caringsafely

10 YEARS

THE FIRST
10 YEARS

SickKids®

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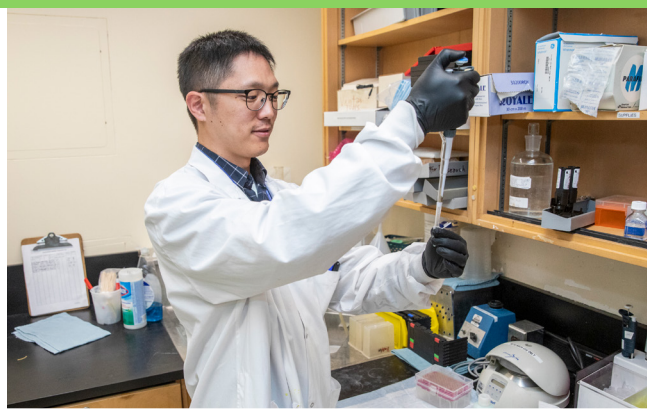
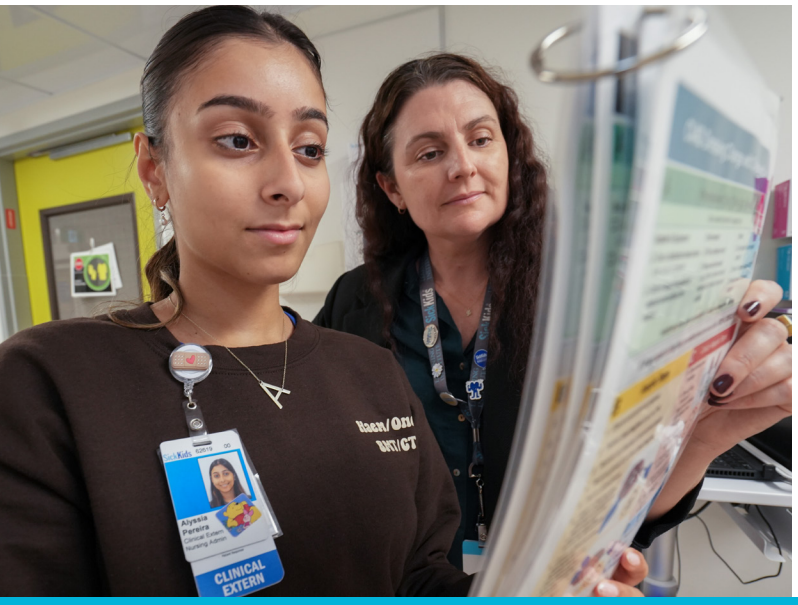


Executive summary

One decade later, Caring Safely has advanced patient and staff safety at SickKids through a focus on accountability, education and continuous improvement. Since its inception, the program has helped significantly reduce preventable harm by embedding safety behaviours, fostering transparent communication and advancing a safety culture to ensure the highest standards of safety and care.

- **Decade of impact:** Caring Safely has transformed SickKids' safety culture by evolving high reliability principles and safety behaviours for all staff, emphasizing learning, accountability and prevention.
- **Collaborative network participation:** SickKids was the first Canadian hospital to join the Children's Hospitals' Solutions for Patient Safety network, contributing to a collective prevention of over 32,000 harms across North America.
- **Preventing safety events:** SickKids estimates the Caring Safely program has contributed to the prevention of 104 serious safety events in 10 years.
- **Reducing hospital-acquired conditions:** Standard care bundles and monitoring have lowered rates of infections, unplanned extubations and other conditions.



> **"One of the main changes that I have observed in our culture since Caring Safely began is that patient and staff safety is always present in all that we do."**
>
> **– Alaina McGoey,** Medical Laboratory Technologist and DPLM non-management Safety Committee Co-Chair

- **Staff safety focus:** Using data and collaborative initiatives, SickKids has reduced staff lost time injuries by about 20 per cent since 2021-22, addressing overexertion, behavioural events and falls with targeted safety bundles.
- **Safety culture pillars:** Education, leadership engagement, Safety Coach program, Just Culture principles and the Good Catch program underpin a transparent, fair and learning-oriented environment.
- **Patient and family partnership:** Families are recognized as safety partners, contributing unique insights and participating in storytelling to prevent errors and improve care.
- **The next decade:** Going forward we will focus on proactive safety, equity in care, staff well-being, and predictive strategies such as AI and simulation to prevent harm before it occurs, building on past successes as we look toward the future.

