Aggregated Learning from Clinically Serious Adverse Events: Analysis that Contributes to Setting Organizational Priorities

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Define Opportunity

- To analyze a collection of learning from clinically serious adverse events from across Alberta Health Services (AHS) for the purpose of determining issues that require an organizational approach to improvement.

It is through the analysis of "critical failures" that a high reliability organization can redesign processes (IHI, 2004).

Act to Improve

- annual aggregate analysis of clinically serious adverse events to determine if there are patterns of issues that are being examined repeatedly throughout the province.
- 2012/2013 Multi-Review Analysis Report : multiple sources of information were considered and themes identified utilizing a common framework aligning with the Health Quality Council of Alberta (HQCA) Quality Matrix for Health User Guide.

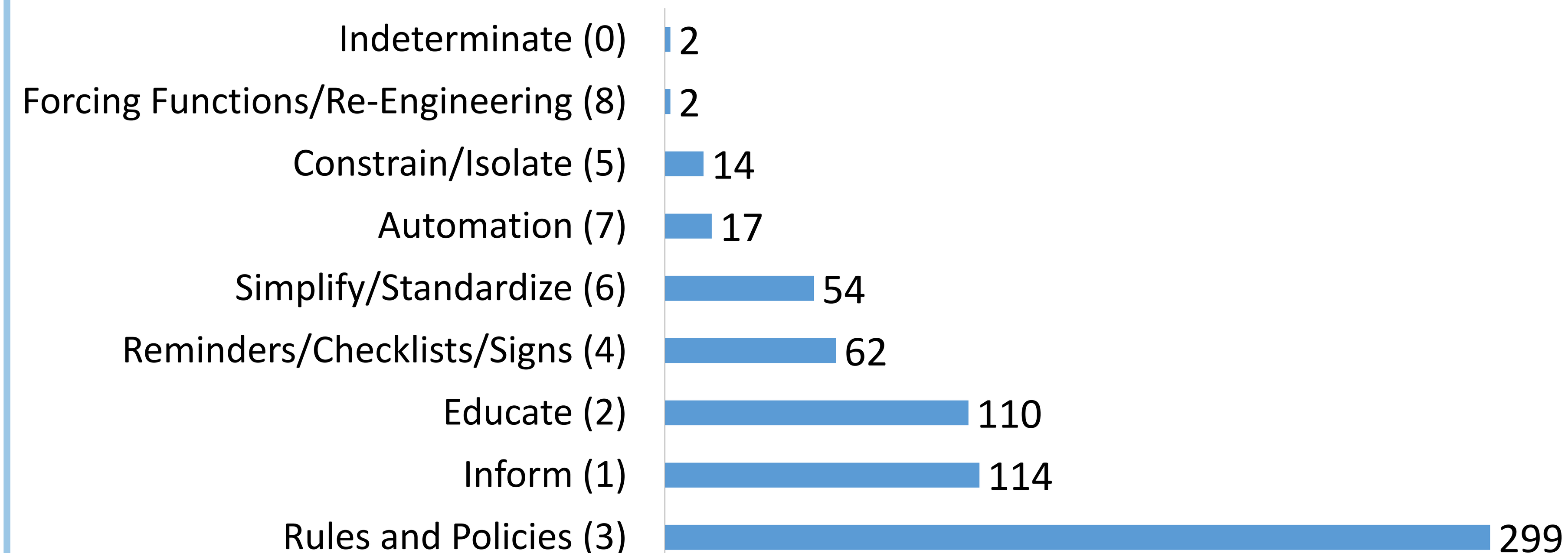
HQCA Dimensions of Quality

Acceptability - Health services are respectful and responsive to user needs, preferences and expectations.
Accessibility - Health services are obtained in the most suitable setting in a reasonable time and distance.
Appropriateness – Health services are relevant to user needs and are based on accepted or evidence-based practice.
Effectiveness – Health services are provided based on scientific knowledge to achieve desired outcomes.
Efficiency - Resources are optimally used in achieving desired outcomes.
Safety – Mitigate risks avoiding unintended or harmful results.

- 2013/2014 Report : added another quality dimension; Accreditation Canada's Required Organizational Practices.

Methods

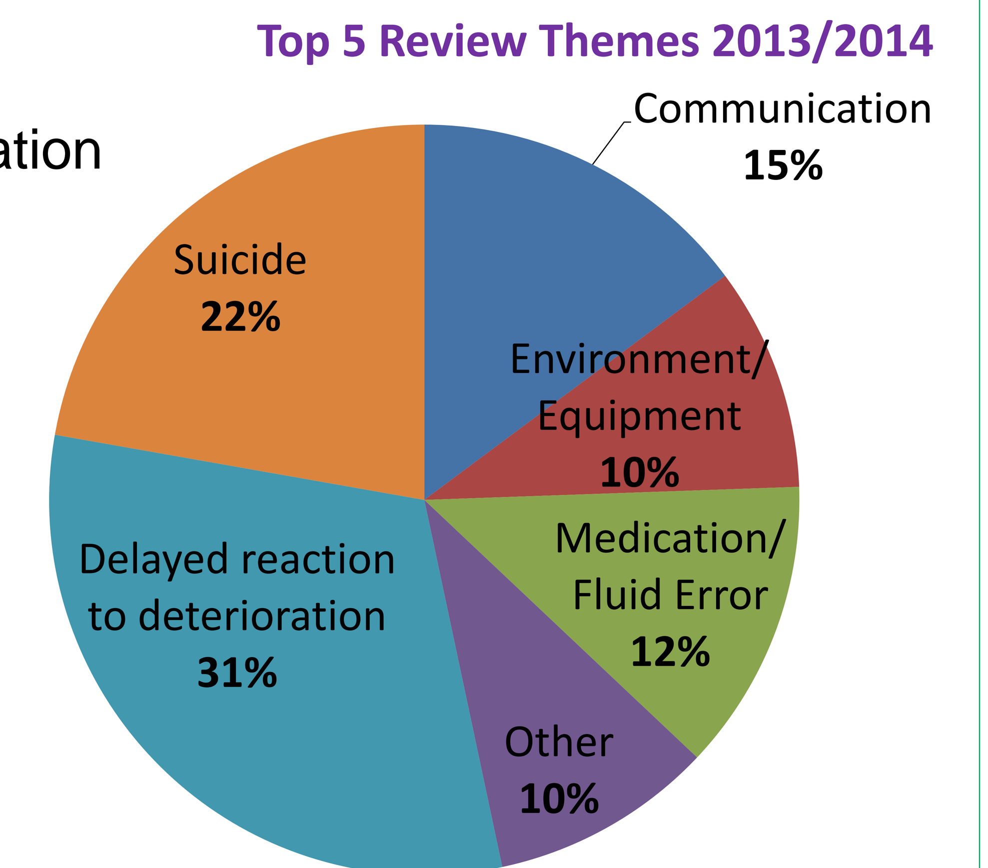
- examines multiple reviews stemming from Quality Assurance Reviews, Health Quality Council of Alberta Reviews and applicable Alberta Justice Fatality Inquiries to identify overarching themes
- categorize recommendations stemming from these Reviews to identify opportunities for synergy where there is redundancy.



