

Greetings from Newfoundland and Labrador, Canada

Newfoundland and Labrador

- Most easterly province in Canada
- 1 ¾ times the size of Great Britain
- 2008 Population estimate— 508,000
- 4 regional integrated health authorities

Map of Canada www.travelcanada.com

Issues Related to the Management of Adverse Events in a Provincial Health System in Canada: Lessons Learnt and Moving Forward

ISQUA 2009 CONFERENCE
DUBLIN, IRELAND

OCTOBER 12, 2009

Background

- Task Force appointed May 30, 2007
- Mandate: Review existing law, policy and practice related to the management of adverse events in NL health and community services system
- Chair –Robert C. Thompson (Secretary to the Cabinet -Health Issues)

Terms of Reference

- To examine and evaluate how the provincial health system identifies, evaluates, responds and communicates in regard to adverse events within the health system
- To examine relevant best practices in other jurisdictions
- To make such recommendations as may be appropriate

Methods

- Private consultation with health authorities and experts
- Regular dialogue with a committee of health authority safety/quality officials
- Public invitation for submissions
- Meetings as necessary with relevant stakeholders
- Symposium on adverse health events

Adverse Event Management Framework

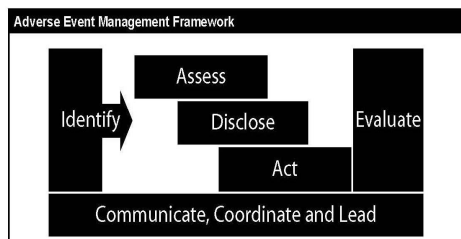


Figure 1. Adverse Event Management Framework

Inputs

- 22 public submissions received
- Forum on Adverse Event Management (130 participants)
- Meetings with all RHAs (trustees, management and medical representatives)
- Background reports that included input from 15 national and international experts, a survey of Canadian and international practices, and five case studies.

What is Adverse Event Management?

The collection of processes within the health and community services system to identify, report, assess, disclose, take action on, communicate and evaluate an adverse health event after it occurs.

Lessons Learnt in 2008

- Variable definitions (e.g., occurrences, adverse events, close calls) used throughout the province and across Canada
- No legal requirement to report, disclose or investigate an adverse event in NL
- Strictly policy based at the RHA level (No government departmental policies)
- RHA policies
 - Reasonably comprehensive framework for occurrence reporting, assessment and disclosure
 - Considerable effort in recent years to develop policy frameworks

Lessons Learnt... Identifiable Gaps

- Electronic reporting
- Compliance with occurrence reporting across all health care sectors
- Expertise for complex assessments
- Training for disclosure
- Dissemination of lessons learned from adverse events
- Reinforcement of a patient safety culture

Focus of 41 Recommendations

- Legislation and Governance
- Human Resources
- Financial Resources
- Implementation

Task Force - Recommended Definitions

Occurrence

An undesired or unplanned event that happens within a health authority.

Adverse Event

An occurrence that results in unintended harm to the patient, and is related to the care and/or services provided to the patient rather than to the patient's underlying health condition.

Recommended Adverse Event Management Process

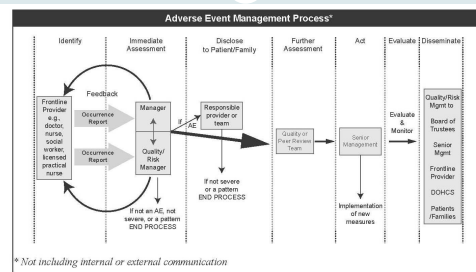


Figure 1. Adverse Event Management Process

Recommended Severity Rating Scale for Occurrences

Table 3. Severity Rating Scale for Occurrences

Severity Rating Scale for Occurrences		Type of Occurrence		
		With Harm	With Potential Harm	No Harm or Potential Harm
Low/ Minor	1	Black	White	Grey
	2	Black	White	Grey
Medium/ Moderate	3	Black	White	Grey
	4	Black	White	Grey
Serious/ Severe	5	Black	White	Grey
	6	Black	White	Grey

Black = Adverse Events;
 White = Close Calls;
 Grey = Other Occurrences;
 Hatched = Not Applicable

Moving Forward - Task Force Recommendations

Implement province-wide electronic occurrence reporting system

- Benefits
 - ✦ Increases the frequency and comprehensiveness of reporting
 - ✦ Ensures feedback to staff
 - ✦ Allows roll-up of data and monitoring
 - ✦ Allows for comparison within and between RHAs
 - ✦ Provides an opportunity for patient safety training
 - ✦ Promotes cultural change

Moving Forward - Task Force Recommendations

Legal/Regulatory

- Mandatory RHA occurrence reporting
- Mandatory participation in provincial roll-up
- Employee protection for occurrence reporting
- Mandatory disclosure of adverse events to patients
- Permit Ministerial access to quality/peer reviews of serious events, but otherwise limit access
- New "apology" legislation

Moving Forward - Task Force Recommendations

Quality and Peer Reviews

- Define quality and peer reviews under existing legislation (*RHA Act*)
- Allow "new" facts and recommendations to be available to patients
- Amend legislation to clarify exemptions (*ATIPPA*) and make consistent with *PHIA (CYA and CR Acts)*
- Establish non-privileged reviews when necessary to provide public with explanation of causes

Moving Forward - Task Force Recommendations

Role of Minister and Department

- Minister should be briefed by RHAs on multi-patient events and other events that raise public concern
- Task Force provided guidance on key points that should be provided to the Minister by way of a written briefing (oral briefing for urgent information)
- As part of accountability relationship, Minister/Department expected to hold RHAs accountable

Moving Forward - Task Force Recommendations

New/Revised Policies Required

- Government (Department Health and Community Services) –Multi-jurisdictional coordination
- RHAs
 - ✦ occurrence reporting; disclosure guidelines; further assessments; multi-patient coordination; public communication

Moving Forward - Task Force Recommendations

- Personnel and Resources
 - 5 patient safety officers
 - 5 database professionals
 - Provincial Coordinating Office
 - Physician Champions (0.5 FTE per RHA)
 - Training
 - Electronic Occurrence Reporting
 - Research and Evaluation
- Cost
 - CDN 2.9 million (1.9 million Euros) per annum

Conclusions

- Revitalized adverse event management system will bring about tangible improvements in patient safety
- A stronger focus on patient safety will help restore trust and build up public confidence in the health system.
- Primacy of patient safety only attainable with clear leadership and the fostering of organizational culture.

Report available at...

<http://www.gov.nl.ca/ahe/reports.htm>



Thank you!