Message from the CEO

It is with immense pride that I share this report marking the 10th anniversary of the Caring Safely program at SickKids. Over the past decade, Caring Safely has not only transformed the way we approach patient safety and quality of care, but has also profoundly shaped our culture, uniting us in a shared commitment to learning, accountability and continuous improvement.

I distinctly remember the day Caring Safely rolled out, and the sense of excitement and hope that filled the halls of SickKids. I had been with the organization for a few years and I knew we were embarking on something that would transform our safety culture. At that time, we identified an opportunity to implement high reliability principles, shift our organizational culture, create a shared mental model and language, adopt error prevention and related behaviours for all staff – and Caring Safely was born.

Central to the success of Caring Safely is the importance of safety education for all staff members – clinical and non-clinical. We do not teach safety, we teach safety behaviours. By investing in comprehensive training, fostering open dialogue and supporting ongoing professional development, we are empowering staff to embody the expected safety behaviours in their daily work. These behaviours, which stem from attentiveness, transparency and mutual respect, are the backbone of a safety culture, where every voice is heard and every concern is acted upon.

Our achievements over the past decade reflect the remarkable dedication and collaboration of our staff, patients and families. Together, we have created an environment where safety is more than an aspiration – it guides every decision we make, large and small, to reduce preventable harm. As we celebrate this milestone, let us reaffirm our commitment to ongoing learning alongside evolution in safety science, to practicing expected safety behaviours and to nurturing a culture where safety thrives.

The name of this report – *The First 10 Years* – says it all. Caring Safely is here to stay because, no matter how much better we become at avoiding safety events, the work to improve and maintain safety at SickKids never stops.

The successes highlighted in this report belong to each of you and I look forward to all that we will accomplish together in the years ahead.

Sincerely,

Dr. Ronald Cohn
President and CEO, SickKids

Message from Caring Safely Co-Executive Leads

As Co-Executive Leads of Caring Safely, we are deeply honored to join in celebrating a decade of commitment, innovation and growth. Over the past ten years, Caring Safely has become a cornerstone of our mission at SickKids, shaping not only how we care for our patients and our staff, and who we are as a community of child health providers and leaders.

One of the first decisions we made was to join the Children's Hospitals' Solutions for Patient Safety (SPS), a network of 150-plus children's hospitals in North America working together to eliminate preventable harm. SickKids was the first hospital from Canada to join. Collectively, the SPS organization has spared more than 32,000 children from harm since 2012, which is a powerful example of what hospitals can accomplish when working together.

SickKids' progress is the result of countless hours devoted to building a robust safety infrastructure, evidence-based care standards to prevent hospital acquired conditions and other sources of harm, fostering open dialogue and integrating safety behaviours into every facet of care. Simulation and experiential learning have been key enablers of this progress, allowing teams to practice safety behaviours, strengthen communication and continuously improve the quality and reliability of care.

Each member of the SickKids community has played an essential role – whether by raising a concern, supporting a colleague, or championing new solutions – reminding us that meaningful change is possible when we work together towards the same goals.

As we mark 10 years of Caring Safely, we also look ahead with hope and determination. The journey is ongoing, and we remain committed to our aspiration to eliminate preventable harm, nurture a culture of transparency and set new standards for paediatric safety.

To all who are contributing to Caring Safely, know that every voice in our community is heard and valued. Thank you for your personal commitment to safety, for ensuring that every child receives the safest possible care and every staff member is kept safe while on the job.

