian Patient Safety Institute can or should do on its own — safety is a collective responsibility, achievable only through collaboration and drawing on the expertise of many organizations and individuals. The Canadian Patient Safety Institute undertook to organize a series of meetings with national, provincial, territorial and local stakeholders in patient safety, each day-long event dedicated to developing a specialized action plan for one of the priority areas.

The first meeting, held in January, 2014, was to build a consortium of leaders from patient groups, governments, national and professional organizations to identify the high-level components of an action plan for patient safety: the patient voice, leadership, measurement and communication. At the request of participants, the Canadian Patient Safety Institute drafted an action plan, with specific goals, immediate- and intermediate-term actions for achieving these, deadlines, and suggestions on who might take up each challenge.

Consortium participants liked the approach, and its promise of driving action, rather than producing another report to sit on a shelf. The same model is being used for the four priority areas as well: the Canadian Patient Safety Institute acting as a facilitator to bring stakeholders to a meeting where they would identify practical action that governments, organizations, professional and patient groups can undertake to drive safety forward. The Canadian Patient Safety Institute then followed up by producing a draft plan and circulating it for approval and action by participants. This report outlines the outcomes of the Surgical Care Safety Summit held in Toronto on March 26, 2014.

* The Government of Quebec did not participate at the Surgical Safety Summit. It is solely responsible for the planning, organization, management and evaluation of patient safety in Quebec

Building a plan

More than 30 people came to the surgical safety summit. Some represented professional associations —respiratory therapists, anesthesiologists, operating room nurses, pharmacists, surgeons. Others represented quality councils, provincial ministries, health authorities, and a patients' group. The meeting began with a sobering reminder of why surgical care safety matters: Raeline McGrath's video told the story of the death of her daughter Claire after surgery. Four rapid-fire presentations on leading practices in surgical care followed — one on each of the National Surgical Quality Improvement Program (NSQIP) and Enhanced Recovery After Surgery (ERAS), and two presentations on Safer Healthcare Now! (SHN!) surgical interventions and measurement. Then the collective part of the meeting began.

To prepare for the meeting, the Canadian Patient Safety Institute sent out a short survey to the summit participants. After a question on participants' roles in safety, the survey asked first "In your opinion, what are the top three concerns or gaps for surgical care safety in Canada?" The follow up question asked for a different point of view: "What do you believe patients and families would identify as their top three concerns or gaps in surgical care safety?" Just over 70 per cent of participants responded. From those answers, the Canadian Patient Safety Institute distilled seven themes for the meeting:

1. Measurement and analysis of timely, relevant and robust data specific to surgical care safety including outcomes and never events.

2. Timely access to surgical care and the impact on patient experience and outcomes.

3. Expertise and application of best practices including knowledge transfer, reliability, reducing variation.

4. Patient engagement, including the role patients play in surgical safety across the continuum of care.

5. Communication and teamwork and their impact on patient safety.

6. Quality improvement infrastructure for surgical safety is required.

7. Reporting and learning is impacted by a culture of silence, failure to learn and failure to share.

Participants were asked to reflect on the themes — specifically, to consider privately and in discussion whether they agreed with the gaps in care the survey identified, whether there were key issues missing, and what works well in surgical patient safety. From there, they moved on to the world café.

A world café is a meeting format designed to bring out creative thinking in large-group discussions. Participants rotate among "café" tables to discuss the issue they're focused on. At the Toronto meeting, each of the seven themes had a table. Here's a glimpse of what participants had to say:

Theme 1: Measurement and analysis of timely, relevant and robust data specific to surgical care safety including outcomes and never events

There's concern about measurement — it's essential for improvement and accountability, and yet, with a plethora of performance indicators available, information can overwhelm. But data alone do not bring improvement. Data must be coupled with feedback and action to influence processes of care. "We have over-auditing but under-feedback," one participant said.

Those issues dominated the discussion of measurement and analysis; there were calls for a common set of national surgical safety indicators chosen to support agreed-upon surgical safety goals. Others cautioned there are already too many indicators and new ones shouldn't be gathered unless others are dropped, to manage the crush of data and avoid measurement fatigue. Participants suggested concentrating on a select few indicators supported by timely, relevant and robust quality data.

