Editorial

> You're never there with patient safety. The questions keep coming up: Are we done yet? Are we safe? But safety is a dynamic and emerging state that is continually renegotiated as things change. And in healthcare everything changes all the time … so [we need] to develop a deeper capacity to deal with these issues so we can understand the complexity that we are working in.
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> – Julie Morath, *Interview with Ross Baker**

May 2009 marked the fifth anniversary of the publication of the Canadian Adverse Events Study. So where do we stand today? This issue of *Healthcare Quarterly* Patient Safety Papers provides some useful evidence of the critical issues and some important lessons learned. In this foreword, I highlight just a few examples; but I urge you to examine them all.

Evidence of risks and their impact on patients continues to emerge, both in hospitals (where the evidence is considerable) and community settings (where it is not). New technologies that improve diagnostic capabilities or offer therapeutic benefits often carry risks. Even if these risks are carefully calibrated, this knowledge is not always widely shared. David Leswick and colleagues inform us that computed tomography radiation doses are larger than many professionals and patients realize, and they offer guidance in managing the associated risks. Jane McCusker et al.'s study of seniors discharged from Quebec emergency departments highlights the importance of identifying vulnerable groups such as the elderly, targeting services to these patients to ensure higher-quality outcomes and improving their transitions home or to other services.

Assessing risk is only the first step in designing safer systems. While there has been considerable interest in prospective analysis and assessment of human factors, there is still only limited application of such tools in many organizations. Joseph Cafazzo and other investigators at the University Health Network illustrate the need for a systemic approach to medication delivery issues, focusing on the larger medication-delivery system as well as specific problems such as the adoption and implementation of smart pumps. Methods and tools alone may be insufficient to create an environment supporting safer care. Lianne Jeffs and her co-authors use results from several studies to argue that safety threats are a constant theme in busy clinical settings and that they need to be recognized and managed. Clinical and organizational resilience, not just the elimination of threats, create the path toward safer care.

Safety solutions are appearing to address adverse drug events, patient falls, healthcare-associated infections and other patient safety events, but poor implementation of these solutions can limit their impact. Maitreya Coffey and colleagues describe how two academic health science centres addressed the challenge of implementing medication reconciliation. While accreditation requirements have made Med Rec a high priority, clinicians needed to devise local strategies for completing medication histories, measuring compliance and reporting results to improve performance levels. Similarly, while hand hygiene is widely recognized as a critical practice for reducing healthcare-associated infections, many audits find only modest levels of acceptable practice. Cynthia Plante-Jenkins and Florentina Belu report on an innovative approach for raising awareness about the proper use of alcohol gels, demonstrating that an examination of personal effectiveness is a critical trigger to better practice.

Many experts believe that healthcare has lagged in creating the types of effective safety learning systems seen in other high-risk industries. Such systems identify threats, investigate contributing causes and remedial actions and then monitor changes and ongoing performance. Better measurement is clearly part of such learning systems. Régis Blais and colleagues provide some guidance on a dashboard of indicators for healthcare-associated infections. Doug Cochrane and his collaborators report on the experience of the BC Patient Safety and Learning System. Finally, Liane Ginsburg and her colleagues report that front-line staff and managers find the current definitions of errors, adverse events and near misses difficult to use; they suggest a new typology that reflects the views of their informants.

The Halifax meetings initiated by Jan Davies, Pat Croskerry and others have provided important information about patient safety to Canada audiences. In this issue, we provide an introduction and link to papers on decision-making in healthcare and the law from a symposium at the Halifax 8 meeting in Winnipeg. These papers offer useful perspectives on a subject that is critical for improving safety but that is often treated in a manner that fails to reflect the complex nature of the perceptions and actions that contribute to good or poor outcomes.

If clear thinking about problems and careful analysis of potential solutions indicate progress, then, judging from all the papers in this volume, we are making important strides forward.

– G. Ross Baker

Professor, Department of Health Policy, Management and Evaluation, University of Toronto.

*Video produced by The Hospital for Sick Children in May 2005