



From Inquest to Insight

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BACKGROUND

In March 1995, The Chief Medical Examiner, Province of Manitoba, ordered an inquest into the deaths of 12 children who died in 1994 while undergoing or shortly after having undergone cardiac surgery at Health Sciences Centre in Winnipeg, Manitoba, Canada. The inquest spanned over five years, and resulted in almost 50,000 pages of transcript, including the testimony of more than 80 witnesses (Sinclair 2000).

Justice Sinclair found that the Pediatric Cardiac Program did not provide the standard of care that it was mandated to provide, as he determined that at least five of the deaths were preventable.

In response to the 516-page report issued by Judge Murray Sinclair, the former Minister of Health, the Honourable Dave Chomiak, established a Review and Implementation Committee to review the recommendations from the inquest and determine (1) what actions had already been taken to address the recommendations, (2) what future actions should be taken and (3) the implications of the recommendations for the broader health system. A learning process began, which would have a ripple effect throughout the Manitoba health system for years to come.

The Review and Implementation Committee, chaired by Professor Paul Thomas, issued a report in May, 2001, entitled *Report of the Review and Implementation Committee for the Report*

of the Manitoba Pediatric Cardiac Surgery Inquest containing 53 recommendations which sought to “identify institutional arrangements and procedures that would provide Manitobans with a stronger guarantee of competent, safe and ethical healthcare in the future” (Manitoba Health 2001).

MILESTONES...

It is the goal of all Manitoba’s healthcare community to be leaders in providing quality care and promoting patient safety. In the keynote speech at a November 2003 Provincial Patient Safety Conference, former Minister Chomiak committed Manitoba Health to a collaborative approach directed toward continuous improvement in patient safety and quality of care throughout Manitoba.

A key component in improving quality of care and patient safety is moving to a culture that views quality of care and patient safety as a systems issue that requires evaluation, inter-disciplinary cooperation and commitment to change, as opposed to a culture of individual blame.

In the journey *From Inquest to Insight*, Manitoba’s approach to patient safety is beginning to result in health system changes that promote a culture of non-blame and will, ultimately, result in the prevention and reduction of critical incidents*.

Recommendations from the Review and Implementation

*Based on the impending proclamation of Bill 17 (legislative amendments to *The Regional Health Authorities Act* and *The Manitoba Evidence Act*, which will define specific Critical Incident reporting and investigation requirements) (Government of Manitoba 2005). “Critical incident” means an unintended event that occurs when health services are provided to an individual and results in a consequence to him or her that (a) is serious and undesired, such as death, disability, injury or harm, unplanned admission to hospital or unusual extension of a hospital stay and (b) does not result from the individual’s underlying health condition or from a risk inherent in providing the health services.

Committee focussed on the patient experience, human resources, accountability, quality and risk management, and health authority policy and procedural issues.

The thrust of the recommendations sent the message that it is necessary to accept that the healthcare system will improve only if the system can respond to errors and concerns without fear of consequence from system errors. The recommendations were intended to promote a structure and environment within which highly skilled and talented people could establish healthcare teams that work together to provide a high standard of care.

A province-wide collaborative approach was undertaken to develop and implement eight provincial policies in response to the inquest in areas where risk to the safety of individuals were identified.

Collaborative working groups with representatives from a variety of health system stakeholders developed each policy, and corporate leadership from health authorities supported implementation, follow-up and monitoring of progress of policy implementation.

These policies were designed to improve quality of healthcare and to begin to change the culture of the system to one of openness in reporting critical incidents, of learning from our mistakes and of support for providers and patients in dealing with critical incidents. These policies and their purposes are described in the following table.

Leaders from each health authority provided regular updates to Manitoba Health on the progress of addressing the Review and Implementation Committee recommendations.

The following nine key activities and initiatives are aimed at promoting a culture and environment of patient safety in Manitoba, which continue to be collaboratively undertaken by health authorities and other stakeholders:

1. On June 21, 2004 The Manitoba Institute for Patient Safety (MIPS) was established, with Dr. Paul Thomas, chair of the Board of Directors. MIPS objectives are:
 - to promote, coordinate, facilitate, participate in and/or stimulate research, activities and initiatives to enhance patient safety in the Manitoba healthcare system
 - to monitor emerging issues related to patient safety and quality care
 - to promote best practices related to patient safety and quality care
 - to raise awareness of patient safety and quality care issues
2. Manitoba Health has set proposed provincial objectives for improving patient safety based on feedback from with internal

Policy Name	Purpose
Critical Occurrence and Critical Clinical Occurrence Reporting	To ensure that health authorities develop timely, comprehensive and factual reporting and investigating processes for critical incidents and other significant occurrences
Internal Disclosure of Staff Concerns	To ensure that health authorities have a process, whereby staff may disclose concerns, and that these disclosures are routed to appropriate people and addressed in a suitable and timely manner
Integrated Risk Management Strategy	To ensure that a comprehensive approach is taken to risk management within healthcare organizations, encompassing all elements that directly or indirectly affect the safety and well-being of clients, staff, medical staff and visitors
Quality Audits	To ensure that health authorities use the quality audit process to provide systematic, critical analysis of clinical care and services
Health Authority's Guide to Health Services	To ensure that health authorities provide the public with contact points for questions and complaints
Notification to Manitoba Health of Critical Occurrences and Critical Clinical Occurrences	To provide a consistent process for health authorities to notify Manitoba Health of critical occurrences and critical incidents
Board Governance and Board/Chief Executive Officer/Chief Operating Officer Accountability	To ensure that health authorities develop good governance practices and strategies for continuously improving programs and services
Reporting of Significant Changes to the Office of the Chief Medical Examiner	To ensure that all significant changes in healthcare programs and reviews that are conducted as a result of program-related deaths are reported to the Office of the Chief Medical Examiner by health authorities

and external stakeholders in the spring of 2005.

