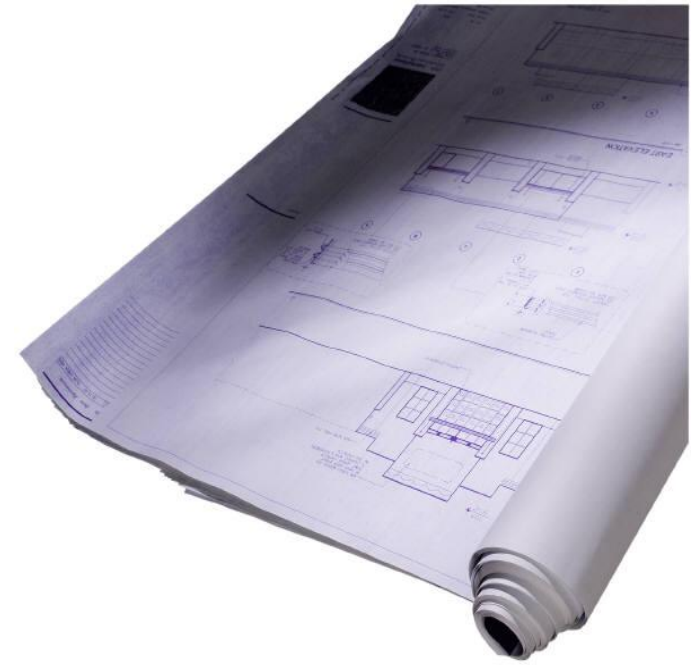


Design, construction and renovation: Realizing a Blueprint for Patient Safety

NICHQ March, 2008



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Agenda

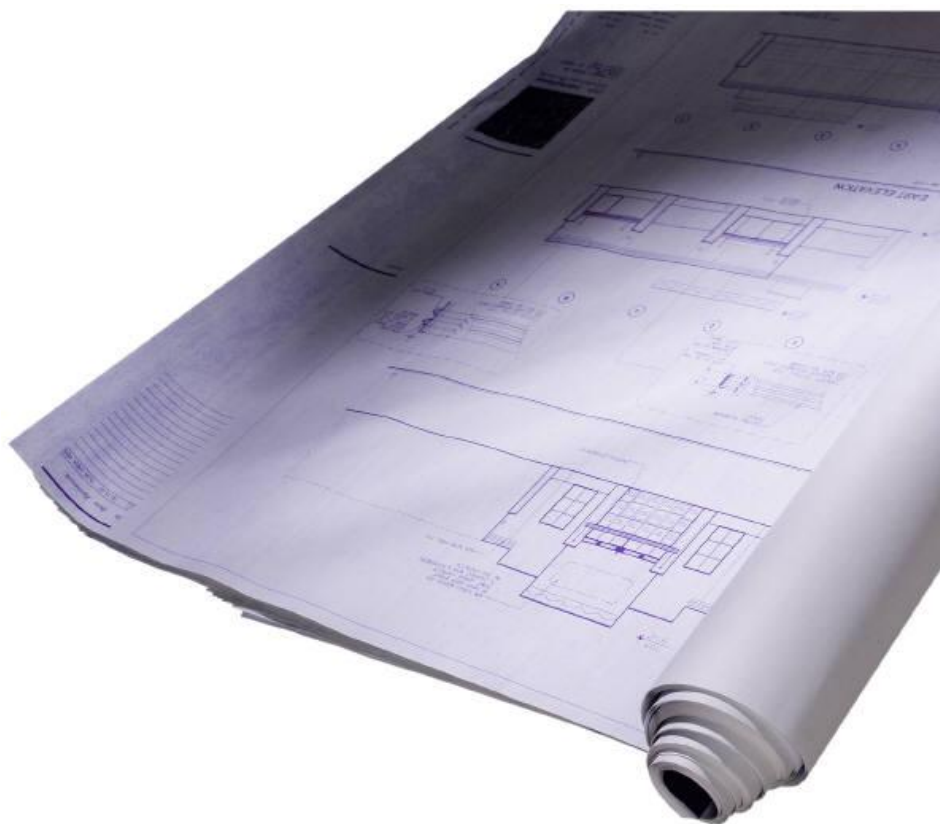
- Where do we start?
 - Joint Commission sample plan
- SickKids Blueprint 2002-08; Design and Construction
 - Impetus
 - Concepts
 - Plan
- SickKids 2009 Blueprint; Renovation
 - Best practices review / consultation
 - Key concepts, projects and initiatives

Why Do We Need a Plan?



The Tower of Babel - Bruegel

Where Do We Start?



