Emily's Musings: Thoughts from UHN's Patient Safety Officer

UHN's Patient Safety Transformation & Never Events for Hospital Care in Canada

Our CEO, Peter Pisters, introduced a challenge to our organization during his presentation at our Board of Trustees Annual General Meeting in June, to focus on the goal of minimizing and eliminating preventable harm. Since that time, we have worked in collaboration with our surrounding hospitals and education partners to develop a Patient Safety Transformation Plan which focuses our efforts around four streams of activity:

- Reducing the occurrence of specific hospital acquired conditions responsible for disproportionate amounts of preventable patient harm
- Decreasing the total number of serious safety events
- Fostering a positive safety culture among staff, volunteers and patients
- Supporting staff safety

This transformation journey will build on the many patient safety and quality improvement initiatives that have been implemented in the past including work related to Human Factors, Positive Deviance, Partners in Care and Lean.

Principles forming the basis of UHN's Efforts

As we move forward, our transformation activities will be based on the principles of High Reliability (a topic covered in the April 16 *Emily's Musings*) which include:

- Commitment to reduce preventable harm
- Anticipation/ assumption of failure
- Integration of mindful awareness into care models

Another essential component is the concept of building a learning health organization which actively seeks to learn from current areas of risk in a manner that engages the full healthcare team.

Never Events for Hospital Care in Canada

Last week, Health Quality Ontario in collaboration with the Canadian Patient Safety Institute released a consensus document highlighting a list of 15 never events for Canada's health care system. The term *Never Events* was first coined in 2001 by Ken Kizer, the former CEO of the National Quality Forum, in reference to particularly shocking medical errors that should never occur. In essence, *Never Events* are adverse events that are:

- Clearly identifiable and measurable
- Resulting in serious patient harm or death
- Reliably preventable using organizational checks and balances

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While provinces such as Saskatchewan and Nova Scotia have previously defined never events for their jurisdictions, this is the first time that a national list has been developed highlighting the top priorities for Canadian never events in hospitals. This list will help to inform the second area of focus within our transformation efforts, namely to actively monitor and implement sustainable changes to our system to prevent serious safety events. Here is the link to download this document: http://www.patientsafetyinstitute.ca/en/toolsResources/NeverEvents/Documents/Never%20Events%20for%20Hospital%20Care%20in%20Canada.pdf