



Caring Safely

Everywhere and Every Day

PROGRESS REPORT 2017-18





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Message from Mike

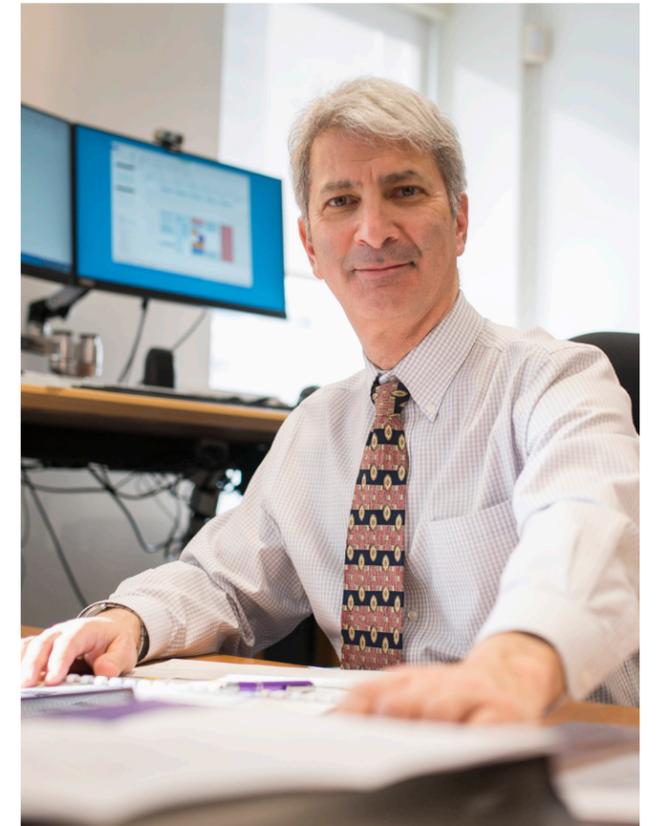
With such remarkable achievements to share, it's hard to believe we began our Caring Safely initiative just three short years ago. We have achieved, and in some cases exceeded, the objectives we chose to pursue at the outset of this project, but the true impact of this transformation goes far beyond numbers on a page.

I'm very proud to report that we have achieved a reduction in our serious safety event rate. We have trained thousands of staff and trainees in behaviours to prevent errors from occurring, and to use tools to ensure we're all speaking the same language of safety. Similarly, we've reduced the frequency of staff injury and begun to see a decline in harm to patients from some hospital-acquired conditions.

This has not always been a simple or straightforward journey. It started with the need to acknowledge that preventable harm was taking place in our organization. Many of the tenets of Caring Safely represent a significant shift from the traditional culture of health care and can create new tensions to manage, with a focus on the principles of high reliability and breaking down of hierarchies. These tensions are evidence of our cultural improvements at work, as we create a place where everyone speaks up for safety.

One of the most remarkable things about SickKids is that we have a team of incredibly dedicated people who continue to step forward and take on roles related to Caring Safely, in addition to their regular duties. We have had over 50 trainers who gave their time to teach error prevention behaviors; 300 safety coaches supporting their peers in implementing the strategies they learn during those sessions; 40 peers to support their colleagues through difficult scenarios and hundreds of other staff engaged in HAC prevention at the unit level.

I'm so proud to lead this dedicated team that has brought the spirit of Caring Safely to life across the organization with their drive and creativity.



Throughout this report you'll get to know just a few of our incredible staff who bring this 'safety first' mindset to their daily work. We are also fortunate to have highly engaged Board Members, Trustees and Family Advisors whose unique perspectives enhance our ability to implement lasting change.

Even though we are celebrating this milestone, it doesn't mean our work is over. Already, teams have come together to set new goals and work plans to push our culture of safety to the next level. We will continue our relentless pursuit of eliminating preventable harm because at SickKids, we believe in *Healthier Children. A Better World.*

Dr. Michael Apkon
President and CEO, SickKids



Progress at a Glance

100%

IMPLEMENTATION OF
HAC PREVENTION BUNDLES



Pressure Ulcers
(PU)



Adverse Drug
Events (ADE)



Surgical Site
Infections (SSI)



Injuries from
Serious Falls



Catheter Associated
Urinary Tract
Infections (CAUTI)



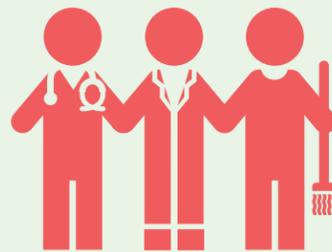
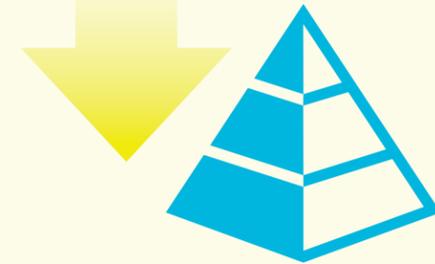
Ventilator
Associated
Pneumonia (VAP)



Central Line Associated
Blood Stream
Infections (CLABSI)

62%

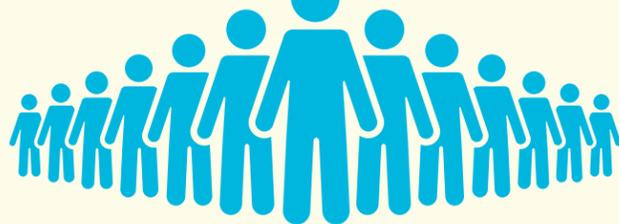
REDUCTION IN
**SERIOUS SAFETY
EVENT RATE (SSER)**
(1.4 TO 0.53)