Sample Patient Safety Plan: Part A – The Foundation

Patient education

Informing patients about their care

Management of the Program

Components (safety-related offices, committees, functions)

Interdisciplinary participation

Oversight

Activities & functions relating to patient safety

Participating sites, settings, and services

Safety-related orientation & training

Team training

Expectations for reporting

Among components of the Program

Among the professional disciplines

Across the organization

Consistent with organization mission

Communicating with Patients	Staff Education
Structure	Coordination
Program Scope	Program Goals

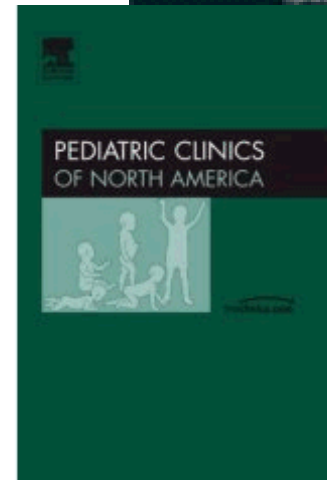
www.jointcommission.org/PatientSafety/pt_safety_plan.htm

Sample Patient Safety Plan: Part B – Safety Improvement Activities

Reporting of Results	
Proactive Risk Reduction	
ID, Reporting & Management of Sentinel Events	
Routine Safety-related Data Collection & Analysis	
Prioritization of Improvement Activities	
Definition of Terms	
Communicating with Patients	Staff Education
Structure	Coordination
Program Scope	Program Goals

www.jointcommission.org/PatientSafety/pt_safety_plan.htm

The Blueprint for Patient Safety @ SickKids



SickKids – One of the Top Children’s Hospitals in the World

- We have “world-class” doctors, nurses, health-care professionals and administrators
- We provide outstanding and innovative care
- We treat the most difficult and challenging cases
- Our research is world-class
- We attract trainees from around the world and have alumni across the globe
- But...



Despite our best efforts, serious harm occurs: SB - Our Burning Platform

- 16 yr. old girl with sickle cell disease
- Very complicated history
- Early June 2000 - discharged from hospital
- Late June - Sickle cell clinic visit, Hgb 85
- July - General surgery clinic visit - OR date set for August
- August - Surgery cancelled
- September – Same day admission, “routine” lap chole (gall bladder surgery), post -op deterioration → death
- Coroner’s Inquest

Sick Kids at the Crossroads - 2001

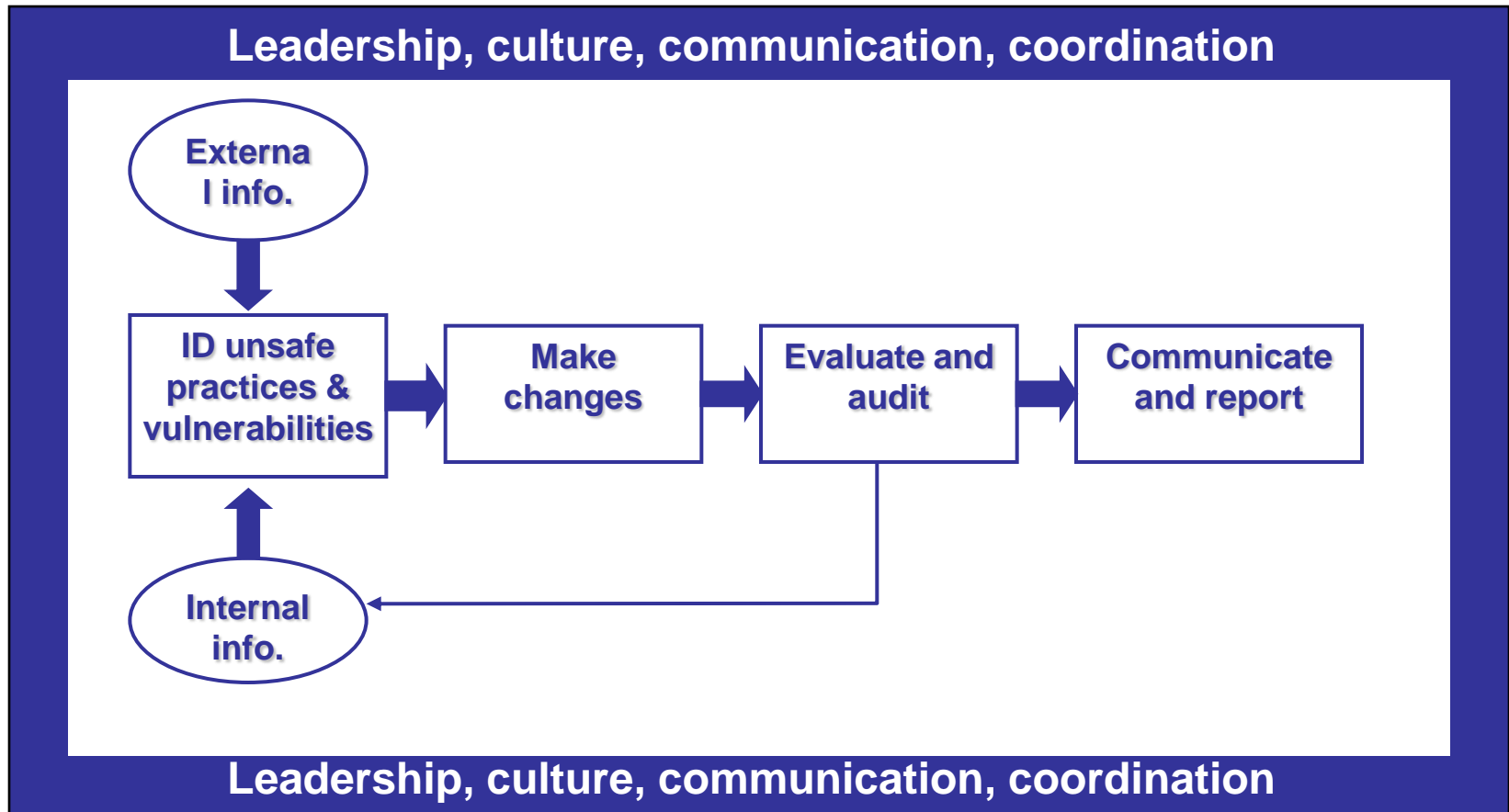
Traditional risk management approach

(self-protection / prevention of real or potential loss)

