SPECIAL EDITION

Healthcare safety

WHAT'S INSIDE

IDENTIFYING RISKS
Finding where the problems reside

SYSTEMS THINKING
Taking a look at the big picture

THE SAFETY PERFORMER
Do you have the right stuff?

CHANGE IS GOOD
Taking action on healthcare safety

THE FUTURE OF HEALTHCARE SAFETY
Paving the way for safer care
SPECIAL EDITION/MAY

05 **Identifying the risks in medical practice**
Being aware of high-risk areas in medical practice can help you recognize the potential for unique risks in your own practice. Reading the CMPA’s research-based articles to identify the high-risk areas is one way to raise your awareness.

08 **How systems thinking can lead to safe care**
Discover why looking at healthcare systems makes a difference. Using this approach to preventing harm goes beyond the individual provider by identifying problems in the system of care delivery.

11 **The safety performer: Putting safe care at the forefront**
Do you have the right stuff to put safety first? Learn about the attributes and competencies of physicians who put safety at the forefront when caring for patients.

14 **Change is good: Taking action on healthcare safety**
You know what needs to change to make your practice safer, now you need to know how to implement the change. Learn about the available research; how to choose an approach to making change; how to recognize barriers and facilitators to change; and how to sustain change.

17 **Collaboration for the future of healthcare safety**
Healthcare organizations nation-wide are working together to improve patient safety. The CMPA is among them. The Association is committed to collaborating with others to push the healthcare safety agenda forward.
Every medical student is taught early in his or her training the Latin phrase *Primum non nocere*, “first, do no harm.” For physicians this means preventing harm and providing safe care, and this must be the first order of business.

As a physician, I have spent much of my life focused on providing safe care. Whether it has been through my work as a surgeon, teaching surgery to young physicians, or as a healthcare administrator and CEO, healthcare safety has always been a passion of mine. I have also seen the same shared passion and conviction to provide safe care among my many physician colleagues and I most definitely see it among our employees at the CMPA.

Whenever I speak on behalf of the CMPA, in defence of our commitment to protect our members, I reiterate: “I have yet to meet a physician who wakes up in the morning with the intention of doing harm.” As every physician knows, our healthcare system relies on a delicate set of interdependencies within a system of care that is complex, stressed, and ever-changing. Within this system, I believe that physicians share a conviction to prevent harm and to provide the best care possible.

As CEO of the Canadian Medical Protective Association, I am personally committed to supporting patient safety by advancing a multi-pronged approach in the prevention of harm from medical care. I truly believe that we can make the Canadian healthcare system safer by focusing our efforts and by first “doing no harm.” The CMPA’s new 2015–2019 Strategic Plan channels increased effort into our goal of supporting the safest possible healthcare system, and we intend to do so in collaboration with our members and other healthcare stakeholders.

This 2015 special edition of *Perspective* focuses on healthcare safety. The articles provide a thought-provoking blend of topics and tackle some of the key safety challenges faced by healthcare providers. It features articles on identifying safety risks at both the system and individual levels and explores why a culture of safety matters. It reviews the role of providers in safe healthcare delivery and examines how we can effect change to advance safety.

I hope this edition provides you with valuable tips and lessons learned that will support you in your continued commitment to deliver safe, quality care to your patients.

Yours in safety,

Hartley Stern, MD, FRCSC, FACS
Patient
The term “patient” is used in this publication to refer to the individual who is the subject of a patient safety incident. The term may also refer to the patient’s family when patient consent has been given to their involvement in the disclosure process; the patient’s substitute decision-maker where the patient lacks capacity to consent; or the patient’s legal representative when the patient is deceased.

Patient safety incident
The term “patient safety incident” is used in this publication. The World Health Organization (WHO) provides terminology to facilitate the sharing and learning of patient safety information globally. The Canadian Patient Safety Institute (CPSI) has adopted some of these terms.

