

An Opportunity for Reflection

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Tenth year anniversaries provide opportunities for reflecting on accomplishments and for making plans for the future. This year—2014—marks two important 10-year anniversaries of watershed events in the evolution of safer patient care in Canada:

- The launch of the Canadian Patient Safety Institute (CPSI), a national non-profit organization dedicated to raising awareness about patient safety and to facilitating the implementation of best practices (www.patientsafetyinstitute.ca).
- The publication of the results of the Canadian Adverse Events Study (Baker, Norton et al. 2004), which identified an adverse events (AEs) rate of 7.5% (projected to be 185,000 events in the year 2000) among all adult acute care hospital admissions in Canada, with over one-third (70,000 events) estimated to be potentially preventable.

Since then, there has been a vast amount of research, discussion, planning and activity aimed at ensuring that the care patients receive – not only in hospitals, but in home and other settings – is safer. For instance, new accreditation requirements have come into force, dedicated patient-safety training and professional development have arisen and been expanded and, across both the healthcare sector and society at large, awareness of the critical value of patient safety has expanded exponentially. On the care-delivery side, considerable evidence has been developed informing implementation of patient safety practices including medication reconciliation, surgical checklists and “bundles” of unit-based practices addressing ventilator-associated pneumonia, central-line infections and other sources of harm.

Despite all these innovations, however, there is still uncertainty over whether patient care is safer now than it was in 2004. A recent study, for example, revealed no statistically significant correlation between the introduction of surgical safety checklists in Ontario – a widely deployed tool in Canadian hospitals – and measures of patient deaths and complications (Urbach et al. 2014). Moreover, studies of adverse events in other environments, including pediatric hospitals (Matlow et al. 2012) and home care (Blais et al. 2013) have emphasized that risks and harm exist in many settings, not just in adult acute care hospitals.

The harsh reality is that even after 10 years of intense efforts and large expenditures, Canadian healthcare is still not reliably safe, a prospect that few anticipated in 2004.

New sources of harms continue to be identified and evidence-based solutions are often difficult to implement and sustain. This reality provided the impetus and context for creating this special patient safety issue of *Healthcare Quarterly*. The collection is divided into two main sections. Part one comprises two edited transcripts of roundtable discussions conducted with some of the leading individuals involved in patient safety efforts across Canada. The first meeting brought together people at the helm of national groups, while the second involved leaders from provincial and regional organizations. Part two of this issue presents six original essays. Each one focuses on a particular “lever” that is crucial to advancing patient safety: governance and policy, education, frontline practice, patient and family engagement and measurement and evaluation.

Roundtable Discussions

The national and provincial/regional telephone roundtables were convened in early 2014. The first of these – the national discussion – involved six participants. That wide-ranging conversation generally took a big-picture view of the patient-safety landscape, starting with several of the past decade’s major achievements, such as the solid increase in awareness of the importance of patient safety and the related development of specific patient-safety agendas. Other positive gains mentioned by participants include the addition of patient and family members’ voices, increased transparency and reporting (including establishment of a national system for medication incident reporting) and medication reconciliation.

Concern was expressed, however, over the pockets of persistent resistance to change, the growing recognition of the dangers of care transitions and the continued repetition of identical events across different jurisdictions. Looking towards what ought to be done in the future, participants underscored the importance of measurement, better communications, leadership, collaboration, sustainability and workplace health.

A few weeks later, a provincial/regional roundtable was convened; this discussion was oriented around many of the same questions. However, given the nature of the participants’ organizations – for example, four health quality councils – the discussion during this meeting tended to delve more into on-the-ground implementation of the patient-safety agenda.

One concern mentioned by the national-level participants and echoed during the provincial/regional roundtable was the integral nature of safety and quality. Too often, both groups noted, these two concerns are artificially isolated. Instead we need to see, in the words of one of the participants, that “safety is the core dimension of quality.” Other issues that received attention during the second roundtable included the increased inclusion of patient safety in provider education and a growing commitment among system leaders to patient safety (coupled, again, with the challenge of making the connection to the front

lines). The roundtable also featured extensive discussion – with recent examples – of efforts to develop adverse-events reporting systems that can also be used for learning purposes.

Assessing and Improving Key Levers to Patient Safety

Key experts were commissioned to write detailed papers on five of the topics addressed during the roundtable meetings. Ross Baker begins with an essay on critical aspects of governance and policy: the “blunt end” of the patient-safety spectrum. This paper provides an overview of developments in the disclosure of incidents to patients and their families, incident reporting and learning, medical liability, accreditation, performance measurement, investments in quality improvement capacity and capability, governance specifically targeted at safety and quality and patient engagement. The paper also points to the regulation of health professionals, an area that “offers opportunities to create safer practices.”

