Public Patient Safety Report 2010/2011 & 2011/2012

OCTOBER 2012

Manitoba

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Improving patient safety is a priority for Manitoba. New research, advancements in technology and emerging treatments all have the potential to provide patients with safer, better quality care. However, the changing and complex health care system does create the potential for errors to happen and this can pose a risk to patient safety. While many potential errors are caught before they harm a patient, some errors do lead to serious injuries and death, and these errors are called 'critical incidents'.

International research has found that medical errors can affect between three and 10 per cent of hospital patients. The Canadian Adverse Events Study found that 7.5 per cent of hospital admissions experience an adverse event. The Manitoba Centre for Health Policy has found that "the frequency of adverse events reported in Manitoba is quite low," ranging from 0.10 per cent to 2.96 per cent.

In the past, medical errors were viewed as an individual's responsibility. Today, it is recognized that there are many contributing factors to critical incidents due to the highly complex and specialized nature of the health care system. Provincial, national and international research recommends ensuring medical errors are reported and investigated so the health system can learn from them and make changes to improve patient safety.

Through critical incident reporting and reviews, the health sector gains valuable information which can help it to better understand and identify how the safety of the health care system can be enhanced and improved. For this reason, the provincial government mandated the reporting and investigation of critical incidents in 2006.

Under the legislation, a critical incident is defined as an unintended event that takes place when health services are provided to an individual and results in a consequence to him or her that:

(a) is serious and undesired, such as death, disability, injury or harm, unplanned admission to hospital or unusual extension of a hospital stay, and

(b) does not result from the individual's underlying health condition or from a risk inherent in providing the health services.

All critical incidents reported are reviewed to determine what could be done to prevent this situation from happening again. If the review indicates that the incident could have been prevented through changes in policies and procedures, the use of different equipment or supplies or further continuing education for a group of health care professionals, these recommendations are put in place.

If a patient or family feels that they or their loved one has been involved in a critical incident, they can report the incident to their health care provider, health authority or to Manitoba Health. For more information on critical incident reporting, visit **http://www.gov.mb.ca/health/patientsafety/ci/index.html**.

In comparison to the numbers of interactions and opportunities for critical incidents to occur, the number of critical incidents reported each year is relatively small. There are some incidents reported that will happen, in spite of the best efforts to prevent these situations. An example might be that of a fall resulting in a fracture in an elderly but very independent-minded individual who knows they should ask for assistance, but refuses to and falls. They sustain the fracture due to the bone loss that occurs with normal aging.

All Manitoba regional health authorities and provincial health agencies such as CancerCare Manitoba and Diagnostic Services Manitoba work with organizations to improve patient safety.

This includes the Manitoba Institute for Patient Safety (MIPS) - Manitoba's patient safety champion, providing Manitobans with tools and resources they can use to advocate for themselves and others for safe health care. MIPS also sponsors patient safety events for Manitoba health care professionals, and collaborates with patient safety partners across Canada, to link Manitoba to up to date, best practice evidence and information necessary to improve patient safety in Manitoba.

