

MANITOBA INSTITUTE FOR PATIENT SAFETY

New Critical Incident Disclosure Resources Launched To Enhance Patient Safety across Province

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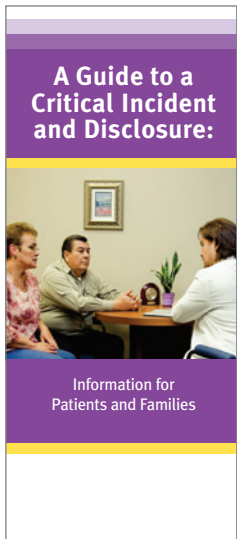
A critical incident (CI), sometimes referred to as an adverse event, occurs when something unexpected happens during the course of patient care that has a serious effect on the patient and is not due to the patient’s illness or the usual risks in treating the disease. Disclosure is the process in which healthcare providers discuss the facts about a critical incident with the patient and their family/advocate.

Manitoba is one of only three provinces in Canada which has mandated the reporting and investigation of critical incidents in legislation. Patients who have experienced a critical incident should receive open, honest and simple-to-understand communication about the facts that happened during the critical incident. A copy of the disclosure record should be provided free-of-charge, upon request.

Included in the information should be:

- a review of the how and why of the event;
- recommendations for changes that can help prevent the same harm from happening again, thus improving patient safety; and,
- the process to improve the health system, not assign blame.

Patients, families and healthcare providers who have experienced a critical incident are most often under tremendous emotional stress. Emotions may often run high and exceptional communications skills are required by staff disclosing or responding to a potential or established critical incident. Misunderstandings can result.



Disclosure pamphlet



Disclosure Resources Launch November 4, 2009
L-R Kathy McPhail, Dr. Chris Hayes, Richard Helston,
Laurie Thompson, Hon. Theresa Oswald



OUR MISSION

To promote patient safety and quality healthcare for Manitobans

OUR VISION

To be a leader in achieving safe, quality healthcare for all Manitobans

Highlights 0910

MAJOR ACCOMPLISHMENTS

The Institute's exhibit was staffed at 18 events. We sponsored 11 events, participated in eight more and made more than a dozen presentations. We promoted patient safety in magazines, digital ads, newspapers, Winnipeg Transit shelters and on buses. We participated in dozens of in-person and telephone meetings, planning sessions and teleconferences.

We distributed about 45,000 medication cards, 1,000 patient advocate forms, 5,000 It's Safe To Ask English brochures, 1,000 brochures and 1,150 posters on disclosure of critical incidents, hundreds of pocket-size lists of Do Not Use Abbreviations, and numerous medication safety DVDs.



"Patient Safety Tree" designed by the Selkirk Patient Advocacy in the Community Group for Selkirk Tree Festival

To improve interaction for patients, families and citizens:

We launched printed material that gives information on what to expect when **disclosure** of a critical incident in healthcare has taken place.

We hosted a **Patient Safety Public Forum**, co-sponsored by the Winnipeg Regional Health Authority on *Balancing Risk and Safety in Long Term Care* that was also accessible across Manitoba via telehealth.

The Institute continued to partner with two regional health authorities to work intensively on the **Patient Advocacy in the Community (PAC) Project** in Carman and Selkirk to improve health literacy and awareness of the need for citizens to be active partners in their healthcare.

Phase 3 of **It's Safe to Ask, a Patient Safety Tool Kit** will provide "how to" instructions on patient safety topics for the public along with a guide for those interested in promoting patient safety.

The number of **inquiries** we received from the public almost doubled this year. The **Institute's websites, www.mbips.ca and www.safetoask.ca** attracted close to 100,000 visitors and one million hits.

To promote and facilitate the adoption of patient safety knowledge and procedures

The Institute continues to support **Safer Healthcare Now!** There are 79 SHN teams in Manitoba. About 100 people attended a Workshop on Medication Reconciliation. A coordinator worked to identify future learning and support needs for teams in Manitoba.

The Institute continued to support the **National Infection Control Week** led by the Community and Hospital Infection Control Association (CHICA) Manitoba Chapter. New this year in the **Power of One** campaign – a media event was held where École Robert Browning elementary students learned ways to stop the spread of infections.

