HANDS *in* HEALTHCARE

Issue 1 / Volume 1

Ask. Listen. Talk.
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A MILLION thanks for your efforts to advance patient safety. Canadian Patient Safety Week provides a good opportunity to profile examples of self-discovery in patient safety and quality innovation.

Riding my Harley Davidson is my road to self-discovery. Every road and intersection presents a choice, and following a road you have never travelled before is a journey. It is about intuition, faith in the road, my Harley and me. When I return home I am a changed person because I have just discovered something new. Riding my motorcycle is a fine-tuning of hand-eye co-ordination, focus and the removal of all other distractions but the yellow painted lines, bending, curving, dipping, flattening and cresting. It reminds me that healthcare is a service that demands full attention at all times.

We recognize that there are thousands of patient safety and quality champions from coast to coast—from board to care delivery—from research to tools and interventions—from policy and funding to operational action. These profiles are just a handful of the nation's patient safety activities.

Through these profiles, we have used metaphors to inspire four key messages:

CONTEXT IS EVERYTHING—While the capacity to change exists in every individual and in every organization, it must align with the organizational history, sense of urgency, readiness for change, culture and degrees of leadership commitment.

DENIAL IS OUR GREATEST THREAT—There is a gap between the patient safety outcomes we see on paper and what patients and providers experience. Silence, unawareness, indifference and complacency are the greatest enemies of improvement.

IT IS ALL ABOUT RELATIONSHIPS—Honest and open relationships between all involved in care together with a culture that supports healthy interactions and is rooted in true values are the sources to achieve excellence.

WE MUST LISTEN TO, ENCOURAGE AND RESPECT THE VOICE OF THE PATIENT-CLIENT-RESIDENT.

Profiled in this edition, the Health Quality Council of Alberta promotes a culture of no blame and no shame. Quebec is applying human factors methodology in incident analysis to look at both human and system interactions to get a grasp on reducing healthcare-associated infections. Health PEI recognizes that having a candid conversation can lead to improvement in patient safety. A strong policy framework developed by the Saskatchewan Health Ministry helps navigate the winds and waters to create a culture of safety. The Manitoba Institute for Patient Safety reinforces that promoting quality and patient safety is a group effort. The University Health Network is using some innovative strategies to control MRSA and other hospital infections. Patients for Patient Safety Canada brings alive the voice of the patient to improve patient safety. The voices of 925 elderly residents are important to Interior Health through their Patient Voices Network. The Ottawa Hospital and the Collaborative for Excellence in Healthcare Quality see the value of measurement, reporting and benchmarking. Finally, a Nova Scotia consortium confirms improved hand hygiene is the cornerstone for reducing infections.

I wish we had space to capture all the hands in patient safety and quality work that is taking place across the country. Let me know about your activities, so that our conversation can continue.

HUGH MACLEOD, CEO, Canadian Patient Safety Institute (patientsafetyinstitute.ca)

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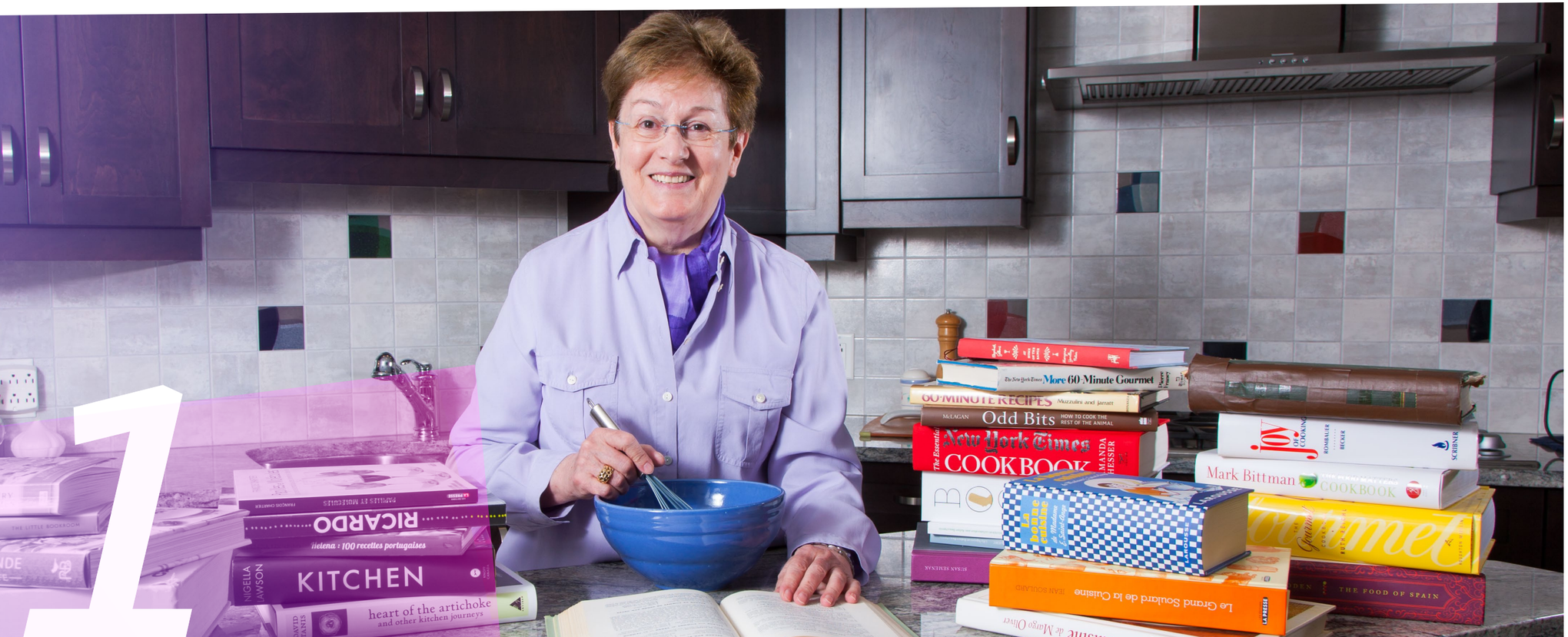
Strumming bluegrass tunes and listening to the twang of his five-string banjo, it is music to Dr. John Cowell's ears that there is a process in place to analyze patient safety incidents in healthcare. Few may notice a missed musical note, but when harmful incidents happen, the ripple effect can have a huge impact.

