PATIENTS FOR PATIENT SAFETY CANADA | PATIENTS POUR LA SÉCURITÉ DES PATIENTS DU CANADA

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Canadian Patient Safety Institute | Institut canadien pour la sécurité des patients

Collaboration for Transformation:

Patients as Partners, Driving Patient Safety Improvement

CADTH Symposium
Concurrent Session F4
April 16, 2019
1:00 – 2:15pm

Patient Safety RightNow

patientsafetyinstitute.ca securitedespatients.ca

Your Moderator and Panel

Patient Safety RightNow

Christopher Thrall
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Kathy Kovacs Burns

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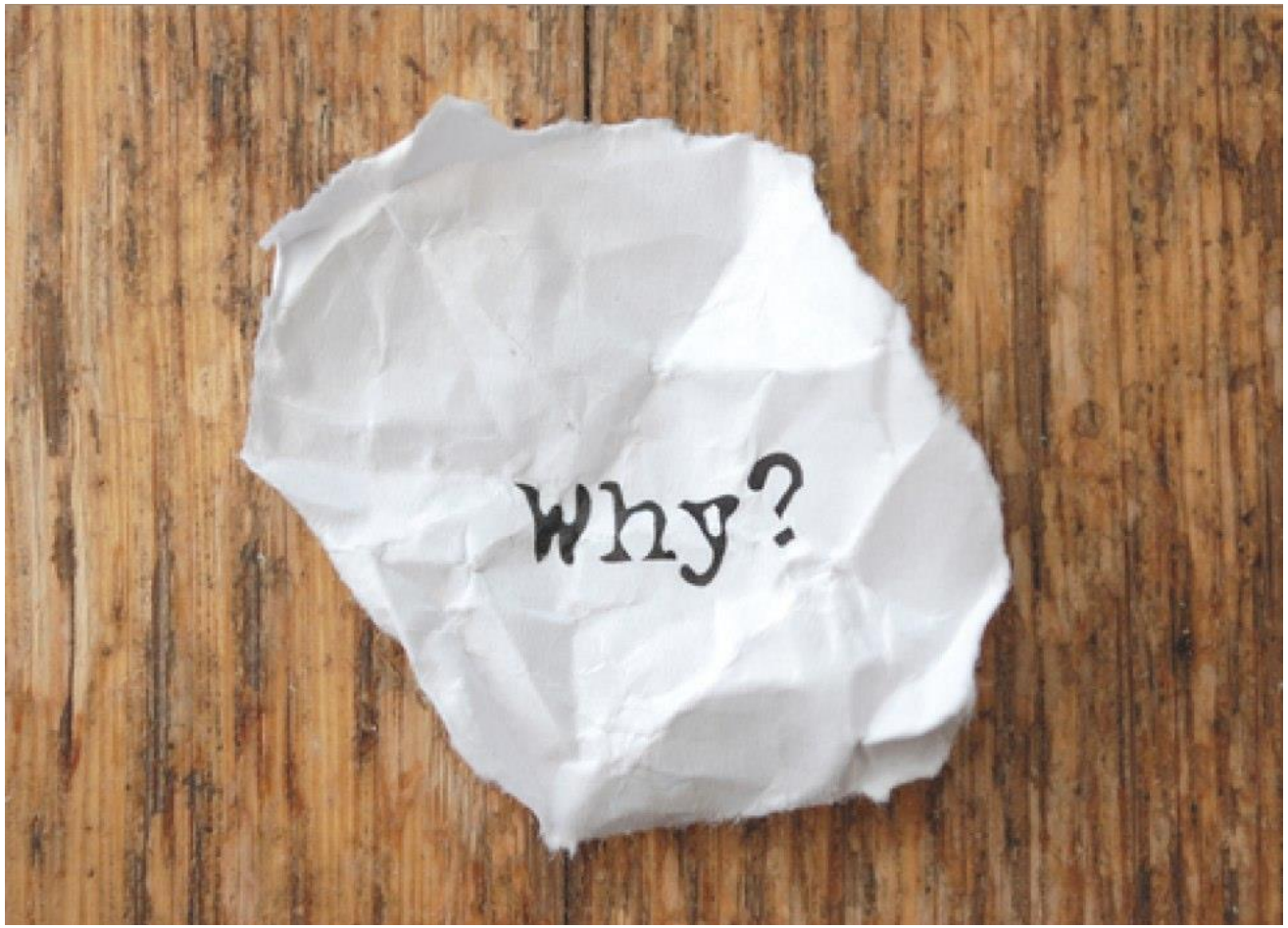
Our Shared Purpose



Patient harm in Canadian hospitals? It does happen.

Hospitals are generally safe, but sometimes harmful events happen that affect patients. Many of these events are preventable.

How often does it happen?

In 2014–2015,

1 in 18

hospital stays

in Canada involved at least 1 harmful event

(138,000 out of 2.5 million hospital stays).

Note
Data from Quebec as well as data for some mental health patients has been excluded.
Source
Discharge Abstract Database, 2014–2015, Canadian Institute for Health Information.

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CIHI ICIS
Canadian Institute for Health Information
Institut canadien d'information sur la santé

