



NATIONAL APPROACH TO PATIENT SAFETY AND CLINICAL QUALITY IN CANADA

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 Canadian Patient Safety Institute
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Background

- Canadian population in 2006 was 32.5 million
- Canadian healthcare spending for 2007 will reach \$160.1 billion
- Public sector healthcare spending forecast projected to reach 70.6%
- Private sector healthcare spending forecast projected to reach 29.4%





Our Mission & Vision


Mission:
To provide national leadership in building and advancing a safer Canadian health system


We envision a Canadian health system where:

- Patients, providers, governments and others work together to build and advance a safer health system
- Providers take pride in their ability to deliver the safest and highest quality of care possible
- Every Canadian in need of healthcare can be confident that the care they receive is the safest in the world



Milestones of the Modern Era

| | |
|------|--|
| 1991 | Harvard Medical Practice Study |
| 1992 | Quality in Australian Health Care Study |
| 1996 | Annenberg conferences begin |
| 1999 | Colorado / Utah Study |
| 1999 | IOM Report: To Err is Human  |
| 2000 | BMA/BMJ London Conference on Medical Error |
| 2000 | SAEM: San Francisco Conference on EM Error |
| 2001 | British study |
| 2001 | RCPSC National Steering Committee on Patient Safety |
| 2002 | RCPSC Report: Building a Safer System |
| 2003 | Canadian Patient Safety Institute & Baker No. 1 Study |
| 2005 | Canadian Patient Safety Institute Established |



What We Know

- Francoeur Committee (Quebec 2001) / Blais *et al* Study (GRIS, Quebec 2004)
- Building a Safer System: A National Integrated Strategy for Improving Patient Safety in Canadian Health Care (2002)
- Adverse Events in Canadian Hospitals (Baker, R. & Norton, P. et al., 2004)
 - Incidence rate of 7.5% in hospitals (2000)
 - 70,000 preventable adverse events (est.)
 - 9,000 - 24,000 preventable AE deaths in Canada (2000)





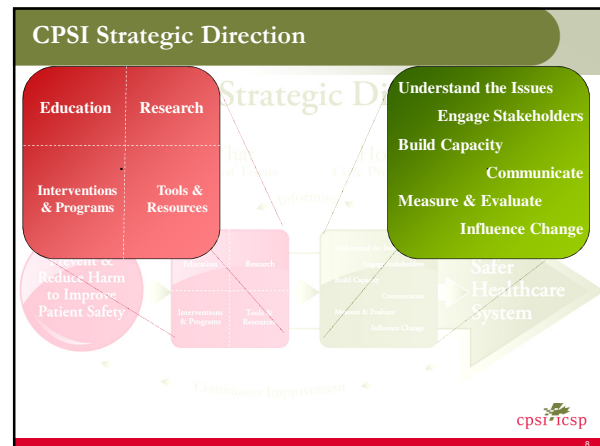
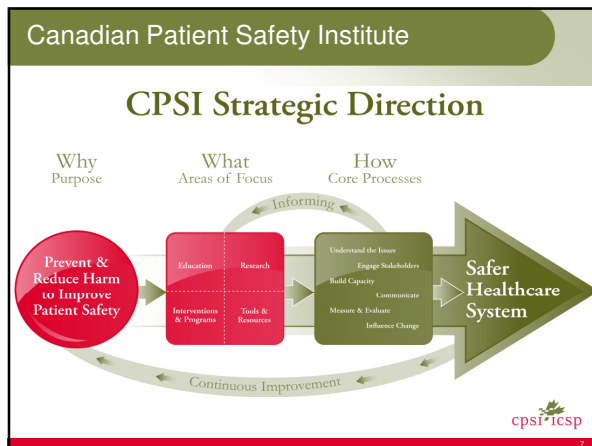

What We Know

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



- ### CPSI Board Advisory Committees
-
1. Education and Professional Development
 2. Health System Innovation
 3. Information and Communication
 4. Legal and Regulatory Affairs
 5. Research and Evaluation
- cpsp-icsp

- ### CPSI Strategic Direction
- | | |
|---|---|
| Education Governance for Quality and Safety Canadian Patient Safety Officer Course Simulation Pan-Canadian IHI Broadcast 2 Annual Patient Safety Conferences Studentships Patient Safety Competencies Canadian Patient Safety Week | Research Building Capacity Through Research Home Care Long Term Care Mental Health Services Emergency Medical Services Primary Health Care Patient Safety Chair |
| Interventions & Programs World Health Organization High 5's Patients for Patient Safety Canada Infection Control Hand Hygiene Campaign Safer Healthcare Now! | Tools & Resources Event Analysis Electronic Health Record Canadian Disclosure Guidelines Canadian Adverse Event Reporting & Learning System Canadian Medication Incident Reporting & Prevention System WHO Safe Surgery Saves Lives Human Factors Teamwork and Communication Bar Coding |
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Education: Patient Safety Officer Course

Objective: Promote the adoption of a patient safety focus in provider education, training and practice

The Canadian Patient Safety Officer Course (CPSOC) is a comprehensive safety course, which includes interactive workshops, case studies, team building activities, networking, and coaching by patient safety leaders. The Patient Safety Competencies provide the framework to understand and thread the sessions together throughout the week.