Starting as a family physician in **1970** and throughout his career, as an emergency room doctor, healthcare administrator and currently leading the Health Quality Council of Alberta (HQCA), Dr. Cowell has seen more than his share of patient safety incidents. One of the mandates of the HQCA is to study patient safety and health service quality in Alberta and make recommendations for system-wide change that will make care safer.

The HQCA promotes a just culture within healthcare organizations where providers are encouraged to report patient safety incidents and near misses without fear of retribution, so that the incidents can be analyzed, changes can be implemented, and learnings can be shared to enhance the safety and quality of patient care.

The HQCA is a strong advocate for the patient safety movement in Alberta and across the country. Dr. Cowell wants patients and families to be aware that when harm has occurred, it is their right to hear "I'm sorry" and receive full disclosure on the incident. They have a right to know what happened, how and why it happened, and what actions are being taken to reduce the risk of similar harm to other patients in the future.

DR. JOHN COWELL is the CEO of the Health Quality Council of Alberta (hqca.ca)



From her eclectic cookbook collection, Dr. Micheline Ste-Marie closely follows a recipe, but often adds extra herbs or spices to enhance the flavour. This avid cook notes that when you alter one ingredient the results may not be quite what you expect. While one ingredient can sweeten or sour the taste, it only takes **1** patient story to influence your perspective on patient safety.

For Dr. Ste-Marie, it was the unfortunate death of a 28-year-old young woman, who broke her leg when she fell off a motorbike. The young woman received multiple doses of narcotics and other drugs that altered consciousness following her accident, which led to her untimely death. Following the incident, Dr. Ste-Marie was inspired by the courage and extraordinary efforts of the girl's mother to put patient safety on the radar that ultimately resulted in patient safety legislation to be enacted in the province of Quebec.

Dr. Ste-Marie says it is unfortunate that it takes harmful incidents to be able to learn from them. In Quebec, the principles of human factors are being used in the analysis of harmful incidents. This approach focuses on: people including healthcare workers and the patient, the system, the environment, as well as the interaction between the three and how all contribute to the harm.

DR. STE-MARIE is a pediatric gastroenterologist, Associate Director of Professional Services at the Montreal Children's Hospital of the McGill University Health Centre (muhc.ca), Associate Professor (Paediatrics), Faculty of Medicine, McGill University and chairs le Groupe VIGILANCE pour la Sécurité des Soins, a group advising the Quebec Ministry of Health and Social Services on matters of patient safety.

Like the native plants that grow in his garden, Keith Dewar, is well-rooted in healthcare. The Dewar family has been intimately involved in the healthcare system for over 50 years, and during his career, Keith has learned that growing a culture of patient safety is much like nurturing the flora and fauna to flourish at his sea-side home.