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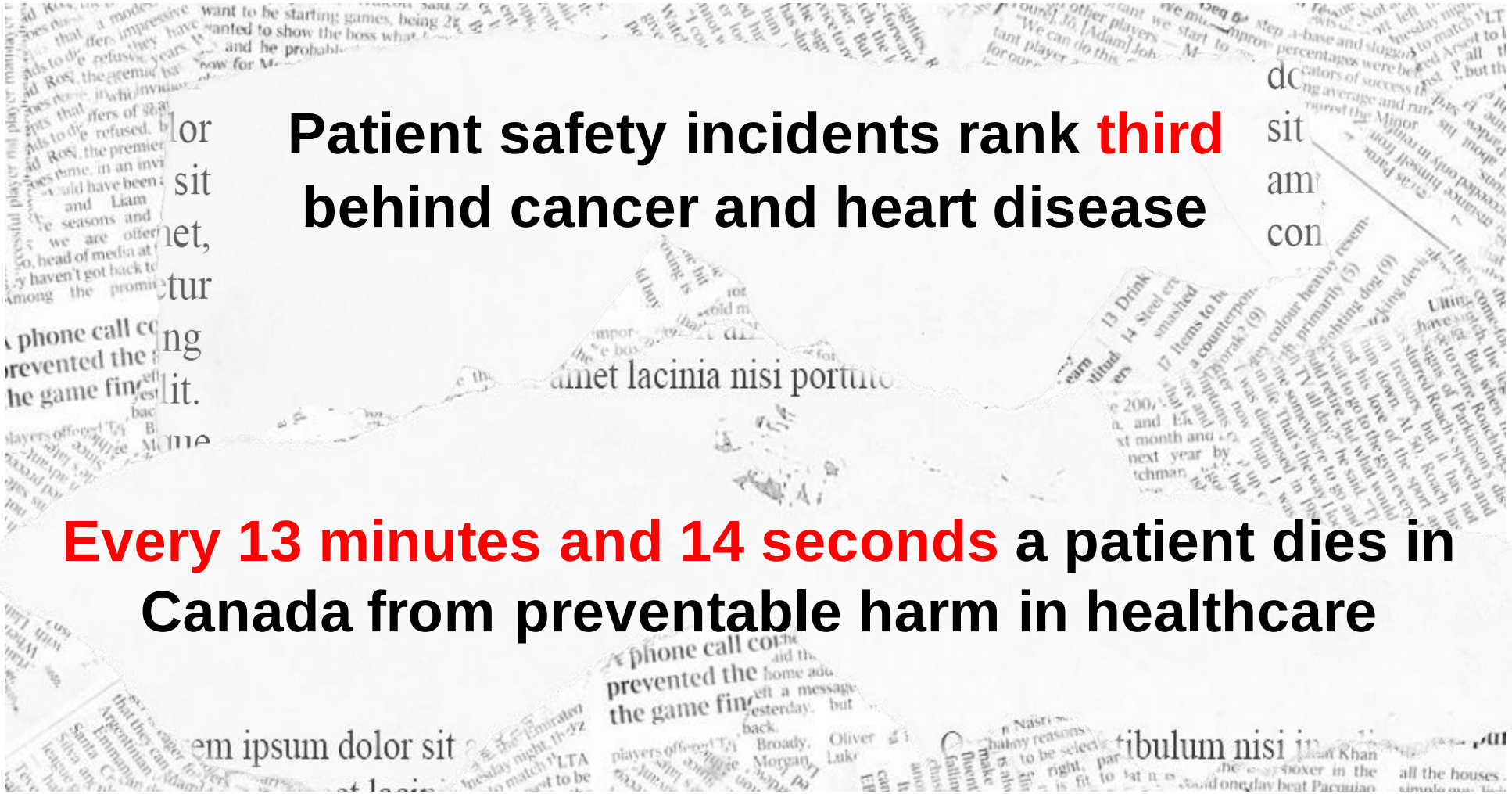

Our Shared Purpose

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Over the next 30 years in Canada:

- 12.1 million Canadians will be harmed by the healthcare system,
- 1.2 million Canadians will lose their lives to a patient safety incident,
- Within acute and home care settings, patient safety incidents will cost the health care system $82B (2017$).

RiskAnalytica. *The Case for Investing in Patient Safety in Canada.* August 2017.

Patients for Patient Safety Canada

Our Shared Purpose: CPSI's Strategy

Patient Safety RightNow

Our Vision of the Future

Vision Statement:
Canada has the safest healthcare in the world

CPSI's Role in Achieving the Vision

Mission Statement:
To inspire and advance a culture committed to sustained improvement for safer healthcare

How We Will Fulfill Our Role

Strategy:
Lead system strategies to ensure safe healthcare by demonstrating what works and strengthening commitment

Mechanisms to Execute the Strategy

Implement	*Evaluate*	*Share with Purpose*
Raise the Profile	*Transparency*	*Commitment*

Our Shared Purpose: CPSI's Strategy

Patient Safety RightNow

Strategic Key Elements

1 Demonstrate What Works
Support is needed for successful implementation of measurable, sustainable patient safety improvement, and initiatives need to be evaluated to demonstrate what works.

2 Strengthen Commitment
The evidence of what works needs to be translated into standard practices for practitioners and providers at all levels of the health system. These best practices can then be incorporated into a more robust system of commitment, responsibility and expectations for patient safety in Canada.

Lines of Business

Safety Improvement Projects – CPSI will work with committed partners to implement and evaluate measurable and sustainable safety improvement projects that align with pan Canadian priorities.

Policy Impact – CPSI will influence policy, standards and regulations so that they incorporate best patient safety evidence and practices.

Making Patient Safety a Priority – CPSI will use the patient voice in reporting, campaigns and media to make patient safety a higher priority across healthcare systems.

Alliances and Networks – CPSI will create and strengthen strategic alliances and networks with patients, governments, industry and other partners who are committed to making care safer.

Our Shared Purpose

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National Integrated Patient Safety Strategy

PATIENT SAFETY FORWARD WITH

National Integrated Patient Safety Strategy
CPSI will provide leadership on the establishment of a National Integrated Patient Safety Strategy

National Patient Safety Consortium
The consortium provides key partners in Canadian healthcare the opportunity to mobilize on common goals and actions, and report on progress to demonstrate system improvement in patient safety

Four Initial Areas of Focus
High risk areas that have a significant impact on quality, cost, and injury burden, and where consensus can be readily achieved

- Surgical Care Safety
- Medication Safety
- Home Care Safety
- Infection Prevention & Control
- Patient Safety Education

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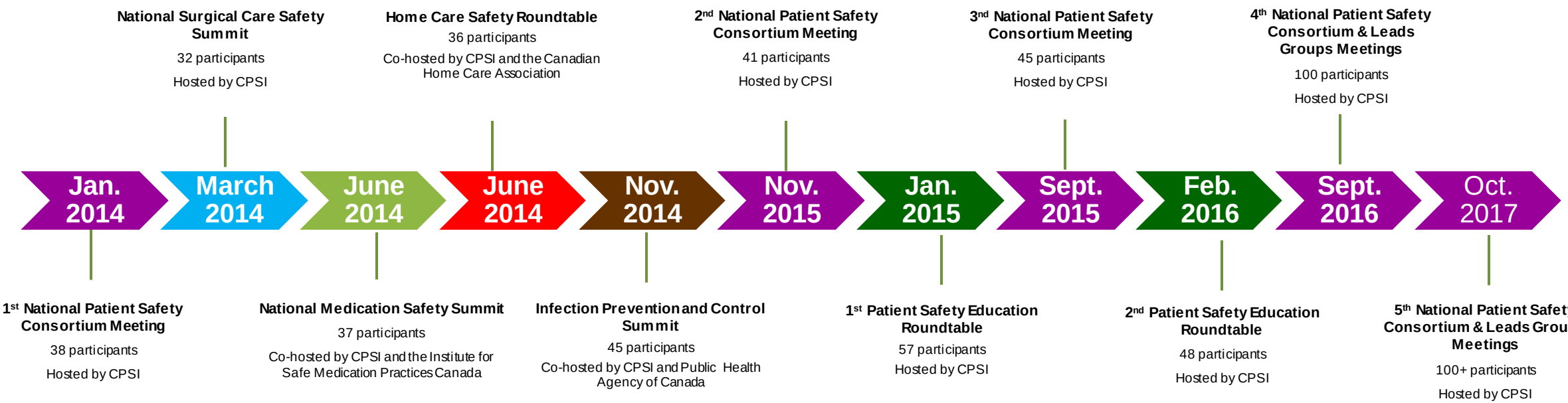
Integrated Patient Safety Action Plan Timeline

PATIENT SAFETY FORWARD WITH



"We must all work together and be vigilant in the safety and quality of health care we provide to all patients… I commend the Consortium's ongoing efforts for continuous improvement."

