Transparency and culture change key to patient safety

See the patient in front of you as an individual, care for them to the best of your abilities and apologize to them directly in a timely manner if you make a mistake.

That is a distillation of some of the patient-centred advice provided at a comprehensive review of patient safety and reducing harm in hospitals provided by a range of participants at the 4th annual invitational forum of the Joint Centres of Transformative Health Care Innovation held at Markham-Stouffville Hospital.

Markham-Stouffville is a member of the joint centres along with Mackenzie Health, Michael Garron Hospital, North York General Hospital, Southlake Regional Health Centre and St. Joseph's Health Centre.

In setting the context for the forum reference was made to the revised Quality of Care Information Protection Act, to be proclaimed this summer, that will increase transparency in dealing with preventable errors in hospitals. It was also noted that Health Quality Ontario has developed the Ontario Patient Safety Incident Learning System to educate about how information on preventable errors will be collected and shared under the legislation.

As keynote speaker at the forum, Chris Power, CEO of the Canadian Patient Safety Institute (CPSI) provided a comprehensive overview of the status of patient safety in Canada today.

"We know that in health care things go wrong despite our best efforts. But most times we get it right," she said. However, Power said someone in a Canadian acute care hospital dies from a preventable event every 17 minutes and this statistic has not changed much in recent years.

Whether it is possible to totally eliminate such errors depends on your perspective, she said, with other speakers in the meeting opining that while total elimination of error was not possible much more could be done to reduce such incidents.

With communication breakdown identified as the main cause of preventable errors, Power said, the key to changing the situation lies in creating a safety culture, and improving teamwork and communications.

Power then talked about work being done at CPSI to identify the "winning conditions" for improving patient safety. These conditions include:

- Improving the reliability of human decision-making – currently seriously underdeveloped in Canada because of a very strong tradition of clinical autonomy and suspicion of standardized work.
- Developing a sense of urgency about the issue – a sense that Power says that "appears to have waned" in recent years.
- Access to reliable data or a granular nature that will be useful for individual clinician

Power said with the increased cadre of sophisticated patient-advocates "patients and the public are going to be the ones that transform health care. Not us."

This was a theme that continued through the panel discussion that followed which included input from panel member, Diane McKenzie, patient and family advisor at St. Joseph's.

The other major focus of the panel discussion was the comparison between managing patient safety in hospitals with how safety is dealt with in the aviation and space industries. Insights were provided by former astronaut and emergency room physician and now CEO of Southlake, Dr. Dave Williams, and Samuel Elfassy, managing director, corporate safety, environment and quality for Air Canada.

The panel discussion was moderated by Dr. Joshua Tepper, president and CEO of Health Quality Ontario. Safety is one of the six dimensions of quality that defines a high quality health care system and drives the work of Health Quality Ontario.

Elfassy said changing the culture in hospitals will require a lot of transparency, data and personal story telling. Williams evoked the power of story-telling and the impact of medical errors can have on clinical staff when he talked about breaking into tears recently during Rounds at Southlake while discussing an incident from 30 years ago.

Williams noted those in the aviation industry have an extensive exposure to a terminology and culture of safety that is only just starting to be embraced by medicine.

While Williams and Power focused on the need for more standardization in health care, McKenzie countered that providers need to focus on the individual needs of patients.

The discussion concluded by return to the focus on individual patient care in order to improve patient safety and reduce medical error.

“We promise patients the highest quality of care and we will build the trust when we fulfill that promise,” said Tepper.