Sincerely,

Jeff Mainland and **Lennox Huang**
Co-Executive Leads, Caring Safely

By the numbers

Through the work of Caring Safely, SickKids estimates* we have prevented:

104
Serious safety events (SSE)

144
Unplanned extubations (UE)

197
Central line associated bloodstream infections (CLABSI)

32
Serious adverse drug events (ADE)

18
Falls with serious harm

Number of staff completing education training

16,938
Error Prevention

438
Leadership Methods

297
Just Culture

HAC Audits

12,824
CLABSI

748
Catheter associated urinary tract infection (CAUTI)

834
Falls

183
Infusion Safety

Good Catch Program

4,434
Good Catch nominations received

298
Good Catch Awards given since December 2017

50+
Different professions represented

Safety Coach Program

740
Staff trained since start of program

200+
Active coaches

*Based on extrapolating baseline rate over time period to estimate expected number of events and subtracting from actual events.

Objectives and results

Reducing Hospital Acquired Conditions (HACs)

Hospital acquired conditions, or HACs, are illnesses or injuries that cause harm to patients, but are potentially preventable and are caused by multiple factors. Not only do these conditions cause physical harm by contributing to poor outcomes for critically ill children, but they also extend a patient's stay in hospital, further disrupting families' lives.

A key pillar of Caring Safely is the implementation of standard bundles of care and processes for monitoring adherence to reduce the occurrence of the following HACs:

- ADE (adverse drug events)
- CAUTI (catheter associated urinary tract infections)
- CLABSI (central line associated bloodstream infections)
- Falls
- PI (pressure injuries)
- PIVIE (peripheral IV infiltration and extravasations)
- SSI (surgical site infections)
- UE (unplanned extubations)
- VAP (ventilator acquired pneumonia)

Central Nursing Practice Observation Leads observe practice at point-of-care to identify opportunities to improve standard bundle adherence through learning and conversations with point-of-care staff. From Left: Allisa Ragnanan, Liz An, Sarah Gallie and Warre Tsu.

The work to consistently apply all the elements of each standard bundle has included observing practice to understand barriers, building dashboards for data display and developing team awareness of risk and risk mitigation. Hundreds, if not thousands, of staff have participated in this work and continue to do so every day. And their efforts are paying off.

The model is collaborative, focused on learning, reinforcing error prevention strategies and coaching to drive continuous improvement and reduce hospital acquired conditions. In 2015, the rate of CLABSI infections at SickKids was 30 per cent higher than the SPS network rate, but today the rate is comparable to SPS. Unplanned extubations were occurring at a frequency of almost 50 a month and this year all three ICUs celebrated three months without an unplanned extubation.

Here's a sample of how much rates have fallen for the following events:

CLABSI — 40% since 2019

UE — 50% since 2017

SSI — 60% since 2022

Other HACs such as severe ADEs and Falls with harm are also occurring less frequently.

Unit 5C (Neurosciences & Trauma) celebrates the achievement of new safety milestones, which is an important way to recognize safety work and learn from what goes right.

Each HAC prevented represents a child and family **spared** from additional treatments, prolonged length of stay and disruption.

However, there are HACs where reductions have been a challenge, notably rates of CAUTI and PIVIE, which remain higher than the SPS network rate. SickKids is committed to continuing to improve by sustaining these efforts, regularly reviewing outcomes and implementing new strategies based on lessons learned. This ongoing dedication ensures that the organization remains vigilant and proactive in identifying risks and driving meaningful change.

Celebrating three months without an unplanned extubation event in the critical care units are (from left) Danyella Dias, respiratory therapist and PICU safety champion; Jason Macartney, senior clinical manager, Respiratory Therapy; and Carly Knight, respiratory therapist and NICU safety champion.

Reducing Serious Safety Events (SSEs)

A serious safety event (SSE) is an event where care has deviated from a generally accepted practice standard and results in moderate to severe harm or death. From the outset of Caring Safely, the goal has been to eliminate these events. By undertaking a standardized approach to reviewing these events and working to strengthen organizational safety culture, SickKids has seen a reduction of more than 70 per cent in SSE rates over the last 10 years. This reduction means more than 100 patients were prevented from experiencing severe harm, and families and staff have been spared from the stress, anxiety and disruption that serious safety events can cause.

The learnings from SSEs have resulted in corrective actions that improve workflow for staff and enhance safety for patients and families. We continue to engage staff, those involved in events and safety experts, to ensure recommendations for improvement are positively impacting safety.