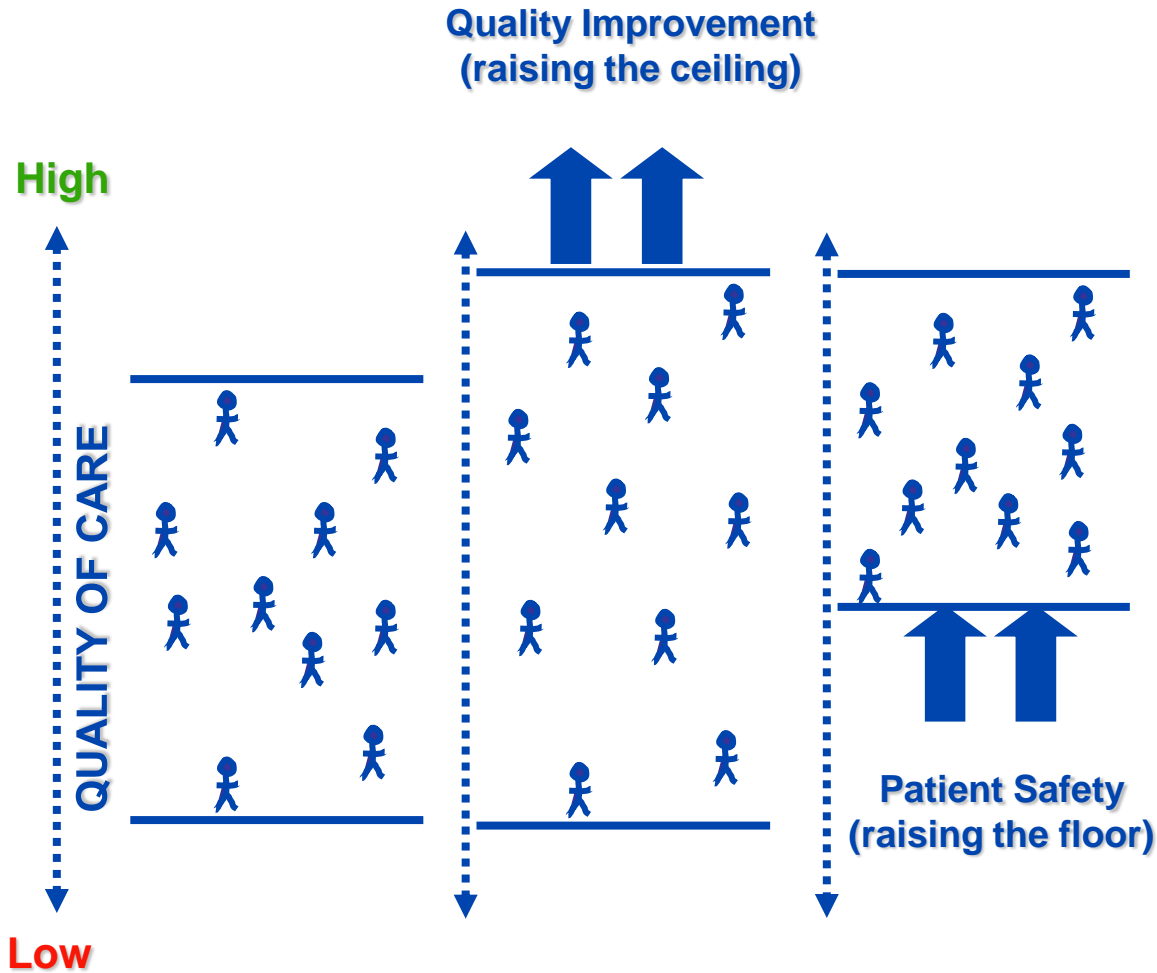


A Better Way?

