Measurement and Monitoring of Safety Collaborative: Evaluation Report Findings

Wednesday, October 14, 2020 at 12pm ET

Measurement and Monitoring of Safety in Canada Webinar Series

Agenda

Topic	Speaker	Time
Welcome and Introductions	Christopher Thrall	5 min
Introduction to Measurement and Monitoring of Safety	Wayne Miller	10 min
Evaluation Overview	Ross Baker	5 min
Evaluation Report and Discussion	Joanne Goldman and Leahora Rotteau	30 min
Wrap-up	Ross Baker	5 min

Wayne Miller

Senior Program Manager
Canadian Patient Safety Institute

Professor Charles Vincent

Dr. Susan Burnett

Dr. Jane Carthey

Collaborative Timeline

Action Period 1
- 2 coaching visits
- Monthly coaching calls
- Monthly all-team huddles

Action Period 2
- 2 coaching visits
- Monthly coaching calls
- Monthly all-team huddles

Action Period 3
- 2 coaching visits
- Monthly coaching calls
- Monthly all-team huddles

LS1
- 2 day learning session in Toronto

LS2
- 2 day learning session in Toronto

LS3
- 2 day learning session in Toronto

Final Congress
- 2 day presentation of results
- Panel feedback
- Keynote speakers

Special Thanks

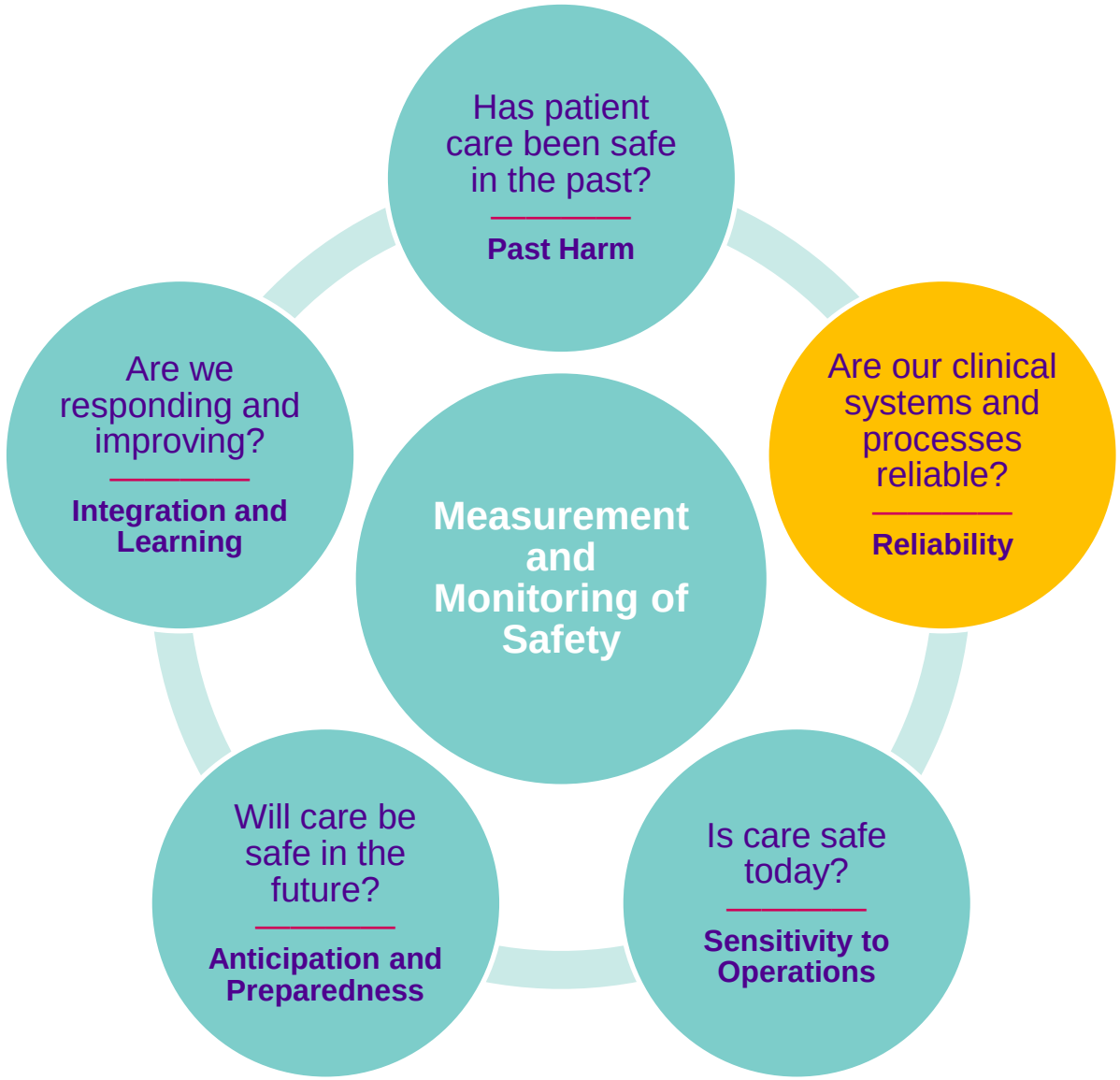
- Ms. Maryanne D’Arpino –Executive Lead
- Dr. G. Ross Baker – Faculty Lead
- Dr. Jane Carthy – Faculty
- Ms. Sarah Garrett – Faculty
- Ms. Anne MacLaurin – Coach
- Ms. Virginia Flintoft – Coach
- Mr. Alexandru Titeu – Project Co-ordinator
- Ms. Maaike Asselbergs – Patients For Patient Safety