One participant suggested that a promising source for a set of surgical safety indicators for Canada is the U.S.-based National Surgical Quality Improvement Program. The participant commented that NSQIP had transformed attitudes in his hospital. "It's gone from a culture of 'it's not our problem' to a culture of 'let's fix this.'"

Theme 2: Timely access and the impact on patient experience and outcomes

The meeting reflected a reality of Canadian health care: great strides have been made in emphasizing the importance of focusing on patient safety, but the focus remains narrow and most commonly starts when the wait for surgical intervention ends, with a focus on Operating Room procedures, addressing surgical errors and often overlooking the patient safety risks within care transitions. Others take a longer view and include wait times as a potential source of harm.

Participants suggested there are limited patient safety data specific to individuals on surgical waiting lists, and concerns centre on a lack of standards for patients in that particular kind of limbo. There is a lack of agreement on how to measure wait times. Depending on the type of surgery, monitoring patients during waits may be more or less rigorous.

Participants noted surgical care access is being addressed by provinces and territories with the support of the national Wait Time Alliance, and therefore felt new action on the matter was not necessary.

The group suggested two activities that the national Wait Time Alliance might undertake to clarify the links between waiting for surgery and patient safety: sharing system-level learning about provincial and national wait time targets and sharing criteria and processes that have been shown to reduce harm associated with waiting.

The goal that ultimately came forward and was

endorsed in the group voting was to seek provincial and territorial health ministers' willingness to contribute to the implementation of a comprehensive surgical care safety action plan through the Conference of Deputy Ministers.

Theme 3: Expertise and application of best practices including knowledge transfer, reliability, reducing variation.

Information alone does not guarantee safe care, as the discussion on applying and sharing best practices made clear. The world café discussion clearly identified the critical need for easy access to best practices in surgical services to improve care. Participants identified pockets of excellence both nationally and internationally but limited success in spreading these leading practices across the broader system. Participants discussed how this might occur and components to be included.

The role of leadership is to build the capacity to deliver evidence based care and nurture a culture of safety in surgical care. Leaders must also ensure best practices are available, understood, applied, and reinforced. Access to best practices would facilitate the delivery of optimal surgical care.

That's a big task. It takes work to change ingrained behaviour, work that must be done at many different levels: from patients, to board members and government, to all members of the interdisciplinary team.

Theme 4: Patient engagement, including the role patients play in surgical safety across the continuum of care

It is not reasonable, one participant noted, to expect patients and families to take a role in surgical safety until they know how to advocate for themselves and are encouraged to do so. "You can't expect patients to be accountable unless you create a safe place for them to participate in their own care."

How that safe place would be created was an important part of the subsequent discussions on patient engagement. Participants called for training to make providers more ready to listen to and involve patients in all aspects of safe care, and formal plans for including patients and their families in surgical safety efforts. The patient participant said what mattered most to patients was being involved in their own care.

Theme 5: Communication and teamwork and their impact on patient safety

There was a sense in the discussions that in Canadian health care we are guilty of taking teamwork for granted — as though it were a convenient term for any group of people carrying out their duties in the same place. The reality, one participant pointed out, is that most people have never been on a team, sports or professional. The education that students receive on communication and teamwork is certainly not mirrored in what students see on the job.

The world café discussion on communication and teamwork demonstrated the interdependent relationship between these elements and education and culture. To explain this dynamic relationship, one participant cited the old saying "repeated action becomes habit, habit becomes behaviour, behaviour becomes culture." In order to create a culture of safety that expects and, in fact, demands effective communication and teamwork, we must begin by promoting the desired behaviour. Standardized interdisciplinary education and training for surgical teams including support services focusing on communication and teamwork must begin in the academic setting and be carried forward into the workplace. Participants were clear that communication and teamwork tools and processes need to include patients and families.

Theme 6: Quality improvement infrastructure for surgical safety is required

There was a note of unease during the world café that

expectations to develop quality improvement expertise are primarily directed at frontline workers (and even families), while high-level managers and boards are often left out. The result is calls for safety that aren't backed with money, time or that elusive factor, cultural change. Participants agreed expecting transformed behavior in an unaltered workplace is unrealistic.

