Perspective

Canadian Patient Safety Institute

As a senior healthcare executive, I experienced several incidents in which patients were adversely affected, though no one had intended to harm or compromise anyone. While these were all difficult and painful, I remember one in particular, in which a patient died on a procedure table due to medication overdose. I remember the emotions of the parents and everyone involved as if it were yesterday. All knew this was an unnecessary loss.

Anyone who has worked in a hospital any length of time has seen patients grievously affected by an adverse event. No one goes to work in healthcare anywhere wanting to make an error. Canada's health professionals and our many other staff are committed to providing care to anyone in need. But occasionally something does go wrong. We know that somewhere between 9,000 and 24,000 people die annually (Baker et al. 2004) from an adverse event in hospitals. And how many more have been adversely affected in home care, long-term care or community care? The research mostly has yet to be done in those areas.

So who is responsible? And who is going to "fix" the now-well-known problem documented by Baker et al.? We are not going to fix the problems by focusing on individual(s) caregivers; instead we need to focus on the system. I have travelled across the country and heard from professional caregivers – doctors, nurses, pharmacists and many others – and they yearn to give *safer care*. That aim resonates with Canadian CEOs who recently attended a session with Dr. Donald Berwick, CEO of the U.S. Institute for Healthcare Improvement.

To get at the issue, boards and CEOs of hospitals must make patient safety a priority, and a few have begun this journey. So too must community and other healthcare organizations. Researchers must help us better understand the problems and the underlying causes – be they processes, human factors, design of equipment or supplies, systems, etc. We must learn from the work of the airline industry and other high-risk ventures that make safety a priority. We must learn and apply all of this to our complex system of healthcare. It will not be easy and it will take time.

I believe that part of what has created compromises in patient safety is the fact that we are asking our staff to master new technologies, processes, drugs, equipment, knowledge, etc. at an alarming rate, and asking them to be increasingly efficient and effective.

The culture of our organizations must change. Being able to report adverse events without blame or retribution, to participate in addressing the causes and to disseminate the

Ontario Hospital Association

The Ontario Hospital Association (OHA) is pleased to co-sponsor this special edition of *Healthcare Quarterly* dedicated to patient safety.

The OHA is a voluntary organization representing Ontario's public hospitals. The OHA, founded in 1924, is the voice of Ontario's hospitals and a leader in shaping the future of the healthcare system, fostering excellence, building linkages with the community and advocating for quality healthcare.

One of the things we are proudest of is our ability to identify patient needs within the healthcare system and then use our expertise to create and implement programs and strategies to address those needs. For example, in the days before universal, publicly funded healthcare and the Canada Health Act, the OHA recognized the need for affordable healthcare coverage and, in response, created the highly successful Ontario Blue Cross program. And in 1957, when the Government of Ontario created the Ontario Hospitals Services Commission to administer a provincial health insurance plan, they relied on staff from the OHA to make this initiative a success. (History buffs will note that the Ontario Hospital Services Commission initiative became the Ontario Hospital Insurance Plan [OHIP], and led to the creation of the present-day Ministry of Health and Long-Term Care.)

Today, we believe that improving patient safety and increasing patient involvement in the management of their own healthcare are among the most pressing challenges that healthcare providers face. We also believe that the solutions to these challenges are interwoven – that successfully increasing our patients' involvement in managing their healthcare will lead to improved patient safety.

That is why, with funding from Ontario's Ministry of Health and Long-term Care, the OHA established the *Patient Safety Support Service* (PSSS), the first service of its kind in Canada.

The mandate of the PSSS is to: raise awareness among hospital management and frontline staff about patient safety; foster the development of local expertise in patient safety; promote effective leadership strategies that enhance patient safety; and provide leadership and be a resource to hospitals in their efforts to effect system change for improved patient safety, with assistance that is both focused and practical.

Since its creation in March 2004, the PSSS has developed key resources, including discussion papers, tool kits, newsletters, and an interactive website to help raise the awareness of patient safety and promote effective strategies that enhance patient safety. The PSSS staff have also worked with the Institute for Safe Medication Practices Canada (ISMP-

lessons learned is part of the solution. This includes permitting patients a voice and some responsibility in their care. It is up to all of us, and leaders such as the boards and the CEOs, to be passionately committed to a different culture. The patients deserve nothing less.

Suppliers of medical products must also make this a priority. Issues have been identified, which they can remedy, in the design, labelling and other features of healthcare equipment, medical supplies and medications. They too must be part of the intricate solutions.

This special issue of *Healthcare Quarterly* is a piece of the puzzle, sharing knowledge and providing hope for each of us that there are solutions. We trust it will help us all become better at caring for our patients and for each other. We have had overwhelming response to this first edition. We thank the authors who have contributed to this publication. We also thank the many who submitted whom we were not able to publish at this time due to space limitations (after expanding to well over 150 pages!). Clearly there will be more to come in the future.

Most importantly, this is dedicated to our patients.

– PHIL HASSAN
President and CEO

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Canada) to encourage hospitals to remove concentrated KCl (potassium chloride) from patient care areas, and are working with the Quality Healthcare Network to encourage hospitals to participate in the ongoing *"Safer Healthcare Now"* campaign.

Recently, the PSSS launched "Your Healthcare – Be Involved," a program designed to empower patients, enhance patient safety and promote better health outcomes by bringing the advice and expertise of health professionals together in five easy-to-understand "tips" for patients to use in any healthcare setting. In a similar vein, the OHA is today working with Ontario's hospitals, patients and our other partners to ensure that our healthcare system is as safe as it can be.

Like the OHA, readers of *Healthcare Quarterly* make meeting the needs of patients their priority. This special issue features an extensive compilation of articles on key patient safety topics such as culture change, reducing risk, medication safety, information technology, patient safety as an agenda for change, and disclosure and accountability. We hope it will provide you with useful information, expand the body of knowledge about patient safety and lead to new patient safety initiatives across Canada.

Enjoy the read!

– HILARY SHORT
President and CEO