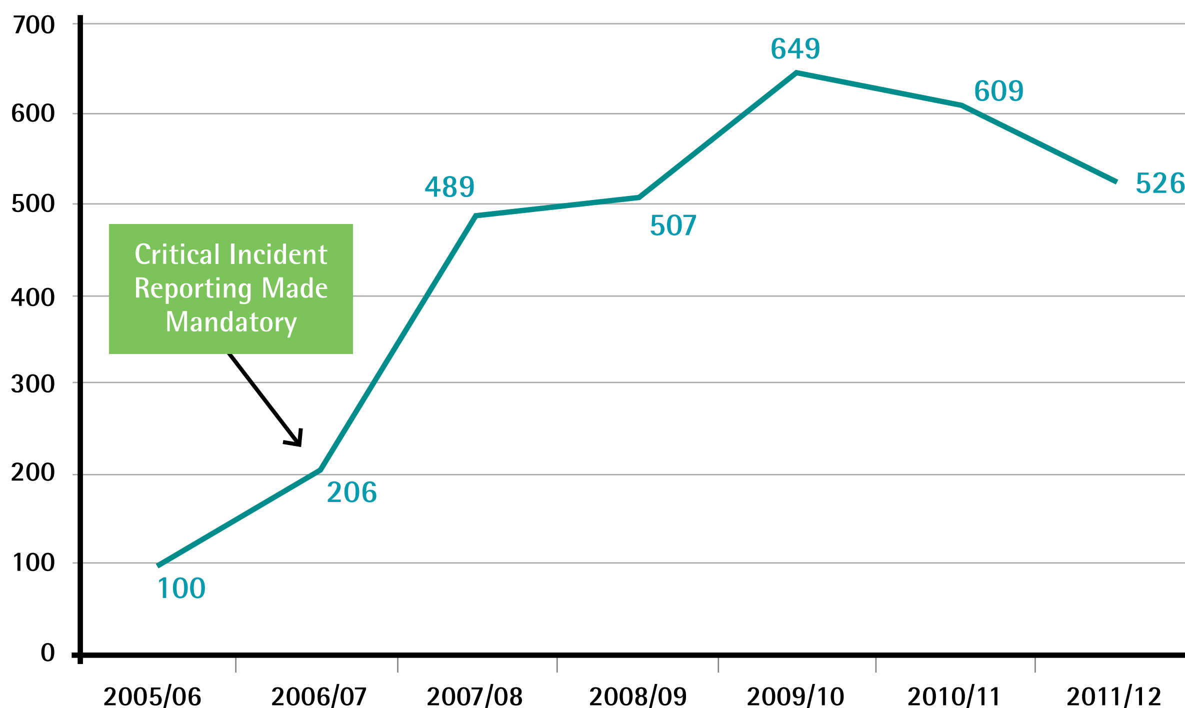
In addition, the Canadian Patient Safety Institute (CPSI) works with patient safety and quality organizations in Canada and beyond to develop and promote strategies and interventions that will assist in making health care safer for all Manitobans and Canadians.

Patients and families play a vital role in the delivery of safe health care. Patients and their families can contribute to positive health outcomes by working as active partners in their health care and sharing information with health care providers, clarifying concerns and asking what they can do to play their part in promoting safety.

To support patient and family efforts in advocating for safe healthcare, MIPS has issued a *"Declaration of Patient and Family Engagement in Patient Safety"*. Three supporting documents are patient values, principles of partnership and patient rights and responsibilities (duties).

Visit the MIPS website **www.mbips.ca** to view these documents. For information and free tools on important patient safety topics, visit **www.mbips.ca** and review the "MIPS TIPS" and **www.safetoask.ca** to review the "It's Safe to Ask" information.

Number of Critical Incidents Reported



Reporting of critical incidents in Manitoba prior to November 2006 was voluntary. The presence of legislation requiring reporting has resulted in increased reporting.

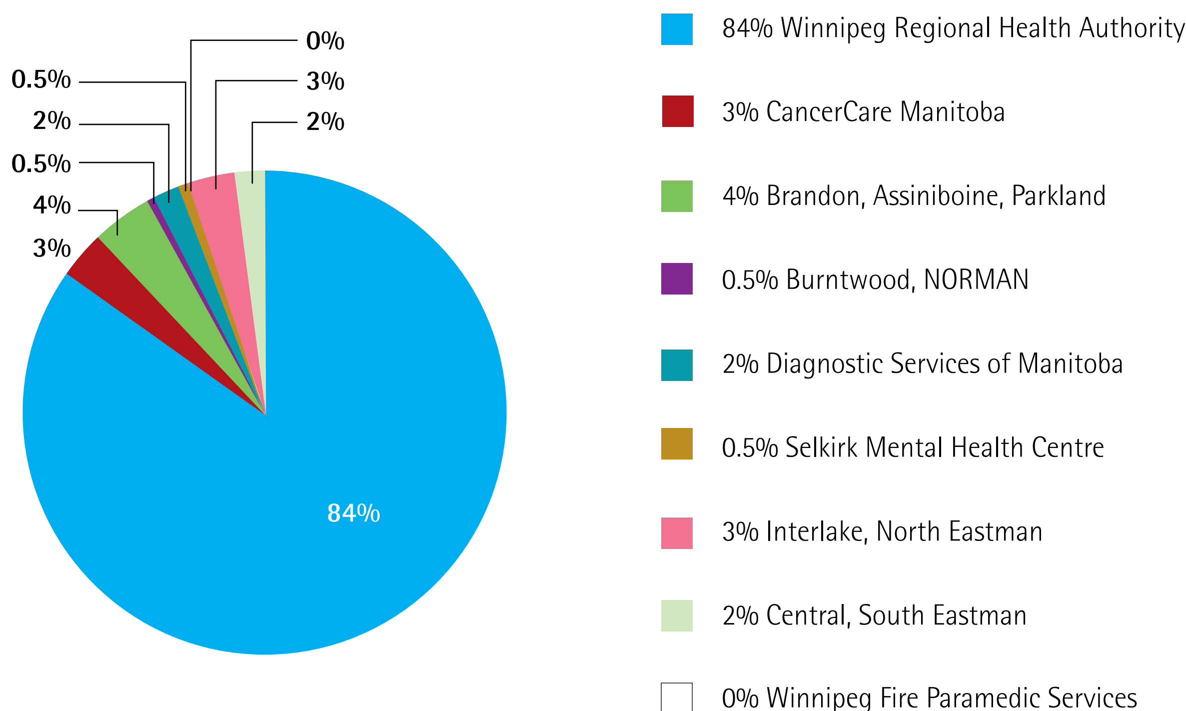
There were a total of 609 critical incidents reported to Manitoba Health in the fiscal year 2010/11 and 526 in fiscal year 2011/12. The trends shown by reports over time can be difficult to interpret.