Patient Safety Learning Model



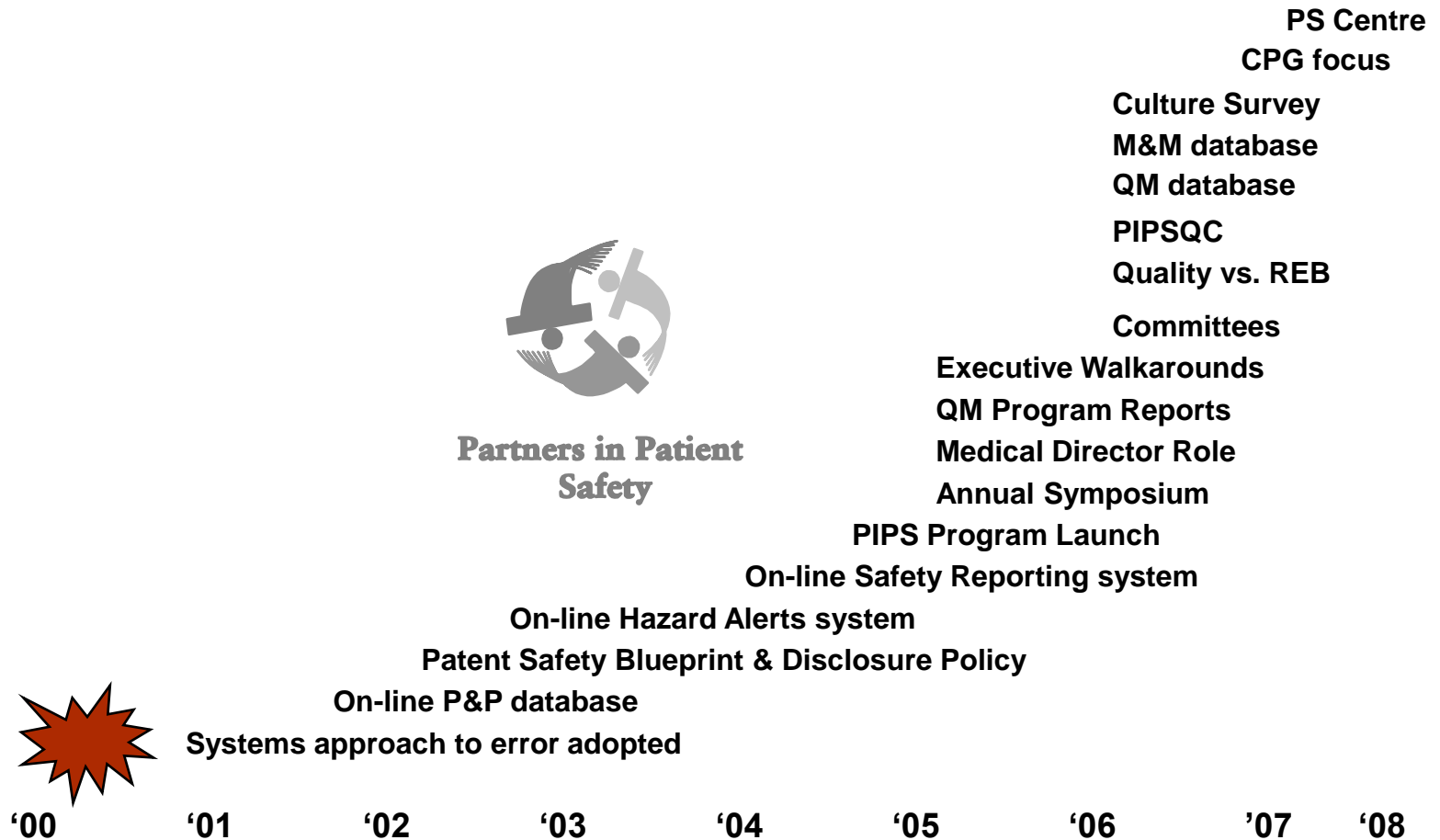
Quality Improvement vs. Patient Safety



SickKids Blueprint for Patient Safety 2002-2008



Construction – It Takes Time!