Measurement and Monitoring of Safety

A New Conceptual Way of Thinking About Safety

"It has given us the avenue to really focus on safety in our daily huddles. We maybe had daily huddles before but what were we talking about? Were we just talking about past harm? So [the MMSF] has really given us the tools to not only talk about past harm but the other parts of the framework too."

Danielle Bellamy, Saskatchewan Health Authority, Yorkton LTC



"The other thing I am seeing that has really shifted with the [MMS] framework is that we were focused a lot on assurance so you would hear a lot of people doing audits or being audited where now it is about inquiry it is a bit more of … it is no longer about let's just look at the outcome it is now - ok we have implemented those processes but are they actually able to follow those processes, are staff able to do what we designed and how do we understand that our processes are reliable not to make people fell badly but to say why are we not able to [deliver the meds] in the way that we designed? It is that inquiry or the curiosity, that really pure problem solving that gets us to what would make a process more reliable?"

Dr. Petrina McGrath, Executive Director Quality and Safety, Saskatchewan Health Authority

"The MMS Framework shifted safety for us from a policy perspective to a day-to-day care-provider and patient interaction. It led to ownership, engagement and passion.

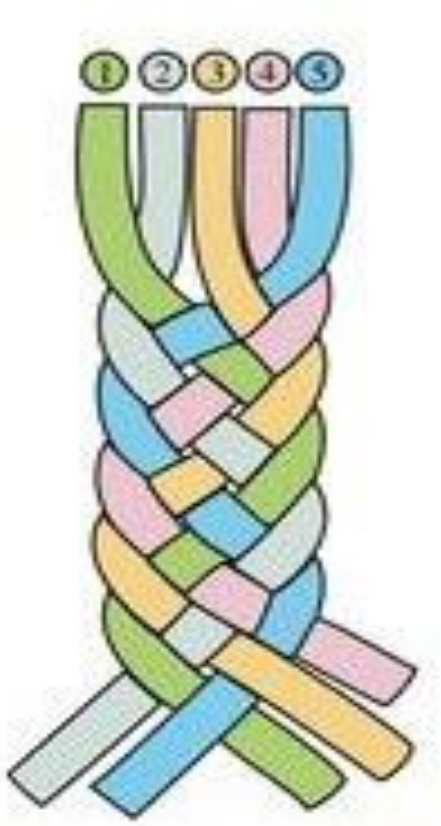
Dr. Jan Sommers, Nova Scotia Health Authority

"The MMSF has really helped us to focus our safety discussions around one hub. Our patient safety board is where we meet. We have our huddles. But I think the staff really now feel safe putting a ticket up and know that it will be addressed. I think it has really helped us with the dialogue of patient safety and brought it to the forefront of the unit which is awesome".

Rosanne Labossier-Gee, Winnipeg Regional Health Authority, Cardiac Sciences Program (ACU)

"Our approach has really been to integrate it into every aspect of our work. So even our standing meetings we talk about the framework and some of the work that we are doing. We have talked about maybe integrating it into existing education sessions, for instance making it a special education session. So really trying to find ways to infiltrate existing systems so that we are not reinventing the wheel".

Crystal Browne, Alberta Health Services, Seniors North Zone, Edson



"What I think about patient safety now I think about it using the [MMSF] dimensions, so more in a holistic way of thinking about what was going on in the past; what reliable systems do we have in place; really moving us more into that anticipation and preparedness whether it is in the moment or even in some of the larger things we are doing as an organization".

Naomi Jensen, Interior Health, British Columbia


Thank you!

G. Ross Baker, Ph.D.

Professor, Institute of Health Policy, Management and Evaluation, University of Toronto

Joanne Goldman, Ph.D.

Scientist, Centre for Quality Improvement and Patient Safety (C-QuIPS)

Researcher, The Wilson Centre for Research in Education

Assistant Professor, Department of Medicine, University of Toronto.