An increase in critical incidents in a given year may not be due to more critical incidents happening that year. Instead, it may be a result of improved reporting by staff, families and patients. An example of this might be the development of pressure ulcers in individuals who are under the care of a facility or regional health authority. Similarly, a decrease in the reporting of one category of critical incidents may mean that incidents still occur but the threshold of serious unintended injury is not met, so the event is not a critical incident.

It's important to note that not all critical incidents are preventable. The Canadian Adverse Events Study found that less than four in 10 adverse events were preventable.

Organizations Reporting Critical Incidents

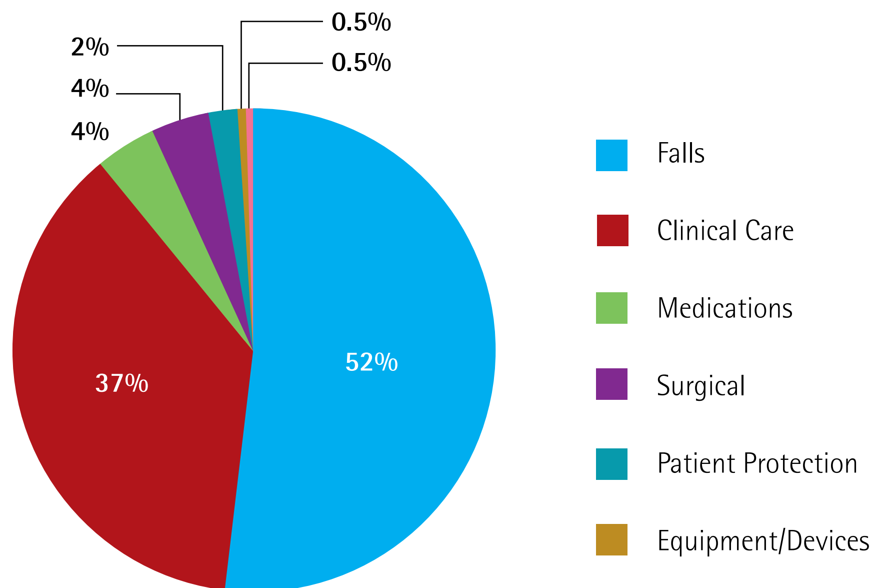
Organizations Reporting, Critical Incidents 2011/12



The Winnipeg Regional Health Authority reported the greatest number of critical incidents: 90 per cent of critical incidents in 2010/11, and 84 per cent in 2011/12. As Winnipeg delivers the majority of health services in Manitoba, and has some of the more specialized critical care such as trauma and cardiac care, this reporting rate is consistent with not only the volume of services but also the complexity and range of services provided.

Type of Critical Incidents

Category (Type), Critical Incidents 2011/12



Over 2010/11 and 2011/12, falls accounted for between 52 and 62 per cent of all critical incidents reported and clinical care incidents were 30 per cent to 37 per cent of reported critical incidents. Between 15 and 20 critical incidents each year are medication incidents (three per cent to four per cent) or events that occur during surgical procedures (three per cent to four per cent).

