Submitted by

Eastern Health

EASTERN HEALTH

Submission to the Task Force on Adverse Health Events

July 2, 2008

Introduction:

The Eastern Regional Integrated Health Authority (Eastern Health) was established in 2005 from the merger of seven legacy health care boards in the province of Newfoundland and Labrador. Eastern Health is responsible for the operation of community –based services, public health, institutional health care facilities and medical clinics. There are 871 acute care beds, 87 critical care beds and 1, 684 long term care beds, in addition to numerous community based services. There are approximately 12,000 employees, 600 physicians, over 3, 000 volunteers providing services. It serves a regional catchment area of approximately 292, 000 residents over a large geographic area comprised of urban and rural sites, as well as the whole province for select services.

The development of best practices in healthcare is paramount to patient safety. Patient Safety is defined by the Canadian Patient Dictionary (2003) as the reduction and mitigation of unsafe acts within the healthcare system, as well as through the use of best practices shown to lead to optimal outcomes. Patient safety initiatives have been increasingly on the national and international agenda in recent years. In 2002, Health Canada established the Canadian Patient Safety Institute in an effort to coordinate best practices and national standards in the area of patient safety. In 2004, the report of Baker and Norton's Adverse Events study emphasized the need to improve patient safety in Canadian hospitals. The study reported the incidence of adverse events to be at a rate of 7.5% of acute care hospital admissions. Of these, it is estimated that 70,000 were

preventable adverse events. This research supports the development and implementation of initiatives to improve patient safety.

Eastern Health adheres to the philosophy of providing high quality service and care that is evidence based and consistent with its strategic plan. In keeping with patient safety this submission to The Task Force on Adverse Events will highlight the issues that impact the coordination and management of adverse events. An adverse event is defined by the Canadian Patient Safety Dictionary as an unexpected and undesired incident directly associated with the care or services provided to the patient; an incident occurs during the process of providing health care and results in patient injury and death; or an adverse outcome for a patient, including an injury or complication.

There are many components related to patient safety of which the management of adverse events is only one. This submission will focus mainly on the issues related to the management and prevention of adverse events.

While Eastern Health is responsible for the management of adverse events, there are related issues that require provincial involvement and/or coordination:

1. Coordination of the management of adverse events that involve more than one health authority
2. Development of consistent definitions, policies and procedures related to adverse events throughout the province

3. Development of mechanisms to share information from adverse events throughout the province's healthcare system
4. Development of public notification guidelines
5. Review of relevant legislation such as the *Evidence Act, Public Inquires Act, Access to Information and Protection of Privacy Act, Child and Youth Advocate Act, Citizen's Representative Act*, to identify the implications for Quality/Peer Review processes
6. Support for the development of a " just and trusting culture" and to improve the reporting of adverse events and learning's from them to prevent re-occurrences
7. Funding for the provision of increased resources for information technology and human resources for the management of adverse events
8. Physician engagement

1. Central Coordination for Management of Adverse Events:

When an adverse event involves multiple patients and/or more than one Health Authority, the degree of complexity multiplies in managing the adverse event. Challenges in the areas of accessing and sharing information, identifying roles and responsibilities of each Authority, disclosure, documentation and ongoing monitoring of progress towards effective resolution must be addressed, if not, there is the potential to increase the negative impact on patients and families .

Eastern Health recommends the designation of a person or monitoring committee to provide provincial coordination and/or assistance in the event of adverse events that involves more than one Health Authority depending on the complexity.

2. Development of Consistent Definitions, Policies and Procedures:

There is a need to have consistent policies related to adverse events throughout the province. These policies include, but are not limited to, Sentinel Event, Occurrence Reporting, Just and Trusting Culture and Disclosure of Adverse Events. These policies should have a common language so they are applied consistently throughout the province. The use of common definitions is necessary if there is information that can be used for comparative analysis and trending.

A key development in the patient safety movement in the past decade has been the call for a common taxonomy for categorizing adverse events. This would guide the principles of classification and aid in understanding why an event happened, how it happened and what the impact of the event is on patient and providers. A consistently applied taxonomy is an important part of any comprehensive patient safety program by providing the structure for the organization's occurrence reporting system.

The World Health Organization (WHO) is in the process of developing an internationally acceptable taxonomy for this purpose. Eastern Health is in the planning stages of introducing a standardized electronic occurrence reporting system and as part of that process is developing a taxonomy reflective of current national/international standards. It is the intent to incorporate the WHO classification where possible.

Eastern Health recommends development of standardized policies and procedures and a standardized taxonomy throughout all provincial health authorities and supports a consistent interpretation of adverse events throughout the province.

3. Development of Mechanisms to Share Information from Adverse Events:

In an attempt to standardize provincial patient safety policies and develop a way to share information across the province a mechanism is needed. The primary purpose would be to share information throughout the province on risk management and adverse events and to provide a forum for education. A provincial network would also be an opportunity to have provincial safety conferences and training in quality improvement tools. However, there may be greater acceptance throughout all key stakeholders, such as Educational Institutions, Regulatory Bodies and Medical staff if this critical need was a government coordinated activity.

