Reporting for Learning and Improvement: The Manitoba and Saskatchewan Experience

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Abstract

Both Saskatchewan and Manitoba have embarked on major provincial quality improvement endeavours that include a mandatory reporting and learning process aimed at enhancing patient safety by reducing the potential for recurrence of critical incidents. This move from a voluntary, less comprehensive process signals a commitment from policy makers that substantial improvements to safety will occur only when adverse events are addressed systemically within the healthcare system.

Saskatchewan took the lead with the passage of legislative requirements to report, investigate and share learnings arising from critical incidents as of September 15, 2004. Manitoba is due to implement similar requirements in 2006. The focus of legislation in both provinces is aimed at reporting for learning in order to strive for further improvements in patient safety.

By empowering staff and physicians to actively participate in risk identification and mitigation, both provinces have become leaders in patient safety. Saskatchewan and Manitoba have taken an innovative and collaborative approach to strive for substantive system changes, seeking out best practices in the areas of quality and patient safety.

Background

Both Saskatchewan and Manitoba have embarked on major provincial quality improvement endeavours that include a mandatory reporting and learning process aimed at enhancing patient safety by reducing the potential for recurrence of critical incidents. This move from a voluntary, less comprehensive process signals a commitment from policy makers that substantial improvements to safety will occur only when adverse events are addressed systemically within the healthcare system.

Saskatchewan took the lead with the passage of legislative requirements to report, investigate and share learnings arising from critical incidents as of September 15, 2004. Manitoba is due to implement similar requirements in 2006. The focus of legislation in both provinces is aimed at supporting a more secure environment for reporting and investigation and an environment of openness that promotes learning and sharing of important safety information. This article is the story of how two provinces are coordinating and striving for patient safety improvement.

Saskatchewan

In late 1997–early 1998 it was clear to officials within Saskatchewan Health, Health Districts (now Regional Health

Authorities), Regulatory Authorities and other concerned individuals in the Saskatchewan healthcare system that they could ill afford to lose the regionally learned lessons. Themes emerged in critical incidents throughout the province, and officials became concerned that without provincial coordination of information similar incidents would occur in each of the Districts. The process for collecting and analyzing the critical incident information varied across the system.

At this time Saskatchewan Health, in partnership with a number of stakeholders, initiated several patient safety activities. Additionally, regional pockets of expertise were developing. These activities came together over the next few years to become a robust and well-coordinated provincial undertaking to improve patient safety by sharing information and resulting lessons learned about critical incidents.

An early theme provincially identified in Saskatchewan was the potential for critical incidents to occur as patients were transferred from one region to another for continuing care. The attempt to address issues related to these handoffs led to an important effort coordinated by Saskatchewan Health with the assistance of several stakeholders from Regions throughout the province. The Department convened the Interdistrict Transfer Process Working Group to develop a process for the standardized movement of patients between health regions based on the available and required resources. The Saskatchewan Interdistrict Transfer Process was completed and approved for use in June 2000. It provides clear guidance on the steps involved in moving patients within (and when necessary outside) the province to receive the appropriate services.

During the same period, the newly appointed Risk Manager for the Regina Health District, Carolyn Hoffman, attended an Institute for Healthcare Improvement (IHI) Conference at which Patrice L. Spath spoke persuasively on the merits of root cause analysis. The impact of Hoffman's IHI experience was significant and facilitated the introduction and implementation of a Critical Incident Review Policy. The implementation of this policy complemented the District's work on updating and simplifying the occurrence reporting process. The District's first critical incident review was facilitated by Hoffman in the mental health setting in 1998. It immediately became clear that this was a tool to bring together the previously disparate risk management activities of the District and move toward a culture of patient safety.

Manitoba

In Manitoba, the deaths of 12 children sparked the Sinclair inquest, which five years later resulted in the Thomas recommendations to "identify institutional arrangements and procedures that would provide Manitobans with a stronger guarantee of competent, safe and ethical healthcare in the future" (Sinclair 2000; Manitoba Health 2001). Collaborative work has been and continues to be undertaken, resulting in the development and implementation of many actions where risk to the safety of individuals has been identified. A quality and risk management network was established and continues to provide valuable support to the provincial patient safety agenda. These champions and other stakeholders were instrumental in the development of eight provincial policies. In response to the Thomas recommendations, several policies were specifically designed to promote openness in reporting critical incidents and learning from mistakes, and to provide support for providers and patients in dealing with critical incidents.