Leahora Rotteau, Ph.D. (Cand.)

Program Manager, Centre for Quality Improvement and Patient Safety (C-QuIPS)

PhD Candidate, Institute for Healthcare Policy, Management and Evaluation, University of Toronto

Are we making progress in Improving Safety?

- Enormous attention and resources have been devoted to improving patient safety across healthcare for the last 20 years
- We know that improving safety requires that “leaders establish and maintain a safety culture” moving from a focus on blame towards a focus on improvement
- The dominant approach to improvement has focused on learning from past harm and then identifying and implementing changes to policy, practice and technology
- Safety is difficult in the current environment but care environments are increasingly hectic, staffing levels are often insufficient and budgets are strained, all factors that limit efforts to Improve safety
- Considerable research and several recent reviews suggest limited progress

The Measurement and Monitoring of Safety

Vincent, Burnett and Carthey, 2013

- Changes our safety focus – moving away from a focus on past harm often required by regulators to a broader view of safety
- Provides teams with a shared and consistent understanding of safety, moving away from managing risk to managing safety
  - More holistic view of safety
  - From assurance to inquiry
  - Empowers frontline to take a proactive role in development of systems for measuring safety
- Promotes a culture of collective responsibility for safety

The new framework “encompasses the principal facets of safety while providing a simplicity and clarity with which to guide and inform safety measurement and monitoring”

The fundamental questions

- Has patient care been safe in the past?
- Are our clinical systems and processes reliable?
- Is care safe today?
- Will care be safe in the future?
- Are we responding and improving?

MEASURING AND MONITORING OF SAFETY: STUDY FINDINGS

OCTOBER 14, 2020

C-QuIPS

Centre for Quality Improvement and Patient Safety

UNIVERSITY OF TORONTO

EVALUATION

OBJECTIVES

1. To examine the effectiveness of the learning collaborative in increasing understanding about the MMSF and guiding MMSF implementation efforts.

2. To examine the implementation and spread of the MMSF in unit, organizational and regional contexts.

DATA COLLECTION

5

Site visits

36

Interview participants

33 hours

of observations

Documents

COLLABORATIVE TIMELINE

Action Period 1

- 2 coaching visits
- Monthly coaching calls
- Monthly all-team huddles

Action Period 2

- 2 coaching visits
- Monthly coaching calls
- Monthly all-team huddles

Action Period 3

- 2 coaching visits
- Monthly coaching calls
- Monthly all-team huddles

Oct 23-24, 2018 → Nov 2018 – Mar 2019 → Mar 26-27, 2019 → Apr – Aug 2019 → Sep 24-25, 2019 → Oct 2019 – Mar 2020 → Mar 24-25, 2020

LS1

- 2 day learning session in Toronto

LS2

- 2 day learning session in Toronto

LS3

- 2 day learning session in Toronto

Final Congress

- 2 day presentation of results
- Panel feedback
- Keynote speakers

We had been given the information prior to going so I had read through it all and there was absolutely nothing in there that I could really disagree with. And it all seemed, like common sense, and doesn't everyone know this.

(Senior leader)

The whole way the framework was based in the beginning was tricky to understand because they (dimensions) all kind of flow together. And to take it and separate it, it's really hard.

(Nurse leader/educator)

LOCAL SHARING AND LEARNING

Formal education

- Routinely scheduled meetings, board retreat, short learning sessions at daily rounds

Using MMSF language

- Daily interactions, emails, huddles, safety concerns

Reflections on dimensions

- What do/don't we tend to focus on?

Adapting the framework language for local context

- Development of tools based on Framework dimensions

I think it was really good to have the calls with the coaches as well as having the coaches come up to the site because they really will push you a lot further, like you're doing ok, but then they can pick up on those things that you're missing or if you've interpreted one of the dimensions a bit differently, can push you ahead.

(Manager)