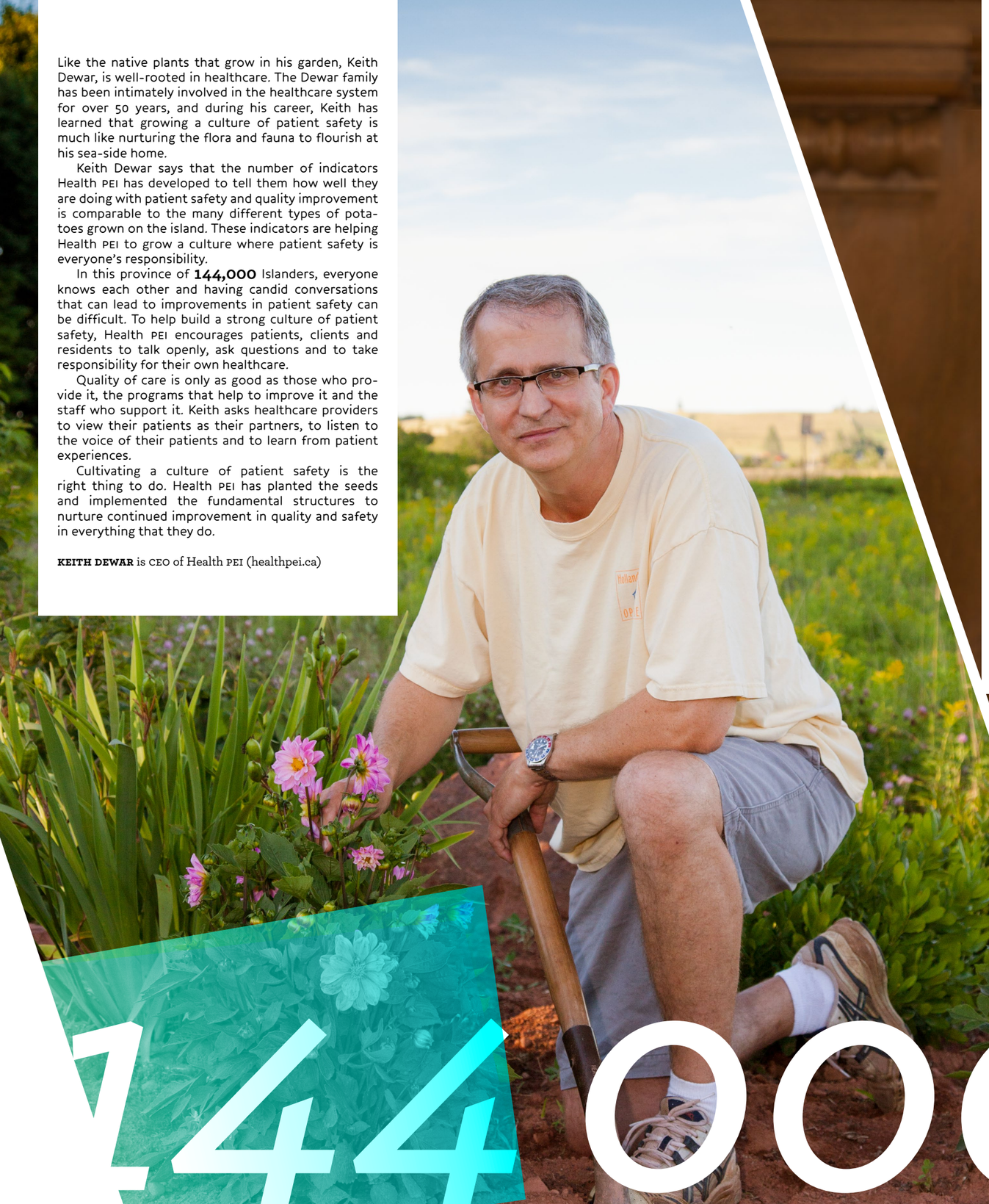
Keith Dewar says that the number of indicators Health PEI has developed to tell them how well they are doing with patient safety and quality improvement is comparable to the many different types of potatoes grown on the island. These indicators are helping Health PEI to grow a culture where patient safety is everyone's responsibility.

In this province of **144,000** Islanders, everyone knows each other and having candid conversations that can lead to improvements in patient safety can be difficult. To help build a strong culture of patient safety, Health PEI encourages patients, clients and residents to talk openly, ask questions and to take responsibility for their own healthcare.

Quality of care is only as good as those who provide it, the programs that help to improve it and the staff who support it. Keith asks healthcare providers to view their patients as their partners, to listen to the voice of their patients and to learn from patient experiences.

Cultivating a culture of patient safety is the right thing to do. Health PEI has planted the seeds and implemented the fundamental structures to nurture continued improvement in quality and safety in everything that they do.

KEITH DEWAR is CEO of Health PEI (healthpei.ca)



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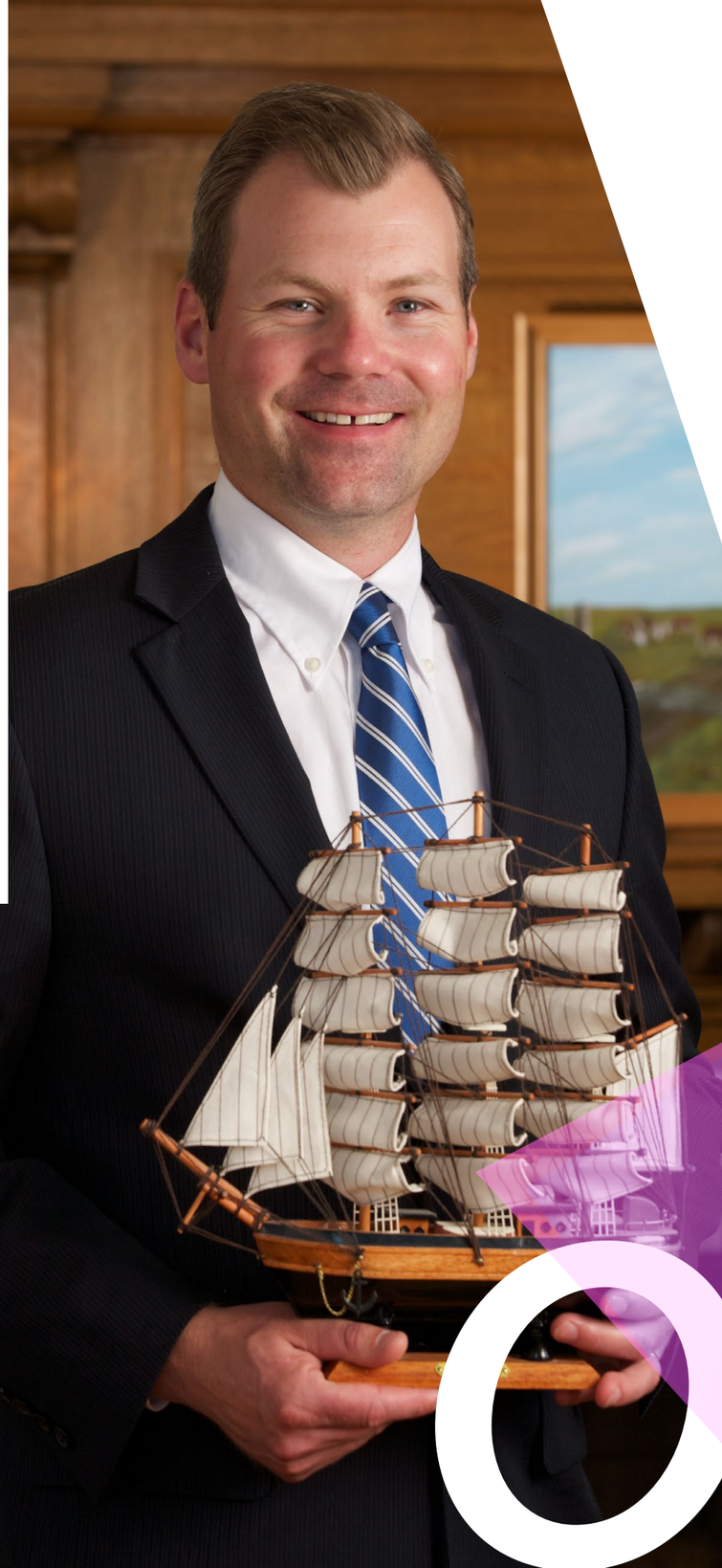
Learning how to sail is a new-found passion for Saskatchewan's Health Minster, the Hon. Dustin Duncan. As the new skipper of a major healthcare transformation, he is navigating the winds and the waters to create and sustain a culture of safety for patients and healthcare providers across the province where a **0** level of harm is acceptable.