25%

REDUCTION IN **STAFF INJURY**

+90%



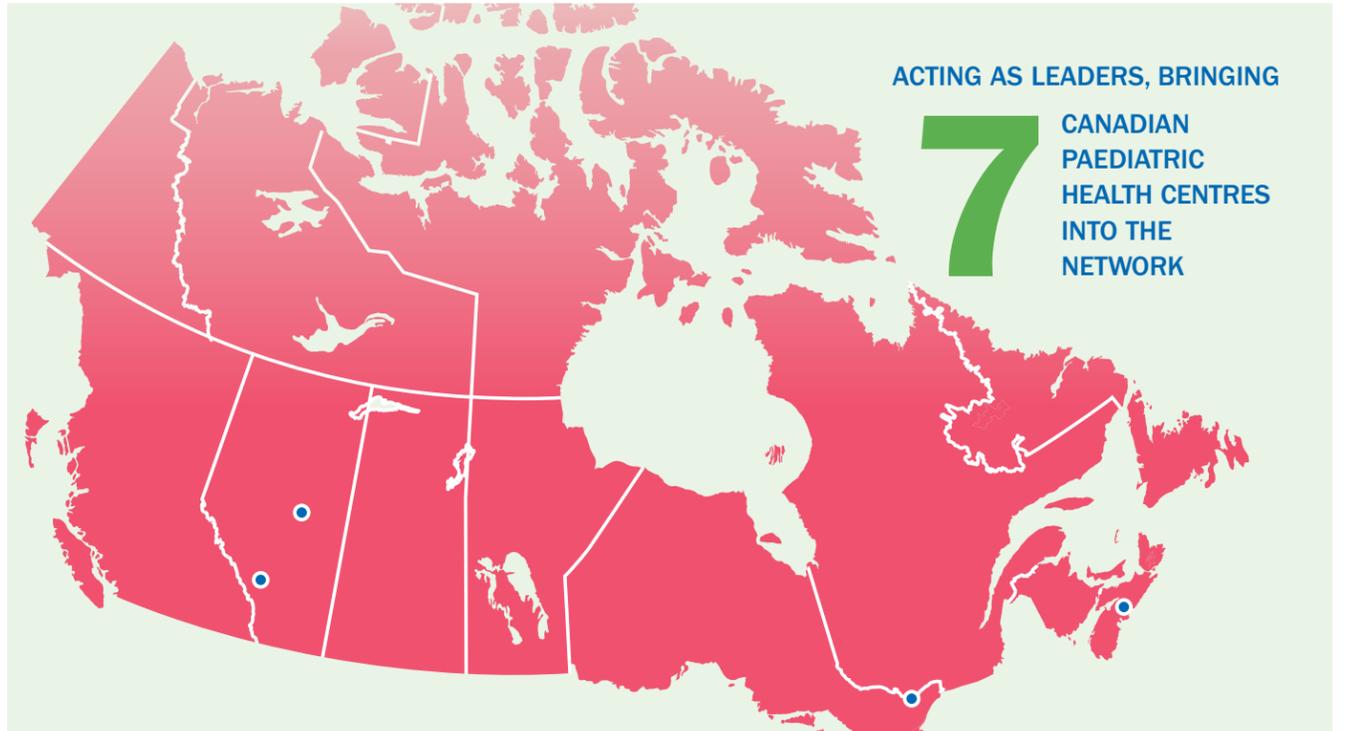
COMPLETION OF STAFF TRAINING
IN ERROR PREVENTION, LEADERSHIP METHODS
AND **JUST CULTURE**

The organization
has already reaped
benefits from this
aggressive campaign
to ensure safe
care for all.

Quoted from SickKids Accreditation Report
by Accreditation Canada
November 2017



Progress at a Glance



ACTING AS LEADERS, BRINGING

7

CANADIAN
PAEDIATRIC
HEALTH CENTRES
INTO THE
NETWORK

ALBERTA:

- Alberta Health Services, Alberta Children's Hospital
- Alberta Health Services, Stollery Children's Hospital

NOVA SCOTIA:

- IWK Health Centre

ONTARIO:

- Children's Hospital London Health Sciences Centre

- Children's Hospital of Eastern Ontario
- McMaster Children's Hospital Hamilton Health Sciences
- The Hospital for Sick Children



+300
SAFETY COACHES

The teams live a
safety first culture and
many aspects of the
Caring Safely program
are evident.

Quoted from SickKids Accreditation Report
by Accreditation Canada
November 2017



Messages from Advisors

A message from Dr. Terry Sullivan, Chair of Board Quality and Safety Committee

As a member of the SickKids Board of Trustees, I am honoured to be part of the governing body that provides oversight to the excellent, high quality care that takes place at this hospital. As a board, we recognize the inherent risks in delivering health care and that working to mitigate these risks is no simple task.

I am chair of the committee which is responsible for governing the overall quality and safety of services provided by the Hospital. We ensure appropriate mechanisms are in place for monitoring, evaluating and improving the safety and quality of patient care, education, and research.

Any high performing health-care organization never stops learning, including the Boards of these organizations. Several members of the Board Quality and Safety Committee have been fortunate enough to attend error prevention training and a Solutions for Patient Safety learning session which has deepened our understanding of error prevention and high reliability principles.

I would like to congratulate all members of SickKids' staff for their achievements to-date, and I am particularly excited to see what the next step in the journey of Caring Safely brings for patients, families and staff at SickKids.