Eastern Health recommends that there be provincially sponsored mechanisms to build a forum to share information and learning's related to adverse events.

4. The Development of Public Notification Guidelines:

In 2008 the Canadian Patient Safety Institute released the Canadian Disclosure guidelines. The purpose of these guidelines "is to support and guide health care providers in these communications and to encourage organizations to develop policies and processes to effectively support the communication between the patients and providers." This document is very useful to organizations in the development of their patient disclosure policies however there is little in the document to assist with public notification of adverse events.

Sherry Espin recently reviewed the literature regarding disclosure in healthcare for the Commission of Inquiry on Hormone Receptor Testing. In her paper, she states

"healthcare organizations have to balance the privacy of patients and the public's right to know." This literature review is useful in assisting organizations in the development of guidelines and policies for public disclosure, and Health Authorities would benefit from a consistent approach.

Eastern Health recommends the development of a discussion document to support provincial public notification guidelines. .

5. Review of Relevant Legislation and Regulations:

Currently, Eastern health interprets the *Evidence Act* in this province as protecting quality and peer review documents and processes. This is critical protection in the investigation of adverse events as it supports a just and trusting culture by allowing open discussion of opinions. Many internal patient safety processes, such as quality reviews, mortality and morbidity rounds have developed under the protection the Act provides; that the opinions expressed cannot be disclosed. Since facts are not protected, the legislation does not inhibit the key patient safety activity of sharing adverse events.

Over the past several years, there are many legislative statutes in this province that have implications for quality processes. These statutes have legislative authority to protect evidence, provide information, produce documents, compel evidence and investigate .In addition Judge Dymond's decision in the Supreme Court of Newfoundland and Labrador raised concern about whether Eastern Heath had properly constituted quality committees in place. The *Public Inquires Act* has the power to compel evidence in relation to quality review documents. Section 5 of the *Access to Information and Privacy Act* regulations provides that the *Evidence Act* shall prevail over access to information requests. There are

investigative powers under the *Citizen's Representative Act* and it has the power to request any records for review, however records will not be released from their office. The *Child Youth Advocate Act* has the right to information respecting children and youth and may compel the release of quality review reports; only solicitor-client documents are protected. Health Authorities in this province require clear direction to move the area of quality review forward.

As well, it is necessary to review the language in the Board and Medical Staff By-laws so that there are consistent approaches provincially with respect to language.

Eastern Health recommends that there be a review of all relevant legislation that has implications for the protection of quality review processes and that there is provincial direction in relation to the implications of provincial legislation;

Eastern Health also recommends that there be provincial direction on the Medical and Board by –laws with respect to language and standard mechanisms for recording and sharing of information as it relates to quality and peer reviews.

6. Support for the Creation of a "Just and Trusting Culture"

The consensus of the researchers conducting patient safety related studies such as Brennan et al, 1991, and Wilson et al in Australia in 1995 was that the largest issue in patient safety was system error rather than individual error. In other words, it was the way a task was performed by a provider in health care, rather than the provider performing the task.

Other researchers such as Wieman & Wieman (2004) explain that this focus on the system within healthcare is the preferable method to prevent errors in medicine. This is further expanded by Ralston & Larson (2005) who discuss that the system approach is the fundamental premise in transforming a health care organization to one, which ensures patient safety.

In Canada, the Canadian Adverse Events Study by Baker and Norton in May 2004 found "that the greatest gains in improving patient safety will come from modifying the work environment of health care professionals, creating better defenses for averting [adverse events] and mitigating their effects" (Baker et al, 2004, p. 1685).

While critical in promoting a safer system, it is imperative that this focus does not dismiss, or dilute, professional or personal accountability. A balance has to be made by the organization to support the focus on the prevention of system error while at the same time not decreasing the individual level of accountability. In the promotion of a just culture, the consistent application of tools such as the National Patient Safety Agency *Incident Decision Tree*, allows Authorities to consistently and fairly make this balance between system error and individual accountability. Unfortunately, the creation of a just and trusting culture is a challenge for many organizations, particularly in our current climate where the actions of individuals are publicly criticized.

Eastern Health recommends that the province recognize the importance of developing a just and trusting culture and assist in creating an environment conducive to this philosophy.

7. Funding for the provision of increased resources

Management of adverse events involves the investigation of actual adverse events including such activities as chart reviews, interviewing, data analysis, contacts with patients and report writing. It can require significant resources especially when it involves more than one patient. Current resources tend to be consumed mostly on these reactive activities. The best approach to adverse events would be to prevent their occurrence in the first place. There are numerous initiatives which must be put in place to assist in the reduction of adverse events. Examples of this include expertise in data management, involvement in national campaigns such as Safer Health Care Now, education in adverse event management and quality improvement tools. There is also a need for positions dedicated to health system re-design and more quality and risk management positions and infection control practitioners.

It is critical to have expertise and resources in data management to assist with the coordination and analysis of data, which allows organization to focus resources on areas of concerns.