The Saskatchewan health system is committed to *Better Health, Better Care, Better Value and Better Teams* for its patients, clients and residents. The province is using the Lean methodology to promote zero harm in healthcare. Lean is a patient-centred approach to identify and eliminate all non-value-adding activities and reduce waste within an organization. The Lean methodology is the foundation to help improve access to health services, the quality of patient care, patient and staff safety, and value and efficiency for patients.

Putting the patient's needs first can improve both patient outcomes and the patient experience. Lean engages frontline staff and patients to make improvements, because they know what works best. Lean is also being used in facility design to enhance quality and safety, reduce wait times and improve the experience for patients, families and healthcare providers.

Much like setting sail on a charted course yet knowing there are obstacles that you may encounter, Lean provides frontline staff the opportunity to visualize and respond to unsafe occurrences. As they jig their sails to transform healthcare, patient safety is a priority and Lean is helping to chart the course that they will sail to reach their destination, where only a zero level of harm is acceptable.

The **HON. DUSTIN DUNCAN** is the Minister of Health for the province of Saskatchewan (health.gov.sk.ca)



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Laurie Thompson often has five or six books on the go at her cottage retreat. While a book may have a single author, Laurie has created a team approach in rewriting the patient safety culture in Manitoba—a concept that runs through the heart of the Manitoba Institute for Patient Safety (MIPS) board, patient advisory committee and staff.

Educated as a nurse, Laurie worked in nursing education and with government developing policies and programs before joining MIPS. Laurie's background has prepared her well for heading an office of three that works with **32** member organizations and countless project partners.

Traveling around the province, Laurie is energized by the encouragement and openness to being part of the dialogue for change. She recently visited a number of small Manitoba towns to engage participation in MIPS' annual "We Listen! We Learn! We Evolve!" forum that gives the public a voice on patient safety issues.

Laurie finds it very rewarding to see organizations living the spirit of the MIPS' "It's Safe to Ask" campaign (safetoask.ca). In her travels, she sees a lot of posters and brochures in health centres that encourage patients and families to ask three key questions: What is my health problem? What do I need to do? Why do I need to do this? Displaying posters sends a visible message to patients and families that this is a place where patient engagement is encouraged.

"This increased openness and partnership between patients and providers is a welcome shift in culture," says Thompson. "With this collective passion, we are writing new chapters in the patient safety story."

LAURIE THOMPSON is Executive Director of the Manitoba Institute for Patient Safety (mbips.ca)

