First Nordic Patient Safety Conference: Patient Safety Challenges

Abstract Submission for Poster Session

Project title

TRACES for health care: Training for adverse and critical events in safety in health care

Research organization

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Project goal and background

The overall goal of this project is to evaluate the impact of a non linear accident investigative model that is being implemented in three health authorities in Western Canada. The project was funded by the Canadian Health Services Research Foundation (CHSRF) jointly with the Canadian Patient Safety Institute, to partner with three health authorities in Canada (Winnipeg Regional Health Authority [WRHA] Saskatoon Health Authority [SHR], Vancouver Coastal Health [VCH]) on an innovative program of system safety research that is based on the theories of resilience and resonance. This four year project provides an opportunity for patient safety leaders from three regional health authorities to work together with researchers from UBC to develop and implement a staff training model for investigating and learning from "near misses" and adverse events in health care. The project also creates an opportunity for the participating health regions to develop and test methods to evaluate the impact of the model on organizational learning with reference to patient safety. The three health authorities already share interests in creating a culture of patient safety. Thus regular engagement around a common interest and responsibility (i.e. patient safety) will strengthen existing collaboration and facilitate collective learning and lay the groundwork for building a community of practice with regard to understanding the genesis of adverse events in healthcare. This creates an opportunity for decision makers and practitioners to continue to learn from and support each other through routine collective engagement beyond the completion of the project. Recognizing that the WRHA is actively engaged in a broad training strategy to create the requisite skills, knowledge and change in culture required to implement an innovative accident model that considers the dynamic and complex nature of safety in healthcare delivery, the key learning activities are being led by mentors from that organization. The approach to learning is focused on building frontline staff and management skills in a number of key areas such as leadership and decision making to facilitate cultural change related to understanding, investigating and learning from "near misses" and adverse events. Moreover applying and, sharing ideas with, and learning from decision makers in different settings that share common challenges with regard to patient safety the three regions will gain additional benefit from comparing the application of new safety concepts in separate regions and provide useful information about the environmental/structural constraints and incentives that influence the uptake and effectiveness of the model across geographic settings.

Research methods

The research activity has four major objectives: 1) to understand how resilience concepts are operationalized for frontline health care staff and senior management at WRHA; 2) to describe current safety activities and culture at VCH and SHR; 3) to assess the understanding of resilience concepts at VCH and SHR to clarify how best to teach these concepts; 4) to undertake textual content analysis of incident reports pre and post training to determine the impact of the training on the depth and relevance of incident analysis, investigation and learning; 5) to create an approach for wider dissemination of lessons learned and understanding of resilience as a fundamental concept to enhance patient safety in Canada. To do this we are using a mix of qualitative and quantitative evaluative research (formative and summative) before and after implementation of the training at VCH and SHR.

- Focus group work is being used to understand safety practice amongst frontline staff and managers both before and after training.
- Face-to-face interviews have been conducted with members of the senior executive teams at each organization, to obtain their perceptions of what factors contribute to and influence safety in acute health care facilities.
- Patient safety culture change is being assessed over time to evaluate learning impact.
- Textual/content analysis standard methods are being used to assess incident report conclusions and recommendations

Results

The implementation of the training model has started at both SHR and VCH and through various activities we have begun to discover how organizational structures, related to patient safety, can influence implementation of the new model. In particular the training workshops reflect a systemic accident investigation and analysis method that encourages people to shift the way they think about critical incidents and accident investigations. Instead of simply searching for causes, the objective is to seek to understand or to make sense of what happened that led to patient harm and reflects a major shift in the way that people see the world before their eyes and how they think about what they see. Organizations with a strong "risk management" approach to safety might be more inclined to look for the "unsafe acts" and then tighten policies to "create" safety. The systemic accident model requires a shift in thinking and therefore, it is critical to understand the context and organizational dynamics in which the training is taking place, as the existing organizational model can potentially limit the success of the implementation of the new model. It is important not to underestimate how organizational dynamics and culture can influence implementation. Furthermore, by the end of the first set of training sessions we observed that the recipient organizations responded differently in planning for the workshops. For example, in one setting there were key issues related to setting aside adequate time for the training and thus the initial round of training was more fragmented in one organization than the other. Nevertheless, the "post training" response from this organization (and recipients of the training) confirms that they now have a better appreciation re the value of a dedicated approach to the training, and this shift in thinking has already been reflected in planning round two of the training, that will take place in Spring 2010. Thus, the issue of support from senior leadership is paramount to the success of the training. The focus group work and interviews have also confirmed the need for strong leadership support and as such we are working with the respective organizations to develop strategies to engage the Boards. This is a four year program of research and we have completed year one of the work. We expect to have additional results related to the textual analysis work and patient safety culture survey available this spring.

Conclusions

We expect that this research will make a major contribution by providing evaluated strategies, assessed in three health authority contexts, for enhanced learning to achieve improved safety and quality in Canadian health care institutions. The key challenge that we have identified to date through our research (literature review and observations of the implementation of the systemic accident training model) is the finding that the risk management approach of many organizations can be a key determinant hindering implementation of the "new lens" model and thus of the kinds of understanding and stories that emerge regarding the genesis of adverse events and the appropriate response to them.

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