Roadblocks as Catalysts for Change and Improvement

Concurrent to Hoffman's activities in the Regina Health District, the Assistant Deputy Minister of Saskatchewan Health and her staff were making plans to bring stakeholders together for the inaugural meeting of the Provincial Critical Incident Review Working Group. This group had originally assembled representatives from various-sized regions, the Registrar with the College of Physicians and Surgeons, the Executive Director of the Saskatchewan Registered Nurses Association, and select staff from Saskatchewan Health. Initial efforts of this working group were focused on the development of a provincial policy to facilitate the sharing of local critical incidents, and the results of the accompanying reviews, at a provincial level. It quickly became apparent that the *Saskatchewan Evidence Act* (Canada 2006) would create a barrier to this type of sharing. Regions were concerned that they would lose the protection provided to their reviews by sharing the findings. By 2001 it was clear that the existing legislative protections would need to be extended to the Minister so that maximum benefit could be attained through sharing the reports. The focus then became the development of appropriate language in the *Regional Health Services Act* (Canada 2002) to enable the sharing of lessons learned. The language contained in the Act, accompanying Regulations and the Saskatchewan Critical Incident Guideline (Canada 2004) was developed through broad and frequent consultation with stakeholders over the next three years, coming into effect on September 15, 2004.

Subsequent to the release of the Thomas recommendations, a somewhat similar movement arose in Manitoba as quality stakeholders voiced similar concerns. Consequently, and also in response to national and international recommendations, amendments to provincial legislation were proposed. The *Regional Health Authorities Amendment and Manitoba Evidence Amendment Act* received Royal Assent in June 2005. When proclaimed into force (at a date yet to be established), it will amend both the *Regional Health Authorities Act* and the *Manitoba Evidence Act* to require the disclosure, reporting and investigation of critical incidents and to provide legislated

protection from use in legal proceedings for information generated in carrying out the required reporting and investigation activities (Government of Manitoba 2005).

The legislation will protect the confidentiality of records and information, including opinions and advice obtained, compiled or otherwise prepared for the purposes of investigating a critical incident – while protecting the rights of individuals affected by an incident, by requiring them to be fully informed of what had actually occurred.

Results to Date

In 2001 Saskatchewan Health began gathering statistics about the voluntary reporting of critical incidents, and during that period fewer than 30 critical incidents were reported. Over time, the definition of *critical incident* and the development of the reporting guideline assisted regions in identifying when a critical incident had occurred. Reporting of critical incidents increased only slightly during the development stage, when reporting was voluntary. After introduction of the legislation, reporting increased significantly, 162 incidents being reported for the 2005/06 fiscal year. More importantly, the Region's consciousness of these types of events was raised.

Here is a breakdown of the 162 critical incidents reported to Saskatchewan Health:

- Surgical events (11) – 6.8%
- Product or device events (13) – 8.0%
- Patient protection events (14) – 8.6%
- Care management (89) – 54.9%
- Environmental events (32) – 19.9%
- Criminal events (3) – 1.9%

In Manitoba, voluntary reporting of critical occurrences and critical clinical occurrences began in early 2003. The legislative amendments to the *Regional Health Authorities Act* and the *Manitoba Evidence Act* will strengthen the intake and notification process, and it is anticipated that there will be increased reporting. Manitoba Health will provide guidance to the regional health authorities and the provincial organizations in the reporting of critical incidents to clarify requirements and standardize reporting mechanisms.

But the primary purpose of reporting of critical incidents is to learn from the experience. Reporting does not improve patient safety; it is the response to the reports that leads to change.

