



## Building a Culture of Patient Safety at CHEO



Presentation to CAPHC Patient Safety Collaborative  
Tracy Wrong – Director, Quality Management – CHEO  
[wrong@cheo.on.ca](mailto:wrong@cheo.on.ca)

# *A Bit of History*



## **Externally:**

**(pre) 2001:** Institute of Medicine (IOM) To Err is Human and Crossing the Quality Chasm

**2004:** Canadian Adverse Event Study (CAES) provided impetus for work of the Canadian Patient Safety Institute (CPSI)

**2004:** QCIPA legislation on Ontario

## **Internally:**

**2001:** Need for Integrated Risk Management Noted

**2002:** CHEO Accreditation Report – Recommendation for Integrated Risk Management

**2004:** Quality Management dept; Manager of Clinical Risk and Patient Safety; CHEO's Quality of Care Committee



**CHEO**

# CHEO Risk Management Response 2005



## Organizational Risk Management

- Joint Health and Safety
- Security incidents
- Fire incidents
- Financial Risk
- Hazardous waste incidents
- Emergency preparedness
- Insurance claims

## Clinical Risk & Patient Safety

- Patient safety prospective analysis and implementation
- Education
- Incident reporting and response
- Medication use
- Patient safety research
- Culture assessment
- Management of alerts



# *CHEO: Entirely Devoted to Pediatrics*

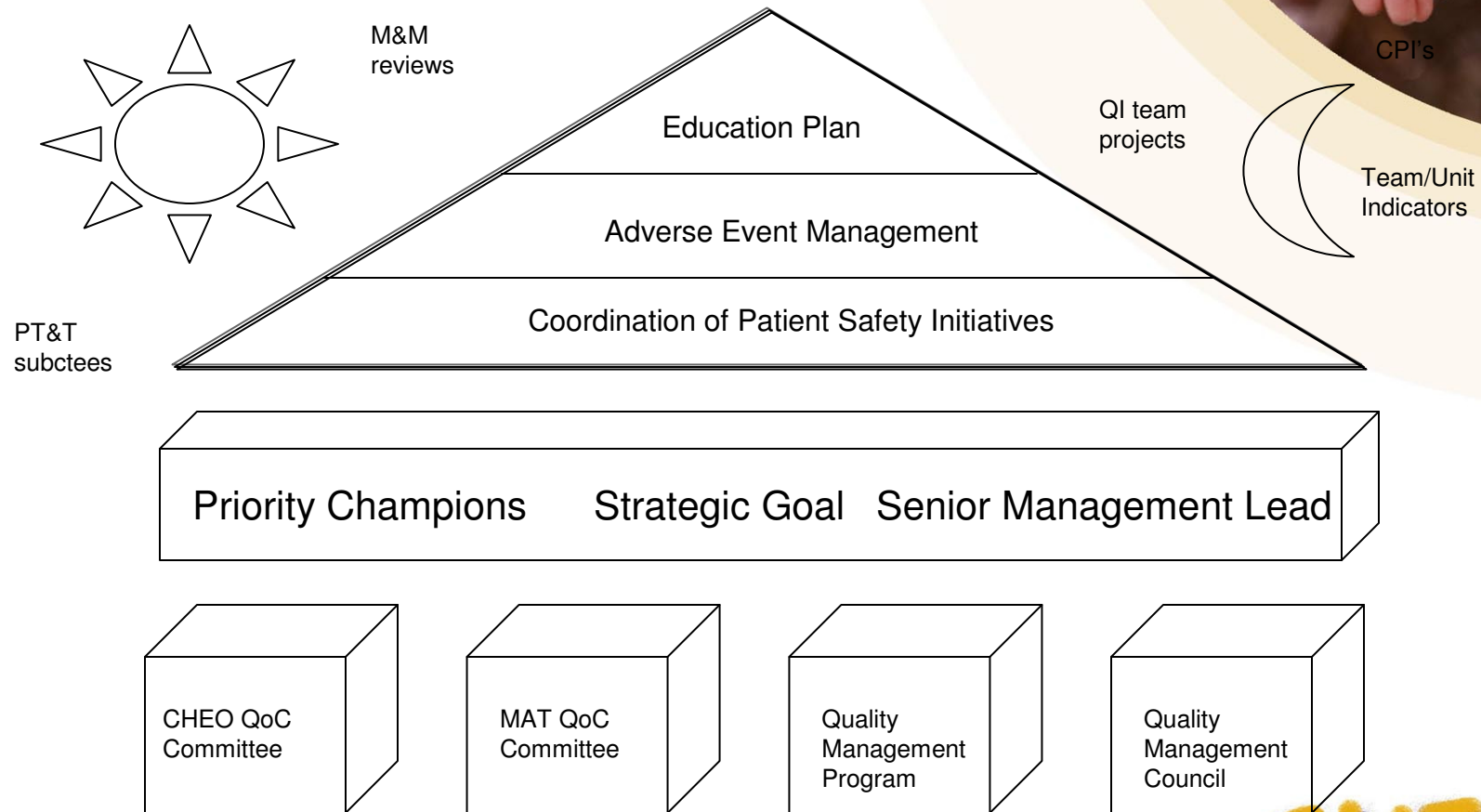


- **2005-06 the focus starts to shift**

- ✓ Patient Safety identified as a Strategic Priority
- ✓ Chief of Staff – Senior Mgmt lead for Patient Safety
- ✓ Patient Safety Priority Champions
- ✓ Incidents reported at Board and Team/Unit level
- ✓ Revised CHEO (QCIPA) Quality of Care committee membership
- ✓ Creation of a corporate Clinical Risk and Patient Safety Committee
- ✓ Role definition and training for Patient Safety priority champions

