



The Manitoba Patient
Safety Framework | 2015



Manitoba 



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“First do no harm” *(Attributed to Hippocrates 470 – 360 bc)*

The updated Patient Safety Framework sets a vision for Manitoba’s safe, high-quality health care system and sets out the strategic direction to guide patient safety improvements in Manitoba’s health care delivery system over the next five years to achieve measurable improvements. Manitoba’s regional health authorities, provincial health service organizations and Manitoba Health, Healthy Living and Seniors will work together to realize the actions and vision set out in this framework. Ongoing engagement, consultation and partnership with Manitoba health care professional associations, health professional regulatory bodies and health care educators will be instrumental to achieving and sustaining this long-term vision.

Learning More – Changes in Patient Safety since 2000

Patient safety is a fundamental aspect of high-quality health care; without safety, quality cannot be achieved. Patient safety is defined as “...the reduction and mitigation of unsafe acts within the healthcare system, as well as through the use of best practices shown to lead to optimal patient outcomes.” (Canadian Patient Safety Institute).

In Manitoba, like in all health-care systems, health-care providers and health-care organizations are working hard to make care as safe as possible. Manitoba health-care stakeholders have increased both health-care provider and public understanding of patient safety issues, working to mitigate these issues whenever possible. Despite this, in Manitoba, an average of 45 patients a year will die as a direct or indirect consequence of care they have received. More than 400 Manitobans per year are significantly injured in the course of receiving care. While these numbers represent less than 0.001 per cent of the total number of health care interactions that occur in Manitoba in any given year, one death as a direct or indirect consequence of care is one death too many. We have learned that in the vast majority of cases, it is not the fault of health-care professionals. Working to reduce the number of events includes recognizing the systems, processes, procedures, conditions, environments and constraints they face in the working context that can lead and contribute to patient safety problems.

Ensuring the safety of patients throughout the delivery of care is a core objective of all health-care organizations and health-care providers. Over the past 15 years, much has been learned about patient safety and the factors which contribute to safe care. The core of this has been the increased understanding that patient safety is improved by health care provider's knowledge, skill or aptitude, as well as from focused attention on patient safety throughout all facets of a system of care. This includes supporting and developing a culture of safety, which does not tolerate conscious disregard of clear risks to patients or gross misconduct of healthcare providers, but does recognizes many errors that occur are not due to individual competence or skill, but due to breakdowns in complex systems and procedures.

A growing body of patient safety knowledge has taught us that the highest performing safe care environments and providers are those that have:

- governing bodies which provide strategic direction and oversight of patient safety within their organization
- leadership teams that make patient safety a central focus of decision making and resource allocation
- a culture that makes it "safe" for people to come forward and identify risks without fear of being blamed or held solely accountable for incidents that resulted from breakdowns in these complex systems
- a culture that acknowledges, anticipates and learns from failures and successes and takes meaningful actions to improve
- engaged and empowered staff that have the skills and knowledge to mitigate patient safety risks whenever possible and to identify patient safety issues and work collaboratively to make improvements in patient safety without fear of reprimand or blame
- engaged patients that are supported to be full and equal partners in their care, identifying potential patient safety risks, and being part of the care team to mitigate and or resolve these risks.
- a culture in which frontline personnel feel comfortable disclosing incidents while maintaining professional accountability (a "just culture"). The culture is fair and supportive and recognizes the complexity of systems and processes of care that contribute to patient incidents

While patient safety occurrences often cannot be attributed to one individual, it is the responsibility of every individual involved in the care process – from health-care administrators and board members to front-line providers and patients - to identify potential risks, report risks and incidents that occur, and learn from these to mitigate future occurrences. The Manitoba Patient Safety Framework (2015) aims to support the development of a safety culture through the advancement of aligned strategic and operational activities and values that enable an appropriate balance of openness, transparency, learning, and organizational and individual accountability.

Key System Milestones to Advance Patient Safety

In 2004, the province established the Manitoba Institute for Patient Safety (MIPS), the only provincial institute of its kind in Canada with a mandate and mission is to promote and enhance patient safety in Manitoba. Over the past 11 years, MIPS has worked diligently to partner with Manitoba health care stakeholders to advance patient safety practices throughout Manitoba. MIPS is an integral collaborating partner in the Manitoba Patient Safety Framework (2015), providing expert knowledge of best practices, and promotion of patient safety to patients, families, the public and health-care providers.