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- ### Education: Patient Safety Officer Course
- Day 1: Contributing to a Culture of Patient Safety**
Patient safety culture introduction, building a strategy and structure to support patient safety, and the role of the senior administration and the Board
 - Day 2: Managing Safety Risks and Optimizing Human and Environmental Factors**
Critical thinking analysis, event analysis, human factors analysis, and designing a framework for tools and resources
 - Day 3: Communicating Effectively and Working in Teams for Patient Safety**
Engaging with physicians, lessons from crew resource management, and managing change and conflict
 - Day 4: Bringing the Competencies Together**
Defining and implementing a patient safety program, patient involvement in patient safety activities, and the role of interventions and campaigns
 - Day 5: Recognizing, Responding to and Disclosing Adverse Events**
Lessons from high reliability organizations, measuring patient safety culture, reporting systems overview, and a primer on disclosing adverse events
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Education: Patient Safety Competencies

Objective: Support the dissemination and integration of *The Safety Competencies Framework* in health professional education and practice

- Implement Competencies
- Identify and engage early adopters of the Competencies
- Create Communities of Practice and "promising practices" repository
- Complete needs assessment for faculty development toolkit
- Establish international linkages through WHO World Alliance for Patient Safety Education Stream

Participant Numbers:
 2006: 135 2007: 180 2008: 230 2009: 628+

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Education

Canadian Patient Safety Week

November 2 – 6, 2009

Act Listen Talk

Participant Numbers:
 2006: 135 2007: 180 2008: 230 2009: 628+

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Research: *Building Capacity*

- Over **60** research and demonstration projects have been funded in the last three years
 - Form the basis for new knowledge of Canadian patient safety challenges and solutions
- Development of background papers
 - To identify the current state of knowledge, future research priorities, key issues, strategies and opportunities for action and improvement

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Interventions & Programs

Objective: Enable timely application of leading patient safety practices through development of pan-Canadian programs that incorporate the perspective of patients and families

- Develop a sustainable mechanism to support the involvement of patients and families in all patient safety activities
- Develop a process for expanding membership in *Patients for Patient Safety Canada*
- Commission and complete research to better understand the continuum of healing from harm resulting from healthcare
- Identify opportunities to provide the patient perspective through speaking engagements at the local, provincial/territorial and pan-Canadian level

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Infection Control

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Canada's Hand Hygiene Campaign

Interventions & Programs

| Hand Hygiene Campaign Goals | MRSA Intervention Goals |
|--|---|
| <ul style="list-style-type: none"> Promote the importance of hand hygiene in reducing the occurrence of healthcare associated infections Respond to the needs of healthcare organizations for capacity building and leadership development by creating and providing them with tools to help promote good hand hygiene | <p>Safer Healthcare Now!</p> <ul style="list-style-type: none"> Enable healthcare organizations and caregivers to prevent patient harm from MRSA Reduce MRSA infection rates |

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Tools & Resources

Event Analysis

- The French adaptation for the Canadian Root Cause Analysis Framework is completed

Electronic Health Record

- Plans are underway to examine the role of EHR as it relates to the process of medication reconciliation

Canadian Disclosure Guidelines

- Available on the CPSI website
- Plans for further dissemination currently in development



Tools & Resources

Canadian Adverse Event Reporting and Learning System (CAERLS)


- Consultation paper available on CPSI website
- Consultation throughout Canada is completed
- Developing an appropriate Canadian Reporting/Learning System

Human Factors

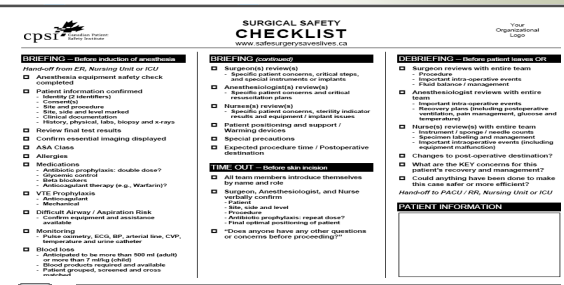
- Key strategy is building human factors capacity

WHO Safe Surgery Saves Lives


- Safe Surgery Checklist currently being adapted and adopted by large hospitals across Canada