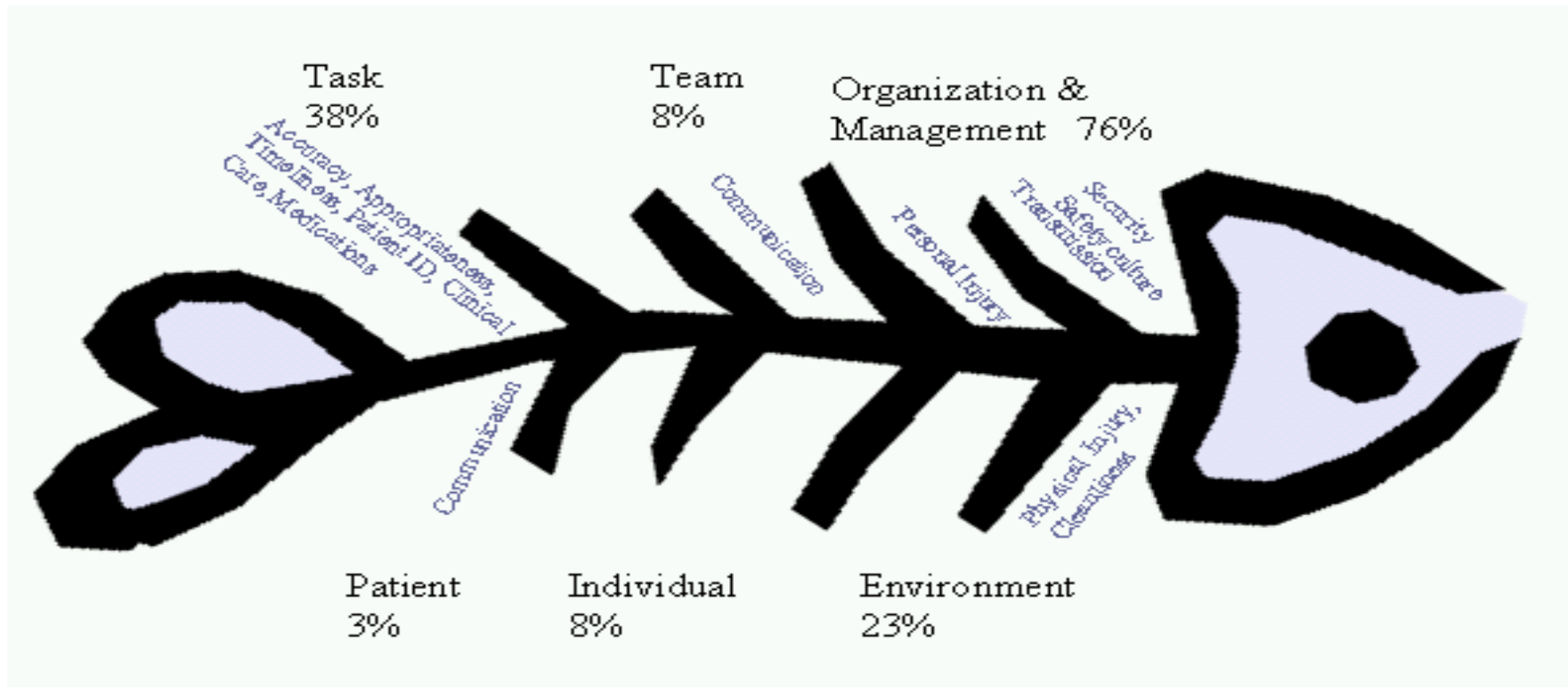
Blueprint 2009 - Renovations

- Best practices review
- Consultation with stakeholders
- Key concepts
- Mandatory initiatives
- The plan – projects and initiatives

Blueprint 2009 – Best Practices Review

- Board Leadership in Patient Safety
- Senior Management Leadership in Patient Safety
- Formal Patient Safety Plan
- Focus on Execution of Strategic Patient Safety Initiatives
- Department / Program / Team Leadership in Patient Safety
- Physician Engagement
- Patient and Family Focus
- Staff Focus
- Evidence-based care Focus
- Measurement and Reporting
- External Collaboration

Consultation with families: factors contributing to parents' safety concerns



Blueprint 2009 – Key Concepts

- Leadership
- Systems approach
- High reliability
- Prioritization and execution of initiatives

Blueprint 2009 – Safety Projects

Aim: Eliminate critical incidents and “never events”

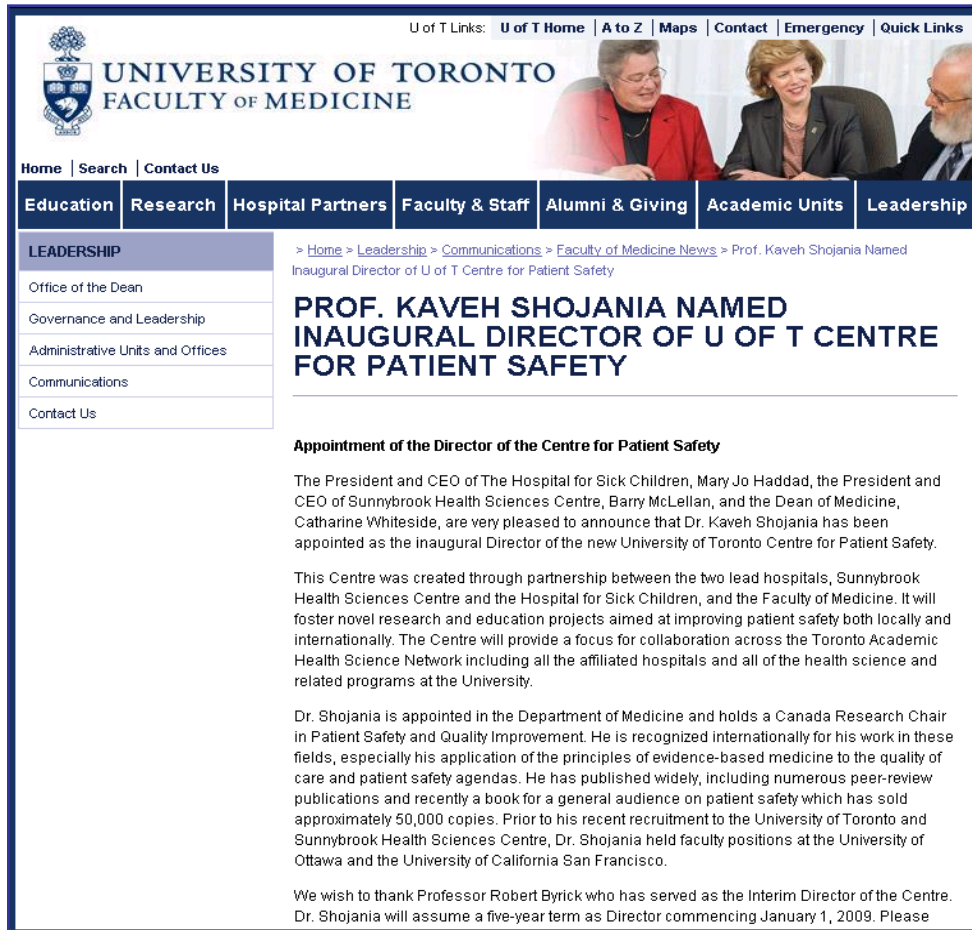
Drivers	Projects / Initiatives	Measures	Areas Involved
Infection prevention and control	1. SSI	1% antibiotic within 1 hour cut time	Perioperative clinics and units
	2. VAP	VAP rate; % compliance daily “bundle”	Critical care units
	3. CLA-BSI	CLA-BSI rate; % compliance insertion bundle; % compliance maintenance bundle	Critical care units
	4. Hand hygiene	% compliance	All areas
Medication manage.	5. Medication reconciliation	% compliance	All inpatient areas, pre-op clinics
Commun. and teamwork	6. Communication in OR (huddle, pause, briefings)	# wrong site / patient / procedure events	Operating room

Critical incidents = any unintended event that occurs when a patient receives treatment that, (a) results in death, or serious disability, injury or harm to the patient, and (b) does not result primarily from the patient’s underlying medical condition or from a known risk inherent in providing the treatment.

