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## PUBLIC REPORTING

The Ontario Hospital Association's (OHA) Patient Safety Department is pleased to bring back its *SAFETY FIRST!* newsletter. It has been a busy and exciting year in patient safety with many new initiatives. In May of 2008, the Ministry of Health and Long-Term Care introduced mandatory public reporting on eight patient safety indicators. Almost one year later, Ontario hospitals are publicly reporting on four of the eight identified indicators, with reporting of the remaining four to be made public at the end of April. This edition of *SAFETY FIRST!* looks at the past year in public reporting and what is in store for the future of health care.



## A Year in Review

By: Dr. Michael Baker, Executive Lead, Patient Safety  
Ministry of Health and Long-Term Care



In the eight months since I was first appointed as executive lead of the government's patient safety agenda, I'm pleased to report that we have met our goal of publicly reporting on the eight patient safety indicators that former Health and Long-Term Care Minister George Smitherman announced last May, 2008.

We set an ambitious goal and I'm happy to say that the results have been highly encouraging. The data we are collecting on all eight indicators is providing us with the information we need to effectively control infectious diseases in hospitals.

Our rates for C. difficile, our first publicly-reported indicator, have remained steady, a definite indication that the many infection control practices that were already in place prior to the reporting are working. Our rates for MRSA and VRE bacteraemia are also low.

The Ministry of Health and Long-Term Care's patient safety website has become an important hub of information for the public, the media and health care professionals. Since the site launched, we have received 42,800 visits from over 100 countries.

And while we may have met our goal of the public reporting on the eight patient safety indicators, that does not mean that our work on patient safety is over. I continue to meet with experts to review what we have accomplished to date and to plan for future initiatives. I hope that the government will be able to announce further patient safety indicators in the near future.

The health and well-being of all Ontarians is something that I know all health care professionals and the government take very seriously. I know that by working together - to quote a rather famous politician - change can happen.

## Some Things To Think About

"Not everything that can be counted counts, and not everything that counts can be counted"

*Einstein*

"When patients seek care, we make two implicit but important promises to them: first, we promise to provide them with excellent care: and, second we promise not to hurt them."

*James L. Reinersten and Carolyn Clancy*

## Public Reporting of Patient Safety Indicators: Driving Performance Improvement

By: Tom Closson, President and CEO  
Ontario Hospital Association



Ontario hospitals are committed to improving patient safety, and have moved quickly to enhance accountability and transparency to the patients they serve. Since September 2008, Ontario hospitals have publicly reported on a series of patient safety indicators. These measures provide valuable information to patients as they navigate Ontario's health system, and help hospitals measure the quality of care they provide as well as the impact of their performance improvement strategies over time.

One of the reasons hospitals have embraced the public reporting of patient safety indicators is that, prior to September 2008, there was no mechanism in place to help hospitals consistently track and report their infection rates. The collection and public reporting of patient safety indicators is helping hospitals improve performance and strengthen the public's confidence in health care services.

From participating in ongoing education and responding to media and public inquiries, to managing multiple deadlines and updating internal processes, hospitals have made considerable efforts to help make the public reporting regime so successful, and hospitals should be commended for their good work.

And while the public reporting of patient safety indicators is still a relatively new initiative, public opinion polls show that most Ontarians can think of something hospitals have done recently to protect the public from health care-associated infections, be it hand washing, cleaning, etc. This reflects positively on our organizations.

The Ministry of Health and Long-Term Care has been conducting ongoing media analyses related to the public reporting of patient safety indicators, and these analyses show that the general public is confident that the initiative is bringing improvements to the health care system. The analyses also suggest that although some people may never actually go to the Ministry's website to look at the numbers, they have more confidence in hospitals because they know there is a reporting system in place.

Given the financial pressures many hospitals are facing in today's current economic environment, it has been, in many cases, especially challenging to take on initiatives as significant as the public reporting of patient safety indicators. But, as patient safety efforts continue to evolve, hospitals should be proud of the work they have done demonstrating their impressive ability to embrace accountability and transparency. The combined efforts of frontline staff, senior leaders, and decision-makers in government have made innovations, such as this one, possible and are, collectively, helping to deliver the best quality care to Ontarians.