There has to be dedicated human resources to support national initiatives such as Safer Health Care Now a campaign supported by the Canadian Patient Safety Institute. Eastern Health has five active teams enrolled in three strategies. These strategies include:

- The improved care of acute myocardial infarction
- Prevention of ventilator associated pneumonia
- Prevention of surgical site infection

It is necessary to have funding for education initiatives for Quality and Risk Management staff to be trained in areas of patient safety. Examples if this include the Patient Safety Officer course that is delivered through the Canadian Patient Safety Institute. Funding is also needed for Quality and Risk Management staff to be trained and then deliver the training to staff in quality improvement tools such as Failure Mode Effect Analysis (FMEA), Root Cause Analysis (RCA), and Plan Do Study Act (PDSA) .

The funding for the addition of new resources is needed in the area of Health System Design and Management. The Conference Board of Canada has established a Centre for Health System Design and Management which provides a forum for health care decision makers to focus on system design and overall quality and efficiency. It conducts research on how current health care system can be improved.

The addition of resources in the area of Infection Control is also important. It is noted that healthcare acquired infections (HAI's) pose a serious threat to patient safety. According to the Canadian Patient Safety Institute, healthcare acquired infections constitute a major category of adverse events in Canadian hospitals. In Canada each year 222,000 patients get a HAI and 8000 of these patients die from their infection. These infections increase hospital stay about four days and cost the health care system one billion dollars per year. This is also a concern in long term care facilities and community care settings. It has been suggested that resources in this area for education, monitoring and developing best practice guidelines up to one half of health-care acquired infections can be prevented. Therefore, it is crucial to have sufficient numbers of Infection Control Practitioners for prevention initiatives, education and the implementation of infection control recommendations.

Eastern Health recommends strategic funding in this area for human resources and data management systems to improve the management of adverse events and enhance prevention initiatives in patient safety.

8. Physician Engagement:

Physicians are a core element in the provision of health care to the people of our province. It is essential that physicians are actively engaged and enabled to participate in patient safety and quality/risk management activities. Physicians receive little training and education in the basic principles of patient safety and quality activities. Furthermore, many physicians are independent practitioners who provide service in both community and in an institutional setting. The considerable workload carried by most physicians and their limited involvement in administrative practices make it very difficult for physicians to participate and play a leadership role. It is critical for physicians to understand how, when, and with whom to participate in the disclosure process when information pertaining to an adverse event is necessary.

Eastern Health recommends the following:

- Institute patient safety and quality within the curriculum of the medical school
- Invest in physician leadership skills and ability including providing appropriate remuneration for leadership and administrative activities; provide clear and precise job descriptions with expectations/goals/objectives; providing ongoing education in management and leadership skills including change management and engage and empower physician leaders to make improvements.

- Provide ongoing physician education specific to the areas of patient safety principles and practice.
- Review provincial legislation both here in Newfoundland and other provinces to look for best practice legislation that will promote active participation in quality initiatives such as mortality and morbidity rounds and provide the highest level protection to the quality assurance committee process.
- Consider developing a new position of physician champion in patient safety and quality with the appropriate investment and remuneration for that position
- Provide appropriate support personnel and tools to enable promotion of quality principles and practice throughout the medical staff organization and activities.

8References

Baker, G.R., Norton, P.G., Liftoff, V., Blais, R., Brown, A. Cox, J., et al. (2004). The Canadian Adverse Events Study: The Incidence Of Adverse Events Among Hospital Patients In Canada. Canadian Medical Association Journal, 170(11): 1678-86.

Brennan, T. A., Leape, L.L., Laird, N.M., Hebert, L., Localio, A.R., Lawthers, A.G., Newhouse, J. P., Weiler, P.C., & Hiatt, H.H. (1991) Incidence Of Adverse Events And Negligence In Hospitalized Patients. Results of the Harvard Medical Practice Study I. New England Journal of Medicine, 324(6): 370-6.

Canadian Patient Safety Institute publications (http:/www.patientsafetyinstitute)

Conference Board of Canada(http://www.conferenceboard.ca/CHSDM)

Espin,S., Examining Disclosure Options Procedures for Disclosing Adverse Events A Literature Review. 1-26. 2008

National Patient Safety Agency *Incident Decision Tree*, (http://www.npsa.nhs.uk/patientsafety/improvingpatientsafety/patient-safety-tools-and-guidance/incidentdecisiontree/)

Ralston, JD and Larson EB (2005). Crossing to Safety: Transforming Healthcare Organizations for Patient Safety. Journal of Postgraduate Medicine, 51(1): 61-67.

Wieman, TJ & Wieman, EA (2004). A Systems Approach To Error Prevention In Medicine. Journal of Surgical Oncology, 88:115-21.

Wilson, R., Runciman, W.B., Gibberd, R. W., Harrison, B. T., Newby, L., and Hamilton, J., D. (1995). The Quality in Australian Health Care Study. The Medical Journal of Australia, 163, November: 458-41.