Prescription Information Services of Manitoba provided orientation sessions for regional health authority staff, management and physicians for **Patient Safety is in YOUR Hand.**

In September 2009, 75 direct care nurses, home care workers, clinical educators, administration support staff, social workers, Aboriginal health program workers, physiotherapists and patient safety consultants and advisors attended **What Difference Can You Make?**, an Institute-



AGM 2009 Hon. Theresa Oswald, Laurie Thompson, Ronald Guse

sponsored workshop hosted by Concordia Hospital to learn how effective communication improves patient safety.

The Institute collaborated with Central Regional Health Authority to once again support the provincial webcasting of the **Canadian Healthcare Safety Symposium** to 20 Manitoba sites in October 2009.

The Institute's executive director is a member of the **Network for Interprofessional – Continuing Professional Development** and is on the **Canadian Adverse Event Reporting and Learning System Advisory Group**. The mandate of the second group is to design and develop a pan-Canadian system that would be used to recognize and analyze emerging patient safety issues as well as be a potential mechanism to send quick alerts to providers across all the provinces and territories.

In December 2009, MIPS launched a **Patient Safety Simulation Project** to teach inter-professional collaboration, communication, and patient/family centered care.

We once again sponsored the University of Manitoba Rural and Northern Continuing Medical Education **Conference for Rural and Northern Physicians** in February 2010.

We awarded the Manitoba Blue Cross sponsored **Dr. John Wade Research Award** to the WRHA for *A Review of Home Care Clients Visiting Emergency Departments*. Recipients were Lori Mitchell, Nawal Lutfiyya, and Michael Routledge. The project examined the interface between Home Care and Emergency Departments and developed a profile of visits and client characteristics of those presenting at emergency departments in Winnipeg.

The Institute awarded **two seed grants** to member organizations: Janis Wisner and Tamara Coombs for *Playing with Culture* and Heather Dean, Carol Enns, Barb Goodwin, Jessica Spence and Nadia Vecherya for *Patient Safety Days: Contextually-Based Learning in Inter-Professionalism and Surgical Checklists*.

Initiatives that increase the awareness, understanding and commitment to patient safety at the leadership level

The number of healthcare providers the Institute officially registered to lead **Canadian Patient Safety Week (CPSW)** initiatives in Manitoba grew by 600% over last year.

The **Taking it From the Top – Governance and Leadership Engagement in Quality and Patient Safety** working group set priorities to help improve board and senior leader capacity in quality and patient safety. The Institute then partnered with CPSI and the Canadian Health Services Research Foundation for Manitoba to be a pilot province for their new toolkit and education program *Effective Governance for Quality and Patient Safety*.

The Institute's executive director is participating in the **Blueprint for Patient Safety and Quality Education** project led by the Health Quality Council (Alberta). It aims to oversee the development of educational content and resources for patient safety and quality improvement.

The Institute/Canadian Patient Safety Institute **Patient Safety Studentship** for 2009/2010 was awarded to Susan Wellings for *Promoting Health Literacy and Patient Safety with Seniors*.

Initiatives promoting provincial policy and program development for patient safety

In June 2009, the Institute presented to The Standing Committee on Human Resources, Manitoba Legislature on **Bill 18, The Regulated Health Professions Act**.

In September 2009, the Institute submitted recommendations to the **Expert Advisory Committee of Health Canada** on naming, packaging and labelling drugs.

The Institute continued to meet with Manitoba's **Health Senior Executive Committee** to discuss ongoing work of mutual interest.

Disclosure



What happens during disclosure?

- Communicable safety and quality issues to people involved understand the facts, steps taken and the response to follow.
- Assigning
- Learn to act on team people involved
- Offer support to people involved and staff.
- Complete a disclosure record.
- Offer a follow-up meeting and key contact information.

What else happens?

- Determine further risk mitigation.
- Assess that critical incidents causing harm occur.
- Learn from the event and try to prevent it from happening again.
- Shift the organization's culture to improve event and error disclosure.
- Make the health care system safer.

