TRANSCRIPTION:
Patients for Patient Safety Canada video
0:10:56

[00:00:04] *Logo:* Patients for Patient Safety Canada
[00:00:09] Narration: Events happen that affect patient safety.
[00:00:20] Does this poorly-written prescription mean this or this?
[00:00:24] Hippocrates said, "First do no harm."
[00:00:29] Poorly-written, illegible prescriptions are a leading cause of error.
[00:00:32] Incomplete admission data and charts are another leading cause of error, as are missing patient data and files.
[00:00:41] Doctors Baker and Norton reported knowing what adverse events occur is only the first step.
[00:00:54] Poor communication is another leading cause of error.
[00:00:54] Narration: Doctor, my wrist hurts.
[00:00:58] You say your fist hurts?
[00:00:58] Narration: Adverse events can sometimes be tragic and fatal.
[00:01:06] There is hope and optimism: It is called Patients for Patient Safety Canada.
[00:01:16] **Story 1:** My name is Barb Farlow, and I came to be involved in Patient Safety as a result of the death of my daughter, Annie, at the age of 80 days.
[00:01:25] Annie suffered and died in a tragic manner due to the absence of patient-centered care.
[00:01:32] My daughter was born with a rare genetic condition related to disabilities.
[00:01:36] Before her birth, we spent a lot of time researching her medical condition and predicted limitations.
[00:01:41] Despite the challenges, we witnessed an immense quality and value to the experience of loving a child whose small accomplishments would be major victories and whose smiles would melt our hearts.
[00:01:52] Sadly, Annie died within 24 hours of arrival at the hospital.
[00:01:57] The coroner described the medical care provided as being inappropriate and the hospital issued a written apology.
[00:02:04] It has become very clear to us that the medical system imposed a value judgment on our daughter's life and consequently with health treatment.
[00:02:12] Thanks to the direction and encouragement of many wonderful patients and health care leader, I tell my daughter's story at health care conferences, medical schools, and workshops.
[00:02:24] I'm deeply grateful to the nurses, doctors, technicians, ethicists, and administrators who recognize the importance of patient-centered care and who have made a pledge to collaborate with patients to improve health care.
[00:02:40] **Story 2:** In January of 2003, our son Dan was an active, bright 17-year-old.
[00:02:47] He just seemed to have a very bad case of flu.
[00:02:49] After a second ER visit a few days apart, Dan was admitted to hospital.
[00:02:55] Just a few hours later, we held him for the last breaths and learned that he had myocarditis.
[00:03:00] Dan did not survive.
[00:03:02] We sought answers relentlessly for four years.

[00:03:04] Reviews of Dan's care by the Ontario Provincial Coroner's Office and professional colleges found that Dan received inappropriate care with evidenced practice deficiencies.
[00:03:16] Dan's abnormal blood tests had been ignored or misinterpreted.
[00:03:22] Questions and warnings for nurses were ignored by medical staff.
[00:03:24] Hospital guidelines for fluid resuscitation, admission, and administration of sedation had not been followed.
[00:03:33] Important information was not passed between health professionals.
[00:03:38] Finally, in February of 2007, we had a meaningful disclosure conversation with hospital administrators
[00:03:43] Our healing started when the CEO of the hospital clearly apologized and outlined the changes that were being made to avoid a similar tragedy.
[00:03:52] Safe health care is possible.
[00:03:55] Family-centered care, leadership, respectful teamwork, and a commitment to learn and change will make safe health care a reality.
[00:04:04] Story 3: Martha was my big sister.
[00:04:06] She was always there guiding me, supporting me.
[00:04:09] She led and I followed.
[00:04:14] She taught me to value life, and she always protected me from danger.
[00:04:15] That's why I miss her so much.
[00:04:18] After high school, my sister became a nursing student.
[00:04:20] She was passionate about helping people in need.
[00:04:23] But before she could graduate, Martha took a prescription medication which caused an unforeseen reaction.
[00:04:30] She just went to bed one night and sometime before morning, her heart stopped.
[00:04:32] My sister died when she was 22 years old.
[00:04:35] I recognized that no one would ever have intended to cause harm, but her life was cut short just the same.
[00:04:44] My sister's death was a terrible personal tragedy, but what made it even harder to deal with was not understanding what caused her death.
[00:04:51] Any time a patient is harmed because of medical treatment, they deserve to be informed.
[00:04:55] In any instance where a patient is harmed, the reaction needs to be reported.
[00:05:00] Nothing can ever bring Martha back, but trying to hide what happened is not the answer.
[00:05:03] My sister Martha taught me that above all else, to care for and protect others.
[00:05:10] And that's exactly what I'm trying to do.
[00:05:15] Story 4: The experience of Donna Davis.
[00:05:18] In 2002, we lost our 19-year-old son, Vance.
[00:05:21] He died a preventable death while receiving medical care following a motor vehicle crash.
[00:05:26] I was concerned about his deteriorating condition.
[00:05:29] His vital signs alarmed me.
[00:05:33] I told the staff of my concerns many times.
[00:05:34] The staff did not hear my concerns and my fears.
[00:05:40] I was powerless as I watched my son die before my eyes.
[00:05:43] I'm a health care provider and this was not supposed to happen to me.
[00:05:47] The patient and family are the most readily-accessible resource health providers have.