To support clarity and consistency, the CMPA now uses these CPSI terms:

Patient safety incident: An event or circumstance which could have resulted, or did result, in unnecessary harm to the patient.

Harmful incident: A patient safety incident that resulted in harm to the patient. Replaces the terms “adverse event” and “sentinel event.”

No harm incident: A patient safety incident which reached the patient but no discernible harm resulted.

Near miss: A patient safety incident that did not reach the patient. Replaces the term “close call.”

In Québec, the applicable legislation defines the terms “accident” and “incident.” Neither of these terms correspond exactly to the WHO terminology. “An ‘accident’ in Québec means “an action or situation where a risk event occurs which has or could have consequences for the state of health or welfare of the user, a personnel member, a professional involved, or a third person.” The term ‘incident,’ on the other hand, is defined as “an action or situation that does not have consequences for the state of health or welfare of the aforementioned parties, but the outcome of which is unusual and could have had consequences under different circumstances.” The term ‘accident’ in Québec legislation would align with the WHO term “harmful incident” whereas the term “incident” would include the WHO terms “no harm incident” and “near miss.”

2. Disclosure Working Group, Canadian Disclosure Guidelines: being open and honest with patients and families, (Edmonton: Canadian Patient Safety Institute, 2011), 22
3. Québec, An Act Respecting Health Services and Social Services, CQLR c S-4.2, art. 8
4. Québec, An Act Respecting Health Services and Social Services, CQLR c S-4.2, art. 183.2
The growing emphasis on healthcare safety has spawned a dramatic increase in scientific knowledge about improvements in patient care and managing risk in clinical situations. Identifying the nature and sources of risk are important elements in quality and safety improvements. For its part, the CMPA contributes to a more thorough understanding of the nature of medico-legal risk in medical care through its analyses of closed cases.

The CMPA’s medico-legal cases help to identify potentially high-risk areas of practice. Notably, in the last 5 years surgery was the area of practice with the highest risk of being involved in a medico-legal matter. Almost half of closed CMPA cases in this period related to a surgical procedure. Diagnostic error, which is often difficult to identify and isolate from other associated issues, comprised 16% of the cases; medication was primarily involved in 8% of cases; and another 8% involved obstetrics.

Risk can also be identified by observing which groups of physicians are most often involved in legal actions. Physicians’ level of medico-legal risk is influenced primarily by the types of patients and conditions they typically treat, as well as by the procedures they perform.

The severity of patient outcomes can also determine the level of risk. Labour and delivery,
While reducing system-level risks may yield the greatest improvements in patient safety, healthcare providers are personally responsible for patient safety in the direct care they provide to their patients. In some cases, a healthcare provider’s personal characteristics place them at higher risk of a legal action or regulatory authority (College) complaint. In addition to attributes such as interpersonal skills, communication style, and technical skills and knowledge, clinical decisions are also shaped by human factors that include cognitive and affective biases.

These biases are a major area of study in the field of risk management and patient safety. Cognitive biases (i.e. distortions and short-cuts in thinking) and affective biases (i.e. intrusion of the physician’s feelings) may interfere significantly with reaching a correct diagnosis. Common cognitive biases associated with error include, anchoring (fixating on one particular symptom, sign, or piece of information, or a particular diagnosis); premature closure (accepting a first plausible initial diagnosis before making a reasonably complete verification); and attribution error (a form of stereotyping that involves explaining a patient’s condition based on their disposition or character). Because these biases are not always easy to spot, physicians must be vigilant to their existence and potential impact in individual cases.

As seen in the following case example, patient safety incidents often involve a combination of system and human factors.

While medico-legal case data can provide a useful snapshot of potential risk, evidence-based patient safety research and advanced analytics delve deeper into the complex reasons for patient safety incidents — at both the system and individual healthcare provider levels. Whether an organization is large or small, system refers to a healthcare organization’s work environment (including resources), processes of care, protocols, and fail-safe systems.