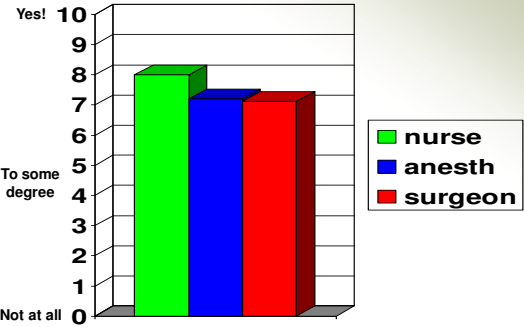
Tools & Resources



WHO Surgical Safety Checklist © World Health Organization, 2008
 Version 1, January 9, 2009




Do you think the use of the checklist has improved patient safety at University Health Network? – Toronto, Canada

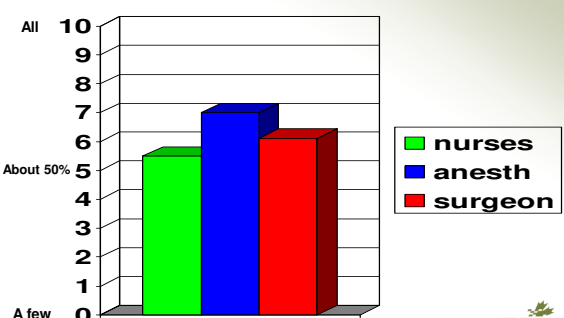


| Response | nurse | anesth | surgeon |
|----------------|-------|--------|---------|
| Yes! | 8 | 7 | 7 |
| To some degree | 1 | 1 | 1 |
| Not at all | 0 | 0 | 0 |

Dr. Bryce Taylor, Chief of Surgery, University Health Network, Toronto, Ontario, Canada




How many surgical teams conduct what you would consider a thorough and adequate checklist? (University Health Network – Toronto, Canada)




| Response | nurses | anesth | surgeon |
|-----------|--------|--------|---------|
| All | 5 | 7 | 6 |
| About 50% | 1 | 1 | 1 |
| A few | 0 | 0 | 0 |

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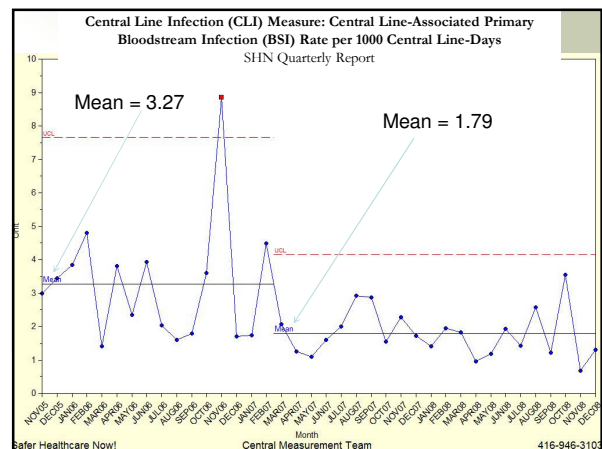
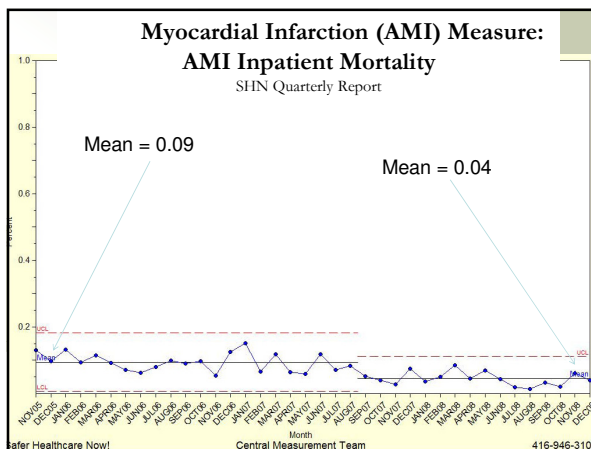
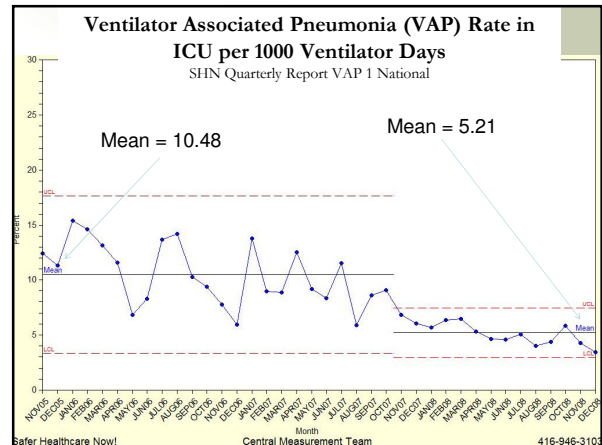
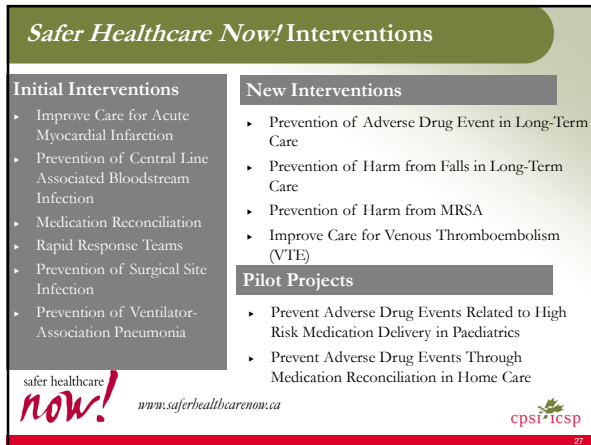
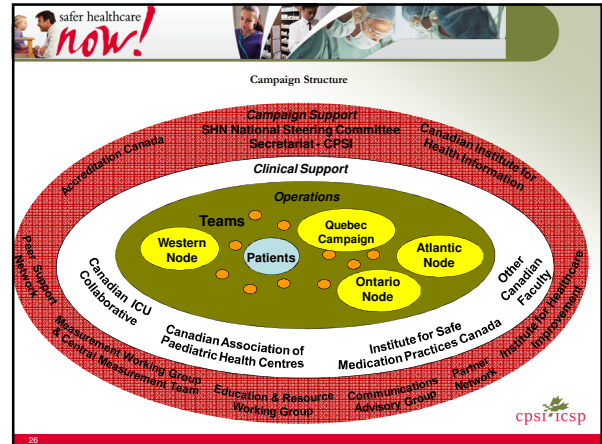
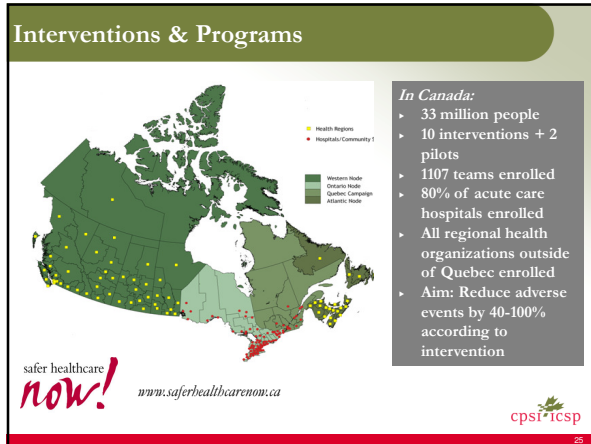
Results of the WHO study