A message from Melissa Jones, SickKids Parent

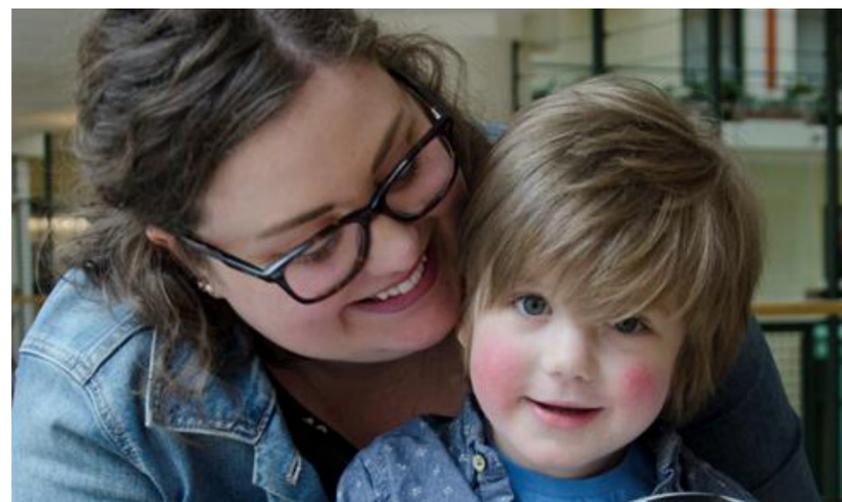
Melissa is a Family Advisor and member of the Families as Partners in Patient Safety Committee

My son Elliott was just one month old when he experienced a medical error at SickKids. He received a dose of morphine through his IV line, instead of the intended heparin, causing an overdose. Luckily, the mistake was caught quickly and Elliot was resuscitated by the Code Blue team. After undergoing an additional surgery and a prolonged hospital stay, today Elliott is a healthy and thriving three year old.

Being involved in an adverse event like this opened my eyes to the safety culture at SickKids. I immediately wanted to get involved in doing what I could to ensure that things like this don't happen again, for parents that weren't as lucky as we were, and give back to the system that ultimately saved my baby's life.

In my role as a Family Advisor over the past three years, I have seen the safety culture grow and flourish through Caring Safely. It was always clear to me that SickKids really does try to be as safe as possible, but of course mistakes do happen. By actively engaging family members who have experienced adverse events first-hand, we are given a voice to provide constructive input on preventing future errors. I'm also involved in the Families as Partners in Patient Safety Committee, working on new and exciting ways to engage families in hospital safety.

I've supported Caring Safely since the beginning, bringing a patient and family voice to the kick-off video as well as a news article describing the changing culture and how hospitals are now addressing medical errors more openly. Through these pieces, I was able to share the impact that Elliott's medical error had on our family, and how SickKids' commitment to open dialogue on medical errors and patient safety will, I believe, ultimately lead to fewer serious safety events like Elliott's.



Achievements

AS leaders in child health, we challenged ourselves to make SickKids an even safer place for the patients and families we serve and the talented staff and trainees who contribute to providing excellent care, each and every day. We know there is strength in numbers so we partnered with organizations locally and internationally, allowing us to share and learn from best practices across North America's leading health care institutions.

We were the first hospital outside the United States to join the Children's Hospitals Solutions for Patient Safety (SPS) collaborative and have spearheaded the development of a Canadian regional group bringing six other Canadian paediatric health centres into the fold. We helped them kick off their



Clinical and operational leaders from SickKids, CHEO, and IWK came together to share ideas and key learnings about the journey to reducing preventable harm including (from left):

Dr. Trey Coffey, Medical Officer

for Patient Safety and Richard Wray, Director, Quality Management, Patient Safety and Infection Prevention, SickKids; Dr. David Creery, Medical Director of Patient Safety and Jennifer Ellis, Director, Quality and Safety, CHEO; Dr. Krista Jangaard, Interim CEO and Matthew Campbell, Director, Quality, Performance & Process Improvement, IWK.

journeys by hosting a learning session to share our experiences, keeping with the spirit of 'all teach, all learn.' SickKids staff now work with SPS in leadership and subject matter expert roles, including Dr. Trey Coffey who was appointed Associate Clinical Director of SPS in 2017.

We are proud to celebrate what we have achieved over the course of three years, at such an incredible pace for a very busy organization undergoing significant change and operating under multiple pressures. This report highlights our success, and sets the stage for the next phase of our safety journey.

THE OBJECTIVES

Reduce the incidence of seven **Hospital Acquired Conditions (HACs)** significantly by the end of 2017-18.

Reduce the incidence of **Serious Safety Events (SSEs)** by two-thirds by the end of 2017-18.

Enhance our **safety culture** by adhering to the principles of High Reliability Organizations (HRO) by the end of 2017-18.

Improve **staff safety** by reducing lost time injury count, frequency rate and/or severity by 20% by 2017-18.

THE RESULTS*

We have seen reductions in some HACs with notable achievements on many units, but will continue to work towards widespread reductions across the hospital, particularly CLABSI and SSIs. HACs include: central line associated blood stream infections (CLABSI), catheter associated urinary tract infections (CAUTI), pressure injuries (PI), surgical site infections (SSI), ventilator associated pneumonia (VAP), adverse drug events (ADE) and falls with harm (falls).

We have achieved an overall reduction in the Serious Safety Event Rate (SSER) and a significant increase in the average days between events.

We started with a baseline of 1.4 SSEs for every 10,000 adjusted patient days in 2015; this value is now 0.53, representing a 62% reduction in our rate.

We have significantly improved our safety culture, based on measures from our 2017 engagement survey and observations from Accreditation Canada. We have also achieved our education targets, exceeding 90% completion of training for all Caring Safely classes.

We reduced staff lost time incident count by 26% over three years. We reduced staff lost time incident frequency by 32% and staff lost time incident severity by 25% over the same period.

*All results as of March 31, 2018.



An iterative process: Serious Safety Event reviews

KEY ACCOMPLISHMENTS

- ✓ Reduced our Serious Safety Event Rate (SSER) by 62% over three years
- ✓ Discovered ongoing trends through Common Cause Analysis of 15 SSE reviews, which will inform the next stages of Caring Safely
- ✓ Developed and implemented updated disclosure policy, enhancing our culture of transparency

A Serious Safety Event (SSE) is an event where care has deviated from a generally accepted practice standard and results in significant preventable harm.