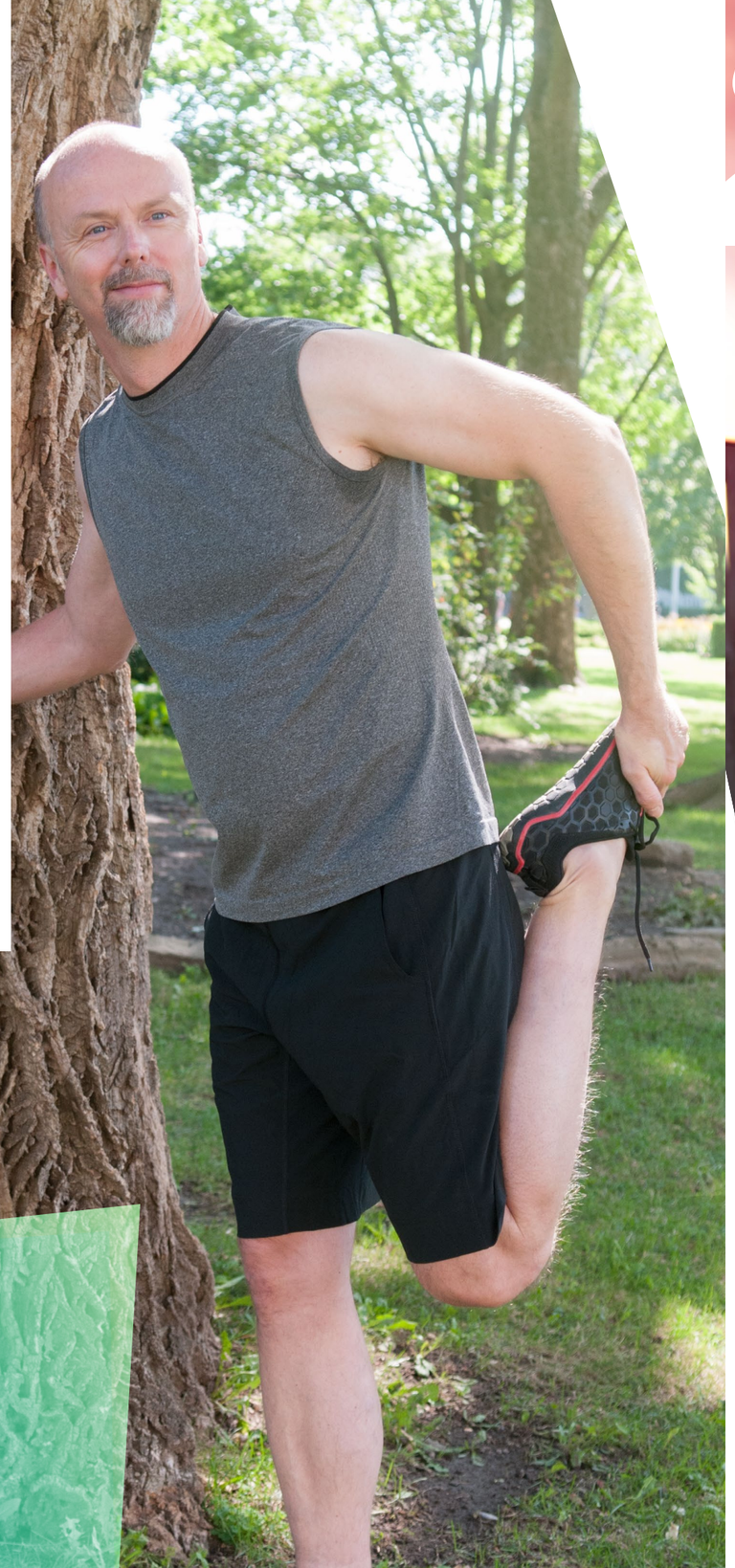
There is nothing like the euphoric feeling of crossing the finish line after a 42.2 km race. Marathon runner Dr. Michael Gardam of the University Health Network (UHN) compares his mixed approach to training for a marathon with his mixed approach for controlling Methicillin-Resistant Staphylococcus Aureus (MRSA) and other hospital infections. It's been **5** years since UHN has had a significant MRSA outbreak and Dr. Gardam says finding the right solutions for UHN was a matter of looking to frontline staff and having the courage to implement some varied and unorthodox strategies.

"Our MRSA rates dropped when we finally started to improve our hand hygiene," says Dr. Gardam. UHN took a novel approach to promote effective hand hygiene to reduce MRSA by focussing less on education and more on encouraging local approaches and solutions. People don't like to be told what to do, so Dr. Gardam started asking healthcare providers, "What do you think we should do and how are you going to do it?"

Dr. Gardam states that measuring change is central to improvement. Providing consistent and transparent data feedback to staff, combined with frontline engagement and identifying hidden experts within the organization are key to their success. This approach is based on Positive Deviance which is a strategy used to help realize behaviour, attitude and culture change within organizations.

"Like training for a marathon it is vital to consult the experts, mix new and traditional techniques and strategies, measure results and tweak where necessary. And, of course, always keep your eye on the finish line," adds Gardam.

DR. GARDAM is the Medical Director of Infection Prevention and Control at UHN and Women's College Hospital (uhn.on.ca). He is also a consultant to various organizations specializing in behavioural change.



