

Canadian Association of Paediatric Health
Centres (CAPHC)

Patient Safety Culture
Sharing and Learning From Each Other
CAPHC National Interactive Teleconference

Friday, June 30, 2006

Proceedings

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

The Canadian Association of Paediatric Health Centres (CAPHC) is a national, not-for-profit organization whose members are multi-disciplinary health professionals that provide care for children, youth and families within community, regional and tertiary/quaternary healthcare facilities, rehabilitation centres, community care access centres and home care facilities nationwide. CAPHC is affiliated with the sixteen Health Sciences Centres in Canada providing linkages to clinical care, education and research.

Promoting best practices and optimizing resources are shared goals of member health care facilities across the country. CAPHC is committed to supporting its members by promoting, facilitating and advocating for improved research, ultimately aimed at establishing national health service delivery guidelines for children and youth supported by evidence-based data. CAPHC is committed to an ever-evolving communication network that provides access for our members and their respective stakeholders to the rapidly increasing knowledge arising from various contributors around the globe.

CAPHC's mission is to support the individuals and the organizations that work to improve health care for Canadian children and youth through:

- raising awareness of the unique character and importance of child health
- facilitating collaboration & partnerships
- sharing information, knowledge & expertise
- promoting best practices
- optimizing resources

Supporting Information:

The presentations from the national teleconference and the proceedings paper are available for download on the CAPHC website at www.caphc.org

General inquiries regarding this document should be addressed to:

Elaine Orrbine
Chief Executive Officer
Canadian Association of Paediatric Health Centres (CAPHC)
Association Canadienne des centres de santé pédiatriques (ACCSP)
401 Smyth Road
Ottawa, Ontario K1H 8L1
(613) 738-4164
email: eorrbine@caphc.org

Acknowledgement:

These proceedings summarize the national interactive teleconference that was held on June 30, 2006. The teleconference is the result of the on-going leadership and commitment of the CAPHC Patient Safety Collaborative and CAPHC Board of Directors to patient safety.

Introduction – Objectives and Context

Elaine Orrbine welcomed participants representing health centres and organizations from across Canada. The interactive teleconference provided an opportunity for colleagues to learn and interact with each other and build a platform to discuss patient safety culture. The teleconference is the first in a series of CAPHC events geared around patient safety.

Setting the Context – Expert Speakers

To set the context for the day, several expert speakers were asked to share their local experiences and learnings with the participants on-line. The teleconference presenters included:

- Liane Ginsburg, Assistant Professor, School of Health Policy & Management, York University and Mark Fleming, Assistant Professor, Department of Psychology, Saint Mary's University
Patient Safety Culture
- Lynn Jones, Sheena Mainland and Dianne Benner, Alberta Children's Hospital, Calgary Regional Health Authority
Moving Toward a Culture of Safety
- Tracy Wrong, Director, Quality Management, Children's Hospital of Eastern Ontario
Implementing an Intervention Project
- Liane Ginsburg, Assistant Professor, School of Health Policy & Management, York University and Mark Fleming, Assistant Professor, Department of Psychology, Saint Mary's University
Patient Safety Culture

Mark Fleming presented the importance of patient safety culture and the need to change and improve the safety culture within organizations as a way to help improve overall patient safety.

Organizational culture is the foundation of patient safety culture. The culture of an organization is the pattern of basic assumptions within a group that has developed over time and is felt to work well from the group's perspective. This sense from the group can often lead to resistance to change. New staff entering this culture learn what is acceptable and how to act and feel in relation to problems that arise.

The culture model is comprised of three components: artefacts (indicators), espoused values (attitudes), and basic assumptions. Artefacts are physical examples of a culture and can be seen. An illustration of an artefact would be reserved parking spaces and the “class” of parking different staff receive. Espoused values and basic assumptions are the core of culture and are fundamental of how an organization views itself and the world around. These are usually more difficult to express verbally.

