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Fall/Winter 2016

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Quality Matters

Volume 9, Number 2

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Accreditation Canada is an independent, not-for-profit organization that accredits health care and social services organizations in Canada and around the world. Its comprehensive accreditation programs foster ongoing quality improvement through evidence-based standards and a rigorous external peer review. Accredited by the International Society for Quality in Health Care (ISQua), Accreditation Canada has been helping organizations improve health care quality and patient safety for more than 55 years.
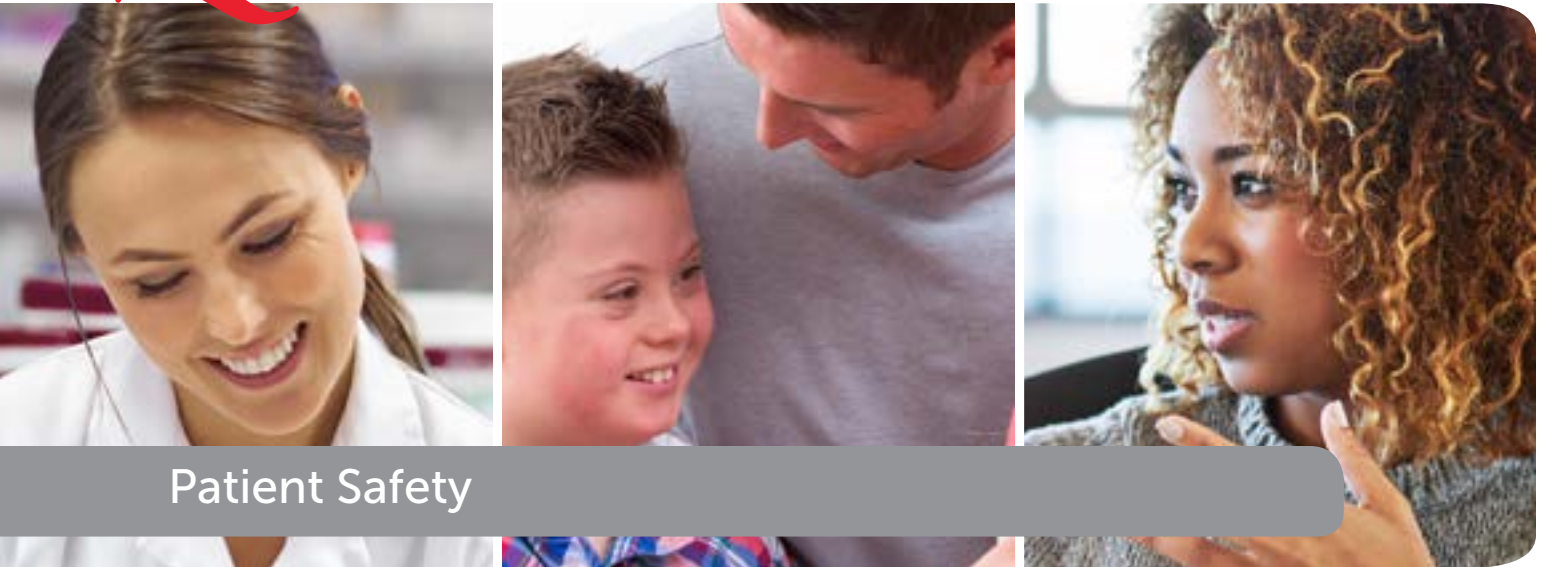
Quality Matters

Patient Safety

Quality Matters is an avenue for sharing expertise, innovation, and Leading Practices across Canada. The publication provides a forum for health and social services organizations that are committed to learning about improving quality and patient safety.

Bringing integrated, patient-centred care to life and working with partners toward quality care for all

Leslee Thompson

President and Chief Executive Officer, Accreditation Canada

These are truly exciting times at Accreditation Canada.

We are going through a deliberate and energizing process, looking at how we do what we do, and where we go from here. We are asking the people who work with us and the people who work for us how we can improve our operations, contribute to better quality care for patients, and demonstrate continued value for our clients in Canada and around the world.

One area where we are committed to improvement is, indeed, in how we engage patients and incorporate their needs into every aspect of our standards and assessment systems. This is one of the many things that sets us apart from our competitors. It is also a feature of our modern and meaningful accreditation systems whose time has come.

In recent months, more than 150 countries have signed onto the World Health Organization's framework for integrated, people-centred health services. The framework has the power to transform how health care is delivered around the world. It is a declaration that we support fully; we are committed to working with our phenomenal health partners globally to help bring it to life.

There is a growing body of research that is backing what many on the front lines of health care have known for a long time: working with patients and their families as equal partners helps generate conversations about safety and can lead to better health outcomes.

Establishing an effective patient pathway makes it possible to break down silos, work across health systems, reduce risk, share learnings, and produce better health outcomes. This is where health care is going, and Accreditation Canada is pleased to work with organizations around the world to make highly functioning, integrated, patient-centred health services the rule, not the exception.

I'm pleased that, in this issue of *Quality Matters* and in our day-to-day work, we're able to connect you with Leading Practices and great partners who are making practical changes happen. Our surveyors and staff are at the forefront of an important movement to improve patient safety and patient engagement, and we're proud to partner with people who share our passion. Let's co-create great things together!

Warm regards,

Leslee Thompson

The Patient Voice

Angela Morin

In 2010, my friend Bonnie was diagnosed with breast cancer, and we began navigating her health care journey. Rather than a smooth patient pathway, it felt like a confusing, stressful labyrinth. I travelled the path with her in hopes of making the process easier on her and her family. Bearing witness to her care convinced me the system was flawed, that it was not designed to provide a seamless, high-quality patient experience. That's why I became a patient and family experience advisor, so I could bring the patient voice to important health care conversations and hopefully make things better for those who followed.

It's not uncommon for people to overlook or excuse faults in our health care system. Yes, they may notice poor information transfers between providers, the brief time allocated to questions and answers, and inconveniences like wait times. And yes, they may be put off by an impatient health care provider who lacks good communication skills, compassion, or empathy. There is a tendency to think of these things as "nice to have" or "the warm and fuzzy stuff." Not everyone equates these issues with safety or efficacy. That's a problem, because these issues all have critical implications.