Improving Staff Safety

Staff safety and well-being is a prerequisite for patient safety. Without a healthy workforce, we can't take care of our patients and families. That's why we're focused on preventing workplace-related harm to employees using the same rigour and methods as we use to prevent patient harm. After seeing an increase in staff safety events during the pandemic, the trends are heading back in the right direction, with lost time injuries down about 20 per cent since 2021-22.

From the early days of Caring Safely, SickKids played a key role in collaborating with other hospitals to look for trends in staff injury data to help identify areas of concern, as well as develop interventions to mitigate harm. Overexertion injuries, patient behavioural events, and slips, trips and falls were identified as the leading causes of staff harm.

The SPS collaborative, including SickKids, saw great momentum with the introduction of a new overexertion cohort in 2023 that used an executive to frontline approach to prevention. This initiative involved focused conversation, rounding and other behaviours to make overexertion top of mind all the time. This model, piloted in the SickKids PICU, led to a substantial decrease in overexertion injuries throughout the SPS hospital network. At SickKids, there are plans to expand the initiative to other departments.

Another area of success is the patient behavioural events cohort, which SickKids joined at the beginning. The safety bundle included assessing patients for risk of escalation, and through collaboration SickKids developed and launched our internal Comfort and Safety bundle. We have since expanded our approach to prevention of workplace violence to include other harms to staff, most recently with the creation of the Family Caregiver Behavioural Escalation Policy and training.

As a leader in the industry, SickKids took charge of identifying areas of improvement and pioneering the safety bundles to make itself – and all hospitals – safer for staff. Our goal is to continue to reduce lost time injuries to staff. Staff safety initiatives now align closely with organizational goals, demonstrating measurable progress and ongoing commitment. SickKids continues to champion staff safety, creating a collaborative environment and clear direction that prioritizes staff well-being and aims to minimize preventable workplace injuries.

Safety culture

Caring Safely is grounded in principles and practices shared by our SPS peers across North America. One of the unique factors that we all share, and that has contributed to our success, is an ongoing focus on safety culture together with targeted tactics and tools to enhance safety. Key aspects of culture include governance, leadership, education, cause analysis, patient and family caregiver engagement, teamwork, communication and Just Culture.

The role of leaders cannot be underestimated in achieving safety goals. Leaders are required to build and reinforce accountability for safety by continually demonstrating that safety is a priority through their actions and attention. They must also understand and eliminate barriers that prevent staff from working in ways that are reliably safe. Here's how SickKids is maintaining and building its safety culture for the future.

Error prevention education

Everyone who works at SickKids is introduced to our safety culture on day one through enrollment in our Error Prevention education session. This three-hour seminar sets the stage by highlighting expected safety behaviours and tools staff can use to keep patients and staff safe. It's all part of the broader Caring Safely program.

Staff who take the Error Prevention course are given a Caring Safely card listing behavioural expectations and associated tools to carry along for quick reference with their ID badge.

Education is core to Caring Safely and so is the team behind it all. From Left: Educators Lisa Fowler, Elena Blackwood and Susan Hu, and Associate Chief of Nursing Bonnie Fleming-Carroll.

Staff are encouraged to use strategies like ARCC, STAR and QVV to speak up when something doesn't seem right. Nearly 17,000 staff have been trained in Error Prevention over the past decade, which is essential to ensure a common language and mental model regarding patient and staff safety. A refresher iLearn course was developed more recently for staff to take annually to brush up on their knowledge.

Key to our successful adoption of Error Prevention is a focus on leadership education. Leaders learn methods to find and fix problems and to reinforce safety behaviours, as well as creating a Fair and Just Culture to cultivate a psychologically safe environment. As we work to evolve this education to be current with the latest safety science, leaders continue to engage with staff and listen directly to their feedback. Learning is a collective endeavor – and always will be – as we work together to identify and improve system issues to make SickKids safer for all.