Since the beginning of critical incident reporting, falls have consistently been the highest reported category of critical incidents in Manitoba. Preventing falls is a priority of Manitoba health sector partners. All regional health authorities have implemented comprehensive falls risk assessment strategies and associated falls prevention activities. Over the past year, the numbers of falls being reported as critical incidents has decreased.

The number of falls reported as critical incidents in personal care homes remains relatively high from year to year. Many individuals that reside in personal care homes have one or more of the risk factors related to falls. Those who have conditions which affect memory, balance, steadiness and/or vision, or on a number of different medications for a variety of medical conditions, are more likely to suffer a fall and perhaps an injury resulting from that fall.

Research has found that the presence of cognitive impairment alone is a strong predictor of a fall.

Falls also happen in the home. For tips on preventing fall at home, visit MIPS "S.A.F.E. toolkit" **http://www.safetoask.ca/safetoolkit/resource9.html**

Critical incidents classified under "clinical care" include a broad range of circumstances. Some examples include:

- an error in diagnosis
- a delay in treatment
- rare and unusual complications related to a procedure including surgery
- the failure to provide care in keeping with an accepted standard of care for a particular patient group
- not understanding/being aware of the contribution of other factors in the patient's history to their presenting condition
- misinterpretation of information, the failure to provide all pertinent information at transition points in care (whether in a facility or in the community), and a lack of clarity regarding medical follow-up in combination with system issues

The most important challenge for all of health care is that of communication. Patients need to feel comfortable speaking up and asking questions of their health care providers and health care providers must not view this as a challenge of their skills and knowledge.

Information such as past medical history, medications, treatments and test results is critical to patient safety. Timely and accurate transfer of this information between healthcare providers in the same and different care settings is particularly important. Information needs to be complete, relevant, appropriate, received and acted upon in order for care to be effectively transferred from one provider to another.

The use of structured communication tools such as SBAR (situation, background, assessment and recommendations) can be very valuable in patient care settings. Much health care is delivered by teams of individuals working together. The skills of teamwork can sometimes be improved in care settings, resulting in improved patient outcomes.

Patients and families can help improve their safety during care. For example, they can be prepared for surgery and hospitalization and talk honestly and openly with healthcare providers about their questions and concerns. For more information, visit the MIPS website at **http://www.safetoask.ca/safetoolkit/index.html**.

Factors that contribute to medication incidents include:

- delivering medications in situations where time is of the essence
- reduced familiarity with medications not commonly used
- distractions during medication preparation and administration, both activities that requires a high level of attention
- errors associated with computerized medication order entry

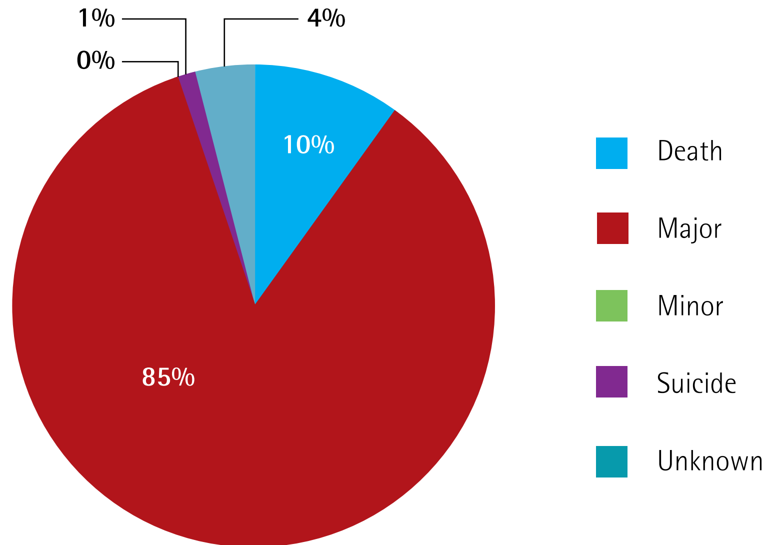
You can help prevent medication incidents by:

- knowing what medications you and your family member are prescribed and taking.
- Completing a medication card, keeping it up to date and carrying it at all times.