Our Serious Safety Event Rate (SSER) is a measure representing the number of serious safety events occurring at SickKids for every 10,000 adjusted patient days.

THE process to review SSEs looks different today than it did at the outset, and that's a good thing: it means we're constantly improving. The Risk Management team and SSE Committee have built collaborative relationships with clinical teams to identify SSEs faster, resulting in more reliable measurement of our SSER.

We have honed the process of identifying recommendations to prevent subsequent events through the root cause analysis by ensuring recommendations are actionable and achievable, while still creating lasting change. We have found success thanks to the engagement of leaders, managers, subject matter experts and involved staff whose diverse and important perspectives contribute to a robust review.

Talking about errors isn't easy. By sharing stories of serious events more openly with staff at meetings, organization-wide fora and on our intranet, we have created an environment where speaking up is encouraged and celebrated. This demonstrates safety stories can be shared without shame and blame attached, but in the spirit of learning how we can be safer.

58 RECOMMENDATIONS IMPLEMENTED

62% REDUCTION IN SSER

Recommendation spotlights

Engaging support services to improve patient outcomes

In one particular event review, it was identified that engaging clinical support service departments earlier in the patient's journey could have influenced a more positive outcome. Many departments at SickKids work collaboratively with health-care providers in managing complex cases, such as Social Work, Risk Management and others. A quick reference guide was developed and distributed to help health-care providers identify the appropriate groups to involve, and how, depending on the scenario.

Best practice for communicating critical results in Diagnostic Imaging

In another review the team identified that we needed a clearer policy regarding the communication of unusual, unexpected, urgent or critical results in Diagnostic Imaging (DI). Effective communication and shared accountability are critical for the delivery of safe care. The DI team has fully implemented a new policy with standard guidelines for classifying the urgency of results and accountabilities for communication and escalation to the most responsible provider.



An iterative process: Serious Safety Event reviews



Zelia Da Silva, RRT
Clinical Director, Neonatology & Respiratory Services

Zelia has been involved in Serious Safety Event Reviews as an Operational Lead, providing an in depth understanding of usual care processes. At SickKids 24 years.

Q: How has Caring Safely transformed the way we approach patient safety?

A: Historically, SickKids has always had a focus on patient safety. The difference through Caring Safely is there is a broader organizational focus; the approach is more structured across the hospital as opposed to a more localized, unit-based approach. In our efforts to become a high reliability organization, we champion a culture of continuous improvement.

Q: Can you tell us about your experience with the SSE review process?

A: As an Operational Lead, I would bring to the group the unique lens of clinical operations

while working in partnership with my colleagues and key subject matter experts. The structure around the process encourages positive change, with clear accountability and timelines for implementing recommendations that come out of the reviews. For many of the reviews I was involved in we were able to share a safety story across the organization which really raises awareness of key learnings.

Q: How does Caring Safely impact our patients and families?

A: When speaking with patients and families about our commitment to safety, the SSE review process is such a great example. Many parents whose child experiences harm want to know what we're doing to prevent these events from happening again. I feel very proud to share that we have a very structured process in place, supported and led by our most senior leaders.



Mollie Lavigne, MSN, NP-Paediatrics
Patient Safety Specialist

Mollie supports the Caring Safely initiative by facilitating Serious Safety Event Reviews. At SickKids 8 years.

Q: What would you say is the biggest change you've seen as part of Caring Safely?

A: The biggest transformation I have seen since the beginning of the Caring Safely initiative is the spread of knowledge and expertise in patient and staff safety across the hospital. A large part of my role is meeting with staff one on one. I frequently hear statements such as "then I ARCCed" or "I knew that I should Stop and Resolve." I am continually impressed at the level of engagement in safety and the adoption and application of the error prevention behaviours throughout clinical and non-clinical areas.

Q: What has been the most challenging?

A: The most challenging part of Caring Safely for me personally has been supporting staff members through difficult event reviews. Everyone comes to work to provide the best possible care to patients and their families. When something doesn't go according to plan and it results in a safety event, it is often distressing for the involved staff members. I am really excited that in collaboration with Occupational Health and Safety, Caring Safely has been successful in establishing a Peer Support and Trauma Program so staff coping with safety events or day to day challenges have this resource to support them.

Q: What are you most proud of?

A: I am most proud of the teams that I work with that under the most difficult and trying circumstances find a way to go above and beyond to support patients, families and each other.



HACs: set the standard, teach the standard, audit the standard

KEY ACCOMPLISHMENTS

- ✓ Implemented HAC prevention bundle education and auditing on all relevant units
- ✓ Sustained excellent performance in Falls, CAUTI and PI related to SPS network
- ✓ Completed education on 'Alone & Apart check' and implemented automated dispensing cabinets to reduce adverse drug events
- ✓ Developed electronic audit tool and CLABSI dashboard for leaders to closely monitor incidence of CLABSIs on their units
- ✓ Significantly reduced rate of ADE to meet SPS network average

Hospital acquired conditions (HACs) are illnesses or injuries that cause harm to patients but are potentially preventable, and are caused by multiple factors. We've made efforts to reduce the frequency of HACs through focused interventions of education, coaching and auditing.

Falls – Injuries from Serious Falls
ADE – Adverse Drug Events
PI – Pressure Injury
CAUTI – Catheter Associated Urinary Tract Infections
VAP – Ventilator Associated Pneumonia
SSI – Surgical Site Infections
CLABSI – Central Line Associated Blood Stream Infections



The CLABSI dashboard is an online tool that provides clinical leaders with key clinical information at a glance.

Patients shouldn't be kept in the hospital any longer than they need, and they certainly shouldn't get any sicker just from being in a hospital. It's this core belief that has driven our efforts to reduce hospital acquired conditions at SickKids.