Beyond medico-legal case data

It is widely recognized that most patient safety incidents result from flawed systems and failures in processes. Because these incidents are often complex, involving multiple players and contributing factors, systems thinking approaches, such as patient safety incident analysis (formerly called root cause analysis), can be useful for identifying the potential multiple contributory causes of unintended outcomes. Indeed, the Institute of Medicine states that the most effective way to reduce error in medicine is to focus on system-level improvements.

WHAT IS A FAIL-SAFE SYSTEM?
The CMPA defines a fail-safe system as protocols, procedures, or systems in hospitals, offices, and clinics designed to prevent or mitigate errors. For example a process to follow up on the results of lab tests and diagnostic imaging studies so abnormal findings are flagged and reliably acted on is a fail-safe system. Another example is the use of checklists in surgery.

MEDICAL CARE ANALYTICS AT THE CMPA

The CMPA uses the following analytic practices to collect and understand medico-legal case data with the goal of contributing to safe medical care:

**CLINICAL CODING:** Case details, including contributing factors, are re-constructed with codes that comply with international standards. This facilitates comparison with other organizations.

**GRAPHING:** Diagrams show relationships between events and contributing factors. This identifies patterns of risk.

**MAPPING:** “Process-of-care” frameworks pinpoint where specific problems occur (e.g. in surgery looking at the pre-operative, operative, and post-operative phases of care). This identifies opportunities for individual and system improvements.

**MODELLING:** Statistical models seek to quantify the influence of certain factors on outcomes. This helps in understanding the contributors to patient harm.
The bottom line

Being aware of high-risk areas as identified through research, and appreciating the diverse influences of individual and system factors on patient safety can help physicians recognize the potential for unique risks in their practice environment. Additionally, physicians may find the following sources of information beneficial when attempting to identify and mitigate risk areas in their practice:

- patient safety incident and near miss reporting systems
- quality improvement reviews
- patient complaints
- morbidity and mortality rounds
- performance or comparative data from the Canadian Institute for Health Information audit results
- Accreditation Canada assessments

ADDITIONAL READING AT cmpa-acpm.ca

CMPP Good Practices Guide, section on Human Factors
“Learning from adverse events: Fostering a just culture of safety in Canadian hospitals and healthcare institutions”
How “systems thinking” can lead to safe care

The traditional response to a patient safety incident was to identify and blame the providers who had the last contact with the patient, which then led to calls for greater vigilance, better training, and sometimes professional sanctions or dismissals. Systems theory, on the other hand, looks at the system, rather than the individual, to identify problems and prevent future adverse outcomes. This stems from the understanding that preventing patient safety incidents often depends on the environment in which patient care is delivered, as well as the interactions between healthcare providers and patients.

There are many ways to analyze incidents at the system level, including use of retrospective and prospective methods. A culture of safety in which reporting patient safety incidents is encouraged, where analysis of incidents to identify causes is standard, and where healthcare providers are not punished for participating in quality improvement reviews is essential for addressing systemic flaws in healthcare systems.

The following case example illustrates how the prevention of maternal and fetal harm requires a strategic approach. Such an approach would be comprehensive and involve labour and delivery teams in multiple birthing units and hospital leadership. At the system level, health quality councils, regulatory and accrediting authorities, liability providers, maternal/fetal health collaboratives, and medical education accrediting bodies would also contribute, within their respective areas of responsibility, to improved outcomes.

Case Example

System Failures Result in Compromised Birth, Legal Action

A 26-year-old woman with a second pregnancy (G2P1) and who had had a previous Caesarean section is admitted after spontaneous rupture of her membranes at term. Her initial examination reveals a cervix at 2 cm dilation. She elects to undergo a vaginal birth. Over the next 6 hours her contractions decrease in regularity with no further progression of her cervical dilation. The bedside nurse calls the obstetrician who asks her to “start the oxytocin protocol.” The hospital has 2 oxytocin protocols: a low-dose protocol for augmentation of labour, and a high-dose protocol for induction of labour. The nurse and obstetrician do not discuss which protocol to use. The bedside nurse institutes the induction protocol. The obstetrician intended to use the augmentation protocol.

