

Canadian Association of Paediatric Health
Centres (CAPHC)

**Multi-Stakeholder National Patient
Safety Workshop**

**Fairmont Queen Elizabeth Hotel
November 7, 2004
Montreal, Quebec**

Final Workshop Proceedings Paper

Executive Summary

Background:

In December 2003, the Canadian Patient Safety Institute announced it would take a lead role in national patient safety issues. Its mandate is to build and advance a safer health system for all Canadians. CAPHC strongly supports this commitment and mandate and is working toward ensuring child and youth health issues are integrated into the work of the new Institute.

A one day workshop in conjunction with CAPHC's annual meeting was held in Montreal, November 7, 2004. Key stakeholders from across the country met to address important patient safety issues and to develop recommendations for CAPHC's Patient Safety Coalition's consideration. These recommendations will help insure the inclusion of child and youth issues in the national initiative and will help establish priorities for the Coalition.

Objectives of the Patient Safety Workshop:

- Introduce workshop participants to the Canadian Patient Safety Institute (CPSI) and the Institute's plans for its first year of operation;
- Discuss the challenges facing the Canadian health care system;
- Consider the role of Child and Youth Health Centres in addressing and contributing to patient safety;
- Increase awareness and understanding of the Canadian Medication Incident Reporting and Prevention System (CMIRPS) and how it has evolved as an independent, multi-disciplinary initiative closely aligned with the objectives of the Canadian Patient Safety Institute;
- Review the results of CAPHC's National Survey of Patient Safety Practices in Child and Youth health Centres and related organizations across Canada and
- Initiate the development of a National Patient Safety Research Agenda.

Workshop Proceedings:

To ensure broad dissemination and subsequent feedback from stakeholders nation-wide, CAPHC agreed to:

- Produce a comprehensive proceedings document that summarizes the workshop content and recommendations
- Disseminate the workshop proceedings through our Association's multi-disciplinary child health network and the CAPHC Patient Safety list serve.

About the Canadian Association of Paediatric Health Centres (CAPHC):

Established in 1968 as the Canadian Association of Paediatric Hospitals, CAPHC is a national, not-for-profit, organization whose members are multidisciplinary health professionals that provide health services for children, youth, and families within community, regional and tertiary healthcare facilities, rehabilitation centres and home care provider agencies nationwide. CAPHC is affiliated with all sixteen academic health sciences centres in Canada, providing linkages to clinical care, education, and research.

CAPHC is committed to developing a firm understanding of emerging and evolving needs of child and youth health centres and their communities, recognizing child and youth health priorities, promoting collaborative opportunities and networks and facilitating national research strategies within priority areas. In addition, CAPHC is committed to enhancing the application of knowledge from research to practice, practice to health policy, to the development and promotion of evidence-based clinical practice guidelines for all children and youth.

Supporting Information:

Attached to this report are the following:

- Agenda of the Multi-Stakeholder National Patient Safety Workshop held on November 7, 2004
- Key Note speaker and presentations from the workshop

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Acknowledgement:

These proceedings summarize the recommendations and consensus generated during the Multi-Stakeholder National Patient Safety workshop held on November 7, 2004 in conjunction with CAPHC's 2004 annual meeting, at the Montreal Fairmont Queen Elizabeth Hotel. The strength and positive outcomes of the workshop are the result of committed partnerships between the Canadian Association of Paediatric Health Centres, Health Canada, and MEDBUY Corporation.

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I. Introduction – Objectives and Context

As a result of the consultative process that was initiated between Health Canada and members of CAPHC during the one-day workshop held in Calgary, Alberta in conjunction with CAPHC's 2003 Annual meeting, CAPHC has been working throughout the past year to facilitate collaboration amongst CAPHC's members, Federal Agencies and Health Organizations to address current and emerging patient safety issues specific to child and youth health.

The 2004 Multi-Stakeholder National Patient Safety Workshop was designed to build on the initial 2003 workshop and provide further specific directions and recommendations for CAPHC in its work, on behalf of its members, to improve the safety of child and youth health. The workshop engaged multi-disciplinary child and youth health professionals and health policy experts from across Canada with several objectives including:

- Raise awareness and understanding of the role of key stakeholders in patient safety, including Marketed Health Products Directorate of Health Canada, Canadian Patient Safety Institute, and the Canadian Coalition on Medication Incident Reporting and Prevention Systems (CCMIRPS);
- Present and discuss the results of CAPHC's National Survey of Patient Safety Practice in Child and Youth Health Centres and related organizations across Canada;
- Develop recommendations for a National Patient Safety Agenda within the paediatric health care system.

