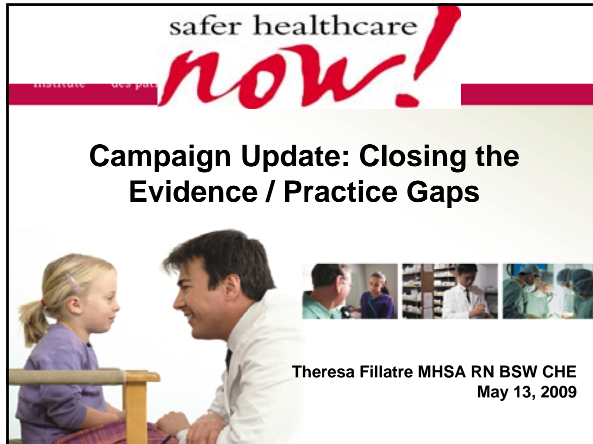
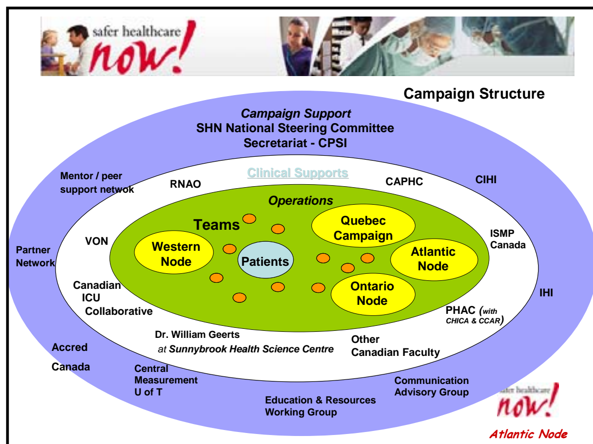


Safer Healthcare Now!

- First pan-Canadian patient safety initiative
- Canadian Patient Safety Institute is Secretariat
- Launched in April 2005…enrolment Sept 2005
- Phase two continues 2008
- 1096 teams today….203 Atlantic Province Teams

now!
Atlantic Node



Safer Healthcare Now! Campaign Platform

1. Deploy Rapid Response Teams
2. Deliver Reliable, Evidence-Based Care for Acute Myocardial Infarctions
3. Prevent Adverse Drug Events (ADEs)
4. Prevent Central Line Infections
5. Prevent Surgical Site Infections
6. Prevent Ventilator-Associated Pneumonia

Phase Two Interventions Sept 2008

- Prevent adverse drug events LTC(ISMP)
- Prevent harm from falls LTC (RNAO)
- Prevent harm from AROs (PH Agency of Canada & Dr Michael Gardam)
- Prevent thromboembolism (VTE) in general surgery and hip fracture surgical patients (Sunnybrook Dr Bill Geerts)

SHN! Pilots 2008-2009

- Prevent adverse drug events related to high risk medication delivery in paediatrics (CAPHC)
- Prevent adverse drug events through Medication Reconciliation in Home Care (VON)

SHN! Operational Principles

•Strategic in it's force (explicitly targeted to address preventable adverse events with interventions relevant to whole of Canada)

•Opportunistic in it's details (just in time & grassroots approach)

•Based on science / evidence (faculty resolution of issues / questions & emerging evidence)

•Improvement Model as the foundation (health system has not traditionally endorsed it's full use resulting in "failure to act" or "tinkering with the edges" of system issues)

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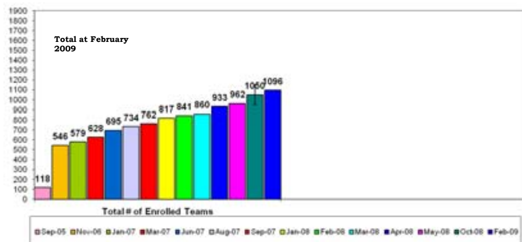
Teams Continue to Enroll

Safer Healthcare Now! Overview Total # Enrolled Teams
September 2005 to February 2009



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Safer Healthcare Now!
Enrollment by Intervention

Intervention	Number of
Deploy Rapid Response Teams	56
Improve Care for Acute Myocardial Infarction	122
Prevent Adverse Drug Events through Medication Reconciliation	336
Prevent Central Line-Associated Bloodstream Infection	96
Prevent Surgical Site Infection	176
Prevent Ventilator-Associated Pneumonia	115
Antibiotic Resistant Organisms (AROs)/MRSA	48
MedRec (Long Term Care)	79
Venous Thromboembolism	13
National Collaborative on Falls in Long-Term Care	40
Med Rec in HomeCare Pilot	15
Total	**1096***

***Total at February 13, 2009**

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The Size of the Patient Safety Problem

- **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 Canadian hospitals annually
  - **One in nine** adults contract infection in hospital(CIHI,2004).
  - **One in nine** patients receive wrong medication or wrong dose (CIHI, 2004).
  - **50% hospitalized patients at risk for VTE and require prophylaxis**
  - **<50%- 60% compliance with hand hygiene evidence- based guidelines**

Epidemiology of Harm: Charles Vincent 2007

Study	Adverse Event Rate (% adms)
Australia	16.6
UK	10.8
Denmark	9.0
New Zealand	11.2
France	14.5
Canada	7.5

Framework for Analysis of Risk & Safety in Healthcare C. Vincent 2007

- Patient factors
- Task factors
- Individual staff factors
- Team factors
- Work environment
- Organization & management
- Institutional context

Reason: On Redesigning Systems

Make it harder to make mistakes:

- Flags & system reminders
- Forcing Functions
- Real time process measures
- "Hardwiring the System"

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What We Know : Communication & Transition Points