We need to address the quality, safety, efficiency, and effectiveness of care at many levels, and it's absolutely vital that we include the patient voice in these conversations. It's not enough to design systems based on safety data alone. We must evaluate the system from the perspective of patients and ensure that it is being designed to meet the needs of patients, their families, and caregivers.

We need to ask questions around 'what ifs.' What if patients and their families always felt safe, informed, involved, and respected? What if you could get the right care, at the right time, in the right place? What if the patient pathway was clear of obstacles, and support was there when you needed it the most? What if we stopped thinking in terms of 'us vs them' and truly started to partner with patients and families?

As a member of Accreditation Canada's Client- and Family-Centred Care (CFCC) Advisory Council, I was part of a collaborative group of health care providers, patients, surveyors, advocates, and accreditation staff working together to try to address these types of questions. We all aimed to move health care organizations toward a more client-centred approach to care, services, and safety. The incorporation of CFCC standards, best practices, and legislation will help support organizations in Canada and around the world in operationalizing client and family centred principles, and simultaneously design safer systems.

There is tremendous value in moving from a mindset of doing for and to patients to doing

with them. It's a subtle, but powerful shift. It's not always easy to do, but it is vital to patient safety.

Every aspect of care can be improved by this shift in thinking.

Through my work in quality improvement activities, it has become clear to me that good design requires all stakeholders to be involved, and that the primary goal needs to be clear—an improved, safe, patient experience. It is transformative to have everyone aiming their expertise at one ultimate goal, and this includes patients and families. When it's done well, that means creating a culture in which patients, clients, and families can challenge the status quo when something doesn't seem right. It's important that people be able to raise questions in a respectful, proactive, and open way. People who are vulnerable need to have their voices heard, both at the bedside and in the design of the health care system.

There are so many ways in which collaborative, client-centred processes contribute to patient safety. For example, making sure patients understand their own care regimen and participate in creating it, is absolutely vital to high-quality, safe care. If their regimen is communicated poorly (e.g., quickly, without time for questions), patient safety is jeopardized. Health care providers need to be sure care plans respect what patients value, that their patients understand their care plan and their role in it, and that their patients have

all the information they need to make informed decisions.

We need staff members and physicians to recognize that disseminating information is not the same as ensuring that someone understands it. High-quality communication helps keep everyone safer. For patients, a conversation they have with their provider may be life-changing or it may be mundane. Either way, they need to leave with information that will keep them safe. I believe that's a conversational skill that can be taught with the right educational tools. We can't force anyone to care or be empathetic, but we can teach them empathetic behaviours that will support them as good communicators, promoting safe practices.

This sounds like common sense but, I once heard a presenter say, "Common sense is not always common practice." He was right. We assume people will do logical things. But they don't, at least, not consistently. That's why we need to build even the most basic procedures into the system. These practices may be simple—from how to introduce yourself to a patient to how to include patients on hiring committees. Patients may not understand all the technical skills necessary for safe nursing practices, but they can spot good communicators, and that's something that will keep patients safer in the long term.

It's important to recognize that CFCC doesn't have to be a burden.

In most cases, it should not be more work, it should simply be different work.

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For example, I've seen surgical program managers send a letter to patients whose surgical procedure was moved due to scheduling conflicts. The letter essentially said we are sorry, we recognize that this is an inconvenience, here's why it happened, and here is what is going to happen next. The number of phone calls from disgruntled patients dropped dramatically. So while it may be more work on the front end of the process, it cuts the amount of work on the back end of the process (i.e., dealing with complaints). It's proactive instead of reactive, and it impacts the patient experience.

In another example, making sure patients and their caregivers understand their care regimen before they're discharged can decrease the chances they'll end up back in the emergency department because of a misunderstanding. Having information empowers patients and families to act. If post-surgical patients know they should be seen by a home care worker within a specific length of time, they are less likely to arrive back at the hospital with an untreated infection days after surgery.

I've been a patient advisor for five years now. Even in that brief time, I've seen a shift from "What is patient- and family centred care, and aren't we already doing that?" to "This approach is just the flavour of the month" to "This is not going away." The reality is, we are

hearing from experts from all over the world that engaging patients in their care and in the design of the health care system is the right thing to do. Creating CFCC standards and guidelines will help organizations understand how to engage these key stakeholders in a meaningful way.

When client- and family centred care is done well, it's about authentic engagement. It is not simply about ticking a box. Inviting a patient into the conversation contributes to safer care and adds value to the health care system, as long as you're truly prepared to hear what they have to say. When you do, it can bring you back to why you got into health care in the first place, to your purpose—to care for people and keep them safe. ∎

Angela Morin

Angela Morin is Co-Chair of the Kingston General Hospital Patient and Family Advisory Council and sits on the Southeast Regional Cancer Centre Patient and Family Advisory Council as well as Accreditation Canada's Client and Family-Centred Care Advisory Group. She is a Core Faculty Member and Coach for the Canadian Foundation for Healthcare Improvement. In 2014 she was appointed Co-Chair of the Ontario Minister of Health's Quality of Care Information Protection Act (QCIPA) Review Committee and is a Board Member of Health Quality Ontario.

Setting patients up for success: Tools to manage medications at transitions in care

Lisa Sever, Alice Watt, Kim Streitenberger, Brenda Carthy, Julie Greenall

Miscommunication at care transitions is commonly cited as a contributing factor to medication-related adverse events. *The Canadian Adverse Events Study* (Baker, 2004) cited drug- and fluid-related events as the second most common type of adverse event. Chart reviews have shown that over half of all hospital medication errors occur at interfaces of care (Rozich, 2001). Effectively communicating about medications at care transitions can be challenging for both patients and health care professionals. Developing processes, tools, and resources to facilitate effective communication will enhance the safety of medication use and optimize medication management for patients.

Communicating information through medication reconciliation

Medication reconciliation is a systematic process whereby health care providers work together with patients, families, and care providers to ensure accurate and up-to-date medication information is communicated during care transitions. It is one component of medication management (see Figure 1 on next page) and will inform and facilitate appropriate prescribing decisions for the patient (SaferHealthcare Now!, 2011).