INTERVENTIONS AND TOOLS

Huddles

Board discussions & reports

Incident reporting & investigations

Healthcare processes

Patient/resident & family initiatives

OUTCOMES

Staff more engaged with patient safety efforts

Deeper and more open conversations about safety

Different approaches to measuring and monitoring patient safety

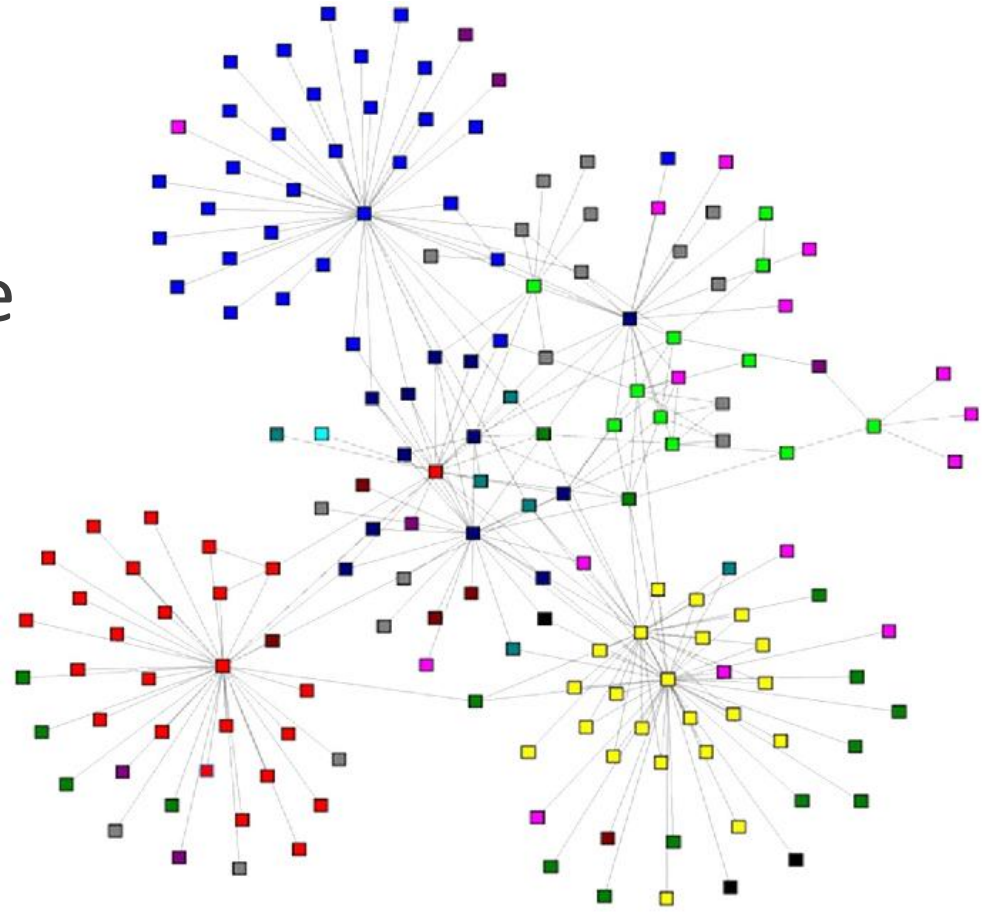
[Staff are] *not just doing their tasks…now they're actively more engaged in thinking 'oh that might be an issue, maybe we need to talk about that issue'. (Manager)*

It's less about those measurable items to me and more about how the conversations changed and [the framework] changed some of the focus [of safety work]. I'm a tough sell on some stuff but I'm kind of sold. (Senior leader)

SPREAD AND SCALE

- Unplanned and planned local spread
- Some organizational and regional scale

- Challenges
  - Dedicated resources and timeline
  - Context specific application of the MMSF
  - Organizational alignment



As an organization, I think it needs to be bigger…to be successful, it can't just be one or two areas. And then the Ministry has to be onboard as well, because their language for critical incidents is different than ours. And so if we want to focus on this Framework and the data they're asking us for, it just doesn't match….If I go to talk about a critical incident with the emergency department, they have no clue what I'm talking about. (Senior leader)

CONCLUSIONS

- MMSF is a new approach to safety
  - Requires intensive learning and local experimentation
  - Time, resources and capacity challenges
- Potential of the MMSF across settings and professional groups
  - Balance between organizational spread and context specific implementation
- Evidence of local spread to other units/groups
  - Further work required to enable organizational or regional spread and scale

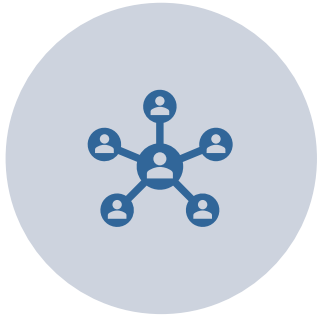
OPPORTUNITIES

New learning and coaching models

Virtual opportunities

Research on MMSF implementation across different settings and professional groups

Organizational support for local MMSF sustainability and spread



Adoption of MMSF at organizational or regional levels

WRAP-UP & DISCUSSION

Ross Baker

Poll

Please take a moment to answer the Poll, we use your feedback to improve and plan future calls

From the Board to the Ward

Virginia Flintoft
Senior Program Manager
416-525-6974
VFlintoft@cpsi-icsp.ca

Anne MacLaurin
Senior Program Manager
902-315-3877
AMaclaurin@cpsi-icsp.ca

Wayne Miller
Senior Program Manager
709-730-0864
WMiller@cpsi-icsp.ca

Alex Titeu
Project Coordinator
416-946-3103
ATiteu@cpsi-icsp.ca