



CMA PATIENT SAFETY POLICY FRAMEWORK (Update 2010)

BACKGROUND

The CMA's mission is to promote the highest standard of health and health care for Canadians. This means, among other things, ensuring that the health care system is safe for patients and providers and effective in achieving good health outcomes for individuals and society. Unfortunately, studies published in recent years have raised concern that health care is not as safe as it could be; data collected by researchers in various countries has shown that there are unacceptably high levels of preventable adverse events, as high as 16% in one study of adverse events associated with hospital admissions. A study conducted by G. R. Baker, P.G. Norton et al, "The Canadian Adverse Events Study: the incidence of adverse events among hospital patients in Canada" showed an adverse event rate of 7.5 per 100 hospital admissions.¹ This suggests that of the nearly 2.5 million hospital admissions yearly in Canada, approximately 185,000 are associated with an adverse event and 70,000 of those possibly preventable.

These studies have focused attention on health care error and adverse events, but patient safety requires that participants in the health care

system are constantly aware of the risks present in the system, and that risks are addressed proactively - preferably before an adverse event occurs. If a preventable adverse event does occur, it provides an opportunity to learn about and correct sources of error.

The CMA considers that a national patient safety strategy, aimed at building a culture of safety, is a priority. This Policy Framework has been developed to provide a clear statement of the CMA's views on the principles that should underpin a patient safety strategy and to ensure clear support and direction for CMA members and staff involved in patient safety initiatives.

PRINCIPLES

The Health Care System

Outcomes

Errors and adverse events are inevitable in any complex system and more complex systems are more prone to errors. Nevertheless, studies have demonstrated an unacceptably high level of preventable adverse events associated with management of health care.

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All policies of the CMA are available electronically through CMA Online (www.cma.ca).

1. Patient safety initiatives should aim to improve health outcomes for patients by minimizing the rate of preventable adverse events and improving the management of events when they occur.

Quality

2. Patient safety is one aspect of quality health care; activities relating to patient safety should result in a net increase in the quality of health care.

Systemic factors

3. Patient safety initiatives should recognize that error and adverse events occur because of qualities of the system within which individuals operate. A primary concern of initiatives should be to prevent future errors by addressing the system rather than blaming and punishing individuals.

Accountability

The Canadian public has a reasonable expectation that health care will not result in avoidable injury.

4. Patient safety initiatives should support the accountability of the health sector, including providers, funders and regulators, to patients and the wider public for the safety of health care.

Participants in Health Care

Patients as partners

5. Patient safety initiatives should promote the role of patients as partners in the provision of safe care, including the prevention and management of adverse events.

6. Patient safety initiatives should encourage and anticipate the full and appropriate

disclosure to patients of relevant information that is material to their health and healthcare, including information about adverse events or effects.

Professional responsibility and support

With a very few exceptions, health care is delivered by competent, caring professionals who are striving to achieve a good outcome for patients.

7. Patient safety initiatives should recognize the responsibility of professionals for achieving and maintaining the standard of their own practice.

8. Patient safety initiatives, while responding appropriately to adverse events, should be sensitive to the professional role and personal well being of individual physicians and other health care providers.

Learning and Collaboration

9. Patient safety initiatives should promote and reflect teamwork, communication and collaboration at all levels.

10. Patient safety initiatives should support learning from one's own experience and the sharing of knowledge so that it is possible to learn from the experience of others.

Legal and Regulatory Environment

11. Patient Safety initiatives should promote a legal and regulatory environment that supports open communication and effective management of adverse events.

12. The protection afforded to the opinions expressed within quality assurance committees must be upheld

Evidence Base and Evaluation

Patient safety initiatives should be based on sound evidence.

Patient safety initiatives should contain provision for appropriate evaluation.

Patient safety initiatives should contain provision for broad dissemination of findings.

PATIENT SAFETY INITIATIVE AREAS

Building a culture of safety in Canadian health care will require the collaboration of many different groups and organizations. The CMA can play a leadership role within this larger group and within its own constituency of over 70,000 physicians. In some instances, it will be the CMA's role to advocate for initiatives that can be delivered only by another provider or through a consortium; in other instances, CMA can assume sole responsibility for taking action. The CMA has identified that, as priorities, it will support:

Advocacy for changes to legislation and regulation that would remove disincentives for health care providers to share information about adverse events.

Raising awareness of patient safety and changing attitudes towards risk, error and adverse events within the health care community.

Developing and providing resources such as clinical practice guidelines and information technology systems that have been shown to standardize practice and reduce adverse events.

Reporting systems that collect and aggregate data on risks so that good practices can be developed and shared.

Education and training for health care professionals and managers to provide them with the conceptual and practical tools to introduce change into their practice and organizations.

Advocacy for, and development of, an agenda for patient safety research in Canada.

The involvement of government at all levels in supporting and committing resources to initiatives for improved patient safety.

GLOSSARY

Adverse event – any unintended injury or complication that is caused by health care management rather than the patient's disease and that leads to prolonged hospital stay, morbidity or mortality. Adverse events do not necessarily result from error, for example a toxic reaction to a drug in a patient without apparent risk factors for the reaction.

Error – the failure of a planned action to be completed as intended (“error of execution”) or the use of a wrong plan to achieve an aim (“error of planning”). An error may not result in an adverse event if the error does not result in harm or is intercepted.

Risk – the chance of injury or loss as defined as a measure of the probability and severity of an adverse effect to health, property, the environment or other things of value.

¹ G. Ross Baker, Peter G. Norton, Virginia Flintoft, Régis Blais, Adalsteinn Brown, Jafna Cox, Ed Etchells, William A. Ghali, Philip Hébert, Sumit R. Majumdar, Maeve O'Beirne, Luz Palacios-Derflingher, Robert J. Reid, Sam Sheps, and Robyn Tamblyn. The Canadian Adverse Events Study: the incidence of adverse events among hospital patients in Canada *Can. Med. Assoc. J.*, May 2004; 170: 1678 - 1686.