Hon. Jane Philpott, PC, MP, Minister of Health

Patient Safety RightNow

Integrated Patient Safety Action Plan

PATIENT SAFETY FORWARD WITH

Outcome:
Safer healthcare in Canada.

Our Shared Purpose

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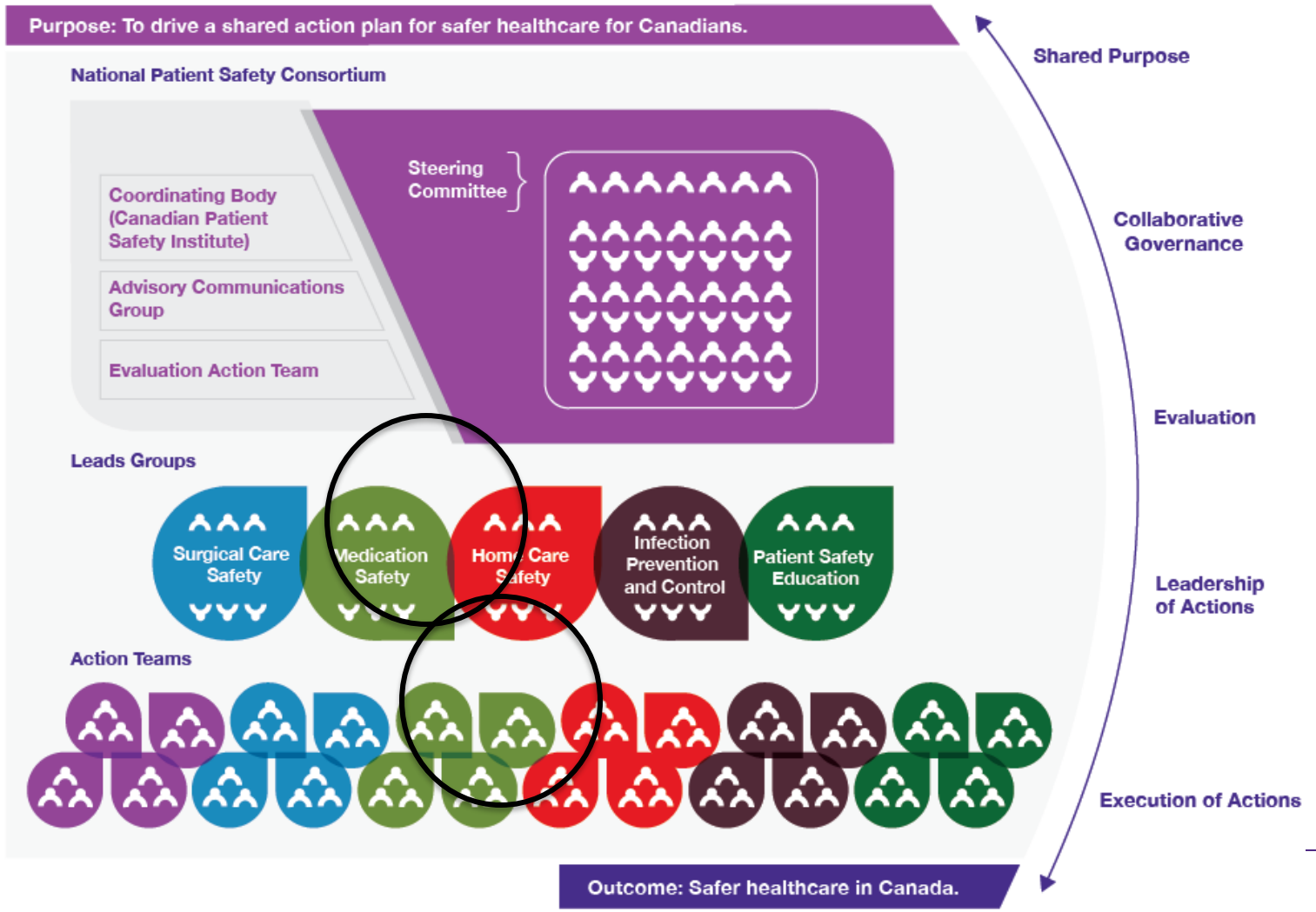
PATIENT SAFETY FORWARD WITH

STRUCTURE AND PROCESS TO SUPPORT THE INTEGRATED PATIENT SAFETY ACTION PLAN



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Integrated Patient Safety Action Plan: Guiding Principles

- Patients and families as partners
- Unprecedented collaboration
- Mobilization on common goals and actions
- Transparency of actions and results
- Accountability to patients, families, partner organizations, and stakeholders
- Commitment to improved quality of care
- Targeted and strategic communications
- Ongoing evaluation of the Integrated Patient Safety Action Plan

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Objectives:

- Share national and international efforts to improve Medication Safety, past to present.
- Share CPSI's new strategic direction as it relates to Medication Safety: Patient Safety Right Now

Medication Safety: A Global Priority

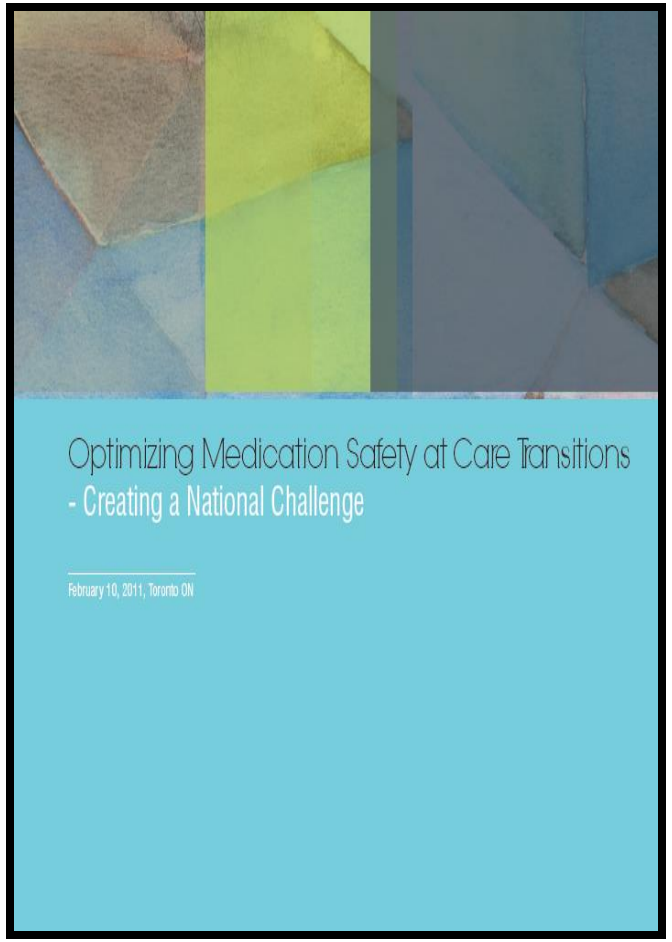
WHO Collaborating Centre for Patient Safety and Patient Engagement

