Submitted by

Canadian Institute for Health Information

Canadian Institute
for Health Information

Institut canadien
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Robert Thompson
Task Force on Adverse Health Events
Government of Newfoundland and Labrador
Suite 1100
West Block, Confederation Block
P.O. Box 8700
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Dear Mr. Thompson:

Re: The Task Force on Adverse Health Events, Call for Submissions

The Canadian Institute for Health information (CIHI) is one of Canada's premier sources of accurate, timely and comparable health information. CIHI offers an array of databases, registries and products, including standards, publications and analytic reports, which provide quality information to inform system improvements and to impact the quality and safety of health services provided to Canadians. This document outlines CIHI's patient safety resources which may be of relevance to the Government of Newfoundland and Labrador's Adverse Health Event Management Framework.

Canadian Medication Incident Reporting and Prevention System

CIHI has collaborated with the Canadian Patient Safety Institute (CPSI), the Institute for Safe Medication Practices Canada (ISMP Canada), Health Canada and other stakeholders to establish the Canadian Medication Incident Reporting and Prevention System (CMIRPS). Within this collaboration, CIHI's role has focused on the development of a Hospital-Based Reporting System for the CMIRPS program. This is a free, pan-Canadian voluntary and anonymous incident reporting system, which hospitals will use to submit medication incident data for the purposes of 1) learning from breakdowns that occur in the medication-use system within facilities; and 2) supporting risk management and quality improvement activities at the local level.

The CIHI Hospital-Based Reporting System includes a secure and confidential data entry tool, a query and analytical tool and a non-identifying communication tool. The reporting system has been designed to minimize the burden of data collection while maximizing its potential through standardized reports and tools. These tools will offer participating organizations an improved ability to submit medication incident data and to conduct local analyses, thus providing a stronger basis for decision-making and a broader capacity for knowledge sharing. Participating organizations will have access to their own data as well as pan-Canadian de-identified incident data. CIHI supports the Hospital-Based Reporting

System with education and client support product/services, including a Resource Manual/User Guide, Standard Operating Procedures, and associated e-Learning Tools.

A four-month national pilot test of the CIHI Hospital-Based Reporting System is scheduled to begin in autumn 2008. It is anticipated that the reporting system will be ready for a phased in national implementation in 2009.

Safer Healthcare Now!

CIHI is a participant organization of the pan-Canadian Safer Healthcare Now (SHN!) campaign. This is a collaborative effort aimed at achieving measurable reductions in avoidable morbidity and mortality. In addition to supporting the campaign's goals and its measurement strategy, CIHI's Discharge Abstract Database (DAD) records acute myocardial infarction (AMI) measures for the campaign's data collection. CIHI has developed draft data collection guidelines for a project field in the DAD, which allows hospitals to enter the additional AMI data in a consistent manner.

Hospital Standardized Mortality Ratio

CIHI has led the effort in calculating the Hospital Standardized Mortality Ratio (HSMR) for Canada. The HSMR is an important new measure that can help support efforts to improve patient safety and quality of care in Canadian hospitals. The HSMR compares the actual number of deaths in a hospital with the average Canadian experience, after adjusting for several factors that may affect in-hospital mortality rates, such as the age, sex, diagnoses and admission status of patients. The ratio provides a starting point to assess mortality rates and identify areas for improvement, which may help to reduce hospital deaths from adverse events.

Publications & Reports

To date, CIHI has produced several reports addressing patient safety:

- *The Canadian Adverse Events Study: the incidence of adverse events in hospital patients in Canada.* G. Ross Baker, Peter G. Norton et al. Canadian Medical Association Journal • May 25, 2004; 170 (11).

  CIHI, along with the Canadian Institutes for Health Research (CIHR), jointly funded the first national study of patient safety in Canadian hospitals.

- *Health Care in Canada, 2004*. Ottawa, Ont.: CIHI, 2004.

  The first part of Health Care in Canada 2004 is devoted to safe care. It includes information on what safe care is, as well as both what is known and unknown about patient safety in Canada and worldwide.

- *Patient Safety in Canada, an Update.* Ottawa, Ont.: CIHI, 2007.

  This report measures the risk of a wide range of adverse events in Canadian health care delivery, including medication errors, in-hospital hip fractures, and traumas sustained during the birthing process. Focusing on results from recent surveys, as

well as several patient safety indicators, this CIHI analysis builds on CIHI's report Health Care in Canada 2004.

- *HSMR: A New Approach for Measuring Hospital Mortality Trends in Canada.* Ottawa, Ont.: CIHI, 2007.

  This is the first report in Canada on the hospital standardized mortality ratio (HSMR). It includes the first publicly available HSMR trends over three fiscal years (2004–05 to 2006–07).

- *Resident Safety: Characteristics Associated With Falling in Ontario Complex Continuing Care.* Ottawa, Ont.: CIHI, 2007.

  This report identifies characteristics associated with a continuing care resident's risk of falling in a facility.

- *Medication Incident Reporting and Prevention Systems Environmental Scan.* Ottawa, Ont.: CIHI, 2007.

  This document highlights relevant research and information management activities, as well as progress achieved to date related to medication incident reporting and prevention, both nationally and internationally.

- Health Indicators Report

  The Health Indicators Report aims to support regional health authorities in monitoring the health of their population and the functioning of their local health system through quality comparative information. The rate of in-hospital hip fractures for seniors is one of the patient safety indicators at the regional, provincial/territorial and national levels reported annually in this report.

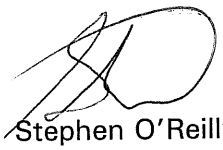
- Hospital Report: Acute Care

  The Hospital Report series is a joint initiative of the Ontario Hospital Association and the Government of Ontario. Patient safety indicators presented in this report include indicators on nurse-sensitive adverse events (conditions captured in this indicator are widely considered to be sensitive to nursing care) as well as adverse events for labour and delivery, documentation and reconciliation of patient medications and reports on the adoption of patient safety policies and practices (Patient Safety Reporting and Analysis, Promoting a Patient Safety Culture and Hand Hygiene Practices Indicator.)

All CIHI publications and analytic reports are available at www.cihi.ca. If you require additional information or more detailed statistics, you may contact CIHI for a custom data request. All data requests are subject to CIHI's principles and policies for the protection of health information.

Through measurement strategies, data analysis and reporting, CIHI is committed to producing high quality information to assist decision makers and policy developers in their efforts to improve the quality and safety of health services. If CIHI can be of further assistance to the Task Force, please contact us at the information below.

Yours truly,



Stephen O'Reilly
Executive Director