Patient safety has changed the language of healthcare. Terms such as *medication reconciliation, critical incident* and *safety briefing* are now part of the daily conversations of clinicians and managers. These shifts in language reflect larger changes in thinking and working, underpinning the currency of patient safety as a critical component of Canadian healthcare.

This is the sixth issue of Patient Safety Papers, published by Longwoods. The first five issues, published since 2005, presented reports on research studies, demonstration projects and leading practices from organizations across Canada. In this issue, we assess our progress and examine the future. To do so, we asked a selection of patient safety experts from across this country to reflect on critical patient safety initiatives in specific domains.

Ward Flemons and Glenn McRae (2012) examine the use of reporting systems to enhance organizational learning. Reporting systems are the foundation of efforts to identify gaps and create safer systems; but their success is predicated on the development of an organizational culture that facilitates reporting, and mechanisms for translating incident reports into recommendations for safer care.

Failures in teamwork and communication contribute to many patient safety events. So it is not surprising that research in these areas has made an important contribution to safer care. Yet researchers have only begun to uncover the complexities of team communication and to identify strategies to improve teams' performance. Lorelei Lingard (2012) challenges researchers and practitioners to delve deeper into team practices to understand their dynamic complexities and contribution to safety. One important tool used in team communication is the checklist. Chris Hayes (2012) helped implement the Surgical Safety Checklist across Canada. In his article, he reviews the successes and continuing challenges of getting operating room teams to use the new tool in a way that ensures safer and more effective care.

Patient safety has married insights from many different disciplines with clinical and managerial sciences. Joseph Cafazzo and Olivier St–Cyr (2012) examine the impact of human factors engineering (HFE) in addressing patient safety challenges and highlighting the importance of design and the human-machine interface. While the tools and insights of HFE have created many opportunities, Cafazzo and St-Cyr note that HFE has not yet fully delivered on its potential impact on safer care.

Work design and service delivery models also hold great promise in creating safer and more efficient care. Patricia O'Connor and colleagues (2012) examine several healthcare systems where innovative work design has translated into better outcomes for patients and staff. Redesigning care processes and physical environments creates a context for safer care; but strong leadership and support are required to implement these changes.

Healthcare-associated infections (HAIs) are another large, high-profile and recalcitrant patient safety problem. Michael Gardam, Paige Reason and Leah Gitterman (2012) identify new approaches to reducing HAIs, including the use of positive deviance to engage and empower staff in developing workable solutions. Reinforcing the insights of other papers in this volume, the authors stress the importance of patient safety culture, teamwork and design in creating a context for safer care.

Patient safety solutions must focus on care between settings, not just within them. Medication reconciliation provides tools to address and prevent adverse drug events stemming from incomplete or inaccurate knowledge about patients' medications as they are admitted, discharged or transferred. But, as Olavo Fernandes and Kaveh Shojania (2012) discuss, this solution has been difficult to implement effectively. They argue that greater efforts are needed to ensure reliable medication reconciliation. More broadly, Irfan Dhalla and colleagues (2012) examine the patient safety threats stemming from poor integration and communication across systems of care. Transitions are complex and varied, and potential solutions need to incorporate a range of interventions and multiple providers before discharges, during transitions and after patients return to the community.

Much of the focus in the past decade has been on problems identified in major national patient safety studies. But other important issues have also emerged. Pat Croskerry (2012) notes that diagnostic error has received limited attention although it is a major contributor to adverse events and malpractice litigation. Croskerry traces the source of diagnostic error to the psychology of decision-making and cognitive bias. He urges greater emphasis on diagnostic reasoning in medical education and a continuing focus on these skills in practice. Safety is an issue outside of institutional settings too. Lynn Stevenson and her colleagues (2012) argue that home care is fundamentally different from hospital-based care and that we need to develop patient safety practices that are client- and family-centred and adaptable to the broad range of settings in which home care is delivered.

Each of these papers provides a lens through which to view a critical issue. While their coverage is not exhaustive, together they offer a perspective on our achievements and the challenges we still face. In a paper examining the strategic elements for broadening our efforts on patient safety and quality of care, I argue that we need to emphasize the business case for safety, move current initiatives to a broader scale and invest in capacity for and capability of leadership and staff to improve (Baker 2012). The gains of the past decade have been impressive, but we need to hard-wire and extend these efforts in our current system to ensure their impact and sustainability.

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