Many organizations have created policies and procedures, allocated staff, and invested in technology resources to support medication reconciliation at admission. Now they are challenged to implement a quality medication

reconciliation process at all care transitions to reduce the potential for medication errors.

Discharge from a health care facility is a particularly high-risk time, when the responsibility for managing medications is transferred back to the patient, family caregiver, or another health care professional. In a recent study, 43 percent of patients experienced medication adverse events related to prescribing errors on discharge, with the majority of these deemed to represent a risk of moderate harm (Riordan, 2016).

Case study[*]

Meet Sharon, who experiences atrial fibrillation and was admitted to hospital after experiencing symptoms that did not resolve with her existing medication. During her hospital stay, she took her medications when they were given to her. She didn't question that the medication regimen was different from the one she had at home. On the day of discharge, Sharon was handed an envelope of papers and told, "Your prescription is in the envelope. You are on a new blood thinner. Take this to your community pharmacist." No further instructions were provided.

Once home, she was tired, so she decided to take her trip to the pharmacy the next day. Sharon had dinner, took her usual bedtime pills, and went to bed. The next day she wasn't feeling well, so she asked her daughter to go to the pharmacy. The pharmacist looked at the papers from the hospital and found

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*This is a fictitious case study based on ISMP Canada experience.

Figure 1: Medication reconciliation as a component of medication management

Medication Management
Medication management is defined as patient-centred care to optimize safe, effective and appropriate drug therapy. Care is provided through collaboration with patients and their health care teams[1]

Clinical Medication Review
Addresses issues relating to the patient's use of medication in the context of their clinical condition in order to improve health outcomes[2]

Medication Reconciliation
A formal process in which healthcare providers work together with patients to ensure accurate and comprehensive medication information is communicated consistently across transitions of care[3]

Best Possible Medication History
A complete and accurate list of all the medications a patient is taking created using at least 2 sources of information including a client and/or family interview[4]

1. Developed collaboratively by the Canadian Pharmacists Association, Canadian Society of Hospital Pharmacists, Institute for Safe Medication Practices Canada, and University of Toronto Faculty of Pharmacy, 2012.
2. www.health.gov.bc.ca/pharmacare
3. ISMP Canada. Medication Reconciliation in Acute Care: Getting Started Kit. 2011
4. ISMP Canada. Medication Reconciliation in Acute Care: Getting Started Kit. 2011

Adapted from Fraser Health, Providence Health Care, Provincial Health Services Authority, Vancouver Coastal Health

(Source: ISMP Canada; used with permission)

the discharge prescription. After reviewing the discharge prescription, the pharmacist identified that:

- Two of her usual medications were not included and there were no instructions to discontinue or continue them
- Several new drugs were added, one of which was not covered by her insurance plan
- Instructions for the new blood thinner were "Take as directed," and the patient was unaware of how to take them

Now the community pharmacist needed to locate the prescriber and clarify what the patient should take. The lack of clearly communicated medication-related information on discharge led to missed doses of new medications, additional work for the community pharmacist, and the potential for medication errors that could have resulted in serious patient harm.

Ensuring a clear medication discharge plan

When being admitted to hospital, the majority of patients are interviewed to determine their Best Possible Medication History (BPMH). A quality BPMH is the foundation of solid decisions about medications during the hospital admission and is also a valuable source of medication information at all transitions in care.

To manage medications successfully once a patient is discharged, a clear medication discharge plan must be provided. This is commonly known as the Best Possible Medication Discharge Plan (BPMDP). The

BPMDP should include instructions about the medications identified on the admission BPMH (e.g., which to continue, change, or discontinue), a rationale for any changes, and information about new medications that were prescribed during or at the end of hospitalization. It should also communicate any monitoring or follow-up requirements to the patient and the health care professionals involved in their care. Communicating the BPMDP is essential to facilitate medication reconciliation in the next care setting (e.g., another acute care facility, primary care, home care, or long-term care) and ensure that patients and health care providers have the information they need for safe medication management post discharge. Even when a clear discharge plan is provided, discrepancies and medication-related problems can occur due to a variety of other challenges including the inability to pay for new medications, unidentified use of over-the-counter and natural health products, or limited patient engagement leading to unfilled prescriptions or non-adherence to medication regimens.

Facilitating safe transitions and empowering patients and families

Several tools and resources have been developed to help patients and health care providers improve the communication of medication information at transitions in care and, in particular, on discharge.

The Hospital to Home: Facilitating Medication Safety at Transitions Toolkit (ISMP Canada, 2015) provides information about why hospitals

should invest in resources at discharge. The toolkit includes a checklist that health care providers can use to help patients and family caregivers better understand the medication regimen the patient is to follow and connect them with supports to help manage their medications once home from hospital.

Helping patients succeed in managing their medications is an important strategy in preventing harmful adverse events. An informed patient or family caregiver can take charge of their health care and may be able to seek help before an error occurs. When patients are engaged in their treatment plans, they can share challenges or limitations to safe medication use and are more likely to ask questions and get the information they need to use their medications safely.

To help patients start a conversation with their health care providers and address knowledge gaps which can lead to medication errors during care transitions, ISMP Canada, with support from the Canadian Patient Safety Institute, and in collaboration with Patients for Patient Safety Canada, the Canadian Society of Hospital Pharmacists, and the Canadian Pharmacists Association, developed *5 Questions To Ask About Your Medications* (2015) (See Figure 2).

The 5 Questions to Ask About Your Medications is available in several languages to meet the needs of a variety of patients. A video is also available to demonstrate how patients can use the questions to start a conversation with their health care provider. Organizations are encouraged to make this information available to patients, families, and health care

providers to foster crucial conversations about medications.

What does this mean for Sharon and other patients?

Let's go back to our case study patient, Sharon, and consider how using these tools might help facilitate future transitions back to self-management:

- *Hospital to Home: Facilitating Medication Safety at Transitions Toolkit*

  Use of the toolkit by the discharging health care provider can help with discharge planning for Sharon, and provide an opportunity for prescribing clarifications such as potential alternatives for a costly new medication before she leaves the hospital. This can facilitate the timely dispensing of new medications by community pharmacists.

- *Best Possible Medication Discharge Plan (BPMDP)*

  Creating a BPMDP as part of Sharon's discharge medication reconciliation process and communicating it to her and her community pharmacist may result in less confusion about medication changes.