Results**

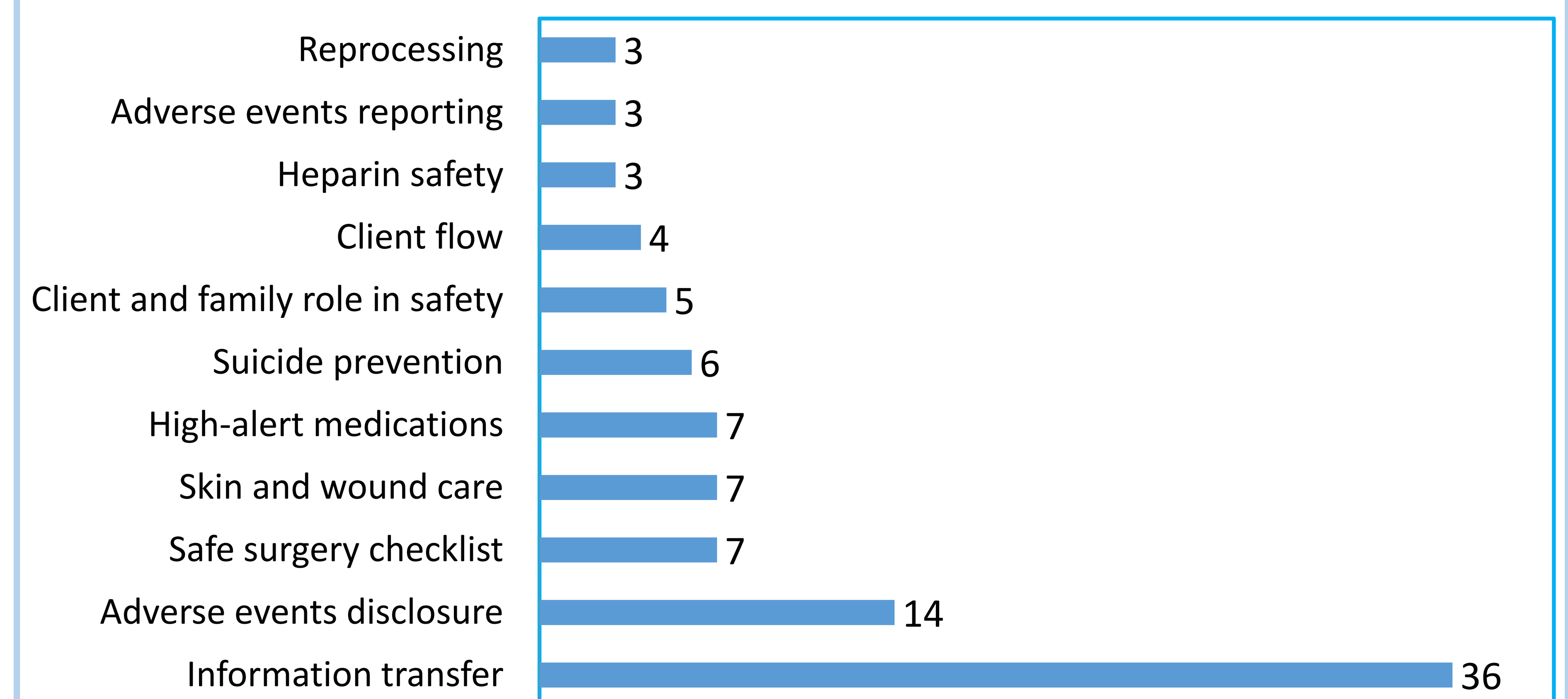
Key Review Themes

- Delayed reaction to patient deterioration
- Communication
- Suicide



Key Recommendations

- improved support/visual queuing to support staff and medical staff to recognize and respond to deteriorating patients
- communication, especially in teams
- need for a more consistent approach to information transfer
- dedicated patient safety and quality supports for addiction & mental health programs



Conclusions

- Important to use an integrated quality framework embedding principles of the Health Quality Council of Alberta, Accreditation Canada, and high reliability organizations
- The Annual Report allows Executive Leaders to set and reinforce organization priorities that will improve the quality of care and safety of the patients

* * This report is an analysis of patient safety issues that Alberta Health Services (AHS) and others chose to focus dedicated resources towards reviewing, but does not constitute a complete picture of the types and volumes of incidents that occur across the organization.

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