Mark Your  
Calendars!



**Canadian Patient Safety Week (CPSW)** is coming November 2 - 6, 2009. The theme for this year's Canadian Patient Safety week is "Ask. Listen. Talk". This is a nationally-designated annual event led by the Canadian Patient Safety Institute which focuses on increasing awareness of patient safety issues in Canada. For more information please visit [www.patientsafetyinstitute.ca](http://www.patientsafetyinstitute.ca).

### Highlighting Patient Safety and Quality Success

The OHA's patient safety team is committed to raising awareness of patient safety and quality initiatives and to the delivery of valuable tools and resources to Ontario hospitals. Sharing patient safety and quality information, strategies, and initiatives can help hospitals learn from each others' experiences to apply and implement new practices and skills. Hospitals are encouraged to submit to the OHA, patient safety and quality success stories - examples of small team initiatives, departmental initiatives, or hospital-wide initiatives, that have contributed to improved patient safety and quality within their unique organization and culture.

Success stories should be 200-400 words in length and should include the goals, objectives, actions, materials, measurement and results of your patient safety or quality of care initiative. Each issue of the *SAFETY FIRST!* newsletter will highlight two success stories. If you have a success story that you wish to share, please submit it to Kerry Vincent at [kvincent@oha.com](mailto:kvincent@oha.com) by June 1, 2009.

# Your Hospital and the Infection Prevention and Control Department: A Healthy Partnership

By: Dr. Barry McLellan, President and CEO, Sunnybrook Health Sciences Centre, and Dr. Mary Vearncombe, Medical Director, Infection Prevention and Control, Sunnybrook Health Sciences Centre



There are many key elements a hospital needs for a successful infection prevention and control program. One of the most important is having strong internal relationships. This starts with senior leaders and works its way throughout the entire organization.

Sunnybrook is fortunate to have a highly talented and well-resourced Infection, Prevention and Control (IP&C) Team that works with staff at all levels to ensure the safety of the hospital's patients, staff and visitors. In addition to the inter-professional skill mix and integration of IP&C team members into Sunnybrook's programs, the department has strong support from the Board and Senior Leadership Team, through to medical and managerial leadership.

Mandatory reporting of Ontario hospital *Clostridium difficile*-associated disease (CDAD) rates gave us the opportunity to identify "best performers" within our peer hospital group. As a result of combined initiatives advised by our IP&C Team and supported by Senior Leadership and by our staff, the hospital has reduced rates of CDAD in the last three months.

For more proactive prevention of CDAD, the Senior Leadership Team supported our Patient Care Managers and front-line staff to implement isolation precautions at the onset of potential CDAD symptoms. The Senior Leadership Team also supported Environmental Services in improvements in cleaning protocols and access to more effective sporicidal disinfectants for CDAD control.

Wherever possible, organizations should live by the mantra '*actions speak louder than words*', and at Sunnybrook the senior leaders took this advice quite literally. The Senior Leadership Team established a team goal to improve hand hygiene compliance. This led to initiatives such as visits to patient care units by senior leaders to discuss hand hygiene with front-line staff.

Along with role modeling and providing opportunities for the IP&C team to be an active part of organizational decision-making, it is beneficial for senior teams and CEOs to have an 'open-door' policy for their IP&C leads. The ability for IP&C to brief senior leaders and when necessary the CEO on emerging issues can be invaluable for managing situations before they consume an organization or become an unfortunate headline.

A partnership approach is the path to success, and it is critical to have a broad understanding in every part of the organization that maintaining an effective IP&C program is a shared responsibility. The IP&C team needs the commitment of everyone in the organization, starting with visible leadership. Together we can create a safer and healthier work and care environment.



Members of Sunnybrook Health Sciences Centre's Infection Prevention and Control Team.

From left to right.