Over the ensuing 3 hours, the nurse regularly increases the infusion rate of the oxytocin. When she reaches the hospital protocol’s maximal oxytocin dose, the nurse elects to continue to increase the dose because she wants to get the contractions as close to every 2 minutes as possible [the latitude is not well outlined in the protocol].

The external fetal monitoring (EFM) strip records the fetal heart rate increasing from a baseline of 130-140 bpm to 160-170 bpm with the appearance of deep variable decelerations from...
Defining safety culture

A safety culture is one that demonstrates an organization-wide commitment to providing the safest possible care. A safety culture recognizes that, while mistakes do happen and outcomes are not always ideal, all healthcare providers share a common goal of providing quality care, and work collaboratively and share knowledge to achieve that goal. Individuals are encouraged to critically assess everyday situations for potential increased risk of harm to patients. Physicians and other providers learn from patient safety incidents when they do occur, and these are analyzed to prevent similar events in the future.

While the focus for quality improvement is on systems, individual physicians and other healthcare providers have responsibilities within the system and are accountable to comply with policies and procedures; practise only if healthy to do so; maintain knowledge and skills; participate in quality improvement activities; and learn from quality improvement reviews and patient safety incident analyses.

Reducing variations in care

An important aspect of healthcare system quality and safety is reducing inappropriate variations in care. Such variations can be reduced using a variety of approaches including clinical practice guidelines and checklists. As well, physicians should be aware of and follow their institution’s safety policies, such

which the fetus recovers spontaneously. The patient later develops a low grade fever and the nurse calls the obstetrician to assess the patient but does not mention the change in the EFM strip. The obstetrician looks at the EFM strip but does not ask about the rate of oxytocin infusion and does not examine the patient. The physician orders antibiotics for the possibility of chorioamnionitis.

Thirty minutes later, the EFM shows a prolonged deep late deceleration which does not recover. An urgent examination reveals palpable fetal parts through the maternal abdominal skin. A uterine rupture is diagnosed and a Caesarean section confirms the diagnosis. The infant is left with significant developmental delay and physical disability requiring lifelong care.

A legal action is commenced. Nursing experts are critical of the nurse’s failure to respect the oxytocin protocol and exceeding the maximal allowable dose, and for failing to identify the significance of the change in EFM tracing after the start of the infusion. Medical experts are critical of the physician’s unclear communication with the nurse, failure to follow up on the effect of the oxytocin, failure to review the dose and rate of infusion, and not examining the patient’s abdomen when she reassessed the patient for fever. Without expert support, a settlement is paid by the CMPA, on behalf of the member physician, and by the hospital on behalf of the nurse.
mental models for communication (whereby care team members share their perceptions of a situation), and speaking up. Tools such as handover mnemonics, the two-challenge rule,3 and techniques such as CHAT (Context, History, Assessment, Tentative plan) and CUS (Concerned, Uncomfortable, Scared) can also help improve communication and safety.

Simulations enable physicians and other healthcare providers to develop and refine their skills without compromising the safety of patients, and permit providers to gain experience with checklists and other tools that impact quality of care. Repetitive simulations with the entire team create a safe environment to learn and practise, and simulation debriefings encourage open dialogue across the team.

The bottom line
The prevention of avoidable harm requires a multi-faceted approach that involves systems thinking. Such an approach includes contributing to a just culture in which patient safety incidents are reported and analyzed to avoid recurrence, and collaboration among care providers to critically assess everyday situations for potential risk. The best possible outcomes for patients may be achieved when all care providers share a collective responsibility to deliver safe medical care.