**CHEO**

# *Patient Safety: Putting in place a supportive infrastructure*



# *Learning on Many Levels*



## Critical Event Reviews:

- We learned how to do formal QCIPA reviews
- In 2006, we completed 3 extensive QCIPA protected reviews
- During 2007- 2008 – we reviewed over 20 incidents using the critical event review process
- Managing the implementation of the recommendations is a challenge
- The review process continues to evolve



**CHEO**

# Other Change Influencers



## Accreditation: Patient Safety ROPs (ongoing)

- Culture
- Communication
- Medications
- Workplace/Worklife
- Infection Control
- Indicator monitoring

HIROC – Risk Management Self  
Assessment Modules (RMSAM)

Patient Safety Leadership Rounds

Prospective process analysis/FMEA/LEAN



The logo for CHEO (Children's Hospital of Eastern Ontario), featuring the letters 'CHEO' in a stylized, yellow, rounded font with a blue shadow effect.

*So much has evolved – where to next??*

Start with our Leaders and Managers

**Patient Safety Education Session**

Remind them of how much we have accomplished

**Inspire, Educate and Call to Action**

1. Introduction by CEO
2. Share a framework
  - Pierrette Leonard – CPSI Competencies
  - Dr Sharon Caughey – CMPA Risk Mgmt Education
3. Put the Competencies to work



# *Goals for Patient Safety Learning Session*

1. To understand that everyone has a role to play in patient safety at CHEO
2. To appreciate that key competencies are required of all of our staff, starting with our Leaders and Managers
3. Using the desired PS Competencies, reflect upon where CHEO is related to a CHEO PS action plan and where we might next focus efforts.



# *Learning the Competencies*



Participants were given

- A number (1-6)
- CPSI Documentation

Each group was facilitated

Posters for each group identified

- Domain
- Definition
- Key Competencies



# *Learning on Many Levels*

Three Questions:

1. What are examples of things we do that address the competency well
2. What needs improvement to enhance our level of competency?
3. What needs to be a priority?



# Example of Feedback

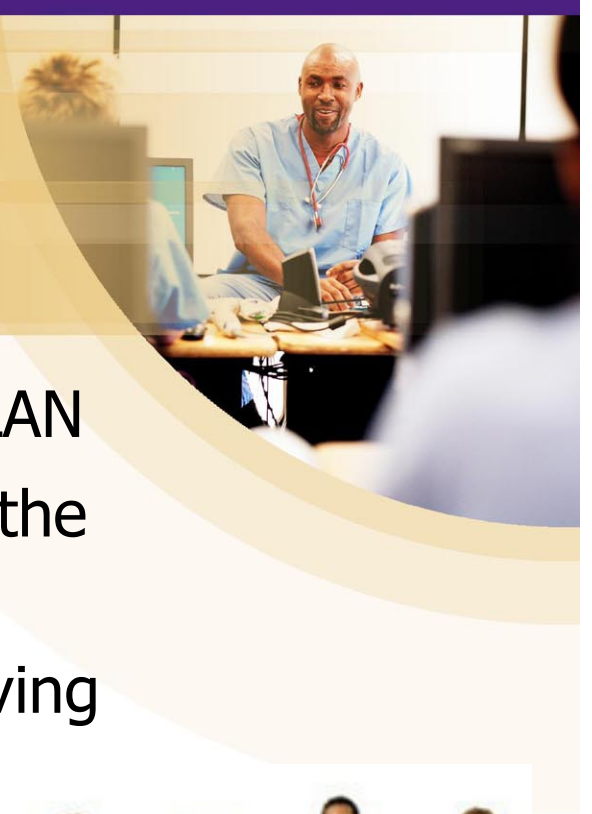
DOMAINE NUMBER	DEFINITION	KEY COMPETENCIES	EXAMPLES OF WHAT WE DO THAT ADDRESS THE COMPETENCY	WHAT NEEDS IMPROVEMENT TO ENHANCE OUR LEVEL OF COMPETENCY?	WHAT NEEDS TO BE A PRIORITY?
6 Recognize, Respond to and Disclose Adverse Events	<p>The professional possesses the knowledge and clinical judgement to recognize adverse events and respond in a timely way to prevent further harm to patients.</p> <p>The professional understands that disclosing the facts of the event to the patient and discussing with him/her the plan for future clinical care should occur as soon as appropriate</p>	<ol style="list-style-type: none"> <li>1) Recognize the occurrence of an adverse event or close call</li> <li>2) Mitigate harm and address immediate risks for patients and other affected by adverse events and close calls</li> <li>3) Disclose the occurrence of an adverse event to the patient and/or their families as appropriate and in keeping with relevant legislation.</li> <li>4) Report the occurrence of an adverse event or close call</li> <li>5) Participate in timely event analysis, reflective practice and planning for the prevention of recurrence</li> </ol>	<ul style="list-style-type: none"> <li>• On line reporting</li> <li>• Policies and procedures for reporting of events and disclosure</li> <li>• Debriefing processes involving pertinent staff</li> </ul>	<ul style="list-style-type: none"> <li>• People not getting the feedback</li> <li>• Focus on education to particular stakeholder groups</li> <li>• Enhance the lack of understanding of the role of the individual to not only identify the event – be actively involved in solution</li> <li>• Some staff do not recognize the importance of participating in the debriefing of events</li> </ul>	<ul style="list-style-type: none"> <li>• The PSU recommendations or report investigations need to routinely go to the Exec level with feedback</li> <li>• Training to support staff. (i.e. what is an adverse event and how to report)</li> </ul>