II. Setting the Context: Expert Speakers

To set the context for the day, several expert speakers were called on to share information with the participants of the workshop. Workshop speakers included:

- Dr. John Wade, *Chair, Canadian Patient Safety Institute (Keynote speaker)*
Building a Safer System Together: The Role of the Canadian Patient Safety Institute
- Mr. Bill Leslie, *Marketed Health Products Directorate, Health Canada*
Canadian Medication Incident Reporting and Prevention System: A Program to Reduce Harm

- Ms. Margaret Zimmerman, *Marketed Health Products Directorate, Health Canada*
Bridging the Gaps and Making the Connections
- Dr. Anne Matlow, *Associate Professor, Department of Paediatrics, University of Toronto, The Hospital for Sick Children; Chair, Hospital Quality Management Committee Association*
CAPHC National Survey on Patient Safety– Identifying Current Patient Safety Practices within Canadian Child and Youth Health Centres

An overview of their comments is provided below. All workshop power point presentations and an electronic copy of the workshop proceedings paper are posted on the CAPHC website www.cahpc.org.

Dr. John Wade, Keynote Speaker

Building a Safer System Together: The Role of the Canadian Patient Safety Institute

Dr. Wade reviewed the role of the Canadian Patient Safety Institute (CPSI) and its focus on building a safer healthcare system through the minimization of adverse events. Through understanding what adverse events are, looking at what we already know through research, and developing strategies to begin to address the issues of patient safety, we will all be able to reduce the occurrence of adverse events within the paediatric health care system.

Patient safety is the reduction and mitigation of unsafe acts within the health-care system and the use of best/smart practices shown to lead to optimal patient outcomes. An adverse event is an unintended injury or complication is caused by health care management which results in disability, death or prolonged hospital stay. That is, adverse events are usually systemic, and not an underlying cause of the disease itself.

According to Dr. Wade, in order to effectively address adverse events and the direct and indirect factors which contribute to their occurrence, further research is needed, both within hospitals and community care settings. The Baker/Norton study (2004) identified additional priorities including the need for leadership to encourage reporting, continued monitoring of incidents, application of new technologies, improved communications and coordination and methods to monitor continuous improvements.

The Canadian Patient Safety Institute (CPSI) has a multi-disciplinary team of health care professional working towards providing national leadership in building and advancing a safer Canadian health system. CPSI is a separate legal entity which is an arm's length government body.

It reports to the Canadian public and looks to influence change and enhance the health system through partnerships with a variety of stakeholders including government, accreditation and education bodies.

Define Patient Safety Issues:

CPSI held provincial and territorial consultation workshops for feedback on the strategic business plan, to learn about local patient safety issues and initiatives, and to obtain feedback on priorities for CPSI. From the consultation process, a national storehouse of patient safety information was recommended; this will begin with an environmental scan and identification of patient safety indicators.

Champion Change:

CPSI will champion change for the health system. Through supporting innovation and technology, developing legislative models to help overcome some of the barriers in addressing patient safety issues such as changes to the Evidence Act and increasing public awareness of the issues, CPSI can begin to make a national difference in patient safety issues which face our health system.

CPSI is working towards creating networks of stakeholder advisory committees, focusing on education and professional development, health system innovation, legal and regulatory issues, research and evaluation and information and communication issues. However, there are still barriers and challenges which the Institute must overcome to ensure the system of change is inclusive, reflective of many disciplines and diverse backgrounds and build on expertise and capacities already established. CAPHC's National Patient Safety Collaborative which represents the majority of children's hospital across the country, has offered their hand in partnership with CPSI as a stakeholder advisory committee for child and youth health care.

Mr. Bill Leslie

Canadian Medication Incident Reporting and Prevention System: A Program to Reduce Harm

Bill Leslie introduced the work the Canadian Coalition on Medication Incident Reporting and Prevention (CCMIRP). CCMIRP partners with the Canadian Patient Safety Institute (CPSI) around preventable medication incidents which may cause adverse and unintentional effects.

Adverse events have significant human and financial costs. According to a Canadian 2003 study, it is estimated that the cost of preventable drug related morbidity in older adults is just under \$11 Billion per year. In 2000, it was estimated that between 9,000 and 24,000 patients experienced preventable adverse events and later died.