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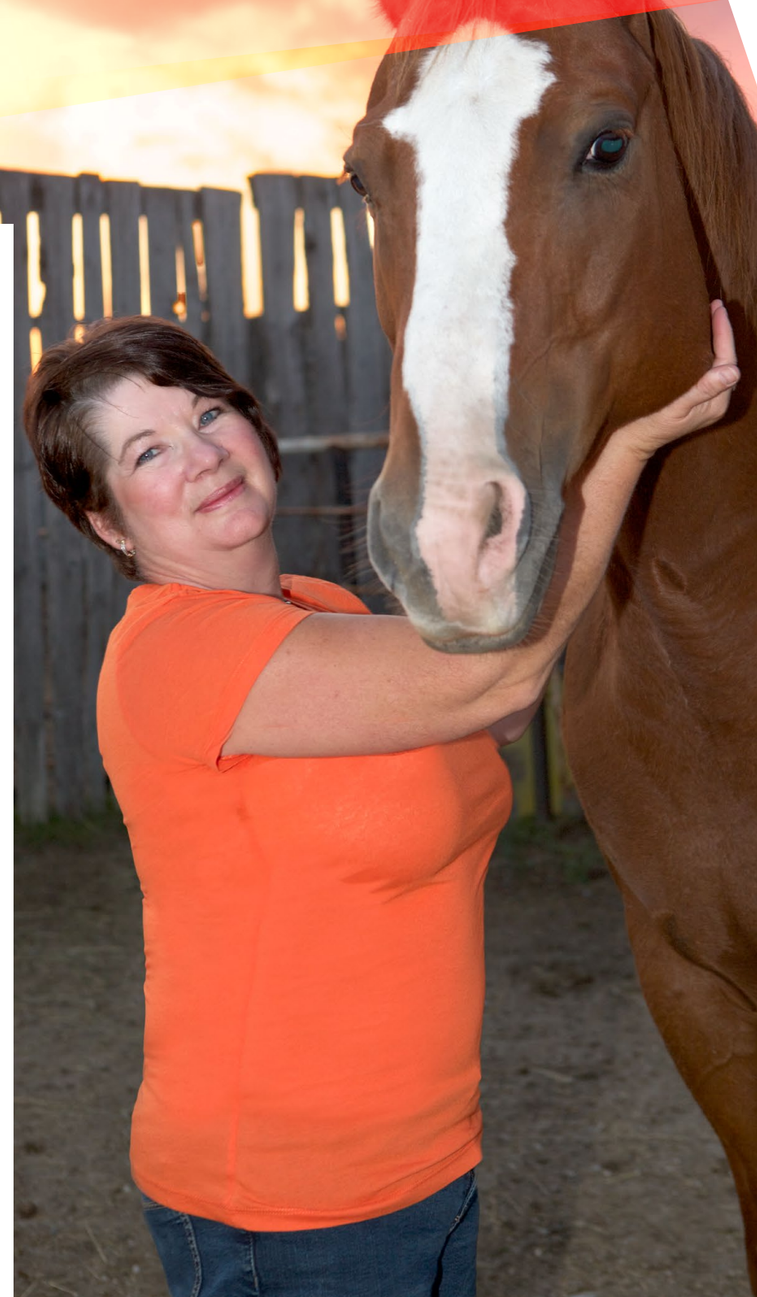
One of the fondest memories Donna Davis has of her son Vance is his love of horses and talent for roping. The Davis family have been formidable competitors in team-roping and barrel racing, with Donna often the timer at the events they have attended. Timing is everything and for Donna it is the minutes and seconds that count most when it comes to communication to avoid harmful incidents in healthcare.

Vance Davis was only 19-years-old when he died in care after suffering a traumatic brain injury as the result of a motor vehicle accident. As a nurse, Donna was well aware of the extent of his injuries, but as his mother, she was aware that her son's behaviour was becoming increasingly unusual. Donna shared her concerns with those overseeing her son's care, but was given staff assurance that Vance only needed time and rest. As Vance's condition worsened, her concerns were left unaddressed. A neurosurgeon had been on duty since Vance was first hospitalized, however it took four days before he was informed about Vance's condition and surgery was finally performed. For many years after, there was little or no communication with the family as to what happened or what could have been done to avoid the harm that led to Vance's untimely passing.

In Canada, about **24,000** patients die needlessly every year due to harm caused from patient safety incidents. For Donna even one death is too many and telling the patient's story to improve communication in healthcare has become Vance's legacy.

The patient and family perspective provides a wealth of knowledge in improving patient safety. Donna says that you can't fix what you don't acknowledge, and she is working to ensure that no one experiences what her family went through. Through Patients for Patient Safety Canada, a patient-led program of the Canadian Patient Safety Institute, that champions the voice of the patient to enhance safer care for all, Donna is using stories rather than statistics to share her learnings in advancing patient safety.

DONNA DAVIS is Co-Chair of Patients for Patient Safety Canada. Visit patientsforpatientsafety.ca