- *5 Questions to Ask About Your Medications*

  This resource creates an opportunity for more open dialogue about medications, to validate the discharge plan and confirm Sharon's understanding of it. This can enhance awareness about which medications to take, how to take them, and what ongoing monitoring is required

Figure 2: 5 Questions to Ask About Your Medications

(Source: ISMP Canada; used with permission)

post-discharge. Being knowledgeable about medications may help protect Sharon from harmful medication errors or avoidable hospital readmissions.

Conclusion

Ensuring safe medication management at transitions in care is clearly a team effort. Medication errors due to dose omissions, inappropriate administration, or lack of monitoring and follow-up can lead to significant patient harm. Organizations are encouraged to proactively implement strategies to reduce or eliminate medication management problems that occur at transitions of care so that patients can safely transition from hospital to home. ∎

Lisa Sever

Lisa Sever, RPh, BScPhm, ACPR, CGP, is a Consultant Pharmacist with ISMP, who graduated from the University of Toronto and completed her hospital residency at St. Joseph's Hospital in Hamilton. She is a Certified Geriatric Pharmacist and enjoys working directly with patients and their caregivers. Her work experience includes hospital, long-term care and in-home pharmacist assessment. She joined ISMP Canada in 2013, participating in home and community care medication safety projects. She is passionate about keeping patients safe from medication harm.

Alice Watt

Alice Watt, RPh, BScPhm, joined ISMP Canada in 2007 as a Medication Safety Specialist and received her BSc. (Pharm.) from the University of British Columbia. She is actively practicing in a community hospital as a clinical pharmacist and has had over 15 years of experience in community and acute care settings. Alice is involved in medication safety and incident analysis, and has a passion for engaging consumers and health care practitioners in safe medication practices.

Kim Streitenberger

Kim Streitenberger, RN, is Project Lead at ISMP, and has a certificate in Quality Improvement and Patient Safety from the University of Toronto. She also has over 35 years of clinical, quality improvement, and patient safety experience. She was a recipient of the OHA Health Achieve Patient Safety Award in 2005 and the Baxter Guardian Scholarship for Excellence in Patient Safety in 2010. Within her current role as Project Lead, Kim has accountability for national medication reconciliation and safe labelling and packaging initiatives.

Brenda Carthy

Brenda Carthy, BA (CompSc), joined ISMP Canada in 2004 as a Project Coordinator. She started her career as a computer system analyst. Her involvement in medication safety began in 2000 when she moved into a team support role in the pharmacy department of a community hospital. Brenda has been involved in many ISMP Canada initiatives, including concentrated potassium chloride, opioids, anticoagulants, and medication reconciliation, and also coordinates ISMP Canada's educational events and workshops.

Julie Greenall

Julie Greenall, RPh, BScPhm, MHSc, ACPR, FISMPC, is the Director of Projects and Education at ISMP. She has more than 30 years of clinical and management experience in pharmacy practice. She completed a Fellowship in Safe Medication Management with ISMP Canada in 2004 and formally joined the organization in 2005 as a Project Lead. As Director of Projects and Education, she has oversight of ISMP Canada's consultation and education programs as well as other projects, including medication reconciliation.

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A SHIFT to safety means more inclusive care

Chris Power

The movement to include patients and their families as equal partners in health care has grown remarkably in recent years, and continues to gain traction. Patients want to be included in their own care, and health care providers and the health system at large are becoming more willing to view them as equal partners.

The Canadian Patient Safety Institute (CPSI) welcomes this shift. We were created 12 years ago, and in that time, we have largely focused our patient safety and quality improvement efforts on frontline health care providers. We came to realize our efforts need to be directed to a broader spectrum across the health care system if we want to help Canadians stay safe in a clinical environment. This applies in particular to patient involvement in care.

Barb Farlow, of Patients for Patient Safety Canada recently said, "We want to be active participants in our health care and these tools and resources now available through Shift to Safety will go a long way toward helping us realize that."

Ms. Farlow lost her infant daughter as a result of a preventable error. She joined Patients for Patient Safety Canada to make a difference in the health care system and change the culture of patient safety. She likens the patient experience to being on a mechanized assembly line, without the human factors one might expect in a health care setting.

"While they don't claim to be experts in medicine, patients are experts about how they feel and in the best position to describe their own context. It is frustrating to be treated like a machine, devoid of this valuable perspective," Farlow says. "Armed with sufficient knowledge of their conditions, and given the opportunity to voice their thoughts and opinions, even

sick patients can be valuable contributors to ensuring a safer health care system."

In 2015, this shifting area of focus led CPSI to conduct an exhaustive consultation process with its stakeholders to better understand their needs. The participants included patients and family members, as well as health care providers, leaders, and staff members. The feedback was crystal clear: transformational change does not happen without cultural change. Frontline engagement is a must, but it is no longer enough. Patients and families must be positioned as full partners in care.

As part of that consultation, one of the major concerns we heard from members of the public was their fear of speaking up in health care settings, and a desire to have opportunities for safe dialogue that would promote patient safety. Many patients and families fear their care will be compromised if there are not greater opportunities for safe and candid conversations with clinicians.

Clearly those conversations are necessary, as the prevalence of harm in health care is staggering. Here is a small snapshot:

- The rate of patient safety incidents among Canadian home care clients was 10% to 13% over a one-year period, or 130,000 Canadians (Doran & Blais, 2013).
- Every year, 200,000 patients suffer hospital-acquired infections (PHAC, 2013).
- A study on the economics of patient safety found that the cost of preventable harm in acute care is more than $396 million per year (Etchells, 2012).

So what's next? We have acknowledged the avoidable harm happening in health care every day, we have people in the system who want to better engage with patients/residents, and

Shift to Safety

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for working with healthcare providers based on my individual needs.

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Join us and make the SHIFT today!

members of the public who want to be full partners in their own health care. How do we make this happen?

SHIFT to Safety, a new initiative from CPSI, gives people tools to educate and prepare themselves to step into an advocacy role and become empowered to ask good questions. We should all expect safe, thorough care. We should also expect to be heard. "It's refreshing to see the public being given a greater voice in their own health care," said Barb Farlow.