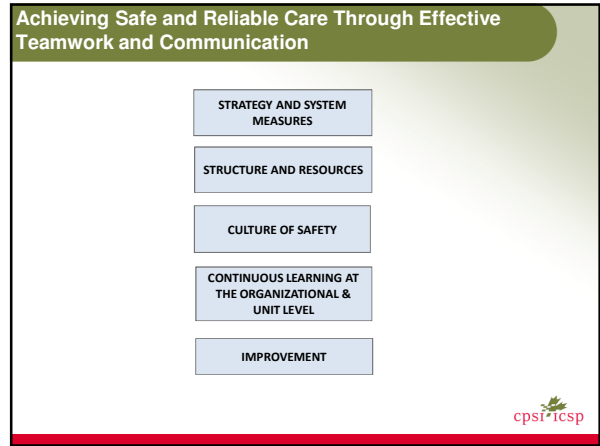
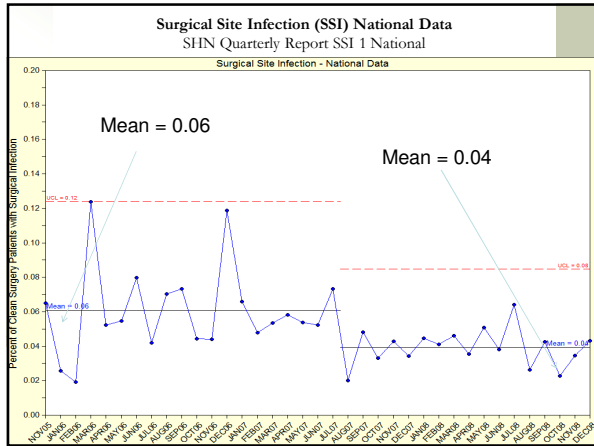


- Increased rate of adherence to basic standards from 36% to 68% – in some hospitals to almost 100%.
- Resulted in substantial reductions in mortality and morbidity

Source: www.safesurg.org







LEADERSHIP CHALLENGES

“I have learned that success is to be measured not so much by the position that one has reached in life as by the obstacles which they have overcome while trying to succeed”

(Booker T. Washington)

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