Blueprint 2009 – Other Initiatives

- University of Toronto – Centre for Patient Safety; SickKids one or two operational hubs

University of Toronto – Centre for Patient Safety



The screenshot shows a news article on the University of Toronto Faculty of Medicine website. At the top, there is a navigation bar with links for 'U of T Links', 'U of T Home', 'A to Z', 'Maps', 'Contact', 'Emergency', and 'Quick Links'. Below this is the University of Toronto logo and the text 'UNIVERSITY OF TORONTO FACULTY OF MEDICINE'. A photograph shows three people, two women and one man, in a meeting. Below the photo is a navigation menu with links for 'Home', 'Search', and 'Contact Us'. A secondary menu includes 'Education', 'Research', 'Hospital Partners', 'Faculty & Staff', 'Alumni & Giving', 'Academic Units', and 'Leadership'. The article title is 'PROF. KAVEH SHOJANIA NAMED INAUGURAL DIRECTOR OF U OF T CENTRE FOR PATIENT SAFETY'. The text below the title describes the appointment of Dr. Kaveh Shojania as the inaugural Director of the new University of Toronto Centre for Patient Safety. It mentions that the Centre was created through a partnership between Sunnybrook Health Sciences Centre, the Hospital for Sick Children, and the Faculty of Medicine. The article also notes that Dr. Shojania is appointed in the Department of Medicine and holds a Canada Research Chair in Patient Safety and Quality Improvement. At the bottom, it expresses gratitude to Professor Robert Byrick for his service as the Interim Director of the Centre.

U of T Links: [U of T Home](#) | [A to Z](#) | [Maps](#) | [Contact](#) | [Emergency](#) | [Quick Links](#)

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> [Home](#) > [Leadership](#) > [Communications](#) > [Faculty of Medicine News](#) > Prof. Kaveh Shojania Named Inaugural Director of U of T Centre for Patient Safety

PROF. KAVEH SHOJANIA NAMED INAUGURAL DIRECTOR OF U OF T CENTRE FOR PATIENT SAFETY

Appointment of the Director of the Centre for Patient Safety

The President and CEO of The Hospital for Sick Children, Mary Jo Haddad, the President and CEO of Sunnybrook Health Sciences Centre, Barry McLellan, and the Dean of Medicine, Catharine Whiteside, are very pleased to announce that Dr. Kaveh Shojania has been appointed as the inaugural Director of the new University of Toronto Centre for Patient Safety.

This Centre was created through partnership between the two lead hospitals, Sunnybrook Health Sciences Centre and the Hospital for Sick Children, and the Faculty of Medicine. It will foster novel research and education projects aimed at improving patient safety both locally and internationally. The Centre will provide a focus for collaboration across the Toronto Academic Health Science Network including all the affiliated hospitals and all of the health science and related programs at the University.

Dr. Shojania is appointed in the Department of Medicine and holds a Canada Research Chair in Patient Safety and Quality Improvement. He is recognized internationally for his work in these fields, especially his application of the principles of evidence-based medicine to the quality of care and patient safety agendas. He has published widely, including numerous peer-review publications and recently a book for a general audience on patient safety which has sold approximately 50,000 copies. Prior to his recent recruitment to the University of Toronto and Sunnybrook Health Sciences Centre, Dr. Shojania held faculty positions at the University of Ottawa and the University of California San Francisco.

We wish to thank Professor Robert Byrick who has served as the Interim Director of the Centre. Dr. Shojania will assume a five-year term as Director commencing January 1, 2009. Please

“It will foster novel research and education projects aimed at improving patient safety both locally and internationally. The Centre will provide a focus for collaboration across the Toronto Academic Health Science Network including all the affiliated hospitals and all of the health science and related programs at the University.”

Blueprint 2009 – Other Initiatives

- University of Toronto – Centre for Patient Safety; SickKids one or two operational hubs
- Canadian Patient Safety Institute; Patient Safety Core Dimensions – curriculum development
- Disclosure policy and process review & revision
- Critical incident policy and process review & revision

Lessons Learned

- Leverage the crisis
 - (& the near miss)
- Engage & involve leaders
 - E.g. Critical incident review leadership “triad”; project sponsorship
- Engage & involve families
- Integrate / build on successful traditions
 - E.g. QI, RM, M&M, REB
- Prioritize & follow up
 - Projects, recommendations
- Collaborate & learn *with* others
 - “If you want to go fast, go alone; if you want to go far, go together”



THANK
YOU
SO
MUCH!