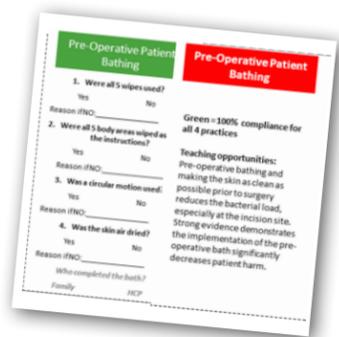
We know that fewer children are developing preventable conditions at SickKids than when we started Caring Safely.

We also know that to achieve long-term reductions in hospital-acquired harm we need to consistently apply the bundle practices, and also try new strategies. Recent innovations, like the CLABSI dashboard, provide leaders the tools they need for real-time situational awareness. Having a snapshot of the state of CLABSI on a particular unit at your fingertips frees up time typically required for data analysis, allowing leaders to find and fix problems quickly.

Expanding our focus

Our focus on reducing hospital acquired conditions is relentless. We're particularly focused on reducing the number of CLABSIs and SSIs patients experience at SickKids, as these two HACs represent a high proportion of our preventable conditions.

We're expanding our HAC program. We started by reducing the instance of some of the most common harm events, and are confident that we can find the improvement we know is possible. We have developed a deep understanding of what needs to be done, and with significant reductions in some HACs, we can deepen our focus on the conditions that are persisting despite significant intervention. Ongoing efforts will focus on building capacity at the unit level to teach and audit the bundle standards that are in place across clinical areas.



Audit Cards



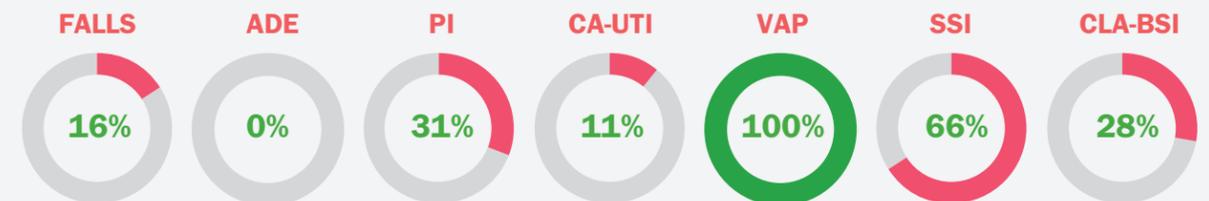
HACs: set the standard, teach the standard, audit the standard

HOSPITAL ACQUIRED CONDITIONS OVERVIEW

	2015/16	2016/17	2017/18	ONGOING
	Clinical and Operational Leads Identified	Haematology and Oncology units added to CLABSI group 6AB & 4D added to CLABSI group	CLABSI call to action event All inpatient areas reporting on CLABSI outcome and process data	Reduce HACs by 10% per year for 3yrs Add additional HAC such as Unplanned extubations, Peripherally interavenous infiltration and extravasion, and Antimicrobial stewardship
	Identified data collection methods and opportunities Gathered baseline outcome data Harm Index created	Introduction of K-Cards for auditing CAUTI centreline shift down* from 2.2 to 0 Pressure Injury rate below SPS network (SPS: 0.092, SickKids: 0.059)	Serious harm from ADEs decreased from 0.6 (2015 12-month rolling average) to 0.2 (2017 12-month rolling average) SSI centreline shift down from 3.61 to 1.91 Clarity of focus on the need to aim for 90% sustained bundle adherence in all clinical areas	HAC Qlik sense expansion Sustainable HAC education plan
	Identified existing practice and policy Developed education where gaps in knowledge existed Adopted SPS bundles	CLABSI toolkit and video created Auditing practice bundles Pressure Injury education completed	Launched electronic audit tool for CLABSI	Coaching and supporting auditors and staff Attention to prevention strategies in addition to bundles
	HAC kick off event	Celebrated 365 days of no falls! Hosted the first Canadian SPS regional meeting	Participated in second Canadian regional SPS meeting. Celebrated 365 days of no VAP! Featured in SPS "Shine" Report for excellent CAUTI performance	
	SET THE STANDARD	TEACH THE STANDARD	AUDIT THE STANDARD	

* A centreline shift is a statistically significant change on a graph. All rates are the number of HACs for every 1,000 adjusted patient days.

HAC BUNDLE IMPLEMENTATION PROGRESS MARCH 31, 2016



HAC BUNDLE IMPLEMENTATION PROGRESS MARCH 31, 2018



Bundle implementation on clinical units is best practice and our goal is to implement wherever care is provided.



HACs: set the standard, teach the standard, audit the standard



HACs: set the standard, teach the standard, audit the standard



Jennifer La Rosa, RN BScN
Manager, Blood and Marrow Transplant Program, Unit 8B
At SickKids 17 years.

Q: As a people leader, how do you support your staff in Caring Safely?

A: I really work to provide a fair and just culture: an environment where my team feels comfortable to come forward with any safety concerns. I also notify my staff of any common themes, or improvements that have been implemented to improve the safety of our staff or patients. By role modelling the safety behaviours and celebrating staff who effectively use the error prevention tools, you set the stage for others on the team to do the same.

Q: How did you convince any naysayers?

A: The key is to engage those individuals, understand why they have doubts and involve them in the solution. Most importantly, regularly share those

safety stories from your program. The teams are highly engaged and want to do what is best for our patients, so if you focus on how to improve the patient/family experience, people will be motivated. Another important factor is that I am not alone in this and have a strong team of safety champions and HAC leads that reinforce all of the good work.

Q: How are you going to sustain the progress you've achieved on your unit?