2. Two-challenge rule: A rubric for challenging others using a conversational technique that is assertive and collaborative, and which may improve the frequency and effectiveness with which healthcare providers “speak up” to others, including superiors.
The safety performer: Putting safe care at the forefront

Physicians strive to provide quality care for their patients, but how can they do so safely?

Much progress has been made in recent years to understand the attributes and competencies of physicians who put safety at the forefront when caring for patients. Medical schools, medical associations, regulatory authorities (Colleges), and the CMPA, among other organizations, are working to nurture these qualities and help to advance healthcare safety.
Affect their decision-making. They look after themselves by staying healthy, avoiding fatigue, and managing stress. Such physicians seek to continuously improve their knowledge skills by participating in professional development activities. And lastly, they recognize when a patient safety incident or a near miss has occurred and respond appropriately. They disclose the incident to patients in an appropriate manner, learn from the experience to improve their own performance, and support necessary system changes to prevent recurrences.

Safe approaches to patient care

The ways in which physicians work with and care for their patients may also contribute to safety. For example, physicians may opt for specific approaches to help deepen patients’ involvement in their care, including actively listening to patients and families, responding to patients’ concerns, providing information in the manner patients prefer to receive it, and carefully considering patients’ level of health literacy. Helping patients understand the implications of the care plan and engaging them in the decision-making process strengthens the exchange and partnership between physicians and patients. This may also enhance the safety of care.
As well, physicians should be attuned to cultural influences which may impact care. A lack of cultural competence can affect patient safety and impact overall health outcomes.¹ To deliver culturally safe care, physicians must develop a relationship of trust with patients and families, one that recognizes and respects individual differences.

**Learning, improving, growing**

Learning and incorporating safety competencies into practice does not necessarily come automatically. These competencies must be encouraged and nurtured.

Organizations such as the Royal College of Physicians and Surgeons of Canada (RCPSC) and the College of Family Physicians of Canada (CFPC) are increasingly emphasizing medical education that focuses on patient needs and the competencies required by physicians to meet those needs. The competency-based approach shifts the emphasis away from the traditional time-based model of education (i.e. number of hours spent in residency programs) and places it on assessing performance and self-auditing of quality.

Later in 2015, the RCPSC’s CanMEDS framework will incorporate milestones for each of the CanMEDS roles (i.e. medical expert, communicator, collaborator, leader, health advocate, scholar, and professional). The milestones will reflect the abilities expected of physicians at defined stages of development and provide clarity for both learners and evaluators as to when a learner is ready to move to the next stage of training. In future, milestones will be integrated from the beginning to the end of a physician’s practice.

Physicians may also be familiar with the safety competencies identified by the Canadian Patient Safety Institute. These competencies identify the knowledge, skills, and attitudes of safe performers in such areas as contributing to a culture of patient safety, working in teams, communicating, managing safety risks, human and environmental factors, and disclosing patient safety incidents.²

---

**Leveraging CMPA educational resources to improve practice**

The CMPA, too, has renewed its educational programming to better focus on safety at both the individual practitioner level and system level. These efforts are being incorporated into the Association’s current offerings — e-learning and education articles. Moreover, the Association’s 2015-2017 symposia and regional conferences focus on practical tips for safe care including diagnosis, prescribing, effective communication between healthcare providers, and pitfalls to avoid when using electronic communication and electronic medical records. Indeed, CMPA members know that the best protection for physicians and their patients is to prevent patient harm from occurring in the first place.

Online resources such as the **CMPA Good Practices Guide** (available at cmpa-acpm.ca/gpg) are increasingly important learning tools. The guide identifies ways of thinking and acting that the CMPA believes will help physicians provide safe care. It focuses on many of the non-clinical aspects of medical practice that contribute to positive patient outcomes, including communication, teamwork, diagnostic processes, cognitive and environmental factors, and cultural and boundary issues.