In 2006, Manitoba was the second province to introduce legislation for mandatory no-blame critical incident reporting across the health system to support a culture of learning and openness.

In 2008, Manitoba introduced the Apology Act, legislation to improve Manitoba's patient safety culture through accountability for and acknowledgement of harm that occurs in the course of delivery of care.

In 2009, Manitoba further strengthened its commitment to patient safety with the introduction of the Regulated Health Professions Act, updating and modernizing legislation to ensure all health professions in Manitoba are governed by consistent, uniform regulations with an enhanced focus on patient safety and accountability. This legislation further strengthens patient safety by ensuring all regulatory bodies establish standards of practice, codes of ethics and competency standards, and enhances the regulation of more clinical procedures. The legislation also requires increased public representation on the boards of self-governing professions to

enable stronger patient and public engagement and enhances accountability between the regulatory bodies and the government.

In 2013, Manitoba established the Manitoba Quality and Patient Safety Council (MQPSC), with membership from all Manitoba regional health care authorities, Manitoba provincial health service organizations and MIPS. The MQPSC provides leadership for provincial health service integration, standardization and policy development in quality and patient safety, aiming to improve health outcomes for Manitobans. Since its initiation, the MQPSC has been working collaboratively to determine aligned strategic direction for patient safety across Manitoba.

Patient Safety Framework for Manitoba

This document sets out the principles underlying the Manitoba Patient Safety Framework (2015); explains the integral pillars of the strategy; identifies the actions Manitoba's regional health authorities, provincial health service organizations and Manitoba Health, Healthy Living and Seniors commit to undertake; and what patients and the public can expect as a result of these actions.



Principles

Manitoba's regional health authorities, provincial health service organizations and Manitoba Health, Healthy Living and Seniors believe a safe high quality health care system is one that:

- is strengthened through provincial collaboration
- fosters a culture of safety
- supports continuous learning and improvement
- reflects shared personal responsibility all for the quality and safety of care provided
- promotes and enhances cultural safety
- reflects client values as organizational values
- actively engages clients and staff
- takes action to improve patient experiences and safety based on data and evidence
- openly shares patient safety information and progress towards improvements

Pillars

The Manitoba Patient Safety Framework (2015) builds on the learning from experience in Manitoba, Canada and internationally, reflecting five pillars central to sustained improvements in patient safety:

Client Focus – Patients and clients must be partners in all aspects of health care; those receiving services and their families are encouraged to participate in decision-making. Health care staff respect and respond to patient choices, needs and values.

Transparent and Accountable – The public and health providers have confidence in the quality and safety of services provided. Leaders cultivate an environment where there are relationships between health-care providers, patients and the public that are built on trust and open communication. Adverse events and close calls are reported and responded to in a transparent manner. Being transparent and accountable includes public reporting of safety performance, learnings and trends.

Governance and Leadership – Safety is central to how health services are planned and delivered; there is a visible commitment to patient safety as a clear priority. A

patient safety lens is consistently applied to governance and leadership decisions. While patient safety is everyone's responsibility, a safe system starts with leadership at the highest level.

Continuously-Improving Clinical Services – Targeted strategies improve patient safety. When organizations continuously examine and improve the way care is delivered, the risk of patients being harmed is reduced.

Continuous learning – Organizational culture that supports learning and improving, rather than blaming. Culture influences patient safety directly by determining accepted practices and indirectly by acting as a barrier or enabler to the adoption of behaviours that promote patient safety. Information about patient safety events is shared for the purpose of ongoing learning. Organizations support providers, patients and the public to continuously search for ways to improve the systems of care. Safe care depends upon having competent, supported health care workers working together in effective teams. Access to continuing education enables health care workers to remain current with changing practice standards, technologies and clinical information.

Through specific, provincially-standardized and aligned actions in each of these pillars, Manitoba can realize its vision of a safe, high-quality health-care system for all Manitobans.

Client Focus

Patient or client-focused care is health care that is respectful of, and responsive to, the preferences, needs and values of patients, their families and health-system users. At times, patient-focused care is misunderstood to suggest that providing patient-focused care means doing exactly what the patient demands. A clinician who provides unnecessary antibiotics to a patient at a patient's request is not providing patient-focused care. However, a clinician who tailors his/her communication to the individual being served, who supports meaningful dialogue and understanding of health care actions, and works to serve the ultimate health care interests of the patient according to what is meaningful and valuable to that patient is providing patient-focused care.

