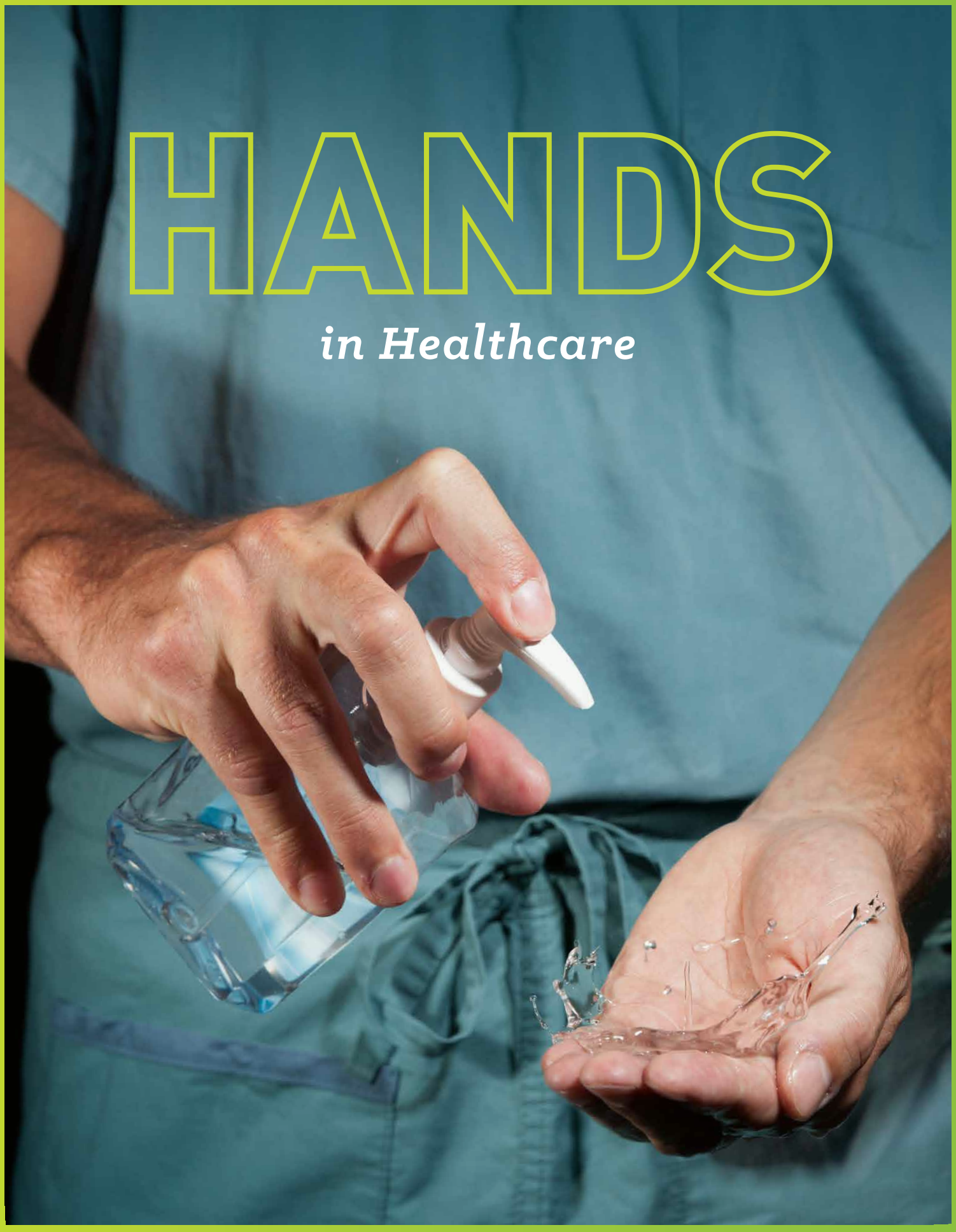
HANDS
in Healthcare

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Hugh MacLeod

When our partners succeed, we succeed.

Deborah Prowse

David U

Theresa Fillatre

Dr. Tony Fields

Wendy Nicklin

Anton Hart

Dr. Bill Geerts

Dr. Ross Baker

Maura Davies

Dr. Doug Cochrane

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I am a person who reflects. By reflecting I am able to build on my leadership and the influences that have impacted me. I often reflect that no one arrives at a destination, or achieves a goal, in the absence of others. Life is about learning through relationships. My life has been moulded by the hands of a multitude of individuals that have graciously cared, shared their time, words, wisdom and encouragement. Many had faith in me before I had faith in myself. They provided challenges that helped me stretch and grow.

Healthcare is a business that revolves around one key word – CARE. It is the care and love I have for my relationships that has propelled my passion and learnings in healthcare.

My Grandfather, John, will forever be my dearest mentor. He was an astute man who lived and radiated the words of Mark Twain, "Never allow your schooling to interfere with your ongoing education." As a man of few words, he offered me these simple yet notable pieces of wisdom: "Always look through and around the obvious. Listen for the purpose of hearing, not countering. You get to create your own freedom. Never tell your employer what you can do; show them. Now get to work; it is the busy people who get things done." To this day, my professional life, and many aspects of my personal life have been profoundly impacted by my grandfather.

