Historical Overview

Pivotal Studies
Catalysts for Change

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Learning Objectives

The learner will understand

- The key research studies that reinforced the urgency of ensuring a safer health care system
- The influence of these studies on
  - The need for ongoing improvement
  - The introduction of legislation aimed at ensuring greater accountability for quality and safety in the health care system.

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To Err is Human: building a safer health system. (1999)

- Institute of Medicine's (IoM) reported alarming data
  - 98,000 deaths/year in U.S. related to medical error
  - Top 10 causes of death in the United States
- A landmark in the quality movement in health care
- Since the publication of this report, QA in health care has steadily become a top priority for health care providers.(de Jonge, et al, 2011)
  - implementation of Quality Management frameworks, establishment of strategies and protocols
  - identification of outcome measures as quality indicators (standardized mortality rates)

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Crossing the Quality Chasm: A New Health System for the 21st Century (IoM 2001, Berwick, 2002, Corrigon,2005)

- follow-up to "**To Err is Human"**
- urgent call for change to close the gap
- comprehensive review of the quality of the health care system,
  - assessment of its safety and effectiveness
  - proposed recommendations for a comprehensive strategy for improvement
    - Performance expectations
    - Guidelines for patient-clinician relationships
    - Organizing frameworks to align accountability for
    - Evidence-based approaches

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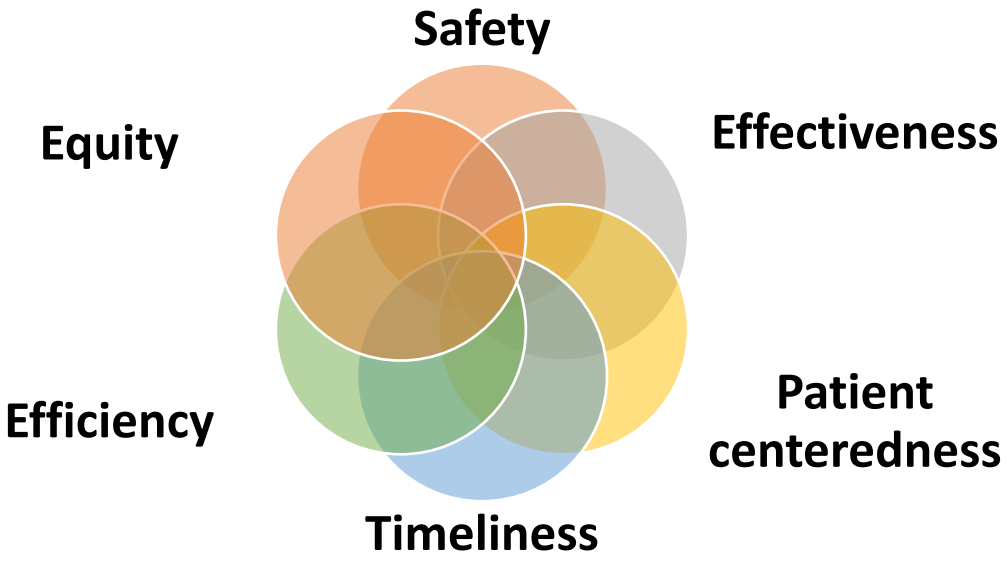
Crossing the Quality Chasm: A New Health System for the 21st Century (IoM 2001, Berwick, 2002, Corrigon,2005)

- identified 6 dimensions of quality:



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Building a Safer System (2002)

- A report published by the National Steering Committee on Patient Safety, *Building a Safer System*
  - proposed a strategy for improving patient safety in Canada.
  - In 2003 Health Canada established the Canadian Patient Safety Institute (CPSI)
    - collaborates with health care professionals, government and health care organizations to advance the quality and safety of patient care.
    - offers a number of programs, including tools and resources, designed to promote patient safety (CPSI, 2016).
- The Canadian Foundation for Healthcare Improvement and the Canadian Patient Safety Institute combined to form a new organization, **Healthcare Excellence Canada**.

> *Safety and quality are closely intertwined, as optimal patient safety can only be achieved with high quality of care throughout the complete patient journey. When the quality of all processes of a patient's journey are ensured, possible threats for patient safety will be recognised early to prevent the threat becoming an accident.*

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The Canadian Adverse Events Study (Baker and Norton, 2004).

- determined the extent of error in Canadian hospitals.
- Reviewed 20 hospitals in five provinces,
  - one in 13 patients experiences an adverse event.
  - the greatest number of these adverse events occurred in teaching hospitals, where patient care is generally more complex and acute.
- Of 185,000 adverse events that occur in Canadian hospitals each year, 70,000 are preventable
- **In a 2017** review of progress on patient safety was undertaken (Hardcastle, 2017)
  - legislative progress has been fragmented and that some provinces lag behind others.
  - lack of data on the link between scientific governance reforms and patient outcomes in Canada limits any assessment of the effectiveness of the measures that have been taken.
- Recommended that hospitals must step forward, take responsibility for the work of all of the heath care professionals, including physicians.

Legislation in Ontario

Excellent Care for all Act (ECFAA)

- Approved June of 2010, a legislative response to the alarming data regarding patient safety
- Strong focus on patient (person) centred care.
- Strengthens the health care sector's organizational focus and accountability to deliver high quality patient care.
- Based on strategic directions that exemplify good governance and high quality patient care it
  - defines quality for the health care sector,
  - reinforces shared responsibility for the quality of care,
  - builds and supports boards' capability to oversee the delivery of high quality of care,
  - ensures health care organizations make information on their commitment to quality publicly available.

Legislation in Ontario
Health Quality Ontario (HQO)

Ontario agency mandated by Excellent Care for All Act, 2010 (ECFAA) to

- **transform** the healthcare system by creating greater public accountability, increasing the focus on quality, bringing patient satisfaction to the forefront and basing patient care decisions on the best scientific evidence available.
- **advise** government and health care providers on the evidence to support high-quality care,
- **support** improvements in quality,
- **monitor** and report to the public on the quality of health care provided in Ontario.

- Supports continuous quality improvement;
  - Requires specific health care organizations to submit an annual Quality Improvement Plan (QIP).
- Promotes health care that is supported by the best available scientific evidence by
  - making recommendations to health care organizations and other entities on standards of care in the health system, based on evidence-based clinical practice guidelines and protocols,
  - making recommendations, based on evidence, concerning the Government of Ontario's provision of funding for health care services and medical devices.

Summary

- Research and evidence has informed the advancement of quality in health care.
- A system wide approach has ensured all levels or organizations take accountability for quality in Health Care.
- The philosophical approach to Quality has shifted over time.