Adverse events in health care settings are a multi-jurisdiction and multi-mandate problem. No *one* person or group owns the problem; only by working together, can we hope to reduce the number of patients who experience adverse events both within institutions and in the community and to ensure that Canadians are receiving quality, safe care.

CCMIRP is a coalition of health care organizations working towards overseeing the development and implementation of medication incident reporting and prevention systems in Canada. The coalition is working towards 5 major activities:

- collection and analysis of standardized medication incident data;
- facilitation of voluntary reporting of medication incidents;
- dissemination of timely and targeted information designed to reduce risk of medication incidents
- development and dissemination of information on best practices in safe medication use
- leadership of efforts to meet the defined goals

Building on strengths and capacities already in place, CCMIRP has been able to make significant strides in attaining their overall goal of reducing the significant human and financial costs of medication incidents via collaborative efforts among industry, regulators, practitioners and the patient. CCMIRP and CAPHC will continue to explore partnership opportunities based on the recommendations of the workshop.

Margaret Zimmerman **Bridging the Gaps and Making the Connections**

Margaret Zimmerman provided an overview of the work done of Health Canada on adverse drug reactions and children . Working in conjunction with Canadian Adverse Drug Reaction Monitoring Program (CADRMP) and CPSI, they hope to bridge the gaps in understanding the scope of serious and life-threatening paediatric adverse drug reactions.

Ms. Zimmerman defined a serious and life-threatening Adverse Drug Reaction (ADR) as a noxious and unintended response to a drug, at any dose, and requires in-patient hospitalization or prolongation of existing hospitalization. It might also cause congenital malformation, result in significant disability or incapacity, be life-threatening or result in death.

It is estimated that of the reported ADR's, approximately 6% were paediatric in nature. However, there is a lack of meaningful information which focuses on the needs of child and youth health. This is a major barrier for institutions to learn from previous ADR and prevent future occurrences.

Yet, despite the lack of reliable data on incidence of ADR's in children, we know it is an important cause of morbidity and mortality. Children are often not included in pre-market clinical trials and may be at increased risk for unique adverse drug reactions or an increased frequency of reactions comparative to the general population.

Although the majority of Canadian paediatric health care settings have established mechanisms for staff to report ADR's, communication between Centres is needed in order to collect and share data and to learn from and support each other. Frontline insight and experience and open dialogue about practical ways to work together to encourage sharing of data for learning and prevention.

A strong credible voice for paediatric patient safety is being built through CAPHC. We need to use that voice to build and support a mechanism of sharing data, so we can learn from each other and raise the profile of paediatric issues.

Dr. Anne Matlow

CAPHC National Survey on Patient Safety – “Identifying Current Patient Safety Practices within Canadian Child and Youth Health Centres

Dr. Anne Matlow presented the findings of the 2004 CAPHC National Survey Patient Safety Practices within Canadian Child and Youth Health Centres. The purpose of the study was to identify current patient safety practices and resources at paediatric health centres/organizations across Canada and to identify national patient safety priorities for children and youth. These priorities will be used to establish CAPHC's future direction and research focus in the area of patient safety.

Dr. Matlow described the methodology and content of the survey. The survey questions were divided into eight categories:

- Strategies to reduce hazards and improve healthcare safety
- Extent of data collection on adverse events (A/E)
- Method of data collection, considering level of automation
- Strategies for reporting and managing A/Es etc
- Mechanisms in place to try to prevent recurrence of A/Es
- Healthcare safety issues of concern
- Current policies associated with A/Es and adverse drug reactions
- Resources – access to information sharing

Several themes emerged from the results of the survey. These themes include:

- The need for automation and the use of technology
- The need for increased communication
- Building patient safety culture within institutions based on sharing and caring and not shame and blame
- Education
- Sharing of resources (knowledge brokering) and access to information

Ninety-two percent of respondents indicated there is a need for more national initiatives to improve child and youth healthcare safety. In support of its members, CAPHC hopes to build further initiatives aimed at bridging these gaps and addressing current and emerging issues for paediatric patient safety.

III. Looking Ahead – Recommendations for a National Child and Youth Patient Safety Agenda

The workshop lead to rich discussion around child and youth patient safety priorities and how CAPHC can contribute to help address these issues. The group discussed long and short-term goals with a national focus on patient safety issues for CAPHC.

The goals, priorities and recommendations for CAPHC to move forward on are provided in detail below.