Continuing education is an important part of becoming a safety performer, but is not a panacea. Attending education sessions and earning CME credits help individual physicians remain up to date, but it may not be enough. Physicians need to reflect on their practice and seek to implement what they learn to improve care. Education needs to be interactive and ongoing, and will likely increasingly take place at the point of care with clinical decision support tools — in other words, it will be integrated into everyday practice.

---

¹. The Hospital for Sick Children, “Introduction to clinical cultural competence,” Cultural competence E-learning modules series, 2013 (slide 10)
Change is good: 
Taking action on healthcare safety

In the quest toward making healthcare safer, physicians and other healthcare providers must first uncover those practices which pose an avoidable and unacceptable risk to patients. Once unsafe practices are exposed, the next step is to take action.

But where do you begin?
Based on various factors such as personal observation of potential risks or reading about best practices, physicians may conclude that a practice needs to be made safer. After determining an activity needs to change, physicians typically look for evidence-based research, choose a new approach from the most appropriate activity, and adapt it to their setting.

In the search for evidence-based practices, doctors and other providers can refer to numerous resources such as those offered by the Canadian Patient Safety Institute and the Agency for Healthcare Research and Quality in the United States. They can also turn to medical and healthcare organizations for evidence-based research. The Canadian Medical Association, for instance, offers CMA Infobase, a database of Canadian clinical practice guidelines. The College of Family Physicians of Canada website offers links to databases and search tools that contain guidelines, systematic reviews, primary research, and critically appraised topics. Through its extensive educational resources, the Canadian Medical Protective Association identifies potential risks in medical care based on research into medico-legal cases.

Doctors may also want to explore the online resources offered by universities with healthcare faculties. For example, the University of British Columbia’s Continuing Professional Development program offers an online resource called “This Changed My Practice.”¹ There, a team of local opinion leaders distill the findings from clinical trials and identify those which were significant enough to change how they deliver care.

Some governments also offer best practice resources. The Government of Manitoba, for instance, offers online patient safety resources focused on healthy living and seniors.² Many libraries provide a wealth of information as well. For example, the Cochrane Library provides access to the Cochrane Reviews — internationally recognized reviews of primary research in healthcare and health policy.

Physicians may also want to research ready-to-adopt patient safety strategies. In 2013 the Agency for Healthcare Research and Quality published the article “Making Health Care Safer II: An Updated Critical Analysis of the Evidence for Patient Safety Practices.”³ The article evaluated the evidence for a large number of patient safety practices, for example, using preoperative checklists and identifying patients at risk for suicide. It identified practices that are “strongly encouraged for immediate adoption by healthcare providers” as well as ones that are “encouraged” for adoption.

After evaluating the evidence healthcare providers should also think about how the recommended practices will fit into their particular setting. For example, will the new activity be appropriate for the patient population’s characteristics and values? Does the new activity require skills, equipment, or other resources, and are these available? Will physicians be able to measure the outcomes the changes have brought to their practice?

Choosing an approach

The next step is finding an approach, model, or framework to begin moving evidence-based information into practice. More than ever, physicians and other healthcare providers have a plethora of implementation models to choose from.

The Canadian Patient Safety Institute (CPSI), for example, provides a detailed framework called Improvements Framework, Getting Started Kit, available on the institute’s website.⁴ Geared to interprofessional and interdisciplinary teams, the kit is based on the PDSA cycle (Plan, Do, Study, Act). The CPSI also offers information on other frameworks, such as Six-Sigma, Positive Deviance (PD), and Lean Improvement.

The Canadian Institutes of Health Research also offers a framework guide for healthcare practitioners. Titled Moving into action: We know what practices we want to change, now what? An implementation guide for health care practitioners,⁵ the online tool provides steps for implementing changes based on evidence.

In determining which framework to use, healthcare providers should consider which one best suits their particular situation. For instance, a simplified model is likely better suited to a solo medical practice, while more complex models may be more appropriate for larger organizations.
Barriers and facilitators

Implementing new safety practices is more effective when healthcare providers take potential barriers and facilitators into consideration. Barriers and facilitators can be identified by examining the characteristics of the proposed change, individual care providers, local setting, and organization (i.e. resources and culture).