Safety Coach program

The best way to think of the Safety Coach program is as an extension of all the education we do. Safety Coaches are specially trained in error prevention strategies to help colleagues use them on a daily basis. They take the theory from the classroom and bring it to the point-of-care. SickKids is fortunate to have more than 200 Safety Coaches, who are easily identifiable to colleagues through wearing a special badge. In addition to helping embed the use of the expected safety behaviours and associated tools into everyday practice, coaches also receive training in safety theory and providing feedback. The goal is to empower coaches to become local safety leaders who champion a strong safety culture with the ultimate goal of reducing staff and patient harm.

Fair and Just Culture

Fair and Just Culture is an essential component of a robust safety culture. It promotes fairness, accountability, and learning in response to errors that result in harm, or could have resulted in harm. While some perceive it as a "blame-free" culture, it's actually one that:

- Systematically distinguishes between human error (unintentional mistakes), at risk behaviours (deviations in what is expected that are believed to be justified or low risk) and reckless behaviour (conscious disregard for recognized unjustifiable risk). It is human to make errors and nobody should be unfairly punished for honest mistakes.

- Balances individual accountability with system design. Systems are rarely failure-proof in design, and people who work in and with failure-prone systems should not be held accountable for errors that result from design flaws. They should be held accountable to speak up and report system risks when they are known and organizations should listen to those concerns and respond.

Just Culture promotes transparency and learning. Robust reporting of all events, especially those that didn't happen but could have, is an opportunity to make changes to be safer. When employees aren't afraid of being treated unfairly or being dismissed when they speak up, we have more opportunities to improve and make systems safer. At SickKids, we have standardized ways to help leaders understand how to manage reported errors and near misses in ways that demonstrate a commitment to Fair and Just Culture principles.

Leader rounding to enable direct feedback and proactively identify system issues promotes a Fair and Just Culture at SickKids, which helps improve safety and quality, builds trust and engagement, strengthens organizational resilience and supports equity and inclusion.

Operating Room Nurse Deborah Newland is one of nearly 300 recipients of the Good Catch award since its inception in 2017. From left: Dr. Abhaya Kulkarni, Surgeon-in-Chief; Deborah Newland; and Quality Leaders Erin Hempel and Chloe Prentice.

Good Catch program

As important as it is to learn from mistakes and errors, it is equally important (if not more) to learn from situations when things go right. The Good Catch program does just that. Every month, a committee reviews nominations for a Good Catch award to recognize individuals or teams whose use of one or more of the expected safety behaviours prevented harm to patients or staff. Recognitions are awarded based on criteria including whether teamwork and collaboration was apparent; whether the impact of the Good Catch goes beyond the area where the event occurred; and whether there was a system or process change.

The 4,434 Good Catch nominations received since the launch of this program in 2017 have resulted in the awarding of 298 Good Catch certificates. Good catches are shared across the organization as another way of learning and working towards becoming a safer organization. Good Catch awards have recently been given to staff for the prevention of prolonged anesthesia, removing equipment beneath operating tables, spotting a misplaced reagent in the diagnostics laboratory and more. Good Catches are safety behaviours in action and proof that adopting these behaviours works and that SickKids is a safer place because of our focus on them.

Safety Reporting System (SRS)

When there is a safety event, safety concern, hazard or breach, the online Safety Reporting System (SRS) is an essential tool for addressing these matters. SickKids fosters a culture of trust in which people are encouraged and rewarded for reporting and providing safety information, combined with clarity about accountability for acceptable and unacceptable behaviour.

The SRS is much more than a log book. The reports submitted to the system are carefully analyzed and used to create positive change. It's not about pointing blame but pinpointing root causes, as event follow-up helps us identify system improvement opportunities to prevent similar situations to keep patients and staff safe.

Since the inception of the SRS in 2016, staff have filed a total of 73,344 safety reports. While this is a big number, we constantly encourage staff to speak up through safety reports because we consider this reporting a signal of a strong safety culture. High rates of safety report submissions reflect trust in the system, a willingness to be transparent about risks and a shared commitment to improvement.

Patient and family engagement

We consider patients and families partners in care and likewise safety. Patient and family engagement is an area of opportunity to enhance SickKids' safety culture. By actively involving patients and their families in care processes, SickKids can incorporate their unique perspectives and experiences to inform safety practices and decision-making.