It is rare that I give a speech or publish my leadership writings without first running them by my wife and my rock – Linda. I receive honest feedback from this incredible woman who provides me with enduring love and support and has allowed me to become the man I am today.

I am fuelled by my son Scott who repeatedly injects passion and energy into all pursuits, and my son Marc has shown me that writing is an art form, an inventive and attentive arrangement of letters and meanings on a blank page. The drive and creativity of both my sons has had a direct influence on my words and thoughts.

I often reflect how my grandfather, wife and sons have impacted my career in healthcare. I know each of the people we profile in Hands in Healthcare have also provided examples of the impact relationships have had on their leadership. We know we have the common purpose of CARE. We care for those we work with and those we go home to every night.

It is this passion and influence that drives improvements in patient safety.

Thank you for your hand in healthcare!

Hugh MacLeod

CEO

Canadian Patient Safety Institute

"The simple act of washing hands would have a profound impact on patient safety."

At the end of a long day, Deb Prowse can count on a loving reception back home from her faithful companions Jazmin and Precious. Her two boxers are good listeners, always ready to celebrate pleasures and console sorrows. Deb says her greatest rewards in life are her son, her dogs and her efforts to help those who have faced harm as a result of an adverse event in healthcare.

That's a harm Deb knows only too well. Ever since she lost her mother in 2004 as a result of a sodium/potassium mix-up at a Calgary hospital, patient safety has become an abiding passion. Drawing from her background in social work and law, Deb has worked with many staff, including those involved in her mother's death, and other patients and family members in pooling experiences and identifying opportunities to advance the voice and participation of patients and their families in safety initiatives across Canada and internationally.

Deb says when you take a no-blame, no-shame approach you can focus on the learning. A true systems approach includes a just and trusting culture, the transparent reporting of adverse events, disclosure of harm and an informed public – all critical elements in the drive to make care safer. Deb believes that disclosure, when done right and with the right parties involved, helps people to heal – both patients and providers.

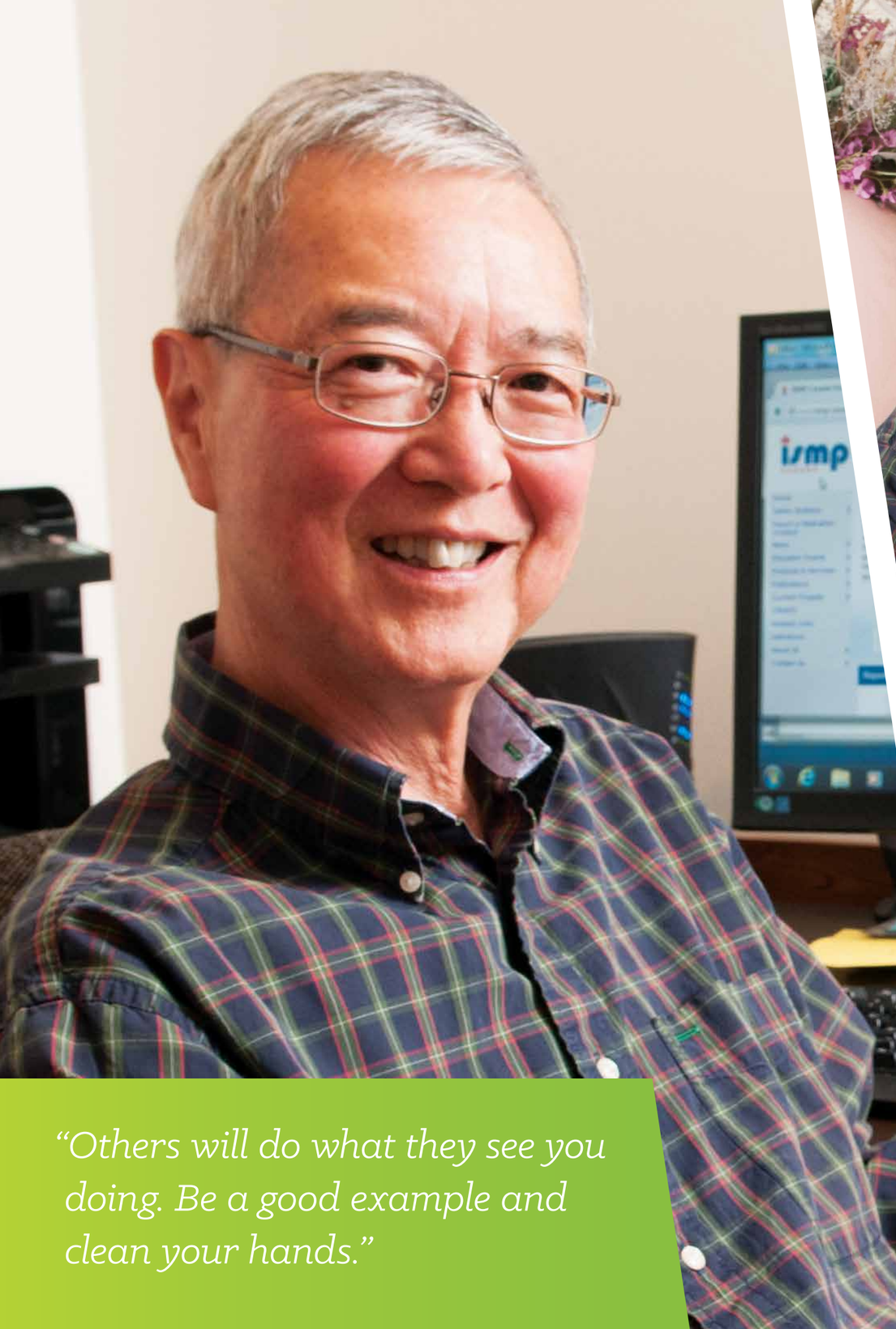
"One of the greatest challenges is overcoming fear of allowing patients to be involved in their own care and the decisions being made in healthcare," says Deb. "It is that fear that prevents dialogue. We need to do more to promote the patient's perspective. Leaders need to step out of their comfort zone to promote a readiness and make the connection between patients and providers."