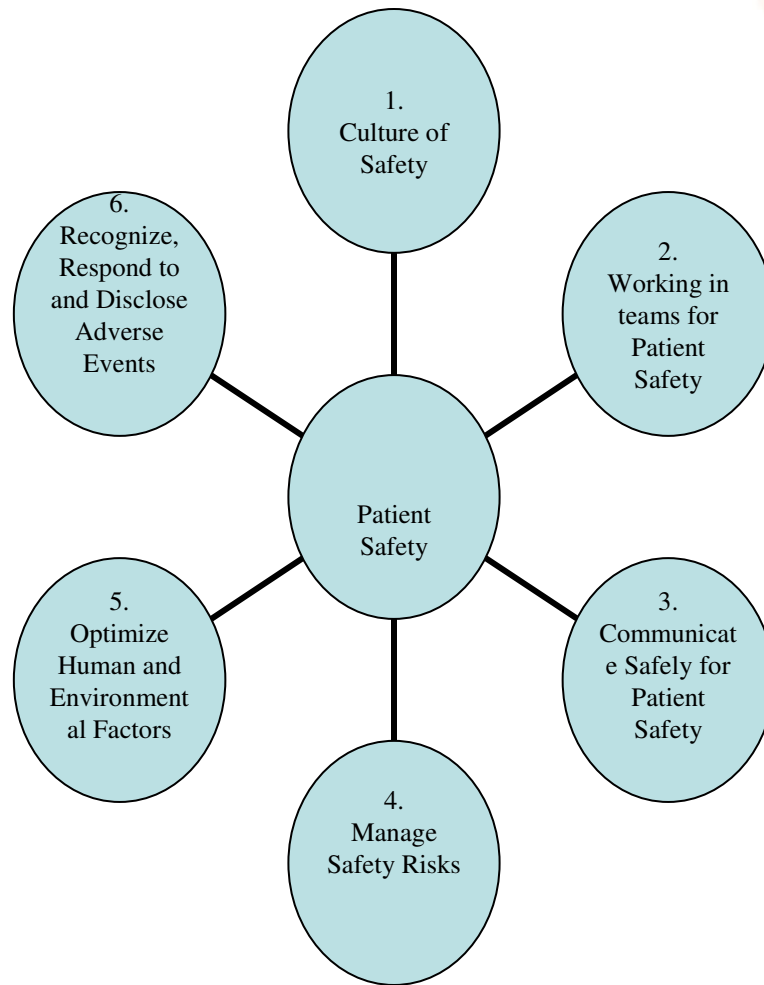
# *Moving Forward*

RETHINKING OUR INFRASTRUCTURE and PLAN

1. What committees do we need to support the work we need to do in each area?
2. Which competencies will we focus on moving forward?
3. How do we keep the front line engaged?



# *Which area is most important*



**CHEO**

# Dialogue is in progress...

<b>Competency</b>	<b>Work to date</b>	<b>Work in future / Gaps</b>
<b>Culture of Safety</b>	Key policies Learning – Orientation Patient Safety Week	PS Culture Survey Structured, annual education
<b>Working in Teams for Safety</b>	Safety a priority at Central PC Lab Liaison PICU PS Coordinator LEAN Coordinator Hand Hygiene program Medication reconciliation Med Error follow up	Standardize Incident Review at team level Family Forum/working with families Disclosure team?
<b>Communicate Safety</b>	Your Healthcare, Be involved Soundbites for PS (Central PC)	WHO Checklist Checklists at Transfer Eclinical Documentation
<b>Manage Safety Risks</b>	Leadership Rounds HIROC RMSAM Public Reporting	Trigger Tools Falls strategy
<b>Optimize Human and Environmental factors</b>	FMEAs Preventive Maintenance MAR validation	Med Management changes Certification New Pumps
<b>Recognize, Respond to and Disclose Adverse Events</b>	Online incident reporting Quality of Care committees	Closing loop with staff/teams post event review



*We Have What It Takes ...  
so stay tuned!*



**CHEO**