A formatted medication card can be downloaded at: **http://www.safetoask.ca/?page_id=145#ge**t.
Questions to ask about medications can be found at: **http://www.safetoask.ca/?page_id=145#medications**

Initial Degree of Injury Reported

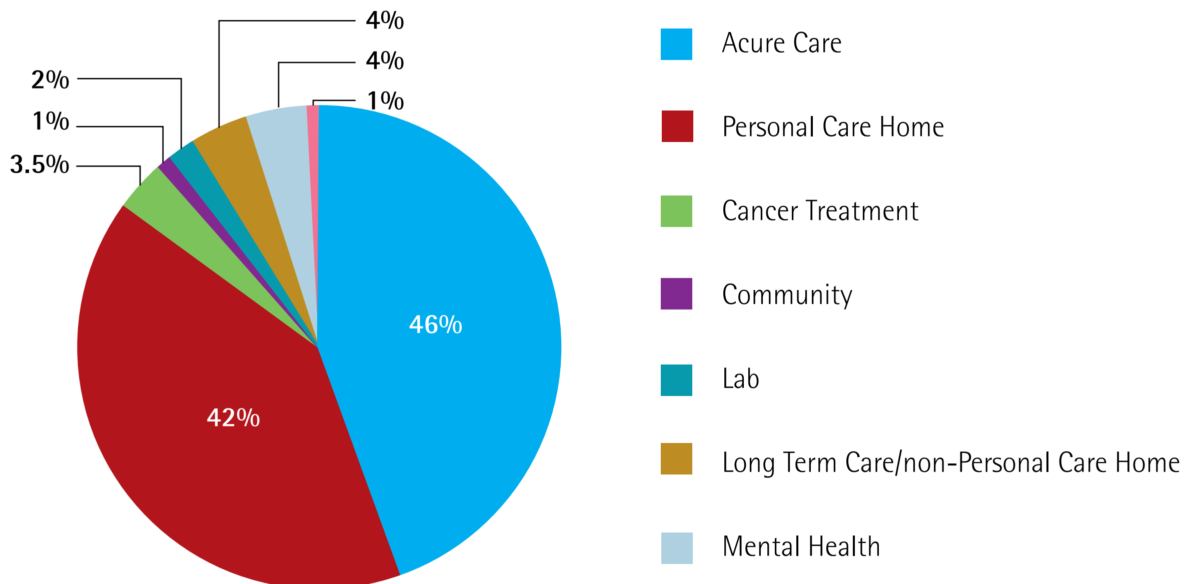
Initial Degree of Injury Reported, Critical Incidents 2011/12



Over 2010/11 and 2011/12, the percentage of critical incidents resulting in death as the initial degree of injury has decreased from 14 per cent to 10 per cent. Major injury, (such as a fracture requiring surgery, development of a pressure ulcer, complications related to treatment or surgery, an error in diagnosis or a delay in treatment) are found in 78 to 85 per cent of critical incidents.

Healthcare Sector Involvement in Critical Incident

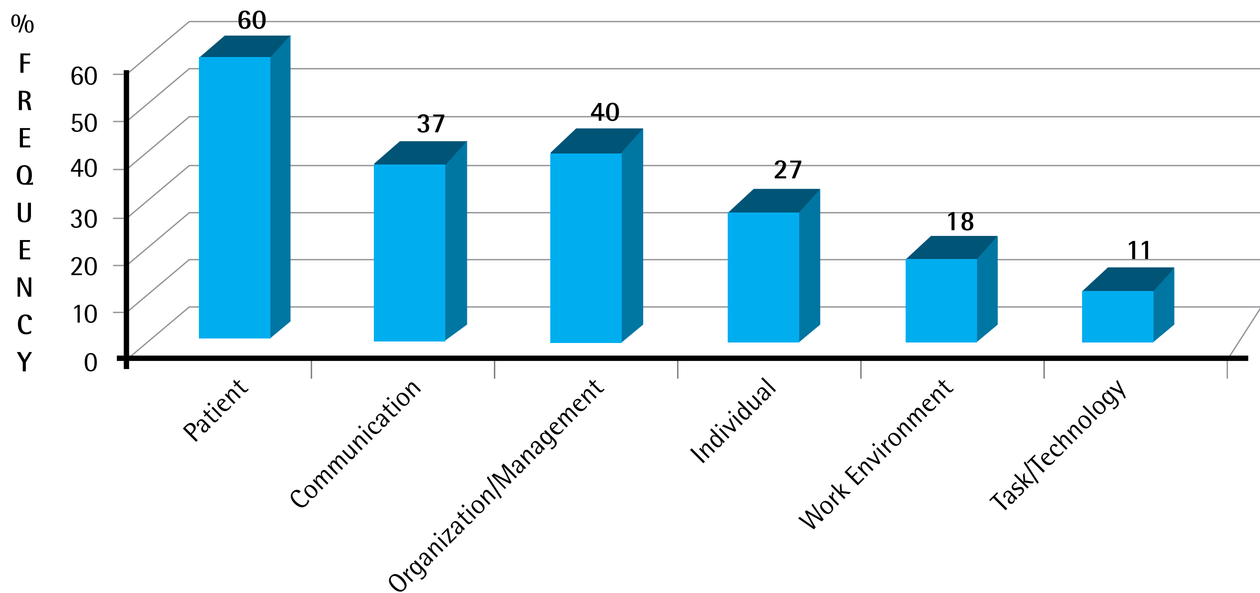
Healthcare Sector Involvement, Critical Incidents 2011/12