Deb Prowse is the Health Advocate for the Province of Alberta, a member of Patients for Patient Safety Canada, the World Health Organization Alliance for Patient Safety, a past member of the Canadian Patient Safety Institute Board of Directors and a past member of the Health Quality Council of Alberta Patient/Family Safety Advisory Panel.

Deborah Prowse

Health Advocate

"I have learned from my work in patient safety that embracing good hand hygiene is one safety practice that we can't overlook."



"Others will do what they see you doing. Be a good example and clean your hands."

As a pharmacist and proud grandfather, David U dreams of a better future for medication safety in this country. He has seen first-hand how traumatic it can be for families who experience a serious medication incident, and he wants to protect others – including his three-year-old granddaughter Genevieve – from harm.

Problems such as miscommunication, confusing drug names, labels and packaging, as well as lack of human factor design, can lead to medication mix-ups with devastating consequences for patients and their loved ones. David believes in a collaborative approach to bolstering drug safety.

As the co-founder, president and CEO of the Institute for Safe Medication Practices Canada (ISMP Canada) David has spent the past 14 years advancing medication safety in healthcare settings. He leads a staff of 20 in studying the underlying causes of medication incidents and developing and promoting workable solutions to help prevent the needless harm they can cause.

"The legal system and healthcare culture often prevent people from talking about what happened and openly sharing information on medication adverse events," David says. "We need to work together to spread best practices."

ISMP Canada is making inroads on patient engagement with their consumer information reporting website, www.safemedicationuse.ca, where anyone can submit incident reports to help improve the system and prevent harmful errors. The reports are fed into the Canadian Medication Incident Reporting and Prevention System (CMIRPS), a voluntary, confidential program that collects, analyzes and distributes information on medication mishaps. Previously, only healthcare providers could report such incidents to CMIRPS.

To enhance safe medication practices for practitioners, ISMP Canada provides training and educational programs to advance root cause analysis in incident reviews. One very successful program is the effective use of the best possible medication history (BPMH), the cornerstone of medication reconciliation to be undertaken for patients when transitioning from one care setting to another. A toolkit has also been developed for healthcare organizations moving from paper-based to electronic medication reconciliation. And, a medication bar-coding program is being developed to make the correct information including packaging for look-alike, sound-alike medications more visible and intuitive.

ISMP Canada partnered with the Canadian Patient Safety Institute in 2005 to lead the *Safer Healthcare Now!* medication safety intervention, and is putting a particular focus on implementing safe medication practices in acute, long-term and home care settings.

David U

President and CEO

ISMP Canada

While beachcombing along the Nova Scotia coastline, Theresa Fillatre takes the time to reflect and rejuvenate. If she comes upon a unique piece of sea glass, it can sometimes spark reflections and new ideas. Those long walks along the beach fuel her enthusiasm for patient safety improvement.

Theresa entered the patient safety field as the Atlantic leader for *Safer Healthcare Now!* in 2005, and had national responsibility for the program from 2011 to 2013. She was instrumental in establishing the Atlantic Health Quality and Patient Safety Collaborative, bringing together the four Atlantic health ministries, the chairs of the provincial quality and patient safety councils and representatives from the delivery system. She helped to create the Atlantic Learning Exchange where over 200 healthcare professionals from Atlantic Canada get together to learn from experts and one another. As senior policy advisor for the Canadian Patient Safety Institute, Theresa is supporting the development of a National Integrated Patient Safety Strategy.

Over her career, Theresa has found that the biggest challenge to patient safety has been the time it takes to affect change.

"Too many priorities and initiatives dilute the ability to see improvements through in a focused way," she says. "There are too many measures and folks will measure because they have to, rather than because the measures are helpful in executing change."

Theresa's advice is to pick one or two critical improvements that will reduce patient harm, and stick to the knitting until they become ingrained in the way you work. She says sustainable improvements cannot be made with single initiatives that are not aligned with strategy. It takes asking the right questions, listening to truths, and talking through possible solutions that can be tried, refined and hardwired into actual practice and policy.