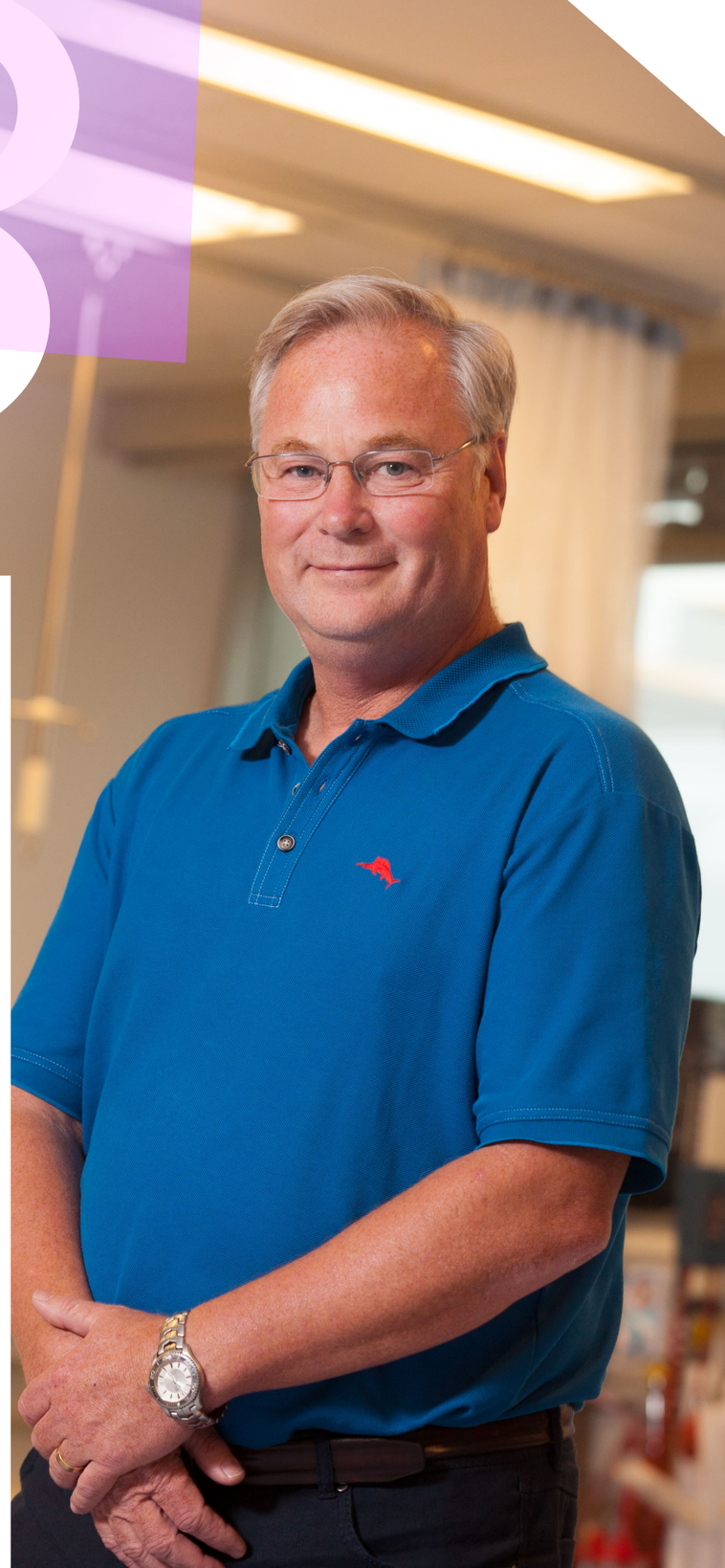
Old-growth forests nurture both the old and the new and for Cindy Regier, that is a fascinating story untold. Using this perspective to advance patient safety, Cindy most appreciates the wisdom and insight of the **925** elderly residents at the 12 care homes she oversees in the south Okanagan.

Interior Health has incorporated a Patient Voices Network and involved Resident/Family Councils to ensure the residents' experiences are integrated into every quality improvement initiative they are working toward. Moving away from embedded past practices and task-based care, the resident is the focus and at the centre of everything they do.

In her role as a Health Services Administrator Cindy values relationships and leads by example. She is always looking for ways to empower and engage staff and residents in improving quality and safety. Interior Health encourages a team approach and looks to build upon their strengths, challenge their thinking, and support one another in facilitating change in the improvement of quality care and safety for the residents and staff.

Cindy learned early in her nursing career that change is inevitable. She was taught to embrace change and to help others adapt to change. Through active listening, Cindy promotes and fosters a culture where staff and residents feel comfortable coming forward with their ideas to be part of the solution.

CINDY REGIER is the South Okanagan Health Services Administrator, Residential Services for the Interior Health Authority (interiorhealth.ca)



On the day this profile was written Dr. Jack Kitts, CEO of The Ottawa Hospital, was on vacation in the Ottawa Valley, playing a rare game of 18-holes of golf, while **18** patients waited in emergency for a bed on a nursing unit at the hospital. Dr. Kitts believes that you can't wait until you're perfect to record your score and The Ottawa Hospital is taking the bold step of publicly reporting occupancy rates and surgical procedures cancelled due to lack of beds.