- Hand offs at transition points are high risk for patient safety communication – related events to occur
- 50% patient safety adverse events are linked to transition points in care
- Transition points include admission, transfer and discharge (as well as shift to shift and unit to unit communication ; and other care handoffs)
- Medication related adverse events are most common during patient transitions

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What We Know: Teams

- Team functioning has a direct impact on patient safety
- Clarity of roles within teams critical
- Understanding of shared & unique competencies within & between disciplines essential
- Use of team performance indicators fundamental
- Definition of communication, decision-making and conflict resolution processes essential
- Use of SBAR framework for communication & documentation helpful
- Safety Competencies Framework Royal College Physicians & Surgeons / CPSI for use in basic education programs health professionals

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What We Know About Rescue of Patients

- Patients in Med Surg (non-ICU beds) show signs of medical decline 8-12 hours before respiratory / cardiac arrest
- Power over dynamics and social structures of workplaces prevent acknowledgement of medical decline / seeking higher level of assessment at an earlier point in time.
- Goal is to transform current clinical models of care & consultation to rescue the patient earlier on

Use of RRT at DGH resulted in:

- 50% reduction cardiac arrests
- 60% reduction cardiac arrest deaths
- Improved post satisfaction with ability to obtain higher level of clinical support when required (physicians & nurses)
- Improved communication with SBAR
- Standardized SBAR clinical assessment & documentation tools / staff education

* Another form of hardwiring the system to reduce risk

Reliability Science & Health Settings

- Largest industry in the world
- Scale of patient safety problem is huge
- Activities are diverse & complex
- Settings are diverse
- Tend to be less "procedure-driven" than other industries
- Causes of error and harm are complex
- Patient safety is becoming a "meeting point" for health disciplines, organizations, professional colleges, health ministries, Accreditation Canada, and patient/family groups….with shared learning internationally

Bringing the Paradigms Together

- Evidence based medicine (targeted interventions)
- Culture change
- Standardization & Technology
- Embracing the notion that people create safety

Safety Culture: Lucien Leape 1998

"Join us in converting a culture of blame that hides information about risk and error into a culture of safety that flushes out information to prevent patient injuries"

Culture as Awareness:
- Awareness of error and harm
- Willingness to discuss openly
- Open and fair / just culture
- Open disclosure

* CULTURE TRUMPS STRATEGY EVERY DAY!

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The Marriage of Culture & High Reliability Organizations

- Preoccupation with failure
- Deference to expertise
- Quest to reduce practice variations
- Greater use of standardized protocols, order sets, preprinted orders, CPOE, clinical documentation tools and checklists, and simulation
- Technical Solutions along with People Solutions (medication reconciliation combined with redesigned med delivery systems)
- Information Management Systems

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Atlantic Examples of Nurses & Multidisciplinary Teams Making a Difference

- Use of PDAs in Gander NL in ICU environment for hourly nursing documentation of VAP Prevention care elements
- Use of Safety Huddles and Rounds in Moncton NB
- Allocation of Pharmacists to ED in Miramichi where highest volumes of admissions occur requiring BPMH and Med Rec

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Atlantic Examples of Nurses & Multidisciplinary Teams Making a Difference

- Med Rec LTC Cornerbrook NL….partnership with transitional care discharge unit
- Electronic Patient Safety Reporting System CDHA
- 65% reduction in catheter –related bloodstream infections IWK PICU since 2004 with spread of standardized protocols to Ped Medical Unit, Med Surg Neuro Science Unit, Perioperative Services, hematology / Oncology, NICU.
- Infection Control electronic tracking system Western Health NL

Atlantic Examples of Making a Difference

- 40% improvements in perfect AMI care measure in regional and tertiary centres
- 70% improvement in smoking cessation / cardiac rehab referrals AMI patients
- 40% improved compliance / prophylactic antibiotic use pre and post abdominal surgeries.
- Enrolment National Hand Hygiene Campaign & Train the Trainer Sessions

Atlantic Examples of Making a Difference

- Standardized order sets VTE, AMI , CLI, SSI
- Standardized AMI care documentation checklists that serve as reminders and sources of process & outcome measures…capacity to be adopted provincially across sectors…integrated in EHR
- Detox / Addiction Services Med Rec Program CBDHA
- Sharing of tools and learning on SHN! web Communities of Practice
- Enhancements to pre hospital care for AMI

Atlantic Examples of Making a Difference

- DHAs 1, 2, 3 National Falls Collaborative participation
- 29 Nursing Homes / Continuing Care Facilities engaged in first formal Atlantic Learning Collaborative
- 12 participants in new Cdn Patient Safety Officer Program 2007-2008
- CEO commitments to Patient Safety and Quality PHSOR implementation strategy
- Participation National Mental Health Patient Safety Research & Roundtable

Challenges & Opportunities

- Streamline Patient Safety & Quality Performance Indicators to the critical few, with alignment provincially, Atlantic Provinces and Nationally (CIHI, Health Infoway, Accreditation Canada, CPSI and other partners)
- Standardization of clinical care processes and documentation within and between Atlantic province sites
- Address of maximum scopes of practice to improve timeliness of assessment & intervention…..Models of Care

Challenges & Opportunities Cont'd

- Streamlined capacity to obtain measurement data for QI & safety accountability monitoring
- Eliminating non-value-added work
- Engagement of patients & families in meaningful ways
- Transitioning phase one SHN interventions to appropriate agents for sustainability
- Collaboration between Clinical QI Teams and IM / IT / ICP colleagues to support evidence-based safer practices

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QUESTIONS

Contact Information

Thank You

Theresa.fillatre@cdha.nshealth.ca
Phone: 902-221-4719