It was highlighted that focusing on patient safety culture will produce higher safety increases within an organization than an approach which focuses on safety alone. Literature has indicated that safety culture is related to actual levels of patient safety and can be used as a measure that is easier to quantify than safety itself.

Culture can be measured using both quantitative and qualitative approaches. Currently, work is being done to examine the sensitivity of quantitative tools in detecting differences between units within organizations. Qualitative measurement provides more in-depth perspectives of the unit or organization.

Quantitative tools are available for organizations to measure their own patient safety culture. The advantages of implementing the tool internally are that the tool can be used as needed and creates an internal baseline to monitor progress over time. However, external comparisons with other organizations can be problematic, even when the same tool is used. This is due to the fact that as organizations implement the tool, different samples and methods of data collection are used. These inconsistencies between organizations make it impossible to accurately compare the data.

Qualitative approaches to data on patient safety culture involve interviews and focus groups to help assess how well surveys are detecting differences in culture and as a quality improvement mechanism (either proactive or reactive) to promote learning and improvement as a way to move forward patient safety in the organization. It was noted that this approach is often under utilized from a quality improvement standpoint.

The data that results from these tools help to identify learning opportunities though highlighting areas in need of improvement and developing strategies in which units can learn best practices from each other. It was noted that some issues and areas are easier to address than others. Areas which are related to the organization or unit’s basic assumptions and values of the existing culture are more entrenched and more difficult to change.

Liane Ginsburg presented work currently being done within the CPSI study. The group are testing instruments to determine applicability and sensitivity to change for different staff groups and sectors. The study is also looking at links between

safety culture measurement and safety improvement activities within an institution. The group is constructing a pan-Canadian database using Fall 2006 data.

Preliminary analysis of the MSI tool suggests that it works well across settings and sectors. However, there are some applicability issues for staff who are removed from direct patient care. It was noted that the tool has been tested in both pediatric and long-term care settings and worked well in both settings.

Lynn Jones, Sheena Mainland and Dianne Benner, Alberta Children's Hospital, Calgary Regional Health Authority
Moving Toward a Culture of Safety

The Alberta Children's Hospital's experience and work in implementing a comprehensive regional patient safety strategy was presented. In 2004, a fatal adverse event took place in the Health Region that resulted in internal and external reviews. These reviews identified that there was inconsistent reporting, no articulated culture of safety and the absence of clear policies for disclosing and informing stakeholders.

A safety framework was developed with four cornerstones for long-term success: leadership/accountability, culture, resources and organizational structure. Principles for the organization were also created around a just and caring culture, and include:

- Emphasis on being proactive
- Commitment to analyze reported issues
- Focus on system contributory factors
- Communicate with patients / families, workforce, the public
- Learn from reported & identified issues & factors
- Address system improvements
- Commit to evaluate progress
- Commitment to support individual(s)

A change in language was also implemented in order to re-direct issues from individual focus to an increased identification of systemic issues. New terminologies are now used to help support the cultural change within the institution.

Patient Safety policies were also developed and implemented that include reporting, informing stakeholders and supporting the culture of change within the organization. Direct feedback on these policies was collected through focus groups from across the region. These policies are intended to directly support the just and trusting culture being developed in the region.

Safe Spaces

The regional initiative Safe Spaces was also highlighted as part of the overall safety strategy. The goal of the program is to develop and test an education and implementation plan designed to enhance and support interprofessional communication and teamwork in the delivery of safe patient care.

Communication is the main focus of the program as it is seen as the basis to all interactions. It was noted that in 70% of sentinel events, communication is a causal factor and that coordinated, cooperative care requires effective communication.

The Safe Spaces pilot was run in the NICU and Special Care Nursery. Six teams participated in the pilot. The initial step was to identify the strengths and pitfalls within each unit. From the initial exercise, strategies and tools were developed in order to assist the units in building on the existing strengths in an effort to improve the overall safety culture of the unit. Situational Awareness strategy was also implemented as part of the pilot. The strategy ensures that staff are providing the right information to the right person and the most appropriate time and setting.