A section of SHIFTtoSafety.com is specifically for the general public, and is filled with the tools and resources they need to become partners in their own health care. We're especially excited about the chance to engage with them directly about patient safety. There are also sections aimed specifically at health care leaders and providers.

Tools and resources available at SHIFTtoSafety.com include:

Canadian Patient Engagement Network

The Canadian Patient Engagement Network is an open, public, and safe space. It's a community for anyone who is passionate about patient engagement or patient-centred care. It helps build individual and system capacity for effective patient engagement toward one common goal: safe health care for all Canadians. Participate in this network through LinkedIn and Facebook.

Questions are the Answer

Questions are the Answer is a series of downloadable and printable information sheets designed to help patients effectively prepare to make decisions about medical treatment options by asking their health care team the right questions. It considers topics for before, during, and after appointments, using past, present, and future medicines, medical tests, and surgeries.

Five Questions to Ask about your Medications

Safety is a notable concern for patients who require multiple medications or who are transitioning between treatments. They may be at risk of fragmented care, adverse drug reactions, and medication errors. To be an active partner in their own health, they need the right information so they can use medications safely. These five questions will help patients and their caregivers have a conversation about medications with their health care provider.

This is just the beginning for SHIFT to Safety. Over time, the website will grow to include a wide range of resources. We will also assess statistics around web traffic and downloads to help gauge interest and impact. The goal of CPSI is to see these tools and resources contribute to safer care in the Canadian health care system and to see patient engagement become second nature to everyone involved.

"Given the opportunity to be regular members of the health care team, family and friends can be key enhancers of safety in the system," Ms. Farlow says. At CPSI, we couldn't agree more! ▮

Chris Power

Chris Power's journey in health care began at the bedside as a front-line nurse. She is now one of the preeminent health care executives in Canada, and is the CEO of the Canadian Patient Safety Institute. Previously, Chris served for eight years as President and CEO of Capital Health, Nova Scotia. Under Chris' leadership, Capital Health achieved Accreditation with Exemplary Standing in 2014 with recognition for 10 Leading Practices.

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Bundling best practices for better outcomes

Debbie Gravelle, Sandra Schmidt

Enhancing lives and transforming care is our vision. Transforming the patient experience allows us to live that as a mission.

Bruyère Continuing Care is a multi-site organization comprising two hospital sites (Élisabeth Bruyère and Saint-Vincent Hospital), two academic family health teams, two long-term care facilities, and a seniors' village. It is affiliated with the Bruyère Research Institute.

At Bruyère, we understand the importance of moving beyond informing patients and families, to actively collaborating with them. That is why we convened a Patient and Family Advisory Committee to partner and co-design initiatives with us. It has connected us to an untapped and incredible resource. We have had great success as a result of listening to our patients and families, and discovering what is most important to them. This has enabled us to partner with them and use evidence-based practices to co-design new processes.

Nursing Always Practices

Nursing Always Practices are aspects of the patient experience that health care providers must perform consistently for every patient, every time—they're that important (IHI, 2016).

When we implemented the Nursing Always Practices in November 2015, we decided to follow the IHI Innovation Series model (Resar, 2012) and bundle together multiple evidence-based practices that are proven to increase the quality of care and patient safety. These bundles are small sets of evidence-based interventions for a defined patient or population and care setting that, when implemented together, result in significantly better outcomes than when implemented individually (Resar, 2012).

Issues we addressed

We created the Nursing Always Practices using a co-design approach, actively involving all the relevant stakeholders. We captured themes in patient stories, conducted concept mapping exercises, held Kaizen events, and partnered with our Patient and Family Advisory Committee. Patients and families have been actively working with us every step of the way.

Through these exercises, communication with nurses emerged as the top priority for patients and families. We used this knowledge to guide our selection of evidence-based practices. The resulting bundle of Nursing Always Practices includes:

- Introducing yourself and your role to the patient
- Actively engaging the patient in the bedside shift report
- Updating the patient's individualized care board
- Conducting a structured hourly round
- Participating in the unit-based safety huddle
- Identifying patients who have had significant changes in their condition
- Completing a priority list for other team members

We decided to use an intensive implementation approach, as it was apparent from our co-design process that these simple, low-cost interventions would quickly transform the patient care experience. We therefore implemented the Nursing Always Practices on the same date on 12 units, in all three shifts at 2 hospital sites. We wanted our Patient and Family Advisory Committee to know how important its voice was, and that it had truly been heard.

Preparation and evaluation

Our initial preparation involved patient and family interviews, direct third-party observations, focus groups, and a nursing survey, in addition to the aforementioned approaches. We worked throughout the development phase to engage clinical managers, nursing educators and leaders, and bedside staff. We posted YouTube videos, created educational pocket cards, and hung posters on our units to raise awareness.

We knew it would be important to gather feedback from participants after implementation, so we embedded questions about the Nursing Always Practices into our clinical manager patient rounds and in patient satisfaction surveys. Regularly evaluating and monitoring our outcomes helps us identify areas for improvement and will ultimately help us realize our goals more efficiently.

In order to sustain the change, we provided staff with a six-month refresher using case studies, simulation, and just-in-time education on the units. We wanted our staff and patients to know we are truly committed to transforming the patient experience on an ongoing basis.

Results and next steps

Over 80% of the nurses felt the Nursing Always Practices increased patient safety and the quality of care delivered. These practices also increased communication among nurses and also between nurses and patients. For example, patients regularly report that they now know the name of the nurse working with them, feel confident they are being listened to, and feel secure in knowing they will be checked on approximately every hour. There was also a decrease in the time it took to answer call bells. Patients and families express that they appreciate being a partner in their shift report

and are able to contribute in the exchange of information about their care. Patients like that their individualized care board communicates what they feel is most important to the care team.

In July 2014, Bruyère was selected by the Canadian Foundation for Healthcare Improvement to join a 22-member, pan-Canadian collaborative called Partnering with Patients and Families for Healthcare Improvement. Our participation will help us accelerate our initiatives by providing structure around and access to quality improvement and measurement experts, and by pairing us with experienced coaches and resources.

In April 2016, Accreditation Canada recognized our Nursing Always Practices as a Leading Practice. We are very proud of this achievement, and know we want to continue to evolve this program.