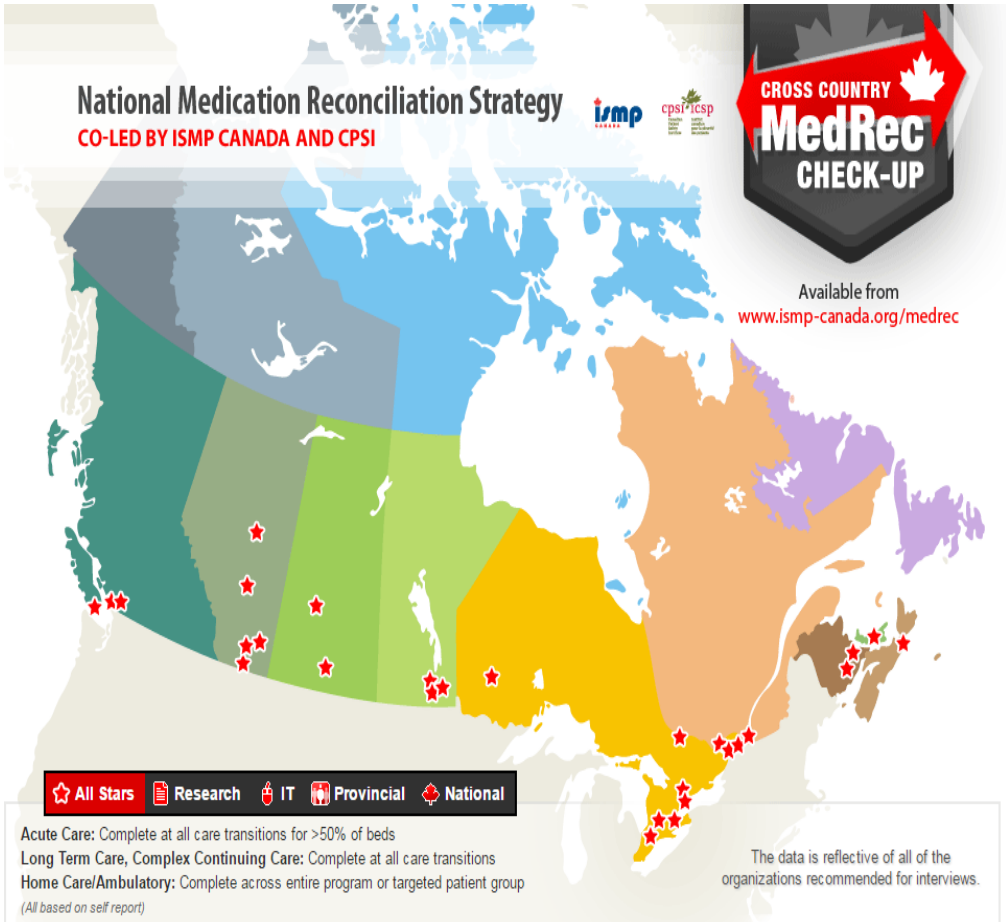
- Adverse drug events occur in **6.5-20%** of hospital patients
- Globally, medication errors cost **$42 billion USD** annually (WHO, 2017)
- More than half of Canadians are using prescription drugs at any given time
- More than **1 in 9** emergency department visits are due to drug related events

Medication Safety: Past Strategies

Patient Safety RightNow

safer healthcare now!





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Medication Safety: Integrated Plan of Action

Patient Safety RightNow

"We are not, as a country, doing enough to ensure the safe use of medications."

PATIENT SAFETY FORWARD WITH

Key Themes:

- Reporting, learning & sharing
- Evidence-informed practices
- Partnering with patients
- Technology

A MEDICATION SAFETY ACTION PLAN

"We are not, as a country, doing enough to ensure the safe use of medications."

Medicine, in all its forms, is the most common treatment in health care and it works miracles every day — when it's used appropriately. But when, as too often happens, a medication error is made, or a patient has a bad reaction to a treatment, the consequences can be terrible for individuals, their families and the health system.

In Toronto in June of 2014, 37 health-care leaders met at a national summit to talk about improving medication safety in Canada. The meeting began with Fervid's story, told by her daughter-in-law Johanna Trimble. It was a compelling reminder of the impact that medications can have and a moving foundation for this important day.

Definition:
Medication safety is freedom from preventable harm with medication use[1]

The summit, co-hosted by the Canadian Patient Safety Institute (CPSI) and the Institute for Safe Medication Practices Canada (ISMP Canada), is one of a series of meetings organized by CPSI as part of its 2013-2018 business plan to accelerate action on patient safety in Canada. The plan is for CPSI to act as a catalyst and secretariat for improving safety for patients through collaboration with other national organizations, multiple levels of government, patients, families, care providers and other stakeholders from across the country. Medication safety is one of the "Forward with Four" priority areas for this joint effort; the others are surgical safety, infection prevention and control, and home care.

Medications are everywhere in health care, and with them, there are almost limitless potential for adverse events. There is a long list of grim facts and statistics detailing drug-related problems: Baker and Norton's Canadian Adverse Events Study (2004) found drug or fluid-related events were the second most common type of adverse events in Canadian hospitals, accounting for 23.6 per cent of the total. A 2006 study found that more than one in nine emergency-department visits were due to drug related adverse events, and 68 per cent of them were preventable.[2] Close to 25 per cent of patients involved in a medication adverse event died or suffered some other catastrophic event, according to the Canadian Medical Protective Association.

Those details come from a scan of evidence on medication safety we did to prepare for the summit. It was distributed to people who were planning to attend, who were also asked to fill out a brief survey. The survey asked what their organization thought the top three concerns or gaps were in medication safety, its top three priorities for it, and what it believed patients and families would identify as their top three concerns. Finally participants were asked "what key components, activities or mechanisms would be most important to you and your organization to include in the action plan?"