1. Priorities of the Participants

Participants at the workshop identified the following key priorities:

- Develop supportive practices and systems for health care providers. Change organizational culture of *shame and blame* when adverse events occur, to one which is more reflective of *caring and sharing*.
- Develop standards around practice and procedure.
- Address Human Resource issues such as work fatigue, staff training and levels of expertise during all shifts. There is a need for further research in this area and to begin to address staff needs through creative approaches and designs.
- Address patient safety issues at all levels and areas of health care, including community level care. This gap can be addressed by studying models such as the Regional Health Authorities (for example the Manitoba and Saskatchewan Authorities).

- Collaborate with specific specialties that are already working in addressing patient safety issues. Obstetrics is a key example where simulations are commonly used as a component of practice. These simulations can involve professionals, managers and Ministries.
- Utilize technology and electronic communication systems for record-keeping so that information moves with patients through the system of care.
- Develop tools that help to identify an institution's patient safety culture and the barriers that are faced in increasing their capacity. Assessing an organization's readiness to address patient safety issues effectively will aid in determining strategies, foster interdisciplinary review and staff participation, as well as, identify the role of governance within health care centres.
- Create a business case for the use of Information Technology in addressing patient safety issues that would outline forceful and pertinent strategies to improve patient safety.
- Challenge the legal and legislative issues regarding reporting adverse events and the legal implications.
- Conduct research and evaluation to develop baselines that are specific for paediatrics.

2. Recommendations for Review

Several ideas and recommendations emerged from the discussion for CAPHC to consider for building a national agenda:

1. Support and advocate for broad child and youth patient safety issues.
2. Act as a clearinghouse and coordinator for child and youth patient safety issues.
3. Develop an IT Business Plan to advocate for improved data and record management and a consistent and/or standard approach to record management. A national incident reporting system and computer order entry were recommended as areas of initial focus. *Please see below for further details.*
4. Develop a "toolbox" of patient safety tools. *Please see below for further details.*
5. Take the lead on the development and implementation of a Patient Safety Culture tool in CAPHC member health centres.

6. Develop and validate paediatric trigger tools that can be made available for all Paediatric Health Centres across Canada.
7. Take the lead on research establishing baselines for paediatrics in a Baker/Norton-type study.
8. Establish a champion for patient safety and risk management issues.
9. Support and promote the increased use of simulations and explore the role of the private sector in these simulations.

3. Implementation of Ideas

Participants took the opportunity to expand on two key recommendations: Patient Safety Tool Box and the Use of Technology. General implementation ideas were provided to CAPHC and are summarized below:

a) Patient Safety Toolbox

A recommendation of the workshop was for CAPHC to take the lead in developing a National Patient Safety toolbox for all child and youth health centres toolbox.

Using the Quality Improvement toolbox as a model, the CAPHC Patient Safety Toolbox could look at a broad range of issues that health care professionals, organizations and hospitals face when dealing with patient safety issues specific to children and youth.

Suggested Tool	Who is/can work in this area?
• Patient Safety Culture Assessment Tool	CAPHC
• Program examples of what enhances positive patient safety culture and how to encourage multi-disciplinary review	Examples such as IWK's Morbidity or Mortality Occurrence Teams (MOM) can be adapted and utilized
• Canadian Paediatric Surveillance Program (CPSP)/GATC Tool	Margaret Zimmerman – Health Canada
• Sharing best/smart practices, policies and procedures which encourage information sharing - Scripts for professionals and staff to talk with families	CAPHC

<ul style="list-style-type: none"> • Safety Analysis Tool <ul style="list-style-type: none"> - Paediatric Tool Development - Root Cause Analysis Tool - Building Critical Pathways: Assessing patient safety culture and gap analysis 	National collaboration with CAPHC members, Health Canada, CIHR, CPSI, CCMIRP etc
<ul style="list-style-type: none"> • Collection of policies across Canada regarding patient safety <ul style="list-style-type: none"> - Disclosure policies - How families receive information and are able to communicate with health centres - How front line staff are supported after adverse events - Roles of key individuals e.g. medical leader 	CAPHC
<ul style="list-style-type: none"> • Systems Analysis of Adverse Events (Contributing Factors) 	Examples such as the Winnipeg model (contact Dr. G. Cronin) could be adapted to a national level
<ul style="list-style-type: none"> • Indicators for transfer <ul style="list-style-type: none"> - When to transfer patients to increase specialty when critical mass is too low 	Toronto (contact Moira Johnson)
<ul style="list-style-type: none"> • Risk Assessment tools for organizations 	Examples such as Winnipeg RHA which could be adapted to paediatrics
<ul style="list-style-type: none"> • Addressing insurance issues (i.e. CMPA) 	Examples to be shared from health centres (for example: Hamilton in Ontario Saskatoon in Saskatchewan)

