University Health Network Reinforces Its Commitment to Zero Harm

By Audrey Doyle

At University Health Network (UHN), safety isn’t a new concept. In addition to providing structured safety programs and ongoing monitoring of hospital-acquired conditions, serious safety events and never events, the organization formed a Safety and Quality Committee of the Board that advises the UHN Board of Trustees on their governance responsibilities for reviewing, ensuring and continuously improving safety and quality of care systemwide approximately 15 years ago.

Despite these efforts, however, leaders felt the Toronto-based health system hadn’t achieved a safety culture or safe environment that was optimal. “Our focus on safety was different from what you see in the United States,” said Emily Musing, Vice President of Quality & Safety and Chief Patient Safety Officer at UHN. “Put simply, we saw the opportunity to standardize and systematize our approach to patient and workplace safety.”

To do this, UHN recently launched Caring Safely, a patient and workplace safety initiative designed to engage patients in safety, and to ensure that everyone is committed to safety and will work together to eliminate preventable harm to patients, their caregivers (i.e., family members) and one another. Recently, UHN began working with HPI, now part of Press Ganey, to assist in and accelerate these efforts.

These steps have resulted in the beginning of a systemwide cultural transformation that’s placing the organization on track to achieve its safety goals. “We needed to sharpen our focus on safety and change how we view safety,” said Susan Brown, Executive Director of Strategy & Transformation Patient Experience, Quality & Safety, and Collaborative Academic Practice. “Safety is an extremely important priority for us and is the backdrop for our strategic plan. We’ve only just started the Caring Safely journey, but we’re already seeing a culture shift that’s more closely aligned with our recently refreshed organizational purpose, values and principles.”

A Challenge to Provide Safe Care

A research hospital affiliated with the University of Toronto, UHN comprises Toronto General Hospital, Toronto Western Hospital, the Princess Margaret Cancer Centre, the Toronto Rehabilitation Institute and the Michener Institute of Education at UHN. Boasting the largest hospital-based research program in Canada, the organization is renowned for its advancements in cardiology, transplantation, neuroscience, oncology, surgical innovation, infectious diseases, genomic medicine and rehabilitation medicine.

According to Brown, although UHN has had a sharp focus on safety for years, key safety issues were difficult to tackle and preventable patient and workplace harm continued to occur. “The Caring Safely initiative was launched to build on our existing strategies and remedy this situation,” Brown said.

Caring Safely began as a challenge that UHN’s president and CEO, Dr. Peter Pisters, issued to employees in June 2015, six months after he joined the organization. The challenge was to focus on the goal of minimizing and eliminating preventable harm, and at the heart of the challenge was the memory of a mistake Dr. Pisters had made more than a decade earlier, when he was a clinician at the University of Texas MD Anderson Cancer Center.

AT A GLANCE

- Toronto’s University Health Network recently launched an organization-wide patient and workplace safety transformation initiative as part of its ongoing commitment to advancing safe, high-quality care.
- The Caring Safely initiative focuses on reducing hospital-acquired conditions, decreasing the occurrence of serious safety events, fostering a positive safety culture and reducing the number of incidents that result in harm to workers.
- The health system is working with Press Ganey’s HPI strategic consulting team, whose methods are based on the best practices of High Reliability Organizations, to accelerate its efforts in preventing human errors and detecting and correcting system weaknesses that can lead to harmful events and unwanted outcomes.
As Dr. Pisters recalled, at the conclusion of a complicated operation the standard instrument and sponge count was one item short; a recount yielded the correct number. Believing the recount to be correct, Dr. Pisters had the patient’s surgical wound closed and sent the patient to recovery; however, a small doubt in the back of his mind convinced him to order an X-ray just to be sure.

The X-ray revealed that something had been left inside the patient, but neither Dr. Pisters nor his surgical team had received training on what specific items left inside a patient looked like on a radiograph. After X-rating a number of items, Dr. Pisters and his surgical fellow determined that the item was a laparotomy sponge.

Although the sponge was surgically removed the following morning and the patient recovered uneventfully, Dr. Pisters said the error taught him an important lesson: that preventable patient harm “is usually a result of complex systems where multiple points of failure or deviance from normal align to create harm in a specific patient.” In this case, the points of failure included the facts that Dr. Pisters had left a sponge inside the patient; multiple instrument and sponge counts yielded inconsistent results; and there was no standard protocol to deal with conflicting counts.

Buoyed by a firm belief that preventable harm can be mitigated or eliminated through cultural change and consistent application of proven safety standards and practices, Dr. Pisters initiated the launch of Caring Safely. A strategic initiative developed in collaboration with Toronto’s Hospital for Sick Children (aka SickKids), Caring Safely is designed to build awareness of the scope of the problem of preventable harm among patients and others engaged at the hospital, and lead to solutions that will eliminate that harm.

To do this, Caring Safely focuses on the following activity streams and goals:

- **Culture stream**—To foster a positive safety culture among staff, volunteers and patients

- **Hospital-Acquired Conditions (HACs) stream**—To reduce the occurrence of the HACs that historically were responsible for a disproportionate amount of preventable patient harm at UHN:
  - Nosocomial *Clostridium difficile* infections
  - Adverse drug events
  - Central line infections
  - Surgical site infections
  - Falls
  - Pressure ulcers

- **Serious Safety Events (SSEs) stream**—To reduce the number of SSEs that occur, ranging from moderate to severe temporary harm, to moderate to severe permanent harm, to death

- **Workplace Safety stream**—To reduce the occurrence of incidents that historically were responsible for the greatest number of employee injuries at UHN:
  - Slips, trips and falls
  - Musculoskeletal injuries
  - Injuries due to violence

The leaders for each activity stream sit on the Caring Safely Transformation Team and coordinate strategies and activities across the streams. For example, because falls can occur to both patients and staff, the leaders of the HACs and the Workplace Safety streams coordinate their strategies across both groups.