Answers ranged from calls to coordinate all the activities listed in the scan, to improving medication reconciliation processes, to advancing the use of digital tools to improve medication safety. At the meeting the ideas raised in the survey were talked about and voted on until five emerged as themes for discussion in the "world café". They were:

- Reporting, learning and sharing
- Evidence-informed practices
- Partnering with patients, families and the public
- Education
- Technology

A world café is a meeting model used to stimulate creative thinking in large groups. At the medication safety meeting, participants rotated among five "world café" tables for 20 minutes at a time to discuss a total of three themes each. Here's some of what they had to say:

[1] ISMP Canada, 2007, available from: http://www.ismp-canada.org/definitions.htm

[2] Zed, P. et al. Incidence, severity and preventability of medication-related visits to the emergency depart: a prospective study, CMAJ. 2008 June 3;178(12) 1563-9.

2

Medication Safety: Action and Results

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Collective Action:

- Multiple lead/co-leads
- Multiple partners

A Bold New Direction

Patient Safety RightNow

Our Vision of the Future

Vision Statement:
Canada has the safest healthcare in the world

CPSI's Role in Achieving the Vision

Mission Statement:
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How We Will Fulfill Our Role

Strategy:
Lead system strategies to ensure safe healthcare by demonstrating what works and strengthening commitment

Mechanisms to Execute the Strategy

Implement	*Evaluate*	*Share with Purpose*
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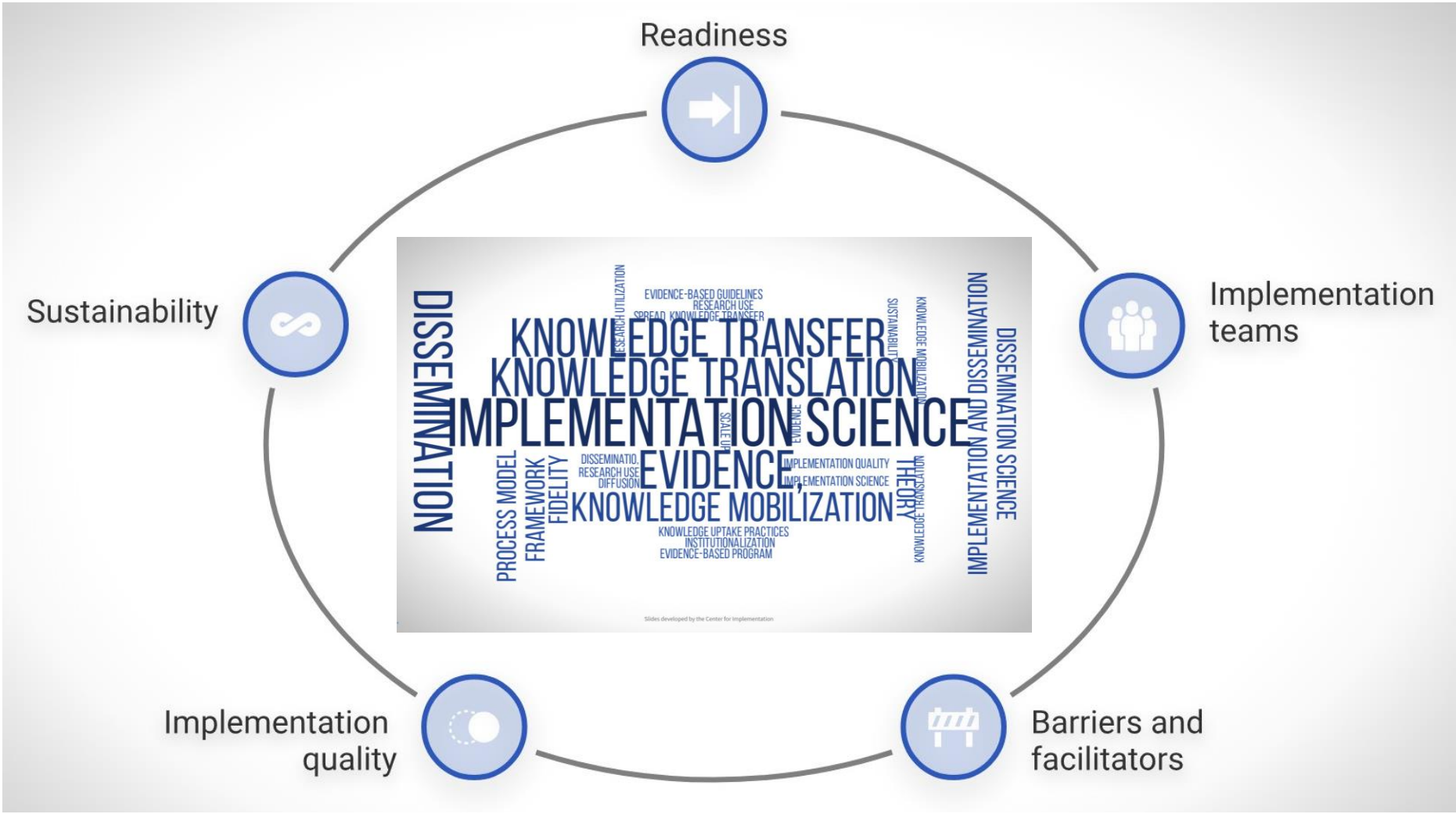
Demonstrating What Works: QI/KTIS Integration