"The healthcare system is a complex business and it often takes 20 years or more to put evidence into practice," says Theresa. "We have a collective obligation as public stewards and citizens to do better. The best learning is generated by doing together and testing different approaches."

Theresa Fillatre

Chair

Atlantic Health Quality and Patient Safety Collaborative

"Hand sanitizer stations in healthcare and public settings that are right in front of your nose serve as a reinforcing reminder to clean your hands."

Every picture tells a story. Taking the perfect picture is all about technique for amateur photographer Dr. Tony Fields. He knows if he does not snap the perfect shot, he needs to adjust his angle and change the settings. The discipline he applies to photography is akin to the clear focus and flexibility he brings to his work in patient safety.

When the former vice president of the Alberta Cancer Board learned of a tragic medication error back in 2006, a mishap that led to the death of a cancer patient from a major chemotherapy drug overdose, he engaged ISMP Canada and the Health Quality Council of Alberta to investigate. What he learned from that process was transformational. He worked closely with the patient's family, and their remarkable capacity for understanding and forgiveness helped to change his outlook and perspective.

To instil a culture of patient safety, Dr. Fields says that healthcare workers need to live and breathe safety, and be conscious of it in everything they do. They need to be aware of the systematic programs that are there to support them in terms of safety. Patients need to be harnessed as partners involved in all aspects of their care. Just as important, patients shouldn't take their treatment for granted, and need to be on the outlook for anything that could cause them harm.

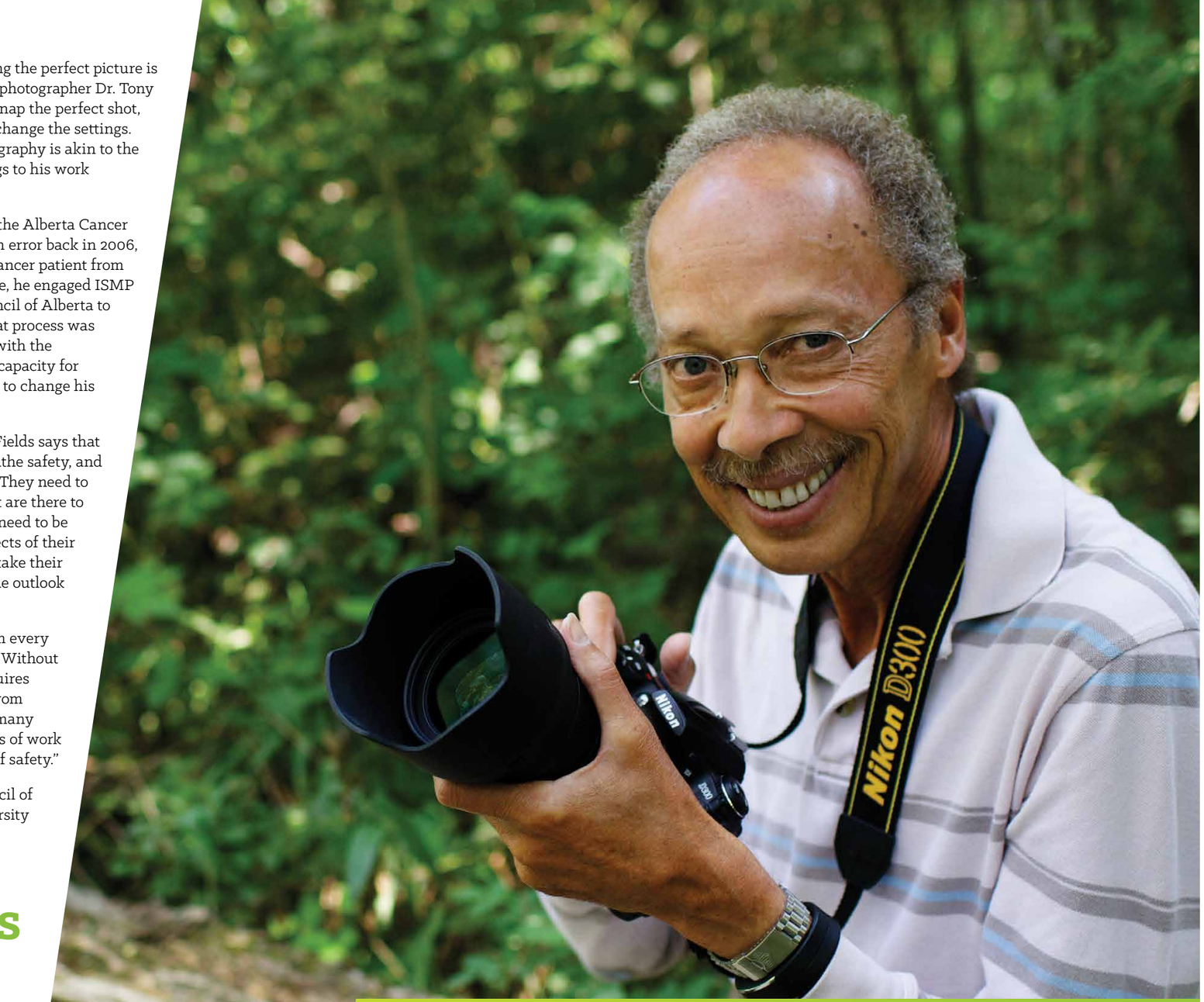
"Safety requires a heartfelt commitment from every physician and practitioner," says Dr. Fields. "Without that focus, patient safety will slip. It also requires diligence at a system level to prevent errors from reaching and harming patients. There are so many bush fires in everyday life and in the pressures of work that it is too easy to take your eye off the ball of safety."