[00:05:51] It could be the difference between life and death to listen, really listen, to what they have to say.
[00:06:00] Listening could have made a difference for Vance.
[00:06:02] When harm does happen, do not shut the patient and family out.
[00:06:07] Families need open, honest dialogue in terms we can understand.
[00:06:09] Acknowledgment of the harm and acceptance of accountability sets the tone for the relationship between the organization and the patient and family.
[00:06:20] Know the words to use when an apology is given.
[00:06:22] Saying, "I'm sorry for your loss," is not the same as saying, "We made mistakes that contributed to your son's death, and for that, we are sorry."
[00:06:37] We now have faith that the culture of patient safety is evolving.
[00:06:38] The fact that the patient voice is being heard tells us of the culture change taking place.
[00:06:45] Our voice was heard.
[00:06:49] After hearing Vance's story, a commitment was made to make improvements in the health region where Vance died.
[00:06:53] Three dedicated people who heard Vance's story developed a patient tracking system with a built-in safety alert, referred to as Vance's stop sign.
[00:07:03] A patient is no longer discharged or transferred until the concern that prompted the stop sign is dealt with.
[00:07:09] This is a one-of-a-kind system in Canada, a true testament that the patient voice is influencing systemic change to make care safer.
[00:07:19] This is our son's legacy.
[00:07:25] Narration: In May 2006, the WHO World Alliance for Patient Safety, Patients for Patient Safety Program held a workshop in San Francisco for concerned patients and professionals.
[00:07:42] As part of the World Alliance for Patient Safety, several Canadians met with others from North, Central, and South America and became Patients for Patient Safety Champions.
[00:07:57] Purpose of meeting: to orient workshop participants to the vision and mission of the World Alliance Patients for Patient Safety Initiative and expand the network of consumer champions in the Americas who are actively engaged in contributing their experience and knowledge.
[00:08:13] The goals of that day were: to examine and articulate the values consumers bring to patient safety work; determine the roles of this group of champions; develop strategies for establishing partnerships, spaces, and locales throughout the Americas; to produce one or more momentum-furthering products, including a statement of values to guide their work; prioritize areas of engagement, work streams, where consumers in North and South America can make meaningful contributions to patient safety work.
[00:08:51] Another workshop was held in Vancouver, British Columbia.
[00:08:54] The meeting was a coming-together of people concerned with the safety of health care in Canada and to explore the role health care consumers – patient – could plan on achieving change through the partnership and collaboration.
[00:09:11] November 2007, Winnipeg, Manitoba: Yet another workshop created more champions and continued to grow.
[00:09:20] A charter was created to govern, guide, and build a network of people with common goals.
[00:09:28] A vision was created: "every patient safe."
[00:09:35] A mission was created: "We champion the patient voice to advance safe health care."

[00:09:41] Together we can make a difference.
[00:09:49] In Edmonton, 2008, PFPSC created its first board of directors.
[00:09:55] So Liam Donaldson, chair of World Alliance for Patient Safety said, “To err is human; to cover up is unforgivable; and to fail to learn is inexcusable.”
[00:10:11] Patients for Patient Safety Canada wants to partner with you.
[00:10:14] Now accepting applications for membership from patients and professionals.
[00:10:20] For more information, contact us at www.patientsforpatientsafety.ca.
[00:10:32] Finally, Confucius said, “Tell me and I will forget. Show me, and I may remember. Involve me, and I will understand.”
[00:10:51] Remember, we are all patients, as are our loved ones. *Logo:* PFPSC.

END OF TRANSCRIPT