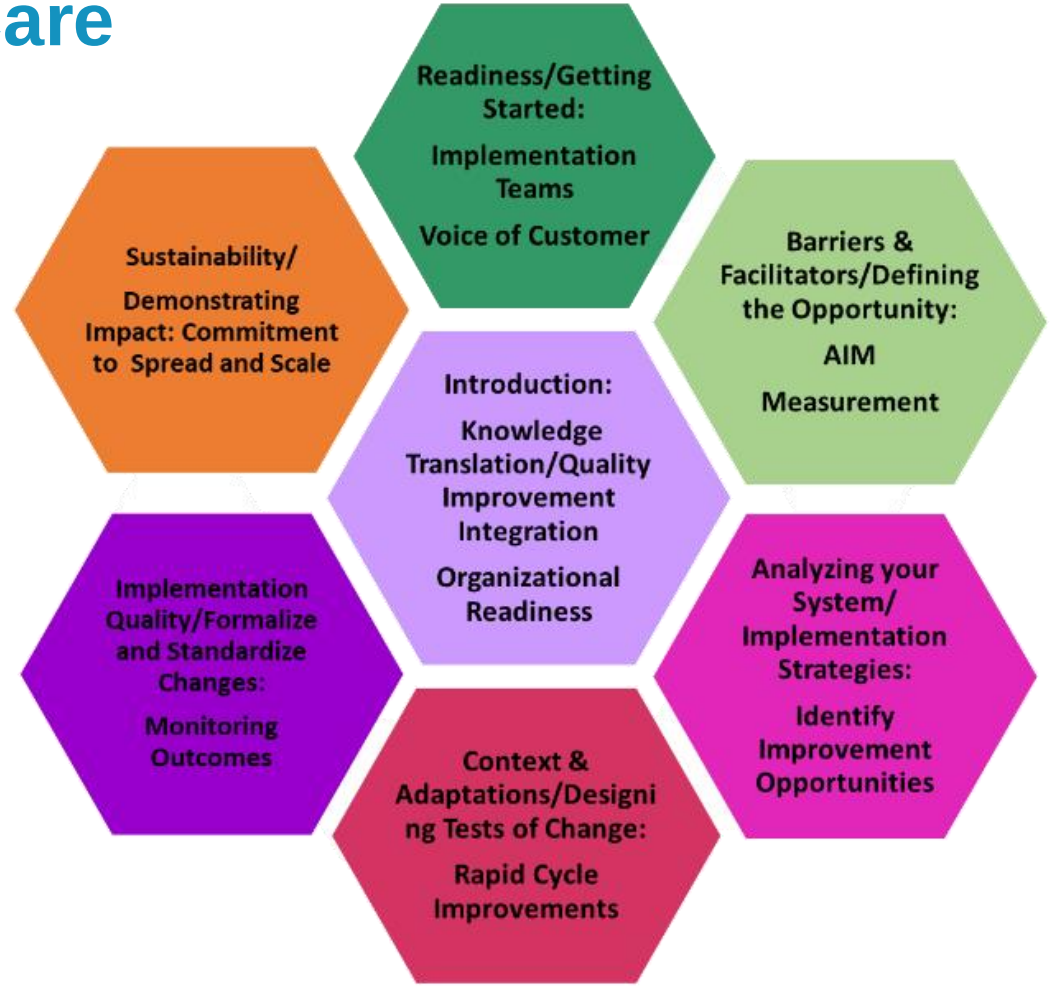
Patient Safety RightNow



Medication Safety at Transitions of Care Safety Improvement Project

Ultimate Goal:

To improve medication safety at transitions of care in vulnerable populations, using quality improvement, knowledge translation and implementation science approaches and techniques.



Policy Advocacy: Medication Safety

PARLIAMENT *of* CANADA

Government of Canada

- Patients on the Hill
- Vanessa's Law (Protecting Canadians from Unsafe Drugs Acts)
- Plain Label Packaging (Legislative amendment to strengthen post-market therapeutic product regulation)
- National Pharmacare Strategy
- Combined commitment to act by governments and health organizations

A Priority for Patients and for the Public

WHO Collaborating Centre for
Patient Safety and Patient Engagement

http://www.patientsafetyinstitute.ca/en/NewsAlerts/News/Pages/Medication-Without-Harm-2018-09-14.aspx

Maryanne D'Arpino

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Patients for Patient Safety Canada

- The patient-led program of the Canadian Patient Safety Institute
- The Canadian arm of the World Health Organization's Patients for Patient Safety Programme

www.patientsforpatientsafety.ca

The ‘So What’ for Patients & Families

Patient Safety RightNow

The Pledge:

In honour of those who have died, those who have been left disabled, our loved ones today, we will strive for excellence, so that all people receiving healthcare are as safe as possible, as soon as possible.

Aim:

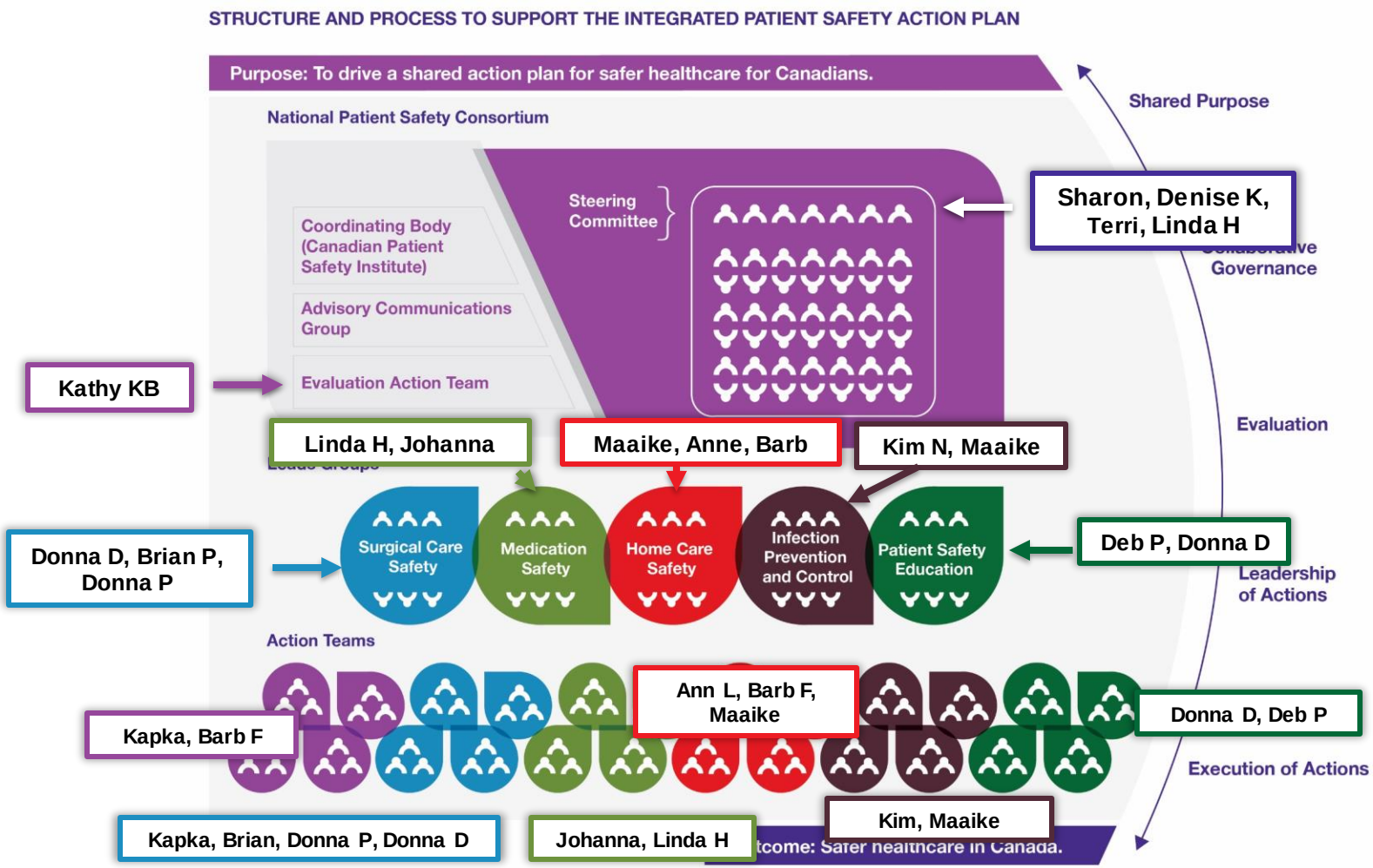
Every time our stories are shared, every time one person takes something from them, we make it a little better, a little safer for those who come behind us.

