



Patient Safety: Le Groupe Vigilance pour la Sécurité des Soins: A Québec Perspective

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In 2000, following a series of tragic adverse events, the Quebec Health and Social Services Minister, Madame Pauline Marois, set up a committee to study adverse events in the province. Under the chairmanship of Mr. Jean Francœur, first Health and Social Services Ombudsman, the committee made a series of recommendations concerning all aspects of patient safety and including leadership, information to patients, research, management of healthcare facilities, risk management, accreditation and competency (Comité ministériel sur les accidents évitables dans la prestation des soins de santé 2001).

The first offshoot of the report was the creation in September 2001 of the Groupe national d'aide à la gestion des risques et à la qualité, forerunner of the current Groupe Vigilance pour la sécurité des soins. The second was the unanimous adoption of Bill 113 (L.Q. 2002, c. 71), as it is commonly known, by the Quebec National Assembly in December 2002 (Québec National Assembly 2002) (see text box). The provisions of the bill are fully integrated in the Quebec Health Act (Gouvernement du Québec 2005).

BILL 113

Bill 113 defines healthcare facilities' obligations on disclosure of accidents, declaration of accidents and incidents, allowance for support measures to patients, their families and healthcare workers involved in the accident, creation of a risk- and quality-management committee, accreditation on patient safety, quality and risk management and the development of a local registry. It also mandates the regional development of health services and social services agencies. As well, the Ministry is mandated to ensure the safe provision of health services and social services. The Bill also makes provision for a province-wide registry of incidents and accidents.

LE GROUPE VIGILANCE POUR LA SÉCURITÉ DES SOINS

Composed of experts in all fields of healthcare and safety, the Groupe Vigilance is a permanent consultative body to the Quebec Minister of Health and social services. The Groupe's philosophy is based on positive reinforcement and transparency. It ensures that priority recommendations from the rapport Francœur are acted upon. Major terms of its mandate include

- promotion and application of a national policy on patient safety, declaration and disclosure of accidents
- promotion of a culture of transparency, open communication, interdisciplinary teamwork and systemic approach to patient safety
- education and incentives for patients and healthcare workers to contribute to the safety of their healthcare delivery and the decrease of adverse events
- advice and recommendations to the Minister of Health and social services, at his request or on their own initiative, on matters related to the safety of health services and social services

OUTCOMES (2001–2005)

The Groupe endorsed Bill 113 and promoted its early adoption. It made recommendations to support research on the incidence of adverse events in Quebec hospitals, develop a unique form for declaration of incidents and accidents and create a patient safety brochure. As an essential part of its mandate, the Groupe organized information and training sessions for healthcare workers on various aspects of patient safety and Bill 113.

Blais et al. (2004) reported a 5.6% overall incidence rate of adverse events in Quebec healthcare facilities. Thus, of the almost 435,000 annual hospital admissions in Quebec similar to the type studied, about 24,000 are associated with an adverse event; close to 6,500 of these are potentially preventable. These results compare very favourably with the Canadian study of Baker et al. (2004).

The revised unique form for declaration is about to be launched in an electronic version; this will help in the establishment of local registries and in developing the national one. A brochure for patients will be available in the fall.

An April 2004 survey showed that over 60% of healthcare facilities had established their quality- and risk-management committee, 64% had a local registry and more than two-thirds of them had solicited accreditation of their facility. Since

September 2003, more than 45 information and training sessions were held throughout the healthcare network with more than 3,000 people attending. Over 12 briefs with advice and/or recommendations were submitted to the Minister of Health and social services; most of the recommendations were endorsed and put into place.

In late 2004, the Minister of Health and social services reviewed the Groupe Vigilance's mandate and confirmed its importance in the promotion of patient safety initiatives. A new Directorate, la Direction de la Qualité, was created; it will support the administrative services of the Groupe and promote its visibility within Quebec healthcare facilities and external organizations. In early 2005, through a multi-media information campaign, the Groupe continued to reinforce its education program for patients and families on patient safety. Finally, an intensive "train the trainers" program for healthcare workers is being developed and should be implemented in late 2005 or early 2006.

THE FUTURE

The Groupe Vigilance will hold a province-wide consultation in late 2005 to seek feedback from healthcare workers and healthcare facilities. It now has its own visual

identity and a Web site will be available shortly. Collaboration with Canadian patient safety groups such as the Canadian Patient Safety Institute (CPSI-ICSP) and the Canadian Council on Health Services Accreditation (CCHSA-CCASS) is established and links with a number of other organizations continue to be put in place. As well as continuing to work on the realization of its mandate, two major initiatives are in their initial stage of development and should be available in early 2006:

- a province-wide "train the trainers" program on the impact of human factors in the incidence of adverse events
- a pilot program to implement the MOREOB (Managing

Bill 113 Explanatory notes

This bill makes amendments to the Act respecting health and social services as regards the safe provision of health services and social services.

It provides that a user has the right to be informed of any accident having occurred during the provision of services that has potential consequences for the user's state of health or welfare. Furthermore, any person working in an institution will be under obligation to report any incident or accident as soon as possible after becoming aware of it.

Every institution will be required to form a risk-management committee responsible for seeking, developing and promoting means to ensure the safety of users and to reduce the incidence of adverse effects and accidents related to the provision of health services and social services.

In addition, the board of directors of every institution will be required to make rules concerning disclosure of all necessary information to the user as well as measures to prevent the recurrence of such an accident.

Finally, the bill makes regional boards responsible, in their region, for ensuring users the safe provision of health services and social services.

Obstetrical Risk Efficiently (OB) program from the Society of Obstetricians and Gynaecologists of Canada in several hospitals with obstetrics and delivery units

We continue to promote a culture of transparency and interdisciplinary team approach to healthcare as the best way to ensure patient safety and eventually eliminate preventable adverse events. These should decrease not only in hospital and other facilities, but also in physicians' offices and clinics and other privately owned facilities such as drug stores and other partners in local healthcare networks. The support of the Ministry of Health and social services is essential; we are grateful that the current Minister of Health and social services has declared patient safety as one of his priorities in the delivery of stellar healthcare in Québec.

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