Creating a Culture of Safety – Error Management and Prevention at The Credit Valley Hospital

Errors in Healthcare have recently been the focus of media attention, particularly since the publication of the Institute of Medicine's startling 1999 report "To Err is Human: Building a Safer Health System" The report estimated that 44,000 to 98,000 people die each year as a result of medical errors. More people die from medical errors than motor vehicle accidents, breast cancer and AIDS combined. Reeder[1] describes three types of cultures as they relate to Safety: "Pathologic cultures" that don't want to know about issues, they shoot the messengers, avoid responsibility, conceal or punish failure and squelch new ideas; "Bureaucratic cultures" that may not hear about safety issues, but when they do, the messengers are listened to, quick fixes are used, and responsibility for improvement is compartmentalized; and "Generative cultures" seek information about safety, rewards those who report issues, share responsibility and, when systems fail, widespread change is triggered.

In 2000, we at Credit Valley Hospital became committed to creating a Culture of Safety and to developing/enhancing supporting processes and systems to promote a generative culture. Not unlike the journey that we took with Quality Improvement, the essential ingredients included senior management leadership and a supportive integrated infrastructure. The senior management leadership commitment includes senior medical staff making a visible commitment to making the institution a safer place. The infrastructure which enables this culture is called the Error Management and Prevention (EMP) Model.

Rather than describing our theoretical model, please consider these examples that we believe reflect our movement towards a Culture of Safety.

1. ***Common Understanding of Error*** – Various education sessions have been held regarding Health Care Error for the Quality Care Committee of the Board, Medical Chiefs, Senior Management, Directors, Divisions and Frontline Staff. Senior management leaders, including the chief of staff, have led all of these sessions. The content features principles of EMP such as using a system approach, blame free reporting, communication, teamwork and disclosure as they relate to ***actual errors that have occurred in the organization*****.** Many sessions are prefaced with the 9 Minute video "Beyond Blame" produced by Bridge Medical, Inc.
2. ***Opportunities for Discussion*** – Errors and Near Misses are brought forward for discussion at monthly Director and Senior Management joint meetings, Quality Care Committee of the Board, Physician Chief Meetings, Departmental Risk Management and Unit Based Councils . These discussions focus on system issues, specifically how processes are being improved across departments so that the same error will not happen again. Improvements are made using the Quality Management processes already in place. The issue of disclosure to the patient/family and other members of the multidisciplinary team is also discussed relative to the errors.

3. ***Best Practices*** – As recommendations are received regarding coroner inquests and external risk reviews, we review our systems to identify gaps and potentially unsafe practices. For example, a coroner's report resulting from a death with intrathecal chemotherapy was circulated in Canada. As well, recent publications have identified methods of error prevention with chemotherapy. A multidisciplinary team reporting to the Oncology Programme Steering Committee was established to do a detailed review of our systems. Many improvements resulted from this comprehensive project. Lessons learned are often shared with our peers. In June the terms of reference for the Pharmacy and Therapeutics committee was expanded to include Medication Safety. A mechanism is being developed whereby recommendations from the ISMP newsletter and special alert bulletin are reviewed and reported to this committee.
4. ***Information Sharing About Errors and Near Misses*** – We are currently customizing new Incident Management software which will further facilitate our shift to a Culture of Safety. This tool will provide hospital wide data on all incidents with a particular focus on contributing factors and system improvements. This common database will be used by all stakeholders, including physicians, to provide information about trends, outcomes and improvements resulting from errors and near misses. We have also established an internal newsletter called "In the Loop". A section called Super Sleuth is dedicated to medication prescribing and dispensing errors.

As we continue to strive to embrace a generative Culture of Safety we realize that the journey has just begun. We believe that through dialogue with other Health Care organizations and by telling our stories that we learn together and from each other.

Reference: Reeder, JM. 2001. "Patient Safety: Cultural Changes, Ethical Imperatives." *HealthcarePapers* Vol 2.(1):48-54

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