



Editorial

Creating Safer Care

Is safer healthcare possible? What needs to be done to fulfil this goal? Research on adverse events and improved reporting systems have elevated the issue of patient safety across Canada. But the work of creating care environments that encourage and sustain safety is more difficult than simply recognizing the problems. We are not the first to confront this. Two years ago, following the fifth anniversary of the Institute of Medicine report, a number of commentators lamented the failure to demonstrate much progress in the United States on the lofty goals enunciated in *To Err Is Human*. Our challenge in Canada is made even more daunting by the concurrent need to focus on other critical system issues such as improving access to care.

The good news is that the past year has seen a blossoming of efforts to improve patient safety in Canada. There is a growing recognition at senior policy levels that improvements in access to care are unsatisfactory unless we concurrently ensure that this care is safe and effective. The Canadian Patient Safety Institute and provincial safety and quality councils have articulated new goals and supported local improvements in quality and safety. But the most heartening developments are the accelerating efforts of clinicians and managers, along with researchers and others, to improve care for patients.

This issue of *Healthcare Quarterly* provides evidence that safer patient care is achievable. We have gathered papers outlining excellent work across Canada addressing this goal.

The papers are grouped by several themes. We begin with articles on *Identifying and Reducing Risks*. Many organizations are working to improve their assessment of incidents and adverse events. Even more challenging is moving from risk identification to improvement. Catherine Cronin outlines the use of the London Protocol in the analysis of critical occurrences in pediatric care in Winnipeg. Mark Daly describes how the analysis of sentinel events was translated into improvements in patient transport and the care for patients who experience a stroke in hospital at the McGill University Health Centre. Important information on risks can also be gleaned from staff: Debbie Barnard and colleagues at Capital Health in Edmonton report on their “Good Catch” program, which now generates over 100 reports per month on “near miss” events. Rosanne Zimmerman and colleagues at Hamilton Health Sciences Centre outline an innovative approach that builds local expertise in identifying and addressing patient safety issues. Patient Safety Triads are three-person groups formed from frontline staff and managers to coordinate unit-based safety efforts.

Similar patient safety problems are emerging in organizations across the country, and mechanisms are needed to share

this learning. Margaret Colquhoun and colleagues at ISMP Canada detail how they used hospital surveys on opioid use to spur improvements in medication use in hospitals in two provinces. Paula Beard and Linda Smyrski report on the development of provincial reporting and learning efforts that spread knowledge about incidents and improvements across institutions in Saskatchewan and in Manitoba.

Hospital-acquired infections remain a critical challenge for Canadian healthcare organizations. Two papers from Toronto hospitals report on successful efforts to reduce the incidence of such infections. Arladeen Tomiczek and colleagues at Toronto East General Hospital outline how they reduced the rate of *C. difficile* cases by 50%. Maryam Salaripour and colleagues at St. Michael's Hospital succeeded in reducing nosocomial MRSA by 60% and sustaining the decrease over several years.

Patient falls are another critical safety issue. Patricia O'Connor and others report on their efforts to transform nursing practice and organizational culture to reduce patient falls. Their work at the McGill University Health Centre built on the best practice guidelines on patient falls developed by the RNAO.

A second group of papers address *Human Factors and Work Redesign*. The transfer of patients between units, or transport to diagnostic departments, can pose serious risks. Rosmin Esmail and her colleagues developed and tested a patient transport decision scorecard to improve the safety of patients transported from the ICU to other parts of the hospital in the Calgary Health Region. Kim Alvarado and others at Hamilton Health Sciences Centre report on the development of guidelines to improve the communication of patient information at shift handover. Innovative work by Edward Etchells and colleagues using a human factors checklist to improve the programming of infusion pumps at Sunnybrook Health Science Centre and an insightful analysis by Sandra Gabriele of safety issues in medication label design provide examples of the need to promote a stronger awareness of the pervasive role of human factors influencing the safety of care.

Much of the effort to improve patient safety draws upon detailed knowledge of clinical practice and safety science. But much can be gained from involving patients and families too. In our section *Involving Patients and Families*, Bonnie Fleming-Carroll and others at the Hospital for Sick Children in Toronto report on their efforts to develop “Families as Partners in Patient Safety.” Work to raise awareness and engage patients in improving safety is gaining momentum in several centres. Sudha Kutty and Sarena Weil at the Ontario Hospital Association provide information on the strengths and weaknesses of such strategies and, more specifically, the impact of the Patient Safety

Tips program in Ontario.

Effective and safe patient care depends upon reliable information. In the section *Using Information to Improve Safety*, Jennifer Turple and colleagues at the Halifax Infirmary and Dalhousie University report on the continuing problem of medication reconciliation. Computerized Physician Order Entry (CPOE) holds considerable promise, but such decision support programs have been difficult to mount and maintain. One success in this area is reported by Anna Greenberg and others at Cancer Care Ontario who have implemented CPOE for cancer medications. Still, changes in information systems pose risks as well as benefits. Andre Kushniruk and colleagues report on innovative work in assessing problems emerging from information system implementation and its impact on work flow.

One heartening development in work on patient safety in Canada has been the broadening focus on care outside of acute care hospitals. Our last group of papers reports on *Identifying Patient Safety Risks in Non-Acute Care Settings*. Ariella Lang and others summarize issues raised in an important roundtable discussion of the patient safety agenda in home care. A critical need in this agenda is information about the incidence and types of adverse events in home care. One of the first studies to report Canadian data comes from the work of Keir Johnson,

who adapted hospital-based research tools to assess adverse events in home care patients in Winnipeg. In another domain, Carol Fancott and her colleagues at the Toronto Rehabilitation Institute provide a profile of patient safety issues identified through qualitative research with staff at TRI.

Together these papers provide a snapshot of leading practices and critical knowledge from across the country, and by implication offer a challenge to others to investigate, adapt and implement these practices in their own organizations. The efforts outlined in this issue demonstrate that safer care is possible. But the work to translate these efforts into different settings and to spread safer practices across the country is still in early stages.



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Dr. Baker is the guest editor of this special issue of *Healthcare Quarterly* focused on Patient Safety.



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