Additional Slides and References

Mandatory Initiatives / Measures – Ontario

Organization / Body	AC	Wait	PS
Culture / Measurement			
1. Patient safety a strategic priority/goal	X		
2. Board Quality Committee		X	
3. Quarterly reports to Board	X	X	
4. Reporting system for adverse events	X		
5. Hospital Standardized Mortality Ratio (HSMR)		NA	NA
6. Status of patients waiting longer than the wait time targets reported to board		X	
7. Policy and process for disclosure of adverse events	X		
8. Prospective analysis (FMEA)	X		
Communication			
9. Patient/client education	X		
10. Information transfer	X		
11. Verification processes for high-risk activities	X		
12. Medication reconciliation at admission	X		
13. Medication reconciliation at referral/transfer	X		
14. Patient/client identification	X		
15. Dangerous abbreviations	X		
Medication Use			
16. Removal of concentrated electrolytes	X		
17. Standardize and limit drug concentrations	X		
18. Training on infusion pumps	X		
19. Heparin safety	X		
20. Narcotic safety	X		

AC = Accreditation
Canada

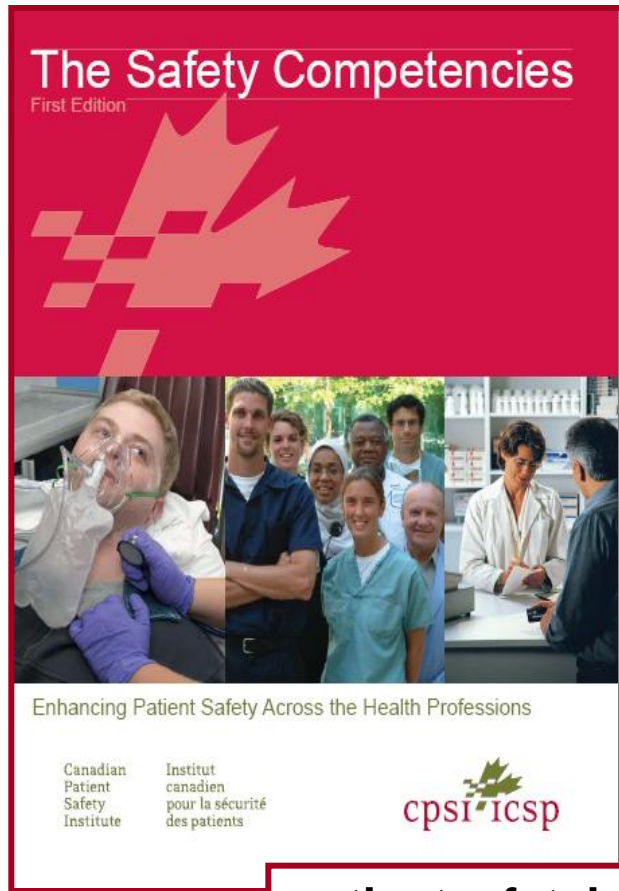
Wait = Ont. Wait times
initiative

PS = Ont. Mandatory
patient safety
indicators.

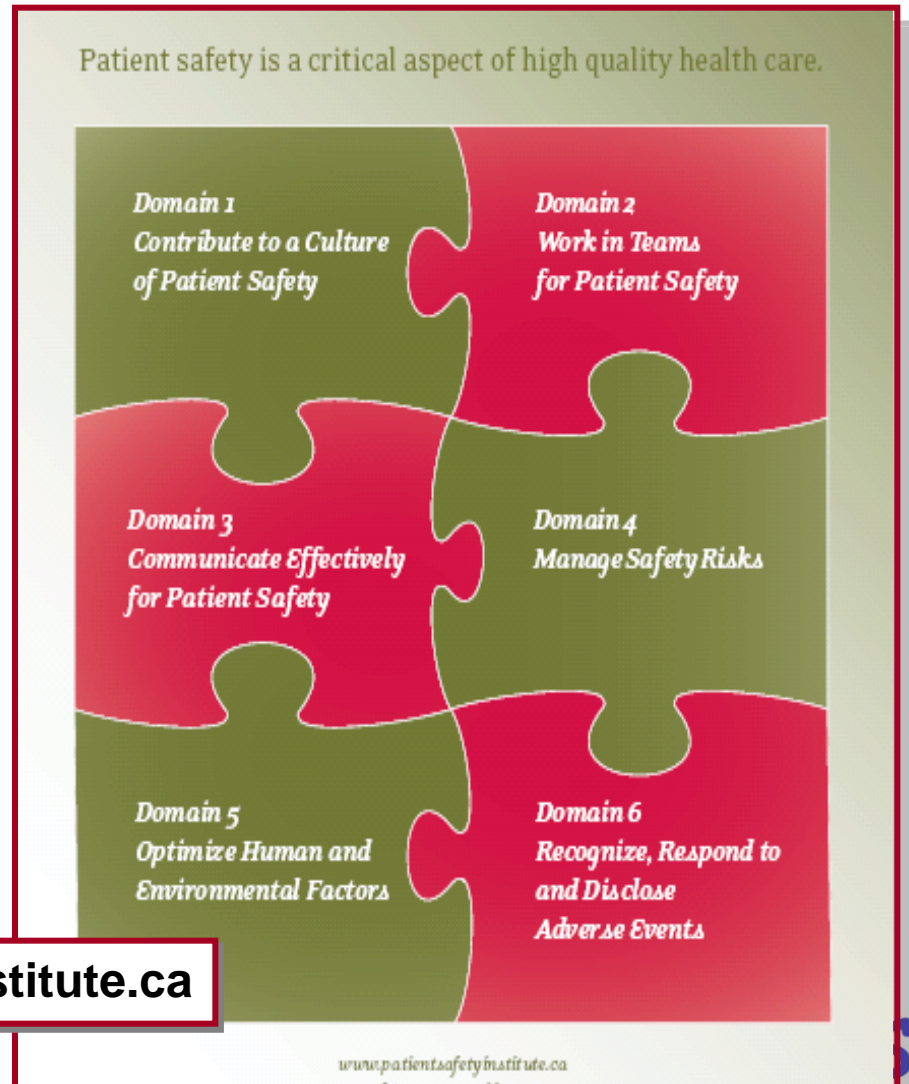
Mandatory Initiatives / Measures – Ontario

