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Canada creates list of events that should never happen in hospitals

Report identifies 15 preventable safety incidents (known as never events) that result in serious patient harm or death

Toronto, ON – Sept. 18, 2015 - Patients rightfully expect safe health care in Canada and providers strive to deliver the best care possible. Unfortunately, events that harm patients do happen, and can be serious or even cause death.

Many of these incidents are avoidable, says a new report from Health Quality Ontario and the Canadian Patient Safety Institute: **Never Events for Hospital Care in Canada**. In the report, *never events* are classified as patient safety incidents that result in serious patient harm or death and are preventable using organizational checks and balances.

Written by a group of health care quality experts from across Canada, the report focuses on 15 events that can occur while a patient is under the care of a hospital. It also highlights strategies to help identify and reduce these events.

“We created this report with the Canadian Patient Safety Institute to help increase awareness for incidents that can be prevented,” says Dr. Joshua Tepper president and CEO of Health Quality Ontario. “We hope that by calling attention to these 15 never events, Canadian hospitals will rally around them and harness their collective knowledge, expertise and experiences to prevent them from happening.”

A few never events in the report include:

- Surgery on the wrong body part or wrong patient, or conducting the wrong procedure
- Wrong tissue, biological implant or blood product given to a patient
- Unintended foreign object left in a patient after a procedure

“Until now, we did not have agreement in Canada on a list of never events,” says Chris Power, CEO of the Canadian Patient Safety Institute. “National consensus on never events is an important step in identifying focus. It’s not about blaming and shaming. It’s about identifying problems and sharing solutions to prevent these incidents from happening.”

The group who wrote the report, known as the Never Events Action Team, was led by Health Quality Ontario and supported by the Canadian Patient Safety Institute. Together the team researched, surveyed and consulted with health system leaders, providers, patients and the public before recommending a list of never events in Canada’s health care system. The Never Events Action Team includes the following experts, and patient representatives:

- Atlantic Health Quality and Patient Safety Collaborative
- British Columbia Patient Safety and Quality Council
- Canadian Patient Safety Institute

- Health Quality Council of Alberta
- Health Quality Ontario
- Manitoba Institute for Patient Safety
- New Brunswick Health Council
- Newfoundland and Labrador Provincial Safety and Quality Committee
- Patients for Patient Safety Canada (a patient led program of the Canadian Patient Safety Institute)

To access the full report and read the complete list of never events, visit patientsafetyinstitute.ca and hqontario.ca.

Or please contact us to coordinate an interview with:

- Chris Power, CEO, Canadian Patient Safety Institute
- Dr. Joshua Tepper, president and CEO, Health Quality Ontario

ABOUT CANADIAN PATIENT SAFETY INSTITUTE

The Canadian Patient Safety Institute was established in 2003 as an independent not-for-profit corporation, operating collaboratively with health professionals and organizations, regulatory bodies and governments to build and advance a safer healthcare system for Canada. The Canadian Patient Safety Institute would like to acknowledge funding support from Health Canada. The views expressed here do not necessarily represent the views of Health Canada. Visit patientsafetyinstitute.ca for more information.

ABOUT HEALTH QUALITY ONTARIO

Health Quality Ontario (HQO) is the provincial advisor on quality in health care. HQO reports public on the quality of the health care system, evaluates the effectiveness of new health care technologies and services, and supports quality improvement throughout the system. Visit www.hqontario.ca for more information.

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Media contact

Jessica Verhey, Senior Communications Advisor, Health Quality Ontario, 416-323-6868 ext. 614, jessica.verhey@hqontario.ca

Cecilia Bloxom, Director of Strategic Communications, Canadian Patient Safety Institute, 780-700-8642; cbloxom@cpsi-icsp.ca