b) The Use of Technology as a Means to Address Patient Safety Issues

A great deal of the workshop discussion focused on the need for automated reporting and consistent record-keeping systems as a method to track and reduce the number of adverse events. This initiative would promote and enable enhanced communication between organizations and institutions. However, the cost of initial set-up, system maintenance and insurance rates, as well as software compatibility, are several barriers organizations face in implementation.

Automated Incident Reporting systems, computerized order entry and funding issues were concerns for all participants. Through automated reporting systems, we could determine where the issues for children and youth are and begin to address these issues.

Volunteers agreed to form a CAPHC *I.T. Working Group* to look at implementing and lobbying for the need for an adverse event automated reporting system in health care centres across Canada. Some participants whose organizations already have the software in place agreed to establish a working group to develop a business plan. The working group includes: Sue Richardson, Donna Wrightson and Kim Streintenberger.

IV. Summary

The 2004 Multi-Stakeholder National Patient Safety Workshop was designed to build on the recommendations of the 2003 Patient Safety workshop and provide recommendations for a National Child and Youth Patient Safety Agenda. The primary objectives of the workshop were:

- To discuss the results of the National Survey of Patient Safety Practice in Child and Youth Health Centres and related organizations across Canada
- To develop recommendations for CAPHC and partners for a National Patient Safety Agenda

Common goals and priorities were discussed and ideas for CAPHC's Patient Safety Research Agenda were generated as outlined in these proceedings. The primary outcomes of the day included:

- Presentation of CAPHC National Survey of Patient Safety Practice in Child and Youth Health Centres and related organizations in Canada.
- Established multi-disciplinary, collaborative priorities for child and youth healthcare safety issues in Canada
- Recommendations for CAPHC's Child and Youth Patient Safety research agenda.
- Formation of an IT Working Group to develop a business plan for the use of technology in reporting and recording adverse events.

Final Comments:

All objectives of the CAPHC Multi-Stakeholder National Patient Safety Workshop were achieved because of the leadership and participation of all delegates. CAPHC is committed to building a National Patient Safety Agenda for all Child and Youth Health Centres across the country and is committed to working with all members and partners to achieve these goals.

In the coming months, in collaboration with members and partners, we will begin to address and implement many of the recommendations. Feedback will be provided on an on-going basis through the CAPHC website, Patient Safety Collaborative and the National Office. Patient safety will remain a priority and therefore, a focus of CAPHC's 2005 Annual Meeting to be held October 16-19 in St. John's Newfoundland.

CAPHC Multi-Stakeholder National Patient Safety Workshop

Sunday November 7, 2004

8:00am – 12:30pm

Mackenzie Room, Fairmont Queen Elizabeth Hotel

Montreal, Quebec

AGENDA

- 7:00 – 8:00 Registration and Continental Breakfast
- 8:00 – 8:15 Welcome and Opening Remarks
Ms. Michele Lahey,
*Chair, CAPHC National Patient Safety Collaborative
Chief Operating Officer, Capital Health's University of Alberta
Hospital and Stollery Children's Hospital*
- 8:15 – 9:00 Key Note Address
Dr. John Wade
Chair, Canadian Patient Safety Institute
- 9:00 – 9:45 The Canadian Medication Incident Reporting and Prevention System
*Mr. Bill Leslie
Marketed Health Products Directorate, Health Canada*
- Bridging the Gaps and Making Connections
*Ms. Margaret
Marketed Health Products Directorate, Health Canada*
- 9:45 – 10:00 Break
- 10:00 – 10:30 CAPHC National Patient Safety Survey – Identifying Current Patient Safety Practices within Canadian Child & Youth Health Centres
Dr. Anne Matlow
Associate Professor, Department of Paediatrics, University of Toronto, The Hospital for Sick Children; Chair, Hospital Quality Management Committee Association
- 10:30 – 12:15 Looking Ahead – recommendations for a National Child and Youth Patient Safety Agenda
- 12:15 – 12:30 Closing Remarks and Adjournment