A: Safety and CLABSI will continue to be the highest priorities. It is important that we not lose the momentum and continue to discuss how we can do better and celebrate successes in our regularly established staff meetings and CIP huddles. Safety is a theme discussed every day with the Clinical Support Nurse as part of a daily status update, often involving the nursing team. It will be important to continue to reflect and celebrate how far we have come as a team, and always refer to actual cases to make this journey real.



Jas Otal, BScPhm, ACPR
Clinical Pharmacist
Jas is also a Safety Coach.
At SickKids 2 ½ years.

Q: How has medication management at SickKids become safer over the past three years, and how has Caring Safely contributed to that?

A: The implementation of various technologies in the pharmacy and throughout the hospital has certainly been a huge driver in improving medication safety over the past few years. That being said, technology is only as safe as the humans behind it! Caring Safely techniques are integral pieces in ensuring we are optimizing safe dispensing and administration of medications - whether it's a pharmacy technician using STAR in the filling of medications for dispensing, a pharmacist using 3-way communication when paging physicians to optimize medication orders, or a clinical pharmacist collaborating with nurses to identify and resolve medication-related problems on the units using QVW.

Q: What has been the most challenging, and what are you most proud of?

A: Some Caring Safely techniques are so ingrained in many of the innate practices that many clinicians partake in, that it's sometimes difficult to consciously recognize and highlight them! That being said, one thing I've noticed within the pharmacy department is a great uptake in the use of SBAR as a meaningful and effective method of communication.

Q: How do coaching techniques help improve our safety culture?

A: By using coaching techniques to prompt even the smallest of dialogues or discussions about safety, we create a culture where individuals are more comfortable using their judgement or instincts to speak up about unsafe practices, reflect on their own actions, and also recognize the value in learning from mistakes or missteps. It's great to see frontline staff embracing this, as it ultimately contributes to safer and better care for our patients.



Staff Safety

KEY ACCOMPLISHMENTS

- ✓ Implemented new Peer Support and Trauma Program for staff, along with an ongoing mental health anti-stigma campaign
- ✓ Launched the Occupational Health and Safety Business Intelligence app to provide easily accessible information to managers on staff health and safety compliance
- ✓ Collaboration with other teams, ensuring staff safety is embedded throughout Caring Safely work
- ✓ Acting as leaders in the Children's Hospitals Solutions for Patient Safety (SPS) collaborative in the area of staff safety

Staff safety has been embedded in Caring Safely since the very beginning, which made us one of few hospitals to distinguish this goal at the outset of our initiative. This area has since become a priority with the Children's Hospitals' Solutions for Patient Safety (SPS) collaborative. Our Occupational Health & Safety team are acting as leaders in the SPS network on the employee safety working group.

The team continues to support staff safety within the walls of SickKids, providing consultation and the important staff safety lens in the Safety Coach Program and the implementation of new and updated technologies like our Safety Reporting System.

Staff safety isn't just about reducing lost-time injuries: it's about supporting the whole person. Establishing a Peer Support and Trauma Program has been critical to supporting the secondary impacts of patient safety events our staff experience.

We know that the safety and wellbeing of our staff is a critical enabler in our ongoing quest to reduce preventable harm for our patients. Our teams will continue to build the Peer Support and Trauma Program, with the Physician Peer Program as the next area of focus.

REDUCED STAFF LOST TIME INCIDENT COUNT OVER THREE YEARS

25%

REDUCED STAFF LOST TIME INCIDENT FREQUENCY OVER THREE YEARS

32%

REDUCED STAFF LOST TIME INCIDENT SEVERITY OVER THREE YEARS

26%

PEER TEAM CONSISTS OF

41

CROSS-DISCIPLINARY STAFF



WITH SPECIALIZED TRAINING AND CERTIFICATION IN ASSESSMENT, COMMUNICATION SKILLS, TRAUMA PRINCIPLES AND TRAUMA RESPONSE



Staff Safety



Chris Maingot
Supervisor, Patient Support Services (Housekeeping, Linen and Transport)
Chris is a Peer in the Peer Support and Trauma Program. At SickKids 10 years.

Q: Why did you become a Peer in the Peer Support Program?

A: I decided to become a peer because having the knowledge and the ability to assist my colleagues in the event they are faced with a crisis that they are unable to cope with is important to me. I was happy to be nominated and selected for this program as I have always felt the need to reach out to colleagues and peers who are in crisis or who have been exposed to distressing or disturbing experiences. I feel comfortable knowing that we could rely on professional guidance from Kelly

MacNaughton, Peer Support Program Manager and her leadership as we face situations requiring more careful responses.

Q: What is most challenging about being a Peer?

A: The biggest challenge is juggling between my daily tasks and responding to individuals that need assistance. Similarly to many roles related to Caring Safely, I have taken on the role of Peer in addition to my regular duties because I know it's important work.

Q: What are you most proud of?

A: I have seen real positive results after working with individuals who received the services of our peer program. I have also enjoyed the sharing of ideas and suggestions that are a direct result of interaction within our peer group.



Najeeb Siddiqui, PhD
Program Manager, Developmental & Stem Cell Biology, Research Institute
Najeeb is a Peer in the Peer Support and Trauma Program, bringing

the unique perspective of the Research Institute. At SickKids 7 years.

Q: How do the principles of Caring Safely apply to research?

A: Research settings can pose significant, often hidden, health risks if appropriate lab practices and procedures aren't followed on a daily basis. Teamwork is crucially important to maintain a safe and healthy environment. Researchers follow the principles of Caring Safely by reminding each other of safety risks, speaking up when necessary and respectfully challenging risky lab practices by fellow staff members.

routinely used in biomedical research while physical harm could come from exposure to extreme temperatures, cuts from improperly disposed sharp objects or slips and falls on wet surfaces. More often than not, harm occurs during routine practices. Training, vigilance, inspections, reminders and coaching help mitigate the risks as much as possible.

Q: As a Peer what do you find to be common challenges faced by researchers?