For more information, contact:

Manitoba your organization's patient and user protection lead or MIPS.

Avez-vous été en cause dans un incident critique? Troublé(e)? En colère? Inquiet ou inquiette?



Ne vous remerciez pas sur vous-même. Vous n'êtes pas seul(e).

- Vous pouvez obtenir des conseils et de l'aide.
- Contactez nous pour obtenir des renseignements sur votre registre d'événements ou votre association professionnelle.

Plus de renseignements, communiquez avec:

Future DIRECTIONS

STATEMENT OF OPERATIONS

YEAR ENDED MARCH 31

REVENUES:	2010	2009
Province of Manitoba	\$ 614,500	\$ 605,400
Conference	–	10,000
Partnership project	12,500	78,048
Canadian Patient Safety Institute	13,140	5,887
Memberships	6,150	6,150
Grants and other income	507	2,914
Interest	3,086	3,240
	<hr/>	<hr/>
	649,883	711,639
EXPENSES:		
Salaries	248,924	244,325
Office operating	98,298	93,837
Board and Governance	54,437	64,897
Mandate operating	327,673	290,494
Amortization	11,415	9,723
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	740,747	703,276
DIFFERENCE BETWEEN REVENUES AND EXPENSES	\$ (90,864)	\$ 8,363

The Institute will continue to:

- identify opportunities to consult on proposed legislation that influences patient safety;
- work with organizations to promote Canadian Patient Safety Week November 1-5, 2010;
- explore opportunities to promote the safety competencies for patient safety published by the Canadian Patient Safety Institute, including faculty development;
- work with the leadership working group to address priority actions with all regional health authorities and CancerCare Manitoba; and,
- oversee the development of the patient simulation project and discuss its incorporation into undergraduate educational opportunities.

The Institute will:

- complete and promote the Patient Safety Tool Kit;
- launch additional tools for healthcare providers to use during disclosure of critical incidents;
- produce a series of short videos on the Institute and patient safety tips; and,
- explore and host educational opportunities for Safer Healthcare Now! teams.

WHO WE ARE

The Manitoba Institute for Patient Safety is an independent, non-profit organization created in 2004 in response to the recommendations of the Manitoba Patient Safety Steering Committee. Incorporated under The Corporations Act, the Institute is a registered charity. Core funding comes from a provincial government grant to cover operational costs. The Institute also partners with other organizations on projects of mutual interest and benefit. The Institute is under the direction of a board of 12 directors. Five are appointed by the Minister of Health. Seven are elected by the members of the Institute.

This summarized version of the Institute's annual report was released on June 10, 2010. It and a full version of the document, including the Audited Financial Statement, is available on the Institute's website.

(continued from page 1)

Front-line staff conducting meetings with patients and families who experienced a critical incident wanted a pamphlet that patients and families could take away with preliminary information that would be helpful to them. The Quality and Risk Management Network (QRMN) of the Regional Health Authorities of Manitoba (RHAM) asked the Institute to collaborate in the development of such a pamphlet.

New patient, family and staff education and support resources were developed by the Manitoba Institute for Patient Safety, in partnership with Regional Health Authorities of Manitoba, Winnipeg Regional Health Authority and Manitoba Health and Healthy Living. These bilingual resources, including four posters and a pamphlet, explain the patient's right to be informed if they are involved in a critical incident and the role of the healthcare system in sharing information.

For healthcare providers, the guidelines and resource materials provide a consistent message about sharing information across the province as well as what should be done to disclose information and help patients and their families when harm occurs.

Manitoba Health and Healthy Living and all eleven regional health authorities represented by the Regional Health Authorities of Manitoba (RHAM) support patient disclosure and the Institute's new education and resource materials.

The resources were launched on November 4, 2009 by the Manitoba Institute for Patient Safety in partnership with Manitoba Health and Healthy Living, Regional Health Authorities of Manitoba and the Canadian Patient Safety Institute, during Canadian Patient Safety Week. At that time the Manitoba Health Minister, Theresa Oswald, confirmed the province's endorsement and implementation of the Canadian Patient Safety Institute's Canadian Disclosure Guidelines.