Dr. Tony Fields chairs the Health Quality Council of Alberta and is a professor emeritus at the University of Alberta.

Dr. Tony Fields

Chair

Health Quality Council of Alberta



"Alcohol-based hand sanitizer and hand sanitizer stations are a significant reminder and powerful influence. I always notice them and they prompt me to clean my hands."

You wouldn't reuse this without cleaning it.

Hands are no different. They carry germs that can make you and others sick. Always clean your hands properly. Your healthcare provider should do the same.

asklistentalk.ca

cpsi icsp Canadian Patient Safety Institute
Institut canadien pour la sécurité des patients

You wouldn't reuse this without cleaning it.

Hands are no different. Always clean your hands properly before and after every patient encounter.

asklistentalk.ca

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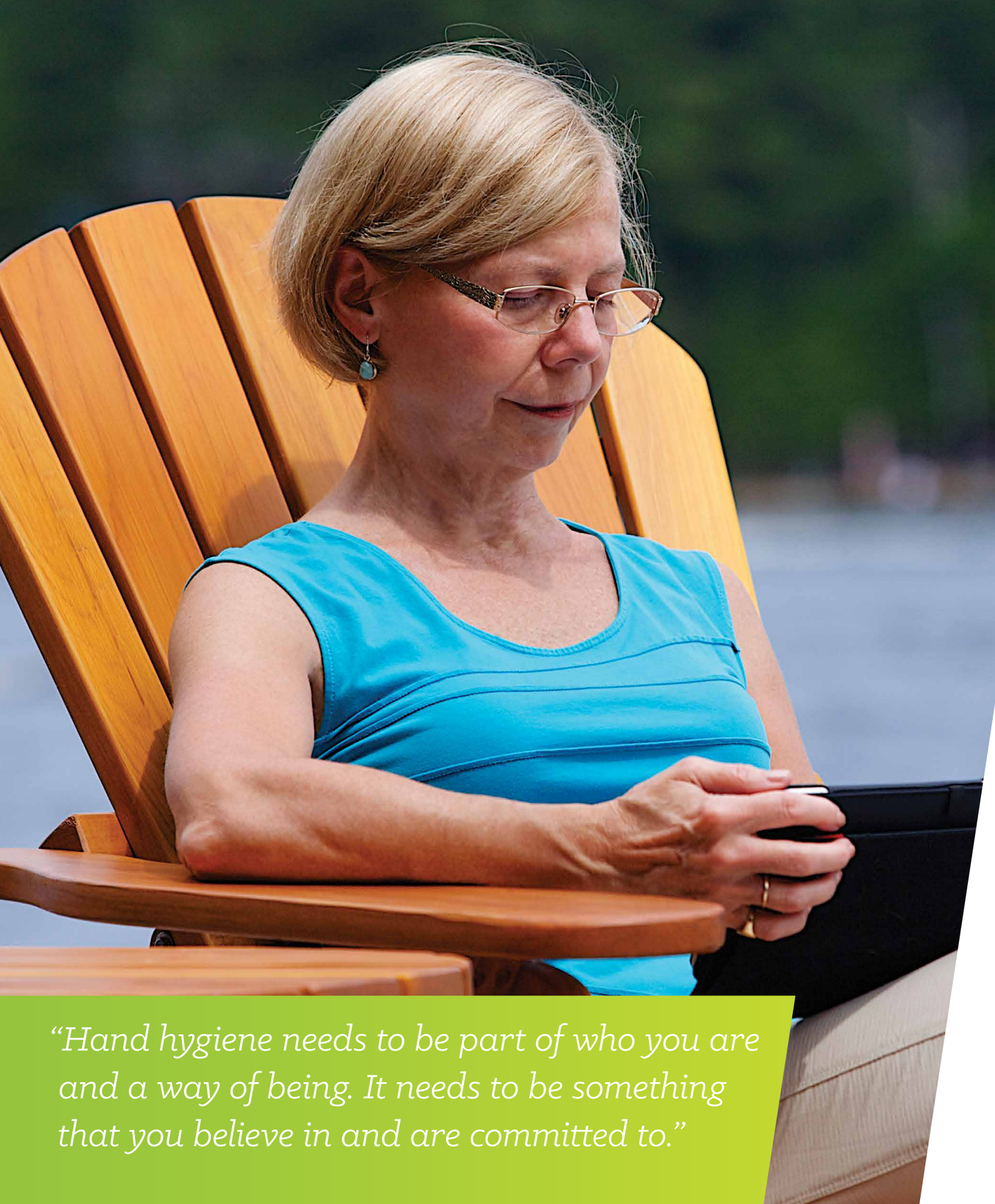


"Hand hygiene needs to be part of who you are and a way of being. It needs to be something that you believe in and are committed to."

