



### Canadian Patient Safety Institute

**W**hat does it mean to make patient care safer? How do we take action on what we know? And what does it mean to us personally as we try to provide the best clinical care to patients?

If we have initially learned anything from other high-risk areas of service like the airlines, railways and nuclear plants, we are only at the very early stages in the journey of understanding what constitutes this important body of knowledge as it applies to healthcare. Clearly, without sound research – new knowledge concerning the nature of the problems we are trying to overcome and how to solve these complex human/system problems – we limit our ability to make the healthcare system safer for those we serve. It cannot be only “eliminating errors” (who’s perfect anyway?); as Charles Vincent reminds us in *Patient Safety* (2006), unsafe care for patients is “inherent in the very structures and processes of the healthcare system itself.” These are not, as some might argue, just human errors or mistakes we must accept as “risks of the business.”

The nature of human error and its relation to adverse events does not appear to be well understood. An example from another field is the recent tragic accident off the British Columbia coast. It was reported in the media that *Queen of the North* sank as a result of “human error,” as if this explained it all. That is far from the truth. Yet it is how some see it in healthcare as well. Sydney Dekker argues convincingly that “human error is not random. It is systematically connected to features of people’s tools, tasks and operating environment.” Furthermore, and most importantly, he points out, “human error is not the conclusion of an investigation. It is the starting point.”

We have much to learn about adverse events. This entails excellent people doing coordinated and methodical research focusing on the extent of the problem and the underlying issues creating unsafe conditions. For example, what is the extent of the unsafe conditions in home care, and if they are unsafe how extensive is the problem? Anecdotal reports from the field suggest that there are serious issues and further investigation is warranted. As we have seen from studying hospitals, we are only beginning to understand the real causes of the multiplicity of problems related to avoidable adverse events and their associated disability and death, and we are only at the early stages of applying solutions to reduce these.

We need to better understand these underlying causes and begin step by step to apply the growing body of knowledge to incrementally improve safety for our patients.

We have been able to admire the remarkable gains in the specialty of anesthesia as they have improved patient safety over many years, and now continue their efforts. In addition, through Safer Healthcare Now!, hospitals in particular are applying a set of six well-documented, evidence-based interventions, knowing

these will improve patient safety. In this regard we must evaluate (measure) whether in fact we are making a difference in our day-to-day application of improvements in care to assure ourselves, patients and the public that we can and are improving the safety of their care.

This journal is one vital foundational effort in knowledge transfer and sharing applications that we trust will help you continue your efforts.

This year we are partnering with the Canadian Council of Health Services Accreditation and the Health Council of Canada – both of whom consider patient safety a priority. We thank them for joining CPSI in this venture.

We also want to thank all those who have contributed to this journal, and even more so those who apply the learnings.

– Phillip Hassen, President and Chief Executive Officer, Canadian Patient Safety Institute

### Canadian Council on Health Services Accreditation

**T**he Canadian Council on Health Services Accreditation (CCHSA) is pleased to co-sponsor their second special issue of *Healthcare Quarterly* with the Health Council of Canada and the Canadian Patient Safety Institute. Whether a direct care provider, a board member or a member of a national health-care association, we all have a role to play in ensuring a safer healthcare system.

Patient safety is fundamental to quality of care and is woven throughout our standards. In 2002, we recognized that a focused CCHSA patient safety strategy was essential. As a result the CCHSA Patient Safety Strategy was released early in 2003.

With the guidance of our Patient Safety Advisory Committee, established early in 2004 and comprising patient safety experts, national and international literature was reviewed to identify the major risk areas and best practices. Patient safety-related accreditation survey recommendations and the top compliance issues were also examined. The approaches being taken by other international accrediting bodies were considered.

The findings of these reviews, coupled with the escalating number of evidence-based safety practices, led to the development of a list of potential priority areas addressing patient/client safety. From this list, five Patient Safety Areas were selected for initial focus – Culture, Communication, Medications,

Workforce/Worklife and Infection Control. Six Patient/Client Safety Goals and 21 Required Organizational Practices (ROPs) were also developed, and publicly released in January 2005. Now, in 2006, the Goals and the ROPs have become an integral part of the accreditation program. They will be integrated into the accreditation standards over the next few years. CCHSA is conducting a comprehensive evaluation of the first six months of this implementation.

Patient safety is a priority at CCHSA, and our surveys show that Canadian healthcare stakeholders embrace this focus. We have seen and are encouraged by the inroads made in this area. However, we must ensure collectively that this issue remains at the forefront of health services.

Our strong relationship with both CPSI and the Health Council of Canada is essential to achieving our goal of a safer healthcare system. Effective partnerships with these and other important organizations will allow us to identify and set a course to our goal. Patient Safety is a critical focus we share, and together, with increasing collaboration, a safer healthcare system will be achieved.

At CCHSA we aim to raise the bar for excellence. Our commitment to improving patient safety and quality care is unwavering.



– Wendy Nicklin, President and Chief Executive Officer, Canadian Council on Health Services Accreditation

## Health Council of Canada

The Health Council of Canada is proud to co-sponsor this second edition of *Healthcare Quarterly* specifically dedicated to issues of patient safety. We are all patients at different points in our lives, and we support all efforts to improve the quality of care Canadians receive.

The debate about healthcare renewal in this country remains largely focused on the question of access. The Health Council of Canada believes that we need to ask ourselves, “Access to what kind of care?” We need to make quality as important an issue as access. Patient safety, like access, is a crucial component of a quality healthcare system. In our 2006 annual report, *Healthcare Renewal in Canada: Clearing the Road to Quality*, the Health Council of Canada declared that the health of Canadians will not be improved by focusing solely on access to healthcare services.

The Canadian Patient Safety Institute’s Safer Healthcare Now! campaign is an important step along the quality improvement pathway. In its 2006 annual report, the Council identified

other steps that might be taken in conjunction with the national campaign:

1. *Make accreditation for healthcare facilities mandatory.* Accreditation is a powerful lever to raise the quality of care and boost patient safety. It should be a condition of public funding.
2. *Require the public release of accreditation information.* To ensure accountability, healthcare facilities should publish the results of their accreditation reviews and explain their plans to improve patient safety and quality of care.
3. *Take a fresh look at how injured patients are compensated in Canada* and whether current insurance schemes inhibit the development of a culture of safety.
4. *Speed up the development of electronic information management systems* to support timely, evidence-based patient care.

The Health Council is currently immersed in these issues. We have undertaken a research project to better document accreditation practices and information disclosure across the country. And, with an eye to providing a forum for all perspectives to be shared, the Health Council of Canada organized a roundtable on patient safety and no-fault compensation in late September in New Brunswick. The participants included key players from within Canada, as well as experts from New Zealand, where no-fault compensation has already been implemented. We want to learn from their experience and perspectives when thinking about the Canadian system and context.

In June of this year, the Council also partnered with Canada Health Infoway to host a conference on implementing the commitment to an electronic health record for Canadians. We focused specifically on how an electronic health record improves quality and efficiency, the scale of investment required to make it a reality for all Canadians and the implementation challenges and corresponding strategies. The summary report can be found on the Council’s website ([www.healthcouncilcanada.ca](http://www.healthcouncilcanada.ca)).

This collection of papers generates new knowledge for all those tasked with the important work of improving patient safety and quality of care. The Health Council of Canada is pleased to contribute to further debate and discussion about these pivotal pieces needed to underpin a high-quality healthcare system.



– Cathy Fooks, Executive Director, Health Council of Canada