Editorial

Lessons learned and challenges ahead: Canadian experiences in improving patient safety

"Medicine used to be simple and ineffective and relatively safe, but now it is complex, effective, and potentially dangerous." (Chantler 2001).

This special issue of *Healthcare Quarterly* reports Canadian experiences in identifying and improving patient safety. The commitment to quality in Canadian healthcare is not new; but the identification of patient safety as a strategic goal is still emerging, and the recognition of the need to master and apply new skills and knowledge has just begun. The papers in this issue bear witness to a growing awareness and accelerating efforts to enhance the reliability of healthcare in our country.

Several events were critical in stimulating this engagement with patient safety. The National Steering Committee on Patient Safety, ably chaired by Dr. John Wade, alerted policy-makers and national organizations to the overlooked burden of injury resulting from poorly designed systems and inadequate communication and teamwork in our healthcare organizations. Their 2002 report, *Building a Safer System: A National Integrated Strategy for Improving Patient Safety in Canadian Health Care,* led to the creation of the Canadian Patient Safety Institute in late 2003. CPSI, together with a set of provincial quality and safety councils in Alberta, British Columbia and Saskatchewan and important initiatives in Quebec, Manitoba, Ontario and elsewhere, provide a growing infrastructure for the development of the skills and knowledge to improve patient safety. Yet policy recommendations and quality councils are not enough to convince those who are skeptical that current patterns of delivery and professional education need to be redesigned to create safer healthcare. The Canadian Adverse Events Study, which reported in May 2004, offered the first national data on the incidence of adverse events in acute care. While the study addresses only one component, it offers a model for understanding the burden of injury across the healthcare system. Just as important as the study was the parallel knowledge linkage and exchange effort designed to engage decision-makers from government and professional organizations. As early as June 2002, the researchers and decision-makers worked to build a receptive environment for the release of the results of the adverse events study two years later.

The reports in this issue bear witness to the achievements of people and organizations across Canada in improving patient safety. They are organized by key themes. First there is a series of articles addressing the critical but elusive task of crafting organizational and professional cultures that enhance patient safety. Such cultures are essential for engaging staff and creating an effective environment for improving care. In the section *Nurturing a Patient Safety Culture,* the authors provide guidance on measure and shifting cultures to support safety.

One critical aspect of an effective patient safety culture is the acknowledgment and reduction of risk. Improving patient safety requires the surfacing of current risks in all critical processes and the use of structured techniques for analyzing and reducing such risks. In the section *Identifying and Reducing Risk*, several papers provide insights into the experiences of organizations in identifying and ameliorating such risks.

The Canadian Adverse Events Study and other research have pointed up the importance of improving medication safety. New tools have been developed to identify issues in medication ordering, dispensing and administration, and to improve practices in these areas. Canadian practitioners and researchers are world leaders in this area; the results of several key medication initiatives are reported in this issue in the *Medication Safety* section.

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Despite the enormous volumes of data generated by the daily work of the hundreds of thousands of encounters, tests and decisions in healthcare, remarkably little useful information is available for those who wish to reduce risk and design more effective systems. Our fourth group of papers, in the section *Developing Information for Improving Safety*, address some of the challenges of collecting and transforming data to inform busy clinicians and managers responsible for safety.

Provincial and healthcare organizations have had varied approaches to patient safety. The lessons learned from these different efforts offer a rich array of experience for those facing choices in the design of their own safety initiatives. In the section *Designing an Agenda for Change*, authors provide accounts of experiences from leading organizations across the country to advance patient safety.

A critical challenge for those working on patient safety has been the fear of litigation and discipline that limits discussion of the actions and conditions leading to adverse events. In the final section of this issue, *Disclosure and Accountability*, we highlight the nature of the legal environment that influences and sometimes steers our efforts to improve safety, and provide important accounts of organizational strategies for improving disclosure and balancing the needs for accountability and safety.

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Together, the more than two dozen papers in this special issue offer an important resource for those just beginning to grapple with these complex issues. Clearly the achievement of more reliable healthcare will require substantial efforts to build new competencies and change the existing attitude that the risk of injury is the inevitable accompaniment of complex care. While risk can never be totally eliminated, we know safer healthcare is possible. The wisdom derived from the experiences reported in this issue highlight the successes achieved and some of the challenges that remain.

– G. ROSS BAKER

Professor, Department of Health Policy, Management and Evaluation, University of Toronto

Dr. Baker is the guest editor of this special issue of *Healthcare Quarterly* focused on Patient Safety.

References

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