Research shows that innovations will be more easily adopted if healthcare providers view them as being evidence-based and more beneficial than the old practices. Innovations requiring new knowledge or skills are more likely to be adopted if the providers see them offering an opportunity to grow professionally. Conversely, this innovation may be a barrier if the resources for gaining new skills are not readily available. Changes in practice are more successful when healthcare providers know a new approach is urgently needed because the status quo is inadequate, and when providers are engaged in the change process and have an opportunity to contribute their knowledge and expertise.

The use of champions — individuals appointed to promote and mentor the adoption of an innovation — may be beneficial in helping to implement change, particularly when clinical champions work with managerial and executive champions.

A patient’s attributes can also either impede or facilitate practice innovation. Patients with strong literacy skills, for instance, may be better equipped to take an active role in their care and make a change easier to introduce. Low levels of individual health literacy have been found to contribute to poorer health outcomes, increased risk of adverse events, and higher healthcare costs. Giving patients or their family specific information on what they can do to manage their healthcare may increase their health literacy.

Measuring the impact, sustaining the change

Finally, when implementing a change, physicians and other providers must determine how they will know if the change improved care. In their implementation plans, they should include a data collection methodology to ascertain whether the change had a positive effect on safety or not.

Many organizations offer tools on how to test changes. For example, the Canadian Patient Safety Institute’s Getting Started Kit provides instructions on testing changes. If the change is positive, the kit gives providers information on how to sustain it.

Changing practice, improving safety

Transferring evidence-based research into practice requires effort and a well thought-out plan. Physicians and other providers can improve the safety of healthcare by identifying evidence-based research and practices, choosing an effective plan or framework for making the change, considering potential barriers and facilitators, testing the impact of the change, and considering the change’s sustainability.

---

1 Faculty of Medicine, University of British Columbia. “This Changed my Practice.” Accessed January 21, 2015 from: http://thischangedmypractice.com/
6 Ibid, p.12
Collaboration for the future of healthcare safety

The expression, “many hands lighten the load,” rings true for the future of healthcare safety in Canada. Medical associations, regulatory authorities (Colleges), federal and provincial health associations, hospitals, and others involved in healthcare generally understand the importance of safe care, and are actively working to raise awareness about safety and reduce harm to patients.

While there are many organizations in Canada that play a strong role in the healthcare safety domain, several stand out.

The Canadian Patient Safety Institute\(^1\) (CPSI) provides leadership for patient safety in Canada, and seeks to build and influence safety knowledge and skills at team, organizational, and system levels. The organization offers education, training, and resources, and supports research on specific patient safety topics. CPSI also leads the Safer Healthcare Now!!\(^2\) program, which gives front-line providers and healthcare organizations clinical interventions that are known to reduce avoidable harm. The CMPA has been involved in a number of the institute’s priority areas and summits, including surgical care safety, medication safety, and infection prevention and control.

Patients for Patient Safety Canada\(^3\) is a patient-led program of CPSI. The group represents the voice of the patient in the healthcare safety discussion. Patients and their families are a valuable resource for healthcare providers in efforts to reduce harm to patients. They possess unique knowledge about the patient experience, which providers can use when making decisions about care. Patients can also help create safety tools and resources, plan and implement safety improvements, and motivate health providers to reach new levels of safety.\(^4\)

Canada’s provincial quality health councils work closely with ministries of health, health
Medical associations and medical regulatory authorities are also highly engaged in safety. Whether it’s continuing medical education or physician wellness initiatives offered by medical associations or federations, or Colleges monitoring and maintaining standards of practice, healthcare safety is a significant part of their mandates.