Wendy Nicklin

President and CEO

Accreditation Canada

Wendy Nicklin is a woman who endeavours to lead by example and strives to strike a healthy balance in life. Whether she is enjoying the outdoors at her lakeside cottage, attending an Ottawa Senators hockey game or working with healthcare organizations to integrate accreditation into their quality improvement program, she makes every effort to ensure that quality of life on the job and at home carry equal weight. She has also made it a fundamental commitment to care for those that she works with and the environment in which they work.

As president and CEO of Accreditation Canada, Wendy works to ensure that the organization continually improves in order to be relevant and add value across the healthcare system. In dialogue with partners and stakeholders across the country, she listens to the healthcare priorities and looks to consider these within the accreditation programs, contributing to improve healthcare quality and safety. With the release of Qmentum in 2008, a shift in mindset is evident where accreditation is looked at as an enabler to quality improvement in healthcare organizations. Accreditation has been reconfigured to move away from a project-focus that adds workload, to one that is integrated into quality improvement programs on an ongoing basis.

"To improve quality and patient safety we need to effectively listen to the voice of patients, clients and families to partner with them," says Wendy. "From the bedside or clinic, through to the board, listening to and partnering with the client and population takes time – however over the long haul, there will be better outcomes and efficiencies because we have taken the time to listen, plan and together address the need appropriately."

Wendy's focus throughout her career has been on quality of care. She was appointed to the National Steering Committee on Patient Safety, the springboard to the creation of the Canadian Patient Safety Institute, and has served as the board chair and is one of the founding directors.

Anton Hart likes to take the road less travelled. On their annual road trips, he and his wife enjoy choosing a destination and then letting unknown highways and scenic detours carry them to new adventures along the way. As a publisher of scientific, academic and professional health sciences journals, Anton uses that same sense of discovery to help shine a spotlight on the challenges and opportunities in healthcare.

When working with so many bright minds, it is important to maintain a fresh perspective and develop an eye for editorial material that will resonate with readers. His editors and authors have made an important contribution to advancing patient safety and quality improvement with the publications they have put together under the Longwoods banner.

Longwoods publishes six healthcare journals that highlight leading practices and innovations in research, policy, administration, nursing, electronic healthcare, law and governance, and world health and population. The publisher's website offers a rich repository of peer reviewed papers, leading practices, commentaries and white papers, as well as a blog that provides a forum for discussion and debate. Everything ever published over the last twenty years is available online. "It is a kind of present-day encyclopedia of healthcare in Canada; search a topic and prepare to be served," Anton says.

Longwoods regularly hosts a range of learning programs. *HealthcareRounds* offers a day and a half of innovation and practice analysis. *Breakfast with the Chiefs* is a monthly speaking series for health leaders to share new ideas, policies and practices with their colleagues.

"It is unfortunate that we have to focus on patient safety," says Anton. "Regrettably the complexity of healthcare does seem to enable errors. Our editors and authors are committed to drawing out the issues at every level and looking at options and alternatives to mitigate these slips and miscalculations."

Anton and his team will not back down from any topic they feel needs to be addressed – even those that can be costly and annoying like hospital parking rates. He has also taken a keen interest in obesity and is chairman of the Canadian Obesity Network.

Anton Hart

Publisher and CEO

Longwoods Publishing Corporation

"I see so much information on the effects of hand hygiene practices that it has become automatic. I have indoctrinated myself to clean my hands whenever I visit a doctor's office or a hospital."

Dr. Bill Geerts knows that maintaining a regular fitness regime is one of the best things you can do for your health. He walks or cycles to work, and a combination of weights and cardio are an essential part of his workout routine. He is someone who understands that multiple approaches will lead to better outcomes, and applies that same philosophy when dealing with the complexities of preventing venous thromboembolism (VTE).

VTE is a condition that includes both deep vein thrombosis, the formation of a blood clot usually in the leg or pelvic veins, and pulmonary embolism when that clot dislodges and travels to the lungs. Thrombosis affects thousands of Canadians each year, and many are preventable.

Dr. Geerts likes to call Sunnybrook his sandbox. He's worked at the Toronto health centre his entire career, focusing on thrombosis in the development of a research program and contributions to international guidelines for standards of care, especially in the prevention of VTE, and quality improvement initiatives. He has helped establish Sunnybrook as one of the leading centers for thrombosis care in the country, and is often sought out for advice from other hospitals, doctors and pharmacists. He has given more than 1,200 presentations to medical students, residents and other health professionals across the country and around the world. In 2009, Dr. Geerts received the Sol Sherry Award from the International Society on Thrombosis and Haemostasis for his international contributions to the prevention of VTE.