The modified SBAR tool was method to build on the strengths of the units. This structured communication tool was modified specifically to the nursery setting and helped staff to present information and recommendations in an appropriate manner. An evaluation was completed after each structured interaction. The results of the pilot are currently being compiled, but based on early evaluations, it is anticipated that the initiative will be expanded.

Family Medication Awareness

The Family Medication Awareness project was introduced as way to enable parents and families to be more involved in their child's care. The program began approximately 2 years ago in response to the idea that increased parental involvement and family centred care would enhance medication safety.

A safety statement protocol was developed. The protocol is comprised of four key elements that are essential in initial conversations with families and is reinforced in subsequent interactions. There is a strong commitment to the medication communication protocol in that every time medication is administered, staff will communicate with families the name of the medication, its purpose in plain language, the amount being administered, the frequency of administration, the last time it was given and the next time it is due. Families are then able to determine the amount of information they wish to receive. Overall, families have provided feedback that they felt the system kept them well informed, empowered and were happy to be part of the team.

Tracy Wrong, Director, Quality Management, Children's Hospital of Eastern Ontario
Implementing an Intervention Project

Tracy Wrong reported on the work currently underway at the Children's Hospital of Eastern Ontario piloting patient safety rounds. The pilot was put into place because it felt that through improved communication between hospital leaders and front line staff concerns and current practices could be easily raised and addressed.

The pilot is running in Emergency, Mental Health Inpatient, PICU and Infant/Toddler Medicine at the hospital. The assumption of the pilot is that staff have the knowledge and expertise on what to do in order to improve patient safety but require an opportunity to address issues.

Patient Safety rounds are seen as one method for building a patient safety framework. The program includes hospital leaders going into the units and asking staff directly about concerns in patient safety, promoting discussion and implementing follow-up initiatives in order to improve quality of care.

The structure of the rounds target four busy areas in the hospital. All available staff on the unit, as well as medical and operations directors, Manager of Clinical Risk and Patient Safety, Patient Safety Priority Champion for the unit, Chief of Staff and the CEO are all invited to the monthly rounds.

The objectives of the rounds are to:

- foster open communication among management and staff regarding patient safety
- enhance the patient safety culture within the hospital
- identify risk issues
- prioritize and implement actions to improve quality and patient safety

The AHRQ Patient Safety Culture survey is used to give a sense of the current state of the culture within the organization. Both pre and post surveys are planned for the pilot.

The content of the rounds are developed with the help of the participating unit. This has resulted in several different strategies implemented for the pilot. The rounds are seen as an opportunity for teams to ask questions around concerns from a patient safety perspective, make recommendations to address these issues and identify personal practices that help to ensure safe patient care.

It was noted that the timelines for the pilots have been a challenge. The rounds are held on a monthly basis. Within 48 hours of each round, a list of topics is posted on the unit for verification from participants. Within a week of the list

posting, the Safety Topic Action Team (STAT) reviews and prioritizes the list for action. The top two priorities are determined and timelines for action with a main contact person are developed. These priorities for action are then re-posted on the unit for feedback and input. It was noted that the timelines and resulting action lists are essential.

Since the launch of the pilot, the rounds have been well received by staff and many are eager to participate in the process. It was also noted that walk-throughs tend to work better than sit down “rounds” and result in a greater variety of issues being raised, as there are fewer tendencies for groupthink during these situations.

Summary

The sharing and learning presentations and interactive teleconference provides CAPHC members from across the country the opportunity to participate in discussions and be kept informed on what is happening in pediatrics health centres across the country in terms of patient safety. Participants were encouraged to provide their feedback on the session as well as ideas for future topics of discussion around patient safety.

Participants were invited to attend the CAPHC annual conference, October 15 – 18th 2006 in Vancouver, B.C. As part of a pre-conference event, a National Patient Safety symposium is taking place Sunday, October 15, 12:30 – 3:30 pm.