A: A high-profile institution such as SickKids offers great learning and research opportunities for trainees and scientists. However, the excitement of asking difficult scientific questions and successfully pushing boundaries to advance science and one's career can be very stressful. A researcher has to learn early on to not take an unsuccessful experimental outcome as a failure but rather as a learning opportunity to constantly evaluate and align research plans accordingly. Resiliency and positive attitude, I believe, are the two key attributes that a researcher should nurture to succeed in science.

Q: What are common safety risks in research and how do the error prevention techniques help mitigate them?

A: Safety risks for staff working in research could be unsafe exposure to biological or chemical agents



KEY ACCOMPLISHMENTS

- ✓ Exceeded 90% completion of education in all Caring Safely classes (Error Prevention, Leadership Methods, Just Culture)
- ✓ Improved safety culture by implementing high reliability methods such as the Daily Safety Brief
- ✓ Established Good Catch Program recognizing use of safety behaviours
- ✓ Implemented Safety Coach Program to support use of behaviours
- ✓ Partnered with family advisors at the level of organizational design and governance



Good catch: stop and resolve in a risky transition

In a recent case involving a child needing emergency surgery, the rush to provide care created a chaotic environment during patient handover. One staff member spoke up amidst all the activity as teams were rushing to prepare the patient. They stopped the handover, and started again with all teams present and attentive. It didn't take long to Stop and Resolve, and it reduced the risk of error as all teams were on the same page. This staff member was celebrated at an all-staff forum for their commitment to safety.

Error Prevention

Error prevention education has been a cornerstone component of Caring Safely. While the course was naturally relevant to clinical staff, many other groups in the hospital were engaged in tailoring the course content to other areas such as the Research Institute. Expected safety behaviours are incorporated in daily discussions of safety, sharing of stories, coaching and more.

Leadership Methods

People leaders ranging from managers to members of the Executive team were educated in methods to support this cultural transformation. Techniques like "five to one feedback" and "rounding to influence" have laid the framework for leaders to empower their staff, have an awareness of the top issues influencing safety, and find and fix problems in the areas they lead.

Fair and Just Culture

A Fair and Just Culture is one in which staff feel safe reporting their mistakes, knowing they will be addressed and staff will be treated consistently in a fair and just manner. This is supported by sharing stories in an open, honest way and education in how to create a working environment that doesn't 'blame and shame'. This class provides introduces the understanding of a strong safety culture and explores why this framework is important for leaders to understand and adopt.





Safety Culture

High reliability at work: The Daily Safety Brief

One of the simplest innovations contributing to our safety culture is a 20 minute phone call. Launched in January 2015 and led each day by the Executive on Call (EOC), this daily 'huddle' has enhanced situational awareness at SickKids. Put simply, situational awareness is knowing what's going on around you, and for us, it's knowing how our ability to deliver safe care could be affected by current challenges and available resources.

Every call follows the same format; the Director on Call begins the reporting by providing an overall look at the hospital census, including challenges or delays moving patients. Other participants listed on the roster, representing a variety of departments, are called in turn to report on significant safety or quality issues from the past 24 hours and a look ahead to any anticipated issues.

One of the early refinements was the adoption of a common language for participants that have nothing to report, "nothing to report, nothing anticipated in the next 24 hours."

Discussing challenges in the format of the daily huddle has also enhanced accountability for the management of issues. The EOC directly assigns accountability to the staff member who reported the issue, and reports the issue back to the Executive team at their weekly meeting.

91%

OF REQUIRED STAFF (7,253 OUT OF 8,000) HAVE COMPLETED IN-CLASS TRAINING IN EXPECTED SAFETY BEHAVIOURS AND ERROR PREVENTION STRATEGIES IN OVER 410 CLASSES

90%

OF ELIGIBLE LEADERS (438 OUT OF 500) HAVE COMPLETED IN-CLASS TRAINING IN LEADERSHIP METHODS TO SUPPORT SAFETY

96%

OF ELIGIBLE LEADERS HAVE COMPLETED IN-CLASS TRAINING IN FAIR AND JUST CULTURE

Patient and Family Engagement

Engaging patients and families throughout Caring Safely has provided us with a holistic perspective of safety at SickKids. Our well established Families as Partners in Patient Safety Committee has provided highly valuable feedback to our HAC teams on how to effectively engage families and to our educators on the error prevention curriculum. One of the most valuable ways families have been involved is by openly sharing their stories and experiences at SickKids and by actively engaging in reviews following serious events. We engage patients and families in discussions around patient safety by listening to their questions, concerns and feedback so we have the opportunity to learn and improve.

Safety Coach Program

The Safety Coach Program is key to ensuring that the use of error prevention strategies becomes an everyday reality – not just a theory. Through training and ongoing support, staff from all disciplines are trained as experts at role modeling the four expected safety behaviours and the associated error prevention strategies.

Coaches observe practice habits and provide instant feedback and constant reinforcement to peers in their unit or department. The goal of the program is to facilitate the habit formation phase of patient and staff safety culture change.