*Back row:* Natasha Vrhovnik, Fatema Jinnah, Roy Dyalsingh, Dr. Andrew Simor, Melanee Eng-Chong

*Front Row:* Sandra Callery, Dr. Mary Vearncombe, Victoria Williams

Photo taken by Dale Roddick—MediaSource

## Does Public Reporting Really Improve Quality of Care?

By: Dr. Ben Chan, CEO  
Ontario Health Quality Council (OHQC)

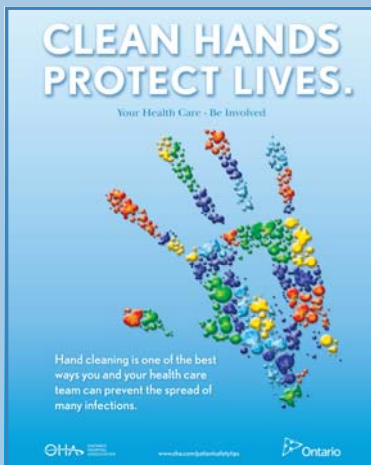


Public reporting is a critical part of any strategy to improve quality in health care. In theory, making information public about deficiencies in quality can spur leaders and staff into taking action. Ontario has had a strong history of promoting transparency in the hospital sector, and the Hospital Report series are a great example of that. More recently, the government has mandated a new wave of public reporting activities, including reporting on health care-associated infections.

This is consistent with a world-wide trend towards greater transparency. Websites in the United States, sponsored by Medicare and Medicaid, now contain detailed information about quality of care for individual hospitals and nursing homes (see [www.hospitalcompare.hhs.gov](http://www.hospitalcompare.hhs.gov) and [www.medicare.gov/NHCompare/](http://www.medicare.gov/NHCompare/)). Some states have even more detailed information on care for specific clinical conditions (e.g., <http://hcgcc.hcf.state.ma.us/>). Information on hospital care is commonplace in the United Kingdom, and some sites have developed independently without government support (e.g., [www.drfooster.co.uk](http://www.drfooster.co.uk)).

But does all this reporting lead to change? Here, the evidence is quite mixed. In a 2007 review sponsored by the Canadian Health Services Research Foundation, there were some studies showing some positive improvements following reporting but many other studies showing no impact. Here in Ontario, data on patient satisfaction with hospital and emergency department care has been reported regularly through Hospital Report, but we have seen no significant improvement over several years. The emerging consensus is that while public reporting is important, it is by itself insufficient to drive significant system-wide improvements. Public reporting seems to work best when the public reporting activities are closely tied to a targeted quality improvement strategy. Thus, it makes sense that Ontario's push to report on health care-associated infections has been coupled to activities like the deployment of infection control resource teams and additional infection prevention and control practitioners.

The OHQC is currently expanding public reporting in the long-term care and home care sectors, with eventual reporting by individual Long-term care (LTC) homes and Community Care Access Centres (CCACs). It is critical that public reporting be tied to a coordinated strategy on improvement that includes getting leaders engaged, setting ambitious targets for quality, developing quality improvements (QI) skills among front-line staff, and creating measurement systems that allow us to measure quality and feed data back quickly to QI teams. Public reporting without a generous degree of support for QI may lead to mediocre improvement or unintended consequences, like gaming of the system. Public reporting with strong support for QI teams will create the environment and culture necessary for sustainable system-wide change.



### CLEAN HANDS PROTECT LIVES Your Health Care—Be Involved

To support your ongoing efforts in educating patients about proper hand hygiene for health care providers, visitors and patients, please visit [www.oha.com/cleanhandsprotectlives](http://www.oha.com/cleanhandsprotectlives). Here you will find a link to the MOHLTC order form for additional French and English language “Clean Hands Protect Lives” pamphlets, “How to Clean” cards, and posters. The materials have also been translated into 27 different languages, which are available free for download. For more information, please contact Dominique Taylor at [dtaylor@oha.com](mailto:dtaylor@oha.com).

## OHA Launches *myhospitalcare.ca*

### Giving Health Care Users Access to Hospital Performance Information

To promote better public access to easy-to-understand hospital performance information, the OHA has launched a new website called [myhospitalcare.ca](http://myhospitalcare.ca) on April 16, 2009.