We have planned several steps for the next phase of this project:

- Develop a sustainability plan for the Nursing Always Practices (Scoville, 2016)
- Implement 'always practices' in other disciplines
- Continue to co-design initiatives identified by our Patient and Family Advisory Committee (e.g., the Path to Home Passport, a process for patient- and family oriented conferences)
- Develop a hiring and onboarding process that responds to patient needs

We have shared our journey with multiple organizations, including the McGill University Institute for Strategic Innovation, Health Quality Ontario Transformation, Health Achieve, the Patient Experience Empathy and Innovation Summit at the Cleveland Clinic, and the Canadian Foundation for Healthcare Improvement at the Institute for Patient and

Family Centered Care Conference in New York City and at the National Surveyor Conference.

We are currently exploring whether there is a correlation between the introduction of the Nursing Always Practices and the number of medication incidents, falls, satisfaction results, and complaints lodged.

Why did it work?

The main reason it worked is that this came from patients, so the nursing buy in was high. Using a bundle and big bang approach confirmed our commitment to improving the patient experience. We know that partnering closely with patient and family advisors was also vital to our success. They provided us with excellent insights and ideas to translate evidence-informed research into concrete initiatives. Partnering with researchers through the Bruyère Research Institute also gave us the opportunity to address patient needs with evidence-based practices.

This type of change cannot be achieved off the side of someone's desk. It requires strong and committed executive leadership in addition to a project lead. ▪

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The Abbreviations Website for health care communicators

Dale Wright

What do these abbreviations mean in your patient care setting?

MS: magnesium sulfate or morphine sulfate?
CP: chest pain or cerebral palsy?
OD: daily or right eye?

Abbreviations have long been a part of the culture of health care, and they have contributed to miscommunication and patient harm for just as long. The benefits of abbreviations seem obvious – they are convenient, easy to use, space saving, and harder to misspell than the full version of many words. Yet, as the example illustrates, abbreviations and acronyms are not universally understood and can have multiple meanings. Some abbreviations are so commonly misunderstood they are considered dangerous, and poor handwriting increases the risk of misinterpretation. That said, the introduction of electronic medical records and e-communication has not eliminated the problem. There is still a need to be vigilant about how abbreviations are used in patient care, and to eliminate the use of abbreviations known to contribute to patient harm.

Real consequences

A patient with diabetes was ordered 7IU (seven International Units) of insulin. The order was written as 7U, and the caregiver misinterpreted the order and gave 70 units instead of the 7 units intended. The patient became seriously hypoglycemic and suffered permanent harm (Institute for Safe Medication Practices Canada, 2003).

The new website, abbreviations.hqca.ca/, is a resource for quality improvement initiatives that change how abbreviations are used.

With the introduction of the Dangerous Abbreviations Required Organizational Practice (ROP) in 2009 (now called The "Do Not Use" List of Abbreviations ROP), Accreditation Canada put the spotlight on the need to curtail abbreviation use to improve health care communication (Accreditation Canada, 2015). The ROP states that "The organization has identified and implemented a list of abbreviations, symbols and dose designations that are not to be used in the organization."

Progress is being made. In 2015, 85 percent of the organizations surveyed by Accreditation Canada met this ROP. This is an improvement after three years (2012 to 2014) during which the compliance rate remained unchanged at 77 percent (Accreditation Canada, 2016). In 2015, compliance was highest in acute care (90 percent) compared to long-term care (80 percent) and home care (67 percent).

The ROP focuses on the use of abbreviations in medication-related communication. However, the use of abbreviations and the potential for miscommunication is broader than medications. In addition to prescriptions, prescription labels, and medication administration records, abbreviations are found in other treatment orders, care plans, clinical notes, discharge summaries, and instructions to patients (Axelsson, 2004; Jefferies, 2011). As texting has become part of everyday communication, more texting abbreviations are being used in health records. Electronic medical records (EMRs) are becoming more widespread in all care settings and reduce the risk of unclear

communication posed by abbreviations in combination with poor handwriting. While EMRs can be programmed to eliminate certain abbreviations (e.g., in order sets or order entry fields) abbreviations can often be used in free-text fields (Jefferies, 2011).

It is challenging to change an established practice and an ingrained habit like abbreviation use. Introducing a "do-not-use" list is a necessary first step in shifting expectations, but will not change the simple fact that people use abbreviations to communicate. A comprehensive change initiative that involves many people and multiple strategies is required. Time and a stepwise approach can help health care providers adapt to new ways of communicating without using error-prone abbreviations.

The Health Quality Council of Alberta's abbreviations website (abbreviations.hqca.ca) is a toolkit of resources to support the development and implementation of a quality improvement initiative focused on abbreviation use. The website's content is organized around a four-step change process:

1. Making the case
2. Engaging the right people
3. Planning for change
4. Making it happen

The toolkit features well-referenced, short literature summaries and more in-depth explorations of selected topics in the

resources. References and links to additional resources are provided. Each step of the change process is illustrated by a case presented in two care contexts—an acute care hospital and a long-term care facility.

1. Making the case

The first step in any quality improvement initiative is making a case for why change is needed (Langley, Nolan, Nolan, Norman, Provost, 1996). Learn more about the problem of abbreviation use from the literature summary and find additional details and an extensive reference list in the resources section. Suggestions and questions are provided to help define the problem in the local setting by gathering evidence of current practices and problems related to abbreviation use. Use this knowledge to draft a clear statement of purpose that describes what will be different if the initiative succeeds.

Questions to help define local practice patterns:

- What abbreviations are most commonly used in the setting?
- What abbreviations are used with high-alert medications (e.g., insulin, warfarin, narcotics)?
- What abbreviations have been implicated in patient safety incidents?
- Who is using abbreviations (e.g., doctor, nurse, pharmacist, other health care provider)?

- How are abbreviations being used (e.g., to order treatments, document patient progress, transcribe treatment orders, give instructions to patients)?
- What abbreviations are commonly used for each purpose in the question above?
- What is the impact of abbreviation use (e.g., orders need to be clarified; abbreviation results in a close call or error, such as a transcription error or patient receiving an incorrect dose of medication)?