"The prevention of hospital-based VTE has a strong evidence base and is a quality of care problem that is fixable," Dr. Geerts declares. "Quality improvement is rarely a quick fix; someone has to be passionate about it and it requires patience, determination, creativity and more determination."

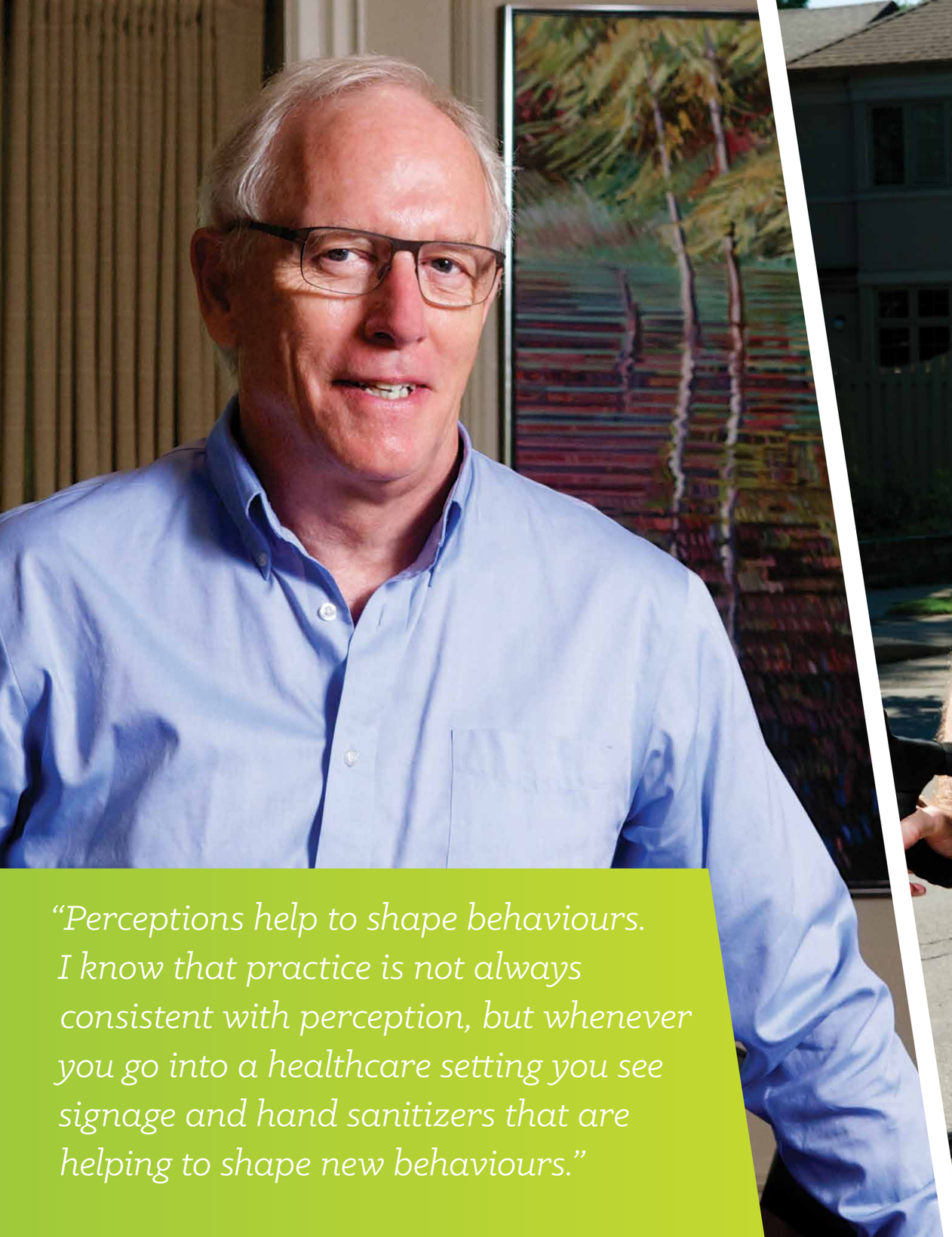
It was during a chance encounter with a stranger in a line-up to buy a coffee that Dr. Geerts first learned about *Safer Healthcare Now!* That conversation led him to pursue adoption of VTE as one of the *Safer Healthcare Now!* targeted interventions. Canadian hospitals now have comprehensive policies in place to protect patients from the consequences of VTE, including death due to pulmonary embolism after a surgical procedure or acute illness requiring admission.

Dr. Bill Geerts

Thromboembolism Specialist

Sunnybrook Health Sciences Centre

"Position hand sanitizer where you need it so that you don't have to look for it and use it every time you have an encounter with a patient. Publish your adherence stats for all to see to encourage higher compliance."



"Perceptions help to shape behaviours. I know that practice is not always consistent with perception, but whenever you go into a healthcare setting you see signage and hand sanitizers that are helping to shape new behaviours."

Learning how to navigate a road bike means that you need to be aware of what's happening around you. If you plan to make even the slightest deviation from your course you need to check over your shoulder and remember that the shortest route is not always the best route.