The ‘So What’ for Patients & Families

Patient Safety RightNow

The 'So What' for Patients & Families

Patient Safety RightNow



The 'So What' for Patients & Families

Patient Safety RightNow

"they [patients] really inspired me to keep working on this because I heard their stories and just hearing some of the challenges that they faced when she brought the checklist to the doctor and the pharmacist both said I don't have time to talk to you about this right now and it just made me realize how important this is because we have to get the healthcare providers on board to answer these questions, **but it really gave me more energy just speaking with them….they were inspiring to work with and I really found that gave me the cause."**

- **Action Team Member**

@Patient_Safety
#SafeCareAction

The 'So What' for Patients & Families

Evaluation Action Team

Health Canada Santé Canada

CADTH ACMTS

CAPHC
CANADIAN ASSOCIATION OF PAEDIATRIC HEALTH CENTRES
ASSOCIATION CANADIENNE DES CENTRES DE SANTÉ PÉDIATRIQUES

CANADIAN NURSES ASSOCIATION

Canada Health Infoway
Inforoute Santé du Canada

ACEN ACDSI

HIROC

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Alberta Health

HQCA
Health Quality Council of Alberta

CASN ACESI
Canadian Association of Schools of Nursing
Association canadienne des écoles de sciences infirmières

CMPA
Empowering better healthcare

THE COLLEGE OF FAMILY PHYSICIANS OF CANADA | LE COLLÈGE DES MÉDECINS DE FAMILLE DU CANADA

ismp CANADA

Mental Health Commission of Canada
Commission de la santé mentale du Canada

Ontario
Health Quality Ontario

ROYAL COLLEGE
OF PHYSICIANS AND SURGEONS OF CANADA

CANADIAN PHARMACISTS ASSOCIATION
ASSOCIATION DES PHARMACIENS DU CANADA

New Brunswick Health Council | Conseil de la santé du Nouveau-Brunswick

Collective Impact Evaluation

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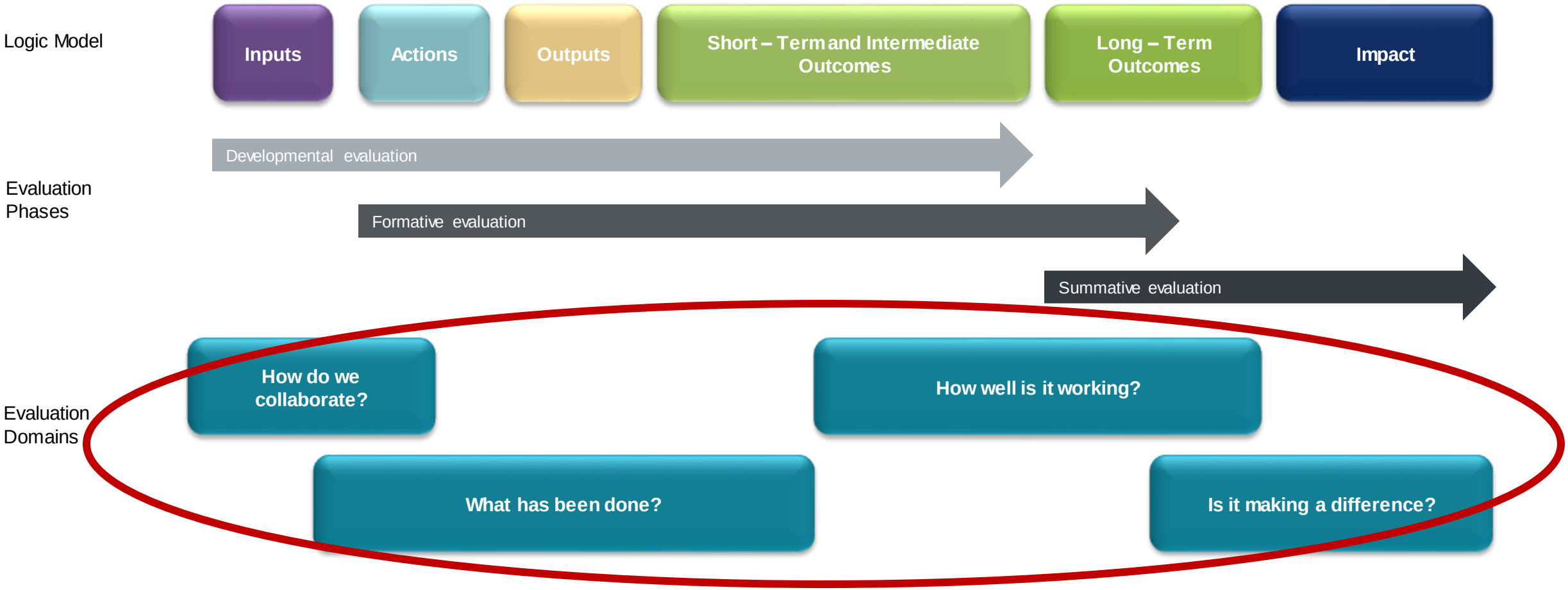
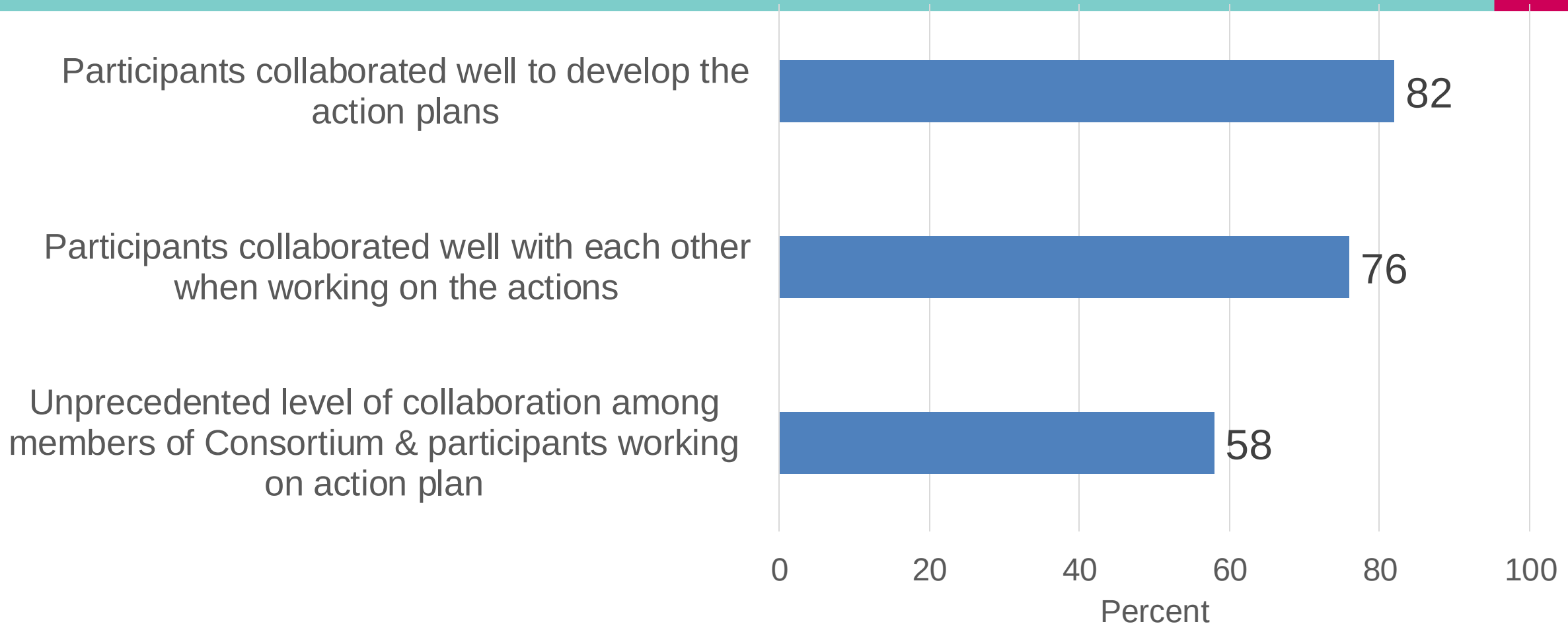