2. Engaging the right people

Changing is a team effort (Institute for Healthcare Improvement, 2016) and this is particularly important for an abbreviations initiative in which many people will be impacted. It requires senior leadership support, champions in the disciplines and departments that have a major stake in how abbreviations are used, and an improvement team that includes frontline providers who are being asked to change their communication habits.

3. Planning for change

This section of the website shows how the Model for Improvement (Langley, Nolan, Nolan, Norman, Provost, 1996) can be applied to designing an initiative to change abbreviation use. A key lesson from the abbreviations literature is that a combination of intervention strategies is required along with a strong emphasis on early and ongoing communication to mitigate resistance to change.

4. Making it happen

Experience shows that a multipronged approach that uses both system-based and person-based strategies from the hierarchy of effectiveness (Institute for Safe Medication Practices Canada, 2013) is required for a successful abbreviations initiative.

Typically, this involves a combination of policies and guidelines, education, reminders, measurement with feedback, the standardization of orders, and information technology support. This section provides a short summary of different strategies from the hierarchy of effectiveness that can be used in an abbreviations initiative. Additional resources explore challenging situations and provide some examples of tools that others have developed. Users can submit short descriptions of their own abbreviations initiatives and tools that have worked in their setting.

Meeting Accreditation Canada's "Do Not Use" List of Abbreviations ROP is an important step toward protecting patients from the harm that can result from unclear communication related to abbreviation use. Health care providers can use information from the HQCA abbreviations website to investigate the problem of abbreviation use in their care setting and develop an initiative to curtail the use of abbreviations known to pose a risk to patient safety. Health care providers should be encouraged to 'write it out' for patient safety. ∎

Table 1: Hierarchy of effectiveness for error reduction strategies

Focus	Strategy	Effectiveness
System-based	Forcing functions (e.g., orders with error-prone abbreviations not accepted)	High leverage (more effective)
	Computerization (e.g., electronic health records, computerized prescriber order entry, alerts/warnings)	
	Standardization of orders (e.g., protocols, clinical order sets)	
Person-based	Audit and feedback (general, personalized)	Low Leverage (less effective)
	Reminders (e.g., posters, stickers on charts)	
	Policies/guidelines (e.g., medication order, writing standards)	
	Education (e.g., presentations, e-learning modules)	

Source: Institute for Safe Medication Practices Canada

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The state of quality improvement work in primary care

Maeve O'Beirne, James A. Dickinson

More than half of all patient visits occur in primary care (UHCHRM, 2014), which means high numbers of medical errors could occur there. In our experience, primary care physicians have not measured or addressed errors well for several reasons:

- Physicians in this setting have not been trained in the culture of quality improvement.

- Most primary care physicians do not have time to develop or implement critical appraisal and inquiry at their clinics.

- Measurement tools developed for other settings do not work well in primary care.

- Funding for tools and activities has not reached primary care.

Estimates on the frequency of medical errors in primary care vary widely depending on the measurements, definitions, and collection methods used (Kingston-Riechers et al., 2010; de Wet, 2012). One review of patient safety incidents in primary care found that the most frequently reported incidents could be categorized as medication-, treatment-, and diagnosis-related (Kingston-Riechers et al., 2010). Although these incidents were relatively frequent, most did not result in severe harm to the patients (Gehring et al., 2012).*

Quality improvement in primary care

Like most health care professionals, primary care physicians seldom have time to consider a system-level view of what caused an incident in a given case. Even if they do, the clinician must then find the time to translate the issue into an improvement. What is more, most physicians who graduated more than a few

years ago were not taught quality improvement techniques, and few have the skills to apply them to their clinical environments.

When we led a project on quality improvement in family practices, we saw that physicians often confused quality improvement with research (O'Beirne et al., 2010). Unfortunately, this led them to believe they needed to collect information about large numbers of events to reach statistical significance so they could justify improvements. They understandably imagined a daunting scenario in which their clinic work was disrupted and they had even less time for their patients. This meant they did not engage in what they saw as a process that was far too time consuming for the benefits they might gain.

What's more, sometimes the physicians we worked with simply were unaware that errors were happening frequently, and that improvements were necessary. If, for example, a patient experiences an error and ends up in acute care, or the consequences are fairly easily remedied, the physician may not even hear about the incident. Furthermore, the effects of some errors may take a long time to develop and the connection between the incident and the outcome may not be clear to the physician (Gandhi and Lee, 2010).

System structure

Primary care is not structured in a way that facilitates systemically responding to errors, even when they are recognized. Most Canadian practices are owned by the physician(s), who hire the rest of the clinic's staff. Under this model, it can be uncomfortable for staff to highlight errors they made or those committed by their employer, the clinician.

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*The scale ranges from no harm to minor harm, moderate harm, severe harm, and death.

Additionally, in North America and the UK, most consultations are approximately 10 to 15 minutes long. This can lead to reflexive test and drug ordering and does not leave enough time to fully consider some patients' complexities and comorbidities (Hernan et al., 2015, Fortin et al., 2005). If this is to change, funding models must enable longer appointments.

Rodrigues et al. (2015) found that primary care practices benefit from team-based safety activities like regular team meetings or huddles. In their study of the Veterans Affairs system in the US, huddles comprising all team members focused on pre-visit planning, strategizing treatment plans for patients with complex needs, and addressing daily workflow and communication issues. They found that although primary care practices were the least likely to have team huddles, those that did were better able to implement the principles of the medical home, which include patient safety and quality improvement. One of the barriers to implementing huddles was a lack of protected time.

The findings from Rodrigues et al. are why we need to address the lack of funding for team meetings in the Canadian fee-for-service model. In fee-for-service clinics, team meetings reduce the clinician's income because the meeting creates overhead costs that are not offset by fees. Furthermore, in Alberta and Ontario, some clinics' team members are provided through Primary Care Networks or Family Integrated Health Teams. They often work part time and are shared among several clinics, which makes meetings difficult to arrange.

Identifying errors

In primary care, some of us have adapted and adopted acute care techniques for identifying errors. These include trigger tools, alarms/alerts, criterion-based audits, adverse event/incident reporting systems, benchmarking, and patient-reported experience measures. None of these techniques are able to identify all the errors occurring in primary care. Each method has its limitations; each can miss certain types of errors.