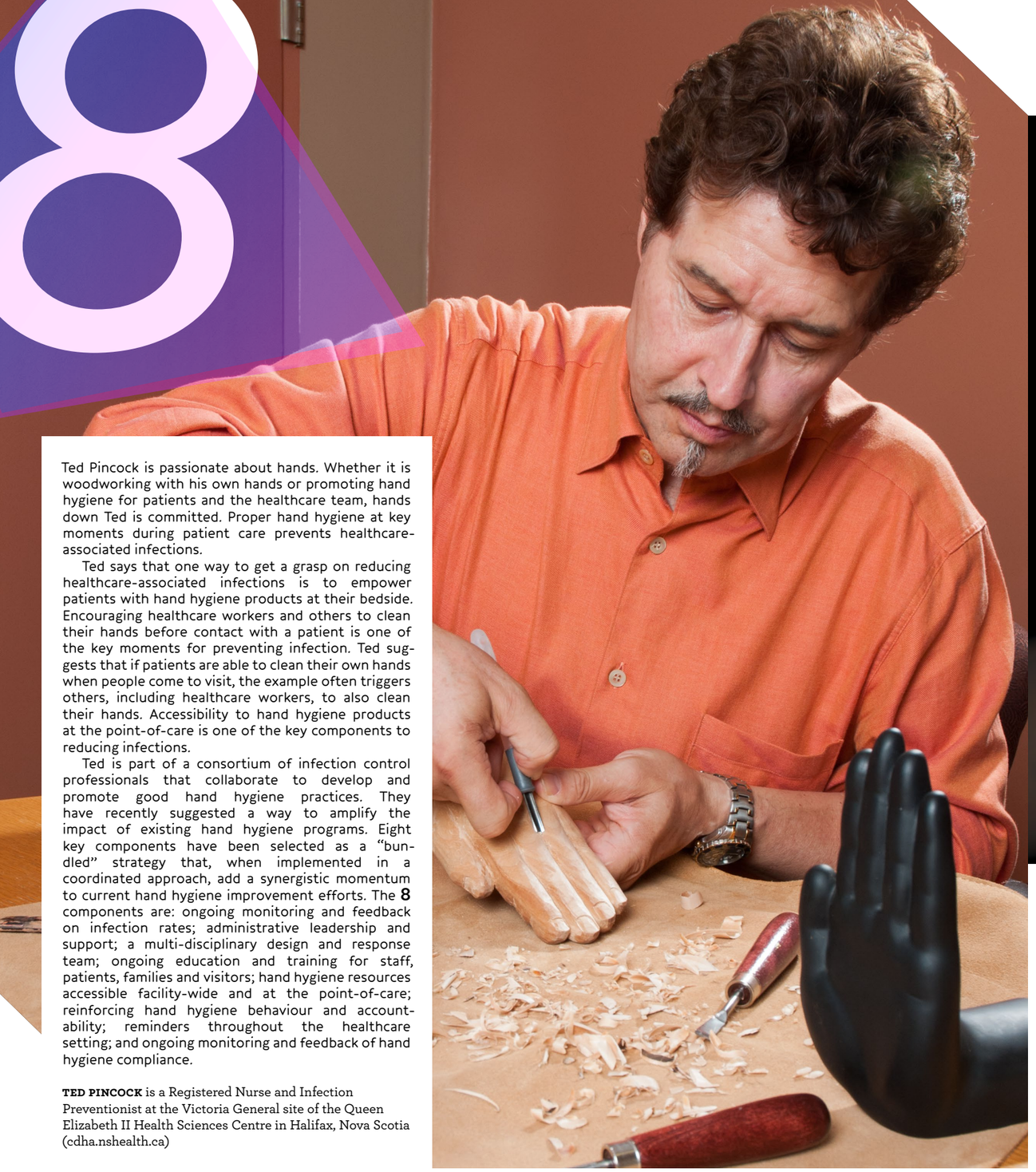
The Ottawa Hospital uses indicators that focus on patient safety and the patient experience to advance its quality improvement initiatives. The data they collect and report helps them to understand where they are, where they are going, and how far they are from reaching certain goals.

Similar to a scorecard where you tally your golf score, on any given day you can visit The Ottawa Hospital's website for a daily update on occupancy rates and surgical cancellations. Quarterly reporting is available on emergency wait times, hand hygiene compliance, surgical site infections, use of a surgical safety checklist, central line infections, ventilator-associated pneumonia, and the mortality ratio.

The Ottawa Hospital is not alone when it comes to reporting on key quality and patient safety indicators. Eleven healthcare organizations and four partners (Accreditation Canada, Canadian Health Services Research Institute, Canadian Institute for Health Information and the Canadian Patient Safety Institute) have come together as the Collaborative for Excellence in Healthcare Quality (CEHQ). Under Dr. Kitts as Chair, the collaborative is creating common performance measures, benchmarking with each other and sharing experiences in quality and patient safety improvement.

Dr. Kitts believes that patient safety leadership comes from the frontline staff and he looks to them for ways to improve. He asks his staff to treat their patients as they would a loved one, and with that, everyone understands what is expected of them.

DR. JACK KITTS is CEO of The Ottawa Hospital (ottawahospital.on.ca)



Ted Pincock is passionate about hands. Whether it is woodworking with his own hands or promoting hand hygiene for patients and the healthcare team, hands down Ted is committed. Proper hand hygiene at key moments during patient care prevents healthcare-associated infections.

Ted says that one way to get a grasp on reducing healthcare-associated infections is to empower patients with hand hygiene products at their bedside. Encouraging healthcare workers and others to clean their hands before contact with a patient is one of the key moments for preventing infection. Ted suggests that if patients are able to clean their own hands when people come to visit, the example often triggers others, including healthcare workers, to also clean their hands. Accessibility to hand hygiene products at the point-of-care is one of the key components to reducing infections.

Ted is part of a consortium of infection control professionals that collaborate to develop and promote good hand hygiene practices. They have recently suggested a way to amplify the impact of existing hand hygiene programs. Eight key components have been selected as a "bundled" strategy that, when implemented in a coordinated approach, add a synergistic momentum to current hand hygiene improvement efforts. The **8** components are: ongoing monitoring and feedback on infection rates; administrative leadership and support; a multi-disciplinary design and response team; ongoing education and training for staff, patients, families and visitors; hand hygiene resources accessible facility-wide and at the point-of-care; reinforcing hand hygiene behaviour and accountability; reminders throughout the healthcare setting; and ongoing monitoring and feedback of hand hygiene compliance.

TED PINCOCK is a Registered Nurse and Infection Preventionist at the Victoria General site of the Queen Elizabeth II Health Sciences Centre in Halifax, Nova Scotia (cdha.nshealth.ca)

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