Patient safety is a topic that is top of mind for the vast majority of healthcare providers, policy-makers and, increasingly, care recipients themselves. In this final 2013 instalment of *Healthcare Quarterly*, we bring you a cluster of five articles that shed light on patient safety in a variety of forms and locations. In addition, you will find three individual articles on care funding, information management and evaluating mental health services.

Patient Safety and Quality

The first of the safety pieces takes a fresh approach by arguing for the merits of treating patient and staff safety as part and parcel of the same whole. Hailing from Island Health in British Columbia (BC), the authors make a persuasive case for demolishing the "traditional siloed approach," and they call on us to unite in realigning our governance systems, organizational structures and systems to achieve "integrated" safety. It's an interesting read, especially alongside Jennifer Kitts' short piece (included in this issue) on the Canadian Healthcare Association's recent position statement on healthcare workers' psychological health and safety.

The role of hand hygiene in preventing hospital-acquired infections is a near-universal tenet. While there has been great progress in convincing healthcare workers to clean their hands, Sharon Rogers observes that "patients and family members [have] not been systematically engaged in any meaningful strategy." At Toronto's University Health Network, therefore, a task force set about researching the subject and formulating tactics (e.g., deploying volunteers) to increase patient and family-member hand hygiene. One of their most interesting findings and key messages is the appeal to individuals' self-interest.

Our next patient-safety article concerns medication reconciliation, which, as Jane Coutts and her co-authors point out, could play a "key role in reducing health and financial burdens." The inadequacies of current medication reconciliation policies and practices across Canada are well known, as are the challenges to improvement, including workflow, lack of e-health systems and shortage of financial and human resources. Despite these obstacles, Coutts et al. point to instructive examples of progress from coast to coast. If this subject interests you, you will want also to read the précis (included in this issue) of the recent report on medication reconciliation issued by Accreditation Canada and three other organizations.

Coutts et al. underscore the need for a "system-wide solution," and our fourth article likewise looks to the same level, albeit from the perspective of measuring health quality. In this case, the Toronto Central Local Health Integration Network set about to understand and then assess quality across sectors and at points of transition within its system. A highly complex undertaking involving numerous provider organizations with variant measurement protocols and categories, the process eventually led to the creation of core themes and indicators (e.g., unscheduled in-patient readmissions within 30 days of discharge). "The power of data is strongest when it is shared and used," Rachel Solomon et al. conclude, while acknowledging that such use requires leveraging information to relate "activity in different parts of the healthcare system to one another."

Information of a less tangible kind informs Paula Chidwick et al.'s quest to develop a checklist to help give ethical and legal guidance to the discharge process for alternate-level-of-care patients. The authors' discussion of patient "capacity" is particularly helpful, and the two short case studies give instructive substance to a subject often shrouded in a certain amount of decision-making fog.

Funding Care

We return to BC in this piece on the activity-based funding (ABF) model used in that province for outpatient renal care. Widespread in other parts of the world but much less so in Canada, ABF's "essential components" in the BC instance are integrated point-of-care data capture (echoing a theme in Solomon et al.'s article), accurate patient volume projections and "protected" funding from the Ministry of Health. Since it was launched 10 years ago, the ABF has, Adeera Levin et al. observe, provided "effective incentives for innovation, accountability and collaboration," making it a key component in BC's "coordinated" approach to kidney care.

Managing Information

In Central Vancouver Island, researchers recently wrapped up a study examining the adoption of e-prescribing by primary care physicians. Comparing—through quantitative and qualitative analysis—the "ideal," "possible," and "current" states of e-prescribing, the authors arrived at five key findings that help to explain various barriers to physicians' full use of the tool. Their results also provide the foundation for clear technological, policy and interpersonal recommendations to improve e-prescribing adoption.

Primary Care

Our final article also concerns primary care. Elina Farmanova and her co-authors document the development and testing of evaluation tools for patients and providers receiving and delivering mental-health care within Ontario family health team (FHT) clinics. Pilot-testing (in English and French) of the unique questionnaires among 15 FHTs addressed six domains of care, including accessibility, continuity and comprehensiveness. As the authors note, their tools are the only such instruments specifically tailored for the FHT context; future validation efforts will be required, but this early work looks promising.

– The Editors