For confirmed road biker Dr. Ross Baker, the journey to improved patient safety in Canada has been an occasionally bumpy but satisfying ride, one that he knows is far from over.

Together with Dr. Peter Norton, Dr. Baker authored the landmark Canadian Adverse Events study published in 2004 that raised a new national interest in patient safety. He was a member of the national steering committee that recommended the formation of the Canadian Patient Safety Institute, helped to lead the grassroots movement behind *Safer Healthcare Now!* and spearheaded the development of the Patient Safety Metrics measurement system. Dr. Baker is recognized nationally and internationally; he co-chaired a key committee for the World Health Organization Patient Safety Alliance, and he's also a board member of the Saskatchewan Health Quality Council.

"We have achieved a lot in patient safety over the last decade; our knowledge and interest have increased and there are a wide array of initiatives that have helped to create progress toward what we can do and how we can do it effectively in different settings," says Dr. Baker. "We have built a strong foundation, but have only scratched the surface. There is a lot more to do, particularly to advance knowledge, education and culture."

Dr. Baker would like to see better engagement at all levels. There are a lot of champions, he says, but not a consistent, reliable approach to safety. He advocates for a system designed for frontline clinicians that allows them to do the right thing by default, resulting in safe and consistent high-quality care.

Dr. Ross Baker

Professor

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

Dr. Doug Cochrane wears many hats in his efforts to keep patients safe. He is chair of the British Columbia Patient Safety and Quality Council (BCPSQC); a provincial Patient Safety and Quality Officer; a professor in Neurosurgery at the University of British Columbia; and he serves on numerous boards and committees provincially, nationally and internationally. All of this while maintaining a clinical practice as a pediatric neurosurgeon at the BC Children's Hospital.

Dr. Cochrane's interest in patient safety began as a result of a harmful incident, where he felt a responsibility for not being able to rescue the patient from death. He knew that the system around him had failed and that realization became the impetus for his campaign to help improve the quality and safety of care. He subsequently chaired a BC Patient Safety Task Force that focused on addressing policy and care issues. This lead to the implementation of a province-wide adverse event reporting system; a system that provides the necessary framework to support staff in reporting adverse events, treating staff appropriately when those events occur and learning from the events so that the system can protect patients.

"Policy changes have penetrated every healthcare institution in almost every dimension," says Dr. Cochrane. "When the Task Force was formed we had a handful of people interested in patient safety, quality improvement activities and systems thinking. Today, we have over 200 people in BC healthcare who have been trained in quality improvement and are using these skills in their day-to-day work."

Clinical Care Management (CCM) was developed based on successes BC saw as a result of *Safer Healthcare Now!* This initiative has since been adopted by the BC Ministry of Health to implement best practice, evidence based care in all healthcare sectors in BC. Today, through CCM, clinical care is improving in 11 targeted areas, with more to come.

With the support of the BCPSQC and the Ministry, BC hospitals were amongst the first to join the National Surgical Quality Improvement program. The multi-institutional initiative involves 400 healthcare organizations from across North America in measuring surgical quality in the same way, so that they can better compare results.

Dr. Cochrane has been involved with the Canadian Patient Safety Institute since its inception, has served on the board and is a former chair.

Dr. Doug Cochrane

Chair

British Columbia Patient Safety & Quality Council

"Cleaning my hands is intrinsic – I do it all of the time. I am a mentor; therefore, I want to be an example to others."

Maura Davies

CEO

Saskatoon Health Region

At the end of a long week, Maura Davies looks forward to a standing date night with her physician husband, a tradition the couple has enjoyed for more than 42 years. With Maura's demanding job as the CEO of the Saskatoon Health Region, that's a dedicated time for them to reconnect and spend quality time together. Maura values the importance of nurturing relationships with those you love, no matter how committed you are to your work.

Quality and safety is the primary focus in the Saskatoon Health Region, and a commitment to zero harm has been adopted across the province of Saskatchewan. A lean management system has been implemented to focus on mistake-proofing, eliminating defects and making care safer.

"Patient safety is all about the culture of the organization," says Maura. "Compared to other industries, healthcare has become far too accepting when harm happens. Patients and families need to feel they have a much stronger voice in ensuring that care is safe."

The Saskatoon Health Region has developed a prototype for a safety alert, stop-the-line system that will be replicated province-wide. Anyone can easily notify or report a safety concern or incident and a call centre is available around the clock to take their call. Since the system was put into place, patients, families, visitors, physicians, and healthcare employees have been making those calls.

Maura believes that what leaders pay attention to sends a strong message within an organization. Her mantra is simple: "We will not harm anyone who receives or provides care in the system." She says that when senior leaders send and demonstrate their commitment to that message, patient safety becomes job one.

Maura has been a member of the Canadian Patient Safety Institute Board of Directors since 2007, and is a former chair. She is particularly proud of the Institute's work with the Canadian Health Services Research Foundation to clarify the role of boards in quality and safety and the development of the Effective Governance for Quality and Patient Safety program to help boards advance safe care.

"I love it when staff tells me about a safety concern. It doesn't matter who you are or what position you hold, it is okay to ask others to wash their hands."

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