



We celebrate the efforts of the organization as they develop noteworthy activities, practices, or processes that are innovative and tied to CCHSA's Quality Standards

Implementing a Safety Reporting System

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This Practice is Linked to CCHSA Standards

Patient Safety Goal:

Create a culture of safety within the organization

ROPs:

- Client/Patient Safety as a written strategic priority/goal
- Quarterly reports to Board on client/patient safety
- **Reporting system for actual and potential adverse events**
- Policy and process of disclosures of adverse events
- One prospective analysis per year

CHEO: Entirely Devoted to Pediatrics

- **167 inpatient beds; located in Ottawa, ON**
 - 20 in Neonatal Intensive Care (NICU)
 - 10 in Pediatric Intensive Care (PICU)
 - 106 in Pediatrics, Oncology, Adolescent medicine and Surgery
 - 31 in Psychiatry

Emergency Department, including trauma program

Medical Day Unit: providing day treatment in oncology, hematology and dialysis

Surgery: pre-assessment, day surgery unit, 8 operating rooms, post-operative care and 33-bed inpatient unit

Clinics: 63 outpatient specialty clinics

Diagnostic Services: 2 MRIs, CT Scan, Ultra-sound

The CHEO Team

- **380+ physicians**
- **700 nursing staff**
- **1,000 allied health, administrative, support staff**
- **200 health professionals engaged in research**

This Practice Demonstrates Efficiency in Practice

Last Year

- Pile upon pile of paper & 1 excel table
- Much frustration at all levels – just ask our Manager of Clinical Risk and Patient Safety!
- Too many different forms
- Trending was not up to date and was manual
- No way to find the needle in a haystack
- Notification not always timely; follow up with staff "hit and miss"
- Inconsistent classification systems
- Paper would get lost before it was tallied

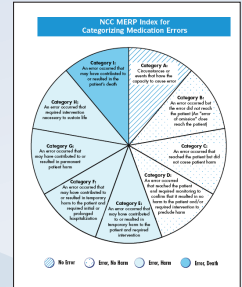
This Practice Demonstrates Efficiency in Practice

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This year

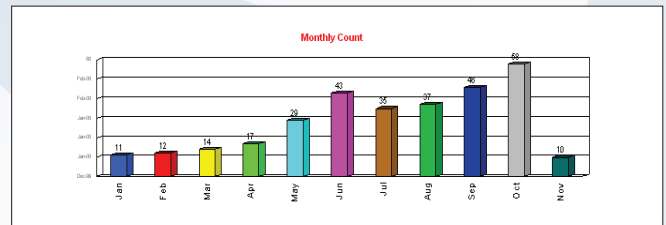
- (Almost) all data is in the database
- One stop shopping
- Consistent look and feel to data entry screens (it's much easier!)
- Trending is immediate
- The haystack is manageable
- Notification instantaneous for high risk events
- Classification system adapted for patient related and medication repts www.nccmerp.org/010612_color_index.pdf
- We don't "lose" the report



This Practice Demonstrates Successful Results

- We started slowly with two supportive, keen units (thank you PICU and NICU!) - Jan 07
- Took the time to learn, allow culture to adjust
- Added a major user group (Pediatric Medicine) May 07
- Smaller group (Cardiology) - Oct 07
- Surgery - Nov 07, Diagnostic Imaging - Dec 07
- 9 remaining areas to be on board by Jan 31, 2008

312 events reported
132 were medication related



This Practice Can be Adapted by other Organizations

- You need a Champion or two (in our case, 14 !)
- A friendly I.S. resource is always handy (we couldn't have done it without her...)
- Involve staff at key opportunities
 - Software testing, keen users on the planning group, key pilot units
 - Roll it out where there is a willingness or champion
 - Support staff & managers through the learning curve
- Mobilize subtly but do not dilly-dally; The timing will never be perfect
- Don't make this the only project in your organization... let other things be out front and just "let this happen"...