+2,000

SAFETY COACHES HAVE HAD OVER 2,000 DOCUMENTED CONVERSATIONS ABOUT SAFETY

~300

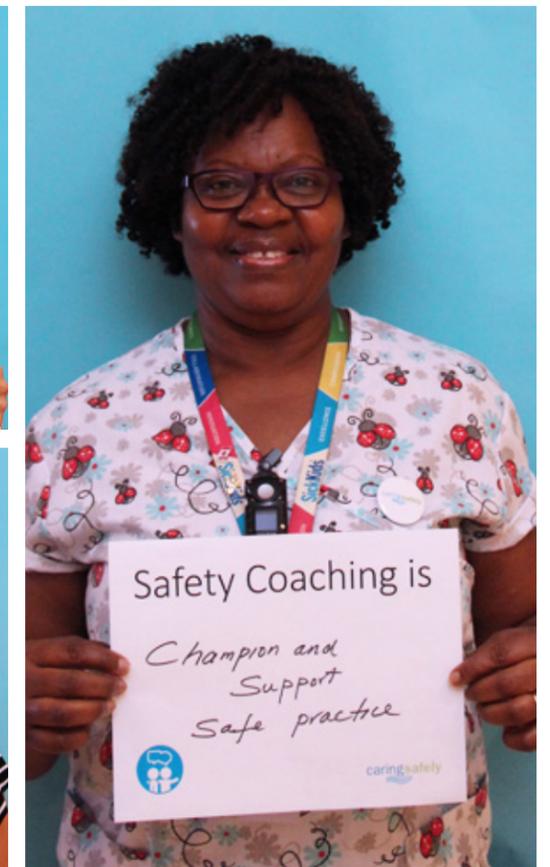
APPROXIMATELY 300 STAFF TRAINED IN SAFETY COACH TECHNIQUES ACROSS 19 CLINICAL AREAS INVOLVING MULTIDISCIPLINARY ROLES.

94.7%

FROM THE 2017 ENGAGEMENT SURVEY IN 2017, 94.7 PER CENT OF EMPLOYEE SURVEY PARTICIPANTS AGREED THE ORGANIZATION ENCOURAGES REPORTING OF ERRORS/INCIDENTS. THIS REPRESENTS A 5 PERCENTAGE POINT INCREASE FROM OUR 2015 RESULT.



Safety Culture





Safety Culture

Good Catch Program

Situations where staff or patient harm was prevented due to intervention are excellent opportunities to spread learning across the organization. The Good Catch Program recognizes individuals or teams whose use of the expected safety behaviours prevented harm to patients or staff.

This program facilitates the identification of good catch events through our safety reporting system

and assists local unit leaders to recognize staff and report good catch rates and trends. A subset of the events will be selected for recognition at the hospital level. This allows us to learn from events where things have gone well, which is just as important as learning from our mistakes.

Sustaining our culture

Sustaining the safety culture we have built upon is critical to our

ongoing success. Training in error prevention strategies will continue for new hires, and eLearning refresher courses will be required for all staff annually. We will explore further opportunities to coach families and caregivers in utilizing error prevention strategies and advocating for patient safety by formally reporting concerns. Most importantly, we will continue to live the culture of safety each and every day.



Anne-Marie Landis-Groom
Occupational Hygienist, Occupational Health & Safety

Anne-Marie is one of many staff trained in educating her peers in the error prevention curriculum. Of all the staff who have taught these sessions, Anne-Marie taught the most – an impressive 26 sessions! At SickKids 5 years.

Q: What do you enjoy about teaching your colleagues about Error Prevention?

A: Engaging staff from all parts of the hospital has been very rewarding. As human beings, we share many of the same hopes and fears related to human error and

acknowledging this fact brings people together to help reach the goal of reducing human error.

Q: What was the most challenging?

A: The most challenging piece of this work has been challenging the notion that “these tools don’t apply to me.” To help overcome this resistance, I would think of as many examples in different settings as possible – small and big – to illustrate that they apply to everyone!

Q: What are you most proud of?

A: I am very proud that I often heard “Great class, I can definitely apply these tools to my work!”



Chant Sleiman, RCT
Cardiology Technologist, Heart Centre – Cardiology Clinic

Chant is a Safety Coach. At SickKids 4 years.

Q: Why did you want to become a Safety Coach?

A: It was an opportunity for me to learn more about safety practices and to ensure that they are followed according to the Caring Safely program. I find the importance of following safety procedures within a hospital setting extremely important.

Q: What has been the most challenging about coaching your peers in error prevention behaviours?

A: I really haven’t come across any challenges yet, as my peers have been very receptive to any comments that I have made about error prevention. I think that speaks to the culture we’ve created.

Q: What’s the most important thing we need to keep doing to ensure we’re always Caring Safely?

A: Keeping the behaviours in mind, like asking questions whenever in doubt is always a good idea and paying attention to detail will also help to eliminate errors.



Safety Culture





The journey isn't over

We are proud of what we have achieved over our journey so far, but we know the work isn't over. Sustaining this progress requires continued focus and effort. That's why we're starting the second phase of Caring Safely.

We're already looking ahead to what's next, starting with a new focus on the concepts of human factors and ergonomics and how the design of our physical space and technologies can better support safe care.

We have incredible opportunities to enhance these areas with the implementation of our new health information system, and as we reimagine our campus with Project Horizon.

Some may question if you can truly eliminate preventable harm, but we will not stop trying. We are setting new, bold targets, challenging our organization to push beyond what we thought was possible. We will continue to work collaboratively in pursuit of the goal of eliminating preventable harm.

Thank you to Wendy and John Crean, the Kavelman-Fonn Foundation and all the donors who support the patient safety program through SickKids Foundation for their generous support.



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- Dr. Lennox Huang**, Chief Medical Officer, Vice-President of Medical and Academic Affairs

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- Surgical Site Infection Leads:** Dr. Michelle Science and Dr. Peter Dirks, Clinical; Laurie Streitenberger, Karen Clarke, Millie Markovich, Pamela Sehdev and Janet Ahier, Operational
- Pressure Injury Leads:** Dr. Joel Fish, Clinical; Kim Colapinto, Operational
- Adverse Drug Event Leads:** Dr. Conor McDonnell, Clinical; Renu Roy, Operational

“Even though we are celebrating this milestone, it doesn’t mean our work is over. Already, teams have come together to set new goals and work plans to push our culture of safety to the next level. We will continue our relentless pursuit of eliminating preventable harm because at SickKids, we believe in *Healthier Children. A Better World.*”

– Dr. Michael Apkon, President and CEO, SickKids