Hospitals and other health facilities

Hospitals, regional health authorities, and other health facilities are also central to healthcare safety. Within organizations, a robust culture of safety is a powerful tool for reducing patient harm. That culture is strengthened when healthcare providers, leaders, and patients share a collective commitment to safety and quality improvement processes that are based on fairness and trust. Further, the culture is strengthened by teamwork, structured communication, measurement, and safety teams.

We all benefit when hospitals across the country continue to demonstrate their commitment to safety and tackle areas for improvement, whether through hand hygiene or falls prevention programs, for example, or by improving discharge plans to reduce preventable readmissions.

Every physician counts

Every physician has a part to play in improving the safety of care. No matter what the practice arrangement or work setting, physicians should review their practice, knowledge, communication skills, and team functioning abilities with a view to consistently providing safe medical care.
or workgroups), practices, and even the uptake of technology to enhance patient safety. By getting involved in improving healthcare safety, physicians can provide direction, contribute knowledge, and partner with patients and other providers for better outcomes.

Healthcare provider safety

The future of healthcare safety also includes the safety of physicians and other providers. Physicians, nurses, and all healthcare professionals must be safe at work, including safe from infections, medical equipment mishaps, verbal and physical assault, and other harmful situations.

When a patient is harmed, doctors and other providers often suffer shock, sadness, fear, and stress. These providers require treatment that is just, and they require respect, compassion, supportive care, transparency, and an opportunity to contribute to the prevention of future safety incidents. Hospitals and other healthcare institutions need to establish effective support initiatives for healthcare providers involved in patient safety incidents, and providers must know how to access assistance.11

Sharing lessons learned

There is growing recognition that healthcare providers everywhere need to share their safety knowledge to prevent the reoccurrence of patient safety incidents and to improve patient outcomes. While reporting systems for sharing information exist, all healthcare stakeholders need to learn safety lessons from other providers, organizations, or jurisdictions. If insights and lessons arising from patient safety incidents or near misses are not shared, neither healthcare providers nor patients benefit, and the healthcare system is weakened. Physicians should support the sharing of patient safety lessons, as well as the solutions implemented to prevent harm. Physicians can do so while respecting any restrictions or requirements that might apply due to provincial or territorial legislation, regulations, hospital/institutional bylaws and policies, and legal privilege.

CMPA support

The CMPA is committed to being an essential component of the healthcare system. As the Association continues to advance a system level approach to the prevention of harm, it expects to collaborate even further with other healthcare organizations to push the healthcare safety agenda forward.

1. For more information about the Canadian Patient Safety Institute, see: http://www.patientsafetyinstitute.ca/English/About/Pages/default.aspx
2. For more information about the Canadian Patient Safety Institute’s Safer Healthcare Now! program see: http://www.saferhealthcarenow.ca/EN/Pages/default.aspx
6. For more information on the British Columbia Patient Safety and Quality Council, see: http://bospqc.ca/
7. For more information, see: http://www.msss.gouv.qc.ca/ministere/vigilance/index.php?accueil
9. For more information on ISMP Canada, see: http://www.ismp-canada.org/
10. ECRI Institute, Medical Leaders in Patient Safety, Accessed October 31, 2014 from: https://www.ecri.org/Products/Pages/Medical_Leaders_in_Patient_Safety.aspx
UPCOMING CMPA EVENTS
cmpa-acpm.ca

CMPA FULL-DAY SYMPOSIA
Calgary – May 29th
Québec – October 2nd (offered in French)

CMPA EVENING REGIONAL CONFERENCES
New Brunswick
Moncton – May 5th
Saint John – May 6th
Fredericton – May 7th

British Columbia
Victoria – June 9th
Nanaimo – June 10th
Kelowna – June 11th

CMPA ANNUAL MEETING AND INFORMATION SESSION
Halifax – August 26th
Information session topic
End-of-life care : Medical legal issues

• Earn CME credits
• Network with your colleagues
• Get advice from CMPA physicians and legal experts