The following article was published in a regular column that appears in Hospital News. January 2003

The Ontario Ministry of Health is Walking the Walk when It comes to Patient Safety

Since the release of the Institute of Medicine report "To Err is Human, Building Safer Health System", patient safety has been a hot topic for healthcare organizations, professional associations, academic researchers and regulatory agencies in many countries. In some countries strategies, action plans and other programs are being laid out for improving the safety of patients. The United States Congress has earmarked millions of dollars to ensure appropriate patient safety programs and systems are put in place. In Australia and the United Kingdom, respectively, the government is involved in creating a patient safety council and agency to oversee a similar patient safety program.

In September 2002 the Steering Committee on National Patient Safety, spearheaded by the Royal College of Physicians and Surgeons of Canada, released its final report. The report calls for the creation of a Canadian Patient Safety Institute to provide oversight on various aspects of patient safety in Canada. The report also calls for the financial support of the federal government. So far, there has been no official response to this recommendation.

At the provincial level, a number of keen patient safety advocates in Alberta, along with the government of Alberta, have been working to heighten awareness and to drum up actions directed at patient safety. It is noteworthy to mention that over the past year, Saskatchewan Health has created a major quality improvement initiative that also touched on patient safety. Effective January 1, 2003, Saskatchewan formally launched the Health Quality Council.

For almost two years now the Ontario government has opted to place a focus on patient safety. In late 2001, the Ontario Ministry of Health and Long Term Care funded the Institute for Safe Medication Practices Canada (ISMP Canada) to undertake a two-year research project examining the impact of some of ISMP Canada's error prevention strategies and tools. This two-year study, involving over 35 Ontario hospitals, also involves the implementation of the Medication Safety Self-Assessment, a workable and practical tool for measuring the efforts that healthcare institutions apply to medication safety.

Recently, the Canadian Institute for Health Information (CIHI) and the Canadian Institutes of Health Research (CIHR) jointly funded a major retrospective chart review of adverse events in Canada. This important research, headed by Dr. Ross Baker of University of Toronto and Dr. Peter Norton of University of Calgary, spans many hospitals in five provinces. Recognizing that medication mishaps contribute significantly to adverse events in the Canadian healthcare system, the Ontario Ministry of Health and Long Term Care is currently supporting the 'Systems Analysis of Medication Errors' study conducted by ISMP Canada in collaboration with the Institute for Clinical

Evaluative Sciences (ICES). The study, which involves collecting and analyzing data on thousands of medication errors from 15 hospitals in Ontario, is the first of its kind in North America.

The Ontario Ministry of Health and Long Term Care has also recently embarked on two other major patient safety initiatives. One is a partnership with the Ontario Hospital Association (OHA) to develop a Patient Safety Team to enhance patient safety in hospitals and the other is a partnership with ISMP Canada to create Canada's first Safe Medication Support Service. The service will provide advice and support both at a distance and on-site at Ontario's hospitals. Using the internet, telephone and other communication vehicles, ISMP Canada will alert hospitals and ambulatory care clinics to potential medication problems (errors and near-misses) and will help to ensure that safe drug management processes are in place.

At the time of writing, the Medication Safety Support Service is in place. The first focused project is to assist Ontario hospitals in eliminating the need for keeping potassium chloride (KCl) concentrate (a lethal drug when injected without dilution) in patient care areas. As part of the strategy to ensure the safe use of KCl, a comprehensive KCl Safe Use tool has been created. The tool will be available not just to Ontario hospitals, but also to hospitals in all provinces and territories.

ISMP Canada has begun very positive dialogue with the ministries of health in other provinces, including Alberta, Saskatchewan and Manitoba, on providing a similar medication safety support service. With Ontario’s example of such a practical service to follow, and its impending results showing improvements in patient safety, it is expected that other jurisdictions will establish similar programs. After all, patient safety has no boundary - its safeguards are both needed and long overdue.

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