In a reflective piece that complements Baker’s essay, Dennis Kendel provides a more detailed assessment of the importance of using regulatory and policy levers to narrow the “gap between worker capacity to perform safely ... and actual worker performance.” In this context, Kendel strongly underscores the vital importance of applying accountability expectations uniformly to all provider groups, presently a major shortcoming across the Canadian healthcare system.

Kendel’s argument that policy and regulatory levers have been differentially applied to various groups finds an interesting corollary in Brian Wong’s article on the need to educate frontline staff in the fundamentals of patient safety and healthcare quality. In this regard, he analyzes the formal, informal and hidden curricula, arguing that the last of these is “perhaps the most underappreciated but incredibly powerful influence” on care providers’ education and a necessity to help mitigate the risk of providers unlearning formally taught lessons and practices.

Andrea Bishop and Mark Fleming also explore a critical dimension of the “hidden” side of learning in their discussion of frontline staff – “sharp end” – engagement. While more research needs to be done to establish clear connections between engagement and patient-safety outcomes, Bishop and Fleming argue that “ensuring that frontline providers, especially physicians, are engaged in safety leadership positions is vital to ensuring more widespread adoption of safety behaviours by healthcare professionals.” There are also several points of convergence in their piece with the two roundtable discussions; for example, in the discussion of “culture,” leadership (traditional executive but also among frontline staff) and adequate resourcing for change.

Another form of engagement is the focus of Carol Kushner and Donna Davis’s contribution: patients and family members, they contend, absolutely must be integrated into efforts to improve patient safety. Noting that “the perspectives of patients and family members may often differ from those who work in

the system,” Kushner and Davis see value in this divergence for developing and sustaining safer practices. While they admit that hard evidence on outcomes is limited, Kushner and Davis present six anecdotes from members of Patients for Patient Safety Canada that speak to the positive potential of such engagement. Again, though, it is important to note that culture – in this case, an “inability” to listen and stereotyping of patient and family concerns – again resurfaces as a major barrier to change.

Our final paper explores measurement and evaluation. Setting his discussion in the broader context of measuring healthcare performance in general, Gary Teare laments Canada’s “many, uncoordinated measurement and reporting initiatives,” which have sometimes “created a cacophony of measures, measurement approaches and messages” – a veritable “state of ‘indicator chaos.’” Not unlike several of the other contributors who address the importance of frontline care provision, Teare identifies one of the major sources of difficulty as the distance and disconnect of measurement from “the daily processes of care.” By focusing only on outcomes, care teams are unable to learn about either the performance of the processes – or their “inputs” (e.g., patients and materials) – that led to those outcomes. Teare argues that even in successful initiatives such as Safer Healthcare Now!, measurement runs the risk of being an “add on” function and not a seamless part of work.

Will Canada – or some part of this vast country – eventually produce a high-performing and safe system? The roundtable reports and essays presented in this special issue show that the previous 10 years have brought us a good part of the way to achieving that goal. They also all make clear that considerable challenges remain in developing the collective will, implementing effective practices and creating the leadership and culture necessary to achieve reliably safe care. **HQ**

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References

- Baker, G.R., P.G. Norton, V. Flintoft et al. 2004. “The Canadian Adverse Events Study: The Incidence of Adverse Events among Hospital Patients in Canada.” *Canadian Medical Association Journal* 170(11): 1678-86. Retrieved August 16, 2014. <<http://www.cmaj.ca/content/170/11/1678.full>>
- Blais, R., N.A. Sears, D. Doran et al. 2013. “Assessing Adverse Events among Home Care Clients in Three Canadian Provinces Using Chart Review.” *BMJ Quality & Safety* 22(12): 989-997. doi: 10.1136/bmjqs-2013-002039
- Matlow, A. G., G.R. Baker, V. Flintoft et al. 2012. “Adverse Events among Children in Canadian Hospitals: The Canadian Paediatric Adverse Events Study.” *Canadian Medical Association Journal* 184(13): E709-E718. doi: 10.1503/cmaj.112153
- Urbach, D. R., A. Govindarajan, R. Saskin et al. 2014. “Introduction of Surgical Safety Checklists in Ontario, Canada.” *New England Journal of Medicine* 370(11): 1029-1038. doi:10.1056/NEJMs1308261