

# **ESTABLISHING CHILD AND YOUTH HEALTH INDICATORS WORKSHOP “PART DEUX”**

**November 10, 2004 from 2:30 – 8:30pm  
The Grand Salon at the Fairmont Queen Elizabeth Hotel, Montreal, Quebec**

## **EXPERT PANEL PRESENTATION OF RECOMMENDATIONS**

- 1. Name of the Expert Panel: Patient Safety Expert Panel**
- 2. We would like to thank the following Expert Panel members for their time and support:**

- Brenda Fischer (Co-Chair), Calgary Health Region
- Anne Matlow (Co-Chair), The Hospital for Sick Children
- Marilyn Abraham, St. Joseph's Healthcare
- Darlene Boliver, IWK Health Centre
- Barb Brady-Fryer, Stollery Children's Hospital
- Carol Cooke, Children's Hospital of Eastern Ontario
- Gerarda Cronin, Winnipeg Regional Health Authority
- Mark Fleming, Saint Mary's University
- Paula Greco, Council for Canadian Health Services Accreditation
- Mary Ann Hiltz, IWK Health Centre
- Catherine Hogan, The Hospital for Sick Children
- Mary MacLeod, Credit Valley Hospital
- Kathryn Hayward-Murray, Credit Valley Hospital
- Peggy Sangster, Montreal Children's Hospital
- Annemarie Taylor, Children's and Women's Health Centre of British Columbia
- Megan Wright, Children's Hospital of Eastern Ontario
- Tracy Wrong, Children's Hospital of Eastern Ontario

## **REVIEW OF PROCESS**

The Patient Safety Expert Panel was struck on September 7th with the initial discussion focusing on clarifying the scope of the task and the proposed goals and objectives of the Patient Safety Expert Panel.

A scan was then done to determine if other organizations had identified goals related to patient safety and pertinent items from the literature. It was identified that safety goals were already identified by CCHSA and JCAHO and that these could be used to initiate discussion. Panel members were asked to review these goals to determine:

- If any of these already defined goals were appropriate to guide the development of a framework for child and youth health patient safety.
- What changes, if any, needed to be made to these goals to reflect a child and youth health perspective.

- What goals were missing?

Using this information, the Expert Panel identified and prioritized key areas of focus and from this, the outline of a framework began to emerge.

### KEY DELIVERABLES

The five key areas of focus were determined to be Culture, Communication, Medication Use, Infection Control and Patient Identification.

Subsequent safety expert panel meetings focused on articulating first the goals related to each focus area and then specific indicators the group felt were possible to measure at this time (potential indicators).

The indicators currently available are primarily process related, reflecting the simplicity of our current measurement tools. The panel then engaged in developing some recommendations for future indicator development.

### Patient Safety Expert Panel – Key Questions Framework

CCHSA	JCAHO/04 National Patient Safety Goals	Suggested Goals	Potential indicators that can be quantified (Existing/available to address key goals)	Process or Outcome Indicator	Recommendations/ Future directions
Culture		Create a culture of safety within the organization	<ul style="list-style-type: none"> <li>• Existence of a disclosure policy</li> <li>• Number of years the disclosure policy has been in place</li> <li>• Number of times the disclosure policy has been used</li> <li>• Existence of fair and just (non-punitive) policy for reporting adverse events and near misses</li> <li>• Existence of a mechanism for staff to receive feedback regarding adverse events and near misses</li> </ul>	Process  Process  Outcome  Process  Process	<ul style="list-style-type: none"> <li>• Culture surveys</li> <li>• Comprehensive patient safety program</li> <li>• Characteristics of a learning organization</li> </ul>
Communication	Improve effectiveness of communication among caregivers	Enable parents/caregivers to become partners in patient	<ul style="list-style-type: none"> <li>• Existence of written information for parents/caregivers on ensuring that the provision of health services is a</li> </ul>	Process	<ul style="list-style-type: none"> <li>• Electronic health record</li> <li>• Consistent mechanism to communicate critical pieces</li> </ul>

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		safety for their children	<p>safe for their child</p> <ul style="list-style-type: none"> <li>• Existence of a Family Advisory Committee to review/track complaints/suggestions in order to facilitate change and improvement</li> <li>• Number of changes that have been made on the basis of parental suggestions</li> </ul>	<p>Process</p> <p>Outcome of one step, process of another</p>	critical pieces of data
Medication Use (Including improve the safety of using Infusion Pumps etc.)	Improve safety of high-alert medications	Decrease in medication errors	<ul style="list-style-type: none"> <li>• Concentrated KCl has been removed from all nursing units</li> <li>• Existence of list of high alert medications</li> <li>• Defined strategy in place for handling and administering of high-risk medications where they are used (locked up, double signing, etc.)</li> <li>• Existence of an education program for nursing and pharmacy positions for paediatric medication use process</li> </ul>	Outcome ?	<ul style="list-style-type: none"> <li>• Delivery system</li> <li>• Nurse/patient ratio</li> <li>• Transfer points</li> <li>• Work environment</li> <li>• Electronic health record</li> </ul>
Infection Control	Reduce the risk of health care-acquired infections	Reduce hospital acquired infections	<ul style="list-style-type: none"> <li>• Existence of handwashing protocols and audits</li> <li>• % of staff that receive flu shot</li> </ul>	<p>Process</p> <p>Outcome</p>	<ul style="list-style-type: none"> <li>• Benchmarking of nosocomial infections across all paediatric institutions</li> </ul>