The following “sources” have all identified three common areas for patient safety improvement: facility-based critical incidents, medication safety and infection control:

- Institute of Medicine (IOM) 10-Year Quality of Healthcare Project (Kohn et al. 1999)
- Joint Commission on Accreditation of Healthcare Organizations (JCAHO) 2004-05 Goals (JCAHO 2004)

- 2004 Canadian Institute of Health Information (CIHI)/ Canadian Institute of Health Research (CIHR) *Incidence of Adverse Events Among Hospital Patients in Canada* (Baker/ Norton Study) (Baker et al. 2004)
- *CIHI & Health Canada Fifth Annual Report: Health Care in Canada* (CIHI and Health Canada 2004)
- The Canadian Council on Health Services Accreditation (CCHSA) Patient Safety Goals 06/07 (CCHSA 2005)

Based on this, Manitoba's proposed short-term provincial objectives are the promotion of regional, facility-based best practices in

- identification, reduction and/or prevention of critical incidents all areas
- medication administration
- infection control

A Provincial Patient Safety Action Plan will serve as a common reference point for those interested and involved in patient safety to work collaboratively for the common goal of enhancing the safety and quality of care provided to Manitobans.

3. On April 12, 2005, the *Safer Healthcare Now!* (2005) campaign was launched by a national steering committee comprised of patient safety leaders from across Canada, including the Canadian Patient Safety Institute (CPSI). The Manitoba Institute for Patient Safety is leading the *Safer Healthcare Now!* campaign in Manitoba.
4. Manitoba Health has commissioned the Manitoba Centre for Health Policy (MCHP) to undertake a research study entitled "Patient Safety Issues: A System-Wide Approach for Manitoba" (Manitoba Centre for Health Policy 2004). The study is due to be released in 2005.
5. Progress is underway to prepare for the Proclamation of Bill 17 – amendments to the Regional Health Authority (RHA) and Manitoba Evidence Acts that are aimed to have a positive impact in improving patient care through timely reporting and investigation of critical incidents.
6. In order to address Manitoba Health's commitment to provide healthcare professionals ongoing access to the latest developments and information available on patient safety, the following collaborative activities have been undertaken or are underway:
 - Advancing Quality in the Name of Patient Safety conferences are a series of provincial patient safety conferences held in collaboration with the College of Registered Nurses of Manitoba, the College of Physicians and Surgeons, the Manitoba Pharmaceutical Association, the Canadian College of Health Service Executives, the Winnipeg

Regional Health Authority and, as of 2005, the Manitoba Institute for Patient Safety.

- Manitoba was the first to partner with the Institute for Safe Medication Practices Canada (ISMP) in their Failure Mode and Effects Analysis workshop. A follow-up workshop was held where participants shared lessons learned in using these tools in their daily practices.
 - Manitoba was the first province to work with the CPSI to hold a Root Cause Analysis workshop for health authorities, sponsored in part by the MIPS.
7. The Institute for Safe Medication Practices Canada (ISMP) Medication Safety Self-Assessment is available and is being utilized by health authorities as part of their quality and risk-management strategy. The Department also sponsors and distributes the ISMP Medication Safety Bulletin and in Medication Alert Newsletter to all health authorities.
 8. The Regional Health Authority Quality and Risk Management Network shares and promotes best practices in patient safety and quality of care.
 9. Improved environments and structure to promote patient and family involvement in patient safety are being established. For example, the Winnipeg Regional Health Authority (WRHA) has recently announced their Patient Advisory Council.

These activities have given Manitoba thrust to achieve positive patient safety outcomes, and have placed Manitoba with other leaders of patient safety across the country.

Assessment of culture change from one of blame to one of learning may include increased reporting and investigation of critical incidents, evidence of development, implementation and sharing of best practices, increased use of tools (i.e., FMEA, RCA) implementation of culture surveys and evidence of teamwork.

Insights gained during the journey *From Inquest to Insight* are that there are many complex aspects to the culture of safety – not only systems changes, but the promotion of teamwork, culture assessment, openness and patient involvement, and accountability. Much has been accomplished; more is yet to be done.

References

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ACCORDING TO A RECENT PATIENT SURVEY OF CCHSA'S CLIENTS...

Approximately ninety (90) percent of organizations indicated that they had removed concentrated electrolytes (including, but not limited to, potassium chloride, potassium phosphate, sodium chloride) from patient care areas.

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