Participants identified that quality improvement needs to be integrated into all work within an organization. There are models of excellence, and plenty of tools for adopting them. Participants said leaders need to get out on the floor, to take part in regular, genuine sharing and learning sessions. Anyone should feel free to bring up a safety issue (including near-misses), to initiate the search for a solution. Leaders must demonstrate their accountability if they want other people to be accountable. "The message has to be we are all in this together," one speaker said.

Policy makers, executives and physicians should get quality-improvement training that reflects that given to frontline staff, so everyone has a common understanding of the language and methodology.

Theme 7: Reporting and learning is impacted by a culture of silence, failure to learn and failure to share

There is limited understanding in the continuum of surgical services regarding this problem in patient safety. The world café discussions offered suggestions for improved reporting of patient safety incidents and learning. Often, leaders do not close the loop with clinicians when patient harm or threats to safe care are reported. As a result those who do the reporting become disenfranchised that no actionable change has happened. With less than ideal reporting there is no chance for surgical teams to learn and there is no transfer of learning across or between organizations. This increases the likelihood the same event is repeated. Participants also discussed the inconsistent and sometimes confusing language around reporting and learning. A need for standardized language was suggested.
A need for strategies and mechanisms to include patients and families in real time reporting was recognized. "You might have a really good reporting system but also to make it worthwhile, you need families. They have suggestions how to make it work better."

The world café discussion focused on the importance of learning from surgical patient safety incidents. The group determined that a prospective, preventative approach to harm in surgical care was needed. This could be gained through retrospective analysis of surgical harm data, as well as promoting best practice in proactive surgical safety incident management using evidence informed tools and resources. A preventative approach needs
to be inclusive of patients and families.

Getting from "not our problem" to "let's fix this"

After all participants had moved four times within the world café to discuss different themes, they met in plenary to discuss action items that could be distilled to tackle issues raised for each theme. The final step was voting: every participant had five red sticky dots to put by the actions he or she rated highest. Significantly, there was an overwhelming winner for each theme, and all the leading choices drew about the same level of support. Summit participants strongly agreed on where to begin to make surgery in Canada safer. The themes in this report are presented in the order of highest number of votes to lowest.

A SURGICAL CARE SAFETY ACTION PLAN

THEME 1 – MEASUREMENT AND ANALYSIS

Goal	Action
A common set of national surgical safety indicators.	Assemble a working group to review current surgical care indicators including those used in the National Surgical Quality Improvement Program (NSQIP) and Enhanced Recovery After Surgery (ERAS) for suitability for inclusion in a national set of surgical safety indicators. Assemble a group for evaluation and implementation of the common set of national surgical safety indicators.

THEME 2 – ACCESS TO CARE

Goal	Action
Explore provincial willingness to collaborate on a surgical care safety action plan.	Pursue support of the surgical care safety action plan by the provincial and territorial health ministers through the Conference of Deputy Ministers. Explore the role of the Wait Time Alliance to understand how it might contribute to the actions under the measurement theme and their findings on the connection between access to care and patient safety.

THEME 3 – BEST PRACTICES

Goal	Action
Improved access to recommended evidence based guidelines and best practices for surgical care safety.	Convene partners to collect and contribute evidence based guidelines and best practices for surgical care safety including methods for implementation.

THEME 3 – BEST PRACTICES continued

Goal	Action
Improved access to recommended evidence based guidelines and best practices for surgical care safety.	Identify top three to five recommended evidence based guidelines and best practices in surgical care safety and gain consensus from national, provincial and territorial leaders to support implementation across all jurisdictions.

THEME 4 – PATIENT ENGAGEMENT

Goal	Action
A web based inventory of guidelines for patient and family engagement in surgical safety.	Convene appropriate partners to collect and contribute leading patient and family engagement guidelines and tools applicable to surgical care safety. Develop and launch web based inventory of those guidelines and tools for patient and family engagement in surgical safety.