Adapted from Guide to Evaluating Collective Impact: https://www.fsg.org/publications/guide-evaluating-collective-impact

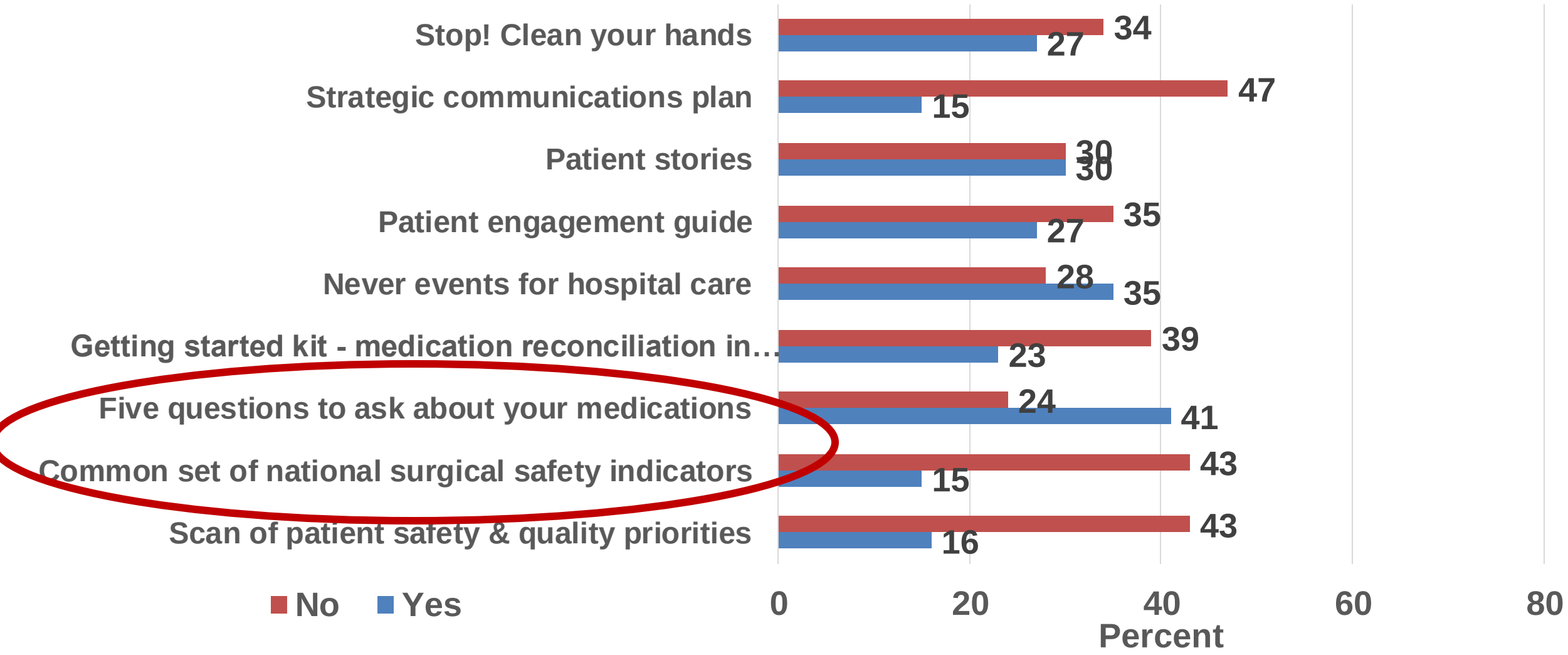
Survey Results: Consortium Partners and Leads Groups



(Rating scale 1 to 10)

N=50

Survey Results: Have Used Outputs



Medication Safety

"as we move forward…include the patient…sometimes it gets forgotten… we have to include the patient voice"
(Leads Group Member)

Key Insights

- Collaboration
  - Essential for collective impact
- Leadership and infrastructure
- Early and ongoing engagement
  - Patients and families, providers, leaders, policy makers
- Culture and behaviour change
- Ongoing and open communication
  - Builds trust and momentum
- Persistence
  - System-level transformation is challenging – but worth the effort

Kathy Kovacs Burns

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Questions and Discussion

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Thank you!

Patient Safety RightNow

Thank you for welcoming us to the 2019 CADTH Symposium

Contact us:
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