Information for healthcare providers is in development.



Canadian Patient Safety Week 2009



Presentation, Dr. John Wade Research Award at AGM June 2009.
L-R Andrew Yorke, Lori Mitchell, Dr. John Wade, Carol Green.

MANITOBA INSTITUTE FOR PATIENT SAFETY PARTNERS

The Manitoba Institute for Patient Safety continues to work with member organizations and other partners in working toward our objectives. In addition to our member organizations, Institute partners included First Nations and Inuit Health Branch, Prescription Information Services of Manitoba (PrISM), Canadian College of Health Service Executives, Carman Patient Advocacy in the Community Group, Selkirk Patient Advocacy in the Community Group, University of Manitoba Faculty of Medicine Continuing Medical Education, Canadian Patient Safety Institute,

Health Quality Council of Alberta, Health Quality Council of Saskatchewan, British Columbia Patient Safety and Quality Council, Manitoba Health, Healthcare Insurance Reciprocal of Canada (HIROC), Manitoba Blue Cross, Canadian Community and Hospital Infection Control Association, the Manitoba Seniors and Healthy Aging Secretariat, and Victoria Life Line. We look forward to continuing to work with these partners and new ones in the year ahead.

MEMBERS 2009/2010

The board of directors encourages organizations wishing to work with the Institute to apply for membership. Applications are available at www.mbips.ca/membership.

MEMBERS OF THE MANITOBA INSTITUTE FOR PATIENT SAFETY AS OF MARCH 31, 2010

The Arthritis Society of Manitoba	Faculty of Nursing, University of Manitoba	Manitoba Speech and Hearing Association
CancerCare Manitoba	Faculty of Pharmacy, University of Manitoba	Northern Medical Unit, University of Manitoba
College of Licensed Practical Nurses of Manitoba	Grace General Hospital	Nursing Department, Red River College
College of Medical Laboratory Technologists of Manitoba	Long Term and Continuing Care Association of Manitoba	Paramedic Association of Manitoba
College of Physicians and Surgeons of Manitoba *	Manitoba Centre for Health Policy	Regional Health Authorities of Manitoba *
College of Registered Nurses of Manitoba *	Manitoba Chiropractors' Association	School of Medical Rehabilitation, Faculty of Medicine, University of Manitoba
College of Registered Psychiatric Nurses of Manitoba	Manitoba College of Family Physicians	Seven Oaks General Hospital
Concordia Hospital	Manitoba Dental Association	St. Boniface General Hospital *
Diagnostic Services of Manitoba	Manitoba Health *	Victoria General Hospital
Faculty of Medicine, University of Manitoba	Manitoba Pharmaceutical Association *	Winnipeg Regional Health Authority *
	Manitoba Association for Medical Laboratory Science	

* denotes Premier Member

2009-2010 BOARD OF DIRECTORS

- Mr. Reg Toews****, *Chair*
- Mr. Ronald Guse***,
Vice-Chair and Chair, Finance Committee
- Ms. Sue Neilson***, RN,
Chair, Audit Committee
- Mrs. Kim Poppel****,
Chair, MIPS Patient Advisory Committee
- Dr. Brent Kvern***,
Chair, Research Committee
- Ms. Wendy Peppel****,
Chair, Membership Committee
- Mr. Rene Comte****
- Ms. Louise Evaschesen***
- Ms. Carol Green***
- Ms. Connie Gretsinger****
(from January 2010)
- Ms. Kathy McPhail***
- Dr. Luis Oppenheimer***

*Elected ** Ministerial Appointment

STAFF MEMBERS (L-R)

- Ms. Dawn White**, *Consultant*
- Ms. Laurie A. Thompson**,
Executive Director
- Ms. Vi Pelc**, *Administrative Assistant*
(from January 2010)



Front Row L-R Wendy, Kim, Kathy, Connie
Back Row L-R Ronald, Reg

2nd Row L-R Louise, Rene, Carol
Far Right Sue, Luis, Brent



**MANITOBA INSTITUTE
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