This focus on better communication between the patient, the patient's family and medical staff is part of patient-focused health care, and has been shown to improve providing patient health, lessen symptoms and reduce chances of a misdiagnosis due to poor communication. Studies show when health-care administrators, providers, patients and families work in partnership, the quality and safety of health care rises, costs decrease and provider and patient satisfaction increases.

Manitoba health-care delivery stakeholders are committed to undertaking the following actions to improve client focus:

- regional health authorities / health service organizations / the department will create declarations of patient values and ensure they are regularly reviewed in consultation with clients.
- Structures will be in place for active and ongoing engagement of clients.
- Mechanisms will be in place for clients, staff and administrators to identify patient safety improvements.
- Clients and patients will be educated on how to be informed health-care users and can access the information they need to inform their health-care decisions.
- Clients and staff will be aware of and empowered to take action to reduce patient safety risks.
- Clients and staff will be actively involved in identifying improvements when things don't go as planned.
- Clients will be encouraged and supported to be active participants in their care.
- Organizations will have mechanisms in place to hear the patient voice.
- Patients and clients will be informed honestly, openly and in a timely manner when harm has occurred.
- When harm has occurred, patients and clients will receive an apology.
- Patients and clients will be treated equitably and cultural values will be respected.

Measuring progress on improvements in client focus will be done through patient experience surveys, client and patient feedback and through the existence of audited policies and procedures which sustain these actions.

As a patient or client of health care services in Manitoba, you can expect:

- You and your family will have opportunities to provide input on what is important to you in the delivery of your care.

- You and your family will have the information you need to help you make decisions about your care.
- You and your family will be treated equitably and your cultural values will be respected.
- You and your family will be considered active partners in your care and treated as a member of the health-care team.
- You and your family will be encouraged to ask questions and provide feedback about your experience of care.
- If you are harmed in the course of care, you will be openly informed of this harm.
- The healthcare team involved in your care will be accountable, and openly discuss with you the incident and the actions being undertaken to reduce the chances future similar incidents will occur.

Transparent and Accountable

Transparency and accountability help build trust between patients, the public and the health-care professionals and organizations they have entrusted with their care. Through transparency, opportunities for improvements can to be fully understood, identified and mobilized. Accountability means learning and improvement opportunities are acted upon. Being accountable for actions and openly communicating progress ensures patients have the information they need to make informed decisions about their care and are able to be active partners in their care and improvements in care overall.

Manitoba health-care delivery stakeholders are committed to undertaking the following actions related to transparency and accountability.

- Provincial structures and systems will be in place to enable performance measurement, monitoring and reporting.
- Patient safety performance, learning from patient safety events and trends are reported publicly.
- Organizations have formal open disclosure processes which enable effective staff and client participation.
- Organizations, undergo external review of quality and patient safety activities through the accreditation process, and share the results of these reviews publicly.
- Organizations have transparent and accessible client concern resolution processes.

Sharing progress publically with indicators and regular updates on the implementation of this framework, our partners and patients will be informed of our improvements and continued opportunities for improvement.

As a patient or client of health-care services in Manitoba, you can have confidence that:

- Organizational leaders and boards are undertaking actions on a continuous basis to evaluate the safety of care in the environments they lead and working to improve safety .
- Improvements and challenges in advancing patient safety are openly disclosed to consumers of health-care services.
- If you encounter a problem in your care, you will be listened to and your concerns will be acted on.
- You will be provided service in an accredited hospital or health-care facility.
- Self-regulated health-care providers are held accountable to the quality and patient safety standards of their profession through their regulating bodies.

Governance and Leadership

Patient safety is everyone’s responsibility; however, a safe health system needs to start with leadership. Health-system leaders are accountable for quality and safety performance. Legislation, policy, standards and expectations are established for the delivery of safe healthcare by government., boards, regulatory colleges and organizational leaders. Safe patient care happens when health-care organizations are functioning at the highest level. Leadership, through their actions, establish the environment that supports and enables safe patient care.