Developing a Tool Kit

The development and delivery of the root cause analysis methodology was pivotal to building capacity for the recognition and review of critical incidents at the regional level. In February 2003 the first workshop was developed by Saskatchewan Health to assist efforts to spread patient safety provincially. In the subsequent three years, the tool continued to be refined, and the Department ensured that all regions were exposed to it. The introduction of the tool and reporting was simplified by the existence of Regional Quality of Care Coordinators (QCCs), who had a well-developed relationship with the Provincial Quality of Care Coordinators (PQCC) at Saskatchewan Health. The QCCs quickly became the access points for moving critical incidents and root cause analysis information within their regions and to and from Saskatchewan Health. Additionally the commitment was made by Saskatchewan Health to ensure that regions would be supported by the PQCCs through their initial endeavours to utilize the RCA tool in reviewing local critical incidents. In many cases the PQCC co-facilitated the first RCA conducted in the region with the QCC.

By September 2005 there was an overwhelming demand for training in the use of the root cause analysis tool, a hybrid of the Spath model first utilized in Saskatchewan by Hoffman and the Veterans Administration National Center for Patient Safety methodology (Hoffman et al. 2006; Department of Veterans Affairs 2005). Therefore, Saskatchewan Health approached the Canadian Patient Safety Institute (CPSI) to take on the continuing national spread of this tool. CPSI partnered with Saskatchewan Health and ISMP Canada. The workshop has since been refined and developed into what is now known as the Canadian Root Cause Analysis Framework (Hoffman et al. 2006). Workshops can be facilitated by qualified individuals at any one of the three partner organizations. Efforts are under way to develop a Train the Trainer Workshop to be delivered in late 2006 or early 2007.

In March 2005, Manitoba became the first province outside of Saskatchewan to pilot and provide support to its regions to attend the inaugural national workshop. Health authorities have begun to implement these methods to review processes and systems related to how critical incidents might occur or have happened. Using both Root Cause Analysis and Failure Mode & Effects Analysis methods, aggregated patient data are being utilized to improve patient safety and quality of care.

Saskatchewan Health collates and disseminates the information received related to reports of critical incidents in an effort to provincially share learnings through *Issue Alerts*. The information contained in the *Alerts* is gleaned from critical incident reports provided to Saskatchewan Health by Regions. Both parties work together to ensure that the information alluded to in the *Alert* is de-identified, and that recommendations are circulated appropriately to reduce the likelihood of harm to others. In the period between fiscal year 2002/03 and 2005/06, fifteen *Alerts* were released by Saskatchewan Health. These speak to topics such as the safe labelling and storage of fluids, labelling of solutions used in the perioperative setting, surgical count policies and telephone advice, among others.

At the time of the writing of this article, pending Proclamation,

Manitoba continues to encourage the reporting, investigation and notification to the Minister according to the current provincial policies. As a result of each region's commendable work in reporting and analyzing their critical incidents, opportunities for learning and improved patient/client care have been implemented. A few examples are comprehensive orientations, alerts about instruments and devices, safety inspections and education about equipment, review of staffing ratios, changes to services provided within emergency rooms and the sharing of safe medication practices.

In Manitoba, collaborative effort is under way to prepare for implementation of the legislative amendments, including policy revisions and frontline staff education. Provincial workshops are planned that will help support the regions with disclosure and the use of system analysis for their critical incident investigations. Manitoba is already benefiting from ongoing, collaborative conversations with Saskatchewan Health. Following Proclamation, Manitoba will need to consider mechanisms of communication that will best enable sharing of information to facilitate system learning.

The Saskatchewan experience, with Manitoba well positioned to follow, demonstrates that cooperation among stakeholders, and a real commitment to changing how the healthcare system recognizes and shares information about critical incidents, provides support to both the patient and the healthcare providers. All parties are impacted by critical incidents. Frequently the desire of all involved is aligned. "Make the experience valuable by learning from it." Saskatchewan and Manitoba have made more than a positive step in this regard. By empowering staff and physicians to actively participate in critical incident identification and analysis, both provinces have become leaders in patient safety. Saskatchewan and Manitoba have taken an innovative and collaborative approach to strive for substantive system changes, seeking out best practices in the areas of quality and patient safety.

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