The acute care sector and the personal care home/long term care sector continue to report the most critical incidents, accounting for 88 to 91 per cent of the critical incidents reported. Higher rates of critical incident reporting in these sectors is expected as the complexity of care and interaction with patients is significantly increased in both of these sectors, and a higher proportion of patients with factors which can contribute to risk for patient safety tend to be cared for in these environments.

Contributing Factors to Critical Incidents

Contributing Factors in Critical Incidents 2011/12



CONTRIBUTING FACTORS

Critical incidents often have multiple contributing factors. Six broad categories of factors that contribute to critical incidents have been identified in the Manitoba data, following review of the incident by regional health authority and provincial health organization staff.

Patient factors (such as conditions which affect understanding, memory, balance, and vision or where patients are on a number of different medications for a variety of medical diagnoses) are evident in the majority of critical incidents reported.

Communication and organization/management (such as staffing policies and procedures) are noted as in almost 40 per cent of reported critical incidents.

In 25 to 27 per cent of reported critical incidents, individual (human) factors have been identified, and the work environment (the complexity and pace of health care delivery) is a contributing factor in 18 to 20 per cent of the reported critical incidents.

What are Manitoba health care partners doing to improve patient safety?

Activities aimed at improving patient safety occur each and every day in Manitoba health care organizations, agencies, and facilities. Regional health authorities have dedicated staff whose work is that of patient safety. Examples of ongoing work in patient safety include:

- fall prevention initiatives
- medication reconciliation to improve medication safety
- Required Organizational Practices (ROPS) as determined by Accreditation Canada
- continuing education sessions for all staff
- Patient safety campaigns such as hand washing awareness/compliance to prevent the spread of infection

Regular meetings of patient safety officers from across the province provide the opportunity to discuss patient safety activities being undertaken, make others aware of the issues that they are experiencing and review learning in their own areas so others can learn from their experience as well.

Periodically, Manitoba Health issues provincial alerts to regional health authorities when an issue is identified with equipment used in health care delivery or an issue of particular safety concern is recognized. It is then the responsibility of the organization to initiate changes to address the issues, whether it is removing equipment from use, returning it to the manufacturer or providing additional education to staff.

Safer HealthCare Now! , managed by the Canadian Patient Safety Institute provides information for health care providers and organizations about best practices known to reduce the risk of patient harm. Examples include prevention of surgical site infections and medication safety.

All regional health authorities have been involved in using tools and resources developed by and shared through Safer HealthCare Now! As an example, all Manitoba facilities that provide surgical services use a surgical safety checklist. More information can be found at **www.saferhealthcarenow.ca**.

While much is being done to make health care services as safe as possible, Manitoba Health and its partners continue to identify ways to further improve health care safety. The aim is to prevent a similar critical incident from happening again to another individual.

For this reason, Manitoba continues to require health care partners to report critical incidents, undertake critical incident reviews, and implement the changes and learning gleaned from these reviews. It is not expected that the rate of reported critical incidents will ever be zero, but the degree of injury and the kinds of critical incidents should change over time.

For more information please contact:
Manitoba Government Inquiry
Phone: 204-945-3744 or toll-free 1-866-626-4862
www.manitoba.ca/health

This information is available in alternate formats upon request.