Manitoba health-care delivery stakeholders are committed to undertaking the following actions related to governance and leadership.

- Quality and patient safety plans will be in place in each organization.
- Patient safety training will be provided regularly to boards.
- Boards understand and will enact their accountability for patient safety.
- Patient safety will be reflected in organizational strategic and operational plans.
- Clear policies, practices and processes will exist to enable a fair and just culture of safety.
- Clear expectations for patient safety and a just culture will be communicated throughout all organizational processes.

- A patient safety lens will be consistently applied to decisions.
- Organizations will engage regulatory bodies and unions in collaborative action for patient safety.

We will measure our progress towards improvements in governance and leadership through audited policies and procedures that sustain these actions.

As a patient or client of health-care services in Manitoba, you can have confidence that:

- The health care organization you are receiving care in has policies, procedures and processes to guide the delivery of safe, quality care.
- Organizational leaders have the education necessary to promote and sustain a just culture of care.
- Organizational leaders demonstrate the behaviours expected of all members of the health care team by promoting openness, transparency and are client focus.
- Your safety is paramount in all organizational decisions.
- The health-care organization you attend is actively working with its partners to ensure your safety across the continuum of care.

Continuously Improving Clinical Services

Creating a safer health care system means continuously improving health care services based on evidence. Manitoba health care delivery stakeholders are continuously working to improve the quality and safety of care in all areas of care. While all areas of care are important, from 2015 to 2020 the specific focus will be applied to implement evidence-based care to improve safety in the following areas:

- Surgery
- Medication safety
- Infection prevention and control
- Transitions throughout the patient journey
- Pressure ulcers

We will measure our progress towards patient safety improvements in clinical services by measuring and reporting from the following areas:

- Hand hygiene compliance
- Healthcare acquired infections– including surgical site infections, urinary tract infections and, and C. difficile infections
- Surgical safety checklist compliance

- Medication reconciliation on admission to personal care homes, home care and acute care
- Pressure ulcer development during the provision of health care services (Stage 3, Stage 4 and unstageable)
- Hospital standardized mortality ratio
- Critical incident reporting

As a patient or client of health care services in Manitoba, you can expect:

- Your care is provided based on up to date knowledge and evidence.
- The health-care organization where you are receiving care monitors key indicators and take actions to improve where indicated.
- Improvements to care in these areas are actively underway and progress will be transparently reported.
- The hospital where you are receiving care has processes in place to reduce the likelihood of you getting an infection as a result of your hospitalization.
- The health system will continue to identify and address opportunities to improve quality and safety.
- Policies and procedures are in place and regularly audited to ensure improvement efforts are undertaken and being sustained.

Continuous Learning

Continuous learning helps providers, staff and health system administrators maintain the knowledge, skills, attitude, and judgement they need to provide the best possible care and to ensure health care structures, policies and procedures enable this.

Manitoba health care delivery stakeholders are committed to undertaking the following actions related to continuous learning:

- Patient safety events will be identified, reviewed and learned from.
- Structures will be in place to enable organizational dialogue and interprofessional learning from patient safety events.
- Staff have the skills and education needed to support a just culture and improve patient safety.
- Patient safety education is delivered annually by health care organizations.

- Learnings from patient experiences, client concerns and performance reporting are shared organizationally and beyond, and applied in planning.
- Governors, leadership and staff will receive the training necessary to promote and enhance cultural safety.

We will measure our progress towards improvements in continuous learning through client and staff surveys which identify the health care culture as a just culture and the existence of audited policies and procedures which sustain these actions.

As a patient or client of health care services in Manitoba, you can expect:

- Health-care professionals and administrators have the training and information they need to provide safe care.
- Health care providers practice according to professional standards.
- On-going learning is encouraged and supported.
- Health organizations, administrators and providers have processes in place to learn from patient safety events and patient feedback.
- Governors, leadership and staff understand the importance of cultural safety, treat all clients and patients equitably and respect client and patient cultural values.

Conclusion

Without ensuring the safety of patients, achieving high-quality health care is not possible. The Manitoba Patient Safety Framework (2015) sets out key objectives and measurable outcomes for enhancing patient safety in the province.

By committing to implementing patient safety initiatives and regularly tracking progress, the department, regional health authorities, providers and other key stakeholders will ensure proper patient safety is a key part of the provision of health-care services.