Various studies have also examined the use of preventive tools such as checklists (Dubey & Glazier, 2006), trigger tools (Singh et al 2009), clinical pathways, and accreditation. Tools that were developed specifically for acute care (e.g., surgical checklists) seldom fit with the typical consultation structure in primary care. Decision aids and clinical pathways (Elliot et al 2016) are often developed by specialists who concentrate on a particular body part or system without taking into consideration the whole person (Feeny 2014). Primary care physicians often treat several issues at once and must prioritize them. This means we do not necessarily follow a pathway for one particular problem.

Primary care physicians face a wide range of health care issues in their practices. Family physicians in Alberta over three months, diagnosed a mean of 109 diseases/conditions; internal medicine specialists diagnosed 17; pediatricians diagnosed 23, and other specialists diagnosed 12 (L. Svenson, personal communication, June 21, 2013).

In economists' terms, family practice is a multi-product firm—a supermarket, rather than a butcher or baker—and applying measurements for a specialty shop simply does not work.

For example, a typical family physician may only diagnose two cases of the many possible types cancer each year. Measuring errors in their diagnostic process is therefore extremely difficult given the low sample sizes.

CIHI's publication, *Primary Health Care Indicators Chartbook* (2016) also points to the measurement issues faced in primary care. It identifies 51 indicators, and excluded 36 because of insufficient data. Among the 51 indicators, none relate to the care of acute or chronic problems, which arguably is the central and most common activity in general practice. Instead, it focuses on issues around access, recommended care, and the delivery of services. Therefore, we must rethink how to measure practice in these settings.

Solution: Address the process

As an alternative approach, we could consider measuring the care process. Table 1 provides a process map of a primary care visit, which demonstrates the complexity of each interaction, usually compressed into a 10- to 15-minute time frame. Not all of these components are necessarily present in each consultation, though most are. The table presents errors that might occur at each step, as well as what is and what could be measured.

Table 1: Current and proposed primary care measures

Step in the visit	Possible error	What is typically measured	What could also be measured
• Patient needs medical attention	• Patient does not contact medical care	• Patient panels in some provinces	• Population requiring care, including social determinants of health
• Patient books an appointment	• Patient does not attend clinic	• No-show appointment rates	• Reason for no show • Error in detail (identification, contact information, social information, family contacts)
• Preparation for visit	• Staff recording of blood pressure, weight, etc.	• Measures performed	• Accuracy of measurements
• Patient-physician interaction	• Poor communication	• Patient satisfaction with interaction	• Whether patients were able to tell their story
• Examination	• Appropriate examination not performed, poor quality examination	• Painful examination (especially vaginal exam)	• Accuracy of findings, appropriate focus of exam
• Physician makes a diagnosis or compiles a differential	• Diagnosis errors	• Diagnostic delays	• Missed diagnosis • Over-diagnosis

Step in the visit	Possible error	What is typically measured	What could also be measured
• Physician orders a test	• Orders tests that are not required • Does not order a test that is required	• Number of tests ordered • Whether specific tests are/are not ordered	• Number of tests ordered that are not required • Harms from ordering unnecessary tests • Patient does not understand reason for tests or medications ordered
• Negotiation with patient about diagnosis, prevention, and management	• Failure in understanding	• Patient satisfaction with the interaction	• Patient understanding of medical situation • Physician understanding of patient views
• Physician prescribes a medication	• Orders a medication that is not required for that particular patient • Does not order a medication that is required • Wrong dose, inappropriate amount	• Prescribing rates for certain medications • Prescribing errors (dose, frequency)	• Prescribing appropriateness
• Physician refers to specialist or paramedical service	• Inappropriate referral, late referral	• Referral rates • Inadequate information transfer	• Referral not made when they should be • Over-referrals
• Patient leaves clinic	• Frequency of visits	• Return visit rate	• Appropriateness of return visit rate
• Patient manages self-care	• Patient does not understand advice on how to manage illness	• Clinical and immediate outcomes • Compliance with medication adherence	• Burden of self-care • Appropriateness of advice
• Investigation or consultation results sent to clinic	• Results not followed up as recommended	• Results not relayed to patient • Physician knowledge	• Did results change patient care or outcome?

Next steps

We need a cultural shift so primary care physicians can reflect on how to improve their practices. We might begin by introducing education about quality improvement methods and techniques into residency programs. New graduates can influence the practices of more experienced physicians, so we expect this would have a rolling effect on the system as a whole.

Another useful mechanism may be engaging patients and families more in their own care, to help create tools that can be easily used in this setting (AHRQ, 2016). This more patient- and family-centred approach is occurring in Canada as well as other jurisdictions.

It is also worth noting the current efforts of several key organizations in Canada and the UK:

- *The College of Family Physicians of Canada* emphasizes practice reflection in its continuing medical education program. It also embraces 'The Patient's Medical Home' concept.

- Structures such as the *Primary Care Networks* in Alberta and the *Family Integrated Health Networks in Ontario* are working on providing support to community-based primary care practices.

- *Accreditation Canada* has developed a module for primary care.

- *The Royal College of General Practice* in the UK has an emphasis on graduating general practitioners' understanding how to perform and use an audit.

We believe these changes can lead to stronger, more robust methods for increasing patient safety in primary care. Still, we need to realign resources for development and directed support, as they do for many in-hospital practices. We need to change funding mechanisms to encourage and support patient safety through error prevention and safety promotion in primary care. ▪

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Strategy Update

November 2016

Work on our 'Bold Ambition' strategy process continues apace.

In recent months, as part of this process, we have spoken with more than 500 stakeholders from every region of Canada and from around the world.

A handful of stakeholder reflections surfaced time and again during these many conversations. In fact, we discovered several of the same unmet needs were reflected to us over and over, and from across the health ecosystem.

We heard these messages. We truly listened. And we are working to address these needs as we move forward.

We have work to do still, but a number of pieces are falling into place. Leadership is about choices, and we are making a number of extremely important ones.

We know we must deliver value for our clients and the marketplace. We know we must put patients and their families at the centre of everything we do. We know we must move boldly and strongly to deliver on our potential.

Soon, we are going to be living our strategy and living the choices we make.

We will have more details to share on all these fronts in the weeks and months to come.

We look forward to working with you and all people who share our passion for achieving quality health services for all!