CCHSA	JCAHO/04 National Patient Safety Goals	Suggested Goals	Potential indicators that can be quantified (Existing/available to address key goals)	Process or Outcome Indicator	Recommendations/ Future directions
Patient Identification	Improve accuracy of patient identification	Ensure the accurate identification of patients	<ul style="list-style-type: none"> <li>• % of patients wearing armbands (audit required)</li> <li>• Existence of a policy for double checking when administering blood products</li> <li>• Existence of a policy for double checking when administering expressed breast milk</li> <li>• Existence of an audit mechanism within the hospital to ensure the "double checking" policy is enforced</li> <li>• Existence of a policy for procedural verification</li> </ul>	<p>Process</p> <p>Process</p> <p>Process</p> <p>Process</p>	<ul style="list-style-type: none"> <li>• Bar coding</li> </ul>

### Summary of Existing/Available Indicators

Goal	Indicator
Culture	<ul style="list-style-type: none"> <li>• Existence of: <ul style="list-style-type: none"> <li>• Disclosure Policy <ul style="list-style-type: none"> <li>○ # years policy in place</li> <li>○ # times used</li> </ul> </li> <li>• Fair/ just policy for reporting adverse events/near misses</li> <li>• Staff feedback mechanism regarding adverse events/near misses</li> </ul> </li> </ul>
Communication	<ul style="list-style-type: none"> <li>• Existence of: <ul style="list-style-type: none"> <li>• Written information to involve parents/care-givers</li> <li>• Family Advisory Committee to review incidents and facilitate improvements <ul style="list-style-type: none"> <li>○ # changes based on parental suggestions</li> </ul> </li> </ul> </li> </ul>
Medication Use	<ul style="list-style-type: none"> <li>• Existence of: <ul style="list-style-type: none"> <li>• High alert medications list</li> <li>• Medication use process education program for nursing and pharmacy staff</li> </ul> </li> <li>• Concentrated KCl removed from all general nursing units</li> </ul>

Goal	Indicator
	Policy in place for handling/ administering high-risk medications where appropriate (e.g. double signing, etc.)
Infection Control	<ul style="list-style-type: none"> <li>• Existence of handwashing protocols and audits</li> <li>• Percentage of staff that receive flu shot</li> </ul>
Patient Identification	<ul style="list-style-type: none"> <li>• Existence of: <ul style="list-style-type: none"> <li>• Double checking blood products</li> <li>• Double checking breast milk</li> <li>• Policies to ensure the “double checking” policies are enforced</li> <li>• Procedural verification (e.g. surgical site, etc.)</li> <li>• Wearing armbands (audit required)</li> </ul> </li> </ul>

## RECOMMENDATIONS

### Summary of Recommendations for Future Indicator Development

Goal	Indicator
Culture	<ul style="list-style-type: none"> <li>• Culture surveys</li> <li>• Comprehensive patient safety program</li> <li>• Characteristics of a learning organization</li> </ul>
Communication	<ul style="list-style-type: none"> <li>• Electronic health record</li> <li>• Consistent mechanism to communicate critical pieces of data</li> </ul>
Medication Use	<ul style="list-style-type: none"> <li>• Delivery system</li> <li>• Nurse/patient ratio</li> <li>• Processes at transfer points</li> <li>• Work environment</li> <li>• Electronic health record</li> </ul>
Infection Control	<ul style="list-style-type: none"> <li>• Benchmarking of nosocomial infections across all paediatric institutions</li> </ul>
Patient identification	<ul style="list-style-type: none"> <li>• Bar coding</li> </ul>

### Recommended Process to Validate Indicators at a National Level

#### **Baseline**

- Establish definitions and data collection procedures
- Consider risk stratification, surveillance intensity, staffing requirements and training
- Establish reliability determination procedures

#### **Going Forward**

We have proven that the CAPHC affiliates can work together to establish paediatric patient safety goals and indicators. The challenges are to:

- Implement locally
- Aggregate data centrally
- Catalyze the initiative

### ***Recommendations***

- Establish partnerships with organizations with shared values ( CCHSA, CPSI, CIHI)
- Promote the paediatric patient safety agenda and increase visibility through scholarly activities
- Pursue research opportunities with established funding agencies (CIHR)