Within the Culture stream, the Caring Safely Transformation Team coordinated the following activity and strategies:

- Speak Up for Safety survey
- Communication strategy
- Education strategy
- Patient engagement strategy
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According to Musing, the UHN Speak Up for Safety survey, a tool based on a safety survey developed by the Agency for Healthcare Research and Quality, was conducted organization-wide at the onset of the Caring Safely transformation to establish a baseline. “We also included questions specific to workplace safety because we wanted to get a good sense of whether employees felt they were working in an environment that ensured safety,” Musing said. The survey identified that UHN’s areas for improvement were patient handoffs and transitions; staffing; and non-punitive response to errors.

Meanwhile, the strategies around communication, education and engagement have begun and are ongoing. “Our continuing focus is on communicating with one another to increase awareness of safety, educating employees on the tools required to ensure safety and engaging patients in safety throughout the Caring Safely transformation process,” said Musing.

Engaging Patients as Partners in Safety

In terms of patient engagement, Musing and Brown point to two tools in particular that were put in place before Caring Safely began but that fit perfectly with the initiative’s safety goals.

The first is UHN’s Patient Partners Program. Developed in April 2015 to support the Partners in Care Roadmap, an aspirational plan that served as the framework to enhance patient and workplace safety, quality and experience at UHN, the Patient Partners Program recruits, selects and prepares patients and their caregivers to engage with UHN leaders in important hospital planning and decision-making activities.

“For this program, we look for patients and caregivers who are ready to contribute constructively, regardless of whether their experience was positive or negative,” explained Brown. “We don’t just want people who will sing our praises. We want people who can tell us in a constructive way what went wrong in their experience.”

Each Patient Partner is matched up with a UHN leader directing an activity in which the patient’s voice, perspective and participation can help shape safety and other hospital priorities. Initiatives may be cross-organizational (affecting all hospital sites and care programs), site-corporate (affecting one hospital site and all its programs), program-corporate (affecting one program within a hospital site) or program-local (affecting a unit within a program).

Leaders request Patient Partners for a variety of activities. “They may be asked to speak at a meeting, join a committee that meets monthly, present at a retreat or be a panel member at an academic conference,” said Brown. “We act like a matching service, in that we work closely with the leaders to understand what they need and then engage the Patient Partners who best fit the bill.”

At press time, more than 70 patients were members of the program, and more than 100 requests had been made by leaders to have Patient Partners participate in an initiative or activity. Because the majority of Patient Partners thus far have represented the experience of patients, UHN plans to recruit and orient more caregivers to bring more perspectives to the program.

The second patient engagement tool that’s playing a role in Caring Safely is UHN’s Virtual Patient Focus Group. Recognized by Accreditation Canada in 2014 as being an exemplary method of patient engagement, the Virtual Patient Focus Group is an online forum of current and former UHN patients and caregivers who contribute, through online surveys, input and feedback on important hospital policies, procedures, priorities and projects, including those involving patient safety.

According to Brown, members of both the Patient Partners Program and the Virtual Patient Focus Group have been instrumental in providing their views on safety for several initiatives, most recently the latest iteration of the organization’s Purpose, Values and Principles statement. “Participants in both programs have given us a lot of meaningful feedback regarding the importance of safety as a UHN organizational value,” she said, adding that the programs have also been instrumental in sensitizing internal stakeholders to the need to engage patients and their caregivers in safety to solicit their views.

HPI and High Reliability

In addition to embracing safety as an organizational priority and engaging patients and employees in safety initiatives, Caring Safely also emphasizes the importance of consistently improving patient and workplace safety.

Toward that end, UHN recently began partnering with Press Ganey’s Healthcare Performance Improvement (HPI) strategic consulting team to evaluate and optimize its patient and workplace safety programs. As HPI’s methods are based on the best practices of High Reliability Organizations, the key characteristics of the High Reliability concept—preoccupation with failure, reluctance to simplify, sensitivity to operations, deference to expertise and commitment to resilience—will play a key role in the Caring Safely initiative.
According to Musing, HPI will accelerate UHN’s efforts in preventing human errors and detecting and correcting system weaknesses that can lead to harmful events and unwanted outcomes. “It’s all about enhancing the safety culture so that we’re identifying where process improvements can be made when a safety event occurs, not identifying who was at fault,” she said.

Thus far, HPI has completed a diagnostic assessment comprising a common cause analysis focusing on patient and workplace safety; a safety climate assessment; and a safety governance assessment. HPI also has worked with UHN to implement a structure to identify and measure serious safety events. Meanwhile, an implementation plan that includes High Reliability leadership methods and error prevention tools is in the design stage. Leadership education will begin this month, followed by physician and staff education in the spring.

According to Brown and Musing, UHN’s Caring Safely initiative represents a major step forward in the advancement of patient and workplace safety in Canadian hospitals.

“The Ontario government, which is our primary funder, as well as other hospitals and health systems in Canada are paying a lot of attention to what we’ve done and what we plan to do with [the strategic consulting team] moving forward,” said Musing. “We’ve received lots of requests from other hospital boards and quality teams to visit them and discuss how we’re advancing safety, and we recently gave a presentation at an Ontario Hospital Association conference to share what we’ve done so far with the other hospitals in this province.”

“We’re very excited about the work we’re doing,” concluded Brown. “This isn’t a ‘flavor of the month’ or a limited-time initiative. It represents a huge organizational transformation in the delivery of high-quality, safe care at UHN, both now and in the future.”