Organization / Body	AC	Wait	PS
Worklife / Workforce			
21. Training on patient/client safety	X		
22. Patient safety plan	X		
23. Roles and responsibilities established for patient/client care and safety	X		
24. Preventive maintenance program	X		
Infection Control			
25. Infection control guidelines	X		
26. Education/training on hand-hygiene	X		
27. Infection rates	X		
28. Sterilization of equipment and facilities	X		
29. Influenza vaccine	X		
30. Hand-hygiene compliance	X		X
31. Clostridium difficile (C. difficile)			X
32. Methicillin-resistant Staphylococcus aureus (MRSA)			X
33. Vancomycin-resistant Enterococci (VRE)			X
34. Rates of ventilator-associated pneumonia (VAP)		X	X
35. Rates of central line infections (CLA-BSI)		X	X
36. Rates of surgical site infections (SSI)		X	X
Fall Prevention			
37. Fall prevention strategy	X		
Risk Assessment			
38. Suicide prevention strategy	X		

Canadian Patient Safety Institute – Safety Competencies



patientsafetyinstitute.ca



CPSI – Disclosure Guidelines

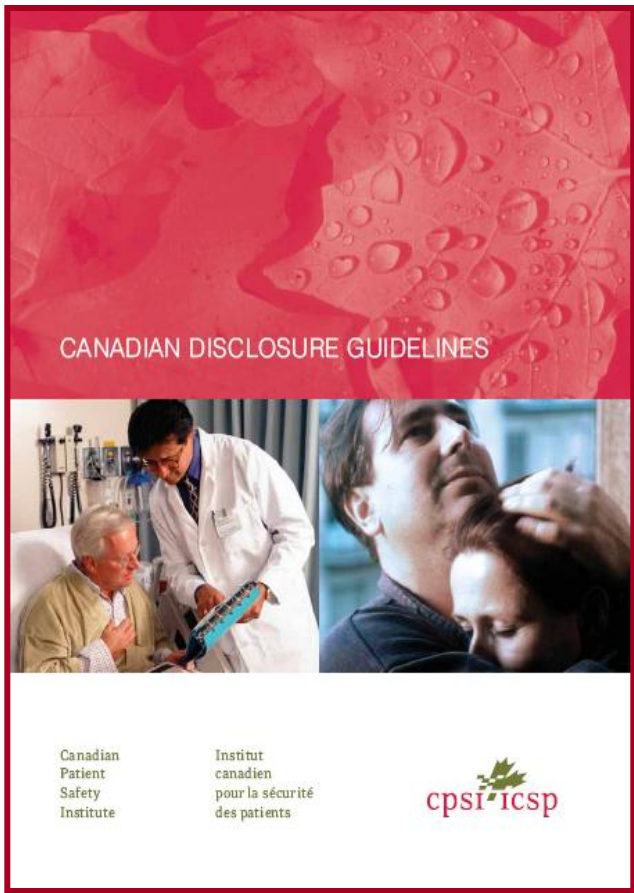
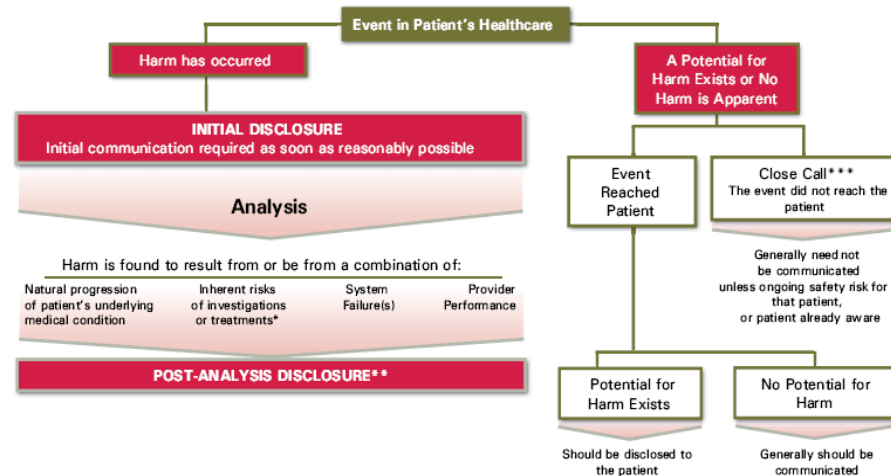


Illustration B: Determining the Type of Event and the Requirements for Disclosure



- * Refers to harm known to be associated with the investigation or treatment
- ** Management in consultation with providers to determine what further information is to be disclosed.
- *** It is strongly encouraged that close calls be reported to healthcare organizations