Knowing that patients rarely access existing hospital performance information, and when they do, often find it overly technical and difficult to understand, the OHA created [myhospitalcare.ca](http://myhospitalcare.ca) to make public information about hospitals both accessible and useful to health care patients and their families.

[myhospitalcare.ca](http://myhospitalcare.ca) features 39 different indicators drawn from publicly-available resources (such as Hospital Report, the Ministry of Health and Long-Term Care, and the Canadian Institute for Health Information) and explains, in plain language, what these indicators mean in terms of clinical outcomes, care, patient satisfaction, and patient safety indicators.

The indicators on [myhospitalcare.ca](http://myhospitalcare.ca) highlight information that is relevant to the patient experience – i.e., indicators members of the general public are most interested in.

Patients want to know more – and understand more – about how well their hospitals are performing. By making the information easy for people to access, the OHA is empowering patients to become more educated about and more involved in their own health care. The site is also intended to help hospitals become even more accountable than they already are.

Created as an education tool for patients, and not a guide to choosing or comparing hospitals, [myhospitalcare.ca](http://myhospitalcare.ca) ushers in a new era of health system transparency for patients. Like all public reporting on health system performance, [myhospitalcare.ca](http://myhospitalcare.ca) will inspire improved performance, enhance patient safety, and strengthen the public's confidence in Ontario's hospitals. For more information, please visit <http://www.myhospitalcare.ca>.

## What's New in Patient Safety at the OHA?

**Quality and Patient Safety Strategic Plan 2010-2013** - The OHA will be developing its first ever Quality and Patient Safety Strategic Plan (QPSSP). Development of the plan commenced this month with the first meeting of its working group, the launch is set to take place in early 2010. For more information, please contact Kerry Vincent at [kvincent@oha.com](mailto:kvincent@oha.com).

**"Your Health Care - Be Involved"** - The OHA has partnered with the Ontario Association of Community Care Access Centres (OACCAC) to launch the "Your Health Care - Be Involved" client tips campaign for the home and community sector. Launch of the campaign will take place at the OACCAC annual conference on June 4, 2009 at the Westin Harbour Castle, Toronto. For more information, please contact Kerry Vincent at [kvincent@oha.com](mailto:kvincent@oha.com).

**Patient Safety in Mental Health** - The OHA and Canadian Patient Safety Institute (CPSI) jointly commissioned a team of researchers from British Columbia Mental Health and Addiction Services (BCMHS) in early 2008 to conduct a comprehensive synthesis of the unique patient safety issues in the mental health sector. The research included an extensive literature review, interviews of key informants in the field, and qualitative analysis of discussions and key issues gathered from a Patient Safety and Mental Health Roundtable held in September 2008. Specific areas of practice, policy and research have been identified as areas for further improvement. Release of this research paper is scheduled for early May 2009. For more information, please contact Dominique Taylor at [dtaylor@oha.com](mailto:dtaylor@oha.com).

**Safe Surgical Checklist (SSCL) Implementation Toolkit** - In response to a recent article by the World Health Organization (WHO), strongly suggesting that the use of a SSCL can reduce the incidence of surgical complications, the OHA has formed an expert working group. The working group will be releasing a toolkit in Summer 2009 to assist Ontario hospitals with implementing the SSCL in operating rooms. For more information, please contact Dominique Taylor at [dtaylor@oha.com](mailto:dtaylor@oha.com).

## Patient Safety and Quality Conference Calendar

DATE	CONFERENCE	LOCATION
September 2009	Public Reporting of Indicators: A Year in Review	Toronto
Fall 2009	Accreditation	Toronto
Fall 2009	Patient Safety in Mental Health	Toronto
Fall 2009	Lean In Health Care	Toronto



### Read All About It Patient Safety and Quality Literature

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The **SAFETY FIRST!** newsletter is published by the OHA's Patient Safety Department.

Content suggestions are always welcome!

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