Such a collaborative approach empowers families to speak up about concerns or observations and also helps the organization identify potential risks and improvement opportunities that might otherwise go unnoticed. At times, families involved in safety events have bravely participated in storytelling to help ensure errors are never repeated. By valuing and integrating patient and family input, SickKids can strengthen its commitment to a culture of safety and continuous learning.

Governance

Governance plays a vital role in patient and staff safety by providing oversight, strategic direction, and accountability for safety initiatives. At SickKids, the Board Quality and Safety Committee ensures that safety remains a top priority by setting policies, monitoring performance, and supporting a culture where safety practices are continuously evaluated and improved. This leadership helps to align organizational efforts, promote transparency, and allocate resources to address safety concerns effectively, ultimately safeguarding both patients and staff.

The next 10 years…

As we reflect on the progress made over the past decade, it is clear that SickKids is embarking on the next 10 years from a position of strength. Evolutions in safety science are leading to a shift in methodologies, and we are embracing new directions as we embark on the next chapter of Caring Safely. Looking ahead, our vision is anchored in advancing proactive safety by leveraging the expertise and experience of our staff, addressing equity and disparities across all aspects of care and continuing to focus on all aspects of staff safety.

By embedding predictive safety strategies, we aim to shift from reacting to incidents to preventing them before they occur. Some of these strategies will involve innovative machine learning models and simulation methodology. Moreover, using data-driven insights will help us further evolve safety science to anticipate risks and eliminate preventable harm.

Equity remains at the forefront of our efforts, ensuring that every patient and family receives high-quality, inclusive care tailored to their unique needs. We will

By working together, Patricia Cameron (4C Clinical Support Nurse); Jo-Anne Marcuz, Physiotherapist Practitioner; and Maria D'Amario, 4C Patient Care Information Coordinator, helped ensure a patient wasn't subjected to any unnecessary treatment. The trio was recognized with a Good Catch award.

continue to design services that actively reduce disparities and promote health equity, embracing the diversity of our community and striving to eliminate barriers to care. Our focus will remain on collaborating with patients, families and staff to create seamless health journeys, harmonizing physical, mental and behavioural health and fostering a culture of continuous learning and improvement.

In addition to patient safety, SickKids remains committed to staff safety and well-being, recognizing that the two are closely interconnected. SickKids believes that when staff feel supported, valued and safe in their work environment, they are better equipped to deliver high-quality, attentive care to patients. Initiatives aimed at promoting staff mental health, fostering open communication and providing resources for stress management contribute not only to a healthier workplace but also to improved patient safety outcomes.

> **"My favorite part of safety coaching is being able to empower others, whether encouraging a colleague to speak up about a concern, celebrating teams' safe practices, or helping problem-solve in real time."**
>
> **– Dr. Dimitri Parra,** Paediatric Interventional Radiologist

The next decade promises new challenges and opportunities, but with our dedication to proactive safety and prediction, equity, and staff safety, SickKids is poised to create a safer and more inclusive future for all. Together, we will build on our successes, champion innovation and set new standards in patient and staff safety for years to come.

Outgoing message from Rick Wray

It's been my privilege to serve SickKids in many capacities since starting my career here more than four decades ago. Co-leading Caring Safely, watching it grow, and seeing it make an important difference in patient and employee safety through the first 10 years has been a highlight to be sure.

As I look back on where we started and where we are today, I am deeply proud of what we have achieved together in creating a culture where safety and quality are at the heart of everything we do. What is most meaningful to me is what didn't happen – harm that would have occurred if we did not take this journey together. To those who will carry the Caring Safely torch forward, I urge you to remain focused on your commitment, being collaborative in your approach and passionate in your pursuit of excellence.

The path ahead will bring new opportunities and challenges, but with your leadership, compassion and innovation, the future of safety at SickKids will be brighter than ever. Thank you for your dedication and for continuing to build a safer and more equitable world for everyone at SickKids.

Sincerely,

Rick Wray
Director, Quality Management, Safety and Infection Prevention and Control, and Caring Safely Co-Lead

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