THEME 5 – TEAMWORK AND COMMUNICATION

Goal	Action
Leading practices for teamwork and communication to improve surgical safety across the continuum of surgical care.	Focusing on the surgical services training environment, identify and recommend leading practices for effective surgical teamwork that includes providers, patients, families and all support services. Focusing on the surgical services training environment, spread the recommended leading practices for effective surgical teamwork across Canada.

THEME 5 – TEAMWORK AND COMMUNICATION continued

Goal	Action
Leading practices for teamwork and communication to improve surgical safety across the continuum of surgical care.	Focusing on health sciences education, explore mechanisms to engage the health sciences faculties to teach the recommended leading practices for communication and teamwork in surgical care safety.

THEME 6 – QUALITY IMPROVEMENT INFRASTRUCTURE

Goal	Action
Surgical safety quality improvement training for policy makers, executives and clinical leaders.	Identify, review and recommend evidence-based resources and toolkits for quality improvement education in surgical safety for policy makers, executives and clinical leaders.
	Enlist national, provincial and territorial quality organizations to offer quality improvement education in surgical safety for policy makers, executives and clinical leaders.

THEME 7 – LEARNING FROM SURGICAL PATIENT SAFETY INCIDENTS

Goal	Action
Enhance learning and sharing through prospective analysis to avoid surgical harm.	Conduct an environmental scan on best practices in prospective analysis for harm reduction in surgical care; identify and endorse a select number of leading practices and tools and distribute across the country.
	Conduct retrospective analysis of Canadian surgical harm data and synthesize findings into an information report to be nationally disseminated.

Alignment

The Surgical Care Safety Summit identified three themes that were similar to three named by the National Consortium: measurement, communication and patient engagement. The fourth theme the National Consortium identified, leadership, also came up in surgical safety,
as part of quality improvement.

We expect these kinds of similarities to keep occurring at the upcoming summits and the roundtable. It is important for us to be ready to build on the connections between the work of the national consortium and the four priority areas — surgical care, medication safety, infection prevention and control, and homecare.

The surgical care summit, however, identified three new themes: best practices, access, and reporting and learning.

Because we expect similar themes will arise in other priority areas, we anticipate some overlap in their action plans. To avoid partner fatigue, duplication of resources and general confusion if multiple actions are rolled out simultaneously, we must coordinate action plans and timelines. That calls for a strategic, collaborative approach to all the action plans. As summits and roundtables are completed, we'll map shared themes and complimentary actions and, wherever possible, coordinate the approach on the shared areas for efficiency, collaboration and maximized outcomes.

Next Steps

We have identified action items as either an immediate priority (for completion by September 2015) or an intermediate priority (for completion by September 2016).

After this report has been reviewed for approval by the Canadian Patient Safety Institute's board of directors, the next steps are:

1. Review of the report by all summit participants for sign off and acceptance of their roles.
2. Telephone meetings will be held with the leads for immediate priority actions to determine a process for engaging partners.
3. Action plan working groups will be launched with standardized terms of reference (including deliverables and timelines).

SURGICAL CARE SAFETY SUMMIT PARTICIPATING ORGANIZATIONS

- Accreditation Canada
- Alberta Health
- Association Québecoise des établissements de santé et de services sociaux
- Atlantic Health Quality and Patient Safety Collaborative
- BC Patient Safety & Quality Council
- Best Practices in General Surgery
- Canada Health Infoway
- Canadian Anesthesiologists' Society
- Canadian Association of General Surgeons
- Canadian Institute for Health Information
- Canadian Medical Protective Association
- Canadian Nurses Association
- Canadian Society of Respiratory Therapists
- Canadian Society of Hospital Pharmacists
- Healthcare Insurance Reciprocal of Canada
- Health Canada
- Health Quality Council of Alberta
- Health Quality Ontario
- IPAC Canada
- Jewish General Hospital
- Northwest Territories Department of Health and Wellness
- Nova Scotia Department of Health & Wellness
- Ontario Ministry of Health and Long Term Care
- Operating Room Nurses Association of Canada
- Patients for Patient Safety Canada
- Royal College of Physicians and Surgeons of Canada
- Safer Healthcare Now!
- Saskatchewan Surgical Initiative
- University of Calgary

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